HEALTH COMMITTEE

Tuesday, September 13, 2022 – 9:30 a.m.

AGENDA

1. Call to order.
2. Land Acknowledgement.
3. Roll call.
4. Disclosure of pecuniary interest and general nature thereof.
5. Adoption of minutes of previous meeting held on August 10, 2022.
6. Delegations: None at the time of mailing.

10. New Business.
11. Closed Meeting – None at time of mailing.
12. Date of next meeting (Wednesday, October 12, 2022) and adjournment.

NOTE: a) **County Council: Wednesday, September 28, 2022.**
b) Submissions received from the public, either orally or in writing may become part of the public record.

Strategic Plan

Strategic Plan Goal # 1: To inform the Federal and Provincial government on our unique needs so that Renfrew County residents get their "fair share".

Initiatives:

a) Create a strategic communications plan
b) Identify and advocate for issues important to the County of Renfrew.

Strategic Plan Goal # 2: Fiscal sustainability for the Corporation of the County of Renfrew and its ratepayers.

Initiatives:

a) Commitment from Council supporting principles within the Long-Term Financial Plan
b) Establish Contingency Plan to respond to provincial and federal financial pressures and opportunities beyond the Long-Term Financial Plan.

Strategic Plan Goal # 3: Find cost savings that demonstrate our leadership while still meeting community needs.

Initiatives:

a) Complete community needs assessment
b) With identified partners implement plan to optimize service delivery to the benefit of our residents.

Strategic Plan Goal # 4: Position the County of Renfrew so that residents benefit from advances in technology, to ensure that residents and staff have fair, affordable and reasonable access to technology.

Initiatives

a) Ensure that the County of Renfrew is top of the list for Eastern Ontario Regional Network funding for mobile broadband
b) Lobby for secure and consistent radio systems for first responders and government
c) Put a County of Renfrew technology strategy in place.

COUNTY OF RENFREW
LONG-TERM CARE REPORT

TO: Health Committee

FROM: Mike Blackmore, Director of Long-Term Care

DATE: September 13, 2022

SUBJECT: Department Report

INFORMATION

1. **COVID-19 Pandemic Update – Long-Term Care (Strategic Plan Goal #3)**

Homes Outbreak Status:

Bonnechere Manor: On August 22, 2022, the Renfrew County and District Health Unit (RCDHU) declared a facility wide COVID-19 outbreak. Pinnacle Resident Home Areas (RHAs) North and South outbreak status was lifted on September 1, 2022; RHA HM1 South was lifted on September 2, 2022; and RHA HM1 North was lifted on September 3, 2022. Committee will be provided with an update during the meeting.

Miramichi Lodge: We are pleased to advise that Miramichi Lodge is clear of outbreak status since August 31, 2022.

Ontario's Plan to Stay Open:

Effective August 30, 2022, the requirements for homes to set beds aside for pandemic-related isolation has been updated. All new residents and other transfers into the home must be placed in a single room or double room. Where a double room is used, every effort must be made to allow for adequate space (minimum two metres) between beds. Both Homes are compliant.

Licensees are advised that the occupancy funding protection cap will expire as of September 30, 2022.

The Ministry has advised that Long-term care homes are to bring beds set aside for isolation back online as quickly as possible. Beds set aside for isolation purposes will not become subject to occupancy target requirements until January 1, 2023.

By September 30, 2022, Ontario Health will notify homes that currently have short-stay beds deemed converted to long-stay beds of Ontario Health's decision regarding whether or not the short-stay program beds are to be reopened. The reopening date must be between August 26, 2022, and December 31, 2022.

Up to and including December 31, 2022, funding for short-stay beds deemed converted to long-stay beds under the COVID-19 Funding Policy will continue to be provided as per the rate set out for the respective short-stay bed types.

Effective January 1, 2023, only the LTC homes that Ontario Health notified of its decision that a specified number of convalescent care or respite care beds are to reopen will receive funding for the specified number of convalescent care and respite care.

Ministry of Long-Term Care Funding:

The Ministry of Long-Term Care (MLTC) announced that it plans to provide the remaining funding of up to $146,622,200 for the 2022-23 fiscal year allocated for COVID-19 Prevention and Containment and personal protective equipment (PPE). The funding is conditional on the Government receiving the necessary appropriations from the Ontario Legislature. The Government, in May 2022, announced $244M for Prevention and containment and $34M for PPE.

This remaining funding will flow to eligible Long-Term Care homes (LTCHs) based on the methodology outlined below. Every eligible licensee of a LTCH will receive:

- Baseline funding of $30,000, with an additional $1,308 per bed to support necessary incremental expenditures to help stop the spread of COVID-19; and
- An additional amount of $315 per bed to support homes with personal protective equipment (PPE) expenditures.

LTCHs will receive more funding based on this methodology compared to the funding they received from April to June. From April to June, LTCHs were provided $10,000 in base funding and $436 per bed for prevention and containment, and $35 per bed for PPE.

The Ministry indicated in their memo that they expect incremental expenditures related to prevention and containment measures to decline in 2022-23. They will continue to monitor the evolution of the pandemic and will explore adjustments to funding levels should circumstances change.

Below is the 2022-23 funding allocations for each Home:

Funding Model	Bonnechere Manor	Miramichi Lodge
Prevention and Containment (P&C)	$265,400	$247,100
Personal Protective Equipment (PPE)	$56,700	$52,300
Total	$322,100	$299,400

Public Health Guidance:

Public health guidance will apply to all respiratory illnesses and will not be COVID-19 specific due to the complexity of diseases this fall. As a result, the 5-day isolation requirement for COVID-19 will no longer be mandatory, however the 10-day isolation will generally remain for long-term care staff with some differentials as permitted by Public Health. An example would be an employee post day 5 having tested positive for COVID with no current symptoms, could return to work, wearing full Personal Protective Equipment and working only with COVID positive residents.

In addition, the protocols for high risk contact isolation have been revised such that an asymptomatic High Risk contact staff and essential caregivers may attend work/visit. Essential caregivers must wear a well-fitted medical mask, and staff must wear an N95 during the period of high-risk (10 days) when in the building. Screening must include rapid antigen testing for a ten

day period or day one and day five PCR tests. Both Homes are employing the ten day RAT as well as a day 5 PCR test.

Vaccine Preparedness

Health Canada approved the Moderna / Spikevax COVID-19 bivalent vaccine which offers more targeted protection against the Omicron variants. The province is working with public health units and sector partners to make sure doses are ready to be administered once supply is received from the federal government. It is anticipated that long-term care homes will be prioritized for the booster, along with other high-risk settings and populations. Our staff will be ready to administer the vaccine as soon as it arrives.

Amendments to Personal Support Worker Permanent Wage Enhancement Funding Policy:

The Ministry recently reviewed the implementation of the Personal Support Worker (PSW) Permanent Wage Enhancement (PWE) in the long-term care (LTC) sector. As a result of this review, the LTC PWE for PSWs will now be incorporated as part of an employee's base salary. In order to implement these changes, the following amendments have been made:

- The PWE is considered pensionable earnings and may impact benefit plans paid by employers, subject to the terms of the applicable collective agreements and/or pension plans.
- Salary-related benefits such as life insurance coverage and long-term income protection will be impacted by the PWE.
- PWE is part of an eligible employee's base salary and applies to all paid hours including vacation, any authorized paid leave (including sick leave and statutory holidays) and time and benefits awarded under the Workplace Safety and Insurance Act, 1997.

2. **Funding for Behavioural Supports Ontario Program (Strategic Plan Goal #1)**

The Ministry is expanding access to specialized supports and services, such as behavioural supports for individuals with dementia, to support transitions into long-term care through new investments, including in 2022-23:

- An increase of $5M in funding for Behavioural Supports Ontario (BSO) to establish more BSO long-term care (LTC) teams and purchase more therapeutic equipment and supplies.
- A $20M investment to create a new Local Priorities Fund to be administered by Ontario Health. The fund will support a variety of interventions to enable the admission of new residents who have needs that are beyond the existing capabilities of a particular long-term care home.

3. **Co-payment and Preferred Accommodation (Strategic Plan Goal #2)**

Consistent with previous years, the Ministry of Long-Term Care advised of an inflationary increase of 2.5% to co-payment for basic and preferred accommodation rates to take effect on October 1, 2022 as attached as Appendix LTC-I.

4. **Miramichi Lodge Living Classroom**

Miramichi Lodge partnered with Algonquin College, Pembroke Campus to provide educational space on site at the Lodge for a Personal Support Worker program that commenced on September 6, 2022 with nineteen students.

5. **Director of Care – Miramichi Lodge (Strategic Plan Goal #3)**

Mrs. Nancy Lemire has been in the acting Director of Care position at Miramichi Lodge since June 2021. I am pleased to announce that effective Monday, September 5, 2022 Mrs. Lemire assumed the role on a permanent basis.

6. **Capital Budget 2022 – Miramichi Lodge - $585,760 (Strategic Plan Goal #2)**

We wish to provide Committee with an update on Miramichi Lodge Capital Budget projects as follows:

- Humidifier for Air handler #1 - $103,000:
  Project – Engineer Bob Howard, awarded contractor Saffco. Humidifier ordered by contractor to specifications, installation of venting, gas pipe and water softener to be installed this fall.

- Butterfly Dementia Care - $161,600 – where and when possible to continue with environmental improvements to the Resident Home Area (RHA).
- Solid Waste Handling Equipment – $67,760 - will be utilized to improve handling process for eight (8) yard containers inside the building and pickup point outside.
- LED Lighting - $30,000 - replacing existing fluorescent tube lights to reduce energy costs.
- Server upgrade installed (not budgeted) – $23,400 reallocated funds for flooring that were replaced using COVID Infection Prevention and Control (IPAC) funding.
- $200,000 - reallocated to 2026. Operational maintenance has extended the life cycle.
    - $71,500 - variable air vent actuators replaced to meet our continued goal of controlling air quality on all RHA common areas per Ministry Standards. These units are nearing end of life. The existing units will be kept to support the C-Block until budgeted for replacement in 2023.
    - $35,000 – Four (4) Engineered air energy recovery ventilators require DC to AC conversion motor kits to maintain tempered air energy savings and to extend life cycle of units.
    - $17,500 - Auto Scrubber –Since using IPAC funding to remove carpet and replace with vinyl flooring on all six (6) RHA hallways, we require an auto scrubber to assist with maintaining standards for infection control on the units.
    - $40,000 – Phase One - Upgrade the Nurse Call front end Software – Existing Connexall server maintenance agreement (SMA) has become cost prohibitive ($36,000 over five (5) years). Will be replaced with Advanced Care system with no ongoing SMA required.
    - $36,000 – Purchase 50 handheld portable phones for nurse call system. The Existing units are no longer manufactured or supported.

BY-LAWS

7. **Fixing Long-Term Care Act (Strategic Plan Goal #1)**

Recommendation: THAT the Health Committee recommend to County Council that Policy **G-011 Declarations and Police Record Checks under the Fixing Long-Term Care Act, 2021** for the Council Members for the Corporation of the County of Renfrew, including the City of Pembroke representatives for the Long-Term Care Homes (Bonnechere Manor and Miramichi Lodge) be approved. AND FURTHER THAT a By-law be passed at the next session of County Council.

Background

Committee will recall that the Fixing Long-Term Care Act, 2021 (FLTCA) came into force on April 11, 2022, which repeals and replaces the existing Long-Term Care Homes Act, 2007 and revokes Ontario Regulation 79/10. Further to the overview given in the April report, the May report provided an overview on the new regulation that is significant to the elected within article 256 pertaining to screening measure requirements:

256 (1) Every licensee of a long-term care home shall ensure that screening measures are conducted before permitting any person to be a member of the licensee's board of directors, its board of management or committee of management or other governing structure.

(2) The screening measures shall include police record checks.

(3) The police record check must be,

(a) conducted by a police record check provider within the meaning of the Police Record Checks Reform Act, 2015; and

(b) subject to subsection (4), conducted within six months before the person becomes a member of the licensee's board of directors, its board of management or committee of management or other governing structure.

(4) Where a person will become a member of the licensee's board of directors, its board of management or committee of management or other governing structure as a result of their election under the Municipal Elections Act, 1996, the person must provide a police record check in accordance with this section that was conducted no earlier than six months prior to the date their term of office begins and no later than one month after their term of office begins. This section of the Act comes into force for councillors elected / re-elected November 2022.

The FLTCA prohibits any members that have been found guilty of prescribed offences or prescribed acts of professional misconduct to sit on the Board. In the County of Renfrew, all of County Council manages the County of Renfrew Long-Term Care Homes, Bonnechere Manor and Miramichi Lodge through the Health Committee.

There are no restrictions under the Municipal Elections Act that prevent a member of Council from running or being elected with a criminal record or professional misconduct findings.

It would be beneficial to Council, staff and members of the public to understand the application of the FLTCA to Council management of the County of Renfrew Long-Term Care Homes for both this and future Council terms. The policy was developed to provide clarity for Council, staff and members of the public.

The attached policy as adapted from Lanark County, is for Committee's review. Staff obtained legal advice related to the application of the declaration requirements to Council meetings. The policy does not establish any new requirements or regulations other than what is already required in the FLTCA. The policy was developed only to provide clarity to staff, Committee and Council on the application of the FLTCA declarations.

The policy includes:

- Date of effect of policy: November 1, 2022;
- Scope of policy: it will apply to all elected members (re-elected and newly elected members);
- Requirements for the Chief Administrative Officer/Clerk to maintain records in a confidential manner, subject to any disclosure obligations required by law;
- Requirements for Council members to recuse themselves from meetings if they have provided a declaration under the FLTCA in which they disclosed a finding of guilt of a prescribed act or offence;
- Information related to the application of the declarations.

Staff are recommending that Committee adopt **G-011 Declarations and Police Record Checks under the Fixing Long-Term Care Act, 2021** policy attached as Appendix LTC-II and please note that if Committee/Council decides to not adopt the policy, the FLTCA would still apply to Council

proceedings that are related to the management of the County of Renfrew Long-Term Care Homes, Bonnechere Manor and Miramichi Lodge.

Bulletin to Residents of Long-Term Care Homes: Important News Regarding Long-Term Care Home Accommodations Charges

Ministry of Long-Term Care

FALL 2022

Renseignements aussi disponibles en français

Due to the COVID-19 outbreak, the annual long-term care home resident co-payment rate increase was deferred to October 1, 2022. Consistent with prior years, an inflationary increase of 2.5% will be applied to the co-payment for basic and preferred accommodation in Long-Term Care (LTC) Homes.

Basic Accommodation Rates

On October 1, 2022, the co-payment that residents pay for basic accommodation in Long-Term Care (LTC) homes **will increase by $1.55 per day from $62.18 per day to $63.73 per day**, consistent with recent inflationary increases. This will help cover the rising costs of meals and accommodation.

Preferred Accommodation Rates

The maximum charges will also be increasing for residents admitted to newer preferred accommodation beds **on or after October 1, 2022**. The premium charged for semi-private accommodation will increase by $0.32 from $12.78 to $13.10 per day, and the premium for private accommodation will increase by $0.67 from $26.64 to $27.31 per day.

The table below provides the new rates that will apply as of October 1, 2022 to all types of accommodation based on a resident's date of admission to the bed.

Type of Accommodation	Daily Rate	Monthly
Long-Stay Resident:		
Basic	$63.73	$1,938.46
Semi-Private		
Residents admitted to newer beds on or after July 1, 2015.	$76.83	$2,336.92
Residents admitted to newer beds on or after September 1, 2014, but prior to July 1, 2015.	$75.74	$2,303.76

Continued…

Ontario

Residents admitted to newer beds on or after July 1, 2013, but prior to September 1, 2014.	$74.65	$2,270.61
Residents admitted to newer beds on or after July 1, 2012, but prior to July 1, 2013.	$73.54	$2,236.84
Residents occupying older beds, or residents admitted to newer beds prior to July 1, 2012.	$72.47	$2,204.30

Private		
Residents admitted to newer beds on or after July 1, 2015.	$91.04	$2,769.14
Residents admitted to newer beds on or after September 1, 2014, but prior to July 1, 2015.	$89.13	$2,711.04
Residents admitted to newer beds on or after July 1, 2013, but prior to September 1, 2014.	$87.21	$2,652.64
Residents admitted to newer beds on or after July 1, 2012, but prior to July 1, 2013.	$85.30	$2,594.54
Residents occupying older beds, or residents admitted to newer beds prior to July 1, 2012.	$83.38	$2,536.14
Short-Stay Resident (Respite Bed)	$41.25	N/A

NOTE: "Newer beds" – beds classified as "NEW" or "A" according to ministry design standards

"Older beds" – beds classified as "B", "C", "Upgraded D" or "D" according to ministry design standards

Effective from October 1, 2022, the basic accommodation rate is determined using the following formula:

- 2019 / 2020 / 2021 rate x (1 + CPI Rate up to a maximum of 2.5%) = 2022 co-payment rate. [i.e., $62.18 x (1+2.5%) = $63.73]
- The monthly rate is determined by multiplying the daily rate by 30.4167. [i.e., $63.73 x 30.4167 = $1,938.46]

If you have requested a transfer from your current accommodation into a preferred accommodation bed, please call the LTC home administrator to confirm the rate that you will be required to pay. Preferred rates for semi-private and private accommodation in your current LTC home or in another LTC home may be different if you are offered a bed on or after October 1, 2022.

If you are currently paying less than $63.73 per day because you are receiving a reduction in the basic co-payment, known as a "Rate Reduction," you should not be affected because your co-payment amount is determined based on what you can afford. However, if you did not qualify for a rate reduction during the 2022-23 Rate Reduction cycle (which began on July 1,

2022, and ends on June 30, 2023) due to your income being slightly too high, you may reapply as of October 1, 2022 to see if you now qualify. All residents receiving a rate reduction should re-apply for a reduction in the basic co-payment rate for the 2023-24 cycle, beginning on July 1, 2023. Staff at your LTC home will provide you with the application form and will help you to submit your application to the Ministry of Long-Term Care.

For more information on co-payment rates or the changes to the rate reduction application process, please speak with your home's Administrator. Should you have any additional questions, please contact: LTC.RateReduction@ontario.ca.

Ontario

COUNTY OF RENFREW

BY-LAW NUMBER -22

A BY-LAW TO APPROVE A DECLARATION AND DISCLOSURE POLICY FOR LONG-TERM CARE HOMES

WHEREAS the Fixing Long-Term Care Act, 2021 came into force on April 11, 2022, which repeals and replaces the existing Long-Term Care Homes Act, 2007 and revokes Ontario Regulation 79/10.

AND WHEREAS regulation states Article **256 (1) Every licensee of a long-term care home shall ensure that screening measures are conducted before permitting any person to be a member of the licensee's board of directors, its board of management or committee of management or other governing structure.**

(2) The screening measures shall include police record checks.

(3) The police record check must be,

(a) conducted by a police record check provider within the meaning of the Police Record Checks Reform Act, 2015; and

(b) subject to subsection (4), conducted within six months before the person becomes a member of the licensee's board of directors, its board of management or committee of management or other governing structure.

(4) Where a person will become a member of the licensee's board of directors, its board of management or committee of management or other governing structure as a result of their election under the Municipal Elections Act, 1996, the person must provide a police record check in accordance with this section that was conducted no earlier than six months prior to the date their term of office begins and no later than one month after their term of office begins. This section of the Act comes into force for councillors elected / re-elected November 2022.

NOW THEREFORE the Council of the Corporation of the County of Renfrew hereby enacts as follows:

1. That Policy G-011 Declarations and Police Record Checks under the Fixing Long-Term Care Act, 2021 for Long-Term Care Homes be hereby enacted.
2. That this By-law shall come into force and take effect upon the passing

thereof.

READ a first time this 28th day of September, 2022.

READ a second time this 28th day of September, 2022.

READ a third time and finally passed this 28th day of September, 2022.

_____	_____
DEBBIE ROBINSON, WARDEN	CRAIG KELLEY, CLERK

County of Renfrew Long-Term Care Homes Policy			
DEPARTMENT: General			**POLICY #:** G-011
POLICY: Declarations and Police Record Checks under the Fixing Long-Term Care Act, 2021			
DATE: Sept 2022	**REV. DATE:** New	**COVERAGE:** Members of Council	**PAGE #:** 1 of 3

1.0 Purpose

This policy outlines the responsibilities of members of Council related to the requirement for disclosure of certain charges, convictions, findings, orders and commencement of proceedings as detailed below, in order to manage the operations of the County of Renfrew Long Term Care Homes, Bonnechere Manor at 470 Albert Street, Renfrew, ON and Miramichi Lodge, 725 Pembroke Street West, Pembroke, ON regulated under the Fixing Long Term Care Act, 2021 (FLTCA) and provides clarity around the procedure when a member discloses such information in their declaration.

This policy is intended to provide an outline of procedures for Council and staff to follow to meet the requirements of the legislation.

2.0 Legislative Authority

Section 81(5) of the FLTCA, in conjunction with Regulation 246/22 under the FLTCA, requires that no person who has been found guilty of an offence or act prescribed in the Regulations shall be permitted to serve as a member of the board of management. To this end, members of the board of management must disclose certain charges, convictions, findings, orders, and proceedings. In the case of the County of Renfrew, the Board of Management is the Council of the Corporation of the County of Renfrew.

3.0 Application

This policy applies to all members of County Council, including the Head of Council. Chief Administrative Officer/Clerk's office staff will be responsible for the administration of this policy. Health Committee representatives from the City of Pembroke are subject to this policy.

4.0 Date of Effect

This policy will come into effect on November 1, 2022.

5.0 General Provisions

Declarations

Upon swearing into office of any new term of Council, Council members shall provide a completed and signed copy of Form A, **Initial Declaration of Councillors.**

Subsequently, if a member becomes aware of a charge or finding of guilt or other disclosable event related to offenses and misconduct, as set out in Regulation 246/22 of the FLTCA, they must provide a completed and signed copy of Form B **Ongoing Declaration for Councillors** no later than 30 days from the date the member became aware of the disclosable event.

Council members should consult with the Chief Administrative Officer/Clerk of the County if additional clarification is needed in specific circumstances related to disclosable events and declarations.

Police Record Check

Upon swearing into office, Council members are required to provide a Police Record Check as soon as possible, but no later than 30 days after the swearing in. The police record check shall be dated no earlier than six (6) months prior to their swearing in date.

Information Management

The Clerk shall be responsible for maintaining the records of the declarations and police record checks of Council in a confidential manner and in accordance with Regulation 246/22. The records will not be made available to the public in any way, subject to any disclosure obligations required by law.

Procedures at Meetings

If a member has provided a declaration which indicates an offence or a finding of professional misconduct as provided by the regulations, that member cannot participate in the management

of the Long-Term Care Homes, Bonnechere Manor and Miramichi Lodge during Health Committee and Council, Committee of the Whole meetings or otherwise.

During the discussion of any item pertaining to the management of the Long-Term Care Homes, Bonnechere Manor and Miramichi Lodge, the member shall recuse themselves for the item and shall not participate in the debate or vote.

a) If the meeting is in open session, the member can remain in the room but not be seated at the Council table
b) If the meeting is in closed session the member shall leave the room.

The member is not obligated to publicly declare the nature of the conflict when they recuse themselves for the item.

During the approval of the budget, the Long-Term Care budget will be approved in a separate vote than the overall corporate budget.

6.0 Enforcement

Fixing Long Term Care Act

Under the FLTCA all members of the Board of Management have an obligation to ensure compliance with the legislation.

The FLTCA outlines that those members responsible for non- compliance can be subject to prosecution. Additionally, the corporation may be subject to fines and prosecution.

Appendices:

Form A – Initial Declaration of Councillors
Form B – Ongoing Disclosure for Councillors

Form A

Initial Declaration of Councillor

Under Subsections 252 (4) and 256(6) of O.Reg 246/22

This declaration form is for use by County of Renfrew (the "Licensee").

Disclosure Required by Law

Section 81(5) of the *Fixing Long-Term Care Act, 2021* (the 'Act'), in conjunction with Regulation 246/22 under the Act, require that no person who has been found guilty of an offence or act prescribed in the Regulations be permitted to serve as a member of the board of management. To this end, members of the board of management must disclose certain charges, convictions, findings, orders and proceedings.

Instructions

1. Identify the date that the vulnerable sector check you submitted to the Home was conducted.
2. Carefully review the list of offences in Section A1 and the list of misconduct in Section B1.
3. Answer all the questions under the Offences section and Misconduct section below.
4. If you answer "yes" to any of the questions, provide details in the Appendix to Form A.
5. Sign the declaration at the end of the form and return it to the Chief Administrative Officer/Clerk.

Section A - Offences – Charges, Orders and Convictions

Since the date the vulnerable sector check that I provided to the home was conducted:

I have been charged with one or more of the offences listed in section A1 below.

□ No

□ Yes and every charge (with details and outcomes) is disclosed in the Appendix.

I have been the subject of an order by a judge or justice of the peace (includes a peace bond, probation order, prohibition order or warrant to arrest) in respect of an offence listed in Section A1 below.

□ No

□ Yes and every order is disclosed in the Appendix.

I have been convicted of one or more of the offences listed in Section A1 below.

□ No

□ Yes and every conviction is disclosed in the Appendix.

Section A1 - List of Offences

1. Any offence under the *Fixing Long-Term Care Act, 2021*, the *Long-Term Care Homes Act, 2007*, the *Nursing Homes Act*, the *Charitable Institutions Act* or the *Homes for the Aged and Rest Homes Act*.
2. Any offence referenced at section 742.1 of the *Criminal Code* (Canada).
3. Any offence under the *Cannabis Act* (Canada), the *Controlled Drugs and Substances Act* (Canada) or the *Food and Drugs Act* (Canada).
4. Any other provincial or federal offence if the offence involved,

    (a) improper or incompetent treatment or care of a vulnerable person* that resulted in harm or a risk of harm of any kind to the vulnerable person, including but not limited to physical, emotional, psychological or financial harm,

    (b) abuse or neglect of a vulnerable person* that resulted in harm or risk of harm of any kind to the vulnerable person, including but not limited to physical, emotional, psychological or financial harm,

    (c) unlawful conduct that intentionally resulted in harm or a risk of harm of any kind to a vulnerable person*, including but not limited to physical, emotional, psychological or financial harm, or

    (d) misuse or misappropriation of a vulnerable person's* money.

    * A "vulnerable person" is a person who, because of their age, a disability or other circumstances, whether temporary or permanent,

        (a) is in a position of dependency on others, or

        (b) is otherwise at a greater risk than the general population of being harmed by a person in a position of trust or authority towards them.

Section B - Professional Misconduct – Proceedings and Findings of Guilt

Within the past five years, a proceeding has commenced against me that could lead to a finding of guilt relating to an act of misconduct set out in section B1 below.

□ No

□ Yes and every proceeding is disclosed in Appendix.

There is a finding of guilt against me relating to an act of misconduct listed in Section B1 below. (Answer "No" if the finding of guilt: (a) resulted in a suspension that ended more than five years ago, or (b) if the finding of guilt did not result in a suspension and the finding occurred more than five years ago.)

□ No

□ Yes and every finding of guilt is disclosed in the Appendix.

Section B1 – List of Misconduct (which includes incompetence)

1. An act of misconduct as a member of a health profession as defined in the *Regulated Health Professions Act, 1991*.
2. An act of misconduct as a member of a regulated profession as defined in the *Fair Access to Regulated Professions and Compulsory Trades Act, 2006*.
3. An act of misconduct under any other scheme governing a profession, occupation or commercial activity, including a scheme a person is not required to participate in in order to practice or engage in the profession, occupation or activity.

I declare that the information I have provided in this form (including any information in the Appendix to Form A) is true and complete.

Print first and last name	Signature	Date (day/month/year)

Appendix to Form A

Instructions

1. Use this Appendix to Form A to particularize disclosure if you answered "yes" to any of the questions on the declaration form.

2. In the space below, provide details of every charge, order, conviction, commencement of proceeding, or finding.

3. Details must include the date, name and location of the court or regulatory authority, and the name and brief description of the charge, order, conviction, proceeding, or finding. Attach additional pages as required.

FORM B

Ongoing Disclosure for Councillors
under Subsections 256(7) and 253(1) of O.Reg 246/22

This declaration form is for use by a member of Council of the County of Renfrew (the "Licensee") who becomes aware of a charge or finding of guilt or other disclosable event relating to offences and misconduct set out in the *Fixing Long-Term Care Act, 2021* (the "Act") after their Initial Disclosure.

Disclosure Required by Law

Regulation 246/22 (the "Regulation") under the Act requires the disclosure of certain charges, convictions, findings, orders, and proceedings promptly after a staff member, volunteer, or a member of the board of directors becomes aware of one or more of these events.

Instructions

1. Carefully review the list of offences in Section A1 and the list of misconduct in Section B1 below.
2. If you are subject to anything listed in Section A1 or Section B1, check the box beside the relevant statement and provide particulars regarding outcomes and details in the Appendix to Form B.
3. Sign the declaration at the end of the form and return it to the Licensee.

Section A - Offences – Charges, Orders and Convictions

□ I have been charged with one or more of the offences listed in section A1 below.

□ I have been the subject of an order by a judge or justice of the peace (includes a peace bond, probation order, prohibition order or warrant to arrest) in respect of an offence listed in section A1 below.

□ I have been convicted of one or more of the offences listed in section A1 below.

Section A1 - List of Offences

1. Any offence under the *Fixing Long-Term Care Act, 2021*, the *Long-Term Care Homes Act, 2007*, the *Nursing Homes Act*, the *Charitable Institutions Act* or the *Homes for the Aged and Rest Homes Act*.
2. Any offence referenced at section 742.1 of the *Criminal Code* (Canada).
3. Any offence under the *Cannabis Act* (Canada), the *Controlled Drugs and Substances Act* (Canada) or the *Food and Drugs Act* (Canada).
4. Any other provincial or federal offence if the offence involved,

    (a) improper or incompetent treatment or care of a vulnerable person* that resulted in harm or a risk of harm of any kind to the vulnerable person, including but not limited to physical, emotional, psychological or financial harm,

    (b) abuse or neglect of a vulnerable person* that resulted in harm or risk of harm of any kind to the vulnerable person, including but not limited to physical, emotional, psychological or financial harm,

    (c) unlawful conduct that intentionally resulted in harm or a risk of harm of any kind to a vulnerable person*, including but not limited to physical, emotional, psychological or financial harm, or

    (d) misuse or misappropriation of a vulnerable person's* money.

    * A "vulnerable person" is a person who, because of his or her age, a disability or other circumstances, whether temporary or permanent,

    (a) is in a position of dependency on others, or

    (b) is otherwise at a greater risk than the general population of being harmed by a person in a position of trust or authority towards them.

Section B - Professional Misconduct – Proceedings and Findings of Guilt

□ A proceeding has commenced against me that could lead to a finding of guilt relating to an act of misconduct set out in section B1 below.

□ There is a finding of guilt against me relating to an act of misconduct listed in section B1 below.

Section B1 – List of Professional Misconduct (which includes incompetence)

1. An act of misconduct as a member of a health profession as defined in the *Regulated Health Professions Act, 1991*.
2. An act of misconduct as a member of a regulated profession as defined in the *Fair*

Access to Regulated Professions and Compulsory Trades Act, 2006.

3. An act of misconduct under any other scheme governing a profession, occupation or commercial activity, including a scheme a person is not required to participate in in order to practice or engage in the profession, occupation or activity.

I declare that the information I have provided in this form (including any information in Appendix to Form B) is true and complete.

Print first and last name	Signature	Date (day/month/year)

Appendix to Form B

Instructions

1. Use this Appendix to Form B to particularize disclosure if you answered "yes" to any of the questions on the declaration form.

2. In the space below, provide details of every charge, order, conviction, commencement of proceeding, or finding.

3. Details must include the date, name and location of the court or regulatory authority, and the name and brief description of the charge, order, conviction, proceeding, or finding. Attach additional pages as required.

COUNTY OF RENFREW

EMERGENCY SERVICES REPORT

TO: Health Committee

FROM: Michael Nolan, Director of Emergency Services/Chief, Paramedic Service

DATE: September 13, 2022

SUBJECT: Department Report

INFORMATION

1. **County of Renfrew Palliative Care [Strategic Plan Goal # 1)**

   Commander Amber Hultink co-authored an article entitled, "*Palliative paramedicine: Comparing clinical practice through guideline quality appraisal and qualitative content analysis*, attached as Appendix ES-I, that has been published in the August 8, 2022, issue of Palliative Medicine.

2. **Clinical Assessment Centres [Strategic Plan Goal # 3]**

   Bivalent Vaccine

   The Bivalent vaccine was approved for release by RCDHU on September 12. This vaccine is an adapted version of the Moderna Spikevax COVID-19 vaccine.

   Health Canada has determined that the bivalent Moderna Spikevax booster is safe and effective. Clinical trial results showed that a booster dose of the bivalent Moderna Spikevax vaccine triggers a strong immune response against both Omicron (BA.1) and the original SARS-CoV-2 virus strain. It was also found to generate a good immune response against the Omicron BA.4 and BA.5 subvariants and is expected to extend the durability of protection.

   This adapted vaccine has a similar safety profile to the previously approved Moderna Spikevax booster, with the same mild adverse reactions that

resolved quickly. The vaccine will be available to retirement homes and congregate living (residents, staff, and primary caregivers). On September 19, it will be available at Assessment Centres for those who are 70 plus, immunocompromised, and Indigenous/Metis groups. There is currently no schedule for release to other cohorts.

3. **Provincial Models of Care Strategy [Strategic Plan Goal # 3)**

The following is an excerpt from a Provincial news release "Ontario Introduces a Plan to Stay Open: Health System Stability and Recovery", released August 18, 2022.

Providing the Right Care in the Right Place

- Ontario is expanding the hugely successful 9-1-1 models of care to include additional ailments and is now giving paramedics the flexibility to provide better, more appropriate care. Patients diverted from emergency departments through these models received the care they needed up to 17 times faster with 94 per cent of patients avoiding the emergency department in the days following treatment.
- Ontario is implementing several initiatives to help avoid unnecessary hospitalizations, improve the process for ambulance offloading, and reintroduce respite services in long-term care.
- Ontario is introducing legislation that, if passed, will support patients whose doctors have said they no longer need hospital treatment and should instead be placed in a long-term care home, while they wait for their preferred home.
- Ontario continues to fund community paramedicine to provide additional care for seniors in the comfort of their own homes before their admission to a long-term care home. These initiatives will free up to 400 hospital beds.

4. **Feedback and thanks from Arnprior Health**

The Paramedic Service, in conjunction with Arnprior Regional Health developed an agreement to deliver triage services in the Emergency Department of the Arnprior Hospital. In an email attached as Appendix ES-II, received from Ms. Andrea McClymont, Vice President Human Resources, Arnprior Health, she provides feedback that was relayed to her by an admitting clerk about the assistance Paramedic Andy Fortington provided to a patient.

BY-LAWS

5. **Lease Agreement – County of Renfrew and Arnprior Regional Health**

Recommendation: THAT Health Committee recommend that County Council adopt a By-law authorizing the Warden and CAO/Clerk to sign the Lease Agreement between the County of Renfrew and Arnprior Regional Health for ongoing tenancy of 275 Ida Street, Arnprior, the current location of the Renfrew County Virtual Triage and Assessment Centre (RC VTAC).

Background

Renfrew County Virtual Treatment and Assessment Centre (RCVTAC), located at 275 Ida Street in Arnprior, the previous site of the Grove Long-Term Care facility, a property owned by Arnprior Regional Health, has been the site of RCVTAC since its inception. In August 2021, when operational responsibility for RCVTAC was transferred to the County of Renfrew, a monthly lease rate was agreed upon and managed internally by Arnprior Health as the flow through for funding from the Province. The County of Renfrew has requested that the lease agreement be formalized. This lease, attached as Appendix ES-III, is for a yearly term, commencing April 1, 2022, to March 31, 2023, for monthly rental of $4000 for approximately 1693 square feet of space.

Original Article

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Palliative paramedicine: Comparing clinical practice through guideline quality appraisal and qualitative content analysis

Madeleine L Juhrmann[1,2], Natalie E Anderson[3,4], Mark Boughey[5,6], Duncan S McConnell[7], Paul Bailey[8], Lachlan E Parker[9], Andrew Noble[10], Amber H Hultink[11], Phyllis N Butow[12] and Josephine M Clayton[1,2]

Abstract

Background: Palliative care is an emerging scope of practice for paramedicine. The COVID-19 pandemic has highlighted the opportunity for emergency settings to deliver palliative and end-of-life care to patients wishing to avoid intensive life-sustaining treatment. However, a gap remains in understanding the scope and limitations of current ambulance services' approach to palliative and end-of-life care.

Aim: To examine the quality and content of existing Australian palliative paramedicine guidelines with a sample of guidelines from comparable Anglo-American ambulance services.

Design: We appraised guideline quality using the AGREE II instrument and employed a collaborative qualitative approach to analyse the content of the guidelines.

Data sources: Eight palliative care ambulance service clinical practice guidelines (five Australian; one New Zealand; one Canadian; one United Kingdom).

Results: None of the guidelines were recommended by both appraisers for use based on the outcomes of all AGREE II evaluations. Scaled individual domain percentage scores varied across the guidelines: scope and purpose (8%–92%), stakeholder involvement (14%–53%), rigour of development (0%–20%), clarity of presentation (39%–92%), applicability (2%–38%) and editorial independence (0%–38%). Six themes were developed from the content analysis: (1) audience and approach; (2) communication is key; (3) assessing and managing symptoms; (4) looking beyond pharmaceuticals; (5) seeking support; and (6) care after death.

Conclusions: It is important that ambulance services' palliative and end-of-life care guidelines are evidence-based and fit for purpose. Future research should explore the experiences and perspectives of key palliative paramedicine stakeholders. Future guidelines should consider emerging evidence and be methodologically guided by AGREE II criteria.

Keywords

Palliative care, terminal care, paramedic, emergency medical services, policy, qualitative

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What is already known about the topic?

- Palliative paramedicine is an emerging scope of practice. Community-based ambulance services are a widely unharnessed asset capable of facilitating home-based care to patients with life-limiting illnesses, particularly after-hours.
- Global ambulance services have developed specialist roles capable of delivering palliative care. However, the broader paramedic community requires the skills to take a generalist palliative approach to care where appropriate.
- Palliative care guidelines are a key enabler for standardising paramedic practice, yet a gap remains in understanding their prevailing scope and limitations.

What this paper adds?

- The findings of this study suggest ambulance guidelines are shifting away from protocol driven paramedic practice to broader clinical models, calling on the discretion and decision-making skills of paramedics instead of fixed algorithms.
- The study identified the prevalence of clinical back-up pathways across all the included guidelines, recognising the developing nature of palliative paramedicine and need for multidisciplinary approaches to care.
- The overall lack of content related to communication skills and care after death underscores a significant gap in current clinical practice.

Implications for practice, theory, or policy

- This study highlights the opportunity to employ more robust methodological approaches to developing future best practice palliative paramedicine guidelines and shape future practice on integrated models of care.
- Future research could investigate broader stakeholders' perspectives to better inform paramedicine practice related to care after death and translate the palliative care skills of specialist paramedics across to the generalist paramedic workforce.

Introduction

Palliative care is an emerging scope of practice for paramedicine, a clinical discipline traditionally associated with emergency treatment and transport of patients to tertiary facilities for further care.[1] The World Health Organization (WHO) recognises that high quality and equitable access to palliative care requires an integrated multidisciplinary approach[2] and community-based ambulance services are a widely unharnessed asset capable of facilitating home-based care to patients with life-limiting illnesses,[3] particularly after hours. The COVID-19 pandemic has highlighted the perpetual challenges global health care systems face to sustainably care for ageing populations with end-of-life needs[4–6] and the opportunity for emergency settings to deliver palliative and end-of-life care to patients wishing to avoid intensive life-sustaining treatment and transport to hospital.[7] Furthermore, international community preferences to die at home are increasing,[8,9] resulting in a greater need for paramedics to provide palliative and end-of-life care in community-based settings and deviate away from long-established assumptions of needing to transport all patients to hospital.[10,11]

Within an Australian context, evidence indicates a higher need for ambulance response at the end of a palliative care patient's life.[12] Despite this, all national, state and territory level palliative care strategies fail to address the role paramedics play in delivering palliative and end-of-life care in communities.[12,13] Globally, ambulance services have developed specialised roles capable of delivering palliative and end-of-life care, such as Extended Care Paramedics,[14] to mirror the pioneering success of Canada's community paramedicine model.[15] However, these roles will not suffice the growing demand for palliative paramedicine alone and, instead, the broader paramedic community requires the skills to take a palliative approach to care for patients with end-of-life needs.[16]

A recent systematic review identified end-of-life care Clinical Practice Guidelines (guidelines) as a key enabler to standardising palliative care practice for paramedics.[17] The WHO also recognises that palliative care guidelines vastly improve the effectiveness of palliative care service delivery at the point of care.[2] International literature suggests paramedics have expressed a strong desire to support palliative care patients in the community[18–24]; however, they lack guidelines for managing these types of patients,[20,25] particularly those wishing to remain and die at home.[26] Furthermore, although it is well established internationally that paramedics have been traditionally protocol driven,[3] in many jurisdictions there is little or no option for variation and there remains a gap in understanding the prevailing scope and limitations of ambulance services' approach to palliative care. This study aimed to examine the quality and content of existing Australian palliative paramedicine guidelines with a sample of guidelines from comparable Anglo-American ambulance services.[27]

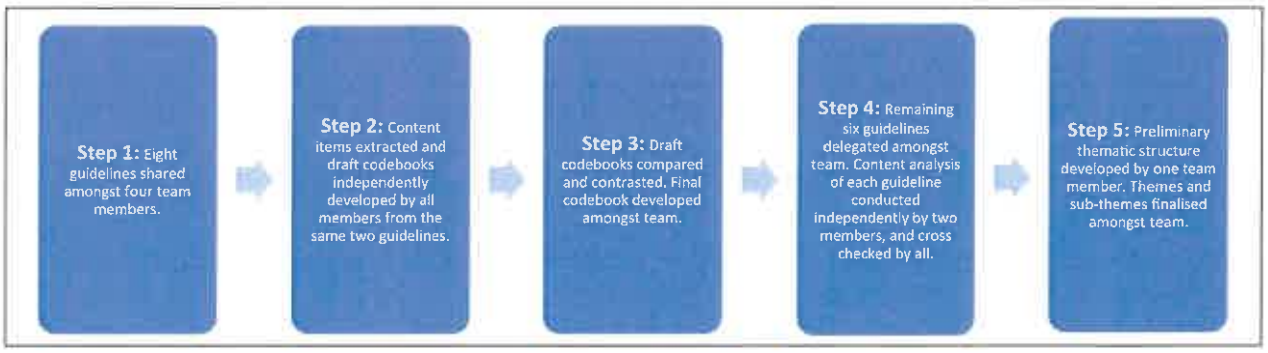

Figure 1. Content analysis process.

Methods

Design and approach

This study consisted of two components: (1) critically analysing the content of the guidelines employing a collaborative qualitative approach,[28,29] and (2) appraising their methodological quality using a validated instrument.[30] The Standards for Reporting Qualitative Research (SRQR) criteria guided the conduct and reporting of the methods and results.[31]

Data collection

Guidelines were collected in March 2021. Representatives from all eight Australian ambulance services were invited to put forward their respective palliative and/or end-of-life guidelines for inclusion in this study. In discussion with the international authorship team, a sample of guidelines were also sourced from countries with Anglo-American ambulance services[27] the team determined comparable to current Australian paramedic practice. This included New Zealand (NZ), the United Kingdom (UK) and Canada.

NZ has a single national ambulance sector collection of guidelines, including one specific to end-of-life. The UK's Joint Royal College Ambulance Liaison Committee developed a national end-of-life care guideline adapted from many locally derived protocols. One Canadian service was selected to reflect contemporary best practice derived from the findings of a recently implemented palliative paramedicine quality improvement programme.[15] However, variation in palliative paramedicine practice is apparent across Canada and it was acknowledged amongst the team this one service may not reflect all.

Data extraction and analysis

The content analysis process is outlined in Figure 1. Authors were not blinded to guideline origin, as they were already familiar with them from clinical practice. A manual collaborative content analysis using Word and Excel was conducted to identify key themes and sub-themes in the data following a four-step process: (1) establishing candidate content items, (2) developing the codebook and pilot testing, (3) undertaking collaborative coding; and (4) reviewing coding and finalising thematic analysis.[29] Four authors (MJ, paramedicine academic; MB, professor and palliative care physician; NA, emergency nurse and academic; and DM, paramedic and ambulance service clinical services manager) independently coded the same two guidelines, each constructing a draft codebook of candidate content items and sub-items and an audit trail. The codebooks were compared, with oversight from JC (professor and palliative care physician) and, upon reaching consensus, a data extraction form was devised and piloted on the same two guidelines. The remaining six guidelines were then delegated amongst MJ, MB, NA and DM and independently conducted by two members of the team, then cross checked by all four members. Each content sub-item was coded as: comprehensively addressed (yes), partially addressed (partial) or missing (no). MJ reviewed the coding for each guideline, made numerical counts for each sub-item (Table 3) and developed a preliminary thematic structure of the results through inductive coding. The team met to review and gain consensus on the thematic structure.

Quality appraisal

The methodological quality of each guideline was assessed using the validated Appraisal of Guidelines for Research and Evaluation (AGREE) II instrument, comprising six domains: scope and purpose, stakeholder involvement, rigour of development, clarity of presentation, applicability and editorial independence.[30] As per the manual, two authors independently conducted the appraisal: PB, an ambulance service medical director and emergency physician and LP, a critical care paramedic and ambulance service director of clinical policy. MJ coordinated the appraisal and resolved discrepancies. Both appraisers had previous experience using the AGREE II instrument for appraisal of ambulance guidelines.[32] The appraisers used the online My AGREE PLUS platform, for 23 items across the six domains employing a seven-point Likert scale to strongly

Table 1. Included guidelines.

Region, country	Ambulance service	Guideline, version, year
Victoria, Australia[34]	Ambulance Victoria	Palliative Care Clinical Practice Guideline A0712, version 1, 2016
New South Wales, Australia[33]	New South Wales Ambulance	Palliative Care Protocol S9, version 1, 2020
Queensland, Australia[35]	Queensland Ambulance Service	Other/Palliative Care Clinical Practice Guideline 0417, version 1, 2017
Northern Territory, Australia[36]	St John Ambulance Northern Territory	Palliative Care Patients Clinical Practice Guideline, version 2.3, 2013
South Australia, Australia[37]	South Australian Ambulance Service	Extended Care Paramedic Clinical Pathway Palliative Care, version 2, 2017
New Zealand[38]	St John New Zealand National Service	End of Life Care Clinical Procedure and Guideline 1.13, version 1, 2019
Ontario, Canada[40]	County of Renfrew Paramedic Service	Community Paramedic Palliative Care Booklet, version 2, 2021
United Kingdom[39]	Joint Royal Colleges Ambulance Liaison Committee	End of Life Care General Guidance, version 1, 2019

YwM: Yes with modifications.

disagree (1) or strongly agree (7) the item was met. Results were then compared and appraisers modified their score based on the discussion, in accordance with AGREE II methodology. An overall average appraisal score, scaled domain percentages and an overall percentage rating of quality were calculated for each guideline (see Table2 for methodology and results). Based on these scores, a recommendation of whether to use, use with modifications or not use each guideline was made. As AGREE II assesses the methodological quality of development processes and not content, coders additionally responded to the following statement for each guideline: 'I would recommend this guideline for use' (based on my knowledge of the clinical validity of the guideline recommendations).

Results

Guideline characteristics

A total of eight guidelines published between 2013 and 2021 were included in the study (Table 1). Five guidelines were Australian,[33–37] one NZ,[38] one from the UK[39] and one Canadian.[40]

Quality assessment

Table 2 summarises the AGREE II appraisal of included guidelines. No guideline was recommended without amendments by both appraisers for use based on AGREE II evaluations; however, Canada's guideline was recommended for use by both based on their knowledge of its clinical validity. This guideline also scored highest (83%) in the overall summary of domains 1–6. Scaled individual domain percentage scores varied significantly across the guidelines: scope and purpose (8%–92%), stakeholder involvement (14%–53%), rigour of development (0%–20%), clarity of presentation (39%–92%), applicability (2%–38%) and editorial independence (0%–38%).

Main findings and key themes

Extracted data are included in Tables 2 and 3. Six themes and sub-themes, as illustrated in Figure 2, emerged from the content analysis data: (1) audience and approach; (2) communication is key; (3) assessing and managing symptoms; (4) looking beyond pharmaceuticals; (5) seeking support; and (6) care after death.

Audience and approach

Each guideline had substantial differences in stylistic approach, which could be categorised into three general types. New South Wales (NSW),[33] South Australia (SA)[37] and Victoria's (VIC)[34] guidelines were structured as protocols, comprising prescriptive direction and often accompanied by a flow-chart.

> *"In cases where there is no person responsible and/or paramedics are unsure about the patient's treatment goals and the patient is unable to communicate, paramedics should commence treatment per specific protocol(s) until additional information becomes available".*[33]

In contrast, Queensland (QLD),[35] the Northern Territory (NT)[36] and NZ[38] guidelines adhered to a broader framework, offering guidance rather than instruction.

> *"Paramedics may administer drugs and may recommend the patient not be transported; providing this is consistent with ongoing symptom control and they make contact with the patient's palliative care team".*[36]

Table 2. Quality appraisal using the AGREE II instrument.

Guideline	Domain score (%)						Overall score, Domains 1–6 (%)	Recommendation for use based on the outcomes of all AGREE II evaluations, Domains 1–6	Recommendation for use based on knowledge of the clinical validity of the guideline recommendations
	Scope and purpose	Stakeholder involvement	Rigour of development	Clarity of presentation	Applicability	Editorial independence			
Canada	69	53	20	92	38	0	83	YwM (Reviewer 1) Yes (Reviewer 2)	Yes (Reviewer 1) Yes (Reviewer 2)
New South Wales, Australia	61	14	0	53	19	0	33	YwM (Reviewer 1) No (Reviewer 2)	Yes (Reviewer 1) YwM (Reviewer 2)
New Zealand	36	17	2	72	15	0	50	YwM (Reviewer 1) No (Reviewer 2)	YwM (Reviewer 1) YwM (Reviewer 2)
Northern Territory,Australia	42	35	3	42	2	0	25	YwM (Reviewer 1) No (Reviewer 2)	YwM (Reviewer 1) YwM (Reviewer 2)
Queensland, Australia	75	36	6	53	13	38	58	YwM (Reviewer 1) No (Reviewer 2)	YwM (Reviewer 1) Yes (Reviewer 2)
South Australia, Australia	8	17	2	39	4	0	42	YwM (Reviewer 1) No (Reviewer 2)	YwM (Reviewer 1) YwM (Reviewer 2)
United Kingdom	92	14	13	89	38	0	50	YwM (Reviewer 1) Yes (Reviewer 2)	Yes (Reviewer 1) No (Reviewer 2)
Victoria, Australia	78	14	0	69	13	0	33	YwM (Reviewer 1) No (Reviewer 2)	Yes (Reviewer 1) No (Reviewer 2)

Individual ratings across all 23 items were averaged to yield an overall average appraisal score for each guideline. To determine scaled domain percentages, both appraisers' ratings of items within each domain were added and the maximum and minimum possible domain scores were scaled before being converted into an overall percentage for the domain.

Table 3. Content analysis summary of content items and sub-items.

Content items and sub-items	Guideline								Total Yes (Y) =1 No (N) =0 Partial (P) =0.5
	Canada	New South Wales (Australia)	Northern Territory (Australia)	New Zealand	Queensland (Australia)	South Australia (Australia)	United Kingdom	Victoria (Australia)	
Content item 1: Who does this guideline apply to?									
a) Palliative care definition	Y	Y	Y	Y	Y	N	P	P	6
b) Indicators for a paramedic to apply a palliative approach	Y	Y	Y	N	N	N	Y	Y	5
c) Circumstances where an ambulance service may be required for a palliative patient	Y	N	Y	P	Y	Y	Y	Y	6.5
Content item 2: Determining the person responsible for making decisions									
a) Establishing the patient's capacity	N	N	N	N	Y	N	P	N	1.5
b) Identifying proxy-decision makers	N	P	N	P	Y	N	P	N	2.5
Content item 3: Determining the patient's wishes with respect to treatment and transport									
a) Documentation describing the patient's wishes for life sustaining treatment and hospital care	N	Y	Y	P	P	P	P	N	3
b) Medical orders to withhold CPR and/or other life sustaining treatment (goals of care)	P	Y	Y	Y	Y	N	P	P	5.5
c) Indications for transfer to hospital	N	Y	Y	P	Y	Y	Y	Y	6.5
Content item 4: Partnering in care with the family									
a) Communication approaches for establishing rapport with families	N	Y	P	P	P	Y	P	N	4
b) Cultural considerations	N	N	N	N	N	N	N	N	0
Content item 5: Recognising and responding to imminent death									
a) Signs and symptoms of approaching death	Y	Y	N	N	N	N	Y	N	3
Content item 6: Managing pain									
a) Identifying the analgesia type and dosage the patient is already receiving	Y	P	P	Y	Y	N	Y	Y	6
b) Specific drug type and dosage recommended to manage this symptom	Y	P	P	Y	N	P	P	Y	5
c) Route and location of drug administration	Y	Y	N	P	Y	P	Y	Y	6
d) Recognising drug contraindications and offering alternatives	P	N	N	N	N	N	P	Y	2
e) Non-pharmaceutical approaches	Y	Y	N	N	N	N	Y	N	3
Content item 7: Managing nausea and vomiting									
a. Identifying the antiemetic type and dosage the patient is already receiving	Y	P	P	P	Y	N	P	Y	5
b. Specific drug type and dosage recommended to manage this symptom	Y	P	N	N	P	N	P	P	3
c. Route and location of drug administration	Y	Y	N	N	N	N	N	Y	3
d. Recognising drug contraindications and offering alternatives	Y	N	N	N	N	N	N	N	1
e. Non-pharmaceutical approaches	Y	Y	N	N	Y	N	P	N	3.5

(Continued)

Table 3. (Continued)

Content items and sub-items	Guideline								Total Yes (Y) =1 No (N) =0 Partial (P) =0.5
	Canada	New South Wales (Australia)	Northern Territory (Australia)	New Zealand	Queensland (Australia)	South Australia (Australia)	United Kingdom	Victoria (Australia)	
Content item 8: Managing breathlessness									
a. Identifying the drug type and dosage the patient is already receiving	Y	P	P	Y	N	N	P	Y	4.5
b. Specific drug type and dosage recommended to manage this symptom	Y	P	P	Y	N	P	P	Y	5
c. Route and location of drug administration	Y	Y	N	P	N	P	N	Y	4
d. Recognising drug contraindications and offering alternatives	Y	N	N	N	N	N	N	N	1
e. Non-pharmaceutical approaches	Y	Y	N	N	N	N	Y	N	3
Content item 9: Managing confusion									
a. Identifying the drug type and dosage the patient is already receiving	N	N	P	P	P	N	P	N	2
b. Specific drug type and dosage recommended to manage this symptom	N	N	N	N	N	N	P	N	0.5
c. Route and location of drug administration	N	N	N	N	N	N	N	N	0
d. Recognising drug contraindications and offering alternatives	N	N	N	N	N	N	N	N	0
e. Non-pharmaceutical approaches	Y	N	N	N	N	N	P	N	1.5
Content item 10: Managing constipation									
a. Identifying the drug type and dosage the patient is already receiving	N	N	P	P	N	N	N	N	1
b. Specific drug type and dosage recommended to manage this symptom	N	N	N	N	P	N	N	N	0.5
c. Route and location of drug administration	N	N	N	N	N	N	N	N	0
d. Recognising drug contraindications and offering alternatives	N	N	N	N	N	N	N	N	0
e. Non-pharmaceutical approaches	Y	N	N	N	N	N	N	N	1
Content item 11: Managing dehydration									
a. Identifying the drug type and dosage the patient is already receiving	N	N	P	P	N	N	N	N	1
b. Specific drug type and dosage recommended to manage this symptom	N	N	N	P	P	N	N	N	1
c. Route and location of drug administration	N	N	N	N	N	N	N	N	0
d. Recognising drug contraindications and offering alternatives	N	N	N	N	N	N	N	N	0
e. Non-pharmaceutical approaches	Y	N	N	N	Y	N	N	N	2
Content item 12: Managing the patient's anxiety and agitation									
a. Identifying the drug type and dosage the patient is already receiving	Y	P	P	P	N	N	P	Y	4
b. Specific drug type and dosage recommended to manage this symptom	Y	P	P	Y	N	P	P	Y	5
c. Route and location of drug administration	Y	Y	N	P	N	P	N	Y	4
d. Recognising drug contraindications and offering alternatives	Y	N	N	N	N	N	N	Y	2
e. Non-pharmaceutical approaches	Y	Y	N	N	N	N	P	N	2.5
Content item 13: Managing respiratory secretions									
a. Identifying the drug type and dosage the patient is already receiving	Y	N	P	P	N	N	P	N	2.5
b. Specific drug type and dosage recommended to manage this symptom	Y	N	N	N	N	N	P	N	1.5
c. Route and location of drug administration	Y	N	N	N	N	N	N	N	1
d. Recognising drug contraindications and offering alternatives	Y	N	N	N	N	N	N	N	1
e. Non-pharmaceutical approaches	Y	N	N	N	N	N	Y	N	2

(Continued)

Table 3. (Continued)

Content items and sub-items	Guideline								Total Yes (Y) =1 No (N) =0 Partial (P) =0.5
	Canada	New South Wales (Australia)	Northern Territory (Australia)	New Zealand	Queensland (Australia)	South Australia (Australia)	United Kingdom	Victoria (Australia)	
Content item 14: Options for clinical back-up									
a. Generic and local sources of assistance	Y	Y	Y	Y	Y	Y	P	Y	7.5
b. Hierarchy of who to contact	N	N	N	N	N	N	N	Y	1
Content item 15: Care after death (technical skills)									
a. Verification of death	N	P	N	N	N	Y	P	N	2
b. Who to contact	N	N	P	N	N	Y	N	N	1.5
c. Identifying who will complete the death certificate and process to avoid calling police when the death is expected	N	N	N	N	N	Y	N	N	1
Content item 16: Care after death (soft skills)									
a. Breaking bad news	N	N	N	N	N	N	N	N	0
b. Bereavement support for the family	N	N	N	N	P	N	P	N	1
c. Cultural considerations	N	N	N	N	N	N	N	N	0
Content item 17: Documentation									
a. What is needed to be recorded by the paramedic	Y	Y	Y	Y	N	P	P	Y	6
Content item 18: Additional items included in the guideline									
b. Any additional and imperative information which is included in this guideline but is not already covered by an existing content item	Y	N	N	Y	Y	N	Y	Y	5

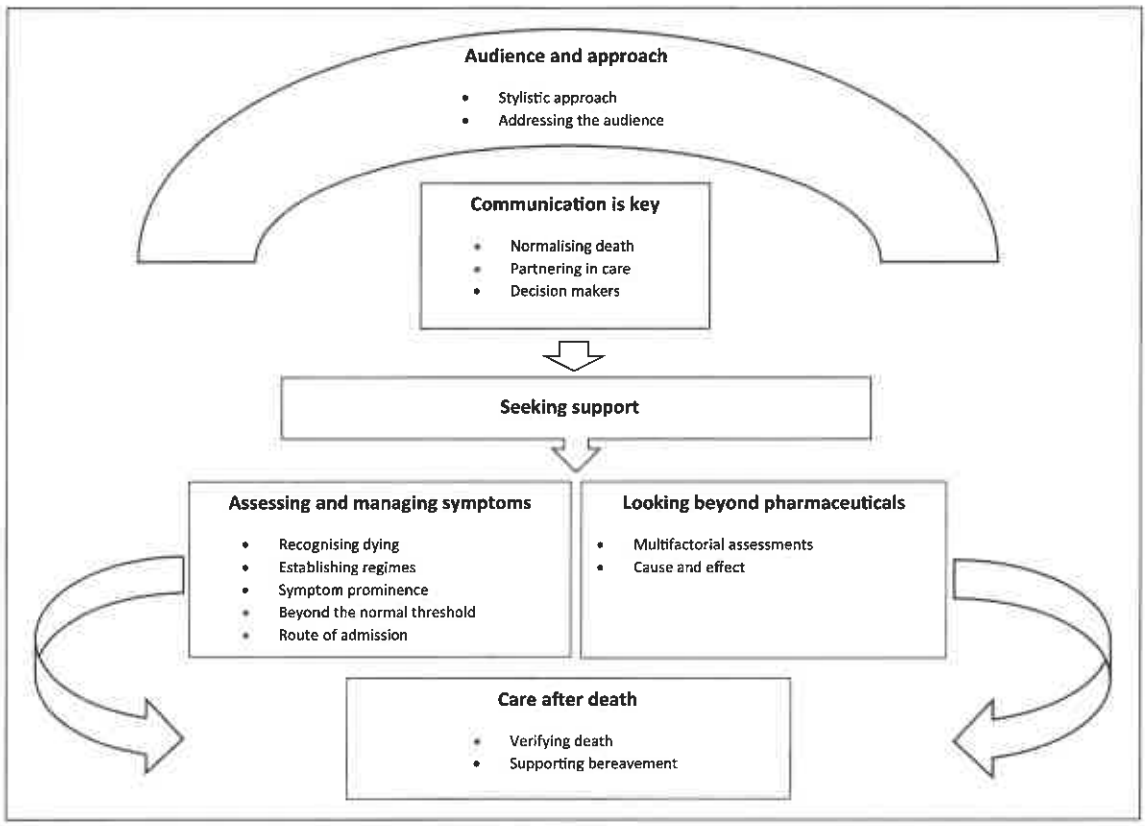

Figure 2. Thematic summary of content analysis.

The Canadian[40] and UK[39] guidelines were comprehensive booklets, detailing many aspects of care and integrating both a prescriptive and guiding approach.

> *"Patient-centred care is the cornerstone of all medical directives. Should the patient already have a symptom management kit in the home, prescribed by their primary care provider for the management of palliative care, the paramedics may provide symptom assist to the patient and/or family for the patient's prescribed medications in accordance with the prescription. This may include, but is not limited to, drawing up medications as prescribed, aiding in the administration of prescribed medications and assisting the family with mediation administration and/or education".*[40]

Variations in the audience addressed were also apparent across guidelines. Two were written exclusively for specialist community-based paramedics,[37,40] while the other guidelines were applicable to generalist paramedic audiences. Furthermore, four jurisdictions required the patient to be registered with a community-based palliative care service for the guideline to be applicable.[33,34,38,40]

Communication is key

All but one guideline[37] defined palliative care to varying degrees and recognised dying as a normal process of life, a key strength of the guidelines which offered paramedics clarity to communicate these principles in end-of-life emergencies. Eliciting information from the patient and bystanders is a basic task for paramedics; however, only two guidelines acknowledged the importance of partnering in care with families, addressing communication approaches for building rapport with and supporting these important stakeholders.[33,37]

> *"Families/carers may be committed to caring for the patient in the place of their choice, but at times may need support over and above that which is currently being provided or is available. Acknowledgement of the burden of this type of care and support may be all they require at this difficult time. Normalising the feelings that the family may experience will assist to minimise the family's distress".*[33]

Other key palliative care communication skills were tackled to varying degrees. Only one guideline comprehensively covered establishing patient capacity and determining proxy-decision makers,[35] while two others referred to seeking medical advice if the decision-maker was unclear.[38,39] Another two guidelines clarified what constituted valid medical directives within their jurisdictions,[33,36] equipping paramedics with the medicolegal literacy of what to request and look out for.

> *"If the patient can communicate and has the capacity to make decisions regarding treatment and transport, consult*

directly with the patients and obtain the patient's consent before any treatment and/or transport is provided".[35]

Assessing and managing symptoms

Recognising dying to initiate a palliative approach was a strong point amongst the guidelines. Three jurisdictions offered prescriptive lists of the signs and symptoms of a patient approaching death[33,39,40] and more outlined circumstances where an ambulance may be called to care for a palliative patient.[34–40] However, overwhelmingly most cited transportation to or from a hospital as the primary reason for paramedic intervention.

"A point comes when the person enters the 'dying phase'. Ambulance services are frequently called upon at this stage. This may be for planned transport, such as the rapid transfer of a person from hospital or hospice to their preferred place of death. Ambulance services are also frequently called during the dying phase because of an unexpected complication, or a sudden deterioration in condition".[39]

Seven guidelines clearly directed paramedics to establish the patient's existing medication regime before initiating management of any palliative symptoms.[33–36,38–40] Pain was most comprehensively referenced and addressed across guidelines; however, nausea and vomiting, breathlessness and agitation were also commonly considered. Other less reported symptoms included confusion, constipation, dehydration and respiratory secretions. Depending on the guideline approach, pharmaceutical symptom management details varied to include drug types,[34,38,40] pharmacokinetics,[40] contraindications[34,39,40] and dosages.[34,38,40] One guideline provided paramedics with an online application to assist with calculating dosages, reducing room for error in a high-pressure environment.

"Morphine is recommended as the mainstay treatment for palliative pain. When the palliative care service is unavailable to advise paramedics on management, the dose of subcutaneous Morphine to be administered is calculated by using the Ambulance Victoria CPG App to convert each of the patient's regular opioid analgesics to a total equivalent daily dose of oral morphine".[34]

All guidelines suitably recognised palliative care patients often have stronger pain relief requirements and recommended administering analgesia beyond the normal thresholds of an opioid-naive patient, if required, thereby permitting paramedics to work outside their traditional scope. Differences in the location and route of administration were also discussed by seven guidelines,[33–35,37–40] most preferencing the subcutaneous delivery of pharmaceuticals in the arm to speed uptake. Other technical skills addressed outside a paramedic's usual repertoire included using syringe drivers[34,37,39,40] and transdermal patches[39] for pain management. Importantly, paediatric pathways of care were only acknowledged by one guideline,[34] highlighting a potential gap in current palliative paramedicine practice.

Looking beyond pharmaceuticals

All guidelines addressed the medicinal management of symptoms to some degree; however, non-pharmaceutical approaches were not broadly adopted across guidelines. Only one guideline prescribed a multifocal approach to comprehend the holistic needs of a palliative patient, recommending paramedics undertake medical, sociological and psychological assessments before commencing treatment.[39] Another guideline offered two pages of generic information about the process of dying, albeit directed at family caregivers, which included non-pharmaceutical comfort-focussed interventions.[40] These two guidelines and another encouraged the paramedic to explore the causative root of palliative symptoms beyond superficial assumptions, highlighting opportunities for paramedics to identify when a non-pharmaceutical approach may be applied to better effect.[35,39,40]

"From a pre-hospital care perspective, as an ambulance clinician it is vital that you are mindful of the evidence which concludes that the use of a fan and low dose opiates is as effective, if not more effective, than the administration of oxygen. The disadvantages often outweigh the benefit of administering oxygen in that if a patient feels that they cannot breathe and a paramedic attends and administers oxygen, the patient may believe that they need oxygen therapy each time thereafter that they feel breathlessness. Even worse, the patient may fear that the thing they need to breathe is being taken away when you leave the house. This may result in the person feeling that they need an emergency response whenever they feel breathless."[39]

Seeking support

Options for clinical back-up was the only content item addressed by all guidelines, emphasising a requirement to identify and contact the patient's leading medical professional, usually the community palliative care service, when responding to a palliative emergency.

"Treatment should be in consultation with palliative care team, medical officer managing patient's care or South Australian Ambulance Service Extended Care Paramedic Mentor".[37]

Half of the guidelines listed contactsforsupport,[34,36,37,40] while the other half referred to options but did not stipulate specific details.[33,35,38,39] Two guidelines provided details for a 24/7 palliative care specialist specifically on call to provide support for paramedics[34,36] and another

guideline permitted paramedics to treat patients beyond their normal practice if directed by clinical supports.[38]

> *"All personnel may administer medicines outside their delegated scope of practice if instructed to do so (including over the phone) by a registered medical or nurse practitioner".*[38]

Care after death

Content items relating to care after death were underrepresented across all guidelines, including the more comprehensive guidelines of Canada and the UK. No single guideline addressed the content items breaking bad news or cultural considerations, highlighting two clear gaps in current documented clinical practice. Three guidelines referred to separate protocols covering the skills of verifying death,[33,38,39] raising the question of utility for interrelated content across multiple guidelines. One jurisdiction directed paramedics to complete a declaration of life extinct document when the death was expected and stipulated who could complete the certification, assisting paramedics in avoiding unnecessary police involvement at a time of bereavement.[37]

> *"There is no requirement for South Australian Police to attend the case provided a declaration of life extinct document is completed and a palliative care medical officer or the patient's GP can complete the certificate within the 24 hours of the death".*[37]

Finally, supporting family and carer distress and grief after the death of a loved one was only partially addressed by two guidelines,[35,39] highlighting an under-recognition of the potential for paramedics to employ vital communication skills, support early bereavement, respond to acute grief and provide culturally responsive care.

> *"Ambulance clinicians will often be on the scene at or shortly after the point of death. There may be occasions where the patient is in the final stages of dying. If all reversible causes have been considered, then supportive care for the patient and the relatives/carers may be all that is required"*[39]

Discussion

Palliative paramedicine is an evolving scope of practice: only five of Australia's ambulance services had existing guidelines suitable for inclusion in this study. The diversity of approaches reported across the included guidelines reflects the international shift away from protocol-driven paramedic practice to broader clinical models, calling on the discretion and decision-making skills of paramedics instead of fixed algorithms.[1,41–43]

Overall, the quality of guideline development was poor to moderate. Notably, Australian and Canadian ambulance guidelines are usually part of a comprehensive suite of policies and procedures, not to be used in isolation. Thus, despite succinct guidelines potentially offering greater utility for paramedics, they were rated poorly according to AGREE II criteria, as reflected in another study employing the same tool to appraise paramedic practice.[32] Looking ahead, the AGREE II instrument offers substantial methodological guidance for developing future best practice palliative paramedicine guidelines;[44] however, the instrument should not be used to determine their clinical validity.[45]

The need for community-based palliative care provision by paramedics has emerged from the recognition of ambulance and out-of-hours community palliative care service shortfalls, an increasing acuity of elderly populations living in communities and a greater need to respond to illness with preventative and rehabilitative approaches.[46] However, relegating palliative paramedicine to specialist roles alone – as was the case for only two guidelines – seems an unviable option to support the ever growing demand for community-based palliative care and increasing community preferences to die at home.[16] Future research could investigate opportunities to integrate the palliative care skills of specialist paramedics across to the generalist paramedic workforce and embed palliative and end-of-life care principles into undergraduate paramedicine curriculum.[12,47]

Constraining the provision of palliative and end-of-life care exclusively to patients already receiving specialist community palliative care services is another barrier to practice. Paramedics often encounter frail and chronically ill patients with rapidly deteriorating health, some of whom might benefit from or prefer a palliative approach to their care. Paramedics' unique position as clinicians entering patients' homes allows them to gather important information about social contexts; details that can be used for holistic palliative care needs assessments and inform immediate careplanning.[12] However, systems must be in place for this information to be shared with multidisciplinary palliative care teams in order to also influence future care planning. Broadening guidelines to allow these patients to be eligible to receive palliative care from a paramedic where appropriate, with clinical back up, would increase access and equity and entrench palliative care as a core skill of paramedicine. This would require the capability to link with specialist palliative care services at the time of need or for future follow up and assessment if time and circumstances permit.

Clinical back-up pathways were a key strength present across all eight guidelines, recognising the developing nature of palliative paramedicine and highlighting the need for multidisciplinary approaches to care. A recent study confirmed Australian paramedics have a high level of intention to use a specialist palliative care telehealth service if it were made available to them.[47] Opportunities remain to shape future ambulance service palliative care policies and practice on integrated models of care.

Finally, the overwhelming lack of content related to communication and care after death identified a significant gap in current practice. These concepts are difficult to translate into simple algorithms, which could potentially justify their exclusion in protocol-based guidelines. However, current literature also fails to address the experiences of families and paramedics responding to the death of a palliative patient.[48] Instead, we generalise practice based on in-patient and emergency department environments, which fail to recognise the nuance of prehospital settings.

Future research ought to investigate all stakeholders' perspectives to better inform practice related to care after death. Literature supports the need for soft skills communication training for paramedics to initiate advance care planning,[49] break bad news[50] and discuss end-of-life matters[48]; a gap that has only been reinforced by the broadening role of paramedics providing grief support during the COVID-19 pandemic.[51]

Findings from our study have the potential to shape future policy and practice, identifying the need to broaden palliative care beyond a specialised role, remove restrictions on prerequisite services required to apply a palliative approach, invest in integrated models of care and address care after death. Prospective research should explore the experiences and perspectives of key palliative paramedicine stakeholders to inform future guidelines; the methodological development of which ought to follow the AGREE II criteria to achieve best practice.

Strengths and limitations

To our knowledge, this is the first study to explore palliative paramedicine practice from a policy perspective. Only palliative and end-of-life care specific guidelines were included in this study, therefore excluding potentially relevant information from other guidelines within each ambulance service's suite. Furthermore, only one Canadian guideline was included, which may not reflect the variation in palliative paramedicine practice across the country. However, review of all guidelines would have been significantly more resource intensive and out of scope for this study. Further, the specific inclusion criteria allowed us to analyse the utility of each guideline.

Conclusion

Palliative care is a growing component of paramedicine and translated into practice by ambulance services' palliative and end-of-life care guidelines. This study examined both the quality and content of existing Australian palliative paramedicine guidelines with a sample of guidelines from comparable Anglo-American Ambulance services. The study highlights the variance in methodological quality, approach and content of these guidelines to reveal six key themes: audience and approach, communication is key, assessing and managing symptoms, looking beyond pharmaceuticals, seeking support and care after death.

Acknowledgements

The search strategy was developed by MJ, JC, PB, NA, MB, DM, PBa, LP, AN and AH in consultation with the Australasian Palliative Paramedicine Advisory Group. The quality appraisal was coordinated by MJ and completed by PBa and LP. MJ, NA, MB and DM performed the collaborative qualitative content analysis, which was overseen by JC. MJ conducted the thematic analysis, which was cross-checked by NA, MB and DM and drafted the manuscript. All authors critically revised the manuscript, making substantial contributions and approving the final version.

Declaration of conflicting interests

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Ethics approval

Ethical approval was not required for this study as the research method was a quality appraisal and content analysis of publicly available material.

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From: Andrea McClymont <AMcClymont@arnpriorhealth.ca>
Sent: Tuesday, August 9, 2022 8:59:24 AM
To: Mathieu Grenier <MGrenier@countyofrenfrew.on.ca>
Cc: Michael Nolan <MNolan@countyofrenfrew.on.ca>
Subject: Positive Feedback and Thanks re: Paramedic Andrew Fortington

[CAUTION -- EXTERNAL E-MAIL - Do not click links or open attachments unless you recognize the sender.]

Good Morning Mathieu,

I hope you are doing well.

I wanted to share with you some very positive feedback I received from one of our Admitting clerks who worked in ER with Andy last week. She noted that it was an extremely busy night and the ER was short. There was a significantly challenging mental health/addiction patient that had been brought in by her family and left in the ER. They advised they no longer wanted any contact with her and wanted to be removed as emergency contacts. They provided the name of her boyfriend and advised we call him. The patient was quite ill and very unstable. The clerk doesn't think the boyfriend initially understood the gravity of the situation. When he found out, he broke down. From what I understand from her the boyfriend was having difficulties of his own, was living in his truck and not coping well. He was very distraught. Our clerk noted that Andy sat with this gentleman for quite a long time and talked with him. Andy showed this gentleman kindness, compassion and most of al the utmost respect. He took the time to support him, provide him some guidance and be that someone who would listen and show they care. This is not a trait we see often when dealing with mental health concerns and its devastating. The clerk was so moved by the way Andy handled the situation and the difference he likely just made for this gentleman.

It takes one person to make a difference when someone hits rock bottom and Andy certainly demonstrated what a true healthcare professional is. We wanted to make sure he was recognized and acknowledged for this. His actions did not go unnoticed and were certainly appreciated.
We were very lucky to Andy here that night and I'm sure the patient and her boyfriend would certainly feel this way as well. In the midst of a healthcare staffing crisis where so many are burning out and packing it in, Andy rose above and provided exceptional care when it was needed most.

Thanks Mathieu. Have a good day

Andrea

Andrea McClymont, **CHIM CCDIS**
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COUNTY OF RENFREW

BY-LAW NUMBER

A BY-LAW AUTHORIZING THE WARDEN AND CLERK TO EXECUTE A LEASE AGREEMENT BETWEEN THE COUNTY OF RENFREW AND ARNPRIOR REGIONAL HEALTH FOR ONGOING TENANCY OF 275 IDA STREET, ARNPRIOR FOR THE RENFREW COUNTY VIRTUAL TRIAGE AND ASSESSMENT CENTRE.

WHEREAS Sections 8, 9 and 11 of the Municipal Act, 2001, S.O. 2001 as amended, authorizes Council to enter into agreements,

WHEREAS the County of Renfrew deems it desirable to enter into an agreement with Arnprior Regional Health for ongoing tenancy of the RCVTAC at 275 Ida Street, Arnprior, for the monthly lease of $4,000 to be reviewed yearly.

NOW THEREFORE the Council of the Corporation of the County of Renfrew hereby enacts as follows:

1. The agreement attached to and made part of this by-law shall constitute an agreement between the Corporation of the County of Renfrew and Arnprior Regional Health.

2. That the Warden and Clerk are hereby empowered to do and execute all things, papers, and documents necessary to the execution of this by-law.

3. That this by-law shall come into force and take effect upon the passing thereof.

READ a first time this 28th day of September 2022.

READ a second time this 28th day of September 2022.

READ a third time and finally passed this 28th day of September 2022.

_____ _____

DEBBIE ROBINSON, WARDEN CRAIG KELLEY, CLERK

THIS LEASE made in duplicate this 22 day of July 2022

BETWEEN:

ARNPRIOR REGIONAL HEALTH,
incorporated under the laws of the Province of Ontario
and having its head office at the Town of Arnprior

(the "**Lessor**")
- and -
VTAC
(the "**Lessee**")

Background

A. The Lessor operates a public hospital (the Arnprior Regional Health, the "**Hospital**") and long-term care facility in Arnprior, Ontario.

B. The Lessee wishes to lease space in the former long- term care facility.

FOR VALUE RECEIVED, the Lessor leases to the Lessee the following premises:

In the Town of Arnprior, in the County of Renfrew and being composed of part of the first level of the building known as the Old Grove, municipally known as 275 Ida Street North, Arnprior, Ontario, with approximately 1693 square feet of rental space as more particularly described in Schedule A.

TERM:

To have and to hold the said demised premises for and during the term twelve months to be computed from the 1st day of April 2022 and to end on the 31st day of March 2023.

RENT:

Lessee shall pay rent during the term to the Lessor, payable in monthly installments, each in advance on the first day of each month during the term commencing April 1, 2022 in the amount indicated on Schedule A. On or prior to the commencement date, the Lessee shall provide Lessor with post-dated cheques or preauthorized electronic fund transfers for each month of the term.

The parties hereto further covenant and agree that the rents and additional payments herein reserved are exclusive of any retail sales taxes, goods and services taxes, value added taxes, business transfer taxes or any such similar or other taxes imposed by any taxing authority and the parties further covenant and agree that in the event that such taxes are imposed same will be for the account of the Lessee who agrees to indemnify and save harmless the Lessor in respect of payments made by the Lessor on account of these said taxes, but same shall not be considered by the parties to be additional and further rent.

The Lessor agrees to supply and pay for all electricity, heating, air conditioning, water charges and data lines; however, the Lessee is responsible for any charges for using the data lines (e.g., Internet, email costs). Any costs relating to the use or occupation of the premises not expressly made the obligation of the Lessor in this Lease are at the expense of the Lessee.

RENEWAL:

The Lessor agrees, provided that the Lessee is not in arrears of payment of rent or any other amounts hereunder or in breach of any of the Lessee's obligations hereunder, to renew the lease for further one-year terms, subject to the successful negotiation of rent and all other terms and conditions between the Lessor and the Lessee, in writing and signed by both parties. The Lessee acknowledges that the amount of rent payable in any renewal term will be based on the Lessor's actual costs to operate the premises and, as such, will reflect the effects of inflation.

TERMINATION:

This lease agreement may be terminated in the following circumstances:

1. by the Lessor in the event of 5 days' arrears of rent;
2. by the Lessor in the event of any significant wilful or negligent damage to the premises caused by the Lessee or by persons permitted on the premises by the Lessee;
3. should either party be in substantial and ongoing breach of any of the terms of this lease agreement, which remains unremedied after the non-breaching party has provided at least 30 days' written notice of the substantial and ongoing breach to the breaching party; or
4. by the Lessee providing at least 90 days' written notice as to its intentions to terminate this lease agreement.

Upon the expiry or termination of this lease agreement, the Lessee shall deliver vacant possession to the Lessor of the premises in the same condition as at the commencement of this lease agreement, reasonable wear and tear excepted.

USE OF PREMISES:

The Lessee accepts the premises in the state and condition in which they are received from the Lessor.

The Lessee covenants that he/she will not permit to be done on the said premises anything which may be annoying to the Lessor, or which the Lessor may deem to be a nuisance.

The Lessee covenants that he/she will not permit to be done any act or thing which may make void or voidable any insurance upon any building, or part thereof, upon the said premises, or which may cause any increased or additional premium to be paid for such insurance.

The Lessee shall:

a) keep the premises at all times in a safe, neat, clean, orderly, first-class and inviting condition, including a reasonable state of repair, all to the satisfaction of the Lessor;
b) be solely responsible for obtaining and maintaining in good standing from all authorities having jurisdiction all necessary permits, licences and approvals as may be necessary to permit the Lessee to occupy the premises and conduct his/her business thereon, as required by all applicable laws:
c) not make improvements or alterations to the premises without the prior consent of the Lessor; and
d) not erect, install or display any sign on or visible from the exterior of the premises other than in-house signage which the Lessor shall approve and supply and for which the Lessee shall be charged.

COMMON FACILITIES:

Subject to all other relevant provisions of this lease agreement, the Lessor grants to the Lessee the non-exclusive licence during the term to use, for their intended purposes in common with others entitled thereto, such portions of the building that are generally accessible to the public for the purposes of accessing the premises (e.g., the washrooms) (the "Common Facilities") as same are reasonably required for the use and occupancy of the premises. The Lessor is responsible for maintaining the Common Facilities.

The Lessee shall not obstruct any Common Facilities or use or permit to be used any Common Facilities for purposes other than their intended purposes. Without limiting the foregoing, nothing shall be placed or stored anywhere in or on the Common Facilities.

INSPECTION RIGHTS:

The Lessor or any persons designated by it shall have the right to enter the premises at any time upon reasonable notice to view the state of repair and condition thereof and to carry out repairs. Provided also that during the last two (2) months of the said term any agents of the Lessor may inspect the said premises, on any day except Sunday, on producing a written order to that effect signed by the Lessor.

Provided that the Lessor may place upon the said premises at any time during the said term a notice that the said premises are for sale, and within two (2) months prior to the termination of the said term may place a notice on the said premises that are to be let, and the Lessee agrees that he/she will not remove any such notices, or permit them to be removed.

LESSOR'S RIGHT OF EARLY TERMINATION:

Provided also that if during the term hereby granted:

a) any of the goods and chattels of the Lessee shall be at any time seized or taken in execution or in attachment by any creditor of the Lessee;
b) a Writ of Execution shall issue against the goods or chattels of the Lessee;
c) the Lessee shall execute any chattel mortgage or bill of sale of any of his/her goods or chattels;
d) the Lessee shall make any assignment for the benefit of creditors, or become bankrupt or insolvent or shall take the benefit of any Act that may be in force for bankrupt or insolvent debtors;
e) the said premises become vacant and so remain for the period of thirty (30) days;
f) the said premises be used for any other purpose than that of which they were let;
g) the Lessee shall attempt to abandon the said premises;
h) the Lessee shall attempt to assign or sublet this lease agreement without Lessor authorization; or

i) the Lessee shall attempt to sell or dispose of his/her goods and chattels so that there would not in the event of such sale or disposal be, in the opinion of the Lessor, a sufficient distress on the premises for the then accruing rent,

then,

1. the current month's rent together with the rent for the next three (3) months accruing and the taxes for the then current year (to be reckoned on the rate for the next preceding year in case the rate shall not have been fixed for the then current year), shall immediately become due and payable, and
2. the said term shall, at the option of the Lessor, forthwith become forfeited and terminated upon written notice to the Lessee, and the Lessor may re-enter and take possession of the said premises as though the Lessee was hold over after the expiration of the said term, and in every of the above cases such taxes or accrued portion thereof shall be recoverable by the Lessor in the same manner as the rent hereby reserved.

Provided that the Lessee may remove his/her fixtures if all rent due hereunder has been paid. These rights are in addition to any other rights of early termination provided for in this lease agreement.

The Lessee covenants that he/she is the sole owner of all goods and chattels that are to be brought upon the premises, and that they are free from any mortgage, lien or other charge, save and except for any equipment or office systems related to the Lessee's practice which may be leased or financed.

LIABILITY INSURANCE:

The Lessee convenants to obtain and maintain during the term a policy of comprehensive general liability insurance on the premises providing coverage for personal injury, property damage, property loss and all other potential liability arising out of the occupation and use of the premises, which policy shall

1. be in the amount of not less than TWO MILLION DOLLARS ($2,000,000.00) per occurrence and on other terms satisfactory to the Lessor and this amount shall be increased if so required by the Lessor to a reasonable amount specified, by the Lessor, on one hundred and twenty (120) days' written notice;
2. include all risks Lessee's legal liability in an amount sufficient to cover a loss to the premises and the Lessee's own contents, as well as business interruption insurance to allow for the continued payment of rent should the Lessee's business operations upon the premises be suspended;
3. include the Lessor, as an additional named insured;
4. provide that the policy cannot be cancelled or materially altered without providing thirty (30) days' prior written notice to the Lessor by the insurer;
5. deliver to the Lessor proof of insurance and payment of its premiums within ten (10) days after execution of this lease and to deliver to the Lessor from time to time upon request by the Lessor evidence satisfactory to the Lessor, of the continued maintenance of the insurance during the term;
6. upon request, allow the Lessor to obtain information regarding liability insurance directly from the Lessee's insurance agent or insurance broker.

MAINTENANCE:

The Lessor will be responsible for the maintenance of the grounds and the Common Facilities.

The Lessor will provide at its expense snow removal from the parking lot and access road, steps and entrances leading to the leased premises.

HEATING, AIR CONDITIONING:

The Lessor agrees to provide heating and air-conditioning to the demised premises at appropriate times. All equipment is to be maintained by the Lessor at the Lessor's expense.

FIRE AND OTHER DAMAGE:

If during the term or other extension to it the building on which the premises are situate or the premises shall be destroyed or damaged by fire or the elements, or other causes beyond the control of the Lessee, the following provisions shall have effect:

(l) If the premises shall in the Lessor's opinion be so badly injured (or destroyed) as to be unfit for occupancy and to be incapable of being repaired with reasonable diligence within ninety (90) days of the happening of such injury, then the term shall cease at the option of the Lessee (and be at an end to all intents and purposes) from the date of such damage or destruction and the Lessee shall immediately surrender and yield up possession of the premises to the Lessor, and shall pay rent only to the time of such surrender.

(2) If the premises in the Lessor's opinion be capable with reasonable diligence of being repaired and rendered fit for occupancy within ninety (90) days from the happening of such injury but if the damage is such to render the premises wholly unfit for immediate occupancy, then the rent hereby reserved shall not run or accrue after such injury or while the process of repair is going on, the Lessor shall repair the premises with reasonable speed, and the rent shall re-commence immediately after such repairs shall be completed.

(3) If the premises can in the Lessor's opinion be repaired within ninety (90) days and if the damage is such that the premises are capable of being partially used, then until such damage shall have been repaired by the Lessor, the rent shall abate in the proportion that the part of the premises rendered unfit for occupancy is of the whole of the premises.

The Lessee shall repair, promptly and at the Lessee's own cost, any damage caused by the Lessee during the term of this Lease, after notifying the Lessor of such damage. At its option, the Lessor may assume responsibility for completing the damage repairs using its own staff or contractors, to ensure consistent repairs throughout the building, at the Lessee's expense.

LESSOR NOT LIABLE;

The Lessor shall not be liable for any damages, direct or indirect, resulting from or contributed to by any interruption or cessation in supply of any utilities or heating, ventilating, air-conditioning and humidity control. Without limiting the generality of the foregoing, the Lessor shall not be liable for any and all indirect or consequential damages or damages for personal discomfort or illness of the Lessee or any persons permitted by the Lessee to be on the premises, by reason of the suspension or non-operation of any utilities, heating, ventilating, air-conditioning or humidity control.

The Lessee agrees that the Lessor shall not be liable or responsible in any way for any damage to the Lessee's property or any third party property nor for any injury or death to any person in or coming to or from the premises, unless such damage or injury is caused by the gross negligence or wilful misconduct of the Lessor or any person for whom the Lessor is responsible in law (including employees and agents).

ASSIGNMENT:

The Lessee may assign or sublet the demised premises with the prior written consent of the Lessor, but such consent will not be unreasonably withheld, provided the Assignee's practice is reasonably equivalent to the Lessee's practice and in compliance with this Lease.

SALE OF BUILDING:

The Lessor agrees that upon the sale of the building the new purchasers will be bound by the terms and conditions of the lease or any extensions thereof.

REMOVAL OF FIXTURES:

Provided that the Lessee is not in arrears of rent at the expiry of the lease, the Lessee may remove any of his/her fixtures.

LESSOR'S OBLIGATIONS:

The Lessor covenants with the Lessee for quiet enjoyment.

The Lessor covenants to provide adequate fire insurance on the building and to pay realty taxes except for business tax.

GENERAL PROVISIONS:

And it is further agreed by and between the parties hereto that wherever the singular and masculine are used throughout this lease the same shall be so construed as if the plural or the feminine had been used where the context or the party or parties hereto so require, and the rest of the sentence shall be construed as if the necessary grammatical and terminological changes thereby rendered necessary had been made.

All notices to be delivered to the Lessor shall be in writing addressed to it at the following address or to such other address as it may in writing direct:

Arnprior Regional Health
350 John Street North
Arnprior, Ontario K7S 2P6
Attention: Chief Executive Officer

All notices sent to the Lessee shall be in writing addressed to him/her at the following address or to such other address as he/she may in writing direct:

VTAC
275 Ida Street
Arnprior, Ontario K7S 3M7

This lease agreement, including Schedule A, constitutes the entire agreement of the parties and supersedes any previous arrangements or agreements, written or oral. This lease agreement may be amended only in writing signed by both parties. This lease agreement is governed by the laws of Ontario.

IN WITNESS WHEREOF the Lessor and Lessee have signed this lease agreement:

ARNPRIOR REGIONAL HEALTH

_____

Brad Hilker, Vice President of Finance & Chief Financial Officer

_____ _____

Witness

COUNTY OF RENFREW

_____ _____

Debbie Robinson, Warden **Craig Kelley, CAO**

Schedule A

Details of leased premises:

275 Ida Street and having an area of approximately 1693 square feet

Rent:

1. April 1, 2022 to March 31, 2023 $4,000 per month
2. Subsequent annual rate increases will be applicable based on the lease amount per square foot for the previous year +/- the change in the Consumer Price Index as published by Statistics Canada for the previous 12 month period.

Renfrew County and District Health Unit

"Optimal Health for All in Renfrew County and District"

Board of Health

Regular Board Meeting, via *Microsoft Teams*

Tuesday, June 28, 2022

The Regular meeting of Renfrew County and District Health Unit's Board of Health was held on the virtual software platform—*Microsoft Teams*. Members were present by audio and/or video.

Members:

Ann Aikens	Chair
Christine Reavie	Vice-Chair
James Brose	Member
Michael Donohue	Member
J. Michael du Manoir	Member
Jane Dumas	Member
Peter Emon	Member
Joanne King	Member
Jennifer Murphy	Member
Carolyn Watt	Member

Staff:

Vicki Benoit	Director, Health Protection
Dr. Robert Cushman	Acting Medical Officer of Health
Heather Daly	Acting Chief Executive Officer/Director, Corporate Services
Dr. Michelle Foote	Public Health Physician
Marilyn Halko	Executive Assistant (Secretary)
Patti Smith	Director, Health Promotion

Regrets:

Wilmer Matthews	Member

Guest:

Karen Black	Scott Rosien Black & Locke

01. Call to Order

Chair Aikens called the meeting to order at 10:03 a.m.

02. Agenda Approval

The Chair requested that the 2021-2022 Annual Reconciliation and Auditor's Attestation for the Ministry of Children, Community and Social Services for the Healthy Babies Healthy Children Program be added to the agenda.

Resolution: #1 BoH 2022-Jun-28

Moved by J. Dumas; seconded by C. Reavie; be it resolved that the Board approve the addition of the 2021-2022 Annual Reconciliation and Auditor's Attestation for the Ministry of Children, Community and Social Services for the Healthy Babies Healthy Children Program, to the agenda.

Carried

The agenda was approved, as amended, with the addition of the 2021-2022 Annual Reconciliation and Auditor's Attestation for the Ministry of Children, Community and Social Services for the Healthy Babies Healthy Children Program, as item 06. c. i.

Resolution: #2 BoH 2022-Jun-28

Moved by C. Watt; seconded by C. Reavie; be it resolved that the Board approve the agenda, as amended.

Carried

03. Declarations of Conflict of Interest

There were no declarations of conflict of interest.

04. Delegations

There were no delegations.

05. Minutes of Previous Meetings (Approval)

a. Regular Meeting Minutes 2022-May-31

The meeting minutes were approved for Tuesday, May 31, 2022.

Resolution: #3 BoH 2022-Jun-28

Moved by J. Murphy; seconded by J. M. du Manoir; be it resolved that the Board approve the meeting minutes from the Regular Board meeting held on Tuesday, May 31, 2022, as presented.

Carried

06. Business Arising

a. Rescind Resolution #2 BoH 2022-May-31

Resolution: #4 BoH 2022-Jun-28

Moved by J. Dumas; seconded by C. Watt; be it resolved that Resolution: #2 BoH 2022-May-31 be rescinded.

Carried

b. Draft Financial Statements of Renfrew County and District Health Unit—Year ended December 31, 2022—revised with markups

Karen Black, Scott Rosien Black & Locke, reviewed the *Draft Financial Statements of Renfrew County and District Health Unit—Year ended December 31, 2022—revised with markups,* with the Board. These documents were a reference for Board Members, during the discussion of the *Statements*:

i. *Draft Financial Statements of Renfrew County and District Health Unit—Year ended December 31, 2022—revised with markups*

ii. *Accumulated Surplus Worksheet 2021(revised)*

The Chair called for questions and comments from the Board.

Resolution: #5 BoH 2022-Jun-28

Moved by C. Reavie; seconded by J. Dumas; be it resolved that the Board accept the *Financial Statements for the year ended December 31, 2022*, as revised, and further that the Chair and Vice-Chair sign the Statements presented on June 28, 2022.

Carried

c. 2021 Annual Reconciliation Report and Auditor's Attestation

K. Black reviewed the *2021 Annual Reconciliation Report and Auditor's Attestation for the Ministry of Health*, with the Board.

The Chair called for questions and comments from the Board.

Resolution: #6 BoH 2022-Jun-28

Moved by J. King; seconded by C. Reavie; be it resolved that the Board accept the *2021 Annual Reconciliation Reports and Auditor's Attestations for the Ministry of Health*, as presented.

Carried

i. 2021-2022 Annual Reconciliation and Auditor's Attestation for the Ministry of Children, Community and Social Service for the Healthy Babies Healthy Children Program

K. Black reviewed the *2021-2022 Annual Reconciliation and Auditor's Attestation for the Ministry of Children, Community and Social Services for the Healthy Babies Healthy Children Program*, with the Board.

The Chair called for questions and comments from the Board.

Resolution: #7 BoH 2022-Jun-28

Moved by J. Dumas; seconded by J. Murphy; be it resolved that the Board accept the 2021-2022 Annual Reconciliation and Auditor's Attestation for the Ministry of Children, Community and Social Services for the Healthy Babies Healthy Children Program, as presented.

Carried

The Board Chair thanked K. Black, and commended the Acting Chief Executive Officer/Director, Corporate Services and her Team for another clean audit.

K. Black left the meeting at 11:07 a.m.

A Board Member advised that this audit firm has completed their last audit for the County of Renfrew. The Resources Committee will discuss if there are any ramifications the Board of Health regarding this at their next meeting.

d. Action List—Regular Board Meeting—2022-May-31

All items from *Action List* were completed or deferred to a later date.

07. Staff Reports

a. Report to the Board—Dr. Robert Cushman, Acting Medical Officer of Health

Dr. Robert Cushman gave a verbal update to the Board on current COVID-19 activity in Renfrew County and District, which included the:

i. *COVID-19 Case Summary—June 23, 2022*
ii. *COVID-19 Renfrew County and District (RCD) COVID-19 Vaccine Rollout at a Glance*.

Chair Aikens called for questions and comments.

b. RCDHU Programs and Services During COVID-19 Pandemic
V. Benoit, Director, Health Protection and P. Smith, Director, Health Promotion reported on the following:

- *RCDHU Programs and Services During COVID-19 Pandemic*.

The Chair called for questions and comments from the Board.

Resolution: #8 BoH 2022-Jun-28

Moved by J. M. du Manoir; seconded by J. King; be it resolved that the Board accept the Report to the Board from Dr. Robert Cushman, Acting Medical Officer of Health.

Carried

Chair Aikens thanked Dr. Cushman, V. Benoit, and P. Smith for their reports to the Board.

Dr. Cushman thanked V. Benoit, and P. Smith for their presentations.

At 11:41 a.m., the Chair recessed the meeting until 11:50 a.m.

Dr. Foote left the meeting during the recess.

08. Board Committee Reports

a. Executive
Committee Chair Christine Reavie presented the following:

- *Executive Committee Board Report*.

Chair Aikens reviewed the items on the *Report* and called for questions and comments from the Board.

Resolution: #9 BoH 2022-Jun-28

Moved by C. Watt; seconded by J. King; be it resolved that the Board accept the *Executive Committee Board Report*.

Carried

b. Governance
Committee Chair Joanne King presented the following:

- *Governance Committee Board Report*.

Chair Aikens reviewed the items on the *Report* and called for questions and comments from the Board.

Resolution: #10 BoH 2022-Jun-28

Moved by C. Reavie; seconded by J. Dumas; be it resolved that the Board accept the *Governance Committee Board Report*.

Carried

c. Resources

Committee Chair J. Michael du Manoir presented the following:

- *Resources Committee Board Report*.

Chair Aikens reviewed the items on the *Report* and called for questions and comments from the Board.

Resolution: #11 BoH 2022-Jun-28

Moved by J. M. du Manoir; seconded by J. Murphy; be it resolved that the Board accept the *Resources Committee Board Report*.

Carried

At 12:02 p.m., M. Donohue left the meeting.

09. Correspondence

The Board received the following correspondence:

Subject:		From:	Action:
a.	*alPHa Board of Directors 2022-2023*	• Association of Local Public Health Agencies (alPHa)	• Received as information.
b.	*Support for South West Tobacco Control Area Network*	• Grey Bruce Public Health	• Received as information.
c.	*2020-2021Annual Report*	• Simcoe Muskoka District Health Unit	• Received as information.
d.	*Information Break – June 2022*	• alPHa	• Received as information.
e.	*Healthy Babies Healthy Children Funding*	• Public Health Sudbury & Districts	• Received as information.

10. By-Laws

There were no By-Laws.

11. New Business

a. Board Engagement and Education Session—Ottawa West Four Rivers Ontario Health Team—June15, 2022

The Chair attended the virtual *Board Engagement and Education Session*—Ottawa West Four Rivers, Ontario Health Team. The Board discussed the updates provided by the Chair.

12. Notice of Motions

There was no notice of motion.

13. Closed

There was no closed meeting.

14. Date of Next Meetings

The date of the next Regular Board meeting is Tuesday, September 27, 2022, at 10:00 a.m., or at the call of the Chair.

15. Adjournment

Resolution: #12 BoH 2022-Jun-28

Moved by J. King; seconded by C. Watt; be it resolved that the Regular Board of Health meeting be adjourned at 12:16 p.m.

Carried

The Regular Board meeting, held by *Microsoft Teams*, adjourned at 12:16 p.m.

_____

Chair

These meeting minutes were approved by the Board at the Regular BOH meeting held on Tuesday, September 27, 2022.