Clinic Accreditation Consultants

GOVERNANCE

Policy & Procedure Manual

2025 January Revision

YOUR CLINIC NAME HERE

INTRODUCTION

GOVERNANCE | Policy & Procedure Manual **|** YOUR CLINIC NAME
2025 January Revision

Summary

This manual is designed to establish a comprehensive set of policies and procedures that align with our organizational goals and the referenced Accreditation Canada guidelines. It serves as a reference document to guide staff, stakeholders, and management in the consistent and effective implementation of our operational standards. The manual is structured to provide clarity, ensuring that all users can easily navigate and understand the responsibilities, procedures, and expectations outlined herein. Our commitment to transparency, accountability, and excellence is reflected in the meticulous design and organization of this manual.

Rationale

The rationale behind this manual is to provide a clear, structured framework that supports our organization's operational integrity and strategic objectives. By articulating our policies and procedures explicitly, we aim to foster an environment of trust and collaboration, enabling every member of our organization to contribute effectively towards our shared goals. This manual is not only a testament to our commitment to best practices but also a tool to facilitate our journey towards sustainable growth and success.

Reference to Standards

ACCREDITATION CANADA

This document is written to ensure compliance with Accreditation.ca's Standards and guidelines

PROGRAM:	*QMENTUM Program Standards*	**STANDARDS ORG:**	*Accreditation Canada*
REFERENCE STANDARDS:	*GOVERNANCE*	**REFERENCE VERSION:**	*October 2022*
ADMINISTRATOR RESPONSIBLE	Contact	**CONTACT INFORMATION**	contact@email.com

1 – DEFINING A CLEAR DIRECTION FOR THE ORGANIZATION

1.1 – The governing body works with the organization to engage its stakeholders including clients, families, and the community in defining the direction for the organization.

GOV1.1.1	1.1.1 – The governing body ensures that the organization regularly engages with stakeholders to assess the organization's mandate and performance expectations.

OBJECTIVE
Competency assessments and performance reviews are performed annually for all regulated health professionals and staff with positions that require entry-to-practice certification.

POLICY

The Organization is committed to providing constructive feedback and maintaining open communication with all employees. The Performance Review Policy (the "Policy") provides a general overview of how employees are coached, evaluated, and rewarded.

YOUR CLINIC NAME Management department has clear processes for recruitment, orientation, and training and performance evaluation to help ensure that highly qualified people are in the right positions and to monitor the competency and performance of staff. From physicians to nurses to administrative assistants – YOUR CLINIC NAME makes sure that people have the right qualifications to do their jobs, as well as the ongoing training, support, and evaluation needed for them to meet our expectations of quality.

SCOPE
The Policy applies to all employees of the Organization.

POLICY STATEMENT
The performance management practices are designed to:

- Ensure employees understand their job responsibilities and have specific goals to meet.
- Provide employees with actionable and timely work feedback.
- Invest in development opportunities that help employees grow professionally.
- Recognize and reward employees.

Good performance
Generally, employees who do the following things are more likely to receive positive performance reviews:

- Consistently meet their targets.
- Complete their job duties as expected.
- Show a willingness to learn and develop.
- Follow the Organization's policies.
- Have a good attitude and collaborate well with colleagues.

Reviews
The Organization conducts annual performance reviews. Managers will complete the performance review form and arrange a meeting with the employee to discuss the review. The goal of the discussion is to:

- Recognize employees for good performance
- Talk about career moves and employee motivations
- Identify areas of improvement

In addition to formal performance reviews, managers should meet with their employees regularly to provide feedback and discuss any other matters.

Rewards
Pay increases or bonuses after a performance review are not guaranteed.

Training
Training and development opportunities are available for all employees throughout the year and may be discussed during performance reviews.
If necessary, the Organization may implement an improvement plan, on-the-job training, job shadowing, or other training methods to develop an employee.

YOUR CLINIC NAME management performs competency assessments of personnel following initial training and annually thereafter. Retraining and reassessment occur when the need is identified.

Refer to:
Appendix GOV1.1.1 Physician Annual Performance Review
Appendix GOV1.1.1 General Performance Evaluation
Appendix GOV1.1.1 Administrative Assistant Annual Competency Assessment
Appendix GOV1.1.1 Nurses Annual Competency Assessment

- **Future Employees:** Present YOUR CLINIC NAME as a rewarding workplace with opportunities for professional development and community impact.

Advocacy Efforts

In consultation with organizational leadership, the governing body will determine the level of involvement and scope of advocacy activities. This may include:

- **Public Policy:** Supporting policies that address the social determinants of health for diverse communities. This may involve advocating for initiatives such as:
  - **Smoking bans:** Promoting smoke-free environments to prevent tobacco-related health issues.
  - **Environmental health laws:** Advocating for policies that protect overall community health.
  - **Addressing historical injustices:** Supporting policies that address the health effects of historical and current injustices.
  - **Equitable healthcare access:** Advocating for equitable access to healthcare services for all.
- **Community Events:** Participating in fundraisers and campaigns that align with our mission and community needs.
- **Public Education:** Raising awareness about health issues and the importance of healthy practices, including culturally-relevant approaches.
- **Sharing Results:** Communicating the results of quality improvement initiatives and progress towards organizational and health system goals.
- **Transparency and Accountability:** Providing transparent information about our performance, including opportunities for improvement and planned initiatives.

Facilitating Transparency

We recognize the importance of transparency and trust. Therefore, we will share information about:

- **Services:** Comprehensive descriptions of our services, eligibility criteria, and referral processes.
- **Quality of Care:** Metrics and data illustrating our commitment to high-quality service delivery.
- **Performance Indicators:** Regular updates on progress towards goals, key performance indicators, and achievements.
- **Challenges and Opportunities:** Transparent communication about identified opportunities for improvement and planned improvement initiatives.
- **Results:** Sharing the outcomes of quality improvement initiatives and their impact on client care.

Methods of Information Sharing

The methods we use to share information will vary depending on the audience and accessibility considerations. Here are some examples:

- **Annual Public Reports:** Publish annual reports on our website and make them available in print upon request.
- **Annual General Meetings:** Host annual general meetings open to the public and stakeholders.
- **Website:** Make key information readily accessible on our website in various formats and languages.
- **Client Satisfaction Surveys:** Regularly conduct and share the results of client satisfaction surveys.
- **Media Communications:** Utilize press releases, media briefings, and interviews to share relevant information with the public.
- **Community Meetings:** Participate in community meetings to provide updates and address community concerns.
- **Multi-Language Resources:** Develop and disseminate key information in multiple languages to reach diverse audiences.

2 – BUILDING AND MAINTAINING AN EFFECTIVE GOVERNING BODY

2.1 – The governing body's composition is defined in a transparent manner.

GOV2.1.1 2.1.1 – The governing body achieves its defined objectives regarding its composition.

OBJECTIVE

YOUR CLINIC NAME is dedicated to effective governance. This policy outlines the factors considered when defining the objectives, composition, and competencies required for the governing body.

POLICY

Objectives

The governing body will establish clear objectives based on the following factors:

- **Roles and Responsibilities:** A well-defined framework outlining the governing body's roles and responsibilities (e.g., strategic oversight, risk management, financial accountability).
- **Decision-Making Areas:** Clear delineation of areas where the governing body holds decision-making authority.
- **Strategic Planning:** Alignment with the organization's strategic plan, goals, and objectives.
- **Legal and Regulatory Environment:** Compliance with relevant laws, regulations, and contractual obligations.

Composition

The size and composition of the governing body will be determined by considering the following factors:

- **Organizational Size:** The size and complexity of YOUR CLINIC NAME will guide the optimal board size.
- **Risks and Opportunities:** The board composition will reflect the organization's risk profile and potential opportunities.
- **Services Offered:** Representation on the board will consider the diverse services offered by YOUR CLINIC NAME.
- **Population Served:** The board will strive to reflect the demographics of the population served.
- **Legal and Regulatory Environment:** Relevant laws and regulations may dictate board composition considerations.

Member Competencies

The governing body will require a diverse range of competencies to effectively fulfill its responsibilities and support YOUR CLINIC NAME's vision, mission, and values. These competencies may be categorized as follows:

Attributes:

- **Integrity and Ethical Standards:** Board members must demonstrate unwavering integrity and a commitment to the highest ethical standards.
- **Judgment and Decision-Making:** Sound judgment and strong decision-making skills are essential for effective governance.
- **Empathy and Interpersonal Skills:** Compassionate understanding and the ability to build positive relationships are crucial.
- **Cultural Competency:** Sensitivity and respect for diverse cultures must be embedded within the board.
- **Community Commitment:** Board members should have a strong commitment to the health and well-being of the community we serve.

Subject-Specific Expertise:

- **Governance Activities:** Specific knowledge and experience in areas like quality and safety, law, finance, risk management, technology, human resources, and sustainability are crucial.
- **Lived Experience:** Including individuals with lived experience of addiction or mental health challenges enriches the board's perspective.

The governing body and the organization will maintain a competency matrix that outlines the required skillsets. This matrix may evolve to reflect changes in the organization's environment, or its vision, mission, and values.

Government Involvement

In jurisdictions where the government dictates the governing body's composition, YOUR CLINIC NAME will strive to:

- Provide expert input on the required competencies, diversity, perspectives, and structure for effective governance.
- Offer recommendations to promote board effectiveness and alignment with community needs.
- Participate fully within the framework established by the government.

GOV2.2.3 2.2.3 – The governing body documents the required operational conditions by which it functions.

OBJECTIVE

The governing body documents the required operational conditions by which it functions.

POLICY

1. **Documentation:** The governing body will maintain a comprehensive set of documents, often referred to as the governing body bylaws, charter, or constitution. These documents will detail the operational conditions and requirements of the governing body.
2. **Codes, Policies, and Procedures:** The governing body will establish and adhere to a set of codes, policies, and procedures that guide its operations and decision-making processes.
3. **Roles, Responsibilities, and Accountabilities:** The governing body will clearly define the roles, responsibilities, and accountabilities of the governing body as a whole and of individual members. These definitions will be documented and communicated to all members.
4. **Terms of Reference:** The governing body will establish terms of reference that outline the scope and limitations of its authority and responsibilities.

Evidence of Compliance:

1. **Documentation:** The facility maintains a comprehensive set of governing body documents, including bylaws, charter, and constitution.
2. **Meeting Minutes:** The facility maintains records of all governing body meetings, which include discussions and decisions related to operational conditions and requirements.
3. **Training Records:** The facility maintains records of training provided to governing body members on their roles, responsibilities, and accountabilities.

This policy will be reviewed annually to ensure its continued relevance and effectiveness in guiding the operations of our governing body.

GOV2.2.4 2.2.4 – The governing body ensures that each member acknowledges their accountabilities.

OBJECTIVE

The governing body ensures that each member acknowledges their accountabilities.

POLICY

YOUR CLINIC NAME is committed to ensuring that each member of the governing body acknowledges their individual roles, responsibilities, and accountabilities. This policy outlines the process for obtaining and documenting these acknowledgements.

Policy Guidelines:

1. **Acknowledgement of Accountabilities:** Each member of the governing body is required to acknowledge their individual roles, responsibilities, and accountabilities, as well as those of the governing body overall. This acknowledgement will be in the form of a signed statement.
2. **Signed Statement:** Each member will sign a statement that outlines their understanding and acceptance of their roles, responsibilities, and accountabilities. This statement will be reviewed and updated annually, or as needed.
3. **Documentation:** All signed statements will be documented and securely stored by YOUR CLINIC NAME. These documents will be accessible for review by the governing body and auditors.

Procedure:

1. **Preparation of Statement:** A statement outlining the roles, responsibilities, and accountabilities of each member and the governing body overall will be prepared.
2. **Review of Statement:** Each member will review the statement and seek clarification if needed.
3. **Signing of Statement:** Each member will sign the statement to acknowledge their understanding and acceptance of their roles, responsibilities, and accountabilities.
4. **Storage of Statement:** The signed statements will be securely stored in a designated location.
5. **Annual Review:** The signed statements will be reviewed and updated annually, or as needed.

Evidence of Compliance:

1. **Signed Statements:** YOUR CLINIC NAME maintains a record of all signed statements from governing body members acknowledging their roles, responsibilities, and accountabilities. (refer to *Schedule "A": Employee Acknowledgement Form* in the *SIM009 - Employee Handbook V9* and *Acknowledgement of Understanding all onboarding documents)*
2. **Annual Review Records:** YOUR CLINIC NAME maintains records of annual reviews of signed statements.

This policy will be reviewed annually to ensure its continued relevance and effectiveness.

GOV2.2.5 2.2.5 – The governing body follows the organization's code of conduct that includes procedures to address breaches of the code.

OBJECTIVE

The governing body follows the organization's code of conduct that includes procedures to address breaches of the code.

POLICY

YOUR CLINIC NAME's governing body is committed to upholding the organization's code of conduct and ensuring that all members adhere to the same behavioural expectations as the organization's workforce. This policy outlines the procedures for addressing breaches of the code.

Policy Guidelines:

1. **Code of Conduct:** The governing body will follow the organization's code of conduct, which describes the minimum behaviour expectations of everyone working in or on behalf of the organization.
2. **Accountability:** The governing body holds itself accountable to the same behaviour expectations as the organization's workforce.
3. **Addressing Breaches:** The governing body will follow the organization's policies and procedures on addressing breaches of the code by its members. This includes reporting, investigating, and resolving breaches.
4. **Sharing the Code:** The governing body will ensure that the organization shares the code of conduct with stakeholders.

Procedure:

1. **Reporting Breaches:** Any breaches of the code of conduct should be reported to a designated member of the governing body.
2. **Investigating Breaches:** The governing body will conduct a thorough investigation into any reported breaches of the code of conduct.
3. **Resolving Breaches:** The governing body will take appropriate action to resolve any confirmed breaches of the code of conduct. This may include disciplinary action, up to and including removal from the governing body.
4. **Sharing the Code:** The governing body will ensure that the code of conduct is shared with all stakeholders, including staff, volunteers, and clients.

Evidence of Compliance:

1. **Code of Conduct:** YOUR CLINIC NAME maintains a current copy of the organization's code of conduct. (refer to *YOUR CLINIC NAME Code of Ethics and Conduct_Nov 2022*)
2. **Breach Records:** YOUR CLINIC NAME maintains records of all reported breaches of the code of conduct, including the results of investigations and any actions taken.
3. **Stakeholder Communication:** YOUR CLINIC NAME maintains records of all communications sharing the code of conduct with stakeholders.

GOV2.2.6 2.2.6 – The governing body follows its defined meeting schedule.

OBJECTIVE

The governing body follows its defined meeting schedule.

POLICY

The governing body of YOUR CLINIC NAME is committed to maintaining a regular meeting schedule and ensuring the active participation of all members. This policy outlines the frequency of meetings, attendance requirements, and procedures for sharing the meeting schedule.

Policy Guidelines:

1. **Meeting Frequency:** The governing body will meet at least once every quarter, including the annual general meeting. Special meetings may be scheduled as required.
2. **Quorum:** A quorum, defined as a majority of the governing body members, must be present for a meeting to proceed.
3. **Virtual Attendance:** Members may attend meetings virtually via audio and/or video conferencing, if they cannot be physically present.
4. **Voting:** Decisions will be made by a majority vote of the members present. Each member has one vote, and the Chair has a casting vote in case of a tie.
5. **Meeting Schedule:** The governing body will share its meeting schedule with the organization and stakeholders.

Procedure:

1. **Scheduling Meetings:** The Chair, in consultation with the governing body, will schedule the meetings for the year.
2. **Notifying Members:** All members will be notified of the meeting schedule and any changes to it.
3. **Sharing the Schedule:** The meeting schedule will be shared with the organization and stakeholders through appropriate communication channels.

Evidence of Compliance:

1. **Meeting Records:** YOUR CLINIC NAME maintains records of all governing body meetings, including attendance, decisions made, and voting outcomes.
2. **Communication Records:** YOUR CLINIC NAME maintains records of all communications sharing the meeting schedule with the organization and stakeholders.

GOV2.2.7 2.2.7 – The governing body ensures its members can access required information before meetings, with enough time for members to prepare for meetings and be ready to make informed decisions.

OBJECTIVE

The governing body ensures its members can access required information before meetings, with enough time for members to prepare for meetings and be ready to make informed decisions.

POLICY

The governing body of YOUR CLINIC NAME is committed to ensuring that all members have access to the necessary information in a timely and accessible manner to prepare for meetings and make informed decisions. This policy outlines the procedures for distributing meeting materials and ensuring members have adequate time to review them.

Policy Guidelines:

1. **Access to Information:** The governing body will ensure that all members can access the required information before meetings. This includes making the information available in electronic and paper formats, and in languages and at a literacy level that is accessible to all members.
2. **Time for Preparation:** The governing body will outline in its operational documents (e.g., terms of reference) the amount of time that is required for members to review the information before meetings. The governing body will ensure that this time requirement is met.
3. **Explanation of Content:** The governing body will ensure that any abbreviations or technical terms in the meeting materials are clearly explained.

Procedure:

1. **Distribution of Information:** The governing body will distribute the necessary information to all members well in advance of meetings.
2. **Time for Review:** The governing body will ensure that members have adequate time to review the information and prepare for meetings.
3. **Accessibility:** The governing body will ensure that the information is accessible to all members, taking into account their preferred format, language, and literacy level.

Evidence of Compliance:

1. **Distribution Records:** YOUR CLINIC NAME maintains records of when and how meeting materials were distributed to governing body members.
2. **Meeting Preparation:** YOUR CLINIC NAME maintains records of the time provided for members to review meeting materials.

Here are the steps that would be taken to ensure effective communication and preparation for meetings:

1. **Meeting Agenda Preparation:** A detailed agenda is prepared at least one week before the meeting. This includes all the topics/items to be discussed during the meeting.

2. **Email Communication:** At least three days before the meeting, the meeting agenda is emailed to all team members. This email includes the date and time of the meeting, the platform (if it's a virtual meeting), and the topics/items for discussion.
3. **Follow-Up Reminders:** A day before the meeting, a reminder email is sent to all team members, reminding them about the meeting and encouraging them to review the agenda if they haven't already done so.
4. **Open for Questions:** Team members are encouraged to reach out via email or in-person if they have any questions or need further clarification on any of the agenda items.
5. **Meeting Minutes:** After the meeting, meeting minutes are sent out to all team members, summarizing the discussions and decisions made during the meeting. This ensures everyone is on the same page, even if they were unable to attend the meeting.

GOV2.2.8 2.2.8 – The governing body provides an up to date orientation for its new members.

OBJECTIVE
Orientation and training records are kept for all staff.

POLICY
YOUR CLINIC NAME maintains extensive and relevant personnel records in a confidential manner in compliance with all applicable laws and standards.
New Employee Orientation (NEO) is provided to ensure that all new YOUR CLINIC NAME Imaging employees have the information, resources, and support necessary for an easy and successful transition into their new job.
The following topics will be discussed:

- The Mission, Vision, Values and Strategic Plan of YOUR CLINIC NAME
- YOUR CLINIC NAME Personal Service Expectations
- Tour of the YOUR CLINIC NAME Facilities
- Policies and Programs
- Employee Health and Safety
- Patient Safety
- Infection Control
- Emergency Procedures
- Employee Benefits
- Personal protective equipment (PPE)
- Ergonomics
- Confidentiality and Privacy
- Information System Training
- Management Of Aggressive Behaviour
- Medical Gas Storage And Management

YOUR CLINIC NAME maintains a personnel file for each employee for which they have access. The personnel file includes such information as the employee's job application, resume, and records of training, documentation of performance evaluation, immunization records and other employment records.
Personnel files are the property of YOUR CLINIC NAME and access to the information they contain is protected. Generally, only the HR manager, Office manager and senior management of YOUR CLINIC NAME who have legitimate reason to review information in a file are allowed to do so. It is the responsibility of each employee to promptly notify YOUR CLINIC NAME of any changes in personnel data. Personal mailing addresses, phone numbers, individuals to be contacted in the event of emergency, educational accomplishments, and other such status reports should accurate and current at all times. If any personal data has changed, please inform HR.

ORIENTATION OVERVIEW AND CHECKLIST

OBJECTIVE

To ensure that all staff employed by YOUR CLINIC NAME provides the top of the line service and prioritizes patient care. The orientation will familiarize staff with the facility such as the location of emergency supplies, location of exits, fire plans, as well procedures and policies to ensure patient safety and quality.

POLICY/PROCEDURE

New Staff - Orientation Package

YOUR CLINIC NAME management wants new staff members joining our team to feel comfortable and appreciated. We recognize that joining a new organization can be stressful at first, even intimidating. To make this as painless as possible, new staff members will be assigned a "buddy", who will be available to orient the new staff member and answer questions until satisfactory orientation has been achieved.

Our Orientation Package includes:

- Welcome, Letter of Appointment.
- TD 1 form, to be completed.
- Benefits information.
- Automatic Banking information.
- Position description.

Letter of Employment

This letter includes the following:

- Name of new employee, position and status of position being offered.
- Start date.
- Start salary.
- Vacation and personal day entitlement, benefit and pension plan eligibility.
- Probation period.
- Request for S.I.N., TD1, bank, address/phone, current active registration card if applicable.
- Misc. information.

The following orientation material will be provided to all staff:

ORGANIZATIONAL ORIENTATION

- Mission, vision, and values of the organization
- Sensitivity to cultural and religious diversity
- Relevant policies and procedures related to performing the duties of the position
- Roles and responsibilities of the individual and key staff
- Patient rights and patient consent
- Patient safety (e.g. adverse events and critical incident reporting)
- Patient identification

Guidance: Staff must also be oriented to their responsibilities during the universal protocol, if appropriate.

PATIENT FOCUS AND SAFETY

- Patient confidentiality
- Information management processes and systems
- Management of infectious materials including routine precautions, needle stick injury

PROTOCOL, PERSONAL PROTECTIVE EQUIPMENT

- Sharps handling and disposal
- WHMIS and other local, provincial and federal requirements
- Injury prevention and reporting staff injuries (e.g. use of patient lifts and transfer devices)
- Management of aggressive behaviour
- Violence and harassment in the workplace
- Emergency response/codes
- Fire safety
- Disaster response ‘
- Hand Hygiene education

GENERAL FACILITY

- Exits
- Door security
- Fire routes
- Fire pull stations
- Fire extinguishers
- Washrooms
- Staff lunch room
- Staff fridge
- Water cooler
- Office locations
- Phone intercom system
- Review booking procedure
- Review billing procedure
- Review linen services
- Review Radiologist contact information

REGISTRATION PROCEDURES

- Patient registration
- Protocol selection
- Scanning process
- Sending patient information to EMR
- Burning CDs

New Employment Information

Personal Information	
Start date (DD/MM/YYYY)	
Employee Social Insurance No.	
First name	
Middle name	
Last name	
Gender	
Citizenship	
Home address	
Home phone	
Cellular phone	
Home e-mail address	
Birthday (DD/MM/YYYY)	
Emergency Information	
Emergency contact's name	
Relationship	
Address	
Phone number(s)	
Direct Deposit Information	
Transit (Branch) Number	
Financial Institution	
Financial Institution Number	
Account Number	

New Employee Orientation Checklist

Manager/Supervisor: _____

Work Location: _____

Each new staff member and their immediate supervisor are required to **complete this Orientation Checklist** before starting work. After all the topics below have been reviewed and are clearly understood by the employee, please sign below and return to Manager/Supervisor.

COMPANY POLICY/PROCEDURE	Initials	LOCAL TOUR	Initials
Mission, vision and values of the organization		Exits, stairwells, access points	
Sensitivity to cultural and religious diversity		Fire pull stations	
Relevant policies and procedures related to performing the duties of the position		Extinguishers	
GENERAL POLICY/PROCEDURE		Emergency eye wash stations	
Role and responsibilities of the individual		Locations of personal protective equipment	
Patient rights and patient consent		Other:	
Patient safety		**SAFETY/EMERGENCY PROTOCOLS**	
Patient identification		**First Aid:** Calling for first aid	
Patient confidentiality		Location of FA/Crash cart equipment	
Information management processes and systems		**Fire:** Acronym RACE	
SAFETY		Evacuation procedure/Your role/Muster	
Management of infectious materials including routine precautions, needle stick injury protocol, personal protective equipment		Hand hygiene education (Appendix Hand Hygiene Education) No nail polish for staff with Pt direct contact	
Sharps handling and disposal		**QUALITY**	
WHMIS: • Accessing MSDSs • Safe work procedures for hazardous products in workplace • Location of spill kit		Orientation and training is provided to existing staff in response to the changing roles, technology, competency demands, laws and regulations or after and extended absence.	
Personal Protective Equipment: • Infection prevention and control • Gowns/gloves/masks and use • Clothing (as applicable) • Eye protection • Respiratory Protection Program (includes fit testing		• Imaging system and ancillary equipment use, maintenance and safety features • Information management system functions relevant to position • Continuing education	
Injury prevention and reporting staff injuries			
Management of aggressive behavior			
Violence and harassment in the workplace policies			

Supervisor Signature: _____ Initials: _____ Date (yyyymmdd): _____

Employee Signature: _____ Initials: _____ Date (yyyymmdd): _____

GOV3.3.3 – 3.3.3 – The governing body ensures that the organization establishes procedures to regularly evaluate the performance of clinical service providers who have been granted privileges and address any performance issues identified.

OBJECTIVE

The governing body of YOUR CLINIC NAME is committed to ensuring that the organization's procedures to evaluate the performance of clinical service providers who have been granted privileges are focused on setting the provider's performance and professional development goals and targets, and monitoring the provider's progress toward them. This policy outlines the procedures for performance evaluation and addressing performance issues.

POLICY

1. **Performance Evaluation:** The governing body ensures that the performance evaluation procedures require clear performance targets to be set for each provider, so the provider is aware of what is expected of them and can make it part of their professional development goals.
2. **Measures of Performance:** The governing body ensures that the performance evaluations include measures of skills, behaviours, performance, and outcomes.
3. **Addressing Performance Issues:** The performance evaluation procedures include steps to address identified performance issues, such as restriction, suspension, or removal of privileges, or cancellation of the appointment by the relevant authority.
4. **Role of Performance Evaluations:** The performance evaluations play an important role in the organization's accountability to stakeholders and in advancing the organization towards its people-centred care and health and safety goals.

Procedure:

1. **Setting Performance Targets:** The organization sets clear performance targets for each clinical service provider who has been granted privileges.
2. **Conducting Performance Evaluations:** The organization conducts performance evaluations based on the set targets and monitors the provider's progress toward them.
3. **Addressing Performance Issues:** The organization follows its procedures to address identified performance issues.

Evidence of Compliance:

1. **Performance Targets:** YOUR CLINIC NAME maintains a current copy of the performance targets set for each clinical service provider.
2. **Performance Evaluations:** YOUR CLINIC NAME maintains records of all performance evaluations conducted for clinical service providers.
3. **Performance Issue Records:** YOUR CLINIC NAME maintains records of all actions taken to address performance issues.

YOUR CLINIC NAME strives to provide a safe environment of mutual respect for both patients and staff. Any instances which may result in conditions contrary to this need to be reported investigated and dealt with.
An Incident/Accident Report needs to be completed as soon as possible by the staff member involved in the incident. As much information and context as possible should be provided including names, time and a detailed description of the incident. This information may be used to evaluate and, where appropriate, adjust our policies and procedures to ensure the safest and most respectful environment possible.
For all events involving injury or potential injury to patients, visitors or staff, the investigations, conclusions and any treatments prescribed by our medical staff must be recorded in full detail as soon as possible.

EXAMPLES OF INCIDENTS TO REPORT:
Any instances of inappropriate, disrespectful or abusive behaviour by patients, companions or staff towards anyone else in our office.
Procedure to follow in these situations:

- Approach and cautiously engage the parties in conversation.
- Explain clearly and respectfully that the behaviour is not appropriate and may be causing discomfort or distress to other patients and staff in our facility.
- If the behaviour is not corrected, the individuals involved may be requested to leave the premises.
- If at any time you are not comfortable dealing with the situation, do not hesitate to call upon a supervisor, manager or Radiologist to take over or assist.
- Any sudden, unexpected, or unusual occurrences. These may not involve actual physical injury, But may be situations or incidents with a “risk” of injury.

Please see

PR-004 - Complaints Management Residents

SIM009 - Health and Safety Manual

ADVERSE EVENTS POLICY

Prevention of unintended and accidental medical exposure

- The introduction of safety barriers at identified critical points in the radiology pathway, with specific quality control checks at these points. Quality control is not confined to physical tests or checks but can include such as actions as correct identification of the patient.
- Actively encouraging a culture of always working with awareness and alertness.

Whenever possible or necessary, staff should inform patients at the commencement of a procedure as to the limits of our patient confidentiality obligations, including any circumstances under which such information may be disclosed without consent. When disclosure becomes necessary, staff should inform patients regarding the information to be disclosed, to whom it will be conveyed and the reasons for the disclosure.

From the Privacy Toolkit:
The privacy officer should also do the following to protect personal information stored in EMRs:

- Create a unique user ID and strong password for every authorized user.
- Grant role-based access to staff working in the practice on an individual basis based on a "need to know" and "least privilege" principles.
- Revoke user IDs and passwords as soon as authorized users resign or are dismissed.
- Install strong, up-to-date, industry-standard encryption.
- Implement password changes forced at regular intervals.
- Install firewall software and regularly update internet-based computer systems.
- Create audit trails to track when a patient record is accessed and by whom, including date and time.
- Verify that data backup methods and disaster recovery plans are in place and are periodically reviewed and tested.
- Activate password protected screensavers or auto log out for computers after a period of inactivity to avoid unauthorized viewing.
- Consider installing a privacy screen filter to prevent viewing of the screen from an angle.

OBJECTIVE
Electronic medical records are backed up and the backup is securely located in a separate physical location.
Guidance: Electronic records database back-up is performed to prevent deletion or loss of information. Back-up should be performed regularly. Although the board does not specify the frequency of back-up, it is recommended that electronic records database back-up be performed each day

POLICY
All backup strategies will serve the purpose of storing and making data directly available for as long as prescribed by the Periods for Retention. Data storage will be redundant and fully automated. A scheduled maintenance has been implemented for the servers and network equipment. Proactive maintenance can reduce.

potential issues and increase availability and performance of the network.
Proper network infrastructure can provide the company with reliable, secure and high performing systems that ensure that outages and disruptions are minimized. Having the proper scheduled maintenance and warranties also ensures that potential problems are minimized and that in case of failure the time to resolution is predictable.

Implement a network monitoring software that can gather information and provide alerts on a 24/7 basis. Being able to identify issues before they become problems can reduce interruption to business and lost time.

GOV4.2.2 4.2.2 – The governing body regularly evaluates the performance of its chair to provide them with feedback based on the results.

OBJECTIVE

This policy outlines the process for conducting regular evaluations of the performance of the Chair of the Governing Body at YOUR CLINIC NAME. Effective leadership from the Chair is essential to ensure the smooth operation, strategic direction, and accountability of the governing body.

POLICY

Evaluation Frequency and Process

- The performance of the Chair will be formally evaluated annually.
- This evaluation may be supplemented by informal feedback throughout the year.
- The evaluation will utilize a combination of approaches:
    - **Self-Assessment:** The Chair will complete a self-assessment questionnaire reflecting on their performance against established criteria.
    - **Peer Feedback:** Governing body members will confidentially provide feedback on the Chair's leadership through a survey or facilitated discussion.

Evaluation Criteria

The evaluation will assess the Chair's performance in the following key areas:

- **Achievement of Roles and Responsibilities:**
    - Effective facilitation of governing body meetings, ensuring orderly and productive discussions.
    - Clear and concise communication of information and agenda items.
    - Promotion of collaboration and participation among governing body members.
    - Representation of the governing body to external stakeholders.
    - Fulfilling leadership functions between meetings, including representing the governing body in relevant dealings with the CEO.
- **Adherence to Values and Ethics:**
    - Upholding the values and ethical principles of YOUR CLINIC NAME and the governing body.
    - Ensuring fair and respectful treatment of all governing body members.
    - Avoiding conflicts of interest and managing potential conflicts effectively.
- **Meeting Attendance and Preparation:**
    - Consistent attendance at governing body meetings and committee meetings (if applicable).
    - Thorough preparation for meetings, including reviewing agenda materials and anticipated discussions.
- **Leadership and Follow-Through:**
    - Providing clear direction and strategic guidance to the governing body.
    - Effective management of discussions and decision-making processes.
    - Ensuring follow-through on action items and implementation of governing body decisions.

GOV6.1.2 6.1.2 – The governing body implements an action plan, in partnership with Indigenous partners, to address Indigenous-specific systemic racism in the organization.

OBJECTIVE

POLICY

This action plan, co-developed with Indigenous partners representing First Nations, Inuit, and Métis communities, outlines concrete steps to dismantle Indigenous-specific systemic racism at YOUR CLINIC NAME. It aligns with the Truth and Reconciliation Commission of Canada's Calls to Action and prioritizes a distinction-based approach that recognizes the unique needs and perspectives of each Indigenous population.

Themes and Priorities

1. **Cultural Competency and Safety**
    - **Activities:**
        - Develop and deliver culturally competent training for all staff and governing body members, co-designed with Indigenous partners.
        - Integrate cultural safety principles into service delivery models and all client interactions.
        - Develop resources and protocols for respecting diverse spiritual practices and traditional healing approaches.
    - **Roles and Responsibilities:**
        - **YOUR CLINIC NAME:** Allocate resources and staff time for training development and delivery.
        - **Indigenous Partners:** Provide expertise and guidance on cultural competency training content and delivery methods.
    - **Measurement:**
        - Track staff and governing body member participation in cultural competency training.
        - Conduct client satisfaction surveys to assess their experience of cultural safety and respect.
2. **Indigenous Leadership and Representation**
    - **Activities:**
        - Increase Indigenous representation on the governing body through targeted recruitment strategies.
        - Establish an Indigenous Advisory Committee to provide guidance and feedback on policies and service delivery.
        - Encourage and support career development opportunities for Indigenous staff.
    - **Roles and Responsibilities:**
        - **YOUR CLINIC NAME:** Develop recruitment strategies that attract qualified Indigenous candidates for board and staff positions.
        - **Indigenous Partners:** Identify potential board and staff candidates and participate in the recruitment process.
    - **Measurement:**
        - Track the number of Indigenous members on the governing body and staff.

- Gather feedback from the Indigenous Advisory Committee on their impact and effectiveness.

3. **Equitable Access to Services**
    - **Activities:**
        - Conduct a comprehensive review of service delivery models to identify and address any barriers for Indigenous clients.
        - Expand access to culturally appropriate resources and translation services.
        - Develop outreach programs to raise awareness of services among Indigenous communities.
    - **Roles and Responsibilities:**
        - **YOUR CLINIC NAME:** Allocate resources for service delivery review and implementation of identified changes.
        - **Indigenous Partners:** Collaborate in the service delivery review to ensure its effectiveness for their communities.
    - **Measurement:**
        - Analyze data on Indigenous client access to services compared to non-Indigenous clients.
        - Track utilization rates of culturally appropriate resources and translation services.
4. **Indigenous-led Healing and Wellness**
    - **Activities:**
        - Develop partnerships with traditional healers and Indigenous knowledge keepers.
        - Integrate trauma-informed care approaches that acknowledge historical and intergenerational trauma.
        - Develop culturally appropriate holistic care plans, incorporating traditional healing practices when desired by clients.
    - **Roles and Responsibilities:**
        - **YOUR CLINIC NAME:** Establish partnerships with Indigenous healing practitioners and provide appropriate cultural spaces within the facility.
        - **Indigenous Partners:** Identify and connect YOUR CLINIC NAME with traditional healers and knowledge keepers.
    - **Measurement:**
        - Track the number of partnerships established with Indigenous healers and knowledge keepers.
        - Monitor client satisfaction regarding the integration of traditional healing practices in their care plans.
5. **Anti-Racism Education and Continuous Learning**
    - **Activities:**
        - Provide anti-racism training for all staff and governing body members, exploring Indigenous-specific experiences of racism in healthcare.
        - Develop a multi-module training program on Indigenous-specific racism in healthcare, delivered by Indigenous facilitators with expertise in the subject matter. The training program will include the following core modules:
            - **Module 1: Introduction to Indigenous Peoples and Cultures:** This module will provide a broad overview of the diverse histories, cultures, and traditions of First Nations, Inuit, and Métis peoples in Canada. It will challenge stereotypes and misconceptions about Indigenous peoples and emphasize the importance of cultural humility.