

Committee:		Medical Advisory Committee					
Date:		September 25, 2025		Time:		8:00am-9:00am	
Location:		Boardroom B110 / MS Teams					
Chair:		Dr. Sean Ryan, Chief of Staff		Recorder:		Alana Ross	
Members:		All SHH Active / Associate, CEO, VPs, Clinical Managers					
Guests: <i>(Open Session Only)</i>		Shari Sherwood, Heather Zrini, Christie MacGregor (Board Representative), Katie Howard					
	Agenda Item		Presenter	Anticipated Actions		Time Allotted	Related Attachments
1	Call to Order / Welcome - Notifications: - Video/Audio recordings and transcriptions of the open session meeting are retained for the purpose of creating accurate minutes and will be expunged on final approval of the minutes by the Committee; in-camera sessions are not recorded or transcribed						
2	Guest Discussion / Education Session						
2.1	Diagnostic Imaging		Howard	Information		2min	G11-048 Release of Critical Value ECG Messages for Outpatients
3	Approvals and Updates						
3.1	Previous Minutes		COS	Decision		1min	2025-06-12-MAC Minutes
	<i>*Draft Motion: To accept the June 12, 2025 MAC Minutes.</i>						
4	Business Arising from Minutes						
5	Medical Staff Reports						
5.1	Chart Audit Review		Nelham	Information		as needed	
5.2	Infection Control		Kelly	Information		as needed	
5.3	Antimicrobial Stewardship		Nelham	Information		as needed	
5.4	Pharmacy & Therapeutics		Pres. MS	Information		as needed	
5.5	Lab Liaison		Bueno	Information		as needed	
5.6	Recruitment and Retention Committee		COS	Information		as needed	
5.7	Quality Assurance Committee		CNE / Sherwood	Information		as needed	
	<i>*Draft Motion: To accept the September 25, 2025 Medical Staff Reports to the MAC.</i>						
6	Other Reports						
6.1	Lead Hospitalist		Pres. MS	Information		5min	
6.2	Emergency		Chief of ED	Information		20min	
6.3	Chief of Staff		COS	Information		5min	2025-09-Monthly Report-COS
6.4	President & CEO		CEO	Information		5min	2025-09-Monthly Report-CEO
6.5	CNE		CNE	Information		5min	2025-09-Monthly Report-CNE
6.6	CFO		CFO	Information		5min	2025-09-Monthly Report-CFO

6.7	Patient Relations	Klopp	Information	5min	• 2025-09-Monthly Report-Patient Relations • Privacy Policy (19-001) • MAC Privacy Education
6.8	Patient Care Manager	Walker	Information	5min	
6.9	Clinical Informatics • Physician IP/OP	Sherwood	Information	5min	
*Draft Motion: To accept the September 25, 2025 Other Reports to the MAC.					
7	New and Other Business				
7.1	Physician Application	Ryan / Ross	Discussion Decision	5Min	• HHS Application for Privileges to Medical Professional Staff • HHS Application for Privileges-SHH Related Policies & Forms • SM-Physician Reference
7.2	Discovery Week	Ryan	Information	5min	• See email
8	In-Camera Session • Notifications: ○ Guests will be invited by the Committee Chair, as required; any members with conflicts of interest during in-camera discussion, can be recused as needed ○ All participants of the in-camera session are expected to ensure that their surroundings are secured from unauthorized participants				
8.1	Move into In-Camera • Credentials	Chair	Motion, if needed		• 2025-09-25-Report to MAC-Credentials
*Draft Motion: To move into the in-camera session at XX:XXam.					
8.2	Move out of In-Camera	Chair			
*Draft recommendation made to move back into open session at XX:XXam.					
8.3	Motions made based on In-Camera discussion	Chair	Acceptance Recommendation		
*Draft Motion: To accept the Credentialing Report of September 25, 2025 as presented, and recommend to the Board for Final Approval.					
9	Next Meeting & Adjournment				
	Date	Time	Location		
	October 30, 2025	8:00am-9:00am	Boardroom B110 / MS Teams		

	☒ Policy ☐ Procedure ☐ Protocol ☐ Terms of Reference	Section Diagnostic/Medical Imaging	Number G 11-048
Release of Critical Value ECG Messages for Outpatients			
Date Issued: October 2014 Date Review/Revised: August 11, 2025 Next Review Date: August 11, 2028			
Owner: Manager, Diagnostic Imaging, Cardiorespiratory	Reviewer(s): Manager of Clinical Services Manager of Diagnostic Imaging and Cardiorespiratory MRT(R) Senior Technologist	Approver: Chief Financial Officer, VP of Finance	
Cross Reference:			

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Purpose

To ensure the timely release of “Critical Value” ECG messages by Diagnostic Imaging (DI) Personnel.

Policy

The staff performing the ECGs for outpatients are a diagnostic service only, and are unable to interpret, act on, or finalize results for ECGs performed.

If any critical value messages appear on the ECG i.e. *Complete Heart Block, Very High Heart Rate, Acute MI or Acute Ischemia*, before releasing the patient, the DI Personnel will contact the ordering physician or care team directly (2 attempts over 15 minutes). It is the responsibility of the ordering physician or care team to provide the patient with further directions. A preliminary ECG print out will be faxed to the ordering physician or care team for all ECGs performed in the DI department. This preliminary report is for your information only, and all urgent findings are the responsibility of the ordering physician or care team to follow up as appropriate.

All reporting of outpatient ECG examinations are the responsibility of the Cardiologist who must be certified by the College of Physicians and Surgeons of Canada, or its equivalent. ECGs will be interpreted by the reading physician in approximately two weeks' time.

Committee:	Medical Advisory Committee		
Date:	June 12, 2025	Time:	08:00am-09:00am
Chair:	Dr. Sean Ryan, Chief of Staff	Recorder:	Alana Ross
Present:	Dr. Bueno, Dr. Kelly, Dr. Nelham, Dr. Ondrejicka, Dr. Patel, Dr. Ryan, Lynn Higgs, Heather Klopp, Robert Lovecky, Adriana Walker		
Guests:	Shari Sherwood, Christie MacGregor (Board Representative)		
1	Call to Order / Welcome		
1.1	- Dr. Ryan welcomed everyone and called the meeting to order at 08:00am - Notifications: - Video/Audio recordings and transcriptions of the open session meeting are retained for the purpose of creating accurate minutes and will be expunged on final approval of the minutes by the Committee; in-camera sessions are not recorded or transcribed		
2	Guest Discussion		
3	Approvals and Updates		
3.1	<u>Previous Minutes</u> - Approval / Changes - None <i>MOVED AND DULY SECONDED</i> <i>MOTION: To accept the May 8, 2025 MAC minutes. CARRIED.</i>		
4	Business Arising from Minutes		
4.1	<u>CT Scanner Application:</u> - Support letter from SHH Foundation is pending; anticipating receipt by the end of next week - Once the letter is received, the submission will be made to OHW and MOH		
5	Medical Staff Reports		
5.1	<u>Chart Audit Review:</u> Audit of charts per QIP will begin in Jul		
5.2	<u>Infection Control:</u> - The HPPH Unit has some new epidemiological summaries available for the measles outbreak 2,000 cases in 2025; multi jurisdictional outbreak in communities where vaccinations rates are lower - No change to case management		
5.3	<u>Antimicrobial Stewardship:</u> Next meeting scheduled for Jun 25		
5.4	<u>Pharmacy & Therapeutics:</u> No discussion		
5.5	<u>Lab Liaison:</u> No discussion		
5.6	<u>Recruitment and Retention Committee:</u> - Recruiter and COS attended the Western County Medicine Retreat at Oakwood in Bayfield; good opportunity to make connections with graduating physicians - Two more large recruiting opportunities scheduled; McMaster/Sep and Ottawa/Nov - Jo-Anne Bowen, who handles Discovery Week at South Huron has expressed interest in attending - Physicians are looking for more specific plans in regards to recruitment and retention - Full time Recruiter starting in Nov		
	<u>Action:</u> If interested in attending recruitment fairs, please contact alana.ross@amgh.ca or jimmy.trieu@amgh.ca	<u>By whom / when:</u> All; ASAP	

5.7	<u>Quality Assurance Committee:</u> - Quality Improvement Program (QIP) data is in line where we are expected to be - The LWBS data had a jump in Apr, which may have been due to higher volumes in the ED; both ED volumes were up significantly - Indicator measurements are in place	
	<u>MOVED AND DULY SECONDED</u> <u>MOTION: To approve the Medical Staff Reports as presented for the June 12, 2025 MAC Meeting. CARRIED.</u>	
6	Other Reports	
6.1	<u>Lead Hospitalist:</u> - Increased daily stipend for hospitalist shifts (top up funding from hospital); now equal to HPHA physicians - Appreciation extended to Leadership and Board for the supporting this - Anticipating reassessment by the end of the year - Lack of competitive compensation has resulted in regular hospitalists picking up shifts elsewhere; the new rates have been shared via HFO, which is starting to gain some traction - No information received from AFA in the last three years regarding increases - Hospitalist schedule continues to be a challenge with several gaps over the next few months	
6.2	<u>Emergency:</u> - Funding letter received from Ministry; new rates emailed to physicians on Jun 11 - Working through gaps in the ED schedule, and remaining open - Working with Quality and Privacy leads to develop a process for charting patients who 'leave without being seen by a physician' 1,200 visits short of qualifying for the next AFA funding level; number is based on shadow billings - Considering a change in practice - Responsibility for management and delegation	
	<u>Action:</u> Template build	<u>By whom / when:</u> Ryan; This week
6.3	<u>Chief of Staff:</u> - Documents circulated: 2025-06-Monthly Report-COS 2025-06-Medical Staff Letter - General Internal Medicine clinic starting Nov 1 - Dr. Peirce and Dr. Vergara will be alternating weeks to begin with - Reading ECGs and Holter Monitor reports - Providing inpatient consults - Seeing outpatients with a family physician in the SHH area; unattached patients will be seen in Stratford - Dr. Fiaani will continue to read Echoes - Discussed Hospitalist rates - Finance is doing an analysis of the impact on the bottom line; impact should be approximately \$14K - Stipend top up rates were approved via Resources/Board for ED the previous year and the remainder has been approved for use for Hospitalist top up this year - Discussed HOCC; no new information has been received regarding the burden-based funding program - No news regarding AFA - There is no provincial program for hospitalist staffing, therefore it is crucial to remain competitive in order to attract physicians to cover the shifts	
6.4	<u>President & CEO:</u> 2025-06-Monthly Report-CEO, circulated - No discussion	
6.5	<u>CNE:</u> 2025-06-Monthly Report-CNE, circulated - Shout Out to the team for handling the increases in ED activity, which results in a number of overflows - New staff coming on board; retention is good	

	○ A number of externs are in place ○ Physician opportunities on website - Huron Health System - Physician Opportunities		
	<table> <tr> <td> <u>Action:</u> • Forward posting for SHH physician recruitment to alana.ross@amgh.ca for addition to the website </td><td> <u>By whom / when:</u> • Ryan; Jun </td></tr> </table>	<u>Action:</u> • Forward posting for SHH physician recruitment to alana.ross@amgh.ca for addition to the website	<u>By whom / when:</u> • Ryan; Jun
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6.6	<u>CFO:</u> • 2025-06-Monthly Report-CFO, circulated ○ Review of year-end reporting and audited financial statements ○ SHH projected deficit was \$2.2M and landed at \$887K; great results ○ Deficit is under 1%, which is outstanding compared to hospitals in our region ○ OneChart Go Live Phase II (advanced capture scanning) is reducing paper, folders, labels, etc.; benefits will start to show in the coming months ○ 67% reduction in transcription volume; great results; use of Dragon transcription continues to increase ○ There are currently gaps in lab and registration HHR		
6.7	<u>Patient Relations:</u> • Documents circulated: ○ 2025-06-Monthly Report-Patient Relations ○ 2025-06-Patient Experience Story ▪ Process finalized for new patient experience surveys, results shared quarterly ▪ Reviewed the 'shout outs' and feedback relating to improvements and challenges ○ Drs. Kluz now have a mechanism in place for patients to sign up		
6.8	<u>Patient Care Manager:</u> • Guidelines changing next week re triage levels • New central lines kits available; open sample in Adriana's office for review • 1st Trillium Gift of Life Network (TGLN) meeting held; scheduled twice / year ○ 100% notification rate for 1st four months; each ocular recovery can help up to 10 people • Review of severe burn case; identified gaps in the process and possible fixes; looking for corrections in the Criti-Call process		
6.9	<u>Clinical Informatics:</u> • eScanning / eFax (inbound only currently) are working well ○ Instructions for finding scanned documents will be circulated today ○ Reviewed eFax process ▪ Paper faxing will be turned off and new incoming fax numbers will be posted on the website once the downtime process has been finalized; communication will happen • In the system, the Hospitalist position will be change to Physician IP/OP ○ Shari will be working with physicians, using My Experience, to get switched over, and will provide a review at MAC in Sep ▪ Dr. Patel is supporting the Walk-In Clinic perspective ○ Shari will provide a full list of available templates • In the system, credentials are being populated and are showing up behind Physician names; contact shari.sherwood@shha.on.ca if you don't see this • Pocket Health provider sharing Go Live on Jun 18; access codes will be provided, and CD burning will decline • Pocket Health will also be updating the patient information that is received from the hospital, i.e., reports • Reviewed document process; working through challenges of duplication; paper charting will be scanned and stored in the system; process for writing discharge notes has not changed • Review electronic prescription process		
	<i>MOVED AND DULY SECONDED</i> <i>MOTION: To approve the Other Reports as presented for the June 12, 2025 MAC Meeting. CARRIED.</i>		
7	New Business		
8	Education / FYI		
9	In-Camera Session ○ Notifications:		

	▪ Guests will be invited by the Committee Chair, as required; any members with conflicts of interest during in-camera discussion, can be recused as needed ▪ All participants of the in-camera session are expected to ensure that their surroundings are secured from unauthorized participants		
9.1	<u>Move into In-Camera</u> • Credentialing and Reappointment List, circulated <u>MOVED AND DULY SECONDED</u> <u>MOTION: To move into In-Camera at 8:50am. CARRIED.</u>		
9.2	<u>Move out of In-Camera</u> <u>MOVED AND DULY SECONDED</u> <u>Recommendation made to move back into open session at 8:52am.</u>		
9.3	<u>Motions Moved Out of In-Camera</u> <u>MOTION: To accept the Credentialing Report of June 12, 2025 as presented, and recommend to the Board for Final Approval.</u>		
	<u>Action:</u> • Forward report to Board for final approval	<u>By whom / when:</u> • Today	
10	Adjournment / Next Meeting		Regrets to alana.ross@amgh.ca
	Date	Time	Location
	September 11, 2025	8:00am	Boardroom B110 / MS Teams
	<u>Motion to Adjourn Meeting</u> <u>MOVED AND DULY SECONDED</u> <u>MOTION: To adjourn the June 12, 2025 meeting at 09:00am. CARRIED.</u>		
Signature			
Dr. Sean Ryan, Committee Chair			

Hospital Operational Report – August 2025

1. Executive Summary

In August 2025, Huron Health System experienced stable patient volumes, improved emergency department wait times, and progress on several strategic projects. Key challenges included workforce shortages in nursing and potential SHH ED/Acute Care closures due to physician manpower. Overall, the hospital remains financially stable and focused on quality improvement.

2. Operational Performance

- Patient Volumes: 2,450 ED visits, 1,120 inpatient admissions, 1,800 outpatient visits, 180 surgeries
- Capacity & Occupancy: 92% average daily census, 7.2 days average length of stay
- Wait Times: ED median wait time reduced to 2.8 hours (down from 3.5 hours in July)

3. Workforce

- Staffing Levels: 485 FTEs, 7% vacancy rate, 12% nursing vacancy
- Recruitment: 8 new hires onboarded; international recruitment campaign underway
- Wellbeing: Sick days averaged 4.5%

4. Financial Overview

- Revenue: \$54.2M (primarily from Ministry funding and patient services)
- Expenses: \$54.8M (salaries \$10.6M, supplies \$4.2M, capital \$3.1M)
- Variance: Net positive variance of \$0.6M vs. budget
- Efficiency: Contracted procurement saved \$50,000 in supply costs
- MoH and OH directive to achieve a balanced budget in F29. Working on plans which will be presented to Resources Committee and the Board

5. Quality & Safety Indicators

- Hospital-acquired infections: 0 MRSA, 0 C. diff cases

- 30-day readmission rate: 8.6% (target <9%)
- Patient falls: 14 (with minor injuries only)
- Accreditation prep on track for 2026 review

6. Patient Experience & Community Engagement

- Patient satisfaction: 87% overall positive rating (target 85%)
- Top compliments: compassionate nursing care, improved food services
- Community: Hosted Health Camp with 30 high school participants in Goderich, 2 med students in Exeter and 4 med students in Goderich

7. Risk & Mitigation

- Workforce: Nursing shortages remain critical; mitigation through recruitment fairs and partnerships with local colleges
- Financial: Inflation pressure on supplies; mitigation through bulk purchasing agreements
- Operational: IT downtime risk mitigated by expanded cybersecurity systems

8. Strategic Projects & Next Steps

- Continue to work with MoH and OH on SHH CT submission. Confirmation from July 14, 2025 the MoH Team is reviewing the submission. On Sept 10, received an email from OHW that the MOH would like to meet with the hospital as part of the capital review process. This review will be conducted in parallel with the CT designation process.
 - SHH Council had a delegation at AMO in August and I requested that council bring up the SHH CT Scanner with the Minister of Health
 - Ted Oke reported at the Recruitment and Retention Committee (Sept 2, 2025) that he brought up the SHH CT Scanner to the Parliamentary Assistant to the Minister of Health at their delegation
 - Also spoke with MPP Thompson regarding the SHH CT Scanner submission on July 7, 2025
- Master Facility Plan: Will hold another community meeting in Goderich in the next couple of months.
- Digital Transformation: EMR optimization project at SHH 90% complete
- Next Quarter Goals: Reduce ED wait times <2.5 hours, recruit 20 nurses, continue to recruit physicians

**Report to Board CNE
September 2025**

I hope everyone had a wonderful summer, even though it always seems to pass by more quickly than we would like.

****Acknowledgments****

I would like to begin this report by recognizing the incredible team at Huron Health System. To all staff, managers, and physicians—thank you for your ongoing commitment, dedication, and the compassionate care you provide every single day.

Additionally, I extend my gratitude to the senior leadership and board members for your collaboration and support in navigating challenges, seizing opportunities, and driving our initiatives forward. It is truly a privilege to be part of this esteemed team, and I genuinely believe that this is a wonderful place to work.

Please accept my apologies as I am unable to attend the board meeting tonight in person; however, I will ensure to get up to speed upon my return.

****Focus Areas****

1. **Safe Quality Patient Care**

We are continuing our collaboration with Ontario Health at Home to enhance discharge planning for patients and families, ensuring that they receive the necessary supports and services post-discharge.

2. **Our People and Workplace**

I am pleased to report that our emergency departments remain operational. We have successfully recruited several excellent candidates for the ER, while also actively pursuing specialists for areas such as OR, OB, and ICU. Alongside our nursing staff, we have received positive feedback regarding our clinical externs.

We are addressing financial challenges by working to decrease overtime, callbacks, sick time, and transfers. We are exploring additional budget improvement strategies.

Some feedback has indicated that new staff experience a lack of support from some existing employees. This matter is a high priority for our managers, who will address behaviors as necessary. On a positive note, the Clinical Educator has been doing an outstanding job supporting our new recruits.

3. **Increasing Value in Our Healthcare System**

All approved capital equipment purchases for the hospital have been completed for the current fiscal year. The renovations of the AMGH Mental Health Unit are ongoing; Phase 1 is expected to conclude around Thanksgiving, with Phase 2 commencing the following week.

In response to the increasing number of potential stroke patients, we are collaborating with the Southwestern Ontario Stroke Network to explore increased funding for the AMGH Telestroke Program.

4. **Integrated and Sustainable Rural Healthcare System**

We are committed to collaborating with regional hospitals on patient repatriation, ensuring that patients are returned to their referring hospitals within 48 hours.

Our partnership with regional agencies and Public Health continues, focusing on reporting outbreaks of diseases such as measles, COVID-19, and legionella that have occurred in London and surrounding areas.

Lastly, Lasalle Living has acquired the old Maitland Manor building in Goderich and is engaging with HHS to discuss future plans and opportunities.

Thank you again for your hard work and dedication. Together, we continue to make a significant impact in the lives of those we serve.

Thank you
Lynn Higgs CNE VP Clinical Services.

CFO Report to Board

DATE: September 16, 2025
FROM: Rob Lovecky, Vice President of Finance and CFO
TOPIC: CFO Report to Board of Directors

Financial Snapshot (YTD July Period 4) FY 2025-26:

- **Total HHS: As of YTD July, FY 2025-26, actual hospital operations results total **-\$700,340 deficit** compared to a budgeted deficit of **-\$1,610,889**, which equates to a **\$910,550 positive variance** to budget.**
 - **AMGH: Actual Operating Deficit of **-\$325,102** compare to Budgeted Deficit of **-\$923,088****
 - **SHH: Actual Operating Deficit of **-\$375,238** compared to Budgeted Deficit of **-\$687,801****
-

Finance:

- HHS received a directive from Ontario Health to complete a 3 year Operating Budget Forecast and 3 year Balanced Budget Plan to balance operating resulting at AMGH and SHH by the end of FY2027-28. Finance and Senior Leadership have developed balanced budget plans and initiatives to present to Resources Committee for review, and the HHS Board for discussion, guidance, and approval in September. Finance will submit final operating forecasts and balance budget plans to Ontario Health in October.

ITS:

- SHH – working on replacement for end of life Staff Right time entry and scheduling system. Completed two vendor demos, expected to obtain quotes and select solution as soon as possible.
- HHS – engaged HMMS to help develop ERP RFP and procurement strategy to purchase an HR, Finance, Procurement, and Payroll systems that can be implement at both AMGH and SHH. This process could take up to 3 months, then vendor selection and implementation could take up to 24 months for all systems and modules. (need to confirm funding source)

Laboratory:

- HHS: Both sites have completed 3 audits of particular analytes on our chemistry analyzer to ensure we are providing reliable results to physicians.
 - HHS: Both sites will be starting a review of their policies and procedures for their upcoming Self-Accreditation in Jan. Although this is a large process that requires dedicated time from each staff it ensures that standards are being met before Accreditation in early 2027.
-

Diagnostic Imaging:

- AMGH: CT Downtime policy revised to assign communication responsibilities to DI Manager or MRT to inform all stakeholders (vendor, ED Physician or Charge Nurse, all staff using email) of unplanned downtimes
- AMGH: MRI RFP to select vendor equipment and solution continues, moved to evaluation and scoring stage for 3 potential vendors. Expect to complete scoring by end of October, then move to vendor demos in November, and final selection and contract finalized in December 2025.
- AMGH: X-Ray/Fluoroscopy unit RFP, short listed 3 vendors and moving onto demonstration in October/November.

- SHH: Late Patient Arrival and Critical Value ECG procedures revised
- SHH: Awaiting for Ontario Health endorsement of hospital CT scanner. Expecting response from Ontario Health in October, then move to Ministry of Health capital project review and approval that can take up to 90 days to complete.

Patient Relations, Registration, Privacy, and Health Records:

- AMGH: Registration Clerks and Nurses are 100% ready for E-CTAS go-live on Sept 4th. OneID access and E-CTAS training are completed.
- AMGH: Recruitment and retainment challenges for Registration/Switchboard Clerks – looking at working with HR and Senior Leadership to develop job fair

- SHH: Health Records supplies and transcription costs decreasing due to implementation OneChart Phase II e-faxing and e-referral processes. No need to create new paper chart

INSERT

PENDING



Alexandra Marine and General Hospital
120 Napier Street
Goderich, ON N7A 1W5
T 519-524-8323 | F 519-524-8504

South Huron Hospital
24 Huron Street West
Exeter, ON N0M 1S2
T 519-235-2700 | F 519-235-3405

Sept 2025 MAC/Board/PEP Patient Experience Story

Submitted by Heather Klopp, Manager Patient Relations, Patient Registration, Privacy and Health Records.

From a family member of an Emergency Department Patient at SHH:

“Dr. Pereira is an exceptionally compassionate doctor. I lost my dad to lung cancer recently. The morning of, my dad had a fall due to exceptionally high blood sugar that landed him in the ER. Dr. Pereira recognized that my dad was failing fast and offered to find him a bed for palliative care. The relief my dad felt getting answers he had been waiting for, and knowing he was being taken care of, and didn’t have to suffer anymore was amazing. He thanked the doctor profusely and was very grateful. Dad passed peacefully and comfortably later that day. We can’t thank Dr. Pereira enough for the care and compassion he showed my dad and family members.”

	☒ Policy ☐ Procedure ☐ Protocol ☐ Terms of Reference	Section <i>Privacy</i>	Number 19-001
Privacy			
Date Issued: December 2004 Date Review/Revised: September 2017, September 2020, June 2024 Next Review: June 2027			
Owner: Manager Patient Relations, Patient Registration, Privacy and Health Records	Reviewer(s): Manager Patient Relations, Patient Registration, Privacy and Health Records	Approver: Corporate Leadership	
Cross Reference: Policy #18-008 Retention of Patient Records Policy #19-003 Access to Personal Health Information for Research, Education and Quality Assurance Policy #19-004 Anonymous Patient Policy. Policy #19-007 Request to Amend Personal Health Information Policy #19-008 Management of Requests to Restrict Collection, Use and Disclosure of Personal Health Information Policy #19-009 Information Security Policy Policy #19-011 Auditing of the Electronic Patient Record (EPR) Policy #19-012 Privacy Breach Policy and Procedure Policy #19-015 Confidential Waste Policy Policy #19-016 Confidential Faxing Policy Policy #19-019 Access to Personal Health Information for Patient/SDM			

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Purpose

South Huron Hospital (SHH; the Hospital) has implemented a number of shared services, including some consolidated clinical services, common medical staff, laboratory services and integrated information systems. To the extent that personal information is collected, used, disclosed, and retained within the shared services, the Hospital recognizes that each organization has both independent and joint obligations with respect to fair information practices.

The privacy policy is the foundation for other policies and procedures, setting the principles upon which the Hospital will collect, use and disclose personal information and personal health information (PHI).

Policy

The Hospital is responsible to comply with the Personal Health Information Protection Act (PHIPA, 2004). SHH, as the Health Information Custodian (HIC), is therefore responsible for PHI under its custody and control and is committed to a high standard of privacy for information practices. The Hospital adopts the following 10 Principles set out in the National Standard of Canada Model Code for the Protection of Personal Information.

1. Accountability for Personal Information

2. Identifying Purposes for the Collection of Personal Information
3. Consent for the Collection, Use, and Disclosure of Personal Information
4. Limiting Collection
5. Limiting Use, Disclosure, and Retention of Personal Information
6. Ensuring Accuracy of Personal Information
7. Ensuring Safeguards for Personal Information
8. Openness about Personal Information Policies and Practices
9. Individual Access to Own Personal Information
10. Challenging Compliance with the Hospital's Privacy Policies and Practices

This policy will apply to PHI collected, used, disclosed and retained by the Hospital, subject to legal requirements.

Principle 1 – Accountability for Personal Information

The Hospital is responsible for PHI under its control and has a designated individual (Privacy Officer) to set privacy and confidentiality standards, as well put measures in place to make employees and affiliates aware of their privacy and confidentiality obligations.

- Accountability for the Hospital's compliance with the policy rests with the Chief Executive Officer, Leader of Health Information and Privacy, and the Privacy Officer of the organization. In the circumstance of a privacy breach, Human Resources where applicable.
- The name of the Privacy Officer designated by the Hospital to oversee compliance with these principles is a matter of public record.
- The Hospital is responsible for PHI in its possession or custody, including information that has been transferred to a third party for processing. The Hospital will use contractual or other means to provide a comparable level of protection while the information is being processed by a third party.
- The Hospital will:
 - Implement policies and procedures to protect PHI, including information relating to patients, staff and agents.
 - Establish policies and procedures to receive and respond to complaints and inquiries.
 - Train and communicate to staff and agents information about the Hospital's privacy policies and practices.
 - Mandatory annual Privacy Training for staff
 - Develop plans and communicate to the public and key hospital stakeholders' information to explain the Hospital's privacy policies and procedures.

Principle 2 – Identifying Purposes for the Collection of Personal Information

At or before the time PHI is collected, the Hospital will identify the purposes for which PHI is collected. The primary purposes for collecting PHI are the delivery of direct patient care, the administration of the health care system, research, teaching statistics, fundraising, and meeting legal and regulatory requirements.

A patient has the right to consent, refuse, or place restrictions on the collection, use and disclosure of PHI.

The Hospital meets these requirements by the following policies and processes:

- Policy #19-019 Access to Personal Health Information for Patient/SDM.
- Policy #19-003 Access to Personal Health Information for Research, Education and Quality Assurance.
- Posted notices and brochures inform patients/SDMs about purposes for the collection, use and disclosure of their PHI.
- Information on the Hospital website.

Principle 3 – Consent for the Collection, Use, and Disclosure of Personal Information

The knowledge and consent of the individual is required for the collection, use, or disclosure of PHI, except where inappropriate. PHI can be collected, used or disclosed without knowledge and consent of patient/SDM only where permitted or required by law.

A patient/SDM may withdraw or restrict consent at any time, subject to legal or contractual restrictions and reasonable notice. The Hospital will inform the individual of the implications of such withdrawal.

The Hospital meets these requirements by the following policies and processes:

- Policy #19-019 Access to Personal Health Information for Patient/SDM.
- Policy #19-003 Access to Personal Health Information for Research, Education and Quality Assurance.
- Policy #19-004 Anonymous Patient Policy.
- Policy #19-008 Management of Requests to Restrict Collection, Use and Disclosure of Personal Health Information.

The form of the consent sought by the Hospital may vary, depending upon the the purpose of collection, use and/or disclosure.

Principle 4 and Principle 5 – Limiting Collection, Use, Disclosure and Retention of Personal Information

The collection of PHI will be limited to that identified to the patient/SDM and for which consent was obtained, except with the consent of the patient/SDM or as required by law.

PHI will be retained only as long as necessary for the fulfillment of the above purposes.

Principle 6 – Ensuring Accuracy of Personal Information

PHI will be as accurate, complete, and up-to-date as is necessary for the purposes for which it is to be used. A patient/SDM has the right to request correction if they feel their PHI is inaccurate or incomplete.

SHH meets these requirements by the following policies and processes:

- Policy #19-007 Request to Amend Personal Health Information.

Principle 7 – Ensuring Safeguards for Personal Information

The Hospital is responsible for ensuring reasonable security measures are in place to protect PHI against risks of loss, theft, unauthorized access, use or disclosure, or unsecure disposal in any format which it is held.

SHH meets these requirements by the following policies and processes:

- Policy #19-011 Auditing of the Electronic Patient Record (EPR).

-
- Policy #19-016 Confidential Faxing Policy.
 - Policy #19-015 Confidential Waste Policy.
 - Policy #19-009 Information Security Policy.
 - Policy #19-012 Privacy Breach Policy and Procedure.
 - Policy #18-008 Retention of Patient Records.

Principle 8 – Openness about Personal Information Policies and Practices

The Hospital will make readily available to individuals specific information about their policies and practices relating to the management of PHI. Information Includes:

- Contact information posted of Privacy Officer including private e-mail and extension number.
- Patient Directory explaining how to access information.
- Posted notices informing patients/SDM of the purpose for the collection, use and disclosure of their PHI.

The Hospital is responsible for patient notification in the event their PHI has been lost, stolen, accessed or disposed in an un-secure manner.

- Policy #18-011 Loss of Patient Information
- Policy #19-012 Privacy Breach Policy and Procedure

Principle 9 – Individual Access to Own Personal Information

A Patient/SDM has the right to request access to their PHI and will be given access to that information except in limited situations outlined by PHIPA. SHHA is responsible to respond to the patient's/SDM's request within the timeline set by PHIPPA. The Hospital has determined fees for access as determined in partnership with their regional partners.

- Policy #19-019 Access to Personal Health Information for Patient/SDM.

Principle 10 – Challenging Compliance with the Hospital's Privacy Policies and Practices

A patient/SDM has the right to challenge the Hospital concerning compliance with PHIPPA and this policy. Preventive measures are in place to ensure compliance of privacy practices.(i.e., routine audit of electronic health record, confidentiality agreements by staff and affiliates and mandatory privacy training of staff).

- The Privacy Officer, and where appropriate the Director of Human Resources, will investigate all complaints, suspected breaches or privacy concerns. If a complaint is found to be justified, the Hospital will take appropriate measures, including, if necessary, amending their policies and practices, and/or termination of employment or affiliation with the organization.

References

Personal Health Information Protection Act, 2004.
Freedom of Information Act December 4, 2023.



South Huron Hospital
24 Huron Street West
Exeter, ON N0M 1S2
T 519-235-2700 | F 519-235-3405

MD Privacy Education MAC SEPT 2025

Privacy Officer, H Klopp

PHIPA DECISION 298

PHIPA Decision 298 (dated August 27, 2025) involves a privacy breach under Ontario's *Personal Health Information Protection Act, 2004 (PHIPA)*, reported by Windsor Regional Hospital (WRH), Chatham-Kent Health Alliance, and Erie Shores HealthCare.

Key Findings:

- A physician with privileges at WRH accessed the hospitals' **shared electronic health record (EHR)** system to **search for newborn males**.
- He then **contacted their parents** to offer **circumcision services** through his **private clinic**, WE Kidz Pediatrics.
- This was deemed an **unauthorized collection, use, and disclosure** of personal health information.

Commissioner's Determinations:

☑ **Recommendations** were issued to WRH to improve its **record-keeping and information practices**.

☑ The Commissioner found that **Administrative Monetary Penalties (AMPs)** were appropriate:

- **\$5,000** fines against the physician.
- **\$7,500** fines against WE Kidz Pediatrics.

☑ The physician and WE Kidz were ordered to **securely dispose** of all improperly obtained personal health records.

☑ WE Kidz was also directed to:

- **Strengthen its privacy policies.**
- Ensure **staff undergo privacy training**.

Implications:

- All Healthcare providers (including must ensure that **access to shared EHR systems is strictly controlled and monitored** – Audit trails and access controls
- Written privacy policies and training programs must be in place. Policies must clearly outline how personal health information (PHI) is collected, used, disclosed, and safeguarded.
- WRH must be able to **demonstrate compliance** with PHIPA, not just have policies in place.
- Health information custodians must ensure that **agents (e.g., physicians)** understand and follow privacy obligations.
- Agreements should explicitly prohibit unauthorized use of PHI for personal or commercial gain.

MDs to review 19-001 Privacy Policy



Alexandra Marine and General Hospital
120 Napier Street
Goderich, ON N7A 1W5

South Huron Hospital
24 Huron Street West
Exeter, ON N0M 1S2

APPLICATION FOR PRIVILEGES-PROFESSIONAL STAFF

To the Huron Health System Board of Directors, I hereby apply for appointment to the Medical / Professional Staff(s) of **Alexandra Marine and General Hospital (AMGH)** and/or **South Huron Hospital (SHH)** (heretofore known as '**the Hospital(s)**') and declare that the following information is true and accurate to the best of my knowledge.

I am applying for privileges at: AMGH SHH Both Anticipated Start Date (YYYY-MM-DD):

PERSONAL INFORMATION

Surname Legal First Name / Middle Name Chosen Name

Present Mailing Address

Preference Specify

Date of Birth (YYYY-MM-DD) Citizenship Languages

Mobile Phone Home Phone Fax # Email

I consent to having my contact number added to the HHS Code Orange Disaster Lists.

EMERGENCY CONTACT

Name Relationship Contact

APPOINTMENT REQUEST

Appointment Requested Clinical Departments / Privileges Requested

Licensed to practice in Ontario Yes No Medical Degree
Certification

CPSO# OHIP Billing# & Specialty Code WSIB Billing# CMPA# & Work Code

CNO# / CMO# OHIP Billing# & Specialty Code WSIB Billing# Medical Protective Association / #

(***Statement of Protection** must be attached, i.e., CMPA, AOM, Marsh, etc.)

EDUCATIONAL QUALIFICATIONS

Pre-Medical / Pre-Dental

University Degree Dates

Postgraduate Qualifications and Professional Training

University	Degree	Dates
------------	--------	-------

Degrees and Other Qualifications

University / College	Degree	Dates
----------------------	--------	-------

Currently Certified in (YYYY-MM)

ACLS	ATLS	ALARM	PALS	NRP
Other (specify)				

Eligibility to Sit Certification Examinations:

Royal College of Physicians & Surgeons of Canada	Yes	No
Royal College of Dentists of Canada	Yes	No
College of Family Physicians of Canada	Yes	No
Other College	Yes	No

Specialty	Date exam to be taken (YYYY-MM-DD):
-----------	-------------------------------------

Teaching Appointments Appointment	Institution	Dates
--------------------------------------	-------------	-------

Hospital Appointments Category / Privileges	Institution	Dates
--	-------------	-------

Professional Societies of which you are a member (list any offices held, with dates)

REFERENCES**Referee #1****Referee #2****Referee #3**

Name

Primary
Institution

Phone

Email

Fax

Has there been any failure to obtain, voluntary or involuntary alteration, restriction or limitation of your license to practice medicine or any certification, fellowship or professional academic appointment in Ontario or elsewhere?	Yes	No
Has your application for privileges or your privileges in any other hospital or healthcare institution voluntarily or involuntarily been rejected, terminated, revoked, suspended or restricted?	Yes	No
Have you been subject to any professional misconduct proceedings, competency investigations, performance reviews or other disciplinary action conducted by your College in which there was an adverse finding against you?	Yes	No
In relation to any medical malpractice or other civil action, have any judgements or findings or other decisions been entered or made against you; or any settlements made on your behalf; or are there currently any actions pending?	Yes	No
In relation to criminal proceedings, have you been convicted of a crime in any province or country, or are there currently any criminal charges pending?	Yes	No
Do you currently suffer from substance abuse or any physical, psychiatric condition, impairment, disease or illness that may impact upon your ability to carry out assigned privileges or on your ability to practice, or could reasonably be a concern to the Hospital's patients?	Yes	No

***You may be requested to provide a Release of Information to your treating Physicians, and / or a Certificate of Professional Conduct.**

*If your response to any of the above questions is 'yes', please provide details

IMMUNIZATION REQUIREMENTS

All members of HHS Professional Staff(s) who work on-site **MUST** be current with immunization requirements (see Appendix A), as laid out in the Communicable Disease Surveillance Protocols for Ontario Hospitals.

I am current with HHSs immunization requirements: Yes No

I am fit/current with an N95 respiratory mask: Yes No Off-Site Radiologist

(3M N95 Masks utilized at HHS include: 8210, 9210+, 9211+ (SHH only), 8110S, 1870+)

***Proof of N95 fit testing must be attached to the application for all staff working on-site**

If you answered 'no' to either of the above statements, please confirm that you will have all necessary items completed prior to your start date: Yes

DECLARATION

As a condition of consideration and acceptance of my application to the Professional Staff of Alexandra Marine and General Hospital (Goderich, Ontario) and/or South Huron Hospital (Exeter, Ontario), as well as my continued appointment(s) thereto, I hereby agree and do consent:

- To abide by the Code of Ethics of my respected profession and to conduct myself at all times, in a manner which does not reflect adversely upon the dignity of the medical profession or the welfare of the Hospital(s) and associated patients;
- To abide by the By-laws of the Hospital(s), Rules and Regulations of the Medical Staff(s) as effective, and as they may from time-to-time be amended, substituted or revised by the HHS Board of Directors; and to abide by the Public Hospitals Act and the general regulations of such Act; and I acknowledge that refusal to abide in accordance with the Hospital(s) By-Laws, Policies, and Rules and Regulations may result in refusal of appointment to the Medical / Professional Staff(s)
- That I have received, read and agree to abide by:

[Public Hospitals Act and Regulation 965](#)

Professional Staff By-Laws AMGH

Professional Staff By-Laws SHH

{ÚN1-ÚŠEJÖ tNA2NÁÚŠä lyÖfzŘlyE} Mission Vision, Values

Hospital Policies as provided

- d. To maintain membership in the Canadian Medical Protective Association and/or maintain other professional liability protection coverage (insurance);
- e. That failure to provide the services stipulated in the Application in accordance with applicable legislation will constitute a breach of my obligations to the Hospital(s), and the Hospital(s) reserve(s) the right to remove access to any and all Hospital resources, including the limiting or restricting of OR time;
- f. To abide by rules, regulations and ethical principals in relation to no 'fee splitting' and agree not to pay to, or receive from, another practitioner (either directly or indirectly) any part of a fee received from any patient for professional services;
- g. To concur that my appointment will depend on an assessment of performance and operational criteria, including review of my clinical competence, compliance with record keeping, attendance at meetings, maintenance of a reasonable on-call schedule, professional compatibility with hospital staff, relationship with peers, staff and patients, and, attention to fiscal responsibility (effective use of hospital resources);
- h. To concur that any misstatements in, or omissions from, this application shall constitute cause for rejection of this application and, at any time thereafter, forfeiture of membership in the Medical Staff(s), in the sole and final discretion of the HHS Board of Directors; and
- i. To authorize and consent the Hospitals, its Administrator, Chief of Department/Staff or delegate, through its credentialing process, to consult with other institutions at which I have provided medical care, with respect to matters relating to my professional qualifications, competence and character as they relate to the practice of my profession.

Signature of Applicant

Date

CHECKLIST

Completed Application	Confidentiality Policy
Proof of Professional Liability Insurance, i.e., CMPA	Completed Group Billing Forms (as applicable)
Proof of COVID-19 Vaccinations	Collection Services Request Form (SHH only)
N95 Mask Fit documentation	Electronic Funds Transfer Form (SHH only)
Curriculum Vitae	Void Cheque (SHH only)
Photograph (current)	Directive Approval Agreement (SHH only)
CPSO Certificate of Professional Conduct (as requested)	Medical Directive Policy Acknowledgement (SHH only)
	Delegation of Proxy Access (SHH only)

MANDATORY ONLINE LEARNING

[Privacy](#)

[Vanessa's Law](#)

[Accessibility](#)

I have completed each of the above mandatory learning modules.

FORWARD APPLICATION TO

Alana Ross, Executive Assistant to President / CEO
Huron Health System
alana.ross@amgh.ca
T: 519-524-8323 x5712 | F: 519-524-8504

Appendix A-Immunization Requirements

VACCINE OR TEST	REQUIREMENTS
TB Skin Test	- Employees/Professional Staff/Students/Volunteers whose TB status is unknown, as well as those previously identified as TB negative, require a baseline two-step Mantoux skin test (TST). - If the 2nd step is within the last 12 months, no additional testing is required. - If the 2nd step is dated longer than 12 months ago, an additional single step TST is required. - Individuals who have a history of a positive TST are required to provide documentation of the results of a chest x-ray within the last 6 months. - Tuberculin testing: If 2-step given, 2nd step must be given 7 to 21 days after 1st test in opposite arm if 1st test is less than 10mm in duration (read within 48-72 hours). TST must not have been read by the Employees/Professional Staff/Students/Volunteers themselves and must be recorded by a physician or a trained Registered Nurse. - For a list of sites performing TSTs visit this link.
Measles/Mumps	2 doses of the measles, mumps, rubella (MMR) or live Measles vaccine (regardless of birth); OR - Laboratory evidence of immunity/infection (blood test resulting in a positive titre).
Rubella	- Laboratory evidence of immunity; OR 1 dose of live Rubella vaccine.
Varicella	- Physician diagnosed chickenpox or herpes zoster; OR - Laboratory evidence of immunity (blood test resulting in a positive titre); OR - Documentation of 2 chickenpox vaccines, given at least 4 weeks apart.
Hepatitis B	- It is highly recommended that all Employees/Professional Staff/Students/Volunteers who are at risk of exposure to blood/blood products/bodily fluids, as identified by Occupational Health, be vaccinated, and a follow-up blood titre done 1-6 months post immunization. - No routine screening and no intermittent booster are recommended.
Tetanus/Diphtheria	- Employees/Professional Staff/Students/Volunteers must have documentation of having received the primary course of immunization as recommended by Health Canada. - A booster is required every ten (10) years. Employees/Professional Staff/Students/Volunteers who have not received a dose of dTap (Adacel) should receive one dose for their next booster.
Polio	- Employees/Professional Staff/Students/Volunteers must have received the primary course as recommended by Health Canada. - Routine boosters are not considered necessary.
Influenza	- Annual Employee/Student/Volunteer vaccination not mandatory, but highly recommended. - Annual vaccination for Professional Staff mandatory.
COVID-19	- Mandatory for Employees/Professional Staff/Student/Volunteers. - Proof of a complete COVID-19 vaccine series (2 doses). - Mixed vaccines are acceptable.
N95 Respirator	Mandatory fit testing for Employees/Professional Staff/Students/Volunteers every 2 years.

	☒ Policy ☒ Procedure ☐ Protocol ☐ Terms of Reference	Section Privacy	Number 19-002
Confidentiality			
Date Issued: Dec. 2004 Date Review/Revised: Dec. 2004, Nov. 2006, Apr. 2010, Feb. 2012, Sept. 2017 Next Review Date: Sept. 2020			
Owner: Chief Financial Officer	Reviewer(s): Privacy Officer	Approver: Chief Financial Officer	
Cross Reference: 19-001 Privacy Policy, 20-010 E-Mail Policy, 18-007 Release of Information Policy, 32-003 Receiving and Tracking Freedom of Information Requests			

This is a CONTROLLED document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the document (titled as above) on the file server prior to use.

Policy

South Huron Hospital Association (SHHA; the Hospital) has a legal and ethical responsibility to protect the privacy of patients/residents/clients, their families, and staff/affiliates, and ensure confidentiality is maintained.

SHHA considers the following types of information to be confidential:

- Personal information and personal health information regarding patients/residents/clients (hereafter referred to as “patients”) and their families;
- Personal information, personal health information, employment information, and compensation information regarding staff and affiliates; and,
- Information regarding the confidential business information of the organization’s operations, which is not publicly disclosed by the organization (e.g., unpublished financial statements, legal matters).

This policy applies whether this information is verbal, written, electronic, or in any other format. Audits are performed to determine compliance.

In addition to standards of confidentiality, which govern Regulated Health Professionals, staff and affiliates are bound by the organization’s responsibility to maintain confidentiality. The organization expects staff/affiliates to keep information, which they may learn or have access to because of their employment/affiliation, in the strictest confidence. It is the responsibility of every staff/affiliate:

- To become familiar with and follow the organization’s policies and procedures regarding the collection, use, disclosure, storage and destruction of confidential information (See References).
- To collect, access, and use confidential information only as authorized and required to provide care or perform their assigned duties.
- To use, view, divulge, copy, transmit, or release confidential information only as authorized and needed to provide care or perform their duties. (See Release of Information Policy)

- To safeguard passwords and/or any other user codes that access computer systems and programs.
- To identify confidential information as such when sending E-mails or fax transmissions and to provide direction to the recipient if they receive a transmission in error. (See E-Mail Policy)
- To discuss confidential information only with those who require this information to provide care or perform their duties and make every effort to discuss confidential information out of range of others who should not have access to this information.
- To continue to respect and maintain the terms of the Confidentiality Agreement after an individual's employment/affiliation with the organization ends.
- To participate in the organization's Privacy and Confidentiality education program, review this policy, and sign a Confidentiality Agreement before beginning assigned duties at the organization. These activities are a mandatory condition of employment/privileging contract/association for staff/affiliates at SHHA. Annual privacy training is mandatory for all employees, students and volunteers and sign a yearly Confidentiality agreement.
- To report to their Director (Leader) or the Privacy Officer suspected breaches of confidentiality, or practices within the organization that compromise confidential information. If the Director is the individual suspected of the breach, staff/affiliates may contact Human Resources or the Privacy Office.

Misuse, failure to safeguard, to use or the disclosure of confidential information without appropriate approvals may be cause for disciplinary action up to and including termination of employment/contract or loss of privileges or affiliation with the organization.

("use" of PHI is to view, handle or otherwise deal with the information)

All employees/affiliates that are no longer employed by or are affiliated with SHHA are still legally bound by this agreement/policy and will be held accountable up to and including legal action in the event of a breach of this agreement/policy.

Procedure

A General

- Directors must review any department specific information or procedures related to confidentiality with new staff and affiliates.
- Staff/affiliates may consult their Director, professional Practice Director, Human Resources, Risk Management, or the Privacy Office regarding confidentiality issues or inquiries.

B Confidentiality Agreement

- Confirmation of the successful completion of the educational program and the signed Confidentiality Agreement will be kept on the individual's file in:
 - Human Resources for staff and volunteers,
 - Health Records/Privacy Office for vendors, or consultants (i.e. any individual employed by third-party organizations who are performing work in the organization on a temporary basis)

- Medical Affairs Office for Physicians, Residents, Medical Students, Dentists, and Midwives, secretaries who are privately employed by physicians
- It is the responsibility of Signing Directors to stipulate in Education Affiliation Agreements with education institutions, the obligation to ensure that students and faculty abide by the organization's standards of confidentiality.

C Investigating Alleged Breaches of Confidentiality

- It is the responsibility of Directors, in conjunction with Human Resources, Risk Management, and Privacy, to investigate alleged breaches of confidentiality.

References

Legislation:

Personal Information Protection and Electronic Documents Act, (PIPEDA) (2004)

Personal Health Information Protection Act (PHIPA) (2004)

Public Hospitals Act (1990)

Regulated Health Professional act, 1991 (as amended)

Freedom of Information and Protection of Privacy Act, (FIPPA) (2008)

Standards:

College of Nurses of Ontario, Standards of Practice – Confidentiality

<http://www.cno.org/nursing/standard/confidentiality.html>

College of Physicians and Surgeons of Ontario – Confidentiality and Access to Patient Information

<http://www.cpsso.on.ca/Policies/confidentiality.htm>

APPENDIX A



CONFIDENTIALITY AGREEMENT

South Huron Hospital Association

All residents/patients/clients under the care of South Huron Hospital Association (SHHA) and all staff and affiliates have a fundamental right to have their health/medical/personal information treated in confidence.

This statement confirms that I have read and understand the Confidentiality Policy for SHHA, Exeter, Ontario

I commit to hold in confidence all information about patients, residents, clients, and their families, staff and affiliates, as well as the confidential business information of the organization, which comes to my attention while carrying out my duties as agreed within the organization.

I commit to continue to respect and maintain the confidentiality of patients, residents, clients and their families, and staff and affiliates of the organization, as well as the confidential business information of the organization even after my employment/affiliation with the organization ends.

I understand that I may consult my Director, Human Resources, Risk Management, or the Privacy Office for details regarding this and related policies.

I understand that misuse, failure to safeguard, or the disclosure of confidential information without appropriate approvals may be cause for disciplinary action up to and including termination of employment/contract or loss of appointment or affiliation with SHHA.

I have completed the (please check which applies to you) module of the Privacy and Confidentiality education program.

- ☐ Professional
- ☐ Regulated Health Professional
- ☐ Clinical Support
- ☐ Non-Clinical Support
- ☐ Volunteer/Student

Printed Full Name _____

Signature _____

Date (YYYY-MM-DD) _____





South Huron Hospital
24 Huron Street West
Exeter, ON N0M 1S2
T 519-235-2700 | F 519-235-3405

Delegation of Authority for Proxy Access

I, _____, allow proxy Cerner access to Dr. Craig McLean as **Chief of Emergency of the South Huron Hospital (SHH)** to my account.

This will allow Dr. McLean to give final authorization by providing his electronic signature to my transcribed documents since I am no longer in the area and not renewing privileges at SHH.

Signature

Date (YYYY-MM-DD)



South Huron Hospital
24 Huron Street West
Exeter, ON N0M 1S2
T 519-235-2700 | F 519-235-3405

Request for Collection Services

I authorize South Huron Hospital to process the billable services checked below that are generated while working in the Emergency Department, for an administrative fee of 5% in accordance with the terms of policy 06-001 Collection of Physician Payments for Services.

Uninsured Residents of Ontario

Non-Residents of Canada

Second On-Call

Other (specify)

OR

I give written notice to stop processing billable services on my behalf, effective date below, for all services not yet billed.

Name of Physician

Signature

Date (YYYY-MM-DD)

Form 06-001A

Policy 06-001 Collection of Physician Payments for Services



South Huron Hospital
24 Huron Street West
Exeter, ON N0M 1S2
T 519-235-2700 | F 519-235-3405

Electronic Funds Transfer

Name of Company (if applicable): _____

Payment Information:

To ensure the accuracy of your account information, please attach a copy of a VOID cheque or a direct deposit form issued by your financial institution.

Remittance Notification Information:

Contact Name: _____

Title / Position: _____

Email Address: _____ Phone: _____

Signature

Date (YYYY-MM-DD)



South Huron Hospital
24 Huron Street West
Exeter, ON N0M 1S2
T 519-235-2700 | F 519-235-3405

Acknowledgement of Medical Directive Policy for Medication Distribution

SHH Pharmacy services are provided by Tele-pharmacy along with on-site Pharmacy. As such, we require each Physician who seeks hospital privileges to authorize the Pharmacists to act under a Medical Directive in order to comply with all hospital policies related to our medication formulary system (see below complete list of policies governed by this medical directive (policy 28-031)).

- 28-001 Hospital Formulary System
- 28-002 Therapeutic Interchange and Auto-substitution Policy
- 28-005 Pharmacy Non-Formulary Medications
- 28-006 Medication Administration Times
- 28-007 Adjustment of Standard Administration Times
- 28-008 Diabetic Medications Standard Administration Times
- 28-017 Automatic Stop Orders
- Medical Directive 005 – Removal of Saline Lock

By signing this agreement, I _____
(please print)

authorize the North West Telepharmacy Solutions and Hospital Pharmacists to enact all policies noted above and to alter any and all medication orders written by me only as it relates to the requirements of these policies and as it pertains to the inpatients of SHH.

I understand that medication orders will be modified within the parameters as set out in the above stated policies. I also recognize that at any time should I not want a medication order overridden that “No Sub” is to be placed by me on the medication order form and is to be notated beside each relevant order.

Name of Physician

Signature

Date (YYYY-MM-DD)

***A full copy of 28-031 Medical Directive Policy for Medication Distribution is available on request
This form is to be signed on an annual basis at time of application for re-appointment for privileges.***



South Huron Hospital
24 Huron Street West
Exeter, ON N0M 1S2
T 519-235-2700 | F 519-235-3405

AGREEMENT

Chief of Staff Approval of Directives on Behalf of Physicians

For the Period: July 1, 2025 to June 30, 2026
(either party may terminate this agreement at any time with notice)

Chief Agreement:

I Dr. Sean Ryan, accept proxy from the undersigned physicians(s) and agree to:

- Approve a medical directive that is agreed to by each physician at MAC/Credentialing Process
- Ensure each physician is kept informed of the directive

2025-07-01

Signature of Chief

Date

Medical Directives

- 001 Acetaminophen (Tylenol®)
- 002 Ibuprofen (Advil®)
- 003 Aspirin (ASA®)
- 004 Obtaining Intravenous (IV) Access and Starting Intravenous Fluids
- 005 Removal of Saline Locks (SL)
- 006 Salbutamol (Ventolin®)
- 007 Urine Testing
- 008 Ketoralac (Toradol®)
- 009 Dimenhydrinate (Gravol®)
- 010 Diphenhydramine (Benadryl®)
- 011 Administration of Nitroglycerine sublingual
- 012 Tetanus (Tdap) Prophylaxis
- 013 Tetracaine 0.5% Ophthalmic Solution
- 014 Topical Anesthetic Application for Dermal Analgesia
- 015 One Ampule of 50% Dextrose
- 016 Epinephrine (for suspected anaphylaxis)
- 017 X-rays - Ankle Wrist and Knee
- 018 Influenza Immunization

ED Physician Agreement:

I, an undersigned physician, give proxy to the Chief named above to approve a medical directive on my behalf under the conditions identified above and agreed to:

Name of Physician

Signature

Date (YYYY-MM-DD)

***A full copy of 09-001 Delegated and Medical Directive Controlled Acts is available on request
This form is to be signed on an annual basis at time of application for re-appointment for privileges.***

Purpose

This form will authorize the Ministry of Health (the ministry) to make payment directly to the Group identified below. If you are joining more than one group, complete and sign an Authorization for Group Payment form **for each group** where you will be providing services on behalf of the Group.

Section 1 - Group Information

Group Name

South Huron Hospital

Group Billing Number

AA47 ER COVERAGE

Effective Date (for services rendered on or after) (yyyy/mm/dd)

End Date (if known) (yyyy/mm/dd)

Group Address

Unit Number

Street Number

24

Street Name

Huron Street West

PO Box

City/Town

Exeter

Province

Ontario

Postal Code

N0M 1S2

Telephone Number

519-235-5151

Section 2 - Health Care Professional Information and Authorization

Last Name

First Name

OHIP Billing Number (include 2 Digit Code, i.e., -00, -13, -33, etc.)

Current Registration Number (issued by governing body)

I hereby authorize the ministry to make payment to the Group named above for services provided by me on behalf of the Group. I understand that only services provided by me personally or delegated by me in accordance with the Schedule of Benefits will be billed under my OHIP billing number, and that payment will be made to the Group and the monthly Group RA will be issued directly to the Group.

Physician Signature

Date

For more information on completing this form, contact the ministry's Service Support Centre by email: SSContactCentre.MOH@ontario.ca or by calling 1-800-262-6524.

Submit this authorization form through **one** of the following options:

Email: ProviderRegistration.MOH@ontario.ca

Fax: 613-545-5848

Mail: Ministry of Health
Claims Services Branch
Provider Registry Unit
PO Box 68
Kingston ON K7L 5K1

The ministry's collection of the personal information on this form is authorized under the *Health Insurance Act*, R.S.O. 1990, c. H.6, section 4.1, and Ontario Regulation 57/97. The information will be used to authorize the ministry to make payment to the named group and to verify and monitor your eligibility for payment. It will also be used for health systems planning and coordination purposes. For information about this collection, contact the Director, Health Data Branch, Health System Information Management and Investment Division, Ministry of Health, 5700 Yonge Street, 4th Floor, Toronto ON M2M 4K5, by telephone: 1-866-803-0104 toll free and in Kingston, 613-548-4049 or by email: IMsupport@ontario.ca.

Purpose

This form will authorize the Ministry of Health (the ministry) to make payment directly to the Group identified below. If you are joining more than one group, complete and sign an Authorization for Group Payment form **for each group** where you will be providing services on behalf of the Group.

Section 1 - Group Information

Group Name

South Huron Hospital

Group Billing Number

0141 2ND ON-CALL

Effective Date (for services rendered on or after) (yyyy/mm/dd)

End Date (if known) (yyyy/mm/dd)

Group Address

Unit Number

Street Number

24

Street Name

Huron Street West

PO Box

City/Town

Exeter

Province

Ontario

Postal Code

N0M 1S2

Telephone Number

519-235-5151

Section 2 - Health Care Professional Information and Authorization

Last Name

First Name

OHIP Billing Number (include 2 Digit Code, i.e., -00, -13, -33, etc.)

Current Registration Number (issued by governing body)

I hereby authorize the ministry to make payment to the Group named above for services provided by me on behalf of the Group. I understand that only services provided by me personally or delegated by me in accordance with the Schedule of Benefits will be billed under my OHIP billing number, and that payment will be made to the Group and the monthly Group RA will be issued directly to the Group.

Physician Signature

Date

For more information on completing this form, contact the ministry's Service Support Centre by email: SSContactCentre.MOH@ontario.ca or by calling 1-800-262-6524.

Submit this authorization form through **one** of the following options:

Email: ProviderRegistration.MOH@ontario.ca

Fax: 613-545-5848

Mail: Ministry of Health
Claims Services Branch
Provider Registry Unit
PO Box 68
Kingston ON K7L 5K1

The ministry's collection of the personal information on this form is authorized under the *Health Insurance Act*, R.S.O. 1990, c. H.6, section 4.1, and Ontario Regulation 57/97. The information will be used to authorize the ministry to make payment to the named group and to verify and monitor your eligibility for payment. It will also be used for health systems planning and coordination purposes. For information about this collection, contact the Director, Health Data Branch, Health System Information Management and Investment Division, Ministry of Health, 5700 Yonge Street, 4th Floor, Toronto ON M2M 4K5, by telephone: 1-866-803-0104 toll free and in Kingston, 613-548-4049 or by email: IMsupport@ontario.ca.

Purpose

This form will authorize the Ministry of Health (the ministry) to make payment directly to the Group identified below. If you are joining more than one group, complete and sign an Authorization for Group Payment form **for each group** where you will be providing services on behalf of the Group.

Section 1 - Group Information

Group Name

South Huron Hospital

Group Billing Number

0175 INPATIENT/HOSPITALIST

Effective Date (for services rendered on or after) (yyyy/mm/dd)

End Date (if known) (yyyy/mm/dd)

Group Address

Unit Number

Street Number

24

Street Name

Huron Street West

PO Box

City/Town

Exeter

Province

Ontario

Postal Code

N0M 1S2

Telephone Number

519-235-5151

Section 2 - Health Care Professional Information and Authorization

Last Name

First Name

OHIP Billing Number (include 2 Digit Code, i.e., -00, -13, -33, etc.)

Current Registration Number (issued by governing body)

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Physician Signature

Date

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Section 1 - Group Information

Group Name

South Huron Hospital

Group Billing Number

8799 RADIOLOGY

Effective Date (for services rendered on or after) (yyyy/mm/dd)

End Date (if known) (yyyy/mm/dd)

Group Address

Unit Number

Street Number

24

Street Name

Huron Street West

PO Box

City/Town

Exeter

Province

Ontario

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Telephone Number

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Section 2 - Health Care Professional Information and Authorization

Last Name

First Name

OHIP Billing Number (include 2 Digit Code, i.e., -00, -13, -33, etc.)

Current Registration Number (issued by governing body)

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Physician Signature

Date

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Purpose

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Section 1 - Group Information

Group Name

South Huron Hospital

Group Billing Number

8931 Holter Monitor/ECG/Stress

Effective Date (for services rendered on or after) (yyyy/mm/dd)

End Date (if known) (yyyy/mm/dd)

Group Address

Unit Number

Street Number

24

Street Name

Huron Street West

PO Box

City/Town

Exeter

Province

Ontario

Postal Code

N0M 1S2

Telephone Number

519-235-5151

Section 2 - Health Care Professional Information and Authorization

Last Name

First Name

OHIP Billing Number (include 2 Digit Code, i.e., -00, -13, -33, etc.)

Current Registration Number (issued by governing body)

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Physician Signature

Date

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Kingston ON K7L 5K1

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Purpose

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Section 1 - Group Information

Group Name

South Huron Hospital

Group Billing Number

9162 ULTRASOUND

Effective Date (for services rendered on or after) (yyyy/mm/dd)

End Date (if known) (yyyy/mm/dd)

Group Address

Unit Number

Street Number

24

Street Name

Huron Street West

PO Box

City/Town

Exeter

Province

Ontario

Postal Code

N0M 1S2

Telephone Number

519-235-5151

Section 2 - Health Care Professional Information and Authorization

Last Name

First Name

OHIP Billing Number (include 2 Digit Code, i.e., -00, -13, -33, etc.)

Current Registration Number (issued by governing body)

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Physician Signature

Date

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	☒ Policy ☐ Procedure ☐ Protocol ☐ Terms of Reference ☐ Position Description	Section Medical Staff	Number 09-003
<i>Code of Conduct</i>			
Date Issued: February 2009 Date Review/Revised: September 2013, September 2020 Next Review Date: September 2023			
Owner: President & CEO		Reviewer(s): Chief of Staff	Approver: Chief of Staff
Cross Reference:			

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Preamble

The medical staff of South Huron Hospital Association (SHHA) is committed to supporting a culture that values integrity, honesty, and fair dealing with each other, and to promoting a caring environment for patients, physicians, nurses, other health care workers and employees.

The medical staff of SHHA endeavours to create and promote an environment that is professional, collegial, and exemplifies outstanding teaching, research and patient care.

Towards these goals, the medical staff strives to maintain a workplace that is free from harassment. This includes behaviour that could be perceived as inappropriate, harassing or that does not endeavour to meet the highest standards of professionalism.

Purpose

The purposes of this Code of Conduct are to:

- clarify the expectations of all medical staff during interactions with any individuals at SHHA;
- encourage the prompt identification and resolution of alleged inappropriate conduct; and
- encourage identification of concerns about the well-being of a physician whose conduct is in question.

Disruptive conduct and inappropriate workplace behaviour may be grounds for suspension or termination of a contract, or cancellation, suspension, restriction or non-renewal of privileges.

SHHA will follow due process for matters which have an impact upon a medical staff members privileges and will abide by the Hospital's by-laws/*Public Hospitals Act*/Institutional policies.

Policy

General Expectations

1. Consider first the well-being of the patient.
2. Interactions with patients, visitors, employees, physicians, volunteers, health care providers or any other individual shall be conducted with courtesy, honesty, respect and dignity.
3. All medical staff of SHHA community are expected to refrain from conduct that may reasonably be considered offensive to others or disruptive to the workplace or patient care.

Offensive conduct may be written, oral or behavioural. Examples of inappropriate conduct would include, but are not limited to:

Inappropriate words:

- profane, disrespectful, insulting, demeaning or abusive language;
- shaming others for negative outcomes;
- demeaning comments or intimidation;
- inappropriate arguments with patients, family members, staff or other care providers*;
- rudeness;
- boundary violations with patients, family members, staff or other care providers;
- gratuitous negative comments about another medical staff care (orally or in chart notes);
- passing severe judgment or censuring colleagues or staff in front of patients, visitors or other staff;
- outbursts of anger;
- behaviour that others would describe as bullying;
- insensitive comments about the patient's medical condition, appearance, situation, etc.; and
- jokes or non-clinical comments about race, ethnicity, religion, sexual orientation, age, physical appearance or socioeconomic or educational status.

***NOTE:** Comments that are or may be perceived as being sexually harassing which are directed at patients may fall under the definition of sexual abuse at s. 1 (3) in the *Regulated Health Professionals Act, 1991*. Such comments which are directed at non-patients may be professional misconduct.

Inappropriate actions/inaction:

- throwing or breaking things;
- refusal to comply with known and generally accepted practice standards such as the refusal inhibits staff or other care providers from delivering quality care;
- use or threat of unwarranted physical force with patients, family members, staff or other care providers;
- repeated failure to respond to calls or requests for information or persistent lateness in responding to calls for assistance when on-call or expected to be available;
- not working collaboratively or cooperatively with others; and
- creating rigid or inflexible barriers to requests for assistance/cooperation.

DOMESTIC VIOLENCE & ACCESS TO SUPPORTS

The purpose of this document is to ensure that all Physicians working at the South Huron Hospital Association ("SHHA") are familiar with SHHA's Policies respecting Domestic Violence as it relates to employees of the Hospital, as well as the supports available to victims.

SHHA's Workplace Violence & Harassment Prevention Program (Policy # 13-021-A) defines "Domestic Violence" as, *a person who has a personal relationship with a worker- such as a spouse or former spouse, current or former intimate partner, or a family member- and may physically harm, or attempt or threaten to physically harm that worker.* This is considered a form of Workplace Violence when the harm takes place at work, or when the worker's job performance is impacted (e.g.: the worker is unable to attend work due to injuries).

Our position on Domestic Violence – as well as all other forms of Workplace Violence – is clear at SHHA: we have zero tolerance to any type of workplace violence. This applies to any potential perpetrator of Violence: employees, employee family members, members of the public, strangers, students/residents, and Physicians with credentialing privileges. We must take every reasonable precaution to protect all employees from physical injury, and we require only a belief, reasonable in the circumstances, to justify investigating potential Domestic Violence (as opposed to proof/evidence).

Therefore, SHHA expects Physicians to uphold the following expectations:

1. Facilitate medical treatment for both Domestic Violence victims and perpetrators.
 - Alternate treatment should be arranged for perpetrators if it is unsafe or unsuitable to treat them concurrently with the victim.
2. Where assistance is required to de-escalate an imminent or potentially violent situation or to manage a difficult/aggressive person, please contact law enforcement for support, in accordance with our "Code White" protocol.
 - If you require additional training on Code White, please contact the Chief of Staff.
3. Physicians have a special relationship of trust with both the public and the hospital's workers. If a worker discloses to you or if you suspect that they may be or may become a victim of Domestic Violence, you must, 1: notify the employer, and, 2: take every precaution reasonable in those circumstances for the protection of the worker.
 - This may include participating in the development of an individualized safety plan. The plan would describe in detail what steps can be taken to reduce or eliminate contact between the perpetrator and the worker.
 - This may also include notification to law enforcement, as appropriate.
4. You must participate in the investigation of any Domestic Violence incident (actual or suspected) of which you were witness or otherwise involved. For greater clarity, this point applies to both internal and external (i.e.: law enforcement) investigations.
5. In the aftermath of a violent incident, supports must be offered to those involved in the incident. Physicians have an important role in this, as they will often be among the first on the scene. Supports offered may include:
 - De-briefing session[s] with those involved. Due to the trust relationship described above, Physicians may be looked to by staff to facilitate the de-briefing process. We would encourage Physicians to seek professional facilitation (i.e.: on-call psychiatric support, law enforcement) if appropriate/necessary.
 - SHHA encourages workers of all types to make use of our EFAP services offered by Homewood. Please contact the Chief of Staff if you require further information about EFAP.

- Referrals to community agencies and/or to the family practitioner of a victim may be appropriate. Physicians are expected to stay informed in regards to the appropriate community agencies that a victim may be referred to.

We appreciate your attention to this document. With your help, we will be able to ensure that our Policy of Zero Tolerance for all forms of Workplace Violence is upheld.

Sincerely,

A handwritten signature in blue ink that reads "Peter Kronenberg". The signature is fluid and cursive, with the first name "Peter" and last name "Kronenberg" clearly distinguishable.

Peter Kronenberg

HR Associate

South Huron Hospital Association

O: 519-235-5172 | F: 519-235-3405

	☒ Policy ☐ Procedure ☐ Protocol ☐ Terms of Reference	Section Medical Staff	Number 09-005
Mission, Statement and Goals, Rules and Regulations			
Date Issued: June 2002			
Date Review/Revised: September 2020			
Next Review Date: September 2023			
Owner: President & CEO		Reviewer(s): Chief of Staff	Approver: Chief of Staff

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Policy

Mission Statement

To provide the best possible medical care (and treatment) through continuously improving service to meet (or exceed) the needs and expectations of patients, hospital staff, the Board of Governors and the community served by South Huron Hospital Association (SHHA; the hospital).

Goals

1. To appoint membership to the various Board committees.
2. To promote continuing education for the Medical and Hospital staff.
3. To participate in the development and implementation of a Human Resource Plan for medical staff for the South Huron region.
4. To participate in quality improvement teams to continuously improve patient care and promote effective communication between Medical Staff, Board and Hospital Staff.
5. To encourage participation in regional health care planning.

Board Committees that medical staff sit on:

Executive, Governance & Planning

Joint Conference

Fiscal Advisory

Medical Advisory Committee:

- Pharmacy and Therapeutic
- Infection Control
- Lab Liaison

Quality teams that medical staff sit on:

Credentials Committee

Board Quality, Utilization and Risk Committee

Rules and Regulations

All physicians shall adhere to the By-Laws of SHHA and the Public Hospital Act.

1. Admissions

- a) No patient shall be admitted to hospital until after an admission order and provisional diagnosis have been recorded.

- b) Within twenty-four (24) hours of admission an admitting note that clearly sets out the reason for admission of the patient and is authenticated by a member of the medical staff is entered in the medical record of the patient.
- c) Within seventy-two (72) hours after a patient is admitted to hospital the attending physician will be responsible for:
 - i. Taking a medical history of the patient.
 - ii. Giving the patient a physical examination.
 - iii. Making a provisional diagnosis of the patient's medical condition.
 - iv. Recording, dating and authenticating the history and a report of the findings of the physical examination and the provisional diagnosis of the patient.
- d) When a patient is readmitted within ten (10) days of separation with the final diagnosis unchanged, the previous history and physical examination with a signed interval note will suffice.
- e) Patients who are admitted by the Emergency physician will be attended by the Emergency physician until the hospitalist accepts responsibility at the beginning of their shift.
- f) All patients who are admitted will be managed by the hospitalist.

2. Orders

All orders for admission, discharge and treatment (including standing orders) shall be in writing and signed by the attending physician. Orders dictated over the telephone shall be signed by the person to whom dictated with the name of the physician per his or her name. The attending physician shall sign these orders within twenty-four (24) hours, or at the next visit, whichever is soonest.

A physician who proposes a course of treatment must ensure that it is not administered unless consent to the course of treatment has been given from the patient if capable, or from the person's substitute decision-maker, if the patient is incapable.

3. Doctors Medical Orders

- a) Medications accepted for regular use in the hospital will be listed in the Drug Formulary.
- b) All physicians shall write orders for narcotics and other therapeutic agents, as defined by the Pharmacy and Therapeutics Committee, with a stated limit as to the number of doses or the hours or days of administration. For orders written without such dosage or time limitation, an automatic stop order shall be instituted;
 - i. For all injectable medication excluding insulin and including narcotics – seventy-two (72) hours.
 - ii. For all oral antibiotics and ventolin puffers – seven (7) days.
 - iii. For insulin new found – daily; dependent – weekly.
 - iv. Anticoagulants – forty-eight (48) hours – following Heparin protocol.
 - v. Injectable antibiotics – forty-eight (48) hours.

4. Progress Notes, Final Diagnosis, Discharge Summary

- a) Progress notes will be written daily for active and chronic patients.
- b) A final diagnosis compatible with clinical and pathological findings shall be recorded at the time of discharge.
- c) The entire patient's medical record shall be completed and signed by the attending physician or his designate within fourteen (14) days of the patient's separation. If the record remains incomplete after fourteen (14) days and all essential reports have been received and placed on the record, the Chief Executive Officer or designate shall notify the physician that these records must be completed within seven (7) days of notification.

A second notification will be sent if required. If the records have not been completed by that time, the physician and Chief of Staff shall be notified that the physician's privileges to admit shall be suspended immediately and shall be reinstated after the records have been completed.

- d) All records are the property of the hospital and shall not be taken out of the hospital without the written permission of the hospital's Chief Executive Officer.

5. Transfer of Responsibility for Patients

- a) The attending physician is the hospitalist as per the schedule.
- b) A completed history and physical will be completed by the attending physician before transferring patient care responsibilities.

6. Discharge of Patients (Separations)

Patients shall be discharged on written order of the physician. A discharge includes death or transfer. In the case of a patient leaving the hospital against the advice of the attending physician, a release shall be signed by the patient or responsible party and in the case in which such release cannot be obtained; this shall be documented in the patient's record.

The attending physician completes the patient discharge sheet.

In the event of death of a patient, the physician certifying the patient dead shall also record the date and time of death on the patient's medical record. The cause of death shall be recorded on the medical record by the attending physician.

Every person who has reason to believe that a deceased person died,

- a) as a result of,
 - i. violence,
 - ii. misadventure,
 - iii. negligence,
 - iv. misconduct, or
 - v. malpractice;
 - b) by unfair means;
 - c) during pregnancy or following pregnancy in circumstances that might reasonably be attributable thereto;
 - d) suddenly and unexpectedly;
 - e) from disease or sickness for which he or she was not treated by a legally qualified medical practitioner;
 - f) from any cause other than disease; or
 - g) under such circumstances as may require investigation,
- shall immediately notify a coroner or a police officer of the facts and circumstances relating to the death, and where a police officer is notified he or she shall in turn immediately notify the coroner of such facts and circumstances. Coroners Act R.S.O. 1990, c. C.37, s. 10 (1).

7. Complaints

Should any member of the medical staff have a complaint against any hospital employee, he/she shall report it to the employee's department head who will in turn take necessary action within his/her jurisdiction, or take the matter through the proper administrative channels. Members of the medical staff have no authority to discipline hospital employees. This is the sole prerogative of the administration of the hospital.

8. Continuing Education

Every active and associate physician will pursue a minimum of fifty (50) hours of CME credits annually, commensurate with the Standards Established by their College.

9. Credentials Committee

- a) The Credentials Committee may be established as a subcommittee of the Medical Advisory Committee.
- b) The Credentials Committee shall be comprised of:
 - i. Chief Executive Officer, and
 - ii. the Chief of Staff/Chair of the Medical Advisory Committee;
- c) In the event of a dispute as to the proper composition of the Credentials Committee, the dispute shall be determined by the Medical Advisory Committee.
- d) The Medical Advisory Committee shall appoint the chair of the Credentials Committee.
- e) The terms of reference of the Credentials Committee shall be set out in these Rules and Regulations or in a resolution of the Board, on recommendation of the Medical Advisory Committee.

10. Quality, Utilization and Risk Committee

- a) The Quality, Utilization and Risk Committee shall be comprised of:
 - i. any one (1) member of the Active Medical Staff deemed appropriate by the Chief of Staff.
- b) The Quality, Utilization and Risk Committee shall:
 - i. review quality and utilization patterns in the hospital, compare to benchmarks and identify where improvements in utilization patterns could be achieved;
 - ii. monitor overall trends in admission, length of stay and program volumes and provide appropriate information to the Medical Advisory Committee and hospital;
 - iii. report quality and utilization findings and make recommendations on policy and procedure changes to the Medical Advisory Committee and Board Quality, Utilization and Risk Committee on a regular basis at least quarterly;
 - iv. comment on the resource implications of proposed additions to the medical staff;
 - v. report to the Medical Advisory Committee, for the purpose of discipline, any staff member who is delinquent in completing the medical record of any patient who is or has been under his/her care in the Hospital;
 - vi. prepare and submit an analysis of all deaths occurring in the Hospital since the previous meeting to the Medical Advisory Committee;
 - vii. assure medical audits are undertaken as necessary;
 - viii. perform other duties as requested from time to time by the Medical Advisory Committee and hospital management.

11. Pharmacy and Therapeutics Committee

- a) The Pharmacy and Therapeutics Committee shall be comprised of one (1) member of the Medical Staff deemed appropriate by the Chief of Staff.
- b) The Pharmacy and Therapeutics Committee shall:
 - i. compile and, at least once yearly, review a pharmacopoeia for the Hospital's use;
 - ii. study drugs and medications and make recommendations to the Board and the Chief Executive Officer or his or her delegate regarding their necessity, usefulness, duplication, toxicity and cost.
 - iii. Assess regularly the appropriateness and adequacy of medication-related policies and make policy recommendations to the Medical Advisory Committee regarding drug utilization to ensure safe, effective and economical use of drugs.

- iv. Evaluate drug utilization, new drugs and current therapeutics and recommend addition/deletions to a formulary that is suited to the Hospital's needs, and periodically assess the effectiveness of and adherence to the formulary.
- v. Develop a procedure for the use of non-formulary drugs and a mechanism for their evaluation.
- vi. Periodically analyze a summary of medication errors and their causative factors and make appropriate recommendations regarding prevention to the Professional, Nursing and/or pharmacy staff.
- vii. Develop an adverse drug reaction reporting program to review all these reports and ensure that a summary is circulated to Professional and Nursing Staff when the need arises.
- viii. Review all standing orders related to medications annually, or more often if deemed necessary.
- ix. Develop protocols governing programs such as total parenteral nutrition, investigational drugs, self medication or ensure that such protocols have been developed after appropriate committee review.
- x. Identify and/or arrange appropriate educational programs for the Professional Staff and Hospital staff to enhance their knowledge of drug therapy and practices.

12. Infection Control Committee

- a) The Infection Control Committee shall be comprised of:
 - i. any one (1) member of the Active Medical Staff deemed appropriate by the Chief of Staff;
 - ii. the Chief Executive Officer; or delegate,
 - iii. the Infection Control Practitioner.

Other members of the Professional Staff and/or Hospital staff shall attend committee meetings as requested by the Chair of the Infection Control Committee.

- b) The Infection Control Committee shall:
 - i. develop a reporting system by which all infections will come to its attention, including whenever possible post-discharge infections;
 - ii. review reports from its members, develop and monitor the infection control system in the Hospital, make recommendations to the Professional Staff including matters relating to:
 - the employee health service;
 - an immunization program for employees;
 - visitor restrictions or instructions both in general terms and in special circumstances;
 - patient restrictions or instructions;
 - an educational program for Professional Staff members, employees, patients and visitors;
 - communicable disease isolation procedures;
 - aseptic and antiseptic techniques; and
 - environmental sanitation in the Hospital.
- c) The Infection Control Committee shall review the actions taken and results of each of its recommendations.

	☒ Policy ☒ Procedure ☐ Protocol ☐ Terms of Reference	Section Human Resources	Number 13-021
Workplace Violence and Harassment Prevention Program			
Date Issued: July 2008 Date Review/Revised: April 2024 Next Review Date: April 2025			
Owner: Human Resources	Reviewer(s): Human Resources	Approver: Human Resources	
Cross Reference: See "Related Documents" section, pgs. 11-12			

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Policy Review

This policy will be reviewed annually.

Application / Departments Affected

All staff and affiliates (including contractors, Physicians, clients, guests/visitors, and any other users of the facility for hospital business purposes).

Preamble

South Huron Hospital Association (SHHA) is committed to providing a safe, healthy and supportive working environment by treating our employees and clients with respect, fairness and sensitivity. Violence and harassment in the workplace can have devastating effects on the quality of life for our employees and on the productivity of the organization.

Prevention Program

The Workplace Violence and Harassment Prevention Program shall include the following:

1. Definitions of behaviour that constitutes workplace violence and harassment;
2. Definitions of the roles and responsibilities of workplace parties with respect to workplace violence and harassment;
3. Measures and procedures to control risks of workplace violence that are likely to expose a worker to physical injury;
4. Measures and procedures for workers to summon immediate assistance when workplace violence occurs or is likely to occur;
5. Measures and procedures for workers to report complaints of and incidents of workplace violence and/or harassment to the Employer or Supervisor;
6. How the employer will investigate complaints of and incidents of workplace violence;
7. Measures and procedures for the education and training of employees regarding workplace violence and harassment.

SHHA is committed to providing a working environment free of violence and harassment by ensuring that all workplace parties are familiar with the definitions of workplace violence and their individual responsibilities for prevention and corrective action. To establish this policy, SHHA has consulted the Joint Health and Safety Committee (JHSC) and the following legislation governing workplace violence in Ontario:

- The Occupational Health and Safety Act
- The Criminal Code of Canada
- The Ontario Human Rights Code
- The Workplace Safety and Insurance Act
- The Regulated Health Professionals Act

Policy Statement

NOTE: The most senior representative of the Employer in the workplace is the Chief Executive Officer. Responsibilities of the Employer will ultimately be under the purview of the CEO to execute.

SHHA recognizes the potential for violence and harassment in the workplace and is committed to the prevention of workplace violence and harassment. SHHA will make every reasonable effort to identify all potential sources of violence and harassment and to eliminate or minimize these risks through the Workplace Violence & Harassment Prevention Program. It is the responsibility of SHHA to ensure that the Program is implemented and maintained; this includes providing appropriate training and instruction to all SHHA employees. Resources shall be available for employees to seek help to address workplace violence and harassment; these may include- but are not limited to- the following:

- | | |
|--|---|
| • JHSC Members | • Human Resources |
| • EFAP Services | • Police (in threatening situations) |
| • Union Representatives (where applicable) | • Government agencies, such as the Ministry of Labour |

SHHA has a zero-tolerance standard to any type of workplace violence and harassment, within the workplace or at work-related activities. Zero tolerance means that we will not accept any of the following behaviours under any circumstances:

- | | |
|------------------------------|------------------------------------|
| • Yelling | • Spitting |
| • Hitting others | • Kicking or throwing items |
| • Angry or violent outbursts | • Swearing or threatening language |

Zero tolerance also means that every reported event of harassing, abusive/aggressive or threatening behaviour will be tracked, investigated and resolved based on the individual facts.

It is important to note that behaviours described in this Policy may result in criminal charges where they are referred to the Police for investigation.

SHHA shall ensure that workers will have methods of summoning assistance when a violent event occurs or is likely to occur.

- Workers will not be subject to reprisals for reporting an incident in good faith or for participating in an investigation of an incident.
- Individual cases may require different resolutions. Although measures will be put in place to assist parties in conflict resolution, where appropriate, disciplinary action will be taken, up to and including termination of employment, revocation of physician's privileges or termination of volunteer/student/contract agreements.
- Information about a complaint or incident will not be disclosed except to the extent necessary to protect workers, to investigate the complaint or incident, to take corrective action, or as otherwise required by law.

- SHHA will also take every reasonable precaution to protect all employees from physical injury if we become aware, or believe domestic violence or harassment in the workplace is occurring.

SHHA is committed to the expenditure of time, attention, authority, and resources to the workplace parties to ensure a safe and healthy working environment for all employees and clients for whom we provide care. This Policy- and the Procedure that implements it- is to be upheld by everyone as we work together to prevent workplace violence.

Definitions

Threat: a communicated intent (verbal or written) to inflict physical or other harm on any person or to property by some unlawful act. A direct threat is a clear and explicit communication distinctly indicating that the potential offender intends to do harm, for example, "I am going to make you pay for what you did to me." A conditional threat involves a condition, for example, "If you don't leave me alone you will regret it." Veiled threats usually involve body language or behaviours that leave little doubt in the mind of the victim that the perpetrator intends to harm.

Verbal Abuse: Any behaviour meant to intimidate, belittle, threaten, or demean another person. May include but is not limited to:

- shouting,
- stalking,
- swearing,
- bullying,
- mobbing,
- veiled threats or open threats,
- gestures with the hand or other body parts that indicate harm,
- displays of use of any kind of weapon that could be interpreted as being dangerous.

Workplace Violence: The exercise or attempted exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker, or a statement of behaviour that is reasonable for a worker to interpret as a threat to exercise physical force against the worker, in a workplace, that could cause physical injury to the worker. Violence can be better classified into the following types:

- **Type I – Criminal Intent:** Wherein the perpetrator of violence has no relationship to the workplace.
- **Type II – Patient:** Wherein the perpetrator is a patient at the workplace who becomes violent towards a worker or another patient.
- **Type III – Worker to Worker:** Wherein the perpetrator is a present/past employee of the workplace or is a volunteer or member of the medical staff.
- **Type IV – Personal Relationship:** Wherein the perpetrator has a relationship with an employee outside the workplace, e.g.: Domestic Violence.

It should be noted that the perpetrator of violence may not have the capacity to appreciate that these actions could cause physical harm. For example, a patient whose medical condition causes them to physically act out uncontrollably in response to environmental stimuli.

Examples of physical violence may include but are not limited to:

- physical assault
- slapping,
- shoving/pushing,
- pinching,
- hair pulling,
- punching,
- hitting,
- kicking,
- scratching,
- tugging at clothes,
- Near misses
- biting,
- domestic violence,
- shooting/stabbing,

- suicide/attempted suicide,
- mobbing
- property damage, e.g.: vandalism,
- throwing of objects, etc.,

Domestic Violence: A person who has a personal relationship with a worker- such as a spouse or former spouse, current or former intimate partner, or a family member- and may physically harm, or attempt or threaten to physically harm that worker. In these situations, Domestic Violence is considered to be workplace violence.

Workplace Harassment: Engaging in a course of vexatious comment or conduct against a worker in a workplace that is known or ought reasonably to be known to be unwelcome.

Examples of workplace harassment may include:’

- Remarks, jokes or innuendos that demean, ridicule, intimidate, or offend
- Displaying or circulating offensive pictures or materials (in print or electronic format)
- Abusive/aggressive behaviour and Bullying (see definition below)
- Exclusion from workplace activities that you would normally participate in
- Repeated offensive or intimidating phone calls or e-mails
- Rude, disparaging, or discriminatory behaviour towards another person on the basis of one of the *Ontario Human Rights Code*’s prohibited grounds, which are:

➤ Race	➤ Sex (including pregnancy)	➤ Age
➤ Ancestry	➤ Sexual orientation	➤ Marital status
➤ Place of origin	➤ Gender identity	➤ Family status
➤ Colour	➤ Gender expression	➤ Disability
➤ Ethnic origin		➤ Receipt of public assistance
➤ Citizenship		
➤ Creed (religion)		

IMPORTANT: Reasonable action taken by an employer or supervisor relating to the management and direction of workers or the workplace is not workplace harassment. For example, negative performance reviews and commands issued by supervisors are not considered workplace harassment.

Workplace Sexual Harassment:

- Engaging in a course of vexatious comment or conduct against a worker in a workplace because of sex, sexual orientation, gender identity or gender expression, where the course of comment or conduct is known or ought reasonably to be known to be unwelcome, or,
- Making a sexual solicitation or advance where the person making the solicitation or advance is in a position to confer, grant or deny a benefit or advancement to the worker and the person knows or ought reasonably to know that the solicitation or advance is unwelcome.

Sexual Abuse: an unwelcome verbal or physical advance or sexually explicit statement, displays of pornographic material, pinching, brushing against, touching, patting or leering that causes the person to believe their health and safety is at risk.

Sexual Assault: the use of threat or violence to force one individual to touch, kiss, fondle or have sexual intercourse with another. Sexual assault is a criminal offence.

Abusive/Aggressive Behaviour, Bullying: Acts of an individual or a group of individuals that compromise the physical and psychological safety of an individual or a group of individuals by their behaviour that strays from expected behaviour in the workplace, whether intentionally or unintentionally. In the case of *Bullying*, these acts occur in a context where there is a power imbalance- either real or perceived- between the perpetrator and the victim.

Psychological Abuse: an act that provokes fear or diminishes an individual's dignity or self-work or that intentionally inflicts psychological trauma on another.

Child Abuse: an act of non-accidental harm to a person under 16 years of age, where the perpetrator is a person who has charge of the person under 16 years of age.

Elder Abuse: an act that results in physical or psychological harm, abuse, or neglect of an elderly person, where the perpetrator of the act is a person in a position of trust or authority.

Roles and responsibilities of Workplace Parties

Accountability

All workplace parties are accountable for complying with the policy, program, measures and procedures related to workplace violence and harassment.

Employer: The most senior representative of the Employer in the workplace is the Chief Executive Officer. Responsibilities of the Employer will ultimately be under the purview of the CEO to execute.

1. Prepare and implement Policy and Program with respect to workplace violence and harassment and review the policies as often as necessary, but at least annually. The policies shall be in written form and shall be posted at a conspicuous place in the workplace.
2. In consultation with JHSC and in compliance with the *Occupational Health and Safety Act*, conduct regular assessments of workplace violence risks and hazards.
3. Ensure that measures and procedures identified in the violence and harassment prevention program are carried out and that management is held accountable for responding to and resolving complaints of violence.
4. Take action to mitigate the danger of reprisals resulting from good faith reports of workplace violence or harassment.
5. Monitor adherence to the Policy. Ensure compliance by all persons who have a relationship with the organization, such as physicians, contractors, volunteers, etc.
6. Integrate safe behaviour into day-to-day operations.
7. Ensure that there is a means to identify, and document electronically, patients who are exhibiting violent behaviour during their hospital stay.
8. Investigate all reports or threats of violence as soon as possible if an employee is disabled from performing their own work or receives medical attention as a result of an incident. The JHSC will be promptly informed of all such incidents, and will have an opportunity to participate in the investigation.
9. Review all reports of violence, threats of violence or harassment in a prompt, objective and sensitive manner. This includes a review of all investigations associated with violence-related incidents.
10. Take corrective action.
11. Provide response measures.
12. Facilitate medical attention and support for all those either directly or indirectly involved.
13. Ensure any deaths or critical injuries are reported consistently with OHS standards.

14. Ensure that injuries resulting from a workplace injury are reported to the WSIB, as appropriate.
15. In consultation with JHSC, establish and deliver training and education for all employees.

Managers/Supervisors

1. Uphold and enforce policy, procedures and programs and monitor worker compliance.
2. Ensure that employees who conduct assessments of workplace violence risks are properly trained to utilize Behavioural Safety Alert protocols and assessments.
3. Identify and alert staff to violent patients and hazardous situations. Inform workers of workplace violence hazards of which they are aware.
4. Ensure that a notation is made in the patients chart or the "Violent Behaviour Alert" has been applied electronically.
5. Investigate all workplace violence using the organization's Incident Management System, and contact the police department as required.
6. Facilitate medical attention for employee(s) as required.
7. Facilitate post-incident debriefing for those either directly or indirectly involved in the incident.
8. Where appropriate, connect workers to resources for post-incident support (e.g.: EAP) and counselling, including legal counselling.
9. Track and analyze incidents for trending and prevention initiatives.
10. Ensure any deaths or critical injuries are reported consistently with OHS standards.
11. Ensure that injuries resulting from a workplace injury are reported to the WSIB, as appropriate.
12. Ensure there is a review at least annually of the workplace violence prevention program.

Employees

1. Participate in education and training programs to be able to respond appropriately to any incident of workplace violence.
2. Understand and comply with this policy and all related procedures.
3. Report all incidents or injuries relating to violence, threats to violence, or harassment to their supervisor immediately, completing an Employee incident report or *Workplace Harassment Complaint Form* (Appendix D).
 - a. **IMPORTANT:** employees will never be punished or penalized for such reports where the report is made in good faith.
4. *Where applicable* Ensure that patients exhibiting violent behaviour during their current visit are assessed using the appropriate Behaviour Safety Alert ("BSA") protocols. Refer to the following Appendixes as applicable:
 - a. Appendix A: *BSA Process- Inpatient Unit or Direct Admission*
 - b. Appendix B: *BSA Process- Emergency Dep't.- Electronic Triage Form*
 - c. Appendix C: *BSA Process- Registration-Outpatient Clinics*
5. Inform the JHSC, or worker member of the JHSC, about any concerns about the potential for violence or harassment in the workplace.
6. Seek support when confronted with violence or threats of violence.
7. Seek medical attention, when necessary or as required.
8. SHHA employees may refuse unsafe work if they have reason to believe that workplace violence is likely to endanger them, however, limitations for health care workers may apply. Health care workers cannot refuse work when:
 - a. The risk is inherent in the worker's work or is a normal condition of their employment, or,

- b. The worker's refusal to work would directly endanger the life, health or safety of another person.
9. Cooperate with investigators of an incident. During the investigation, the employee must remain in a safe environment and be available for the investigation.

Joint Health and Safety Committee

- Be consulted about the development, establishment and implementation of violence measures and procedures (the violence and harassment prevention program).
- Participate in a review at least annually of the workplace violence prevention program.
- Be consulted and make recommendations to the employer to develop, establish and provide training in violence and harassment measures and procedures.
- Take part in a review at least annually of the workplace violence and harassment prevention program.
- The worker designate should investigate all critical injuries related to violence.
- Receive and review reports of any critical injury or death in relation to workplace violence.
- Review reports of injuries where any person is disabled from performing his or her usual work or requires medical attention as a result of workplace violence.

Controlling Workplace Violence Risks

Risk Assessment

In order to control workplace violence risks, we must first understand what risks exist in our workplaces. SHHA assesses workplace violence hazards in all jobs, and in the workplace as a whole. The JHSC participates in the risk assessment process so that workers can be involved.

The results of the assessment will be reviewed by senior management and the JHSC.

Risk assessments are reviewed at least annually, as well as:

- Whenever renovations to the workplace that impact the risk rating occur,
- Whenever there are significant changes to the type of work being performed,
- Whenever the conditions of work change significantly,
- Whenever new information on the risks of workplace violence that impacts the risk rating arises,
- During the follow-up on a violent incident, especially where the incident occurred as a result of a risk not identified in the assessment.

Control Measures

Once violence risks are identified through the Risk Assessment process, control measures can be developed. Control measures may be broad in scope (applicable to a wide range of tasks, conditions of work or workplace circumstances), or they may be narrow in scope (applicable to a specific task, condition, or workplace circumstance). The employer is responsible for the following:

- Developing controls appropriate to the identified risk.
- Implementing risk controls.
- Monitoring the status of implementation and effectiveness of controls.

Controls for Domestic Violence

If an employer becomes aware, or ought reasonably to be aware, that domestic violence that would likely expose a worker to physical injury may occur in the workplace, the employer shall take every precaution reasonable in the circumstances for the protection of the worker. Such precautions may include an individualized safety plan. A safety plan would be developed with the worker, the supervisor, and any other relevant parties (e.g.: Union representatives). The plan would describe in detail what steps can be taken to reduce or eliminate contact between the abuser and the employee.

One possible step in a safety plan may be to provide information to workers, including personal information, related to a risk of workplace violence from a person with a history of violent behaviour if, (1) the worker can be expected to encounter that person in the course of his or her work; and, (2) the risk of workplace violence is likely to expose the worker to physical injury. No employer or supervisor shall disclose more personal information than is reasonably necessary to protect the worker from physical injury.

Measures for Summoning Assistance

Code White

SHHA utilizes a “Code White” protocol for responding to, “an imminent potential or actual violent/behavioural situation where assistance is required to deescalate the situation or manage *[sic]* a difficult and/or aggressive person.” Code White should therefore be referred to for SHHA’s measures for summoning immediate assistance.

All employees will receive training with respect to Code White at the start of their employment, as well as in annual reviews thereafter. SHHA has a Code Committee, whose members are responsible for the conducting of drills for Code White as well as for review and revision of the Code White protocol.

For further information, refer to the Emergency Code Manual, “*Code White – Violent / Behavioural Situation*”.

Additional Measures

Further measures for summoning assistance may be identified and implemented through the Risk Assessment process.

Reporting

Workers

All workers are responsible for reporting all violence-related incidents or acts of harassment to their supervisors or managers. If the employee’s direct supervisor is involved in the act, the employee is to contact Human Resources.

In cases of workplace violence, an Employee incident report form must be completed. In cases of harassment, a *Workplace Harassment Complaint Form* (see Appendix D) must be completed.

- The reporting worker may make the report confidentially by simply indicating the need for confidentiality to her or his direct manager or supervisor, or in the manager’s or supervisor’s absence, to another manager or supervisor.
- If the perpetrator has no relationship to the organization or has a personal relationship with the employee, the supervisor consults with Human Resources and contacts the

police department. The police are also to be called in incidents involving serious, life-threatening injuries to any client or employee.

- Report incidents of client abuse immediately and complete a incident report form. The supervisor must immediately notify the appropriate agency.
- Where an investigation is conducted and it is necessary to investigate immediately before the scene of the incident is disturbed, the worker shall remain in a safe place that is as near as reasonably possible to his or her work station; and be available to the employer or supervisor for the purposes of the investigation.

Supervisors

Supervisors must investigate all reports of violence and harassment in accordance with the procedures described below. In staff-to-staff, staff-to-management, or management-to-staff incidents, Human Resources and the Union representative (if applicable) shall be contacted.

- SHHA takes all reported incidents of violence and harassment seriously and will not ignore, condone or tolerate threatening, violent or harassing behaviour by any member of the organization.
- Managers, supervisors, staff, physicians or visitors engaged in such behaviour shall be removed from the premises as quickly as safety permits. They shall be banned from access to SHHA premises pending the outcome of an investigation. Where applicable, the employee's professional college or regulatory body may be notified.
- Supervisors will return reports and any relevant documentation to Human Resources for filing, record-keeping, and reporting.

Investigation Procedure

Where an investigation into an incident of workplace violence or harassment is required, the following principles will apply:

- Generally, the investigation will be conducted by Human Resources. However, the CEO may intervene and determine who will conduct the investigation. The investigation may be referred to an external party if it is necessary to do so in order to conduct an impartial investigation.
 - Where criminal charges are possible, an investigation may be conducted by the Police. SHHA and its employees will cooperate to the fullest extent where a Police investigation takes place.
- Where SHHA conducts the investigation, SHHA is responsible for ensuring that the investigation is appropriate to the circumstances of the incident. Where appropriate and where necessary, a report will be sent to the MOL and or the WSIB as required by the Occupational Health and Safety Act and Workplace Safety and Insurance Act. (If a violent incident results in a critical injury to a worker or loss of time this report is made).
- Investigations will be completed in a timely manner: generally within 90 days or less unless there are extenuating circumstances.
- SHHA will do its best to preserve and protect the anonymity of those involved and confidentiality in the alleged case, however, it may be necessary for SHHA to take action, including consultation with others. Workers who are subject to investigation must not discuss the investigation with any other workers or witnesses.
- Investigators will have the authority to:
 - Interview both the alleged victim and the alleged perpetrator (where the alleged perpetrator is an SHHA employee)

- Where the alleged perpetrator is an SHHA employee, provide the alleged perpetrator with information about what they are accused of, so that they can make a response
- Interview any relevant witnesses employed by SHHA
- Collect and review any relevant documents (e.g.: written complaints from the victim, SHHA policies)
- Take notes and statements pertaining to the investigation
- Prepare reports, findings, and conclusions
- The findings of the investigation (including any corrective action that we be taken) will be made available to the alleged victim of violence or harassment, as well as to the alleged perpetrator where the perpetrator is an SHHA employee.
- If an individual involved believes the matter has not been resolved in a satisfactory matter, the individual may file a grievance in accordance with the employee's union contract and/or bring forth a complaint under SHHA's Whistleblower Policy. In no circumstance will any person, who in good faith, reports an incident of threatened, intimidation or violence or harassment, or assists in its investigation, be subject to any form of retribution, retaliation or reprisal.
- Any person who makes or participates in such retribution or retaliation, directly or indirectly, will be subject to disciplinary action. A person who believes she/he has been or is being subjected to retribution or retaliation should immediately notify the Human Resources, his/her designate or file a reprisal complaint with the Ontario Labour Relations Board or file a grievance.

Response Procedures

- The manager or supervisor documents all reports of workplace violence and hazards reporting and measures taken to address them
- If the resolution of the incident is beyond the authority of the manager or supervisor receiving the report, they must make the Chief Executive Officer (CEO) or equivalent aware of the report. The CEO or designate involves other managers or supervisors in the investigation, as appropriate (for example, when the incident involves clients or employees under another manager's or supervisor's area of responsibility).
- Management reviews all incident reports, monitors trends and makes recommendations for prevention and enhancements of the Workplace Violence & Harassment Prevention Program to the CEO or designate.
- These findings are shared with JHSC, which is consulted about any revision to the Violence & Harassment Prevention Program and Training Program.
- The CEO or designate reviews report of workplace violence and ensures that actions have been taken.
- The managers/supervisors who investigate the reported incident warn all staff who might be affected of dangerous situations. The same managers/supervisors tell the reporting employee of the outcome of the investigation enough to minimize the change of similar incidents.
- The JHSC and Ministry of Labour will investigate an incident which results in a critical injury to a worker.

Records

All records of reports and investigations of workplace violence are kept for five years.

Workplace Violence and Patients

When violent behaviour is exhibited by a patient, staff will utilize the Behavior Safety Alert protocols appropriate in the situation: depending on whether the patient is being admitted for the first time or is being re-admitted / re-assessed. The *SHHA Clinical Violence Risk Assessment Form* (Appendix A) can be referenced in order to complete the assessment. When indicated the electronic chart will be clearly marked with a “Violent Behaviour Alert” to identify the potential risk to other staff (see Appendix B).

Emergency Response Measures

Refer to the organization’s emergency response procedure (Code White).

Support for Employees Affected by Workplace Violence

Management will respond promptly, assess the situation and ensure that these interventions are followed:

- Facilitation of medical attention.
- Debriefing (by skilled professional).
- Referrals to community agencies, treating practitioner and Employee-Family Assistance Program.
- Referral to trade union (where applicable).
- Completion of incident reports, WSIB reports, reports to MOL (critical injury or fatality).
- Reporting to police (as required).
- Team debriefing.

Education

All new employees will receive both general and department-specific orientation to the Workplace Violence & Harassment Prevention Program upon hire and every two years to all staff thereafter. Included in this orientation will be information and instructions on the history of violent behaviour in the workplace and what to do if the employee may encounter the individual or may be exposed to physical injury.

Program Evaluation

The effectiveness of the Workplace Violence & Harassment Prevention Program overall is evaluated annually by management and reviewed by the JHSC. Incidents of workplace violence are reviewed on a quarterly basis by management.

Workers, managers and supervisors are accountable for the policy and procedures related to workplace violence and harassment. This is part of the responsibilities to comply with health and safety policy in the manager, supervisor and worker’s job descriptions. Management responsibilities for enforcing policy and procedures, investigation of and response to workplace violence and harassment are also included in health and safety components of job descriptions.

Related Documents

- Workplace Violence Employee Survey and Environmental Assessment Tool
- Emergency Code Manual, “*Code White – Violent/Behavioural Situation*”
- Policy # 15-032, “*Code of Conduct (all staff)*”
- Policy # 09-003, “*Code of Conduct (Medical staff)*”
- Policy # 02-012, “*Code of Conduct (Board of Directors)*”
- Policy # 15-041, “*Disclosure of Misconduct Whistleblowing*”
- Workplace Violence / Harassment Policy

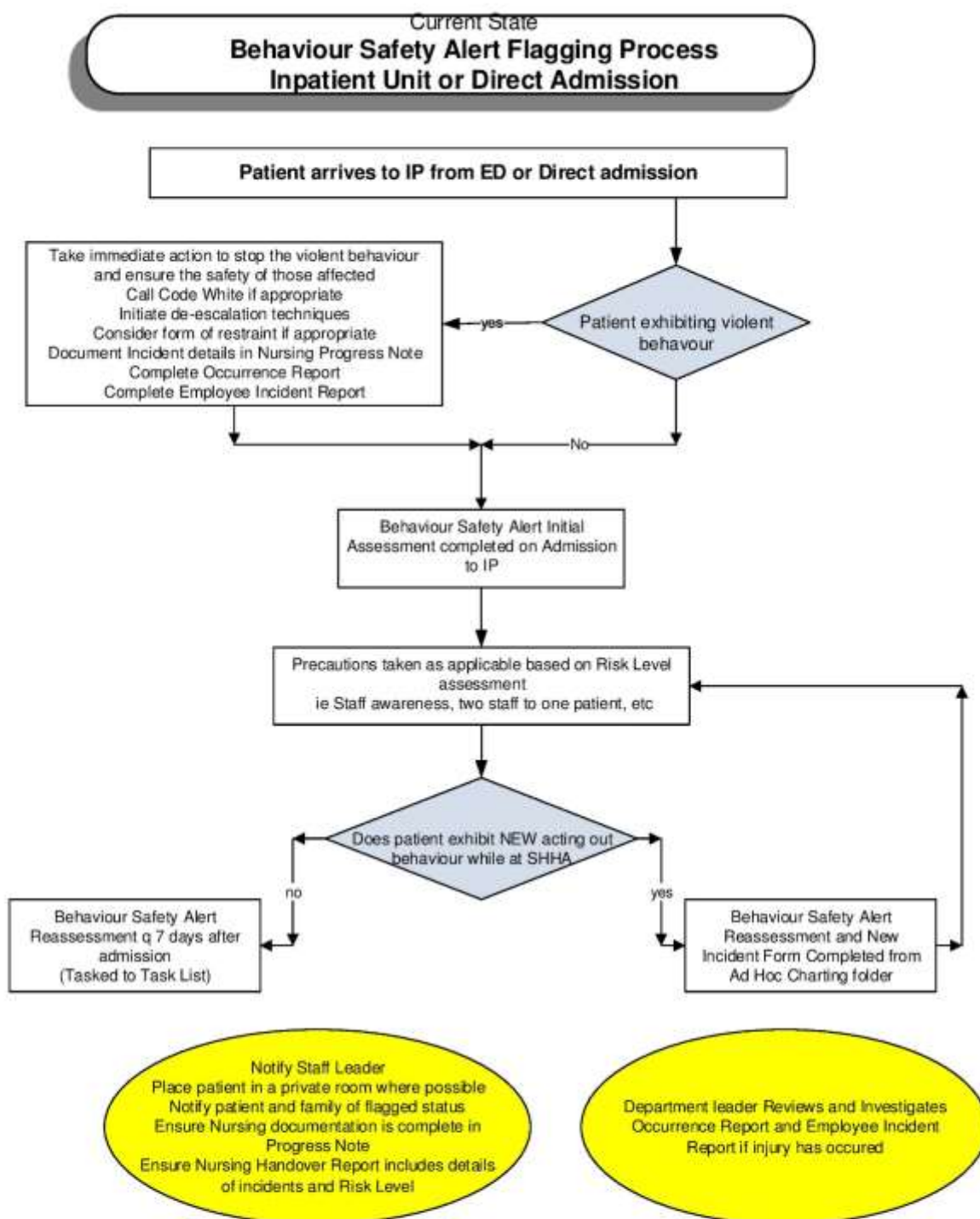
- Policy # 15-046, “*Working Alone Policy*”
- Personal Alarms Policy (TBA)

References

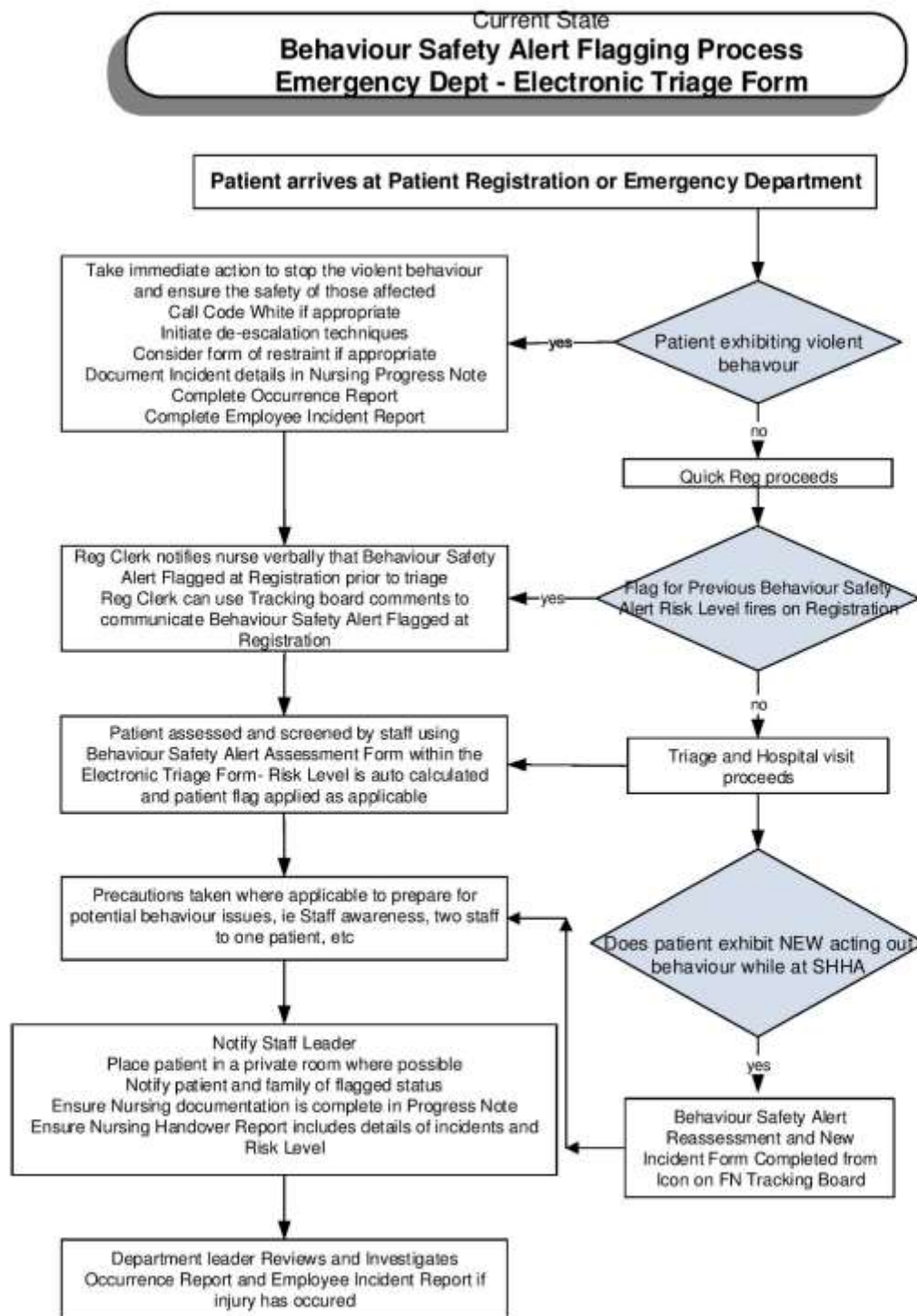
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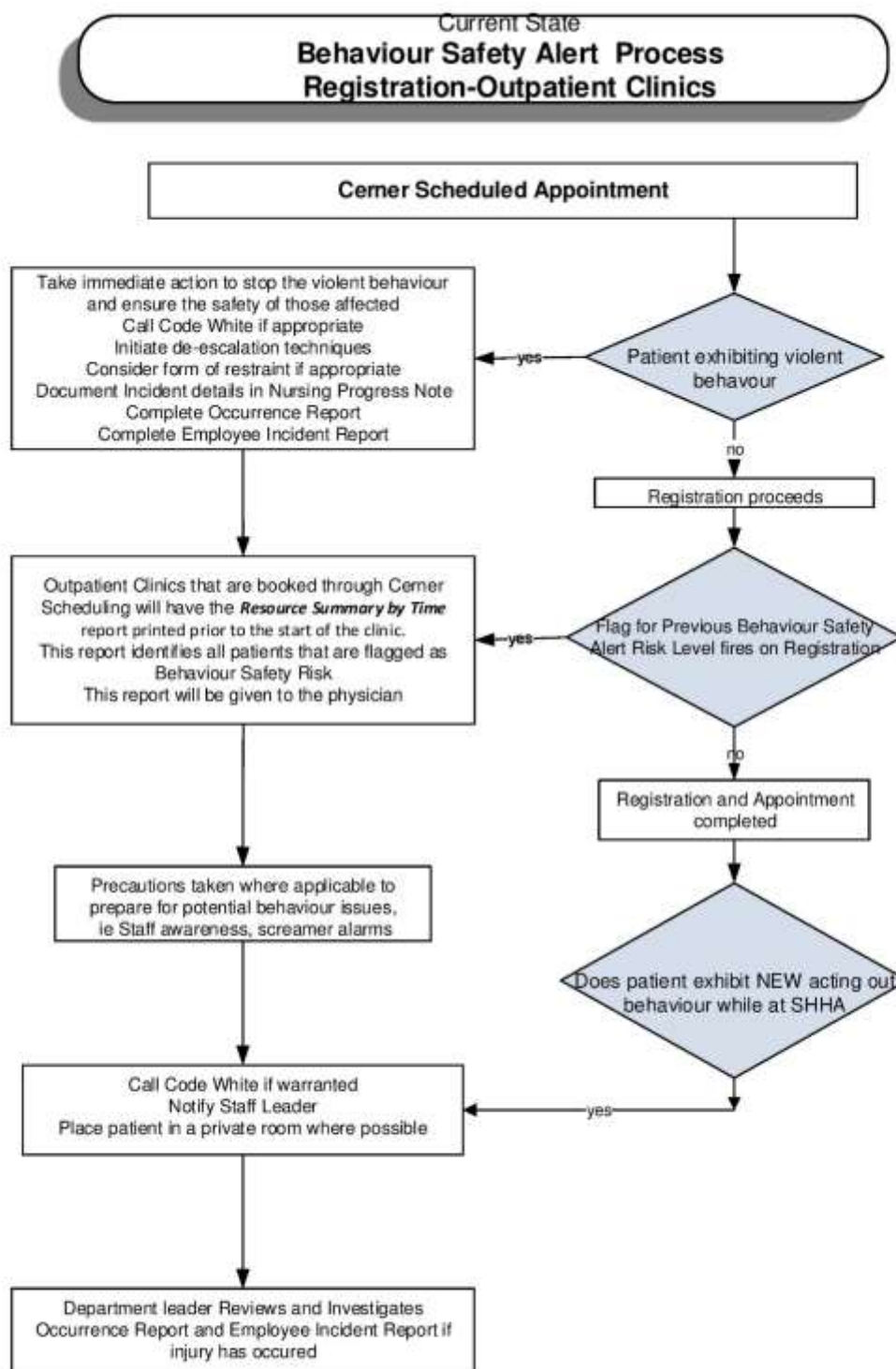
APPENDIX A



APPENDIX B



APPENDIX C



APPENDIX D

Workplace Harassment Complaint Form

Name	
Department	
Phone Number	
Name of Alleged harasser(s)	
Department	
Details of the complaint of workplace harassment: Please describe in as much detail as possible the bullying and harassment incident(s), including: (a) the names of the parties involved; (b) any witnesses to the incident(s); (c) the location/date/ time of the incident(s); (d) details about the incident(s) (behaviour and/or words used); (e) any additional details. (Attach additional pages if required) Please attach any supporting documents (emails, notes, pictures, physical evidence)	
Signature/ Date of Report	
Report received by:	

	Policy/ Procedure	Section Emergency Code Manual
Title Code White – Violent/Behavioural Situation	Original Effective Date September 2010 Review/Revised Date(s) June 2011, October 2013, February 2016, October 2016, August 2019 Next Review Date: October 2022	
		Authorization: SHHA Code Committee

Disclaimer: In the event of a Code White at the South Huron Medical Centre (SHMC) located at 23 Huron Street West in Exeter, staff will press the panic button located under the front Registration desk. This will notify the Emergency Department to contact 911 immediately.

Patient Registration will notify the SHMC of all emergency codes (except blue/pink) called/“All Clear” at South Huron Hospital Association (SHHA; the Hospital). Contact SHMC for physician and staff assistance.

PURPOSE

South Huron Hospital Association is committed to providing a safe environment for all staff, visitors, and patients. SHHA is committed to assisting the Ontario Provincial Police with the management of violent situations. If weapons are involved the police will be notified immediately for assistance.

DEFINITION

CODE WHITE – refers to an imminent potential or actual violent/behavioral situation where assistance is required to deescalate the situation or manage a difficult and/or aggressive person.

Clinical Staff will be expected to respond– anyone with direct patient contact, including the following departments:

- Nursing
- Laboratory
- Physiotherapy
- DI
- Speech/SW/RD
- Health Care Aides
- Pharmacy staff

AUTHORITY TO DECLARE

Anyone who encounters violent behavior and an unmanageable individual(s).
For hostage taking, refer to CODE PURPLE.

RESPONSE

1. Call Patient Registration – Dial 3333 and report details/location.

CODE WHITE checklist for Patient Registration (0700-2200)

Clinical staff to assume Patient Registration responsibilities (2200-0700)

1. Announce "CODE WHITE. PLEASE PROCEED TO _____ (location)" (repeat x3).
 2. Call 9-9-1-1 for police assistance.
 3. Ensure maintenance, when on duty, is paged.
 4. Ensure in-house physician notified or paged.
 5. Ensure reception window and reception doors are locked.
 6. Once directed, announce "CODE WHITE – All Clear" (repeat x 3).
2. Upon hearing CODE WHITE the following personnel must proceed to the area, when available:
 - Clinical staff.
 - Any in-house physician.
 - Maintenance.
 - Department Leaders.
 3. Upon hearing CODE WHITE, all non-clinical staff will remain in their current location and await further instruction.
 4. Staff in the area shall ensure safe evacuation of persons in the area.
 5. Isolate the area to prevent injury to self and others.
 6. Ensure all staff in department are accounted for.
 7. If possible, have staff meet police or use automated door device.
 8. Maintenance or Most Responsible Nurse ensure security by checking entrances and exits.
 9. Consider Emergency Operations Centre, the Board Room (Rm. B110); and if situation escalates to a CODE PURPLE to call Administrator-on-Call.
 10. If appropriate, persons involved should wear PPE.
 11. Clinical staff to bring PINEL Restraints bag (located in ER and In-patient unit).
 12. Control the situation as quickly as possible using as few persons as possible using de-escalation techniques.
 13. Support police as required.
 14. Document with RL6.

RECOVERY PROCEDURES

1. Staff involved shall debrief following a violent situation.
2. Consider Employee wellness access through the EAP program at 1-800-265-8310.
3. Risk manager to assess the CODE WHITE report and consider opportunities for improvement.
4. Enter into RL6 and then add violent patient flag in Cerner and include comment as to why or give more information.

ASSUMPTIONS

1. Staff have initiated measures to deescalate the situation and these measures have been unsuccessful.
2. The situation/person is posing a threat to self or others.
3. Whenever possible the use of non violent crisis interventions will be used to attempt to deescalate the situation.

4. In situations where a person is violent, out of control, known to be dangerous, hostage taking, or has weapons the police will be called immediately.
5. To initiate the CODE WHITE dial 3333 and call for police assistance by dialing 9-9-1-1.
6. In responding to a CODE WHITE, the safety of the CODE WHITE responders will be paramount at all times during a response.

RELATED POLICIES

SHHA Workplace Violence and Harassment Prevention Policy #13-021

SHHA Least Restraints Policy #04-068

SHHA Occurrence Management System Policy #23-005

CODE PURPLE – Hostage Taking

REFERENCES

Basic Cardiac Life Support (BCLS)

Huron Perth Hospital Alliance (HPHA) Code White Policy

NYGH Emergency Preparedness Manual Policy & Procedures Code white – Violent patient #XIII-80

Salvation Army Toronto Grace Hospital Health Centre Emergency Procedures – Code #EPC-8

Sault Area Hospital Code White violent-behavioral situation

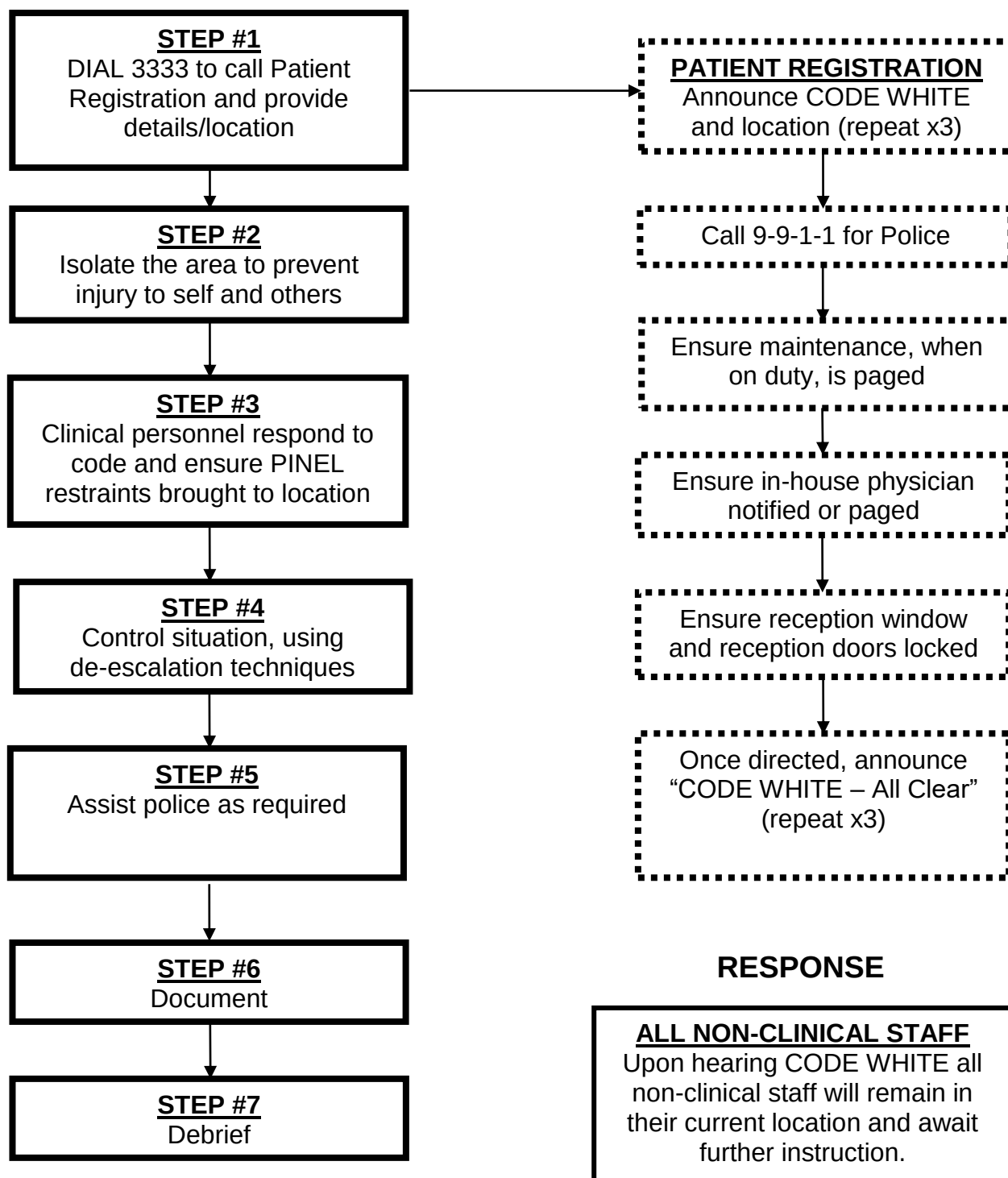
APPENDICES

- Appendix A – Code White Flow Chart
- Appendix B – Personal Alarms

APPENDIX A

CODE WHITE Flow Sheet

ANYTIME THERE IS VIOLENCE OR A THREAT OF VIOLENCE



APPENDIX B**Personal Alarms**

The following locations will be issued a personal alarm for use when working alone or in isolation away from other employees.

These alarms will be tested bi-annually with Code Purple and Code White. All staff, however, should familiarize themselves with the sounds of these devices should a staff member require assistance and are unable to reach a telephone to dial 3333 for assistance.

The following departments/rooms will be equipped with a personal alarm MC-223. Staff in the following departments are expected to regularly check to ensure batteries (three LR44 or AG13 batteries) are functioning. Should a replacement alarm be required, please contact the Director of Diagnostics/Operations.

1. Diabetes Education Office, B117
2. Social Work Office, 506
3. OTN Office, B402
4. Speech Office, B107
5. VON Office, B105
6. Diagnostic Imaging Department
7. Laboratory Department
8. In-patient Unit
9. Kitchen
10. Housekeeping Department
11. South Huron Medical Centre (SHMC) – Reception and Counselling Room
12. Emergency Department
13. Finance Department, B406
14. Business Office/Medical Records
15. Human Resources Office
16. Corporate Office
17. President/CEO Office



MEDICAL STAFF REFERENCE REQUEST (HHS)

* 1. Referee Name

* 2. Applicant Name

*The above named applicant has applied for privileges at **Alexandra Marine and General Hospital** and/or **South Huron Hospital**.*

To assist the named physician, please respond to the following questions as objectively as possible. Include any additional comments you care to make. Please be assured that the information provided will be treated in confidence.

PROFESSIONAL RELATIONSHIP TO APPLICANT

* 3. How long have you known/worked with the Applicant?

* 4. In what professional capacity are you acquainted with the Applicant?

* 5. Please describe the nature and extent of personal observation of Applicant's clinical performance...

* 6. Were you previously, are you now or are you about to become related to the Applicant as family or through a professional partnership or financial association?

☐ Yes

☐ No

If 'YES', please specify:

* 7. **CLINICAL ABILITIES**

Please rate the following based on QA/Peer Review data, personal knowledge, and/or direct observation:

	Satisfactory	Unsatisfactory	Unable to Assess
Basis medical knowledge	☐	☐	☐
Technical ability / skill	☐	☐	☐
Patient history-taking skills, record keeping	☐	☐	☐
Physical examination skills	☐	☐	☐
Attention to preventive measures	☐	☐	☐
Professional judgement	☐	☐	☐
Medical procedures	☐	☐	☐
Case presentations	☐	☐	☐
Patient management	☐	☐	☐

Explanation of 'unsatisfactory' elements, or **general** comments:

*** 8. ADMINISTRATIVE AND EDUCATIONAL ABILITIES**

	Satisfactory	Unsatisfactory	Unable to Assess
Timeliness of medical records	☐	☐	☐
Appropriate utilization of services and resources	☐	☐	☐
Compliance with hospital and medical staff By-Laws, rules and regulations and policies	☐	☐	☐
Participation in medical staff affairs	☐	☐	☐
Teaching abilities / interest	☐	☐	☐
Research abilities / interest	☐	☐	☐

Explanation of '**unsatisfactory**' elements, or **general** comments:

*** 9. PROFESSIONAL CONDUCT**

To the best of your Knowledge, has the applicant ever:

	Yes	No	No Knowledge
Been in a situation where he/she has acted inappropriately with patients or their families?	☐	☐	☐
Been the subject of any professional misconduct proceeding?	☐	☐	☐
Been engaged in professional practice patterns that would endanger patient safety or welfare?	☐	☐	☐
Been the subject of legal actions against him/her, complaints to his/her professional organization, or found guilty of medical malpractice?	☐	☐	☐
Had his/her academic			

appointment

denied, suspended,
revoked, modified,
or voluntarily
surrendered?

☐☐☐

Had his/her **license**

denied, suspended,
revoked, modified,
or voluntarily
surrendered?

☐☐☐

Had his/her **clinical**

privileges denied,
suspended, revoked,
modified, or
voluntarily
suspended?

☐☐☐

Received complaints
by colleagues, staff
or patients?

☐☐☐

Shown a lack of
responsibility
regarding his/her on-
call duties? (i.e.,
inappropriate delay
in responding to
calls)

☐☐☐

If you answered '**YES**' to any of the above questions, please explain:

*** 10. APPLICANT'S CHARACTER - PART A**

To the best of your knowledge:

Yes

No

No Knowledge

Has the applicant
been in a fraudulent
or dishonest
situation?

☐☐☐

Has there been a
situation where the
applicant's conduct
was unethical?

☐☐☐

If you answered '**YES**' to the questions above, please explain:

*** 11. APPLICANT'S CHARACTER - PART B**

To the best of your knowledge:

	Yes	No	No Knowledge
Does the applicant take a genuine interest in his/her work?	☐	☐	☐
Does the applicant possess and demonstrate a sense of responsibility?	☐	☐	☐
Does the applicant have appropriate self-assessment abilities?	☐	☐	☐
Does the applicant work collegially and respectfully with other medical staff?	☐	☐	☐
Does the applicant work collegially and respectfully with non-medical staff?	☐	☐	☐

If you answered 'NO' to the questions above, please explain:

*** 12. SUMMARY RECOMMENDATION**

- ☐ Highly, without reservation
- ☐ As qualified and competent
- ☐ With some reservation
- ☐ Do not recommend

*** 13.** Is there any information of a sensitive nature that you would prefer to discuss by phone?

- ☐ Yes
- ☐ No

14. GENERAL COMMENTS

*** 15.** By completing this reference survey, I agree that the information I have provided is true to the best of my knowledge, and that it may be used for privileging purposes only for the above noted candidate.

- ☐ Yes

*** 16. REFEREE INFORMATION**

Name	
Institution / Position	
Certification	
Phone Number	
eMail Address	

**Source: Health Force Ontario EDLP Confidential Peer Reference Form, AMGH Reference Form, SHH Reference Form*

INTER-OFFICE MEMORANDUM

TO: SHH MAC / HHS Common Board

FROM: Dr. Sean Ryan, Dr. Craig McLean

DATE: September 25, 2025

RE: Applications for SHH Professional Staff

It is the recommendation of the credentialing process to appoint the following named individuals to the SHH professional staff. Privileges will be extended to June 30, 2026 and then subject to the re-application process, with the exception of HFO-EDLP physicians, which run from Jan-Dec. New LCAP are requested for HFO-EDLP physicians at the beginning of each year.

LOCUM	CHANGE / STATUS	COMMENTS
ABDELRAZEK, Dr. Mohamed	NEW	Consulting-RAD
DREYER, Dr. Jonathan	NEW	Locum-EDLP
GRAYBIEL, Dr. C. Elias	NEW	Consulting-RAD
KLUZ, Dr. Andrzej	NEW	Active
KRUSE, Dr. Michael	NEW	Locum-EDLP
MacISAAC, Dr. John	NEW	Locum-EDLP
PEIRCE, Dr. Michael	NEW	Courtesy-IM
PLASKOS, Dr. Nicholas	NEW	Consulting-RAD
UMER, Dr. Hafiz	RETURNING	Locum-EDLP