BOARD OF DIRECTORS MEETING

IN-CAMERA SESSION

Thursday, November 27, 2025

5:30 pm – La Verendrye General Hospital / Webex

A G E N D A

Item	Description	Page
1.	Call to Order 1.1 Conflict of Interest & Confidentiality	
2.	Consent Agenda 2.1 In Camera Board Minutes – September 25, 2025 * Pg 3 2.2 Board Chair & Senior Leadership In-Camera Report – D. Clifford, H. Gauthier, D. Harris, C. Larson, J. Ogden, Dr. L. Keffer * Pg 8 2.3 Governance Committee In-Camera Report – B. Norton * Pg 11 2.4 Audit & Resources Committee In-Camera Report – B. Norton * Pg 21 2.5 Quality Safety Risk Committee In-Camera Report – M. Kitzul * Pg 29	
3.	Approval of Agenda	
4.	Presentation – Health Care and Transparency – BLG – Katharine Byrick * Pg 88	
5.	Business Arising There was no business arising.	
6.	Strategic Discussion: Hospital Stabilization Planning (Ethical Decision-Making Framework – standing attachment *) Pg 126	
7.	New Business 7.1 Chief of Staff Report –Medical Staff Privileges - Dr. L. Keffer * Pg 128 7.2 Audit & Resources Committee – Verbal Update	
8.	Other Business 8.1 For the Good of the Board 8.2 In-Camera with CEO 8.3 In-Camera without CEO	
9.	Date of Next Meeting: January 29, 2026	
10.	Termination	

* denotes attached in board package

**denotes circulated under separate cover

*** denotes previously distributed

BOARD OF DIRECTORS MEETING
ANTICIPATED MOTIONS – IN CAMERA SESSION

Thursday, November 27, 2025

3.	Motion to Approve the In Camera Agenda	THAT the RHC Board of Directors approve the Agenda as circulated/amended
7.1	Chief of Staff Report – Medical Staff Privileges	THAT the RHC Board of Directors approves the privileges for the listed physicians for the 2025 term as reviewed and recommended by the Medical Advisory Committee. AND THAT the RHC Board of Directors approves Medical Learner privileges for the listed learners, as reviewed and recommended by the Medical Advisory Committee.
10.	Termination	THAT the RHC Board of Directors In Camera meeting terminate and return to the Open Session at (time)

RIVERSIDE HEALTH CARE FACILITIES INC.
MINUTES
IN-CAMERA SESSION

Date of Meeting: October 30, 2025 **Time of Meeting**: 5:44 pm

Location of Meeting: Webex / LVGH Board Room

PRESENT:	H. Gauthier	M. Kitzul	Dr. L. Keffer	D. Clifford
	K. Lampi	E. Bodnar	D. Pierroz	D. Loney
	M. Jolicoeur	B. Norton	*via Webex	

STAFF: B. Booth, D. Harris, J. Ogden, C. Larson

REGRETS: A. Beazley, Dr. K. Arnesen

GUESTS: J. Park (Item 4.0)

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1. CALL TO ORDER:

D. Clifford called the meeting to order at 5:44 pm. B. Booth recorded the minutes of this meeting.

1.1 Conflict of Interest & Confidentiality

The Chair asked if there was any conflict of interest or duty with items on the agenda and reminded members of the confidentiality of the in-camera session. There were no conflicts declared.

2. CONSENT AGENDA:

The Chair asked if there were any items to be removed from the consent agenda to be discussed individually. There were no items removed. D. Clifford acknowledged the Senior Team expressing appreciation for the consolidated executive report.

3. APPROVAL OF AGENDA:

It was,

MOVED BY: M. Jolicoeur SECONDED BY: E. Bodnar

THAT the Board approve the Agenda as circulated.
CARRIED.

4. PRESENTATION – Rainy River District Ontario Health Team (RRDOHT) – Jackie Park

D. Clifford welcomed Jackie Park, Executive Lead for the RRDOHT, to the meeting, who provided a presentation on the RRDOHT. The following was highlighted:

- OHT Development
- OHT Progress
- Vision, Mission & Values. The 7 Teachings plus forgiveness was highlighted.
- Building a Framework for Collaboration
- Our Brand Story
- Our Journey
- Our Partners
- Our Service Area
- Unique Rainy River District Factors

- Ontario Health Connection – OH, provides funding for the OHT
- About Ontario Health
- Ontario Health Teams by Region
- Northwest Region Ontario Health Teams
- Northwest statistics were discussed
- The Northwest Crisis
- OHT Structure
- Leadership Council Overview
- Leadership Council Representatives
- Management Team
- Indigenous Engagement
- Indigenous Advisory Council – Mature State Engagement Plan
- Regional Specialized Services Network (RSSN) – Connection
- Discussion took place regarding funding for the 4 OHT's. Jackie confirmed all funding is the same.
- Further discussion took place regarding whether the OHT reports to OH and whether the OHT can make decisions outside of OH approval. Jackie confirmed this was the case and noted they have done this based on priorities. She further noted the OHT still needs to meet the OH mandates. Henry reported when it's an OH mandate, this will dictate. Outside of this, the OHT's can make decisions independently. Jackie recalled OH still funds the OHT.
- Joanne discussed reporting requirements.
- Conversation ensued around limited funding received. There is not a lot of money for the priorities needed.
- Jackie shared that the OHT will be at the Fort Frances High School for the Health & Wellness Showcase and encouraged all to attend.
- Joanne provided Jackie with the Shine the Light poster.

D. Clifford thanked Jackie for her presentation. Jackie exited the meeting.

5. BUSINESS ARISING:

There was no business arising.

6. STRATEGIC DISCUSSION:

There was no topic of discussion this month. D. Clifford asked the Board if anyone had any comments regarding the OHT presentation. The following was discussed:

- Henry reported on Monday, the CEO's need to present the notional plans for balancing the budget to OH and the Ministry. Henry shared he would be opening the presentation confirming it is notional and the Board has not approved it.
- Henry shared he attended a meeting where a physician from Greater Napanee presented a CHC hospital model and this was commended. There are things happening at the MOH and serious consequences to what is happening. The Northwest is "pocket change" to the rest of the province. Issues and deficits are large everywhere.
- In regard to the OHT, OH drives them and wants them to lead primary care and not the hospital. There are a lot of moving pieces and people are not feeling stable. The goal is to attach every resident to a physician; however, we need more physicians and NPs, and they aren't identifying ways to fill these gaps.
- Henry noted all CEOs are seeing the chaos and the games the Ministry is playing. He reiterated his plan to open his presentation on Monday with the term "notional" and then will follow up with an email to OH as well, so the same messaging is being received.
- Henry shared some hospitals have tried to increase their lines of credit however were denied.
- Discussion took place around whether the Board could do anything. Henry noted this is above local and we will see what happens after Monday's presentation.
- Hospitals are large providers, however, OH is dictating a lot of things. OH, has stated the Family

Health Team is working with OH regarding primary care for the west end of the district. The physician model will remain the same. Henry recalled our previously discussed enhancements to primary care (ie. CHC model), noting this has been shut down by OH. Henry noted we have many initiatives on the go therefore they can run primary care, and we will focus on our initiatives.

- Henry shared the OHT has problems culturally in the way they function. This is not what we promote. It is very dysfunctional and unprofessional. Changes need to occur at the OHT on how to work better together however we have been discussing this for some time and there has been no change.
- Discussion took place regarding politics being at the forefront instead of the patient/resident.
- Henry noted we always experienced back door games however, there is now a new partner which is the OHT.
- Henry reported once someone wants to absorb the Rainy River Clinic, we will assist with the transition however we can not get a clear plan from OH on how they are moving forward.
- Henry discussed “One Hits” and the lack of defined scope of the Meditech Expanse project. They are driving changes without vetting properly. There is very poor planning being seen at the regional and provincial level as well as the OH level. We are pushing back as our management is frustrated. This is an example on where we will be focussing our energies.
- Henry confirmed we will be cognizant on government intentions.
- Henry referenced our Code of Conduct noting there are things happening at the OHT table that are not appropriate, and we will be pushing back and asking how this is being dealt with. Behaviours are very unprofessional. Efforts will be focused on this as well.
- Discussion took place regarding OHT decisions and how these are made. Joanne explained the process noting unanimous decisions are required. Decisions are made by consensus. She shared decisions are being made by people who don’t know “wheelhouses”.
- Henry recalled RHC will be focussing energy on the following:
  - OHT Behaviours
  - Ministry/OH notional changes, and put this in writing
  - Get on with business of stabilizing HHR

Diane thanked Henry for the update.

7. NEW BUSINESS

7.1 Chief of Staff Report – Medical Staff Privileges

Dr. Keffer shared Dr. Westgard, a US physician came to work with us. Todd Hamilton worked with him to obtain a work permit. This was a process we have never done before. Henry shared we received good feedback on Dr. Westgard.

Dr. Keffer reported Practice Ready Ontario (PRO) physicians are still coming through and working with us for their 12-week rotations. We also continue to accept and work with our NOSM medical learners.

7.1.1 Privileges – Medical Staff

2025 Appointment and Reappointment Applications for Privileges

It was,

MOVED BY: D. Pierroz SECONDED BY: M. Jolicoeur

THAT the RHC Board of Directors approves the privileges for the listed physicians for the 2025 term as reviewed and recommended by the Medical Advisory Committee.

CARRIED.

Medical Learners

It was,

MOVED BY: D. Pierroz SECONDED BY: D. Loney

THAT the Board of Directors approves medical learner privileges for the listed attached for the 2025 term, as reviewed and recommended by the MAC.

CARRIED.

7.2 Audit & Resources Verbal Update

B. Norton shared Henry covered the majority in his update, however highlighting the following:

- The deficit is large, and the cash advance is bad.
- Discussion took place regarding the Fund Type 2 – Community Support Services shortfall. Carla shared Bill 124, a budgeting error, admin costs are over, and unfunded wage increases for community services all contribute. Roughly 40% of the shortfall is covered however, we are looking at the rest of it.

8. OTHER BUSINESS

8.1 For the Good of the Board

H. Gauthier shared he has received a lot of positive feedback from those who have attended the Indigenous Training by Robert Horton, Seven Generations, coordinated by Christie Brown, Indigenous Liaison. He noted the training is a full day and there is a total of 5 sessions being offered to our staff. Henry noted those who have attended have stated it was impactful and informative. Brooke attended the session and shared the session was educational and Robert is a great speaker and used interactive exercises to connect with those in attendance. Some of the items Robert spoke of were around the history timeline, Treaty and the importance of the language. Brooke noted it was very interesting and insightful however, there was a lot of information to absorb and suggested a possible handout/take away for people to reference after the session would be helpful.

D. Clifford asked if Board members could possibly attend the session as well. Henry agreed this session would be great for Board members to attend. He noted the current scheduled sessions are specifically for staff however, we could look at opening the next set of sessions to Board members in 2026.

ACTION: Diane will send Henry an email reminder to add Board members to the attendee list for upcoming sessions in 2026.

8.2 In-Camera with CEO

The Board met with the CEO.

8.3 In-Camera without the CEO

The Board met without the CEO.

9. DATE OF NEXT MEETING:

November 27, 2025

10. TERMINATION OF THE IN-CAMERA SESSION:

It was,

MOVED BY: B. Norton

THAT this meeting terminates and return to the Open Session at 8:06 pm.
CARRIED.

_____ _____

Chair Secretary/Treasurer

Riverside Health Care

Board Chair, Chief of Staff & Senior Leadership Report – November 2025
In Camera Session

Strategic Pillars & Directions

Investing in Those Who Serve - Strategically Leveraging our Human Resources

- **Work Life Pulse (WLP)**
  - Physician WLP is open - several responses received.
  - Staff WLP survey will go out on surge in January.
- **Emo & Rainy River Health Centre Management**
  - Andrea Meghie will assume the role of Administrator at both the Emo and RR Health Centres. Andrea's start date originally scheduled for November 24, 2025, has been pushed back a few weeks to enable our team to confirm lodging and transportation.
  - Andrea has been contracted for a 1-year contract term to focus on change management within Emo and RR.
  - Andrea recently worked as Manager of Transition Programs at Toronto Grace Hospital. She has considerable experience, including 20+ years of nursing at Baycrest Hospital in Toronto.
  - Andrea has the experience and skills that will enable her to strengthen the teams at both facilities and enable her to work closely with the leadership across RHC in pursuit of standardized hospital care delivery and building an exceptional health care program west of Fort Frances.
- **Diagnostic Imaging & Lab**
  - Health Canada approved the Siemens MRI Magnetom Flow with the 70cm bore. Our contract qualifies us to receive this newest technology.
  - Two staff members from RHC have been accepted to the Michener Institute MRI program. This is a 15-week online course and a 15-week placement to commence in Thunder Bay. ROS agreements are being established for both. We already have one graduate of this program on staff.
  - Our Kenora/Rainy River Regional Lab Program Fall Symposium in Kenora was a success. It will take place in Fort Frances in 2026 allowing for more local staff to attend. Topics and speakers for the 2026 conference are being determined.

One Riverside - Promoting a Consistent and Empowering Culture

- **Complaints**
  - Patients
    - 8 written complaints received by patients/families/visitors from Sept 16 - Nov 11, 2025.
    - 3 complaints were related to physician care/treatment and/or behaviour.
    - 2 complaints were related to RHC staff members.
    - 2 complaint was related to RHC Facilities.
    - 1 written compliment received about great care by NP.
  - Staff
    - 1 related to lack of care by not answering patient call bell.
    - 2 related to RN behaviour.
    - 1 regarding environment of smoking by an entrance.
- **Behaviour Incidents**

Site	# of events	Type	Harm
LVGH	8	7 patient to staff, 3 physical violence, 4 threat of physical violence, 1 intoxicated individual yelling and pulled out a hatchet. OPP responded, added to restricted access list.	8- No harm
RRHC	4	4 patient to staff, 2 physical violence, 2 threat of physical violence, 1 included aggression to property	4- no harm
EHC	1	1 patient to staff, 1 verbal comments	1-No harm
RC	6	2 patient to staff, 2 physical violence, 2 threat of physical violence. 2 patient to patient, 2 physician violence. 1 wandering, 1 behavioural (using lighter in room).	6-No harm

- **Legal Update Summary**
  - Legal Claim - Loss of hearing in newborn with physician and RHC at fault – discovery in early November. Debrief with legal counsel next step on November 19, 2025.
  - Legal Claim – Emo Clinic client injury due to slippery conditions. Dates for discovery planned for April 2026.
  - Criminal Proceeding – 1 staff and 1 agency PSW charged for abuse of Rainycrest resident(s) and have appeared in court twice, both times were remanded.
  - Legal Claim – Mid-20s Female Patient deceased and statement of claim received on July 4, 2025, naming both staff and physicians.

- Human Rights Tribunal – complaint to HRTO being reviewed as individual received No Trespass letter.
- Criminal Proceeding – Emo Health Centre resident charged by OPP related to sexual behaviour towards staff member. This resident passed away on October 9, 2025.
- Potential legal claim – terminated employee indicates they will claim wrongful dismissal.

- **Communications**
  Continuing to identify priority stories for inclusion as full-page, in-depth feature stories with the Fort Frances Times. These stories will focus on milestone achievements, capital enhancements, service expansion/improvement, good news stories, and public interest. The next story for the FF Times will be related to our generator expansion at LVGH – outlining what this means for care and safety of patients during extensive power outages.

Tomorrow's Riverside Today - Investing Today to Support Tomorrow

- **Supply Chain**
  A meeting was held on November 14, 2025, with the former head of the Northern Supply Chain who is now operating his own supply chain group to discuss opportunities to supplement our supply chain efforts. In addition to providing supplemental access to RFP process management beyond Mohawk MedBuy, we will also be utilizing this new service to provide education to our existing supply chain team. The education focus relates to procurement legislation, standards, and achievement of necessary policy development.
- **Project Update**
  - A bi-weekly meeting is scheduled including Project Managers for the MRI, Digital Radiography, Keffer Physician Clinic, and NAPRA Compliant Pharmacy. Engineering, finance, and the CEO also attend these touch point meetings.
  - RHC has notified the LTC branch that it is returning the license for 4 LTC beds at Rainycrest that are currently in abeyance. There is no future plan to reopen these beds. This step has been taken as a segment of Rainycrest will be renovated to accommodate our CSS/AL and transportation staff as well as provide offices for Home and Community Care. These individuals will be relocated from the 3rd floor at LVGH to allow for redevelopment of the pharmacy and clinic to proceed.
  - The next MRI meeting with the MoH is scheduled for early December.
  - Signage required by the Ministry as part of the MRI project to announce the funding investment by the MoH will be two-fold – one sign with English and French and the other with two distinct Ojibway dialects.
- **Nurse Call System**
  The nurse call system at Rainycrest has reached the point of 'imminent failure'. As a result, we have approved this significant purchase on an emergency basis. The cost of this system is estimated at $800k. An emergency funding request has been submitted by the CFO to both OH and the MLTC. Maintenance of this system is essential to ensuring resident safety and proper care.
- **Pharmacy**
  - A return of service (ROS) agreement has been utilized to support education of a pharmacy assistant to progress to pharmacist certification (was a pharmacist in India). At present, we are utilizing remote services in Thunder Bay and Winnipeg to meet our pharmacist needs.
  - The Hazardous Drug List unique to Riverside is complete. The policy and procedure redevelopment requires that housekeeping, stores, laundry, nursing, chemo and pharmacy are all aligned within the protocol, requiring considerable effort.
  - Risk Mitigation
    - Daily medication over-ride reports are brought to unit managers attention who obtain clarity through direct nurse engagement. Concern with lack of timely engagement. Unresolved over-rides are brought to the Pharmacy Manager's attention for further assistance that may include video surveillance, records review, etc. Follow up with Managers required.
    - Medication cameras are now in place in all MedDispense locations.
    - LVGH Med-Rooms not fobbed. Identified as high priority. Emo and Rainy River acute Med-Room FOBs complete. Rainy River Emergency room MedDispense has no camera as it is in the treatment area.
- **Foundation Audit**
  As per or Financial Compliance Lead - "Grant Thornton is finalizing the Foundation's bookkeeping and has been in contact with Foundation representatives regarding missing information for March. The Riverside team has reconnected with Grant Thornton, and we believe they now have the full list of Riverside records needed to complete their portion of the work. Once the outstanding Foundation records are received, the auditors (MNP) will follow up to schedule the onsite visit."
- **UKG Pro Suite Payroll & HR Implementation**

RHC continues to streamline its scheduling process. The scheduling team is fully established with ongoing training and process development as a key focus area. These changes will inevitably improve operational efficiency, reduce errors, and create a more manageable work environment.
The UKG Pro payroll system continues to evolve through implementation, including running payroll on both the existing and new system to evaluate accuracy. At present, there is an issue with the payment service being only located in the USA. While we plan our due diligence this issue does create a risk to a January 1 go-live.

Striving To Excel in Equity, Diversity & Inclusion (EDI)

- **Clinical Audits**
  - Patient family meetings attended for 2 patients – plans to address service gaps.
  - Venous Thromboembolism (VTE) chart audits completed for both LVGH and RRHC- data review in process.
  - ER Wait time follow-up chart audits for both LVGH and RRHC- data review in process.

Thank you to the Riverside Team for their submissions, they are invaluable in the preparation of this report.

Respectfully Submitted,
Diane Clifford, Board Chair
Dr. Lucas Keffer, Chief of Staff
Diana Harris, Chief Nursing Executive
Carla Larson, Chief Financial, Information & Technology Officer
Joanne Ogden, Quality Assurance & OHT Executive Lead
Henry Gauthier, President & CEO
RHC Directors, Managers & Supervisors

Riverside Health Care

In Camera Governance Committee Report – November 2025

2.3.1 Minutes: Governance Committee
November 12, 2025 – not yet reviewed by the Committee *

2.3.2 President & CEO Evaluation Results *

2.3.3 New Board Member Orientation Results *

RIVERSIDE HEALTH CARE FACILITIES INC.
BOARD GOVERNANCE COMMITTEE
MINUTES

Date of Meeting: November 12, 2025 **Time of Meeting:** 4:00 pm

Location of meeting: LVGH – Board Room / Webex

PRESENT:

D. Clifford	H. Gauthier	E. Bodnar
K. Lampi*	B. Norton *	D. Pierroz
Dr. L. Keffer *	*via Webex	

1. CALL TO ORDER:

E. Bodnar called the meeting to order at 4:05 pm. B. Booth recorded the minutes of the meeting.

1.1 Confidentiality Reminder:

E. Bodnar reminded members of the confidentiality of the session.

2. ADOPTION OF AGENDA:

It was,

MOVED BY: D. Pierroz SECONDED BY: D. Clifford

THAT the agenda be approved as circulated.
CARRIED.

3. MINUTES OF THE LAST MEETING: October 14, 2025

It was,

MOVED BY: K. Lampi SECONDED BY: D. Clifford

THAT the minutes of the October 14, 2025, meeting be approved as circulated.
CARRIED.

4. MATTERS ARISING FROM THE MINUTES:

4.1 President & CEO Evaluation Results

D. Clifford reviewed the circulated noting her, Ben and Edith met and reviewed the results. 10/13 responses were returned. Diane shared in hindsight; the three new board members shouldn't have been required to complete the survey due to the short timeframe that they have worked with Henry. She shared there were no concerns with the comments received. Henry also completed a self-evaluation. Diane shared her and Edith met with Henry to discuss the results in detail and again no concerns were raised. The report will be filed in Henry's personnel file.

D. Pierroz expressed concern regarding the comment made about the survey, including the three new board members who may have had difficulty completing it and the fact that three people didn't complete the survey. He noted this could be perceived as the three new board members were the ones who didn't complete, and this would go against the survey being anonymous. D. Pierroz asked that this comment be removed. Discussion took place. Henry noted he feels the comment needs to remain on the document that goes into his personnel file, however, could be removed from the high-level report that goes to the Board. It was also

noted that this CEO evaluation was for the 2024-25 term and therefore the new board members technically shouldn't have been requested to complete as they were appointed for the 2025-26 term. Further discussion took place regarding the number of surveys circulated compared to previous years. Diane explained the difference between a 360 review versus internal process, noting the Board tries to do a 360 review every second year which would include external partner engagement. All agreed that the comment regarding the three new board members be removed from the report that goes to the Board.

ACTION: Diane will revise the report for the Board. Brooke will include this in the Board package.

4.2 Alternate Solutions for Accessing Timely Legal Services – Follow Up

Henry provided an update sharing legal did end up responding therefore we have not pursued other options further. He noted he is still waiting on a follow up regarding Melanie Murray correspondence, confirming the response to Mrs. Murray is still pending. Diane shared she did follow up with legal noting she recognized they were busy and then received a response right away back from legal apologizing for the delay. Henry confirmed he will be following up regarding the Melanie Murray response again. Diane shared the response to Mrs. Murray will flow through HR and not the Board.

Henry shared a meeting will be held with the Ethics Committee to discuss the OHT conduct/behavior's and how to move forward with this and what the right steps are. He discussed the ad-hoc participants that will be included in this discussion.

5. NEW BUSINESS:

5.1 New Board Member Orientation Evaluation Results

Edith reviewed the circulated for information. It was noted there were some typo errors in the comments received (ie. "disgusted" assumed it should state "discussed"). The comments were positive, and the orientation was informative for new board members.

5.2 Governance Policy Review – Board Composition Policy Development

Henry recalled when we moved to the ONCA standards, we built into our bylaws an option to grow the Board. We have always had 9 voting board members however, the bylaws now state 6 – 16 directors therefore we need to develop a policy to note we remain at 9 board members. Henry confirmed the new policy will reference the bylaws.

ACTION: Henry and Brooke to meet in early December to develop the policy. This will then be shared and reviewed with 2 members of the Board Policy/Workplan Working Group for input and then will come back to the Governance Committee for review and recommendation for approval.

5.3 In Camera with CEO

All agreed this item wasn't necessary this meeting.

6. OTHER BUSINESS:

6.1 SUMMARY OF ACTIONS / COMMUNICATION REQUIREMENTS

- President & CEO Evaluation Results - Diane will revise the report for the Board. Brooke will include this in the Board package.
- Board Composition Policy Development - Henry and Brooke to meet in early December to develop the policy. This will then be shared and reviewed with 2 members of the Board Policy/Workplan Working Group for input and then will come back to the Governance Committee for review and

recommendation for approval.

6.2 Meeting Summary: November Board Meeting Agenda Items

Discussion took place around what items are to appear on the Open and In-Camera agendas for the November Board meeting. It was decided by consensus that the items appear as follows:

Open Session – Consent Agenda:
There were no items for the open consent agenda.

Open Session – Separate Agenda Item:
There were no separate items for the Open session.

In-Camera - Consent Agenda:

- Draft Meeting Minutes
- 4.1 President & CEO Evaluation Results
- 5.1 New Board Member Orientation Evaluation Results

In-Camera – Separate Item:
There were no separate items for the In Camera session.

7. DATE AND TIME OF NEXT MEETING:

January 13, 2026

8. TERMINATION:

The meeting terminated at 4:43 pm.

_____ _____

Chair Recording Secretary

President and CEO Performance Review 2025 Report

The Performance Review survey was circulated in September using Survey Monkey with responses being anonymous. The survey was circulated to all board members as well as the Chief of Staff and Senior Leadership. Thirteen surveys were circulated with ten responses received.

The survey questions covered the following areas:

- Values and Ethics
- Transparency and fairness
- Personal Effectiveness
- Respect for diversity
- People Management
- Resource Management
- Results Focus
- Decision Making
- Vision
- Strategic Thinking
- Goal Setting
- Communication
- Staff Engagement
- Relationship Management
- Organizational Compliance
- Managing Organizational Risk
- Advancing the Strategic Plan\
- Relationship Management
- Initiative
- Supporting Good Governance

Ben Norton, Vice Chair, Edith Bodnar, Second Vice-Chair and Diane Clifford, Chair reviewed the results and subsequently Edith and Diane met with Henry on November 6, 2025, to discuss the results of the survey.

Overall, results of the survey show that Henry consistently met all expectations with only a couple of areas that noted he met the expectations sometimes. There were no concerns in these areas. We discussed the comments compiled from the questions - the CEO's major strengths, areas of growth, most significant achievements and something that could have been done better, and general comments.

Henry had completed a self-evaluation and the results of the survey, and his self-evaluation were aligned. Henry is very self-aware – knows his strengths as well as his areas for growth. There are no concerns or follow-up needed at this time. The notes and survey results have been filed in Henry’s personnel file.

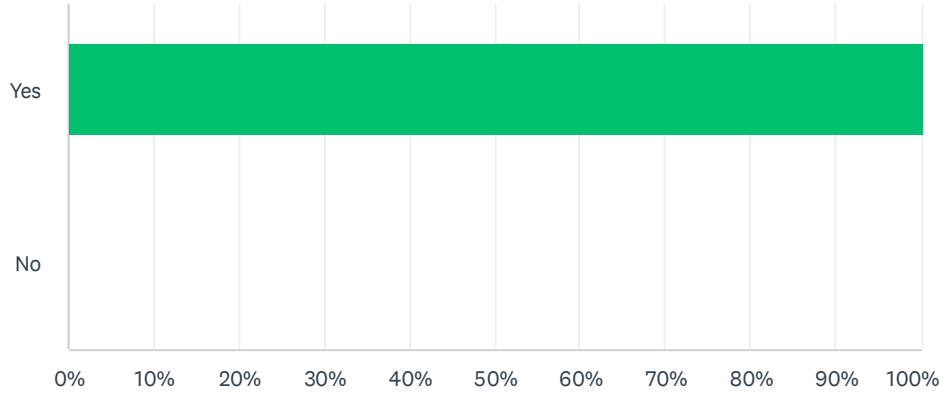
Respectfully submitted,

Diane Clifford	Ben Norton	Edith Bodnar
Board Chair	Vice-Chair	Second Vice-Chair

November 2025

Q1 Were relevant materials provided?

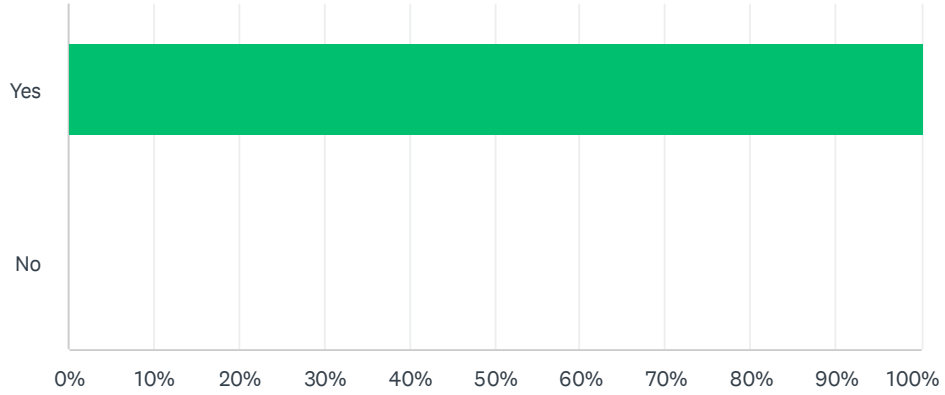
Answered: 3 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	100.00%	3
No	0.00%	0
TOTAL		3

Q2 Were the materials sufficient to assist you in your on-boarding activity on the board?

Answered: 3 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	100.00%	3
No	0.00%	0
TOTAL		3

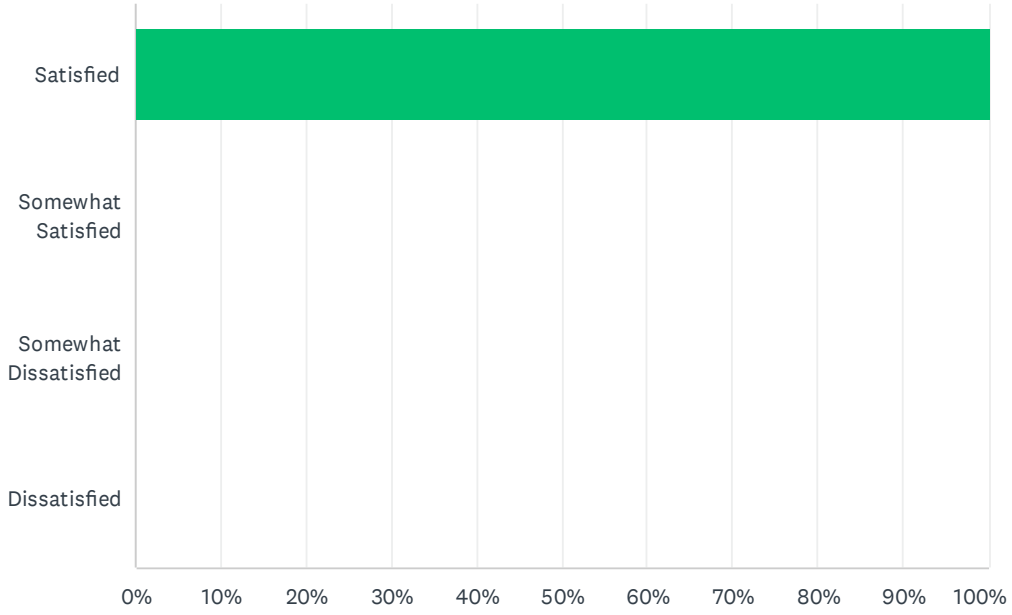
Q3 Comments on the materials provided:

Answered: 3 Skipped: 0

#	RESPONSES	DATE
1	Excellent	10/10/2025 7:29 PM
2	Helped to better understand provision, and intergration of the various disciplines within the District	10/10/2025 6:40 PM
3	Details regarding the organization and depsrments	10/10/2025 4:18 PM

Q4 Were you satisfied with your opportunity to participate in the orientation?

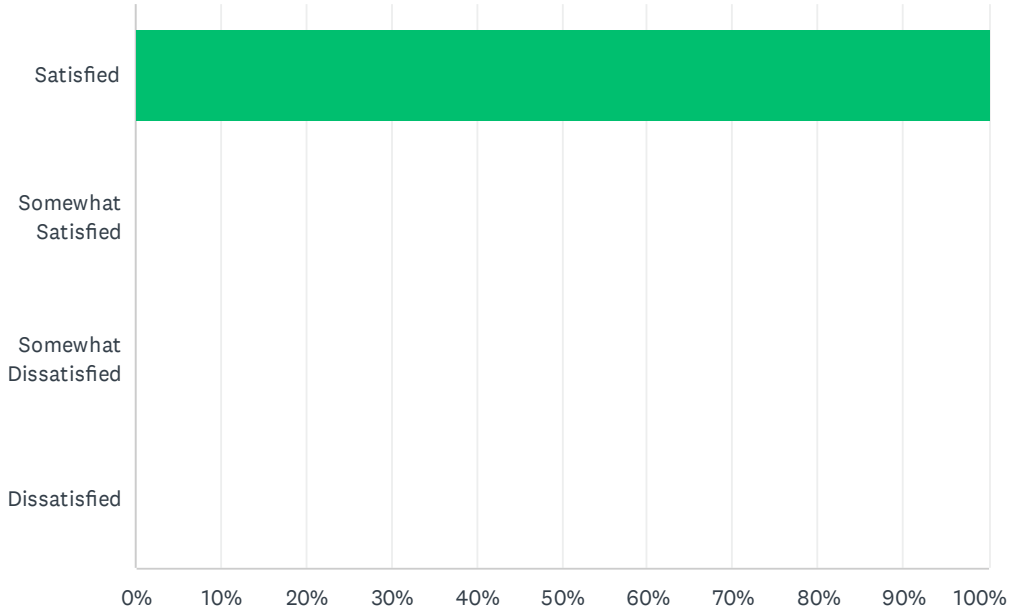
Answered: 3 Skipped: 0



ANSWER CHOICES	RESPONSES	
Satisfied	100.00%	3
Somewhat Satisfied	0.00%	0
Somewhat Dissatisfied	0.00%	0
Dissatisfied	0.00%	0
TOTAL		3

Q5 Were you satisfied with other new board members contribution to the orientation?

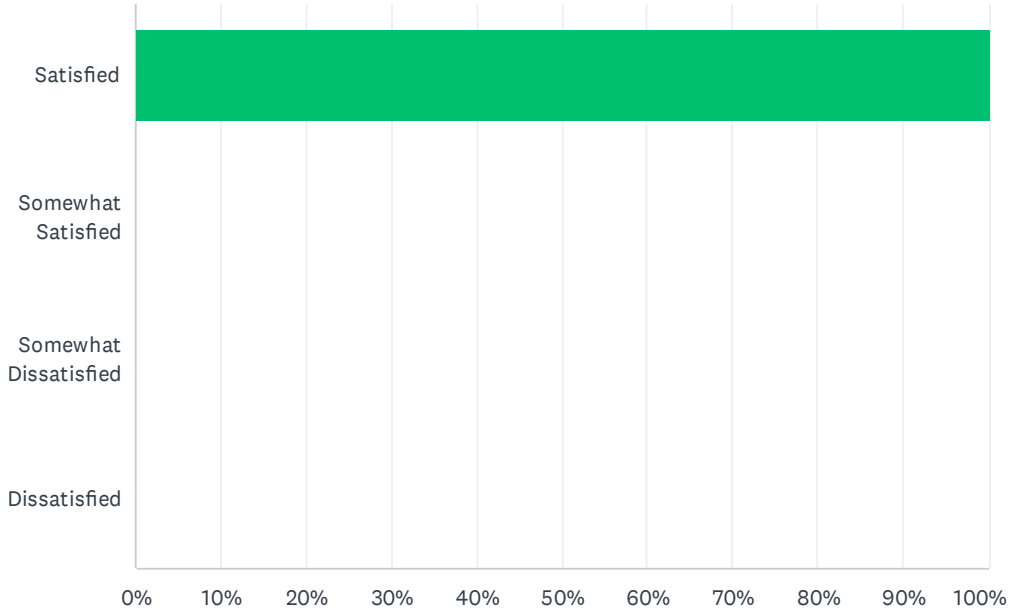
Answered: 3 Skipped: 0



ANSWER CHOICES	RESPONSES	
Satisfied	100.00%	3
Somewhat Satisfied	0.00%	0
Somewhat Dissatisfied	0.00%	0
Dissatisfied	0.00%	0
TOTAL		3

Q6 Were the presentations effective in providing you information as a new board member?

Answered: 3 Skipped: 0



ANSWER CHOICES	RESPONSES	
Satisfied	100.00%	3
Somewhat Satisfied	0.00%	0
Somewhat Dissatisfied	0.00%	0
Dissatisfied	0.00%	0
TOTAL		3

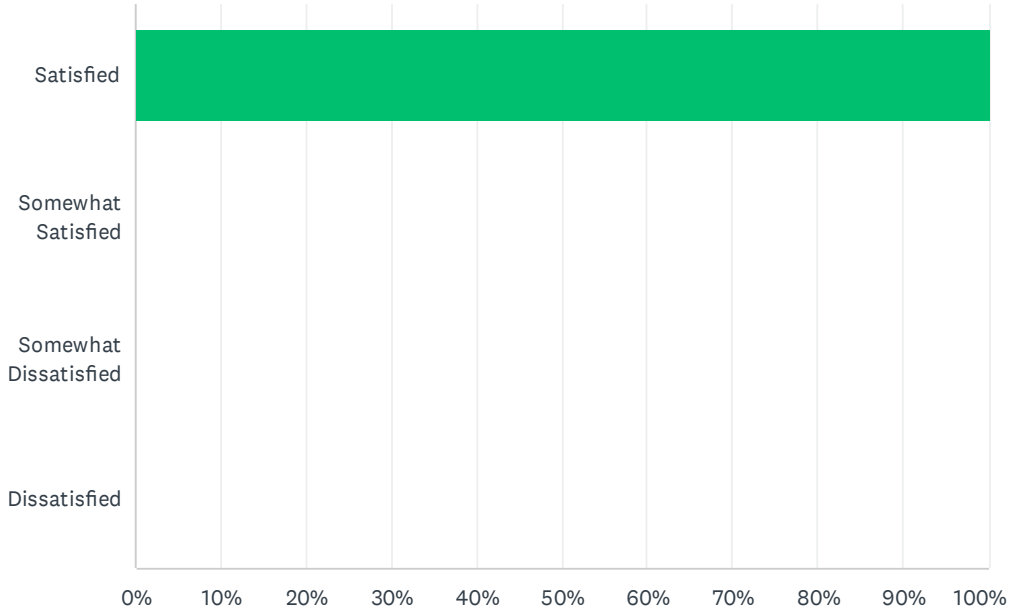
Q7 Comments on the value of the presentations:

Answered: 3 Skipped: 0

#	RESPONSES	DATE
1	Well done	10/10/2025 7:29 PM
2	Helped to understand and appreciate challenges for the organization	10/10/2025 6:40 PM
3	There were details about the organization I did not know as well as clarification on what the direction riverside is headed	10/10/2025 4:18 PM

Q8 Were you satisfied with the overall orientation?

Answered: 3 Skipped: 0



ANSWER CHOICES	RESPONSES	
Satisfied	100.00%	3
Somewhat Satisfied	0.00%	0
Somewhat Dissatisfied	0.00%	0
Dissatisfied	0.00%	0
TOTAL		3

Q9 Comments on how to improve the orientation:

Answered: 3 Skipped: 0

#	RESPONSES	DATE
1	None	10/10/2025 7:29 PM
2	I thought well done, identified, disgusted various strategies for dilevery of care. helped understand the difficulties to balance budget in health care. Satisfied with the format and content.	10/10/2025 6:40 PM
3	It was well organized and presenters were all on time.	10/10/2025 4:18 PM

Riverside Health Care

In Camera Audit & Resources Committee Report – November 2025

2.4.1 Minutes: Audit & Resources Committee *
October 23, 2025 – reviewed and approved by the Committee

2.4.2 Board & Management Travel *

2.4.3 CEO Compliance *

2.4.4 Non-Union/Management Wage Increase *

RIVERSIDE HEALTH CARE FACILITIES INC.
BOARD AUDIT & RESOURCES COMMITTEE MINUTES

Date of Meeting: October 23, 2025 **Time of Meeting:** 4:00 pm

Location of meeting: LVGH – Board Room / Webex

PRESENT:	E. Bodnar	H. Gauthier	D. Pierroz
	C. Larson	M. Jolicoeur	M. Kitzul
	B. Norton*	*via Webex	

1. WELCOME AND ROUND TABLE CHECK IN:

B. Norton called the meeting to order at 4:05 pm. B. Booth recorded the minutes of the meeting.

1.1 Confidentiality Reminder

B. Norton reminded members of the confidentiality of the session.

2. ADOPTION OF AGENDA:

It was,

MOVED BY: D. Pierroz SECONDED BY: E. Bodnar

THAT the agenda be approved as circulated.
CARRIED.

3. REVIEW OF MEETING MINUTES: September 18, 2025:

It was,

MOVED BY: M. Jolicoeur SECONDED BY: D. Pierroz

THAT the minutes of the previous meetings held on September 18, 2025, be approved as circulated.
CARRIED.

4. BUSINESS ARISING:

There were no matters arising.

5. STANDING ITEMS:

5.1 Financial Report – September 2025

Carla reviewed the circulated in detail highlighting the following:

- Overall Combined Deficit is roughly $7.5 million.
- Hospital Deficit is approximately $4.7 million. This is an increase of roughly $108.9k due to surgical QBP's.
- Rainycrest (LTC) Deficit is approximately $2.8 million. This is an increase of roughly $262.6k due to miss coded agency costs as well as other one-time compensation costs.
- CSS/Assisted Living is sitting with a deficit as well. This is being investigated as they need to balance their budget. Carla noted she isn't sure what the contributors are, however, feels Bill 124 and wage increases contribute. Carla recalled this is being investigated to determine what this deficit is due to.

5.2 OT, Sick & FTE Reports – September 2025

Carla reviewed highlighting the following:

- At the end of September, we are seeing similar trends in sick and OT with little decline.
- There was a small improvement in Emo.
- LVGH OT and sick has increased significantly. Sick time is being covered by OT and agency. The hospital is experiencing an increase in surge activity, and we are upstaffing for this and agency staff contribute here. Carla noted for the majority of September we were at 44 beds including 1 overflow bed, and we are budgeted to operate with 30 beds.
- Rainy River is experiencing an increase in OT and sick (all clinical) and all of this is covered by agency staff.
- Rainycrest is also seeing increased OT and sick; all in clinical areas. The Administrator is looking at a plan to control this.
- Discussion took place regarding a casual pool. Henry and Carla noted these pools have disappeared and no longer exist. There is no base left.
- Rainycrest has eliminated the use of agency for food services, however, agency is still being used for RPN's.
- Carla shared we are using more agency at hospital than ever. Discussion took place regarding housing for these agency staff and the costs associated. Henry and Carla confirmed its huge dollars and accommodations are an issue to secure. Further discussion took place regarding transportation costs.
- Conversation ensued around government/political/MPP, and issues with this.
- Henry confirmed we will continue to try and recruit staff and recruit foreign workers in order to sustain services.

6. NEW BUSINESS:

6.1 Performance Conversations

Henry reviewed the circulated noting as of today we are actually at 48% compliance for performance conversations. Strong expectations have been set. The deadline is early December. 100% is a stretched target, however, we are aiming for it. Henry shared education is also a push. Henry noted these are important engagement initiatives. We are supporting our management, however, pushing accountability.

Discussion took place with Rainy River having zero performance conversations complete. Henry shared there is no management out there permanently right now, further noting, he doesn't see Rainy River being able to meet the target by the end of the year. Henry reported we are bringing in a third party to manage Rainy River, and the hope is this individual will change culture there.

Henry recalled we simplified the performance conversation process to assist with making it easier for all. Discussion took place regarding managers demanding portfolios and having to make time to complete these.

6.2 Cashflow

Carla provided the following update, highlighting the following:

- On October 16, 2025, we received $7 million in cash advance from OH. However, we need to pay this back starting in December and ending in March as well we need to provide weekly and monthly reporting requirements.
- As of today, our bank balance is $4.4 million. Based on our cashflow forecast our next biweekly payroll with Rainy River Clinic will be approximately $1.1 million.
- Carla shared cash failure is projected for the last week in December noting this is when we would need to start paying back the cash advance.
- We need 1-time funding as soon as possible.
- Henry confirmed we have not received any funding for the Rainy River Clinic.

6.3 CHC Model and Rainy River Clinic

Henry recalled approximately 3 ½ years ago we put in for a CHC model for Emo and then were going to extend that model to Rainy River. Last Monday we were told we were not being given this and OH was giving this to the FF FHT. OH, is pressing us hard for meetings. Henry noted we were told the RNPGA agreements in Rainy River would not fit with a CHC model and they want a RNPGA agreement in Rainy River. Regardless, there are contractual changes that would need to occur. Henry confirmed we will continue to run the Rainy River Clinic until a new provider is deemed and then we will assist with transitioning over. He noted we do not need to be involved in the planning phases.

Henry shared meetings occurred yesterday and the FF FHT does not want to go into the west end of the district with primary care. Henry discussed our CHC model and how it would allow physicians to move and be more flexible to the west end. He recalled we will support by keeping the Rainy River Clinic functioning for now. Discussion took place noting this seems more political versus about patient care.

Henry wanted all aware as the original proposal for the CHC model in Emo was to then redirect funds to Rainy River and LVGH to help with the deficit, however, this is not the case now. Henry reported OH said they were not in support of a CHC model however, 2 ½ years ago they were. Henry defined RNPGA and how these agreements work. He shared that OH and the MOH state that an RNPGA fits well with a FHT model versus a CHC model. Henry recalled, either way contractual changes would be required regardless. Overall, the feeling is this is very politically driven.

7. SUMMARY OF ACTIONS / COMMUNICATION REQUIREMENTS

7.1 Meeting Summary: September Board Meeting Agenda Items

Discussion took place around what items are to appear on the Open and In-Camera agendas for the October Board meeting. It was decided by consensus that the items appear as follows:

Open Session – Consent Agenda:

- 6.1 Financial Report – September 2025

Open Session – Separate Agenda:
There were no separate items for the Open Session agenda.

In-Camera – Consent Agenda:

- September 18, 2025, Meeting Minutes
- 6.1 Performance Conversations

In-Camera – Separate Item:

- Audit & Resources Verbal Update

8. DATE OF NEXT MEETING:

November 20, 2025

9. TERMINATION:

The meeting terminated at 5:24 pm.

_____ _____

Chair Recording Secretary
/bb

RIVERSIDE HEALTH CARE

operating as Riverside Health Care Facilities, Inc.

Executive and Board - Travel, Meal and Hospitality Expenses

April 1, 2025 to September 30, 2025

Date	Event Description	Expense	Expense Category
Henry Gauthier President & Chief Executive Officer			
Joanne Ogden Quality Assurance Auditor & OHT Executive Lead			
Diana Harris Chief Nursing Executive			
Carla Larson Chief Financial, Technology & Information Officer			
Diane Clifford Board Chair			
Benjamin Norton Vice Chair			
Edith Bodnar Second Vice Chair			
Marianne Kitzul Board Member			
Kathy Lampi Board Member			
Aimee Beazley Board Member			
Dan Loney Board Member			
Michael Jolicoeur Board Member			
Dr. Daniel Pierroz Board Member			
**** Travel Expenses that are reimbursed by other agencies are not included in this report****			
Total for April 1, 2025 to September 30, 2025		**$0.00**	

Printed: October 17th, 2025

BRIEFING NOTE

TO: Board of Directors

FROM: Henry Gauthier

DATE: November 14, 2025

RE: Chief Executive Officer Certificate of Compliance 2025-2026 Q1-Q2

SUMMARY

- Riverside Health Care must comply with all applicable government laws and remittances, in accordance within the terms below:
  - Income Tax Act (Canada);
  - Canada Pension Plan Act (Canada);
  - Employment Insurance Act (Canada);
  - Employer Health Tax (Ontario);
  - All material taxes collected pursuant to the Excise Tax Act (GST); and
  - Retail Sales Tax Act (Ontario).

- On a quarterly basis, the President & CEO and Chief Financial, Technology & Information Officer will review all items on the Compliance Certificate to ensure that there are no irregularities. If all are in compliance, the CEO will sign and submit the certificate to the Board through the Audit and Resource Committee. If irregularities are found, they will be noted with a resolution plan.

- Note: All material taxes collected pursuant to the Excise Tax Act (GST) and the Retail Sales Tax Act (Ontario) for **Riverside Health Care (RHC)** for the period of April 1, 2025 to September 30, 2025 have been collected. The taxes have been remitted to the appropriate authorities for **RHC**.

  - The attached report covers the period from April 1, 2025 to September 30, 2025.

RECOMMENDATION

That the Board of Directors approve the CEO Certificate of Compliance for the period from April 1, 2025 to September 30, 2025.

Henry Gauthier

attachment

Riverside Health Care

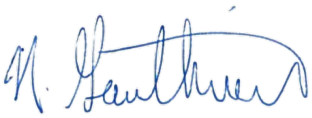
Compliance Certificate

The undersigned, President and Chief Executive Officer of Riverside Health Care hereby certifies as set forth below:

1. That all material source deductions relating to the employees of Riverside Health Care have been made and remitted to the proper authorities, under the following statutes in respect of the financial quarters ended June 30, 2025 and September 30, 2025:
    - Income Tax Act (Canada)
    - Canada Pension Plan Act (Canada)
    - Employment Insurance Act (Canada)
    - Employer Health Tax (Ontario)

2. That all material taxes collected pursuant to the Excise Tax Act (GST) and the Retail Sales Tax Act (Ontario) have been collected and remitted to the appropriate authorities in respect of the financial quarters ended June 30, 2025 and September 30, 2025.

As President and Chief Executive Officer of Riverside Health Care, I hereby certify, that to the best of my knowledge, Items 1 and 2 detailed above have been completed.



Henry Gauthier, President/CEO

November 14, 2025

Date

BRIEFING NOTE

TO: Audit & Resource Committee

FROM: Carla Larson, Chief Financial, Information & Technology Officer

DATE: November 17, 2025

SUBJECT: **2025-2026 Salary Increase for Qualifying Non-Union/Management Staff**

SUMMARY

- Riverside Health Care (RHC) historical wage increases for non-union and management staff:

	Board Approved	Bill 124 Increase	Total Wage Increase
2021-2022	1%	1%	2%
2022-2023	1%	2%	3%
2023-2024	2%	1.5%	3.5%
2024-2025	3%	0%	3%

- Our ONA and CUPE unions have agreed to a 3% increase in 2025-2026. To maintain alignment with these two groups, and consistent with the region, RHC will provide the same 3% increase for the non-union and management staffing groups (excluding senior leadership and select red lined positions) at an estimated retroactive cost of $208,000 effective April 1, 2025.

Recommendation

For Informational Purposes Only

Riverside Health Care

In Camera Quality Safety Risk Committee Report – November 2025

2.5.1 Minutes: Quality Safety Risk Committee
November 13, 2025 – not yet reviewed by the Committee *

2.5.2 Critical Incident Report (Q2) *

2.5.3 Scorecard Trends (Q1) *

2.5.4 IPAC – Immunization Rates (previous fiscal) *

2.5.5 Ethics Committee Minutes *

2.5.6 Annual Ethics Report *

2.5.7 Review of Patient Complaints *

2.5.8 QIP Quarterly Update (Q1) *

2.5.9 Quality Reports – Summary Spreadsheet *

2.5.10 Experience Surveys Update *

2.5.11 Integrated QSR Framework *

RIVERSIDE HEALTH CARE FACILITIES INC.

MINUTES
QUALITY SAFETY RISK COMMITTEE

Date of Meeting: November 13, 2025 **Time of Meeting:** 12:00 pm

Location of Meeting: Webex/LVGH – Board Room

PRESENT:	M. Kitzul	S. LeBlanc	J. Ogden	Dr. L. Jenks
	D. Black	D. Harris	E. Bodnar	H. Gauthier
	D. Loney*	C. Cole	C. Larson	*via Webex

REGRETS: A. Beazley, T. Morelli, J. Cousineau

1. CALL TO ORDER:

M. Kitzul called the meeting to order at 12:00 pm. B. Booth recorded the minutes of the meeting. M. Kitzul reviewed the virtual meeting etiquette and welcomed everyone.

1.1 Confidentiality Reminder

M. Kitzul reminded members of the confidentiality of the session.

2. CONSENT AGENDA

M. Kitzul asked if there were any items to be removed from the consent agenda to be discussed individually. The following was removed:

- 2.5 Scorecard Trends (Q1)

3. ADOPTION OF THE AGENDA:

ADD: 7.2 Scorecard Trends (Q1)

It was,

MOVED BY: C. Cole SECONDED BY: D. Loney

THAT the agenda be accepted as amended.
CARRIED.

4. PRESENTATION

No presentation this month.

5. MATTERS ARISING FROM THE MINUTES:

5.1 Risk Register

Deferred to the March meeting as per the committee workplan.

5.2 QIP Quarterly Update (Q1)

Joanne reviewed noting the numbers are moving in the right direction. She referenced the scorecard sharing this is updated monthly which makes it easier to update the QIP.

6. UPDATES AND REPORTS:

6.1 Quality Reports – Summary Spreadsheet

Joanne reviewed the three circulated reports confirming she is receiving reports on time. She confirmed she has followed up on a few past reports that required additional follow-ups as well. Discussion took place regarding the Sysmex Hematology Analyzer – Rainy River Hospital report and it was questioned who funded this. Joanne confirmed RHC funded this. Marianne shared the Auxiliary was keen on fundraising for this; Carla confirmed nothing had been received from the Auxiliaries.

6.2 Accreditation

Simone provided an update noting accreditation is fast approaching and scheduled for 2027. Teams continue to work on their assessments. Simone shared some new teams have been formed as well. Simone shared the previous acronym ROP is now called RSP (Required Safety Practice), and these indicators are mandatory. There is a total of 24 RSP's. Simone noted she is working with communications to develop a communication strategy. She also hopes to develop a cheat sheet for staff to use and review prior to the surveyor's arrival.

6.3 Experience Surveys (Q1)

Joanne reviewed the circulated noting that any follow-ups are dealt with quickly and at the time they occur. She shared our numbers are down compared to last year noting the kiosks are still having some issues with timing out which contributes to this. Joanne reported that people are using the QR code, which is positive. She confirmed the QR code is posted everywhere and people are reminded to complete the survey. Discussion took place noting age of the patient could contribute to the decline in numbers however, Joanne shared the elderly population has been filling out the survey as well.

6.4 Integrated QSR Framework

Cindy reviewed the framework noting this is a broad overarching document. She confirmed there were minimal changes since the last update.

7. NEW BUSINESS:

7.1 January Presentation & Department Walk-Around

Discussion took place regarding the January presentation. Joanne referenced the circulated QI reports suggesting the Sysmex Hematology Analyzer – Rainy River Hospital report or the Rainycrest Vending Machine Dietary report for a presentation. Carla noted the Dietary report has some follow-up challenges and might not be appropriate for a presentation at this time. It was decided by consensus to invite Andrea Faragher to present on the Sysmex Hematology Analyzer – Rainy River Hospital report in January.

ACTION: Brooke will send an invitation to Andrea Faragher for the January meeting.

7.2 Scorecard Trends (Q1)

Marianne questioned current ratio. Carla defined noting this is a financial term meaning do we have enough assets to pay off our liabilities; it is a ratio of current assets to current liabilities. The lower the number, the worse the position.

Total margin was discussed and Carla clarified that this is our deficit (negative (red) is deficit and positive (black) is to the good). Henry noted the ratios and margins are standard and you will see these indicators on everything. Carla confirmed this information also is submitted to the Ministry.

Turnover Rate was discussed and Marianne requested clarification. Joanne confirmed this relates to all staff and we are still in the process of gathering information. She shared that any data regarding LTC will be behind 3 months due to the Ministry. Joanne confirmed a lot of data is gathered manually.

Henry noted the scorecard is to be used year after year and will hopefully improve as it progresses. Henry and Joanne discussed challenges and the lack of capabilities of systems. Discussion took place regarding current programs allowing us to make our own reports. Joanne confirmed some programs do however, Henry and Carla shared we need educated staff to this as well. Joanne shared that even though our stats and data gathering is still manual it is still better than it was.

Discussion took place regarding the acronyms used on the scorecard and people not understanding the meaning. For example, RR means Rainy River, HSN means Health Systems Navigator.

Further discussion took place regarding ER Wait Times. Joanne noted there are some challenges with the physicians/NPs not entering in their times however, this is being worked on. Discussion occurred around reasons for the wait time (ie. Waiting on results, some doctors work slower than others). Dr. Jenks noted there are many reasons for the wait times. She shared the biggest wait is getting in to see the physician or waiting on admission to the floor. Joanne confirmed we are well below the provincial data, which is positive. She also shared wait times depend on CTAS score as well. Diana noted communication to patients is where we can improve to update people who are waiting. Henry shared the shared patient responsibility with the physicians and NP has decreased the wait times dramatically. Simone shared Kenora did a social media campaign regarding triaging patients and wait times. Conversation ensued on how to better communicate with patients. Henry suggested we put something into the paper and pair this with internal communication as well.

ACTION: Henry, Joanne and Diana to connect regarding communication for the media. Once drafted, engage Dr. Keffer and Dr. Jenks for input.

Marianne questioned ER targets and whether there is benchmarking. Joanne confirmed this is the provincial average. She shared we are collecting baseline data currently. Henry noted we can still set our own targets, however, we won't be able to do this until we have our data collected.

Discussion took place regarding the number of workplace violence and behaviors. Cindy provided clarification.

8. OTHER/FUTURE BUSINESS:

8.1 SUMMARY OF ACTIONS / COMMUNICATION REQUIREMENTS

- January Presentation - Brooke will send an invitation to Andrea Faragher for the January meeting.
- Henry, Joanne and Diana to connect regarding communication for the media regarding wait times. Once drafted, engage Dr. Keffer and Dr. Jenks for input.

8.2 Meeting Summary – September Board Meeting Agenda Items

Discussion took place on what items are to appear on the Consent Agenda and In-Camera agendas for the November Board Meeting. It was decided by consensus that the items appear as follows:

Open session – Consent Agenda

- 2.3 Board Quality Metrics

Open Session – Separate Agenda Items:
There were no separate agenda items for the Open Session.

In – Camera – Consent Agenda

- Draft Minutes
- 2.4 Critical Incident Report (Q2)
- 2.5 Scorecard Trends (Q1)
- 2.7 IPAC – Immunization Rates (previous fiscal)
- 2.8 Ethics Committee Minutes
- 2.9 Annual Ethics Report
- 2.11 Review of Patient Complaints
- 5.2 QIP Quarterly Update (Q1)
- 6.1 Quality Reports – Summary Spreadsheet
- 6.3 Experience Surveys Update
- 6.4 Integrated QSR Framework

In – Camera – Separate Agenda Items:
There were no separate agenda items for the In Camera Session.

9. DATE OF NEXT MEETING:

January 8, 2026

10. TERMINATION:

It was,

MOVED BY: D. Black

THAT the Quality Safety Risk Committee Meeting terminated at 1:10 pm.
CARRIED.

/bb

2025/2026 Q2 Critical Incident Summary

Long Term Care Critical Incident Summary

(This includes incidents at Rainycrest, EHC and RRHC)

A total of 23 critical incidents were submitted to the MOHLT Critical Incident System.

12 were no harm incidents and 11 were harmful incidents.

11 - Falls – 10- Harmful, 1-No harm

3- Outbreaks – 1-Enteric, 2- Respiratory (1-Enterovirus, 1-Rhinovirus) (3- No Harm)

3- Environmental Hazards: 1-scheduled power outage, 1- Dishwasher failure, 1-Door access failure

2- Aggression - Resident to Resident – Substantiated – 2- No Harm

1 – Improper/Incompetent treatment: Staff to Patient – Unsubstantiated, No Harm

1- Misuse/Misappropriation of Resident Money

1- Medication/Adverse Drug Reaction

1- Contaminated Water Supply

All incidents were fully investigated and closed. Corrective actions were put into place and included multidisciplinary meetings with families, staff education, reinforcement of policies and procedures and steps of discipline.

Acute Care Critical Incident Summary

There were no critical events in Acute Care that resulted in harm.

Actions / Improvements:

Falls:

- Encourage participation in PT program and support patients/residents through physiotherapy program for strengthening and improved mobility.
- Ensure 4P's are addressed every time prior to leaving room – comfort rounds
- Nearby wheelchair to assist with transfers
- Temporary relocation closer to Nursing Station
- 1:1 staff for initial 48 hours
- Engagement with Resident and Families in care plans
- Dietician referral

Outbreaks:

- Education and reinforcement of outbreak measures and proper wearing of PPE for family and visitors.
- Daily huddles with staff throughout the outbreak reinforcing all best practices.
- Reinforce prompt internal reporting to OH&S and IPAC or delegates

Aggression:

- Reviewing care plans and ensure all up to date and behaviour triggers and interventions up to date for those displaying responsive behaviors or aggression.
- Medication review completed

Environmental Hazards:

- Dishwasher and Door Access Failures were promptly repaired with mitigating strategies in place until that occurred.

Financial, Customer, Internal Process, and Learning and Growth.

Riverside Health Care
Balanced Scorecard
2025-26 Fiscal Year

Indicator	Trending	Preferred Direction	Target		
				August	September
Current Ratio	⇔	⬆	2	0.56	
Total Margin	⇔	⬇	1%	-21.31%	
Employee Satisfaction (annual survey)	⇔	⬆	85%		Jan-26
Medical Staff Satisfaction (annual survey)	⇔	⬆			no responses
Average Sick Days Per Employee (quarterly)	⇔	⬇	85hrs/staff avg.		
Turnover Rate	⇔		20%		
Appropriate referral to Mental Health follow up for those meeting criteria through the Emergency Department	⬇	⬆	70%		

Number of clients seen through the ED who are experiencing a MH disorder RR	⇧	collecting baseline	**collecting baseline**		
Number of clients seen through the ED by the HSN who are experiencing a MH disorder.	⇧	⬆	**75% seen by HSN**	35 (141)	27 (168)
Emergency Department Wait Time for Physician Initial Assessment	⇩	⬇	**collecting baseline**		
Emergency Department Wait Time for Registration to Triage/Assessment	⇩	⬇	**collecting baseline**		
ER Dept. Time in ER until disposition decision-High urgency CTAS (<8hrs goal)	⇩	⬇	**collecting baseline**		
ER Dept. Time in ER until disposition decision-low urgency CTAS (<4hrs goal)	⇩	⬇	**collecting baseline**		

Experience Survey-Short Survey Reponse Rate	⇔	↑	**500/year**		20/53
Mandatory Education Compliance	↑	↑	**100%**	35.50%	36.94%
Performance Conversations	↑	↑	**100%**	35%	41%
Employee retention (excluding retirements)	⇧	↑	**97%**		97.70%
Position Stabilization (#filled positions / #total FT & PT positions)	⇧	↑	**82%**		85.00%
Quality of work life - vacation utilization (% = vacation hours used/total vacation hours accrued within year)	⇔	baseline	**collecting baseline**		
Workforce stability - agency staffing utilization (% = agency costs (wages, fees and housing)/ total expenditures)	↑	↓	**20%**	23.26%	
OT Hours total corporation	⇧	↓		8.24%	
OT hours Rainy Crest (Staff and Agency)	↑	↓	**50% reduction**	14.62%	
Number of workplace violence incidents reported by workers (physical violence or threat of physical violence) within a 12 month period. Hospital/Community	↓	↑	**10-20% increase**	0	3

Number of workplace violence incidents reported by workers (physical violence or threat of physical violence) within a 12 month period. LTC/ELDCAP	⇧	↑	**10-20% increase**	5	5
Behaviours		baseline	**collecting baseline**	8	13
Rainy Crest Activation Program	⇧	↑	**Milestone 1-3**	40%	50%
Review of Residents in Daily Physical Restraints in Rainy River Eldcap	⇩	↓	**20%**		15-Dec
Falls report	⇧	↑	**600/yr**	41	50/336
Medication Reconciliation on Admission form signed	⇧	↑	**100%**	96.80%	100%

Medication Reconciliation on Discharge form signed	⬇	⬆	**100%**	81.50%	77.30%
Medication Incidents	⬆	⬇	**100/yr**	10	15/72
VTE (AppropriateDrug)		⬆			
VTE Prophylaxis Audit Report (patients assessed)	⬇	⬆	**100%**		
Surgical Services	⇧	⬆	**100%**	98%	96%
IPAC	⇧	⬇	**125 days**	8	12/100
IPAC	⬇	⬆	**97%**	95.41	92.98
IPAC-corporate	⇧	⬆	**80%**	77%	77%
AEMS	⇧	⬆	**1200**	108	129/784

Number of hospital patients admitted as ALC	⇩	⬇	**decrease by 15% (126)**	27/56	10/66
Number of riders to utilize Specialty and Diagnostic Transportation	⇧	⬆	**500/yr**	15/42(57) Total 85/337 (422)	20/49(69) Total 105/386 (491)

Riverside Quality Improvement Report

Program/Team	IPAC				**Date**	August 2025		
QI Indicator/Project Name	COVID-19 & Influenza Program 2024-25							
Strategic Pillar	Quality		Organizational Health	X	Partnerships		Advocacy	
Quality Dimension	Accessibility		Client-Centred Service		Efficiency		Safety	X
	Appropriateness		Continuity of Service		Population Focus	X	Work Life	X
Indicator Type	Process	X	Structure		Outcome		Balancing	
Predetermined Standard	Yes No	X	If_Yes, What is the Standard		Accreditation Canada and Public Health Guidelines			
Previous rate, score or measurement (please explain)	IPAC achieved 100% during the Accreditation standards review in October 2023. Other rates from 2023-24 looked at influenza & COVID-19 for employees and residents, and the number of Respiratory outbreaks through out RHC see graphs attached.							

Improvement Team: Briefly describe who was involved in this QI initiative. How were direct staff involved? What phases have they been involved in?

All staff are involved in participating in the COVID-19 & influenza Immunization program. All staff monitor for signs and symptoms that trigger outbreaks. This is an evaluation of the programs and to recognize if more measures are needed to sustain or enhance these programs.

Were Front Line Staff involved in this QI initiative? Yes X No □
At what stage? Planning □ Implementing change ideas X Evaluating □ Sustaining change X

PLAN: Briefly describe the project. What is the problem to be fixed? What was the aim (goal) of this QI indicator/project?

Timeframe: October 2024 to April 2025
Description: Ensuring Influenza and COVID-19 immunization program is in place and being monitored. Areas of concern are outbreaks being identified, monitored, and controlled. The goal of Influenza and COVID-19 immunization program is to reduce/eliminate COVID-19 / Influenza (Respiratory) Outbreaks to keep patients/residents and staff safe.
IPAC has 2 SMART goals

1. Riverside will see respiratory outbreaks decrease in both length and severity (total number of cases) by 10% in 2024/25. This will make the goal for length 142.2 days and the goal for number of cases 145.8: and
2. 80% of Riverside staff will be vaccinated against influenza and Covid-19.

DO: What did you do and how did you measure what you did?

Infection Prevention and Control (IPAC) team provided.

1. Education to staff/family/visitors on signs and symptoms of infections and reporting to Registered staff and IPAC. Educating family and visitors to stay home when ill or feeling unwell and proper masking if required for respiratory outbreaks. Conversations with resident/families/staff on the effectiveness of influenza and COVID-19 vaccines.
2. More IPAC personnel and staff health were available to attend each site during the fall/respiratory season to help with annual immunization clinics for residents and staff.,
3. Each site had a dedicated champion to assist in administering vaccine to staff and residents.

IPAC team evaluated the program as followed.

- staff influenza and COVID-19 immunization rates,
- # of outbreaks,
- # of influenza cases in Riverside Health Care (RHC) and
- # of influenza cases in the community with respect to the whole program.

STUDY: What was the outcome?

Influenza Vaccine:

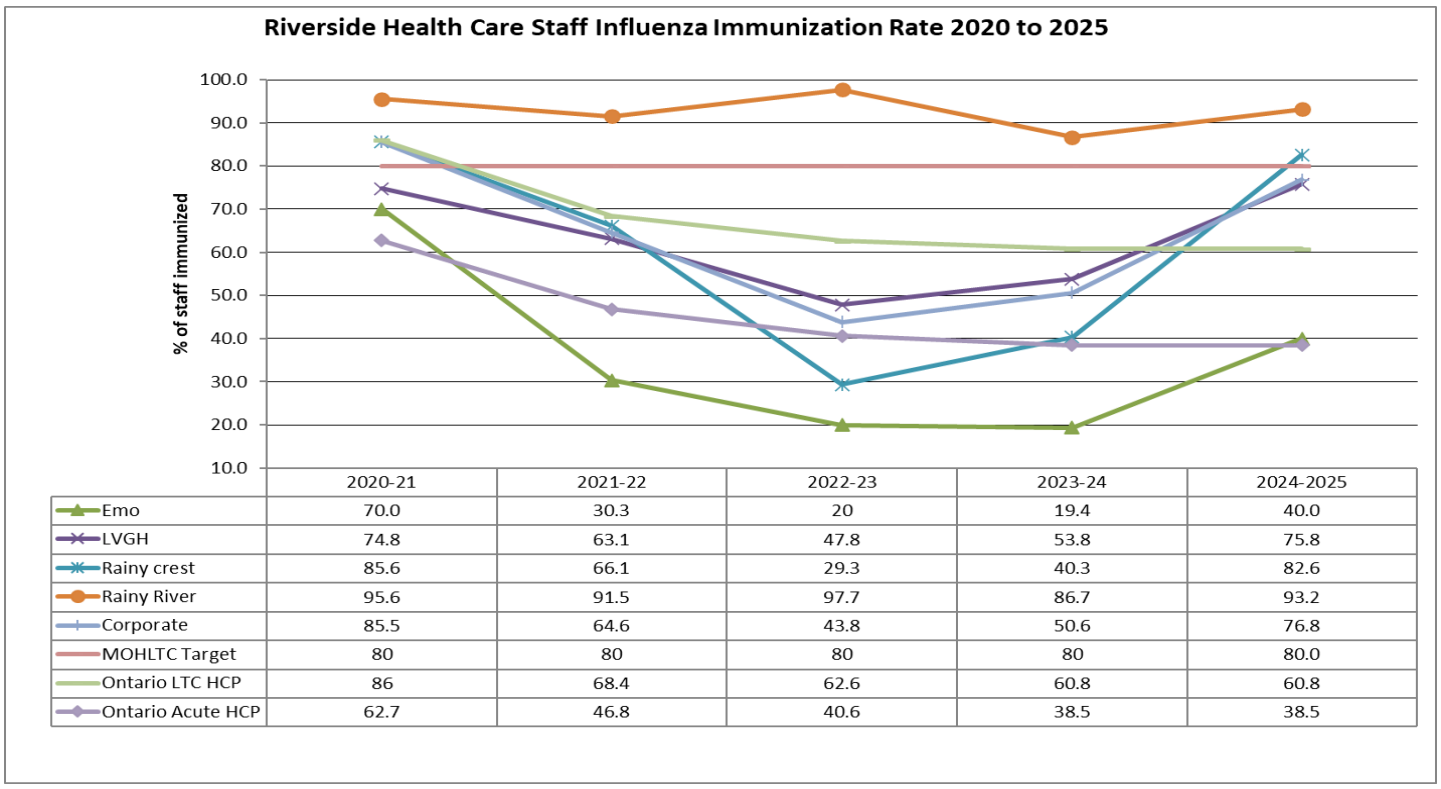
Employee Rates

1. RHC corporate staff influenza immunization rate is 76.86% at Feb 15, 2025 which is Public Health mandatory reporting date - see table below for each site's 5-year analysis.

   There was an increase from previous year (50.6%). This increase is attributed to more education to staff on benefits of getting influenza immunization as well as having more champions at each site. There were also increased influenza outbreaks which influenced staff to get the vaccine. The employee influenza immunization policy was also updated to reflex RHC commitment for staff to obtain the vaccine in a timely manner this update occurred in Spring of 2025.

   Reasons for rate below the Ministry of Health and Long-term care (MOHLTC) target

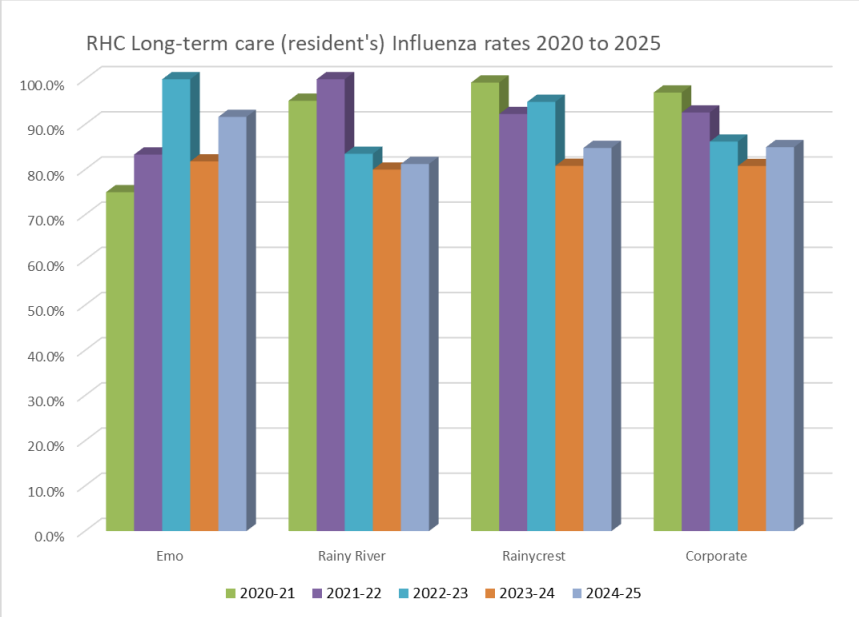
   • Staff have vaccine fatigue after the years of COVID-19 where multiple COVID-19 doses were required. Staff are hesitant and some unwilling to be vaccinated against influenza and COVID-19.



	2020-21	2021-22	2022-23	2023-24	2024-2025
Emo	70.0	30.3	20	19.4	40.0
LVGH	74.8	63.1	47.8	53.8	75.8
Rainy crest	85.6	66.1	29.3	40.3	82.6
Rainy River	95.6	91.5	97.7	86.7	93.2
Corporate	85.5	64.6	43.8	50.6	76.8
MOHLTC Target	80	80	80	80	80.0
Ontario LTC HCP	86	68.4	62.6	60.8	60.8
Ontario Acute HCP	62.7	46.8	40.6	38.5	38.5

Resident Rates

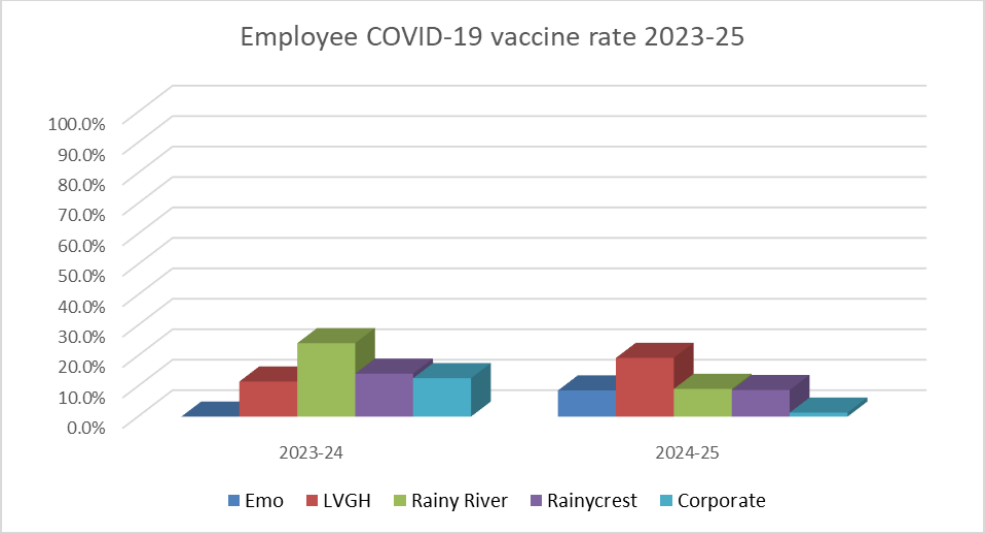
RHC Long-term care resident's Influenza Immunization corporate rate is 85.0% as of Jan15, 2025



COVID-19 Vaccine:

Employee Rate

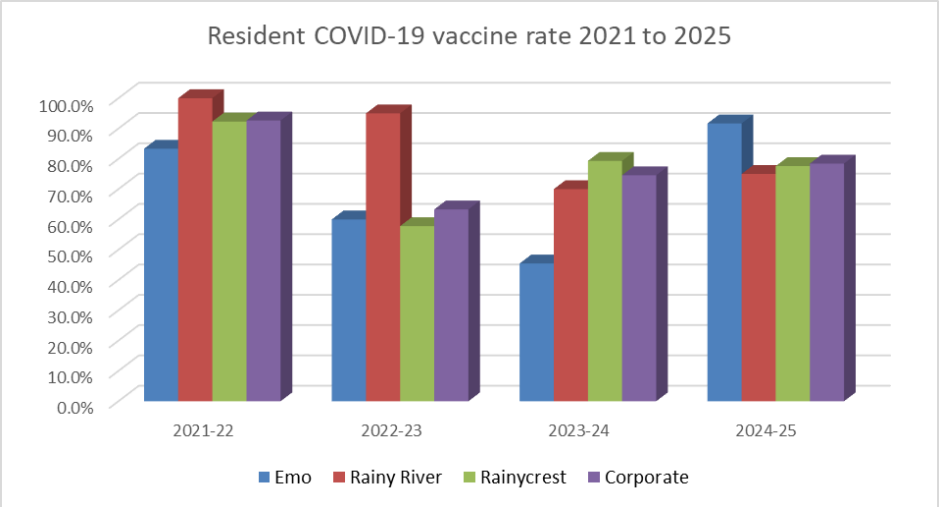
On January 31, 2023 RHC removed the mandate for employees to have 3 doses of COVID-19 vaccine. RHC recommends employee, patients, residents, volunteers, and contractors to stay up to-date with their COVID-19 vaccine (having a COVID-19 booster/vaccine within the last 3-6 months). Once the mandate was lifted many employees stopped getting the vaccine. It is difficult to track the up-to-date status of employees (i.e. previous COVID-19 infection with in 6 months are exempt from the vaccine). There also is no mandate to for COVID-19 vaccine during a COVID-19 outbreak compared to the Influenza Outbreak mandate from the Public Health Ontario/Ministry on Health Ontario.



*Prior to Jan 2023 employee's COVID-19 immunization was at 100%.

Resident Rate

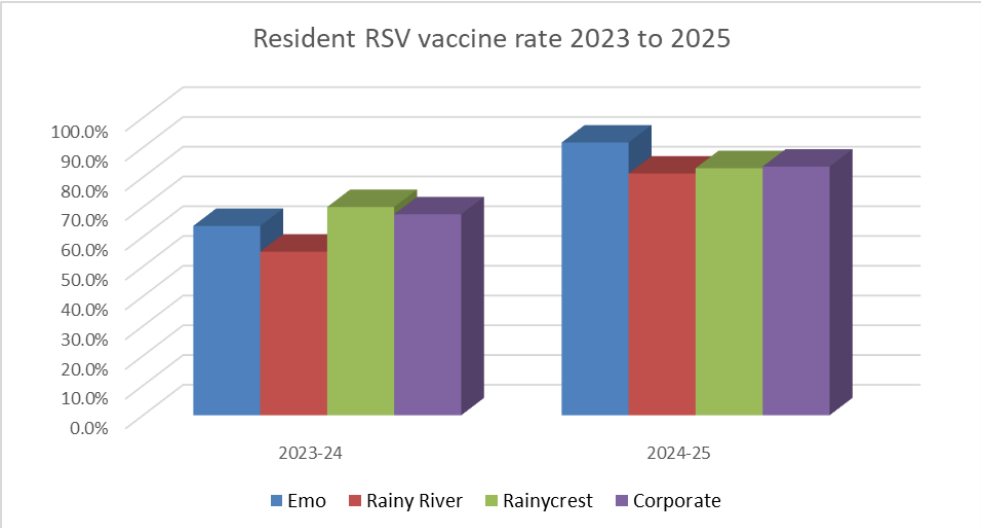
RHC Long-term care resident's COVID-19 Immunization corporate rate is 78.4% for resident receiving their up-to-date vaccine as of June 30, 2025. Emo and Rainy River LTC resident COVID-19 vaccine rates have improved over the past year due to change in residents and more information provided as residents are being admitted to LTC. There have been few residents being admitted who refuse all vaccines upon admission as well.



RSV (Respiratory syncytial virus)

Residents

As of September 2024, Public Health Ontario and the Ontario Immunization Advisory Committee recommends residents of long-term care facilities be offered the RSV immunization if they meet the eligibility. RSV immunizations were available to residents over the age of 60 in the fall 2024 for the first time. RHC corporate rate has increased to 83.6% due to the 2nd year available for this select group of individuals. Education was provided to substitute decision makers on the risks of RSV and the studies that were completed prior to releasing the vaccine to the public. Regular education will still be available to residents and substitute decision makers so they can provide informed consent upon admission to Long Term Care.



Riverside Quality Improvement Report

Respiratory Outbreaks

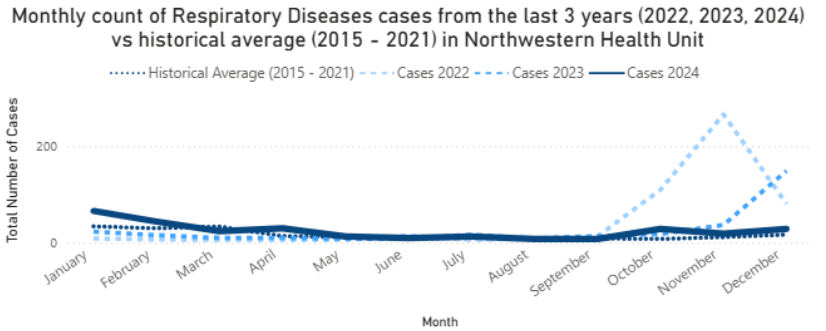
In 2024-25 there were 5 Respiratory outbreak (1-COVID-19, 3- Influenza A, and 1-Coronavirus OC 43) throughout RHC sites (2- Rainycrest, and 3-LVGH,). Emo and Rainy River Health Centres did not experience respiratory outbreaks during the “Respiratory” season October to April 2024-25.

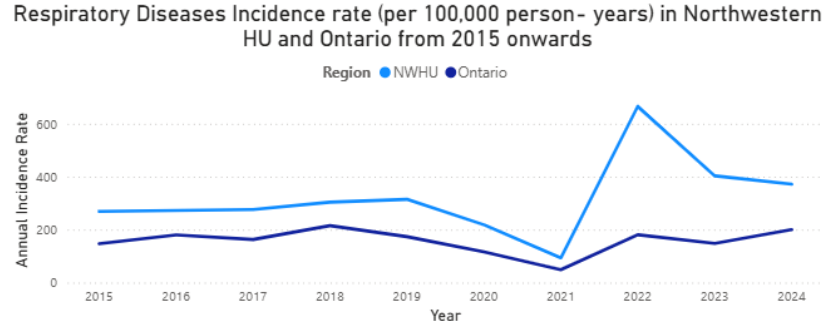
- LVGH COVID-19 November last for a duration of 17 days affecting 15 patients and 2 staff.
- LVGH Influenza A outbreak in January last for a duration 9 days affecting 6 patients and 0 staff.
- Rainycrest Influenza A outbreak in February last for a duration of 13 days affecting 4 residents and 1 staff.
- LVGH Respiratory Influenza A outbreak in February last for a duration 19 days affecting 5 patients and 0 staff.
- Rainycrest Respiratory coronavirus OC43 outbreak in April for a duration of 19 days affecting 23 residents and 0 staff.

Laboratory Results:

A total of 270 COVID-19 and 260 Influenza A&B tests were completed at RHC’s lab including ED, Inpatients and LTC. There were 43 Inpatients who tested positive for influenza A (15 patients/residents acquired influenza A within an RHC facility); no Inpatients tested positive for Influenza B. There were 25 positive COVID-19 tests in acute care, 16 Inpatients (15 inpatients acquired COVID-19 while admitted at LVGH)

Community Prevalence:



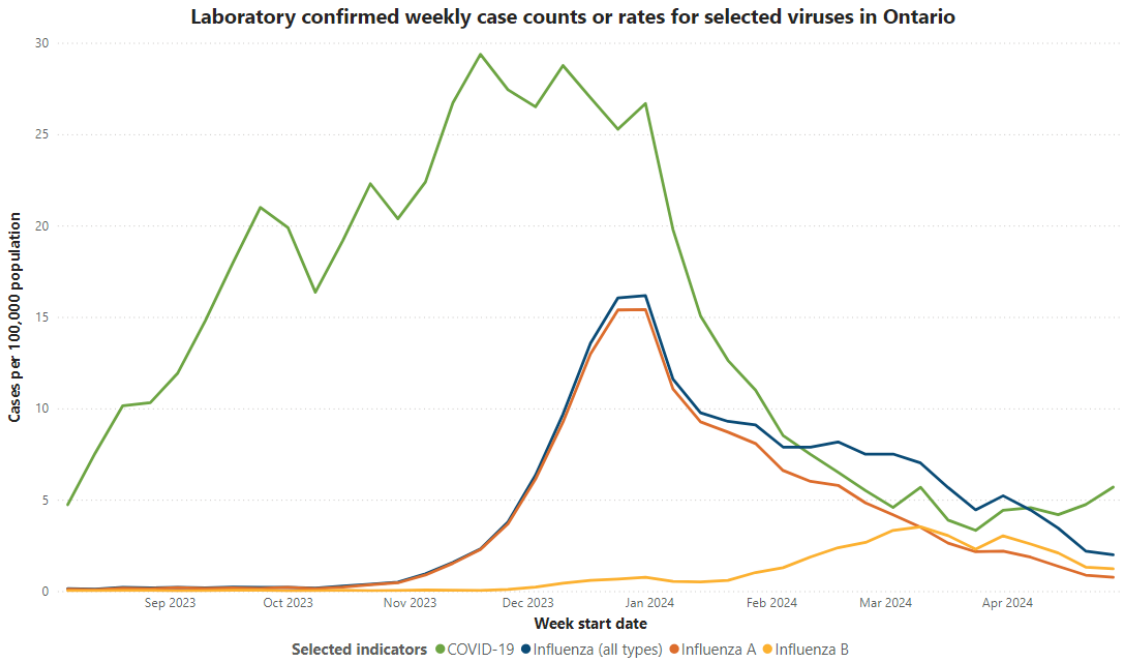


Data Source: integrated Public Health Information System (iPHIS) [2015-2024]. Date Extracted: January 20, 2025
When hovering over graphics above, a tooltip box will appear showing the values and additional information.

Some counts and rates are suppressed due to small numbers within small populations, and will appear as blanks on the graphs. Try changing filters to larger geographic areas, broader age groups, a different disease, or combine more years of data to avoid data suppression.

Northwestern Health Unit (NWHU) stats (COVID-19, Influenza A & B)

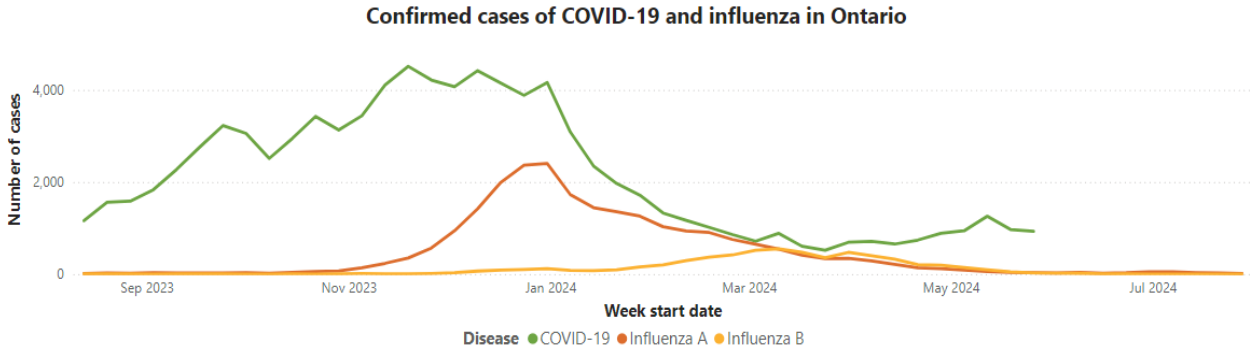
These are stats from **2023-2024**



Notes:

COVID-19 and influenza indicators should be compared and assessed with caution due to differences in provincial testing strategy, populations eligible for testing, data collection and entry requirements. There are significantly more COVID-19 tests performed compared to influenza tests. Reported cases of COVID-19 and influenza are placed in time by reported date. COVID-19 case data are no longer being updated; data remain available up to June 1, 2024. For further details, please refer to the technical notes.

Incidence rates for 2023-24



Notes:

COVID-19 (SARS-CoV-2) test positivity is based on information from the Ontario Laboratory Information System (OLIS), while all other test positivity data used in these figures are based on information from Public Health Agency of Canada (PHAC). Hospital bed occupancy refers to the average daily bed occupancy for the week. For further details, please refer to the technical notes.

In Northwestern Health unit community, there was an increase of Influenza A cases, there was a direct relation to the outbreak at LVGH and RC during this time.

Goals for 2025-2026 respiratory season

1. IPAC will share the QI report with IPAC committee (which includes representation from Northwestern Health Unit) and Leadership Committee.

2. Provide education regarding influenza and COVID-19 vaccine to staff, residents, and residents' families, allowing staff, residents/families to make an informed consent.

3. Fall preparedness meetings are scheduled for all sites in partnership with the Northwestern Health Unit.
    - Fall preparedness includes ordering sufficient vaccines (Influenza and COVID-19 for both staff and residents at all sites), supplies (needles, syringes, PPE, etc.,), staffing (vaccine champion at each site), cleaning supplies, review surveillance of respiratory illnesses and respiratory outbreak protocols, educational campaign and public awareness.
    - Creating a system to ensure staff have been offered the influenza and COVID-19 vaccine which is documented in staff health files.
        - If staff refuse the vaccines, they will be required to sign a refusal letter. If refusing influenza vaccine they will be required to complete a Tamiflu request/consent to ensure RHC will have adequate amount of Tamiflu in the event of an Influenza outbreak. If staff refuse Tamiflu in the event of an influenza outbreak staff will sign that they will be off work without pay. This will help departments prepare for staff shortages in the event of an influenza outbreak.

Definitions:

Quality Dimensions: All standards in the Accreditation process are based on the following eight quality dimensions. By linking quality improvement reports to one of the quality dimensions it is possible to get an overview of how the organization is doing against each quality dimension.

Quality Dimension	Definition
Population Focus	Work with my community to anticipate and meet our needs
Accessibility	Give me timely and equitable services
Safety	Keep me safe
Worklife	Take care of those who take care of me
Client Centred Services	Partner with me and my family in our care
Continuity of Services	Coordinate my care across the continuum
Appropriateness	Do the right thing to achieve the best results
Efficiency	Make the best use of resources

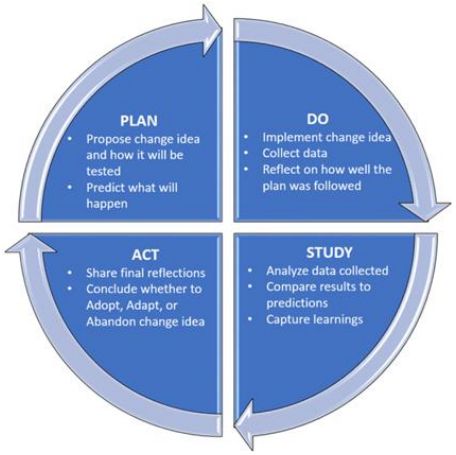
INDICATOR TYPE

Indicator Type	Definition
Process	How healthcare is provided? How the system works?
Structure	Physical equipment, raw material, parts and facilities.
Outcome	Health status change? Does it make a difference? The final product results.
Balancing	Measurement of any unintended consequences to project?

PREDETERMINED STANDARD

Yes	The Quality Improvement indicator being reviewed is specific to a regulation/standard such as an Accreditation Required Organizational Practice, RHC Policy, standard measure etc. (Ex: 100% of staff are to complete online Hand Hygiene & PPP education annually.) The predetermined standard should be identified in the Indicator Section of the report.
No	The indicator being reviewed is not specific to a regulation/standard. (Ex: Report on busted water pipes and how to ensure that when this happens we are best equipped to deal with the situation.

Plan-Do-Study-Act Model



RIVERSIDE HEALTH CARE

ETHICS COMMITTEE

MINUTES

Date of Meeting: October 7, 2025 **Time of Meeting:** 12:00 pm

Location of Meeting: LVGH Board Room / Webex

PRESENT: Brooke Booth, Henry Gauthier, Diana Harris, Simone LeBlanc*, Cindy Cole, Dan Loney, Joanne Ogden

REGRETS: Carla Larson

1. CALL TO ORDER:

S. LeBlanc called the meeting to order at 12:06 pm. B. Booth recorded the minutes of this meeting.

1.1 Conflict of Interest

No conflicts of interest were declared.

1.2 Ethical Decision-Making Framework

Standing attachment for information.

2. ADOPTION OF THE AGENDA:

It was,

MOVED BY: C. Cole SECONDED BY: H. Gauthier

THAT the Ethics Committee approves the Agenda as amended.
CARRIED.

3. ADOPTION OF MINUTES: May 6, 2025

It was,

MOVED BY: C. Cole SECONDED BY: H. Gauthier

THAT the minutes of the May 6, 2025, meeting be accepted as circulated.
CARRIED.

4. BUSINESS ARISING:

4.1 Ethics Framework Posters Update

Simone provided an updated noting she followed up with Communications, and they are working on getting the posters printed and then hung up shortly.

5. STANDING ITEMS:

5.1 Bioethicist Consult Update

There were no bioethicist consults.

Henry questioned whether there was any follow up from the Emo/HR issues and the concerns around engaging the bioethicist. Simone noted we typically do an evaluation after, and she noted she will follow up to see if this was done.

ACTION: Simone to follow up on the above to confirm an evaluation was done.

Discussion took place regarding how this issue was lead. Henry noted those involved expressed some concerns with the recommendations discussed.

ACTION: Henry asked Simone to follow up and bring back to the next meeting.

Simone noted that the people that were engaged in this specific bioethicist consult weren't concerned with the issue. The participation wasn't appropriate and the individuals that were directly involved should have been engaged in this consult with the bioethicist. Diana discussed what she hoped the bioethicist consult would have included and Simone reported education may have been more of an appropriate avenue. Henry shared what was told to him was that the bioethicist's decision didn't seem to be realistic in today's healthcare environment. Simone noted it was not clear on what the bioethicist was to be used for in this specific issue however, she will go back and review her notes to see what the feedback was from the bioethicist. Simone confirmed we can provide the bioethicist some feedback if necessary.

ACTION: Simone will circle back with those involved and give the bioethicist feedback if necessary.

Simone shared she felt the staff involved didn't feel comfortable speaking up with so many management present. Simone noted we can also suggest education topics/scenarios to the bioethicist for workshops as well. She confirmed our membership includes 6 bioethicist consults, education and 2 workshops.

5.2 Ethics Education

Simone recalled the monthly offered webinars. She highlighted September's webinar on Reducing Harm noting she attended and provided an overview of the session. The committee asked if a recording could be obtained.

ACTION: Simone will request the link of the session and share with the Committee.

Simone noted at the beginning of November we celebrate Ethics week. She discussed previous initiatives we have done to promote Ethics. Discussion took place regarding a topic for this year's Ethics week. The following was highlighted:

- Behaviour challenges in healthcare
- Linking the cultural component and linking our principles of conduct into this
- Information regarding Ethical values and working as a team – implementation of when present and not present.

All agreed to using this above topic for Ethics week.

ACTION: Simone will draft something and circulate to the committee.

Henry noted Harvard has a Cultural Ethics & Balance in the Workplace article that could be used as reference.

5.3 Scenario Discussion

Cindy discussed a scenario regarding Free Birth. She defined what this would mean noting a pregnant woman would come into our facility to deliver her baby with no intervention from the healthcare team; just wants the space/room to deliver. Discussion took place and the following was highlighted:

- Why wouldn't the woman deliver at home and not come to the hospital if no intervention was required.
- What would their needs be with us? What is our role.
- Cindy noted HIROC is aware of this and is developing some information as this is really new.
- Risks and liabilities discussed.
- Physician admittance required.
- Cindy shared Janice Angus was also going to bring this up at MORE OB to see how the physicians feel about this.
- Policies and procedures would be required.
- Adults can choose for themselves.
- Legal obligations discussed.
- We have a legal obligation to report.
- There are many ethical issues around this.
- Cindy noted she intends to follow up with HIROC as well.
- At this time, we are not sure we would be able to accommodate this.

6. NEW BUSINESS

6.1 Terms of Reference Review

Simone reviewed the circulated highlighting the edits in red. Henry provided a history of the Ethics committee and the broader membership. He noted a redesign occurred last year and 2 committees were formed (Core and Sub-Committee) however, now moving back to one committee with ad-hoc participation and subject matter experts invited when needed. Henry confirmed the Sub-Committee will be disbanded. Discussion took place regarding communication regarding this to the previous members.

ACTION: Henry and Simone will follow up off-line to discuss communication further.

Discussion took place regarding advocates of Ethics. Further discussion took place on having a standing item on the agenda for Ethics Capacity Building. It was noted this could be a discussion around a general Ethical issue or a submitted Ethical issue. Once the Ethics Capacity Building topic is determined, ad-hoc invitees will be determined and invited to the next committee meeting.

ACTION: Add Ethics Capacity Building as a standing agenda item moving forward.

Henry reviewed the 8 core committee members noting there could possibly be up to 8 ad-hoc members invited to meetings depending on the topic discussion. Discussion took place around adding a minimum and maximum of ad-hoc invitees to the TOR.

ADD: Under Membership – note Ad hoc members may consist of a range of 4-8 diverse invitees.

The committee agreed to the Terms of Reference as revised.

6.2 Research Project – Dr. T. Marion – First 200 Hips Adverse Events – Project Extension

Simone reviewed for information.

6.3 Research Project – Dr. Chiachen Cheng – Patient Engagement in Medical Student Admission at NOSM - Approval

Simone reviewed for information. It was noted this was previously approved by Senior Leadership.

6.4 Next Meeting – Ad hoc Invitation Discussion

Discussion took place regarding a topic to discuss. It was suggested further discussion occur around the topic of Free Birth. This will be the Ethics Capacity Building topic for discussion and the following ad-hoc invites will include:

- Food Services
- Housekeeping
- HR
- 2 x OB nurses (one to include Janine Angus)
- Health Records
- Finance
- Dr. Jenks

ACTION: Brooke will send an email to the Managers/Supervisors and request they delegate a member to be invited.

7. CORRESPONDENCE

There was no correspondence.

8. OTHER

None.

9. NEXT MEETING DATE:

November 4, 2025

10. TERMINATION: The meeting terminated at 1:18 pm.

Ethics Committee Annual Report

Sept 2024- Aug 2025

Summary of Activities throughout the year:

- The Ethics Committee met four times over the past year, with additional communication occurring through email regarding requests for research approvals/renewals.
- There was one ethical issue submitted to the Ethics Committee for consultation.
- The Ethics Committee engaged the CHCE on one ethical issue for additional support from the bioethicist.
- The Ethics Committee reviewed and updated the Riverside Ethics Framework
- The Ethics Committee reviewed two research approvals. One was recommended approval, and one was respectfully declined as it wasn't relevant to Riverside.
- The Ethics Committee approved an extension of two research projects previously approved.
- The Ethics committee reviewed Accreditation standards related to ethics throughout the year.
- Riverside continues to receive value from our membership with the Centre for Health Care Ethics at Lakehead. CHCE provides monthly webinars, quarterly workshops, and a newsletter. Riverside also participates in the Regional Ethics Advisory Committee through CHCE.
- Ryan Tonkins, bioethicist at CHEC provided a presentation on November 5, 2024, to the Ethics Committee about the purpose of the bioethicist and how a bioethicist can support Riverside.
- For National Bioethics Week in Nov 2024, the Ethics Committee prepared a newsletter article on the Ethics of boundaries for the portal and ran contests throughout the month of November, as well as a bulletin board at LVGH.
- There were 25 staff who participated in the Awareness week contest activities, and three staff won prizes.
- The Ethics Committee provided teams with an ethics discussion topic on the Ethics of Boundaries to be discussed at staff meetings.

Current Focuses for the Ethics Committee

- Continue to provide meaningful activities for Bioethics week and increase everyone's understanding of ethics.
- A renewed structure of the ethics committee with a focus on capacity building.
- Distribution of visual resources of the Ethical Decision-Making Framework & overall increase in understanding and use of the Riverside Ethical Decision-Making Framework.

Acute Care Feedback (Concerns) Summary 2024-2025

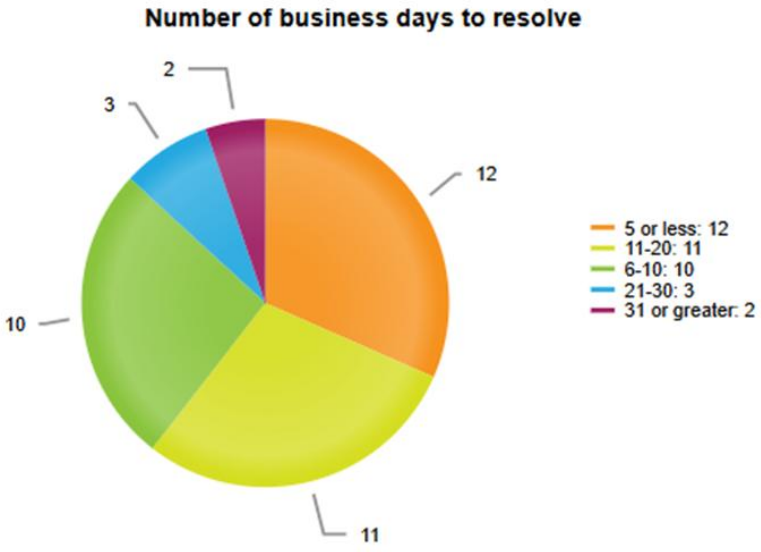
The information in this report is received from our acute, emergency and outpatient population as well as general feedback.

In February of 2025 we expanded the Feedback section of AEMS reporting to include a category for feedback related to employees. This is further defined as code of conduct, facilities/environment, safety as well as a category for receiving compliments.
In 2024/25 Riverside has received 41 complaints related to patients. 38 were received through or formal written feedback process by patients &/or concerned family/caregiver feedback while 3 were submitted by employee's on behalf of patients. This year has seen an increase in complaints largely in the Emergency Departments. Common themes for complaints are related to wait times, unsatisfaction with care received, as well as courtesy of staff or physicians.
100% of written complaints by patients &/or family/caregivers were acknowledged by the CEO or designate within a day of receiving the complaint. A formal follow up from the manager was completed for 100% of the complaints to date that included discussing it with staff involved. A full investigation into some complaints can involve multiple stakeholders and occurs over time before coming to complete resolution.

This year in 2024/25 we have also received 8 compliments. Much gratitude expressed on excellent care and compassion provided by Surgical Services, ED nurses and physicians, Health Records, Laboratory staff, DI staff. Four compliment letters were received to directly compliment specific employees on the care they provided. Compliment letters were shared with staff.

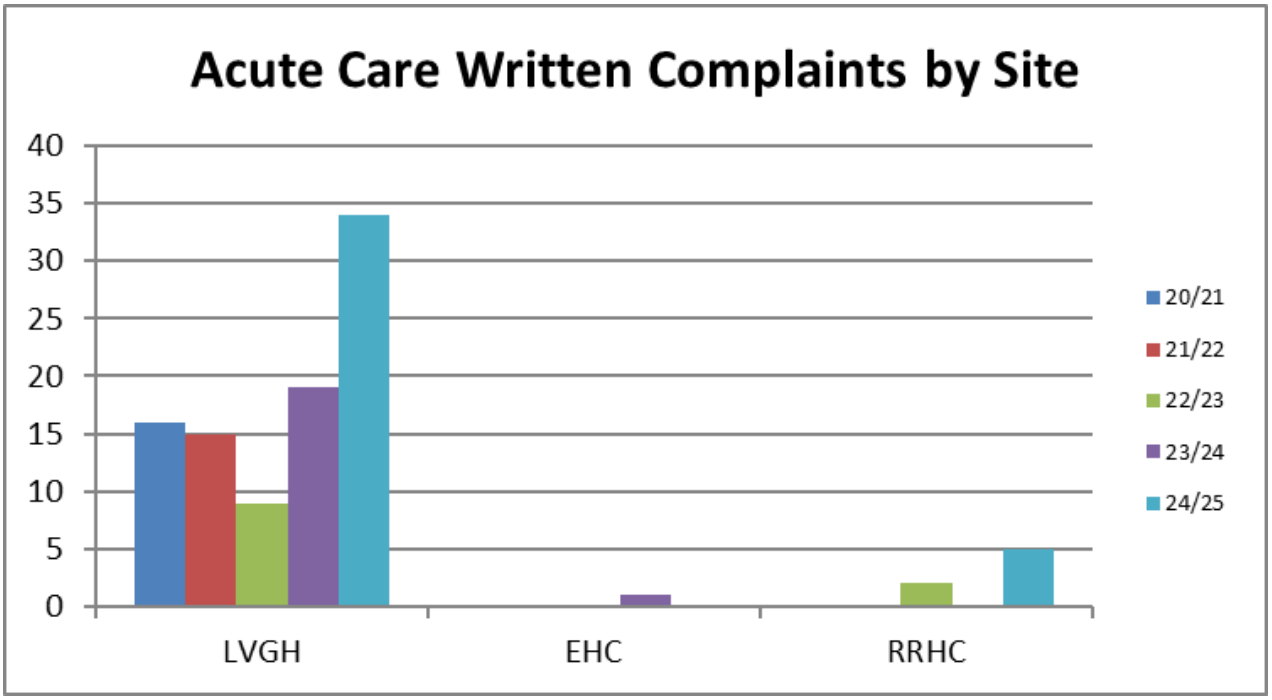
Complaints were submitted against medical staff, nursing staff, security, and facilities.

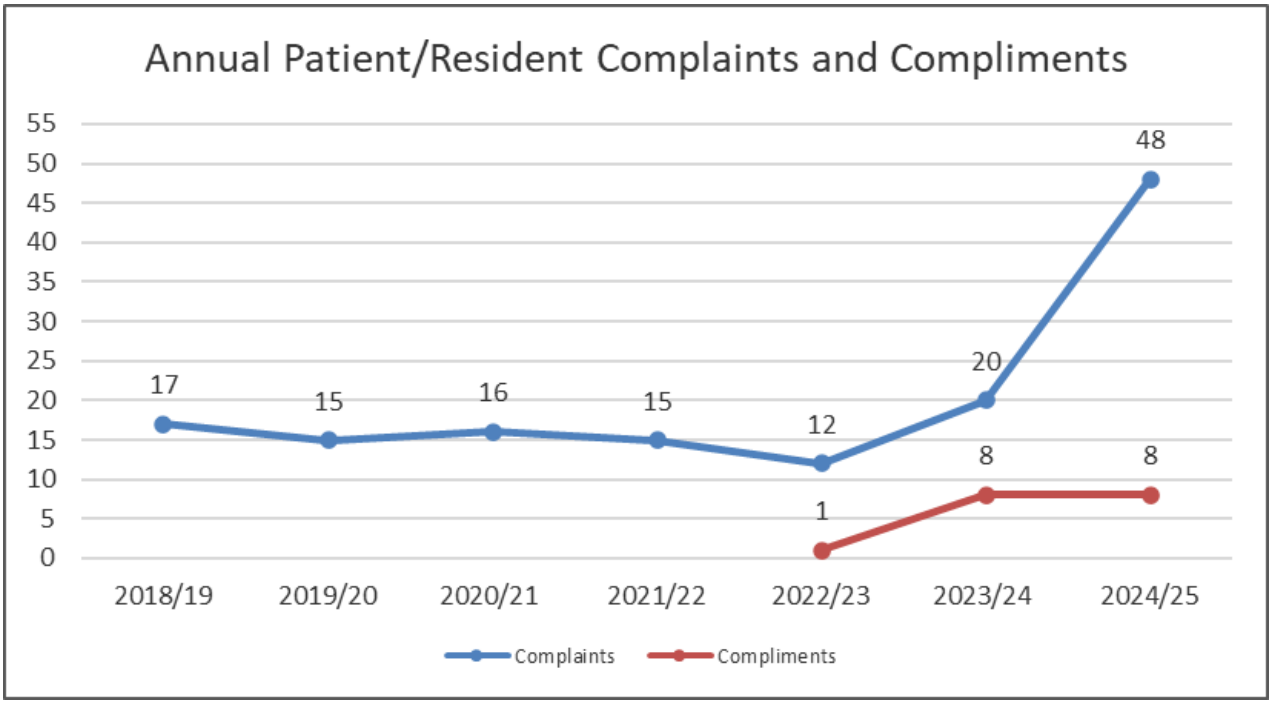
Number of business days to resolve:



Comparison of Patient/Resident Written Complaints by Site:

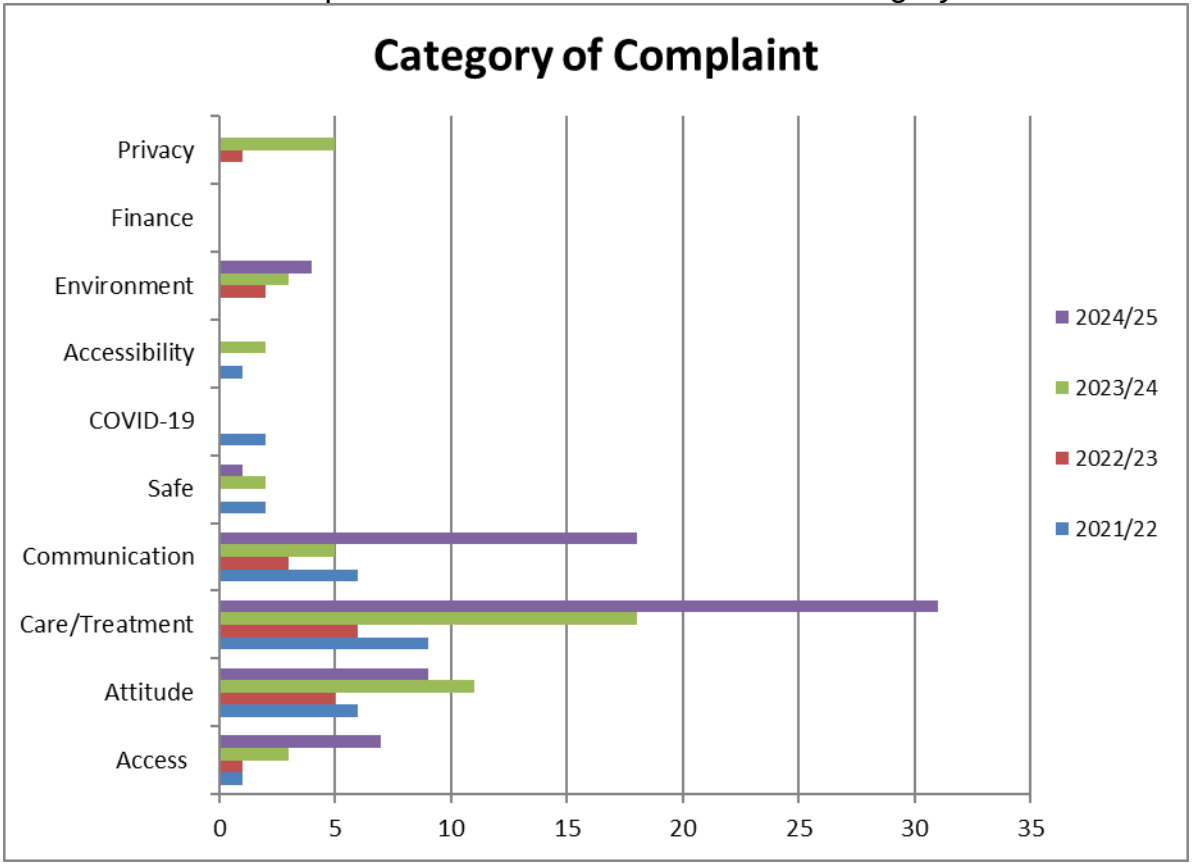
LVGH – 34, EHC – 0, RRHC – 5





Integrity • Respect • Excellence • Growth

Note: Concerns/complaints can fall in more than one category.



Categories

(Note: a complaint may be reflected in more than one category)

Accessibility - feedback resulting from the accommodation of a disability.

Access - Access to Service - feedback related to wait times, bookings, time spent in departments/clinics, scheduling of procedures, obtaining test results, delays in care, wayfinding.

Attitude - Attitude/Courtesy - whether staff are perceived as courteous, helpful, sensitive; includes manner, tone, friendliness and attention.

Care - Care/Treatment - demonstration of professional and technical skills. May pertain to accident/injury, coordination and continuity of care, in-hospital infection or discharge issues.

Communication - feedback related to communication style, information, clarity in explanations, willingness to answer questions.

Environment - degree to which expectations of cleanliness, privacy, temperature, noise, aesthetics, comfort, upkeep, etc. were met.

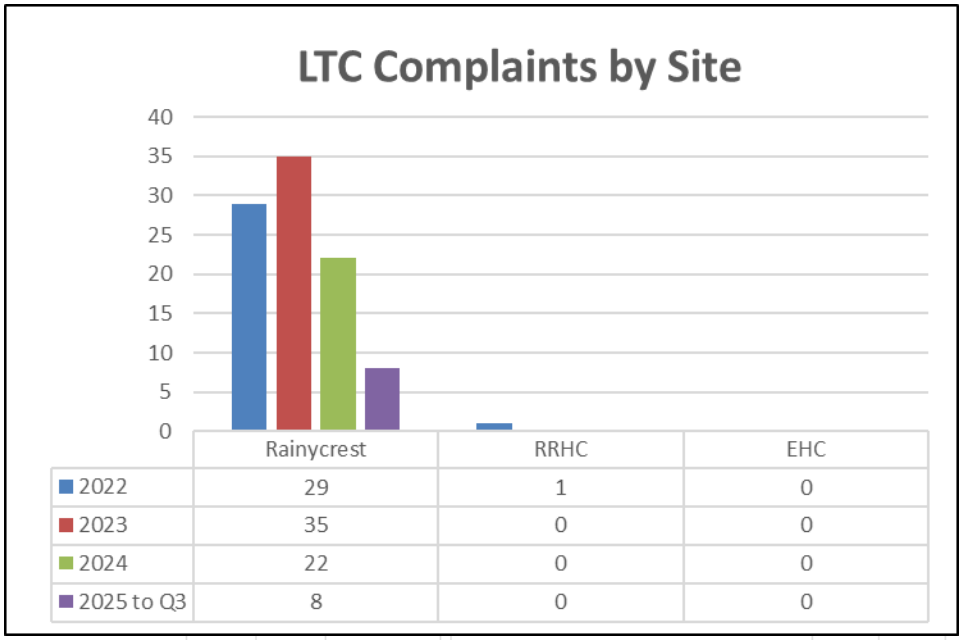
Finance - feedback related to completeness or accuracy of charges for which a patient or third party is billed.

Privacy - Privacy/Confidentiality - feedback suggesting that information had been shared inappropriately due to environment constraints or without appropriate consent.

Safety - the extent to which provisions are made for safety and security of people and belongings.

Long Term Care Complaints Summary

The Fixing Long Term Care Act requires LTC homes to “investigate and resolve where possible, and a response be provided within 10 business days of the receipt of the complaint”. These are captured on a calendar year rather than fiscal year. Rainycrest has 8 complaints to date in 2025 while Emo and Rainy River Health Centre’s did not have any complaints reported. All complaints for this year were appropriately followed up on in the legislated time frame and deemed to be compliant with this requirement.



Nature of Complaint	2023	2024	2025 to Q3
Care/Treatment	17	8	6
Communication	2	6	3
Attitude	0	0	3
Resident Rights	3	1	1
Confidentiality/Privacy	0	1	
Safety	1	2	1
Program	0	0	1
Food	3	2	1
Laundry	1	0	
Cleanliness/Environment	1	2	
Security	1	0	
Resident to Resident	0	5	
Financial	0	1	
Operational/Admin	2	0	
Timing of Access to Care	1	0	

Actions taken to address complain	2023	2024	2025 to Q3
Revisions to Care Plan	12	4	3
Education / Re-training	3	1	4
Performance Management / Termination	0	1	1
Policy Change	0	0	
Practice Change	2	6	2
Communication	15	18	6
Resident to Move/Transfer/Discharge	0	2	
Report to regulatory body	0	0	
Apology	3	11	7
Communications to external party	1	0	
Other	2	3	
None	0	0	

Riverside Health Care 2025/26QIP

Theme	Measure/Indicator		2024/25 performance (Q3)	Suggested 2024/25Target	Q1 Apr-Jun	Q2 Jul-Sep	Q3 Oct-Dec	Q4 Jan-Mar
Experience	**Employee retention (excluding retirements)**	x	96.0%	97.0%	99.2%			
Experience	**Position Stabilization** (1.0 - (# filled positions/ # total FT & PT positions)) x100		80.00%	82.0%	84.9%			
Experience	**Workforce stability - agency staffing utilization** (% = agency costs(wages, fees and housing)/ total expenditures)		13.90%	20.0%	pending			
Experience	**Quality of work life - #days refused vacation requests** (% = vacation days refused within year)		n/a	collecting baseline	pending			
Experience	**Performance Conversations**	☒	n/a	100.0%	19.0%			
Equity	**Mandatory Education Compliance**		n/a	100.0%	27.0%			
Equity	**Appropriate referral to Mental Health follow up for those meeting criteria through the Emergency Department**	☒	41.0%	70.0%	72 seen by HSN			
Experience	**Experience Survey-Short Survey Reponse Rate**	☒	collecting baseline	500/year	14			
Experience	**Emergency Department Wait Time for Registration to Physician/NP Initial Assessment**		n/a	collecting baseline	1.2hrs			
Safety	**# completion of medication reconciliation upon discharge**			100%	pending			
Experience	**# riders to utilize specialist and diagnostic transportation**		n/a	collecting baseline	85			
Experience	**OT hours Rainycrest (Staff and Agency)**		n/a	collecting baseline	pending			
Experience	**Rainycrest Activation Program**	☒	n/a	Milestone 1,2,3	40.0%			
Experience	**Emergency Department Wait Time for Registration to Triage/Assessment** (Time in ER until disposition decision)			collecting baseline	12 min			
Safety	**Review of Residents in Daily Physical Restraints in Rainy River ELDCAP**		39.90%	20%	31.1%			
Safety	**Number of workplace violence incidents reported by workers (physical violence or threat of physical violence) within a 12 month period Hospital/Community sites**		# wpv in 24-25	10-20% increase in reporting	5			
Safety	**Number of workplace violence incidents reported by workers (physical violence or threat of physical violence) within a 12 month period. LTC/ELDCAP Sites**	x	# wpv in 24-25	10-20% increase in reporting	28			

⌘ =performance based compensation

Updated Feb 2024

Quality Improvement Report
Sysmex Hematology Analyzer-Rainy River Hospital
Team/Dept
LAB
PLAN: Briefly describe the project
The planning began last fall with University Health Network Description: With the need for Complete Blood Count testing on-site at Rainy River Hospital, research began on finding the right point of care testing analyzer. Our original choice of analyzer was no longer available, so we had to look for a new reliable analyzer. University Health Network recommended Sysmex as a leader in Point of Care Testing for hematology. After engaging Sysmex and meeting with the vendor, we found the technology that would be the best fit for Rainy River Hospital. At the time of meeting with the Sysmex team, they announced that they had newer technology that would allow for Quality Control and operator lockout. These are key risk mitigators with equipment being off site from the main lab. The decision was made to wait for the new technology to be approved by Health Canada. This occurred in February 2025. We placed our order in March/25 once inventory was available for order. We were the first hospital in Canada to have this technology. Our current process has nursing sending blood samples to Fort Frances to be ran which can involve a 24 hour wait depending on time of collection and transportation. Rainy River Hospital now keeps 2 uncrossed units of blood on-site so having this technology allows physicians to make informed and accurate decisions on transfusions. It helps diagnose possible sepsis and infection in minutes instead of hours.
Timeframe for the DO phase:Currently ongoing Description:This project is well under way. We are finalizing the validation process with out Medical Lab Technologt's reviewing 80 CBC slides for comparison. We have initiated Meditech for the interface and will begin regional project meetings starting August 20/25. Sysmex has already been on-site to train staff to be able to train the trainer. Our IST department has been engaged with Sysmex to ensure a smooth connection to our network.
STUDY: What was the outcome?
Ongoing Description:Results have been analyzed, and samples are currently being compared
ACT: What will you do next?
Nursing feedback will be collected after go-live. Physician engagement will also occur once the equipment has been moved to Rainy River Hospital

Quality Improvement Report
Streamlining Crisis response services in ER
Team/Dept
HSN/MH&A
PLAN: Briefly describe the project
HSN to attend Crisis response staff meeting in October, to provide education and training on updated HSN referral form, HSN Data collection form and SI RISK assessment form HSN has written policy and procedure of when to refer to HSN Program, HSN has updated all forms associated with program and created training documents for share with crisis response staff
DO: What did you do and how did you measure what you did?
HSN will provide training to Crisis Response staff on the updated HSN Referral form, patient data collection form and SI Risk assessment form
STUDY: What was the outcome?
The outcome hasn't happened and but HSN will provide an update to Housing Manager and Staff at 6 month mark
ACT: What will you do next?
HSN will keep track on change implementation and will communicate to the housing manager on a monthly basis when meeting to reconcile stats/

Quality Improvement Report

Rainy Crest Vending Machine

Team/Dept

Dietary

PLAN: Briefly describe the project

Staff brought forward at meetings that they would like to have food available for purchase 24/7, rather than only having the option to purchase meal tickets and limited options. Leadership purchased vending machines that allow staff to have access to many different food items/beverages 24/7.

DO: What did you do and how did you measure what you did?

Vending machines was purchased, worked with vending machine company, and IST to have it installed. Vending machine was purchased in April 2025 but due to lack of communication from the company, we had to ask senior leadership for help in engaging the company to move forward with the project. Once everyone was on board, we were able to get the vending machine up and running by August.

STUDY: What was the outcome?

The vending machine is up and running, and staff are now starting to purchase the food items/beverages.

ACT: What will you do next?

Engaging with senior leadership about the pros/cons of starting up the vending machines at LVGH and Rainy River site. Continue to monitor the Rainy Crest vending machine.

Experience Survey Reporting Schedule
2025-2026

Each Program/Department listed below is required to submit summary report of their experience surveys in the month listed below.

Program/Department	Report Timeframe	Contact	September	October	November	December	January	February	March	April	May	June	July	Date Submitted	Date to QSR Committee	Date to PFAC Committee
LTC & ELDCAP Resident Experience Survey	Annual Report	Calli Vandenbrand					x									
LTC & ELDCAP Family Experience Survey	Annual Report	Calli Vandenbrand					x									
Inpatient Experience Survey	Quarterly	Carley Romyn/Julie Cousineau		x			x			x			x			
Inpatient Post-Discharge Phone Calls	Annual Report	Carley Romyn/Julie Cousineau							x							
Obstetric Patient Survey	Annual Report	Carley Romyn/Julie Cousineau										x				
Emergency Patient Experience Survey	Quarterly	Julie Cousineau		x			x			x			x			
Diagnostic Imaging Patient Survey	Annual Report	Andrea Faragher					x									
Riverside Mental Health and Addictions Survey	Bi-annual Report	Megan Baskie				x						x				
Day Surgery Post-op Phone calls	Annual Report	Julie Cousineau					x									
Endoscopy Patient Survey	Annual Report	Julie Cousineau		x												
Chemotherapy and PICC Line Insertion Survey	Annual Report	Julie Cousineau									x					
Rehab Services Survey	Annual Report	Heidi Loney			x											
Riverside Diabetes Education & Management	Annual Report	David Black		x												
Community Support Services Survey	Annual Report	Kelli Bolen								x						
Non Profit Supportive Housing Survey	Annual Report	David Black		x												
Transportation	Annual Report	David Black		x												
Telemedicine Patients	Annual Report	Heidi Loney									x					
Laboratory Patient Survey	Annual Report	Penny VanDrunen										x				
Laboratory Physician and Nurse Satisfaction survey	Annual Report	Penny VanDrunen										x				
Worklife Pulse Staff Survey	Annual Report	Joanne Ogden								x						
Worklife Pulse Physician Survey	Annual Report	Joanne Ogden						x								

Riverside Health Care

Caring, Together

Patient Experience Overview Q1 2025-26

Surveys completed both short and extended survey indicate 65.5% were of the long variety and 95.6% of the long surveys were completed at LVGH, none in Emo and 4.4% in Rainy River.

Long Survey

- Almost 43% of the respondents received care in the ER
- 9.25% were from inpatient and the rest were from DI, Rehab or Telemedicine. Only 16.67% felt that they had a long wait for care. Of those that answered gave the ER a rating of 4.42/5
- 61.5% of the respondents were seen but not admitted.
- All responses were shared with the appropriate dept. to address, both positive and areas of concern. These will be reflected in the Patient experience reports coming from each unit starting in October.

Short Survey

- Almost 50% of the respondents had visited diagnostics, either lab or DI
- 11.5% were in the ER and 23% were from the 1st floor inpatient areas (ICU, Med-Surg, Maternity)
- Chemo, telehealth and other were the remaining short surveys
- 84% of respondents thought their needs were met.
- LVGH had 87.5% of the surveys, Emo had none, the rest were from Rainy River and Rainy Crest.
- All responses on the short survey were positive there were no concerns shared

All surveys both short and long are reviewed at time of response and concerns and kudos shared with the managers and directors. Change ideas are instituted on a timely basis and followed by Quality and Risk as required.

Riverside Health Care

Integrated Quality, Safety, Risk Framework

Contents

Executive Summary

The integrated quality, safety, risk framework illustrates Riverside's commitment to quality improvement, safety and risk management and the integration of these commitments into the daily work of our team members.

Riverside's integration of quality, safety and risk are embedded at the governance and strategic levels, with a highly engaged Board of Directors and a strategic plan with a strong emphasis on continuous quality improvement, enhancing safety and mitigating risks. Our leadership team regularly participates in quality improvement activities, and is accountable for the safety of their teams and identifies risks as they arise. Our direct care team members work each day to provide a high quality, caring and safe environment for our patients, residents and clients. Riverside's commitment to quality, safety and risk continues into the community with many partnerships throughout our community.

This framework is an ever evolving network of integration of our quality, safety and risk activities at Riverside. The following pages detail the key activities Riverside uses to integrate quality, safety and risk into our daily activities and the accountability structure in place to ensure we monitor, measure and maintain these activities. This framework also demonstrates how Riverside is meeting legislative requirements regarding quality, safety and risk, including the *Excellent Care for All Act*, Q*uality of Care Information Protection Act*, *Occupation Health and Safety Act, Long Term Care Act* and *Public Hospitals Act.*

Structure and Framework

All employees of Riverside are responsible for participating in quality improvement, and risk management activities and to contribute to a safe environment for patients, clients, residents and team members. These responsibilities include: complying with policies and procedures, identifying and reporting issues and risks, and actively participating in quality improvement work with their teams.

The Integrated Quality, Safety, Risk Framework illustrates activities and structure at Riverside to promote quality improvement activities, a safe environment for patients, clients, residents and staff and risk mitigation. At the centre of our work is every person we serve.

Throughout this framework narrative we may refer to the people we serve as our “patients”. This term will be used to include our patients, our residents and our clients. We use team members to encompass our staff, physicians, volunteers, students and vendors.

Integrated Quality, Safety, Risk Framework

Organizational Structure and Integrated Quality, Safety and Risk

Board of Directors

The Riverside Board of Directors have a significant governance role in improving quality and safety, and managing organizational risk by fostering an environment where clinical and non-clinical staff and leadership are committed to quality, patient safety efforts and ensuring a safe environment for staff to work in.

The Board is responsible for establishing a process and a schedule to monitor and assess performance in areas of board responsibility, including: fulfillment of the strategic directions in a manner consistent with the mission, vision and values, oversight of management performance, quality of care and services, financial conditions, external relations, and the board's own effectiveness. The Board also ensures management has identified appropriate measures of performance.

Section 32 of OHSA requires that the Board to take all reasonable care to ensure the Organization's compliance with the Act and the regulations, orders and requirements of inspectors and directors, and orders of the Minister.

The reporting structure of operational and governance committees ensure the Board has knowledge of inherent and emerging risks in the Organization's operations. The Board also integrates risk management into its decision-making processes. The Board ensures appropriate programs and processes are in place to protect against risk, and the Board is responsible for identifying unusual risks to the organization and ensuring there are plans in place to prevent and manage such risks.

The Board sets the direction and strategic plan for the organization. The Board's focus on an integrated approach to quality, safety and risk is evident in our strategic plan. Our strategic pillars are Quality, Organization Health, Partnerships and Advocacy.

Senior Leadership

Senior Leadership directs the functioning of the organization and the management team. Senior Leadership is directly responsible for developing, implementing, monitoring and modeling a culture of quality, safety and risk management. The development of an explicit quality agenda by Senior Leadership is a key factor in promoting a high performing healthcare system. Setting a strategic direction focused on quality, safety and risk empowers Riverside to continue to improve quality of care and the work-life of our employees.

Senior Leadership sets the tone for a culture of safety, and a just culture[1], through strategic planning activities, organization structure, resource allocation and general direction. Senior Leadership must continue to monitor safety trends, support leaders and help problem solve during challenging safety events.

[1] Just Culture is defined as an environment which seeks to balance the need to learn from mistakes and the need to take disciplinary action.

To ensure patient safety is a priority, Senior Leadership is accountable to provide appropriate supports and resources for those assigned to delivering safe patient care, including the necessary infrastructure, equipment and human resources, and ensuring employees are prepared to talk with the patient about their role in patient safety. Senior Leadership plays an important role in monitoring the patient, resident and client safety trends and advocating as needed to ensure everyone can be cared for in a safe environment.

The Senior Leadership team has significant accountability to ensure our legislative requirements for staff safety are met. Section 25 of the Occupation Health and Safety Act (OHSA) imposes obligations on employers to, among other things, ensure (i) the safety of equipment, materials and safety devices; (ii) that measures and procedures are carried out to ensure safety in the workplace; (iii) that the building is safe; and (iv) that every precaution possible is taken to ensure the safety of the workplace.

Organizational Leadership

Riverside's leadership includes directors, managers, supervisors, coordinators and subject matter experts. Leadership must be consistent and supportive of quality improvement activities, safety requirements and risk management activities. Leaders are responsible for identifying models for improvement and adapting the models to their own departments. All levels of leadership must be aligned in the Riverside strategic direction, and should ensure involvement of all team members in their quality, safety and risk activities.

All organizational leaders are responsible for the quality of the services delivered by their departments.

The Institute for Healthcare Improvement (IHI) suggests in their 2017 Framework for improving *Joy in Work*, when leaders have the skills to lead improvement in daily work, and engage their teams effectively, this improves staff satisfaction and the quality of care patients, residents and clients receive. In addition to our Directors, Managers and Supervisors, Physician leadership has a particularly important role in driving quality improvement. Physician leaders have a strong influence on team members in driving quality improvement activities.

Every member of the organization's leadership team has a responsibility for ensuring their departments are adhering to patient safety requirements and precautions. Riverside has a comprehensive set of patient safety policies, procedures, guidelines, best practices and requirements for each department to reduce the risk of a safety event from occurring and to appropriately respond to events when they do happen. Physician leadership also has an important role in patient safety; physicians are expected to be following all the same safety requirements as the rest of the team.

Under the Occupation Health and Safety Act Organizational Leadership is responsible for meeting the duties of a supervisor (OHSA 27(2)(2)):

> *"works in the manner and with the protective devices, measures and procedures required by this Act and the regulations; and uses or wears the equipment, protective devices or clothing that the worker's employer requires to be used or worn; advise a worker of the existence of any potential or actual danger to the health or safety of the worker of which the supervisor is aware; where so prescribed, provide a*

worker with written instructions as to the measures and procedures to be taken for protection of the worker; and take every precaution reasonable in the circumstances for the protection of a worker."

Staff and Physicians

Staff members of our health care team who provide direct care and services are vital resources to improve quality of care, ensure a safe environment and manage risk. Riverside is committed to engaging physicians and staff in quality, safety and risk initiatives; this is essential to achieve high performance in healthcare systems. Direct Care (aka Front Line) employees are ideally placed to identify and carry out quality-improvement initiatives and if not consistently involved in efforts aimed at creating a quality improvement culture in healthcare organizations, the organization loses this key perspective.

Leaders, staff and physicians have an important role for ensuring our teams are successful in delivering safe, high quality care to our patients, residents and clients, and creating a safe health work-life for our employees and teams. It is expected everyone is role modeling the expected behaviors, and fully participating in all quality improvement activities, safety standards and requirements, as well as actively participating in risk management activities within their department and throughout the organization.

As Mother Teresa stated: "*You can do what I cannot do. I can do what you cannot do. Together we can do great things."*

Quality Improvement Programs at Riverside

Overview and Guiding Principles

At Riverside, we strive to deliver safe, high quality care to our patients, residents and clients, and we are committed to creating a safe healthy work-life for our employees and teams. The guiding principles supporting the delivery of care and service are based on the quality dimensions Accreditation Canada uses to develop the standards and criteria for providing safe, high quality health care. The quality dimensions are:

- Accessibility – Give me timely and equitable service
- Appropriateness – Do the right thing to achieve the best results
- Client-centred Services – Partner with me and my family in our care
- Continuity of Services – Coordinate my care across the continuum
- Efficiency – Make the best use of resources
- Population Focus – Work with my community to anticipate and meet our needs
- Safety – Keep me safe
- Work-life – Take care of those who take care of me

The *Excellent Care for All Act* (ECFAA) defines a high quality health care system as one that is "accessible, appropriate, effective, efficient, equitable, integrated, patient-centred, population health focused and safe."

Quality Committees and Teams

Riverside has a well-established structure to support the quality improvement activities within our organization. The work of the committees is driven by the direction set by our Strategic Plan. The Board of Directors determine the organization's mission, vision and values based on input from patients, staff, physicians, key stakeholders and the community.

Quality, Safety, Risk Committee of the Board

The Quality, Safety, Risk (QSR) Committee of the Board is established under the authority of ECFAA. The QSR Committee is a governance committee and is accountable to the Board of Directors as well as the patients, clients, residents and the communities served by Riverside. The role of the QSR Committee of the Board is to monitor and report to the Board on quality, safety and risk issues. Through operational reports the QSR Committee provides strategic oversight on the overall quality of services provided in the organization, with reference to appropriate data, such as performance indicator, patient experience, reports from Medical Advisory Committee, critical incidents etc. The QSR Committee is responsible for reviewing and making recommendations with respect to risk management, for overseeing the preparation of annual quality improvement plans and to consider and make recommendations to the Board regarding quality improvement initiatives and policies.

Quality, Safety, Risk & Privacy Review Team

The Quality, Safety, Risk & Privacy (QSRP) Review Team is an operational working group consisting of Senior and Organizational Leaders. This committee is responsible for analyzing, aggregating and reporting information provided by teams throughout Riverside and reports to the QSR Committee of the Board and Senior Leadership promoting quality, safety, risk and privacy integration. The QSRP Review Team functions as a resource to enhance the awareness and capacity of the organization in the areas of quality, safety, risk and privacy. The group ensures lessons learned are shared throughout the entire corporation.

Quality of Care Committee

The Quality of Care Committee is designated under the *Quality of Care Information Protection Act, 2016* (QCIPA). The Quality of Care Committee has overall responsibility for quality of care reviews related to critical incidents within a health facility[2]. The purpose of the Quality Care Committee is to carry out quality of care reviews for the purpose of studying, assessing, or evaluating the provision of health care with a view to improving or maintaining the quality of health care, or the level of skill, knowledge and competence of the persons who provide health care.

Event Review or Incident Analysis

Riverside utilizes the Canadian Patient Safety Institute Canadian Incident Analysis Framework to conduct event reviews or incident analysis. It is a structured process that aims to identify what happened, how and why it happened, what can be done to reduce the risk of recurrence and make care safer, and what was learned. Recommendations from the review are brought forward to the Medical Advisory Committee as well as shared broadly with staff in their respective departments.

Medical Advisory Committee

The Medical Advisory Committee (MAC) is appointed by the Board to consider and make recommendations on matters pertaining to the professional staff, including granting of privileges, appointments and reappointment and assuring that quality health care is delivered by professional staff.

Long Term Care Continuous Quality Improvement Program

Rainycrest has a Continuous Quality Improvement (CQI) Program. The CQI Committee's role is to provide a forum to review all aspects of the quality programs of the home with an emphasis on Quality Management and Improvement. The goal is to improve the quality of life for our residents and staff, in partnership with our stakeholders. The subcommittees of the CQI Committee include: Falls Prevention, Restraints, Pharmacy and Therapeutics, Skin and Wound, Continence Care and Bowel Management, and Professional Advisory Committee.

[2] Under QCIPA legislation "health facility" refers to hospitals as per the *Public Hospitals Act* and to long-term care homes within the meaning of the Long-Term Care Homes Act, 2007. This legislation does not relate to our Community or Housing Programs

Emo Health Centre and Rainy River Health Centre have ELDCAP[3] beds and may integrate its quality improvement and utilization review system with that of the adjoining long-term care home (LTC Reg 79/10 s.317.(4)10). The CQI activities are shared across the organization.

Patient and Family Advisory Council

The Patient & Family Advisory Council (PFAC) is committed to enhancing the quality of patient care at Riverside through collaborative efforts with patients, families, caregivers, staff and leadership. PFAC works to identify current and future opportunities to improve the care experience for patients and caregivers. Riverside works with this council to identify and integrate the patient perspective into our planning and activities with a focus on continuous quality improvement. We ensure the perspective of patients, family members and caregivers is always considered and incorporated in organizational activity. Listen and learn from patients/families/caregivers to embed the patient voice throughout the organization.

Long Term Care Residents' Councils

Each of our Long Term Care and ELDCAP locations has their own residents' council. A Residents' Council is made up of, and represents, all residents in the home. Through the Long-Term Care Homes Act, 2007, all long-term care homes are mandated to form and support Residents' Councils.

The Residents' Council of a home provides an avenue for residents to maintain a degree of control over their lives, share in the management of the home, and thereby contribute to the welfare of all involved, including staff and administration.

Long Term Care Family Councils

Family Councils are included in the Long-Term Care Homes Act, sections 59-68. The Act outlines the Long Term Care Home's obligations to support the establishment of a Council, the powers of a Council, and who may and may not be a member of the Council. Each long term care and ELDCAP location within Riverside has an established Family Council.

Our Family Councils focus on improving the quality of life and assuring quality of care for all residents and supporting each other.

Ethics Team

Riverside's Ethics team is a multidisciplinary team that acts as a forum committed to maintaining high levels of professional ethics and excellence to serve and protect our patients. The Team guides and supports the various disciplines within the organization and strives to create an environment that enables maximum participation in ethical decision making.

[3] ELDCAP: The Elderly Capital Assistance Program (ELDCAP) provides services to Long-Term Care residents in units that are collocated within hospitals in small northern communities. ELDCAP beds are subject to the Long-Term Care program requirements but are funded through a hospital's global budget.

Other committees with a focus on quality

- Pharmacy and Therapeutic Committee (P&T)
- Infection Prevention and Control Committee (IP&C)
- Joint Occupational Health and Safety Committees (JOHSC)
- Audit & Resource Committee (A&R)
- Transfusion Medicine Committee
- Accreditation Teams

Key Quality Improvement Activities

Quality Improvement Plan

A Quality Improvement Plan (QIP) is a public, documented set of quality commitments that a health care organization makes to its patients, clients, residents, staff, and community on an annual basis. The quality commitments are aimed to improve quality through focused targets and actions. Each year the QIP is designed to build off the one before. We are required to develop and submit our QIP to Health Quality Ontario (HQO) on or before April 1 of every year.

The goals of the QIP program are to:

- Promote quality as a strategic focus;
- Foster a culture of quality within organizations and providers of care;
- Set and advance both local and provincial priorities for quality improvement through an alignment with the Quality Matters framework

The Riverside QIP includes indicators that focus on quality of resident and patient care, employee engagement & satisfaction as well as safety of our staff and those we care for. The QIP is provincially mandated for Hospital and Long Term Care and is the reason many of the indicators are focused on our patient and resident populations. We include indicators related to all aspects of Riverside by reporting on key staff engagement indicators.

ECFAA also requires patient involvement in the development of our annual QIP and to improve patient relations processes. The Patient and Family Advisory Council plays an active role in the discussion and development of the annual QIP. With the start of the COVID-19 Pandemic in March 2020 Health Quality Ontario stated that submission of the 2020/21 Quality Improvement Plans has been paused. The mandatory submission of a QIP to HQO remains paused for 2021/2022. Riverside will continue with ongoing quality improvement activities in a condensed more manageable internal QIP as managing pandemic efforts continue throughout the organization.

ECFAA requires the compensation of CEOs and other executives to be linked to the achievement of performance improvement targets laid out in the QIP of every health care organization in Ontario.

Quality Improvement Communication

Formal and informal quality improvement activities are happening throughout Riverside daily. Quality improvement activities including monitoring, reporting and trending of indicators are communicated through newsletters, staff meetings, town halls, emails and posters. The quality improvement activities are also communicated through Riverside's Quality Improvement Program QI reports and quarterly Quality Improvement Plan (QIP) updates. These reports are regularly reviewed by the QSRP Review team and communicated up to the QSR Committee of the Board. Board committees with a quality focus, including the QSR Committee, Governance Committee, and Audit and Resource Committee, provide regular reporting to the Board of Directors. Quality Improvement activities are reported publically through the QIP narrative annually and in Riverside's Annual Report.

ECFAA requires all hospitals to have a patient declaration of values in place that has been developed in consultation with the public and is accessible to the public. Riverside's declaration can be found on the website and entitled Patient Declaration of Rights & Responsibilities.

The ECFFA clearly states that hospitals must also publicly post their annual QIPs. The Riverside QIP is posted annually on the organization's website as well as the Health Quality Ontario (HQO) website.

Accreditation

Accreditation Canada uses national standards of excellence to enable organizations to improve the quality and safety of their services. Accreditation Canada's standards help organizations assess quality at the point of service delivery and embed a culture of quality, safety, and client- and family-centred care into all aspects of service delivery.

Health Care Accreditation is an ongoing process and Riverside participates in the Accreditation Qmentum on-site survey roughly every four years. Qmentum Accreditation program provides organizations with an independent, third-party assessment using Health Standards Organization's (HSO) world-class standards of excellence and is delivered by an HSO Assessment Partner.

The Qmentum Accreditation program involves all members of the organization, from the board of directors to direct-care staff as well as members of the community including patients and families and community partners.

Departmental Quality Improvement Programs

Riverside is continuously working to enhance and improve our departmental quality improvement program. The current program is based on the Health Quality Ontario's (HQO) IDEAS (Improving & Driving Excellence Across Sectors) program, the Institute for Healthcare Improvement (IHI) quality improvement and other patient safety and quality improvement best practices.

Many of our managers at Riverside participated in quality improvement training. Each department is expected to submit a quality improvement report on a departmental quality improvement initiative at least once per year, as

indicated on the Quality Improvement Reporting Schedule. These reports are reviewed at the QSRP Review Team and a summary is reported to the QSR Committee. Authors of these reports may be asked to present at the QSR Committee occasionally to highlight their teams quality improvement activities.

Riverside has a standard set of tools intended for quality improvement activities. These tools include:

- **Quality Improvement Project Charter** – This "one pager" provides leaders and staff to collectively design their QI project. The intention is to allow teams to quickly and easily document the project scope, identify the problem, define the aim statement, determine measurements, identify any root causes and barriers, brainstorm change ideas and identify the quality dimension the project is working to improve. The QI project charter is a living breathing document and will evolve as the project evolves. It is intended for large and small QI projects, not major organizational strategic initiatives.

- **Plan – Do – Study – Act Worksheet** – The Plan-Do-Study-Act (PDSA) worksheet template allows a team to document their PDSA journey and the template takes the team through the Plan – Do – Study – Act process by asking promoting questions to help the team work through the process. The final stage of "Act" asks the team if they will Adopt, Adapt or Abandon the project. This decision will determine if and how the next PDSA cycle will be designed.

- **Failure Mode and Effects Analysis Template** - Failure Mode and Effects Analysis (FMEA) is a multi-step proactive risk assessment process. It allows us to identify, assess and mitigate failures in a process before they happen to improve the quality and safety during any patient experience. The FMEA template provides step by step instruction for the team to move through their risk assessment.

- **Quality Improvement Report Template** – This template is available to all teams to document and report their departmental quality improvement initiatives to be shared at the QSRP Review Committee and QSR Committee of the Board. Quality Improvement reports may be related to completed, ongoing or planned quality activities within a department or team.

- **Quality Improvement Reporting Schedule** – this schedule is updated annually and identifies the months each department is required to submit a quality improvement report.

- **Future Standardized tools** – The Riverside Quality Improvement Program is in its infancy and will continue to grow as new QI tools and resources are needed to support this burgeoning program.

Quality Indicators

Riverside records, reports and trends a number of quality indicators as a measurement of success in achieving organizational goals, provincial requirements and industry standards. Accreditation Canada defines an indicator as *"A single, standardized measure, expressed in quantitative terms, that captures a key dimension of individual or population health, or health service performance."* Tracking indicator data over time identifies successful practices or areas requiring improvement; indicator data is used to inform the development of quality improvement activities. Types of indicators include: structure measures (indicators involving capacity and

systems), process measures (indicators involving a process), outcome measures (indicators related to any difference made), and balancing measures (indicators involving any unintended outcomes).

The Board tracks and monitors key quality indicators including participation, attendance, reflection, decision making and education.

Mandatory Reporting

Riverside monitors and reports indicators to Ministry of Health and Long Term Care (MOHLTC) to meet the mandatory reporting requirements. These indicators include:

1. Surgical Efficiency Targets program (SETP)
2. Critical Care information system (CCIS)
3. Emergency Reporting NACRS Initiative (ERNI)
4. Employee Wellness indicators (eg., WSIB stats, recruitment, retention)
5. MOHLTC Mandatory Public Reported Patient Safety Indicators: These are presently under review by the MOHLTC with several being recommended for retiring and proposed new indicators to be added. There remains the requirement that we collect and report on our website. Not all are reported on the HQO website. We will await further direction from the MOHLTC.
    a. CDI Clostridium Difficile Infection
    b. MRSA Methicillin Resistant Staphylococcus Aureus
    c. VRE Vancomycin Resistant Enterococcus
    d. VAP Ventilator Associated Pneumonia
    e. CLI Central Line Infection
    f. Hand Hygiene Audit
    g. Surgical Site Infection Rates (TKA)
    h. Surgical Checklist compliance
    i. HSMR (Hospital Standardized Mortality Rate)
6. MIS (Management Information System) guidelines
7. OHRS (Ontario Health Reporting Standards)
8. DATIS- Drug & Alcohol Information System
9. CONNEX Ontario- Mental Health & Addictions Public Information Source (No mandatory reporting)
10. CDS-MH- Common Data Set for Mental Health
11. Service Accountability Agreements (H-SAA, M-SAA, L-SAA)
12. Program Activity, Statistical and Financial Compliance Reporting

Mandatory reported data can often be used for benchmarking and comparing Riverside's data to other facilities or provincial and national averages.

Organizational Monitoring

Through various departments, committees and the Board, Riverside routinely monitors a number of indicators:

1. Patient Safety incidents and trends (includes medication events, falls)

2. Workplace occurrence incidents and trends
3. Employee engagement results
4. Inpatient satisfaction results
5. Resident satisfaction results
6. Emergency Department satisfaction results
7. Client & Outpatient satisfaction results
8. Diagnostic Services satisfaction results
9. Community Support Services satisfaction results
10. Infection Control indicators
11. Employee absenteeism
12. Financial indicators
13. Departmental indicators
14. Quality Improvement Plan indicators
15. Statistical and program activity indicators

Safety at Riverside

Overview and Guiding Principles

A high quality and safe environment for staff, patient, client, residents and visitors is a priority for Riverside. Health care is a high-risk, high-demand, high-stress industry in perpetual change, one with unique health and safety challenges. Both pro-active and responsive approaches to safety are utilized. Patient, resident and client safety best practices, such as falls prevention, medication reconciliation and monitoring patient safety trends are seen throughout Riverside to ensure patient safety is a priority. Staff safety requirements are legislated by the OHSA, which outlines the requirements for our Internal Responsibility System (IRS). Industry best practices like those provided by Public Service Health and Safety Association (PSHSA) are also utilized to create a safe environment for staff.

Riverside strives to create a 'Just' culture as part of the overall safety culture. A just culture is an environment which seeks to balance the need to learn from mistakes and the need to take disciplinary action. The Canadian Patient Safety Institute (CPSI) defines a just culture as the importance of fairly balancing an understanding system failure with professional accountability.

Safety Committees and Teams

Riverside has an integrated approach in quality, safety and risk. All of the Quality Committees listed earlier in the document also have a safety and risk focus. There are a number of safety focused committees within Riverside and these committees have quality and risk integrated in the work that they do.

Infection Prevention and Control Committee

The Infection Prevention and Control Committee (IPACC) is responsible to monitor and ensure compliance of the Infection Prevention and Control Program, review all cases of nosocomial infections, maintain policies and procedures and assess the training needs of staff related to infection prevention and control.

Corporate Falls Prevention Committee

The Corporate Falls Prevention (Falls) Committee functions as a resource to enhance the awareness and capacity of the organization in the areas of falls prevention. The Falls Committee also recommends and supports improvement measures for quality patient safety, in relation to falls prevention, that will ensure consistency across the Corporation, integration between disciplines and providers, and the implementation of best practices.

Emergency Planning Committee

The Emergency Planning Committee is responsible for developing written plans for the proper and timely care of patients and casualties arising from both external and internal disasters and to periodically rehearse these plans. The Emergency Planning committee is responsible for the development of our Emergency Code Program, including developing process, providing education to staff and facilitating mock codes and drills. The Emergency Planning Committee works collaboratively with our external partners, including the fire departments, municipalities and police to ensure the safety of patients, staff and the public are maintained.

Joint Occupational Health & Safety Committees

Riverside has five JOHSC's: La Verendrye including Non Profit Supportive Housing (LVGH & NPH), Rainycrest Long Term Care (RCLTC), Emo Health Centre (EHC), Rainy River Health Centre (RRHC), and Community Support Services (CSS). These committees are governed by Occupational Health & Safety Law and follow the OH&S Act & Regulations. Some of the activities that these committees perform are monthly workplace inspection checks at each facility, meeting no less than quarterly and reporting workplace deficiencies. All safety concerns in our workplaces must be set as a priority to ensure a safe and healthy work environment for our staff.

Workplace Violence Prevention Working Group

Riverside has two workplace violence prevention (WVP) committees that are sub-committees of our JOHSC's. There is one that focuses on Long Term Care and one for all other facets of our corporation. These committees endeavour to meet three times per year, and more often when necessary.

There are many groups and huddles that bring information to the main workplace violence committees. Our "OH&S WVP Huddles" review any workplace violence incidents that are caused by residents/patients/clients and how we can do things differently to avoid these events happening again.

There is also a "Responsive Behaviours Committee", "Respectful Workplace Committee" and a "Restricted Access Committee" to name a few. The overall goal of the WVP committees is to education our staff and examine the work environment for ways to improve safety and guard against violence.

Key Safety Activities

Improving the quality and safety for patients, residents, clients and staff requires an organization-wide commitment to building and sustaining a culture of safety. The leadership of an organization is central to setting the values and beliefs of an organization's culture. The Board has a critical role to play in building a safety culture that is open and fair. This commitment to safety is evident in the Riverside Strategic Plan.

Riverside policies and procedures provide the foundation to our safety activities. Policies and procedures are developed to address our commitment to preventing workplace violence, provide guidance to maintaining safe work practices and set expectations for delivering safe care.

Patient, Resident, Client Safety

A key tool for managing and monitoring safety is the Incident Reports process. Any unexpected, unusual or unplanned event and/or near miss affecting or potentially affecting safety is reported using the Incident Reporting System. In addition to reporting incidents and near misses, Riverside has a number of practical strategies for eliminating or mitigating potential safety issues such as safety inspections, audits, risk assessments (ie falls), patient and resident satisfaction surveys, emergency preparedness and quality improvement activities.

Staff Safety

Staff safety incidents are also managed and monitored through Incident Reports. All safety events or near misses involving the injury or potential injury of a staff member are reported through a Workplace Occurrence Report. The JOHS committees review workplace occurrences as well as conduct regular safety inspections to identify and mitigate safety risks.

Monthly safety topics are developed and distributed by the Occupational Health and Safety Coordinator for managers to review with their teams. Riverside also has an Employee and Family Assistance program (EFAP) available to all staff and their families.

Staff safety training is comprehensive and includes online training modules as well as in-person and hands on training. Much of the training is mandatory for all staff and additional training is provided based on job type and location of work.

Risk Management at Riverside

Overview and Guiding Principles

Risk management is a proactive strategy to eliminate or control the chance or possibility of danger, loss or injury to residents, clients, patients, staff, the public, property, reputation, environment, organizational function, and financial stability. Risk management is integrated into our quality improvement activities, safety practices, decision making, processes and operations.

Riverside's risk management activities aim to eliminate or reduce the risk of loss or injury to our patients, residents, clients, staff, visitors, directors, facility and to personal and real property. They also aim to eliminate or reduce the risk of liability or other losses due to such injuries.

Key Risk Management Activities

Policies and Procedures

Ensuring an organization has comprehensive policies and procedures is a proactive risk management practice. Riverside policies contain high-level principles or requirements that the organization or a specific department or area must follow, as formally agreed upon by management. These policies set the directional tone for our work. Procedures and processes provide direction on how job-activities are to be completed, related to a particular policy. Risk management is embedded in these agreed upon and documented organizational practices. Leaders and staff at Riverside are responsible for the ongoing deployment, implementation and monitoring of the compliance of policies, procedures and protocols. This supports a standardized practice and quality of work from all employees.

Integrated Risk Management

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" (TBSC, 2010). Riverside's IRM program aligns with Accreditation Canada standards and is currently being developed to include a Risk Register to record and report risks, Risk Profiles and Reference Sheets highlighting mitigation strategies to manage risk and Risk Assessment Checklists (RAC) which is a web based, risk management assessment self-assessment system. As this program develops a report of the risk identification will be provided to Senior Leadership and the Board annually.

Alerts and Recalls

Riverside has a system to address hazard information received through recalls and alerts to ensure the safety of our patients, residents, clients, staff, visitors, and volunteers. Alerts and recalls are follow up on, tracked, monitored regularly and reported on annually.

Drills and Mock Evacuations

Important elements of the Emergency Preparedness plan are Fire drills and mock evacuations. Fire Drills are conducted monthly, with at least one drill a year on an evening shift. Riverside works alongside the local Fire Department to conduct an annual mock evacuation at LaVerendrye General Hospital, Emo Health Centre, Rainy River Health Centre and Rainycrest LTC. The Fire Department observes the mock evacuation and provides a debrief and feedback to the staff and leaders at the end of the drill.

Riverside has comprehensive emergency code procedures. Mock codes are also conducted on a routine basis throughout the organization.

Contingency Plans

Riverside has a number of contingency plans to manage risk related to planned and unplanned events causing a disruption in service. These include:

- Emergency preparedness plans
- Information Services and Technology downtime procedures
- Staffing/Human Resources contingency plans
- Infrastructure contingency plans
- Emergency code procedures
- Pandemic planning
- Departmental contingency plans

Inspections and Audits

Regular inspections are conducted at all Long Term Care and ELDCAP facilities by Inspectors from the Ministry of Health and Long Term Care (MOHLTC). The Northwestern Health Unit completes quarterly food safety inspections in the food services areas at each facility. The Ontario College of Pharmacists inspects our pharmacy on an annual basis. Our laboratory is accredited through the Institute for Quality Management in Healthcare (IQMH).

Audits are performed throughout the organization in patient care areas, service areas as well as in finance, IST, privacy and maintenance.

Concerns, Complaints and Compliments Process

Riverside strives to make every encounter with patients, residents, clients, families and the public an opportunity for quality improvement. The Concerns, Complaints and Compliments (CCC) Process allows Riverside to address feedback received in a timely manner. A summary of the CCC program is reported to the QSR Committee annually.

Code of Conduct

Riverside has an established a Code of Conduct to outline the behaviours that are expected from all persons who work, volunteer, practice and learn in our corporation. Abiding to this code of conduct demonstrates their commitment to Riverside's Vision, Mission and Values.

Preventative Maintenance Program

Riverside's maintenance and biomed teams have a Preventative Maintenance Program. This is managed through a new software program that will monitor both planned preventative maintenance and on-demand maintenance requests. The IST department also has a preventative maintenance program for Riverside hardware and software applications.

Contracts and Financial Processes

Riverside has formalized policies and procedures for budgeting, requesting tenders, issuing Request for Proposals, and securing contracts based on the legislative requirements of the Broader Public Sector Accountability Act (BPSAA).

Insurance

Not all risks can be avoided, mitigated or accepted. Insurance allows Riverside to transfer all or some of a particular risk to a third party. Riverside maintains insurance coverage to protect against losses or damages to corporate property or property of others for which the corporation may have responsibility, this includes cyber security.

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  - https://www.oha.com/Documents/OHA%20High%20Performing%20Healthcare%20System%20Paper.pdf
- Excellent Care for All Act Updates
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- HIROC
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  - http://www.health.gov.on.ca/en/common/legislation/qcipa/
- Long Term Care O. Reg. 79/10
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  - http://www.healthscape.ca/Pages/resources-11032016-QCIPAguidancefromtheOHA.aspx
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RIVERSIDE HEALTH CARE FACILITIES

Hospital Accountability and Transparency

Presented By

November 27, 2025

Borden Ladner Gervais

Overview

- Legal Framework
- Hospital Liability
- Directors' Fiduciary Duties
- Understanding Your Hospital's Legal Accountabilities
- Hospital Transparency
- Engaging Hospital Stakeholders

Note: Materials based on Ontario Hospital Association's Guide to Good Governance, Fourth Edition

Legal Framework

Legal Framework: What is a hospital corporation?

- Typically, a corporation incorporated under the *Not-for-Profit Corporations Act, 2010* ("**ONCA**") and approved as a public hospital under the *Public Hospitals Act* ("**PHA**")
- Limited liability - Directors and members are not liable for corporate obligations (some limited exceptions)
- Members not shareholders
- Objective of governance is organization's mission (Letters Patent / Articles)
- Multiple accountabilities

Hospital Liability

Hospital Liability

- “Vicarious” (indirect) liability for employees
- Direct liability for:
  - Protection of patients
  - Facilities and equipment
  - Safe operation of hospital systems and processes (coordination, policies, protocols)
  - Professional staff selection and monitoring competence
- Physicians are liable for clinical services (generally independent contractors)

Directors’ Fiduciary Duties

Directors' Fiduciary Duties

- **Duty**: Act honestly and in good faith with a view to the best interests of the hospital (not to any one group or representational interest)
- **Standard of Care**: Exercise the care, diligence and skill that a reasonably prudent person would exercise in comparable circumstances
- Comply with applicable legislation and regulations, articles, by-laws, contracts, etc.

Understanding Your Hospital's Legal Accountabilities

Legal Context Setting

- Hospitals are not ‘crown agents’ – key implication – enjoy surpluses but responsible for deficits
- They have a clear accountability to Minister of Health through *Public Hospitals Act* (“**PHA**”)
- Additional fiscal accountability to Ontario Health through *Connecting Care Act* (“**CCA**”)

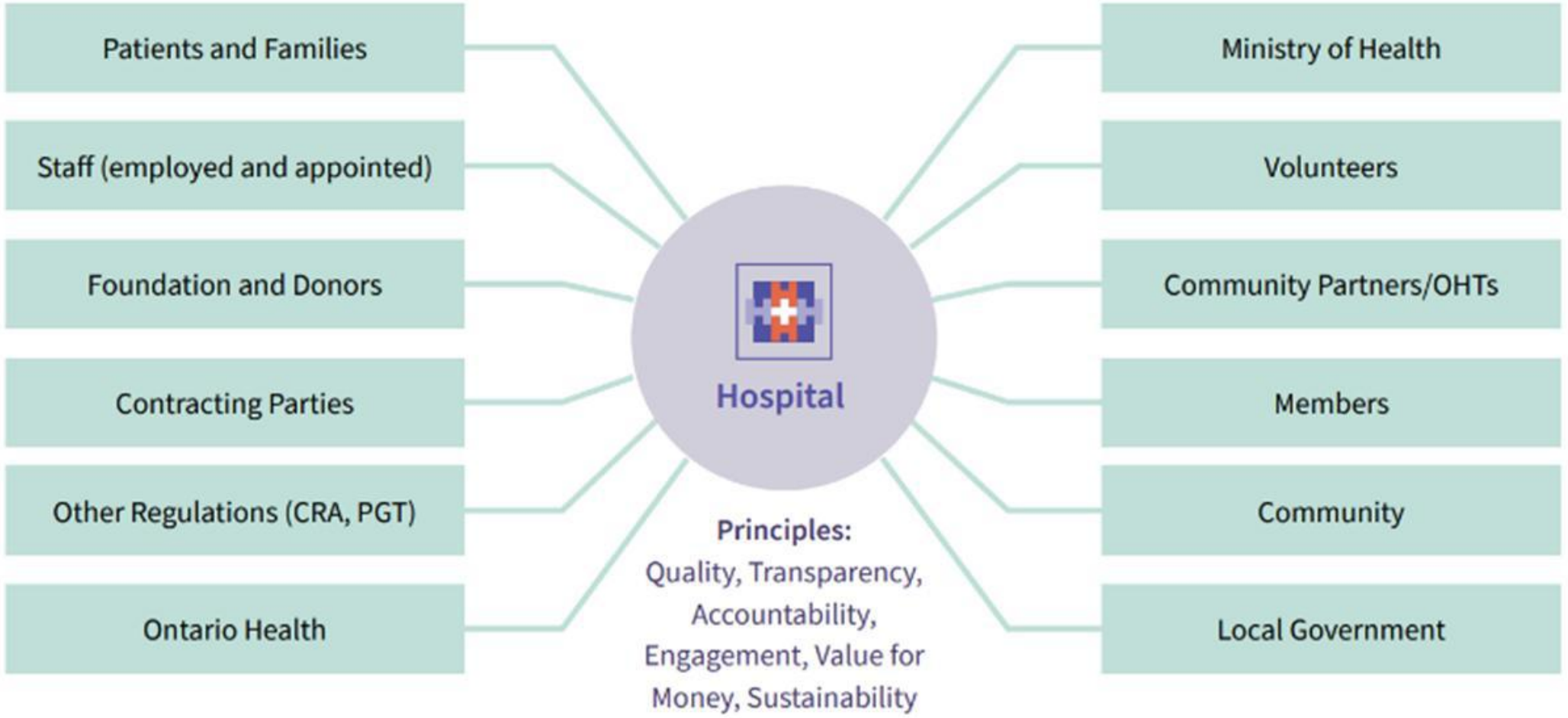
Hospital Stakeholders

A hospital is accountable to multiple stakeholders, including the following:

- Patients, their families and caregivers, and the needs of the communities served
- Obligations under its funding agreements, including service accountability agreements
- The requirement to comply with applicable legislation
- The role of Ontario Health
- The supervisory and regulatory authority of the Ministry of Health and others, such as the Ministry of Long-Term Care and Ministry of Children, Community and Social Services

- → The interests of its employees and its professional staff
- → The interests of the volunteers who provide financial support and many unpaid hours that contribute to the fulfillment of the hospital's mission
- → The contribution of its donors and financial supporters
- → The hospital's relationship with Ontario Health Teams (OHTs), other providers of health care, academic institutions and social services agencies along the continuum of care

Hospital Stakeholders (Continued)



Hospital Stakeholders (Continued)

- It will be challenging for the Board when choosing between competing demands for limited resources
- It can be helpful for a board to develop a statement outlining the hospital's accountability to guide effective decision-making
- See attached as Appendix 1 a sample Accountability Statement, included in the Ontario Hospital Association's Guide to Good Governance

Ontario Health and Ministry of Health

Ontario Health

- Enters into Service Accountability Agreements with Hospitals
- May:
  - Require audits and reports
  - Appoint investigators with approval of Lieutenant Governor in Council
  - Facilitate integrations
  - Delegate any power to an employee (except power to appoint investigator)

Ministry of Health

- → Enters into Accountability Agreements with Ontario Health
- → May:
  - Issue directives
  - Appoint investigators and supervisors
  - Issue integration orders requiring any form of integration
  - Stop voluntary integrations
  - Issue transfer orders
  - Delegate any power to Ontario Health (except power to make regulations)

Ministry of Health and Ontario Health as Funder

Ministry of Health

- Overall oversight under PHA
- Capacity for funding under PHA (operating funds via OH)
- Capital funding (still used frequently)
- Key Players: Lieutenant Governor in Council , Minister, Deputy Minister, Multiple Branches

Ontario Health

- Primary funder of operating dollars under CCA: “global budget”, others
- Ontario Health has contractual oversight (SAAs) and powers under CCA
- Key Players: President and CEO, Senior Team, Chief Regional Officers

Connecting Care Act, 2019:
SAA Funding Basics

- Accountability for explicit performance outcomes
- Process for service accountability agreements to be negotiated with Ontario Health
- Balanced budget requirements and processes if breach
- H-SAA, L-SAA, M-SAA
- Form negotiated with Ontario Hospital Association every few years (only the schedules with specific funding and accountabilities negotiated locally)
- **A hospital that does not enter into a service accountability agreement can be compelled to do so pursuant to the CCA*

SAA – Not the Usual Arm's Length Negotiation!

Negotiation Period: 90 Days from Notice of SAA from OH

Agreement NOT reached

OH delivers "notice of offer" to hospital (and MOH)

60 days negotiation period

Agreement NOT reached

Notice of offer **deemed** to be SAA

SAA enforceable against hospital

Agreement Reached

SAA Complete

Accountability:
Broader Public Sector Executive Compensation Act

Purpose: To manage compensation costs in the broader public sector

Who: Applies to designated hospital executives: C-Suite (VP, CAO, COO, CFO, CIO, or any other executive position regardless of title) who are entitled to receive or could potentially receive compensation of $100,000 or more per year

Reg. 406/18: Generally, “freezes” executive compensation as of Aug. 13, 2018 (see **Note** below)

Board Role:

- Determine caps on salary and other elements of compensation for new positions
- Adjust performance-related pay envelope for positions that are created, eliminated, vacated, or filled
- Ensure compliance with compensation program: Chair signs annual compliance report

Accountability:
Broader Public Sector Accountability Act

- Furthers themes of transparency and accountability, and adds emphasis on value for money
- Impacts various areas of Hospital operations:
  - Procurement
  - Restriction on Public Funds to Hire Lobbyists
  - Consultants
  - Expense Claims
  - Perquisites
- Compliance Reporting (Attestations, public posting of expense claims, etc.)

Hospital Transparency

Transparency

- Transparency involves open processes and public disclosure
- Transparent processes aid in demonstrating and implementing accountability and may be achieved through several means, including:
  - Public disclosure of key information
  - Open and transparent processes

Public Disclosure of Key Information

Public disclosure of key information may include the following:

- Regular written communications such as newsletters and media releases
- Robust and effective website with current and relevant information
- Disclosure through a community annual report
- Media relations policies
- Information required to be disclosed under applicable legislation

Open and Transparent Processes

Open and transparent processes may include the following:

- Nomination and recruitment processes that provide for participation in board select board candidates based on objective criteria and consider all potential applicants, and committees by community members
- Open board meetings or public reports on board decisions and processes
- Annual member meetings or other “town hall” style meetings open to the public
- Patient ombudsman or patient relations processes

Transparency and Privacy: What you need to know

- *Freedom of Information and Protection of Privacy Act* took effect January1, 2012
  - Applies to “records” that came into custody or under control of hospital as of January 1, 2007
  - Includes electronic records and emails (subject to exemptions/exclusions)
  - Provides for access and process for requests/appeals
  - Protects privacy of personal information (collection, use, disclosure)
  - Annual reporting requirements
- *Personal Health Information Protection Act* governs personal health information

Engaging Hospital Stakeholders

Engaging Stakeholders

- Engagement is a different concept from transparency
- Engagement generally involves two-way communications between a hospital and its stakeholders, that provide opportunities for input from stakeholders to enrich the hospital's decision-making
- Effective engagement also assists in relationship-building, and aids in demonstrating accountability

Engaging Stakeholders: Legislative Requirements

Connecting Care Act

- Hospitals are required to conduct community engagement: in particular, hospitals "shall establish mechanisms for engaging with patients, families, caregivers, health sector employees and others as part of their operational planning processes"
- In hospitals, processes for engagement are seen as compatible with models of patient or family/caregiver centered care
- They involve a range of participation and interactions with key impacts in areas of policy, planning, access and services

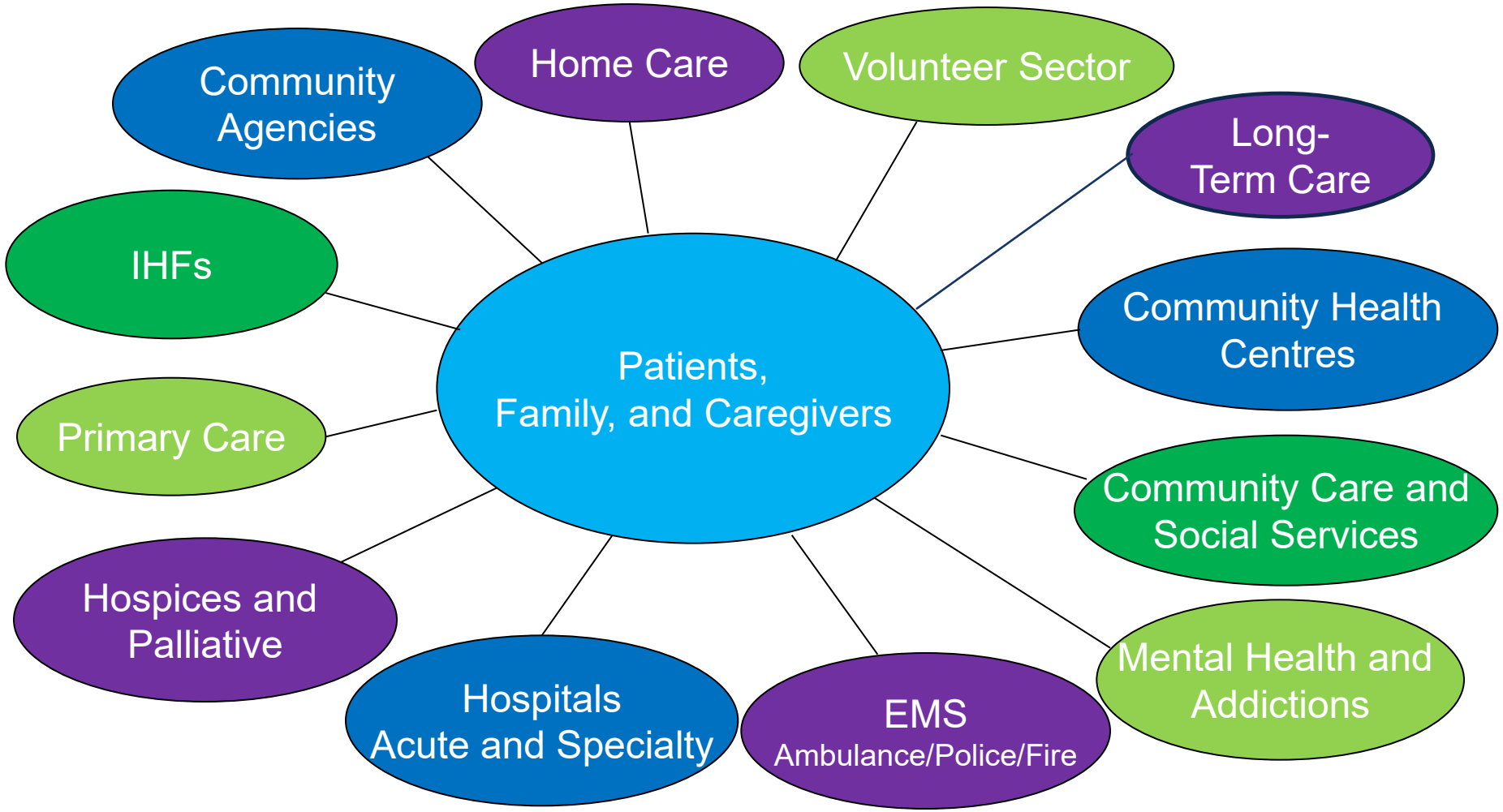
Engaging Stakeholders: Legislative Requirements (Continued)

Excellent Care for All Act

- Hospitals are required to conduct employee/care provider and patient satisfaction surveys, and to have in place a patient relations process

Hospital’s Role in an Integrated Health System

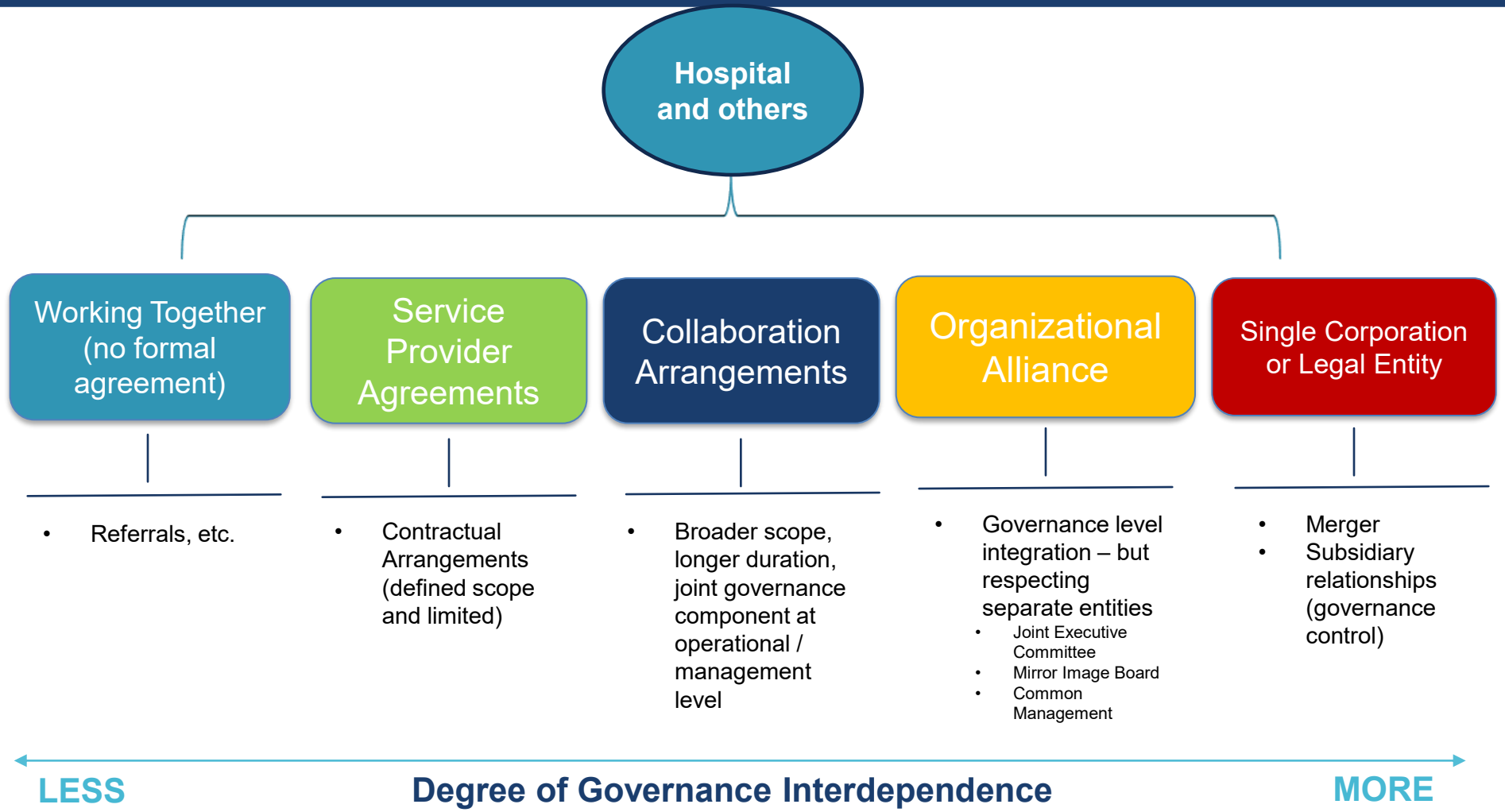
Patient/Provider Relationships Today



COVID era – improved collaborations! (yet still separate funding, regulation, accountabilities)

Accountability for Integrated Care: *Connecting Care Act*

- Provides framework for voluntary and directed integration of the health system:
  - Section 30: [Ontario Health] and each health service provider and Ontario Health Team shall separately and in conjunction with each other **identify opportunities to integrate the services of the health system to provide appropriate, co-ordinated, effective and efficient services…**


Hospital and others
Working Together (no formal agreement)
Service Provider Agreements
Collaboration Arrangements
Organizational Alliance
Single Corporation or Legal Entity
• Referrals, etc.
• Contractual Arrangements (defined scope and limited)
• Broader scope, longer duration, joint governance component at operational / management level
• Governance level integration – but respecting separate entities
• Joint Executive Committee
• Mirror Image Board
• Common Management
• Merger
• Subsidiary relationships (governance control)
LESS
Degree of Governance Interdependence
MORE

Implication of *Connecting Care Act*: "Enlightened Self Interest"

- CCA framework, including duty to explore integration opportunities, requires Board take a 'system' view
- Acting in the best interest of the Hospital will often align with the best interests of other organizations – but not always
- Let your fiduciary duty be your guide!
- Expect integration dialogue to hit the Board agenda more and more often:
  - Strategic planning
  - Stakeholder relations and engagement
  - Integration and collaboration transaction approvals

The Role of the Board in Integrated Care

Key Considerations for Boards

#1 – Knowledge and Governance Context

- Common understanding is key

#2 – Leadership

- Initially management led discussions but will have a governor-level role so commit to involvement at the right time
- Trust and respect is key (hospital is the gorilla in the room)
- Cadence and Resourcing: remember your management team is still running a hospital!

#3 – Define and Refine Principles for Participation

- What is the business case for integration? Do all agree ?
- Limit “non-negotiables” – look forward not backward

#4 – Engagement

- Commit to investing in stakeholder consultation and ensure issues raised by communities served are well understood and dealt with appropriately

#5 – Approval and Implementation

- Let your fiduciary duty be your guide!

Questions?

Thank You

For more information, contact:

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Borden Ladner Gervais

Appendix 1: Sample Accountability Statement

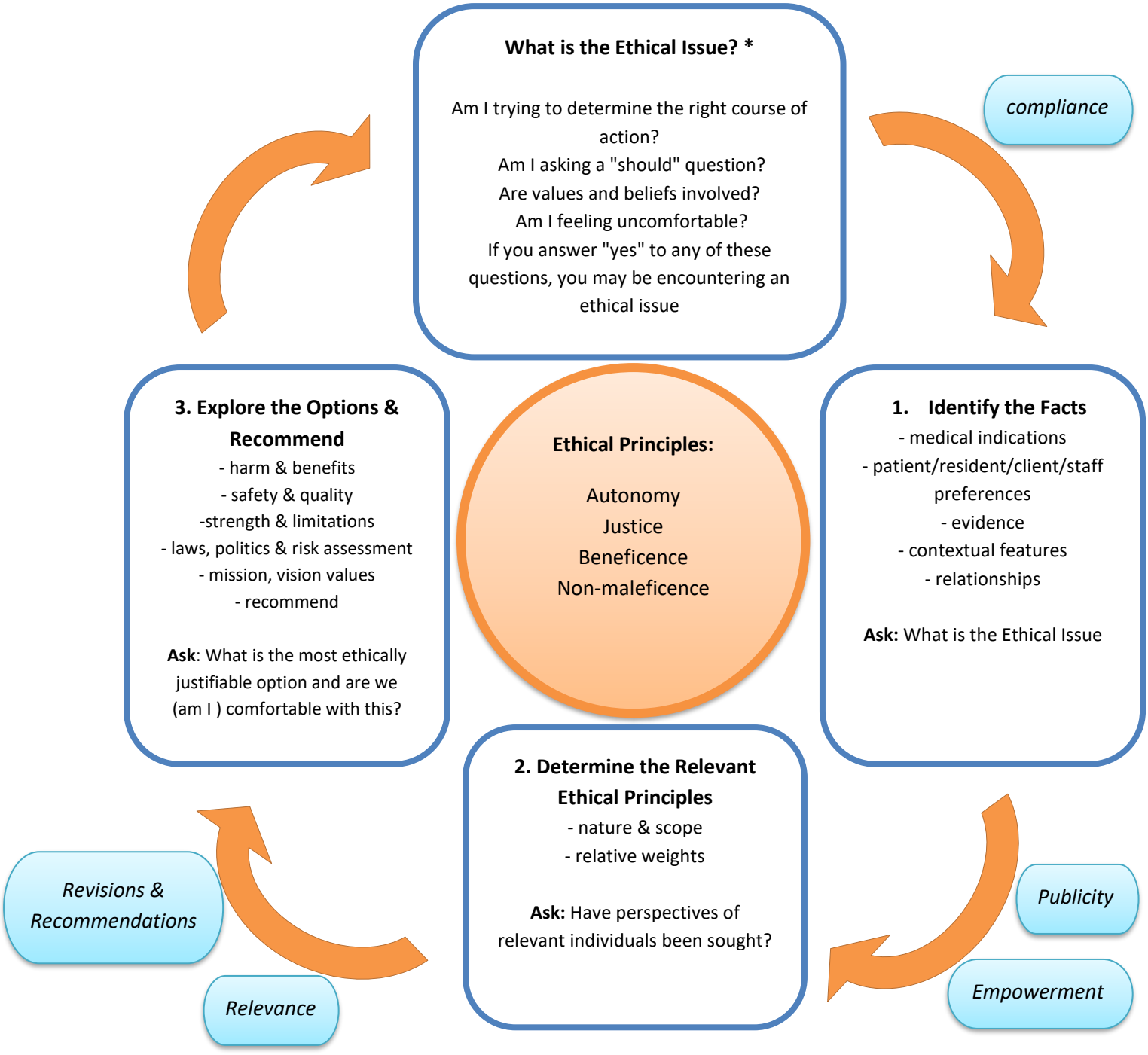
- The duty of the board is to make decisions that are in the best interests of the hospital. Decisions that are in the best interests of the hospital will be decisions that further the hospital's mission, move it towards its vision, are consistent with its values, but also discharge its accountabilities. The hospital has adopted a mission, vision and values statement.

- To guide the board in making decisions in the best interests of the hospital, the board has confirmed the following accountabilities of the corporation:

Appendix 1: Sample Accountability Statement

Stakeholder	Nature of Accountability
To patients, families and caregivers	For quality services, patient safety, patient and family/caregiver-centered care and best practices.
To the community we serve	For efficient utilization of resources, clear communication, transparent processes, advocacy, and expectation management.
To the Ministry of Health (and other regulators, as applicable)	For compliance with applicable legislation, regulation and policies, including funding policies for capital.
To Ontario Health	For performance of HSAA, participation in OH-led initiatives, expenditure management and performance management.
To donors	For financial stewardship.
To staff and volunteers/foundation	For establishing and communicating expectations and providing a safe work environment.
To health system partners (including Ontario Health Teams, local government)	For cooperation and collaboration.
To members of the corporation	For complying with the by-laws and applicable legislation as it governs the corporation, and for the achievement of its mission and vision in a manner consistent with its values and accountabilities.

Ethical Decision-Making Framework



*All research activity occurring within Riverside Health Care must be reviewed by the Riverside ethics committee

Adopted from the IDEA: Ethical Decision-Making Framework from the Toronto Central Community Care Access Centre Community Ethics Toolkit (2008)

Updated Sept 2022

Key Terms:

The Ethical Principles

Autonomy - Persons are rational agents capable of choosing for themselves;

Justice - Fairness and impartiality ought to prevail;

Beneficence - To promote the good and provision of benefit; and

Non-maleficence - Obliges us to refrain from inflicting harm.

The Conditions:

Empowerment: There should be efforts to minimize power differences in the decision-making context and to optimize effective opportunities for participation

Publicity: The framework (process), decisions and their rationales should be transparent and accessible to the relevant public/stakeholders

Relevance: Decisions should be made on the basis of reasons (i.e., evidence, principles, arguments) that "fair-minded" people can agree are relevant under the circumstances

Revisions and Recommendations: There should be opportunities to revisit and revise decisions in light of further evidence or arguments. There should be a mechanism for challenge and dispute resolution

Compliance: There should be either voluntary or public regulation of the process to ensure that the other four conditions are met

Deciding How To Decide

With any difficult situation, it is a good practice to have a conversation about how a decision will be made, up front and early on in the discussion. There are four key types of decision making:

1 – Consensus – Everyone involved must agree to support the decision
2 – Consult – Everyone gives input, then a subset of one or more people makes the decision. Consulting with people who will be affected and experts on the topic are helpful to the person or people responsible for making a decision or recommendation.
3 – Vote – All have a voice but majority rules
4 – Command – One person decides with little or no involvement from others. This may occur when someone has a high level of knowledge or authority within the situation

Scope:

This ethical framework applies to all Riverside activities, including as part of the IPAC program

Adopted from the IDEA: Ethical Decision-Making Framework from the Toronto Central Community Care Access Centre Community Ethics Toolkit (2008)

Updated Sept 2022

Medical Staff Privileges – November 2025

2025 Appointment and Reappointment Application for Privileges

See attached list.

Medical Learners

Rajpreet Panesar (PGY1) – Supervisor Dr. M. Ruppenstein – November 3 – December 14, 2025
Dr. Kokei Dodeye Ubana (PRO Candidate) - Supervisor Dr. K. Arnesen – November 10, 2025 - February 2, 2026 (12 week assessment/rotation)

PROFESSIONAL STAFF PRIVILEGES FOR APPROVAL

RECOMMENDATIONS TO THE MEDICAL ADVISORY COMMITTEE - 12-11-2025

2025

Appointment				
	Staff Status		Alt Department / Primary Org	Area Of Work
Guy, Dr. Courtney	Locum Tenens	Physician		

* Family Practice Privileges as per training and experience [T]

* Emergency Privileges as per training and experience [T]

Mir-Rahimi, Dr. Seyed-Arash	Courtesy	Physician	Red Lake Margaret Cochenour Memorial Hospital	

Radiology Privileges as per training and experience [T]

Regional Ordering	Staff Status		Alt Department / Primary Org	Area Of Work
Angles, Dr. Adrean	Regional Staff	Physician	Sioux Lookout Meno Ya Win Health Centre	
Awad, Dr. Mina	Regional Staff	Physician	Sioux Lookout Meno Ya Win Health Centre	
Bonofiglio, Ms. Erika	Regional Staff	Nurse Practitioner	Thunder Bay Regional Health Sciences Centre	
Crawford, Ms. Jessie Lynn	Regional Staff	Nurse Practitioner	North of Superior Healthcare Group	
Elchuk, Ms. Stephanie Ann	Regional Staff	Nurse Practitioner	Thunder Bay Regional Health Sciences Centre	
Elkoushy, Dr. Mohamed	Regional Staff	Physician	Thunder Bay Regional Health Sciences Centre	
Gunka, Dr. Barbara	Regional Staff	Physician	Thunder Bay Regional Health Sciences Centre	
Hassan, Dr. Abeera	Regional Staff	Physician	Dryden Regional Health Centre	

* core privilege, [R] Has medical licence restrictions,
[NR] # of Reviewers Not Recommending privilege, [T] Privilege granted temporarily

PROFESSIONAL STAFF PRIVILEGES FOR APPROVAL

RECOMMENDATIONS TO THE MEDICAL ADVISORY COMMITTEE - 12-11-2025

Regional Ordering	Staff Status		Alt Department / Primary Org	Area Of Work
Javan, Dr. Abdolrasoul	Regional Staff	Physician	Thunder Bay Regional Health Sciences Centre	
Mishra, Dr. Siddharth	Regional Staff	Physician	Lake of the Woods District Hospital	
Montpellier, Dr. Renee-Anne	Regional Staff	Physician	Sioux Lookout Meno Ya Win Health Centre	
Pollock, Ms. Hannah	Regional Staff	Nurse Practitioner	Lake of the Woods District Hospital	
Pugh, Ms. Sarah Marie	Regional Staff	Nurse Practitioner	Thunder Bay Regional Health Sciences Centre	
Rutka, Dr. John Alexander	Regional Staff	Physician	Dryden Regional Health Centre	
Schwindt, Dr. Stephanie Marie	Regional Staff	Physician	Sioux Lookout Meno Ya Win Health Centre	
Wilkins, Dr. Taylor Ann	Regional Staff	Physician	Lake of the Woods District Hospital	

* core privilege, [R] Has medical licence restrictions,
[NR] # of Reviewers Not Recommending privilege, [T] Privilege granted temporarily

PROFESSIONAL STAFF PRIVILEGES FOR APPROVAL

RECOMMENDATIONS TO THE MEDICAL ADVISORY COMMITTEE - 12-11-2025

2025

Reappointment

Regional Ordering	Staff Status		Alt Department / Primary Org	Area Of Work
Power, Dr. Alexandra	Regional Staff	Physician	Lake of the Woods District Hospital	

* core privilege, [R] Has medical licence restrictions,
[NR] # of Reviewers Not Recommending privilege, [T] Privilege granted temporarily