PART IV

Board Policies

OVERVIEW

The Board of Directors in governing The Perley and Rideau Veterans' Health Centre (Perley Health) is guided by a number of authorities. At the highest level is the legislation, set by government bodies, to which Perley Health must comply. These are augmented by the articles of incorporation that have been filed with relevant government authorities and by the Perley Health By-Laws.

Within this framework of authorities, the Board adopts "Policies" or statements of intent that provide principles to guide decisions and conduct in the pursuit of desired outcomes for Perley Health.

Board Policies set the rules by which the organization is expected to fulfill its responsibilities in carrying out the corporate mission. Board Policies reflect high-level thinking, leaving operational detail to responsible managers.

In addition to Board Policies, Management adopts policies, guidelines, protocols and procedures to guide, direct and control the day-to-day functioning of the organization.

Board Policies must be approved by resolution of the Board and must be recorded in the Board decision record (see the ***Appendix*** for the process leading to approval). Once approved, they are direction to the Board, Board members and Management as to how to conduct themselves in the execution of their responsibilities to Perley Health.

Board Policies must include:

- Title, date, authorization (including signature);
- Statement of the Board Policy;
- Roles and responsibilities (the Board Chair, the Board as a whole, Committees, Management); and
- Review – how the Policy is to be monitored, by whom, and the frequency.

The Board shall review Part IV as required, or at least every three years.

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Appendix
to the Board Policy Overview

Process for Approval of Perley Health Board Policies

The process for approval of Board Policies is as follows:

1. The sponsoring Committee and/or management develops a Policy and it is approved at the Committee level. Note: It is recommended that policies under consideration by Board Committees be developed in consultation with the Board Chair and CEO.

2. The Committee submits the Policy to the Governance Committee for review (context, completeness, consistency relative to other Board Policies, etc.). The Governance Committee Chair discusses the Policy with the submitting Committee Chair, if required.

3. The Chair of the sponsoring Committee recommends the Policy for Board approval at the next Board meeting that the Board Chair feels would be suitable. The recommended Policy may be a stand-alone item for decision in the Board agenda or it may be included in Part II of the Board's Consent Agenda along with a Briefing Note.

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Index of Board-Approved Policies

The Board-approved Policies in this Part are in chronological order according to their policy numbers. Original policy approval dates are noted on the policies, along with revision dates, if applicable.

Policy Number	Board Policy re:
BOARD-2014-01	**Culture of Safety**
BOARD-2014-02	**Official Languages**
BOARD-2014-08	**Advocacy on Behalf of Perley Health**
BOARD-2014-09	**Disclosure of Information**
BOARD-2014-10	**Smoking at Perley Health**
BOARD-2014-11	**Honouring Perley Health's Military Heritage**
BOARD-2015-01	**Community and Stakeholder Engagement**
BOARD-2015-02	**Partnering Arrangements & Risk**
BOARD-2015-03	**Shared Governance Oversight for Clinical Partnering Arrangements**
BOARD-2016-01	**Cash Management and Investment Policy Statement** "The Ted Gordon Cash Management and Investment Policy Statement"
BOARD-2017-01	**Code of Ethical Conduct** Appendix A: **Core Values of Perley Health** Appendix B: **Residents' Bill of Rights** Appendix C: **Board Process for the Resolution of Ethical Issues**
BOARD-2020-01	**Corporate Identity**
BOARD-2020-02	**Procurement Approval Authority**
BOARD-2021-01	**Research Activities**
BOARD-2021-02	**Enterprise Risk Management**

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Perley Health

Policy

Classification:	General	**Number:**	**BOARD-2014-01**
Category:	Administration	**Date:**	**02Mar2023 – R** 04Nov2021 – R 05Nov2020 – R 03May2018 – R 01May2014 – R 02May2013 – O
Issued by:	Chair of the Board		
Authorized by:	Board of Directors		

Board Policy re: Culture of Safety

Statement of Board Policy

The Perley and Rideau Veterans' Health Centre (Perley Health) promotes and supports a culture of safety whereby the safety of residents, tenants, clients, families, staff, volunteers, and visitors is a priority commitment held by every employee, every team and every department at every level and by the Board itself. This is aligned with the fundamental principle of the *Fixing Long-Term Care Homes Act (2021)*, which states that: *"…a long-term care home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met."*

At Perley Health, safety is an integral aspect of the quality of care and services for residents and clients. In providing care and services, Perley Health shall ensure that the care and services are safe, ethical, effective and person- and family-focused in a safe and healthy work environment for staff and volunteers.

Perley Health shall ensure that measures are put in place to contribute to reducing injury, accidents and adverse events while carrying out the complex and risk-prone work of a health care organization that serves the frail and elderly. As part of ensuring a culture of safety, Perley Health shall proactively strive to improve its processes and systems based on information gained through monitoring, analysis, improvement and feedback.

Principles

The following principles support Perley Health's culture of safety:

- Safety is a commitment and priority of every employee and team at every level. In an organization with a vulnerable population like Perley Health, safety, respect, and quality must all be at the forefront.

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- Disciplinary processes are kept separate from safety management and improvement. Individuals and teams are accountable for adverse events and near misses, but the focus is on the problem, not on any individual.

- There is zero tolerance for abusive, negligent, or reckless behaviour.

- Firearms, as defined in section 2 of the Criminal Code of Canada, are not permitted on the Perley Health Campus, with the exception of those carried by peace officers in the course of their duties.

- Full disclosure about client or work safety issues is essential. Timely reporting and communication of safety performance measures, adverse conditions and occurrences, negative trends and sentinel events is expected, as is their follow-up (to the Board if warranted), and includes disclosure to clients and families, as appropriate to the situation.

- Full disclosure requires a culture of trust and respect whereby persons observing unsafe acts, events or conditions can report their safety concerns in confidence, and will not be subject to retribution in any form by Perley Health personnel.

- A culture of safety is based on interdisciplinary and cross-functional learning, collaboration and shared decision-making that is resident-focused and based on continuous quality improvement.

- A culture of safety takes risk management beyond prescribed tasks to pro-active assessment and improvement of unsafe conditions, processes and systems.

- A culture of safety, quality and respect is a 'reflective culture' in which performance and improvement are supported and informed through the systematic gathering of information, measurement and performance data, benchmarking, analysis for root causes and trends, follow-up and review.

- A culture of safety is an integrated whole within the organization. Resident safety, environmental safety, staff and volunteer wellness, safety and preparedness, and human resources practices reinforce and support each other.

Roles and Responsibilities

The Board:

The Board shall provide visible and committed leadership in effecting a culture of safety.

The Board shall consider Perley Health's safety performance in evaluating the CEO's performance annually.

The Quality of Life and Safety Committee:

The Quality of Life and Safety Committee has general oversight of this Policy, its implementation and its review and shall provide oversight and monitor the priorities, progress and outcomes of the safety and quality improvement plan developed by the CEO.

The Chief Executive Officer (CEO):

The CEO shall provide leadership to Management in effecting a culture of safety.

The CEO shall develop and implement an integrated *safety and quality improvement plan* reflecting the goals of this Policy and provide *sufficient resources* to implement and sustain the plan.

The CEO shall keep the Board apprised of significant safety-related variations from the *safety and quality improvement plan* and significant safety events.

Policy Review

The Board shall review this Policy and its implementation (including the *safety and quality improvement plan*) as required, or at least every three years.

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Perley Health

Policy

Classification:	General	**Number:**	BOARD-2014-02
Category:	Administration	**Date:**	**04Nov2021 – R** 05Nov2020 – R 03May2018 – R 01May2014 – O
Issued by:	Chair of the Board		
Authorized by:	Board of Directors		

Board Policy re: Official Languages

Statement of Board Policy

The Perley and Rideau Veterans' Health Centre (Perley Health) shall seek to provide services to all residents, clients and tenants in the official language of their choice. This goal may be constrained from time to time by resource issues and availability of translators.

Under the terms of the 1992 Transfer Agreement between Veterans Affairs Canada and the Ontario Ministry of Long-Term Care, Perley Health is obligated to provide care and treatment to **Veterans** in the official language of their choice.

Roles and Responsibilities

The Board:

The Board, as part of its fiduciary oversight, is responsible for ensuring that the affairs of Perley Health are conducted in accordance with the law.

The Quality of Life and Safety Committee:

The Quality of Life and Safety Committee has general oversight of this Policy, its implementation and its review.

The Chief Executive Officer (CEO):

The CEO shall, to the extent feasible, ensure that residents, clients and tenants receive services in the official language of their choice.

The CEO shall ensure that the care and treatment of Veterans is in the official language of their choice and that these services and any program that has a bilingual designation are provided with resources to ensure it meets its language obligations.

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Policy Review

The Board shall review this Policy and its implementation as required, or at least every three years.

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Perley Health

Policy

Classification:	General	**Number:**	BOARD-2014-08
Category:	Administration	**Date:**	**04Nov2021 – R** 07May2020 - R 03May2018 – R 06Nov2014 – R 02June2011 – O
Issued by:	Chair of the Board		
Authorized by:	Board of Directors		

Board Policy re: Advocacy on Behalf of Perley Health

Statement of Board Policy

Advocacy on behalf of The Perley and Rideau Veterans' Health Centre (Perley Health) and its clients shall be undertaken as a planned and focused process that aims to influence or change public policy or resource allocation while supporting Perley Health's mission, vision or strategic goals.

Advocacy as used in this Policy includes lobbying. Lobbying is a form of advocacy where a direct approach is made to legislators and other public representatives.

Principles

1. Advocacy that is undertaken by Perley Health must be consistent with the ethics and values of Perley Health.
2. Advocacy is a responsibility that shall be shared between the Board, the Board Chair and the CEO.
3. The CEO or the Board Chair or their delegate is the official spokesperson for advocacy on behalf of Perley Health unless the Board has specifically delegated another spokesperson.
4. Advocacy activities must comply with the applicable laws of Canada. As a registered charity, Perley Health is prohibited from engaging in partisan political activities. This includes the direct or indirect support of a political party, fund raiser or candidate by a representative or spokesperson for Perley Health, in fact or perception.
5. The organization and its leaders must not be drawn into calls for political action or advocating for the needs or goals of broader client groups that are not consistent with those of Perley Health.
6. While in some cases, an independent approach to advocacy may be considered, Perley Health shall endeavor to partner or collaborate in the advocacy process with other like-minded stakeholders, including funders, who share common objectives or who provide services to the same population or client groups.
7. Information about advocacy activities will be shared on an as needed basis with the Perley Health Foundation (the Foundation).

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Context

In a complex, competitive and constantly changing world, advocacy is a recognized and vital part of positioning the organization and influencing or effecting beneficial change for the organization and its clients.

Roles and Responsibilities

The Board:

- Advocacy issues may arise through the strategic planning process or independently as a result of individual issues or external appeals. The Board is responsible for determining and approving what advocacy issues are to be advanced. In approving advocacy issues, the Board shall ensure that:
  - they are aligned with Perley Health's mission, values, principles, vision and strategic plan;
  - that sufficient resources are available to sustain the activities; and
  - if needed, a spokesperson other than the Board Chair or CEO is designated.
- In rare cases where a strategic level advocacy issue is both opportune and immediate, the CEO and Board Chair, together, shall come to a decision as to the necessity of taking preliminary action on the issue prior to it being taken to the Board for discussion and further direction.
- The Board monitors and oversees the effectiveness of the advocacy activities of Perley Health.
- The Board shall consider the CEO's leadership and collaborative role in advocacy in evaluating the CEO's annual performance.

The Chief Executive Officer (CEO):

- The CEO, with advice from the Board Chair, shall identify advocacy opportunities and develop an advocacy strategy for Board approval. In developing the strategy, the CEO shall follow the principles outlined in this Policy.
- The CEO, with support from the Board Chair or designated spokesperson, is responsible for carrying out advocacy activities.
- The CEO shall advise the Board of any significant variations from the advocacy strategy and shall inform the Board, in a timely, open and transparent manner, of any risks or issues that arise during advocacy activities, thus allowing for the opportunity for Board discussion, advice or direction.

Policy Review

The Board will review this policy (and the implementation of the Perley Health Corporate Advocacy Plan) as required, or at least every three years.

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Perley Health

Policy

Classification:	General	**Number:**	**BOARD-2014-09**
Category:	Administration	**Date:**	**04Nov2021 – R** 05Nov2020 – R 02Oct2014 – R 14Feb2013 – O
Issued by:	Chair of the Board		
Authorized by:	Board of Directors		

Board Policy re: Disclosure of Information

Statement of Board Policy

The Perley and Rideau Veterans' Health Centre (Perley Health) shall:

- be open and transparent in relation to matters that are in the public interest;
- comply with all laws and regulations that require or prohibit the release of any information; and
- favour more release of information rather than less.

In taking decisions on the release of information, Perley Health shall:

- take into consideration that its businesses that are government- and donor-funded have different legal requirements for the disclosure of information from non-public businesses funded through private or market sources;
- treat the release of information not governed by current laws, regulations or publicly funded accountability requirements, such as information related to non-government funded programs and services, to be broadly discretionary;
- protect the confidentiality of its internal discussions leading to Board decisions; and
- refrain from disclosing non-governmental information that would negatively impact the best interests of the Corporation.

Requests for information shall be processed as quickly as possible but normally within a month. Where requests, due to their magnitude or complexity, cannot be completed within a month, the requester shall be advised in writing of the delay and of the forecast date that the information will be provided.

Information shall generally be provided free of charge. Some requests may incur costs due to their magnitude and complexity. The requestor shall be advised in writing of the costs in advance of the request being actioned and arrangements for payment made.

Context

In an age where the public is demanding increased transparency from organizations, disclosure of information is vital to maintaining the credibility of Perley Health. At the same time, disclosure of

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information must be subject to the requirement to maintain Perley Health's legal and corporate responsibilities and to protect the privacy of individuals.

Roles and Responsibilities

The Board:

The Board is responsible for ensuring compliance with this policy and for ensuring that the affairs of Perley Health are conducted in accordance with the law.

The Board shall make itself available, upon request, to discuss and advise the Chair or the CEO on disclosure issues.

The Chair:

The Chair is responsible for managing disclosure for all Board and governance information requests.

The Governance Committee:

The Governance Committee has general oversight of this Policy, its implementation and its review.

Chief Executive Officer (CEO):

The CEO shall receive all requests for information related to both governance and corporate operations, including those related specifically to the Chief Executive Officer or the Secretary of the Board of Directors. The CEO shall ascertain whether the request is related to governance or corporate operations, and shall direct the request accordingly.

The CEO or his/her delegate is responsible for managing disclosure for all corporate information, consistent with this policy.

Policy Review

The Board shall review this policy and its implementation as required, or at least every three years.

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Perley Health

Policy

Classification:	General	**Number:**	BOARD-2014-10
Category:	Administration	**Date:**	**04Nov2021 – R** 05Nov2020 – R 04Apr2019 – R 06Nov2014– O
Issued by:	Chair of the Board		
Authorized by:	Board of Directors		

Board Policy re: Smoking at Perley Health

Statement of Board Policy

The Perley and Rideau Veterans' Health Centre (Perley Health) is a smoke- and vape-free facility. Smoking or vaping is not permitted in any of the Perley Health buildings. Smoking or vaping is **only** permitted outside of Perley Health buildings, a minimum of 9 metres from entrances and exits. This applies to tobacco and cannabis, aligned with the *Smoke-Free Ontario Act (2017)*.

This policy applies to residents, tenants, clients, families, staff, volunteers and visitors.

Roles and Responsibilities

The Board:

As part of its fiduciary oversight, the Board is responsible for ensuring that the affairs of Perley Health are conducted in accordance with the law, including the *Smoke-Free Ontario Act (2017)*.

The Governance Committee:

The Governance Committee has general oversight of this Policy, its implementation and its review.

The Chief Executive Officer (CEO):

The CEO shall monitor and enforce compliance with this policy.

To ensure the safety of all to whom this policy applies, the CEO shall ensure that a comprehensive smoking or vaping assessment, as applicable, is completed and reviewed regularly as necessary with each individual to whom this policy applies.

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Policy Review

The Board shall review this Policy and its implementation as required, or at least every three years.

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Perley Health

Policy

Classification:	General	**Number:**	**BOARD-2014-11**
Category:	Administration	**Date:**	**04Nov2021 – R** 05Nov2020 – R 04Dec2014 – O
Issued by:	Chair of the Board		
Authorized by:	Board of Directors		

Board Policy re: Honouring Perley Health's Military Heritage

Statement of Board Policy

The Perley and Rideau Veterans' Health Centre (Perley Health) is committed to:

- recognizing former Canadian Armed Forces members' unique contribution to Canada;
- honouring Perley Health's military heritage; and
- reflecting both the civilian community and the military culture of Perley Health.

The current "look and feel" of the Perley Health campus, which reflects both its military heritage and the general population of Ontario seniors, shall be preserved. Perley Health shall endeavour to have a significant number of activities, programs, services and apartments for former members of the Canadian Armed Forces.

Context

The Perley and Rideau Veterans' Health Centre has a long history dating back to 1897. In 1995, a number of institutions were brought together on the Perley Health campus. These included: the Perley Hospital (originally established as the Perley Home for Incurables in 1897 and renamed the Perley Hospital in 1955), the Rideau Veterans' Home established in 1945 and the Veterans' Wing of the National Defence Medical Centre established in 1961. Thus, Perley Health has for many years had a dual role of serving both Veterans and the community.

In recent years the services offered at Perley Health have expanded beyond long-term care to offer other services along the continuum of care. In addition, the organization has built independent living apartments. While the facilities and services offered are changing, the organization continues to serve Veterans and to honour its military heritage.

Roles and Responsibilities

The Board:

The Board is responsible for ensuring that Perley Health honours the Policy.

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The Governance Committee:

The Governance Committee has general oversight of this Policy, its implementation and its review.

The Chief Executive Officer (CEO):

The CEO shall implement this Policy in a practical manner, taking into account the operations and financial sustainability of Perley Health.

Policy Review

The Board shall review this Policy and its implementation as required, or at least every three years.

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Perley Health

Policy

Classification:	General	**Number:**	BOARD-2015-01
Category:	Administration	**Date:**	**04Nov2021 – R** 07May2020 – R 08Jan2015 – O
Issued by:	Chair of the Board		
Authorized by:	Board of Directors		

Board Policy re: Community and Stakeholder Engagement

Statement of Board Policy

The Perley and Rideau Veterans' Health Centre (Perley Health) shall engage and seek input from the community and stakeholders to guide its decision making related to its vision, mission and strategy, and to the effectiveness of its services or changes to them.

Perley Health shall develop an annual Community and Stakeholder Engagement Plan that is aligned with its Strategic Plan.

Principles

1. Community and stakeholder engagement undertaken by Perley Health must be strategic and client-focused, and targeted at those who will be most directly affected by the vision, strategy or actions of Perley Health.
2. Engagement must be timely, beginning early in the decision-making process so that key issues and concerns of the target group(s) inform operational or strategic decisions.
3. Engagement must be participatory and inclusive. Relevant parties must be given the opportunity to share their ideas and provide input into the development of alternatives and proposed solutions. Those with opposing viewpoints shall have adequate opportunity to participate and be heard. The process must include follow up with all participants and the outcomes of the engagement must be available to them.
4. Engagement must be respectful and trust- and values-based without ulterior motives, and free of manipulation and coercion; and communications must be open and transparent with clarity as to the desired outcome of the engagement.

Context

Perley Health undertakes community and stakeholder engagement to guide both its strategic decisions, as well as operational decisions. Community and stakeholder engagement helps Perley

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Health to understand the community context and perspective and to use this information to prevent or solve problems, foster social partnerships, and generally contribute to the quality of life in the community. It also helps to ensure that actual and perceived risks, along with potential gaps, inconsistencies or hardships arising from decisions, are understood and minimized or eliminated.

Community and stakeholder engagement is also a requirement of the *Local Health System Integration Act,* (2006). For this reason, Perley Health's service accountability agreement with Ontario Health East requires Perley Health to engage diverse communities, persons and entities when setting priorities for the delivery of health services and when developing plans for submission to the government.

In this Policy, ***community engagement*** refers to a broadly-based but purposefully-directed process that involves outreach or dialogue with a broader community or public; ***stakeholder engagement*** is a focused process to obtain input from, and foster dialogue with, specific individuals, groups or organizations that may be affected by decisions or that can influence the implementation of decisions through their support or opposition.

Roles and Responsibilities

The Board:

1. The Board is accountable for the *Perley Health Community and Stakeholder Engagement Plan* developed by the Strategic Planning Committee and management.

2. The Board shall be advised by the Strategic Planning Committee and the CEO of any strategic issues that may arise during the implementation or evaluation of the Plan.

3. The Board shall maintain a broad network of strategic relationships in support of Perley Health's mission, vision and strategic plan. The Board shall also seek to increase collaboration with stakeholders who share common objectives or who provide services to the same populations or client groups.

4. Perley Health may be required to balance competing, and sometimes conflicting, interests and priorities among communities and stakeholders. The Board shall, therefore, seek to understand all the various interests, needs and priorities to make the best decisions possible on behalf of Perley Health.

The Strategic Planning Committee:

1. The Strategic Planning Committee has general oversight of this Policy, its implementation and review.

2. The Strategic Planning Committee as part of the strategic planning or review process (in collaboration with the CEO and other Board committees as required) shall develop the *Perley Health Community and Stakeholder Engagement Plan*, recommend its approval to the Board and, on behalf of the Board, shall monitor its implementation, and oversee its evaluation and follow up.

3. The Strategic Planning Committee shall act as a sounding board for the CEO:
    a. in anticipating and assessing the strategic potential of specific communities or stakeholders to be affected by or to influence decision-making at Perley Health;

b. in assessing their particular interests, needs and priorities;
c. in developing plans and follow-up actions and responses.

The Chief Executive Officer (CEO):

1. The CEO is responsible for the management of all community and stakeholder engagements including strategic engagements that are part of the *Community and Stakeholder Engagement Plan*, as well as those engagements undertaken to inform operational decisions. In managing these engagements, the CEO shall follow the principles outlined in this policy and ensure that engagement processes include a plan for reporting results and follow-up actions to the Board.

2. The CEO shall inform the Board or the Strategic Planning Committee of any risks or issues which arise during engagement activities.

3. The CEO shall prepare Perley Health's *Community and Stakeholder Engagement Plan*.

4. The CEO shall prepare a quarterly *Stakeholder and Competitive Intelligence Report* for the Strategic Planning Committee assessing changes in the environment and risks.

5. The CEO shall report to the Board, through the Strategic Planning Committee, at least once a year, on the key engagements undertaken during the year. The report must include an assessment of the effectiveness of the engagements, the stakeholder and community response and the key learnings; and must include recommended follow up, as appropriate

Policy Review

The Board will review this policy and its implementation as required, or at least every three years.

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Perley Health

Policy

Classification:	General	**Number:**	**BOARD-2015-02**
Category:	Administration	**Date:**	06Oct2023 – R 04Nov2021 – R 05Nov2020 – R 07May2015 – O
Issued by:	Chair of the Board		
Authorized by:	Board of Directors		

Board Policy re: Partnering Arrangements and Risk

Statement of Board Policy

All partnering arrangements (as defined in Principle 1, below) with The Perley and Rideau Veterans' Health Centre (Perley Health) must align with its mission, vision, and strategic plan. Prior to entering into any Partnership Agreement management must assess the risks of partnership. This applies regardless of the type, form, or size of the arrangement.

Partnerships can provide benefits by bridging gaps in knowledge and expertise, adding capacity, providing access to cash flow, generating cost efficiencies, and providing new perspectives. However, there are risks to a partnership. When the potential negative impacts exceed the prospective benefits, material risk can occur. Significant risks include actions or circumstances that would negatively impact the intent, stability, sustainability, scope, or balance within Perley Health.

Where the risk of partnership is material or significant, Board approval is required prior to entering into the agreement.

When considering the approval of prospective partnering arrangements, Management should as a minimum consider the risks of partnership to include:

1) Strategic alignment,
2) Impact on reputation,
3) Resource implications of collaboration,
4) Loss of autonomy,
5) Conflict of interest, and
6) Lifecycle risk.

Principles

1. A partnering arrangement, typically described in a memorandum of understanding, a letter of intent, a partnership agreement, or some similarly structured document, may or may not be legally binding. For the purposes of this policy it is the function, not the form, type, or size of an arrangement that exposes Perley Health to the risks of partnership. However, it is not the intent

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of the policy to sweep in all contractual agreements. A non-exhaustive list of contractual arrangements not covered by this policy are service level agreements, commercial consulting contracts, vendor agreements, and union contracts.

2. Partnership risk descriptions.

   2.1. Strategic Alignment risk: There is a relational risk that an alignment with one partner may preclude opportunities with other desirable partners. There is a performance risk that a partnership does not create sufficient value to achieve the shared vision of the partners. There is a risk that a partnership does not have the capacity and motivation to sustain investment in changing business conditions or through adverse periods.
   2.2. Impact on reputation: the damage that can occur to the partners when the partnership fails to meet the expectations of its stakeholders and is thus negatively perceived. In the case of partnerships, there is an additional tangential risk that misdeeds by the partner will damage the good name of Perley Health.
   2.3. Resource implications of collaboration: when there are more players involved in a project, there is a diffusion of responsibility, which may lead to a decrease in an overall work performance and output. Groupthink is also a risk if certain players dominate within the partnership. This may result in poor decision making. Typically, collaborations require additional management, tracking, reporting and evaluation requirements causing diversion of resources from other areas.
   2.4. Loss of autonomy: the challenge of shared decision-making processes; the need for building consensus with partners before action can occur and the implications of wider accountability to others.
   2.5. Conflict of interest: while partners share a mutual interest in the outcome of the partnership, other internal goals of the two organizations may not align and differences in the priority of other organizational goals may create friction and underperformance.
   2.6. Life-cycle: throughout the term of a partnering arrangement the risks identified in paragraphs (2.1) through (2.5) are likely to evolve and the resultant change to the overall level of partnership risk may become material.

3. Evolving Risk Profiles. As articulated in paragraph (2.6) partnership risk may become material or significant throughout the life cycle (planning, selection/establishment, development/construction, service/operations, and dissolution) of partnering arrangements. For this reason, monitoring of this risk must continue throughout the lifecycle. Whether initially Board-approved or not, should the risks of a partnership increase to a material or significant level, Management will inform the **Board. The Board's guidance on the continuation of that partnership arrangement is required.**

4. A material impact is the potential negative outcome of:
   4.1. Financial losses: the lesser of 0.25% of revenue or 2.5% of reserves,
   4.2. Reduction of clients: A decline in clients greater than 5% of the existing client base,
   4.3. Increase demand on human resources: an increase in full time equivalent (FTE) hours greater than 1% of existing FTE hours.

5. Negative **impact on Perley Health's reputation as a result of delivery or outcome failures.** Management should consider the overall impact when two or more of the measures in (4.1) through (4.3) are increasing. While no individual measure may be considered material, Management should seek Board guidance if multiple measures are assessed as showing increased risk.

Context

Partnering arrangements form a vital part of the Perley Health vision and execution of its strategy. These arrangements, as defined in this Policy, include any arrangement based on common goals and commitments under which parties agree to cooperate to advance their mutual interests. Knowledge and management of the inherent and acquired risks associated with partnering arrangements form the base from which risk management approaches are developed. In turn, these risk management approaches mitigate the probability and/or magnitude of negative outcomes for Perley Health.

These arrangements may be with academic organizations, other service providers, health care agencies, physician groups, for-profit organizations, or other not-for-profit organizations. Complex partnering arrangements are likely to pose the highest overall risk. Complex arrangements are generally those involving: multiple client streams, joint delivery of care or services, multiple partners, multiple stakeholders, or multiple accountability streams.

Roles and Responsibilities

Per the section 3.8 of the **BOARD GOVERNANCE GUIDE FOR DIRECTORS**, the Terms of Reference (ToR) for each Committee outline specific responsibilities. The descriptions listed below provide an overview of the functions of the Board and Board Committees with respect to this policy. Specific requirements are in the ToR of an individual committee. Nothing in this policy supersedes a Committee's Terms of Reference.

Board of Directors

- The Board is responsible for policy approval, approving partnerships as required and, providing guidance to management when material partnership risk arises at any stage of the life-cycle of a partnering arrangement.
- The Board is responsible for ensuring that relevant strategic risks and opportunities are systematically identified and acted upon to the benefit of Perley Health.

Audit and Risk Committee

- The Audit and Risk Management Committee has general oversight of this Policy, its implementation and review.
- The Audit and Risk Management (ARM) Committee is responsible for ensuring that there is an ongoing process in place to monitor risks and to support discussion with the Board and action, as appropriate.
- The Audit and Risk Management (ARM) Committee shall assume a lead role on behalf of the Board when material issues of risk arise during the lifecycle of a partnering arrangement.
- The ARM Committee shall work in collaboration with other Committees of the Board and the Management team to produce a briefing document for the Board when material risk arises during the lifecycle of a partnering agreement.

Governance Committee

- Provide support and guidance to other Perley Health Board Committees' with respect to reflecting ***ethical standards and values*** into material partnering arrangement governance models.

Strategic Planning Committee:

- Provide support and guidance to other Perley Health Board Committees' with respect to reflecting the ***strategic use of partnerships*** into material partnering arrangement governance models.

Quality of Life and Safety Committee:

- Provide support and guidance to other Perley Health Board Committees' with respect to reflecting ***care, service and safety standards*** into material partnering arrangement governance models.

Special Committee on Centre of Excellence:

- Provide oversight to Management's activities of developing research partnerships.
- Provide support and guidance to other Perley Health Board Committees' with respect to reflecting ***research partnership standards*** into material partnering arrangement governance models.

Special Committee on Senior Living Expansion:

- Provide expertise in implementing those partnerships assigned to it by the Board of Directors.

The Chief Executive Officer (CEO):

- The CEO is responsible for the oversight of all partnering arrangements and will inform the Board and the relevant Committee(s) when material risks arise during the lifecycle of the partnering arrangement.
- The CEO provides input to the development of discussion papers for the Board when material risk arises during the lifecycle of a partnering agreement.
- The CEO shall ensure that all partnering agreements reflect the operating standards of Perley Health and that performance and monitoring obligations under such agreements meet the standards required by Board and its committees.

Policy Review

The Board shall review this policy and its implementation as required, or at least every three years as required.

Definitions

Material risk- a financial risk that may negatively impact the organizations performance. The threshold for material risk is defined in section 4.

Significant risk – are non-financial risks (although they may create financial impacts) that would have large negative impacts on outcomes. Significant risk is not easily quantifiable and will be determined by management using professional judgement and guidance from the Board.

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Perley Health

Policy

Classification:	General	**Number:**	**BOARD-2015-03**
Category:	Administration	**Date:**	**04Nov2021 – R** 07May2020 – R 03Sept2015 – O
Issued by:	Chair of the Board		
Authorized by:	Board of Directors		

Board Policy re:
Shared Governance Oversight for Clinical Partnering Arrangements

Statement of Board Policy

Any clinical partnering arrangement requiring The Perley and Rideau Veterans' Health Centre (Perley Health) to enter into shared governance must be approved by the Board and is subject to the Board Policy on Partnering Arrangements and Risk as well as this Policy.

The key decision makers within a shared governance arrangement must maintain a designated accountability and reporting relationship with the Perley Health CEO and, through him or her, the Perley Health Board.

Context

This policy relates to governance of those partnering arrangements that involve the provision of direct client care, clinical services or programs, and applies specifically in those circumstances where there is clearly a joint responsibility and accountability to provide a client group or population with care or services.

Shared governance is an arrangement, formalized and satisfactory to all members, that offers appropriate influence to each one in governing the integrated provision of care and can range from an advisory committee to a formal decision-making body for the clinical partnering arrangement.

Principles

1. The health providers in any clinical partnering arrangement entered into by Perley Health must each retain their own identities and corporate or agency structures, and shall implement a binding shared governance agreement.
2. Shared governance agreements must be flexible, accountable and subject to ongoing review and clinical partnering arrangements must include:
    - a joint strategic plan;

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- clear management and business rules, as well as boundaries;
- clear financial authorities;
- solid processes to ensure robust clinical and non-clinical performance measurement and continuous quality improvement;
- defined accountabilities for outcomes and risk management;
- defined reporting relationships;
- defined employment relationships, such as the status as an employee of the host institution, collaborating institution or an independent contractor;
- defined rights relating to the development, acquisition and ownership of intellectual property;
- defined processes to be used to resolve conflict under the agreement; and
- defined processes to modify the partnering arrangement in any way, including changes to activities, changes to membership and termination of the arrangement.

3. Perley Health must not assume unnecessary risk in its shared governance arrangements. At the same time, opportunities for strategically beneficial clinical partnering should not be dismissed simply because risks are to be jointly shared. Careful consideration must be given to risk definition, mitigation, transfer and management, in the shared governance oversight.

4. The clinical partnering arrangement must specify a designated lead or trustee institution; and

5. The clinical partnering arrangement must adhere to the policies and procedures of the lead or trustee institution, unless the shared governance agreement provides a specific and detailed instruction to the contrary.

Roles and Responsibilities

The Board:

- The Board, supported by the CEO, is responsible for determining what shared governance arrangements are to be advanced as well as the governance and accountability structure for partnering arrangements.
- The Board shall take the time necessary to understand, deliberate and approve any shared governance arrangement.
- The Board is responsible for the shared governance agreement for any shared governance arrangement and is responsible, though the Quality of Life and Safety Committee, to review and have input into the broad approach of the ongoing strategic plans and accountabilities under the partnering arrangement.
- The Board, or the Quality of Life and Safety Committee, shall act as a sounding board for the CEO and shall at regular intervals monitor the progress and achievement of the strategic objectives and outcomes of the strategic governance arrangement.

The Quality of Life and Safety Committee:

- The Quality of Life and Safety Committee has general oversight of this Policy, its implementation and review.
- The Quality of Life and Safety Committee shall assume a lead role on behalf of the Board for the identification and monitoring of issues arising from shared governance arrangements, and, in particular, oversight of the identification, monitoring and mitigation of any significant risks associated with these arrangements.

- The Quality of Life and Safety Committee shall act as a sounding board for the CEO for all clinical partnering arrangements with shared governance agreements
  - in anticipating and assessing potential clinical partnering arrangements,
  - in developing plans and follow-up actions and responses, and
  - in developing advice for the Board.

The Chief Executive Officer (CEO):

- The CEO shall ensure that the Board has all the relevant information necessary to make a considered decision about any shared governance arrangement.
- The CEO shall oversee the ongoing and day-to-day work of:
  - planning, identifying and achieving joint strategic and operational objectives and outcomes;
  - managing and coordinating relationships and communication; and
  - identifying, preventing and managing inherent and acquired risks throughout a clinical partnering arrangement lifecycle.
- The CEO shall report to the Quality of Life and Safety Committee significant partnering risks as they arise, including financial regulatory and labour relations risks, their evaluation, joint mitigation strategy and their resolution.
- The CEO shall report to the Board annually on the performance of clinical partnership arrangements with shared governance.

Policy Review

The Board shall review this policy and its implementation as required, or at least every three years.

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Perley Health

Policy

Classification:	General	**Number:**	BOARD-2016-01
Category:	Administration	**Date:**	**04Nov2021 – R** 06Feb2020 – R 01Sept2016 – O
Issued by:	Chair of the Board		
Authorized by:	Board of Directors		

Board Policy:
The Ted Gordon Cash Management and Investment Policy Statement

Purpose

The purpose of the Cash Management and Investment Policy Statement (CMIPS) for The Perley and Rideau Veterans' Health Centre (Perley Health) is to establish a systematic process to guide decision making with respect to cash management to help Perley Health achieve its financial objectives and contribute to its sustainability while managing investment risks.

The CMIPS:

i. Sets out cash management and investment objectives;
ii. Defines the investment planning assumptions; and
iii. Creates a framework for asset allocation.

An Appendix to the policy:

i. Sets prudent investment parameters including permitted investments and establishes limits consistent with Perley Health's risk objective; and
ii. Recommends performance benchmarks that target acceptable long-term returns within an appropriate level of risk to achieve the objectives for Perley Health.

Policy

A. Goals

Perley Health's primary cash management and investment goal is to ensure sufficient cash is available to meet its expected short-, medium- and long-term obligations.

A secondary goal is to provide transparency in cash allocation to various funding requirements and investment opportunities.

A third goal is to ensure appropriate investment returns.

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B. Cash Allocation

Perley Health will allocate available cash into Funds. The criteria to determine the allocation include:

i. The amount to be held in the liquidity contingency reserves,
ii. Opportunities to pay down debt,
iii. Projected capital expenditures,
iv. Projected investments in strategic objectives,
v. Projected Perley Health Foundation donations.

The following monies are to be excluded from the allocation into Funds:

i. Resident Accounts Held in Trust,
ii. Tenant Trust Accounts,
iii. Amounts identified as due to the Ontario Ministry of Long-Term Care, and/or Veterans Affairs Canada as a result of overpayment of cash advances.

The specific investment approach and the return objectives will vary for each Fund and will depend on intended use of the Funds by Perley Health. Perley Health will establish appropriate benchmarks for each of the Funds. In all cases, the Funds will be invested consistent with prudent investor standards.

C. Description of the Funds

Operating Fund:

This Fund maintains cash, or access to cash, or short-term investments (such as bank deposits, lines of credit or money market products) to meet the required needs of support for day-to-day operations. This requirement is defined as operational requirements for two weeks (payroll, vendor payments, etc.) plus planned capital expenditures for the current calendar year.

This allocation will be maintained and controlled by Perley Health.

The sole objective is preservation of capital.

Expansion Fund:

This Fund is excess cash set aside to invest in the Strategic Objectives or major capital replacement or overhaul (not otherwise covered by a segregated fund) and where the expenditures are anticipated to occur within 1 to 4 years.

The objective is preservation of capital while optimizing return.

Senior Housing Capital Reserve Fund:

This Fund is required under the terms of the debentures with Ontario Infrastructure and Lands Corporation (OILC). Perley Health is required to deposit money into a segregated account for the exclusive purpose of major capital replacement and overhaul. The majority of these expenditures are not expected to begin occurring until the early 2030's.

Any use of this money requires the express consent of OILC and is assignable to OILC.

The objective is growth of capital.

Other Reserves:

Other Funds may be designated, named and used on occasions when Perley Health wishes to hold or restrict cash for various periods of time for the benefit of specific initiatives.

Note: Collectively the Funds listed above are referred to as the "Invested Assets".

D. Investment Procedures and Authorized Investment Vehicles

Perley Health will only invest in authorized investment instruments and will follow the guidance outlined in Appendix A. Acceptable instruments for Cash, Cash Equivalents, Money Market, Bonds, and Equities are also identified in Appendix A.

E. Prohibited Investment Practices

Perley Health is prohibited from the following investment practices:

i. Borrowing funds for the sole purpose of reinvesting the proceeds of such borrowing;
ii. Short sales (selling a specific security before it has been legally purchased);
iii. Speculative trading (repetitive buying and selling of the same or similar securities or instruments for the purpose of capital gains);
iv. Investment via derivatives.

F. Standards of Care

Prudence:

Except as may otherwise be prescribed by applicable laws or regulations now or in the future, investments shall be made with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

Indemnification:

Perley Health volunteers, Members of the Board, officers and employees involved in the investment process are covered by the Indemnification section contained in the By-Laws of the Corporation.

Ethics and Conflicts of Interest:

Perley Health volunteers, Members of the Board, officers and employees involved in the investment process shall follow the Conflict of Interest guidance contained in the By-Laws of the Corporation and the Governance Guide.

Custody/Trust:

Perley Health will not take physical possession of investment securities. Securities will be held by an independent third-party custodian selected by either Perley Health or by External Investment Managers contracted by Perley Health.

Internal Controls:

Perley Health's internal control framework will apply to all investments not held by External Managers. Perley Health's internal control framework will not extend to External Managers. However, transactions with External Managers will follow the Perley Health internal control framework.

Risk Objective:

While recognizing the importance of the preservation of capital, this Policy acknowledges that achieving overall objectives will require prudent risk-taking, as risk is the prerequisite for generating investment returns. Thus, Perley Health will structure its Invested Assets to provide a rate of investment return commensurate with an appropriate level of risk.

Since investment risk cannot be eliminated, it will be managed by diversifying holdings, not only in terms of asset class, but also in terms of securities, sectors, and geography. Guidance on risk exposures is outlined in Appendix A.

Investment Monitoring and Reporting:

The Funds and their investments will be monitored and reported as follows:

i. Quarterly to the Audit and Risk Management Committee of the Board of Directors:
   a. The allocation of cash across Invested Assets at quarter end
   b. The asset mix of each Fund at quarter end
   c. The return of each fund versus its benchmark for the quarter
   d. Confirmation that the Fund is in compliance with the IPS for the quarter.

ii. Annually to the Board of Directors:
   a. The allocation of cash across Invested Assets at year end
   b. The asset mix of each Fund at year end
   c. The return of each fund versus its benchmark for the year
   d. A review of investment fund manager performance on a rolling five-year basis.

Roles and Responsibilities

The Board of Directors is responsible for:

i. Approving the Cash Management and Investment Policy Statement,
ii. Approving the investment objectives of all Funds,
iii. Approving the selection of qualified investment professionals to assist in the implementation of, management of, and advisement on the investment policies,
iv. Approving the termination of an investment manager,
v. Ensuring that conflicts of interest are properly addressed, and
vi. Approving any exceptions to the CMIPS in accordance with identified procedures.

The Audit and Risk Management Committee (ARM) is responsible for:

i. Conducting a review of the Cash Management and Investment Policy Statement every three (3) years,

ii. Overseeing policy implementation, monitoring adherence to and ensuring that investments meet the CMIPS requirements,
iii. Monitoring investment fund performance on at least a quarterly basis,
iv. Reporting investment fund performance to the Board on an annual basis
v. Recommending the Investment Fund Manager(s), if engaged, to the Board of Directors,
vi. Monitoring Investment Fund Manager performance,
vii. Meeting with the Investment Fund Manager annually, and
viii. Recommending approval of exceptions to the CMIPS, if any, to the Board of Directors.

The Chief Financial Officer (CFO), under the oversight of the Chief Executive Officer (CEO), is responsible for:

i. Ensuring that there is an adequate amount of money in the Operating Fund to meet the ongoing needs of Perley Health,
ii. Providing annually to the Audit & Risk Management Committee (ARM) a capital budget which includes a 10-year cash projection along with a recommendation on the allocation of Invested Assets.
iii. Providing direction to the Investment Manager. The CFO, in agreement with the CEO, may provide direction to the investment manager that will result in an exception to this policy. This may occur in the event of significant market instability or a credit event that would require a significant reallocation of the portfolio in order to protect the safety and/or liquidity of the Invested Assets.
    a. Any directed exception will remain in place until no later than the next meeting of the Audit & Risk Management Committee at which time the CFO will suggest a course of action (agreed to by the CEO) with regard to the policy and seek input on and support by the Audit & Risk Management Committee for a recommendation to the Board of Directors of such action.
    b. Any non-directed exception will be corrected immediately and reported to the ARM at its next meeting.
iv. Providing quarterly reports to the Audit & Risk Management Committee, or more frequently if circumstances warrant, and annual reports to the Board of Directors.

Policy Review

The Board will review this policy and its implementation every three (3) years or more frequently as required.

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Appendix A

Investment Procedures

Quality and Limitations:

Investment restrictions and quality levels apply within the context of all funds.

Limitations based on type of investment instrument are described below.

A. Fixed Income and Money Market Investment Instruments (FIMMII)

i. Shorter-term notes and other evidences of indebtedness of governments, corporations, banks and trust companies, whether acquired separately or as part of an investment pool, shall have a rating of at least "R-1 (med)" and "A-", as measured by Dominion Bond Rating Services (DBRS) (or equivalent rating agency) at the time of acquisition.
ii. Bonds, debentures, real return bonds, and other debt securities, whether acquired separately or as part of an investment pool, shall have a minimum rating of "A-" or better for any individual issuer, as measured by DBRS (or equivalent rating agency) at the time of acquisition.
iii. Where multiple ratings exist, the lowest rating shall be used.
iv. Bonds with high convexity relative to similar duration bonds are not permitted.
v. Securitized, asset-backed or similar instruments are not permitted.
vi. Private Placements are not permitted.

B. Equities

i. Investments in Canadian equities (pooled or otherwise) will be limited to those shares listed in the S&P/TSX composite index.
ii. Investments in U.S. and international equities (pooled or otherwise) will be limited to shares listed in the following major indices:
    a. S&P 500 (SPX)
    b. Dow Jones Industrial (DJIA)
    c. Nasdaq Composite (IXIC)
    d. MSCI EAFE
iii. Equity investments can include common shares of Canadian, foreign and emerging markets equity, warrants, preferred shares, and American depository receipts. Investment managers may use pooled unit trusts or mutual fund vehicles that align with the IPS.

C. Derivatives

i. Are not permitted in any of the funds except to manage currency exposure.

Limitations across all holdings are outlined below.

D. Concentrations

i. There will be no limits on direct or guaranteed Federal government securities within the FIMMII holdings.
ii. The maximum "FIMMII" exposure to securities which represent direct draws on the Federal government will be 25% of the market value across all FIMMII holdings.

iii. The amount with any single corporation will be limited to 10% of the market value across all (Fixed income/money market and equity) portfolio holdings.
iv. The maximum "A-" exposure will be 15% of the market value of across all FIMMII holdings pool.
v. Individual equity participation in all classes of any issuer's equity securities will not exceed 10% of the market value of a specific firm's index weight.
vi. Furthermore, equity holdings shall be diversified to avoid undue exposure to any single economic sector, industry group or similar classification and every sector or group must be within 10% of the index weight[1] without the approval of the Board.

Risk Exposures:

Perley Health will evaluate and monitor market risks associated with its Invested Assets.

E. Market Exposures

i. Interest Rate Risk – the Duration of all non-equity investments within a fund must be within plus or minus 15% of the benchmark index or aggregated indices.
ii. Currency Risk – No currency risk is allowed with the portfolio.
iii. Liquidity Risk – This guidance applies to individual investment instruments held within the Invested Assets. The global liquidity risk of the Corporation is addressed via the IPS.
    a. The "Quality and Limitations" section sets parameters with respect to credit, instrument type and convexity that are intended to ensure individual investments are liquid through most market conditions.

F. Asset Mix

Perley Health has a number of Funds that compose the Invested Assets. The asset mix for each of those funds is outlined below.

Operating Funds

Type	Minimum	Maximum
Cash and Cash equivalents	75%	100%
Fixed Income	0%	25%

Expansion Funds

Type	Minimum	Maximum
Cash and Cash equivalents	0%	35%
Fixed Income	50%	85%
Equities	0%	20%

[1] For example, if the index weight is 30%, the portfolio can range from 20% to 40%.

Senior Housing Capital Reserve Funds

Type	Minimum	Maximum
Cash and Cash equivalents	0%	5%
Fixed Income	50%	90%
Equities	0%	15%

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Perley Health

Policy

Classification:	General	**Number:**	BOARD-2017-01
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Issued by:	Chair of the Board		
Authorized by:	Board of Directors		

Board Policy re: Code of Ethical Conduct

Statement of Board Policy

The Perley and Rideau Veterans' Health Centre (Perley Health) is committed to having an ethical culture that is reflected in the behaviour of the individuals associated with Perley Health. All directors, officers, members, staff, residents, tenants, clients, and volunteers are expected to maintain the highest ethical standards, to behave lawfully, in a reasonable and prudent manner, and to adhere to and be guided by the ***Core Values of Perley Health*** (Appendix A), which were developed as part of the Strategic Plan ***(Whither the Perley Rideau v. II)*** and are articulated within it.

To support the maintenance of an ethical culture, Perley Health shall:

- ensure that all policies, practices, research and ways of doing business are carried out in accordance with ethical standards and the law and that they are measured and assessed accordingly;
- have policies and procedures that govern the investigation and resolution of allegations of ethical impropriety or ethical issues/dilemmas that may arise; and
- ensure that those reporting ethical concerns may do so without fear of reprisal and are not subject to retaliation or retribution of any kind.

As Perley Health is primarily the home of its residents and tenants, it shall be operated in a way that will ensure that it is a place where they may live with dignity, and in security, safety and comfort. In so doing, Perley Health shall adhere to and be guided by the ***Residents' Bill of Rights*** as set out in the *Fixing Long-Term Care Act, 2021* (Appendix B).

Definitions

Ethical behaviour is conduct that is morally correct, honourable, just, principled, and trustworthy.

A ***Resident*** refers to a person admitted for long-term care at Perley Health and, where appropriate, includes the resident's family and/or other support network.

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A ***Tenant*** refers to a person who pays rent for the right to live in a rental unit at Perley Health.

A ***Client*** refers to a person receiving care at Perley Health or from Perley Health staff and, where appropriate, includes the client's family and/or support network.

Expected Behaviours

All will be committed to:

Responsibility to the Individual

- Promote the well-being of all residents, tenants, and clients of Perley Health.
- Strive to provide the highest possible quality of appropriate services.
- Use courtesy, tact and cooperation in all interactions with residents, tenants, clients, other staff, volunteers and visitors.
- Respect the customs, beliefs, language, property and autonomy of others.
- Protect the confidentiality of all personal information.
- Act always to prevent harm.

Responsibility to the Workplace

- Help to ensure a culture of the highest level of integrity.
- Report any legal or ethical concerns in confidence and without fear of reprisal.
- Exercise accountability in all actions.
- Comply with all applicable laws, policies, and procedures.
- Disclose any and all conflicts of interest.
- Recognize limits of competence and expertise and act within them.
- Be truthful about qualifications and expertise.
- Not tolerate any form of abuse, harassment or discrimination, and report any such behaviour to the appropriate authority in accordance with Perley Health policies and procedures.
- Not use Perley Health resources for personal benefit.
- Help to ensure the protection and proper use of Perley Health assets.

Roles and Responsibilities

The Board:

The Board is responsible for ensuring that this Policy is respected in the conduct of the people covered by this policy and in its policies, practices and research. The Board shall:

- Lead by example in its practices and the behaviours of Board members.
- Ensure there are Core Values expressly articulated for Perley Health.
- Adhere to this Code, and the policies included within it, in all its decisions and actions.
- Investigate any evidence or allegations of ethical impropriety concerning individual Board members or ethical issues/dilemmas pertaining to Board business or functioning and ensure that there is a process in place to deal with allegations of any such ethical impropriety. (See Appendix C.)
- Provide advice and direction to the Chief Executive Officer (CEO) on ethical issues that may arise.

- Monitor the effective implementation of this Policy by the CEO, and consider Perley Health's ethical performance in evaluating the CEO's performance annually.

Directors shall sign annually and adhere to an Oath of Office (see *Oath of Office* in Part II, Chapter 4, Appendix B).

The Governance Committee:

The Governance Committee has general oversight of this Policy, its implementation and its review.

The Chief Executive Officer (CEO):

The CEO is responsible for promoting an ethical culture at Perley Health and for establishing the necessary policies, practices and structures to implement this Policy. The CEO shall:

- Ensure that documentation and procedures are in place so that **all** staff, residents, tenants, clients, and volunteers are informed of the Code of Ethical Conduct of Perley Health (including the Residents' Bill of Rights and the Core Values of Perley Health), and of the professional and association codes applicable at Perley Health.
- Ensure that all operational policies, procedures and structures of Perley Health are in compliance with this Policy.
- Ensure that policies, procedures and structures are in place so that services are delivered and decisions are made according to this Policy. This may include any significant decision that:
  - affects residents, tenants, or clients;
  - might positively or negatively impact on the mission of the organization and/or;
  - would affect local communities, vulnerable populations or the environment.
- Promote a blame-free culture and trust within Perley Health with policies and mechanisms in place to ensure that staff, residents, tenants, clients, visitors and volunteers can report ethical concerns or pose questions of an ethical nature without fear of retribution or reprisal and that such issues are investigated and resolved in a timely, transparent and objective manner. This includes the establishment of:
  - An Ethics Consultation Service that is available to any individual in the Perley Health community, for any reason, at any time, and without fear of reprisal.
  - An Ethics Advisory Committee to formulate policies and provide advice on ethical standards and ethical dilemmas arising from clinical, treatment, or research activities at Perley Health.
  - Non-retaliation protection so that staff, residents, tenants, clients, visitors and volunteers are free to alert those in authority to potential ethical dilemmas without fear of reprisal or retribution.
- Ensure that policies and procedures are in place so that all research performed at Perley Health is undertaken in the best interests of Perley Health, conducted in an ethical manner and performed pursuant to approval by a recognized research ethics board. The CEO shall further ensure that in approving any research the impact on resources, operations and reputation are considered and deemed acceptable.
- Report at least annually to the Board on any ethical issues investigated, ethical policies or procedures developed or implemented, and the research activities being carried out at Perley Health. Any significant ethical issues that may negatively impact Perley Health or its reputations shall be reported to the Board as they arise in a timely manner)

Policy Review

The Board shall review this Policy and its implementation as required, or at least every three years.

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Appendix A
to the Code of Ethical Conduct

Core Values of Perley Health

Perley Health operates under the belief that ageing well is rooted in living well – that there is joy in living every day. We also believe that each person is unique and valuable, and is entitled to purposeful, person-centred and compassionate healthcare. Our core values and the expected behaviours that flow from them will guide the implementation of our strategy and the realization of our vision.

Compassion is to understand the condition of others, and to commit oneself to the caring necessary to enhance health and quality of life, and to relieve suffering. We commit to:

- Providing a safe, comfortable, caring and friendly environment, and ensuring a good quality of life;
- Maintaining flexibility and adaptability in relationships;
- Displaying empathy, tolerance and forgiving in all interactions.

Respect is the basis of all of our relationships. Accordingly, we commit to:

- Taking a person- and family-centered approach to care;
- Respecting cultural, social, gender, class, spiritual, and linguistic differences;
- Maintaining respect for our unique responsibilities to both Veteran and community residents;
- Respecting privacy and confidentiality;
- Respecting all members of the team – their contributions and views are valued, acknowledged and rewarded;
- Valuing ongoing and open communication.

Integrity and ethical practice must permeate all actions of Perley Health. We commit to:

- Honesty and trustworthiness in all that we do;
- Being accountable and responsible for all of our actions.

Excellence. Perley Health is dedicated to achieving excellence in all that we do and commits to:

- Excellent quality of care;
- Employing caring, engaged staff committed to excellence, innovation and continuing improvement;
- Taking pride in what we do.

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Appendix B
to the Code of Ethical Conduct

Fixing Long-Term Care Act, 2021

Residents' Bill of Rights

3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

RIGHT TO BE TREATED WITH RESPECT

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.
2. Every resident has the right to have their lifestyle and choices respected.
3. Every resident has the right to have their participation in decision-making respected.

RIGHT TO FREEDOM FROM ABUSE AND NEGLECT

4. Every resident has the right to freedom from abuse.
5. Every resident has the right to freedom from neglect by the licensee and staff.

RIGHT TO AN OPTIMAL QUALITY OF LIFE

6. Every resident has the right to communicate in confidence, receive visitors of their choice and consult in private with any person without interference.
7. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
8. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
9. Every resident has the right to meet privately with their spouse or another person in a room that assures privacy.
10. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop their potential and to be given reasonable assistance by the licensee to pursue these interests and to develop their potential.
11. Every resident has the right to live in a safe and clean environment.
12. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
13. Every resident has the right to keep and display personal possessions, pictures and furnishings in their room subject to safety requirements and the rights of other residents.
14. Every resident has the right to manage their own financial affairs unless the resident lacks the legal capacity to do so.

15. Every resident has the right to exercise the rights of a citizen.

RIGHT TO QUALITY CARE AND SELF-DETERMINATION

16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.
17. Every resident has the right to be told both who is responsible for and who is providing the resident's direct care.
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.
19. Every resident has the right to,
    i. participate fully in the development, implementation, review and revision of their plan of care,
    ii. give or refuse consent to any treatment, care or services for which their consent is required by law and to be informed of the consequences of giving or refusing consent,
    iii. participate fully in making any decision concerning any aspect of their care, including any decision concerning their admission, discharge or transfer to or from a long-term care home and to obtain an independent opinion with regard to any of those matters, and
    iv. have their personal health information within the meaning of the *Personal Health Information Protection Act, 2004* kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.
20. Every resident has a right to ongoing and safe support from their caregivers to support their physical, mental, social and emotional wellbeing and their quality of life and to assistance in contacting a caregiver or other person to support their needs.
21. Every resident has the right to have any friend, family member, caregiver or other person of importance to the resident attend any meeting with the licensee or the staff of the home.
22. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
23. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
24. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
25. Every resident has the right to be provided with care and services based on a palliative care philosophy.
26. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

RIGHT TO BE INFORMED, PARTICIPATE, AND MAKE A COMPLAINT

27. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

28. Every resident has the right to participate in the Residents' Council.
29. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of themself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else:

    i. the Residents' Council.

    ii. the Family Council.

    iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part IX, a member of the committee of management for the home under section 135 or of the board of management for the home under section 128 or 132.

    iv. staff members.

    v. government officials.

    vi. any other person inside or outside the long-term care home.

Further guide to interpretation

(2) Without restricting the generality of the fundamental principle, the following are to be interpreted so as to advance the objective that a resident's rights set out in subsection (1) are respected:

1. This Act and the regulations.
2. Any agreement entered into between a licensee and the Crown or an agent of the Crown.
3. Any agreement entered into between a licensee and a resident or the resident's substitute decision-maker.

Enforcement by the resident

(3) A resident may enforce the Residents' Bill of Rights against the licensee as though the resident and the licensee had entered into a contract under which the licensee had agreed to fully respect and promote all of the rights set out in the Residents' Bill of Rights.

Regulations

(4) The Lieutenant Governor in Council may make regulations governing how rights set out in the Residents' Bill of Rights shall be respected and promoted by the licensee.

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Appendix C
to the Code of Ethical Conduct

Board Process for the Resolution of Ethical Issues

1. Allegations of ethical impropriety with respect to a Board member are presented to the Chair of the Board of Directors (or if the matter involves the Chair, to the Chair of the Governance Committee of the Board of Directors) in writing and include the ethical issue with which there is a concern.

2. The ethical issue and potential resolutions are disclosed to all people involved or who have direct interest in the resolution of the issue. Individuals informed shall be given the opportunity to respond to the issue and provide other options for resolution, within a reasonable time established by the Chair of the Board of Directors.

3. The Chair of the Board of Directors (or if the matter involves the Chair, the Chair of the Governance Committee of the Board of Directors) consults with the Executive Committee who makes a recommendation to the whole Board of Directors on the matter. The Ethics Consultation Services may also be accessed if required.

4. The Board of Directors receives the recommendation of the Executive Committee in the presence of the individual named in the allegation and asks the individual if he/she has any further representations. The Board of Directors votes on the recommendation of the Executive Committee.

5. Ethical dilemmas not involving individual impropriety but related to the work of the Board are brought to the attention of the Chair of the Board of Directors and investigated by the appropriate committee of the Board. The committee may ask for the assistance of management in the investigation. The committee makes a recommendation to the Board of Directors on how best to resolve the matter. The Board of Directors votes on the matter.

6. If the individual who made the allegation or raised the ethical dilemma is not a member of the Board, the decision of the Board is communicated in writing to the individual.

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Perley Health

Policy

Classification:	General	**Number:**	**BOARD-2020-01**
Category:	Administration	**Date:**	**04Nov2021 – R** 05Nov2020 – R 09Jan2020 – O
Issued by:	Chair of the Board		
Authorized by:	Board of Directors		

Board Policy re: Corporate Identity

Statement of Board Policy

The Perley and Rideau Veterans' Health Centre (Perley Health) shall preserve the integrity and corporate recognition of the Perley Health name and its Corporate Identity. They represent the official identity of the corporation and are solely owned by Perley Health. Any visual material or information created by Perley Health must be appropriately credited to it and must not be used in a manner that is misleading or puts the reputation of Perley Health at risk. All uses of the Corporate Identity of Perley Health are subject to approval by Perley Health in advance of their use.
Actions resulting in immediate termination of the right to use of the Perley Health name and its Corporate Identity include, but are not limited to, the following:

- misleading, unethical or illegal behavior; conflicts of interest;
- any use of the Perley Health name or its Corporate Identity that improperly implies endorsement or approval of any person, activity, product or service; and
- any inappropriate modification to the Perley Health name or any aspect of its Corporate Identity.

As the Perley Health Foundation (Foundation) is a key stakeholder and a major contributor to the financial stability of Perley Health, Perley Health shall work together with the Foundation to protect the integrity and identity of the Perley Health Marks.

An Advisory Body, including representation from both Perley Health and the Foundation, shall be established to support the Chief Executive Officer (CEO) of Perley Health in assessing all requests pertaining to the Corporate Identity of Perley Health as identified in this Policy.

Definitions

Corporate Identity: The Corporate Identity relates to the manner in which Perley Health is seen or understood by the public (including residents, clients, families, funders, donors, volunteers, other businesses and employees). It distinguishes an organization from others and includes Logos and the Perley Health Marks.

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- ***Logo:*** A logo is a graphic that can include words, pictures and icons, and is created to represent a corporate entity, program or service. It creates a recognizable, consistent visual link to a corporate identity.
- ***Perley Health Marks:*** The Perley Health Marks include the trade names, trade-marks, logos, logo progeny (derivatives or sub-brands), service marks, corporate signature, icons and other similar proprietary designations owned and licensed by Perley Health, and include, among any others, the following:
  1. Centre of Excellence in Frailty-Informed Care
  2. Perley Health Physiotherapy & Massage
  3. Perley Health Active Seniors
  4. Perley Health Lifelong Learning
  5. Perley Health Senior Living
  6. SeeMe™: Understanding *frailty* together
  7. Specialized Behavioural Support Unit (SBSU)
  8. Sub-Acute care for Frail Seniors (SAFE) Unit
  9. Interprofessional Clinic at Perley Health

Licensee: A licensee is a third party that is authorized pursuant to this Policy to use the Perley Health name or Corporate Identity.

Roles and Responsibilities

The Board:

The Board of Directors of Perley Health shall ensure that the integrity and corporate recognition of the Perley Health name and its Corporate Identity are preserved.

The Governance Committee:

The Governance Committee has general oversight of this Policy, its implementation and its review. It shall, on behalf of the Board of Directors, ensure that it is aligned with the vision, mission and values of Perley Health.

The Chief Executive Officer (CEO):

The CEO shall implement this Policy in the day-to-day operations of Perley Health, shall take any decisions relating to this Policy, and shall direct and oversee management in the development of operational policies and procedures under this Policy.

The CEO is responsible for supporting the Board of Directors of Perley Health in preserving the integrity and corporate recognition of the Perley Health name and its Corporate Identity, and for supporting the Governance Committee in the oversight of the effectiveness of this Policy and in its application.

The CEO shall inform the Board of any concerns he/she has in relation to the implementation of this policy.

The CEO shall create an Advisory Body to support the CEO in assessing all requests pertaining to the Perley Health name or its Corporate Identity. (See ***Appendix 1*** for the Role of the Advisory Body.)

The CEO shall appoint the members of the Advisory Body, in consultation with the Foundation, and may sit on the Advisory Body. It shall include representation from staff of both Perley Health and the Foundation.

The CEO shall ensure that any Licensee authorized to use the Perley Health name or Corporate Identity complies with this Policy. The terms authorizing use by the Licensee shall be outlined in a license agreement between Perley Health and the Licensee and the CEO shall ensure that the Licensee does not sub-license or otherwise authorize the use of elements of the Perley Health name or Corporate Identity by other third parties in any manner. (See ***Appendix 2*** for required terms in a Licensee agreement.)

Policy Review

The Board shall review this policy and its implementation as required, or at least every three years.

* * * * *

Appendix 1

Role of Advisory Body

Advisory Body:

The Advisory Body supports the CEO of Perley Health in assessing all requests pertaining to the Corporate Identity of Perley Health as identified in this Policy. It also advises on matters related to intellectual property and Corporate Identity issues resulting from the creation of new programs and services at Perley Health or elsewhere on behalf of Perley Health. It meets quarterly, or more frequently if required.

The Advisory Body is the primary forum for the Foundation to raise proposals for third party fundraising events as well as all naming and recognition requests.

Procedure:

Perley Health and the Foundation bring requests to use the Perley Health name, the Perley Health Marks or other elements of its Corporate Identity to the Advisory Body. Such requests shall include a description of, and rationale for, the proposed use.

In assessing requests, the Advisory Body will be guided by this Policy.

Appendix 2

Agreements with Licensees

Each agreement between a Licensee and Perley Health shall include:

- a description of the uses to be made of elements of the Perley Health name, its Corporate Identity, its Brand and the Perley Health Marks, the right of Perley Health to audit the use of the Perley Health name, Corporate Identity, Brand and the Perley Health Marks, and related materials;
- the right of Perley Health to revoke or terminate the Licensee's use of the Perley Health name, Corporate Identity, Brand and the Perley Health Marks and require the return to Perley Health or destruction of materials used by the Licensee; and to pursue additional corrective actions, as may be appropriate.

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Perley Health

Policy

Classification:	General	**Number:**	**BOARD-2020-02**
Category:	Administration	**Date:**	**04Nov2021 – R** 06Feb2020 – O
Issued by:	Chair of the Board	(Previously BOARD-2017-02, Delegated Signing Authority, 01June2017 - R)	
Authorized by:	Board of Directors		

Board Policy re: Procurement Approval Authority

Purpose

The purpose of this policy is to:

- Ensure that adequate controls are in place for the authorization of the procurement of goods and services in order to safeguard the assets of The Perley and Rideau Veterans' Health Centre (Perley Health) against loss through fraud, theft or improper use;
- Ensure that goods and services are procured by Perley Health through a process that is consistent, open, fair and transparent;
- Ensure that the methods used by Perley Health in procuring goods and services seek to maximize the value for money spent;
- Identify the positions that can authorize expenses; and
- Identify the positions that can execute the documents associated with procuring goods and services.

Policy / Roles and Responsibilities

The Board of Directors authorizes the annual expenses of this organization by approving the annual budget. Where an annual budget is not approved by December 31st the budget levels of the last approved budget will be used to authorize expenses.

For major purchases or an aggregation of small expenses not reflected in the budget, the Board of Directors delegates authorization to the Chief Executive Officer (CEO). However, the Board shall be informed of major expenses or an aggregation of smaller expenses that exceed $275,000 and are not reflected in the budget.

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The CEO has the authority, in the ordinary course of carrying out his/her responsibilities **consistent with Board-approved budget**, By-Laws and procedures, to enter into contracts on behalf of Perley Health for the procurement of goods, non-consulting services, construction and consulting services. The related contracts and expenditures must be:

- Procured in accordance with the "Procurement Method" in the appended Procurement Approval Authority Schedule (**Appendix A**);
- Consistent with the spirit and intent of the Government of Ontario's Broader Public Sector Procurement Directive;
- Aligned with approved operating and capital plans and budgets; and
- Valued at less than $1 million dollars per year with a contract duration of not more than 5 years.

The Board delegates to the CEO the responsibility to ensure that appropriate procedures and controls are in place for the procurement method and signing of agreements as defined in **Appendix A** (Goods, Non-Consulting Services, Construction, and Consulting Services). For clarity this delegation includes updating and publishing the signing officers and revising Procurement Values in line with inflation.

Agreements that are not related to the procurement of goods, non-consulting services, construction, and consulting services are to be executed per paragraph 13 of the By-Laws.

Policy Review

The Audit & Risk Management Committee will review this policy and its implementation every three years or more frequently, if necessary.

References:

- By-Laws of the Corporation - Section 7, 12, 13
- Governance Guide -, Part III: Executive Authority, Chapter 1: The Chief Executive Officer, and its appendices including the CEO contract
- Government of Ontario's Broader Public Sector Procurement Directive

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Appendix A

The Perley Health Procurement Approval Authority Schedule

Procurement Approval Authority Schedule (PAAS) for Goods, Non-Consulting Services, and Construction		
Procurement Value[1] [2]	**Procurement Method**	**Signing Officer**
$0 to $3,000	Direct Purchase including Procurement Card, Purchase Order, or Group Purchasing Organization (GPO), if appropriate	One (1) of Program Managers/Directors, Manager Support Services, COO, CFO, CEO
3,000 to $25,000	Purchase Order to a Group Purchasing Organization (GPO), or a Pre-Qualified Supplier selected through a competitive process	One (1) of Program Managers/Directors, Manager Support Services, COO, CFO, CEO
$25,000 to $100,000	Invitational Competitive(A) or Open Competitive(B)	One (1) of Program Managers/Directors and One (1) of Manager Support Services, COO, CFO or CEO
$100,000 to $1,000,000	Open Competitive(B)	Any two (2) of COO, CFO, CEO
More than $1,000,000		Two (2) Officers of the Corporation
Service Contracts where no direct payment by Perley Rideau, but paid with public funds	Invitational Competitive(A) or Open Competitive(B)	One (1) of Program Managers/Directors and One (1) of Manager Support Services, COO, CFO or CEO

Procurement Approval Authority Schedule (PAAS) for Consulting Services		
Procurement Value[3]	**Procurement Method**	**Signing Officer**
$0 to $50,000	Invitational Competitive(A)	One (1) of Program Managers/Directors, Manager Support Services, COO, CFO, CEO
$50,000 to $100,000	Invitational Competitive(A) or Open Competitive(B)	One of (1) Program Managers/Directors and One (1) of Manager Support Services, COO, CFO or CEO
More than $100,000	Invitational Competitive(A) or Open Competitive(B)	Any two (2) of COO, CFO, CEO
$0 to $100,000	Sole Source(C)	CEO
$100,000 to $1,000,000		Any two (2) of COO, CFO, CEO
More than $1,000,000		Two (2) Officers of the Corporation

A - Invitational Competitive uses a Request for Tender or Request for Quotation. The evaluation is based primarily on price or price and delivery. A minimum of three (3) potential suppliers should be approached.

B - Open Competitive requires a Request for Proposal (RFP). The RFP enables selection on factors other than price or price and delivery alone. The evaluation criteria (including mandatory) must be established before the bids are opened.

C - The CEO may authorize the sole source procurement method up to $100,000. Using sole sourcing as a procurement method above $100,000 must be authorized by the Board. Sole sourcing is to be used when time constraints exist or where suppliers are very limited.

[1] Contracts beyond 5 years require Board of Director Approval
[2] Value of contract over the term of the contract not to exceed $5 million
[3] Value of contract over the term of the contract not to exceed $5 million

Perley Health

Policy

Classification:	General	**Number:**	BOARD-2021-01
Category:	Administration	**Date:**	**04Nov2021 – R** 01Apr2021 – O
Issued by:	Chair of the Board		
Authorized by:	Board of Directors		

Board Policy re: Research Activities

Purpose

The purpose of this policy is to provide direction regarding the conduct of research activities at The Perley and Rideau Veterans' Health Centre (Perley Health).

Statement of Board Policy

Perley Health supports and promotes a culture of applied research in order to develop and expand innovative, evidence-based practice to advance the care of older adults living with frailty in long-term care.

Research activities undertaken at Perley Health must be in compliance with the principles set out in this Policy.

Context

The vision of Perley Health is to lead innovation in frailty-informed care to enable Seniors and Veterans to live life to the fullest. To accomplish this vision, the Perley Health strategic plan foresees the need to improve our ability to deliver greater value to the healthcare system by specializing in frailty-informed care.

Achieving this vision requires that Perley Health undertake research to better understand and enhance practices in areas such as excellence in care; innovation in education, best practices and knowledge translation; and applied research in the care of seniors living with frailty.

Principles

The following principles must be respected when undertaking research projects:

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- **Strategic Alignment:** Proposed research activities must be clearly connected to the overall strategy of Perley Health, including alignment of values.
- **Current Climate:** Proposed activities should address a current or anticipated need, gap or problem, taking into consideration internal and external pressures and circumstances.
- **Resource Implications:** Resource input (financial, infrastructure, human resources etc.) must be assessed and balanced against anticipated outcomes.
- **Risk Management:** Where risks (financial, reputational etc.) are identified, due diligence is imperative and mitigating strategies must be considered.
- **Ethical Implications:** Potential ethical issues must be clearly assessed before starting a project and any issues that arise thereafter must be quickly addressed, with disclosure to senior management and/or the Board if appropriate.
- **Partnerships:** Where partnering is considered beneficial, well-defined guidelines for decision-making and accountability must be developed and the resource implications clearly established.
- **Responsible Conduct of Research:** All research activities will be conducted in accordance with the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans (TCPS 2, 2018).

Scope

This policy applies to all research conducted at Perley Health including: long-term care; short-term care; independent living; the Interprofessional Clinic; or any other Perley Health program. The policy seeks to protect residents, patients, clients, families, staff, volunteers and the organization and applies to any staff member, researcher, volunteer or other collaborators involved in research activities at Perley Health.

Centre of Excellence

The focal point for research at Perley Health is the Centre of Excellence in Frailty-Informed Care (Centre of Excellence). All research conducted at Perley Health will be subject to review and approval by the Centre of Excellence following procedures established in the Operational Research Policy (dated November 25th 2020 and as may be subsequently amended).

Roles and Responsibilities

The Board:

The Board has general oversight over the execution of this policy and the research strategy of the Centre of Excellence.

The Centre of Excellence Committee:

The Centre of Excellence Committee is responsible for overseeing the execution of the research strategy, monitoring performance and providing strategic advice to Centre of Excellence activities. The Centre of Excellence Committee supports the Research Chair and the Director of the Centre of Excellence in developing and implementing the research strategy and identifying and pursuing opportunities for the Centre of Excellence to grow and thrive.

The Centre of Excellence Committee oversees implementation of this Policy and its review, and shall provide recommendations for change as required. It shall also, through its Chair, advise the Board of any key issues it deems appropriate for Board consideration or corporate attention and shall provide the Board with an annual report as well as quarterly updates.

The Chief Executive Officer (CEO):

The CEO is responsible for the management of the Centre of Excellence and all research carried out at Perley Health.

Policy Review

The Board shall review this policy and its implementation as required, or at least every three years.

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Perley Health

Policy

Classification:	General	**Number:**	BOARD-2021-02
Category:	Administration	**Date:**	**01Dec2022 – R** 04Nov2021 – R 01Apr2021 – O
Issued by:	Chair of the Board		
Authorized by:	Board of Directors		

Board Policy re: Enterprise Risk Management

Purpose

The purpose of the Enterprise Risk Management Policy (ERMP) of The Perley and Rideau Veterans' Health Centre's (Perley Health) is to define a systematic risk management framework and articulate the roles and responsibilities of the Board of Directors, Perley Health management, and relevant committees.

Policy

A. Goals

Perley Health's primary risk management goal is ensuring that its risks are appropriately mitigated or managed.

A secondary goal is in defining a framework for risk management such that risk management is an integral part of Perley Health's governance framework and its operating environment; and as such, is embedded in the organization's strategic planning, business planning, project and partnering approval, and communications processes.

B. Definitions

Risk: an event or activity occurring internally or externally that can have an effect on the achievement of Perley Health's strategic or operational goals.

Enterprise Risk Management: a systematic approach to managing all the organization's key enterprise risks (strategic risks).

Operational Risk Management: a systematic approach to managing uncertainties resulting from inadequate or failed internal processes, people or systems.

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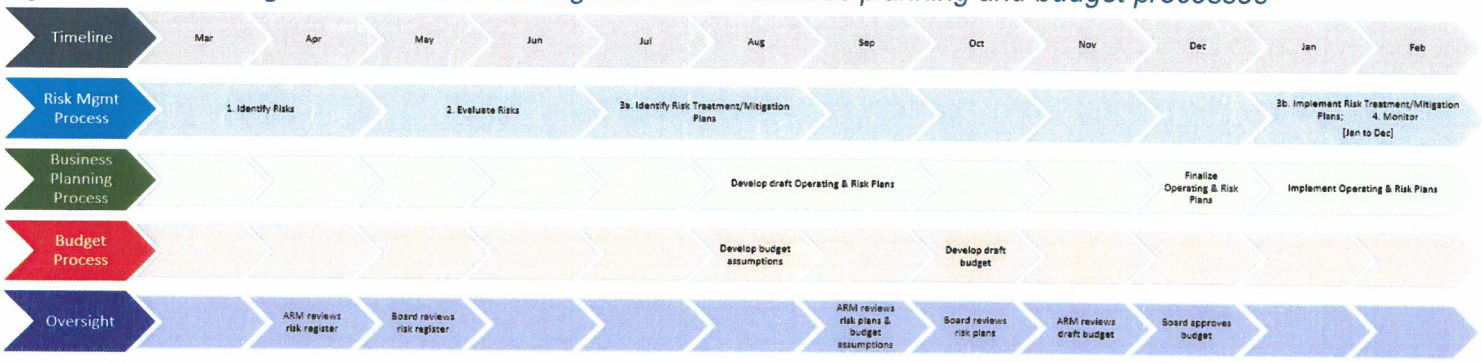
C. Framework

As outlined in Figure 1 below, the risk management process consists of the following four (4) steps:

1. Identify risks;
2. Evaluate risks;
3. Identify and implement risk treatment and risk mitigation plans;
4. Monitor and report.

Details on each of these steps are outlined in the **Appendix**. The CEO has oversight for the risk management activities listed below in consultation with the Audit & Risk Management Committee. (See Roles and Responsibilities for additional information.)

Figure 1. Risk Management Process and alignment with business planning and budget processes



Roles and Responsibilities

The Board of Directors (Board) is responsible for:

i. Approving the Enterprise Risk Management Policy and overseeing its implementation;
ii. Approving the corporate risk register;
iii. Approving action plans to address strategic risks; and
iv. In evaluating the CEO's annual performance, considering the leadership and collaborative role taken by the CEO in identifying, evaluating and managing enterprise and operational risks.

The Audit and Risk Management Committee (ARM) is responsible for:

i. Evaluating the effectiveness of risk management processes;
ii. Assessing action plans for top enterprise risks;
iii. Monitoring the performance of action plans;
iv. Reviewing and recommending the corporate risk register and risk rating results to the Board of Directors;
v. Acting as a sounding board for the CEO.

The Chief Executive Officer (CEO) is responsible for:

i. Ensuring that risk management processes are established and in place;
ii. Providing general risk management oversight to ensure Enterprise Risk Management adoption throughout the organization;
iii. Promoting a risk management culture across the organization;

iv. Overseeing the development and implementation of policies and processes for risk management aligned with best practices;
v. Overseeing the annual update of the corporate risk register;
vi. Updating ARM and the Board of emerging enterprise risks faced by the organization between the annual cycles;
vii. Ensuring that enterprise and operational risks are identified and appropriately managed throughout the organization;
viii. Ensuring that recommendations and directions of the Board in relation to risk management are acted upon.

Policy Review

The Board will review this policy and its implementation as required, or at least every three years.

Appendix: Detailed Risk Management Process

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Appendix

Detailed Risk Management Process

1. Identify risks

i. Management team to generate comprehensive list of enterprise and significant operational risks through annual review and update of the corporate risk register. Update to include all relevant risk treatment and mitigation activities;
ii. Updated risk register reviewed by ARM committee and Board with focus on emerging enterprise risks not addressed.

2. Evaluate risks

i. Management to rate the risks by determining the impact of risks identified and the likelihood of them occurring (see below for rating definitions). Rating is completed on the residual risk – the risk remaining after treatment and mitigation plans have been applied.
The objective of this step is to prioritize risks into priority levels to enable attention to be focused primarily on higher risks (risk score matrix and priority levels included below).

Table 1: Impact

Category	People	Finance	Reputation
Minor (1)	Unlikely to cause injury*, illness or death in residents/clients or staff	Negligible financial impact (<$100K)	No impact
Moderate (2)	Minor injury or illness in residents/clients or staff	Minor financial impact ($100K - $500K)	Potential damage
Major (3)	Moderate to life impacting injuries or illness in residents/clients or staff; low probability of death	Moderate financial impact ($500K - $2.5M)	Damaged
Severe (4)	Life threatening injuries or illness, and high risk of death in residents/clients or staff	Significant financial impact (>$2.5M)	Loss of confidence

** injury – includes physical, emotional, financial harm*

Table 2: Likelihood/Frequency of occurrence

Likelihood	Description	Frequency
Rare (1)	Incident may only occur in exceptional circumstances. Incident has not occurred in the past.	Once every 5-10 years
Unlikely (2)	Incident is not expected, but could occur infrequently.	Once every 5 years
Likely (3)	Incident is likely to occur. Incident has occurred in the past.	Once a year
Almost Certain (4)	Incident is highly likely to occur. Has occurred in the past, and conditions exist for it to occur again.	Multiple times a year

Table 3: Risk Score Matrix

Likelihood/Frequency	Severity/Impact			
	Minor (1)	Moderate (2)	Major (3)	Severe (4)
Almost Certain (4)	4	8	12	16
Likely (3)	3	6	9	12
Unlikely (2)	2	4	6	8
Rare (1)	1	2	3	4

Note: Risk score of 7 falls between the Medium and High Priority levels. As such, risk score of 7.0 -7.4 = Medium Priority; and 7.5 – 7.9 = High Priority

Table 4: Risk Priority Level and Required Actions

Priority	Action
High	Immediate corrective action required Board of Directors made aware and oversees the implementation of corrective action More frequent monitoring and reporting
Medium	Some corrective action may be required – implemented as soon as possible (within the year) Regular monitoring
Low	No corrective action required Regular monitoring

3. Identify and implement risk treatment and risk mitigation plans

i. Management team to evaluate progress against risk mitigation/treatment plans implemented year-to-date (to address top enterprise risks identified in previous year);
ii. Management team to develop high-level recommendations for addressing top enterprise risks (typically between 3-5);
iii. ARM Committee and Board to review progress against risk mitigation/treatment plans implemented year-to-date, ranking results and high-level recommendations;
iv. Management to develop detailed risk mitigation and communications plans, specifying key activities, risk owner(s), necessary resources, and timelines;
v. Risk owners to ensure mitigation plans are enacted.

4. Monitor and report

i. Management team to regularly monitor progress and effectiveness of mitigation activities and report to the appropriate Board committees.

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