ST. MARY'S HOME • MAISON SAINTE-MARIE

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COM A.1: COMMUNICATIONS AND MEDIA RELATIONS

SCOPE:

This policy applies to the Board of Directors all staff and volunteers of SMH

PURPOSE:

To outline the procedures for staff when communicating with the media.

DEFINITIONS AND ACRONYMS:

St Mary's Home: SMH
Staff: refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement and service partners of SMH.
Service Partner: is an agency and its staff, and/or an individual who have signed service protocols and/oragreements with SMH to provide services to clients on site.
Leadership Team: Executive Director, Director of Operations and Support Services

POLICY:

Effective media relations are critical to the ongoing success of SMH and the way that SMH is perceived by our clients, supporters, partners, and community. SMH will work to ensure that information regarding the organization is accurate, informative, and positive. SMH will work to manage information provided to media outlets, including traditional news media formats and online coverage.

IMPLEMENTATION:

Responsibilities:

1. SMH staff shall direct all media inquiries to the Executive Director or a designated back-up.
2. SMH staff are prohibited from speaking on behalf of the organization, releasing confidential information, releasing news, or communicating as a representative of the organization without prior authorization to act as a designated SMH representative.
3. Information regarding our programs and services will be provided to the media and the public at large asappropriate.
4. SMH Leadership and Board, where appropriate, will be responsible for gathering all facts in a crisis situation.

Public Statements:

1. Public statements regarding, or in reference to, SMH must use positive language, and shall not defame,and/or speak negatively of SMH as an organization, as a staff team or SMH programs and services;
2. SMH strictly prohibits the disclosure of confidential information regarding our processes, objectives, Participant/client information, financial information, or any other information protected as confidentialunder the SMH Privacy policies;
3. SMH strictly prohibits the public communication of unverified information, e.g., rumors or information gathered from a third party;
4. SMH media releases must use appropriate branding guidelines: logo and bilingual name; and

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Approved by BOD: July, 2024

5. SMH media releases must be approved by the Executive Director or designate prior to their release.

Crisis Communication:
In the event of a crisis, SMH will communicate with the public/media in a timely fashion and provide as much detail as is deemed necessary by the Executive Director, the Director of Support Services, the Board, and legal and confidential restraints. When a crisis happens, it is important to gather all the facts of the situation and develop a clear message to transmit to the public/media. The message should include:

1. A concise, clear and factual explanation of the crisis and what caused it;
2. An expression of care and concern for the crisis and its impact on stakeholders (employees, clients,supporters, partners, the general public, etc.);
3. An honest and sincere apology, if warranted;
4. A commitment to identifying the underlying factors that caused the crisis and how SMHwill address/correct them; and
5. A positive conclusion that establishes confidence that the crisis will be resolved and that SMH will moveforward in a positive/successful manner.

Depending on the severity and type of crisis, the message may be written and delivered to the media or announced verbally by the Executive Director, or a designated media spokesperson. In most cases, a written message will suffice, but at times SMH may want to make a formal public announcement or media interview.

SMH leadership should continue to monitor the media/public's reaction to the crisis includingsocial media and SMH response to determine if further messages / announcements are necessary. Monitoring public reaction can clarify what information might need to be transmitted in more detailand will help SMH remain pro-active in their management of the crisis.

Any SMH employee who discloses confidential information, releases news, or communicates as a representative of the organization without prior authorization will be subject to disciplinary action, up to andincluding termination. This includes communications made to the media, public at large, friends, family members, etc. through all forms of transmission including, but not limited to, verbal, written, and electronic (email, social media, blogs, etc.)

RELEVANT LEGISLATION AND STANDARDS:

N/A

RELATED POLICIES:

CCA: ORG-COM-5.1,5.2,5.4
St. Mary's Home Policy: Risk and Safety - Crisis Management
St. Mary's Home Policy: Systems and Structures - Collection, Use and Release of Information
St. Mary's Home Policy: Systems and Structures - Use of Client Information in Public Relations Activities
St. Mary's Home Policy: Confidentiality of Client Information

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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COM A.2: USE OF EMAIL, SOCIAL MEDIA, INTERNET, AND OTHER COMPUTING DEVICES

SCOPE:

This policy is designed to provide all SMH participants with information and employees with guidelines regarding electronic and online communications through the appropriate use of the company's social media accounts with Facebook, Twitter, LinkedIn, Instagram, Snapchat, and any other social media platforms St. Mary's participates in.

PURPOSE:

To establish guidelines for the appropriate use of SMH information system and electronic communication such as but not limited to phones, cell phones, cameras, and tablets.

DEFINITIONS AND ACRONYMS:

St. Mary's Home: SMH
Staff: refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement and service partners of SMH.
Service Partner: is an agency and its employees, and/or an individual who have signed service protocols and/or agreements with SMH to provide services to participants on site.

POLICY:

SMH is responsible for securing its networks and computing systems against unauthorized access and/or abuse, while at the same time making them accessible for authorized and legitimate users. This responsibility includes informing users of expected standards of conduct and the measures which may be taken for not adhering to them. Any attempt to violate the provisions of this policy will result in disciplinary action, regardless of the success or failure of the attempt.

The users of our computers and networks are responsible for respecting and adhering to local, provincial, federal, and international laws. Any attempt to break those laws using computers or networks may result in litigation against the offender by the proper authorities and potential dismissal from SMH. If such an event should occur, SMH will fully comply with the authorities to provide any information necessary for the litigation process.

IMPLEMENTATION:

General Computing Policy
Users are solely responsible for all actions taken while using our computer systems and network facilities. Use of SMH computer systems and network facilities and/or services for commercial purposes is prohibited. Sexually explicit material may not be accessed displayed, archived, stored, distributed, edited, or recorded using SMH computer or network resources and deletion, examination, copying, or modifying files belonging to other users without their prior consent is prohibited. Any deliberate action which damages or disrupts a computer system or network, alters its normal performance, or causes it to malfunction is prohibited including but not limited to the below:

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Approved by BOD: July, 2024

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1. The installation of non-approved software; and uninstalling or disabling any approved anti-virus software;
2. Introduction of viruses, worms, Trojan horses, or other disruptive/destructive programs into SMH computer systems or networks or into external networks;
3. Encryption of system or user passwords.

Prohibited actions for computer use include:

1. Use of our computer systems and/or networks in an attempt to gain unauthorized access to remote systems;
2. Copying of system files;
3. Copying of copyrighted materials, such as third-party software, without the permission of the owner or the proper license; and
4. Any file that is downloaded from the Internet or read from any external electronic media (such as memory stick, CD-ROM) must be scanned for viruses before it is run or accessed.

Electronic Mail Policy:

All e-mail messages created, sent, received, or stored on company e-mail facilities and the information contained therein are the sole property of SMH and are business records, St, Mary's Home reserves the right to access, monitor, read, disclose, and use any of these e-mails without prior notice or consent of the creators or recipients:

1. Participants do not have access to the SMH internal sites;
2. SMH provides its employees and associates with electronic mail (e-mail) for company-related business purposes;
3. SMH cannot guarantee the security of its e-mail system and only authorized individuals may access and use SMH's e-mail;
4. Users are responsible for all electronic mail originating from their user account; users must log in with a password, and those without one may not access nor use e-mail;
5. E-mail messages may not contain any company confidential information i.e. participant information, even if the e-mail is meant for another employee of SMH;
6. Users must remember that deleted e-mail messages may exist in hard copy, be forwarded to third parties, or be retrieved from a back-up system;
7. E-mail messages may not include content that is offensive, libelous, illegal, derogatory, harassing, threatening, or discriminatory;
8. Sexually explicit language, cartoons, jokes, and images are prohibited, as are racial and religious slurs and foul or inappropriate language;
9. Forgery (or attempted forgery) of electronic mail messages is prohibited;
10. Attempts to read, delete, copy, or modify the electronic mail of other users are prohibited; and
11. Sending unsolicited junk mail, "for-profit" messages or chain letters is prohibited.

Disciplinary Action:

Users found violating our e-mail policy are subject to disciplinary action, including but not limited to: verbal and written warning, revocation of email privileges, suspension, and termination.

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Internet Policy:

SMH provides its users and associates with Internet access for company-related business purposes Only:

1. Participants have access to internet service while participating in programs/services at SMH and must abide by the procedures in this policy;
2. Participants are to be made aware of internet usage during intake;
3. Employees may use their Internet facilities for non-business research or browsing during mealtimes or other breaks, or outside of work hours, provided that all other usage policies are adhered to;
4. SMH reserves the right to monitor employee use of the Internet at any time without prior notice or consent of the users;
5. Users waive their rights to privacy regarding any website they may access;
6. SMH also reserves the right to use the information we may learn of in any administrative, judicial, or other proceeding;
7. Each user of the Internet facilities shall identify themselves honestly, accurately, and completely when participating in chats or newsgroups, or when setting up accounts on outside computer systems; and
8. Users that connect accidentally to a site that contains sexually explicit or offensive material must disconnect from that site immediately, regardless of whether that site had been previously deemed acceptable by any screening or rating program.

Prohibited Internet usage activities:

Users may not participate in the following Internet activities:

1. View, download, send, or receive pornographic materials;
2. Intentionally damage or interfere with others (hacking, distributing viruses, etc.);
3. Distribute or post confidential company information;
4. Play games;
5. Gamble;
6. Post any material that is discriminatory, offensive, libelous, illegal, harassing, or derogatory; and
7. Engage in other personal activities.

Disciplinary Action:

Users found violating the SMH's Internet Policy are subject to disciplinary action, including but not limited to: verbal and written warning, revocation of Internet privileges, suspension, and termination.

Social Media Policy:

Employees may not disclose confidential or proprietary information on any of SMH social media pages. The disclosure of confidential or proprietary information without prior authorization may result in immediate termination. Only designated employees are permitted to post on behalf of SMH and anything outside of the previously accepted messaging – such as regular program and service information, updates and calendars, must be pre-approved by leadership before posted. Employees are required to receive prior approval before posting anything related to SMH to SMH's social media platforms or their personal platforms. Inflammatory comments, disparaging remarks, or negative / inappropriate language or posts are not permitted. Employees are required to respect copyrights and never post text, images or video created by someone else without proper attribution and/or authorization. If employees have questions about copyright law and/or the usage of certain media, they may learn more here:

1. http://laws-lois.justice.gc.ca/eng/acts/C-42/index.html; or
2. https://brocku.ca/marketing-communications/social-media/resources-how-to/copyright.

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Social media is not a substitute for inter-company communications. Important information should be transmitted within normal company communication channels (i.e. the company's email platform), and not through social media outlets. If a SMH staff member discovers any group(s) that formed to discuss the company, its products or services, employees are requested to bring them to the attention of Leadership.

Designated employees should always carefully consider what to post in response to an argumentative or accusatory post and always adopt a positive attitude when responding to comments on the company's pages or applications, or comments about the company in general. When in doubt of how to respond to a particular post, employees should discuss the issue with management prior to posting.

Participants and Instant Messaging:
One cell phone at SMH is dedicated to text messaging between participants and SMH;

1. These cell phones are password-protected and are to be held in secure locations;
2. Participants are given the number to these cell phones and are informed that all staff have access to the texts they send to this number;
3. Staff are to check incoming messages on a regular basis and respond accordingly;
4. At times, sensitive information is shared by participants through text messaging on these cell phones, therefore, it is important to note that St. Mary's Privacy of Information Policy procedures must be adhered to and any persons accessing this information must have a signed Confidentiality Agreement on their file; and
5. No messages are to be deleted from these cell phones unless this is highly confidential information.

Photography:
Consent is required prior to posting any photographs of employees, volunteers, or participants on any of SMH's social media pages. Please refer to and complete the appropriate Photo Release Consent form.

RELEVANT LEGISLATION AND STANDARDS:

RELATED POLICIES:

SMH Policy: Human Resources – Employees – Employee Participant Relations

Created: March 22, 2016
Review Date: July 2024
Approved by BOD: July, 2024

ST. MARY'S HOME / MAISON SAINTE-MARIE

ACKNOWLEDGEMENT AND AGREEMENT STATEMENT FORM

EMPLOYEES / BOARD OF DIRECTORS / FIELD PLACEMENT STUDENTS / VOLUNTEERS / PARTNERS

I,_____, understand that I must comply with all St. Mary's Home Policies and Procedures. I have reviewed all policies and procedures, with special attention being given to policies and procedures relating to my job description/role.

I agree to adhere to these policies, procedures and guidelines in whole:

Name: _____

PLEASE PRINT

Signature: _____

Date: _____

To be placed in the employee's, volunteer's, field placement student's or partner's HR file

Revised: March 2017

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GOV A.1: BOARD OF DIRECTORS – ROLE, RESPONSIBILITIES AND ACCOUNTABILITY

SCOPE:

This policy applies to all SMH Board of Directors or Officer on the Board.

PURPOSE:

To outline the role, responsibilities, and accountability of the St. Mary's Board of Directors (further specifics, including the structure of the Board of Directors, can be found in the St. Mary's Home/Maison Sainte-Marie Constitution and By-laws: #3 and #4.)

DEFINITIONS AND ACRONYMS:

Board: Board of Directors
Director or Officer: A person occupying the position of Director or Officer on the Board
Member: Any member who is elected as a Director
Executive Committee: A committee comprised of Directors selected for key organizational activities and decision making

POLICY:

Role of the Board of Directors

The Board of Directors are responsible to manage and supervise the affairs of St. Mary's Home. The Board is bound by the Bylaws as well as the policies and procedures that support the Bylaws. This involves making decisions that affect the organization while incorporating its mission, vision, and values into those decisions. The Board will possessthe knowledge, skills, and experience to make informed decisions based on a broad knowledge of the sector and an inclusive perspective. The Board executes this responsibility by providing leadership and fiduciary oversight of the activities of St. Mary's Home. The Board of Directors has both a legal obligation, as per the Not-For-Profit Corporation Act, and moral obligation to fulfill the mission of the organization.

Accountability

The Board of Directors of St. Mary's Home are accountable for the organization's performance in relation to its mission, vision, values, and strategic directions and for the stewardship of financial and human resources. The Board is accountable to each other, clients, community, funders, donors, and staff.

Authority

No individual Board member has the authority to approve actions, direct staff, or speak in an official capacity for St. Mary's Home unless given such authority by the Board President.

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IMPLEMENTATION:

Governance

The Board will:

1. Work with the Executive Director in setting the organization's mission and strategic directions and objectives, identifying the outcomes the organization seeks, and the strategies needed to achieve them in the future;
2. Establish committees from time-to-time and as defined by St. Mary's Home/Maison Sainte-Marie Constitution and By-Laws: #2 and #5.01 to provide guidance to the Board by vetting ideas, programs, and practices (e.g., Executive, Finance, Personnel and Nominating committees);
3. Take responsibility for its own management, succession planning and sustainability;
4. Enforce upon itself whatever discipline is needed to govern with excellence;
5. Review policies to ensure that the Executive Director adheres to sound financial management and to best practices with respect to personnel and provision of services;
6. Acknowledge that the day-to-day operational activities of St. Mary's Home are the responsibility of the Executive Director and appropriate staff, and not the Board per se;
7. Be accountable to the public for competent, conscientious, and effective accomplishment of its mandate as a governing body; and
8. Speak with one voice through policy and Board motions. No individual Board member or Committee of the Board shall usurp this authority.

Planning and Performance

The Board will:

1. Establish and review as needed or at minimum every three-to-five years, the organization's mission, vision, values and strategic direction to ensure relevance and responsiveness to changing client needs and/or the changing landscape of the community;
2. Evaluate annually how effectively the organization is achieving its goals, and delivering major activities and services as outlined in the strategic directions, and make recommendations when necessary;
3. Assess organizational performance in relation to identified goals and adherence to budget; and
4. Access all appropriate resources to support the achievement of goals.

Stewardship of Resources

The Board will:

1. Provide leadership in obtaining funding to advance the mission of the organization;
2. Support the development and execution of fundraising initiatives;
3. Oversee the financial management of the organization including maintaining strong financial controls;
4. Ensure that ethical Human Resources policies are in place and are implemented consistently;
5. Hire and give direction to the Executive Director;
6. Monitor and evaluate the work of the Executive Director; and
7. Practice careful risk management and identify and appropriately deal with potential sources of harm.

Community as Partners

The Board will:

1. Ensure staff of St. Mary's Home provide broad organizational accountability, transparency, and active meaningful communication to all stakeholders;
2. Report on an annual basis to the community through the annual general meeting, information on a variety of activities and programs, a celebration of achievements and the audited financials;

Created: March 22, 2016
Review Date: July 2024
Approved by BOD: July, 2024

3. Develop strategies and advocate to influence government and legislation related to the mission statement;
4. Attend public events from time-to-time to show a broad level of support to St. Mary's Home;
5. Support marketing and public relations campaigns to ensure that the organization is known to its stakeholders and the public, and that it is seen as making a positive contribution to the well-being of the community;
6. Be accountable to stakeholders and invite input and feedback regarding the organization's planning, programs and services.

Self-Evaluation
The Board will:

1. Evaluate its work at least once a year in the fourth quarter to monitor Board's performance, efficiency and effectiveness, and improvement opportunities.
2. Ensure each director fills in and completes an electronic copy of the annual reflection and evaluation in the fourth quarter received from the Board secretary;
3. Use the results of the annual evaluation to inform board effectiveness and continual improvement in oversight of the organization strategic objectives
4. Discuss a summary of results, including recommended next steps, at the next regularly scheduled Board meeting.
5. Upon completion of the self-assessment portion of the annual reflection and evaluation commit to their own personal goals for continued effectiveness; and seek out guidance and/or opportunities for training and/or professional development, if necessary, including group trainings;
6. Monitor the implementation of recommendations as per the quality improvement cycle.

Performance Evaluation of Executive Director
The Executive Director of St. Mary's Home is entitled to a formal written evaluation of their performance by the Board of Directors every year. The evaluation shall be part of the Boards' annual governance work but may be initiated at any time by the Board or at the request of the Executive Director. The evaluation will be carried out by the Executive Committee, which will make recommendations to the Board of Directors based on the information acquired through the evaluation process.

The Board will:

1. Establish evaluation criteria that may include but not me limited to:
   - Accomplishments of the organization's mission, values, vision, strategic directions and objectives;
   - Performance of responsibilities as outlined in the Executive Director's job description;
   - Adherence to Board-Approved policies; and
   - Annual outcome driven objectives established
2. Agree, in advance with the Executive Director, on indicators of success and the evidence required.
3. Treat the evaluation report and final recommendations with the strictest of confidence

RELEVANT LEGISLATION AND STANDARDS:

N/A

RELATED POLICIES:

CCA: ORG-GOV-2.1, 2.5, 4.4, 7.1
St. Mary's Home/Maison Sainte-Marie Constitution and By-laws #3 and #4

Created: March 22, 2016
Review Date: July 2024
Approved by BOD: July, 2024

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GOV A.2: BOARD OF DIRECTORS – ETHICAL CODE OF CONDUCT

SCOPE:

This policy applies to the Board of Directors of SMH.

PURPOSE:

To establish a code of conduct for the Board of Directors, and a due process by which potential, actual or perceived conflicts of interest are dealt with especially to maintain public confidence that the Board of Directors will always act in the best interests of St. Mary's Home.

DEFINITIONS AND ACRONYMS:

Board: means Board of Directors
Director: means a person occupying the position of Director in the Board
Conflict of interest: Any existing, perceived, or potential conflict between the interests of St. Mary's Home and its clients, and any Director. A conflict occurs when a Director could potentially benefit or be perceived as benefitting from an action or circumstance arising at St. Mary's Home, regardless of the size of that benefit, from a contract, business relationship, investment or similar matter or whose vote at Board meetings could be influenced by that conflict.
Immediate Family: Immediate Family of a Board of Director is defined as spouse, live-in partner, child, or parent.

POLICY:

The Board of Directors will perform their duties in a manner that:

1. Supports the mission and serves the best interests of St. Mary's Home;
2. Brings credibility and goodwill to St. Mary's Home;
3. Demonstrates respect for principles of due process and, respect for individuals and diverse and opposing viewpoints;
4. Demonstrates good faith, fairness, prudent judgment, honesty, transparency, and openness;
5. Avoids real or perceived conflicts of interest;
6. Follows required practices outlined in The St. Mary's Home Constitution and By-Laws and confirms with policies, including but not limited to:
   - Privacy of information, including privacy of others in all St. Mary's Home activities
   - Anti-discrimination, and Anti-racism, Diversity, and Inclusion
   - Workplace Harassment and Violence
7. Respects the confidentiality of information discussed and reviewed at Board meetings and otherwise on behalf of the Board;
8. Supports decisions made by the Board, even when not aligned with a Director's personal viewpoint; and
9. Represents St. Mary's Home informally in a positive manner.

IMPLEMENTATION:

Discussion on confidential issues: in-camera sessions
There may be times when it is in the best interest of St. Mary's Home, that confidential discussions be held during Board meetings. In that event, it is proper to agree by the facilitator's proposal or by formal motion, whichever the meeting prefers, to move "in-camera" especially if the business to be discussed would otherwise:

Created: March 22, 2016
Review Date: July 2024
Approved by BOD: July, 2024

1. Breach employee confidentiality;
2. Jeopardize internal or external contract negotiation; and
3. Cause discomfort or harm to any person or the family of any person or others with pertinent information relating to a situation involving a person in whose interests or to whose benefit the organization has in any way become involved.

The Executive Director is entitled to attend in-camera sessions, except for instances which involve a conflict of interest between the subject matter to be discussed and the Executive Director.

Conflicts of Interest

Board of Directors shall inform the Board President of any potential, actual, or perceived conflict of interest that they or their immediate family may have with any circumstance or issue related to St. Mary's Home including but not limited to operations, personnel, clients, partners, and/or donors.

For any direct or indirect, pecuniary, or other interest in a matter, whether or not they appear to be in conflict, the Director shall declare such interest at the meeting, under the Board's existing confidentiality provision, and shall not take part in any discussion or voting relating to the matter. Should a potential, actual, or perceived conflict of interest be brought to the attention of a Director by someone outside of St. Mary's Home, that Director shall bring the matter to the attention of the Board President.

At the request of the Board President, the Director shall remove themselves from the meeting while such matter is being considered. The Board of Directors, through discussion, will assist the Board President in deciding on a course of action, and a timely decision will be made. In all circumstances, the decision of the Board President is final.

Where a conflict of interest, potential, actual, or perceived is irresolvable, even when disclosure of details is withheld for confidentiality reasons, the Director in breach of this policy shall resign.

Breach of Code of Conduct

A suspected breach in the Board of Directors' Code of Conduct is dealt with by following the guiding principles of respect for the person(s) involved, objectivity, protection of confidential information, and due diligence. The Board President (or Vice-President if the President is the subject in question) is obliged to investigate and make every effort to resolve the issue between the complainant and the subject. The investigation should be done in a timely manner depending on the complexity of the allegation.

Should the investigation by the Board President or Vice-President indicate that a breach has occurred; the Board President or Vice-President will recommend the removal of the Director in question from the Board of Directors, which would require a resolution supported by two-thirds of the Board membership.

RELEVANT LEGISLATION AND STANDARDS:

Ontario Human Rights Code 1962 and the Ontario Human Rights Code-rso. C.h.19

RELATED POLICIES:

St. Mary's Home/Maison Sainte-Marie Constitution and By-laws #3.14
CCA: ORG-GOV-1.1,1.2
SMH Workplace Harassment
SMH Sexual Harassment and Violence
SMH Anti-Discrimination
SMH Anti-Racism, Diversity and Inclusion

Created: March 22, 2016
Review Date: July 2024
Approved by BOD: July, 2024

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GOV A.3: BOARD OF DIRECTORS – ROLE, RESPONSIBILITY, ACCOUNTABILITY OF DIRECTOR

SCOPE:

This policy applies to the Board of Directors of SMH.

PURPOSE:

To outline the role of a Director on the St. Mary's Home Board of Directors.

DEFINITIONS AND ACRONYMS:

Board: means Board of Directors
Director: means a person occupying the position of Director or Officer on the Board

POLICY:

Directors on the St. Mary's Home Board of Directors share in the authority, accountability, and responsibility with other Directors on the Board to ensure that the organization functions according to its mission, values, and strategic objectives.

IMPLEMENTATION:

Directors will:

1. Prepare for and attend all Board meetings;
2. Work as a team member and support Board decisions;
3. Participate in the review of the mission and objectives and the development of a strategic plan;
4. Monitor the performance of the organization in relation to its strategic objectives, and financial performance in relation to the budget;
5. Review and abide by the by-laws and policies of St. Mary's Home;
6. Sign a confidentiality agreement;
7. Establish, review and monitor policies that guide financial and risk management;
8. Participate in the budget approval process;
9. Participate in hiring, evaluating and, if necessary, releasing the Executive Director;
10. Participate in the Board orientation;
11. Participate in committees as required;
12. Be an advocate and/or ambassador for St. Mary's Home; and
13. Support organizational events.

RELEVANT LEGISLATION AND STANDARDS:

N/A

RELATED POLICIES:

CCA: ORG-GOV -2.1
St. Mary's Home/Maison Sainte-Marie Constitution and By-Laws
SMH Board of Directors - Role, Responsibilities and Accountability
SMH Board of Directors – Code of Conduct
SMH Board of Directors – Conflict of Interest

Created: March 22, 2016
Review Date: July 2024
Approved by BOD: July, 2024

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GOV A.4: ROLE, RESPONSIBILITIES AND ACCOUNTABILITY – EXECUTIVE DIRECTOR

SCOPE:

This policy applies to SMH Board of Directors and the Executive Director

PURPOSE:

To outline the role, responsibilities, and accountability of The St. Mary's Home Executive Director

DEFINITIONS AND ACRONYMS:

Board: means Board of Directors
Director: means a person occupying the position of Director or Officer on the Board.

POLICY:

The long-term strategic plan aligned with the mission statement of St. Mary's Home will direct the Executive Director's work. The Executive Director is to ensure that all practices are legal, prudent, and ethical.

IMPLEMENTATION:

Communication/Disclosure and Counsel to the Board
The Executive Director shall keep the Board Informed and be supportive of its work. They shall:

1. Ensure the Board has adequate and appropriate information to make informed decisions;
2. Submit monitoring data required by the Board;
3. Ensure the Board is made aware of any actual or potential non-compliance with any Board-approved policies and Board-staff relationships; and
4. Ensure the Board is provided with actual or incidental information it requires, including current trends, organizational events and, internal and external changes facing the organization.

Financial Practice
The Executive Director shall ensure the fiscal integrity of St. Mary's Home. They shall:

1. Ensure expenditures do not deviate materially from Board-stated priorities;
2. Ensure proper approvals are in place prior to any financial commitments being made on behalf of St. Mary's Home including incurring debts or withdrawals from reserves;
3. Follow approval procedures and monetary limits for payment of money as per St. Mary's Home / Maison Sainte-Marie Constitution and By-Laws: 3.12
4. Ensure proper segregation of duties is maintained for all financial transactions;
5. Operate with a current financial and capital budget;
6. Settle payrolls;
7. Submit tax payments or other government-ordered payments by required due dates; and
8. Receive or disburse funds with controls sufficient to meet the standards of the Board-appointed auditor.

Created: March 22, 2016
Review Date: July 2024
Approved by BOD: July, 2024

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Treatment of Paid and/or Volunteer Staff
They Shall:

1. Ensure hiring practices that assess employees and candidates for employment are based on their job-related qualifications and capabilities, including their ability to contribute to the organization as part of a team;
2. Implement the performance development program to monitor the performance of staff, and to support staff to be as successful as possible in their work; and
3. Ensure that staff abides by The St. Mary's Home Staff Code of Conduct/Ethics.

Risk Management
They Shall:

1. Ensure staff and participants are prepared for emergency situations;
2. Ensure staff and participants have safe working conditions by maintaining the building and equipment to avoid accidents and risk to the organization;
3. Ensure that insurance coverage IS KEPT FOR DIRECTOR AND OFFICER LIABILITY, COMMERCIAL GENERAL LIABILITY AND OTHER AS NEEDED IS CURRENT
4. Maintain the safekeeping of legal documents;
5. Operate with the secure use of computer technology and secure storage of electronic and other data;
6. Minimize risk to the organization by effectively addressing conflict of interest situations; and
7. Ensure that the activities of St. Mary's Home are operating in compliance with all the relevant statutes and legislations created at the Municipal, Provincial and Federal Government levels.

Personal Conduct
They Shall:

1. Uphold and model the values central to the mission of St. Mary's Home; and
2. Uphold the principles central to St. Mary's Home policies dealing with Diversity, Inclusion, Anti-Discrimination, And Anti-Racism.

RELEVANT LEGISLATION AND STANDARDS:

N/A

RELATED POLICIES:

CCA: ORG-GOV-2.3, 7.4
SMH Board of Directors – Role, Responsibilities, And Accountability
St. Mary's Home/Maison Sainte-Marie Constitution and By-Laws: #3.12

Created: March 22, 2016
Review Date: July 2024
Approved by BOD: July, 2024

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GOV A.5: EXECUTIVE RELATIONSHIP

SCOPE:

This policy applies to SMH Board of Directors and Executive Director.

PURPOSE:

To establish the working relationship between the Board of Directors and the Executive Director

DEFINITIONS AND ACRONYMS:

Board: means Board of Directors

POLICY:

To further strengthen the working relationship between the Board and the Executive Director, it is important to delineate the roles and responsibilities of each. St. Mary's Home will maintain policies on the role, responsibilities, and accountability of the Board of Directors, (Role, Responsibility and Accountability) and, for the Executive Director, Executive Director Performance Evaluation, and an Executive Director Job Description/Contract Agreement.

In addition, a set of guidelines called: our working relationship has been developed to assist both the Executive Director and the Board of Directors in clarifying roles based on specific tasks. As part of succession planning, these guidelines act as a resource for the new Board Members and Executive Director.

IMPLEMENTATION:

Refer to tasks outlined in St. Mary's Home Guideline: Our Working Relationship.

RELEVANT LEGISLATION AND STANDARDS:

N/A

RELATED POLICIES:

CCA: ORG-GOV 2.3, 7
SMH GOV A.1: Board of Directors: Role, Responsibility, and Accountability
SMH GOV A.4: Role, Responsibility and Accountability – Executive Director
Executive Director Job Description
Executive Director Performance Evaluation
GUIDELINES: Our Working Relationship

Created: March 22, 2016
Review Date: July 2024
Approved by BOD: July, 2024

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GOV A.6: ACCESS BY EMPLOYEES TO BOARD OF DIRECTORS

SCOPE:

This policy applies to SMH Board of Directors and all staff.

PURPOSE:

To clarify lines of communication to the Board of Directors by St. Mary's Home employees.

DEFINITIONS AND ACRONYMS:

SMH: St. Mary's Home
Board: Board of Directors

POLICY:

The Board of Directors of SMH shall operate in an open and approachable manner. The normal line of communication by employees to the Board of Directors shall be through the Executive Director. In the case of a complaint against the Executive Director by an employee, the President of the Board of Directors shall be the first line of communication by staff.

IMPLEMENTATION:

1. Relevant information and/or issues for the Board to address shall be given by staff to the Executive Director in writing;
2. As an opportunity for staff to inform the Board about the services that they provide, staff presentations to the Board or to its committees shall be held periodically and at the invitation of the Board; and
3. In circumstances where there is a complaint by an employee against a member of the Board of Directors or against the Executive Director, the employee is required to follow the procedures outlined in St. Mary's Home Policies – Risk and Safety and Human Resources: Reporting Illegal Unethical and/or Improper Conduct.Where at all possible, the Board President, at minimum shall be consulted.

RELEVANT LEGISLATION AND STANDARDS:

N/A

RELATED POLICIES:

CCA: ORG-GOV-2.4
SMH HR A.10 Reporting Illegal, Unethical Conduct and/or Improper Conduct

Created: March 22, 2016
Review Date: July 2024
Approved by BOD: July, 2024

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GOV A.7: DEVELOPMENT, REVIEW, IMPLEMENTATION AND ENFORCEMENT OF POLICY

SCOPE:

This policy applies to SMH Board of Directors and Leadership Team.

PURPOSE:

1. To ensure a consistent and evidence-based process for the development, implementation review, and approval of policies, procedures, and guidelines at SMH;
2. To acknowledge that where SMH has not issued specific policies and procedures, staff are guided by regulations such as Code of Ethics and Standards of Practice – Ontario College of Social Workers and Social Services Workers; and
3. To acknowledge the roles that various stakeholders play in the development, implementation, review, approval, and enforcement of SMH Policies and Procedures.

DEFINITIONS AND ACRONYMS:

Staff: For the purposes of this policy, staff refers to employees, volunteers, partners with whom SMH has a contract to provide services to clients, and students in field placements working at SMH.
Service Partner: Is an agency and its staff, and/or an individual who have signed service protocols and/or agreements with SMH to provide services to clients on-site.
SMH: St. Mary's Home
Board: means Board of Directors

POLICY:

SMH has designed this policy to provide a robust process for policy development and implementation to address the accountability and risk management requirements of the organization. All staff and Board of Directors members are expected to not only familiarize themselves with SMH Policies as part of their orientation during the hiring/election/appointment process but are also expected to adhere to such policies as volunteers and employees of SMH.

It Is the responsibility of the Executive Director to provide the Board of Directors with updates on the policy review process. A report on such reviews shall be standing item in regular Board of Director meetings and recorded in the minutes to the Board of Directors. The Board of Directors are required to approve all newly developed, amended and/or revised SMH Policies.

Created: March 22, 2016
Review Date: July 2024
Approved by BOD: July, 2024

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IMPLEMENTATION:

Policy Development Requisites

- Purpose:

To provide context, a policy will often include background information or a rationale to support the existence of a policy.

- Definitions of Terms:

To maintain a common understanding and the consistent application of practice, at times, it is necessary to provide a definition of terminology in a policy statement.

- Policy:

A policy is a statement which guides decision-making based on the organization's mission, strategic direction and objectives. It sets out the general aim of the organization in a specified area and includes objectives, responsibilities, and guidelines for implementation.

- Procedure:

This will provide step-by-step guidance on how a policy is to be implemented. While a policy sets out general aims and responsibilities, a procedure will state clearly who will do what, when and how.

- Guidelines:

Guidelines can be developed for all staff to follow or for specific program areas. Guidelines are meant to be a support to the decision-making process only. If applicable, guidelines are cited in a policy with information on where to access them including through hyperlinks embedded in the policy.

Identification of Need

Often a policy needs to be written and/or revised when new legislation pertinent to the operation of SMH is introduced. Changes in programs and/or services and/or increased risk to the organization can also prompt a policy revision. Policies should be written in such a way as to enable the organization to successfully implement them given the resources available while still meeting any legal obligations.

Stakeholder Involvement

Appropriate stakeholders (i.e. members of the Board, staff, community partners) are involved in the development of a new policy or document that guides or impacts practice. The Executive Director or Board President will designate a lead author or team of authors, to guide the development process of any new policy. The author(s) can then act as a resource to stakeholders who may want to provide further feedback or who may need further guidance.

Evidence-Based Policy

Review of current research to establish whether new procedures and/or guidelines need to be incorporated into policy is an important part of the development and review process. Documents that provide guidelines related to regulations or professional practices are used to inform policy. Documents from other organizations that demonstrate leading practices may also be used to develop policy. An example of an evidence-based resource for an organization to measure its current practice against, is the Canadian Centre for Accreditation Standards.

Policy Development and Review Documentation

It is important to document the historical development and review of policies to ensure the organization is in line with the most current legislation and/or is continuing to be responsive to the changing needs of all stakeholders. SMH has a comprehensive policy implementation cycle of review.

Created: March 22, 2016
Review Date: July 2024
Approved by BOD: July, 2024

Policies will be reviewed using the review calendar based on funder and accreditation requirements or as often as required by relevant legislation. For example, health and safety policies and procedures must be reviewed annually. The Director of Operations and Support Services and/or their designate will keep a record of when policies are due to be reviewed and send a reminder to the author(s)/review team prior to review date. The Director of Operations and Services or their designate will ensure that outdated versions of policies are archived. In addition, a policy template is used to ensure consistency among policies. It includes sections on revision and implementation dates. The policy tracking form requires the organization to keep detailed documentation on policy changes and is maintained by the Executive Director or their designate.

- Appendix 1 – SMH Policy Tracker Cycle of Review
- Appendix 2 – SMH Policy Template
- Appendix 3 – SMH Policy Tracking Form
- Appendix 4 – SMH Policy Tracker – Acknowledgement and Agreement Verification

Communication of Policies

Upon the completion of the review, amendment and approval process of a policy, the Executive Director or designate will send out an e-mail to all staff to alert them to the existence of the new or amended policy. The leadership team is responsible for ensuring that staff is aware of this information and obtain the proper acknowledgements and agreements.

Approval of Policies

All changes and updates to policies as well as new policies must be approved by the Board of Directors. Policies that have procedures that directly impact or minimize risk to the Board must be reviewed and approved by all members of the Board of Directors. Such policies include stewardship and finances, governance, human resources risk and crisis management, and privacy: collection, use and release of information.

Implementation of Policies and Guidelines

1. Compliance with policies and guidelines is one measure used by SMH to enhance organizational operations and governance and to minimize organizational risks. It is a requirement within employees' employment terms and conditions that policies and procedures are followed; and
2. St Mary's Home staff and members of the Board of Directors, and volunteers during their orientation to the organization, are required to sign a form acknowledging that they have read and agree to follow the SMH Policies. The review process may prompt the need to sign the acknowledgement and agreement statement form at various times of the year and/or whenever a significant policy change is made.

Enforcement of Policies

Failure to comply with the SMH Policies is covered in the SMH Policy and Procedures Manual: Risk and Safety and Human Resources Section – "Reporting Illegal/Unethical Conduct."

RELEVANT LEGISLATION AND STANDARDS:

N/A

RELATED POLICIES:

CCA:ORG-GOV-2.6; CCA: ORG-SS-1.1,1.2, 1.3,1.5
SMH HR A.10: Reporting of Illegal/Unethical and Improper Conduct

Created: March 22, 2016
Review Date: July 2024
Approved by BOD: July, 2024

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GOV A.8: SUCCESSION PLANNING - BOARD OF DIRECTORS and EXECUTIVE DIRECTOR

SCOPE:

This policy applies to SMH Board of Directors and all staff.

PURPOSE:

To establish a succession planning process at SMH for the renewal and sustainability of the Board of Directors and for SMH leadership through the Executive Director.

DEFINITIONS AND ACRONYMS:

SMH: SMH
Leadership Team: Executive Director and Director of Operations and Support Services

POLICY:

Succession planning at SMH has a three-year planning horizon. Through collaboration with the Board of Directors and the Leadership Team, a plan is determined using key steps to effective succession planning. Additionally, to protect SMH from sudden loss of executive services, the Executive Director must ensure that senior staff members are familiar with respective internal directors' and executive director management issues and processes.

IMPLEMENTATION:

Identification: Succession planning needs are identified by aligning with SMH organizational goals and the core competencies required to meet these goals;
Assessment: Once needs are identified, an assessment is done to determine where the potential exists within SMH to meet such needs;
Development: Board Members and the Executive Director are encouraged to build their knowledge and capacity by seeking out professional learning activities that may include training, courses, workshops, mentoring, leadership development and/or taking on acting positions; and
Management: Succession plans should also be reviewed and evaluated at a minimum, annually.

RELEVANT LEGISLATION AND STANDARDS:

N/A

RELATED POLICIES:

SMH Constitution and By-Laws
SMH Policy: Human Resources – Hiring Practices
SMH Board of Directors Talent Matrix
SMH Board of Directors Biographies
SMH Board of Directors Orientation Handbook

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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GOV A. 9: DISSOLUTION OF THE ORGANISATION

SCOPE:

This policy applies to SMH Board of Directors and Executive Director

PURPOSE:

To outline procedures if dissolution of SMH is necessary

DEFINITIONS AND ACRONYMS:

St. Mary's Home: SMH

POLICY:

It is the policy of SMH to continue operations and meet their obligations to the best of its ability.
However, if there were a reason that the organization could no longer continue operations, and all other reasonable solutions to remedy the situation have been explored, then the organization may need to dissolve.

IMPLEMENTATION:

1. Following legal consultation, the Board of Directors must approve the dissolution of the organization and follow other procedural steps; A decision to dissolve the organization must be made in accordance with the requirements of the SMH Letters Patent and the Corporations Act (Ontario). Additionally, dissolution must take place with the advance permission of the Charities Directorate of the Canada Revenue Agency;
2. Assets will be distributed in accordance with the requirements for registered charities as set out in the Income Tax Act and set out in St Mary's Home constating documents;
3. SMH will make best efforts to match each participant to alternate service provider;
4. SMH will terminate staff in accordance with the Employment Standards Act (Ontario).

RELEVANT LEGISLATION AND STANDARDS:

The Corporations Act (Ontario)
Income Tax Act
Employment Standards Act (Ontario)

SMH FORMS:

N/A

RELATED POLICIES:

St Mary's Home: Risk and Safety - Disaster Recovery and Business Continuity
St Mary's Home's Letters Patent

Created: March 22, 2016
Review Date: July 2024
Approved by BOD: July, 2024

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HR A.1: ANTI-DISCRIMINATION, ANTI-RACISM, DIVERSITY AND INCLUSION

SCOPE:

This policy applies to the Board of Directors, employees, volunteers, participants, and partners of SMH.

PURPOSE:

To establish procedures at SMH to eliminate discrimination across the organization and to ensure a workplace environment that promotes diversity and inclusion and is free of racist behaviour.

DEFINITIONS AND ACRONYMS:

Anti-racism: "Anti-racism is a process which acknowledges the existence of systemic racism including institutional and societal, and through policies and practices, seeks actively to identify, challenge and eliminate racism in all its various forms wherever they exist". - Ontario Anti-Racism Secretariat

POLICY:

SMH is committed to the principles of workplace diversity, racial equality and the elimination of systemic racism and continues to develop and implement the anti-discrimination principles in policies, procedures, and decision-making processes. SMH strives to reflect the community in its structure (all staff) and to promote equal access to the services it provides. The Human Rights Code in Ontario provides a legislative means to protect the rights of all individuals in Ontario. The Code provides that every person in Ontario has a right to freedom from discrimination in employment on the grounds of:

1. Mental illness
2. Record of offences
3. Sexual orientation
4. Creed
5. Gender
6. Ancestry
7. Ethnic origin
8. Marital status
9. Pregnancy
10. Colour
11. Place or origin
12. Citizenship
13. Family status
14. Disability
15. Gender history
16. Religious beliefs
17. Same-sex partnership status

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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IMPLEMENTATION:

SMH will:

1. Prohibit any harassment and/or intimidation in all aspects of the Agency;
2. Establish employment and participation practices that are representative of equity for staff within the diversity of its own group including recruitment related and other decision-making based on merit i.e. a person's qualifications, ability, and performance;
3. Provide services that are sensitive to the needs of diverse individuals;
4. Implement programs that seek to eliminate systemic barriers to full participation and promote positive race relations and attitudinal change;
5. Reasonably accommodate the needs of persons with disabilities in a manner that respects their dignity and helps maximize their contribution to SMH;
6. Increase cultural competence through training that may include obtaining knowledge of differing cultural practices and views, encouraging positive attitudes toward cultural differences, and allowing awareness of one's own cultural view;
7. Ensure that work-related communications be written in gender-neutral language, and represents a positive and balanced portrayal of racial and cultural minorities; and
8. Post this policy in SMH where it is visible to all.

RELEVANT LEGISLATION AND STANDARDS:

The Canadian Multicultural Act 1970 - Declaration of Multiculturalism Policy
Human Rights Code 1981: Ontario Human Rights Commission
Canadian Charter of Rights and Freedoms 1982
Child and Family Services Act 1990
Guidelines: "Achieving Cultural Competence", Ministry of Children and Youth Services

SMH FORMS:

RELATED POLICIES:

SMH Policy: Governance – Board of Directors Code of Conduct
SMH Policy: Human Resources Employees: Staff Code of Ethics and Conduct

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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HR A.2: STAFF CODE OF CONDUCT AND ETHICS

SCOPE:

This policy applies to SMH staff, with regards to Code of Conduct and Ethics. Supervisors and the Executive Director have the responsibility for the application and implementation of this policy.

PURPOSE:

To establish a code of conduct and ethics for staff of SMH; and to establish a process to address breaches in this code.

DEFINITIONS AND ACRONYMS:

Staff: refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement and service partners of SMH.
Service Partners: is an agency and its employees, and/or an individual who have signed service protocols and/or agreements with SMH to provide services to participants on site.
All service partners are expected to follow this policy while at SMH. It is recognized that some service partners may have professional standards that guide their conduct such as the College of Nurses, College of Social Workers, etc. When entering a partnership, SMH will work with partners to ensure that this policy can be implemented in harmony with such professional standards.
Supervisor: person in charge of overseeing and directing the staff member.Agency: SMH
Conflict of Interest: Conflict of interest means any potential, existing and/or perceived conflict between the interests of SMH, its participants, suppliers and any staff. A conflict occurs when a staff could potentially benefit personally or be perceived as benefitting personally from an action or circumstance arising at SMH.

POLICY:

Staff and service providers will follow the Code of Conduct and adhere to organizational commitments displaying honesty and integrity and reaching company goals solely through honorable conduct to ensure SMH upholds its credibility.

IMPLEMENTATION:

Staff and service partners are expected to:

1. Act at all times as role models;
2. Honour commitments made to participants and to the programs they deliver;
3. Understand the importance of confidentiality and always abide by it. All participant information is strictly confidential to SMH and must not be breached;
4. Be at work when scheduled;
5. Make the needs of the participants and the programs a priority;
6. Be positive in their interaction with participants and with each other;
7. Refrain from bringing their children to work. While SMH endeavours to make accommodation to meet special family needs, it is a workplace that requires focus on our young participants. Exceptions to this policy may be considered by Supervisors in response to urgent situations, but must be pre-approved;
8. Carry out the duties detailed in their job descriptions; and
9. Follow all regulations, policies, health, safety and emergency procedures

Staff Participant Relationship:
SMH strives to provide a caring, supportive, and family-friendly atmosphere for participants while ensuring excellence in services and programs. Much of the success working with participants is based on building a strong relationship with them. However, it is important to address the parameters around such relationship. SMH believes that the only relationship a participant and staff should have is in the professional context of their work at the Agency.

Staff will not:

1. Engage in social activities with participants at or outside the Agency. This includes such things as going to a participant's home for dinner, inviting them to their own homes, going shopping, going to a movie, a club, etc. with participants other than for program purposes. Activities that may superficially appear to be "social" e.g., lunch, coffee, etc. should only be engaged in where there is a specific treatment-related and planned purpose;
2. Give or sell cigarettes to the participants;
3. Lend personal or Agency items or money to participants;
4. Hire participants for any purpose including babysitting either at the Agency or in their home, housekeeping, or have participants do personal favours for any sort of reward;
5. Purchase personal items from participants. If a participant is selling items as their employment, for example: Avon, or for the purpose of a special event, e.g. raising money for a charity, should staff wish to make purchases from participants, it is acceptable although they should not feel obliged and a supervisor must beinformed ahead of the purchase;
6. Volunteer in activities for participants unless they are program-related;
7. Give out their home phone or cell numbers to participants, personal phone calls and/or texts aren't permitted;
8. Use personal Facebook and other social media tools to communicate with participants;
9. Contact participant or their family after they terminate service with the Agency;
10. Make work-related calls from their homes where it can be avoided or made by another staff person at the Agency. When leaving messages for participants on voicemail/answering machines, confidential information must not be released;
11. Release any confidential information upon termination of employment and/or position at SMH including when seeking and/or obtaining employment/positions in any other organization;
12. Participate in one-on-one activities with participants in a volunteer capacity without written permission by the Executive Director or designate; and
13. Give rides to participants in the staff's vehicle
14. Use of personal vehicles for work related activities, must always receive pre-approval by a supervisor and proof of personal appropriate insurance coverage must be provided in advance.

Conflicts of Interest:
SMH encourages staff to engage in community and/or civic activities but those activities must not conflict with the interests of SMH. Staff will not:

1. Engage in outside employment, directorships, business or volunteer activities that:
    a. cause an actual or apparent conflict of interest;
    b. are performed in such a way as to appear to be an official act of or to represent SMH;
    c. unduly interfere with a staff's ability to exercise independent judgment or perform the duties of their job/position/placement/directorship;
2. Conduct activities that are not work-related during working hours or use St. Mary's equipment or facilities for non-work-related activities without advance approval;
3. Befriend participants;
4. Engage in activities or provide services/resources requested by participant/partners not within organization mandate;
5. Ignore the action of a participant promoting to other SMH participants a practice not supported by SMH;

6. Accept gifts,
entertainment or services from customers or suppliers, other than the customary exchange of gifts, such as Christmas gifts, that are of nominal value (less than $10). If a staff receives a gift that is of more than nominal value or if they are uncomfortable with a gift which has been offered or given, the staff is asked to speak to their Supervisor.
7. Make any public appearances or publish any documents in which they appear to be representing SMH, without prior approval from their Supervisor or Executive Director;
8. Use SMH letterhead for personal correspondence; and
9. Conduct business dealings with SMH on behalf of their relatives or their businesses.

Reporting a Conflict of Interest:

1. Staff should identify and report any possible or potential, existing, and/or perceived conflict of interest to their Supervisor or Executive Director if the Supervisor is in question, regardless of whether or not there is a benefit associated with it. Should a staff bring a potential, actual, or perceived conflict of interest to the attention of a Supervisor and/or the Executive Director, the Executive Director will investigate and determine a course of action. If the Executive Director is in question, staff are to follow the procedures as outlined in the SMH Policy: Human Resources - Employee HR A.10 – Reporting Illegal, Unethical, and/or Improper Conduct.

Breach of Code of Ethics and Conduct:
The following are examples of prohibited or unacceptable conduct:

1. Willful violation of any SMH policy, procedure or Confidentiality Agreement including Alcohol and Drug Use Policy, and/or violation of Child and Family Services Act of Ontario;
2. Deliberate action that is detrimental to SMH's efforts to operate professionally;
3. Negligence or any careless action that endangers the life or safety of a participant or staff;
4. Engaging in corporal punishment or physical restraint of any kind;
5. Refusal to comply with expectations of job description in a manner that affects the immediate physical or emotional well-being of a participant;
6. Borrowing money from participants or using participants to provide services;
7. Smoking less than 9 meters from the Outreach Centre and/or when in the company of participants;
8. Taking participants or their children into the staff's home without the prior consent of the Executive Director;
9. Engaging in criminal conduct or acts;
10. Insubordination or refusing to obey instructions properly issued by a Supervisor or the Executive Director pertaining to a staff's work;
11. Engaging in an act of sabotage; willfully or with gross negligence causing the destruction or damage of SMH property, or the property of fellow staff or participants;
12. Theft of SMH property or the property of fellow staff; unauthorized possession or removal of any agency property, confidential documents, from the premises without prior permission from the Executive Director or designate; unauthorized use of equipment or property for personal reasons; using equipment for profit;
13. Introducing a treatment method or any intervention without the knowledge and permission of the Executive Director;
14. Bringing weapons or firearms into the building and/or on the property;
15. Using abusive and/or profane language in front of or towards participants or staff;
16. Falsifying any report or record;
17. Opening mail addressed to the Executive Director, another co-worker or a participants, interfering with postage, or publicly posting letters for participants - It is illegal to forward mail, it can only returned to sender, however, intended recipients of mail and past employees/employees on leave, can be contacted by the appropriate person and informed of mail sent to SMH on their behalf and arrangements can be made for such mail to be picked up, but all mail picked up must be signed for and dated by the recipient -

-when they pick it up;

18. Letting a participant know one's own personal feelings about a plan for keeping or relinquishing a child; and
19. Letting a participant or others outside SMH know how one feels about a particular participant's plan for
20. their child.

Disciplinary Procedures/Corrective Measures:
A suspected breach of the Code of Conduct and Ethics policy is dealt with by following the guiding principles of respect for the persons involved, objectivity, protection of the confidential information, and due diligence; disciplinary action will be taken in cases where the Code of Conduct and Ethics has been breached and will be consistent with the severity of the violation.

Corrective measures:
Circumstances shall dictate the type of corrective action to be taken with staff. Depending oncircumstances, any of the following can be administered:

1. Verbal warning;
2. Written warning;
3. Suspension with or without pay; and
4. Dismissal.

Generally, the following criteria shall apply when determining if corrective action is required:

1. Seriousness of actions;
2. Actual or potential risk to participant (physical or emotional);
3. Past performance;
4. Frequency of occurrence; and
5. Previous corrective action taken.

Other criteria, if relevant, may be considered. In all cases of breach of policies and of the Code of Conduct, the immediate Supervisor will first review the circumstances and if action is to be taken, recommend a course of action to the Executive Director. The Executive Director shall then decide on a course of action. A staff may be dismissed for cause and in cases of serious disciplinary offenses or acts, termination of employment/placement is effective immediately and without notice.

RELEVANT LEGISLATION AND STANDARDS:

RELATED POLICIES:

SMH Policy: Human Resources – Anti-Racism, Diversity and Inclusion; Anti-DiscriminationWorkplace Harassment, Sexual Harassment and Violence
SMH Policy: Systems and Structures - Use of Email, Internet and Other Computing Devices
SMH Policy: Human Resources Employees – Reporting Illegal/Unethical and or Improper Conduct

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HR A.3: STAFF DISPUTE RESOLUTION PROCEDURES

SCOPE:

This policy applies to all staff and volunteers.

PURPOSE:

To establish procedures to assist staff in resolving internal disputes.

DEFINITIONS AND ACRONYMS:

Support Person: A staff with a concern may wish to exercise their option to have another staff in attendance at meeting(s) in a role of "support person". A support person is active in the meeting only in so far as to ensure that the staff voicing the concern is being listened to and as an observer to the discussion on behalf of the staff. If more than one step is required in the process, the same support person is required to participate in the meetings throughout the process.
Staff: refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement and service partners of St. Mary's Home.
Service Partners: is an agency and its employees, and/or an individual who have signed service protocols and/or agreements with St. Mary's Home to provide services to clients on site.
Board: means Board of Directors

POLICY:

St. Mary's Home encourages teamwork, open communication, and the timely resolution of staff concerns. If a staff has a dispute or conflict on the job/in their position, it is expected that they make every effort to resolve the matter with the colleague with whom the staff is having difficulty. Problems should be dealt with immediately so that they do not become more difficult or awkward to handle. To promote a healthy workplace culture, disputes or conflicts should only be brought to the person the difficulty is with or someone who is in a position to address the conflict, as outlined in the next section, not to other colleagues as this would not accomplish resolution and could further complicate the difficulty. When teamwork and open communication are working, it is anticipated that problems can be resolved less formally than the following procedures describe. The procedures below have been established considering that St. Mary's Home is a non-unionized environment.

IMPLEMENTATION:

Steps to be taken when other attempts at dispute resolution have failed:

1. The staff will bring the concern to the attention of their immediate Supervisor during either a regular one-on-one supervision meeting or at a meeting specially requested to address the concern;
2. If the concern cannot be resolved in discussion through the supervisory process, the staff may put their concern in writing, outlining the nature of the concern, the efforts made to date to resolve the matter and what action the staff is requesting in response to the concern;

Created: May 30, 2017
Review Date: July 2024
Approved by BOD: July, 2024

The written concern should be directed first to the staff's immediate supervisor and if no resolution is reached, then to the Executive Director. If the staff has a concern with their supervisor, they should make the concern known directly to the Executive Director in writing. If the staff has a concern with the Executive Director, they should make the concern known directly to the President of the Board of Directors in writing. Every effort will be made to schedule meetings during regularly scheduled work hours and at all levels of the process, a written response to the staff involved regarding the status of the resolution and next steps must be given in a timely manner. The timeline for response is directly related to the complexity of the issue and time must be allotted to respect the process, the people involved, and to encourage a positive result. It is understood that if the situation were life-threatening and/or legal intervention is required, response would be immediate.

Should the staff lodging the concern wish to invite a personal "support person" to attend a meeting with them, the name of the person should also be included in the written concern.

Group Concerns:
If agreed upon by both the Supervisor and the staff, should more than one staff have the same concern to present, one or two staff, of the group's choosing, will represent the group to the Supervisor and, if necessary, throughout further steps in the process.

Final Decision
In day-to-day supervision of staff, Supervisors and the Executive Director have decision-making authority as assigned according to their job descriptions. Supervisors are accountable to the Executive Director, who is accountable to the Board of Directors. Ultimately, should it be required to involve the Board of Directors in a dispute between staff, a decision by full vote of the Board of Directors at a Board meeting is required. In the case of emergencies, in between Board Meetings, the Executive Committee of the Board will have decision-making authority. The decision of the Board is final.

RELEVANT LEGISLATION AND STANDARDS:

Employment Standards Act, 2000 (2023 Update)
Occupational Health and Safety Act, 1990 (2023 Update)
Ontario Human Rights Code, 1990 (2023 Update)
Workplace Harassment Policy, 2023
Privacy Act, 1985 (2023 Update)

SMH FORMS:

RELATED POLICIES:

SMH Policy: STAFF CODE OF CONDUCT AND ETHICS
SMH Policy: WORKPLACE HARASSMENT, SEXUAL HARASSMENT AND VIOLENCE
SMH Policy: REPORTING ILLEGAL, UNETHICAL AND/OR IMPROPER CONDUCT

Created: May 30, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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HR A.4: WORKPLACE HARASSMENT, SEXUAL HARASSMENT AND VIOLENCE

SCOPE:

This policy applies to the Board of Directors, employees, volunteers, participants, and partners of SMH.

PURPOSE:

To ensure that SMH staff, visitors and service partners offering services to our participants on site, and participants understand what workplace harassment and sexual harassment is; and to establish procedures to report incidents of harassment and violence in the workplace.

DEFINITIONS AND ACRONYMS:

Staff: refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement and service partners of SMH.
Worker: refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement and service partners of SMH.
Service Partner: is an agency and its employees, and/or an individual who have signed contracts or agreements with SMH to provide services to participants on site.
Workplace: is any location in which a staff is engaged in work-related activities, this includes, but is not limited to:

1. SMH owned or leased facilities, vehicles and parking lot; and
2. Restaurants, hotels or meeting facilities used for work-related functions or social events.

St. Mary's Home: SMH
Workplace Harassment: defined as any unsolicited or unwelcome interaction, which directly or indirectly affects or threatens to affect a person's job security, prospects of promotions or earnings, working conditions or opportunity to secure a position.
Workplace Violence: The exercise or an attempt of physical force by a person against a worker, in a workplace, that causes or could cause physical injury; or a statement or behavior that is reasonable for a worker to interpret as a threat of physical force that could cause physical injury to the worker.
Forms of Harassment/Violence:

1. Physical abuse, sexual abuse, emotional abuse, verbal abuse, psychological abuse, bullying behaviour, neglect, personal harassment;
2. Engaging in comments or conduct against a worker in a workplace based on gender, race, ethnicity, religion, sexual orientation, gender identity or gender expression, where the course of comment or conduct is known or ought reasonably to be known to be unwelcome; and/or
3. Comments which draw attention to a person's gender, gender identify, race, ethnicity, sexual orientation and have the effect of undermining such person's role in a professional or business environment.

Workplace Sexual Harassment: a sexual solicitation or advance where the person, regardless of their gender, making the solicitation or advance is in a position to confer, grant or deny a benefit or advancement to the worker (regardless of gender) and the person knows or ought that the solicitation or advance is unwelcome.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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Identifying Sexual Harassment

The test of whether harassment has taken place is whether the person knew or should have known that the comments or conduct of a sexual nature, when viewed objectively, might reasonably be:

1. Expected to cause insecurity, discomfort, offence or humiliation to another person or group;
2. Considered to have the purpose or the effect of making it appear that the submission to or rejection of such conduct is or may be a basis for any work-related decision (including matters of hiring, promotion, evaluations or job security); or
3. Considered to have the effect or the purpose of interfering with a person's work performance or creating an intimidating, hostile or offensive work environment.

Types of behaviour, which may constitute sexual harassment include, but are not limited to:

1. Leering or suggestive, persistent staring, and inappropriate gestures;
2. Displaying sexually offensive material;
3. Sexually suggestive or obscene comments and gestures;
4. Requests for sexual favors;
5. Unwelcome remarks, jokes, innuendoes, propositions and taunting about a person's body or attire, Inquiries
6. or comments about a person's sex life, sexual prowess or sexual deficiencies;
7. Physical contact of a sexual nature such as touching or caressing; and/or
8. Sexual assault.

Personal Harassment

Personal harassment is also a form of discrimination. It includes comments or conduct that are not welcome and/or are offensive because of a person's race, ancestry, age, sexual orientation, place of origin, ethnic origin, colour, level of ability or perceived disability, marital status, family status, citizenship or any other protected grounds as per the Ontario Human Rights Code. Personal harassment may include:

1. Hostile, intimidating or offensive comments or conduct based on one of the protected grounds;
2. Hostile behaviour not necessarily referring to a person's colour, religion, etc. but directed at a person because of their membership in a protected group; and/or
3. Behaviour that humiliates, intimidates, excludes, and isolates an individual or group.

Poisoned Work Environment

Harassing comments or conduct can poison the work environment making it an uncomfortable place in which to work. This is also considered harassment. Some examples of actions that can create a poisoned work environment include but are not limited to the following:

1. Displaying offensive or sexual materials, such as posters, pictures, calendars or screen savers; and/or
2. Making jokes, insults and sending e-mail messages that are offensive or sexual in nature.

POLICY:

SMH ensures everyone experiences an environment that is free from all forms of harassment. SMH does not tolerate or condone any form of harassment in the workplace. It is the mutual responsibility of all who work at SMH to ensure that a harassment-free environment is created and maintained.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

IMPLEMENTATION:

Prevention:

SMH will:

1. In consultation with the Joint Health and Safety Committee and/or a representative from that committee, develop and maintain a plan for training to implement this policy that may include but not be limited to:
   - Information and instruction that is appropriate for the worker on the contents of this policy; and
   - Ontario Human Rights, harassment, sexual harassment and discrimination prevention training;
2. Revise the policy as often as necessary, and review every three years; and
3. Keep a copy of this policy in a readily accessible location for use by staff and participants.

Complaint Procedure:

Informal Procedure:

If a staff feels they are being discriminated against or harassed, the first step, only if they feel safe to do so, is to approach the "harasser" directly and demand that they immediately stop engaging in the harassing conduct. It is understood that it is difficult to approach someone who displays harassing conduct.

Formal Procedure:

If it feels unsafe for a staff to address the matter by dealing directly with the person, then they should report it directly to their Supervisor. If the Supervisor cannot resolve the complaint, or if it is too serious to handle at that level, then the complaint is to be referred to the Executive Director. If a staff is not comfortable approaching their Supervisor about concerns, they may proceed directly to the Executive Director. A staff may also choose to report an incident to a member of the Joint Health and Safety Committee. The Executive Director will explore all options with the complainant. One such option is to initiate a formal complaint. The complainant will be asked to provide as much written information as possible using the SMH Workplace Violence Incident Report Form; Workplace Harassment Incident Report Form and/or Workplace Sexual Harassment Incident Report Form. The complaint should be made as soon as possible and once the complaint is received, a formal investigation will be initiated.

Investigation:

The sensitive nature of harassment complaints is recognized and every complaint will be kept confidential to the extent possible. Information will be released only as necessary to investigate and respond to the complaint.If a person is questioned as part of an investigation, it is expected that all discussions will be treated as Confidential. Identifying information about any individuals involved, will not be disclosed unless the disclosure is necessary for the purposes of investigating or taking corrective action with respect to the incident or complaint, or is otherwise required by law. SMH will commence an investigation as quickly as possible and may choose to use either an internal or external investigator, depending on the nature of the complaint. The investigation will include giving the alleged/accused harasser an opportunity to respond to the allegations. It will also include speaking to witnesses and reviewing any related documentation. A person making a complaint must be able to do so without risk of reprisal. Any form of retaliation or threat against anyone who complains about harassment or takes part in an investigation will not be tolerated. Anyone who retaliates against or threatens a complainant in relation to a harassment complaint may be disciplined or terminated. SMH will make best efforts to complete its investigation and communicate the results, in writing, to the complainant and the accused harasser within 30 days after the complaint is received. The following forms/resources are to be used when investigating a complaint of harassment, sexual harassment, and/or violence in the workplace:

1. SMH Workplace Violence and Harassment Investigation Checklist
2. SMH Workplace Sexual Harassment Investigation Checklist
3. SMH Workplace Harassment Interview Questions

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Order for Workplace Harassment Investigation:
If an employer fails to investigate allegations of harassment and/or sexual harassment, the Ministry of Labour will have the power to order an independent workplace investigation and hire an inspector to conduct the investigation at the expense of the employer and the inspector will provide a written summary of the results of the investigation to the appropriate parties.

The Follow-Up
After an investigation is completed, the following written report must be completed listing any necessary action and a copy provided to the complainant and the respondent:

1. SMH Workplace Violence Investigation Follow-Up Form
2. SMH Workplace Harassment Investigation Follow-Up Form

Corrective Action
If staff has engaged in sexual or personal harassment, they will be subject to disciplinary action, up to and including dismissal for cause. If staff retaliates or threatens to retaliate against someone for exercising their rights under this policy, they will be disciplined or dismissed for cause. The Executive Director will determine the appropriatecorrective action and if staff makes an informal or formal complaint in good faith and without malice, regardless of the outcome of the investigation, the staff will not be subject to any form of discipline. However, the Agency will discipline or dismiss staff if false accusations of discrimination or harassment are made, either maliciously or in bad faith.

Alternative Routes
If the alleged harasser is the employer, or at any time no matter what the circumstance, every person has the right to seek assistance from the Human Rights Tribunal of Ontario, Human Rights Commission or to pursue remedies under the Ontario Human Rights Code (as amended) or the Criminal Code of Canada, if applicable.

RELEVANT LEGISLATION AND STANDARDS:

Child Care and Early Years Act 2014
Ministry of Community and Social Services (regulations)
Ministry of Children and Youth Services (regulations)
Ministry of Education (regulations)
Ontario Human Rights Code
Human Rights Criminal Code of Canada: Employment Standards Act
Ontario Occupational Health and Safety Act
Bill 132: Sexual Violence and Harassment Action Plan

RELATED POLICIES:

SMH Policy: Governance – Board of Directors Code of Conduct
SMH Policy: Risk and Safety – Health and Safety
SMH Policy: Risk and Safety – Health and Safety – Roles and Responsibilities
SMH Policy: Risk and Safety – Joint Health and Safety Committee
SMH Policy: Human Resources – Anti-Discrimination, Anti- Racism, Diversity and Inclusion and Anti-Discrimination

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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HR A.5: REPORTING ILLEGAL, UNETHICAL AND/OR IMPROPER CONDUCT

SCOPE:

This policy applies to any person who wishes to report illegal, unethical and/or improper conduct by a staff of, or activities by SMH.

PURPOSE:

1. To identify the obligation to report illegal, unethical, and/or improper conduct;
2. To assure reporting in good faith can be done without fear of reprisal; and
3. To document a process to be followed for reporting suspected illegal, unethical and/or improper behaviour or activities

DEFINITIONS AND ACRONYMS:

Staff: refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement and service partners of SMH.
Service Partners: is an agency and its employees, and/or an individual who have signed service protocols and/or agreements with SMH to provide services to participants on site.
Agency: SMH
Other person: refers to participants, suppliers or other people supporting, residing, working or visiting SMH.

POLICY:

SMH requires individuals to come forward with information on illegal, unethical, and/or improper conduct at the Agency before problems have a chance to become more serious. This policy is separate from, but in addition to the SMH Policy regarding access to a complaints process for participants and the public regarding any aspect of services provided at SMH.

IMPLEMENTATION:

How to Raise a Concern:
Staff should normally raise concerns with their immediate Supervisor. Any other person who wants to report alleged illegal, unethical and/or improper activity or conduct should approach the Executive Director. Examples of conduct that should be reported as illegal, unethical, and/or improper include, but are not limited to, the following:

1. Conduct which is an offence or a breach of law;
2. Deriving personal benefit from dealings with contractors and vendors;
3. Possible fraud and corruption such as inappropriate recording or reporting of revenues, or lack thereof;
4. Embezzlement of SMH's assets;
5. Sexual behavior toward or physical, emotional and/or psychological abuse of anyone associated with St. Mary Home;
6. Incompetence in the performance of an employment role, such that it creates a risk to SMH or to its participants; and
7. An intentional breach of confidentiality.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

Where the staff or other person is not comfortable bringing their concerns to their immediate Supervisor, the staff or other person should contact the Executive Director. If the staff or other person is not comfortable bringing their concern to the Executive Director, the staff or other person may contact the President of the Board of Directors.
Concerns can be raised verbally or in writing. Verbal concerns will be documented in writing and must be signed and dated by the complainant and the person receiving the complaint. As much specific informationas possible should be provided. Reports should be factual rather than speculative to allow for proper assessment of the nature, extent, and urgency of preliminary investigative procedures.

Confidentiality:
Every effort will be made not to reveal the identity of staff or other person who reports suspicious or problematic conduct pursuant to this policy, or who cooperates, gives testimony or participates in an investigation in any manner. Their identity will only be disclosed in connection with furthering the objectives of the investigation, or if required by law to do so. At the appropriate time, the staff or other person may need to come forward as a witness.

SMH Response:
When appropriate, meet with the person in violation. SMH will contact the staff or other person who has raised the concerns and acknowledge receipt of the reported violations or misconduct within five (5) business days.
SMH will review the information provided to decide whether an investigation is appropriate and, if so, what form it should take. Concerns or allegations which fall outside the scope of SMH Policies and Procedures will be referred to the appropriate authority (for example: police, child welfare) by the Executive Director. Where appropriate, the matters raised may:

1. Be investigated by management or the Board;
2. Be referred to the police;
3. Be referred to the external auditor; and/or
4. Become subject of an independent inquiry.

Where an investigation is conducted and the Agency wishes to meet with the individual raising the concerns, a meeting may be arranged, off-site if the individual wishes, and they can be accompanied by a personal "support person". SMH will advise the staff or other person who has raised the allegations of the outcome of the investigation, unless the Agency believes that the interests of SMH might be compromised or is precluded from advising by the operation of law or policy (for example, in the case of privacy concerns).

Untrue Allegations:
If an individual makes an allegation in good faith, but it is not confirmed by the investigation, no action will be taken against them. If, however, an individual makes an allegation frivolously, maliciously or for personalgain, disciplinary action will be taken against them up to and including termination.

The Responsible Officer:
The President of the Board of Directors and the Executive Director have the responsibility for the maintenance and operation of this policy. They will maintain a record of concerns raised and the outcome (but in a form which does not endanger confidentiality) and will report, as necessary, to the Board.

Escalation Process:
This policy is intended to provide staffs or other persons with an avenue within SMH to raise concerns. If the staff or other person is not satisfied with the response of the Agency, and if they feel it is right to take the matter outside the Agency, the following are possible contact points:

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1. External auditor;
2. Relevant professional bodies or regulatory organizations; and/or;
3. Relevant voluntary organization; and/or;
4. Police.

If the staff or other person does take the matter outside SMH, they should ensure that they do not disclose any confidential information.

RELEVANT LEGISLATION AND STANDARDS:

Ontario Human Rights Code
Human Rights Criminal Code of Canada: Employment Standards Act
Ontario Occupational Health and Safety Act
Bill 132: Sexual Violence and Harassment Action Plan

RELATED POLICIES:

SMH Policy: Governance – Board of Directors Code of Conduct
SMH Policy: Risk and Safety – Health and Safety
SMH Policy: Risk and Safety – Health and Safety – Roles and Responsibilities
SMH Policy: Risk and Safety – Joint Health and Safety Committee
SMH Policy: Human Resources – Anti-Discrimination, Anti- Racism, Diversity and Inclusion and Anti-Discrimination

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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HR A.6: POLICE VULNERABLE SECTOR CHECK (PVSC)

SCOPE:

This policy applies to existing/potential employees and new staff at SMH.

PURPOSE:

1. To ensure that all staff have a Police Vulnerable Sector Check;
2. To establish the process for the collection of Police Vulnerable Sector Check from staff

DEFINITIONS AND ACRONYMS:

Staff: refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement and service partners of SMH.
Service Partners: is an SMH and its employees, and/or an individual who have signed service protocols and/or agreements with SMH to provide services to participants on site.
Candidate: is an employee being considered for recruitment for a job at SMH, in a work, placement or volunteering capacity.
St. Mary's Home: SMH

POLICY:

For the protection of our participants, all staff of SMH are required to complete and submit a Police Vulnerable Sector Check prior to starting work/placement/position or within 30 days of starting work/placement/position and are not to work with participants on their own until the document has been submitted.

IMPLEMENTATION:

Prior to Hiring:
Successful candidates will be required to provide a Police Vulnerable Sector Check from their local police department that was completed within 6 months prior to hiring date. Copies will not be accepted, but once the Executive Director or designate views the original PVSC, a copy may be taken for filing in the Personnel file. In the event the staff candidate has made application to the Police for a PVSC but does not have a current Police Vulnerable Sector Check and is required to start work or volunteering immediately, the staff candidate may begin orientation to the workplace and position, provided that the following precautions are taken:

1. The staff candidate must work alongside individuals who have their PVSC in place;
2. The staff candidate must not be alone behind closed doors with a participant; and
3. The staff candidate must not handle any financial transaction on behalf of the SMH.

Results of the Police Vulnerable Sector Check
Arrangements are made to ensure that the results of the Police Vulnerable Sector Check are kept confidential. Only the Executive Director or their designate shall have access to the information; and the records of the results of PVSC are filed in the individual personnel records

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

Confirming or Denying Employment or Volunteer Opportunities/Student Placements:
In the event of a charge or conviction on the Police Vulnerable Sector Check, the Executive Director will interview the candidate, volunteer or field placement student to determine the nature and circumstances of the charge. In making this decision, the Executive Director or designate will also consider:

1. Whether the specific charge or conviction has any bearing on the duties or responsibilities;
2. The results of reference checks;
3. Whether or not the candidate engaged in any rehabilitative program or activity;
4. The length of time that has lapsed between the charge or conviction; and
5. The position applied for.

If the charge proves to be unrelated to any of the duties or responsibilities of the candidate and if the Executive Director's review shows the candidate to be otherwise desirable, the final hiring of the candidate may proceed. The Executive Director will confirm, in writing, if there is a reason to deny confirmation of final hiring of the employee, or placement of a volunteer or field placement student. The confirmation will be kept in the human resources file for a minimum of seven years after they leave.

Given the vulnerabilities of the young parents and children involved with SMH and the nature of work done by SMH, types of charges which would render a candidate unsuitable for hiring or volunteer opportunities/student placements may include, but would not be limited to, the following:

1. child molestation;
2. any form of abuse or assault;
3. criminal negligence;
4. reckless/dangerous driving;
5. drug use or trafficking;
6. breach of trust and theft.

If a successful candidate refuses to provide a Police Vulnerable Sector Check the candidate will be deemed to have withdrawn their application for a staff or a volunteer position/student placement and no further action will be taken by the SMH in respect to this candidate.

RELEVANT LEGISLATION AND STANDARDS:

SMH FORMS:

RELATED POLICIES:

SMH Policy: Human Resources Employees - Hiring Practice

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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HR A.7: TRAINING AND PROFESSIONAL DEVELOPMENT

SCOPE:

This policy applies to SMH staffs' training and professional development.

PURPOSE:

To establish for staff the process to participate in required training and outline procedures to access other professional learning opportunities.

DEFINITIONS AND ACRONYMS:

Staff: refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement and service partners of SMH.
Service Partner: is an SMH and its employees, and/or an individual who have signed contracts or agreements with SMH to provide services to participants on site.
SMH: SMH

POLICY:

SMH encourages professional development for staff both as part of continuous learning for professional development process, to stay updated on knowledge and skills, and as an opportunity to ensure organizational effectiveness in the service to participants. It is expected that providing learning opportunities for staff will further incentivize them to engage in the mission of the organization so that they can feel valued and satisfied in their work. All staff are strongly encouraged to keep up with the knowledge and skills of best practice and, as much as possible, are supported to attend seminars and workshops, in addition to the in-service training provided by SMH on topics related to participant service and professional practice. Permanent staff are encouraged to attend training workshops annually that best relate to the areas of their primary function. Staff benefit from regular professional development that is appropriate, relevant, and affordable, and are supported to participate when it doesn't negatively impact the work of the SMH. For the aforementioned reasons, some trainings and meetings are considered mandatory and are identified as such when provided.

Professional development may take place through:

1. Individual supervision;
2. Team meetings;
3. SMH in-service training activities;
4. Availability of resources for independent learning including;
5. Books, professional journals, audio and/or video training tapes; and
6. External workshop/conferences.

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

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Core Training:
Regular and annual core training for staff may include based on their role:

1. A comprehensive job function orientation
2. Non-Violent Crisis Prevention Intervention
3. Fire safety, including the use of fire extinguishers
4. Policies and procedures review
5. Cultural Competency
6. WHMIS
7. Workplace Violence and Harassment Policy
8. CPR and First Aid
9. Suicide Prevention
10. Accessibility Customer Service Policies
11. Medication and Health Management Policies
12. Food Handling Certification

IMPLEMENTATION:

Staff training needs and interests are identified annually at the time of the formal Performance Evaluation Process, it is both the responsibility of the employee and employer to identify learning and development opportunities. Financial resources for professional development are allocated and managed centrally against all of the above professional development activities. The allocation and use of resources (funds and time) take into consideration in-service training plans, identified needs for the SMH, teams and individuals. The Executive Director holds the final approval with respect to the allocation of funds to professional development activities. In-service and individual professional development activities within the SMH at the individual, team and SMH levels will take place at the discretion of the Supervisor and/or Leadership Team based on identified needs, following these guidelines:

1. Is the topic and identified goal for a team, individual or all of the SMH?
2. Does the professional development activity assist the individual to meet a minimum or preferred qualification of a position?
3. If the goal is an SMH or team goal, is this the individual who is best suited to participate in this opportunity?
4. Can this individual be allowed the time to participate? E.g. is there a participant or program activity which takes priority over attending this workshop; are there work performance issues which take priority over professional development opportunities; is this person on contract or still on probation?
5. Is this professional development opportunity affordable for the SMH? Approvals must consider the cost of the conference, course, or workshop, including fees, the payment of work time, travel costs and the cost of replacing staff if necessary. Full payments of the above are not guaranteed.
6. Attendance at any mandatory in-service training and meetings at the team or SMH level will be considered work time. Any additional hours accrued as a result of in-service training or meetings will be paid or accrued as equivalent lieu time or the staff schedules will be adjusted during the pay period of the training.

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

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Purchase requests for professional development materials:
Requests for the purchase of professional development resources will be made in writing to the immediate Supervisor. It is at the discretion of the immediate Supervisor to authorize the purchase of such resource material if it is within the program budget. Any resource material purchased by SMH will be owned by SMH and the use of it will be at the discretion of SMH.

External professional development:
Requests for individual professional development external to the SMH, e.g., conferences, workshops, courses, will be made to immediate Supervisor in writing prior to the training. It should include specific information about the workshop or conference with respect to topic, cost, dates, and the reason for the request.

Staff attending external professional development activities under SMH name are representing the SMH in public and are expected to conduct themselves accordingly and in compliance with SMH policies and procedures. Anyone attending a professional development activity under the SMH name will be expected to make a verbal presentation to staff (minimally the Leadership Team, optimally all staff), and submit a written summary of the activity as a central record and/or provide the SMH with any materials obtained as a result of the activity.

Post-secondary field placement:
Approval for a post-secondary field placement student to attend training during their practicum is at the discretion of the Supervisor of the team with whom the student is placed. SMH will not pay for fees, transportation, or any other incidental costs with respect to a field placement student attending workshops. If students wish to avail themselves of an opportunity, which is of personal interest, but it is not consistent with an identified learning goal with respect to this field placement, they must be able to make up the placement hours to replace those lost in attending the workshop/conference.

RELEVANT LEGISLATION AND STANDARDS:

SMH FORMS:

RELATED POLICIES:

SMH Policy: Human Resources – Employees – Employee Travel Expenses
SMH Policy: Human Resources – Performance Development

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

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HR A.8: ORIENTATION OF NEW EMPLOYEES

SCOPE:

This policy applies to staff and volunteers of SMH.

PURPOSE:

To establish procedures to ensure that all new employees at SMH receive an orientation.

DEFINITIONS AND ACRONYMS:

St. Mary's Home: SMH

POLICY:

SMH recognizes the importance of providing an orientation for all new employees to familiarize them with goals and objectives, and policies of the organization. Orientation provides them with the information required to successfully transition into the job. It is understood that all new employees will complete their orientation within five (5) working days of hire or placement. The leadership team andsupervisory staff play a vital role in the orientation process in ensuring that new employees are welcomed, in communicating necessary information regarding expectations, performance standards as well as the organization's mission and overall goals, objectives, policies and procedures.

IMPLEMENTATION:

The Supervisor responsible for the new employee is required to arrange and ensure a full orientation is completed and all documentation required is filed in the personnel file (see the Orientation Checklist). Once policies and procedures have been reviewed, the new employee states that they have read and agreed to such policies by completing an Acknowledgement and Agreement Statement Form and they must complete a "Confidentiality Agreement Form". Orientation includes, but is not limited to:

1. Review of Mission, vision, values of SMH;
2. A tour of the Young Parent Outreach Centre;
3. Review of Organization chart; understanding of roles and responsibilities including reporting structure;
4. Review of programs and services;
5. Review of relevant policies and procedures including "Workplace harassment and violence", "Anti-racism, Diversity and inclusion" and "Anti-discrimination";
6. Review of Workplace health and safety – including emergency procedures;
7. Understanding safe use of equipment and supplies;
8. Understanding of confidentiality, including signing a confidentiality agreement form; and
9. Use of electronic sign-in system, email system, IT and telephone systems.

SMH FORMS:

Orientation Checklist

Acknowledgement and Agreement Statement Form

Confidentiality Agreement Form

RELATED POLICIES: N/A

Created: March 22, 2016
Review Date: July 2024
Approved by BOD: July, 2024

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HR A.9: STAFF PERFORMANCE DEVELOPMENT PROCESS

SCOPE:

This policy applies to staff and volunteers of SMH.

PURPOSE:

To establish performance appraisal process and procedures to be followed during a new employee's probationary period, and process for the regular and effective appraisal of an employees' performance.

DEFINITIONS AND ACRONYMS:

St. Mary's Home: SMH

POLICY:

The performance development process at SMH is seen as a strength-based process designed to recognize and build on an employee's strengths while engaging them in a process to improve, learn and grow in their capacity and be more effective in their work. SMH believes that honesty, respect, trust and open communication are the foundation to an effective performance development process. The performance development process is intended to be mutually participatory in nature. The employee is expected to assess their own performance and set goals to grow and improve. If the employee's supervisor recommends goals based on the requirements of the job, it is important that the employee understands and agrees with these goals before beginning the formal process. This will ensure that employees have ownership over their performance and their contributions to the efforts of the entire team. While there is a formal performance evaluation process in place, employees are encouraged to discuss their performance at any time with their supervisor. Newly appointed employees, and employees who are appointed to new responsibilities or positions, shall undergo a six-month probationary period to ensure mutual suitability for the position or six months if required. Specific objectives of the performance development process are to:

1. Ensure that employees are meeting their responsibilities as per their job descriptions;
2. Encourage frank and honest discussion;
3. Highlight employee's strengths;
4. Challenge and continually build on the performance of employees;
5. Keep employees informed about their progress in order to maximize achievements by giving specific and timely feedback;
6. Set goals for the coming year;
7. Annually verify credentials, licenses, registration, certification and/or professional liability insurance required for the positions;
8. Annually verify that regulated health professionals, e.g. Social workers, nurses, etc. have current valid and up-to-date registration with their professional college;
9. Provide evidence that relevant staff have been oriented to any changes;
10. Invite the employee to give regular input / feedback on their job description; invite employees for feedback on job satisfaction and suggestions for improvement to the work environment, services and programs; and see associated employee performance appraisal with changes for new accreditation requirements; and
11. Assist the agency in making decisions about training, professional learning opportunities and future staffing needs.

IMPLEMENTATION:

Permanent Employees:

The employee's Supervisor will periodically assess an employee's job performance on an informal basis through observation and feedback. A formal, written performance evaluation will be conducted annually, ideally in conjunction with the employee's anniversary date of hire by the employee's Supervisor using the Performance Evaluation Form

(specific to the employee's position). The Supervisor will set a mutually agreeable plan with the employee to prepare for the formal process that includes dates for supervision meetings. This plan must be developed early in the process. Once a formal performance evaluation is completed, the Performance Evaluation Form must be signed by both the Supervisor and employee whose work is being reviewed. If an employee changes positions in the agency, the anniversary date for the purpose of conducting the formal performance evaluation becomes the date of hire into the new position. If an employee changes positions in the agency and their most recent formal performance evaluation was more than six months previous, at the discretion of the Executive Director, the Supervisor will preparean interim summary of the employee's work performance before the employee is moved into the new position. The next formal evaluation will be based only on the work performed in the new position. The formal performance evaluation may be initiated at any time by either the Supervisor or the employee outside of the timeline. The formal performance evaluation process is considered successful when both the Supervisor and employee sign the corresponding documents indicating achievements and next steps. If the employee refuses to sign the Performance Evaluation Form; the Executive Director will determine the appropriate course of action; and completed formal performance evaluations will be stored in the employee's personnel file.

Employees in Probationary Period:
During the probationary period, the new employee's Supervisor will:

1. Use the Performance Evaluation Form (for the employee's specific position) to document the performance of new employees;
2. Provide specific feedback to the employee on a bi-weekly basis;
3. Provide written feedback at the mid-point of the probationary period; and
4. Sign the completed Performance Evaluation Form at the end of the probationary period

During the probationary period the new employee will:

1. Devise a plan for performance with their supervisor using the Job Description;
2. Seek assistance and direction whenever needed;
3. Seek feedback on performance on a regular basis; and
4. Sign the completed Performance Evaluation Form at the end of the probationary period.

At the end of the probationary period, the Agency will review the new employee's performance using theinformation contained in the completed Performance Evaluation Form and decide whether or not to continue their employment on a full-time basis or if the probationary period should be extended. A three-month extension of the probationary period is at the discretion of the Executive Director. Satisfactory completion of the probationary period requires a satisfactory performance evaluation by the employee's Supervisor. For new employees who are being recommended for full-time employment, the completed performance evaluation must outline mutually developed goals for the employee to work on until the next formal performance appraisal period.

RELEVANT LEGISLATION AND STANDARDS:

SMH FORMS:

Performance Evaluation Form

RELATED POLICIES:

SMH: Human Resources – Employees: Performance Development Process – Employees inProbationary Period
SMH Annual Performance Appraisal

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HR A.10: EMPLOYEE HIRING AND TERMINATION

SCOPE:

This policy applies to the Board of Directors, employees, volunteers, participants, and partners of SMH.

PURPOSE:

To establish procedures for the hiring and termination of SMH employees.

DEFINITIONS AND ACRONYMS:

POLICY:

SMH is committed to excellence in participant service. SMH strives to select, promote, and assign the best-qualified human resources to fulfill the agency's objectives. To ensure that the most qualified candidates are selected, the hiring process is carried out in adherence to the following principles:

1. Merit: as a priority, candidates must possess at least the minimum qualifications of the position as stated in the job description and demonstrated success in skills and experience required of the job; and
2. Equal Opportunity: SMH strives to provide a work environment free of discrimination and harassment (see: Ontario Human Rights Primer: Guide to Developing Human Rights Policies and Procedures, December 2013 and the Ontario Employment Standards Act 2000.)

While the Agency views dismissal of employees as a last resort, there may be times when this is necessary. As such, SMH follows the minimum standards set out in the Ontario Ministry of Labour guidelines regarding termination found here: http://www.labour.gov.on.ca/english/es/pubs/guide/termination.php.

IMPLEMENTATION:

Hiring:

Staff recruitment is the responsibility of the Executive Director, who may delegate some of the functions to members of the Leadership Team. The Executive Director reserves the right to expand upon the preferred procedures stated below. SMH is an Equal Opportunity Employer. When a new position is created that is an expansion of an existing role, with no new sources of funding, promotion of the individual in the existing role is the preferred process. When a new position is created with new funding sources, all qualified staff are invited to apply, along with external applicants. The hiring process will generally consist of the following steps carried out by the Leadership Team and Executive Director:

1. Reviewing and updating the existing job descriptions and/or develop ones for new positions;
2. Preparing a job posting for the position with application and job requirements;
3. Posting the position/opening in selected web media and emailed to local networks; (i.e. Charity Village).

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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Selection Process:
Applications will be reviewed by the Supervisor responsible for the vacant position. Once a shortlist of potential candidates is created, arrangements will be made for interviews with an ad Hoc Hiring Committee, which will include the Executive Director/or designate, the Supervisor of the vacant position, and/or a staff person from the program. In the case of hiring for projects, administered by SMH, the Project Manager reviews candidates with the Executive Director, or delegate from the leadership team of St Mary's Home, but the Executive Director has the final decision-making authority in this matter.

The selection process will include the following:

1. Ensuring that the candidates have the necessary qualifications and experience as outlined on the job posting;
2. Interviewing candidates and rating their responses;
3. Requesting and confirming three employment references prior to any offer of employment being made to a candidate;
4. Supervisors may determine the appropriateness of the reference offered by the candidate;
5. References should relate to various previous employment and be completed using the Reference Check Form;
6. A current supervisor or manager is a preferred reference;
7. Results of the reference checks will be documented in the personnel file;
8. Medical clearance and vaccination history must be provided and;
9. A Police Vulnerable Sector Check must be completed as required by law;

Confirmation of Employment:
At the time of employment, all employees shall sign a document attesting to compliance with a confidentiality statement regarding work at SMH. Prior to commencing work with SMH, all potential employees are required to provide proof of required vaccinations and a physician's statement of present health, indicating freedom from communicable diseases and health compatible with performing the assigned duties. All such examinations and vaccinations shall be at the employees' expense. Once the selection process is completed and prior to offering a position to the applicant, the following statement shall be included in the letter of offer of employment "Contingent on a Vulnerable Sector Police Check and medical evidence of immunization records based upon the recommendation of the Medical Officer of Health for the City of Ottawa for all employees. The candidate will provide documentation and proof of educational qualifications. Photocopies will be made, signed, and placed intheir personnel file.
Permanent full-time or part-time candidates will receive a Letter of Employment and Employment Contract.
Candidates "on contract" will receive a Letter of Employment for signature. One copy will be placed in their personnel file. The Letter of Employment and Employment Contract shall specify job description, starting date, salary, hours of work, benefits, probationary period, the Employee's Supervisor, and the Employee's receipt of the Employment Policy information. An orientation plan will be determined and conducted within 5 days of employment when the Orientation Checklist will be completed.

Hiring Family Members:
To avoid potential conflicts that can arise when family members work together, the agency will not normally hire spouses, children or parents of staff or Board members to work for SMH either as employees or independent contractors. However, this is at the discretion of the Executive Director and may occur when other options have been exhausted.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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Termination

1. Resignation: Employees shall provide a written notice of their intended resignation at least two weeks prior to the last day of work;
2. Term Employment: The position ends due to discontinuation of funding source or completion of the contract term;
3. Poor Job Performance: As identified by documented performance evaluation and;
4. Disciplinary Reasons: As a last measure following corrective measures.

The Appeal Process for termination of employment is that designated by the Employment Standards Act of Ontario.

RELEVANT LEGISLATION AND STANDARDS:

Ontario Employment Standards Act 2000
Ontario Ministry of Labour guidelines
Ontario Human Rights Primer

SMH FORMS:

Reference Check Form

RELATED POLICIES:

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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HR A.11: HOURS OF WORK, OVERTIME AND LIEU TIME POLICY

SCOPE:

This policy applies to all staff of SMH.

PURPOSE:

To define and establish the regular working hours and the application of overtime hours and time off in lieu for employees of SMH.

DEFINITIONS AND ACRONYMS:

Permanent Full-Time: Employees who normally work at least a 35-hour week or more.
Permanent Part-Time: Employees whose appointment calls for a specific lesser number of hours per day, or days per week on a continuing and regular basis.
Hourly Part-Time: Employees whose hours vary, depending upon which shift they work on a regular basis.
Contract Term: Hired for a specific period of time for a particular project. Continuation of employment beyond the specified term is contingent upon continuation of specific funding for the position.
Casual / Relief: Hired by the day, week or hour to meet relief staffing (back-fills) requirements, and for specific situation seasonal needs. * Casual employees, except for the individual in the one remaining key relief position, are not eligible for employee benefits.
Purchase of Service: Engaged to carry out special tasks or projects for a specific period of time, at a specific fee for service.

POLICY:

SMH is committed to providing fair and equitable terms of employment for all staff including the hours worked. SMH strives to maintain an objective, transparent and respectful human resource system. In order to balance client safety and a positive work environment, all reasonable effort is to be made to avoid having employees work overtime. The Employment Standards Act of Ontario is the over-riding legislation that governs employment practices and policies of SMH. Where there is dispute between that legislation, as updated annually, and this document, the legislation shall be deemed as authority. The Child and Family Services Act of Ontario also applies as noted in specific areas of this policy.

IMPLEMENTATION:

Hours of Work:
The Executive Director or designate shall determine and assign the hours of work and shall maintain an ongoing review of demands placed on staff. When required and feasible, duties can be re-aligned, with new staff hired or temporary assistance provided. Work hours may fluctuate as required at the discretion of the employer, examples include making sure essential coverage/ratio needs are met and ensuring all staff are able to attend required staff meetings/trainings/development sessions. In such cases, in collaboration with the staff member(s) and dependent on operational needs, work hours will be adjusted to accommodate, lieu time may be accrued, or the additional hours can be paid to the employee(s).
An employee who is going to be unavoidably late or absent for work shall notify their supervisor or another employee if the supervisor is unavailable, as soon as possible.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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Overtime:
Except in the case of an emergency, all overtime or hours in addition to scheduled hours, must be pre-approved by an employees' direct Supervisor or the Executive Director.

If required to work additional hours at the request of their Supervisor, hourly employees (Part-Time, Casual and Relief) will be paid hourly, examples include: meeting essential coverage/ratio needs and attendance at meetings/staff development/training that occur outside of their regular work hours. These are considered extra hours and NOT overtime hours. Hourly employees (Part-Time, Casual and Relief) will be paid for all hours worked, including overtime hours, at the end of the next Pay Period following the Pay Period in which the extra hours occurred, upon final verification and approval of their Supervisor or Executive Director. In the absence of their direct Supervisor, all approvals must come from the Executive Director. Overtime worked by Full-Time (salaried) staff shall be compensated by time off in lieu and must be approved in advance by the employees' direct Supervisor or Executive Director.

Time Off in Lieu:
Time off in lieu must be taken within the year in which it is earned. Exceptions to this must be approved by the Executive Director. A maximum of two weeks of time off in lieu may be taken within the year in which it was earned. Exceptions to this must be approved by the Executive Director. A maximum of three days of time off in lieu can be taken at any one time; and all time off in lieu taken must be requested and approved in advance by the responsible direct Supervisor. In the absence of the direct Supervisor, approvals must come from the Executive Director.

RELEVANT LEGISLATION AND STANDARDS:

The Employment Standards Act of Ontario
Child and Family Services Act of Ontario

RELATED POLICIES:

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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HR A.12: LEAVE AND TIME OFF WORK

SCOPE: This policy applies to all staff of SMH.

PURPOSE: To establish the types of leaves and paid holidays that SMH employees are entitled to.

DEFINITIONS AND ACRONYMS:

Day: A Day is calculated by dividing the employee's total weekly hours by five (5). For example, if during the week, an employee works shifts of eight (8) hours, six (6) hours, four (4) hours, and twelve (12) hours, for the purpose of this Policy, the employee's Day is six (6) hours (8+6+4+12=30/5=6).
SMH: SMH
ESA: Employment Standards Act
IME: Independent medical examinations
IMA: Independent medical assessments

POLICY:

SMH recognizes that employees take time away from work for a variety of reasons. All procedures in this policy are aligned with and will be amended as per requirements of the Ontario Employment Standards Act, 2000. This Policy establishes vacation, public holiday, sick leave and leave of absence procedures for SMH employees.

IMPLEMENTATION:

Paid Sick Leave Credits:
General
Paid Sick Leave Credits for personal illness or injury are provided to Permanent Full-Time and Permanent Part-Time employees contracted to work at least twenty-five (25) hours per week. Such employees earn Paid Sick Leave Credits upon commencement of work and are entitled to use these credits, after the completion of continuous employment with SMH for the 6 (six) month probationary period, on the following basis:

1. A Permanent Full-Time employee working a minimum of 35 hours may earn up to the equivalent 3 weeks prorated Paid Sick Leave Credits in each fiscal year, accumulated based on one and a quarter (1.25) days per month in which the employee works at least ten (10) days, including scheduled vacation (see definition of Day above);
2. A Permanent Part-Time employee contracted to work at least twenty-five (25) hours per week is entitled to earn up to the equivalent of twelve (12) days of Paid Sick Leave Credits in each fiscal year, accumulated based on one (1) day per month in which the employee works at least 10 (ten) days, including scheduled vacation (see definition of day above);

During an employee's probationary period, that is, the first 6 (six) months of continuous employment, sick leave shall be accumulated on a prorated basis in accordance with the above but cannot be used. Accrued sick leave may only be taken during the probationary period with approval by the Executive Director.

Created: August 28, 2017
Review Date: July2024, Revised: June 2025
Approved by BOD: June, 2025

Should an employee require sick leave which is not yet accrued it must be approved by the Executive Director and the employee must sign an agreement setting out the repayment schedule and providing permission to SMH to deduct any amount owing if the employee leaves SMH before said time is accrued. Sick leave with pay may be accumulated for use during active employment, leave may be accumulated without pay during inactive employment.

Employees hired after October 1, 2003, may accumulate sick leave to use during their time of employment, from year to year. However, if employment is terminated for any reason, the employee will not receive reimbursement for the unused accumulated sick leave. Accumulated Paid Sick Leave Credits have no cash value at any time. Employees hired on or prior to October 1, 2003, shall be reimbursed based on one (1) day for each two (2) days credit for any unused portion of earned but unused Paid Sick Leave Credits upon termination of employment, up to a maximum of thirty (30) days' pay.

Medical Information:
If an employee is absent from work for three (3) consecutive days or more, by reason of personal illness or injury, the employee will be required to submit a medical note to validate their absence. If an employee makes a claim for extended sick leave or a disability requiring accommodation under the Ontario Human Rights Code, other applicable legislation, or any other claim for extended sick leave or benefits, the employee agrees that they will consent to the disclosure of sufficient medical information from the employee's attending physician or other health care provider to SMH. SMH will use the information provided to assess the scope of SMH's duty of reasonable accommodation, the employee's ability or inability to perform the essential requirements of the employee's employment, and to substantiate the employee's claim.

An employee's medical information will be treated as confidential information. Such information will only be shared as required to facilitate the accommodation process or for the evaluation of the employee's entitlements, or with the consent of the employee and it is understood that if your employee is absent for an extended period, the Employer may hire a replacement for the duration of their absence. In the circumstances, it is expected that the employee shall provide the Employer with reasonable notice of their anticipated return to work. The hiring of a replacement and the requirement for notice of return to work shall not constitute constructive dismissal.

Independent Medical Assessment:
In the event of any dispute arising out of or related to the section "Medical Information," above, SMH will be entitled to request, at SMH's expense, that the employee undergo independent medical examinations (IME) or assessments (IMA) by a mutually agreed upon qualified medical professional. SMH will request an IME or IMA as deemed reasonably necessary to determine or verify the employee's ability or inability to perform the essential duties and requirements of the employee's job, their entitlement to continuing salary or benefits, and, where applicable, to determine or verify the extent of accommodation which the employee may require under the Ontario Human Rights Code or other applicable legislation.

Annual Vacation Leave:
General
Paid vacation is earned through active service and, as such, an employee on leave may earn vacation time but will not earn vacation pay. All vacation time accrued above statutory vacation time prescribed by the ESA must be taken within the fiscal year in which it is accrued. Any accrued and unused vacation time beyond statutory allowances may not be carried over into the next year except with prior written approval by the Executive Director. Any vacation time that has been carried over must be taken within ten (10) months of the year in which it was accrued. In unique circumstances, the Executive Director, in consultation with the employee's Supervisor, may authorize an employee to carry forward additional unused annual vacation time to a maximum of two (2) weeks to the following fiscal year.

Accumulated vacation balances shall not exceed six (6) weeks unless approved in writing by the Executive Director. Employees with more than six (6) weeks accumulated vacation balances are required to bring their balances to six (6) weeks. Upon termination of employment, employees are entitled to receive payment of any earned vacation pay that has been accrued but has not yet been paid. Vacation leaves are approved by the employee's supervisor or Executive Director on the following basis:

1. Staff may only take vacation leave to a maximum of the amount accumulated, except with prior written permission from the Executive Director for advancement of vacation credits in which case;
2. Employees must sign an agreement setting out the repayment schedule or SMH will deduct any amount owing if the employee leaves SMH before said time is accrued; and
3. Notwithstanding the entitlements set out above, during any approved leave or protected leave of absence under the ESA, vacation time and vacation pay shall accrue only in accordance with the requirements of the ESA.

Vacation Accumulation:
All annual vacation leave entitlements are prorated based on the number of hours and partial years worked. During an employee's probationary period, that is, the first 6 months of continuous employment, vacation leave is accumulated on a prorated basis in accordance with the charts below but cannot be taken without approval of the Executive Director. Accrued vacation leave may be taken after the completion of the probationary period with the approval of the employee's supervisor or Executive Director.
Permanent Part-Time employees contracted to work less than twenty-five (25) hours of regularly scheduled hours per week and Casual/Relief/Term and Purchase of Service employees may elect to be paid their vacation pay owing on each pay period, or in a lump sum prior to the time that vacation time would have been taken, in accordance with the ESA. An employee who wishes to have their vacation pay paid on each pay period must request this in writing to their supervisor for approval of the Executive Director.

Annual Vacation Leave shall be provided as follows:

Permanent Full-Time, Full-Time Term, and Permanent Part-Time Employees contracted to work at least twenty-five (25) hours per week shall accrue vacation time and vacation pay as follows:

Years of Service	Vacation Time	Vacation Pay
1-7 years	4 weeks' vacation, at the rate of 1.66 days per month worked (see definition of day above)	8%
8-14 years	5 weeks' vacation, at the rate of 2.08 days per month worked (see definition of day above)	10%
15 years or more	6 weeks of vacation, at the rate of 2.49 days per month worked (see definition of Day above)	12%

Created: August 28, 2017
Review Date: July2024, Revised: June 2025
Approved by BOD: June, 2025

Permanent Part-Time employees contracted to work less than twenty-five (25) hours of regularly scheduled hours per week and Casual/Relief/Term and Purchase of Service employees are entitled to vacation time and vacation pay as follows, in accordance with the ESA:

Years of Service	Vacation Time	Vacation Pay
Less than 5 years	3 weeks' vacation, at the rate of 1,.25days per month (See definition of Day above)	6%
5 years or more	4 weeks' vacation, at the rate of 1.6625 days per month (See definition of Day above)	8%

Vacation Scheduling:
Vacation time should be structured in a way to meet the needs of each employee while ensuring that their time away from work does not negatively affect, as much as possible, the programs and services for SMH's participants. It is management's responsibility to ensure that staff plan for and take their vacations. Vacation time is to be pre-scheduled with the approval of the Supervisor and timing is subject to SMH's requirements for staff coverage. All vacation requests, other than the closure of the Outreach Centre in December between Christmas Day and New Year's Day, must be approved by the Supervisor, in a manner that ensures programs and services are adequately covered during the vacation period. During the December closure, employees working at the Young Parents Outreach Centre may be required to take leave without pay if they do not retain sufficient vacation pay accumulation. SMH encourages employees to take theirvacation in blocks of one (1) or two (2) weeks at a time; smaller leaves of a day or two can also be approved. A medicalnote may be requested for leave due to illness or injury taken immediately before or immediately
after vacation time. The Employer reserves the right to schedule vacation.

Public and Other Holidays:
Religious Holidays
Additional time off for religious holidays, which are not included in the designated public holidays, may be accommodated in the following manner subject to the usual process of requesting time off and approval: using unpaid leave, vacation days, time off in lieu, or adjusting the work schedule / switching shifts.

Public Holidays
SMH observes the following Public Holidays, in accordance with the ESA:

1. New Year's Day
2. Family Day
3. Good Friday
4. Victoria Day
5. Canada Day
6. Labour Day
7. Thanksgiving Day
8. Christmas Day

All obligations and entitlements regarding Public Holidays are in accordance with the ESA. Public holidays are provided to employees as per the Ministry of Labour guidelines found here:
http://www.labour.gov.on.ca/english/es/pubs/guide/publicholidays.php.

The Young Parents Outreach Centre is closed on the above Public Holidays, if for a unique situation, at the direction of the Executive Director, an employee was required to work on a Public Holiday, it would be inaccordance with the ESA. Employees who work on the above holidays have two options:

1. The employee is entitled to receive regular wages for all hours worked on the public holiday, plus asubstitute day off work with public holiday pay; or
2. If the employee agrees electronically or in writing, they are entitled to public holiday pay for the public holiday plus premium pay for all hours worked on the public holiday. In this case, the employee will notbe given a substitute day off.

Other Holidays:
In addition, SMH also observes the following Holidays:

1. Easter Monday
2. August Civic Holiday
3. Remembrance Day

The Young Parents Outreach Centre is closed on Easter Monday and August Civic Holiday but open on Remembrance Day, if an employee works on this day it can be banked as a "floater" to be taken at any other approved time.

Vacation and Public Holidays:
If a Public Holiday, as defined in the ESA, falls during an employee's vacation period, the day remains a vacation day, and if an employee qualifies for the Public Holiday, they are entitled to one of the following:

1. A substitute day off work with Public Holiday pay, in accordance with the ESA. This substitute day off must be taken within three (3) months of the public holiday or, if agreed upon in writing, within twelve (12) months of the Public Holiday; or
2. SMH may pay Public Holiday pay for that day without giving a substitute day off work, with the written agreement of the employee.

The employee may also agree in writing to work on a Public Holiday that falls while they are on vacation, in which case the employee will receive paid Public Holiday pay in accordance with the ESA, and the vacation day will be put back in the employee's vacation bank.

Jury Selection Duty or Court Attendance:
In the event that an employee is either: (a) required to attend for jury selection; (b) required to serve as a juror; or (c) subpoenaed to attend court as a witness in a court proceeding:

1. SMH shall grant a leave of absence with pay for a combined total of up to five (5) working days, provided the
2. employee is not a party to, nor one of the persons charged, in thecourt proceedings;
3. If any of the processes above require more than five (5) working days, employees may be eligible for unpaid leave at the Executive Director's discretion. Such leave will be considered to draw down any and all applicable entitlements the employee may have under this Policy or the ESA;
4. In all of the situations above, the employee must present proof of the required attendance or service;
5. The employee will remit to SMH any money received, not including expense money, from the Court (Ministry of the Attorney General) for the required attendance during the five (5) paid days;
6. SMH and the employee will carry the usual premium costs for the employee's regular Health/Dental/LTD/Life Insurance benefits plan (in effect at the time) during the duration of the time required for this service,and the employee will continue to accrue regular benefits as per the employment contract in effect, during the time of their leave for court service; and
7. Requests for additional leave without pay may be granted at the discretion of the Executive Director.

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Employment Standards Act Leaves:
All SMH employees are entitled to unpaid leaves in accordance with the ESA. For more information about ESA leaves, please follow this link: https://www.labour.gov.on.ca/english/es/pubs/brochures/br_leaves.php;
For Permanent Full-Time and Permanent Part-Time Employees contracted to work at least twenty-five (25) hours per week, the first three (3) days of such leave will be paid. Reasonable proof of entitlement to pay may be requested. Paid leave under this provision has no cash value, is not carried forward from year-to-year, and is not paid out when the employee leaves SMH.

Please note that in the case of pregnancy and parental leave taken during the probationary period, the period of such leave is not included when determining whether the employee has completed the probationary period. If an employee was on probation at the start of a leave, they must complete the probationary period after returning to work.

Unpaid Personal Leave:
If additional personal leave is required, outside of that provided for in the ESA, all employees may request up to ten (10) additional days of unpaid personal leave, which may be granted at the discretion of the Executive Director or their designate.

Paid Personal Leave:
Permanent Full-Time and Permanent Part-Time employees contracted to work 25 hours or more per week may be entitled to Paid Personal Leave. Please note, this leave is not guaranteed and is approved at the discretion of the Executive Director. Paid personal leave is:

1. Prorated based on the number of hours and partial years worked.
2. Up to a maximum of three (3) pro-rated, accrued, paid Personal Leave days may be granted to allow employees to tend to urgent family or personal matters (see definition of Days above);
3. Personal Leave can be taken in hourly increments;
4. Personal Leave does NOT carry forward from year-to-year and expires on March 31st annually; and Unused Personal Leave is not paid out to employees when they leave the agency.

Unpaid Personal Emergency Leave:
All other employees are entitled to ten (10) unpaid pro-rated Personal Emergency Leave days during each fiscal year (see definition of Days above). Unpaid Personal Emergency Leave can be taken in hourly increments; and Unpaid Personal Emergency Leave does NOT carry forward from year-to-year.

Compassionate Leave/Bereavement Leave:
Leave of up to 5 days with pay shall be granted, with the approval of the Executive Director. When an extremely serious illness occurs in the immediately family, which includes (but is not limited to) spouse either through marriage or common law relationship, parents, siblings, children and parents of the spouse. In the event of the death of: a spouse/partner, mother, father, mother-in-law, father-in-law, son, daughter, stepson, stepdaughter, brother, sister, son-in-law, daughter-in-law, sister-in-law, brother-in-law, grandparents, grandchild, ward, or guardian.

Request For Leave:
Employees seeking a leave of absence in accordance with this Policy are required to complete a Request for Leave Form and Employees are required to provide SMH with as much reasonable notice as possible in the circumstances prior to taking any leave, and in any event, no less than the amount of notice prescribed in the ESA.

Created: August 28, 2017
Review Date: July2024, Revised: June 2025
Approved by BOD: June, 2025

Notwithstanding the entitlements set out within this policy, during any approved leave or protected leave of absence under the ESA, vacation time shall be accrued in accordance with the requirements of the ESA. This is the same for sick leave which is not included in the ESA. Therefore, vacation and sick time is accrued while on an approved or protected leave of absence, but vacation and sick pay is only earned through active service.

RELEVANT LEGISLATION AND STANDARDS:

Ontario Employment Standards Act, 2000
Ontario Human Rights
https://www.ontario.ca/document/your-guide-employment-standards-act-0

RELATED POLICIES:

Created: August 28, 2017
Review Date: July2024, Revised: June 2025
Approved by BOD: June, 2025

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HR A.13: ALCOHOL, ILLEGAL AND RECREATIONAL SUBSTANCE/DRUG USE AND IMPAIRMENT FROM PRESCRIPTION DRUG USE

SCOPE:

This policy applies to the Board of Directors, employees, volunteers, participants, and partners of SMH.

PURPOSE:

To communicate expectations and guidelines surrounding substance use:

1. To ensure a safe and healthy workplace;
2. To establish procedures if a staff uses alcohol, illegal or recreational substance / drugs of any kind on SMH property; and
3. To establish procedures if a staff is impaired in any way and unable to perform their duties due to alcohol, illegal, recreational or prescription drug use.

DEFINITIONS AND ACRONYMS:

Staff: refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement and service partners of SMH.
Service Partner: is an agency and its staff, and/or an individual who have signed contracts or agreements with SMH to provide services to clients on site.
Drug: Any substance which can change, impair or adversely affect the way a person thinks or feels, whether obtained legally, illegally or prescribed.
Drug Paraphernalia: Material or equipment used or intended for use in injecting, ingesting, inhaling, or otherwise introducing a drug, illegal or controlled, into the human body.
Medication: Includes a drug obtained legally, either over the counter or through a prescription issued by an authorized medical practitioner. For this policy, medications of concern are those that inhibit a worker's ability to perform their job/placement/position safely and productively.
Alcohol: Any beverage containing any quantity of alcohol, including, beer, wine, and distilled spirits.
Agency: SMH

POLICY:

SMH provides services for an extremely vulnerable population. As such, staff are not able to work if they are impaired in any way from alcohol, illegal, recreational and/or prescription, substance/drugs. Because such impairment could pose a significant safety risk, SMH must employ "zero tolerance" in regards to alcohol and illicit or recreational drug use and requires a Functional Abilities Form be completed by the prescribing physician/medical provider in the case of any prescription medication that impairs a staff's abilities to safely carry out their duties.

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

IMPLEMENTATION:

The following expectations apply to staff and management alike while conducting work on behalf of the company, whether on or off company property:

1. Staff are expected to arrive to work fit for duty and able to perform their duties safely and to standard;
2. Staff must remain fit for duty for the duration of their shift;
3. The use, possession, distribution, or sale of drugs or alcohol during work hours, including during paid and unpaid breaks, is strictly prohibited;
4. Staff are prohibited from reporting to work while under the influence of alcohol, recreational cannabis and any other non-prescribed substances;
5. Use and possession of medically prescribed drugs is permitted during working hours, subject to the terms and conditions of the company's policies and all applicable legislation;
6. Staff taking any prescribed medications, including medical cannabis, where there is risk of impairment, are required to provide to their Supervisor, or the Executive Director: a copy of medical documentation/prescription stating prescribed use and proof that the prescription was filled at an authorized Government dispensary;
7. A Functional Abilities form completed by the prescribing physician/medical Provider is required stating any potential risk, limitation, or restriction requiring modification of the staff's duties or temporary reassignment;
8. Staff are expected to abide by all governing legislation pertaining to the possession and use of cannabis; and
9. In the case of prescription cannabis, staff cannot smoke cannabis anywhere on or within close proximity of the agency –- and must not share, give or sell their prescription with/to other staff, participants, or anyone else associated with the Agency, at any time.

Roles and Responsibilities:
SMH will:

1. Clearly communicate expectations surrounding alcohol and drug use, misuse, and abuse;
2. Maintain a program of staff health and awareness;
3. Provide a safe work environment; and
4. Review and update this policy regularly.

Management will:

1. Identify any situations that may cause concern regarding a staff's ability to safely perform their job/placement/position functions;
2. Ensure that any staff who asks for help due to a drug or alcohol dependency is provided with the appropriate support (including accommodation) and is not disciplined for doing so; and
3. Maintain confidentiality and staff privacy.

Staff must:

1. Abide by the provisions of this policy and be aware of their responsibilities under it;
2. Arrive to work fit for duty, and remain so for the duration of their shift;
3. Perform work safely in accordance with established safe work practices;
4. Refrain from the consumption, possession, sale, or distribution of drugs or alcohol during working hours or
5. anytime on, or within close proximity of, company property;
6. When off duty, refuse a request to come into work if unfit for duty;

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

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7. Report limitations and required work modifications/accommodations as a result of prescription medication;
8. Report unfit co-workers to management;
9. Seek advice and appropriate treatment, where required;
10. Communicate dependency or emerging dependency to management or human resources; and
11. Follow the after-care program, where established.

Staff Impairment from Substance Use:

1. If a staff reports to work and is unable to perform their duties because they are impaired due to the use of alcohol, illegal, recreational drugs, or prescribed medications; or use alcohol or illegal or recreational drugs during working hours, they will not be allowed to work the rest of their shift. Safe passage home will be arranged and the staff may be asked not to return to work for up to three days;
2. Suspicion that a person may have illegal drugs on the property is justifiable cause to notify the police. The staff's Supervisor and/or the Executive Director will investigate and document any suspected substance abuse and will determine what disciplinary action is required. Upon request by the staff, the agency will provide information on alcohol and/or substance abuse, and provide referrals to organizations and agencies that can help assist in this regard. If a staff has a substance abuse problem, the agency may, at its discretion, attempt to assist the staff to address their problem, for example, through referral to a rehabilitation program.
3. Arrangements regarding absence from work will be made on an individual basis if a staff must be absent from work for substance abuse treatment. If a staff is not willing to address their problem and repeated incidents of substance abuse occur, the staff's employment/position/placement may be terminated with justcause.

The use, sale or possession of illegal drugs while on the job/position/placement or on company property is cause for immediate dismissal. Any illegal substance will be turned over to the appropriate law enforcement agency. The following procedure may be enacted if there is reasonable concern that a staff is impaired at work:

1. If possible, the staff's manager or supervisor will first seek another manager's or supervisor's opinion to confirm the staff's status.
2. Next, the manager or supervisor will consult privately with the staff to determine the cause of the observation, including whether substance use has occurred and if the staff's ability is impaired. Concern of a staff's ability to function safely may be based on specific personal observations. If the staff exhibits unusual behaviour including but not limited to slurred speech, difficulty with balance, watery or red eyes, or dilated pupils, or if there is an odour of alcohol, or ability is impaired the staff should not be permitted to return to their assigned duties to ensure their safety and the safety of other staff, clients or visitors to the workplace.
3. If a staff is considered impaired and deemed "unfit for work," this decision is made based on the best judgement of two members of management and DOES NOT require a breathalyzer or blood test. The staff may be advised that SMH has arranged a taxi or shuttle service to safely transport them to their home address or to a medical facility, depending on the determination of the observed impairment. The staff may be accompanied by a manager or supervisor or another staff if necessary.
4. An impaired staff will not be allowed to drive. The staff should be advised if they choose to refuse St. Mary's Home organized transportation and decide to drive their personal vehicle, the company is obligated to and will contact the police to make them aware of the situation.
5. A meeting may be scheduled for the following work-day to review the incident and determine a course of action which may include a monitored referral program as part of a treatment plan.

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

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Possession of Non-Prescribed Drugs at Work:
Possession of alcohol, illegal drugs, and drug paraphernalia on company property is prohibited. Company property encompasses all company owned or leased property used by staff, including without limitation parking lots, vehicles, lockers, desks, and closets. Possession of alcohol, illegal drugs, and drug paraphernalia is also prohibited while staff are acting on behalf of the organization off of company premises. This includes attending events as a company representative.

Substance Dependency:
SMH understands that staff may develop a substance use health issue, which may be defined as a health concern or a disability. SMH promotes early diagnosis. Any staff who suspects that they might have an emerging substance use issue is supported to seek appropriate treatment promptly. SMH will support the individual who requests accommodation in an effort to ensure that the measures taken are both effective and mutually agreeable, up to the point of undue hardship. Staff are encouraged to provide any need for accommodation to their immediate supervisor, and to work with them in addressing the concern. Staff are encouraged to communicate if they have a substance use health issue so that their rights are protected, and they can be accommodated appropriately. Staff will not be disciplined for requesting help or due to current or past involvement in a rehabilitation effort. All medical information will be kept confidential by SMH, unless otherwise authorized by law.

Agreement for the continuation of employment:
SMH reserves the right to invoke an agreement for the continuation of employment/ placement/position in accordance with a staff's commitment to become and remain alcohol and illegal and recreational drug-free. The agreement will outline the conditions governing the staff's return to the job/placement/position and the consequences for failing to meet the conditions.

Disciplinary Action:
Staff may be subject to disciplinary action up to and including termination of employment/placement/ position for failure to adhere to the provisions of this policy, including but not limited to:

1. Failure to meet prescribed safety standards because of impairment from alcohol, drugs or substances; and
2. Engaging in illegal activities (for example, selling drugs or alcohol while on company premises).

RELEVANT LEGISLATION AND STANDARDS:

SMH FORMS:

Functional Abilities Form

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

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HR A.14: EMPLOYEE SALARY AND BENEFITS

SCOPE:

This policy applies to the Board of Directors, employees, volunteers, participants, and partners of SMH.

PURPOSE:

To establish a salary and benefit structure for employees at SMH.

DEFINITIONS AND ACRONYMS:

Benefits: Extended Health Care, Dental Care, Basic Life Insurance, and Long-Term Disability (LTD) for Full- Time employees and for Part-Time employees hired prior to 2005 (who work between 20 and 25 hours per week). Other benefits may be provided as approved from time-to-time by the Executive Director and Board of Directors. Part-Time employees hired in 2005 or later do not have Long Term Disability benefits.

POLICY:

In the best interest of its clients, SMH is committed to attracting, retaining and motivating skilled employees reflecting the community we serve. Therefore, we strive to provide the best benefits possible within thelimits of our financial resources. In addition, SMH complies with pay equity requirements when determining salaries for employees. For each position in the organization, there is an established base salary. The salary rates are set in accordance with guidelines set out by funding bodies and/or comparators in like organizations and approved by the Board of Directors.

IMPLEMENTATION:

Employee Salaries:
Salaries are paid bi-weekly by direct bank deposit and salary stubs are provided to employees at the same interval.

Payroll Deductions:
As required, the following regular deductions are made from payroll at source:

1. Federal Income Tax;
2. Provincial Income Tax;
3. Employment Insurance;
4. CPP – Canada Pension Plan; and
5. RRSP (pre-tax) if applicable and pre-arranged at the employee's request.

Employee Benefits:
Employees in the Permanent Full-Time, Term Full-Time, Permanent Part-Time and Hourly Part-Time categories whose contract stipulates that they are regularly scheduled to work 25 hours per week or more, are eligible to apply for a comprehensive range of employee benefits once the probationary period is satisfactorily completed, including a satisfactory performance review confirmed by the Supervisor. As a requirement of the insurance industry, employees do not automatically receive benefits unless they complete application forms. Details of coverage are available to employees from the Administration.

While an employee is on leave of absence:
An employee who is on pregnancy, parental, sick, family responsibility, bereavement, declared emergency, family caregiver, family medical, critical illness, organ donor, domestic or sexual violence, child death or crime-related child disappearance leave has the right to continue to participate in pension plans, life insurance plans, accidental death plans, extended health plans and dental plans during their leave. If a leave is prolonged, arrangements would need to be made by the employee directly with the benefit provider(s) for continuation of such benefits and payments would become the sole responsibility of the employee. Before such change would take place, the employer would provide the employee with two months' notice, to ensure there is sufficient time for the employee to make such arrangements if they so choose. Any questions concerning this can be brought to the Administrative Assistant or the Executive Director.

RELEVANT LEGISLATION AND STANDARDS:

https://www.ontario.ca/document/your-guide-employment-standards-act-0/benefit-plans

SMH FORMS:

RELATED POLICIES:

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HR A.15: STAFF DECISION-MAKING, DELEGATION OF AUTHORITY AND SUPERVISION

SCOPE:

This policy applies to the Board of Directors, employees, volunteers, participants, and partners of SMH.

PURPOSE:

To establish lines of communication, authority, responsibility, and accountability between staff at SMH.

DEFINITIONS AND ACRONYMS:

Staff: refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement

POLICY:

SMH's Organizational Chart outlines the Agency's levels of authority. As well, levels of responsibility, authority and accountability are outlined in all of SMH's job descriptions. The SMH Leadership Team consists of the Executive Director, the director of Operations, Programs and Services, the Manager of Support Services and the Manager of Programs and Outreach. The Leadership Team is responsible for the oversight and monitoring of programs and services and staff within their respective portfolios. They are responsible for clarifying levels of decision-making with all staff. SMH believes that the role of the Supervisor is to ensure the success of each staff by offering support through informal mentoring, providing regular feedback and conducting performance appraisals that focus on building on strengths and development opportunities, as well as receiving feedback regarding job descriptions. Supervisors, including clinical supervisors, are responsible for the operational decisions related to the effective supervision of their program, staff, and participants. It is expected that the relationship between the Supervisor and staff is one of mutual respect and trust. All SMH staff have access to the Director of Operations and Support Services for support in case coordination for participants.

Supervision:
Staff are accountable to their supervisors and are expected to carry on the duties as needed to best meet the needs of the participants and the SMH team as a whole.

Decision-Making:
Decision-making related to administrative, participant and community issues is supported at the level closest to the issue, participant and/or program where possible and appropriate. All decisions are made in the best interest of the participants, staff, and the Agency as a whole. Through staff meetings and other means, staff may bring forward issues for consideration which are then reviewed and decided upon by the Leadership Team. The Executive Directoris the link between the staff and Board of Directors and they are required to adhere to the SMH Governance policiesrelated to authority, decision-making, roles and responsibilities and accountability.

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

Delegation of Authority:
Delegation of authority is appropriate where the delegation will enhance the effectiveness and efficiency of the Agency without risking the integrity of the internal control necessary for accountability.

IMPLEMENTATION:

Supervision:
The Executive Director and Leadership Team will:

1. Ensure that the frequency of supervision meets the performance appraisal requirements and/or as needed to effectively meet the needs of the staff and participants;
2. Be clear on their expectations for performance of their staff and delegate tasks accordingly;
3. Be accessible to the staff;
4. Conduct supervision during working hours when possible;
5. Establish the frequency of supervision meetings with staff as deemed necessary;
6. Establish a plan for communication if they are not going to be available to the staff for an extended period of time, or in the case of absence due to an emergency; and
7. Support and promote professional learning needs (for example clinical leading practice, evidence informed programs and services approaches).

Staff will:

1. Review with their Supervisor, when hired, the job description and any other duties assigned specific to the role they are performing;
2. Be accessible to their Supervisor;
3. Participate in supervision meetings; and
4. Keep a record of these meetings, including the dates of the meetings, any decisions made and recommendations that need to be implemented.

Conflict Management:
Should conflicts arise between Supervisors and staff during the supervisory process that cannot be resolved by means other than mutual feedback about the process, consistent clear communication and/or the performance management process, the Executive Director is to be involved in the conflict resolution process. The Executive Director may involve a third party, as appropriate to the nature of the conflict and upon the request of either the Supervisor or supervisee, to assist throughout the resolution process.

Decision-Making:
Consensus decision-making approaches are applied where practical. A collaborative problem-solving and trauma-informed decision-making approach is used where applicable. In situations, requiring a more immediate response, the Supervisor and/or senior staff on site or on-call will make the decisions. Supervisors or designates are responsible for attending and/or facilitating, where appropriate within the scope of their role, the following team meetings:

1. Weekly Management Team;
2. Quality Assurance Team and Quality Improvement Teams;
3. Program Meetings;
4. Multi-Disciplinary Participant Services Meetings;
5. Multi-Disciplinary Case Management Meetings;
6. SafeCare/Infant Mental Health Team Meetings; and
7. Staff Meetings.

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

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The chair of the meeting facilitates the discussion helping to analyze the critical issues and promote the sharing of opinions and ideas. They support the team to arrive at an appropriate/needed decision. The chair ensures that minutes are kept, communicated to and reviewed by the members of the meeting and team members how may have been absent from the meeting. The chair, or their designate will post minutes of meetings to SMH Teams to provide ongoing access of information for staff. All decisions made relating to participant care, support and intervention are recorded without identifying information.

Delegation of Authority:
Individuals who receive delegated authority will have sufficient knowledge of SMH programs and services, policies and procedures, legislation, and regulations to minimize risk to the organization and to ensure compliance legislation as applicable. In their absence, the Executive Director will delegate responsibility to a member of the Leadership Team to act on their behalf. For a planned or unplanned absence of the Executive Director of a significant duration, the Board of Directors will consult with the Leadership Team and determine the re-assignment of authority and the duration of such re-assignment as appropriate.

RELEVANT LEGISLATION AND STANDARDS:

SMH FORMS:

RELATED POLICIES:

SMH Organizational Chart
SMH Job Descriptions

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

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HR A.16: OFFENCE DECLARATION

SCOPE:

This policy applies to the Board of Directors, employees, volunteers, participants, and partners of SMH.

PURPOSE:

To establish procedures for the collection of Offence Declaration Forms from all staff of SMH.

DEFINITIONS AND ACRONYMS:

Offence Declaration: means a written declaration signed by an individual that lists all of the individual's convictions for offences under the Criminal Code (Canada), if any, during the period specified in the declaration.
Staff: refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement and service partners of SMH.
Service Partner: is an agency and its employees, and/or an individual who have signed contracts or agreements with SMH to provide services to participants on site.

POLICY:

Completion of a Police Vulnerable Sector Check (PVSC) is required of all staff at SMH and is collected during orientation. A new PVSC is required every five years. In the years following, all staff are required to disclose any information that could impact their ability to fulfill their responsibilities or put themselves or participants at a potential risk. Offence declarations are placed in the staff files. All staff at SMH are to complete an Offence Declaration Form as per the procedures outlined below.

IMPLEMENTATION:

For staff with no offences to declare, annual Offence Declaration Forms are completed by the staff and submitted to the Executive Director for review and then filed. Alternatively, in the event of an offence to declare, staff are to submit an Offence Declaration Form to the Executive Director within 14 days of an occurrence that may impact the safety of themselves or their participants. Such occurrences include but are not limited to any of the following events:

1. Any relevant professional certification or registration that has been revoked, restricted, suspended or voluntarily relinquished or withdrawn;
2. A regulatory, licensing, or professional body has determined that the staff has committed professional misconduct;
3. The person has been convicted of a serious crime related to their role at SMH; and
4. A formal charge or formal accusation has occurred related to any of the above.

Offence Declaration Form can be found on the SMH database. The Offence Declaration Form will be kept in employee's Human Resource file. Knowledge of the content of the form will be limited to the Executive Director and/or designate. The obligation to report such events exists regardless of any appeal process or whether a condition or sanction has already expired. Reports will be reviewed by the Executive Director to determine whether the reported event should/will result in a change of the individual's employment/placement, volunteer, partner, student, board status. Failure to report a matter on the Offence Declaration Form could result in termination of employment/placement/position/service.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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RELEVANT LEGISLATION AND STANDARDS:

SMH FORMS:

Offence Declaration Form

RELATED POLICIES:

SMH Policy: Human Resources – Employees – Police Vulnerable Sector Check

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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HR A.17: AODA – INTERGRATED ACCESSIBILITY STANDARDS REGULATION (ISAR) PARTICIPANT SERVICE POLICY

SCOPE:

This policy applies to the Board of Directors, employees, volunteers, participants, and partners of SMH.

PURPOSE:

To outline procedures to remain compliant specific to the requirements of the Participant Service Standards included in the Integrated Accessibility Standards of the Accessibility for Ontarians with Disabilities Act, (AODA) 2005.

DEFINITIONS AND ACRONYMS:

Staff: refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement and service partners of SMH.

Service Partners: is an agency and its employees, and/or an individual who have signed service protocols and/or agreements with SMH to provide services to participants on site.

Assistive Device: Is a technical aid, communication device or other instrument that is used to maintain or improve the functional abilities of people with disabilities. Personal assistive devices are typically devices that participants bring with them such as a wheelchair, walker or a personal oxygen tank that might assist in hearing, seeing, communicating, moving, breathing, remembering and/or reading.

Disability: The term disability as defined by the Accessibility for Ontarians with Disabilities Act, 2005, and the Ontario Human Rights Code, refers to:

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

Guide Dog: a highly trained working dog that has been trained at one of the facilities listed in Ontario Regulation 58 under the Blind Persons' Rights Act, to provide mobility, safety and increased independence for people who are blind.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

Service Animal: an animal is a service animal for a person with a disability if:

1. The animal can be readily identified as one that is being used by the person for reasons relating to the person's disability, as a result of visual indicators such as the vest or harness worn by the animal; or
2. The person provides documentation from one of the following regulated health professionals confirming that the person requires the animal for reasons relating to the disability:
   - A member of the College of Audiologists and Speech-Language Pathologists of Ontario;
   - A member of the College of Chiropractors of Ontario;
   - A member of the College of Nurses of Ontario;
   - A member of the College of Occupational Therapists of Ontario;
   - A member of the College of Optometrists of Ontario;
   - A member of the College of Physicians and Surgeons of Ontario;
   - A member of the College of Physiotherapists of Ontario;
   - A member of the College of Psychologists of Ontario; or
   - A member of the College of Registered Psychotherapists and Registered Mental Health Therapists of
   - Ontario.

Service Dog:
As reflected in Health Protection and Promotion Act, Ontario Regulation 562 a dog other than a guide dog for the blind is a service dog if:

1. It is readily apparent to an average person that the dog functions as a service dog for a person with a medical disability; or
2. The person who requires the dog can provide on request a letter from a physician or nurse confirming that the person requires a service dog.

Support Person: a support person means, in relation to a person with a disability, another person who accompanies them to help with communication, mobility, personal care, medical needs or access to goods and services.

POLICY:

All programs and services provided by SMH shall follow the principles of dignity, independence, integration, and equal opportunity. SMH is in compliance with the Accessibility for Ontarians with Disabilities Act, 2005. This policy applies to the provision of goods and services to the public or other third parties, not to the goods themselves. For the purpose of this policy "goods" refers to programs and "participant" refers to participants.

IMPLEMENTATION:

The Provision of Goods and Services to Persons with Disabilities:
SMH will make every reasonable effort to ensure that its policies, practices and procedures are consistent with the principles of dignity, independence, integration and equal opportunity by:

1. Ensuring that all participants receive the same value and quality;
2. Allowing participants with disabilities to do things in their own ways, at their own pace when accessing goods and services as long as this does not present a safety risk;
3. Using alternative methods when possible, to ensure that participants with disabilities have access to the same services, in the same place and in a similar manner;
4. Considering individual needs when providing goods and services; and
5. Communicating in a manner that considers the participant's disability.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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The Use of Assistive Devices:
Persons with disabilities may use their own assistive devices as required when accessing goods/programs or services provided by SMH. In cases where the assistive device presents a safety concern or where accessibility might be an issue, other reasonable measures will be used to ensure the access of goods and services. For example, open flames and oxygen tanks cannot be near one another. Therefore, the accommodation of a participant with an oxygen tank may involve ensuring the participant is in a location that would be considered safe for both the participant and business. Or, where elevators are not present and where an individual requires assistive devices for the purposes of mobility, service will be provided in a location that meets the needs of the participant.

Guide Dogs, Service Animals and Service Dogs:
A participant with a disability that is accompanied by guide dog, service animal or service dog will be allowed access to premises that are open to the public unless otherwise excluded by law. "No pet" policies do not apply to guide dogs, service animals and/or service dogs.

Food Service Areas:
A participant with a disability that is accompanied by guide dog or service dog will be allowed access to food service areas that are open to the public unless otherwise excluded by law and other types of service animals are not permitted into food service areas due to the Health Protection and Promotion Act, Ontario Regulation 562 Section 60.

Exclusion Guidelines:
If a guide dog, service animal or service dog is excluded by law (see applicable laws below) SMH will offer alternative methods to enable the person with a disability to access goods and services, when possible (for example, securing the animal in a safe location and offering the guidance of an employee).

Applicable Laws:
Food Safety and Quality Act 2001, Ontario Regulation 31/05: Animals not intended for slaughter or to be euthanized are not allowed in any area or room of a meat plant. It also makes an exception for service dogs to allow them in those areas of a meat plant where food is served, sold or offered for sale to participants and in those areas that do not contain animals or animal parts and are not used for the receiving, processing, packaging, labelling, shipping, handling or storing of animals or parts of animals.

The Health Protection and Promotion Act, Ontario Regulation 562 Section 60, normally does not allow animals in places where food is manufactured, prepared, processed, handled, served, displayed, stored, sold or offered for sale. It does allow guide dogs and service dogs to go into places where food is served, sold or offered for sale. However, other types of service animals are not included in this exception.

Dog Owners' Liability Act, Ontario: If there is a conflict between a provision of this Act or of a regulation under this or any other Act relating to banned breeds (such as Pit Bulls) and a provision of a by-law passed by a municipality relating to these breeds, the provision that is more restrictive in relation to controls or bans on these breeds prevails.

Recognizing a Guide Dog, Service Dog and/or Service Animal:
If it is not readily apparent that the animal is being used by the participant for reasons relating to his or her disability, SMH may request verification from the participant.

Care and Control of the Animal:
The participant who is accompanied by a guide dog, service dog and/or service animal is responsible for maintaining care and control of the animal at all times.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

Allergies:
If a health and safety concern present itself, for example in the form of a severe allergy to the animal, SMH will make all reasonable efforts to meet the needs of all individuals.

The Use of Support Persons:
If a participant with a disability is accompanied by a support person, SMH will ensure that both persons are allowed to enter the premises together and that the participant is not prevented from having access to the support person. There may be times where seating and availability prevent the participant and support person from sitting beside each other. In these situations, SMH will make every reasonable attempt to resolve the issue; and in situations where, confidential information might be discussed, consent will be obtained from the participant, prior to any conversation where confidential information might be discussed.

Notice of Disruptions in Service:
Service disruptions may occur due to reasons that may or may not be within the control or knowledge of SMH. In the event of any temporary disruptions to facilities or services that participants with disabilities rely on to access or use SMH goods or services, reasonable efforts will be made to provide advance notice. In some circumstances such as in the situation of unplanned temporary disruptions, advance notice may not be possible. In the event that a notification needs to be posted, the following information will be included unless it is not readily available or known:

1. Goods or services that are disrupted or unavailable;
2. Reason for the disruption;
3. Anticipated duration; and
4. A description of alternative services or options.

Notification Options:
When disruptions occur SMH will provide notice by:

1. Posting notices in conspicuous places including at the point of disruption, at the main entrance and the nearest accessible entrance to the service disruption and/or on the SMH website;
2. Contacting participants with appointments;
3. Verbally notifying participants / visitors when they are making an appointment; or
4. By any other method that may be reasonable under the circumstances.

Participant Feedback:
SMH shall provide participants with the opportunity to provide feedback on the service provided to participants with disabilities. Information about the feedback process will be readily available to all participants and notice of the process will be made available online and in hard copy available at reception. Feedback forms along with alternate methods of providing feedback such as verbally (in person or by telephone) or written (handwritten, delivered, website or email), will be available upon request. Participants who wish to provide feedback by completing an onsite participant feedback form or verbally can do so directly to the Executive Director. Participants who provide formal feedback will receive acknowledgement of their feedback, along with any resulting actions based on concerns or complaints that were submitted.

Submitting Feedback
Participants can submit feedback to:
Executive Director
613-749-0340 ext. 732
780 rue de l'Église, Ottawa, ON K1K 3K7

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

Training:
Training will be provided to:

1. Every person who is an employee of, or a volunteer with, the provider;
2. Every person who participates in developing the provider's policies; and
3. Every other person who provides goods, services, or facilities on behalf of the provider.

Training Provisions:
Regardless of the format, training will cover the following:

1. A review of the purpose of the Accessibility for Ontarians with Disabilities Act, 2005;
2. A review of the requirements of the Participant Service Standards;
3. Instructions on how to interact and communicate with people with various types of disabilities;
4. Instructions on how to interact with people with disabilities who:
    - Use assistive devices;
    - Require the assistance of a guide dog, service dog or other service animal; or
    - Require the use of a support person (including the handling of admission fees).
5. Instructions on how to use equipment or devices that are available at our premises or that we provide that may help people with disabilities;
6. Instructions on what to do if a person with a disability is having difficulty accessing your services; and
7. SMH policies, procedures and practices pertaining to providing accessible participant service to participants with disabilities.

Training Schedule:
SMH will provide training for its staff regarding the IASR and the Ontario Human Rights Code as they pertain to individuals with disabilities. Training will also be provided to:

1. Individuals who are responsible for developing SMH policies;
2. All other persons who provide goods, services, or facilities on behalf of SMH.

Training will be provided as soon as is reasonably practicable, but no later than 30 days from date of Hire. Training will be provided on an ongoing basis to new staff and as changes to SMH accessibility policies occur.

Acknowledge and Agreement Statement:
All staff are required to sign a SMH Acknowledge and Agreement Statement Form upon hire indicating that they have read and understood SMH policies. Failure to adhere to this or any other SMH policies will lead to disciplinary action up to and including termination of employment/position/placement.

RELEVANT LEGISLATION AND STANDARDS:

Accessibility for Ontarians with Disabilities Act, (AODA) 2005

SMH FORMS:

Acknowledge and Agreement Statement Form

RELATED POLICIES:

SMH Policy: Human Resources – IASR Employees – IASR Information and Communications;
AODA - Integrated Accessibility Standards Regulation (IASR) Employment Policy

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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HR A.18: AODA – INTERGRATED ACCESSIBILITY STANDARDS REGULATION (ISAR) EMPLOYMENT POLICY

SCOPE:

This policy applies to the Board of Directors, employees, volunteers, participants, and partners of SMH.

PURPOSE:

To outline procedures to remain compliant specific to the requirements of the Employee Standards included in the Integrated Accessibility Standards of the Accessibility for Ontarians with Disabilities Act, (AODA) 2005

DEFINITIONS AND ACRONYMS:

Staff: refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement and service partners of SMH.
Service Partners: is an agency and its employees, and/or an individual who have signed service protocols and/or agreements with SMH to provide services to participants on site.
Accessible Formats: Include but are not limited to large print, recorded audio and electronic formats, braille and other formats usable by persons with disabilities.
Communication Supports: Include but are not limited to captioning, alternative and augmentative communication supports, plain language, sign language and other supports that facilitate effective communications.
Performance Development/Appraisal: Activities related to assessing and improving employee performance, productivity and effectiveness with the goal of facilitating employee success.
Redeployment: is the reassignment of employees to other departments or jobs within the organization as an alternative to layoff, when a particular job or department has been eliminated by the organization.

POLICY:

All employment services provided by SMH shall follow the principles of dignity, independence, integration and equal opportunity. SMH is in compliance with the Integrated Accessibility Standards, Ontario Regulation 191/11 for the Employment Standard set forth under the Accessibility for Ontarians withDisabilities Act, 2005. This policy applies to the provision of accessible employment services for persons withdisabilities.

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

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IMPLEMENTATION:

General Requirements:
General requirements that apply across all of the five standards (information and communication, employment, transportation, design of public spaces, and customer service) are outlined as follows:

1. Establishment of Accessibility Policies and Plans
   - SMH will develop, implement, and maintain policies governing how it will achieve accessibility through these requirements as per SMH Policy: Governance - Development, Implementation, Review and Enforcement of Policies.

Training Requirements:
SMH will provide training for its employees and volunteers regarding the IASR and the Ontario Human Rights Code as they pertain to individuals with disabilities. Training will also be provided to:

1. Individuals who are responsible for developing SMH policies; and
2. All other persons who provide goods, services or facilities on behalf of SMH.

Training will be provided as soon as is reasonably practicable, but no later than 30 days from date of hire; and training will be provided on an ongoing basis to new staff and as changes to SMH accessibility policies occur.

Recruitment, Assessment and Selection:
SMH will notify staff and the public about the availability of accommodation for job applicants who have disabilities. Applicants will be informed on all job postings that these accommodations are available, upon request, for the interview process and for other candidate selection methods. Where an accommodation is requested, SMH will consult with the applicant and provide or arrange for suitable accommodation; and successful applicants will be made aware of SMH policies and supports for accommodating people with disabilities.

Accessible Formats and Communication Supports for Staff:
SMH will ensure that staff are aware of our policies for employees with disabilities and any changes to these policies as they occur. If an employee with a disability request it, SMH will, wherever possible, provide or arrange for the provision of accessible formats and communication supports for the following:

1. Information needed to perform their job; and
2. Information that is generally available to all staff in the workplace.

SMH will consult with the employee making the request to determine the best way to provide the accessible format or communication support.

Workplace Emergency Response Information:
Where required, SMH will create individual workplace emergency response information for employees with disabilities. This information will consider the unique challenges created by the individual's disability and the physical nature of the workplace and will be created in consultation with the employee. This information will be reviewed when:

1. The employee moves to a different physical location in the organization;
2. The employee's overall accommodation needs, or plans are reviewed; and/or
3. SMH reviews general emergency response policies.

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

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Performance Management and Career Development and Advancement:
SMH will consider the accessibility needs of employees with disabilities when implementing performance development/appraisal processes, or when offering career development or advancement opportunities and individual accommodation plans will be made, wherever possible, as required.

Redeployment:
The accessibility needs of employees with disabilities will be considered in the event of Redeployment and individual accommodation plans will be made, wherever possible, as required.

Review:
This policy will be reviewed regularly to ensure that it is reflective of SMH current practices as well as legislative requirements.

Acknowledge and Agreement Statement:
All staff are required to sign a SMH Acknowledge and Agreement Statement Form upon hire indicating that they have read and understood SMH policies. Failure to adhere to this or any other SMH policies will lead to disciplinary action up to and including termination of employment/placement/position.

RELEVANT LEGISLATION AND STANDARDS:

Accessibility for Ontarians with Disabilities Act, 2005

SMH FORMS:

Acknowledge and Agreement Statement Form

RELATED POLICIES:

SMH Policy: Governance – Development, Implementation, Review and Enforcement of Policies
SMH Policy: Human Resources – Employees - AODA Integrated Accessibility Standards Regulation (IASR) Customer Service; AODA – Integrated Accessibility Standards Regulation (IASR) Information and Communications

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

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HR A.19: AODA – INTEGRATED ACCESSIBILITY STANDARDS REGULATION (IASR) INFORMATION AND COMMUNICATIONS POLICY

SCOPE:

This policy applies to all staff of SMH.

PURPOSE:

To outline procedures to remain compliant specific to the requirements of the Information and Communications standards included in the Integrated Accessibility Standards of the Accessibility for Ontarians with Disabilities Act, (AODA) 2005

DEFINITIONS AND ACRONYMS:

Staff: refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement and service partners of SMH.
Service Partners: is an agency and its employees, and/or an individual who have signed service protocols and/or agreements with SMH to provide services to participants on site.
Accessible Formats: Include but are not limited to large print, recorded audio and electronic formats, braille and other formats usable by persons with disabilities.
Communication Supports: Include but are not limited to captioning, alternative and augmentative communication supports, plain language, sign language and other supports that facilitate effective communications.
Performance Development/Appraisal: Activities related to assessing and improving employee performance, productivity and effectiveness with the goal of facilitating employee success.
Conversion Ready: An electronic or digital format that facilitates conversion into an acceptable format.

POLICY:

All information and communications materials and services provided by SMH shall follow the principles of dignity, independence, integration and equal opportunity. SMH is in compliance with the Integrated Accessibility Standards, Ontario Regulation 191/11 for the Employment Standard set forth under the Accessibility for Ontarians with Disabilities Act, 2005. This policy applies to the provision of information and communications services and materials for people with disabilities.

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

IMPLEMENTATION:

Feedback Process:
In accordance with the AODA Information and Communication Policy Standards, SMH will make known the availability of accessible feedback formats. SMH will ensure that all feedback processes (both internal and external) are made accessible to participants or staff, upon request. SMH shall provide participants or staff with the opportunity to provide feedback on the service provided to individuals with disabilities. Information about the feedback process will be readily available to all participants and staff. Notice of the process will be made available online and in hard copy available at reception. Feedback forms along with alternate methods of providing feedback such as verbally (in person or by telephone) or written (handwritten, delivered, website or email), will be available upon request. Participants who provide formal feedback will receive acknowledgement of their feedback, along with any resulting actions based on concerns or complaints that were submitted.

Accessible Formats and Communication Supports:
Unless deemed unconvertible, SMH will provide or arrange, whenever possible, for the provision of accessible formats and communication supports for persons with disabilities, upon request. Accessible formats and communication supports will be provided in a timely manner and at no additional cost to the individual. SMH will consider the person's accessibility needs when customizing individual requests and shall consult with the individual making the request to ensure suitability; and SMH will make the availability of accessible formats and communication supports publicly known.

Emergency Procedures, Plans or Public Safety Information:
SMH will ensure that all publicly available safety and emergency information (e.g. evacuation procedures, floor plans, etc.) is provided in an accessible format or with appropriate communication supports, upon request.

Exceptions:
The Information and Communications Standard does not apply to:

1. Products and product labels;
2. Unconvertible information or communications; or
3. Information that the organization does not control either directly or indirectly through a contractual relationship.

Unconvertible Information or Communications:
If it is determined, in consultation with the requesting party, that information or communications are unconvertible, SMH will ensure that the individual who made the request is provided with an explanation and a summary of the information and SMH will classify information or communications as unconvertible where:

1. It is not technically practicable to convert; or
2. The technology required to make the conversion is not readily available.

Review:
This policy will be reviewed regularly to ensure that it is reflective of SMH current practices and legislative requirements.

RELEVANT LEGISLATION AND STANDARDS:

Accessibility for Ontarians with Disabilities Act, (AODA) 2005

RELATED POLICIES:

SMH Policies: Human Resources – Employees - AODA - Integrated Accessibility Standards Regulation (IASR) Customer Service Policy; AODA - Integrated Accessibility Standards Regulation (IASR) Customer Service Policy

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

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HR A.20: SUCCESSION PLANNING -EMPLOYEES

SCOPE:

This policy applies to the Board of Directors, employees, volunteers, participants, and partners of SMH.

PURPOSE:

To establish a succession planning process at St. Mary's Home

DEFINITIONS AND ACRONYMS:

St. Mary's Home: SMH

POLICY:

Succession planning at St. Mary's Home is not an event but an embedded practice with a three-year planning horizon. Through collaboration with the Board of Directors, the Executive Director and the St. Mary's Home Leadership Team, a plan is determined using the key steps to effective succession planning that include:

1. Identification: Succession planning needs are identified by a clear alignment to St. Mary's Home organizational goals and the core competencies required to meet these goals;
2. Assessment: Once needs are identified, an assessment is done to determine where the potential exists within St. Mary's Home to meet such needs;
3. Development: High-potential employees at St. Mary's Home are encouraged to build their knowledge and capacity by seeking out professional learning activities that may include: workplace learning opportunities training, courses, workshops, mentoring, leadership development and/or taking on acting positions;
4. Management: The succession planning process should be as transparent as possible. Employees are made aware of the process informally and/or in conversations during the annual performance development process. Succession plans should also be reviewed and evaluated annually in conjunction with the strategic plan.

IMPLEMENTATION:

Specific to succession planning, the Executive Director, in collaboration with the St. Mary's Home Leadership Team, will:

1. Maintain "Handover Documents" that outline specific information about each role/position in the organization;
2. Determine staffing needs annually based on the changing requirements of clients and the strategic directions that have been identified as a focus for the organization;
3. Identify future potential vacancies;
4. Ensure employees have an opportunity to express interest in various positions in the organization. This can be done informally through discussion with Supervisors and/or formally through the performance development process;
5. Make employees aware of future opportunities including the position of Executive Director; and
6. Provide and encourage employees to seek out, learning, mentoring and/or coaching opportunities to help prepare them for the future and to support the succession planning process.

RELEVANT LEGISLATION AND STANDARDS:

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

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RELATED POLICIES:

St. Mary's Home Policy: Human Resources – Employees – Hiring Practices
St. Mary's Home Handover Documents

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

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HR A.21: RECRUITMENT, SCREENING, SELECTION AND SUPERVISION OF VOLUNTEERS

SCOPE:

This policy applies to the Board of Directors, employees, volunteers, participants, and partners of SMH.

PURPOSE:

To outline the recruitment, screening procedures for the supervision of volunteers, and procedures for volunteers supervising children.

DEFINITIONS AND ACRONYMS:

Agency: SMH

POLICY:

SMH encourages the use of volunteers as they can play an important role in supporting the Agency's philosophy and daily operations. Effective supervision of volunteers allows for a rewarding experience for the volunteer and a great opportunity for the Agency to seek feedback about its programs and services.

IMPLEMENTATION:

Recruitment of Current/Past Staff to Volunteer:
Appropriate staff are made aware of and invited to upcoming community events in support of SMH that require the unpaid assistance of volunteers and that may occur outside of the regular work schedule and former employees who wish to volunteer at SMH and/or at special events are recruited, screened, and selected as per the procedures below.

Former and Current Participants as Volunteers in SMH Events:
Former and current participants are sometimes requested to speak at various events either onsite or in the Community. For current participant's procedures are followed as per SMH Policy: Systems and Structures: Collection, Use and Release of Personal Information and Recruitment, Screening, Selection and Supervision of Volunteers (see SMH Volunteer Handbook). Participants must attend the event with a staff member. Their role and responsibilities are clearly outlined by SMH staff prior to attending any event.

Recruitment of Volunteers:
The SMH Volunteer Coordinator, in collaboration with the Executive Director and Leadership Team, is responsible for the recruitment, selection of and administration for volunteers:

1. Volunteers must be over the age of 18 – on occasion very specific short-term volunteer opportunities can be supported for people under 18, these must be pre-approved by the Executive Director or their designate;
2. Direct supervision access (i.e.: when the adult is alone with a child) is not permitted
3. All pertinent policies and procedures are to be reviewed including SMH Volunteer Handbook by volunteers during orientation and reviewed at least annually afterwards;
4. Volunteers will sign an Acknowledgement and Agreement Statement Form indicating they have reviewed appropriate policies;
5. Volunteers will sign a Confidentiality Agreement Form;
6. A Police Vulnerable Sector Check is required for volunteers working with children or vulnerable persons, all other volunteers are required to provide a Level-2 Criminal Records Check. There is no requirement for a Police Records Check for speaking engagements;
7. Volunteers are screened and given an orientation by the Volunteer Coordinator;
8. With the support of the Volunteer Coordinator, volunteers will be supervised by assigned staff members who are working directly with the volunteer;

Created: March 22, 2016
Review Date: July 2024
Approved by BOD: July, 2024

9. An evaluation of the volunteer's performance will be completed by their supervisor after 3 months of volunteering and then annually thereafter using the SMH Volunteer Performance Evaluation Form;
10. In the Child Development Program, an individual plan for a child with special needs is reviewed byvolunteers who will be assisting in providing care or guidance within the childcare program;
11. The role of the volunteer in the Child Development Program is to assist the educators in the program in any way that the educator feels is appropriate;
12. If a policy is breached by a volunteer, the Volunteer Coordinator, Supervisor and, when applicable, the Executive Director will deal with the situation using the guiding principles of respect for the persons involved, objectivity, protection of confidential information, and due diligence, using disciplinary measures that may be applicable and justifiable;
13. If the concern raised in a volunteer evaluation is a risk to the health and well-being of SMH participants,the volunteer will be released immediately from their duties as a volunteer.

Volunteers and the Supervision of Children in the Child Development Room:
Volunteers are not to be counted in staffing ratios and, therefore, Supervisors are to ensure that direct one- on-one supervision (i.e., when the adult is alone with a child) is not permitted for persons who are not employees of SMH.

Volunteer Delivery Drivers:
To support the safety and well-being of our volunteer drivers, SMH must ensure that every volunteer driver understands and adheres to the following policies:

1. Volunteer drivers must be over the age of 18;
2. The volunteer driver vehicle must have a Safety Standards Certificate as per the Province of Ontario;
3. The vehicle must also be insured with a minimum of $1,000,000 liability insurance;
4. The volunteer will ensure, to the best of their knowledge, that the motor vehicle being used is in good mechanical condition;
5. The volunteer driver will provide a copy of their current driver's license and proof of insurance to SMH to keep on file;
6. The volunteer driver will advise SMH if/when said driver's license and/or insurance is updated and will provide the updated records for SMH's files;
7. The volunteer driver will operate the vehicle in a safe manner and not in contravention of any statute or regulation governing the operation of motor vehicles;
8. The volunteer driver must be in good health and have no physical or medical conditions that restrict their ability to drive;
9. The volunteer driver will not be taking any medications that would impair their ability to drive.
10. The volunteer driver will not have any other passenger(s) in their car during the course of their deliveries to SMH participants, due to privacy and confidentiality, unless otherwise approved by SMH; and
11. The volunteer driver will limit their interaction with participants they deliver to as per the job description provided.

RELEVANT LEGISLATION AND STANDARDS:SMH FORMS:

Acknowledgement and Agreement Statement FormConfidentiality Agreement Form
Volunteer Performance Evaluation Form

RELATED POLICIES:

SMH Volunteer Handbook
SMH Policy: SS A.1 Collection, Use and Release of Personal Information

Created: March 22, 2016
Review Date: July 2024
Approved by BOD: July, 2024

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HR A.22: EMPLOYEE DRIVING POLICY

SCOPE:

This policy applies to all staff and volunteers of SMH.

PURPOSE:

To outline the requirements of employees that are expected to drive for program/service provision; and to outline the procedures and expectations for these circumstances.

DEFINITIONS AND ACRONYMS:

St. Mary's Home: SMH

POLICY:

SMH provides outreach programs and/or services that require employees to regularly drive to meet participants. Outreach provides an opportunity to extend service and/or program delivery to work directly with participants in their own environment. This approach to programming aligns with the Agency's philosophy to build on the strengths of participants by assessing needs and minimizing barriers within real-life situations. This policy supports the safety and well-being of SMH employees by ensuring that every driver understands and adheres to the following procedures.

IMPLEMENTATION:

Vehicle Safety & Driving Standards:

1. Drivers must be over the age of 18;
2. Employees must have permission from leadership to drive for work purposes;
3. The vehicle must be insured with a minimum of $1,000,000 liability insurance;
4. The employee will ensure, to the best of their knowledge, that the motor vehicle being used is in good mechanical condition;
5. The employee will provide a copy of their current driver's license and proof of insurance to SMH to keep on file;
6. The employee will advise SMH if/when said driver's license and/or insurance is updated and will provide the updated records for SMH's files;
7. The employee will operate the vehicle in a safe manner and not in contravention of any statute or regulation governing the operation of motor vehicles;
8. The employee must be in good health and have no physical or medical conditions that restrict their ability to drive;
9. The employee will not be taking any medications that would impair their ability to drive;
10. The employee will not have any other passenger(s) other than another SMH employee, due to privacy and confidentiality, unless otherwise approved by SMH leadership; and
11. The employee will never drive participants.

Mileage Reimbursement:

SMH reimburses employees at the pre-approved mileage rate. After confirming with their supervisor, employees can claim mileage for:

1. Outreach program facilitation;
2. Picking up large donations; and
3. Purchasing approved program materials/food.

SMH does not reimburse mileage driving to and from work. This includes when an employee starts or ends their shift off-site.

RELEVANT LEGISLATION AND STANDARDS:

SMH FORMS:

RELATED POLICIES:

Created: March 22, 2016
Review Date: July 2024
Approved by BOD: July, 2024

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LE A.1: SUPERVISION OF FIELD PLACEMENT STUDENTS

SCOPE:

This policy applies to all staff, existing/future students, and their institution supervisors.

PURPOSE:

To outline the procedures for the supervision of Field Placement Students referred to herein as "student(s)".

DEFINITIONS AND ACRONYMS:

St Mary's Home: SMH

POLICY:

Students play an important role in supporting SMH philosophy and daily operations. Our purpose is to ensure that every Field Placement Student at SMH is supervised in a way that is guided by SMH policies and procedures and supports a positive and productive learning experience for the student, including the requirements set out by their post-secondary educational institute. In addition to ensuring that students follow the appropriate St. Mary's Home policies and procedures.

IMPLEMENTATION:

Young Parent Outreach Centre:
:

1. All potential students will participate in an interview with a member of the Management Team to determine the suitability of the student to the agency. This will include checking references. The student's academic supervisor may or may not attend this interview;
2. A learning contract, agreed to between the organization and the student, will be signed;
3. The role of students will be to develop a greater understanding of the social services/child and youth work field;
4. Each student will be assigned an on-site supervisor who has the relevant experience, knowledge and educational requirements needed to successfully supervise the student;
5. Students will meet with, and be provided a brief initial orientation by a manager, depending on the role in which they will be working;
6. Students will receive a more in-depth orientation and on-boarding, followed by ongoing training and support, by their onsite supervisor;
7. All pertinent policies and procedures are to be reviewed by students who will be providing care or guidance in the programs before entering the program and at least annually afterwards;
8. Students will sign an Acknowledgement and Agreement Statement indicating their review of appropriate policies;
9. All students are required to sign a Confidentiality Agreement Form;
10. Individual plans for a participant with special needs are reviewed by students who will be assisting in providing care or guidance in the program;
11. Police Vulnerable Sector Check, Standard First Aid and CPR, as well as all updated immunizations are required for all students;
12. SMH will provide a safe working environment for the students;

Created: September 2017
Review Date: July 2024 , Revised: Nov 2025
Approved by BOD: Nov 2025

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13. SMH staff will provide timely and constructive feedback on the students' performance and skills;
14. Supervisors and students will engage in weekly meetings and complete all evaluations set out by their respective post-secondary institutions;
15. Students will be expected to work closely with the Centre staff team members, along with the St Nicholas High School Achievement Centre teacher, other partner staff and SMH participants;
16. Students will be expected to be well-rounded, supportive role-model for the participants. Students whose performance or behaviour does not match agency standards and expectations, will be asked to meet with staff and their academic advisor to determine what steps need to be taken to rectify the situation. The agency reserves the right to terminate the placement if a satisfactory resolution cannot be found;
17. Students will be asked to complete a post-placement exit interview (a modified version of the employee exit interview), the results of which will be used to inform SMH practice on future student placements.

RELEVANT LEGISLATION AND STANDARDS:

N/A

SMH FORMS:

Acknowledgement and Agreement Statement
Confidentiality Agreement Form

RELATED POLICIES:

St Mary's Home Volunteer Handbook – Section on Field Placement Student

Created: September 2017
Review Date: July 2024 , Revised: Nov 2025
Approved by BOD: Nov 2025

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LE A.2: EXTERNAL RESEARCH

SCOPE:

This policy applies to all staff and existing/future research partner institutions and researchers.

PURPOSE:

To establish procedures at St. Mary's Home to support external clinical research involving participants.

DEFINITIONS AND ACRONYMS:

Agency: St. Mary's Home
Leadership Team: Executive Director and Director of Operations and Services
St Mary's Home: SMH

TRI-COUNCIL POLICY STATEMENT: ETHICAL CONDUCT FOR RESEARCH INVOLVING HUMANS:

is a joint policy of Canada's three federal research agencies: Canadian Institute of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada. This policy expresses the Agencies' continual commitment to the people of Canada to promote the ethical conduct of research involving humans. It has been informed, in part, by leading international ethical norms, all of which may help in some measure, to guide Canadian researchers, in Canada and abroad, in conduct of research involving humans.

POLICY:

SMH does not conduct its own formal research projects but is committed to assisting external research teams in expanding the research base in the field of child and youth, specifically in relation to pregnant and parenting youth and their children. SMH supports and participates in clinical research conducted by universities and researchinstitutes. SMH acknowledges that external researchers must adhere to the Canadian Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans 2010. External research study proposals must support the mission, vision and guiding principles of SMH and must protect the rights and welfare of SMH participant's and staff.

IMPLEMENTATION:

Criteria for Research Proposals from External Agencies:
A written submission must be given to the Executive Director, it should include:

1. Names of the researchers and their backgrounds;
2. The benefits and potential risks of participation in such research for the SMH community;
3. The title of the study, background, and main purpose of the study (plain language statement); research methodology;
4. Recruitment strategy and guidelines including characteristics of the proposed study participants, including sample size and agency programs to recruit from;
5. Method for obtaining informed consent, including risks and benefits and protection of confidentiality that are aligned with SMH policies. (A copy of consent forms, potential risks and other information must be provided to participants in writing.);
6. Mechanisms to safeguard research participants from harm, abuse, exploitation and/or discrimination;
7. Budget and agency resources required; and
8. A copy of the Research Ethics Board approval governing the university and/or institution to conduct such research at SMH.

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

Review of External Research Proposals:

All external formal research proposals must be reviewed by the Executive Director and the SMH Leadership Team with all written research proposals meeting the above criteria. The Executive Director, in collaboration with the Leadership Team, will consult with individuals with relevant expertise to ensure that the research has scientific merit; and must determine the feasibility of participating in the research based on:

1. Alignment with trauma-informed practice and impact on participant's;
2. A comparison of its level of intrusion on programs and services against the level of impact on the community;
3. A determination of the impact it will have on SMH resources.

After consultation with the Leadership Team, the Executive Director is responsible for the approval of external formal research to be conducted at SMH; and once approved, a member of the Leadership Team will inform the researchers and arrange a meeting to discuss next steps.

Implementation of External Research at St. Mary's Home:
The Executive Director or their designate is responsible for overseeing and monitoring the implementation of external formal research at SMH. Participants of programs and services at SMH, who chose not to take part the formal research project, will continue to have full access to this support. The Executive Director and/or their designate will arrange a meeting to discuss next steps that may include but not be limited to:

1. A brief orientation to SMH;
2. A review of any applicable SMH Policies and Procedures such as Health and Safety, Crisis Management, Anti-Discrimination;
3. A review of the schedule and timelines for conducting research; and
4. Access to staff and an introduction to their key contact (a designate assigned by the Executive
5. Director)

The Executive Director is responsible for communicating to the Board of Directors and to all stakeholders, information about research being conducted at SMH including the findings of such research and how they will be used to inform practice at SMH.

RELEVANT LEGISLATION AND STANDARDS:

N/A

RELATED POLICIES:

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

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PS B.1: PARTICIPANT ASSESSMENT

SCOPE:

This policy applies to all staff, volunteers, and participants of SMH.

PURPOSE:

To outline the appropriate assessment tools to screen and assess participants

DEFINITIONS AND ACRONYMS:

SMH: SMH
ASQ 3: Ages and Stages Questionnaire 3
ASQ SE: Ages and Stages Questionnaire – social and emotional
DSP: Developmental Support Plan
GAIN-SS Assessment:

POLICY:

SMH takes a dyadic trauma-informed approach to assessment and care/case management, addressing both the parent and the child's mental health needs together. Standardized, qualitative and quantitative evidence-informed and trauma-informed screening and assessment is undertaken to ensure a physically and psycho-emotionally safe environment for participants, their children, and staff. Assessment is done in accordance with the complexity, severity, and evolving nature of the participant's need.

IMPLEMENTATION:

SMH engages participants, including parents, children, and youth, in the screening and assessment process. Staff discuss benefits and risks of assessment and care/case management with the participant. The participant signs to acknowledge their understanding of the assessment process and as a means of providing SMH with their informed consent. Standardized evidence-informed screening/assessment tools are used. The screening/assessment shall:

1. Be appropriate to the participant's request and need for service;
2. Evaluate the holistic needs of the participant;
3. Accommodate the cultural, ethnic, religious, sexual orientation, gender identity, gender expression, and language diversity of the participant;
4. Document the participant's description of strengths, and areas for growth that are socially, emotionally and developmentally appropriate;
5. Consider any previous assessments, where applicable; and
6. Use screening/assessment results to inform service coordination, care/case management planning, participant expectations and program evaluation.

Screening/assessment findings shall be shared with the participant in a manner that is accessible. If the participant has received services elsewhere in the past two years, a consent to Release Information Form may be obtained, if it is in the best interest of the participant for SMH to work with other providers to ensure a more seamless coordination of care and it supports the participants case management plan.

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

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Child Development Program:
SMH provides specialized childcare, serving children from 4-months to 6 years with an emphasis on infant mental health (social-emotional development), child development and individualized programming.

1. A Looksee Developmental Screener and/or ASQ assessment is completed, in collaboration with the parent, at regular intervals, as prescribed by the screener, to screen for developmental milestones;
2. A Developmental Support Plan (DSP) is developed, in collaboration with the parent, to support the child's growth in at-risk areas of development; and
3. Referrals are made to internal and external resources as required.

Intensive Care / Case Management Support Program
All participants complete an Intake Interview and Orientation Screening before beginning programming at SMH.

1. A GAIN-SS Assessment is created for each participant at intake;
2. Regular care/case management meetings occur between the Case Manager / Support Workers and the participant to monitor the progress of goal attainment and/or to monitor existing goals; and
3. Referrals are made to internal and external resources as required.

Therapy – Mental Health/Addiction Counsellor

Mental Health/Addiction Counsellor completes the GAIN-SS with participants as an initial screener within the first 30 days. Therapist will complete the clinical portion of the CANS-PPY 30-40 days after the participant enrolls in programming, then at 30-90-day intervals until discharge. Therapist will assess participant's progress on the stages of change. Personal mental health and addiction goals are developed and monitored. Referrals may be made (with participant consent) to internal and external agencies as required. Mental Health/Addiction counsellor uses a wide-ranging approach to treatment that is tailored to meet the individual needs of the participant. Treatment approaches include, but are not limited to:

1. Motivational Interviewing,
2. Cognitive Behavioural Therapy,
3. Solution Focused Therapy, and
4. Mindfulness Based Approach;

Example of other assessment tools which may be utilized according to participant's needs are:

1. Drug-Taking History; and
2. Opiate Supplementary Form.

RELEVANT LEGISLATION AND STANDARDS:

SMH FORMS:

Release Information Form
Opiate Supplementary Form

RELATED POLICIES:

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

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PS B.2: MULTIDISCIPLINARY CASE MANAGEMENT/SERVICE COORDINATION

SCOPE:

This policy applies to all staff, volunteers, and participants of SMH.

PURPOSE:

To address treatment/service planning across the continuum of care beginning at intake and culminating with discharge, and to establish a process for using a multi-disciplinary approach to service delivery.

DEFINITIONS AND ACRONYMS:

St. Mary's Home: SMH
CDP: Child Development Program
DSP: Developmental Support Plan
Collaborative Problem Solving: focuses on building supportive relationships and teaching at-risk parents the skills they need to succeed. It is used to address challenges encountered by the participant in developing a range of solutions.
Individual Care/Case Management Plan: A plan that is developed in collaboration with the participant and staff members who are working directly with the participant. The plan outlines goals for the participant that are directly linked to the participant's identified area of need as assessed through formal assessment such as the GAIN-SS and/or informal assessments based on partner/staff observations and feedback from the participant, as well as the actions the participant intends to take to achieve their goals.
Multidisciplinary Team: Parenting Support Workers, Case Management Staff, , Mental Health/Addiction Counsellor, SafeCare/Attachment Counsellors, Child Development Program staff, and, when participant needs determine, agency and community partners, such as, the Achievement Centre Teacher, Public Health Nurses, Medical Clinic Staff, CAS Social Workers.

POLICY:

Case management and service coordination are key processes that place the child or youth at the centre of treatment, and bring together the partners in service delivery to provide an integrated and coordinated response to best meet the needs of the participants. These processes are adjusted based on the evolving, complex, individual needs of the participant. SMH believes that working within a multi-disciplinary framework ensures the best possible treatment and services for its participants. The needs of each individual participant determine who would be involved in a participant's care/ case management plan. Care Teams/Case Management Teams are expected to work collaboratively to inform their work, recognizing that the complex issues that bring participants to the agency often require a broader, trauma-informed lens within a multi-disciplinary perspective.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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IMPLEMENTATION:

Youth:

1. Service coordination begins with the initial intake;
2. The front line support staff make the initial contact with the prospective participant either in person or by telephone inquiry to determine if the participant meets the criteria for service;
3. An active offer is made to every participant in respect to the participant's preference to receive services in the English or French language;
4. If the prospective participant does not meet the criteria for service, the staff making the initial contact will assist the person with identifying alternative programs and services in the community that may meet their needs;
5. If the prospective participant meets the criteria for service, a meeting is arranged to discuss the programs and services at SMH, thus determining further suitability and to begin the intake process;
6. Participants sign a Consent Form so that their personal information can be collected;
7. During this initial meeting, participants are introduced to the myriad of programming and services available at St. Mary's Home. Participants are informed of their rights and responsibilities and sign forms to acknowledge their understanding of this.
8. Other policies related to participants are reviewed at this time (refer to SMH Policy - Participant Intakeand Orientation Process);
9. In consultation with participants front line staff make internal referrals where appropriate as wellas referrals to external agencies when required;
10. With the consent of the participant, external referrals may occur at any time to meet their evolving needs.
11. Front line staff and participants complete assessments as needed to inform service planning.
12. Participants review their Individual Care/Case Management Plans regularly with their case coordinator, to monitor goal attainment or for goal modification;
13. A collaborative problem-solving approach is employed. Transition planning meetings are held with each
14. participant as they prepare to leave SMH;
15. The Transition Plan meeting is an integral part of the Individual Care/Case Management Plan whereby the case coordinator and the participant review personal strengths and identify areas of growth;
16. Unmet goals could be selected, and new goals could be made as the participant works collaboratively with the case coordinator on their Transition Plan;
17. A SMH resource booklet, provided to every participant who leaves SMH, includes
    information about how to contact the organization for services in the future as well as information about community services/agencies;
    SMH staff may attend an initial transition meeting with the participant at external agencies, to support the transition process;
18. Participant satisfaction surveys are completed regularly throughout the participant's journey. The outcomes are used to inform services and programming; and
19. Where case closure in unplanned, every effort is made to contact the participant to suggest further or alternate services.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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Child:

1. The staff making the initial contact and intake will assign the child to the appropriate Child Development Program (CDP). The staff in the program will begin the Integration Process with the child;
2. Trained Registered Early Childhood Educators and Child and Youth Workers, provide specialized, individualized programming for the children, emphasizing infant mental health and child development;
3. Early identification of children who are at risk for developmental delays is accomplished using standardized screening tools;
4. A Developmental Support Plan (DSP) is developed, in collaboration with the parent(s), to support the child's growth in at-risk areas of development;
5. Information gathered from the CDP screening tools on child's socio/emotional development and developmental milestones may assist participants when collaboratively developing parenting goals in the Individualized Care/Case Management Plans;
6. Child Development Program staff meet with participants on a regular basis to discuss their child's progress, develop, monitor and modify developmental support plans and discuss their child's development;

CDP staff may make referrals, in collaboration with the parent, to internal resources and/or external

1. agencies as required, at any point during the participant's participation in the program;
2. A Transition Plan for the child is completed in collaboration with the parent(s). It may include the most recent assessment indicating successes achieved, ongoing or anticipated participant needs, and information regarding external childcare agencies as well as other information pertinent to the individual child's DSP; and
3. Where case closure is unplanned, every effort is made to contact the parent(s) to suggest further or alternate services.

Multi-Disciplinary Meetings:
Although staff members conduct informal case consultations as required, it is expected that multi disciplinary, participant Service and Case Management meetings are held weekly or bi-weekly. The Multi-Disciplinary, Participant Service and Case Management scheduled meeting agenda will include administrative updates as well as participant case reviews. The attendees of the Multi-disciplinary, Participant Service and Case Management meetings will include: all relevant staff working with the participant and their child(ren). The Director of Operations and Support Services or case manager is responsible for chairing the weekly Multi-disciplinary, Participant Service and Case Management meetings. The Chair is responsible for ensuring that the agenda is prepared and disseminated before the meeting; and participant concerns and child concerns are discussed collaboratively with the intent of informing treatment, modifying the treatment plan and/or making recommendations.

RELEVANT LEGISLATION AND STANDARDS:

SMH FORMS:

Consent Form

RELATED POLICIES:

SMH Policy - Participant Intake and Orientation Policy
SMH Service Delivery Model

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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PS B.3: STAFF SUPERVISION

SCOPE:

This policy applies to all staff, volunteers, and participants of SMH.

PURPOSE:

To provide support and supervision to all staff in implementing trauma and evidence-informed practices withparticipants.

DEFINITIONS AND ACRONYMS:

DOPS: Director of Operations, Programs and Support Services

POLICY:

The supervisory process is intended to foster the development of trust and mutual respect between the staff and their supervisor. Effective supervision provides a reflective space and emotional support and will build on an individual's strength and competencies within the care/case management framework. Using a collaborative approach, supervision has a skill development, administrative, and a care/case management focus.
The supervisory process will include the opportunity to cover individual support, programming, administrative and professional development issues, as well as individual goals. The frequency of such will be determined by the needs of the staff, participants, and the organization.

IMPLEMENTATION:

All SMH staff have access to their DOPS for support in front line and program work. The agenda for a supervision meeting is collaboratively developed and includes care/case management, program and administrative issues as well as a discussion about the professional needs of the staff, the agency, and the evolving needs of the participants

Supervision meetings with staff may occur on an individual or group basis. Sufficient time must be allowed to provide mutual feedback concerning the supervisory process and to address any areas of concern. DOPS make careful decisions, in collaboration with the DOPS and Executive Director, about how evidence-informed programs and services will be implementedand adopted.

The DOPS will regularly assess how well the evidence-informed practice is being implemented and adhered to ensure fidelity.

The DOPS will audit participant records according to the CCA Participant File Review Checklist. The Individual Care/Case Management Plan strategies and goals are regularly monitored to ensure participant needs and assessments are utilized to inform treatment.

The DOPS and/or the ED must be consulted in situations where there is an identified risk of harm to self or others including crisis consultation. When required, a safety plan will be developed collaboratively with the participant and the DOPS and shared with other staffwhen appropriate.

Staff must bring controversial or ethical issues in their service delivery with participants to the attention of the DOPS in a timely manner. If warranted, the DOPS will discuss the issue with the Executive Director regarding the appropriate resolution while consulting relevant legislation, policies, and codes of ethics of professional regulatory bodies.

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

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The DOPS, in collaboration with the supervisor is responsible for annual performance appraisals with staff which will include information discussed during supervision sessions and the DOPS will advise staff of professional development opportunities and training required.

Frequency of Supervision:
Supervision meetings will be at minimum monthly.
It is the responsibility of the staff to bring to their DOPS' attention critical issues that arise between regularly scheduled supervisory meetings. All notes regarding the supervision meeting will be documented.

The DOPS is available to all staff for consultation purposes to meet the evolving needs of participants, staff, and the organization. Consultation with the DOPS (or Executive Director in his/her absence) is required whenever a risk of harm to self or others is suspected in a participant (i.e.: suicide, family violence, abuse, risk of harm).

RELEVANT LEGISLATION AND STANDARDS:

SMH FORMS:

CCA Participant File Review Checklist

RELATED POLICIES:

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

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RS A.1: RISK MANAGEMENT

SCOPE:

This policy applies to all staff, volunteers and external contractors of SMH.

PURPOSE:

To establish a risk management strategy aimed at identifying, reducing, and managing all areas of risk to SMH.

DEFINITIONS AND ACRONYMS:

Staff: refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement and service partners of SMH.
Service Partner: is an agency and its staff, and/or an individual who have signed service protocols and/or agreements with SMH to provide services to participants on site.

POLICY:

SMH has risk management processes that are embedded within all aspects of the organization. This includes the identification of potential risk factors; recommendations for strategies to address the potential risk factors; the development and implementation of policies, procedures and practices that will reduce or eliminate risk; and monitoring and analysis of any risk situation that may arise.

IMPLEMENTATION:

General

1. Working with the Executive Director, the Board of Directors ensures that the organization complies with all laws related to fiscal accountability and governance, including ensuring adequate liability and asset insurance coverage;
2. The Executive Director and the Leadership/Management Team ensure that risk management processes based on legislated requisites are implemented and functional, including the identification of current and potential risk for each area of service and operation within SMH, strategies to address the risks, and making available "best practices" and other resources;
3. All staff are expected to participate in managing and reducing risk through adherence to the SMH policies and procedures;
4. Annually, SMH's performance in risk management will be reviewed and the results will be reported to the Board of Directors. The review includes: the identification of risks, actions taken to address the risk, recommendations for improvement and emerging areas of risk that may need to be addressed in the future. The review will include, but is not limited to, the following areas: participants, staff, physical plant and property, information, and operational/ fiscal procedures; and
5. Evidence of the review and commitment to risk management can be found in the MCCSS Risk Mitigation Plan Summary that is available upon request via the Executive Director or the President of the Board of Directors.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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External Contractors

To minimize risk to the organization, it is important to address how safety procedures apply to external contractors who work at SMH for short periods of time. External contractors are not required to complete a Police Records Check; therefore, they are required to:

1. Notify all appropriate staff prior to doing any work at the Centre;
2. Sign in and out at the reception desk;
3. Wear a uniform and/or have visible identification on them at all times;
4. Refrain from engaging the participants in conversation;
5. Seek out an employee for assistance should any issue arise with a participant;
6. Sign keys out with appropriate staff and return them at the end of each day unless other arrangements are made with the appropriate staff;
7. Although rare, should external contractors have access to confidential information, they must sign a SMH Confidentiality Agreement Form.
8. Sign a contractual waiver indicating:
   - They will work within the confines of the Occupational Health and Safety Act, WSIB and this policy;
   - They have adequate and current liability insurance and Workers Compensation Board coverage;
   - They will not hold SMH liable for damage to the premises or personal injury as a result of their negligence or contravention of Occupational Health and Safety Act standards;

RELEVANT LEGISLATION AND STANDARDS:

Occupational Health and Safety Act, WSIB

SMH FORMS:

Confidentiality Agreement Form

RELATED POLICIES:

CCA: ORG-RS-1.1

Created: August 28, 2017
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RS A.2: CRISIS MANAGEMENT

SCOPE:

This policy applies to all staff and volunteers.

PURPOSE:

To establish procedures for employees to follow in a crisis and to manage high-risk service situations at SMH.

DEFINITIONS AND ACRONYMS:

Staff: refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement and service partners of SMH.
Service Partner: is an agency and its staff, and/or an individual who have signed service protocols and/or agreements with SMH to provide services to participants on site.
NCVI: Non-Violent Crisis Intervention
CPI: Crisis Prevention Intervention

POLICY:

It is important that all employees are equipped to handle high-risk service situations. Employees, as appropriate to their job responsibilities, will have the training and skills needed to handle a crisis. SMH is a safe haven for young pregnant women, young moms and dads, and their infants and young children. As such, physical safety is paramount. Physical restraints and or mechanical restraints are not used at SMH, due to health factors related to pregnancy and the perinatal period. There is no exception to this policy. While this policy is specific to employees, anyone supervising volunteers must ensure they are aware of any policies and procedures that need to be followed to perform their tasks safely.

IMPLEMENTATION:

Training
Every reasonable effort will be made to ensure that employees receive appropriate crisis intervention training to:

1. Ensure the safety of participants, employees and volunteers during emergency situations;
2. Ensure that emergency situations are diffused in a planned and calm manner as possible;
3. Minimize confusion during emergency situations;
4. Deal quickly and effectively with potentially volatile and violent situations; and
5. Work cooperatively as a team in dealing with the emergency situation.

SMH shall ensure that all Employees who provide direct service, are trained through Crisis Prevention Intervention (CPI) in the use of Non-Violent Crisis Intervention, (NVCI within 90 days. Until new employees are trained in CPI, they must work alongside a staff member who is CPI trained. SMH's Leadership Team will ensure thatemployees have refresher training in these methodologies as appropriate for their job responsibilities. This training noted above is to be in accordance with a training program approved by the Ontario Ministry of Children and Youth Services;

1. SMH shall ensure that all Outreach Centre staff who provide direct service to participants are trained in the use of Non-Violent Crisis Intervention (CPI) annually;
2. During the CPI training, staff are taught that if a child or youth was to be restrained, the following observations must be made by staff of the child or youth being restrained, to ensure that they are not experiencing severe distress, including:
   - Signs of cardio-pulmonary distress, as evidenced by:
     - Shallow, rapid breathing;

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- Grunting;
- Bluish tinge to fingernails or around mouth;
- Flushed or Pale complexion;
- Cold Extremities;
- Nasal Flaring; and
- Absence of Breathing.

▪ Signs of possible Neurological distress, evidenced by:
- Confusion / disorientation / flashbacks;
- Seizures;
- Vomiting;
- Diarrhea;
- Difficulty breathing;
- Hyperventilation;
- Unconsciousness; and
- Headache.

Notwithstanding this intensive, important and specific training, all employees must observe the NO-RESTRAINTS policy of SMH. Failing to follow the NO-RESTRAINT policy will result in disciplinary action of the employee, with expected loss of employment at SMH; additionally, all employees sign a document to indicate that they understand this policy.

Serious Occurrence:
Serious incident and/or occurrence may include but is not limited to:

1. Death of a participant;
2. Any injury of an infant or child;
3. The serious injury of a participant or staff member;
4. Flooding on the property;
5. Fire on the premises;
6. A serious mechanical or building issue; and
7. Any other incident of comparable urgency and seriousness.

Intervention Guidelines

1. Employees will intervene in an emergency;
2. At no time should an employee put themselves physically at risk while dealing with an emergency;
3. The first employee to the scene will be in charge of the situation. However, another employee may take over if the first person is not the most appropriate person to be the first responder or if the situation warrants it as per the CPI guidelines;
4. Should assistance be needed, it will be requested by the employee in charge, who is the first responder;
5. Where possible, two employees should work together to handle an emergency situation;
6. Once an incident has been diffused, employees involved will meet to debrief on the incident;
7. All required corresponding forms shall be completed by the appropriate employee; and
8. All forms are to be submitted to the appropriate authorities when applicable.

Physical Altercations/Violence

1. In the event of a crisis involving the physical attack by one participant against another participant, or against staff or a volunteer, police are to be called to intervene (911 if an attack appears to be imminent or is in progress);
2. As part of their professional responsibilities, staff is to use NCVI techniques to prevent situations from escalating to physical violence. The focus is on early intervention and de-escalation;

Weapons

If an emergency involves a weapon:

1. Under no circumstances are employees to attempt to disarm a person wielding a weapon;
2. All persons are to leave or be removed from the area as soon as possible; and
3. Police (911) are to be called.

Calling 911 Police

1. If a situation escalates and the safety of participants and/or employees is at risk - 911 is to be called;
2. When 911 is called, an assigned staff member will be on the phone to inform the police of the situation and to direct police on how to enter the building;
3. If deemed safe to do so, the Crisis Team Leader will assign an employee to greet the police outside at the main door of the building and inform them of the situation; and
4. Every effort should be taken to minimize the involvement of participants not directly involved in the emergency situation.

Medical

1. If a medical situation occurs where a participant cannot go on their own or be safely transported to the hospital by taxi, an ambulance is to be called;
2. If 911 is called for a medical emergency and ambulance, the ambulance personnel are to be greeted outside at the main door of the building and informed of the details by an employee;
3. The employee(s) in charge must have the participant file available with appropriate medical information, authorization for treatment, contacts, etc.;
4. Once an incident has been diffused, employee(s) involved will meet to debrief the incident and appropriate corresponding incident reports will be written and submitted to the appropriate agencies; and
5. Incident Reports are reviewed and filed on a regular basis by the Leadership Team to determine any furthercourse of action (i.e. potential preventative measures).

Communication of Procedures

Detailed procedures are outlined in the SMH Disaster Recovery/Crisis Response Plan:

1. All emergency procedures are posted on the wall of every room at SMH including common spaces such as hallways and entrances;
2. The Executive Director or their designate is responsible for communicating with the President of the Board of Directors in the event of a major crisis within 24 hours;
3. In consultation with staff directly involved in a crisis, the Leadership Team will prepare debriefing information to staff and, if necessary, any information that needs to go to other stakeholders; and
4. This communication is to be done through the Executive Director.

RELEVANT LEGISLATION AND STANDARDS:

RELATED POLICIES:

SMH Risk and Safety Policy: Non-Violent Crisis Intervention
SMH Risk and Safety Policy: Emergency Preparedness
SMH Risk and Safety Policy: Disaster Recovery and Business Continuity
SMH – Disaster Recovery/Crisis Response Plan

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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RS A.3: REPORTING OF SERIOUS OCCURRENCES –PARTICIPANTS – MCCSS

SCOPE:

This policy is for all staff at SMH.

PURPOSE:

To establish procedures for the reporting of incidents and serious occurrences at SMH.

DEFINITIONS AND ACRONYMS:

Staff: refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement and service partners of SMH.
Service Partner: is an agency and its staff, and/or an individual who have signed service protocols and/or agreements with SMH to provide services to participants on site.
Accident: an unfortunate incident that happens unexpectedly and unintentionally, typically resulting in damage or injury.
Child/Youth: Newborn-18years.
Participant: Individual receiving service or program.
Designated Authority: is the Executive Director or their designate.Incident: an even or occurrence
Participating in Service: a participant who is in direct receipt of service from St. Mary's Home and/or under the direct care of staff of SMH is considered participating in a service.SO: Serious Occurrence
Serious Occurrence categories:

1. Death
2. Serious injury
3. Serious illness
4. Serious individual action
5. Restrictive intervention
6. Alleged, witnessed or suspected abuse of mistreatment
7. Error or omission
8. Serious complaint
9. Disturbance, service disruption, emergency situation or disaster

SOR: Serious Occurrence Report
PACY: Provincial Advocate for Children and Youth Amendment Act COOP: Continuity of Operations Plan
ISP: Individual Service Plan
PASD: Personal Assistance Service DeviceYCJA: Youth Criminal Justice Act
MCCSS: Ministry of Children, Community, and Social Services

POLICY:

St. Mary's Home ensures that serious occurrences are responded to in a manner appropriate to the situation with participant safety of paramount concern.
St. Mary's Home ensures that timely reports are provided to all necessary stakeholders in keeping with their requirements.

IMPLEMENTATION:

SMH Staff Responsibilities Step-By-Step Guide:
SMH supervisors, in consultation with the Executive Director, are responsible for managing any incident that occurs.

Created: March 22, 2016
Review Date: July 2024
Approved by BOD: July, 2024

The steps are outlined below, as per MCCSS Serious Occurrence Reporting Guidelines, 2019 Key Enhancements link below:
Step 1: Assess the situation for any risk factors that may affect the health and safety of otherparticipants/children;
Step 2: Deal with immediate situation and, if required, provide medical treatment/First Aid and call 911;
*** Notify the emergency contact person/parent/guardian/partner/spouse***
Step 3: Determine whether an incident is SO in accordance with MCCSS Guidelines;
Step 4: Determine the category of reporting (review the chart below);
Step 5: Determine the timeline for reporting (review the chart below);
Step 6: Initiate the initial notification to MCCSS about Level 1 SOs (phone call or text to supervisor).
SMH must immediately notify MCCSS about level 1 SOs. The initial notification should be a brief description of the incident, including:

1. Type of incident (e.g.: death, serious injury, serious illness, etc.);
2. Approximate date and time of the incident;
3. Approximate number of individuals involved;
4. Whether any of the individuals involved have immediate health or safety needs, and whatSMH is doing to address these needs;
5. Who has been notified about the incident;
6. Whether any initial actions have been taken by SMH in response to the incident; and
7. Whether the incident has garnered media attention or is expected to garner media attention.

Step 7: Submit an initial SOR to MCCSS submitted through online SOR-RL. SOR must include, at a minimum:

1. SMH's site information;
2. Date and time of the SO;
3. Date and time of becoming aware of the SO/deeming the incident to be a SO;
4. SO category or categories;
5. A description of the SO (individuals involved including first and last name, DOB, gender);
6. Who has been notified about the incident;
7. Whether any initial actions have been taken by SMH in response to the incident;
8. Whether the incident resulted in any media attention and whether St. Mary's Home expects there to be any media attention in the future; and
9. Whether the initial SOR is expected to be the only/last report submitted for the SO.

Step 8: MCCSS will review the submission and may contact SMH to seek clarification of any information submitted, additional information or suggest additional actions to be taken about the SO; and request information submitted to be corrected, including having SMH change the SO category selected if it is not correct or remove any unnecessary personal information.;
Step 9: Provide updates until MCCSS deems that no further action is required from SMH: Updates are required at a minimum every 7 business days thereafter until MCCSS deems that no further action is required from SMH. MCCSS may request updates at any time and MCCSS will review each SOR to determine when no further action is required from SMH, which includes checking that SMH:

1. Filled out all required fields;
2. Made all required notifications;
3. Has undertaken all further action or follow-up, as requested; and
4. Met all SO requirements.

Different Levels of Serious Occurrence:
Based on the type of incident, a SO is designated as either a Level 1 or Level 2. The level indicates the timeframe in which the SO must be reported to MCCSS.

1. Level 1 Serious Occurrences: Immediately notify MCCSS and submit an SOR within 1 hour of becoming aware of the SO or deeming the incident to be an SO.
2. Level 2 Serious Occurrences: Submit an SOR as soon as possible but no later than 24 hours of becoming aware of the SO or deeming the incident to be an SO.

Created: March 22, 2016
Review Date: July 2024
Approved by BOD: July, 2024

SMH Reporting Requirements:
Any serious occurrence occurring while on a trip offsite must be reported as soon as possible to the Designated Authority;

1. The Designated Authority will inform the Board President when Serious Occurrence Report is filed; and.
2. The Annual Summary and Analysis Report (regarding participants) will be submitted to MCCSS annually by the ISP Manager.

Additional Note for SO reporting:

1. When a SO involves an individual, SMH should include the individual's view/perspective of the SO in the SOR in their own words:
   - SMH must ensure that the individual has provided their informed consent to having their view/perspective included in an SOR;
   - Also include in this section who completed the debriefing with the individual to obtain the aforementioned information;
   - If SMH is unable to include the individual's view/perspective on the SOR, an explanation should be given.
2. Documenting the incident on a SMH Incident Report Form (staff/participant) will allow SMH Leadership to monitor SO for reporting trends and utilizing SO data to assess compliance with requirements, develop strategies to reduce or prevent SOs, identify staff training needs, and/or evaluate program/service effectiveness.
3. Part X (Personal Information) establishes a new personal information privacy framework for the child and youth services sector. a. Clarifies authorities for MCCSS to collect, use and share individuals' personal information to improve service system planning and better understand participant and service outcomes.

SERIOUS OCCURRENCE (SO) REPORTING PROCEDURES:

Type	Reporting	Reporting Timeline	Categorization	Description	Other guidelines
Death	If death of an individual occurs while receiving service. If a child dies where they or their family received services at any time in 12 months prior to the demise	Level 1: Immediately notify MCCSSand submit a SOR within 1 hour of becoming aware of the death or deeming the death to be a SO	Suicide Violence/Homicide Accidental: Choking, fall, falling object, fire, motor-vehicle accident, poisoning(i.e. alcohol, etc.), or other(specify) Known illness or other Naturalcause Unknown cause (i.e.: the reason for death is unknownat the time of submitting theSOR or the Coroner has classified the death as Undetermined)	Apparent cause of death. Whether there was anyone present at the time of death/any witnesses to the death; Witness accounts of the death(where applicable/known); and Where applicable, confirm thatthe *Child Death Reporting and Review Joint Directive* is being adhered to.	Reporting of an individual'sfamily members, friends is not required. However, if their deathtriggers a SO for the individual receiving a service, it should be reported under the relevant SO category

Created: March 22, 2016
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Approved by BOD: July, 2024

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Type	Reporting	Reporting Timeline	Categorization	Description	Other guidelines
Serious Injury	A participant incurs a serious injury which requires unscheduled medical attention from a regulated health professional and/or unplanned hospitalization	Level 1: Immediately notify MCCSSand submit a SOR within 1 hour of becoming aware or deeming it as SO: A life-threatening injury; An injury caused by SMH; or An injury requiring emergency medical services Level 2: Submit a SOR as soon as possible but no later than 24 hoursof becoming aware or deeming it aany other serious injury than the aforementioned	Accidental Choking, fall, falling object, fire, motor vehicle accidents, poisoning (i.e.: alcohol, etc.),or other (specify) Aggressive behavior (e.g.: physical altercation between individuals) Self-harm (including injuries sustained during a suicide attempt) Unknown cause (e.g.: the reason for injury is unknownat the time of submitting theSOR or there are conflicting accounts regarding how the injury was sustained During a physical restraint, mechanical restraint or placement in a secure de-escalation room Other (specify)	How the injury was sustained/type injury Date(s) and time(s) the individual was taken to see a regulated health professional and/or to the hospital, and dateand time of release Name of the hospital(s) and/orclinic(s) where the individual was taken Parties involved in the injury including witnesses and their statements (where applicable) Any treatment provided by a regulated health professional,and any follow-up treatments required or expected	A hunger strike that resultsin a serious injury should bereported under the Self- Harm subcategory

Type	Reporting	Reporting Timeline	Categorization	Description	Other guidelines
Seriou sIllness	A participant incurs a serious illness or has an existing seriousillness which requires unscheduled medical attention from a regulated health professional and/or unplanned hospitalization	Level 1: Immediately notify MCCSSand submit a SOR within 1 hour of becoming aware of or deeming the incident to be a SO for: A life-threatening illness; or An illness requiring emergency medical services. Level 2: Submit a SOR as soon aspossible for all other serious illnesses but no later than 24 hours of becoming aware of or deeming the incident to be a SO	Mental health (e.g.: an individual is taken to the hospital due to mental health concerns) Communicable disease Other disease, illness or infection Unknown cause (i.e.: cause of illness is not known at time of submitting the SOR)	Types of illness (where known) How the illness was sustained(where known). Date(s) and time(s) the individual was taken to see a regulated health professional and/or to the hospital, and date and time of release. Name of the hospital(s) and/or clinic(s) the individual was takento. Whether there was anyone present at the time of the onsetof the illness. Any treatment provided by a regulated health professional, and any follow-up treatments required or expected. For communicable disease SOs, confirmation of preventative measures taken by SMH to stopthe spread of the disease, and any follow-ups recommended by and/or conducted with public health officials (where applicable).	If an individual at children'sresidence, a supported group living residence, intensive support residence, has or may havea disease of public health or communicable disease, SMH should notify Ottawa Public Health Report communicable disease outbreaks under SO Category 9: Disturbance, Service Disruption, Emergency orDisaster

Created: March 22, 2016
Review Date: July 2024
Approved by BOD: July, 2024

Type	Reporting & Categorization	Reporting Timeline	Description
Serious Individual Action	Suicidal behavior: An individual receiving a service attempts suicide, utters asuicidal threat of a serious nature or that results in the individual being placed on suicide watch. Alleged, witnessed, or suspected assault: A participant is assaulted or isaccused of assaulting someone: 1. Individual on individual 2. Individual on staff 3. Individual on others Contraband/Safety Risk: Participant is suspected or discovered to be inpossession of a substance or object that: ▪ is prohibited by legislation or policies and procedures, ▪ has the potential to cause injury or death, and/or ▪ is deemed by SMH to be a significant danger or concern.Examples: 1. Weapons 2. Narcotics/illegal substances 3. Setting fire (including arson) Inappropriate/unauthorized use of information technology (IT): Participantuses IT in a way that: 1. has or could result in criminal charges, and/or 2. is or could be a threat to the health, safety or well-being of the individual or other individuals Unusual, suspicious or unauthorized individual absence: When a participant'sabsence is unauthorized, or without permission, which includes: 1. Escaped lawful custody 2. Unlawfully at large (UAL) 3. Unusual or suspicious circumstances. Serious charges: Participant incurs serious charges Threat of or relinquishment of care: Relinquishment of care byfamily/primary caregiver(s) has been fulfilled	Level 2 – Submit a SOR as soon as possible but no later than 24 hours of becoming aware or deeming the incident to be a SO	Suicidal Behaviour: Whether the suicidal behavior resulted in an injury: Whether the individual was taken to see a regulated or non-regulated health professional (such as a traditional Indigenous healer) and/or to the hospital, and if so: 1. The name of the hospital and/or clinic where the individual was taken 2. The date and time of going to the hospital and/or clinic 3. Any treatment provided, and any follow-up treatments required or expected If the individual was placed on suicide watch, the status of thesuicide watch. Information on debriefing conducted with the individual, staff, andothers as applicable, including witnesses. Services and supports that are being provided for the individual(where applicable), including actions taken to prevent future incidents. Alleged, witnessed or suspected assault: 1. Whether the assault resulted in an injury 2. If the police were called, describe their involvement 3. Where the individual was taken to see a regulated healthprofessional and/or to the hospital, and if so: ▪ The name of the hospital and/or clinic where theindividual was taken ▪ The date and time of going to the hospital and/orclinic ▪ Any treatment provided, and any follow-up treatmentsrequired or expected ▪ Any efforts that have been taken to keep individualsinvolved in the assault separate, safe, etc. Contraband/safety risk: 1. Type of contraband/safety risk. 2. Was site search completed to ensure no further contrabandare in possession. 3. Whether the contraband has been properly disposed of (asappropriate) Inappropriate/Unauthorized Use of Information Technology: 1. Type of inappropriate/unauthorized use 2. Whether the use was via SMH's information technology, theindividual's personal information technology, or other 3. Actions taken by SMH to mitigate or prevent futureoccurrences. Unusual, Suspicious or Unauthorized Individual Absence: 1. Describe whether the individual poses a serious risk tothemselves or others (e.g.: the individual is without their daily medication, the individual hashistory of suicidal behavior, etc.) 2. Actions taken to locate the individual 3. Type of absence/how the individual became absent 4. Prior history of being missing/absent without permission 5. Individual's state of mind before becoming absent (where known) 6. Information on where staff were at the time of the individualbecoming absent 7. For young persons who escape lawful custody or are or unlawfully at large, any new charges incurred by the youngperson

Created: March 22, 2016
Review Date: July 2024
Approved by BOD: July, 2024

			8. Indicate when the individual has returned/is locatedSerious Charges: 1. List the new charges 2. Detail the events that led to the charges (where known); 3. Detail any media attention, anticipated or has occurred 4. Court dates (where known) Threat of or Relinquishment of Care: 1. Indicate who relinquished or threatened to relinquish care 2. Describe the plan for the individual going forward 3. Reason for relinquishment of care

Type	Reporting	Reporting Timeline	Description
Restrictive Intervention	Physical restraint: A physical restraint is used on a child or young person while receiving service. A physical restraint is used on an adult with a developmental disability who is receiving a service in circumstances where: 1. To address a crisis when positive interventions haveproven to be ineffective 2. There is challenging behavior that is new or more intense and intervention strategies havebeen ineffective in addressing the behavior 3. There is immediate risk of harming themselves or others or causing propertydamage 4. De-escalation attempts failed The physical restraint was used with an adult with a developmental disability and the physical restraint resulted in: 1. Injury to the restrained individual, staff, and/or anyone else in the vicinity where the physical restrainttook place. 2. An allegation of abuse. ▪ A participant is placedin a secure de- escalation (or secure isolation/confinement time-out) room	Level 1: Immediately notify MCCSS and submit a SOR within 1 hour ofbecoming aware or deeming the incident to be a SO for any restrictive intervention that: 1. Contravenes MCCSS legislation, regulations and/or policy 2. Results in physical impairment/injury and/or emotional harm 3. Results in treatment by a regulated health professional,requiring emergency medical services 4. Was administered by an unauthorized person Level 2: Submit a SOR as soon as possible but no later than 24 hoursof becoming aware of or deeming the incident to be a SO all other restrictive intervention SOs	Type of restraint used and technique (where applicable). Reason for the use of a restraint or placement in a secure de-escalation room. Approvals received for use of restraint or placement in a securede-escalation room (where applicable). Where applicable, the imminent threat that led to the use of arestraint or secure de-escalation room. Any injuries to individuals involved (including staff, volunteers,etc.). If treatment was provided by a regulated health professional,and any follow-up treatments required or expected. Less intrusive measures used prior to SO, including de-escalation attempts. If no less intrusive measures or de-escalation method wasused, explain why not. Witness accounts (where applicable) including verbal orwritten debriefing. Where applicable, information on care or treatment plan for the use of a PASD /behavior support plan in place prior to the SO, and what the next steps are (e.g.: review of the plan, etc.). Secure de-escalation specific: 1. Whether a search was completed 2. Whether photographs were taken

Created: March 22, 2016
Review Date: July 2024
Approved by BOD: July, 2024

Type	Reporting	Reporting Timeline	Categorization	Description	Other guidelines
Abuse or Mistreatment	There are allegations of, suspected or witnessed abuse or mistreatmentof a participant. There are new allegations of historical abuse or neglect of a child or young person receiving a service.	Level 1: Immediately notify MCCSS andsubmit a SOR within 1 hour of becoming aware of or deeming the incident to be a SO for any allegations of, witnessed or suspected abuse or mistreatment where: 1. There is an immediate threat to the health, safety, or well-beingof the individual or others 2. A current SMH staff, volunteer,etc. is implicated 3. The individual is receiving threatsor harassment from a human trafficker Level 2: Submit a SOR as soon as possible but no later than 24 hours of becoming aware of or deeming the incident to be a SO for all other alleged,witnessed or suspected abuse or mistreatment SOs	Alleged, witnessed, or suspected: 1. Physical Abuse 2. Emotional harm 3. Neglect 4. Exploitation (e.g.: humantrafficking; financial abuse) 5. Sexual abuse	Who the allegations are being made against. Who the allegation was disclosed to(staff, volunteer, etc.). When the alleged incident occurred. Steps being taken to ensure thesafety and/or support of the individuals involved. Whether the individual requiresmedical attention/any injuries sustained. Whether investigation is required, underway and verified, or has been investigated but not verified. Outcome/results of any investigation. Please do not includeany information that could impact an ongoing investigation.	Notify a society, when there are reasonable grounds to suspect that a child needs protection (see Section 125, "Duty to report child in need of protections", of the CYFSA or full requirement). Notify police when there are allegations of abuse or mistreatment of a young person. Notify Office of the Independent Police Review Director (OIPRD), when the allegations are made against apolice officer.

Type	Reporting	Reporting Timeline	Categorization	Description	Other guidelines
Error or Omissions	There is a breach or a potentialbreach of privacy and/or confidentiality, including any instance/suspected instance when personal information of an individual who is receiving aservice has been collected, used, stolen, lost or disclosed without authority (in accordance with applicable legislation or MCCSS/SMH policy) that results in serious harm or risk of serious harm to the individual and/or others, oris in contravention of the YCJA	Level 1: Immediately notify MCCSSand submit a SOR within 1 hour of becoming aware of or deeming the incident to be a SO for: 1. Breach/potential beach of privacy and/or confidentiality: The individual has been seriously harmed or is at risk of serious harm because of a breach of personal information of the breach contravenes the YCJA Level 2: Submit a SOR as soon aspossible but no later than 24 hours of becoming aware of or deeming the incident to be a SO for all other error and omissions SOs	Breach/potential breach of privacy or confidentiality. Examples include but are not limited to: 1. a staff laptop is stolen with an individual's files on it 2. SMH's computer system has been hacked and personal information has been stolen 3. An individual's personal information is posted on social media 4. hard copy materials that contain an individual's personal information are left in a public place	Breach or potential breach of privacy/confidentiality: 5. Nature of the breach 6. Description of information breached 7. Steps taken by SMH to address breach and prevent re-occurrence 8. Where applicable, confirmation that the affected individual was notified of their rights tomake a complaint to the Information and Privacy Commissioner (IPC), andindicate whether the IPCwas contacted 9. Whether the affected individual was notified ofthe breach/potential breach, and if not, why not.	

Created: March 22, 2016
Review Date: July 2024
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Type	Reporting	Reporting Timeline	Categorization	Description	Other guidelines
Serious Complaint	A complaint is made by or on behalf of a participant regarding the alleged violation of their human rights or privacyrights A complaint is made by or about a participant that SMHconsiders to be of a serious nature A complaint is made about theoperational, physical or safety standards of the services received by an individual	Level 1: Immediately notify MCCSSand submit a SOR within 1 hour of becoming aware of or deeming the incident to be a SO if: 1. The complaint is about SMH staff, director or Board beingcharged or arrested for a crime that may affect or has affected an individual or individuals receiving a service Level 2: Submit a SOR as soon aspossible but no later than 24 hours of becoming aware of or deeming the incident to be a SOfor all other serious complaint SOs.	Rights-based complaint: 1. Privacy-related 2. Human rights-related Service-related complaint: 1. Operational 2. Physical environment 3. Safety standards Complaint about a participant 1. Complaint about physical contact between individuals 2. Other (specify)	What is the complaint Who made the complaint Who the complaint is against Who the complaint affects and how it affects them What is being done to review,address and resolve the complaint Information about the complaint being reported through other complaints processes, where applicable(e.g.: the Information and Privacy Commissioner for privacy-related complaints) Any impact on SMH and/or participants	Service-related complaints: 1. If the complaint is about SMH specifically, report it under Operational inthe "service-related complaint" subcategory 2. If the complaint is about a police officer,ask participant to submit a complaint form to the Office of the Independent Police Review Director
Type	Reporting	Reporting Timeline	Categorization	Description	Other guidelines
Disturbance, Service Disruption, Emergency or Disaster	The disturbance, service disruption, emergency or disaster occurs on SMH premises, or within close proximity of wherethe service is provided, and it interferes with SMH or foster parent's ability to provide routine services.	Level 1: Immediately notify MCCSSand submit a SOR within 1 hour of becoming aware of or deeming the incident to be a SO if: The Continuity of OperationsPlan (COOP) or business continuity plan was activatedin response to an incident that threatened the health or safety of individuals or others 1. The incident is perceived tobe a significant danger to orconcern of the community 2. There was a site evacuationbecause of the incident 3. Police intervention isrequired Level 2: Submit a SOR as soon as possible but no later than 24 hours of becoming aware of or deeming the incident to be a SO for all other disturbance, service disruption, emergency or disasterSOs	1. Adverse water quality 2. Fire 3. Flood 4. Natural disaster 5. Power outage (e.g.: an outage that causes a significant disruption to services, an outage of an essential IT system, etc.) 6. Gas leak 7. Carbon monoxide 8. Abduction 9. Infectious outbreak 10.Riot 11.Stand-off 12.Hostage taking 13.External threat (e.g.: bomb threat, SMH's computer system has been hacked, etc.) 14.- Other (specify)	Who was involved in theincident Any injuries to individuals, staffor others present Whether a crisis resolution team and/or other crisis intervention processes weredeployed Indicate if COOP or other emergency plans have been activated, including transitionto alternative supports Include details about individuals' safety, number of individuals affected, as well as details about staff safety and number of staff affected For infectious outbreaks, confirmation of preventative measures taken by SMH to stopthe spread of the outbreak and any follow-ups conducted with public health officials (where applicable) Evacuation details (whereapplicable)	When multiple individuals partake in a hunger strike, report under the Stand-Off subcategory Notify Ottawa Public Health when there is a suspected outbreak of a disease of public health significance including a communicable disease.

Created: March 22, 2016
Review Date: July 2024
Approved by BOD: July, 2024

MCCSS CONTACT:

Ministry of Children, Community, and Social Services
Natalie Kent:
Phone: 343-997-7016
Natalie.Kent@ontario.ca

PACY:

Information will be provided to youth/parent in the event of a serious occurrence PACY (written report)
http://provincialadvocate.on.ca/main/en/investigations/dsbh/PACY
contact information:
Diana Cooke – diana.cooke@provincialadvocate.on.ca
Phone: 416-325-9781

RELEVANT LEGISLATION AND STANDARDS:

Ministry of Children, Community, and Social Services Serious Occurrence Reporting Guidelines 2019
Ministry of Education (MOE) policy and BILL 117
The Provincial Advocate for Children and Youth Amendment Act 2015 (PACY)

SMH FORMS:

SMH Incident Report Form

RELATED POLICIES:

CCA: ORG-RS-1.2, 1.3

Created: March 22, 2016
Review Date: July 2024
Approved by BOD: July, 2024

ST MARY'S HOME • MAISON SAINTE-MARIE

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RS A.4: HEALTH AND SAFETY

SCOPE:

This policy applies to all staff, volunteers, students, and participants of SMH.

PURPOSE:

To establish procedures to ensure the health and safety of SMH "workers", establish the roles and responsibilities of staff at SMH in maintaining a healthy and safe work environment; and
to identify the process for reporting hazardous conditions that may arise in the workplace.

DEFINITIONS AND ACRONYMS:

St. Mary's Home: SMH
Workers/Staff: refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement and service partners of SMH.
Service Partner: is an agency and its staff, and/or an individual who have signed service protocols and/or agreements with SMH to provide services to participants on site.
Employer: for the purposes of this policy the employer is the Executive Director acting on behalf of the Board of Directors.
OHSA: Occupational Health and Safety Act
WHMIS: Workplace Hazardous Materials Information System

POLICY:

SMH makes every effort to provide a healthy and safe work environment to its employees and reducing the risk of injury or illness. Commitment to health and safety shall form an essential part of this organization from the President of the Board of Directors to the staff. A Joint Health and Safety Committee shall be established and maintained, responsible for ensuring the proper application of this policy based on required legislation. This policy is to be reviewed on an annual basis.

IMPLEMENTATION:

Communication of Policy:
Established procedures to ensuring a healthy and safe environment at SMH can be found in the SMH *Health and Safety Handbook* kept in the front offices of both the Young Parent Outreach Centre; and to protect the safety of staff, participants, and visitors to SMH, procedures to be followed in the event of emergenciesare posted on the wall of every room and common space such as hallways and the front entrance (flip books and red cards).

Roles and Responsibilities

Executive Director:
The Executive Director or their designate is required to:

1. Provide equipment, materials and protective devices that are well-maintained and stored in a safe manner (e.g., first aid kits, gloves, etc.);
2. Provide information, training and supervision to staff related to Health and Safety;
3. Ensure supervisors are familiar with and trained under the OHSA and regulations that apply to the workplace;

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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4. Ensure supervisors have knowledge of any potential or actual danger to health or safety in the workplace;
5. Provide (upon request), in a medical emergency, information including confidential business information to a legally qualified medical practitioner, and to such other persons as may be required by law;
6. Acquaint a staff, or a person in authority over a staff, with any hazard in the workplace and in the handling, storage, use, disposal and transport of any article, device, equipment or a biological, chemical, or physical agent;
7. Afford assistance and co-operation to the Joint Health and Safety Committee (JHSC), and any Health and Safety member of that committee in the carrying out any of their functions;
8. Take every precaution reasonable in the circumstances for the protection of a staff;
9. Provide to the JHSC or to a Health and Safety representative, the results of an outside agency report (such as a fire safety report done by the Fire Department). If that report is in writing, a copy of the portions of the report that concern occupational Health and Safety are to be released to the JHSC or to a Health and Safety representative;
10. In general, the Executive Director, or their designate, must also advise staff of the results of a report and, if the report is in writing, make available to them, upon request, copies of the portions of the report that concern Occupational Health and Safety;
11. Respond in writing, within 21 days, to any Health and Safety recommendations submitted by the JHSC or Health and Safety representative;
12. Post a copy of the Occupational Health and Safety Act and pertinent regulations in an accessible workplace location;
13. Post, review, and re-post annually, a copy of the SMH Health and Safety policy in an accessible workplace location; and
14. Develop and maintain a Health and Safety program at SMH based on legislation and this policy.

Managers/Supervisors:
Managers/Supervisors are required to:

1. Ensure employees work in the manner and with the protective devices, measures and procedures required by the *OHSA* and regulations (e.g. fall-arrest systems, confining hair, jewelry or loose clothing around moving machine parts, etc.);
2. Ensure staff use or wear the equipment, protective devices, or clothing that SMH requires to keep them safe while working;
3. Advise staff of the existence of any potential or actual danger to the health or safety of which the Supervisor is aware;
4. Provide staff with written instructions as to the measures and procedures to be taken for their protection;
5. Take every precaution reasonable to protect staff from risk and unsafe conditions;
6. Develop and demonstrate a positive "health and safety" attitude and working climate;
7. Be interested in and involved with the organization's Health and Safety initiatives;
8. Uphold safety rules and procedures and support enforcement including disciplinary action;
9. Develop a working relationship with JHSC members/Health and Safety representative and support their role;
10. Make every reasonable attempt to resolve the health and safety concern of staff;
11. Ensure training of staff in safe work practices and job safety requirements associated with a particular job process and provide written instructions where appropriate;
12. Correct unsafe acts and unsafe conditions;
13. Report and investigate all incidents and injuries to staff, volunteers and guests and any property damage or

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14. loss of property;
15. Ensure that a maintenance program for any equipment and machinery in the workplace is carried out;
16. Implement emergency plans when necessary and ensure that staff have been properly trained to comply;
17. Inform superiors of any known Occupational Health and Safety concerns; and
18. Regularly evaluate employee performance and provide periodic feedback with respect to Health and Safety.

Workers:
Workers are required to:

1. Work in compliance with the provisions of the OHSA, regulations, and internal policies and procedures;
2. Use or wear the equipment, protective devices, or clothing that SMH requires to be used or worn;
3. Report to their Supervisor any contravention of the Health and Safety policies, any hazards they are aware of, and the absence of or defect in any equipment or protective device of which the worker is aware and which may endanger themselves or another worker;
4. Work in a manner that doesn't endanger themselves or another worker;
5. Avoid engaging in any prank, contest, feat of strength, unnecessary running, or rough and boisterous conduct;
6. Know, understand and employ established rules and procedures for handling materials, equipment and processes (e.g. report unlabeled containers, use proper lifting techniques, etc.);
7. Request replacement for worn out or defective equipment;
8. Use all safety devices provided, ensuring optimum condition of devices and reporting any defects immediately to a Supervisor;
9. Use equipment and materials only in the manner intended;
10. Use only equipment that the worker has been trained to operate safely;
11. Report all injuries, incidents, and unusual conditions immediately to Supervisor;
12. Carry out repairs, alterations and process changes only when authorized; and
13. Inspect work area daily and report any hazards immediately to Supervisor.

Reporting Procedure:

1. The staff who identifies a safety-hazard/concern is responsible to report this to their Supervisor immediately using the agency Health and Safety Incident Reporting Form; and
2. The Supervisor will review the Incident Report and pass it on to the Executive Director, or their designate, for signature.

Joint Health and Safety Committee:
Composition of SMH JHSC will adhere to the requirements of the OHS Act which outlines:

1. The ratio requirements of committee members to number of staff;
2. The percentage of committee members that must be non-management workers;
3. The worker member(s) must be selected by the workers;
4. The employer shall select the member(s) representing management;
5. The minimum number of years members will fill this role;
6. If possible, terms of office will overlap so continuity can be maintained;
7. The names and work location of all JHSC members must be posted; and
8. At least two members of the JHSC must be certified, one representing the workers and one representing management.

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Approved by BOD: July, 2024

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Roles and Responsibilities
Meetings
Meetings and Minutes of SMH JHSC will adhere to the requirements of the OHS Act which outlines:

1. How often the Committee must meet;
2. Members are responsible for making arrangements with their Supervisor for attendance at the JHSC meetings and for preparation time prior to the meetings;
3. A schedule of JHSC meetings for the year is to be developed, published and posted at the beginning of each calendar year, listing the date, time and location;
4. An agenda is to be developed by the co-chairpersons for each meeting and circulated at least one week in advance of the meeting;
5. What must be included in all minutes of each meeting;
6. Minutes are to be signed by the co-chairpersons and circulated within a week to:
    - Executive Director,
    - JHSC members,
    - Leadership Team and
    - Managers/ Supervisors; and
    - One copy is posted on the Health and Safety bulletin board.

General:
SMH JHSC's general duties will adhere to the guidelines outlined in the *Occupational Health and Safety Act and includes:*

1. Identify areas of Health and Safety training for all Employees;
2. Develop and post a schedule for the monthly health and safety workplace inspections for the year and conducting these inspections;
3. Reviewing Employee Injury/Incidence/Property Damage Reports;
4. Make recommendations to management on Health and Safety programs in general and with regards to specific incidents;
5. Document all substandard acts and working conditions;
6. Obtain information regarding:
    - Hazardous materials, processes or equipment;
    - Designated substances and the respective control-program reports workplace testing that is being carried out for Health and Safety purposes.
7. Be present for, or assist in, work refusal investigations;
8. Be available to accompany a Ministry of Labour officer on their inspection tour of the workplace;
9. The co-chairpersons are responsible for submitting, in writing, recommendations to the Leadership Team for any items not already identified on the *Workplace Inspection Report*; and
10. Written reports include:
    - The nature of the concern with background information and justification; and
    - Recommended remedial action, suggested solutions, methods of and timelines for implementation of recommendations.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

Response to Recommendations made by JHSC will adhere to guidelines outlined in the Occupational Health and Safety Act which includes:

1. A member of the Leadership Team, where applicable, will respond to the recommendations of JHSC, in writing within 21 days;
2. If there is an agreement on the recommendations, the response will include:
   - Actions that may be taken; and
   - A timeline for implementation if the Employer agrees with the recommendation.
3. If there is disagreement on recommendations the response will include: reasons for the disagreement; and
4. The Executive Director will report any necessary reports/recommendations to the Board.

Staff Injury, Incident, Property Damage Reporting:

1. Should a member of the JHSC receive a report from a staff regarding Harassment, Sexual Harassment, and/or Violence in the workplace, the SMH Policy: HR 7 – Workplace Harassment, Sexual Harassment, and Violence in the Workplace procedures are to be followed;
2. The Supervisor or Executive Director will forward the Incident Report to the Employee Representative of the Health and Safety Committee using the joint *Health and Safety Incident Reporting Form;
3. The Supervisor is expected to deal with the matter promptly, consult with others as needed, and advise the staff of the plan of action to resolve the matter. Reasonable time would depend on the potential risk of the situation but should not exceed one week;
4. If the staff's concern is not satisfactorily resolved after a reasonable period of time, the staff is encouraged to bring the concern directly to the attention of a member of the Joint Health and Safety Committee or the Employee Health and Safety representative on the Committee;
5. The staff will be asked to document the concern, outlining the facts and the information requested in writing;
6. All concerns will be thoroughly investigated with factual information pertaining to the concern;
7. The Joint Health and Safety Committee/representative and the staff's Supervisor will be responsible for ensuring that the staff is informed of the progress of the resolution of the concern; and
8. If the concern remains unresolved, the Joint Health and Safety Committee/representative may contact the Ministry of Labour Inspector for assistance.

Note: This procedure does not preclude the workers from exercising their right to refuse unsafe work, as defined under the Occupational Health and Safety Act.

Workers' Right to Confidentiality:

1. Whenever possible, staff are encouraged to resolve issues through the usual process prior to contacting the Joint Health and Safety Committee;
2. If a staff has a serious concern to report which cannot be addressed through the usual reporting process and wishes to remain anonymous, they are entitled to submit the safety concern directly to one of the Health and Safety Representatives in confidence;
3. Workers must be able to make reports without fear of reprisal; and
4. The Health and Safety Representatives are bound by legislation to keep the name of the informant confidential and cannot divulge the staff's name even to other members of the committee.

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Food Safety:
Canada's Food Guide and Ottawa Public Health have been used as references for making decisions regarding healthy eating and safe food handling at St Mary's Home, to comply with all Health Inspection recommendations.

Food Handler Certification:
The Kitchen Facilitator and the primary staff involved in kitchen duties are to have an up-to-date Food Handling Certificate and best practice knowledge on the safe use of kitchen equipment, food storage safety and food preparation safety in accordance with Ontario legislation:

1. A copy of the Food Handler Certificate for the Kitchen Facilitator is to be posted in the kitchen;
2. A copy of the Food Handler Certificate for any staff member is to be provided to the Executive Director for filing in the staff personnel file; and
3. A new employee waiting to attend training cannot prepare food without the guidance of the staff on duty that has their certificate in Safe Food Handling.

Donated Food
The handling of donated foods should follow the Food Handling Certification guidelines and so should only be managed by the Primary Cook or staff who hold this certification. Therefore, donated foods and goods coming into SMH outside of the cook's scheduled hours are to be put aside until the cook is in next; and "Donated Food" does not include Food Bank items that come through the agency.

Reporting Safe Food Handling Issues
• Any issues or concerns regarding safe food handling must be reported immediately to a member of the Leadership Team:

1. A member of the Leadership Team will follow up within 24 hours of receiving a report on safe food handlingissues;
2. If the Leadership Team member does not follow up and resolve the safe food handling issue within three (3) days of business, the reporting person will make a report to the Executive Director and the JHSC; and
3. This will be addressed within 24 hours.

No Smoking at SMH:
SMH is a smoke-free environment:

1. Every employee, participant, field placement student, volunteer and visitor are to be informed that smoking is prohibited on the premises;
2. "No smoking" signs are posted throughout the Young Parent Outreach Centre as well as at the entrance, exits, and washrooms;
3. No person should smoke tobacco or hold a cigarette for public view on the premises of SMH, from a radius of nine meters from all entrances and exits into the agency and the parking area;
4. Any person who refuses to comply is in contravention of the Smoke Free Ontario Act. A Public Health enforcement officer will be contacted and administer corresponding fines, and employees will be dealt with as per SMH Policy: Code of Ethics and Conduct – Employees; and
5. The "No Smoking Policy" is to be reviewed with all employees, participants, field placement students and volunteers prior to commencing employment, and/or placements and/or services and reviewed with them annually thereafter.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

Workplace Hazardous Materials:

1. All SMH staff including maintenance and cleaning staff will complete WHMIS training and will adhere to WHMIS standards;
2. Environmental hazards such as chemicals and cleaning compounds will be safely secured and stored in accordance with WHIMIS standards and are kept locked away from participants at all times;
3. All supplies and cleaning materials will have a Workplace Hazardous Industrial Materials Information Sheet or Label, which advises staff of the First Aid measures necessary should the substances be spilled, ingested or released into the air for others to breathe;
4. Maintenance and Housekeeping contractors must also have WHMIS training and maintain up-to-date information on all products used at SMH

Reporting WHMIS Issues:

1. Any issues or concerns regarding Workplace Hazardous Materials must be reported immediately to a member of the Leadership Team;
2. That member of the Leadership Team will follow up within two (2) business hours upon receiving thereport; and
3. If the member of the Leadership Team does not follow up within two business hours, a report will be made to the JHSC and the Executive Director for follow up and the Executive Director/JHSC will address the issue/concern immediately and follow up three (3) days after to ensure measures have been taken to correct the issue.

RELEVANT LEGISLATION AND STANDARDS:

Occupational Health and Safety Act (OHSA)
Smoke Free Ontario Act
Federal and Ontario Workplace Hazardous Materials Information System

SMH FORMS:

Health and Safety Incident Reporting Form
Workplace Inspection Report
Health and Safety Handbook

RELATED POLICIES:

SMH Policy: Human Resources – Employees – Code of Ethics and Conduct – Employees and Reporting Illegal, Unethical and/or Improper Conduct

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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RS A.5: DISASTER RECOVERY AND BUSINESS CONTINUITY PLANNING

SCOPE:

This policy applies to all staff, volunteers and participants of SMH.

PURPOSE:

To establish procedures in the event of a major disaster at SMH and the required components of a Disaster Recovery and Business Continuity Plan.

DEFINITIONS AND ACRONYMS:

Disaster: an event of such a magnitude that: programs and services can no longer be delivered for an extended period at the site; and/or information technology structures and/or systems have been compromised or destroyed.
Staff: refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement and service partners of SMH.
Service Partner: an agency and its staff, and/or an individual who have signed service protocols and/or agreements with SMH to provide services to participants on site.

POLICY:

SMH strives to ensure that the organization may continue to operate and provide services to participants in the event of a major disaster. The identification of critical considerations including employees, financial obligations, physical equipment accessibility and security, roles and responsibilities of staff and plan enactment procedures are all components of the Disaster Recovery and Business Continuity Plan. This policy and pursuant plan must be reviewed and updated, if necessary, on an annual basis.

IMPLEMENTATION:

The Disaster Recovery and Business Continuity Plan (See Crisis Response Plan):

1. The operational Disaster Recovery (Crisis) Response plan is posted in the reception office of the Outreach Centre. The plan includes emergency contacts and an alternate site for use during a crisis and/or disaster.
2. This information is also included in the off-site IT backup system.
3. All managers are trained in crisis/disaster recovery and business continuity procedures affecting their positions.
4. An agreement is made with another agency to have temporary use of their space in the event of a crisis (see addendums);
5. Agreements have been made with other agencies to have long-term use of their physical space in the event of a disaster (see Disaster Recovery and Business Continuity Plans – Back-up sites for Outreach Centre)

Created: August 28, 2017
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Approved by BOD: July, 2024

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6. Sufficient reserves are maintained so that key expenses can be paid. This would include the salary of key individuals as per the SMH Policy: Finance Management;
7. A chain of commands has been established to ensure that decisions can be made efficiently and thatemployees will receive appropriate direction and clear communication; and
8. This policy and plan are reviewed on an annual basis and/or as needed should applicable information change during a year.

Plan Activation in the Event of Disaster:
In the event of a disaster, the Executive Director shall oversee implementing the SMH Crisis/Disaster Recovery and Business Continuity Plan. The Executive Director will assign specific IT and program manager responsibilities based upon the circumstances of the disaster and the systems affected.

Ongoing Plan Maintenance and Evaluation:
SMH will ensure that data backups are performed on a regular basis as per SMH Policy: Security of IT Information and Systems. Offsite data is stored in secure sites including "Cloud" servers as per the SMH Policy. Continued employee review regarding disaster recovery should occur annually.

Business Continuity Plan Roles and Responsibilities:
Management is required to:

1. Have current Disaster Recovery and Business Continuity Plans in place along with documents stating guidelines for what, how, who and when business decisions are made;
2. Be prepared to make decisions about when to stay open, when to close to visitors, or when to close the workplace completely;
3. Ensure that core business activities can be sustained over several months;
4. Make sure that everyone knows their roles - managers, employees, health and safety committees, etc. to avoid confusion; and
5. Ensure the security of the vacant building in the event of mass absenteeism.

Employees are required to:
Cooperate with Human Resources in the identification and training of a pool of employees that will perform services essential to the business of SMH, acting as replacements for absent employees. Participate in cross-training that will be provided where duties are not commonly shared.

Business Continuity Leader:
A Business Continuity coordinator will be identified by the Executive Director, who will be responsible for the coordination of recovery efforts, including keeping track of employees and those who are available to come to work. This also includes establishing an alternate for the position and ensuring that these two positions are not absent from the SMH workplace at the same time.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

Other Responsibilities:

1. Equipment:
   - (as established in the above Disaster Recovery and Business Continuity Plan), replacement equipment that is essential to the business processes of SMH will be identified and the IT department will ensure that it will be accessible and operational.
2. Availability of Assets:
   - The management team will ensure access to equipment, facilities, utilities, first aid supplies, office supplies, computers, machinery, tools, vehicles, and communications equipment (as much as possible considering the actual emergency event).
3. Business Commitments:
   - Potential contractual or legal implications of established service level agreements and penalties for non-performance of business arrangements will be reviewed.
4. Reporting Structure:
   - A chain of command based on an updated organizational chart will be established to ensure that all employees are aware of the reporting structure, and the employees that will be tasked with covering extra duties in the event of managerial absences.
5. Accounting:
   - The continued operation of payroll, finance and accounting systems will be ensured.
6. Contact List for Emergencies:
   - An up-to-date list of contact information for employees and participants will be established and needs to be reviewed and updated quarterly and this should be accessible to relevant staff.
7. Communication of the Plan:
   - The Business Continuity coordinator, along with other members of management and the IT department, will establish a plan for the implementation of necessary communications to employees, and when specific actions are to be taken.

Special Operation Shutdown Procedures

Operation:	Individual Responsible:
1. Business Continuity	1. Business Continuity Coordinator with Executive Director /or Executive Director designate
2. IT Backups	2. 3rd party IT contractor / Executive Assistant
3. Emergency Phone Tree	3. Executive Assistant / Receptionist.

RELEVANT LEGISLATION AND STANDARDS:

N/A

RELATED POLICIES:

SMH Disaster Recovery Crisis Response Plan
Disaster Recovery and Business Continuity Plans – Back-up sites for Outreach Centre

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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RS A.6: REPORTING AND INVESTIGATION OF INCIDENTS

SCOPE:

This policy applies to all staff and volunteers of SMH.

PURPOSE:

To establish procedures for the investigation of incidents, (injury and illness) as per Workplace Safety and Insurance Board guidelines (WSIB).

DEFINITIONS AND ACRONYMS:

St. Mary's Home: SMH
Staff: refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement and service partners of SMH.
Service Partner: is an agency and its staff, and/or an individual who have signed service protocols and/or agreements with SMH to provide services to participants on site.
Incidents: are events that may cause injuries, occupational illnesses, property damage and/or near misses.
No Treatment Injury: occurs when there is an injury that does not require any treatment (i.e. bruised finger).
A First Aid Injury is an injury that can be treated at the worksite and does not require treatment from a health care professional (i.e. a cut finger that requires a band aid only).
A Health Care Injury is an injury that requires treatment (i.e. a cut finger that requires stitches) from a health care professional (i.e. physician, dentist, etc.) but is not of a critical nature.
A Critical Injury is an injury of a serious nature that:

1. Places life in jeopardy;
2. Produces unconsciousness;
3. Results in substantial loss of blood;
4. Involves the fracture of a leg or arm but not a finger or a toe;
5. Involves the amputation of a leg, arm, hand, or foot, but not a finger or a toe;
6. Consists of burns to a major portion of the body; and
7. Causes the loss of sight and/or hearing.

POLICY:

Through its Health and Safety Policy and procedures, SMH aims to reduce and minimize the risk to employees and participants. However, on occasion an incident may occur that needs to be addressed. Employees are required to report all incidents to their supervisor.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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IMPLEMENTATION:

General

1. All incidents must be reported immediately by the employee, or a colleague if the employee is unable to do so, to the Supervisor using the Employee Incident Report Form;
2. Immediately after an incidence, the Supervisor shall ensure the safety of employees, participants, volunteers, public, equipment and facilities from further injury or damage and follow the steps laid out in this policy; and
3. The Supervisor is responsible for investigating, reporting – to the ED and DOPS and any required body, such as WSIB - and taking corrective action to follow-up on all incidences.

No Treatment Injury

1. The staff will report the injury to the Supervisor; and
2. The Supervisor will record the injury in the "First Aid Report Book" which is to be kept by the first-floor receptionist.

First Aid Injury

1. The staff is to report the injury to the Supervisor; and
2. First Aid treatment will be provided and the use of materials will be recorded.

Health Care Injury

A Supervisor will:

1. Provide First Aid treatment for the injured staff and record the treatment in the "First Aid Report Book";
2. Arrange for transportation (e.g. taxi, ambulance, etc.) of the staff to a location where professional health care can be delivered;
3. Ensure a "Functional Abilities Form WSIB Form 8" is completed by the attending physician;
4. Investigate immediately, or as soon as possible following the notification to the proper authority of the incident; and
5. Upon receiving notification from the employee involved that a health care injury has taken place, inform the DOPS who shall ensure that a WSIB Form 7 is submitted to WSIB within three (3) days of the injury.

Critical Injury:

The Supervisor will:

1. Provide First Aid treatment of the injured staff and record the treatment in the "First Aid Report Book";
2. Arrange for transportation (e.g. ambulance) of the staff to a location where professional health care can be delivered (e.g., hospital);
3. Immediately notify the Ministry of Labour, Joint Health and Safety Committee/Representative;
4. Secure the scene as per OHSA section 51(2);
5. Ensure a Functional Abilities Form – WSIB Form 8 is completed by the attending physician;
6. Investigate immediately, or as soon as possible following the notification to the proper authority of the injury/illness/incident/property damage;
7. Notify the Executive Director that a critical injury has taken place. The Executive Director will inform the President of the Board of Directors; and
8. Inform the DOPS who shall ensure that a WSIB Form 7 is submitted to WSIB within three (3) days of the injury.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

Investigation of Incidences:
Investigations will be conducted by the department Supervisor, with the optional assistance of a member from the Joint Health and Safety Committee/Representative when any of the following events occur:
(Note: for items with an *, assistance from a representative of the Joint Health and Safety Committee is compulsory)

1. Health care;
2. Critical injury*;
3. Fatality*;
4. Fire or explosion;
5. Property damage above $5,000; and
6. Injury/illness/incident/property damage involving possible public liability.

When conducting the investigation, it is important to:

1. Preserve the injury/illness/incident/property damage scene where practical and possible;
2. Identify witnesses or others having knowledge of the accident/incident;
3. Interview the injured Employee where practical and possible;
4. Identify any primary/secondary causes;
5. Identify any primary/secondary unsafe actions; and
6. Identify any primary/secondary hazardous conditions.

Investigations must be completed within 72 hours of the incident or request related to an incident (Employers are required to send in a WSIB form within 3 business days of the injury + 4 days for OHSA); and the findings of such investigations are documented on the Employee Incident Report Form.

RELEVANT LEGISLATION AND STANDARDS:

SMH FORMS:

Employee Incident Report Form
First Aid Report Book
Functional Abilities Form WSIB Form

RELATED POLICIES:

CCA: ORG-RS-1.1, 2.2

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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RS A.7: COMPLAINTS PROCESS

SCOPE:

This policy applies to all staff, volunteers, and participants of SMH.

PURPOSE:

To establish a process for individuals to register complaints about SMH.

DEFINITIONS AND ACRONYMS:

St. Mary's Home: SMH

POLICY:

SMH believes that constructive criticism is important to informed planning. To this end, the organization has a system in place to manage concerns and/or complaints from persons served as well as from members of the public, about the agency, employees, or other participants. Participants have the right to make complaints regarding how another participant or staff member is treating them at SMH. This policy is separate from and in addition to the SMH Policy: Human Resources: Reporting Illegal, Unethical, and/or Improper Conduct.

IMPLEMENTATION:

Complaints From Members of The Public:

1. Complaints by members of the public can be made in writing or verbally, which is documented by the person receiving the complaint and by following the instructions on the SMH Website: Complaint Process;
2. SMH will provide an acknowledgement of a complaint within 24 hours of receiving;
3. If a concern or complaint is brought to the attention of the Executive Director, the Leadership Team will review such complaint and take appropriate action. Such action, if appropriate (at times sometimes the agency cannot state the actions taken, but can only assure the complainant that appropriate actions were taken), will be made known to the complainant by a designated member of the SMH Leadership Team no later than 7 days after SMH receives the complaint, and subsequently at intervals of no more than 14 days if needed;
4. If concerns or complaints have been directed to the Board of Directors, the Board President will consult with the Executive Director before deciding on the best course of action;
5. The Board President will communicate such action – again, if appropriate, to the complainant;
6. If concerns or complaints brought to the Executive Director and/or the Board President are related to unethical, Improper and/or illegal conduct, then the procedures in the SMH Policy must be followed;
7. Concerns or complaints that involve the safety of persons at SMH will be dealt with immediately by the Leadership Team and/or the Board President;
8. In matters of safety (towards person(s), property or any issues that may put the organization at risk), the Executive Director or designate will inform the Board President or designate, within two (2) hours of receiving said complaint;
9. Concerns or complaints are documented by whomever the complaint is brought to and given to the Executive Director who ensures they are reviewed periodically by the Leadership Team to look for possible trends; and
10. The Executive Director reports on such trends on an annual basis to the Board of Directors.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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Complaints from participants:

Participants have the right to make complaints regarding how another participant or staff member is treating them at SMH:

1. Participants can express concerns and complaints directly to staff on duty, to their Case Manager, to the Executive Director or to the Board of Directors; this information will be documented signed and dated;
2. A child in care may make a complaint in writing or verbally, which must be documented by the person receiving the complaint, with respect to alleged violations of the rights of the child in care under Part II clause 2 (a)(b) or (c) of the Child, Youth and Family Services Act (CYFSA) to a staff member, either in private or in the presence of other children or young persons, and SMH or a person designated by SMH;
3. A parent of a child in care or other person representing the child in care may make a complaint in writing or verbally, which must be documented by the person receiving the complaint, with respect to alleged violations of the rights of the child in care under Part II clause 2 (a)(b) or (c) of the Child, Youth and Family Services Act (CYFSA to a staff member and SMH or a person designated by SMH;
4. SMH will provide an acknowledgement of a complaint within 24 hours of receiving it, determine what action, if any, needs to be taken in response to the complaint, as well as provide support to the child in care or the person making the complaint for them to participate in the complaints review process. An update on the status of the complaint will be provided no later than 30 days after SMH receives the complaint, and subsequently at intervals of no more than 30 days.
5. Minimally, the Participants Concerns & Complaint Procedure must be reviewed by the Case Manager with the participant at the time of her First Plan of Care upon admission, then again 30 days after admission, reviewed three months after admission, six months after admission and every six months thereafter;
6. The complaints procedure is reviewed with participants (in a language appropriate to their age and cognitive abilities) and legal guardians upon admission who are then asked to sign the Participant Concerns & Complaints Procedure Document to confirm that this has been explained to them;
7. Additional reviews of the Procedure will be indicated in the participants Plan of Care;
8. Participants who wish to make a complaint about a staff member can request a confidential meeting with the Executive Director;
9. If the concern is not resolved, they can ask to speak to the Executive Director;
10. As in the procedures for complaints by the public, if a participant concern or complaint is brought to the attention of staff, the Leadership Team will review such complaint and take appropriate action. Such action, if appropriate (at times sometimes the agency cannot state the actions taken, but can only assure the complainant that appropriate actions were taken), will be made known to the complainant by a designated member of the SMH Leadership Team no later than 7 days after SMH receives the complaint, and subsequently at intervals of no more than 14 days if needed;
11. Updates on the status of the complaint review will be provided upon the request of the complainant;
12. Participant concerns or complaints that involve the safety of persons at SMH will be dealt with immediately by the Leadership Team and/or the Executive Director;
13. In matters of safety (towards person(s), property or any issues that may put the organization at risk), the Executive Director or designate will inform the Board President or designate, within two (2) hours of receiving said complaint;
14. Concerns or complaints are documented by whomever the complaint is brought to and given to the Executive Director who ensures they are reviewed periodically by the Leadership Team to look for possible trends; and
15. The Executive Director reports on such trends on an annual basis to the Board of Directors.

1. A participant may choose to contact an external agency such as The Office of the Provincial Advocate for Children and Youth. The phone number for this office is to be located on the participant's bulletin board in the front entry where participants sign in/out of St Mary's Home Outreach Centre (1-800-263-2841 or by email: advocacy@idirect.com)

RELEVANT LEGISLATION AND STANDARDS:

Child, Youth and Family Services Act

SMH FORMS:

N/A

RELATED POLICIES:

SMH Policy: Risk and Safety – Reporting Illegal, Unethical, and/or Improper Conduct

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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RS A.8: INJURY PREVENTION AND TREATMENT

SCOPE:

This policy applies to all staff, volunteers, and participants of SMH.

PURPOSE:

To establish proactive procedures to minimize injury, and requirements for making First Aid accessible to staff and volunteers at SMH

DEFINITIONS AND ACRONYMS:

Staff: refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement and service partners of SMH.
Service Partner: is an agency and its staff, and/or an individual who have signed service protocols and/or agreements with SMH to provide services to participants on site.
Universal Precautions: precautions to be used when a person is exposed to blood or to other body fluids or excretions containing visible blood. They are called "Universal Precautions" because it is recommended that everyone be considered potentially infected with H.I.V, Hepatitis or other bodily fluid borne communicable diseases. Universal Precautions are intended to supplement rather than replace recommendations for routine infection control, such as hand washing and using gloves to prevent gross microbial contamination of hands.
JHSC: Joint Health and Safety Committee

POLICY:

It is the responsibility of the organization and those providing service within the organization to follow the guidelines provided in the SMH Health and Safety Handbook. Taking the time to identify potential dangers through the sharing of information is the agency's attempt at being proactive and minimizing the chance of injury. This policy complies with First Aid Requirements Regulation 1101 found in WSIB legislation.

IMPLEMENTATION:

Lifting:

1. No staff or volunteer shall lift an object that is not within their (limited) capabilities;
2. It is the responsibility of the staff to recognize the need for assistance in lifting and/or handling objects. When necessary, another person should assist. A dolly is available for heavy loads;
3. It is important to plan for assistance when possible;
4. It is the Supervisor's responsibility to ensure that all staff, whose jobs require lifting on a regular basis, are trained in the proper lifting techniques;
5. It is the responsibility of staff to adhere to the following procedures when handling and/or lifting objects safely to prevent injury:
    - Stand as close to the load as possible when lifting, with feet spread apart;
    - Bend at the knee, keeping back straight and stomach tucked in;
    - Grasp load firmly;
    - Lift smoothly with your legs; and
    - Hold load close to the center of your body.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

Computer Usage:
Staff working continuously on a computer or video monitor shall be required to take at least a five-minute break from the station every hour. This will alleviate injury to eyes, hands, and wrists.

Training:
A schedule for various training opportunities is established and reviewed annually and training is done as part of the orientation process.

First Aid:

1. First Aid policies to be followed are outlined in detail in the WSIB Pamphlet: First Aid Requirements (Regulation 1101);
2. First Aid kits will be located on each floor of the building and maintained by the employees as designated by the Joint Health and Safety Committee (JHSC);
3. First Aid is administered by trained employees only;
4. All employees are to have current training in Standard First Aid and CPR;
5. Evidence of training is kept in the employee's personnel file;
6. The contents of the First Aid kits will meet licensing regulations under the Child and Family Services Act, ChildCare and Early Years Act 2015 and as required by the WSIB regulation 1101;
7. All programs will be equipped with latex or vinyl disposable gloves to support universal precautions
8. A "sharp" container will be located in the bathrooms.
9. A *First Aid Report Form* must be completed by the person who administered treatment and submitted to the JHSC; and
10. Employees are to be aware of and follow universal precautions for all individuals in all situations. Universal Precautions include:
    - The use of disposable latex or vinyl gloves when in contact with a person's blood or other body fluids or excretions containing visible blood is required by all;
    - A bleach solution (9 parts water, 1 part bleach) is to be used as a disinfectant on objects/surfaces on which body fluids or excretions containing visible blozaod is found;
    - If a syringe or needle is used (for example to administer insulin to a diabetic), the needle is not to be recapped by hand and, if it is discarded, placed in puncture-resistant containers; and
    - Hands are to be thoroughly washed before and after First Aid treatment and/or housekeeping functions which expose a person to body fluids or excretions containing visible blood.

RELEVANT LEGISLATION AND STANDARDS:

Child and Family Services Act
Child Care and Early Years Act 2015
WSIB regulation 1101

SMH FORMS:

First Aid Report Form

RELATED POLICIES:

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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RS A.9: ALLEGATION OF CHILD ABUSE BY STAFF

SCOPE:

This policy applies to all staff, volunteers, and participants of SMH.

PURPOSE:

To establish procedures to guide personnel in the managing of high-risk service situations such as the recognition and reporting of a child abused by a staff member and procedures at SMH for the reporting of child abuse

DEFINITIONS AND ACRONYMS:

St. Mary's Home: SMH
Staff: refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement and service partners of SMH.
Service Partner: is an agency and its staff, and/or an individual who have signed service protocols and/or agreements with SMH to provide services to participants on site.

POLICY:

All staff at SMH are required to receive training about this policy at the time of orientation. This includes the signing of an Acknowledgement and Agreement Statement Form. This policy will be reviewed annually with all staff and volunteers.
Every person has an obligation to protect and facilitate a child's progress in the social, emotional, physical, and cognitive area of development. All staff at SMH will always strive to create and maintain a safe and healthy environment that supports the growth and welfare of children. Child abuse is a crime. Any person who suspects that a child has been or is at risk of being abused has a personal obligation to report that abuse directly to the Children's Aid Society. Failure to report alleged or suspected abuse or neglect is a criminal offence and is grounds for dismissal from employment or volunteering at SMH. The duty to report child abuse and suspected child abuse includes an obligation of staff and participants to report suspected abuse between / among participants or of suspected abuse from a staff member towards a participant. Any act of abuse committed by or against any employee, volunteer, child, or any other individual is unacceptable conduct and will not be tolerated. The Ottawa Children's Aid Society will be contacted, and a report made.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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IMPLEMENTATION:

Allegation of Child Abuse by Staff:

A complaint about alleged abuse by staff is extremely serious and will be addressed and followed up on immediately. If a participant or another staff observes and/or has a concern about a staff behaving in an abusive way towards a child, the following steps should be taken:

1. If the person observing feels safe to do so, immediately make the individual(s) aware that the behaviour is unwelcome and ask them to stop;
2. Report the incident to the appropriate member of the Leadership Team; and
3. The member of the Leadership Team who receives this complaint must document what is reported, and include:
   - Name(s) of the individual(s) in question;
   - The date, place, and time the incident(s) occurred;
   - Name(s) of any witnesses;
   - The event(s) that led up to the incident(s) in question;
   - Any particular reason why the event(s) occurred; and
   - The actual incident that led to a complaint.
4. The confidentiality of the individuals concerned will be maintained; except if legal actions are taken in which case confidentiality may not be possible.
5. An investigation into the incident(s) will be undertaken immediately along with any additional steps necessary to resolve the problem.
6. If the employee requires support or advice, they should contact their supervisor or the Executive Director. The employee may be placed on leave with pay during the investigation, as determined by the Executive Director.
7. The complainant and the employee in question, along with any individuals who may be able to provide additional and relevant information, will be interviewed individually.
8. Once all relevant information has been gathered, it will be reviewed by the Leadership Team.
9. If the investigation reveals the occurrence of abuse or other unacceptable conduct, appropriate legal advice will be sought and disciplinary action, up to and including termination, and possibly legal actions - will be taken.
10. All documentation will be placed in the employee's file.
11. The complainant will be advised the investigation is complete and informed that appropriate steps have been taken, but not informed of the actions unless further action is required and they need to be called upon as a witness; and should the investigation fail to find fault, all documentation will be kept in a separate file from the employee who was accused of the abuse.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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Reporting Child Abuse:

1. If staff are concerned that a child may be at risk of imminent abuse, they must offer support to the child and family. This support must be extended until it is certain that the child is safe;
2. If staff see a child being abused, suspects on reasonable grounds that abuse has taken place, if a parent informs staff that they are abusing their child, or if a child discloses abuse, staff must immediately notify the Children's Aid Society and report this matter to the Director of Operations and Support Services for SMH;
3. If a person reports child abuse to staff "in confidence", staff must clearly advise that person that it is not legal to retain such information as a confidence and that this information must be passed on to the Children's Aid Society;
4. Staff are to encourage the person reporting the suspected abuse to make a call to the Children's Aid Society themselves once the on-site Supervisor has been informed. Staff may provide support during the call;
5. Staff must inform the SMH Leadership Team of this matter, as well, to ensure the proper documentation occurs;
6. An Incident Report must be completed within four (4) hours;
7. A copy of this report is to be given to the DOPS and the Executive Director, and a copy is to be placed in the participant's file;
8. The Supervising Manager or designate is required to complete a Serious Occurrence Report to the Ontario Ministry of Children, Community and Support Services on any incidents of abuse that occur within the agency within 24 hours;
9. Staff involved with the case will explore alternatives and negotiate a continued plan of care with the family that supports the needs of the child. As appropriate, the Children's Aid Society may be a partner in this plan; and
10. Failure to report alleged or suspected abuse or neglect is a criminal offence and is grounds for dismissal / termination.

RELEVANT LEGISLATION AND STANDARDS:

Child and Family Services Act of Ontario

SMH FORMS:

Acknowledgement and Agreement Statement Form

RELATED POLICIES:

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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RS A.10: PANDEMIC PLAN

SCOPE:

This policy applies to all staff, volunteers, and participants of SMH.

PURPOSE:

To ensure the ongoing health and safety of our staff and to ensure service continuity in the event of a pandemic.

DEFINITIONS AND ACRONYMS:

Staff: refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement and service partners of SMH.
Service Partner: is an agency and its staff, and/or an individual who have signed service protocols and/or agreements with SMH to provide services to participants on site.

POLICY:

Pandemics are not a " business as usual" situation. The priority for service will be to maintain safety and security of all participants and staff. To assist with response planning at SMH, this following table of Pandemic Periods and Phases (Table 1) will be utilized. These guidelines have been sourced from the World Health Organization (WHO).

Table 1- Pandemic Periods and PhasesPeriod	Description	WHO Phases
Inter-Pandemic Phase	New Virus in animals, no human cases	1 - 2
Level 1 - Pandemic Alert	New Virus causes human cases	3
Level 2 - Pandemic Warning	Evidence of increased human-to human transmission	4 - 5
Level 3 - Pandemic	Efficient and sustained human-to-human transmission Suspected/Confirmed case(s) in Ontario	6
Level 4 - Pandemic	Confirmed case(s) at SMH or in Ottawa	
Post-Pandemic Period	Return to inter-pandemic period	7

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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IMPLEMENTATION:

SMH will follow the Ottawa Public Health guidelines, directives and alerts issued during a pandemic and post-pandemic situation.

Level 1

1. Implement identified prevention strategies to minimize exposure – as per Ottawa Public Health Guidelines (addendum) - Communicable Diseases and Sanitary Practices;
2. The Executive Director or Leadership Team Designate will ensure essential messages are communicated to staff and participants to alert them of a potential pandemic;
3. Communicate essential messages to staff, participants, students, and volunteers to alert them of a potential pandemic status; and
4. Communication will be done through our website, company webpage, Mighty Text, and other forms of social media.

Level 2

1. Alert staff and participants to a change in pandemic status;
2. Implement prevention and illness minimization plans/activities;
3. Initiate pandemic information communication activities; and
4. If applicable, alert staff to Ottawa Public Health's international travel plan information.

Levels 3 & 4

1. Alert staff and participants to the change in pandemic status from Ottawa Public Health officials;
2. Activate measures to minimize introduction and/or spread of influenza (social distancing, management / tracking of illness, cancellations, closures, etc.);
3. Activate essential business continuity measures and establish regular review and emergency management process (see SMH Policy – RS 5 - Risk and Safety - Disaster Recovery and Business Continuity);
4. Review and update risk and impact assessment;
5. Set response objective and identify specific action required;
6. Determine activities/services to be maintained and/or discontinued (who needs to come to work);
7. Executive Director or Leadership Team Designate will communicate status update with staff and participants regarding SMH's status and to promote confidence in the workplace and response activities; and
8. Activate the process for recovered/well staff and participants to return to work and to return to their programs.

Post-Pandemic Period

1. Review and update risk and impact assessments;
2. Establish criteria and process for agreeing to return to business normal status;
3. Activate process for communicating business normal status to staff, participants, students, volunteers and visitors;
4. Manage return to regular service;
5. Activate debrief process;
6. Update pandemic plans as appropriate; and
7. Update Disaster/Crisis Response Plan and various services continuity plans as appropriate.

Action Plan for Maintaining Essential Service/Activity:
Action plan for each essential services/activities will be adapted as the pandemic escalates and will be documented throughout the process.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

SMH action plans shall include the following:

1. How to ensure essential services and/or activities to ensure the ongoing success of the organization;
2. Key staff needed to perform essential services and activities will be identified and included in the adapting action plans;
3. Triggers for activating the business/service continuity plan;
4. Back-up staff who possess varied skill sets and are able to perform a variety of duties where needed will be identified;
5. A planned strategy for communicating with Ottawa Public Health, staff, and other stakeholders;
6. An identified chain of command for decision making processes; and
7. Contact information for staff, students, volunteers, participants, and participants will be maintained and available throughout.

Staff Absences and Change of Duties Due to Pandemic

If it is deemed necessary during a Pandemic or significant disaster, all staff may be asked to carry out tasks not usually assigned to them and may be reassigned to a different job function on a temporary basis. Advance planning is encouraged but may not be feasible. Leadership Team members will review with the Executive Director daily to determine if programs must be reduced for a period of time due to lack of appropriate staffing and to organize for the re-deployment of staff as required.

1. Staffing levels will be monitored by the Leadership Team in an ongoing manner to determine adequate staffing levels to maintain productive and safe operation of all programs; and
2. Some programs may be cancelled for a period of time.
3. If staff are required to be re-deployed from regular job functions and work locations, the following policies/principles will be followed:
4. ALL staff of SMH may be involved in re-deployment on an urgent basis;
5. Staff will be paid at their regular salary rate, regardless of the function they are asked to carry out during a time-limited crisis period;
6. Orientation will be provided to the new duties as feasible;
7. As much as possible, the total work week for an individual will be a similar number of hours to that usually worked; however, there could be a requirement for shift work that involves various numbers of hours per shift;
8. Compensation for overtime will follow regular agency policies; and
9. Any member of the Leadership Team may be called upon to provide support and supervision for any staff team as needed.

If staff become ill because of a pandemic:

1. SMH recognizes that in the event of a federally, provincially, or locally declared Pandemic, the current sick leave policy may not address the needs of SMH employees;
2. It is imperative that a staff member who has been diagnosed with Pandemic, or has been exposed to Pandemic Influenza because a member of their household has been diagnosed with Pandemic Influenza, stay at home rather than come to work and potentially infect other staff members; and
3. This protocol will be implemented by the Executive Director only in the event of a significant pandemic or disaster in Ottawa. The President of the Board of Directors will be informed if this plan is implemented.

RELEVANT LEGISLATION AND STANDARDS:

Ottawa Public Health Guidelines

RELATED POLICIES:

SMH Policy: Disaster Recovery and Business Continuity

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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RS A.11: EMERGENCY PREPAREDNESS

SCOPE:

This policy applies to all staff, volunteers, and participants of SMH.

PURPOSE:

Emergency Preparedness Planning means that SMH can:

1. Minimize interruptions to service and business operations;
2. Reduce the number and magnitude of decisions needing to be made during a crisis;
3. Ensure safety for all;
4. Limit the severity of the disruption;
5. Minimize legal liability; and
6. Maintain a positive public image.

DEFINITIONS AND ACRONYMS:

St. Mary's Home: SMH
CPI: Non-violent Crisis Prevention Intervention

POLICY:

SMH is committed to providing the safest environment possible to those who work at and access our services.

IMPLEMENTATION:

SMH has six (6) specific emergency plans related to the various types of emergencies that can occur.

Medical Emergencies

1. When a medical emergency occurs 911 is to be called immediately and as soon as staff can, they are to notify the Professional On-Call Staff to inform them of the situation;
2. The staff on duty at the time of the medical emergency is responsible for writing a detailed report in the Participant's Health Progress Notes; and
3. A Serious Occurrence Report must be filed either by the designated member of the clinical team or by the Professional On-call Staff to the Ontario Ministry of Children and Youth Services within 24 hours of the medical emergency.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

Loss of Essential Services
An interruption in SMH's operations could occur at any time with little warning. Severe weather, storms, power failure, illness, fire, or floods can have significant impact on the capacity of our agency to maintain service. The primary concern in all circumstances is the safety of participants and staff;

1. From there a plan will be made for each participant, depending upon her unique situation; and
2. Contact with Municipal and Provincial funders will be made at this time by Executive Director or delegate to request assistance as needed.

Pandemic Plan
The Pandemic Plan of SMH is complete, up-to-date, and accessible as required to all staff and volunteers.

Threats
All participants, their babies and staff have the right to safety at SMH. A participant physically assaulting another participant, a baby or a staff member will be given an immediate safety discharge.

Assaults
All threats uttered towards other participants or to staff will be taken seriously:

1. If the threat appears real and imminent the staff is to call 911.
2. If the threat is not considered imminent the staff is required to directly report all threats to the Professional On-Call Staff for direction of how to proceed;
3. Once the immediate fallout of a threat has been handled, it is the responsibility of one of the Leadership/Management Team members to follow-up with the participant;
4. Whenever a participant is exhibiting anxious behavior, staff must respond with a supportive stance and when the participant appears defensive and is escalating, staff are to be directive with the participant as per the Non-violent Crisis Prevention Intervention (CPI) protocols; and
5. As per the CPI advice, when a participant has made threats, staff must not engage with the participant so as not to escalate the participant's behavior. Rather the staff is to walk away from the participant that is threatening and is to focus on the safety of the other participants and babies in the Home.

The policy of SMH identifies that staff do not do physical restraints of participants under any circumstances.

RELEVANT LEGISLATION AND STANDARDS:

RELATED POLICIES:

SMH Pandemic Plan
SMH Policy – Risk and Safety – Disaster Recovery and Business Continuity Crisis/Disaster Recovery Plan

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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RS A.12: PARTICIPANT ASSESSMENT

SCOPE:

This policy applies to all staff, volunteers, and participants of SMH.

PURPOSE:

To outline the appropriate assessment tools to screen and assess participants.

DEFINITIONS AND ACRONYMS:

ASQ 3: Ages and Stages Questionnaire
ASQ SE: Ages and Stages Questionnaire – social and emotional
DSP: Developmental Support Plan
GAIN-SS Assessment:

POLICY:

SMH takes a dyadic trauma-informed approach to assessment and care/case management, addressing both the parent and the child's mental health needs together. Standardized, qualitative and quantitative evidence-informed and trauma-informed screening and assessment is undertaken to ensure a physically and psycho-emotionally safe environment for participants, their children, and staff. Assessment is done in accordance with the complexity, severity, and evolving nature of the participant's need.

IMPLEMENTATION:

SMH engages participants, both children and youth, in the screening and assessment process. Staff discusses risks and benefits of assessment and care/case management with the participant. The participant signs
this document to acknowledge their understanding of the document and as a means of providing SMH with their informed consent. Standardized evidence-informed screening/assessment tools are used. The screening/assessment shall:

1. Be appropriate to the participant's request and need for service;
2. Evaluate the holistic needs of the participant;
3. Accommodate the cultural, ethnic, religious, sexual orientation, gender identity, gender expression, and language diversity of the participant;
4. Document the participant's description of strengths, areas for growth that are socially, emotionally, and developmentally appropriate;
5. Consider any previous assessments, where applicable; and
6. Use screening/assessment results to inform service coordination, care/case management planning, participant expectations and program evaluation

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Screening/assessment findings shall be shared with the participant in a manner that is understandable to them (developmentally, culturally and language appropriate). If the participant has received services elsewhere in thepast two years, a consent to Release Information Form shall be obtained, and actions are taken to coordinate the assessment and care/case management plan review process; and referral to specialists (with participant consent) shall be made when a specialized assessment is required (i.e. Ottawa Carleton Treatment Centre, Children's Hospital of Eastern Ontario, Psychiatrist, Physician).

Child Development Program
SMH provides specialized childcare, serving children from 4-months to 6 years with an emphasis on infant mental health (social-emotional development), child development and individualized programming.

1. ASQ 3 and ASQ SE developmental screener is completed, in collaboration with the parent, at regular intervals, as prescribed by the screener, to screen for developmental milestones;
2. A Developmental Support Plan (DSP) is developed, in collaboration with the parent(s), to support the child's growth in at-risk areas of development; and
3. Referrals are made to internal and external resources as required.

Intensive Care / Case Management Support Program
All participants complete an Intake Interview and Orientation Screening before beginning programming at SMH. A GAIN-SS Assessment is created for each participant at intake. Regular care/case management meetings occur between the Case Manager / Support Counsellor and the participant to monitor the progress of goal attainment and/or to monitor existing goals; and referrals are made to internal and external resources as required.

Therapy – Mental Health/Addiction Counsellor
Mental Health/Addiction counsellor uses a wide-ranging approach to treatment that is tailored to meet the individual needs of the participant. Treatment approaches include, but are not limited to:

1. Motivational Interviewing,
2. Cognitive Behavioural Therapy,
3. Solution Focused Therapy, and
4. Mindfulness Based Approach

Mental Health/Addiction Counsellor completes the GAIN-SS with participants as an initial screener within the first 30 days. Mental Health/Addiction Counsellor completes the clinical portion of the CANS-PPY 30-40 days after the Participant enrolls in programming, then at 30-90-day intervals until discharge. Mental Health/Addiction Counsellor assesses participant's progress on the stages of change. Personal mental health and addiction goals are developed and monitored; and referrals may be made (with participant consent) to internal and external agencies as required. Example of other assessment tools which may be utilized according to participant's needs are:

1. Drug-Taking History; and
2. Opiate Supplementary Form.

RELEVANT LEGISLATION AND STANDARDS:

SMH FORMS:

Release Information Form
Opiate Supplementary Form

RELATED POLICIES: N/A

Created: August 28, 2017
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RS A.13: RIGHT TO DISCONNECT POLICY

SCOPE:

This policy applies to all employees of SMH who are covered by the Employment Standards Act, whether their primary location of work is in the workplace, at home, on the road, or a combination of any or all of the above.

PURPOSE:

SMH is committed to taking every reasonable precaution in the circumstances for the protection of the health and safety of workers, as required by the Occupational Health and Safety Act. SMH is also committed to providing a supportive workplace that promotes and supports stress reduction and mental health. Additionally, SMH is committed to ensuring that its employees are able to maintain an appropriate work/life balance and fulfill their family responsibilities. As an organization of more than 25 employees as of January 1. 2022 (note: part-time and casual employees, as well as employees at different company locations are counted in this total), SMH has the following policy in place regarding an employee's right to disconnect from work.

DEFINITIONS AND ACRONYMS:

Disconnecting from Work: means not engaging in work-related communications, including emails, telephone calls, video calls or the sending or reviewing of other messages, so as to be free from the performance of work.
St. Mary's Home: SMH

IMPLEMENTATION:

Employment Standards Time Away from Work:

The Employment Standards Act, 2000, ESA) specifies that employees are not to perform work during the following times:

1. Outside of their hours of work and eating periods
2. During vacation with pay
3. During public holidays (unless the employee has agreed to work on the day of a public holiday in accordance with the ESA)
4. The rules in Ontario Regulation 285/01 that establish when work is "deemed" to be performed

Mental Health in the Workplace:

SMH is vitally concerned with the health and wellbeing of our employees' health, both physical and mental. The organization strongly encourages our employees, especially those who are participating in remote work arrangements to adapt and maintain a good work/life balance. SMH wishes to encourage employees to come forward if they are experiencing any health issues, especially issues related to mental well-being. If an employee feels comfortable doing so, they should talk to their manager/or a member of the management team and/or take steps to seek professional help.

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Approved by BOD: July, 2024

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Email:

Employees are expected to follow the below guidelines regarding the use of SMH's email systems. These guidelines also apply if an employee needs to use their personal email in the event of an emergency or an unforeseen circumstance. Employees are expected to respond to emails during their designated working hours only. SMH does not have an expectation that employees will respond to emails during their off-work time and employees will not be penalized in any way for responding to emails only during their working time. To ensure that these guidelines are not compromised, SMH needs to be aware of when employees are on work time and when they are not. This means that employees need to put an out-office on their email when they will not be working during their normally scheduled hours of employment. Employees are expected to regularly update their out-of-office automatic emails so that the most up-to-date information will be communicated to those who are emailing them outside of their work hours. In the event that an employee is unable to reply within these guidelines, they are expected to speak with their supervisor to discuss their workload and set updated expectations.

1. Response Time for Emails:
   - SMH staff are expected to respond to emails received during the workday/night, up to 30 minutes prior to the end of the workday/night, on the same day whenever possible
   - Emails received after core hours of employment, are expected to be replied to within 24 hours of the following workday.

Phone (Personal and Business):

Employees are expected to follow the below guidelines regarding the use of phones for the completion of their job duties. Employees are expected to respond to phone calls or text messages during their designated working hours only. SMH does not have an expectation that employees will respond to phone calls or text messages during their off-work time and employees will not be penalized in any way for responding to phone calls and text messages during their working time only. Employees are expected to regularly update their voicemail with their expected schedule so that the most up-to-date information will be communicated to those who are calling outside of their work hours.

SMH recognizes that personal cell phones can be valuable tools for employees. If a colleague communicates with an employee on their personal cellular phone during their off-work hours, employees do not need to answer or reply until they are within their working hours the following business day. Employees are encouraged to turn off cell phone notifications when they're away from the office. Personal cell phone numbers should not be given to agency participants.

1. Response Time for Phone Calls, Voicemails, and Text Messages:
   - Employees are expected to respond to phone calls, voicemails, and text messages received during the workday/night, up to 30 minutes prior to the end of the workday/night, on the same day whenever possible
   - Phone calls, voicemails, and text messages received after core hours of employment, are expected to be replied to within 24 hours of the following work day

In the event that an employee is unable to reply within these guidelines, they are expected to speak with their supervisor to discuss their workload and set updated expectations.

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Other Communication Channels:

Employees may use various other means of communication for work such as Social Media platforms, Zoom, Teams, etc. Employees are only expected to respond to work related messages on these platforms during their designated working hours. SMH does not have an expectation that employees will respond to messages, comments, meeting invitations etc. during their off-work time and employees will not be penalized in any way for only replying to them during their working time.

Responsibilities:

Employees are expected to:

1. Follow the guidelines outlined within this policy, such as notifying management and using applicable technologies to notify internal and external parties when they are off duty
    - Otherwise be working during the times set out in their employment contract, taking breaks as outlined in their employment contract and/or their core policies
2. Not pressure fellow employees for taking the down time afforded to them by law
3. Speak to their leader/manager if they have any concerns about their mental health and their right to disconnect from work

Supervisors/managers are expected to:

1. Respect an employee's off-duty time and not expect that an employee will respond to a request on their off-duty hours
2. Compensate employees for any work completed outside of their on-duty hours, as outlined by the hours of work legislation in Ontario's *Employment Standards Act*

3. Provide support as needed to employees who come forward with concerns regarding their mental health and right to disconnect

Exceptions to this policy include:

1. In the case of emergency requiring all employees be informed immediately of any potential or perceived risk, messages may be sent requesting a message be read and receipt acknowledged right away, even if it is outside of an employee's scheduled work hours
2. In the case that unexpected coverage is needed, to safely ensure and meet operational needs, employees may be contacted and asked to respond outside of their regularly scheduled hours – this is usually just the case for staff working in relief/casual positions

Complaints

Employees who have concerns about disconnecting during their time away from work should first speak with their supervisor/manager to resolve the issue. In the event the issue is not able to be resolved at this level, employees are directed to bring the issue forward to Director of Operations and Services.

RELEVANT LEGISLATION AND STANDARDS:

N/A

RELATED POLICIES:

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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RS A.14: RISK REDUCTION AND MANAGEMENT- BED BUG POLICY

SCOPE:

This policy applies to all staff and volunteers of SMH.

PURPOSE:

To establish procedures to prevent and/or minimize the risk of bed bug infestation through onsite and community outreach programs and/or services; and to establish procedures for pest management in the event of an infestation.

DEFINITIONS AND ACRONYMS:

St. Mary's Home: SMH

POLICY:

The nature of direct service work requires particular attention to bed bug risk reduction and management. SMH will strive to protect the health and safety of staff, participants, students, and volunteers by having procedures in place to reduce the risk of bed bug transmission to any stakeholder. While this policy applies to all areas where programs and/or services are provided, particular attention is given to outreach community settings when staff enter a participant's home. Staff have a key role in the early identification and prevention of bed bug transmission and infestation. Due to the nature of direct service work, SMH does not take responsibility for bed bug transmission and/or infestation that may occur while providing programs and/or services.

PROCEDURE:

The leadership team:

1. Ensure employees are provided proper training and complementary resources to support identification of bed bugs and implementation of pest prevention strategies;
2. Ensure regular pest control prevention measures are employed at the center where there is the only risk, and;
3. Ensure risk assessment and risk management plans are established in the case of an infestation at SMH.

Staff will:

1. Participate in required training on pest prevention and management;
2. Adhere to best practices and take proper precautions to minimize risk of bed bug transmission and/or infestation;
3. Keep a set of clothes available (i.e. in car or office) in a sealable plastic bag when providing outreach programming to change into after leaving a participant's living space;
4. After programming, put clothing in the dryer on high for at least 30 minutes; and
5. Report the following circumstances regarding bed bugs to their supervisor immediately, within the context of service delivery:
    - any bed bug sightings;
    - potential bed bug sightings (if not able to accurately identify the type of bug);
    - participant/client reports that they have bed bugs;
    - participant/client reports they suspect they have bed bugs; or
    - staff suspects that participant/client has bed bugs.

RELEVANT LEGISLATION AND STANDARDS:

SMH FORMS:

RELATED POLICIES:

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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STW A.1: FINANCIAL MANAGEMENT AND ACCOUNTING

SCOPE:

All Board members, Executive Director, staff designated and any external contracted individuals or firms.

PURPOSE:

To ensure that SMH finances are managed prudently and responsibly.

DEFINITIONS AND ACRONYMS:

St. Mary's Home: SMH
GAAP: Generally Accepted Accounting Principles
CRA: Canada Revenue Agency
Agency: SMH

POLICY:

SMH follows the Generally Accepted Accounting Principles (GAAP) in managing finances and regulations set out by Canada Revenue Agency (CRA).

IMPLEMENTATION:

Signing Authorities

1. Blank cheques are to be kept in a locked file cabinet in a locked office;
2. A set number of cheques, (20 from St Mary's Home bank account and 12 from Brighter Futures bank account) may be pre-signed with one signature, never two, by an approved signatory as listed below. These pre-signed cheques will be kept in a locked safe, which is only accessible to a maximum of 2 staff members who do not have signing authority. If a pre-signed cheque is used, an email stating the cheque number, amount, what the payment is for, will be sent to the Board Chair and to the person whose signature was pre-signed on the cheque. The use of these cheques will also be reported to the finance committee by email at the time of use;
3. All payments require adequate supporting documentation. This can be in electronic or hard copy format;
4. All payments, whether electronic or by cheque, require two authorized signatories.
5. Signatories are:
    a. Executive Director;
    b. President of the Board;
    c. Vice President of the Board;
    d. Treasurer of the Board;
    e. A Board Member designated by resolution; and
    f. Director of Operations and Support Services
    g. Management Staff, as designated by the Executive Director.

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Approved by BOD: July, 2024

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6. Signatories (e) and (g) are only authorized to be the second signatory for payments made electronically or by cheques and are not authorized to sign contracts which bind the corporation;
7. Signatories (e) and (g) are only authorized together to sign budgeted cheques or electronic payments up to a limit of $4,000 each, over $4,000 in an emergency requires an Over the Limit Form to be signed off by the Board of Directors;
8. The cheque signer(s) /electronic payment approver(s) must not be the person(s) who writes cheques or sets up electronic payments or does the accounting; and
9. The cheque signer(s) / electronic payment approver(s) cannot sign/approve a payment that is for them.

Receivables/Revenue

1. All receipts are recorded in a database and imported into accounting software;
2. Receivables are set up in accounting software with supporting documentation verified during annual audit;
3. All deposits and tax receipts are given reference numbers so they can be easily traced from the bank statement to the deposit records, to the tax receipts and to the General Ledger (GL);
4. Cheques for deposit are date stamped;
5. Deposits are done regularly, as required;
6. The accounts receivable ledger is maintained for each account showing all payments and charges;
7. The control ledger is equal to the receivable ledger for all customers; and
8. A monthly reconciliation is completed between the receivable records for the customers and the control ledger to ensure accuracy.

Revenue Recognition

SMH follows the deferral method of accounting for grants and contributions. Under this method, grants and contributions restricted for future period expenses are deferred and are recognized as revenue in the year in which the related expenses are incurred.

Funding Streams

As the majority of SMH Revenue is generated by funding streams, credit and collection policies are minimal if any:

1. Funders pay either monthly by direct deposit or quarterly in advance.

Cash Donations and/or Cash Equivalents

As a registered charitable organization, SMH receives donations from individuals, foundations, and corporations:

1. Donations are deposited and recorded in the SMH's accounting system and donor database system. Receipts for donations are generated for donors from this database. These receipts are reconciled to deposits annually;
2. Financial controls are established prior to each fundraising event by the Executive Director and the Treasurer;
3. SMH policy is to present bank balances under cash and cash equivalents, including bank overdrafts with balances that fluctuate frequently from being positive to overdrawn;
4. Donation revenue is audited annually by the external auditor;
5. Controls for the receipt of donations are reviewed during the annual audit process; and
6. These controls must be reviewed, improved, and followed on an ongoing basis.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

Cash donations and/or cash equivalent revenue sources are minimal, so risk is reduced with:

1. Cash deposits are kept locked in the safe at all times;
2. The process is monitored by managers not directly involved; and
3. Deposits are done weekly
4. In-Kind donations are recorded at fair value when they can be reasonably estimated and when the materials and/or services are used in the normal course of SMH's operations.

Preparation of Charitable Receipts

Charitable receipts are prepared within 40 days of receipt by the computer database. The Executive Director signs all charitable tax receipts. In their absence, a senior staff member designated by the Executive Director may sign tax receipts.

1. Tax receipts are not issued for amounts less than $20;
2. Duplicate receipts can be generated by the database if requested by the donor;
3. Each individual donation is to be entered into the database and receipted through the same system;
4. SMH is responsible for guarding against the unauthorized use of official receipts, therefore access to the database will be limited and password protected; and any changes will be verified by the accountant; and
5. All regulations set out by Canada Revenue Agency (CRA) must be followed.

Payables/Expenditures

Invoices

1. Must be submitted to the Finance/Accounting Services and be date stamped;
2. Where applicable, original invoices must be matched with the Purchase Request Form and verified to the vendor statements;
3. Invoices are coded and entered by the Accounting Clerk and are prepared for payment within 30 days unless otherwise stated and signed by two authorized signatories; and
4. These are then filed in the Accounts Payable filing cabinets.

Purchase Requests

1. Purchase Request Forms should be filled and submitted for any non-operating purchases before an expense has occurred and are to be submitted to the immediate supervisor for approval;
2. Forms are available on the Microsoft Office Suite under SMH "Accounting Forms";
3. Approved requests are then submitted to the Finance/Accounting Services for payment;
4. Should any concerns arise, the Accountant/Accounting Clerk will forward them to the Executive Director and Supervisors/ Managers. A final decision is made based on all information provided;
5. All requests for purchases must be approved prior to ordering;
6. Larger or irregular proposed purchase orders are discussed at leadership meetings to ascertain whether the proposed purchase is warranted and that funds are available in the budget and/or cash flow;
7. Irregular purchases must be pre-approved by the Executive Director;
8. Cheques/electronic payments are processed on a weekly basis, except in the case of an emergency, and approved by the supervisor and signed/approved by two authorized signatories as per the signing procedures; and
9. Records are then filed in the Accounts Payable electronic files.

Payroll

The Executive Director sets salaries based on current annual budgeting limits and requirements;

1. Majority of SMH staff are salaried and paid bi-weekly; relief staff are hourly and paid bi-weekly;
2. The hours staff work is recorded through an electronic clocking-in/out in system and any exceptions are recorded through the web-based payroll system. Hours are approved, or not, through this system by Supervisors/Managers;
3. Supervisors/Managers have salaried staff submit completed leave requests for vacation, sick and other leave using the Web-Based Payroll Software;
4. The bi-weekly payroll ledger is approved by the Executive Director, or their designate if they are away;
5. The accountant or their designate enters the payroll information into QBO and produces a monthly report which is reviewed and approved by Executive Director;
6. Changes to salaries or new salaried employees are review annually and approved by the Executive Director and reported to the Accountant/Bookkeeper by the Program Supervisors/Managers.

Employee Benefits/Deductions

In each pay period, automatic deductions are made for each employee for Income Tax, Canada Pension Program, Employment Insurance and Group Benefits; and WSIB and EHT premiums are remitted as well as all other source deductions.

Accrued sick leave benefits and vacation pay

SMH does not record a liability for accrued sick leave benefits. Accruement of vacation pay is payable to employees should they leave their employment with the SMH. Unrecorded sick leave benefits and vacation pay as of March 31st, year-end is recorded in a note to the Financial Statements.

Year-End Reporting

Summary statements and reconciliations are submitted to the following:

1. Ministry of Health for the Employer's Health Tax reconciliation;
2. Workers Health & Safety Board for reconciliation of all WSIB installments;
3. T4s to CRA; and
4. All salaries are reconciled to financial statements and to payroll company reports. The statements/reports are reviewed and signed by the Executive Director.

Employee Expenses

Allowable expenses for travel and mileage for business purposes must be supported by receipts and an expense claim form and submitted to Finance/Accounting. Where necessary, advances for expenses are allowed up to $100.00 per day per person. Any unused funds are to be returned to the Accountant/Accounting Clerk, accompanied by the expense claim forms.

1. Expense claims must be filled out completely, state what the expenses are for, signed off by the employee and be approved by the immediate supervisor;
2. Approved expensed claims along with receipts must be scanned to Hubdoc and originals, not duplicates or photocopies, must be provided to the Accounting Clerk, – unless otherwise approved by the Executive Director
3. Reimbursements are made to employees electronically and processed on a weekly basis, except in the case of an emergency, they must be approved by the supervisor first and signed/approved electronically by two authorized signatories as per the signing procedures before being distributed; and
4. Records are then filed in the Accounts Payable electronic folders or filing cabinets.

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Reimbursable expenses:

1. Program Supplies;
2. Airline fees (Coach), baggage fees, fees to confirm your flight, parking;
3. Taxis/subway fees/bus rates;
4. Automobile rentals;
5. Incidentals;
6. Mileage;
7. Meals;
8. Lodging;
9. Office expenses;
10. Taxis;
11. Parking receipts;
12. Mailings;
13. Approved miscellaneous expenses by supervisors; and
14. Participant emergency items approved by supervisors.

Non-reimbursable expenses:

1. Alcoholic beverages;
2. Cost incurred for failure to cancel transportation or hotel reservations;
3. Entertainment expenses, including movies in a hotel room;
4. Parking or traffic tickets; and
5. Laundry or dry cleaning.

Mileage Rates

The rate is established by the Executive Director and approved by the Board of Directors. The current approved rate is stated on the mileage expense claim found on the Microsoft Office 365 SMH SharePoint. Mileage, in kilometers, must be recorded on this form for a reimbursement claim to be made.

Meals

The rate is established by the Executive Director and approved by the Board of Directors. The current approved rate is stated on the expense claim found on the Microsoft Office 365 SMH SharePoint. Original receipts must be included with this form for a reimbursement claim to be made.

Corporate Credit Card Use

Careful consideration must be given to decisions about who is issued a corporate credit card (CCC). This decision is made by the Executive Director;

1. Card limits are kept as low as possible to reduce risk;
2. Employees holding a CCC will:
   - Read and will follow the provisions of the cardholder agreement by signing the Corporate Credit
   - Card Use - Acknowledgement and Agreement Form;
   - Keep the card in a secure location;
   - Notify the credit card company and SMH immediately if the card is lost or stolen;
   - Not make personal purchases with the corporate card;
   - Get prior approval from their director/supervisor for all purchases - this is not required by the Executive Director, however, the Treasurer or Board Chair reviews these expenditures;

- Not give the card to any unauthorized persons; and
- Submit invoices immediately to finance department.

3. A cardholder who makes an unauthorized purchase with the card or uses the card in an inappropriate manner will be subject to revocation of the credit card and disciplinary action that may include repayment and/or restitution to SMH for unauthorized purchases, possible card cancellation, termination of employment at SMH, and/or, criminal prosecution.

Debt Management

Forecasting of real and possible deficits are made monthly and expenses are adjusted when/as necessary to reduce further deficits;

1. Diverse funding sources are sought, and fundraising activities are undertaken – the Board of Directors has created a sub-committee, the Fundraising Task Force, to assist in diversifying the agency's funding base and increasing discretionary funds;
2. A contingency fund of short-term operational funding is maintained, and these resources are protected; and
3. The agency has a line of credit available at the bank which holds the agency's accounts.

Financial Instruments

Measurement of Financial Instruments

SMH initially measures it financial assets and liabilities including investments at fair value, except for certain non-arm's length transactions. Subsequently, all financial assets and financial liabilities are measured at amortized cost, except for investments in equity instruments that are quoted in an active market, which are measured at fair value. Changes in fair value are recognized in operations;

1. Financial assets measured at amortized cost include cash and accounts receivable; and
2. Financial liabilities measured at amortized cost include bank indebtedness, bank loan, accounts payable and accrued liabilities.

Impairment

Financial assets measured at amortized cost are tested for impairment when there are indicators of possible impairment. SMH determines whether a significant adverse change has occurred in the expected timing or amount of future cash flows from the financial asset. If this is the case, the carrying amount of the asset is reduced directly to the higher of the present value of the cash flows expected to be generated by holding the asset, and the amount that could be realized by selling the asset at the balance sheet date. The amount of the write-down is recognized in operations. The previously recognized impairment loss may be reversed to the extent of the improvement, provided it is no greater than the amount that would have been reported at the date of the reversal had the impairment not been recognized previously, the amount of the reversal is recognized in operations.

Transaction Cost

SMH recognizes its transaction costs in operation in the period incurred however, transaction costs related to financial instruments subsequently measured at amortized cost reduce the carrying amount of the financial asset or liability and are accounted for in the statement of operations using the straight-line method.

Financial Reporting

Fund Accounting

To ensure limitations and restrictions placed on the use of resources available are observed, for reporting purposes, the account of SMH is classified into funds in accordance with the activities or objectives specified by the donors or in accordance with the directives issued by the Board of Directors. For financial reporting purposes, the fund balances have been classified into two funds consisting of an Operating Fund and a Campaign Fund.

1. The Campaign Fund was established to record contributions received for the purchase of the Residence and

the Young Parent Outreach Centre and to fund expenditures related to their operations which are not funded through the Operating Fund.

2. The Operating Fund reports the current operating activities of SMH

Transaction Cost

SMH recognizes its transaction costs in operation in the period incurred however, transaction costs related to financial instruments subsequently measured at amortized cost reduce the carrying amount of the financial asset or liability and are accounted for in the statement of operations using the straight-line method.

Financial Reporting
Fund Accounting
To ensure limitations and restrictions placed on the use of resources available are observed, for reporting purposes, the account of SMH is classified into funds in accordance with the activities or objectives specified by the donors or in accordance with the directives issued by the Board of Directors. For financial reporting purposes, the fund balances have been classified into two funds consisting of an Operating Fund and a Campaign Fund.

3. The Campaign Fund was established to record contributions received for the purchase of the Residence and the Young Parent Outreach Centre and to fund expenditures related to their operations which are not funded through the Operating Fund.
4. The Operating Fund reports the current operating activities of SMH.

Internal Financial Statements

An unaudited financial statement is prepared monthly by the Accountant/Bookkeeper and reviewed first by the Executive Director to ensure accuracy. The financials are then distributed to the Treasurer and the Finance Committee for review. The Treasurer distributes it to all Board members to review and, at the next available Board meeting, the Treasurer presents them for Board approval. SMH would not be able to carry out its activities without the services of the many volunteers who donate a considerable number of hours. Due to the inherent difficulty in compiling these hours and determining their fair value, contributed services are not recognized in the financial statements. The preparation of financial statements requires management to make estimates and assumptions that affect thereported amounts of assets and liabilities, and the reported amounts of budgeted versus actual revenues and expenditures with significant, if any, variances noted and explained and approved, and approval is included in the minutes of the meeting.

Annual Audited Financial Statements
Year-end audited financial statements are finalized by mid-July and presented to the Finance Committee by the Auditor; to the Executive Committee by the Treasurer, and finally to the Board at the next Board meeting. Each year the Auditor completes the Registered Charity Information Form T3010A, reporting the charitable work of the organization and the donations received, and the return is signed by the Executive Director.

Budgets
Various fundraising and budget reports are prepared by the Executive Director for the Finance Committee/Executive Committee throughout the year. The budgets are presented to and reviewed and approved by the Finance Committee and then the Board.

Retention of Financial Record

1. All financial records must be retained for a minimum of 7 years;
2. Medium may be electronic or hard copy; and
3. Financial records include but are not limited to invoices, donation records, charitable receipt records, deposit records and payroll records.

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Procurement

No employee, officer, or agent shall participate in the selection, award, or administration of a contract if a real or apparent conflict of interest would be involved. Such a conflict would arise when the employee, officer, or agent, any member of their immediate family, their partner, or an organization which employs or is about to employ any of the parties indicated herein, has a financial or other interest in the firm selected for an award;

1. Organization conflicts of interest: suppliers that are in any way related to the Board or SMH management are not eligible for contracts, except in urgent circumstances, when all other options have been exhausted. When this is the case, the Board Chair and/or Executive Committee is made aware of the situation;
2. Awards shall be made to the bidder or offer or whose bid or offer is responsive to the solicitation and is most advantageous to the Agency, price, quality, and other factors considered; and
3. Contracts entered for purchase of goods and services must be in writing and include:
   - A description of the goods and services to be rendered;
   - Specific deliverables and timelines where applicable; and
   - Procedures for fee payment.

Auditing Review/Procedures

An external audit is completed each year for the year ending March 31st. This usually involves 4-5 days of on-site/online field work by the auditing firm to review internal controls, financial records, policies, reports, and files as per Accepted Accounting Principles (GAAP). It is the responsibility of the Accounting Clerk, in conjunction with the Accountant/Bookkeeper, to prepare for the audit and to ensure that all preparatory documents are in place and ensure all reconciliations and accruals are analyzed and entered, such as:

1. Final bank reconciliation;
2. Analysis of salaries balanced to T4s;
3. Reconciliation of all income to contracts and legal agreements with private and public funders;
4. Analysis of all balance sheet accounts including investments, accrued interest, prepaid expenses, accounts payable, etc. and
5. Other analyses required by the auditing firm.

Internal controls protect SMH assets against waste, fraud, and inefficiency. They also ensure the accuracy of financial data. Internal controls are maintained by the accountant and reviewed annually by the Executive Director, Treasurer and finally the auditors to ensure proper financial management.

Communication of Financial Information

1. Budget/Financial information is shared on a regular basis during Board meetings by the Treasurer of the Board;
2. The Finance Committee provides recommendations to the Board regarding the budget as needed throughout the year;
3. Year-end audited financial statements are finalized by mid-July and presented to the Finance Committee by the Auditor; to the Executive Committee by the Treasurer, and to the Board ahead of the AGM; and
4. The audited report is presented by the auditor and made available to the public at SMH Annual General Meeting, along with the Annual Report, and both are then posted on the agency website.

Cash Reserves & Management

To mitigate the risk of unexpected expenditures, minimum cash balances equal to two months payroll plus half a month's operating expenditures should be maintained.

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RELEVANT LEGISLATION AND STANDARDS:

SMH FORMS:

Over the Limit Form
Purchase Request Form
Expense Claim Form
Corporate Credit Card Use - Acknowledgement and Agreement Form

RELATED POLICIES:

SMH/Maison Sainte-Marie Constitution and By-Law #3 – 3.11, 3.12, 6.01, 6.02

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STW A.2: ANNUAL BUDGET PROCESS

SCOPE:

All Board members, Executive Director, external contracted individuals or firm, staff designated responsibility for budget forecasting and reporting.

PURPOSE:

To establish an annual budget process.

DEFINITIONS AND ACRONYMS:

St. Mary's Home: SMH
Budget: an estimate of revenues and expenses and the resultant surplus or deficit for a particular period.It may also include separate estimates of capital expenditures.
Budget process: a coordinated process of financial planning and management which incorporates financial, control, and risk management principles.
Forecast: an estimate of the most likely financial results based upon best-available knowledge as to how eventswill unfold.

POLICY:

SMH views the annual budget process as an important part of quality assurance, strategic and operational planning. This policy applies to the Board of Directors, Executive Director, and employees responsible for budget forecasting and reporting. It is the responsibility of:

1. The Executive Director to coordinate the budget and forecast processes;
2. The Leadership/Management Team provide input into the budget based on the needs of their programs and/or services;
3. The Executive Director/Treasurer to ensure that the budget presented to the Finance Committee and Board of Directors for approval represents responsible implementation of the strategic directions of the organization; and
4. The Board of Directors approves the budget ensuring that it reflects the strategic directions of the organization and the prudent stewardship of funds.

IMPLEMENTATION:

1. Last year's actual expenditures are used as a starting reference for estimate when forecasting upcoming year's budget and inflation adjustments are made where necessary;
2. Necessary adjustments are made by the Executive Director in consultation with the Treasurer and the Leadership/Management Team and other appropriate employees;
3. SMH creates an Annual Budget based on actual and anticipated revenues and expenditures before the start date of each fiscal year and presented to the Board of Directors for approval;
4. A draft budget is reviewed with the Treasurer, Executive Director and the Finance Committee before going to the Board for approval; and
5. The budget is presented to the Board of Directors by the Treasurer for approval.

RELEVANT LEGISLATION AND STANDARDS:

N/A

RELATED POLICIES:

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STW A.3: CAPITAL/NON-CAPITAL ASSETS

SCOPE:

This policy applies to all SMH departments and related organizations and includes, but is not limited to, the following assets: land, buildings, building improvements, and landscaping, and administrative equipment (office, audio visual, fitness, maintenance and communication) and furnishings (furniture and fixtures), computers, software, vehicles, and periodicals that are charged or recorded to any operating trust, endowment, minor or major capital general ledger account.

PURPOSE:

To safeguard and identify all assets, capital and non-capital, belonging to, having title to, or in the custody of SMH.

DEFINITIONS AND ACRONYMS:

St. Mary's Home: SMH
ASNFPO: Canadian Accounting Standards for Not-For-Profit Organizations

POLICY:

Responsibility for other assets rests with SMH to the extent that it has explicitly agreed to accept responsibility under a contractual arrangement. When assets are acquired, SMH will identify, safeguard, track and record them in an equitable manner that maximizes the useful life of the asset. SMH will determine which assets are to be capitalized in accordance with Canadian Accounting Standards for Not-For-Profit Organizations (ASNFPO), determine the appropriate valuation of the capitalized asset, provide the appropriate period of amortization of that capitalized asset over its estimated useful life. SMH is responsible under grants, contracts and agreements for the custody of the equipment purchased from the funds provided. Unless otherwise specified by a granting agency, all equipment is considered to be SMH property. All assets purchased through professional allowances, including computers and software, are the property of SMH, even when located off-site, and are included in this policy, unless otherwise specified in an individual's employment contract. While the asset is located off-site the person using it assumes full responsibility for the care and custody of the asset and may be responsible for any loss or damage due to willful negligence.

IMPLEMENTATION:

Responsibilities

1. It is the responsibility of SMH to take appropriate and reasonable measures to identify, safeguard, track and record all capital and non-capital assets.
2. The Finance/Accounting Services department is responsible for the implementation, education and training on all matters relating to this policy, as well as advising on the appropriateness of a capital or non-capital asset for generally accepted accounting purposes.
3. All persons/departments having responsibility for the use and care of capital and non-capital assets are to ensure that reasonable, safeguarding measures are in place at all locations where these assets reside to prevent damage to or the loss of such assets. When disposing of an asset the Asset Disposal Form is to be completed as required;
4. The Finance/Accounting Services department will be responsible for recording in accordance with ASNFPO the addition of all capital assets, donated assets, disposal, amortization and the grants and cash donations received to offset the costs of capital assets.

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Capitalized Assets - Valuation

Capital versus Non-Capital Assets

An asset will be classified as a capital asset, if it is a non-consumable, tangible item, valued at a single amount greater than $2,000 and with a life expectancy of at least two years. Tangible items valued at single amounts less than $2,000 will be classified as a non-capital asset.

Purchased Assets

The capitalized cost of most purchased assets includes the purchase or acquisition price and related freight, installation, customs charges, taxes (net of rebates) and other direct costs of getting the asset into condition necessary for its intended use. Capital equipment purchased sometimes have add-on items that are not initially ordered as a single amount, but should still be included as part of the historical cost. Other direct costs may include software if included with the physical capitalized equipment, and warranty costs for the first year only, if included in the acquisition price. Costs that will not be capitalized include training and maintenance unless these costs cannot be separated from the acquisition cost.

Constructed Assets

Capital assets that are constructed (e.g. buildings or constructed research equipment) are capitalized as work progresses and amortization commences and the building or other constructed asset is ready for occupancy oruse. Construction costs include all direct costs associated with the project that are incurred during the planning period, the construction ends when the construction project is substantially performed. They also include any overhead costs directly attributable to the construction or development activity.

Grants and Cash Donations

Grants and cash donations received to help fund the costs of a capital asset do not reduce the cost of the asset. The amounts received will be recorded as deferred capital contributions and amortized into revenue on the same basis as the asset to which it relates.

Donated Assets

Donated or contributions of capital assets are capitalized at the appraised fair market value at the date of contribution.

Building Improvements versus Repairs and Maintenance

1. Expenditures made to maintain an existing capital asset that restores the capital asset to working condition but does not extend its life will be considered repairs and maintenance expenditures. These may include:
    - repairs to the roof
    - repainting of a building
    - painting of interior offices
2. The cost incurred to enhance the service potential of a capital asset is a building improvement. Service potential may be enhanced when there is an increase in the previously assessed service capacity, associated operating costs are lowered, the useful life is extended, or the quality of output is improved;
3. The cost incurred in the maintenance of the service potential of a capital asset is a repair, not a building improvement. If a cost has the attributes of both a repair and an improvement, the portion considered to be a building improvement is included in the cost of the capital asset.

Created: August 28, 2017
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Amortization

1. Amortization or depreciation is an accounting cost allocation method of a capitalized asset over its useful life. It is not intended, at any time, to necessarily represent the fair or market value of a capital asset. Amortization is recorded for a half-year in the year of acquisition for all capital assets except for constructed capital assets.
2. Amortization does not begin on constructed capital assets until work is substantially performed and the building or other constructed asset is ready for occupancy or use. Capital assets financed by the Campaign Fund are recorded in this fund while other capital asset purchases are recorded in the Operating Fund. Capital assets are placed into categories and amortized on a straight-line manner over the estimated useful lives and annual rates as follows:
    - Buildings 25 years 4%
    - Furniture and equipment 5 years 20%
    - Computer equipment 3 years 33.33%

Write-Down of Capital Assets

When a capital asset no longer contributes to the organization's ability to provide services, it's carrying amount is written down to residual value, if any. The excess of its net carrying amount over the residual value is recognized as an expense in the statement of operations.

RELEVANT LEGISLATION AND STANDARDS:

Canadian Accounting Standards for Not-For-Profit Organizations

SMH FORMS:

Asset Disposal Form

RELATED POLICIES:

CCA: ORG-STW-3.1

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STW A.4: DONATION AND FUNDRAISING POLICY

SCOPE:

All Board members, all staff and volunteers and existing/future donors.

PURPOSE:

To ensure that SMH maintains high standards of integrity and stewardship in both its active fundraising and related communication activities, and its acceptance of donations.

DEFINITIONS AND ACRONYMS:

Restricted Gift: gift that has a specific purpose specified by the donor and agreed to by SMH upon acceptance.
Gifts-in-Kind: any gift that is not cash or cheque, including securities and/or services. Gifts-in-kind services are free services needed to further the goals of the organization, for example consulting services and/or advertising.
Legacy Gifts: bequests, life insurance designations, or other gifts that take effect on or after the donor's death are considered "Legacy Gifts".
Finder's Fee: a fee paid by a business to a person or organization for bringing to its attention financial investors, potential new employees, or buyers or sellers whose relationship with the business will materially benefit it.
Special Events: activities the organization plans and conducts to raise funds.
Fundraising Committee: The Board of Directors Fundraising Task Force

POLICY:

SMH is a registered charity and, therefore, a trustee of charitable dollars. This policy recognizes the critical importance of ethical conduct in fundraising activities to safeguard the status of the organization as a registered charity. In addition, this policy sets out guidelines for due diligence in accepting, receipting, documenting and reconciling donations received by SMH. Adherence to this policy is paramount to ensure that the organization stands up to scrutiny by all its stakeholders and the public. As per the regular review of policies and procedures, the organization will make every possible effort to ensure that this policy is current, relevant and used consistently to achieve the above objective.

IMPLEMENTATION:

General

SMH accepts charitable gifts in the form of cash, cheques, credit card, gifts-in-kind of goods and services, or deferred gifts which include will bequests, transfer of stock, life insurance policies, gift annuities and charitable remainder trusts:

1. Ownership of all gifts resides with SMH whether they benefit the organization in general, or some purpose specified by the donor and agreed to by SMH;
2. SMH prefers to receive unrestricted donations to pursue its greatest needs, but may accept restricted donations after completing due diligence to ensure that such specific purposes are complementary to the overall long-term goals of the organization;
3. SMH may elect to accept or decline any unrestricted or restricted gift;
4. SMH will operate within the Donor Bill of Rights adopted by the Canadian Association of Fundraising Professionals. The Donor Bill of Rights reads as follows:

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- To be informed of the organization's mission, of the way the organization intends to use donated resources, and its capacity to use donations effectively for their intended purpose;
- To be informed of the identity of those serving on the organization's governing board, and to expect the board to exercise prudent judgment in its stewardship responsibilities;
- To have access to the organization's most recent audited financial statement;
- To be assured their gifts will be used for the purposes for which they were given;
- To receive appropriate acknowledgement and recognition;
- To be assured that information about their donations is handled with respect and confidentiality to the extent provided by law;
- To expect that all relationships with individuals representing the organization will be professional in nature;
- To be informed whether those seeking donations are volunteers, employees of the organization, or paid individuals soliciting donations on behalf of St Mary's Home;
- The opportunity to have their names be deleted from mailing lists;
- To feel free to ask questions when donating and to receive prompt, truthful and forthright answers;
- To be assured that all online transactions and contributions occur through a safe, private and secure system that protects the donor's personal information;
- To be clearly informed if a contribution goes directly to SMH or is held by, or transferred through, a third party; and
- To have access to the organization's privacy policy.

5. In addition to the Donor Bill of Rights, SMH will honour a donor's request to:
   - Remain anonymous;
   - No longer be contacted by SMH in any form; and
   - Indicate their preferred method and frequency of contact from St Mary's Home.

Restricted Gifts

1. If the nature of the restricted gift involves a long-term strategic association, a formal partnership agreement will be developed and signed to define the alliance;
2. Documentation and financial accounting must be maintained to ensure easy verification of the use of restricted funds;
3. In the case of restricted donations that result in the creation of new initiatives, the organization must approve the designated donation based on the following:
   - Any new donor wishing to donate funds with external restrictions or for a specific purpose must outline the purpose and intent of their gift in writing;
   - Such gifts may not be contradictory to SMH mission and goals;
   - The donor's business and/or personal activities must be perceived to be socially responsible and not contradictory to the mission of SMH;
   - The gift may not result in unplanned higher operational costs or financial burden in order to actually administer/liquidate the gift;
   - The gift may not be restricted to the benefit of an individual or group of specific participants;
   - The gift must be reviewed by the Executive Director who will make a recommendation to the Board to determine whether to accept the restricted donation; and
   - If the donation is rejected, the Executive Director will inform the donor immediately and will maintain a file of the decision including the due diligence process to support the decision.

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Sponsorships

When the benefits and recognition offered by SMH to a donor, are considered to be material based on the guidelines of the CRA, SMH and the contributor should enter a formal Letter of Agreement with regard to benefits and recognition, and the contribution should be classified as a sponsorship; and no tax receipt will be issued to acknowledge sponsorships.

Gifts-in-Kind

1. Gift-in-kind services cannot be receipted by SMH as they do not represent a transfer of property;
2. Where suppliers donate back-cheques related to payment for services provided, they are issued a receipt for the full amount of the cash donation;
3. SMH may decline acceptance of any gift-in-kind goods or services based on the following:
   - The gift may result in unplanned higher operational costs or financial burden in order to
   - store/liquidate;
   - The gift can't be used within a reasonable period of time by SMH; and
   - The donor's business and/or personal activities aren't perceived to be socially responsible and
   - contradictory to the mission of SMH.
4. The organization has the freedom to make decisions regarding upgrading, maintenance and ultimate disposal of the gift; and
5. Other gifts-in-kind may be tax receipted only where SMH is able to substantiate the value of the gift.

Legacy Gifts

The Chair of the fundraising Task Force or Board President or Executive Director should, to the extent possible, attempt to ensure that any planned Legacy Gift complies with the terms of this policy;

1. If the Chair of the Fundraising Task Force/Board President/Executive Director becomes aware of a planned Legacy Gift that does not comply with this policy, they should inform the Executive Director and then attempt to work with the donor to restructure the terms of the gift so that it does comply;
2. In the event that a Legacy Gift does not comply with the policy and this is not discovered or remedied until after the donor's death, the Chair of the Fundraising Task Force with the Executive Director shall attempt to work with the donor's legal representatives to restructure the gift, although this may not be possible in all circumstances; and
3. As with any other gift, SMH may elect to accept or reject any Legacy Gift.

Refund Policy

Should a donor wish to discuss a refund of their donation they will be asked to inform St Mary's Home in writing of this request which will then be forwarded to the Accountant of St Mary's Home;

1. As per Revenue Canada, in most cases, a registered charity cannot return a donor's gift;
2. According to law, a gift transfers ownership (i.e. money or other gifted property) from the donor to the charity.
3. Once the transfer is made, the charity is obliged to use the gift in carrying out its charitable purposes; and
4. On occasion, a charity may be obliged, by law, to return gifts to donors. This can happen, for instance, when a charity asks the public to contribute to a special project and unforeseen circumstances make it impossible to carry out the project.

Donor Recognition

1. All donors will receive timely and appropriate recognition for their gift;
2. This recognition may include but is not limited to: letters, telephone call, listing in publication, token gift, certificate, and formal recognition events;
3. The Board of Directors Fundraising Task Force and the Executive Director are responsible for establishing and maintaining an ongoing recognition program; and
4. All recognition will be equitable in nature based on the amount of the gift.

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Fundraising
Ethical Guidelines
SMH will:

1. Disclose the organization's name and include an address or other contact information;
2. Accurately describe the organization's activities and achievements;
3. Sensitively and fairly represent the people served by the organization, their needs and how these needs will be addressed;
4. Disclose the purpose for which funds are requested;
5. Disclose its Canada Revenue Agency (CRA) charitable registration number;
6. Disclose the organization's policy with respect to issuing Official Income Tax receipts; and
7. Disclose all costs associated with fundraising activities.

SMH will not:

1. Endorse any products and/or services of donors or sponsors;
2. Accept donations in cash or in kind from companies that create products that cause physical harm to human beings, as determined by the Board of Directors;
3. Use any unethical or unlawful techniques to solicit funds or sell products and services;
4. Take donations if they are deemed to have originated from unethical or unlawful activities as determined by the Board of Directors;
5. Engage in any activities that involve discriminatory practices against any individual or group based on gender, sexual orientation, religious or political affiliation, citizenship, age, race or ethnicity, record of offences, disability, income or family status;
6. Bestow valuable consideration or other privileges on a donor who could have the ability to exercise, directly or indirectly, control or significant influence over the organization;
7. Sell or rent the personal information of our donors;
8. Pay fundraisers "a finder's fee", commission or percentage compensation based on contributions; and
9. Engage external professional fundraisers if fees are a significant portion of the anticipated funds raised as determined by the Board of Directors.

Roles and Responsibilities
A fundraising strategy is developed by the Board of Directors Fundraising Committee in collaboration with SMH and the Executive Director; the fundraising strategy is aligned with the directions set out in the SMH multi-year Strategic Plan including the Annual Budget;

1. On an annual basis, the Executive Director, in collaboration with the Fundraising Committee will review the fundraising strategy to ensure that it continues to meet the needs of the community and organization as a whole;
2. The Fundraising Committee, after reviewing the fundraising strategy, will make recommendations to the Board of Directors, seek their approval and continue to lead the implementation of fundraising for the organization; and
3. Quarterly reviews will be undertaken by the Fundraising Committee and Executive Director to assess the success of the fundraising work to date, with an eye to enhancing and improving current and future fund development initiatives.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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Events
The following will be considered when planning special events:

1. The cost to raise a dollar should be no more than 50% and ideally significantly lower. Rare exceptions may be given if the event is deemed to have significant public relations benefit;
2. The amount of staff time invested in the event versus the overall anticipated revenue will be considered;
3. All required licenses/permits will be obtained;
4. Formal written agreements will be obtained if the event is run in conjunction with another organization;
5. Third party events may be planned and conducted by an outside organization, company or group of individuals and all or a portion of the funds raised are donated to SMH. SMH staff and volunteers may assist in planning and executing these events and at least one individual from SMH will attend to represent the organization; and
6. Third party events are encouraged and the revenue accepted as long as the events and the donor's business and/or personal activities are perceived to be socially responsible and not contradictory to the mission of SMH.

RELEVANT LEGISLATION AND STANDARDS:

Donor Bill of Rights by the Canadian Association of Fundraising Professionals

RELATED POLICIES

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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SS A.1: RECORDS MANAGEMENT

SCOPE:

All staff and volunteers of SMH.

PURPOSE:

To outline procedures for the creation, storage, security, and audit of files/records for staff and participants

DEFINITIONS AND ACRONYMS:

St. Marys Home: SMH
Staff: refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement and service partners of SMH.
Service Partner: is an agency and its staff, and/or an individual who have signed service protocols and/or agreements with SMH to provide services to participants on site
Highly Sensitive Data: Includes personal information that can lead to identify an individual; health information that reveals an individual's health condition and/or history of health service use and assessment information.
Administrative Assistant: AA
Personal Health Information: PHI

POLICY:

SMH maintains all staff and participant records in accordance with legislative requirements. To ensure that records are created, maintained, and audited effectively, SMH follows the Canadian Centre for Accreditation (CCA) volunteer, participant, and employee file checklists.

IMPLEMENTATION:

Types of Records
All Staff records shall be maintained and easily
accessible in the event of an CCA audit; and when a document has reached its expiration date, the organization shall either:

1. Destroy, either by paper shredding or permanent deletion from electronic sources;
2. Render the personal information "non-identifying" so that it can no longer be used to identify an individual; or
3. Move to an inactive folder.

Personal Information
SMH commits to collecting and retaining personal information for the sole purpose of managing its business in accordance with the Personal Information Protection and Electronic Documents Act (PIPEDA).

Employee Files
Canada Revenue Agency requires the retention of all employee records pertaining to taxation and payroll for at least six (6) years from the end of the last taxation year. These records can be kept in paper or electronic format. They may include:

1. CPP contributions, as per the Canada Pension Plan, subsection 24(2);
2. EI premiums, as per the Employment Insurance Act, subsection 87(3);
3. Taxes withheld, as per the Income Tax Act, subsection 230(4)(b);
4. The hours worked by each employee;
5. Form TD1, Personal Tax Credits Return;
6. Form TP1015.3, Source Deductions Return (Quebec only); and

Created: August 28, 2017
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Approved by BOD: July, 2024

7. Canada Revenue Agency letters of authority which allow organizations to reduce the tax deductions for certain employees for a specific year.

All information slips and returns are filed in accordance with Ontario's Employment Standards Act, subsection 15(5), the employer shall retain or arrange for some other person to retain these records for at least three (3) years after the employee ceased to be employed by the employer;

1. Employee files are archived after this time period up to 7 years;
2. Employee files are kept in a locked filing cabinet in the secure Finance office;
3. An Employee File Detailed Tracker will be maintained by the EA or their designate;
4. The DOPS will be responsible for ensuring an annual audit of employee files is completed in the last fiscal quarter of each year (January – March) A sample of ten employee files will be chosen for the audit;
5. Annual verification of credentials, licenses, registrations, certification and/or professional liability insurance as required for relevant positions;
6. SMH will use SMH Employee File Checklist, based on the Canadian Centre forAccreditation Employee File Audit, when conducting the audit; and
7. To ensure employee files are created properly, the Employee Orientation Checklist is completed upon start date.

Volunteer Files

Volunteer files are kept by the Volunteer Coordinator:

1. The Volunteer Coordinator is responsible for ensuring an annual audit of volunteer files;
2. A sample of 10 volunteer files will be chosen for the audit;
3. The audit will be conducted in the first fiscal quarter of each year (April - June);
5. SMH will use the SMH Volunteer File Checklist when conducting the audit; SMH will use SMH Volunteer File Checklist, based on the Canadian Centre for
   Accreditation Employee File Audit, when conducting the audit; and
4. To ensure volunteer files are created properly, the new Volunteer Orientation Checklist is completed upon start date; and
5. Volunteer files will be kept a minimum of five years after the volunteer ceases to be active

Participant Files

1. Electronic participant files are stored in an industry standard database with appropriate logging systems;
2. Paper participant files are kept in locked filing cabinets in locked offices at the Young Parent Outreach Centre;
3. The Director of Operations and Support Services will be responsible for ensuring an annual audit of participant files is completed in the first fiscal quarter of each year (April – June), with a sample of 10 files;
4. SMH will use the SMH Participant File Checklist when conducting the audit;
5. Participant files will be kept a minimum of seven years after the discharge date;
6. Participant files are created based on the procedures outlined in the intake process; and
7. Participant files are never to be removed. If off-site access is required, a copy or secure electronic access will be used.

Board of Director Files

1. Board of Directors files are kept by the EA both in hard and scanned electronic formats;
2. The EA transcribes information to an internal database to facilitate the running of various reports;
3. The EA files the Board of Directors Annual Report, the Corporation/Director's Report and all agendas and minutes of Board meetings;
4. The Board of Directors Secretary, in collaboration with the EA, is responsible for collecting information required for each Director's file using the Board of Directors Orientation Checklist; and

5. The Board of Directors Secretary, in collaboration with the EA, is responsible for ensuring an annual audit of Director's files is completed using the SMH Volunteer File Checklist.

Other Records

Type of Record	Retention Time
Copies of Tax Receipts	Two years after the end of the year in which the donation was made.
Financial Records	Seven years after the end of the most recent year to which they relate (or two years after registration is revoked).
Incorporating Documents	For as long as the charity is registered plus two years after the charity is dissolved, ended or its registration is revoked.
Minutes - Board of Directors and Members	For as long as the charity is registered plus two years after the charity has ended, or been dissolved, or registration has been revoked.

Original Documents
The original hard copies of these documents are stored by the EA:

1. Charity registration letter;
2. Articles of incorporation; and
3. Change of fiscal year end.

RELEVANT LEGISLATION AND STANDARDS:

Personal Information Protection and Electronic Documents Act
Ontario's Employment Standards Act

SMH FORMS:

Employee Orientation Checklist
Employee File Checklist CCA
Participant File Checklist
Board of Directors Orientation Checklist
Volunteer File Checklist CCA

RELATED POLICIES:

CCA: ORG-SS-3.1,3.2; CCA: ORG-HR-6.1; HR 7.3; 11.1
SMH Policy: Programs and Services – Participant Records
SMH File Checklists: Employee, Participant, Volunteer
SMH Orientation Checklists: Employee, Volunteers
SMH Annual Performance Appraisal

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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SS A.2: COLLECTION, USE, AND RELEASE OF PERSONAL INFORMATION

SCOPE:

This policy applies to our participants, donors, staff, volunteers, and board members.

PURPOSE:

To establish procedures for the use, collection and release of personal information collected and maintained by SMH

DEFINITIONS AND ACRONYMS:

St. Mary's Home: SMH
Personal Health Information: PHI
Personal Information: Any information that can be used to distinguish, identify, or contact a specific individual. This information can include an individual's opinions or beliefs, as well as facts about, or related to, the individual. This personal information does not include business contact information or other publicly available information.
Stakeholder: Person, group or organization that has interest or concern or relationship with SMH (for instance: employees, volunteers including Board of Directors, field placement students, participants, partners providing services to participants at SMH).
Donor: Any individual or organization that contributes funds to SMH.
Volunteer: Any individual who performs a service willingly without pay.
Staff: Refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement and service partners of SMH.
Board Member: A Director and policy maker of SMH.
Participant: Child or youth receiving programs and/or services at SMH.

POLICY:

SMH values the trust of participants/participants, donors, staff, volunteers, board members and of the public, and recognize that maintaining this trust requires transparency and accountability in how we treat the information shared with us. Through this policy, SMH will protect the privacy of personal information, no matter how the information is collected, used or disclosed; any use other than for which it was originally gathered or other dealings with this information is subject to consent unless legally required. SMH does not sell, rent or release any private information for commercial purposes. SMH is accountable for all personal information in its possession or custody, including any personal information disclosed to third parties for processing or other administrative functions. SMH has established policies and procedures to comply with this policy and has designated a Privacy Officer to be accountable for compliance. To practice the principles of this policy, SMH will:

1. Inform all stakeholders of its Privacy of Information policies and procedures;
2. Train staff and volunteers to understand and follow policies and procedures; and receive and respond to questions and complaints; and
3. Oversee compliance with these policies and procedures through normal periodic audits; and
4. Only involve participants in public relations activities on behalf of SMH when, in the opinion of the leadership of the agency these activities do not conflict with their service, and only where circumstances allow reasonable control of their personal information.

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IMPLEMENTATION:

When is Information collected?

SMH will identify the purposes for which it collects personal information from stakeholders before or when the information is collected. Specifically, why SMH needs the personal information it is requesting and how it may be used with participant consent for other purpose.

What Information do we collect from Participants?

1. Participants are asked to provide information about themselves, their PHI, health history and their family that is pertinent to provide care. Indirect information is collected (e.g., from family or other professionals) if needed to provide care, with Participant's consent and as permitted by law;
2. Information is collected to provide pre- and post-natal services, counselling, assistance and advocacy, school program and infant childcare, and to comply with legal agreements; and
3. Data may be collected about participants for research and evaluation of services and programs. Any data collected will be in an unidentifiable, coded manner; names will not be released, unless a release of information is obtained.

How is Participant Information Used?

Participant information is collected to:

1. Support employees working at SMH with information to provide services to participants;
2. Inform treatment, academic and child development goals;
3. Support public relations activities (see Policy: Use of Participant Information for Public Relations Activities) and special internal events such as graduation;
4. Maintain a network of alumni;
5. Complete quality assurance tasks, a self-assessment of the organization for accreditation purposes and financial audit;
6. Comply with the requirements of funding contracts and the accreditation process such as site visits and file audits;
7. Maintain professional supervision of programs, services and employees;
8. Establish a relationship and to communicate with donors especially on donor requests for information, their needs and on information about SMH
9. Reach our fundraising goals;
10. Process donations; and recognize individual donations publicly with the donor's consent;

Our employees are trained and understand that participant information is private and can only be used or accessed to provide care and service to participants or to carry out our main activities and sign a Confidentiality Agreement Form as a requisite for their employment or association with SMH.

1. To use participant information for any purpose other than our main activities, prior consent and permission must be acquired from individual participants, specifying the exact use and purpose of this information; this includes research activities which will be followed through the process described in PHIPA; and
2. We will only disclose participant information if the law requires or permits us to do so for instance during an investigation or to other health care professionals that may be providing care to the Participant.

Identifying Purposes

SMH will identify the purposes for which it collects personal information from stakeholders before or when the information is collected. Specifically:

1. Why SMH needs the personal information;
2. How the personal information may be used for other purpose;
3. How anyone can refuse, at any time, permission for us to use personal information for these or other purposes.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

We may collect and use personal information for but not limited to the following purposes:

1. For Participants:
   - To inform treatment, academic and child development goals;
   - For public relations activities (see Policy: Use of Participant Information for Public Relations Activities);
   - For special internal events such as graduation; and
   - To maintain a network of alumni.
2. For Management/Operational Responsibilities:
   - To complete quality assurance tasks;
   - To complete a self-assessment of the organization for accreditation purposes;
   - To comply with the requirements of the accreditation process such as site visits and file audits;
   - To maintain professional supervision of programs, services and employees; and
   - To comply with financial audit requirements.
3. For our Donors:
   - To establish a relationship and to communicate;
   - To understand donor identity and identify how we may improve our services to meet donor needs;
   - To reach our fundraising goals;
   - To process donations;
   - To provide donors with information about SMH;
   - To respond to donor requests for information; and
   - To recognize individual donations publicly with the donor's consent.
4. For our Staff and Volunteers:
   - To recruit, train, recognize and retain highly qualified and motivated individuals;
   - To establish and maintain harmonious employer-staff relations;
   - To administer SMH policies and procedures; and
   - To manage and promote the philanthropic activities of SMH.

Release of Participant Information
Public Speaking Engagements:
Public speaking engagements generally conducted by employees or volunteers of SMH are for public education, recruitment to service, and fund raising. The following applies:

1. Any public speaking requests will be screened and approved by the Executive Director, in consultation with the Leadership Team, before approaching current or former participants;
2. A short list of participants or former participants who may be potential participants will be developed by the appropriate
   designated staff or staff team. In deciding; the purpose of the speaking engagement, the treatment needs and personal situation of the participant or participant group and the availability of the participant to participate will be
   taken into consideration;
3. Generally speaking, the involvement of former participants is preferable to the involvement of current participants,
   depending on the circumstances of both the speaking engagement and the participant themselves;
4. Participants, current and former, will be approached by a staff person most familiar to them. The request will be fully explained to them. It will be made clear that it is a volunteer request and there is no pressure for them to do this. The potential impact of participation will be explained: e.g., that once information is public it cannot be controlled, either who uses it or in what manner; that someone who knows the person or her family members may be privy to personal information including that they are participants of SMH, etc.;

5. Participants who volunteer to speak on behalf of the agency in response to a specific request must be accompanied by an agency staff person. The staff person will prepare and debrief the participant volunteer;
6. The agency should assume any extra financial costs to the participant associated with the participant's participation, e.g. transportation, lunch, childcare; and
7. The participant must sign an Agreement to Participate in a Public Relations Activity Form, indicating that they are aware of the context and the potential impact of this activity on themselves and their child(ren).

Print or Publications

For Public Relations Activity where participants are photographed, videotaped for promotional or public viewing purposes, or share a poem or story, a Media Consent Form specifically designating the use of the materials, will be signed by the participant.

1. The copy of the material and information to be released will be attached to the form;
2. No photos of faces or photos that would be recognizable or would allow for the identification of a participant will be used in print materials or displays for public information purposes without consent;
3. The original Media Consent Form will be kept in the participants file, and a scanned copy will be kept in the participant`s electronic record; and
4. Information about specific participants will not be released to the press by staff or volunteers. Unless a specific agreement is signed, only general information about participants that does not identify the participant, will be released to the press only by and at the Executive Director's discretion; and
5. A pseudonym or first name will be used in written public relations materials or reports for information purposes.

Media

SMH reserves the right to engage with media:

1. SMH will take reasonable steps not to allow representatives of television or radio shows to interview individual or groups of participants except during planned events in public venues where a participant or participant's family has given express consent.
2. If unexpected media coverage is present at a speaking engagement where a participant is scheduled to speak, the staff will substitute for the participant if the participant so desires.
3. If there is planned media coverage at an event where a participant is scheduled to speak, the participant will be briefed by staff and given the option whether to participate.
4. Should a participant wish to participate in an event where it is known in advance that the media will be present, the participant must sign a SMH Media Consent Form and an Agreement to Participate in a Public Relations Activity Form, indicating an awareness of the context and the potential impact of this activity on themselves.
5. Occasionally, as part of a program, participants are taken as a group to the taping of media talk shows. Should they choose to ask questions or make comments as part of the studio audience they should be asked not to identify themselves as SMH participants. They are fully responsible for the outcome of making their comments public.
6. The press will be provided information through a media information kit for the purpose of promoting services and/or advertising events;
7. If SMH wishes to respond publicly to a policy issue, one spokesperson will be designated to provide information to the press. The information may take the form of a press release or a prepared statement. The spokesperson will be the Executive Director or a designate chosen by the Executive Director.

Website and Electronic Commerce

Personal information such as participant name, phone number, e-mail or address isn't collected through our website.

This information is only obtained if it is supplied voluntarily, through contacting us via e-mail, or by asking to receive electronic newsletters or other information;

1. Any personal information provided will not be shared to any third party;
2. Whenever "cookies" are enabled to facilitate transactions, participant will be informed; and
3. If stakeholders choose to participate in an online forum or discussion group, we may ask that they provide personal information such as name and e-mail address for the purposes of effective administration of the forum or discussion group.

Exceptional Circumstances

SMH can disclose personal information without the knowledge and consent of participants in exceptional circumstances where such disclosure is permitted or required by law. For example, we will not ask for consent when personal information is:

1. Given to legal representatives;
2. Disclosed in order to:
   - Comply with a subpoena or warrant;
   - Respond to a lawful authority for lawful purposes;
   - Facilitate the activities of an investigative body or government institution in dealing with a past, potential or actual breach of an agreement or contravention of the laws of Canada or a province;
   - Comply with the law; and
   - SMH will inform participants of the consequences of refusing or withdrawing consent.

Obtaining Consent

The consent to collection, use or disclosure of participant information may be implied or expressed or given through an authorized representative. Each is reliant on the type of personal information needed and the reason for its use. We will seek consent to use and disclose personal information at the same time it is collected. Before deciding what form of consent is appropriate, we will consider the type of personal information needed and the reason for its use. If, after obtaining consent, a new purpose is identified, we will seek consent to use and disclose personal information for that purpose after the information has been collected. A participant or their authorized representative can give expressed consent in writing, electronically or orally -if meeting in-person, online or over the phone with the person they are providing permission to give or receive information regarding them.

1. Express consent is asked when:
   - Disclosing participant information to someone who is not a HIC (e.g., school, employer, lawyer, etc.); or
   - Disclosing participant information to a HIC, but for purposes other than providing health care.
   - When a participant gives an express (written) instruction that specific information is not used or disclosed.
2. Implied consent is when:
   - Where we are collecting, using or disclosing personal health information for health care purposes, the law normally permits us to rely on implied consent, where the surrounding circumstances allow us to make a reasonable determination that the participant would agree to the collection, use or disclosure.

We may sometimes collect, use or disclose personal information without participant consent, in limited instances that are required or permitted by law. For example, some laws require disclosure of participant information, such as the Coroners Act 1990 and the Vital Statistics Act 1990. Consent to use and disclose personal information will be collected at the same time.

Created: August 28, 2017
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Approved by BOD: July, 2024

Consent Validity

Consent is only valid if it is obtained from a capable person. To be capable of consenting, a participant must be able to understand the information relevant to the decision and the consequences of giving, withholding or withdrawing consent. If a participant is found to be incapable of making decisions about PHI, (person who is a minor, seriously ill, or mentally incapacitated) we will obtain consent from a substitute decision-maker, (legal guardian or a person with a power of attorney) as determined by law.

Withdrawing Consent

Stakeholders are free to withdraw consent to share personal information at any time, such request to withdraw consent can be made to a Supervisor and/or a Case Manager and/or Counselor using the Release Information Form. It is imperative to recognize that images shared on social media are not always easy to withdraw if they have been shared by others.

Accuracy of Participant Information

We take reasonable steps to ensure that participant information is as accurate, complete and up to date as necessary at the time of collection. When we are made aware of changes in participant information and/or if the original purpose for the collection of information changes, the information will be updated; and we take reasonable steps to ensure that any information that is disclosed to others under this Policy is accurate, complete or up-to-date; this fact will be indicated at the time of use or disclosure.

How to Access Participant Information

Participants can request access to their own records and personal health information from SMH by writing to our Privacy Officer (Executive Director). The participant will receive a response within 14 days of their written request. When participants are reviewing the contents of their file, they must do so with a SMH staff member present. Participants may only have copies of reports pertaining directly to themselves.

A participant's right to access their information is not absolute. If access to participant records is refused by the Executive Director, there will be a reason given, and the participant will be notified of their right to complain to the Information Privacy Commissioner of Ontario (IPC).

We may deny access when:

1. Required or authorized by law; or
2. The request is deemed to be frivolous, vexatious or in bad faith as determined by the Privacy Officer.
3. In the case of previous residential participants, 17 and under, all files since April, 30th 2024 are now the property of MCCSS and as such request of information must be made to them.

Participants may have access to or receive copies of third-party reports (reports about them written by a professional of another organization). A Release of Information Form will be signed as required;

1. Participant must show identification in order to access the file;
2. A record must be kept in the file, documenting the access or receipt of copies of file materials contained in the file by the participant accompanied by the written request and consents as appropriate; and
3. We may charge a reasonable fee (based on cost recovery) for copies of participant information. We will advise the participant of any fee before we make copies.

Correction of Personal Health Information

Depending on the circumstances, participants have the right to request correction to a record of PHI in our custody or control through a written request to our Privacy Officer (Executive Director). A response will be provided to correction requests within 14 days, except when we require additional time to provide an adequate response.

If correction request is accepted, the correct information will be added to the record and the incorrect information will be crossed out, without obliterating it.

If we refuse to make the correction requested, written reasons will be provided. A correction request may be denied where:

1. Record is incomplete or inaccurate for the purposes for which the information was recorded;
2. Record was not originally created by us and we do not have sufficient knowledge, expertise or authority to correct the record;
3. Record consists of a professional opinion or observation that a professional or agent has made in good faith;
4. The request is deemed to be frivolous, vexatious or made in bad faith as determined by the Privacy Officer (Executive Director);

Requests for removal of information by an individual from their file must be made in writing to the Executive Director

How to contact us

Please direct to our Privacy Officer (Executive Director) any question or concerns regarding our information and practices or this Policy. We will answer all questions and will promptly investigate any concerns raised regarding this Policy or any potential privacy breach. If an issue raised is found to have merit, we will take all appropriate measures, including taking disciplinary action or amendment of our information practices.

1. Our Privacy Officer
   The Executive Director SMH
   780 rue de l'Église, Ottawa, ON K1K 3K7
   Phone: (613) 749-2491 ext 732

Ontario's Information & Privacy Commissioner

Although we will make every effort to provide an amicable resolution to all privacy concerns, if we are unable to do so, complaints to the Information & Privacy Commissioner of Ontario can be made at:

2. The Information & Privacy Commissioner of Ontario
   Suite 1400, 2 Bloor Street East, Toronto, ON M4W 1A8
   Phone: 1-800-387-0073 TTY 416-325-7539

RELEVANT LEGISLATION AND STANDARDS:

Personal Health Information Protection Act 2004
Personal Information Protection and Electronics Document Act

SMH FORMS:

Media Consent Form
Public Relations Activity Form

RELATED POLICIES:

SMH Policy: Systems and Structures Use of Participant Information in Public Relations Activities and
SMH: Programs and Services – Confidentiality of Participant Information

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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SS A.3: CONFIDENTIALITY AND PRIVACY OF PARTICIPANT INFORMATION

SCOPE:

This policy applies to our participants/participants, donors, staff, volunteers and board members.

PURPOSE:

To outline the procedures specific to protecting the confidentiality of information of our participants and if a breach in the privacy of information occurs.

DEFINITIONS AND ACRONYMS:

St. Mary's Home: SMH
Staff: refers to employees, volunteers, Board of Directors, students in an unpaid and/or paid placement and service partners of SMH.
Service Partner: is an agency and its employees, and/or an individual who have signed service protocols and/or agreements with SMH to provide services to participants on site.

POLICY:

This policy pertains to the confidentiality principles applicable to the information collected by SMH. Participants and staff will receive a copy of SMH privacy policies, and staff will comply with the policy by signing an Acknowledgement and Agreement Form.

IMPLEMENTATION:

Internal Agency Confidentiality
All individual participant information obtained verbally and data recorded in the files or computerized records will be treated as confidential. Employees and volunteers working with participants and/or their information shall sign a Confidentiality Agreement Form.

1. All discussions about participants are confidential. Only those who "need to know" are involved in such discussions, under no circumstances will information be discussed in the presence of non-involved parties;
2. Participant information noted in staff meeting minutes will be recorded in a non-identifying manner, by first name and last initial only;
3. All information regarding participants are stored on a cloud-based electronic database to eliminate the sharing of hard copies. Permissions are created so that only those staff who "need to know" are to access electronic files/documents
4. Every effort will be made so that no one else is privy to the discussions. This includes but is not restricted to keeping office doors closed, making phone calls to participants or regarding participants in private and remembering to keep voice volume low to avoid being heard through walls or doors;
5. Participant files may be used in the offices during the day and must be returned to the locked storage area each evening;
6. Participant files are never to be removed from the agency; copies can only be taken from the agency with written authorization from the Executive Director and names and identifying information must be blanked out. If copies of a file are taken off property after written authorization is given, extra care to ensure their safety and security must be taken; and
7. Any information discussed in group, will be held confidential by group members, the group leaders may only share information about participants discussed in group with program staff needing to know this information.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

Interagency Collaborative Participant Service

A participant involved in a program and/or service run by SMH and any number of other partner agencies must sign a Release of Information Form for each of the agencies involved permitting St. Mary's Home staff to discuss participant information among staff involved with the participant.

1. For collaborative participant service, SMH will sign a Release of Information Form as part of any project or program collaboration, ensuring that it is consistent with agency policy; and
2. Participant files remain at the program site in the appropriate location in a locked and fire-proof cabinet; and/or are being stored on the cloud-based online database. New participant files are opened on the online database.
3. Employees working directly with participants will not divulge information on participants without a signed Release of Information Form signed by the participant, except in the following instances:
   - Where required under law or contract, information may be released without a signed release;
   - Where an individual has reason to believe that a child is (or might be) in need of protection, they are
   - obligated to report these concerns to child protection authorities;
   - Where there is a medical emergency or a question of personal harm to the participant, information may be released with discretion; and
   - Where there is reason to believe that a participant intends to harm another person.

Where disclosure must be made, SMH employees and volunteers will inform participants, to the extent possible, about the disclosure of confidential information and its potential consequences before the disclosure is made

Once a participant is no longer using SMH services (e.g. moves out of town, ages out of our services, is no longer pregnant and/or parenting), their file is closed. Once closed:

1. No unnecessary documentation should be kept in a participant's file; and after one year, a closed participant file is moved to the archives;
2. Electronic records that are no longer active are moved to alumni status;
3. Once a year, all participant files at the Young Parent Outreach Centre that have seen no participant activity for the past year are closed. Closed files are re-opened when the participant re-engages with our services and updates their file;
4. When a participant turns 30 and is no longer eligible to access services at SMH, the file is closed and placed in archives;
5. Files for former participants are stored in the archives which are kept locked and are accessible by request to the Executive Director. Participant files must be stored for twenty years.

Disclosure of Participant Information Without Consent

Personal information may be collected, used or released without participant consent in limited instances that are required or permitted by law. For example, some laws require disclosure of participant information, such as the Coroners Act 1990 and the Vital Statistics Act 1990. Participants will be given notice of disclosure of information prior to the disclosure being made if possible. This must be recorded in the file/record. The following people may have access to a participant's file without consent by the participant or legal guardian:

1. Any specific party in which a court orders disclosure;
2. The MCCSS, the City of Ottawa and The Canadian Centre of Accreditation may inspect our records and interview our staff as part of their regulatory activities; they are required to sign Confidentiality Agreements beforehand;
3. Staff personnel if disclosure is necessary to prevent serious bodily harm to the person or another person until the disclosure is made;
4. We have a duty to report to the Children's Aid Society, any unexplained injuries to a participant or a child of a participant;

5. Cases of reportable communicable diseases must be reported to a public health agency; and
6. If a participant is unable to make informed decisions, a parent, guardian or appointed public trustee may have access to the participant's information.

Disclosure of Information about a Participant Involved in Illegal Activities

Staff members, having knowledge of an illegal act being done by or to a participant where there is a plan to harm self or others, are obligated to report this information to the police and notify their supervisor. In any situation regarding abuse, staff is to follow the procedures in the SMH Policy: Risk and Safety - Duty to Report Child Abuse.

Transmission of Confidential Information

Personal information that might identify a participant will not be sent via email without prior consent of the participant unless the email is password protected and encrypted.

1. All outgoing confidential information must be stamped CONFIDENTIAL;
2. Outgoing confidential information should be mailed, if at all possible;
3. When necessary, confidential information may be sent and received by FAX. A FAX containing a participant`s name will be sent with consent of participant; and incoming confidential faxes will be picked up immediately from the FAX machine, put into a closed envelope labeled confidential and addressed to the appropriate staff.

Breach of Privacy

Responding to Privacy Breaches

The leadership team investigates the breach and develops and implements an action plan (including an internal communications plan to communicate to employees). The team will:

1. Investigate the facts surrounding the breach, including:
   - The chain of custody for the information;
   - The date the breach occurred;
   - How the breach occurred;
   - The extent of the breach;
   - When the breach was discovered;
   - The number of individuals affected by the breach;
   - The nature of the information that is the subject of the breach (e.g. personal health information, financial information, contact information, etc.);
   - The risk of harm if the information is, in fact, inappropriately used or disclosed (e.g. physical harm, fraud, identity theft, embarrassment, etc.);
   - Whether there are any physical or technological impediments to unauthorized access to the information (e.g. password protection, encryption, etc.);
   - Whether the information has already been inappropriately used or disclosed, and the likelihood that it will be in the future;
   - Whether other information is at risk; and
   - The steps that St Mary's Home can take to mitigate the effect of the breach, both internal (e.g. retrieve copies, change passwords or access rights, backup databases) and external (e.g. notify affected individuals, law enforcement, privacy commissioners or regulatory authorities, etc.); and
   - To take all reasonable efforts to locate and retrieve data.

Communicating Breach of Privacy

The participant will be notified at the first reasonable opportunity if information is lost, stolen, or subject to unauthorized access, disclosure, copying, use or modification. A notification plan will be developed to advise participants of the breach and determine what information to provide, including the following:

Created: August 28, 2017
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Approved by BOD: July, 2024

1. The fact that a privacy breach occurred and a description of it;
2. The sort of personal information that is involved;
3. The steps the organization has taken to mitigate the harm, and any likely further steps;
4. The steps affected individuals can take to further mitigate the risk of harm;
5. A statement that affected individuals may have a right to complain to a privacy commissioner; and
6. Contact information of the organization where individuals can obtain additional information or assistance.

The action plan developed by the leadership team with include a communication plan to manage follow-up questions and requests from affected individuals, employees, regulators, law enforcement and the media after a breach, particularly identify and implement steps to be taken to prevent a reoccurrence (e.g. changes to procedures, policies and contractual templates, changes to physical or technological safeguards and employee training)

Proactive Preventative Measures

1. Set up flexible team structures that will respond to a breach (depending on unit affected);
2. Regular team meetings will be scheduled to ensure policy remains current and any relevant technologies are still secure;
3. When reviewing policy, the team consults with similar agencies to share processes; and
4. Ensuring that front-line staff is adequately trained in privacy policies and procedures and that they are aware of how to report a breach in privacy.

How to contact us

Please direct to our Privacy Officer (Executive Director) any question or concerns regarding our information and practices or this Policy. We will answer all questions and will promptly investigate any concerns raised regarding this Policy or any potential privacy breach. If an issue raised is found to have merit, we will take all appropriate measures, including taking disciplinary action or amendment of our information practices.

1. Our Privacy Officer
   The Executive Director SMH
   780 rue de l'Église, Ottawa, ON K1K 3K7
   Phone: (613) 749-2491 ext 732

Ontario's Information & Privacy Commissioner

Although we will make every effort to provide an amicable resolution to all privacy concerns, if we are unable to do so, complaints to the Information & Privacy Commissioner of Ontario can be made at:

2. The Information & Privacy Commissioner of Ontario
   Suite 1400, 2 Bloor Street East, Toronto, ON M4W 1A8
   Phone: 1-800-387-0073 TTY 416-325-7539

RELEVANT LEGISLATION AND STANDARDS:

N/A

SMH FORMS:

Acknowledgement and Agreement Form

RELATED POLICIES:

CCA: ORG-SS-2.1, 3.2 PSS REC 1.1,1.2,1.3
SMH Policy: Systems and Structures – Collection, Use and Release of Personal Information
SMH Policy: Systems and Structures – Records Management

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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SS A.4: QUALITY ASSURANCE – STRATEGIC PLANNING AND QUALITY IMPROVEMENT PLANNING

SCOPE:

This policy applies to all staff and volunteers of SMH.

PURPOSE:

To establish goals, processes and responsibilities required to implement quality assurance functions for St. Mary's Home and all its operations.

DEFINITIONS AND ACRONYMS:

St. Mary's Home: SMH
Quality Assurance: refers specifically to administrative and procedural activities across the organization to ensure that high standards for a program and/or service are being fulfilled.
Quality Oversight: refers to the role that the governing body of the organization plays in providing leadership and expecting accountability from staff concerning the quality of programs and services offered.
Quality Improvement: set of structured activities in an organization focused on enhancing the quality of programs, services, and operations. Quality has many dimensions but with respect to programs and services, the needs of persons served should be met effectively and efficiently, thus maximizing outcomes. The process involves identifying areas where improvement is needed, setting goals/targets for improvement, planning activities that are anticipated to result in the improvements, carrying them out, collecting data, monitoring, and reviewing, and using the results to adjust the activities undertaken.
Leadership Team: Executive Director and Director

POLICY:

SMH recognizes the importance in accountability attached to the acquisition and use of funding and to participant outcomes. Increasingly, organizations are asked to report on indicators related to the quality and outcomes of programs and services being provided. SMH has integrated quality improvement planning into the strategic and operational planning cycle and sees it as an opportunity to regularly review, monitor and evaluate the effectiveness of its programs and services. The Agency has a systematic approach to identifying and responding to the needs of participants through the improvement planning and programs and services evaluation processes. SMH uses the Deming Cycle called the "PDSA Cycle" (Plan, Do, Study, Act) which is a series of steps for gaining valuable learning and knowledge for continual improvement.

IMPLEMENTATION:

Quality Assurance Strategic Planning
The Board of Directors is responsible for ensuring that the organization's vision, mission and guiding principles are at the heart of organizational planning, decision-making, resource allocation and operations. The strategic planning process is an important part of building a strong relationship with internal and external stakeholders. The Board of Directors will:

1. Review the organization's mission, vision and guiding principles and strategic directions every four-to-five years;
2. Include in its review data from stakeholders that includes, but is not limited to an environmental scan using surveys, focus groups, SWOT analysis, etc.;
3. Analyze data and use it to inform the strategic planning process and establish strategic directions;
4. Support the Executive Director in the operationalization of the strategic statements; and
5. Review, annually, the progress in achieving the strategic statements.

Created: August 28, 2017
Review Date: July 2024
Approved by BOD: July, 2024

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Quality Improvement Planning:
This is linked to the strategic planning process as it is an integral part of operationalizing the strategic statements. At SMH, the Strategic Plan includes the Multi-Year Operational Plan which is a set of goals established to help achieve the strategic directions. The approach to quality improvement is designed to:

1. Provoke inquiry, reflection, and healthy criticism;
2. Encourage collaboration, consultation, and engagement;
3. Establish informed decision-making through the use of data and research;
4. Provide an opportunity for the organization to assess itself against national leading practices;
5. Ensure that programs and services are reviewed on a continuous basis;
6. Streamline efforts of staff to avoid initiative overload; and
7. Focus funding efforts to ensure the greatest positive impact on participants.

Roles and Responsibilities:
The Board of Directors will:

1. Appoint Directors to act as a resource and a support to the various quality improvement teams;
2. Oversee/monitor the quality improvement work plans (operational plans) twice a year;
3. Communicate achievements to stakeholders once a year at the Annual General Meeting; and
4. Use the results of the quality improvement planning process to respond to and inform the strategic planning process and to establish strategic directions for the organization.

The Executive Director will:

1. In collaboration with the Leadership Team, translate the strategic directions for the organization into an operational/improvement plan including setting up quality improvement teams;
2. Oversee the implementation of quality improvement planning including the schedule for the review and evaluation of programs and services;
3. Engage appropriate stakeholders in the quality improvement planning process;
4. Review data to inform, plan and collaborate with staff to define "quality" standards;
5. Communicate information about quality improvement plans to the Board of Directors two times a year; and
6. Make recommendations to the Board of Directors at the end of every improvement planning cycle.

The SMH Leadership Team will:

1. Assist the Executive Director in the design, implementation, monitoring, and communication of quality improvement plans;
2. Assist the Executive Director in designing a schedule for the review of programs and services;
3. Review data to inform quality improvement plans and collaborate with staff to define "quality" standards;
4. Lead and/or be members of quality improvement teams specific to their area of expertise; and
5. Engage staff in the quality improvement planning process.

Employees will:

1. Engage in the development and implementation of quality improvement plans specific to the service and/or program they provide to participants; and
2. Provide feedback to their supervisors on the improvement planning cycle.

Quality Assurance Committee will:

1. Be made up of the multi-disciplinary team at SMH: Executive Director, Director of Operations and Support Services, Program Manager, Program Support Staff;
2. Collect both quantitative and qualitative data from various sources to determine strengths and areas of needed improvement in programs and services;
3. Collect feedback and recommendations from improvement planning teams;

Created: August 28, 2017
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Approved by BOD: July, 2024

4. Make decisions as to whether a program and/or service needs to be studied in a comprehensive way using an Improvement Planning process and Work Plan (a "deeper dive") or if a more streamlined / short term review by a department is warranted;
5. Monitor the improvement planning process and provide the accountability and support needed to ensure that the process has momentum;
6. Document the progress of the quality improvement teams and department review teams by maintaining a Quality Assurance Committee Action Plan; and
7. Report progress and achievements to the Board of Directors through the Executive Director.

Data to Inform Practice

The following is an example of sources of data (qualitative/quantitative) to inform planning:

1. Participant Database;
2. Participant Program Effectiveness Surveys and Focus Groups;
3. Participant Satisfaction Surveys;
4. Community/Partner Surveys;
5. End of Year Review to obtain Staff Feedback; and
6. External Agency Research.

External Agencies

The following agencies provide the organization with an opportunity to self-assess and set goals for improvement:

1. Canadian Centre for Accreditation – Four Year Accreditation Process;
2. Ministry of Children and Community Social Services – Two Year – Risk Assessment Transfer Payment;
3. External Financial Audit; and
4. City of Ottawa Licensing Requirements.

RELEVANT LEGISLATION AND STANDARDS:

Canadian Centre for Accreditation: Quality Improvement Resources

RELATED POLICIES:

SMH Policy: Planning and Performance – Programs and Services Review and Evaluation
SMH Program Review and Evaluation Schedule
SMH Quality Assurance Action Plan

Created: August 28, 2017
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Approved by BOD: July, 2024

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SS A.5: QUALITY ASSURANCE – PROGRAMS AND SERVICES REVIEW AND EVALUATION

SCOPE:

This policy applies to SMH Board of Directors, Leadership Team, and all staff.

PURPOSE:

To establish a process for the evaluation of programs and services at SMH.

DEFINITIONS AND ACRONYMS:

St. Mary's Home: SMH
CCA: Canadian Centre for Accreditation
Leadership Team: Executive Director and Director of Operations and Support Services (DOPS)

POLICY:

Reviews and evaluations measure programs and/or services outcomes such as: changes in awareness, knowledge, skill, behaviour and well-being of participants and operational outcomes such as human resources need and financial performance. The nature of the review and evaluation is twofold:

1. To provide the Leadership Team and program staff with a clear assessment of the program's strengths and areas of needed improvement; and
2. To provide SMH with an opportunity for periodic self-evaluation.

There are two levels of Programs and Services Reviews:

1. Improvement Planning Work Plan – Long Term; and
2. Programs and Services Review and Evaluation – Short Term and on a schedule.

IMPLEMENTATION:

Multi-Year Schedule
A multi-year schedule for programs and/or services review and evaluation is determined by the Executive Director and the Leadership Team and presented to the Board of Directors.

Annual Review (see Quality Improvement Planning Handbook)

The programs and services that are evaluated each year are done so using an evidence-informed approach. Information/data collected by the agency may include but not limited to:

1. Program effectiveness – participant surveys;
2. Focus groups;
3. Community feedback;
4. Staff observation;
5. Results from new research;
6. Changes in funding requirements; and
7. Changes in Government program requirements.

Created: September 2017
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The Executive Director and Leadership Team will:

1. Oversee and monitor the programs and services review and evaluation process; and
2. Communicate the results to the Board of Directors as well as to various stakeholders (staff, participants, partners, community, etc.)

The Program Manager and/or Director of Operations and Support Services and/or the Support Services Manager will:

1. Lead programs and/or services reviews and evaluations;
2. Ensure that participants and staff have an opportunity to provide feedback each year on their programs and/or services;
3. Ensure, when appropriate, various other community members provide feedback, under the direction of the Executive Director;
4. Summarize feedback/data collection and share results with the Leadership Team and Executive Director at staff and/or Leadership Team meetings; and with the Board of Directors
5. Make recommendations for next steps.

Comprehensive Program and/or Services Review and Evaluation

1. SMH will participate in the four-year Canadian Centre for Accreditation (CCA) accreditation process which provides a comprehensive framework for the agency to measure the effectiveness of its programs and services against effective, research-based, leading practice in Canada;
2. CCA usually contacts SMH at least 12 months prior to the due date of the accreditation. At that time, a schedule for the process will be agreed upon by SMH and CCA; and
3. The Executive Director will review the information provided by CCA with the Board of Directors, Leadership Team and Managers and together they will formulate a plan of action for the entire process.

The Executive Director will:
In consultation with the Board of Directors' President, lead the CCA Accreditation Process specific to CYMH Programs and Services Standards by:

1. Designating an internal or external resource to assist
2. Budgeting for the CCA Accreditation process, if necessary;
3. Designating staff to lead various aspects of the self-assessment process (Accreditation Team);
4. Setting up a communication plan for the sharing of information as the CCA Self-Assessment unfolds;
5. Ensuring the participation of staff in the CCA Accreditation process;
6. Ensuring that findings from the CCA Self-Assessment regarding programs and services are implemented appropriately and responsibly using the quality improvement planning process;
7. Preparing a summary report on the program and/or services review and evaluation that will include the following:
   - A summary of the results of the self-assessment;
   - An implementation plan for any required changes in programs and/or services; and
   - Recommendations to continue, revise or eliminate specific programs and/or services.
8. Sharing the results of the program and services review and evaluation with the Board of Directors, Leadership Team, staff and appropriate stakeholders.

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

The Program Manager and/DOPS will:

1. Lead staff in the year-long review and evaluation of SMH programs and/or services using the CCA Accreditation Self-Assessment Tool;
2. Provide the Executive Director with updates on the progress of the review and evaluation during Leadership Team Meetings;
3. Submit documentation to the Executive Director by the agreed-upon due dates;
4. At the end of the review and evaluation, make recommendations to the Executive Director for next steps; and
5. Lead their staff in incorporating the results of the CCA self-assessment into the annual quality improvement planning cycle as a follow-up to the completed accreditation process.

Post CCA Accreditation Process
Continuous Quality Improvement Process:

1. An agreed-upon schedule for implementation and follow-up regarding any appropriate programs and/or services revisions will be created; and
2. Should it be determined, through this process, that a program and/or service for whatever reason, no longer meets the standard and/or needs of the participants, the program will be recommended to the Executive Director for elimination or change.

RELEVANT LEGISLATION AND STANDARDS:

SMH FORMS:

Quality Improvement Planning Handbook

RELATED POLICIES:

CCA: ORG-OPP-5.1; 5.2; 5.3; 5.4; 5.5 CCA: PSS-KL-1.2; 1.3; 2.1
SMH Programs and Services Review and Evaluation Schedule
SMH Programs and Services Work Schedule

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

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SS A.6: DATA SECURITY: STORAGE AND BACKUP

SCOPE:

This policy applies to all staff and volunteers of SMH.

PURPOSE:

Safeguard the information assets of SMH. To prevent the loss of data in case of an accidental deletion or corruption of data, system failure, or disaster, etc.; and to permit timely restoration of information and business processes, should such events occur. Backups are in place to:

1. facilitate system recovery in case of a major disaster or hardware failure;
2. facilitate application recovery and ability to re-generate documents for meeting local statutory and business requirements;
3. recover critical devices when/as needed.

DEFINITIONS AND ACRONYMS:

St. Mary's Home: SMH
Highly Sensitive Data: Includes personal information that can lead to identify theft if exposed; health information that reveals an individual's health condition and/or history of health service use and other types of sensitive data, such as a people's names, personal and assessment information.

POLICY:

This policy covers the following 4 major systems used within SMH:

1. Microsoft 365 – emails, files and collaboration platform
2. DONATION by Software 4 Nonprofits – donation management platform
3. EMHware – client management platform
4. Mighty Text Pro – communication platform

The Agency is committed to maintaining the privacy and security of confidential personal information and all sensitive data. Data storage, privacy and security are covered under various provincial and federal regulations. The risk of unauthorized disclosure of sensitive data is higher when such data is stored on individual-use electronic devices and mediums, since these devices are easily stolen / lost / misplaced. SMH does not allow the storage of highly-sensitive data on individual devices. The security and storage of data is managed by the IT Support vendor.

IMPLEMENTATION:

Storage of Data:
At St Mary's Home, all Applications and Services are utilizing Software-as-a-Service (SAAS) applications, all data is stored within multiple cloud platforms. There is no local data storage aside from basic laptop and desktop usage. The required retention period defined by the organization is one year.

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

Security – Web, Network, Endpoint:

1. The internal network is protected by a firewall and maintained by the IT vendor;
2. The firewall automatically checks for security updates;
3. When there is a new update, and once the security update for the firewall have been tested, the IT vendor ensures that they are installed;
4. Workstation security updates must be checked for and installed monthly by the IT vendor;
5. All incoming and outgoing email must be virus & malware scanned (Utilizing Office 365 Defender/ATP);
6. Files are stored within Office 365 on SharePoint and OneDrive; and
7. A pristine image of workstations is kept for easy re-imaging of workstations that show any indications of potential infection as this provides a very high assurance that any potential infection has been removed.

Document Sharing:

The only cloud storage in use at SMH is "OneDrive". OneDrive accounts are set up at SMH by the IT vendor upon the request of the Executive Director or their designate. "OneDrive" may be used for projects such as the accreditation self-assessment process. "OneDrive" allows appropriate staff to engage in the editing and revising of a variety of documents.

1. As long as the ownership is internal, SMH can give external access to view and edit documents in "OneDrive";
2. SMH will limit sharing of information to those who need the information in the performance of their duties, or for a legally-authorized purpose;
3. Before sharing files that contain sensitive information, SMH privacy policies and procedures must be adhered to and in the process of sharing such information, the employment roles of the people sharing the file must be identified including, whether they can "read only", "edit" and/ or "comment" on a document.
4. High Risk Data may *not* be placed in "OneDrive". This includes, but is not restricted to:
    - Social Insurance numbers;
    - Financial account numbers;
    - Driver's license numbers;
    - Health insurance policy ID numbers;
    - Credit card numbers; and
    - Patient Health Information.

Systems and Backup Policies:

Microsoft Office 365

Microsoft has its own policy in regard to backups of Office 365 data which falls outside of the scope of SMH. However, in addition, SMH has implemented a 3rd party service to backup Office 365 data, including Email objects, File objects, and Communication threads. Utilizing Datto Cloud to back up our Office 365 provides SMH with best-in-class backup solutions for such Cloud Platforms. The implementation and monitoring is done with our IT vendor with the following configurations. Backup snapshots are retained for up to 1 year in the Datto Cloud, following the schedule denoted below:

1. daily backups are done 3 times a day and are retained for 30 days
2. weekly delta backups once a week
3. rolling weekly backups are retained for 1 year

Data restore is available upon request with IT vendor and typically completed based on urgency, within a 24-hour cycle. The Recovery Time Objective (RTO) for all Office 365 data is 4 hours and Recovery Point Objective (RPO) is less than 2 hours. For a list of compliance and industry-specific regulations, please see Microsoft's official list located here: https://docs.microsoft.com/en-us/compliance/regulatory/offering-home

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024

DONATION Software:
SMH is utilizing DONATION Software's OnDemand tier, which utilizes their Cloud Platform. The application data is saved within a server hosted by Software4Nonprofits where they have ritual backup policies applied to their system. The criteria for their backups are not listed but SMH is able to restore from any point in time as requested. As a cloud service, Software4Nonprofits is responsible for the backups of their own servers and falls outside of the scope of SMH. For data contained within the DONATION Software, we have a RTO of 24 hours and RPO of 24 hours based on our support contract with them.

EMHware:
As a Cloud-based client management software, our data is saved within EMHWare's cloud platform, and the vendor has backups that can be recovered at any time. This falls out of our manageable scope, for data contained within the EMHware, we have a RTO of 24 hours and RPO of 24 hours included in our support contract with them.

Mighty Text Pro:
Mighty Text Pro is an application installed on a SMH dedicated mobile phone and on staff workstations where text messages are being sent to participants through the Mighty Text server.

1. Participants must be advised, during orientation, by the Intake Coordinator and/or Intake Staff, that the text messages they send or receive through this application and server are not confidential as all staff have access to this account;
2. Only SMH staff members that need to communicate directly with participants have access to this application;
3. Partners working with SMH, have access to this application and they are required to first sign a SMH Confidentiality Agreement before proceeding use;
4. If a staff member notices a message that is confidential, they can delete it on their workstation and as a result, the message will be removed from all staff workstations but will remain on the dedicated mobile phone itself. The staff member makes their supervisor aware of such text messages so that the appropriate action can be taken (such as removal of the text from the phone);
5. Messages sent and received from the Mighty Text Pro application remain on the Mighty Text server so that appropriate staff can obtain a copy if need be; and
6. Group messages can be sent through the Might Text Pro application to participants; however, all group messages are sent directly to individuals so that participants see only their own information.
7. As Mighty Text Pro is a Cloud-based service, no data within there is saved locally by SMH as we adhere to the practices of MightyText and our phone providers to safeguard and backup any required data.

Computer Hardware Disposal:

1. Before computers, printers, laptops or similar equipment are disposed of all hard drives must by wiped using a software tool for that purpose, or destroyed; and
2. Equipment should be disposed of in an environmentally safe manner.

RELEVANT LEGISLATION AND STANDARDS:

SMH FORMS:

RELATED POLICIES:

Created: September 2017
Review Date: July 2024
Approved by BOD: July, 2024