Executive Limitation Monitoring Report
EL-12 Ethical Behaviour
Lake of the Woods District Hospital

April 2018

Board policy is indicated in bold typeface throughout.

I hereby present my monitoring report on your Executive Limitations Policy EL-12 "**Ethical Behaviour"** according to the schedule set out. I certify that the information contained in this report is true, and ***represents reasonable achievement of all aspects of the policy unless specifically stated otherwise***.

Signed C.M. Balcaen, CEO Date April 2, 2018

The CEO shall not operate without internal processes that require a high degree of integrity at all levels of the organization.

CEO Interpretation:

I interpret "*internal processes*" to mean policies, procedures and practices that guide behaviors, are written, and are accessible to all staff.

I interpret "*integrity*" to mean honesty, truthfulness, sincerity and reliability which reflects the values of the organization.

I interpret "*all levels of the organization*" to include all staff in all departments in the hospital and community programs as these all fall under the mandate of the hospital.

Evidence:

Evidence of the overall compliance with this executive limitation is provided by the cumulative evidence for the numbered policy statements below.

Further, without limiting the scope of the above by the following list, the CEO shall not:

1. **Operate without an internal Code of Conduct, of which all employees are made aware, that clearly outlines the rules of expected behavior for all employees.**

   CEO Interpretation:

   I interpret "*internal*" to mean within the hospital and its community programs which are housed outside the hospital building but are considered a part of the hospital campus.

   I interpret "*Code of Conduct*" to mean expected behaviors of those doing work in our facilities and programs, including staff and affiliates. The Code of Conduct will be in writing and available to all staff and affiliates.

   I interpret "*employees*" to mean persons working in the hospital in a paid or unpaid capacity and includes students, partners and credentialed staff.

   Evidence: Compliant

   There is a written Code of Conduct in the hospital which was last reviewed in February 2017. In a review of 35 new hires to date in (2016-17) and 74 new hires in (2017-18), it was recorded that 100%

of new hires had reviewed the Code of Conduct as part of orientation. All students at LWDH receive a copy of the Code of Conduct as part of their student orientation package.

The Code of Conduct is also posted throughout the organization, in each department.

1.1. Operate without written policies which prevent conflict of interest.

CEO Interpretation:

I interpret "*conflict of interest*" to mean that the individual's private interests are incompatible or in conflict with their official responsibilities.

Evidence: Compliant

There are several programs and departmental policies in place that address conflict of interest. The policies outline the steps to be taken if an actual or potential conflict of interest exists.

The Board of Directors GP-3 "Code of Conduct" provides directives re ethical behavior to Board members. The LWDH Bylaws also speak to conflict of interest and means to address same.

Declaration of Conflict of Interest occurs rarely at the Board table, most often by the CEO or COS when matters related to the CEO or COS are being discussed. This is recorded in the Board meetings. There was a conflict of interest declared by a Board member during the April 2017 meeting regarding Professional Privileges, however there was no conflict of interest declared for the remainder of the fiscal year.

The Human Resources Department has developed and implemented a "Recruitment & Selection" policy. There were no declarations of a conflict of interest in relation to this HR policy in 2016-17 or 2017-18

2. Operate without providing employees and others with an effective mechanism for confidential reporting of alleged or suspected improper activities, without fear of retaliation.

CEO Interpretation:

I interpret "*effective mechanisms*" to mean procedures and processes which guide actions to achieve a predetermined end.

I interpret "*confidential*" to mean that the name of the person reporting would not be disclosed.

I interpret "*alleged or suspected improper activities*" to mean activities which an employee has reasonable evidence which supports their belief that a colleague is not acting in compliance with normal policies and practices or by-laws of the organization or within the public hospitals act or legal statutes.

I interpret "*fear of retaliation*" to mean fear of revenge or retribution from another person or group of persons.

Evidence: Compliant

There is an Employee Responsibility policy in place which directs staff re their responsibility in adhering to policies and procedures. Further, this policy identifies that "employees will not be subject to discipline or reprisal for the reasonable exercise of their obligations including those related to patient advocacy". This policy also prohibits retaliation against anyone who "reports, in good faith, conduct which they reasonably believe to be a wrongdoing".

Such reports are usually made verbally to a manager or to Human Resources. Concerns can also be brought to the Senior Manager level. The privacy of the person reporting is maintained. A full and

confidential investigation is completed and documented. Should an employee's privacy be breached or should an employee be a victim of retaliation, they have the option under their collective agreement to initiate the grievance process or bring a harassment charge against the perpetrator.

2.1. Permit any employee to be adversely affected because the employee refuses to carry out a directive which would result in an improper activity.

CEO Interpretation

I interpret "*adversely affected*" to mean retaliation or discipline of any type including but not limited to threats of consequences, suspension, termination.

I interpret "*directive*" to be any instruction to perform an activity by another person.

Evidence: Compliant

We have had no incidents of refusal to carry out a directive in 2017-18

We have had no work refusal incidents under the Occupational Health and Safety Act in 2017-18.

There are policies in place to assist staff in refusal to carry out a directive including:

- Work Refusal (last reviewed March 2017) which guides an employee who is being asked to work in a situation where they feel their safety or the safety of others is at risk.
- Nurse/Physician Disagreement Guideline (reviewed March 2016, currently under review) guides nurses in dealing with situations where they feel that a physician directive or the lack of a physician directive is not in the best interests of the patient and may put the patient at risk.
- Decision Tree re Workload / Competency issues (March 2016, currently under review) guides nurses in responding to requests that they do work that they feel is outside their scope of practice.

Such incidents would also be reported in Risk Monitor electronic incident reporting system and an investigation would follow.

Regulated health professionals also have specific professional standards and College guidelines to provide guidance to them if they are asked to perform any act outside their professional standards and scope of practice.

Bargaining Unions protect staff who may feel that they are adversely affected in refusing to work outside their scope of practice by providing an option to submit a grievance under the collective agreement. We have had no such grievances in 2016-17 or 2017-18.

2.2. Allow the Board to be uninformed about any potential reputation exposure related to these matters.

CEO Interpretation

I interpret "*potential reputation exposure*" to mean possible loss of credibility of the organization with our employees or the public we serve related to an event or decision.

Evidence: Compliant

Each month the CEO, the Chief of Staff, the VP Patient Services, the CFO and the VP Community Programs provide a written report to the board regarding any "Anticipated Adverse Media Coverage" and any "Actual or Potential Lawsuits".

If an event occurs which may result in immediate negative media coverage, the Board Chair and the Board are notified immediately by the CEO or his designate by telephone and/or by email. In the

past fiscal year (April 2017 – March 2018) there have been three identified "Anticipated Adverse Media Coverage" items noted in Senior Management reports to the Board of Directors. They were:

1.) Social Media announcements re: shortage of doctors and the vote of non-confidence.
2.) Union central negotiations and the hot topic of workplace violence.
3.) Operational Review draft report and the potential for a leak.

The CEO and the Board are notified of all Critical Incidents by the Chief of Staff, as the Chair of MAC in compliance with the Excellent Care for All Act (2010). Critical incidents are a standing agenda item at the monthly Medical Advisory Committee meetings. Critical incidents are reflected in the MAC minutes and the Board Quality Committee minutes. Critical incidents are also discussed at the monthly Board meetings at the in-camera session. There have been no critical incidents relating to ethical behavior that would pose a risk to organizational reputation or credibility.

2.3. Neglect to maintain detailed records of all matters raised under this Policy.

CEO Interpretation:

I interpret "*detailed records*" to mean documentation, including but not limited to the facts of the occurrence, the scope of the investigation and the conclusions and actions.

Evidence: Compliant

The hospital complies with its policies on Retention and Destruction of Records (reviewed 03/2017). These policies outline specific record retention periods for each type of document. These policies are due for review. The Laboratory and Community Programs also have specific policies on Retention of Records.

Confidential investigations under the Respectful Workplace Policy are recorded and stored in Human Resources.

Patient adverse events are documented in the patient record and in Risk Monitor Pro and the investigation is documented and stored in secure Risk Manager's files. Serious patient incidents or complaints prompt a quality of care review.

Critical Incidents are documented in the patient record and in Risk Monitor Pro and the investigation is documented and stored in the Risk Manager's files. In the event of a Critical/Sentinel event or for Medical/Legal Claims management, there are policies in place to secure both the patient's paper and electronic medical records.

All employee grievances are recorded and documents stored in Human Resources. There were no grievances filed related to this policy in 2017-18.

3. Operate without an ethical framework that defines formal processes for managing ethics-related issues and concerns related to patient care.

CEO Interpretation:

I interpret "*ethical framework*" to mean a written framework to guide the process of examining an ethical dilemma or issue.

Evidence: Compliant

There is an organizational Code of Ethics to guide staff in expected behaviors while acting as an employee of the organization.

There is an organizational ethical framework in place to guide the review of any ethical issue brought forward. GP-19 was developed to ensure a method for the Board to examine ethical concerns. GP-19 was last reviewed/revised in April 2016. The Ethical Framework is included on the back of the laminated "Decision Making Tool" which is provided to each Board member at each Board Meeting. The tool and framework can be referred to by Board members when making any and all decisions at the Board table.

LWDH has an Ethics Committee and we are able to access the advice of an ethicist through Lakehead University.

All regulated professionals have Codes of Ethics specifically related to their professions.

3.1 Permit research studies and/or experimentation involving patients to be done in an unethical manner or without appropriate informed consent.

CEO Interpretation

I interpret "*unethical*" to mean without regard for moral consideration and honorable intent.

I interpret "*informed consent*" to mean that the patient / substitute decision maker has all reasonable information needed to make a decision to participate or not participate.

Evidence: Compliant

All Research studies are reviewed by the Ethics Research committee against validated criteria including the need for informed consent and the ability to withdraw from the study at any time. The committee makes a recommendation to senior management that the request meets ethical standards. All research projects are approved by Senior Management prior to the research project starting at LWDH.

The following table lists all current research projects that LWDH is participating in:

Study	Researcher	Date of Approval
Northwestern Ontario Wellness (NOW): A Gambling Response Program Integrated Research Platform	Dr. Lena C. Quilty	January 10, 2018
Ethical Decision Making Experiences of Registered Nurses in Acute Care Settings in Northern Ontario	Dr. Manal Alzghoul	July 18, 2017 Completion Date: February 2018
A Regional Approach to Integrating Intensive Tobacco Cessation Interventions into Clinical Care in NW Ontario	Dr. Patricia Smith	April 20, 2017 Re-Approval with Modification: August 5, 2017 Completion Date: May 31, 2018
Understanding the Dynamics of Hidden Homelessness in Rural & Northern Ontario	Dr. Rebecca Schiff	October 11, 2016 Completion Date: March 31, 2017
Epidemiology of Invasive Haemophilus Influenza, Streptococcus pneumonia, Neisseria meningitides Infections in the Lake of the Woods District	Dr. Marina Ulanova	September 20, 2016 Completion Date: Spring 2017
Assessing Service and Intervention Needs for Young Drug Users in Northern Ontario	Dr. Benedikt Fischer	March 30, 2016 Re-Approval with Modification: September 2, 2016 Completion Date: April 2017