Status **Active** PolicyStat ID **13372697**

Origination	10/2016
Last Approved	03/2023
Effective	03/2023
Last Revised	11/2018
Next Review	03/2024
Owner	Bryan McNevin: Manager, People Services
Area	People Services

Code of Conduct Policy

Approved by:

Senior Leadership Team

Purpose

The purpose of the Code of Conduct policy is to identify Collingwood General and Marine Hospital's (CGMH) expectations for conduct and identify the steps to be taken when concerns about conduct are identified.

This policy reinforces the principles and intent of CGMH's Code of Conduct expectations contained herein. All members of CGMH's workplace community, defined as our employees, credentialled staff, volunteers, patients, visitors, students, contractors, or any person working on behalf of CGMH, will be treated with, and will treat each other, with dignity and respect at all times. Through individual efforts and the consistent application of this policy, CGMH will have a safe, healthy and respectable environment in which to work, visit and heal.

Policy Statement

The principle of honest, respectful communication and behaviour is a requirement of all persons within the Collingwood General and Marine Hospital. To achieve this, CGMH has established standards of conduct and performance aligned with the I CARE AT values of inclusive, caring, accountable, respectful, excellence, adaptability and teamwork.

By requiring all persons to conduct themselves in a manner consistent with this policy, CGMH seeks to enhance its work environment, the quality of the care it provides and the level of satisfaction that our patients and staff experience.

Definitions

Code of Conduct: A written collection of the rules, principles, values, and employee expectations, behavior, and relationships that an organization considers significant and believes are fundamental to their successful operation. At CGMH, the Code of Conduct is outlined in the I CARE AT Commitment to Excellence form (Appendix B), which aligns with the Hospital's values and requires all workplace parties to sign and abide by.

Code of Conduct Violation: Conducting oneself in a way that violates the Hospitals Code of Conduct and/or is undesirable, unsuitable, improper and/or incorrect. A Code of Conduct violation can range from a minor infraction to repeated offences, and may be a subjective interpretation based on how an individual expects to be treated.

Examples of a code of conduct violation include:

- Comments that are insulting, hurtful, disrespectful or rude;
- Threatening or abusive language directed at an individual;
- Degrading or demeaning comments;
- Profanity or similar offensive language;
- Body language that is irritating or offensive;
- Discussing workplace conduct, concerns and conflicts in front of others;
- Passive-aggressive behaviour which describes behaviour that is passive in expression but is aggressive or malicious in intent. The purpose of passive-aggressive behaviour is to express anger without having to be responsible for that anger, so anger can be denied. Passive-aggressive behaviour may include non-verbal behaviour or body language that is irritating or offensive.

Full review and resolution – The absolute obligation to undertake review and resolution of all complaints made pursuant to this Code of Conduct Policy and the Harassment/ Discrimination/ Code of Conduct Breach Complaint Procedure.

Reprisal/Retaliation – an act in return for harm done by another, an act of revenge. The act can be conspicuous or subtle. Examples range from overt demonstrations such as exhibiting physical violence to less obvious demonstrations such as exclusion from the group; all of which are considered inappropriate behaviours in the workplace and adversely impact the working environment and morale.

Workplace: Workplace is defined as any location where any employee, physician, volunteer, patient, visitor, student, contractor, or any person working on behalf of CGMH is carrying out any work-related function. Any location an employee is required to be during the course of their employment/contractual duties.

Procedure

1. **Roles and Responsibilities**

   Senior Leadership and Operations Leadership Team will:

- Model the substance and intent of CGMH's Code of Conduct while performing their respective roles and demonstrating through words and actions a commitment to maintaining a workplace that ensures all individuals are treated with dignity and respect at all times.
- Ensure that respectful behaviours are integrated into day-to-day operations
- Take all reports of code of conduct violations seriously.
- Ensure corrective actions are taken, appropriate investigations are complete and response measures are in place for Code of Conduct violations.
- Educate and train all employees on espectful work environments and the Code of Conduct.
- Sign the Hospital's I CARE AT Commitment to Excellence at regular intervals, as determined to be necessary (Appendix B).

Hospital Employees and Professional Staff with CGMH Privileges will:

- Demonstrate in their attitudes and behaviour the highest regard for the respect and dignity of all members of the CGMH team.
- Understand the Code of Conduct
- Attend or participate in appropriate training regarding the Code of Conduct
- Promote respectful interactions at work and challenge unacceptable behaviour
- Report all Code of Conduct violations to the applicable supervisor, whether involved or witnessed
- Sign the Hospital's I CARE AT Commitment to Excellence at regular intervals, as determined to be necessary (Appendix B)

Patients, Family Members, Volunteers, Students, Contractors and other Visitors will:

- Expect to be treated with dignity and respect at all times when they come to use the services of CGMH, or are visiting the organization for any reason
- It is also the expectation that patients, family members, volunteers, students, contractors and all other visitors will treat CGMH emplyees with the same respect and dignity, and that they do not exercise abusive and/or aggressive behaviour towards staff
- Students and Volunteers shall sign the Hospital's I CARE AT Commitment to Excellence at regular intervals, as determined to be necessary (Appendix B)

2. **Addressing Inappropriate Behaviours**

CGMH promotes and upholds the Code of Conduct by ensuring the full review and resolution of any inappropriate behaviour directed toward employees, students, credentialled staff, Board Members, contracted parties, volunteers, visitors, patients, or others. Inappropriate behaviour refers to words, actions or inactions that do, or have the potential to:

- Interfere with, or have the potential to interfere with, quality care and/or effective

delivery of care;

- Create or contribute to an unacceptable workplace environment; or
- Create a risk of harm to the individual engaging in the behaviour or to others.

Inappropriate behaviour can manifest as a single incident or a pattern of conduct. It is the effect on others and the workplace environment that makes the conduct "inappropriate". Examples of appropriate behaviour (but not limited to) are provided at Appendix A.

Reporting and Responding to Code of Conduct Violations

CGMH supports the reporting of Code of Conduct breaches that are made in good faith and is committed to providing an environment that is safe from reprisal as a result. All Code of Conduct violations will be investigated in accordance with the Harrassemnent, Discrimination and Code of Conduct Breach Complaint Procedure.

Advocacy, Constructive Feedback, and Differences of Opinion

CGMH recognizes that appropriate advocacy, constructive feedback and differences of opinion can contribute to a positive workplace environment. It can promote good quality patient care and be important for achieving the vision, mission and values of CGMH.

In most cases, these interactions do not constitute inappropriate behaviour. However, in some circumstances advocacy, constructive feedback and differences of opinion, particularly when expressed vigorously, can negatively affect the workplace environment and/or have an impact on the quality of care delivered to patients. Where the workplace environment and/or the delivery of care are impaired by an individual's actions, feedback or differences of opinion, such efforts may be considered inappropriate.

Confidentiality

Confidentiality will be maintained to the extent that is practical and appropriate under the circumstances; in order to protect the interests of the complainant, the respondent and any others who may participate in the investigatory process as legislatively required.

Applicable Legislation

Occupational Health & Safety Act & Regulations
http://www.ontario.ca/laws/statute/90o01

Ontario Human Rights Commission
http://www.ohrc.on.ca/en/ontario-human-rights-code

Workplace Safety and Insurance Act

http://www.ontario.ca/laws/statute/97w16

Appendices

Appendix A: I CARE AT Commitment to Excellence
Appendix B: I CARE AT Commitment to Excellence – My Commitment

Related Resources

Developing Workplace Violence and Harassment Policies and Programs, What Employers Need To Know, developed by the Occupational Health and Safety Council of Ontario http://www.wsps.ca/WSPS/media/Site/Resources/Downloads/2010_April_OHSCO_What_Employers_Need_to_Know_EN.pdf?ext=.pdf

Developing Workplace Violence and Harassment Policies and Programs, A Toolbox, developed by the Occupational Health and Safety Council of Ontario http://www.labour.gov.on.ca/english/hs/pdf/wvps_toolbox.pdf

Ontario Ministry of Labour: Code of Practice to Address Workplace Harassment under Ontario's Occupational Health and Safety Act: https://www.labour.gov.on.ca/english/hs/pubs/harassment/index.php

PATH	COMMITTEE	DATE	PURPOSE	STATUS
Originating Committee	People Services Inclusivity QIP Taskforce	September 12, 2018	**DRAFT Agreement**	☐ completed
Reviewing Committee	Senior Leadership Team People Services	November 15, 2018	**Review & Agreement**	☐ completed
Approving Committee	Senior Leadership Team	November 15, 2018	**FINAL Approval**	☐ completed

Historical Dates:	
Original Policy Date:	October 2016
List of Dates Reviewed and Revised:	June 22, 2018 November 15, 2018
Policies This Document Replaces	Code of Conduct Workplace Violence Prevention Policy Management of Abuse/ Harassment Policy
Policy Archive Date:	October 2016

Appendix A

I CARE AT
Commitment to Excellence

At Collingwood General and Marine Hospital, our I CARE AT values are the beacon that shine from within each employee, credentialled staff and volunteer.

Employees, credentialled staff, volunteers, Board Members, our patients and their families/caregivers from diverse departments and experiences have worked collaboratively to develop and provide input to these standards, which represent our commitment to our community and to one another.

Everyone at CGMH contributes daily through their words and actions to realizing our vision of providing Outstanding Care – For Life

I INCLUSIVE

- We recognize that our diversity is a strength. We treat each other with dignity and compassion.
- We strive to create a safe place for all members of our community.
- We empower patients and their families, putting them at the centre of decision making. They are experts in their care.

C CARING

- We listen actively with empathy and seek to reassure and support.
- We demonstrate compassion to all patients and care without judgement based on their needs.
- We greet each other with a smile, a hello, and use each other's first name.

A ACCOUNTABLE

- We feel a sense of ownership for CGMH and take pride in the quality of care that we provide.
- We help out whenever possible. We do not wait to be asked, we step up and take the initiative.
- We own our actions and recognize the impact of our (in)actions on others.

R RESPECTFUL

- We choose a kind tone of voice and respectful body language in our interactions with others.

- We prioritize the protection of our patient's confidentiality and modesty at all times.
- We challenge statements and behaviours that are inappropriate, disrespectful, discriminatory, or harassing.

E EXCELLENCE

- When appropriate, we go above and beyond ordinary expectations. The smallest gestures can provide great comfort, safety, and reassurance.
- We present ourselves and our workplace professionally to show respect for our patients and create confidence in our ability to care for them.
- We believe safety is everyone's responsibility and do our part to create a safe work environment.

A ADAPTABLE

- We encourage innovation and continuous improvement to quality, efficiency, and safety of care.
- We know that great hospitals are dynamic and always moving forward. We are open to and prepared for change.
- We prioritize our patients and the best outcome over our own interest.

T TEAMWORK

- We recognize that many hands make light work and offer to help one another whenever possible.
- We are all in this together. When we face challenges, we do not take a stance against one another.
- We recognize, support, and celebrate each other.

Appendix B: I CARE AT Commitment to Excellence

Please see the attached file of Appendix B: I Care at Commitment to Excellence

Attachments

Appendix B: I Care at Commitment to Excellence

Workplace Harassment Discrimination or Code of Conduct Breach Complaint Form.pdf

Approval Signatures

Step Description	Approver	Date
Senior Leadership Team	Kris Baird: Vice President, People Services and Safety	03/2023
	Bryan McNevin: Manager, People Services	03/2023

Status **Active** PolicyStat ID **10580173**

Origination	03/2017
Last Approved	06/2020
Effective	06/2020
Last Revised	06/2020
Next Review	06/2023
Owner	Rosemary Frketich: Vice President, Patient Services and Chief Nursing
Area	Operations Leadership Team

Privacy Policy

Approved by:

President & Chief Executive Officer

Purpose

It is the hospital's policy to be compliant with the privacy principles established by the Canadian Standards Association and to provide clear direction to Board Members, employees, physicians and volunteers in terms of privacy and confidentiality of personal health information (PHI) and personal information (PI). All information collected, use and disclosed, by the organization, its staff, and affiliates shall be treated in a manner that accords with the Personal Health Information Personal Act (PHIPA), Freedom of Information and Protection of Privacy Act (FIPPA), organizational and professional obligations.

Policy Statement

The organization values the privacy and confidentiality of the information within its custody and control. As a health information custodian, the organization and its agents (including staff, physicians, students and volunteers) are committed to protecting the PHI and/or PI of all staff and patients served.

The hospital's approach to privacy and access encompasses the following 10 privacy principles, adopted from the Canadian Standard Association:

Principle 1 - Accountability: The hospital is responsible for both PHI and PI under its custody and control and has designated an individual(s), who is accountable for ensuring compliance with PHIPA and FIPPA.

While corporate accountability for the organization's compliance with the principles of PHIPA rests with

the Chief Executive Officer and Officer in Charge, other individuals within the organization are responsible for the day-to-day collection, use and disclosure of PHI through delegation. In addition, the Privacy Officer is the designated privacy contact person for the organization. The organization has implemented information practices in keeping with PHIPA and FIPPA.

The Privacy Officer and/or delegate responds to any access requests, privacy related inquiries, information transferred to a third party for processing and complaints, and Commissioner's investigations.

For the purposes of FIPPA, the Chair of the Board as the head of the institution designates a contact person under the Delegation of Authority.

Principle 2 - Identifying Purpose(s): The organization will make reasonable efforts to identify, in a meaningful way, the purpose for which PHI and PI is collected at or before the time of collection, to the individual and/or substitute decision maker (SDM). Identifying the purpose for the collection will be carried out through the posting of information practice posters throughout the hospital, particularly in registration/intake areas or through verbal discussion.

The organization collects PHI and PI for the following purposes:

- for the delivery of patient care
- for employment
- to plan, administer and manage internal operations
- to teach and/or conduct research
- to compile statistics
- to comply with legal and regulatory requirements
- to obtain payment for patient treatment and care (from OHIP, WSIB, private insurer or others);
- to conduct risk management activities
- to conduct quality improvement activities such as patient satisfaction surveys
- to support fundraising for the hospital's Foundation.

The hospital participates in provincial health information networks, integrated hospital information systems and information portals designed to enhance the care provided to patients.

When personal information/personal health information collected is to be used for a new purpose not previously identified, the new purpose will be identified prior to use. Unless the new purpose is required by law, the consent of the individual is required before information can be used for that purpose. Persons collecting PHI must be able to explain to individuals the purposes for which the information is being collected.

Principle 3 - Consent for Collection, Use and Disclosure: The organization will rely on implied consent, where appropriate, or obtain express consent from the individual or SDM when collecting, using or disclosing PHI and PI unless otherwise exempted by a specific policy, data sharing agreement or legislation. Consent may be obtained verbally or in writing.

To make the consent meaningful, the purpose(s) must be stated in such a manner that the individual can

reasonably understand how the information will be used or disclosed.

To be valid, a consent must:

- be the consent of the individual or substitute decision-maker who is deemed capable
- be knowledgeable – the individual must understand
    - The purpose for the collection, use or disclosure of the information
    - That the individual may provide or withhold consent
- relate to the information
- not be obtained through deception or coercion

PHI can be collected, used, or disclosed without the knowledge and consent of the individual in some circumstances, as set out under PHIPA, Mental Health Act or any other applicable Act.

An individual may withdraw consent for the collection, use or discloser of PHI at any time, subject to legal restrictions and reasonable notice, called a Consent Directive. A Consent Directive will not have a retroactive effect. The organization will inform the individual of the implications of such withdrawal. Consent Directives will be received in writing from the individual stating that they understand the implications of withdrawal. Requests from individuals withdrawing consent must be directed to the Privacy Officer.

Principle 4 - Limiting Collection: The organization will not collect PHI indiscriminately and will limit the collection of personal information/personal health information to that which is necessary, for the identified purpose or for purposes that PHIPA or FIPPA permits or requires. Both the amount and the type of information will be limited to that which is necessary to fulfill the purposes identified.

The organization may collect PHI about an individual indirectly if the information is reasonably necessary to provide health care.

The organization shall take steps that are reasonable in the circumstances to ensure that PHI is not collected without authority.

Principle 5 - Limiting Use, Disclosure, and Retention: PHI and PI in all forms; verbal, written, electronic, printed will not be used or disclosed for purposes other than those for which it was collected, except with the consent of the individual or as required by law.

Use of PHI and PI is limited to those individuals who are authorized to use or handle such information in order to perform their current role, on a need to know basis. Individuals must avoid using PHI or PI in any area where it may come to the attention of another individual who is not entitled to receive such information.

Information is retained in a secure manner and for as long as necessary to fulfill the purpose for which it was collected or as required by law. Information will be kept in accordance with the organization's retention and destruction policy/schedule and applicable legislation. Information that is no longer required will be destroyed, erased, or made anonymous in a secure manner, and in compliance with legislative requirements.

Access controls are used to prevent unauthorized or inappropriate access to PHI or PI, to ensure the protection of the organizations services, prevent unauthorized computer access, detect unauthorized or inappropriate activities and ensure information security.

The organization keeps an electronic record of accesses to all or part of the PHI or PI and ensures the record identifies the person who accessed the information, and the date and time of the access.

An agent of the organization who is granted access to PHI or PI as an authorized agent will have an appropriate level of authority, privacy and security training to warrant access.

Principle 6 - Accuracy: The organization will take reasonable steps to ensure that PHI and PI is accurate, complete, and up-to-date as is necessary to minimize the possibility that inappropriate information may be used to make a decision about an individual for the purposes for which it is used or disclosed.

Principle 7 - Safeguards: Appropriate technical, administrative and physical safeguards are implemented to protect PHI and PI against loss or theft, as well as unauthorized access, disclosure, copying, inappropriate use, or modification. Examples include:

- Technical: access controls including audits, use of passwords and encryption, secure computer networks, etc.
- Administrative: limiting access on a "need to know" basis, confidentiality agreements, etc.
- Physical: locked cabinets, restricted access to offices, etc.

The organization will make all individuals aware of the importance of maintaining the confidentiality of PHI and PI. As a condition of employment or affiliation, all individuals must sign a Confidentiality, Privacy and Security agreement which will be reviewed and signed annually thereafter. This safeguard may also be facilitated through contractual provisions.

Privacy education will be provided to new employees as part of orientation to the organization. Refresher education encompassing current relevant information will be provided on an ongoing basis as required, annually at a minimum. In the event that the individual commences work prior to receiving privacy training, the privacy policy and agreement, at minimum, will be reviewed and signed.

A Program/Department Leader (or designate) will ensure that any program/department-specific information or procedures relating to privacy will be covered with new employees. Care and measures are used in the disposal or destruction of PHI and PI, in order to prevent unauthorized parties from gaining access to information (e.g. confidential shredding bins).

Regular, random and targeted audits are conducted on systems user activity logs in order to monitor for inappropriate activity associated with PHI or PI.

In the event that PHI is stolen or lost, used or disclosed without authority the organization through the Chief Privacy Officer will notify the individual about the PHI that was stolen, lost, used or disclosure without authority. In addition the individual will be made aware of their right to make a complaint to the Information and Privacy Commissioner of Ontario. The organization may, depending on the circumstances report the stolen or lost, used or disclosed without authority PHI to the Information and Privacy Commissioner of Ontario.

An agent within the organization must notify the organization at the first reasonable opportunity if PHI that they collected, used, disclosed, retained or disposed of on behalf of the organization is stolen or lost or if it is used or disclosed without authority.

An agent of the organization who is a member of a professional college who is terminated, suspended or is subject to discipline action, or resigns as a result of or due to unauthorized collection, use, disclosure, retention or disposal of PHI, the organization will notify the professional college within 30 days.

An agent who has privileges at the organization and these privileges have been revoked, suspended, restricted or the agent has relinquished or voluntarily restricted privileges as a result of unauthorized collection, use, disclosure, retention or disposal of PHI the organization shall notify the professional college within 30 days.

Principel 8 - Openness: The organization makes readily available to the public, in a variety of ways, information about its policies and practices relating to the management of PHI and PI. The organization's public statements (Information Practices) will be in place for public viewing such as the organization's website and will include:

- A general description of the information practices;
- The name or title, and the address, of the person who is accountable for the privacy policies and practices and to whom complaints or inquiries can be directed;
- The means of gaining access to PHI or PI held by the organization

Principle 9 - Individual Access: Upon request, and after providing sufficient identification, an individual will be informed of the existence, use, and disclosure of his or her PHI or PI and will be given access to that information in a manner consistent with PHIPA or FIPPA and at a reasonable cost. Fees will be determined and communicated to the requester. Fees are based on the Regional Fee Schedule which is in alignment with the applicable Act.

The individual will be able to challenge the accuracy and completeness of the information and may have it amended as appropriate. When a challenge is not resolved to the satisfaction of the individual the hospital will record the substance of the unresolved challenge. When appropriate, the existence of the unresolved challenge will be transmitted to third parties having access to the information in question.

Principle 10 - Challenging Compliance: An individual will be able to address concerns regarding compliance with this policy to the Privacy Officer (PO) or designated individual(s) accountable for the organization's compliance. An individual may contact the PO at:

Collingwood General & Marine Hospital
459 Hume Street
Collingwood, ON L9Y 1W9

705-445-2550 or privacy@cgmh.on.ca

Procedures are in place to receive, investigate and respond to complaints or inquiries about the organization's policies and practices relating to the handling of PHI and PI.
If a complaint is found to be justified, the organization will take appropriate measures, including, if necessary, amending its policies and practices.

Individuals may also make a complaint to the Information and Privacy Commissioner of Ontario at 2 Bloor St., E., Suite 1400, Toronto, Ontario M4W 1A8 or www.ipc.on.ca , or commissioner@ipc.on.ca

Compliance: The hospital is required to provide the Information Privacy Commissioner with annual reports regarding activities under PHIPA and FIPPA.

Nothing in this policy detracts from the hospital's rights and responsibilities in respect to PHI in its possession, power and/or control as set out in any law applicable in the Province of Ontario including the Public Hospitals Act, Child and Family Services Act, Health Protection and Promotion Act, Mental Health Act and Regulated Health Professions Act and related regulations.

There may be instances where application of PHIPA or FIPPA conflicts with other legislations. In these instances, the hospital may seek advice from legal counsel to determine which legislative requirement is applicable and/or appropriate.

Definitions

Personal Health Information Protection Act, 2004 (PHIPA) - PHIPA outlines privacy provisions for health information custodians in the province of Ontario. The purposes of the PHIPA are as follows:

- To establish regulations for the collection, use and disclosure of personal health information in a manner that protects the confidentiality of the information and the privacy of the individuals in question.
- To provide individuals with the right to access personal health information about themselves and to correct or amend such information, subject to certain exceptions.
- To provide independent review and resolution of personal health information complaints.

Freedom of Information and Protection of Privacy Act (FIPPA) - Public hospitals were brought under FIPPA, effective January 1, 2012. FIPPA provides the right of access to information under the control of the hospital, supports the key concepts of transparency, accountability and the exercise of democracy and protects the privacy of the individuals to whom that information relates. All records created or which came into the hospital's custody or control after January 1, 2007 is subject to the Act.

Personal Health Information (PHI): Recorded identifying information about an individual in oral or recorded form if the information relates the physical or mental health of the individual or related to the provision of health care to the individual. PHI includes, but is not limited to, a patient's name and location in the organization, and a recorded image of the individual.

Personal Information (PI): Recorded identifying information about an individual, where the information relates to an individual's race, colour, national or ethnic origin, sex, age any identifying number and/or symbol assigned to an individual. If a video surveillance system displays these characteristics of an identifiable individual or the activities in which he or she is engaged, its contents will be considered personal information.

Privacy Officer: An individual designated as the contact person to assist in meeting the organization's privacy obligations. This individual is primarily responsible for privacy compliance within the organization. The responsibilities include establishing and maintaining appropriate information

practices, developing privacy policies and procedures and tools, developing access, correction, inquiry and complaint procedures, conducting privacy impact assessments and privacy audits of information use. This individual will also deal with any access requests, privacy related inquiries, complaints and Information and Privacy Commissioner investigations.

Health Information Custodian (HIC): A person or organization that has custody or control of PHI, as a result of, or in connection with, performing the person's or organization's powers or duties or work as set out under PHIPA. Examples of HICs include health professionals, long term care homes, community care access centres, and pharmacies.

Agent: A person that, with the authorization of the organization, acts for or on behalf of the organization in respect of PHI for the purposes of the organization and not the agent's own purposes, whether or not the agent has the authority to bind the custodian, whether or not the agent is employed at the organization and whether or not the agent is being remunerated.

Examples of agents include, but not limited to: employees, volunteers, students, credentialed staff residents, clinicians, consultants, researchers, vendors or contractor.

Data Sharing Agreement: is a formal contract that clearly outlines the obligations of the Parties when data is being shared.

This harmonized policy was developed in collaboration with the following organization:
Collingwood General and Marine Hospital
Georgian Bay General Hospital
Muskoka Algonquin Healthcare
North Simcoe Muskoka Community Care Access Centre
Orillia Soldiers Memorial Hospital
Royal Victoria Regional Health Centre
Waypoint Centre for Mental Health Care

References

- Freedom of Information and Protection of Privacy Act R.S.O 1990, CHAPTER F.31, Last amendment: 2011, c.9, Schedule 15
- Personal Health Information Protection Act, 2004, CHAPTER 3 Schedule A, Last amendment: 2016, c. 30, S. 43
- Mental Health Act
- Public Hospitals Act
- Criminal Code of Canada
- Waypoint Centre for Mental Health Care Access and Privacy Policy, February 2015
- Orillia Soldiers Memorial Hospital Privacy and Access Policy, March 2012
- Muskoka Algonquin Healthcare Privacy Policy, December 2012
- Georgian Bay General Hospital, Access and Privacy Policy, December 2011
- Grey Bruce Regional Health Centre

- North Simcoe Muskoka Community Care Access Centre, Client Privacy and Confidentiality, December 2014

Data Charts

Documents and tracks the progress of policy approval, revision, and archiving.

PATH	COMMITTEE	DATE	PURPOSE	STATUS
Originating Committee	Chief Privacy Officer	14/03/2017	**DRAFT Agreement**	X completed
Reviewing Committee	Senior Management Team	25/05/2017	**Review & Agreement**	X completed
Approving Committee	Chief Executive Officer	30/05/2017	**FINAL Approval**	X completed

Historical Dates:	
Original Policy Date:	May 30, 2017
List of Dates Reviewed and Revised:	
Policies This Document Replaces	
Policy Archive Date:	

Approval Signatures

Step Description	Approver	Date

Status **Active** PolicyStat ID **14194106**

Origination	04/2000
Last Approved	01/2024
Effective	01/2024
Last Revised	01/2024
Next Review	01/2027
Owner	Scott Filman: Manager of Health Information Technology
Area	Health Information Technology

Acceptable Use of Information and Information Technology Policy

Approved by:

President and Chief Executive Officer

Purpose

The purpose of this policy is to define the behavioural requirements for all Agents within CGMH who have authorized access to Information and Information Technology systems. These requirements are intended to help protect the confidentiality, integrity, and availability of these systems, as well as personal information (PI) or personal health information (PHI) stored in or processed by CGMH systems.

Information Technology systems owned and operated by CGMH is one of the facility's most valuable assets. Creating, producing, exchanging and retrieving information using these systems presents valuable opportunities for the facility and the Agents who work at CGMH. While Agents are expected and encouraged to use this technology, its use carries important responsibilities.

All information technology systems provided to Agents is for business use and it is the responsibility of the users to see that these technologies are used in an efficient, ethical and lawful manner. The use of CGMH information technology is a privilege extended by the hospital, which may be revised, restricted or withdrawn at any time.

The success of our facility and the privacy of our patients and Agents depend upon the protection of any and all information from theft, destruction and/or inappropriate disclosure.

This policy will ensure Agents have a clear understanding of their responsibilities in the use of information technology.

The proprietary rights of the companies who develop and support the computer systems we use must be respected. All employees, physicians, consultants, and vendors who use this technology are required to comply with license agreements associated with the software products used. Illegal copies, downloading or transmitting of this software is prohibited and is a violation of copyright laws.

All Agents are required to sign an Acceptable Use of Information and Information Technology Policy agreement, which ensures that they understand their responsibilities in using information system technology within the facility.

Policy Requirements

1. Agents who have been given access to information technology systems at CGMH must:
    1. Always use their assigned credential to access any system(s) delivered by CGMH or associated organization. That are authorized by their Manager/Leader. Agents must keep their credentials confidential and secure as to keep data safe guards in place.
    2. Never leave any device unattended while logged on to CGMH systems within CGMH premises. The Agent is responsible for securing sessions logged into devices or systems with PHI, financial, or sensitive corporate data.
    3. Never allow another person to use their credentials to access any system at CGMH. All Agents are accountable for any action performed on CGMH systems with their ID.
    4. Never access CGMH systems unless their role requires them to do so, they are expressly authorized to do so, it is necessary to do so (e.g., providing or assisting in the provision of healthcare), and in accordance with their CGMH privacy policies.
    5. Never disable, override or willfully bypass any information security control on any CGMH system.
    6. Never attempt to exploit any suspected security weakness on CGMH systems, even to explore that such a weakness may exist, unless it is part of their assigned job duties or responsibilities and they are explicitly authorized to do so.
    7. Never knowingly perform an act that will interfere with the normal operations of CGMH systems or try to disrupt them by either intentionally making the solution unavailable or by affecting the integrity of the data being stored in or processed by CGMH systems.
    8. Never take a picture of data displayed on CGMH systems unless it is part of their assigned job duties or responsibilities and they are explicitly authorized to do so. The taking of pictures of live patient care data is strictly prohibited unless authorized by the Chief Privacy Officer.
2. E-mail
    1. E-mail is used for CGMH business use only and may be monitored by CGMH at any time.
    2. Only email PHI to the EHR Solution Program Office when it is necessary for the purposes of providing or assisting in the provision of health care or the EHR Solution business and is acceptable under their respective HIC's and the EHR Solution's policies or procedures.

3. Fraudulent, harassing, threatening, discriminatory, sexually explicit or obscene messages and/or material are not to be recorded, transmitted, printed, requested or stored. Chain letters, solicitations and other forms of mass mailings are not permitted. Examples of prohibited transmissions include but are not restricted to cartoons, jokes, propositions, ethnic or racial slurs or any other message that can be construed to be harassment or offensive.
4. The e-mail of Personal Health Information (PHI) is strictly prohibited unless authorized by the Chief Privacy Officer.
    1. In the event that PHI must be sent to a stakeholder or partnering agencies, systems will be implemented to ensure that it is encrypted, password protected or by secure file transfer prior to sending.
    2. It is prohibited by Agents of CGMH to use external e-mail addresses such as Hotmail or Gmail to send PHI.
5. Agent's email is data is under the custody of CGMH and as such is subject to security monitoring and audits.

3. Creating and protecting passwords
    1. All Agents must create passwords that are at a minimum of eight characters long and include at least three of the following:
        1. One number
        2. One uppercase letter
        3. One lowercase letter
        4. One special character.
    2. It is suggested that Agents use phrases when creating passwords in order to remember easily (IwanttovisitPariswhen!am40) (IwtvPw!a40)
    3. Agents must never change passwords used to access CGMH systems in an easily recognized pattern (e.g., changing "IL0v3EatingP!zza1" to "IL0v3EatingP!zza2").
    4. Agents must never create passwords used to access CGMH systems that include:
        1. All or part of their ID
        2. Easily obtained personal information about themselves (e.g., names of family members, pets, birthdays, anniversaries, hobbies)
        3. Three consecutive characters (e.g., AAA)
    5. Agents must change any password used to access CGMH systems that is provided to them at initial login and as directed by the IT department.
    6. Agents must ensure their passwords used to access CGMH systems are different from their password(s) used to access other accounts (e.g. personal banking, etc.).
    7. Agents must commit passwords used to access CGMH systems to memory. Agents must avoid keeping a record of their passwords (e.g., on paper, or stored on in a file), unless it:
        1. Can be stored securely, and

2. Does not indicate the associated ID or that it is for the CGMH system

8. Agents must keep their passwords used to access CGMH systems a secret, never telling anyone their password, including a system administrator, help desk personnel or a manager/leader.
9. Agents must immediately change their password used to access CGMH systems if they suspect or confirm that their password has been disclosed or compromised and notify the Chief Privacy Officer as soon as reasonable after the incident

4. Working Remotely
    1. Agents at CGMH may be given access to information technology systems remotely using the approved remote access system on approval of their Manager/Leader.
    2. No software can be installed on remote workstations owned and operated by CGMH without the prior authorization of their Manager/Leader and in consultation with the IT department.
    3. Agents using their own technical equipment must ensure that appropriate virus and malware software has been installed and that no inappropriate software is used that could cause risk to CGMH systems.
    4. Agents must use the login system as assigned to them by IT once approval has been provided.
    5. Agents must follow the proper procedures to disconnect from a remote access connection used to access CGMH systems (e.g., if the remote access solution has a disconnect option, use this option to disconnect rather than simply closing the application).
    6. Agents must never access CGMH systems in an area where unauthorized individuals can view the information (e.g., Internet cafés, public transit, and other non-private settings).
    7. Agents must never leave their mobile computing device that has the ability to access CGMH systems unattended in a public place.
    8. When required to leave their mobile computing device in a vehicle, Agents must lock it in the trunk or place it out of view before getting to your destination. If you get to the destination before securing the device you should take it with you instead.
    9. Agents will not be permitted to download PI or PHI to a mobile device used to access CGMH systems remotely.

5. Security Incidents
    1. All Agents must:
        a. Immediately report suspected or confirmed information security incidents related to the EHR Solution to their information security incident initial point of contact (the ITS Service Desk).
        b. Examples of information security incidents include, but are not limited to:
            i. Unauthorized disclosure of PHI.
            ii. Theft or loss of information technology that contains PHI or has

access to the EHR Solution even if it is encrypted.

iii. Virus or malware infection on a device that has access to the EHR Solution.

c. Attempts (either failed or successful) to gain unauthorized access to the EHR Solution.

d. Compromised password, i.e., another individual knows your password that is used to access the EHR Solution.

e. Provide their full cooperation to the EHR Solution Program Office, their agents or Electronic Service Providers with any information security incident investigation.

Definitions

Agent – from PHIPA – "in relation to a health information custodian, means a person that, with the authorization of the custodian, acts for or on behalf of the custodian in respect of personal health information for the purposes of the custodian, and not the agent's own purposes, whether or not the agent has the authority to bind the custodian, whether or not the agent is employed by the custodian and whether or not the agent is being remunerated

Health Information Custodian – from PHIPA – "subject … means a person or organization … who has custody or control of personal health information as a result of or in connection with performing the person's or organization's powers or duties…". CGMH is Health Information Custodian.

PI – Personal Information as referenced in FIPPA

PHI – Personal Health Information as referenced in PHIPA

References

Personal Health Information Protection Act, 2004
Freedom of Information & Privacy Act, 2012

Reference Policies

Privacy Policy

Data Chart

PATH	COMMITTEE	DATE	PURPOSE	STATUS
Originating Committee	Chief Privacy Officer	05/15/2017	**DRAFT Agreement**	completed
Reviewing Committee	Senior Team	05/01/2017	**Review & Agreement**	completed
Approving Committee	Chief Executive Officer	04/01/2017	**FINAL Approval**	completed
Historical Dates:				
Original Policy Date:		04/01/2000		

List of Dates Reviewed and Revised:	04/04/2017
Policies This Document Replaces	Information Technology Policy
Policy Archive Date:	October 2017

Attachments

Acceptable Use of Information and Information Technology Policy

Approval Signatures

Step Description	Approver	Date
Super User Override	Stephanie Paris: Policy Consultant	01/2024

Status **Active** PolicyStat ID **15488698**

Origination	01/2020
Last Approved	04/2024
Effective	04/2024
Last Revised	04/2024
Next Review	04/2027
Owner	Bryan McNevin: Manager, People Services
Area	People Services

Integrated Accessibility Policy

Purpose

Collingwood General and Marine Hospital (CGMH) Accessibility Policy (hereafter referred to as the "Policy") establishes a framework for compliance with the Hospital's commitment to accessibility, requirements of the Accessibility for Ontarians with Disabilities Act, 2005 (AODA), and requirements of the Integrated Accessibility Standards Regulation (IASR) under the AODA.

Policy Statement

The Collingwood General and Marine Hospital is committed to building an inclusive organization that values the contributions of people with disabilities. It is committed to providing an accessible environment in which people with disabilities can access goods, services, and facilities, including all buildings, public spaces, information and communications, in a way that meets their individual needs. CGMH is committed to the identification, removal and prevention of accessibility barriers, including attitudinal, systemic, information, communications and technology, and built environment and physical barriers.

The AODA provides for development, implementation and enforcement of accessibility standards in order to achieve accessibility for persons with disabilities in all aspects of society. All CGMH policies, procedures, bylaws, standards and guidelines must comply with the AODA, and provide for dignity, independence, integration and equal opportunity for people with disabilities. As required by the AODA, CGMH must:

- identify, prevent and remove barriers people with disabilities face in accessing CGMH goods, services and facilities;

- accommodate the accessibility needs of people with disabilities to ensure they can obtain, use or benefit from CGMH services, and facilities, and that they can do so in a timely manner, at a cost no greater than the cost for people without disabilities; and
- develop and train CGMH employees on providing accessible goods, services, and facilities.

All Collingwood General and Marine Hospital (CGMH) employees, professional staff, volunteers, students/learners, independent and external contract workers, and all individuals who represent CGMH and interact with the public are bound by this Policy (referred to as "Individuals" in this policy).

The Employment Standards Requirements in Section 8 apply only to employees of CGMH.

Guiding Principles

CGMH goods, services and facilities are to be available to people with disabilities in a manner that:

- is free from discrimination,
- strives at all times to respect the individual's dignity and independence,
- is integrated with the provision of service to others, except when alternative measures are necessary to meet the needs of people with disabilities, and
- takes individual needs into account where a uniform response is inappropriate, to ensure that there are no barriers to access or participation, and that individuals with disabilities are treated in a manner similar to others.

Definitions

Accessibility is a concept integral to human rights that refers to the absence of barriers that prevent individuals and/or groups from fully participating in all social, economic, political and cultural aspects of society. The term is often linked to people with disabilities and their rights to access, and also refers to design characteristics of products, devices, information, services, facilities or public spaces that enable independent use, or support when required, and access by people with a variety of disabilities.

Accessible refers to products, devices, information, services, facilities or public spaces that provide for independent, equitable and dignified access for people with disabilities, including but not limited to those with visual, auditory, sensory, cognitive and mobility related disabilities. The concept of accessible design ensures both "direct access" (i.e. unassisted) and "indirect access," referring to compatibility with a person's assistive technology.

Accessible Formats refers to formats that are usable by persons with disabilities including but not limited to: large print, recorded audio and electronic formats, and Braille.

Accommodation, in the context of Human Rights means preventing and removing barriers caused by attitudinal, systemic, physical, information or communications, and technology barriers that unfairly exclude individuals or groups protected by Ontario's Human Rights Code from having equal access to full benefits available to others.
Principles of accommodation include dignity, individualization and inclusion or integration. For more information refer to Ontario's Human Rights Code and CGMH's Accommodation Policy.

Assistive Devices are technical aids, communication devices, or medical aids modified or customized for use to increase, maintain or improve the functional ability of a person with a disability including but not limited to wheelchairs, walkers, white canes, note taking devices, portable magnifiers, recording machines, assistive listening devices, personal oxygen tanks and devices for grasping. Assistive devices may accompany the customer or already be on the premises for the purpose of assisting persons with disabilities in carrying out activities or in accessing the services provided by CGMH.

Barrier, as defined by the AODA, is anything that prevents a person with a disability from fully participating in all aspects of society because of his or her disability, including a physical barrier, an architectural barrier, an information or communications barrier, an attitudinal barrier, a technological barrier, a policy or a practice.

Career Development and Advancement is defined by the AODA as the provision of additional responsibility within an employee's current position or movement from one job to another within the organization that may be higher in pay, provide greater responsibility, or be at a higher level in the organization.

Communications are interaction between two or more persons or entities, or any combination of them, where information is provided, sent or received.

Communications Supports includes, but is not limited to, captioning, alternative and augmentative communications supports, plain language, sign language and other supports that facilitate effective communications.

Conversion Ready are electronic or digital formats which facilitates conversion into an accessible format such as Braille, large print, audio cassettes CDs, DVDs, etc.

Disability is defined, per Section 2 of the Accessibility for Ontarians with Disabilities Act, 2005, S.O. 2005, c. 11 and the Ontario Human Rights Code, R.S.O. 1990, c. H.19, as follows:

a. "any degree of physical disability, infirmity, malformation or disfigurement that is caused by bodily injury, birth defect or illness and, without limiting the generality of the foregoing, includes diabetes mellitus, epilepsy, a brain injury, any degree of paralysis, amputation, lack of physical co-ordination, blindness or visual impediment, deafness or hearing impediment, muteness or speech impediment, or physical reliance on a guide dog or other animal, or on a wheelchair or other remedial appliance or device,
b. a condition of mental impairment or a developmental disability,
c. a learning disability, or a dysfunction in one or more of the processes involved in understanding or using symbols or spoken language,
d. a mental disorder, or
e. an injury or disability for which benefits were claimed or received under the insurance plan established under the Workplace Safety and Insurance Act, 1997."

Goods, Services and Facilities are all aspects of CGMH as an employer and service provider, including: delivery of goods, services, and programs, all information and communication including verbal, print, audio, video, websites, web applications and web content, and other digital technologies including kiosks, and all buildings, facilities, public spaces, and the public realm.

Information includes, but is not limited, to data, facts and knowledge that exists in any format, including text, audio, digital, or images that convey meaning.

Kiosk is an interactive electronic terminal, including a point-of-sale device, intended for public use that allows users to access one or more services or products or both.

Service Animals, as defined by Section 80.45 (4) of the AODA Customer Service Standards (O.Reg 165/16), are animals for use by people with a disability, if the animal can be readily identified as one that is being used by the person for reasons relating to the person's disability, as a result of visual indicators such as the vest or harness worn by the animal; or the person provides documentation from one of the following regulated health professional confirming that the person requires the animal for reasons relating to the disability:

- A member of the College of Audiologists and Speech- Language Pathologists of Ontario
- A member of the College of Chiropractors of Ontario
- A member of the College of Nurses of Ontario
- A member of the College of Occupational Therapists of Ontario
- A member of the College of Optometrists of Ontario
- A member of the College of Physicians and Surgeons of Ontario
- A member of the College of Physiotherapists of Ontario
- A member of the College of Psychologists of Ontario
- A member of the College of Registered Psychotherapists and Registered Mental Health Therapists of Ontario

Support Person is an individual who accompanies a person with a disability to help with communication, mobility, personal care or medical needs or with access to goods or services.

1. Roles and Responsibilities

Accessibility is a shared responsibility and everyone has a part to play in making CGMH accessible to residents, visitors, and co-workers, as described in the following roles and responsibilities.

1. **Employees, Volunteers and Third Parties**

   All employees and other persons acting on behalf of CGMH must:

   - have thorough knowledge of and maintain compliance with this Policy,
   - be familiar with their rights and responsibilities under this Policy,
   - prevent accessibility barriers by including accessibility considerations in the development of goods, services and facilities, including using an Equity Lens,
   - participate in identifying accessibility barriers and planning for barrier removal,
   - provide a welcoming environment for people with disabilities, including any person with a disability using assistive devices or accompanied by a support person or service animal,

- communicate with persons with disabilities in a manner that takes into account their disability,
- provide information and communications in accessible formats upon request, or with communication supports, consulting with the requestor about their preferred format,
- facilitate the process of receiving and responding to feedback about the manner that CGMH provides goods, services, and facilities to persons with disabilities, and ensure all feedback processes are accessible to persons with disabilities by providing or arranging for accessible formats and communication supports upon request,
- facilitate requests for accommodation by members of the public and employees with disabilities in a timely manner, to the point of undue hardship, in accordance with the Ontario Human Rights Code and CGMH's Accommodation Policy,
- when serving customers that have competing accommodation needs, staff will make every effort to meet the needs of all individuals according to the Ontario Human Rights Code and CGMH's Accommodation Policy,
- request support from People Services when accommodation requests are outside their area of responsibility, or beyond their capacity, and
- attend mandatory training and any additional training appropriate to the duties of their role, which may include acquiring skills and competencies necessary to identify, prevent and remove accessibility barriers.

2. **Supervisors, Managers and Directors**

In addition to the above roles and responsibilities, individuals with management and supervisory roles must:

- provide leadership in building an inclusive and accessible environment for the public and employees,
- prevent barriers by including accessibility considerations in the development of new policies, practices, procedures or bylaws, including using an Equity Lens,
- ensure that the Policy is communicated to all CGMH employees and those acting on behalf of CGMH,
- promote awareness of the Policy within their area of responsibility,
- monitor current practices and ensure that management and staff are held accountable for their responsibilities under the policy,
- act on non-compliant issues within their area of responsibility,
- attend training and ensure staff receive training appropriate to the duties of their role, including any skills and competencies required to identify, prevent and remove accessibility barriers,
- ensure volunteers and other third parties providing goods, services, and facilities on behalf of CGMH have been provided training, either by CGMH or their own organization,

- facilitate requests for accommodation by members of the public and employees with disabilities in a timely manner, to the point of undue hardship, in accordance with the Ontario Human Rights Code and the CGMH's Accommodation Policy
- consult with People Services for assistance with accessibility issues.
- ensure resources are budgeted for identifying and preventing accessibility barriers (including attitudinal, systemic, information, communications and technology, and built environment and public space barriers) and for planning for barrier removal
- provide oversight for implementation of this policy and compliance with AODA within area of responsibility
- provide AODA compliance assurance when required.

2. General Requirements

CGMH will ensure the general requirements of the Integrated Accessibility Standards Regulation (IASR) under the AODA are met in order to achieve accessibility for persons with disabilities.

1. **Accessibility Policies**

   The AODA requires CGMH to maintain one or more policies governing how the organization will achieve the requirements of the IASR. CGMH must also make such documents available to the public, and in accessible formats upon request. This Policy is adopted in compliance with this obligation.

2. **Multi-Year Accessibility Plan**

   The AODA requires CGMH to establish, implement, maintain and make public a Multi- Year Accessibility Plan outlining the corporate strategy to identify, remove and prevent barriers and to meet the legislated requirements of the IASR. The plan must be developed in consultation with people with disabilities. It must be posted on CGMH's website and made available in an accessible format or with appropriate communications supports as soon as possible upon request.

3. **Procurement of Goods, Services and Facilitates**

   As required by the AODA, when acquiring or procuring goods, services, and facilities, CGMH must incorporate accessibility criteria and features, and will do so as early as possible in the procurement process. Where it is not practicable to do so, an explanation must be provided upon request.

   Ensuring accessibility is incorporated into all procurement activities is the primary responsibility of the Leaders who manage these activities and contracts. Any third parties that provide goods, services and facilities to members of the public or to other third parties on CGMH's behalf must ensure their staff has received appropriate training as required by the IASR and provide proof of training upon request.

4. **Self-Serve Kiosks**

   The AODA requires CGMH to incorporate accessibility features when designing, procuring or

acquiring self-serve electronic kiosks (interactive electronic terminals).

5. **Training**

   The AODA requires that all employees, volunteers and persons who participate in developing CGMH policies must receive training on the AODA, the Ontario Human Rights Code, and Accessible Customer Service. Training must take place as soon as possible and be appropriate to the person's role. CGMH must keep a record of the training provided to employees and volunteers, including the dates on which accessibility training took place and the names of individuals trained.

   Training must include:

   - A review of the purpose of the AODA
   - Requirements of AODA Standards under the IASR
   - The Ontario Human Rights Code as it pertains to persons with disabilities
   - Accessible Customer Service

3. Information and Communication Requirements

CGMH will provide accessible information and communication by preventing and removing barriers, and providing accessible formats or communication supports to individuals that identify a barrier to accessibility. This section of the Policy addresses CGMH's requirements of the IASR Information and Communications Standards under the AODA.

1. **Accessible Formats and Communication Supports**

   The AODA requires that all information and communications that CGMH produces, directly or indirectly through contractual relationships, must be made available in accessible formats upon request.

   When an accessible format or communication support is requested, CGMH must consult with the person making the request to determine which format or support is required, and provide or make arrangements to provide the material in a reasonable amount of time and at no additional cost to the requestor.

   If it is determined that information or communications are unconvertible, CGMH must provide the person requesting the information or communication with:

   - an explanation as to why the information or communications are unconvertible, and
   - a summary of the unconvertible information or communications.

2. **Notice of Availability of Documents**

   This Policy will be maintained CGMH's website, and must be provided to individuals, upon request, in the appropriate format or with communication supports.

3. **Accessible Websites and Web Content**

   The AODA requires that CGMH's internet website and web content, controlled directly by CGMH or through a contractual relationship that allows for modification of the product, must conform to World Wide Web Consortium (W3C) Web Content Accessibility Guidelines (WCAG) 2.0 at Level AA, in accordance with the timelines set out in the IASR and in the Accessible Information, Communications, and Technology Guidelines.

4. **Emergency Procedures, Plans or Public Safety Information**

   The AODA requires CGMH emergency procedures, plans or public safety information that is available to the public be made available in an accessible format or with appropriate communication supports as soon as possible upon request.

5. **Feedback**

   CGMH must have a process in place for receiving and responding to feedback, including feedback on how services are delivered to people with disabilities. CGMH must make feedback processes accessible to persons with disabilities by providing or arranging for the provision of accessible formats and communication supports upon request.
   Feedback will be collected by phone by dialing 705-445-2550 x8199 or by email at hr@cgmh.on.ca, and in person at CGMH.

4. Customer Service Requirements

CGMH will strive for excellence in serving all customers including people with disabilities and is committed to meeting obligations under the Ontario Human Rights Code and the AODA.

1. **Fares and Fees**

   Persons with disabilities must not be charged more to access CGMH programs or services.

2. **Assistive Devices**

   The AODA requires CGMH to allow persons with disabilities to use their own assistive devices to obtain, use or benefit from the goods, services, and facilities offered by CGMH.

   In circumstances where a person with a disability is unable to access the CGMH's services through the use of their own personal assistive device, CGMH must assess service delivery and potential service options to meet the needs of the individual, in accordance with the Ontario Human Rights Code and CGMH's Accommodation Policy .

   Where CGMH owned assistive devices are available, the AODA requires that they must be kept in good working order and the public must be informed of their availability. Staff must be trained in the application and use of the devices where appropriate.

3. **Support Persons**

   Where a person with a disability accessing CGMH goods, services, or facilities is accompanied by a support person, the AODA requires CGMH to ensure that both persons are permitted to

enter the premises together and the person with a disability is not prevented from having access to the support person while on the premises.

4. **Service Animals**

   The AODA requires that persons with disabilities accompanied by their service animal must be permitted to keep that animal with them in premises that members of the public are permitted to enter. Please see the Definition section of the Policy for definition of service animal.

   In the event the animal is excluded by law, such as in a food preparation area, CGMH must ensure other measures are available to enable the person with a disability to obtain, use or benefit from CGMH goods, services, and facilities. Staff will respectfully explain why the animal is excluded and determine what other arrangements can be made.

   When serving two customers that have different needs, such as serving a customer that has a service animal and a customer that has an allergy to animals, staff will determine how to best meet the needs of both individuals and observe the rights of all individuals involved, according to the Ontario Human Rights Code and the CGMH's Accommodation Policy.

   A person with a disability is responsible for the control of their service animal at all times. If the service animal is not kept under control, has bitten another person or animal, or is a menace to the safety of other persons or animals, the service animal may be required to leave the premises. If this occurs the person will be permitted to continue to access CGMH goods or services without the animal. In addition, CGMH employees will, upon request, consider alternate accommodations for the person in such circumstances. CGMH may refuse to permit the service animal to accompany the person until steps have been taken to correct the situation, and the issue has been resolved.

5. **Notice of Service Disruptions**

   The AODA requires CGMH to give notice of any temporary planned or unplanned service disruption of facilities, services or systems that are relied upon by people with disabilities to access CGMH goods, services or facilities, such as elevators, lifts, or accessible washrooms. In the event of an unexpected disruption, notice must be provided as soon as possible.

   Notice must include information about the reason for the disruption, its anticipated duration and a description of alternative facilities, services or systems that are available.

   Notice must be given by posting the information in a prominent place on premises owned or operated by the provider, posted on CGMH's website or social media, included on telephone recordings, or by other methods as is reasonable under the circumstances

5. Employment Standards Requirement

CGMH will foster an inclusive workforce and provide equitable treatment and accommodation to ensure barrier-free employment. The requirements in this section apply only to employees of CGMH. Volunteers and other non-paid individuals are not captured under this section. This section addresses CGMH's requirements of the IASR Employment Standards under the AODA.

1. **Recruitment, Assessment and Selection Process**

   CGMH must post information about the availability of accommodations for internal and external job applicants with disabilities in its recruitment process. Job applicants who are individually selected for an interview and/or testing must be notified that accommodations are available on request. CGMH must consult with an applicant who requests an accommodation and, in accordance with the Ontario Human Rights Code and CGMH's Accommodation Policy, will provide or arrange for the provision of a suitable accommodation in a timely manner that takes into account the
   applicant's accessibility needs due to disability. Successful applicants must be notified about CGMH's policies for accommodating employees with disabilities as part of their offer of employment.

2. **Employee Supports**

   CGMH employees must be made aware of the policies used to support employees with disabilities and accommodations available in accordance with the Ontario Human Rights Code and CGMH's Accommodation Policy. CGMH provides this information to new employees through employment agreements and orientation materials, and must provide updated information to all employees whenever there is a change to existing policies on the provision of job accommodations that take into account an employee's accessibility needs due to disability.

3. **Accessible Formats and Communication Supports for Employees**

   In accordance with the Ontario Human Rights Code and CGMH's Accommodation Policy, upon an employee's request, CGMH must consult with the employee to provide or arrange for the provision of accessible formats and communication supports for:

   - information that is needed to perform the employee's job, and
   - information that is generally available to employees in the workplace.

   CGMH must consult with the employee making the request in determining the suitability of an accessible format or communications support.

4. **Workplace Emergency Response Information**

   CGMH will provide individualized emergency response information to employees who identify potential accessibility barriers when responding to emergency situations. If the employee requires assistance, CGMH must receive consent from the employee to provide the individualized emergency response information to the person(s) designated to provide assistance. The information must be reviewed when the employee moves to a different department, when the employee's accommodation needs change, when overall accommodation plans are reviewed and when CGMH reviews its general emergency response plan.

5. **Individual Accommodation Plans**
   CGMH's Accommodation Policy describes the mandatory process for the development and maintenance of documented individual accommodation plans to support employees with

disabilities. The process set out in the policy meets requirements of the AODA. If applicable, individual accommodation plans may include information regarding plans for accessible formats and communication supports, as well as individualized workplace emergency response information.

6. **Return to Work Process**

   CGMH must have in place a documented return to work process for employees returning to work following an illness or injury where disability-related accommodations are required. This requirement is met through return to work processes supported by Occupational Health and Safety consistent with the collective agreements and return to work protocols.

7. **Performance Management, Career Development, and Redeployment**

   CGMH will ensure employees with disabilities or individual accommodation plans are provided equitable access to career development, performance management and redeployment opportunities.

6. Transportation Requirements

This section of the Policy addresses the requirements of the IASR Transportation Standards under the AODA. As CGMH does not provide transportation services, this section of the standard does not apply.

7. Built Environment and Public Spaces Requirement

CGMH will ensure accessibility at all its facilities and public spaces by designing with accessibility in mind.

1. **Accessibility Requirements in Codes and Standards**

   The Ontario Building Code, which has a section on Barrier-Free Design, and the AODA, IASR Design of Public Spaces Standards are both standards to which CGMH must adhere. These standards establish the minimum threshold for accessibility in the built environment.

2. **AODA Design of Public Spaces, Additional Requirements**

   In addition to technical design requirements for making public spaces accessible, the AODA also establishes requirements for service environments, maintenance of accessible elements and for the consultation of people with disabilities on accessibility of public spaces.

3. **Obtaining Services**

   When constructing or replacing service counters, fixed queuing guides and waiting areas, the AODA requires CGMH to make them accessible to people with disabilities.

4. **Maintenance of Accessible Elements**

   The AODA requires CGMH to develop and implement procedures for preventative and emergency maintenance and temporary disruptions of accessible elements in public spaces.

5. **Public Consultation**

   The AODA requires CGMH to provide opportunity for public consultation on the development or re-development of public spaces, including:

   - recreation trails,
   - outdoor play spaces,
   - rest areas along exterior paths,
   - on-street parking.

8. Reporting Requirements

CGMH must submit completed compliance reports to the Province every two years, in accordance with the schedule set out in the AODA.

9. Contraventions

Failure to comply with this Policy may result in disciplinary action, up to and including dismissal. CGMH's failure to comply with AODA may result in significant fines and reputational damage.

References

Accessibility for Ontarians with Disabilities Act (AODA), 2005, S.O. 2005, c.11 (AODA)
AODA, Integrated Accessibility Standards Regulation, O. Reg. 191/11
Ontario Building Code, O. Reg. 332/12
Ontario Human Rights Code, R.S.O. 1990, c.H.19
Health Protection and Promotion Act, R.R.O. 1990, Reg. 562
Food Safety and Quality Act, 2001, O. Reg. 31/05
The Blind Person's Rights Act, R.R.O. 1990, Regulation 58

Archived Approval Pathway

PATH	COMMITTEE	DATE	PURPOSE	STATUS
Originating Committee	People Services	08/01/2020	**DRAFT Agreement**	√ completed
Reviewing Committee	People Services	08/01/2020	**Review & Agreement**	√ completed
Approving Committee	Senior Leadership Team	16/01/2020	**FINAL Approval**	√ completed

Historical Dates:	
Original Policy Date:	Original date of development
List of Dates Reviewed and Revised:	List kept of each date of revision approval
Policies This Document Replaces	Tracks policy development and archival processes
Policy Archive Date:	Date a policy is retired and archived

Approval Pathway

Reviewing Committee	Date	Status (Pending/Approved)
Senior Leadership Team	March 21, 2024	Approved

Approval Signatures

Step Description	Approver	Date
Kris Baird, VP People & Safety, CHRE provides Final Approval	Kris Baird: Vice President, People Services and Safety	04/2024
Policy Owner approves changes & completes Data Chart	Bryan McNevin: Manager, People Services	04/2024