UHN Policies and Codes

Current as of: October 28, 2024

Contact for more information: employeeonboarding@uhn.ca

Context and Instructions

This booklet includes UHN Policies and Codes that need to be reviewed by every new employee prior to beginning their employment. Each of these policies is an integral basis of UHN's philosophy. This document is separated into four parts:

Part 1: Code of Workplace Ethics
Part 2: Corporate and Administrative Policies
Part 3: People and Culture Policies
Part 4: Research Policies. *Note, only applies to individuals hired into Research roles.*

Once reviewed and by signing and returning your Offer Letter, you have agreed to adhere to all policies within.

Once you commence your employment, you will be expected to be familiar with all of our Corporate and Departmental policies, which can be accessed via the UHN intranet in the top toolbar called "Policies" (click here).

Note: The links within the policies are only valid when the policy is being read and reviewed inside of UHN. Please refer to these links again once your employment has commenced (click here).

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A Message from UHN's President and Chief Executive Officer

University Health Network (UHN) is committed to supporting a culture which values integrity and ethical leadership. We have a responsibility as Canada's #1 Hospital and the World's #1 publicly funded hospital to lead by example and strengthen our reputation for lawful conduct and responsible governance.

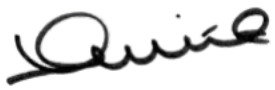
All employees are responsible for our actions and for fostering a culture of respect and integrity. All leaders are responsible for taking concerns raised by our colleagues seriously and seeking solutions for those concerns. Beyond this, we have an obligation to model ethical behaviour in all situations, professional transactions and daily interactions. As UHN's President & CEO, I take this commitment seriously and pledge to lead with respect and integrity.

In return, I ask each member of the UHN community to live our shared values of integrity, safety, compassion, teamwork and stewardship in all of your actions.

As an organization that strives to ensure the needs of patients come first, we must seek to earn the highest level of trust from our communities every day. Ethical issues can sometimes be challenging to navigate and our Code of Workplace Ethics acts as a resource that reflects our values as an organization.

Please read the Code, think about what it means in your own work environment and forward any concerns to me or to Mark Spencer, Executive Vice President – People and Culture.

Welcome to UHN,



Dr. Kevin Smith

President & CEO
University Health Network

UHN Code of Ethics

Introduction

UHN is committed to upholding the highest ethical standards. This Code of Workplace Ethics provides a guide to acting ethically at work, helping to ensure sound decision-making, professional practice, and interpersonal relationships.

Guiding Principles

The values of Safety, Compassion, Teamwork, Integrity and Stewardship set the following guiding principles:

- Comply with legislation and UHN policies
- Foster a respectful working environment, with regard for civility, diversity, inclusion and professionalism
- Protect the hospital's physical, financial and intellectual assets, and use resources wisely
- Deal transparently and fairly in all business relationships
- Take personal responsibility for the safety of patients and of the workplace, and be open to the feedback of others

This Code also provides guidance and resources to assist in making ethical decisions, and for reporting situations that may harm the hospital's patients, staff, clients, business partners or reputation.

Everyone in the UHN community – employees, physicians, students and volunteers – must comply with the standards established by this code. Failure to do so may result in disciplinary action, up to, and including, termination or loss of privilege.

Complying with Legislation and Policies

The UHN value of *integrity* requires honesty, fairness, and commitment to certain legislation and policies, including, but not limited to the following sets of policies:

- Privacy
- Occupational Health and Safety (note, only viewable once employees have access to the UHN Policies intranet page)
- Fostering Respect
- Conflict of Interest

To ensure that regulatory requirements are met, anyone with questions or concerns is encouraged to speak to your leader, your People and Culture representation or to Legal Affairs.

Privacy

Everyone at UHN must treat patients' health information with respect and sensitivity. This is done in accordance with UHN privacy policies, the Personal Health Information Protection Act

(PHIPA) 2004, and the Personal Information Protection and Electronic Documents Act (PIPEDA) Click here to review the Privacy and Access Policy

Conflict of Interest

A conflict of interest exists when someone has a direct or indirect personal interest in a situation that influences, or appears to influence, a decision or action in his/her favor. This can damage UHN's reputation and relationships with patients, colleagues, or those who do business with the organization.

Any conflict of interest must be disclosed to management or to Human Resources in a timely manner. Once reported, management will take action to assist staff in the management of the conflict, including removing the conflicted individual from the situation, if appropriate.

Click here to review the Conflict of Interest policy

Click here to review the Relationship Attestation and Disclosure policy

Fostering a Respectful Working Environment

Respect, civility and professionalism are foundational to UHN's culture. The UHN value of *teamwork* means that we are firmly committed to maintaining a workplace where individual rights and dignity are upheld, diversity is valued, and where everyone's voice is heard.

UHN's Fostering Respect in the Workplace Policy, along with the many supportive provisions in other policies about appropriate conduct, and the training, tips and tools offered through UHN's Respect, Civility & Professionalism @Work program, all serve to assist teamUHN to speak up for themselves, and for others.

Everyone at UHN shares in the responsibility to maintain a respectful culture, free of incivility, harassment, discrimination and violence.

Click here to review the Fostering Respect in the Workplace policy

Protecting Hospital Assets

Adhering to UHN's value of *stewardship* requires that resources are used wisely – responsibly, efficiently, and effectively. Care must be taken to ensure that UHN does not incur unnecessary cost or inconvenience.

Hospital assets, or property, may be physical, financial or intellectual. Physical assets include equipment, computers, supplies, and tools. Intellectual property includes business methods, brands, software, patents, copyrights, trademarks and written materials. Financial assets include cash, and benefits received as part of compensation.

Theft or fraud involving any of these assets will not be tolerated, and anyone who believes that others are engaged in questionable conduct should report to management or to the contacts listed in the Reporting a Breach of the Code section of this document.

Additionally, the mention of UHN on social media must be done with caution and consideration of public perception. The use of the UHN logo must have prior authorization from the Communication and Brand Strategy team.

Click here to review the Administrative Intellectual Property Protection and Commercialization policy
Click here to review the Appropriate Use of Information & Information Technology policy

Acting Ethically in all Business Relationships

It is expected that business relationships with external stakeholders – vendors, contractors, consultants and agents acting on behalf of UHN – carried out with honesty and fairness, and that all commitments and agreements are honoured, as is consistent with the values of *integrity* and *stewardship.*

UHN members should not accept or solicit, directly or indirectly, gifts for personal benefit from third parties, including vendors (including, but not limited to, meals, industry sponsored dinners or events, entertainment, favours, goods or services).

Taking Responsibility for Patient and Employee Safety

UHN's value of *safety* requires vigilance to ensure that nothing compromises a patient's care or a co-worker's physical or psychological safety.

Each one of us is entrusted with fostering an environment where speaking up for ourselves, our colleagues, or for our patients, is expected and welcomed. In such an environment, errors are prevented, staff feel empowered and supported, and everyone stays safe.

This means that we must be open to accepting feedback about our actions. It can be about how we perform our work or how we act towards our colleagues. By hearing out others, we build better relationships, learn about ourselves and improve our performance and success at work.

Reporting a Breach of this Code

When we have little information about a difficult situation or our values seem to be in conflict with each other, we can find ourselves at an ethical crossroads. It is important to make a decision that considers all the consequences, including possible harms. But, it isn't always easy to determine the right course to take.

Decision Making Help	**Ethics Checklist**
• Identify the facts • Determine the ethical principles in conflict: what values represent the different directions you wish to go? • Explore options • Act on your decision	For each possible decision: consider how you might answer each of the following questions: • Does it fit UHN's values? • Does it fit my profession's values? • Is it fair? • Can I justify it? • Will it reflect poorly on UHN? Is it legal?

When you find yourself in an ethical dilemma, you can speak with your manager or People and Culture for guidance.

Whistleblower Line

If the situation is of a serious nature (i.e., cases of theft, fraud, harm to equipment, serious conflict of interest, data falsification, violation of procurement policy) and you are concerned about revealing your identity, you can access UHN's anonymous whistleblower line:

- ClearView Connects: 1-800-344-4491 or through www.clearviewconnects.com

The ClearView whistleblower system allows you to make a report and upload any supporting documents you may have. The information you provide is then sent, without any identifiers, to a number of investigators at UHN who can continue to communicate with you through ClearView, as necessary, all without knowing your identity.
Although UHN cannot guarantee that your identity may be guessed, all efforts to safeguard your identity will be made, unless disclosure is required by law.

Investigations

The more information is provided, the better the investigation. Examples of information that you can report include details about the individuals involved, witness names, location, times, and dates. The ClearView whistleblower system also allows you to upload documents and images. The system is very secure, and only a few people, designated by the Executive Vice President People and Culture, have access to its information.
Investigations will be conducted in a timely and robust manner by the people designated to do so. Whistleblowers themselves should not attempt to investigate, only to provide information. Regardless, UHN will comply with any legal reporting requirements such as those associated with the Occupational Health and Safety Act, environmental protection, or patient safety.

Whistleblower Protection

UHN is committed to protecting whistleblowers, and does not tolerate acts of reprisal against anyone who makes a good faith report of known or suspected ethical or legal misconduct. A "good faith" report means that you have provided all of the information you have and you believe it to be true.
Reprisal is any act that you may experience as a penalty for coming forward. Examples of reprisal include reprimands, intimidation, threats to fire or demote you, and exclusion. Those who engage in reprisal may face disciplinary action up to, and including, termination or loss of privileges. If you believe you experience reprisal, report it immediately through whatever means you used to first report a breach of this Code.
Click here to review the Whistleblower policy

Part 2: Corporate and Administrative Policies

Confidentiality Agreement

1. During my association with University Health Network (UHN), I will have access to information and material relating to patients, medical staff, employees, other individuals, or UHN, which is of a private and confidential nature.

2. At all times, I shall respect the privacy and dignity of patients, employees, and all associated individuals. Specifically with respect to personal health information, I acknowledge that any such personal health information maintained by UHN is subject to the Personal Health Information Protection Act and its regulations and I am familiar with and agree to comply with the Act's provisions related to access, disclosure, retention and disposal.

3. I shall treat all UHN administrative, financial, patient, employee and other records as confidential information, and I will protect them to ensure full confidentiality, including, but not limited to, de-identifying the data, whenever possible. I shall not read records or discuss, divulge, or disclose such information about UHN, unless there is a legitimate purpose related to my association with UHN. This obligation does not apply to information in the public domain. I shall not remove confidential information from UHN premises except when necessary for the provision of health care. When in transit, I shall securely store and ensure the confidential information is in my custody and control at all times. If confidential information must be removed from UHN, I shall ensure it is de-identified, where possible.

4. I shall ensure that confidential information is not inappropriately accessed, used, or released either directly by me, or by virtue of my signature or security access to premises or systems.

5. Violations of this policy include, but are not limited to:
   - accessing information that I do not require for job purposes;
   - misusing, disclosing without proper authorization, or altering patient or personnel information,
   - disclosing to another person your user name and/or password for accessing electronic records.

6. I shall only access, process, and transmit confidential information using hardware, software, and other authorized equipment, as required by the duties of my position. I shall store all electronic confidential information on a UHN secure network. Where electronic confidential information is stored on the local drive, I shall ensure it is de-identified, where possible. I shall report any tools or software requiring hard drive storage for patient care functions to the UHN Privacy Office.

7. I shall immediately report all lost or stolen confidential information to my immediate supervisor and to the UHN Privacy Office.

8. I understand that UHN will conduct periodic audits to ensure compliance with this agreement and its privacy policy.

9. I also understand that should any of these conditions be breached, I may be subject to corrective action up to and including termination of employment, loss of privileges, termination of a contract, or similar action appropriate to my association with UHN. **I understand that a privacy breach is an offence under PHIPA and I may be subject to prosecution by provincial authorities if I am found guilty of this offence.**

10. I understand and agree to abide by the conditions outlined in this agreement, and they will remain in force even if I cease to have an association with UHN. When my relationship with UHN comes to an end, I agree to securely return all property belonging to UHN, including but not limited to keys, devices and any record of personal health information in my possession.

University Health Network
Policy & Procedure Manual
Administrative: Relationship Attestation & Disclosure

Policy

As a publicly funded institution, University Health Network (UHN) has an obligation to preserve public trust and protect the integrity of UHN's mission, which is to provide exemplary patient care, education and research. In order to maintain the highest standard of public trust and integrity, it is expected that staff members will carry out their duties honestly, responsibly and in accordance with the highest ethical standards and professional integrity. It is recognized that relationships exist between UHN and/or UHN staff members and third-party individuals/entities, and that these relationships are critical to fulfill UHN's mission. At the same time, these relationships may give rise to benefits (actual or perceived) for UHN staff members and/or UHN itself, and this may increase the potential for conflicts of interest to arise. As a first step in identifying and managing any potential conflicts of interest, all staff members are required to disclose relevant relationships.

UHN staff members must complete a Relationship Attestation and Disclosure Form annually, and on a transactional basis as new relationships arise, to disclose relationships that influence, or may be perceived to influence, a staff member's duty to patients and their roles, responsibilities and commitments to UHN, and to attest that the staff member is in compliance with this policy.

Disclosures will be managed in a manner that promotes consistency across UHN and may be referred to the UHN Relationship Management Committee (RMC)/UHN Research Subcommittee of the RMC (R-RMC), which will review disclosures and develop management plans, as appropriate, for the purpose of mitigating any actual or perceived conflicts.

Members of the Board of Directors and members of a Committee of the Board of Directors of UHN are required to participate in a disclosure process, and to disclose all relevant relationships pursuant to the UHN Board and Board Committee Conflict of Interest policy.

Note: The requirement to disclose relationships under this policy does not replace any other disclosure requirements that may be applicable external to UHN (e.g. funding agencies, journals, presentations, public communication, guideline committees, etc.). It is expected that staff will adhere to any necessary external disclosure requirements.

Vendors

Staff members must not accept or solicit, directly or indirectly, any offers from vendors which do not comply with UHN procurement policies.

Note: Consult with Procurement Management regarding any interactions with vendors.

Personal Gifts

Staff members must not accept or solicit, directly or indirectly, gifts for personal benefit from third parties, including vendors (including but not limited to, meals, industry sponsored dinners or events, entertainment, favours, goods or services).

Meals served as part of educational events, fundraising activities or business meetings will not be construed as a conflict of interest provided that they comply with any relevant UHN policies and, where applicable, the University of Toronto Faculty of Medicine guidelines, Relationships with Industry and the Educational Environment in Undergraduate and Postgraduate Medical Education.

Funding to attend a charitable event to benefit UHN will not be construed to create a conflict of interest. For clarity, gifts made to a UHN-associated Foundation or to UHN are not considered personal gifts to staff members.

Staff members shall not solicit gifts from patients and/or their families, and should abstain from accepting gifts that fall outside the considerations outlined below. Prior to determining whether to accept a team gift or an individual gift, the staff member recipient shall consider:

- whether the patient/family giving the gift is mentally competent;
- whether the patient/family expects anything in return for giving the gift;
- the potential for negative feelings on the part of other patients who may not be able to, or choose not to give gifts to staff members;
- the monetary value of the gift;
- cultural norms applicable to gifts that are applicable in the circumstances, if any;
- any applicable regulatory requirements; and
- if refusal of the gift would harm the patient-staff member relationship.

Staff members and volunteers are to discuss situations of actual or potential conflict of interest with their supervisor or department head.

Activities and Interests Requiring Disclosure

Conducting Hospital Business

Staff members are required to disclose any hospital business that the staff member conducts, or recommends that UHN and/or its foundation(s) conduct, with:

- a personal associate or
- a company in which the staff member or a personal associate
  a. have a personal and/or a financial interest
  b. are an officer, corporate board director or trustee or have a similar duty

Consulting Activities

Staff members are required to disclose any consulting agreement(s) and activities that they have entered into with any organization or person, insofar as these agreements or activities relate to the staff member's roles, responsibilities and commitments to UHN, and its patients and/or research participants.

Generally, the following activities will **not** be considered to be consulting:

- speaking engagements at academic institutions or other academic work, participation in collegial seminars, or visiting professorships
- honoraria or expense reimbursement from not-for-profit or government organizations
- professional services provided under a hospital service provider contract with another company (e.g. performing independent medical evaluations pursuant to a UHN agreement with WSIB)
- serving as an editor or part of on an editorial board of a medical or scientific journal or a medical or scientific reference textbook
- professional affiliations with governmental agencies or advisory groups to not-for-profit institutions
- acting as a peer reviewer or participating in granting agency peer-group review panels
- clinical consultation

External Appointments

Staff members are required to disclose any positions or appointments held outside of UHN, insofar as they relate to a staff member's roles, responsibilities and commitments to UHN and its patients and/or research participants.

The following appointments do **not** require disclosure:

- academic appointments or medical privileges at other institutions
- membership on peer group review panels
- acting as a corporate board director or officer in the staff member's medical

professional corporation
- editorial board positions

Grants/Contracts and Other Funding

Staff members are required to disclose any funding from any for-profit companies or private foundations (whether received directly, through UHN, including through a department, or via a UHN Foundation) which support a staff member's clinical or other hospital activities (e.g. fellowship salary or educational activity support). The funding can be through grants, donations or other financial awards or through any other non-consulting related contracts.

Funding from the following sources do **not** require disclosure:

- government
- not-for-profit or public sector sources, e.g. World Health Organization, Genome Canada
- public foundations, e.g. Heart & Stroke Foundation
- fundraising events

Staff members are also required to disclose any funding or in-kind support received from a company/organization for research/quality improvement projects if they possess a corresponding personal or financial interest with the company/organization that provides the support.

Holdings

Staff members are required to disclose their or their personal associate's holdings in a company operating in areas related to the staff member's professional field or discipline, hospital operations, or the delivery of healthcare, and which relate to the staff member's roles, responsibilities and commitments to UHN and its patients and/or research participants.

This does **not** include indirect ownership through mutual funds, exchange traded funds, or similar securities. This also does not include ownership of widely held publicly traded shares, **unless the staff member is conducting research involving such corporation's products or services**.

Intellectual Property

Staff members are required to disclose any intellectual property which they have invented or own that is licensed to or acquired by a company/organization, and where the staff member or a personal associate:

- has a personal and/or financial interest in a company/organization that has licensed or acquired the intellectual property, **or**
- is an officer, corporate board director or trustee, or have a similar duty in a

company/organization that has licensed or acquired the intellectual property, **or**
- has a financial interest as inventor(s).

Foreign affiliations

Staff members are required to disclose any positions, associations, affiliations, employment or appointments to non-U.S. foreign institutions and/or any relationships for which they receive any direct or indirect benefits, including funding received abroad, from a non-U.S. international source, whether private, government or academic.

Other Activities

Staff members are required to disclose any other relationships they or their personal associate have not already disclosed that may be perceived to impact the staff member's ability to impartially and objectively fulfill their duties to UHN.

If in doubt as to whether certain activities or situations could be perceived to impact a staff member's role, the staff member should disclose the relationship, as the disclosure process can provide an objective review to identify and prevent any potential issues.

Consequences for Non-Compliance

A staff member's failure to make proper disclosures, to follow a prescribed management plan, or to otherwise comply with this UHN policy may be grounds for corrective action.

Review of Policy

This policy will be reviewed by the RMC every two years, and revised as required.

Confidentiality

The disclosures made further to this policy will not be divulged outside of the RMC without the written consent of the person making the disclosure, with the exception that information may be shared/divulged:

- by UHN for the purposes of complying with its operational policies (including this policy); however, in such circumstances the individuals having access to the disclosed information will be on a "need to know" basis, and further restricted regarding use and disclosure (as appropriate for the context);
- for the purposes of complying with applicable laws.

Relationship Attestation & Disclosure Process

1. Staff members must complete a Relationship Attestation and Disclosure Form annually, and on a transactional basis.

2. An initial review of the completed Relationship Attestation and Disclosure Form will be conducted to ascertain whether any disclosed relationships may require a management plan.

   Note: In any review of consideration of a relationship disclosure, the staff member disclosing the matter may be asked to provide additional information.

3. Relationship disclosures will be considered in light of the following:

   - The extent to which the disclosed relationship will affect the ability of the staff member to meet their duties, responsibilities and commitment to UHN.

   - The importance of the relationship to the mission of UHN, as well as any potential consequences that might result from the relationship (e.g. the effect of public perception on the activities taking place at UHN or on the practices of other staff members).

   - The extent to which the activity can be accommodated and managed without interfering with work being carried out at UHN or raising public perception concerns.

4. If it is determined that a disclosed relationship may give rise to a real or perceived conflict of interest, managing the relationship to reduce conflict of interest risk and allowing the activity to proceed is first explored, as it is understood that relationships are a critical part for UHN to fulfill its missions. In such cases, a management plan shall be developed by the Compliance Office and/or the Committee. To ensure consistency and efficiency, commonly disclosed relationship types will be identified by the Compliance Office and Committee and standard management plans will be developed for such relationships.

5. All management plans will be issued to the disclosing staff member in writing, and plans are considered effective two weeks after they have been issued. If a staff member has concerns about their plan, the staff member should contact the Compliance Office within this two week period of time. The disclosing staff member is expected to follow the requirements set out in the plan. Management plans will also be copied, as applicable, to the discloser's department/ division head, other relevant departments (e.g. procurement, commercialization, research and legal departments), research institute directors, or the senior management team's immediate supervisor. If a staff member is asked to return a signed management plan to the Compliance Office and fails to do so, this will be communicated to their department/division head, research institute director, or immediate supervisor, as applicable.

Note: Staff members are encouraged to discuss any difficulties regarding compliance with the terms of their management plan with their department/ division head, research institute director, or immediate supervisor, as applicable.

6. In the event that the staff member feels they have grounds to appeal the management plan that has been proposed, they may request that the matter be reviewed as follows:

   - In the case of a management plan issued by the Compliance Office, any appeal will be to the RMC or R-RMC, whichever is most appropriate.

   - In the case of a management plan issued by the Committee, individuals may provide a briefing note to the Compliance Office outlining new or different information they wish the Committee to consider and may request to appear before the Committee to ask for re-consideration based on new/different information only. The Committee that developed the management plan (RMC or R-RMC) will be the Committee that conducts the re-consideration.

   - Re-consideration decisions of the RMC/R-RMC are final. Appeals to any further re-consideration decisions of the Committee will be to the chief executive officer (CEO), who may delegate the review to the Executive Leadership Forum (ELF)

Referral to Other Policies

This policy should be read in conjunction with:

- Conflict of Interest policy 2.50.002
- Conflict of Interest of Research Personnel policy 40.90.002
- Procurement policy 1.90.012
- Green Procurement policy 1.120.006
- University of Toronto's Faculty of Medicine guidelines: Relationships with Industry and the Educational Environment in Undergraduate and Postgraduate Medical Education

Implementation

This policy will come into force in a staged manner. Individual groups will be notified well in advance of the need to complete the Relationship Disclosure and Attestation Form.

Definitions

Consulting: Providing a professional service related to a person's field or discipline to a third party where the main objective is to further the interests of the third party. Consulting shall include:

- providing advice and services to industry (e.g. a pharmaceutical or medical device company)
- acting as an advisory board member in a for-profit organization
- acting as an expert witness
- speaking engagements supported in whole or in part by a for-profit organization
- independent medical evaluations outside of UHN

External appointments: Positions or appointments held outside of UHN where a staff member is an officer, corporate board director or trustee, or has a similar duty in a for-profit or not-for-profit organization, a lobby group or industry organization. These positions may or may not include financial benefit and/or ownership interests.

Financial interest: An opportunity to receive anything of monetary value, e.g. salary, royalties, fees, work-in-kind, gifts or other payments, dividends or distributions, including, through equity, partnership or beneficial interests (e.g. stocks, stock options, or other ownership interests) or intellectual property rights.

Foreign affiliation: Any position, association, affiliation, employment or appointment to a non U.S. foreign institution and/or any relationship for which a staff member may receive any direct or indirect benefits, including funding received abroad, from a non U.S. international source, whether private, government or academic.

Hospital business: Having an opportunity in a staff member's role at UHN to influence transactions affecting UHN and/or its foundation(s), such as approving contracts, providing input on the engagement of individuals or companies, or recommending the purchase or use of goods (including, but not limited to participation on a procurement committee evaluating a response to a request for proposal).

Intellectual property: Inventions or discoveries (whether patentable or not), technology, technical information, know-how, trademarks, official marks, industrial designs, or literary and artistic works, and other copyrighted materials.

Personal associate: (i) spouse or spouse equivalent; (ii) a family member or other person in a close personal relationship who could be perceived to influence a staff member's roles, responsibilities and commitments to UHN and its patients and/or research participants.

Relationship: Any association, activity or situation in which a staff member or staff member's personal associate(s) has/have personal, business, professional, or other interests that may impact, or be perceived to impact, a staff member's roles, responsibilities and commitments to UHN and its patients and/or research participants.

Of particular importance are relationships that result in, or may result in:

- a direct or indirect financial benefit to the staff member or their personal associate;
- a gain, advantage or preferential treatment for the staff member or their personal associate;
- the use of privileged or confidential information, including personal health information, for personal gain;
- a reciprocal benefit or arrangement between the staff member and their personal associate, and an external organization or individual;
- outside interests or activities that may erode the public's trust or the trust of staff in the integrity of UHN; and,
- outside interests, activities or commitments that impede or could be perceived to impede the staff member from meeting their duty to patients and/or research participants or the staff member's roles, responsibilities and commitments to UHN.

Staff member(s): UHN physicians/dentists with active-primary and active-provisional appointments, UHN-appointed scientists, select members of the senior management team and those identified as Institutional Officials (IOs), as per UHN's Guidelines for Management of Relationships involving Institutional Officials.

University Health Network
Policy & Procedure Manual
Administrative: Privacy & Access

1. Policy

University Health Network (UHN) is committed to prioritizing the needs of patients. UHN recognizes the right to privacy as a principle of respect for patient autonomy, based on the individual's right to control information related to their healthcare.

Patient privacy and a patient's right to access their health records are protected by law under the Personal Health Information Protection Act (PHIPA).

The privacy of visitors to UHN, including patient family members and caregivers, is protected by the Freedom of Information and Protection of Privacy Act (FIPPA). FIPPA also provides members of the general public with the right to request access to copies of UHN's corporate records. For UHN revenue-generating initiatives, customer privacy is protected by the Personal Information Protection and Electronic Documents Act (PIPEDA) and Canada's Anti-Spam Legislation (CASL).

UHN's commitment to privacy and access to information, as set out in these statutes, requires all of its agents to comply with this policy and related policies concerning information.

This policy applies to UHN as a health information custodian, its agents (including employees, physicians, contractors, consultants, volunteers, learners, and other workers at UHN, including all personnel affiliated with third parties), and to all programs, procedures, and technologies at UHN that involve personal health information (PHI).

1.1 Patient Privacy Rights

UHN makes specific information about its policies and practices relating to the management of patient privacy readily available to individuals. (See Privacy at University Health Network patient education brochure (form D-5053) for more information.)

UHN will provide patients with information about:

- why PHI is collected
- how it is used
- with whom it may be shared and why
- patient rights with respect to the PHI

1.2 Rules for the Use and Disclosure of PHI for the Purpose of Providing Patient Care

1.2.1 Patient Requests for Access to Records

Patients may access some of their PHI collected for clinical care electronically using the UHN patient portal, myUHN. Through myUHN, patients can access upcoming and past appointments, as well as completed results, notes, reports, and other records.

Patients may also contact UHN Health Record Services (HRS) from myUHN or via email at HealthRecordServices@uhn.ca to request access to, or copies of, their clinical records of PHI.

Patients requesting copies of their records for themselves or for third parties (such as lawyers or insurance companies) should complete the Authorization for Disclosure of Personal Health Information form (form 2323) or other equivalent written request which may include documentation by a care provider in the health record. (Form 2323 is available on the myUHN portal and the UHN website.)

Refer to Patient Access to the Medical Record policy 1.40.003 for more information about patients' rights to access their records of PHI, including the right to access their original records and/or their chart during an inpatient admission.

1.2.2 Accuracy of Records

Patients may contact HRS to challenge the accuracy and completeness of their information as contained within their medical record, and to request a correction. If a challenge/correction request is not resolved to the satisfaction of the patient, they have the right to appeal UHN's decision to the Information and Privacy Commissioner of Ontario (IPC), and/or to submit a statement of disagreement, which UHN will store in the patient's medical record.

HRS may send corrected information or the statement of disagreement, at the request of the individual, to the persons to whom UHN has disclosed the information with respect to which the individual requested the correction of the record, except if the correction cannot reasonably be expected to have an effect on the ongoing provision of healthcare or other benefits to the individual.

Refer to Patient Requests for Correction to Medical Record policy 1.40.010 for more information.

1.2.3 Patient-Requested Audits

Patients may contact UHN Privacy to request an audit log of accesses to their electronic medical record. (Refer to the Audit Request Form.)

1.2.4 Consent Directive/Lockbox

Patients may withdraw their consent to the collection, use, and disclosure of their PHI for the purpose of providing healthcare to them. This is commonly referred to as a "lockbox".

Clinicians must request consent to override a lockbox for the purpose of providing care, either from the patient or the substitute decision maker (SDM) for the patient. The clinical user may override the lockbox citing an emergency only when:

- it is not reasonably possible to obtain this consent, **and**
- the risk of not accessing the locked information may lead to serious harm.

Other staff who require access for purposes such as billing, coding, scheduling, etc. do not require express consent and may override the lock in the health information system (HIS) by selecting the reason "Support Functions."

Lockbox requests from patients are generally submitted using a Lockbox (Consent Directive) Request Form and by contacting the Privacy Office at 416-340-4800 ext. 6937 or by email at privacy@uhn.ca.

1.2.5 Information and Privacy Commissioner

Patient privacy concerns should be escalated to UHN's Privacy Office. In situations where UHN Privacy is unable to resolve a concern, patients will be advised that they may contact the IPC by email at info@ipc.on.ca or by phone at 416-326-3333.

1.2.6 Freedom of Information

As part of the broader public sector, all Ontario hospitals are subject to FIPPA. FIPPA provides a public right of access (with limited exceptions) to records in the custody or control of UHN. FIPPA does not apply to records of PHI.

All FIPPA requests must be submitted in writing to the UHN FIPPA Coordinator's Office. Requestors may be referred to UHN's Freedom of Information website or to email at FOI@uhn.ca to obtain further information.

1.2.7 Cooperation with the UHN Privacy Office

All UHN agents are required to cooperate with Privacy Office staff during a complaint, breach investigation, containment or remediation of a privacy issue, a privacy impact assessment, or an audit. Failure to cooperate with Privacy Office staff in their attempts to ensure or support compliance with UHN policy or provincial privacy laws may result in disciplinary measures.

1.2.8 Consent

UHN collects, uses, and discloses PHI with the consent of the patient or their SDM, or as is otherwise permitted or required by PHIPA and the Public Hospitals Act (PHA).

Where consent of an individual is required, the consent must:

- be of the individual
- be related to the information
- not be obtained through deception or coercion

The individual must be informed:

- of the purpose of the collection, use or disclosure of the information, **and**
- that consent may be provided or withheld.

1.2.9 Express and Implied Consent

UHN may rely on express or implied consent when collecting, using, or disclosing PHI for the purpose of providing patient care. PHI may be used and disclosed with assumed implied consent to healthcare professionals within a patient's **circle of care**, which includes, but is not limited to, doctors, nurses, pharmacists, allied health professionals, administrative staff supporting the provision of care, other employees assigned to care for a patient, and learners.

A patient's **express consent** is required for a patient's PHI to be disclosed:

- to a person that is not a health information custodian (HIC); **or**,
- for a purpose other than providing healthcare or assisting in healthcare.

Refer to Release of Patient Information policy1.40.002 for further information on:

- how to obtain a patient's express consent for the disclosure of their PHI for a non-healthcare purpose
- circumstances where disclosure for non-healthcare purpose may occur without consent

Refer to Consent for the Collection, Use & Disclosure of Personal Health Information for more information about when a patient's express consent is required, when implied consent may be sufficient, and when PHI may be used or disclosed without patient consent.

1.2.10 Obtain Consent from the Capable Patient

When consent is required for the collection, use, or disclosure of an individual's PHI, the consent must be obtained from the patient when the patient is capable of consenting to the collection, use, or disclosure.

An individual is capable of consenting to the collection, use, or disclosure of PHI if the individual is able to:

- understand the information relevant to deciding whether to consent to the collection, use, or disclosure of PHI, **and**
- appreciate the reasonably foreseeable consequences of giving, not giving, withholding or withdrawing the consent.

Where the individual is not capable of consenting to the collection, use, or disclosure of PHI, consent must be obtained from the patient's SDM.

1.2.11 Privacy Reviews, Privacy Impact Assessments & Threat-Risk Assessments

All new programs and projects at UHN that impact how PHI/personal information (PI)/corporate confidential information (CCI)/anonymized information is handled or stored require review by the UHN Privacy Office. UHN Privacy and Digital Security will assess projects to ensure that appropriate physical, administrative, and technical safeguards are in place. This requirement does not apply to research projects. For research, refer to section 1.3.4 Research.

The project owner must submit a Privacy Intake Form for Projects to UHN Privacy.

UHN Privacy may conduct a privacy impact assessment (PIA) to assess the impact that the new system, technology, or program may have on an individual's privacy and the confidentiality of their PHI, and to ensure that proper information governance is in place. (Refer to Privacy Support for Projects for more information.)

Where projects involve a new technology or change in technology, a threat-risk assessment by UHN Digital Security is also required.

1.2.12 Security of Systems and PHI

UHN protects PHI through appropriate physical, administrative, and technical safeguards. The safeguards are consistent with industry best practices to protect PHI while being transferred, processed, or stored. These safeguards include security software and encryption protocols, firewalls, locks and other access controls, privacy impact assessments, threat-risk assessments, staff training, and confidentiality agreements.

The Privacy Office and Digital Security monitor the security of PHI by conducting audits of clinical systems and business units.

1.2.13 Appropriate Use of Information Technology at UHN

All UHN agents must be aware of their obligations under, and abide by, Appropriate Use of Information & Information Technology policy 1.40.012, which requires UHN agents to

use only UHN-approved information technology (IT) resources to conduct UHN business.

All forms of technology involving PHI at UHN must be used in a manner consistent with this policy and Appropriate Use of Information & Information Technology policy 1.40.012, including technologies not explicitly mentioned in these policies.

For more information about the appropriate use of IT at UHN, staff can contact UHN Digital at ext. 4357.

1.2.14 Vendor and External Party Access to UHN PHI

All vendors, contractors, consultants, or other external parties who require access to UHN IT and/or UHN PHI must enter into a signed written agreement with UHN, reviewed by Corporate Legal Affairs, that includes:

- UHN Confidentiality Agreement
- UHN Information Practices Agreement, available from the Privacy Office
- requirement for vendors, contractors, or consultants to complete UHN Privacy and Cyber Security eLearning or equivalent training approved by the UHN Privacy Office

(For further information, refer to Vendor & Related Party Access policy 1.40.018, Procurement policy 1.90.012, and Appropriate Use of Information & Information Technology policy 1.40.012.)

1.2.15 Retention, Archiving and Destruction of PHI

UHN has established information retention guidelines that define consistent minimum standards and requirements for the length of time records of PHI are to be maintained. (Refer to Management, Retention & Destruction of UHN Records policy 1.30.007.)

UHN has established appropriate practices and timelines for the secure disposal of PHI, consistent with confidentiality, legal, and regulatory requirements. (Refer to Management, Retention & Destruction of UHN Records policy 1.30.007.)

Researchers are responsible for the storage/retention of research data, as defined in their approved research protocol. (Refer to Data Ownership, Stewardship & Security of Health Information policy 40.50.004 and Management, Retention & Destruction of UHN Records policy 1.30.007.)

1.3 Rules for the Use and Disclosure of Patient Data for Purposes Other Than for Care (Research, Quality Improvement, Education)

PHI or anonymized data that is sent from or received by UHN for research, quality improvement, or educational purposes must be handled in compliance with UHN

policies. Any necessary consents and/or internal approvals must be obtained prior to use or transfer. Also refer to Data Access, Sharing, and Use policy 1.130.002 for guidance on the principles and rules that ensure data is available to support organizational strategy and operations.

1.3.1 Limiting PHI and the UHN De-identification and Anonymized Data Standard

UHN and its agents must only collect, use, disclose, and retain the minimum amount of PHI required to achieve the research, quality improvement, or education purpose.

De-identified information should be used instead of PHI whenever it is feasible to do so.

The **UHN De-identification and Anonymized Data Standard** ("Standard") provides guidance to UHN agents using personal health information for a purpose other than to provide care (i.e. research, quality improvement) with respect to how to modify patient data, images, or recordings in order for the data to be sufficiently de-identified and no longer considered PHI.

Data, images, or recordings that do not conform to this Standard may be considered PHI.

When UHN agents are not able to anonymize information to meet the Standard, the Privacy Office must be consulted for advice and recommendations on risk mitigation.

1.3.2 Use of Anonymized Information

Anonymized information (including data, images, and recordings) is considered a UHN corporate resource. Any use or transfer outside of UHN of anonymized information must comply with UHN policies. Any necessary approvals must be obtained prior to use or transfer.

Anonymized patient/participant information may be used for UHN-supported purposes (including patient care, research, quality improvement, or education) provided it is used in a manner that:

- does not jeopardize the safety or well-being of patients/participants and the UHN community
- does not reflect poorly on UHN
- is consistent with UHN's stated values
- does not expose UHN to unacceptable ethical, reputational, legal, regulatory or technical risks

When publishing, sharing, or presenting anonymized information:

- Do not add information that would cause the data or images to become identifiable, or unnecessarily increase the risk of re-identification.

- Ensure that descriptions and commentary related to anonymized information are professional in both tone and content.

- Follow UHN's Data Ownership, Stewardship & Security of Health Information policy 40.50.004 and Social Media Guidelines.

1.3.3 External Data Sharing of PHI and/or Anonymized Information for Research, Quality Improvement and/or Education

When sharing data outside of UHN for research, quality improvement, or education:

- Always consult with UHN Legal to determine whether a data sharing agreement is required for the data sharing initiative.

- Always consult with Privacy where rare images or data are at play.

- When sharing PHI, consult with UHN Privacy and Digital Security to determine whether a privacy impact assessment and/or threat risk assessment is required.

  Note: Where sharing PHI further to a Research Ethics Board (REB)-approved study, consultation with Privacy and Digital Security is not required.

- When the project involves technology, consult with Privacy and Digital Security.

  Note: For research projects, consultation with Privacy and Digital Security is required only for UHN-investigator initiated studies. Consultation is not required for industry sponsored studies.

Exceptions: Regulatory reporting, OHIP billing, case conferences.

1.3.4 Research

Research project proposals involving the collection, use, or disclosure of PHI, anonymized or any other UHN data must be reviewed and approved by the UHN REB or an authorized external Board of Record (BOR). The REB or BOR will address consent requirements for the use of PHI. (Refer to Requirements for Informed Consent Process policy 40.20.011.)

All data arising from research projects must conform to Data Ownership, Stewardship & Security of Health Information policy 40.50.004 and section 1.3.12 Information Governance for Storage of PHI at UHN Outside of the Health Information System of this policy, including the requirements for access controls, auditing, and secure storage.

1.3.5 Quality Improvement Project Proposals

Quality improvement (QI) projects must:

- be submitted to the UHN Quality Improvement Review Committee (QI@uhn.ca) for review and institutional approval prior to proceeding, **and**
- have approval by the appropriate manager/director/executive sponsor, depending on the scope of the project.

For more information on which projects must be submitted, refer to the Privacy and Security Intake Form.

1.3.6 Consent and QI Projects with External Data Sharing

Except where the patient's express consent has been obtained for such disclosure, PHIPA does not permit the disclosure of PHI to external parties (nor in publications) in relation to QI projects. (For example, the transfer of UHN PHI to a multi-site QI project without patient consent is not permitted.)

1.3.7 Education

PHI may be used without consent for the purposes of educating UHN agents. For internal UHN use, a supervising clinician, department head, or manager must approve the use of PHI for educational purposes where the trainee/agent is not in the patient's circle of care. Where training agents outside of the circle of care, PHI should be anonymized to the greatest extent possible to achieve the purpose.

If collecting and storing patient data outside of the HIS for educational purposes (i.e. in a registry), refer to the Data Access, Sharing, and Use policy 1.130.002.

The sharing of anonymized information for external educational purposes requires approval by an executive sponsor (defined as a vice-president (VP) or executive vice-president (EVP) or appropriate delegate/signatory authorizing the educational initiative).

Exceptions: Where UHN staff share case studies at a conference or share anonymized medical images through social media for educational purposes in accordance with Use of Medical Images in Education, VP/EVP approval is not required as long as the data is fully anonymized and/or patient consent has been obtained and documented.

(Also refer to External Observers and Authorized Guests in Clinical Areas policy 1.40.019 and Remote Observation of Surgical Procedures policy 37.30.001.)

1.3.8 Consent and External PHI Sharing for Educational Purposes

Except where the patient's express consent has been obtained, PHIPA does not permit the disclosure of PHI to external parties for educational purposes. See section 1.3.3 External Data Sharing of PHI and/or Anonymized Information for Research, Quality Improvement and/or Education.

(Also refer to External Observers and Authorized Guests in Clinical Areas policy 1.40.019 and Remote Observation of Surgical Procedures policy 37.30.001.)

1.3.9 External Observers in Clinical Areas

To foster excellence in patient care and academics, select individuals who are not part of a patient's internal care team may observe examinations, procedures, and other activities for educational purposes. Such observerships must comply with the requirements set out in External Observers and Authorized Guests in Clinical Areas policy 1.40.019.

Vendors who require access to clinical areas for patient care or training duties must comply with Vendors in Clinical Areas policy 1.40.025.

1.3.10 Registries

When collecting and storing patient data in internal registries or sharing patient data with registries external to UHN, refer to Data Access, Sharing, and Use policy 1.130.002.

1.3.11 Exceptions

Exceptions to the rules governing the use and sharing of anonymized data set out in this policy must be approved by the Chief Legal Officer.

1.3.12 Information Governance for Storage of PHI at UHN Outside of the Health Information System

The project owner must submit any project involving the storage of PHI outside of the health information system for research, quality improvement, education, or care purposes to UHN Privacy and UHN Digital Security for review and to ensure that the following standards are met:

- access to records is given only to those with a professional need to know
- the records are protected from corruption or loss
- an audit trail is created when records are accessed or released, and audit logs are retained
- records are available in a timely and efficient manner
- records are stored, retained and disposed of in accordance with Management, Retention & Destruction of UHN Records policy 1.30.007 and Appropriate Use of Information & Information Technology policy 1.40.012
- agents are properly trained, including UHN's mandatory annual Privacy and Cybersecurity eLearning, and adhere to the policies and procedures developed for the management of records that they handle in the course of their duties

1.4 Privacy Operations Services

1.4.1 Privacy Incidents

UHN agents must report privacy incidents, including instances when an agent knows, or has reason to believe, that PHI was collected, used, or disclosed without proper authorization and when PHI is lost or stolen. A UHN agent must also report situations that present a risk to patient privacy.

Both the report form and instructions for completing the form can be found on the UHN Safety Event Reporting & Review web portal. Privacy incidents are investigated and managed in accordance with Patient Safety Event Reporting & Review policy 3.20.005.

UHN relies on agents to participate in the review of privacy incidents in order to determine the extent of a breach, to mitigate its impact, and to prevent or reduce the recurrence of similar incidents. Early reporting of privacy incidents can result in mitigation strategies that reduce the extent of the breach and its consequences. (Refer to the Incident Management section of the Privacy Office website for more information.)

When privacy incidents occur, UHN Privacy will assist agents to:

- identify the scope of the breach and take steps for containment;
- notify the individuals affected by the breach, as soon as reasonably possible, and include certain required information in the notice, including a statement that the individual is entitled to make a complaint to the IPC; **and**
- notify any staff (and other custodians, as appropriate) who need to be advised of the breach.

Where required by PHIPA, UHN Privacy will notify the IPC and/or the regulatory colleges as appropriate.

1.4.2 Department and System Audits

The Privacy Office conducts audits of information systems used to collect, use, document, and disclose PHI for the purpose of detecting and deterring unauthorized activity. Site visits are also conducted on request or as part of a review or investigation.

1.4.3 Accessing Records of PHI

UHN agents may only access records of PHI as needed for the purposes of their UHN-authorized role. Any other access is considered a privacy breach and may be reportable to the Information and Privacy Commissioner of Ontario and incur discipline as described in Sanctions for Breaches of Personal Health Information policy 2.50.008.

UHN agents must not directly view their own health records in UHN's electronic systems. These systems are only to be used for work-related purposes. As is the case with any other patient, UHN agents may access their PHI using the myUHN Patient Portal or by contacting Health Records.

UHN agents may not access the records of family members, neighbours, or friends, even with their consent, except for work-related purposes.

1.4.4 Email

Refer to Consent for Use of Email policy 1.40.014, Appropriate Use of Information & Information Technology policy 1.40.012, and Information Security policy 1.40.028 for complete details on the acceptable usage of email and best practices.

1.4.5 Use of Shared Systems for Patient Care Only

Shared systems enable healthcare providers to centrally access PHI from healthcare facilities across Ontario. Examples of shared systems are:

- ConnectingOntario
- OLIS (laboratory test orders and results)
- DHDR (dispensed drug history)
- Care Everywhere

Shared systems may **only** be used for patient care. This is a standard provision in the terms of use for each system. Shared systems **may not** be used for research, training, quality improvement, or educational purposes. These systems are audited and subsequently investigated. Confirmed misuse can result in user access suspension/ termination.

1.4.6 Training and Awareness

UHN makes its agents aware of the importance of maintaining the confidentiality of personal health information.

All UHN agents must sign a Confidentiality Agreement (form D-3236) or online through UHN's mandatory privacy and security training module, and complete UHN privacy training at the onset of their association with UHN and annually thereafter.

Ongoing educational efforts will be delivered by UHN Privacy to ensure all UHN agents are provided with tools, training, and support, as appropriate, to assist them in fulfilling their duties as it relates to the privacy of PHI.

1.4.7 Ministry of Health, Government Agencies & Government-Funded Agencies

The law permits UHN to disclose PHI to organizations such as the Ministry of Health, Ontario Health, Public Health Ontario, Canadian Institute for Health Information, Institute for Clinical Evaluative Sciences (ICES), and other similar organizations for the planning and management of the health system.

An agreement must be in place between UHN and the organization before any PHI is disclosed to the organization. If an agreement is not in place, UHN Legal must be contacted and will assist in developing an agreement.

1.4.8 PHI from Outside Organizations

Whenever an agent of UHN is provided with records of PHI from an outside organization for the purpose of the provision of care (such as a hospital, researcher, or government agency), UHN policies and procedures governing the handling and retention of PHI must be followed with respect to the external records. These records become part of the patient chart.

1.4.9 Enforcement and Sanctions

UHN applies progressive discipline in dealing with privacy breaches; however, any breaches of this policy, including, but not limited to, repeated or intentional breaches and breaches of related privacy policies may result in suspension or termination, and reporting to the relevant regulatory college and the Information and Privacy Commissioner of Ontario as outlined in Sanctions for Breaches of Personal Health Information policy 2.50.008 and the UHN Confidentiality Agreement (form D-3236).

Collection, use, or disclosure of PHI in contravention of PHIPA may result in fines of up to $200,000 for individuals and up to $1,000,000 for UHN upon conviction. UHN will not normally cover or insure individuals for fines resulting from the collection, use or disclosure of PHI in contravention of PHIPA and this policy.

1.4.10 Employee Privacy

UHN is committed to protecting the privacy of its employees. Employee personal information will only be collected, used, and disclosed as per Personal Information Protection policy 2.10.013. Employees who have requests or concerns regarding their UHN employee records should contact People & Culture. UHN may electronically monitor employees' online activities as described in Electronic Monitoring policy 1.40.004.

1.4.11 Policy Review

This policy will be reviewed at least once every two years and as issues arise, including amendments to legislation or new guidance from the IPC. The Privacy Office will be responsible for ensuring that any relevant changes to this policy are communicated to UHN agents, patients, and visitors.

1.5 Related Documents

- Code of Workplace Ethics
- Confidentiality Agreement (form D-3236)
- Consent for the Collection, Use & Disclosure of Personal Health Information

- Data Ownership, Stewardship & Security of Health Information policy 40.50.004
- Data Quality policy 1.40.016
- Patient Safety Event Reporting & Review policy 3.20.005
- Appropriate Use of Information & Information Technology policy 1.40.012
- Patient Access to the Medical Record policy 1.40.003
- Patient Requests for Correction to Medical Record policy 1.40.010
- Personal Information Protection policy 2.10.013
- Release of Patient Information policy 1.40.002
- Sanctions for Breaches of Personal Health Information policy 2.50.008
- Management, Retention & Destruction of UHN Records policy 1.30.007
- Vendors in Clinical Areas policy 1.40.025
- Vendor & Related Party Access policy 1.40.018.
- Electronic Monitoring policy 1.40.004

2. Definitions

Note: All defined terms appear in this policy. The first instance of each term in each section of this policy is hyperlinked to its definition; however, every instance of a defined term has the same definition.

Agent: A person that, with the authorization of UHN, acts for or on behalf of the organization in respect of PHI for the purposes of UHN, and not the agent's own purposes, whether or not the agent has the authority to bind the custodian, whether or not the agent is employed by UHN, and whether or not the agent is being remunerated. Examples of agents of UHN include, but are not limited to: employees, volunteers, learners, physicians, residents, fellows, consultants, researchers, vendors.

Anonymized information: Information for which it is not reasonably foreseeable in the circumstances that it could be utilized, either alone or with other information, to identify an individual and is anonymized in accordance with UHN's Anonymization Standard. Includes data, images, and recordings. Anonymized data is different from coded data.

Coded data: Data that has certain direct identifiers removed but which does not meet the standard of anonymized; it is still considered personal health information.

Collect personal health information: To gather, acquire, receive, or obtain the information by any means from any source.

Confidential information: Confidential information maintained at UHN falls under the following three categories:

- **Corporate confidential information (CCI):** Information maintained by UHN that is not routinely made publicly available, including financial, administrative, commercial, and technical information, and may also include records containing

legal advice and employee-related information. These records may be subject to FIPPA.

- **Personal health information (PHI):** Any identifying information about an individual relating to the individual's health or to the provision of healthcare to the individual. For example, an individual's health insurance number and/or medical record number would be considered personal health information, subject to PHIPA.

- **Personal information (PI):** Information about an identifiable individual not related to the individual's health or to the provision of healthcare to the individual. Examples include an individual's age, religion, address, and telephone number. Records that contain PI may be subject to FIPPA.

Disclose personal health information: To make PHI available or to release it to another health information custodian or to another person outside of UHN.

Health information custodian (HIC): Persons or organizations under PHIPA, such as hospitals, who have custody or control of PHI as a result of the work they do. As a public hospital, UHN is a health information custodian (as per Personal Health Information Protection Act, 2004, Schedule A, Explanatory Note).

Information and Privacy Commissioner of Ontario (IPC): The IPC oversees compliance by public institutions and healthcare providers with provincial access and privacy laws. In performing this role, the IPC will resolve appeals when access to information is refused, investigate privacy complaints related to PI/PHI, review privacy policies and information management practices, conduct research on access and privacy issues, and educate the public.

Personal health information: See confidential information.

Project owner: The UHN manager, director, principal investigator, project manager, or staff member who has been delegated the authority from a department to initiate or oversee a project or research study.

Record of personal health information: PHIPA defines a record as PHI in any form or in any medium, whether it be in written, oral, printed, photographic or electronic form, or otherwise. This includes emails and video recordings.

Substitute decision maker (SDM): If an individual is determined to be incapable of consenting to the collection, use, or disclosure of PHI by a health information custodian, a person described in one of the following paragraphs may, on the individual's behalf and in the place of the individual, give, withhold, or withdraw the consent:

- The individual's guardian of the person or guardian of property, if the consent relates to the guardian's authority to make a decision on behalf of the individual.

- The individual's attorney for personal care or attorney for property, if the consent relates to the attorney's authority to make a decision on behalf of the individual.

- The individual's representative appointed by the Consent and Capacity Board if the representative has authority to give the consent.

- The individual's spouse or partner.

- A child or parent of the individual, or a children's aid society or other person who is lawfully entitled to give or refuse consent in the place of the parent. This paragraph does not include a parent who has only a right of access to the individual. If a children's aid society or other person is lawfully entitled to consent in the place of the parent, this paragraph does not include the parent.

- A parent of the individual with only a right of access to the individual.

- A brother or sister of the individual.

- Any other relative of the individual.

Use personal health information: To view, handle, or otherwise deal with the information within UHN or among UHN agents only. Use does not include disclosure of the information outside of UHN.

University Health Network
Policy & Procedure Manual
Administrative: Intellectual Property Protection & Commercialization

Policy

University Health Network (UHN) encourages the development of inventions, creations and other intellectual property (IP) arising from research, clinical, educational and related activities conducted at UHN. UHN seeks, where it deems appropriate, to secure IP protection for the outputs of such activities. UHN also seeks to encourage the development and commercial investment of UHN IP for the benefit of, amongst other stakeholders, the public, patients, creator(s), and the research sponsors. This requires UHN to secure, manage, and develop the IP, so that the IP may be transferred appropriately to third parties for the development and marketing of new healthcare products and services. This policy sets out the framework through which IP is managed for the benefit of UHN and its stakeholders.

General Matters & Administration

It is the policy of UHN that all IP which is conceived and reduced to practice (i) by UHN personnel using UHN resources, or (ii) otherwise using UHN resources in any manner, is the property of UHN. This UHN-owned IP is either classified as research works (where creator(s) of the IP are entitled to a share of net revenues with UHN) or institutional works (where UHN retains all net revenues). The sole exception to this UHN-owned IP is traditional academic works which remain the property of the author(s).

UHN will exercise ownership and management of UHN-owned IP with due regard to the principles and procedures set forth in this policy.

The Executive Vice-President (EVP), Science & Research is responsible for the general administration of this policy.

No agreement or any other arrangement in respect of the subject matter of this policy will override the application of this policy unless specifically confirmed in writing by the EVP, Science & Research; failing which, this policy will apply in spite of any such agreements or arrangements to the contrary.

This policy shall not be interpreted to limit UHN's ability to meet its obligations under any third party contract, grant, or other arrangement of UHN (including, without limitation, sponsored research agreements, collaboration agreements, service agreements, license agreements, and such other third party agreements which may be impacted by application of this policy). The application of this policy to UHN personnel is subject to

any applicable conditions and rights provided to third parties under such aforementioned contracts, grants, or other arrangements.

This policy is a condition of (as appropriate) the initial or continuing appointment or employment of, or a condition of enrollment and attendance and training of, all UHN personnel. UHN personnel may be required to sign agreements incorporating the terms and provisions of this policy; but, the absence of any such agreement or the failure to sign shall not affect the applicability of the policy nor relieve any UHN personnel from the obligations imposed by the policy.

UHN reserves the right to amend or modify any of the provisions of this policy, as it may determine, from time to time in its sole discretion.

Application

This policy applies to:

- all UHN personnel (for example, all researchers and clinical staff, affiliated individuals and trainees authorized to work at UHN);
- all IP developed by UHN personnel utilizing UHN resources (including research works, institutional works and traditional academic works); **and**
- any other IP arising from, or through the use of, UHN resources

Cross-appointments & Academic/Research Collaborations (e.g. Universities, Colleges, Institutes)

IP developed by UHN personnel who are cross-appointed to a non-UHN institution, or developed in association with individuals who are affiliated with any other non-UHN medical and/or educational organizations, shall be governed by this policy unless (and to the extent) there is a written agreement between UHN and that organization which specifically deals otherwise with any such IP.

UHN Ownership

UHN solely owns:

- all IP developed by UHN personnel utilizing in any manner, whether directly or indirectly, UHN resources; **and**
- any IP otherwise arising through the access to, or the use of UHN resources in any manner, whether directly or indirectly (collectively the UHN IP, as further defined);

with the exception that traditional academic works will remain the property of the author(s) of such works.

By application of this policy:

- UHN personnel irrevocably assign to UHN all of their right, title and interest in and to any UHN IP (which includes research works and institutional works, but excludes traditional academic works) and any associated rights in such UHN IP (e.g. patents, copyrights); **and**
- author(s) of UHN IP (other than traditional academic works) waive any moral rights in such UHN IP in favour of UHN.

IP Policy Management

UHN Technology Development & Commercialization (TDC) manages the matters relating to this policy, including, but not restricted to:

- the receipt and review of intellectual property disclosures;
- the filing and management of appropriate IP-related registrations (e.g. patents, copyrights);
- the commercial licensing or provision of IP rights to external parties;
- the receipt and distribution of any revenues from the licensing or other commercial disposition of UHN IP (including the sale of equity or debt received in connection with the commercialization of UHN IP).

Disclosure & Related Obligations

UHN personnel must disclose to UHN TDC all work products with the potential to create UHN IP in a timely and thorough manner, and well prior to any public disclosure or presentation, attaching all supportive scientific and other related information. This obligation applies to the outputs and/or outcomes from both research-related activities (e.g. manuscripts submitted for publication or abstracts for presentation) and other non-research related activities with IP potential (e.g. hospital/patient management software, clinical trial questionnaires).

UHN TDC shall review all disclosures and conduct an initial assessment, and when required, a detailed evaluation of the commercial potential of the IP. Further to this review and evaluation, UHN TDC will take reasonable steps to register appropriate intellectual property rights in the IP (e.g. patents) as deemed necessary.

At the request of UHN TDC, UHN personnel shall execute assignments and any other documents required to evidence the assignment of IP rights to UHN, and further assist UHN TDC (as necessary) in respect of all other matters associated with the assignment, filing and registering of protective rights in the UHN IP (e.g. preparation, filing and prosecution of patent applications). As such, UHN personnel must provide, in a timely manner, all requested information and execute all documents required by UHN for such registrations and as further required for the formalization and/or recording of UHN's ownership in the UHN IP. In addition, author(s) of UHN IP shall waive, and do hereby waive by application of this policy, any moral rights in such UHN IP in favour of UHN.

If UHN declines to protect or further commercialize any patentable (or other protectable) UHN IP, UHN may, in its sole discretion, agree to license or assign the UHN IP to creator(s) upon request (see IP Assignment back to Creators).

Dispute Resolution

In the event of any dispute arising under this policy, there will be an initial attempt to resolve the dispute by the TDC Director. If resolution is not successful, the dispute will be escalated to the EVP, Science & Research.

Commercialization

General Considerations

UHN TDC has the primary responsibility for negotiating all licenses and/or other agreements pertaining to the commercialization or exploitation of UHN IP for commercial use by third parties and the receipt of gross revenues from this commercialization. UHN TDC will seek the best and fairest deal it can obtain through good faith negotiations on behalf of UHN and creator(s). This includes typical licensing terms such as license fees, royalties, milestone payments and securities (such as equity or debt), as appropriate.

UHN TDC will generate and disseminate marketing materials, including marketing summaries, and work with creator(s) to develop scientific and business presentations and to identify potential licensees for IP.

Any license or other binding agreement in respect of the licensing or commercialization of UHN IP must be approved and executed by the EVP, Science & Research and as further mandated in other relevant UHN policies (e.g. Signing Authorities & Delegations policy 1.90.009 and such other UHN policies as may be relevant).

UHN reserves the right to enter into further agreements with other agencies (e.g. MaRS Innovation (MI), Centre for Commercialization of Regenerative Medicine (CCRM)) for the purpose of advancing the commercialization of specific opportunities, with due consideration being given to the principles of this policy.

Distribution of Commercialization Revenue

In principle, UHN strives to maintain any permitted entitlement of an individual creator to share in UHN net revenues under this policy.

Any distributions of revenue entitlements to individual creator(s) further to this policy will occur at least once annually at the end of UHN's fiscal year. Notwithstanding, UHN may agree to an earlier or more frequent revenue distribution(s) in its (i.e. UHN's) sole discretion.

All revenues received by UHN for distribution to creator(s) will be held in UHN accounts prior to distribution. No interest on such revenue entitlements will accrue and be paid to creator(s).

UHN Reimbursement:

- Prior to any further distribution or use/allocation of commercialization revenue under this policy (e.g. to creator(s)), UHN shall first be reimbursed for the following (in order of priority):

  a. reimbursement of UHN's out-of-pocket costs and fees associated with securing, maintaining, and enforcing intellectual property protection such as patenting and litigation expenses; out of pocket costs incurred by UHN in the commercialization of the intellectual property such as expenses for marketing, commercial assessment, financial valuation, advisory services, agency fees, and the management and liquidation of securities (such as equity); and out of pocket expenses in making, shipping or distributing material;
  b. reimbursement of defined UHN investments, costs and expenses related to defined technical/scientific development required for commercialization or other commercial development activities of the licensed UHN IP (including, but not limited to, financial investments such as direct cash infusions, debt instruments and loans, and other agreed-upon support, costs and expenses, made in support of UHN IP research and development, commercialization or company creation activities), subject to approval by the EVP Science & Research; **and,**
  c. reimbursement of UHN's costs incurred in a dispute resolution process conducted further to this policy.

Research Works:

- Remaining revenue after UHN reimbursement (i.e. net revenue) derived from the commercialization of UHN IP based on research works will be distributed 50% to creator(s) and 50% to UHN; **however**, this distribution is subject to the further terms of this policy. For clarity, a creator has no entitlement to any equity or other interest in securities held by UHN, and any such equity and other securities held by UHN are solely for the benefit of UHN and for no other person. The sole entitlement a creator has under this policy is to their proportionate share of net revenue payable in cash, when and if actually received by UHN, less any applicable withholdings.

- The participation of a creator as a "founding" equity holder in a NewCo involving their UHN IP does not in and of itself preclude such creator from receiving any further entitlements (e.g. revenue share) under this policy.

- An exception to the “50/50” distribution may arise in certain circumstances, such as when creator(s) receive “founders” equity in a UHN “spin-out” company (a “NewCo”). In such cases, UHN TDC will assess the extent of such “founder” shareholding and the further role of the creator(s) in the NewCo (including the mitigation and management of any potential conflicts of interest) so as to determine the scope of any further entitlements under this policy. As such, UHN TDC may determine that such creator(s) should not receive some or all of the creator(s)’ personal share of net revenue. For example, creator(s) with a significant financial interest and/or managerial role in the NewCo may be required to forfeit in advance some (or all) of their individual personal entitlements under the policy. UHN TDC shall make a recommendation in this regard to the EVP, Science & Research, who shall make a final determination. In the event of any such revenue forfeiture, UHN will retain the forfeited revenue.

- Nothing in this policy restricts a creator of UHN IP licensed to a NewCo from entering into a contractual relationship with such NewCo in a personal capacity (e.g. consulting agreement) for compensation involving fees and/or NewCo equity. However, any such contractual relationship will be at the exclusive discretion of the NewCo, and will remain subject to all relevant UHN policies (e.g. Conflict of Interest policy 2.50.002, Conflict of Interest of Research Personnel policy 40.90.002, and any other relevant UHN employment-related policies).

- The creator(s)’ share of net revenues shall be distributed among all creator(s) (if more than one) in the proportion as unanimously agreed to by the creator(s) in writing/email to UHN TDC. An individual creator’s share of revenue shall be based on the relative proportion of her/his individual contribution to the UHN IP that has generated the net revenue.

- As a general matter, there will be no distributions to creator(s) while any matter under this policy (e.g. finalization of creator(s) list, determination of creator(s) fractional revenue shares, execution of required IP-related document(s)) is unresolved or pending, which includes any dispute resolution occurring further to this policy. Notwithstanding, UHN may agree to an earlier revenue distribution(s) in its (i.e. UHN’s) sole discretion.

- Creator(s) who leave UHN will continue to receive their portion of net revenue as described in this policy. In the case of the death of the creator(s), the portion of their net revenue will be directed to their estate.

- For purposes of clarity, no revenue will be distributed to creator(s) until UHN has been reimbursed for all of the above noted UHN costs/fees/expenses, and (as applicable) any other reimbursable costs incurred in a dispute resolution process.

Institutional Works:

- All net revenue derived from institutional works will be retained by UHN (i.e. 100%), and utilized and/or allocated in UHN's sole discretion by the chief executive officer (CEO) (or delegate). UHN may, on a case-by-case basis in its discretion, financially reward and recognize creator(s) of institutional works.

Securities (e.g. Equity such as company shares):

- All securities in third party companies received by UHN in the course of commercializing UHN IP, whether directly or indirectly, shall be held by UHN Treasury under the authority of the chief financial officer (CFO). Such securities will be managed according to procedures to ensure that decisions are made at arms-length from creator(s) and UHN staff involved in the licensing of the UHN IP. The proceeds from the sale of securities will be treated as gross revenue derived from UHN IP, and will be distributed according to this policy.

- For purposes of clarity, only revenue arising from the liquidation of securities which was specifically received by UHN as identified consideration for the licensing or sale of particular UHN IP will be distributed in accordance with this policy.

UHN "Spin-out"/Company Creation

UHN TDC will participate (on behalf of UHN) in the creation of UHN "spin-out" and any other newly created companies which license or acquire UHN IP. Such participation may include the negotiation of an appropriate UHN equity stake in the UHN "spin-out" or newly created company (each a "NewCo"), the terms and conditions pertaining to the acquisition or licensing of the UHN IP to the NewCo, NewCo corporate documents, UHN personnel involvement in management and/or governance, the use of UHN space or facilities by NewCo, visiting scientist agreements and/or any research contract between the NewCo and UHN.

All company creation activities by UHN personnel which involve the use of UHN IP (whether or not such UHN personnel are creator(s) of such IP) and/or UHN resources must be negotiated with UHN TDC and approved in writing by the EVP, Science & Research. All such company creation activities, in addition to any further contemplated contractual or other arrangement between NewCo and UHN, must be disclosed to the UHN Compliance Department for review and assessment in accordance with relevant UHN policies (Conflict of Interest policy 2.50.002, Conflict of Interest of Research Personnel policy 40.90.002).

IP Assignment back to Creators

If UHN declines to protect or further commercialize any patentable (or other protectable) UHN IP, UHN may, in its sole discretion, agree to assign such UHN IP to creator(s) upon request.

In such event, the creator(s) will be required to repay all costs and expenses incurred by UHN in respect of legal, patenting or other UHN IP registration, **and** UHN will be entitled to twenty five percent (25%) of the "net revenue" derived from any commercialization or exploitation of such assigned UHN IP. As a further condition for such assignment, creator(s) will also be required to agree to additional terms and conditions as may be required by UHN. These additional terms/conditions may include (but are not limited to) the following:

- UHN's retention of a perpetual, irrevocable, sub-licensable (to non-profit institutions/organizations), royalty-free license for research, clinical and educational purposes;
- a requirement to secure indemnity protection for UHN as part of any agreement relating to the assigned UHN IP;
- a prohibition from using UHN's name and logo or being identified in any manner in relation to the assigned UHN IP without prior approval;
- assumption by creator of any governmental or other granting agency or foundation reporting requirement in respect of the assigned UHN IP;
- further agreement that any new IP created at UHN (which includes "improvements" to the assigned UHN IP) will be owned by UHN further to this policy;
- further agreement that, as appropriate, any obligation of creator to UHN will be reflected in any agreement relating to the assigned UHN IP.

Trademarks & UHN Official Marks

UHN personnel shall obtain written approval from the appropriate UHN Public Affairs office for the use of the name or logo of UHN, a UHN member hospital, or a UHN associated research or teaching institute, in any advertising, promotional, endorsement or sales material in any medium.

However, it is generally acceptable (and therefore requires no further approval) for UHN personnel to use the name and logo of UHN, a UHN member hospital, or a UHN associated research or teaching institute, in a traditional academic works or for other academic-related reasons to identify the association of the UHN personnel with any of the aforementioned entities.

No trademarks shall be applied for, or registered, in respect of any product, service or any other activity associated with UHN, a UHN member hospital, or a UHN associated research or teaching institute, without prior permission from UHN's public affairs office.

Unless specifically agreed to otherwise by UHN, any trademark associated with any product, service or any other activity associated with UHN shall be owned by UHN.

Research Contracts & Other Agreements (i.e. Material Transfer Agreements, Confidential Disclosure Agreements/Non-disclosure Agreements)

No research contract (such as sponsored research agreements or research service agreements) may be entered into by any UHN personnel with any research partner, unless it is documented in writing and signed by the EVP, Science & Research (or designate) and as further mandated in other relevant UHN policies (e.g. Signing Authorities & Delegation policy 1.90.009 and such other UHN policies as may be relevant).

All research contracts must incorporate the appropriate UHN institutional overhead charge.

UHN TDC manages the development of material transfer agreements (MTAs) involving the transfer of research reagents, clinical samples, equipment or research-related data to or from any external academic/research organization or private sector research partner.

UHN TDC manages the process for the review and execution of Confidential Disclosure Agreements/Non-disclosure Agreements (CDAs/NDAs) governing the disclosure and/or exchange of any research/technology-related confidential or proprietary information with non-UHN external parties; the Clinical Trials Agreement Office (of Research Legal) manages the process for the review and execution of CDAs/NDAs governing the disclosure of any clinical trial-related confidential or proprietary information with non-UHN external parties.

For clarity, UHN personnel may not separately negotiate or accept any arrangement or offer of financial or other support from a source other than UHN for the development, protection, patenting or licensing of UHN IP, or engage in the transfer of any UHN materials or UHN confidential information to a non-UHN individual or entity without first involving UHN TDC, or first obtaining approval from appropriate UHN executive management.

Definitions

Author(s): An individual (including any UHN personnel) who authors copyrighted IP (as determined in law).

Confidentiality disclosure agreement/non-disclosure agreement (CDA/NDA): A legal agreement between UHN and a non-UHN third party (e.g. company or individual) governing the disclosure and/or transfer and/or exchange of confidential information.

Creator(s): UHN personnel identified as (i) an author, (ii) an inventor, or (iii) in respect of licensed UHN IP which is neither patentable or copyrightable subject matter, a significant intellectual contributor to the development of such UHN IP, but only where such development is not a routine or known practice or activity.

Develop(s/ed): To make, create, invent, conceive, control, discover, improve or author, directly or indirectly, and in any manner.

Gross revenue(s): UHN's income directly arising and received from the commercialization of UHN IP, including but not limited to: upfront fees, milestone payments, license maintenance fees, license transfer fees, sublicensing fees, running royalties, advances against royalties, and income received from the liquidation of securities (e.g. sale of equity) or dividend distribution to UHN as a shareholder. For clarity, this aggregate (i) will not include any securities (such as equity or a shareholder position) held by UHN until such time as the securities are liquidated or converted to cash, and (ii) does not include any fees, monies or other consideration received by UHN further to a research contract.

Institutional work(s): All tangible materials and any other outcome, output, result and matter developed by (i) UHN personnel under explicit institutional direction or instruction, or which otherwise arise in the normal course of carrying out assigned responsibilities, duties or tasks of employment; (ii) UHN personnel and for which such development cannot be attributed to discrete creator(s), or is resulting from simultaneous or sequential contributions over time by multiple contributors; (iii) UHN personnel in the normal course of carrying out assigned responsibilities, duties or tasks of employment pertaining to UHN's educational and training activities, including, without limitation, all educational and training information, manuals, and associated tools and materials (whether in written, electronic, audio-visual, multi-media or other form or format);or (iv) persons hired by UHN for a specific purpose (e.g. consultants, contract engineers, software developers). Institutional works may include IP consisting of patent(s), copyright(s), or both. Examples of institutional works may include the following: software and devices developed by UHN personnel hired for such purpose, or at the specific direction of UHN; software tools developed and improved over time by multiple UHN personnel contributors and where authorship is not appropriately attributed to a single or defined group of author(s); UHN research and clinical databases, and other analogous compilations of UHN data and records; UHN tissue/sera biobanks; research tools/reagents (e.g. cell lines); educational manuals, courses and courseware, program packages, and any materials developed by UHN further to its educational, training and clinical activities; IP arising from UHN's provision of contracted services to external third parties.

Intellectual property (IP): Inventions (whether or not patentable), technology, technical/clinical/research information, confidential information, trade secrets, know how, trademarks, domain names, URLs, brands, service marks, official marks, industrial designs, databases, formulae, chemical discoveries, computer software and hardware, software code and algorithms, drawings, graphics, designs, concepts, ideas, apparatus,

processes, methodologies, research and clinical tools and materials (such as cell lines, antibodies, and other biological materials and reagents) and other tangible research/clinical property (e.g. questionnaires), prototypes, devices, and other literary and artistic works (such as patient-related or educational manuals, program packages and materials), and all associated intellectual property rights (such as, for example, letter patents, copyright, and design patents/registered or industrial designs).

Inventor(s): Any individual (which includes any UHN personnel) who makes an inventive contribution to the creation and/or development of patentable IP (as determined in law).

Material transfer agreement (MTA): A legal agreement that governs the transfer of research material (e.g. compound, antibody, microarray, purified protein, cell line, cloned gene, recombinant mice, human tissue/sera) or equipment from UHN to another non-UHN entity or individual (and vice versa). The agreement names the sender and the intended recipient, specifies the nature of the material/equipment transferred, and establishes ownership and the constraints on its use, including a descriptor of permissible activities to be performed with the transferred material/equipment.

Net revenue(s): Gross revenues **minus**, in order of priority: (i) reimbursement of UHN's out-of-pocket costs and fees associated with securing, maintaining, and enforcing intellectual property protection, such as patenting and litigation expenses; out of pocket costs incurred by UHN in the commercialization of the intellectual property such as expenses for marketing, commercial assessment, financial valuation, advisory services, agency fees, and the management and liquidation of securities (such as equity); and out of pocket expenses in making, shipping or distributing material; (ii) reimbursement of defined UHN costs and expenses related to the technical/scientific or commercial development of the licensed UHN IP (including, but not limited to, debt instruments, loans, and other investments made in support of commercialization or company creation activities), subject to approval by the EVP Science & Research; and (iii) reimbursement of UHN's costs incurred in a dispute resolution process conducted further to this policy.

Research contract(s): A contract between UHN and an entity (including a for-profit entity) by which UHN (and UHN personnel) carries out scientific research or technology development-related activities, either on its own or in collaboration with such entity, and where the entity reserves or is granted rights with respect to the UHN IP arising from the contracted research. Examples include sponsored research agreements, research service agreements, research collaboration agreements, technology development agreements, research grants from traditional grant-funding agencies (e.g. Canadian Institutes of Health Research, National Institutes of Health) and clinical trial agreements.

Research partner(s): Any entity, corporation, partnership, person, association, granting agency, government or other legal body/person with whom, in any manner, any research or development, of any nature, is performed or intended to be performed, on any basis.

Research work(s): Tangible materials and any other outcome, output, result and matter developed by UHN personnel arising from independently conceived and self-directed fundamental experimental research or technology development activities, or other basic discovery or analogous research activities, **and** which are not institutional works or traditional academic works. Research works may include IP consisting of patent(s), copyright(s), or both.

Traditional academic work(s): Any work of authorship made for a scholarly purpose; such as scholarly papers, books, book chapters, theses, abstracts, presentations, whether or not published and whether or not distributed by any means, including print or electronic media.

UHN IP: Any IP (i) developed by UHN personnel utilizing in any manner, whether directly or indirectly, UHN resources, or (ii) otherwise arising through access to, or the use of UHN resources in any manner, whether directly or indirectly, but does **not** include traditional academic works. For clarity, UHN IP includes research works and institutional works.

UHN personnel: Any UHN employee and investigator (whether research, clinical or otherwise); clinical staff and other persons (e.g. adjunct staff) with UHN medical, hospital or educational appointments; persons with contractual arrangements with UHN (e.g. consultants, contractors; UHN research and clinical trainees, such as under- and graduate students, post-doctoral fellows, visiting scientists or other visitors using UHN research facilities; UHN volunteers; visiting investigator(s) and clinical staff on leave seconded or on sabbatical from another institution to UHN; any other person who has any access to or uses, in any manner, directly or indirectly, UHN resources for teaching, research and/or development purposes or otherwise. For clarity, UHN personnel includes all UHN-associated individuals who are also cross-appointed to a non-UHN institution.

UHN Technology Development & Commercialization (UHN TDC): The designated office at UHN assuming primary responsibility for the management of matters related to this policy, and for financial, legal and related commercialization activities associated with UHN IP such as patent protection and prosecution, business transactions (including research contracts, option agreements, license agreements, company agreements, financial agreements) and management of the commercial assessment, business development, marketing, and financial compliance related to such IP.

UHN resources: UHN owned, operated, managed, funded or administered: salaries, research chairs, stipends, student fellowships, research grants and funds, technology development grants and funds, equipment, research/clinical tools and reagents and materials (including humans tissue/sera sourced, stored or banked at UHN), assets, facilities (whether research, clinical or educational), personnel/clinical staff/research and clinical trainees, other monies and funds, software, research/clinical databases and information, medical records, and UHN IP, and further includes access to UHN patients and treatment areas, and UHN facilities.

University Health Network
Policy & Procedure Manual
Administrative: Appropriate Use of Information & Information Technology

1. Policy

University Health Network (UHN) will make all reasonable efforts to protect information and information technology (IT) resources owned or under the custody of UHN ("**UHN information and IT resources**") against disclosure, disruption, inappropriate or unauthorized access, loss or theft, and tampering.

All **UHN agents** (including all UHN employees, physicians/clinicians, learners, researchers, volunteers, observers, consultants, contractors, or other service provider/vendor ("third party"), etc.) who have access to UHN information and IT resources are required to use these resources in a manner that does not reflect poorly on UHN, jeopardize the safety of patients and the UHN community, or open UHN to any negative ethical, reputational, legal, regulatory or technical consequences.

This policy contains requirements for the appropriate use of UHN information and IT resources with respect to:

- general computing
- creating and protecting passphrases/passwords
- protecting personal health information (PHI), personal information (PI), and corporate confidential information (CCI)
- using email
- faxing, photocopying, and printing
- using the intranet, internet, and social media
- telephone, web or video conferencing, paging, instant messaging, and texting
- telecommunication for commercial purposes
- working remotely
- reporting privacy breaches and security incidents

This policy pertains to **all** UHN information and IT resources and technologies, whether or not they are explicitly identified or named in this policy.

This policy applies to **all** UHN agents.

1.1 Exceptions

Any exceptions to this policy must be approved in advance and in writing by the Chief Information Security Officer or, where appropriate, the Privacy Office.

Note: Contact the UHN Digital Security team to initiate the request.

1.2 Enforcement

Failure to adhere to this policy may result in the suspension or loss of access privileges, as well as other disciplinary measures, up to and including cessation of employment or affiliation with UHN.

In the event of a privacy breach, disciplinary action may also include notification to applicable professional college(s), the Information Privacy Commissioner of Ontario, or other legally required or permitted organizations or individuals. Individuals found to have willfully contravened Ontario's Personal Health Information Protection Act (PHIPA) may also face fines up to $100,000 by the Information Privacy Commissioner of Ontario.

1.3 Roles & Responsibilities

1.3.1 All UHN Agents

- Read and comply with this policy.
- Comply with all end user agreements signed as a prerequisite to being provisioned access to any electronic system.
- Read, sign, and comply with the requirements of the UHN Confidentiality Agreement.
- Complete mandatory privacy and security training.
- Fulfil all privacy and security responsibilities as defined in this policy, other relevant security policies and supporting documents, and employment or contractual agreements.
- Use UHN information and IT resources only for its intended purposes.
- Maintain the confidentiality, integrity, and availability of information accessed consistent with UHN's approved safeguards.
- Ask questions when unsure of a privacy or security control, requirement, policy, process, procedure or practice.

1.3.2 Managers & Supervisors

- Understand this policy and any supporting documents.
- Ensure that departmental operating processes, procedures, and practices do not undermine the privacy or security of UHN's information or IT resources.
- Ensure that reports and third parties are aware of and understand their privacy and security responsibilities.
- Hold reports and third parties accountable for privacy and security violations.

1.3.3 Digital Security

- Maintain this policy by reviewing and updating it (at least) annually.
- Identify the need to develop, publish, or maintain any security-related guidance documents to support this policy.
- Act as the point of contact for all questions related to security.

1.3.4 Privacy

- Review and approve this policy.
- Identify the need to develop, publish, or maintain any privacy-related guidance documents to support this policy.
- Act as the point of contact for all questions related to privacy.

1.3.5 IT Executive Committee

- Approve this policy.

1.4 General Computing

UHN has the right to monitor, log, and audit all access to UHN information and IT resources, including the use of its name, logo or identity, whether or not the activity is performed using a UHN device or a personal device (e.g. monitoring, logging and auditing the network activity of personal devices when it is connected to the UHN corporate or guest networks, or user activity on a mobile device management solution). No UHN agent should have an expectation of privacy if they use UHN information or IT resources for personal purposes. All agents will be held accountable for any misuse of UHN information and IT resources.

UHN agents must always:

- ✓ Use only their assigned user ID and passphrase/password ("credentials") to access UHN information and IT resources, with the exception of authorized shared/group credentials.

- ✓ Use UHN-approved IT resources to conduct UHN business.

  Note: Personal IT resources should only be used if UHN has provided the agent with a means of accessing UHN information or IT resources via a personal IT resource in a secure way (e.g. through the use of Office 365 or mobile device management solution).

- ✓ Comply with all UHN policies when using UHN information and IT resources, whether or not those resources are accessed on-site or remotely.

UHN agents must never:

- × Allow another person to use their credentials.

  Note: The agent is accountable for all actions performed with their credentials.

- × Allow their personal use of UHN IT resources to interfere with its normal performance or with their job-related duties and responsibilities.

- × Use UHN IT resources to:

  a. contravene UHN's Purpose, Principle, and Values, Fostering Respect in the Workplace policy 2.50.005, or any other UHN policy;

  b. engage in online gaming or gambling;

  c. solicit or promote commercial interests that have not been sanctioned by UHN (e.g. using the email system for a personal business); **or**

  d. violate provincial or federal laws, professional codes of ethics or standards of professional conduct.

- ✗ Disable, override, or willfully bypass any security control or attempt to exploit any suspected security weakness on any UHN IT resource, unless it is part of their assigned responsibilities and they are explicitly authorized to do so.

- ✗ Knowingly perform an act that will interfere with the normal operations of a UHN IT resource or try to disrupt that resource either by making it unavailable, or by affecting the integrity of the data being stored in or processed by the IT resource.

1.5 Protecting Personal Health Information, Personal Information & Corporate Confidential Information

UHN and all UHN agents have a legal obligation to maintain the privacy and security of PHI/PI. To meet these obligations, only UHN-approved IT resources may be used to collect, use, or store PHI/PI. In the event of a privacy breach with respect to PHI/PI, UHN agents may be subject to disciplinary action, including notification to applicable professional colleges and the Information Privacy Commissioner of Ontario. Where a breach is found to be the result of a willful contravention to this policy, UHN agents may face fines of up to $100,000 by the Information and Privacy Commissioner.

Note: See Privacy & Access policy 1.40.007 for more information on how UHN protects patient privacy and ensures the proper collection, use, and disclosure of personal health information. See Information Security policy 1.40.028 for more information on how UHN secures its information and IT resources.

Note: To confirm whether an IT resource is approved for handling PHI/PI/CCI, contact the local help desk.

UHN agents must always:

- ✓ Ensure any changes to existing IT resources or implementation of new IT resources that store or process PHI/PI/CCI is assessed by UHN Digital Security, and assessed and approved by UHN Privacy prior to implementation.

- ✓ Abide by the terms and condition of shared systems, especially those that provide access to PHI (e.g. RM&R and ConnectingOntario).

- ✓ Use encrypted and UHN-approved devices (e.g. laptops, servers, pagers, etc.) for storage and transfer of PHI/PI/CCI.

- ✓ Ensure that they only access, collect, and transmit/transfer PHI/PI/CCI if they are authorized to do so and it is necessary to fulfill their assigned duties.

- ✓ Store PHI/PI/CCI on UHN-approved devices and storage networks (e.g. a UHN-provided OneDrive, SharePoint, or network drive), and only store the minimal amount of such information that is necessary.

  Note: UHN-provided storage networks should be the primary storage location for important files instead of local hard drives (e.g. 'C' drive or My Documents) even if it is encrypted, as local hard drives are not backed up and information may be unrecoverable in the event of the device experiencing a hardware failure or malicious attack (e.g. ransomware).

- ✓ Where possible, share files containing PHI/PI/CCI with their team using a UHN-provided storage network.

- ✓ Edit documents online (e.g. when using Office365) without saving them to a local computer drive if accessing files on an unmanaged device or a UHN-shared device.

- ✓ Lock their screen (e.g. by pressing ctrl + alt + delete and selecting "Lock this computer" or  +L on a Windows workstation) or log out of all applications on a scratch PC when leaving it unattended.

- ✓ Lock their mobile device (e.g. by using screen lock or storing the mobile device in a locked area) when leaving it unattended.

- ✓ Ensure that any pictures or visual and audio recordings taken on UHN premises do not contain or reveal any CCI or PHI/PI (except where taken for the purpose of providing direct patient care, or unless documented consent has been obtained from the individual about whom the information relates and for the purposes for which the picture was taken).

  Note: PHI can include voice recordings and pictures of a patient's face or body part that can uniquely identify them. Pictures or recordings that capture displays of an application or system may also include PHI/PI/CCI. Always capture the least amount of PHI necessary to achieve the purpose.

  Note: See Consent for Audio/Visual Taping policy 3.20.004.

  Note: For research purposes, documented consent for all approved uses of PHI (including audio and visual recordings) is obtained at the outset of the research study. No additional layer of consent is required.

- ✓ Verify a patient's identity prior to disclosing PHI, as per Positive Patient Identification policy 3.30.016.

- ✓ Transmit or transport PHI/PI/CCI securely.

  Note: When electronically transmitting PHI/PI/CCI, the order of the preferred methods is:

  1. secure email
  2. File Portal, using the Patient Information option for all PHI/PI/CCI, along with a strong passphrase
     Note: The passphrase must be sent though a means other than email, e.g. tell the user the passphrase in person or over the phone.
  3. unsecure email, with PHI/PI/CCI **sent in an encrypted file attachment using a strong passphrase**
     Note: The passphrase must be sent though a means other than email, e.g. tell the user the passphrase in person or over the phone. See Guide to Encrypting Files Using 7-zip.
  4. fax
  5. unsecure email, with certain restrictions (see section 1.6 Using Email)
  6. **For physicians only**, see the Medical Advisory Committee Working Group on Use of Texting for Clinical Purposes Report to the MAC

- ✓ Securely dispose of PHI/PI/CCI and any IT resources that may contain this information by following their department's processes and procedures for destruction (e.g. by placing paper in a secure shredding receptacle).

  Note: See Management, Retention & Destruction of UHN Records policy 1.30.007, Privacy & Access policy 1.40.007, and related policies.

UHN agents must never:

- × Download or save PHI/PI/CCI onto any unencrypted device or unmanaged device, except when urgently required for patient care purposes.

  Note: Where PHI/PI/CCI is downloaded or saved onto unencrypted or unmanaged devices to address an urgent patient care matter, the PHI/PI/CCI must be deleted or removed from the unencrypted or unmanaged device as soon as possible following the event. Where appropriate, ensure to clear the browser's temporary files after accessing a UHN IT resource (e.g. Office 365) from a non-UHN device.

  Note: Opening or viewing file attachments may cause them to download onto the device.

- × Include PHI in any unencrypted message sent by pager, text, email, or other communication method, except when urgently required for patient care purposes.

- ✗ Paste, save, upload, share, send, or receive PHI/PI/CCI to or using unapproved applications, email, file-hosting systems, websites or services (e.g. Google Drive, Dropbox, Slack, etc.).

  Note: For example, never copy & paste PHI/PI/CCI from Office365 to a personal Gmail account.

- ✗ Synchronize files containing PHI/PI/CCI to an unmanaged device, e.g. synchronizing files containing PHI from a UHN-approved solution (e.g. OneDrive) to a personal, unmanaged computer.

  Note: UHN agents are accountable for ensuring PHI/PI/CCI is saved onto UHN-approved devices/applications.

- ✗ Discuss or disclose (through any medium, e.g. email, social media, verbal, etc.) PHI/PI/CCI to anyone, unless that individual has a UHN-defined need-to-know and, in the cases of PHI, only for the purposes for which it has been collected or with patient consent.

- ✗ Discuss PHI/PI/CCI in public areas, including elevators, as it may be easily overheard.

  Note: Be mindful of eavesdropping in offices, wards, or units.

1.6 Using Email

Note: A confidentiality disclaimer is automatically attached to all emails sent to external recipients.

UHN agents must always:

- ✓ Ensure that they have documented consent from patients for the specific purposes under which the patient can be emailed.

- ✓ Delete emails when no longer needed.

- ✓ Send emails containing PHI/PI/CCI using secure email.

  Note: For other methods of transmission, see section 1.5 Protecting PHI/PI/CCI.

- ✓ Double check the “To,” “CC,” and “BCC” fields prior to sending messages containing PHI/PI/CCI.

- ✓ Use a UHN-approved tool for mass distribution when routinely distributing emails (such as newsletters) to multiple patients.

- ✓ Identify themselves when sending an email from a shared account, or an account that has been delegated to them (e.g. by using the “Sent on Behalf of” function).

- ✓ Where possible, retain messages containing PHI in their inbox or in an archive that is saved to a network drive rather than in an archive on a local hard drive (e.g. ‘C’ drive, My Documents, desktop), as only network drives are automatically backed up.

  Note: Messages relevant to an individual's care must be documented in the patient's health record.

- ✓ Keep personal messages in a separate folder marked as “Personal” to distinguish work-related email from personal email in the event of a Freedom of Information and Protection of Privacy Act (FIPPA) request.

- ✓ Only use the email account provided to them by UHN when conducting UHN business.

  Note: External email accounts that are secure (e.g. ONE Mail) may be used to conduct UHN business only if a UHN email account has not been provided. Never use unsecure email accounts (e.g. Hotmail, Gmail, etc.) to conduct UHN business.

- ✓ Ensure that all-user emails (e.g. emails sent to all UHN staff or all UHN staff at a specific site) are of significant importance and clearly relevant to all the users in the list.

  Note: Messages deemed unsuitable for all-user distribution may be disseminated through alternative methods of communication. See Ways to Get Your Message Out at UHN.

UHN agents must never:

- × Click on links or open attachments received from unknown senders, as these may contain malware.

  Note: When in doubt, contact the local help desk or forward the email to spam@uhn.ca.

- × Send emails containing PHI to an unsecured email account, unless:

  a. The patient has provided documented, express consent to communicate by email for the specific purposes that they are emailing the patient. (See the Sending & Receiving Email from Patients section of Email Usage policy 1.40.014 for how to obtain consent); **or**

  b. The email is required for a one-time emergency, urgent, or other

exceptional circumstance for the provision of care or to prevent harm between care providers or patients.

- × Provide someone who is not privileged to see the same information as they are with delegate access to their email account.

- × Auto-forward email to either:

  a. Any external email account; **or**

  b. An internal email account, unless it is to support UHN business (e.g. to provide adequate coverage in the case of short leaves) and they can reasonably expect that the recipient will not receive any PHI/PI to which the recipient would not have a need-to-know.

- × Send PHI in a mass communication, with the exception of a one-time emergency, urgent, or other exceptional circumstance for the provision of care or to prevent harm to a patient (e.g. sending out a Code Yellow email).

- × Recall emails sent externally if they think they may have breached PHI/PI/CCI, as this could result in an additional breach.

  Note: If the UHN agent believes this has occurred, this must be reported as a privacy incident. See section 1.12 Reporting Privacy & Security Incidents.

- × Open attachments that they reasonably believe to contain PHI/PI/CCI on any unmanaged devices or any shared devices (where other users are not authorized to view the information), as attachments may be downloaded automatically.

- × Alter the original content of messages without the author's approval.

1.7 Faxing, Photocopying & Printing

Note: For information on the secure set up of printers, faxes, and photocopying machines, contact UHN Digital Security.

UHN agents must always:

- ✓ Retrieve faxes/papers that contain PHI/PI/CCI from fax inboxes/faxes and printers immediately.

- ✓ Ensure that they do not leave original materials in/on photocopiers or fax machines.

  Note: Delete faxes once they have been reviewed and redirected.

- ✓ To minimize the risk of inadvertent disclosure when faxing, only fax PHI/PI/CCI when it is necessary for the provision of care or other UHN business.

- ✓ Report faxes containing PHI/PI/CCI that are sent to the wrong or unauthorized recipient as a privacy incident. (See section 1.12 Reporting Privacy & Security Incidents.)

- ✓ Double-check the fax number entered on the screen.

- ✓ Whenever possible, enter frequently used numbers into the speed/auto dial of the fax machine/e-fax to minimize input errors.

- ✓ Ensure an accurate source of contact information is used to avoid misdirected faxes.

- ✓ Use a fax cover sheet that clearly indicates the sender's name, recipient's name, and the sender's relevant contact information, as well as the following confidentiality statement:

> ATTENTION: THIS FAX INCLUDES CONFIDENTIAL INFORMATION
>
> This facsimile is intended only for use by the addressee named above. If you are not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, copying or disclosure of the contents of this facsimile is strictly prohibited.
>
> If you receive this facsimile in error, notify us by telephone immediately at [insert phone number].
>
> **********
>
> For any change to your name/location/provider information, you must contact the following organizations: [insert organization/department names & phone numbers].

1.8 Using the Intranet, Internet & Social Media

UHN reserves the right to restrict access to material on social media and external web sites where such content is deemed inappropriate. However, an absence of such restrictions does not imply that any information available for access is authorized.

UHN agents must always:

- ✓ Remember that their personal and off-hours use of the internet and social media could lead to disciplinary action, up to and including cessation of employment or affiliation with UHN if it violates provincial or federal laws, professional codes of ethics, standards of professional conduct, or UHN's Fostering Respect in the Workplace policy 2.50.005.

- ✓ Abide by the Social Media Guidelines when posting or commenting.

- ✓ Ensure that their use or interaction with UHN social media accounts relate to the organization's vision, mission, and values.

- ✓ Obtain approval from Public Affairs & Communications prior to:

  a. creating a UHN-related account on a social media platform or an internet website
  b. posting official UHN-related content to the internet
  c. using the UHN logo on social media or the internet

- ✓ Verify that PHI/PI/CCI is not contained in pictures, audio or visual recordings, comments, or documents that they are going to post, even if they believe personal identifiers (e.g. patient names) have been removed, unless they have documented consent.

  Note: For research purposes, documented consent for all approved uses of PHI (including audio and visual recordings) is obtained at the outset of the research study. No additional layer of consent is required. See also Consent for Audio/Visual Taping policy 3.20.004 and the Social Media Guidelines.

UHN agents must never:

- × Expressly or implicitly attribute personal statements, opinions or beliefs to UHN, unless they have been authorized to do so by Public Affairs & Communications.

1.9 Telephone, Web or Video Conferencing, Paging, Instant Messaging, SMS & Texting

UHN agents must always:

- ✓ Use conferencing solutions that have been assessed by UHN Digital Security and assessed and approved by UHN Privacy for handling PHI/PI/CCI whenever such information needs to be discussed (e.g. TeleHealth).

- ✓ Inform all participants of the risks associated with using conferencing solutions if their PHI/PI will be discussed.

- ✓ Obtain patient consent for the use of any patient-requested unapproved communication solutions.

- ✓ Obtain consent prior to recording any calls with a patient or any calls that will involve PHI/PI.

- ✓ Inform all participants if an audio/video call is being recorded.

- ✓ Ensure that positive patient identification occurs prior to using conferencing solutions to interact with a patient, as per Positive Patient Identification policy 3.30.016.

- ✓ Inform all participants if any activity will be live-streamed (e.g. a surgical procedure being streamed for educational purposes either within UHN or to individuals outside of UHN), and receive documented express consent prior to the procedure, as per Live Broadcasting of Operative Procedures policy 37.30.001.

- ✓ Discuss PHI/PI/CCI in a private setting (e.g. a private office or meeting room).

  Note: Conduct an environmental scan before videoconferencing to ensure that no unintended PHI/PI/CCI is visible to the other party. Close blinds or drapes when using web or video-conferencing, and be mindful of others being able to overhear the call.

- ✓ Limit the information left in a voicemail where there is no documented consent from the patient.

  Note: See Leaving Voicemail for Patients for details.

UHN agents must never:

- × Share PHI/PI/CCI using any unapproved communications solutions.

1.10 Telecommunication for Commercial Purposes

UHN agents must always:

- ✓ Ensure that electronic messages sent for commercial purposes on behalf of UHN or from any UHN IT resources is done in a manner that complies with the Canadian Anti-Spam Legislation (CASL) and its regulations (see 'CASL' The New Canadian Anti-Spam Law intranet page), and with UHN's Telecommunications for Commercial Purposes policy 1.40.027.

1.11 Working Remotely

Remote access hardware (e.g. remote access tokens) must be returned to UHN, or UHN may remove remote access software, under the following conditions:

- cessation of employment or affiliation with UHN
- at the request of UHN
- deactivation of a remote access account
- violation of any provision of this or any other policy or agreement

UHN agents must always:

- ✓ Use managed devices or UHN-approved solutions (e.g. Office365) to work remotely with PHI/PI/CCI.

- ✓ Be aware of "shoulder surfing" (i.e. people looking over their shoulder), as this could lead to a breach of PHI/PI/CCI.

- ✓ Clear the browser's temporary files after accessing a UHN IT resource (e.g. Office 365) from a non-UHN device.

- ✓ Change their UHN passphrase/password as soon as they return to UHN after using a public device (e.g. public library computer).

  Note: Do not access an internal UHN IT resources from a public device unless absolutely necessary.

- ✓ Lock IT resources that contain PHI/PI/CCI in the trunk or place it out of view before getting to their destination when required to leave their mobile device in a vehicle.

  Note: If they get to the destination before securing the device, UHN agents should take it with them instead.

- ✓ Follow the proper procedures to disconnect from any IT resource (including shared systems) that provides access to PHI/PI/CCI remotely (i.e. use the disconnect or logout option rather than simply closing the application).

UHN agents must never:

- × Print PHI/PI/CCI at a remote location or make copies (e.g. by copying files, taking screen shots, taking pictures etc.) of such information at a remote location unless they are authorized by their manager or supervisor to do so.

- × Access PHI/PI/CCI in an area where unauthorized individuals can view the information (e.g. cafés, public transit, and other non-private settings).

- × Leave a device remotely connected to a UHN internal resource unattended in a public place or in any private area in which unauthorized individuals could gain access to the device.

1.12 Reporting Privacy & Security Incidents

Note: Examples of privacy and security incidents include, but are not limited to:

- unauthorized or accidental disclosure, or inappropriate or unauthorized access of PHI/PI/CCI
- attempts (either failed or successful) to gain unauthorized access to any form (paper or electronic) of PHI/PI/CCI
- theft or loss of an IT resource that contains PHI/PI/CCI, even if it is encrypted
- malware infection on an IT resource
- compromised passphrase/password

UHN agents must always:

✓ Immediately report suspected or confirmed:

a. privacy incidents to their manager/supervisor or using the Incident eForm, **and**
b. security incidents to their manager/supervisor or local help desk.

✓ Provide their full cooperation with any privacy or security incident investigation.

1.13 Additional UHN Resources

- 'CASL' The New Canadian Anti-Spam Law
- Consent for Audio/Visual Taping policy 3.20.004
- Guide to Encrypting Files Using 7-zip
- Incident eForm
- Leaving Voicemail for Patients
- Medical Advisory Committee Working Group on Use of Texting for Clinical Purposes Report to the MAC
- Positive Patient Identification policy 3.30.016
- Social Media Guidelines
- Telecommunications for Commercial Purposes policy 1.40.027

2. Definitions

Corporate confidential information (CCI): Information used for UHN management, business, or financial purposes, including, but not limited to:

- information on salaries and benefits
- information on Hospital payments such as OHIP numbers
- information on Hospital budgets, expenses or planning
- patient health information or other data used by administration/management for

logging, registering, scheduling, tracking, or billing patients
- sensitive or privileged legal information
- employee status information/communications regarding any employee
- information that could expose the organization's reputation to damage
- information regarding use of animals at UHN for research
- information regarding use of compounds or devices that could expose internal UHN operation to malicious acts by external parties (e.g. use of a compound or device that would signal to an activist group that certain types of experimentation are being carried out at UHN)

Electronic message: A message sent by any means of telecommunication, including a text, sound, voice, or image message, unless the message is a "two-way interactive voice call" or a facsimile or voice recording sent to a telephone account.

Email: The transmission of electronic messages between an addresser and one or more addressees using dedicated software (e.g. Microsoft Outlook). It does not refer to instant messaging or short-message/multimedia messaging (SMS/MMS) services.

External email: All non-UHN email accounts, whether or not the email is considered secure or unsecure (e.g. email addresses at another organization, ONE Mail, Hotmail, Gmail, etc.).

Information technology (IT) resource: All technology hardware and software assets used for the creation, use, transmission, transport, and destruction of information. A UHN IT resource includes, but is not limited to:

- infrastructure technology owned or leased by UHN (e.g. servers, database, applications, wireless access points, etc.)
- end-points and end user devices owned or leased by UHN (e.g. workstations, laptops, tablets, cellphones, pagers, fax machines, printers, photocopiers, etc.), whether or not they are attached to the UHN network.
- applications and software owned or leased by UHN (e.g. EPR, Patient Portal, Office 365, etc.)
- UHN-branded social media accounts (e.g. Twitter accounts, Instagram accounts, etc.)

Managed device: For the purposes of this policy, a managed device refers to any end user device that is centrally managed by UHN, including Mobile Device Management (MDM) devices. All end user devices not centrally managed by UHN are considered to be unmanaged devices.

MDM devices refer to personal devices that UHN has the ability to secure and manage with centralized security configurations, and that also allows for the remote wipe of a system in cases of loss or theft. See Mobile Device Management policy 1.40.026.

Need-to-know: A principle which stipulates that authorized access to information must only be granted to individuals if it is necessary for them to perform their assign duties.

Personal health information (PHI): Information about an individual, whether living or deceased, and whether in oral or recorded form. It is information that can identify an individual and that relates to matters such as the individual's physical or mental health, the provision of health care to the individual, payments or eligibility for health care in respect of the individual, the donation by the individual of a body part or bodily substance, and the individual's health number. (PHIPA 2004) PHI can be information about a physician or other care provider, a hospital staff person, a patient, or a patient's family member. Examples of PHI include a name, medical record number (MRN), health insurance number, address, telephone number, and PHI related to a patient's care, such as blood type, x-rays, consultation notes, etc.

Personal information (PI): Any information about an identifiable individual, whether living or deceased, and whether in oral or recorded form, that is sensitive in nature. This refers to information collected or accessed by UHN for the purposes of employment or affiliation with UHN, with the exception of business contact information (e.g. information to enable an individual at a place of business to be contacted and includes the name, position name or title, business telephone number, business address, business email, or business fax number of the individual). Examples of PI include, but is not limited to, ethnic origin, race, religion, age, sex, gender, sexual orientation, marital status, information regarding education, financial, employment, criminal history, social insurance number, home address, personal telephone number, etc.

Remote access: Remote access refers to specific situations in which an agent accessing UHN internal resources over an unsecured network (e.g. the internet). An example of remote access includes accessing UHN email or network drive from home.

Secure email: Refers to either (1) internal email, i.e. email sent or received between any UHN email account; or (2) email sent externally to an organization with which UHN has a secure channel. All email addresses that appear in the Global Address List (GAL) are considered secure.

Social media: A type of online media that expedites conversation, as opposed to traditional media, which delivers content but doesn't allow readers/viewers/listeners to participate in the creation or development of the content. Social media is interactive and allows users to comment and participate in the discussion on whichever social media medium they are using, whether it's a social networking site, blog, micro-blog or video-sharing site.

Unmanaged device: All end user devices not centrally managed by UHN. Any end user device that is centrally managed by UHN is considered to be a managed device. See definition for managed device.

Unsecure email: Refers to any email sent or received between a UHN email account and external organization's email account with which UHN does not have a secure channel. Only email addresses that are part of the ONE Mail or ONE Pages

infrastructure are considered secure.

Working remotely: Any situation in which a UHN agent conducts UHN business off-site, including situations in which a UHN agent does not connect to a UHN internal resource, but is using a UHN information or IT resource classified as “internal” or higher to conduct business (e.g. working off-line on a UHN business proposal). See definition for remote access.

Appendix: Contact Information

For questions related to:	Contact:
Access, use, disclosure, or destruction of PHI/PI	The Privacy Office: 416-340-4800 ext. 6937 (14-6937) or Privacy@uhn.ca
Retention of medical records	Health Record Services: healthrecordservices@uhn.ca
Use of intranet, internet, and social media for UHN purposes and all user emails	Public Affairs & Communications: 416-340-4636 (14-4636)
General IT issues and requests	Your local help desk
This policy in general or the digital security of UHN information and IT assets	Digital Security: digitalsecurity@uhn.ca

University Health Network
Policy & Procedure Manual
Administrative: Electronic Monitoring

1. Policy

University Health Network (UHN) may electronically monitor employees' online activities for purposes including, but not limited to, ensuring high quality care, research and delivery of service, information technology (IT) and network improvements, data and cyber security, and workplace safety and efficiency.

Note: This policy is intended to provide employees with insight into UHN's electronic monitoring practices and to create an equitable and transparent work environment. UHN strives to be respectful of its employees' privacy while engaging in electronic monitoring practices to ensure alignment between the needs of the organization and employee expectations. This policy adheres to the Ontario Human Rights Code and the Working for Workers Act, Bill 88, and aligns with UHN's equity seeking policies, including:

- Accessibility for Ontarians with Disabilities Act – Integrated Accessibility Standards Regulation policy 1.20.007
- Accessibility for People with Disabilities – Customer Services policy 1.20.011
- Anti-Racism & Anti-Black Racism policy 1.20.019
- Gender Identity policy 2.50.009

All **UHN agents** (including UHN employees, physicians/clinicians, learners, researchers, volunteers, observers, consultants, contractors, or other service provider/vendors) who fall within the category of "employee" as defined by Ontario's Employment Standards Act (ESA) are subject to this policy, which is meant to outline the various circumstances in which UHN may electronically monitor employees.

Any access to UHN information or IT resources, or UHN devices is subject to electronic monitoring, regardless of whether the UHN employee works onsite or remotely. This includes, but is not limited to:

- UHN device use
- personal devices used for UHN business purposes
- health information system (HIS)
- emails
- audio and video surveillance
- badge access

Examples of UHN's use of electronic monitoring of staff include:

- privacy auditing and investigation of privacy breaches
- investigation of staff complaints and grievances
- investigation of patient complaints and grievances
- review of patient incidents
- review of employee incidents, including workplace violence
- active surveillance for emergency codes such as Code Yellow, Code White, Code Silver, etc.
- code of conduct investigations, including unlawful activity such as theft and vandalism
- patient/visitor/staff safety on hospital property, including parking lots and spaces rented by UHN
- use of UHN software for the purposes of improving quality
- monitoring of network traffic for the purposes of detecting ransomware, malware, or other malicious software
- compliance with Freedom of Information and Protection of Privacy Act (FIPPA)

This policy is not to be misused to target or profile any person. Such conduct is strictly prohibited and subject to consequences up to and including termination.

UHN will maintain and revise this policy as required to ensure it reflects current monitoring practices.

Further information as to how different technologies and UHN agents' use of these technologies may be monitored is set out below.

1.1 UHN Device Use

UHN Digital may monitor the use of UHN-issued devices (e.g. computers, mobile phones, tablets, and other devices deployed in clinical areas) or managed computers and laptops. Monitoring may include websites visited, as well as any and all other browsing activity or network traffic originating from such devices, for the purpose of quality assurance and staff and patient safety. Additionally, UHN Digital collects records pertaining to the use of such UHN devices, location(s) of device(s) if onsite, length of user sessions, and IP addresses.

Corporate-issued mobile phones and tablets are subject to monitoring of the software deployed on them specifically used to access UHN services. This includes, for example, Microsoft Outlook, or other Office 365 tools. UHN does not monitor end-user access to websites outside of these software tools, nor details related to the usage of any other 3rd party software an end-user may have installed on these devices. The only exception is when a device is obtaining a network connection through UHN directly, the traffic of which is then fully monitored.

Users who have personal devices such as computers, cellphones, or tablets through which they access UHN services may be subject to network traffic monitoring when they are accessing UHN through a VPN connection or if they are onsite and connected to a UHN network.

UHN employees are reminded to read and follow Appropriate Use of Information & Information Technology policy 1.40.012 when browsing and downloading files/software. Downloaded files on UHN devices may be investigated if they are flagged for malware by UHN Digital to protect UHN data infrastructure, network security, and personal information.

1.2 Health Information Systems

In order to develop and administer effective healthcare services, UHN utilizes various software and databases to track and maintain patient records, progression of disease, care outcomes, optimize clinician proficiency/ease of use, and more.

Staff members who manage and maintain these systems (e.g. IT administrators), may be subject to key logging and continual recording of the session itself while performing functions such as accessing the back-end of such systems. During these sessions, a warning is displayed onscreen to end-users, alerting them that such recording is ongoing.

For individuals who use electronic systems for the purposes of providing patient care and related activities, access will be monitored/tracked through logs of actions taken while using the software. For example, logs can be generated to capture which patient records were accessed and what orders or documentation were added or modified for patient care purposes. UHN Privacy may use these logs to determine if privacy breaches occurred. The logs may also be used by Quality and Safety groups or for the purposes of improving workflows.

Some software at UHN collects high-level, aggregated user performance metrics (for example, capturing the response time of an IT software system when a user clicks a button) to help tune systems for optimal end-user experiences.

1.3 Emails

All UHN-credentialed emails are subject to monitoring, which may include the collection of information related to email destinations, subject headings, attachments, links, and text. It is important to note that viewing individuals' emails in their UHN mailboxes in their entirety would only occur in the context of a particular investigation initiated by Privacy, Legal, or Security, or at the request of an end-user who requires assistance from UHN Digital.

All emails are automatically screened by software for malware and/or other malicious software before being released to recipients to ensure data/network integrity and to prevent information and data breaches.

1.4 Audio & Video Surveillance

As part of UHN's commitment to keep patients, staff, and visitors safe, UHN premises are monitored via video/audio surveillance. As part of their employment with UHN, employees acknowledge and agree that they may be recorded while on UHN premises.

UHN employees must read and follow Video Surveillance policy 1.60.003.

Phone calls made on or to select UHN devices or phone numbers may be subject to audio recording by UHN for the purposes of quality assurance and staff and patient safety (for example, when calling Switchboard or the UHN HelpDesk). Recorded lines are encrypted, securely stored, and destroyed in accordance with UHN data retention policies (refer to Management, Retention & Destruction of UHN Records policy 1.30.007).
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University Health Network
Policy & Procedure Manual
Administrative: Accessibility for Ontarians with Disabilities Act – Integrated Accessibility Standards Regulation

1. Policy

University Health Network (UHN) is committed to providing a respectful, welcoming, accessible, and inclusive environment in the provision of goods and services for employees, patients, students, visitors, and volunteers.

As a designated public sector organization, UHN is obligated, under the Accessibility for Ontarians with Disabilities Act (AODA), 2005, S.O. 2005, c. 11, to meet the accessibility needs of people with disabilities.

UHN is committed to, and strives to ensure that, the AODA, the standards, and all other relevant legislation concerning accessibility are rigorously observed. UHN ensures that all persons within its community are aware of their rights and responsibilities to promote an accessible and inclusive environment with and for persons who have disabilities.

UHN's services, programs, goods, and facilities are to be available to people with disabilities in a manner that:

- is free from discrimination;
- is inclusive;
- provides accessible formats and communication supports;
- seeks to provide integrated services: **and**
- takes into consideration a person's disability.

This policy is intended to provide the overarching framework to guide the review and development of other UHN policies, standards, procedures, and guidelines to comply with the standards developed under the AODA.

1.1 Application

This policy applies to all UHN employees, patients, students, visitors and volunteers, and to any individual who provides goods, services or facilities to the public or other third parties on behalf of UHN in accordance with the legislation.

1.2 Accessibility Planning Committee

UHN has established the Accessibility Planning Committee ("the Committee") which is constituted by a broad representation of stakeholders. The Committee advises the UHN senior executive about the requirements and implementation of AODA accessibility standards, preparation of accessibility reports, and other matters for which UHN may seek advice.

1.3 Accessibility Plans & Policies

The Committee will produce a Multi-year Accessibility Plan ("the Plan"). The Plan will be posted on UHN's website and will be made available in an accessible format and with communication supports, upon request. Progress on the Plan will be provided annually in UHN's update report to the senior management team. The Plan will be reviewed and, if necessary, updated at least once every five years.

UHN maintains policies governing how it will meet its requirements under the AODA, and will provide policies in an accessible format upon request.

1.4 Accessible Formats & Communication Supports

Except as otherwise provided by the AODA, UHN, upon request and in consultation with the person making the request, will provide or make arrangements to provide accessible formats and communication supports for persons with disabilities. Accessible formats and communication supports will be provided in a timely manner, taking into account the person's accessibility needs and at a cost that is no more than the regular cost charged to other persons, in accordance with the Accessible Formats and Communication Supports Procedure.

This does not apply to products and product labels, unconvertible information, or communications and information that UHN does not control directly or indirectly through a contractual relationship. If it is determined that information or communications are unconvertible, the department will provide the person requesting the information or communication with an explanation as to why the information or communications are unconvertible and a summary of the unconvertible information or communications.

1.5 Procurement of Goods, Services, Facilities & Kiosks

When procuring goods, services, self-service kiosks, or facilities, UHN will incorporate accessibility criteria and features, unless it is not practicable. If not practicable, UHN will provide an explanation upon request.

1.6 Training

All UHN employees, volunteers, and third parties providing goods and services to members of the public on UHN's behalf, as well as those who develop the policies, practices, and procedures governing the provision of goods or services to members of the public or other third parties, will receive accessibility training, which includes:

- A review of the purposes of the AODA and the requirements of the Accessibility Standards for Customer Service (O. Reg. 429/07) and instruction about:

  a. how to interact and communicate with persons with various types of disabilities;
  b. how to interact with persons with disabilities who use an assistive device, or require the assistance of a guide dog or other service animal or the assistance of a support person;
  c. how to use equipment or devices available on the provider's premises or otherwise provided by the provider that may help with the provision of goods or services to a person with a disability; **and**
  d. what to do if a person with a particular type of disability is having difficulty accessing the provider's goods or services.

- A review of the requirements of the accessibility standards referred to in the Integrated Accessibility Standards (O. Reg. 191/11) and on the Human Rights Code as it pertains to persons with disabilities.

The training provided will be appropriate to the duties of the employee, volunteer, or third party. Training will take place as soon as is practicable and, upon completion, UHN will keep a record of the training provided, including the dates when the training took place.

1.7 Feedback

Feedback on how services are delivered to people with disabilities will be collected, forwarded to the appropriate UHN representative for response, documented, and tracked. Feedback will be collected by phone, teletypewriter, email to accessibility@uhn.ca, in person at any of UHN's information service desk locations, and Patient Relations. Feedback will be accepted in accessible formats and with other communication supports, as required.

1.8 Documentation

Documentation that describes this policy and each of its requirements will be maintained on UHN's website and provided to individuals, upon request, in the appropriate format or communication support.

1.9 Customer Service Standards

1.9.1 Assistive Devices

UHN employees, volunteers, and third-party contractors will accommodate the use of personal assistive devices, including, but not limited to, wheelchairs, canes, walkers, scooters, and Braille display boards. Assistive devices, including, but not limited to, assistive listening devices that are available for access to specific services and programs will be kept in good working order, and the public will be informed of their availability.

1.9.2 Service Animals

UHN employees, volunteers, and third-party contractors will accommodate the use of service animals by people with disabilities who are accessing UHN's services or goods, unless the animal is otherwise excluded by law and prohibited from entering areas due to infection control according to the Health Protection and Promotion Act, R.S.O. 1990, c. H.7.

1.9.3 Support Persons

Where a person with a disability accessing UHN's goods or services is accompanied by a support person, UHN employees, volunteers, and third-party contractors will ensure that both persons are permitted to enter the premises together and will ensure that the person with a disability can access the support person while on the premises.

1.9.4 Admission Fees

If UHN charges an admission fee in connection with a support person's presence at an event or function, UHN will ensure that notice is given in advance about the amount, if any, that is payable in respect of the support person accompanying a person with a disability.

1.9.5 Notice of Service Disruption

In the event that there is a temporary service disruption in the availability of facilities, services, or goods used by persons with disabilities (e.g. temporary loss of elevator service), UHN will give notice to the public of the reason for the disruption, the dates of disruption, its anticipated duration, and a description of alternative facilities or services, if available. The notice may vary, depending on the circumstances, and may include postings in conspicuous places at the affected premises, other UHN facilities, and on UHN's website, as well as by other means that will ensure that the notice reaches those persons potentially affected by the temporary disruption.

For details on customer services provided to people with disabilities, refer to Accessibility for People with Disabilities – Customer Services policy 1.20.011.

1.10 Information & Communication Support Standards

1.10.1 Communication

When communicating with a person with a disability, UHN employees, volunteers, and third-party contractors will do so in a manner that takes into account the person's disability. Guidelines for communicating with people who have various types of disabilities are provided in UHN's Accessible Formats and Communication Supports Procedure.

1.10.2 Terminology

When referring to people with disabilities, UHN employees, volunteers, and third-party contractors will use terminology that adheres to guidelines provided in UHN's Accessibility Training for Customer Service.

1.10.3 Accessible Websites & Web Content

Internet websites and web content controlled directly by UHN or through a contractual relationship that allows for modification of the product will conform to the World Wide Web Consortium Web Content Accessibility Guidelines (WCAG) 2.0, at Level A and AA in accordance with the schedule set out in the Integrated Accessibility Standards.

1.11 Emergency Procedures, Plans & Information

UHN will provide all existing public emergency procedures, plans, and public safety information, upon request, in an accessible format or with appropriate communication supports in a timely manner.

1.12 Employment Standards

1.12.1 Recruitment

UHN will post information about the availability of accommodations for applicants with disabilities in its recruitment process. Job applicants who are individually selected for an interview and/or testing will be notified that accommodations for material to be used in the process are available upon request. UHN will consult with any applicant who requests an accommodation in a manner that takes into account the applicant's disability. Successful applicants will be notified about UHN's policies for accommodating employees with disabilities as part of their offer of employment.

1.12.2 Employee Supports

UHN will inform employees of the policies used to support employees with disabilities, including policies on the provision of job accommodations that take into account an employee's accessibility needs due to disability. UHN will provide this information to new employees at orientation or as soon as practicable after they begin their employment and provide updated information to all employees whenever there is a change to existing policies on the provision of job accommodations that take into account an employee's accessibility needs due to disability.

For details on employment accommodation for people with disabilities, refer to Accommodation in Employment for Persons with Disabilities policy 2.10.012.

1.12.3 Accessible Formats & Communication Supports for Employee

Upon an employee's request, UHN will consult with the employee to provide or arrange for the provision of accessible formats and communication supports for information that is needed in order to perform the employee's job, and information that is generally available to employees in the workplace.

UHN will consult with the employee making the request in determining the suitability of an accessible format or communication support.

1.12.4 Workplace Emergency Response Information

If an employee's disability is such that workplace emergency response information is necessary and UHN is aware of the need for accommodation, this information will be provided to employees. In addition, this information will be provided, with the employee's consent, to the person designated to provide assistance. The information will undergo review when the employee moves to a different location, when the employee's overall accommodation needs or plans are reviewed, and when UHN reviews its general emergency response plan. (Refer to the AODA Emergency Response Plan Standard (STND6.30.009) and the UHN Emergency Codes.)

1.12.5 Documented Individual Accommodation Plans

A written process for the development and maintenance of documented individual accommodation plans will be developed for employees with disabilities. If requested, these plans will include information regarding accessible formats and communication supports. If requested, the plans will include individualized workplace emergency response information.

1.12.6 Return to Work Process

UHN will have in place a documented return to work process for employees returning to work due to disability and requiring disability-related accommodations. This return-to-work process will outline the steps that UHN will take to facilitate the return to work.

1.12.7 Performance Management, Career Development & Redeployment

UHN will take into account the accessibility needs of its employees with disabilities, as well as any individual accommodation plans, when providing career development and performance management, and when considering redeployment.

1.13 Transportation Standards

The UHN Shuttle Service provides no-charge transportation between Toronto General Hospital and Toronto Western Hospital. UHN's Shuttle Service is a specialized service committed to meeting the spirit and intent of the AODA. Where required and upon request, UHN will provide equivalent accessible transportation services.

The UHN Library and Patient Education Centres provide services to the public and, upon request, will provide equivalent accessible transportation services.

1.14 Built Environment Standards (Design of Public Spaces)

UHN will comply with the AODA Design of Public Spaces Standards (Accessibility Standards for The Built Environment) when undertaking new construction and redevelopment of public spaces in the following areas:

- recreational trails and beach access routes;
- outdoor public use eating areas;
- outdoor play spaces;
- exterior paths of travel;
- accessible parking;
- obtaining services; **and**
- maintenance of accessible elements.

This policy does not apply to municipal construction that is external to UHN for which UHN has provided a permit; however, compliance with the AODA Built Environment Standards is encouraged.

UHN will ensure that the Accessibility Design Standards reflect the AODA Built Environment Standards.

1.15 Responsibilities

The UHN Accessibility Planning Committee and Inclusion Diversity Equity Accessibility and Antiracism (IDEAA) Office is responsible for reviewing this policy annually and

recommending amendments to ensure on-going compliance with regulated accessibility standards and legislated obligations.

1.15.1 UHN Accessibility Planning Committee

- Provide advice and direction on the implementation of this policy.

1.15.2 Supervisors & Managers

- Ensure that they and their staff are familiar with and comply with this policy.
- Monitor current practices to ensure compliance.

1.16 Monitoring & Contraventions

The failure to comply with the AODA regulations can result in administrative penalties.

Failure to comply with this policy may result in disciplinary action, up to and including dismissal.

Requests for further information on this policy may be sent to accessibility@uhn.ca.

2. Definitions

Accessible formats: May include, but are not limited to, large print, recorded audio and electronic formats, Braille, and other formats usable by persons with disabilities.

Communication supports: May include, but are not limited to, captioning, alternative and augmentative communication supports, plain language, sign language, and other supports that facilitate effective communications.

Disability: Disability (or handicap) refers to all disabilities protected in the Human Rights Code, R.S.O. 1990, c. H.19, defined in s.10 of the Code as follows:

> "(a) any degree of physical disability, infirmity, malformation or disfigurement, that is caused by bodily injury, birth defect or illness and without limiting the generality of the foregoing, including diabetes mellitus, epilepsy, and degree of paralysis, amputation, lack of physical coordination, blindness or visual impediment, deafness or hearing impediment, muteness or speech impediment, or physical reliance on a guide dog or on a wheelchair or other remedial appliance or device,
>
> (b) a condition of mental retardation or impairment,

(c) a learning disability, or a dysfunction in one or more of the processes involved in understanding or using symbols or spoken language,

(d) a mental disorder, or

(e) an injury or disability for which benefits were claimed or received under the Workplace Safety and Insurance Act."

Service animal: Defined under Section 4(9) of the Accessibility Standards for Customer Service (O. Reg. 429/07) as follows:

"an animal is a service animal for a person with a disability:

(a) if it is readily apparent that the animal is used by the person for reasons relating to his or her disability; or

(b) if the person provides a letter from a physician or nurse confirming that the person requires the animal for reasons relating to the disability."

Support person: Defined under Section 4(8) of the Accessibility Standards for Customer Service (O. Reg. 429/07) as follows:

"a support person means, in relation to a person with a disability, another person who accompanies him or her in order to help with communication, mobility, personal care or medical needs or with access to goods or services."

Unconvertible: Not technically feasible to convert the information or communications or the technology to convert the information or communications is not readily available.

3. References

1. Health Protection and Promotion Act, R.S.O. 1990, c. H.7.
2. Human Rights Code, R.S.O. 1990, c. H.19.
3. Ontario Ministry of Economic Development, Trade and Employment. (2008). *Accessibility Standards*.
4. O. Reg. 191/11 Integrated Accessibility Standards.
5. O. Reg. 429/07: Accessibility Standards for Customer Service.
6. University Health Network Accessibility Committee (2012). *Multi Year Accessibility Plan 2012-2021*.

7. University Health Network Accessibility Committee. (2012). *2012-2014 Accessibility Plan*.

8. University Health Network. (2009). *Accessibility training for customer service*.

University Health Network
Policy & Procedure Manual
Administrative: Scent-free Environment

Policy

University Health Network (UHN) is committed to creating a safe and supportive workplace and care environment for all its employees, physicians, students, contractors, patients, and visitors. Health concerns that have been reported due to exposure to scented products include asthmatic reactions, breathing difficulties, upper respiratory symptoms, skin irritation, headaches, light-headedness, nausea and weakness. As such, employees, medical staff, volunteers, patients, visitors, students, and contractors are required to refrain from wearing or using scented personal products while at UHN.

Note: Personal scented products may include:

- shampoos and conditioners
- hairsprays
- deodorants
- colognes and aftershaves
- fragrances and perfumes

In addition, wherever possible, all products used for cleaning will be scent-free.

In cases of extreme sensitivity, UHN will endeavour to accommodate employees. The employees requesting accommodation are to be referred to Health Services to review the accommodation requests.

Departments and clinic areas will display appropriate information and signage to encourage staff, patients and visitors to refrain from wearing scented products.

Note: Contact UHN Safety Services for posters for department and clinic areas.

Any UHN staff member who notices the use of a scented personal product may, in a manner that is polite and respectful, advise the person that is using the product that:

- UHN is a scent-free facility.
- There are staff and patients who may be allergic to scented personal products, and ask the person to remove the scented product if possible, or refrain from wearing the scented personal product in the future.

If a staff member is uncomfortable approaching the person, or where they have concerns about the continued presence of the scented product, they may speak to their

manager/delegate. If the manager is comfortable, they may speak with the person. If not, the manager should contact People & Culture for advice and assistance.

Requests for Accommodation

Employee requests for accommodations will be managed by Health Services and People & Culture, as required.

Part 3: People and Culture Policies

University Health Network
Policy & Procedure Manual
People & Culture: Conflict of Interest

Policy

At University Health Network (UHN), all employees, medical staff, volunteers, and independent contractors must disclose any potential or actual conflict of interest. It is essential that employees, medical staff, volunteers, and contractors maintain the highest standard of public trust and integrity.

An improperly managed or undisclosed conflict of interest will not be tolerated by UHN. Any employee, medical staff member, volunteer, or independent contractor who is found to have engaged in such conduct will be subject to disciplinary action, up to and including termination of employment, volunteer assignment, or contract with UHN.

Requirements have been established to deal primarily with:

- gift acceptance
- business relationships
- vendor relationships
- family relationships
- consensual intimate relationships

Note: Research staff, also refer to Conflict of Interest of Research Personnel policy 40.90.002.

Gift Acceptance

Staff shall not solicit gifts from patients and/or their families, and should abstain from accepting gifts that fall outside the considerations listed below. Prior to determining whether to accept a team gift or an individual gift, the staff member recipient **must** consider:

- whether the patient/family member giving the gift is mentally competent;
- whether the patient/family expects anything in return for giving the gift;
- the potential for negative feelings on the part of other patients who may not be able to or choose not to give gifts to staff members;
- the monetary value of the gift;
- cultural norms applicable to gifts that are applicable in the circumstances, if any;
- any applicable regulatory requirements; **and**
- if refusal of the gift would harm the patient-staff member relationship.

Gifts made to a UHN-associated foundation or to UHN are not considered personal gifts to individuals.

Business Relationships

Staff, volunteers, or contractors shall not, without appropriate approvals from their managers or department head, engage directly or indirectly in any personal business transaction or private arrangement for personal profit that accrues from, or is based upon, their appointment/employment with UHN, or upon confidential or non-public information that they gain by reason of their employment with UHN.

Staff, volunteers, and contractors shall not divulge confidential or restricted information to any unauthorized person, or release such information in advance of authorization for release. (Refer to Privacy policy 1.40.007.)

Staff, volunteers, and contractors shall not, without appropriate approvals from their managers or department heads, have direct or indirect personal business or financial activities which conflict with their official duties and responsibilities, including owning any interest (directly or indirectly) in any organization doing business with UHN.

Vendor Relationships

Staff must not accept or solicit, directly or indirectly, any offers from vendors which do not comply with the UHN Code of Workplace Ethics and the UHN Supply Chain Code of Ethics.

Family Relationships

Staff shall not hire/transfer/promote members of their immediate family in the normal conduct of their responsibilities, nor shall they hire/transfer/promote members of the immediate family of existing staff in situations in which a conflict of interest may arise. This would include situations where the individual would report directly or indirectly to the staff person or work in the same department with an immediate family member.

Consensual Intimate Relationships

Romantic or sexual relationships between a supervisor and an employee or student who they supervise are prohibited.

Staff in this situation must immediately disclose the relationship to their manager, department head, or People Consultant advisor so that appropriate measures can be taken. Measures will include reassigning reporting responsibilities to others.

A supervisor who has direct supervisory authority over an employee/student/volunteer and is at the same time involved in an intimate relationship with that employee/student/ volunteer will be considered to be in violation of this policy and will be subject to

disciplinary action unless disclosure and corrective measures are taken. See Fostering Respect in the Workplace policy 2.50.005.

Agreement to Disclose

Prior to making a commitment through a job offer or volunteer opportunity, new employees and volunteers will be made aware of this policy. By signing the offer, new staff confirm that they have received, reviewed, understood, and agree to comply with this policy.

UHN physicians/dentists, UHN-appointed scientists, and members of the senior management team must comply with Relationship Attestation & Disclosure policy 1.30.009.

Definitions

Conflict of interest: In general terms, an employee has a conflict of interest when that individual or member of their immediate family has the ability to influence, directly or indirectly, a decision or action in their favour. Care should be taken to avoid potential or actual conflict of interest.

Examples of conflict of interest include:

- using privileged or confidential information for personal gain
- accepting or offering personal rewards in order to influence business transactions
- conducting business on behalf of UHN with an enterprise in which the employee or member of their immediate family has a personal or financial interest
- participating in actions that would deprive UHN of the time and attention of staff required to perform their duties properly
- using one's position, influence, or authority to promote the purchase, lease, or use of goods or services used by UHN, where the employee or member of their immediate family stands to gain financially from such promotion

Immediate family: Grandparents, uncles, aunts, cousins, parents, brothers, sisters, spouse, father-in-law, mother-in-law, brother-in-law, sister-in-law, nephews, nieces, children, and grandchildren.

Procedure

1. In order to avoid inadvertent or unintentional involvement in unpleasant situations or the appearance of conflict of interest, staff, and volunteers are required to

discuss situations of actual or potential conflict of interest with their supervisor or department head.

2. If facts disclose a potential or actual conflict of interest, this must be reported immediately to the department head. The department head will conduct an investigation in a timely and effective manner. Following the completion of the investigation, the staff member will be personally advised of the findings and the conclusions which have been reached.

3. If the department head, after investigating the relevant circumstances, finds there is no actual or potential conflict of interest, the manager will document this finding and advise the employee.

4. If the department head finds that there is a potential conflict of interest, they will advise and work with the individual to avoid a situation of conflict of interest. The department head will attempt to achieve an acceptable solution in this matter. If the potential conflict of interest is resolved to the satisfaction of both parties, a file will not be compiled, unless requested by the individual.

    - If the potential conflict of interest cannot be resolved to the satisfaction of either party, or if the department head finds that there is an actual conflict of interest, such conflict will be reported to the general counsel, vice-president, or the president.

    - The department head may recommend that disciplinary action be taken. Such action could include a suspension, reprimand, demotion, transfer or termination of employment or volunteer engagement.

5. The president or designate will review the potential or actual conflict of interest and attempt to resolve the situation. If an acceptable solution is found, the conflict and agreed upon solution will be recorded and retained in the employee file. If the president's decision supports a potential or actual conflict of interest and an acceptable solution is not found, a report and record of appropriate remedial action will be placed in the individual's People & Culture file.

University Health Network
Policy & Procedure Manual
People & Culture: Whistleblower

Policy

University Health Network (UHN) is committed to upholding the highest ethical standards and expects that everyone in the UHN community will conduct themselves with honesty and integrity. Staff, physicians, volunteers, students, vendors, contractors, consultants, patients, and any external partners, are encouraged to raise concerns and report behaviours inconsistent with UHN standards in good faith (i.e. genuine, truthful, and with no exaggeration), and to do so without fear of reprisal.

Individuals who report behavior inconsistent with UHN standards, i.e. **whistleblowers**, are a valuable resource to UHN as they help maintain accountability, integrity and public confidence.

The protections under this policy **do not** apply to individuals making false, exaggerated or misleading reports.

All reports will be subject to confidentiality and sensitivity, and any subsequent investigations will follow the appropriate investigation processes.

Those found to engage in reprisal against whistleblowers will be subject to discipline, up to and including dismissal, suspension or loss of privileges. All members of the UHN community are expected to cooperate fully with investigations.

Scope

UHN standards that are covered under this policy include:

- fraud
- theft
- embezzlement
- conflict of interest
- harm to UHN equipment
- data falsification or manipulation (including information relating to financial accounting or procurement processes)

Whistleblowers may also raise concerns on how reports of any wrongdoing were handled by others, and may report any individual(s) who may interfere, or have interfered, with a fair resolution.

This policy does not apply to People & Culture matters for which there are other established processes for the reporting and investigation of inappropriate conduct, including:

- Health Services incident reporting
- incivility, harassment or discrimination incidents covered by Fostering Respect in the Workplace policy 2.50.005
- provisions in collective agreements

Investigations

Investigators should obtain the full details of the complaint.

The member(s) of staff who has had the complaint launched against them will be informed as soon as practically possible. That member will be informed of their right to be accompanied by a union representative if applicable.

Investigations will follow the principles of procedural fairness to allow those suspected of wrongdoing to explain or defend actions.

All allegations of wrongdoing will be addressed, regardless of the source of the allegation. Where an investigation is warranted, it will be conducted in a timely and comprehensive manner.

The whistleblower will be kept informed of the progress of the investigation and, if appropriate, the final outcome.

Note: While UHN will do everything in its power to protect confidentiality, legal proceedings or obligations may require the whistleblower's identity to be revealed or the investigation process may result in their identity becoming known or inferred.

Note: Whistleblowers themselves should not attempt to investigate, only to provide information.

Definition

Reprisal: Reprisal includes any form of reprimand, intimidation, threats to fire, demote or impugn reputation, and exclusion.

Guidelines

General Principles

- Incidents should be reported as soon as possible after the whistleblower becomes aware of them.

- Whistleblowers may make reports verbally, by phone or in person, or in writing (by mail or email) as outlined in the Reporting section.

Reporting

Those who wish to report wrongdoing under this policy can do so by:

- speaking to a trusted member of management
- speaking to a People & Culture representative (People Consultants, Inclusion Diversity Equity Accessibility)
- calling the Ethics and Civility Helpline 416-340-3344
- reporting anonymously, online, by phone, or mail, through https://www.clearviewconnects.com/home, 1-866-344-4491

If the situation involves a member of senior management or a physician, individuals may contact the executive vice-president (EVP) People, Culture & Community or report anonymously through https://www.clearviewconnects.com/home.

University Health Network
Policy & Procedure Manual
Administrative: Photo Identification Cards

Policy

All University Health Network (UHN) staff, medical students, residents, nursing and allied health students, contractors, permanent, on-site retail vendors, volunteers, and UHN visitors (hereinafter referred to as "**cardholder**") must wear official photo identification (ID) cards while on UHN premises in a work-related capacity. Only one card is permitted to any cardholder at any one time. A replacement card will not be issued to a cardholder if a previously issued card has not been confirmed as returned to Security Operations.

The ID card must be worn in an appropriate place on the front of the person with the name and photograph in full view. ID cards are not to be defaced or obscured by stickers, etc., preventing the card from being used for identification purposes.

ID cards must be in the possession of the cardholder at all times. Cardholders must take their cards home with them when they leave UHN, as access to UHN is restricted at times.

All photo ID cards identify the cardholder's full first name, full last name, job title, and department of employment. While the employee's last name must be provided, for safety purposes employees may request not to have their last name included on the printed ID card. Department names must be consistent with the corporate intranet directory listing. Only "Dr." will be added to this information, if applicable. Middle initials, educational degrees and personal titles (Mr., Mrs., etc.) will not be added to photo ID cards.

As each cardholder is given specific access clearances, they are prohibited from lending their cards to anyone. People found in possession of someone else's card will be reported to their manager, and Security Operations will confiscate the card.

UHN will assume the cost of providing the initial ID card and it remains the property of UHN at all times.

Upon resignation or termination, all cardholders must surrender their ID cards to their managers, who will send them to Security Operations for recycling. Managers must be vigilant in notifying Security Operations of any ID cards not received from terminated or resigning employees to ensure that ID card access permissions are invalidated. Managers who do not forward cards of resigning or terminated staff, contractors, etc. may be held responsible for unauthorized use of ID cards.

Contractors

All contractors are required to have ID cards while on UHN premises to identify them as having authorization to be on the property. (See Constructors Health & Safety Program policy 6.10.008.)

For contractors on short-term projects, a temporary ID card will be issued without a photo. These cards are to be signed out from, and returned to, the applicable site Security Operations on a daily basis.

For contractors on long-term projects, a completed Photo ID Request Form, authorized by the UHN contact person to whom the contractors are reporting, is required. The contractors must obtain the ID cards from a photo ID location during its regular hours of operation.

Temporary ID cards not received will be deactivated on a daily basis and the project contact will be billed a $10.00 (per ID card) replacement fee for the lost card(s).

If contractors do not return photo ID cards to Security Operations upon project completion, they will be billed a $10.00 replacement fee for each ID card not returned.

Permanent, On-site Retail Vendors

All permanent, on-site retail vendors are required to have ID cards while on UHN premises to identify them as having authorization to be on the property.

A completed Photo ID Request Form, authorized by the UHN contact person to whom the permanent, on-site retail vendors are reporting, is required. The vendors must obtain ID cards from a photo ID location during its regular hours of operation.

If vendors do not return photo ID cards to Security Operations upon cessation of their employment with the on-site franchise, they will be billed a $10.00 replacement fee for each ID card not returned.

UHN Visitors

Authorized or official UHN visitors (e.g. auditors, accreditation surveyors, observers, etc.) will be issued an ID card upon presenting a completed and authorized Photo ID Request Form to a photo ID location during the hours of photo ID operation. The UHN contact person to whom the visitor will be reporting must authorize the Photo ID Request Form.

Photo ID Request Forms

Incomplete or altered information (excluding minor spelling corrections) on a Photo ID Request Form will not be accepted.

Damaged ID Cards

Damaged ID cards require replacement to ensure their functionality. Clean card breaks or breaks at the hole-punch location will be replaced at no cost. Only cards damaged by negligent means require a $10.00 replacement fee, payable at the Cashier's Office.

Procedures

1. The user completes the online Photo ID Request Form through Digital's Service Portal.

2. Once the form is submitted, the manager will receive an email to authorize the request.

3. The user will receive authorization confirmation via email and can proceed to a photo ID location for processing.

   Note: For locations and schedules, go to the Photo ID Cards webpage.

4. Security Operations issues an ID card with the cardholder's photograph, first name (in full), last name (in full), job title and department information.

Lost ID Cards

1. If an ID card is lost or misplaced, immediately notify the department manager and Security Operations at 14-4111 or 416-597-3422 ext. 3070 for Toronto Rehab.

2. The user completes a new Photo ID Request Form through Digital's Service Portal and submits for authorization

3. The manager will receive an email to authorize the request.

   Note: Once complete, the user will receive confirmation of approval.

4. The user will be required to:

   - Pay the required replacement cost of $10.00 at the Cashier's Office.
   - Bring the receipt to Photo ID for a replacement ID card during regular Photo ID hours of operation.

     Note: For locations and schedules, go to the Photo ID Cards webpage.

Damaged ID Cards

1. If an ID card is no longer functioning or is damaged, bring it to Photo ID for replacement.

   Note: For locations and schedules, go to the Photo ID Cards webpage.

2. Security Operations assesses the damage as negligence or accidental.

3. If the damage is assessed as being caused by negligent means, Security Operations instructs the cardholder to pay the required replacement cost of $10.00 at the Cashier's Office.

4. If a card is broken, bring all the pieces to Photo ID for replacement.

Employment Change

If a staff member changes their name, job title, or department:

1. The user completes an online Photo ID Request Form through Digital's Service Portal.

2. The manager will receive an email to authorize the request.

   Note: Once complete, the user will receive confirmation of approval.

3. The user can then go to a Photo ID location for a replacement ID card at no cost to the employee.

   Note: For locations and schedules, go to the Photo ID Cards webpage.

Note: Access changes on cards with no printed (ID card) information require a manager's authorization.

University Health Network
Policy & Procedure Manual
People & Culture: Fostering Respect in the Workplace

1. Policy

University Health Network (UHN) is committed to an environment where all persons are treated with respect, dignity, and equitable treatment in alignment with UHN's Purpose, Values, and Principles (PVP). This policy provides a dispute resolution process which applies to any conduct described as incivility, bullying, harassment, sexual harassment, or discrimination as described in UHN's equity policies (Anti-Racism and Anti-Black Racism policy 1.20.019, Accessibility for Ontarians with Disabilities Act – Integrated Accessibility Standards Regulation policy 1.20.007, Accessibility for People with Disabilities – Customer Services policy 1.20.011, and Gender Identity policy 2.50.009). In the case of violence, refer to Violence & Domestic Violence in the Workplace policy 6.30.004.

All employees, physicians, learners, volunteers, and contractors are required to uphold this policy, and will be held accountable by UHN. Any person or organization conducting business with UHN found to have engaged in behaviour constituting discrimination and/or harassment in UHN environments will be subject to disciplinary action, up to and including dismissal.

1.1 General Principles

All persons have a right to an environment free from discrimination and harassment.

All persons have a right to safely engage in UHN's resolution processes under this policy without reprisal or threat of reprisal. Disciplinary action may result where participants in resolution processes experience any form of retaliation.

All persons have a right to seek remedies under applicable collective agreements, the Ontario Human Rights Code (Code), Employment Standards Act (ESA), Workplace Safety and Insurance Act (WSIA), or Occupational Health and Safety Act (OHSA). If such a remedy is sought, or if any other external legal claim is initiated, while also engaged in the processes described in this document, the internal UHN processes will be paused.

Each case will be considered on its own merits.

If there is evidence that a complaint was made in bad faith or found to be vexatious, the person who submitted the complaint may face disciplinary measures.

Leadership may initiate measures to correct inappropriate behaviour, even in the absence of a formal complaint.

All documentation is confidential (including reports) to UHN and will not be distributed to any party, unless required by law.

UHN's Health Services department will be alerted in the event that an employee loses time from work as a result of an incident that breaches this policy or UHN's equity policies.

1.2 Responsibilities

All members of UHN have a personal responsibility to:

- ensure that their behaviour and conduct complies with this policy; and
- immediately report to their leaders or People & Culture (P&C) any inappropriate conduct that become aware of or witness.

All supervisors, managers, and physicians at UHN are responsible to:

- establish and maintain a respectful work environment which is free of incivility, bullying, discrimination, and harassment;
- address incidents of incivility, bullying, discrimination. and harassment;
- actively work to eliminate any incivility, bullying, discrimination, or harassment, and promptly inform P&C of any incident or situation;
- report any matter that breaches this policy or the Code to P&C; and
- adhere, communicate, and enforce this policy.

People & Culture is responsible for leading investigations under this policy, and providing information, education, and consultation to all members of UHN on inappropriate conduct, including the interpretation and application of this policy.

1.3 Confidentiality

All persons involved in the processes defined in this policy are expected to maintain confidentiality. Information that is collected about an incident or complaint, including identifying information about any person involved, will not be disclosed unless necessary for the purposes of investigating or taking corrective action, or as required by law.

1.4 Conflict Resolution and Complaint Process

The conflict resolution and complaint process may be initiated by any employee, physician, learner, volunteer or contractor working at, or on behalf of, the UHN environment. Any conflict and/or complaint raised by patients alleging inappropriate conduct by UHN staff, physician, or volunteers will be dealt under separate proceedings.

Note: Any concerns or suspicions of fraud, theft, embezzlement, conflict of interest, harm to UHN equipment, or data falsification or manipulation (including information relating to financial accounting or procurement processes) are covered by Whistleblower policy 2.50.010.

In the event that an incident of incivility, bullying, harassment, or discrimination occurs, persons are encouraged to first address the issue at an early stage and in a collaborative manner. If this does not resolve the issue, or is not appropriate, individuals may engage the Formal Resolution Process as described in step 4.

Individuals are encouraged to seek advice on how to proceed, and may do so from either a member of their management team, or from People & Culture (People Consultants, Inclusion Diversity Equity Accessibility & Anti-Racism (IDEAA), or the Centre of Excellence for Workplace Investigations).

Also refer to Appendix: Conflict Resolution & Complaint Process Flowchart.

The **Conflict Resolution Process** follows 4 steps:

1. Discussing the concern directly with the person believed to be acting inappropriately towards the employee. Advice on how to do so can be found at the Respect, Civility & Professionalism @ Work intranet site.

2. If the behaviour continues after having discussed the concerns with the person, or if unsure about how to proceed, asking a member of leadership or P&C for advice.

3. If the behaviour continues, asking a member of leadership or P&C to facilitate or mediate a resolution with the person.

4. If the behaviour continues, or is of a serious nature, submitting a complaint under the Formal Resolution Process. Speak to leadership **or** a member of P&C for further advice.

Notes:

- Unionized employees must seek advice from their union representative.

- If the source of the behaviour is a patient or someone associated with a patient, employees, learners, or volunteers should inform their supervisor. Patient Relations may also be contacted for advice.

- If the complaint names a member of P&C as a respondent, the investigation will be reviewed to appropriately determine who will be responsible for the investigation under the supervision of the executive vice-president (EVP), People, Culture & Community. If the complaint involves the EVP, People, Culture & Community, the investigation will be conducted by an external third party.

- In the event where behaviour of persons not named in the complaint are believed to be in breach of this or other UHN equity policies, the matter may be referred for further review.

- Anyone may contact the confidential Ethics and Civility Helpline at 416-340-3344 (14-3344) for advice on all options available.

1.4.1 Formal Resolution Process

A person (the complainant) who wishes to engage in the Formal Resolution Process must first approach a member of leadership **or** P&C (People Consultants, IDEAA, or the Centre of Excellence for Workplace Investigations) to discuss the complaint.

A member of leadership who receives a formal complaint under this policy, either verbally or in writing, is required to report this to a member of P&C (People Consultants, IDEAA, or the Centre of Excellence for Workplace Investigations).

The individual must submit the complaint in writing (see Writing a Complaint), submitting as soon as possible after the alleged behavior has occurred, and within one year of the last incident.

Within 10 working days of receipt of the complaint, a member of P&C will meet with the complainant to determine the merit and scope of the complaint and provide the complainant with the necessary supports and advice. If appropriate, mediation will be offered.

The complainant must be prepared to be identified by name to the person alleged to be in contravention of this policy (the respondent). The respondent will be notified, and given a reasonable amount of time to respond in writing to the allegations. If the complaint involves a physician, the physician/surgeon-in-chief, the EVP and chief medical officer (CMO), and the EVP, People, Culture & Community will be alerted and briefed on the allegations. If the complaint involves a learner, the EVP Education will be alerted and briefed on the allegations.

Note: If a complaint of discrimination involves a University of Toronto (UofT) learner or faculty member, the UofT Office of Human Rights will be notified as per the UofT and affiliated hospitals agreement. If a learner from another educational institution is involved, that school will be engaged per academic affiliation agreement.

After the respondent has provided their version of events, the P&C representative reviewing the case will determine if, and how, to proceed with an investigation, including which witnesses to interview and what evidence to be reviewed. If the complaint involves violence, an incident report will be filed using the incident reporting tool. For clarity, the investigation process commences once the respondent has provided their version of events. In absence of a response, the investigator may use their discretion to proceed with the investigation where an investigation is warranted, based on available information.

All reasonable efforts will be made to complete the investigation within 60 working days after the response is received. In the event the investigation exceeds 60 days, the parties to the complaint will be notified with reasons for the delay and expected timeline for the conclusion of the investigation. At the end of an investigation, the complainant(s) and respondent(s) will be advised of the outcome in writing, as confidentiality allows.

During investigations, the complainant and respondent may be physically separated to allow for a safe working environment.

In the event that the outcome is unsatisfactory to the complainant or respondent, either party may submit a written appeal to the EVP People, Culture & Community (or designate). (Refer to Criteria for Submitting an Appeal.)

If there is evidence that this policy has been breached, appropriate disciplinary action may be levied, ranging from a written reprimand and apology, up to and including dismissal.

All members of the UHN community are expected to cooperate fully with investigations.

The EVP, People, Culture & Community (or designate) will determine the most appropriate course of action in the event that the Ministry of Labour, Immigration, Training and Skills Development (MLITSD) requires a third-party investigation, or if the complaint involves an executive leader.

Two or more complaints alleging similar violations by the same person, or having facts in common, may be dealt with under the same proceeding.

A complainant may, at their discretion, decide to withdraw a complaint at any point in the procedure under this policy. However, UHN may choose to continue to pursue the complaint despite the withdrawal.

Investigation reports will be filed with P&C and kept for at least one year following the date of the last incident.

1.4.2 Writing a Complaint

A complaint must be in writing and should be made as soon as possible after the alleged behaviour has occurred, and within one year of the most recent incident.

The complaint should provide a description of the behaviour experienced, as well as all relevant dates, times, places, and persons involved. The Workplace Complaint Form can be used for filing a complaint and the complainant can contact P&C (People Consultants, IDEAA, or the Centre of Excellence for Workplace Investigations) for technical support. If the complainant prepares a paper copy in their own format, they must ensure that it is signed and dated. Separate from the complaint, the complainant must provide a list of all witnesses who are believed to have some knowledge of the complaint and provide any relevant evidence they may have.

Note: To manage one's well-being during the process, individuals are encouraged to visit the This is Wellness@UHN intranet site.

1.4.3 Criteria for Submitting an Appeal

If the complainant or respondent is unsatisfied with the outcome of a complaint under this process, they may submit a written appeal to the EVP, People, Culture & Community for review. The person making the appeal must provide evidence that the investigation was improperly conducted, or that there have since arisen significant new facts that could change the outcome of the original investigation.

1.5 Disciplinary Action

The purpose of any actions taken as a consequence of a violation of this policy is to create an environment that is free from incivility, bullying, discrimination, and harassment.

Where a violation of this policy has occurred, UHN may take appropriate action, upon any respondent, including, but not limited to, one or more of the following remedies and sanctions:

- an apology (verbal or written)
- counselling
- education or training
- written reprimand or warning
- job or program transfer
- change of work assignment or appointment
- termination of appointment, employment, volunteer position, contract

agreement or any other privileges
- support/counsel persons affected by discrimination and/or harassment
- monitoring and follow-up to ensure that any incivility, bullying, discrimination, and/or harassment has stopped and no incidents of reprisal have occurred
- suspension of the respondent without pay
- reporting to appropriate licensing body, as required

Where there is evidence that a complaint under this policy was made in good faith and there is no evidence of incivility, bullying, discrimination, or harassment, no adverse consequences and no documentation of the complaint will appear on the alleged harasser's record, or any person involved in the complaint.

2. Definitions

Bullying: Refers to a range of behaviours in which targeted individuals are repeatedly, and over time, treated in a mean, insulting or abusive way. Bullying can be initiated deliberately or unconsciously. The affected person may feel upset, afraid, isolated, or humiliated. The bully sometimes acts alone and sometimes as part of a group of people. Examples include:

- insulting a person's skills, looks, or habits
- spreading false or malicious rumours, gossip, or innuendo
- berating/belittling an individual
- unwarranted criticizing or ridiculing, especially in the presence of others
- giving insulting nicknames
- engaging in practical jokes that humiliate
- undermining or deliberately impeding a person's work
- physical gesturing that intimidates, offends, degrades, or humiliates
- refusing to work or converse with a person or group of persons
- mocking a person's accent, abilities or mannerisms
- yelling or shouting which intimidates, coerces, or belittles

Complainant: A person (or persons) making a verbal or written complaint of incivility, bullying, discrimination, and/or harassment under this policy. The complainant does not need to be the target of the alleged behaviour.

Discrimination: Differential treatment based on a personal characteristic which has an adverse impact on an individual or group. Examples of personal characteristics include: race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status, disability, gender identity, and gender expression. Adverse impact is defined as the denial of employment-related benefits and/or injury to dignity, feelings, and respect arising from an offensive comment, question, or request that is linked to a Code ground.

Environment: Includes:

- campus, offices, and buildings of UHN
- cafeterias
- lunch rooms
- washrooms
- locker rooms
- work sites
- work assignments outside of UHN property
- off-site work-related social events and functions
- work-related seminars, conferences, and training
- work-related travel
- telephone communications
- faxes
- email
- social networking sites and virtual spaces (e.g. Facebook, YouTube, Twitter, Microsoft Teams, Zoom)
- elsewhere if the person is feeling incivility, bullying, harassment, or discrimination against them as a result of work-related responsibilities, which may include a work-related relationship

Gender expression: An individual's characteristics and behaviors (such as appearance, dress, mannerisms, speech patterns, and social interactions) that may be perceived as masculine or feminine.

Gender identity: A person's internal and individual experience of gender. It is a person's sense of being a woman, a man, both, neither, or anywhere along the gender spectrum. A person's gender identity may be the same as, or different from, their birth assigned sex. A person's gender identity is fundamentally different from and not related to their sexual orientation.

Harassment: Any objectionable course of behaviour, comment, display, or communication that is known or ought reasonably to be known to be unwelcome, intimidating or offensive. Harassment may also include discrimination as set out in the Ontario Human Rights Code and prohibited grounds. Examples include:

- yelling or shouting which intimidates, coerces or belittles another person
- unwanted actions based on a person's characteristics, such as race, ethnicity, sexual orientation, disability, gender or religion
- unwelcome remarks, jokes, innuendoes or taunting
- unwelcome initiations, requests, or remarks

Stalking is also a form of harassment, defined as repeatedly following the other person or anyone known to them from place to place; repeatedly communicating with, either directly or indirectly, the other person or anyone known to them; besetting or watching

the other person's dwelling/house, or place where the other person or anyone known to them, resides, works, carries on business or happens to be; or engaging in threatening conduct directed at the other person or any member of their family.

A reasonable action taken by an employer or supervisor relating to the management and direction of workers or the workplace is not workplace harassment.

Homophobia: Negative attitudes, feelings, or irrational aversion to, fear, or hatred of gay, lesbian, bisexual, or asexual people and communities, or of behaviours stereotyped as "homosexual." It is used to signify a hostile psychological state leading to discrimination, harassment, or violence against gay, lesbian, bisexual, or asexual people.

Incivility: Behaviours that are rude, disrespectful, inconsiderate or insensitive. There may not be an intention to harm, but the end result of such behaviour makes for an unpleasant work environment, decreased performance and commitment to the organization, co-workers, learners, and patients. Examples include:

- skipping basic courtesies such as hello, thank you, and please (in person, in email, or virtually)
- sarcasm
- cliques, gossip, and social exclusion
- intruding on personal or physical boundaries
- arriving late when relied on by others for coming on time
- body language that conveys dismissiveness or negative judgment
- use of profanity
- speaking loudly to disturb others

Mediation: A voluntary resolution process in which a neutral, third party facilitates a discussion between the people in dispute. The mediator ensures that communication is clear, that all parties are given full and equal voice, and that a final resolution is determined by the disputants themselves. Whatever takes place within the mediation session may not be revealed if the disputants seek another forum for resolution.

Respondent: A person (or persons) alleged by a complainant to have committed an act in breach of this policy.

Transphobia: The fear of, discrimination against, or hatred of trans people, the trans community, or gender ambiguity. Transphobia can be seen within the queer community, as well as in general society.

Violence: The use, threat, or attempt of physical force against another person that causes, or could cause, physical injury. Examples include:

- pushing or shoving
- hitting, or trying to hit, a worker

- jabs or punches
- throwing objects
- verbal threats of physical harm
- gestures that simulate or threaten physical harm, such as waving fist or punching an open palm
- blocking an exit or path in order to keep someone from leaving the area
- wielding a weapon
- sexual violence

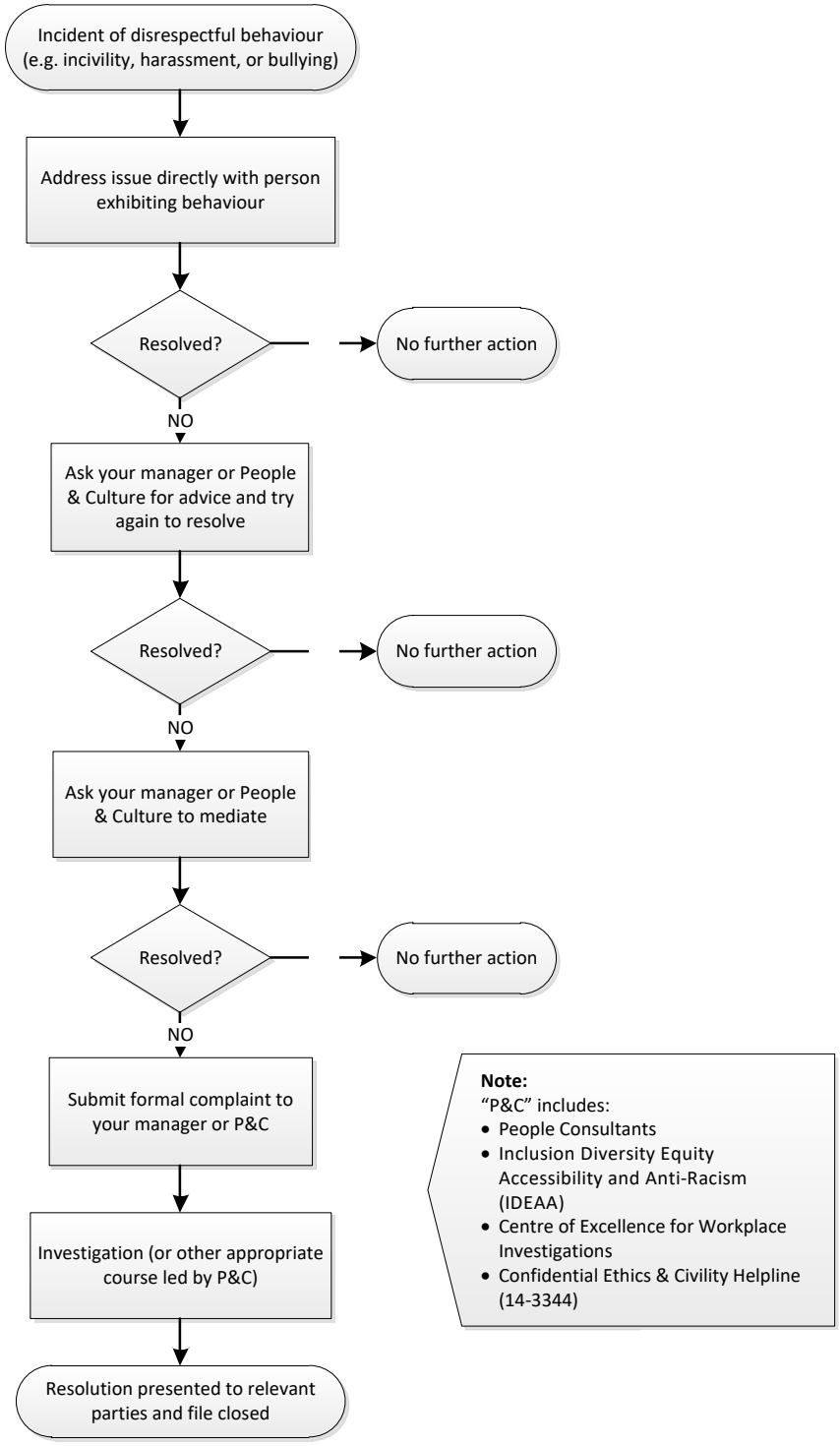
Sexual harassment: Engaging in a course of vexatious comment or conduct against a worker in the UHN environment because of sex, sexual orientation, identity, or gender expression, where the course of comment or conduct is known or ought reasonably to be known to be unwelcome. Examples include: making sexual remarks, leering, touching, massaging, or displaying pornographic material.

Making a sexual solicitation or advance where the person making the solicitation or advance is in a position to confer, grant, or deny a benefit or advancement to the worker and the person knows or ought reasonably to know that the solicitation or advance is unwelcome.

An individual who rejects a solicitation or sexual advance should not subsequently experience reprisal as a result. Reprisal is subject to disciplinary action.

Romantic or sexual relationships between a supervisor and an employee, physician, Researcher, learner, intern, or volunteer whom the individual supervises, are prohibited because of the influence, authority or power imbalance in the relationship. Individuals in this situation should immediately disclose the relationship to their manager or P&C representative so that appropriate measures can be taken. Measures will include reassigning reporting responsibilities to others. Failure to disclose the relationship will be subject to disciplinary action. Refer to Conflict of Interest policy 2.50.002 for more information.

Appendix: Conflict Resolution & Complaint Process Flowchart



University Health Network
Policy & Procedure Manual
People & Culture: Disconnecting From Work

Policy

University Health Network (UHN) respects its employees' right to disconnect from work and be free from the performance of work outside of their working hours to maintain a healthy work-life balance and employee wellness. "Disconnecting from work" is defined by the Employment Standards Act as refraining from the engagement of work-related communications, including emails, telephone calls, video calls, or the sending or reviewing of other messages. Disconnecting from work ensures that all UHN employees are free from the performance of work outside of their working hours.

UHN acknowledges and respects that everyone has distinct preferences when it comes to "disconnecting" and will respect each other's choices. UHN encourages employees to work with their managers to ensure their preferences can be implemented. Employees might prefer to:

- Stay connected and up-to-date with emails when they are on vacation or outside of their working hours.
- Disconnect completely and arrange for full coverage from a team member.
- Catch up on emails in the evening and take advantage of greater flexibility during the day.

This policy does not restrict UHN's right to schedule and modify the hours of work of employees, nor does it prohibit employees from working outside of their typical work hours as it pertains to Flexible Work Arrangements policy 2.50.006.

Note: Independent of this policy, UHN embraces flexibility, consistent with Flexible Work Arrangements policy 2.50.006, and provides options to TeamUHN when it comes to how, when, and where they work while taking into account the job responsibilities of the role. Flexibility includes doing what's best for UHN teams and ensuring that the needs of the patient come first. As a result, it is recognized that there will be times where employees work outside of their typical working hours. Situations may arise where TeamUHN employees will be contacted for urgent/emergency matters outside of their work hours, as per Service Continuity policy 2.50.007 or to meet deadlines that otherwise would lead to patient safety concerns or other adverse operational impacts on UHN.

An FAQ for this policy is available on the People & Culture website.

Application

This policy applies to all UHN employees (permanent, temporary, full-time part-time, casual, unionized, and non-unionized).

In the event of any inconsistency between this policy and the Employment Standards Act, the provisions of the Employment Standards Act shall prevail.

Note: The rights of an employee to not perform work continue to exist under other provisions of the Employment Standards Act (e.g. hours of work, eating periods, vacation, public holidays, etc.), subject to the exemptions provided for in the Employment Standards Act.

Responsibilities

All TeamUHN employees are responsible for complying with this policy, taking ownership of their own ability to disconnect from work, and respecting the rights of others to disconnect from work.

UHN management is responsible for participating in and enforcing this policy.

People leaders are responsible for modelling appropriate behaviours surrounding disconnecting from work and enforcing the efficacy of this policy, in addition to employees' responsibilities.

People & Culture is responsible for supporting employees in all matters involving the development, implementation, operation, and continual improvement of this policy. This includes investigating disputes arising under the policy.

Guidelines for Disconnecting From Work

- When off work, employees should set an automated "out of office" reply in Outlook, record a voicemail message, and set a notification in other communication platforms (e.g. Microsoft Teams) so colleagues know the employee will not be responding until the next scheduled workday.

  Note: In the notification messages, the employee should indicate their typical hours of work and indicate to the caller when to expect to hear a response.

- Employees should avoid checking and responding to emails outside of normal working hours or when on vacation to use the time to fully rejuvenate and disconnect from work.

- To the best extent possible, work-related emails should be sent solely during working hours.

  Note: The “delay delivery” function in Outlook may be used outside of this timeframe.

- When sending non-urgent emails to colleagues, employees should indicate that an immediate response is not required whenever this is the case.

- Employees should seek support from a people leader if struggling to effectively manage their workload and work-related communications during working hours.

- Employees should encourage colleagues and team members to disconnect when they are off work by providing coverage.

Related UHN Policies

- Overtime policy 2.30.002
- Paid Relief Periods policy 2.30.009
- Flexible Work Arrangements policy 2.50.006
- Holidays policy 2.20.001
- Vacations policy 2.20.005
- Service Continuity policy 2.50.007
- Leaves of Absence policies (refer to People & Culture Policies & Procedures)

Definitions

Disconnecting from work: TeamUHN employees’ right to disengage from work and be free of work-related obligations, including work-related communications outside of their typical working hours, except in cases of emergencies or prior agreement. The prior agreement includes on-call or standby arrangements.

Emergency: Unexpected and aberrant situations that demand attention outside of the employee's typical work hours to avoid significant adverse consequences. Significant adverse consequences may include the inability to continue operations for the organization, material financial costs, and a significant negative impact on the delivery of patient care or other services. Emergencies can arise in various contexts. An urgent need to fill an important shift because of a failure of typically adequate scheduling practices qualifies as an emergency.

People leader: A TeamUHN employee who has the delegated authority to recruit, conduct performance reviews and discipline; supervise, control, or assign the allocation and use of human, capital, and financial resources; and act on behalf, and represent the interests of UHN management in the affairs of the organization.

TeamUHN: Includes permanent, temporary, full-time, part-time, and casual employees.

Working hours: Hours of work are defined as 7 hours or 7.5 hours per day, unless stipulated otherwise in the employment contract, the applicable collective agreement, and/or any other scheduling change that UHN and the employee has agreed to.

Work-related communications: Any communication, including phone or video calls, and sending, reading, or responding to emails, texts, instant messages, social media messages, and other electronic communications.

Part 4: Research Policies

University Health Network
Policy & Procedure Manual
Research: Conflict of Interest of Research Personnel

This policy is currently under revision (as of November 2019). For clarification on the policies and practices stated in this document, contact Christine Snidal via email at Christine.Snidal@uhn.ca.

1. Policy

In keeping with its commitment to maintaining public confidence in research, University Health Network (UHN) addresses additional requirements that relate specifically to conflicts of interest (COIs) of research personnel.

Research personnel will not conduct research or any actions involving the expenditure of research funds with a known and unmanaged COI. All research personnel must disclose, in writing, all actual, apparent, perceived and potential COI situations. It is essential that research personnel maintain the highest standard of public trust and integrity.

All conflicts of interest will be disclosed and managed, approved or rejected in accordance with the process for disclosure as described herein.

In addition to their obligations regarding their individual COI situations, all research personnel have the obligation to report institutional COI situations to the executive vice-president (EVP) Science & Research.

This policy applies to all research personnel. Failure to adhere to this policy may result in disciplinary action up to and including termination of employment, engagement, appointment, or contract with UHN.

The UHN Research Ethics Board's review and determination regarding conflicts of interest is separate from the process in this policy.

1.1 Disclosure

Research personnel will make a written disclosure to the EVP Science & Research or designate of all actual, apparent, perceived and potential COI situations in advance, or as the COI situations arise and/or become known, but no later than 30 days from the time the COI situation becomes known. Disclosures will include sufficient information to allow the EVP Science & Research or designate to accept, reject or require management of a COI situation. The disclosure must also include notification of any additional reporting obligations related to the COI situation. (See Conflict of Interest and Confidentiality Agreement Online.)

For COIs involving the leadership positions identified below, disclosure will be made, in writing, as follows:

- department/division head to EVP Science & Research
- EVP Science & Research to chief executive officer (CEO)
- CEO to UHN Board of Trustees

1.2 Annual Declaration

All research personnel are required, on an annual basis, to complete and submit a written declaration to the EVP Science & Research or designate, confirming that they have disclosed all COIs throughout that particular year as required by this policy, and that they are in compliance with the policy.

1.3 Approval Process

COI situations are not permitted prior to review by the EVP Science & Research or designate. The EVP Science & Research or designate agrees to render decisions about managing COI situations in a timely fashion and in writing. In any review of a COI situation, the EVP Science & Research or designate may attach such terms and conditions as the EVP Science & Research or designate considers appropriate or necessary to manage the COI situation.

The designate will provide an annual report to the EVP Science & Research, summarizing all COI disclosures made to the designate, along with the management plans for managing the COI situation regarding the disclosures.

1.4 U.S. Federal Funding

UHN research personnel participating in research funded by the U.S. Public Health Service (PHS), which includes National Institutes of Health (NIH), must also comply with PHS regulations Responsibility of Applicants for Promoting Objectivity in Research for which PHS Funding is Sought and Responsible Prospective Contractors. (Refer to the NIH Financial Conflict of Interest webpage.) Investigators (including sub-investigators) applying for and receiving U.S. federal funding must:

- Complete and submit a UHN COI Disclosure and/or Annual Declaration prior to applying for funding, and continue to follow this policy throughout the period of the award.

- Complete the UHN COI training module prior to starting the research and renew the training not less than every four years.

- Provide sufficient information to allow the EVP Science & Research (or designate) to approve the management plan for a COI situation involving any significant financial interest.

- Ensure that they have provided sufficient information to facilitate the required financial conflict of interest reports to the funding agency, both prior to the start of the research and annually throughout the award period.

The EVP Science & Research will review all disclosures involving significant financial interest in consultation with other senior management (including the chair of the Research Ethics Board, if the research involves human subjects), as needed.

1.5 Management of COI Situations

Research personnel should propose a plan to manage their COI situation at the time of making the disclosure. The EVP Science & Research or designate has the discretion to assess adequacy and impose additional requirements that must be incorporated into the management plan.

The following conditions or restrictions could be proposed by the research personnel to manage COI situations (though others may also be included, depending on the nature and kind of the COI situation):

- ensuring no direct reporting relationship with research personnel's immediate family
- monitoring of the research by independent reviewers
- modification of the research plan, patient recruitment, or sites
- independent data collection or data analysis
- an independent data monitoring committee
- disqualification from participation in all or a portion of the research
- divestiture of financial interests
- non-acceptance of the gift, goods, or expenses
- severance of relationships that create the COI situation

1.6 Confidentiality of COI Disclosures

The disclosure information will not be divulged without the written consent of the research personnel, except:

- internally by UHN for the purposes of complying with policies, including this policy
- for the purposes of complying with applicable laws
- to cooperate with procedures being undertaken to address allegations of research misconduct

- where the research team involves other institutions, the institution administering the funds will copy the disclosure to other relevant institutions if a significant financial interest is involved or may be involved

UHN will share disclosures with funding agencies as required. If the research is to be conducted at more than one institution, the institution administering the grant funds will make the required disclosure to the funder (subject to the funder's direction).

1.7 Appeals Process

Research personnel may appeal a negative decision to the CEO or, in the case of research personnel covered by the Medical-Dental Staff By-laws, following procedures outlined in the Medical-Dental Staff By-laws.

1.8 Responsibilities

1.8.1 Research Personnel

- Review and maintain familiarity with current related UHN policies.
- Provide written disclosure to the EVP Science & Research (or designate) of all actual, apparent, perceived and potential COI situations, in advance or as the COI situations arise and/or become known.
- Provide sufficient information to allow the EVP Science & Research to manage the COI situation by completing the COI disclosure form. (See Conflict of Interest and Confidentiality Agreement Online.)
- Propose a plan to manage the COI situation at the time of making the disclosure.
- Report institutional COI situations related to research to the EVP Science & Research.

1.8.2 EVP Science & Research/Designate

- Review and maintain familiarity with current related UHN policies.
- Review all disclosures and render decisions regarding managing COI situations in a timely fashion and in writing.
- Assess adequacy of management plan submitted and impose additional requirements, if required.
- Maintain confidentiality of disclosures according to this policy.

- Designate will provide annual report to the EVP Science & Research, including disclosures and management plan received and decisions made

- EVP Science & Research will review all disclosures involving significant financial interest and ensure appropriate monitoring and reporting as required.

- EVP Science & Research will review annual summary report from designates.

2. Definitions

Conflict of interest (COI): Activities or situations that place a person or institution in a real, perceived, or potential conflict between their duties or responsibilities related to research and their personal, institutional or other interests. A COI may include a significant financial interest.

COI situations: Conflicts of interest that may occur when individuals' or institutions' judgements and actions in relation to research are, or could be, affected by personal, institutional or other interests, including, but not limited to, business, commercial, or financial interests, whether of individuals, their immediate families, their friends, or their former, current or prospective professional associations or of the institution itself.

Designate: A department/division head designated by the EVP Science & Research, to receive and review disclosures of COI situations in accordance with this policy.

Division head (or equivalent): Heads of a clinical/research division, including the Cancer Clinical Research Unit (CCRU) at the Princess Margaret Cancer Centre.

Immediate family: Grandparents, uncles, aunts, cousins, parents, brothers, sisters, spouse, father-in-law, mother-in-law, brother-in-law, sister-in-law, nephews, nieces, children and grandchildren.

Institutional conflicts of interest: Those that may occur when UHN, any of its senior management or trustees, or a department, centre or other sub-unit, or an affiliated foundation or organization is in a real, perceived, or potential conflict between their duties or responsibilities related to research and their personal, institutional or other interests.

Research personnel: All personnel, paid by UHN, or by other sources, involved in the conduct of research. This includes, but is not limited to, those personnel working in laboratory, administrative, clinical or support areas.

Significant financial interest: Includes significant financial interests in the specific research (or in the specific research program) of the individual, their spouse and dependent children, and means anything of monetary value, including, but not limited to,

salary or other payments for service (e.g. consulting fees or honoraria), equity interests excluding mutual funds (e.g. stocks, stock options of other ownership interests) and intellectual property rights (e.g. patents, copyrights and royalties from such rights) where:

- such payments to the individual exceed $5,000 annually, or
- the individual's equity interest exceeds five percent ownership or a value of $5,000 (whichever is greater) at fair market value, or
- royalty payments received by the individual exceed $5,000 annually

3. Related UHN Policies

- Intellectual Property Protection & Commercialization policy 1.20.013
- Research Authorship policy 40.60.001
- Conflict of Interest policy 2.50.002
- Relationship Attestation & Disclosure policy 1.30.009
- News Releases policy 1.50.003

4. References

1. Canadian Tri-Council Agreement on the Administration of Agency Grants and Awards by Research Institutions

2. Toronto Academic Health Sciences Network (TAHSN) Statement: "Policy Requirements for a Research Financial Conflicts of Interest (FCOI) Policy," adopted May 2006.

3. U.S. Regulations 42 C.F.R. 50 Subpart F.

University Health Network
Policy & Procedure Manual
Research: Responsible Conduct of Research

Policy

In keeping with its commitment to maintaining public confidence in research, University Health Network (UHN) addresses requirements that relate specifically to the conduct of research. UHN is committed to the promotion of research integrity through its ongoing education, training programs and centres and, therefore, all research at UHN will be conducted with the highest degree of integrity.

Research activity at UHN depends on freedom of inquiry, thought, expression and publication since these are the cornerstones of scientific progress. Each member of the research community has a responsibility to foster intellectual honesty and integrity, and to be vigilant regarding the conduct of research, whether their own or other's. It is essential that research personnel maintain the highest standard of public trust and integrity.

All concerns raised regarding failures to comply with regulations, potential misconduct, or allegations of misconduct should be made in good faith. They will be investigated in an impartial, timely, fair, and transparent manner while maintaining the greatest level of confidentiality.

Consistent with relevant laws, rules and regulations, UHN is committed to the protection of the privacy and/or confidentiality of respondents, complainants, and research subjects identifiable from research records or evidence.

This policy should be reviewed in conjunction with the following applicable UHN policies:

- Academic Authorship & Public Access of Publications policy 40.60.001
- Conflict of Interest of Research Personnel policy 40.90.002
- Reporting & Investigation of Suspected Fraud policy 1.30.006
- Fostering Respect in the Workplace policy 2.50.005
- Violence & Domestic Violence in the Workplace policy 6.30.004

Further, this policy is intended to be consistent with the University of Toronto's Policy on Ethical Conduct in Research; the Tri-Agency Framework: Responsible Conduct of Research containing the requirements of the Tri-Agencies (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council, and Social Sciences & Humanities Research Council of Canada); and the contractual obligations and/or requirements of other granting agencies such as the United States Department of Defense, and operating divisions of the United States Public Health Service (PHS), for example the National Institutes of Health.

This policy applies to anyone who is involved in the conduct of research at or under the auspices of UHN and covers:

- misconduct in research
- concerns that fall outside the scope of research misconduct
- response to concerns regarding research integrity
- responsibilities
- complaints process
  a. step 1: inquiry
     i. timing of inquiry
     ii. inquiry process
     iii. appeal
  b. step 2: investigation
     i. investigation committee
     ii. conduct of investigation
     iii. investigation report
     iv. investigation outcome
     v. appeal
  c. indemnification
- definitions

Misconduct in Research

Research misconduct at UHN includes the following behaviors:

- falsification
- fabrication
- plagiarism
- material non-compliance with accepted standards and regulations

Due latitude is given for honest errors, honest differences in methodology, interpretation or judgment, or divergent paradigms in science; what is at issue are genuine breaches of the integrity of the research process.

Depending upon the severity and magnitude, the following examples may be construed as research misconduct:

- fabrication of recording or reporting and other falsification of data or results (fraud)
- the use of someone else's written words or ideas without giving appropriate credit (plagiarism)
- material failure to use scholarly and scientific rigour and integrity in obtaining, recording, and analyzing data, and in reporting and publishing results
- deliberately failing to appropriately include, as authors, other collaborators who prepared their contribution with the understanding and intention that it would be

a “joint” publication
- inaccurate attribution of authorship, including attribution of authorship to persons other than those who have contributed sufficiently to take responsibility for the intellectual content, or agreeing to be listed as author to a publication for which one made little or no material contribution
- deliberately failing to provide collaborators with an opportunity to contribute as an author in a “joint publication” when they contributed to the research with the understanding and intention that they would be offered this opportunity
- falsely claiming someone else’s data as their own
- preventing access to research data to a legitimate collaborator who contributed to the research with the explicit understanding and intention that the data was their own or would be appropriately shared
- giving or receiving honourary authorship or inventorship
- denying legitimate inventorship
- knowingly agreeing to publish as a co-author without reviewing the work including reviewing the final draft of the manuscript
- failing to obtain consent from a co-author before naming them as such in the work
- portraying one’s own work as original or novel without acknowledgement of prior publication or publication of data for a second time without reference to the first
- willfully misrepresenting (for any reason) findings resulting from conducting research activities
- actively condoning or not reporting direct knowledge of the performance by another researcher of any of the acts noted above
- taking retribution or retaliating against a whistleblower or individual who is acting in good faith through reporting or providing information about alleged misconduct
- encouraging or facilitating another researcher to carry out scholarly research misconduct (e.g. a supervisor telling their graduate student to falsify data); or otherwise creating an environment that promotes research misconduct by another
- failure to honour the confidentiality that the researcher promised or was contracted to as a way to gain valuable information from a party internal or external to UHN
- deliberate destruction of one’s own research data or records to avoid the detection of wrong doing or the deliberate destruction of someone else’s data or records
- material failure to comply with relevant federal or provincial statues or regulations applicable to the conduct and reporting of research
- failure to comply with a direction of UHN's Research Ethics Board upon which an approval to proceed with the research was granted, or failing to notify the Research Ethics Board of significant protocol changes that may affect its prior decision to approve the research proceeding
- failure to adhere to reporting requirements of regulators, sponsors, or funding agencies (e.g. adverse event reporting)

- failure to obtain consent from research subjects
- failure to comply with a direction of UHN's Animal Care Committee or Biosafety Committee upon which an approval to proceed with the research was granted, or failing to notify the committee of significant protocol changes that may affect its prior decision to approve the research proceedings
- failure to provide relevant materials to UHN's Research Ethics Board (or to the Animal Care Committee or Biosafety Committee) required by UHN or which the research or academic community considers to be materials relevant to decision-making
- failure to reveal material conflicts of interest to UHN, sponsors, colleagues, or journal editors when submitting a grant, protocol, or manuscript, or when asked to undertake a review of research grant applications, manuscripts, or to test or distribute products
- making false or misleading statements that are contrary to good faith reporting of alleged research misconduct or failing to declare any conflicts of interest when reporting alleged research misconduct

Concerns that Fall Outside the Scope of Research Misconduct

This policy does not address concerns that reflect professional misconduct that fall outside of the scope of research misconduct. Concerns that fall outside of the scope of research misconduct must be directed to the appropriate UHN leadership and will be managed according to the relevant policies and/or processes. Examples of this include:

- conduct described as incivility, bullying, harassment, sexual harassment, or discrimination will be referred to People & Culture (see Fostering Respect in the Workplace policy 2.50.005)
- review of alleged violence directed toward staff and patients will be referred to UHN Safety Services and People & Culture (see Violence & Domestic Violence in the Workplace policy 6.30.004)
- activities that might reasonably be characterized as fraud will be referred to general counsel (see Reporting & Investigation of Suspected Fraud policy 1.30.006)

Response to Concerns Regarding Research Integrity

Any member of the research community is obligated to report concerns regarding suspected research misconduct to the appropriate leadership who will communicate these concerns to the executive vice-president, Science & Research (EVPSR).

To the extent possible, an individual making an allegation in good faith or providing information related to an allegation, will be protected from reprisal in a manner consistent with relevant legislation.

Concerns may also be identified as a result of routine administrative processes by the Institution, or third parties, in the course of standard audits, or other reviews that, upon initial fact finding, may be flagged as possible research misconduct. These concerns, when identified, will be initiated as an inquiry, in accordance with this policy, and follow the processes thereafter as further outlined below, recognizing that such processes will be adjusted, as needed, for the fact that no complainant will be designated.

Responsibilities

Complainant

- Discuss concerns with EVPSR and other appropriate UHN leadership.
- Report concerns in good faith.
- Fully cooperate with all parties conducting the inquiry or investigation.

Respondent

- Meet with the EVPSR and other appropriate UHN leadership to discuss the raised concern and participate in inquiry and investigation processes, as required.
- Fully cooperate with all parties conducting the inquiry or investigation.
- Provide written responses, as required.

Executive Vice-president, Science & Research

- Manage research integrity concerns raised at UHN.
- Establish the inquiry panel.
- Establish the investigation committee.
- Consult with and engage appropriate UHN leadership throughout inquiries and investigations; this may include taking immediate action to protect the administration of the funds of any of the tri-agencies or other granting agencies. Immediate actions could include freezing grant accounts, requiring a second authorized signature from an appropriate UHN representative on all expenses charged to a respondent's grant accounts, or other measures, as appropriate.
- Subject to any applicable laws, including privacy laws, advise the Secretariat on Responsible Conduct of Research immediately of any allegations related to activities funded by the agency that may involve significant financial, health and safety, or other risks.

- Determine sanctions in conjunction with appropriate UHN leadership.

  Note: For the purpose of inquiry and investigation, UHN leadership will exclude the chief executive officer (CEO).

- Notify respondents and complainants of the appeal process to the CEO.

Complaints Process

The processing of complaints of research misconduct must be carried out carefully, thoroughly, objectively, fairly and as promptly as possible, to resolve all questions regarding the integrity of the research.

Individuals responsible for carrying out any part of the research misconduct proceeding may not have unresolved personal, professional, or financial conflicts of interest with the complainant or respondent.

All persons involved, those making allegations, those who are the subject of the allegations of research misconduct, and those who assist in the inquiry and investigation, will be treated with respect, fairness and with due sensitivity.

All proceedings will be conducted in a timely manner and will be documented appropriately.

The highest possible degree of confidentiality will be maintained regarding all allegations of suspected research misconduct, inquiries and investigations, subject to any disclosure that might be required by law.

Anonymous allegations will be considered if accompanied by sufficient information to enable the assessment of the allegation and the credibility of the facts and evidence on which the allegation is based, without the need for further information from the complainant.

Any person who makes an anonymous allegation will be encouraged to identify themselves properly and to express their concerns in good faith. If a person wishes to remain anonymous, reasonable efforts will be made to gather relevant information relating to the concerns and to protect their confidentiality to the extent permitted.

Where the allegation related to conduct that occurred at another institution (whether as an employee, a student, or in some other capacity), the institution that receives the allegation will contact the other institution and determine, with that institution's designated point-of-contact, which institution is best placed to conduct the inquiry, and investigation, if warranted. The institution that received the allegation must communicate to the complainant which institution will be the point-of-contact for the allegation.

Two-step Approach

There are potentially two steps in the procedure to address and manage a complaint: an inquiry step to determine if an investigation of an allegation is warranted, and an investigation step to determine if there is sufficient evidence to support a finding of research misconduct.

Step 1: Inquiry

An inquiry is initiated to ascertain whether there are reasonable grounds to proceed to an investigation, not to determine whether research misconduct has occurred.

The inquiry is a preliminary process where the following threshold assessments are made:

- Is the complaint outside UHN's jurisdiction?
- Is it clearly mistaken or unjustified?
- Does it involve allegations that, even if proven, would not constitute research misconduct?
- Is it frivolous, vexatious or made in bad faith?

and if not any of the foregoing:

- Is there a reasonable prospect that a further investigation will materially enhance the integrity of the scientific process?

The inquiry also provides an opportunity to determine whether it is appropriate to offer the complainant and the respondent an alternative dispute resolution process.

The inquiry team will be vigilant not to permit personal conflicts between colleagues to obscure the facts and divert attention from the substance of the allegation.

Timing of inquiry:

Every effort will be made to ensure that an inquiry is completed in a timely manner, and within requirements of granting and oversight bodies.

Prior to commencing the inquiry:

- The EVPSR will meet with the complainant to discuss the concern that has been raised and review the inquiry/investigation process.
- The EVPSR will meet with the respondent to discuss the concern that has been raised and review the inquiry/ investigation process.

- The EVPSR will establish an inquiry panel.

Inquiry process:

- All potential inquiry team members will be polled to see whether they have a potential conflict of interest. No person with a direct interest in the research or a personal connection with the complainant or respondent will serve on the inquiry panel.

- The inquiry panel will consult as necessary and make a decision and recommendations to the EVPSR as to whether an investigation is warranted.

- Where the inquiry panel decides to recommend that a formal investigation be undertaken, it will provide written notice of its decision to the respondent and the complainant. The respondent may provide written comments on the inquiry report.

- Where the inquiry team decides not to proceed with an investigation, it will provide written notice of its decision to the respondent and the complainant. The notice will include a brief written summary of the reasons for such a determination.

- If the inquiry panel has reasonable grounds to believe that the complainant did not act in good faith, it will write to the complainant and respondent to summarize these grounds and inform them that the matter is being referred to appropriate leadership to be assessed in accordance with the relevant code of conduct.

- The highest level of confidentiality possible will be maintained throughout the inquiry process.

- If an investigation is warranted and if deemed appropriate, the EVPSR will inform, as appropriate, internal UHN leadership (e.g. Medical Advisory Committee chair, Research Ethics Board chair).

- The respondent may **appeal** the application of this policy to the CEO with respect to the inquiry.

- Consistent with relevant laws, rules and regulations, the EVPSR will cooperate with relevant governmental authorities, for example the United States Office of Research Integrity (ORI), in matters involving PHS funding.

Step 2: Investigation

If an investigation is recommended, the EVPSR will seek to establish an investigation committee and name the chair of this committee. The investigation committee will include at least one external member who has no current affiliation with UHN. The EVPSR may not participate on the committee.

All potential committee members will be polled to see whether they have a potential conflict of interest. No person with a direct interest in the research or a personal connection with the complainant or respondent will serve on the committee.

The purpose of the investigation is to examine the allegations and to weigh the evidence to determine whether or not research misconduct has occurred, and, if so, whom the involved parties are.

The EVPSR will provide the respondent with written documentation of the allegation, notification of investigation, an outline of the investigative process, and the names of the members of the investigation committee.

The EVPSR will notify internal and external authorities, as appropriate, (e.g. funder, University of Toronto, Secretariat on Responsible Conduct of Research, US Office of Research Integrity) of the initiation of the investigation and, subsequently, will report the results of the investigation. In matters involving PHS funding, the EVPSR will provide written notice to the ORI of any decision to open an investigation on or before the date on which the investigation begins. Consistent with relevant laws, rules and regulations, the EVPSR will provide to ORI notice of any facts that may be relevant to protect public health, PHS funds, and the integrity of the PHS funded research process.

If there is a finding of research misconduct, the EVPSR, in conjunction with other appropriate UHN leadership, determines sanctions/consequences.

Complaints of research misconduct may vary greatly with respect to urgency, seriousness and complexity. The EVPSR will exercise their discretion in determining the appropriate timelines for commencing, conducting and reporting on investigation.

The **investigation committee:**

- Has the authority to interview persons whose evidence is thought to be helpful, to examine relevant documents and data records, and to consult with experts both within and outside UHN, as required.

- Consults confidentially with anyone who comes forward with information regarding the complaint.

- Maintains confidentiality during the entire course of the investigation in order to protect the rights of all parties involved.

- Is vigilant not to permit personal conflicts between colleagues to obscure the facts and divert attention from the substance of the allegation.

- Maintains appropriate documentation of the investigation, including summaries of interviews and all original submissions and correspondence.

The **chair of the investigation committee** will ensure that the members of the committee are informed of the:

- investigative process
- requirements to conduct the investigation carefully and thoroughly and to endeavour to address all questions raised by the complaint regarding the integrity of the research
- responsibility to be vigilant and not to permit personal conflicts between the complainant and the respondent to obscure the facts and divert attention from the substance of the allegation
- importance of protecting the reputations of the complainant and respondent throughout the investigation
- requirement that proceedings be kept strictly confidential and documents be kept confidential and obtainable only by those who are entitled to them in order to protect the rights of all parties involved, subject to any legal requirements

Conduct of investigation: The respondent has the following rights:

- to know the identity of the complainant
- the opportunity to present their case to the investigation committee at the initial and final stages of the investigation
- access to supporting documents provided by the investigation committee and that have been made anonymous
- to be informed whenever significant new directions are taken if, in the course of the investigation, additional information emerges that broadens the scope of the investigation beyond that of the inquiry

Any involved parties are to be informed that they will be required to cooperate with the proceedings of the investigation in a timely manner.

If, **during** the course of the investigation, the respondent leaves UHN, the investigation will be continued to its full conclusion.

If the complainant decides not to proceed with the allegations after the investigation has been initiated, the investigation committee may decide to proceed with the investigation even without the further participation of the complainant.

Investigation report and documents:

- Within 60 days from the making of a final decision by the investigation committee, the chair will submit a written report to the EVPSR, summarizing the process, findings and conclusions of the investigation.

- The report may include recommendations on any remedial actions to be taken in the circumstances and/or recommendations of changes to procedures or practices to avoid similar situations in the future.

- The EVPSR, in conjunction with the appropriate area VP, such as the executive vice-president and chief medical officer (EVP/CMO), where a respondent is covered by the Medical Staff By-laws, will decide on implementation of any recommendations contained in the report.

- The originals and/or certified copies as appropriate, of all documents examined during the investigation and summaries of all interviews conducted will be kept by the EVPSR's Operations department for document control purposes.

- The respondent will have an opportunity to provide written comments on the draft report of the investigation, and the investigation committee will have an opportunity to consider and address the comments before issuing the final report.

- The EVPSR, in conjunction with the appropriate area VP, will provide a copy of the final report to the respondent and other appropriate UHN leadership.

Investigation outcome:

- In cases where no research misconduct has been found:

    a. The EVPSR, in conjunction with the appropriate area VP, will ensure that a letter confirming the finding of no research misconduct is sent to the respondent, the complainant, and any appropriate UHN leadership.

    b. To the extent possible, the EVPSR, in conjunction with the appropriate area VP, will make reasonable and practical efforts, if requested and as appropriate, to protect or restore the reputation of persons alleged to have engaged in research misconduct but against whom no findings of research misconduct is made.

    c. To the extent possible, the EVPSR, in conjunction with the appropriate area VP, will make reasonable and practical efforts to protect or restore the position and reputation of any complainant, or committee member, and to counter potential or actual retaliation against these complainant and committee members.

d. In the case where the investigation may disclose evidence of serious scientific error that requires further action, even when no research misconduct is found, the EVPSR will discuss this case with the chair of the investigation committee and the respondent, will consider the respondent's submissions, if any, and will decide what action to take.

e. No disciplinary measures will be taken against the complainant if the complaint was made in good faith.

- In cases where research misconduct has been found:

  a. The EVPSR, in conjunction with the appropriate area VP, such as the EVP/CMO, where a respondent is covered by the Medical Staff By-laws, will consider what remedial action, appropriate to the circumstances, should be taken in accordance with applicable procedural requirements, such as those outlined in the above mentioned By-laws and other relevant policies.

  b. The decision with respect to any remedial action will be made within 15 working days from the date of the EVPSR's receipt of the Respondent's written response to the findings. If there are no further procedural requirements under UHN policies, the EVPSR, in conjunction with the appropriate area VP, may sanction disciplinary measures.

  c. Any remedial action is subject to any applicable UHN policies.

- The EVPSR may communicate the outcome of the investigation, as required, directly, or through other UHN leadership, to parties within UHN, such as the chairs of the Medical Advisory Committee and the Research Ethics Board, or external to UHN.

- The respondent may **appeal** the application of this policy and appropriateness of any disciplinary sanction to the CEO or, in the case of a respondent covered by the Medical Staff By-laws, following procedures outlined in the Medical Staff By-laws.

Indemnification

Individuals serving as members of the investigation committee, ad hoc advisors, participants in the process who are acting in good faith, etc., will be indemnified by UHN.

Definitions

Complainant: An individual who raises a concern about potential misconduct in research or who makes an allegation of research misconduct.

Good faith: As applied to a complainant, good faith means having a belief in the truth of one's allegation or concern that a reasonable person in the complainant's position could have, based on the information known to the complainant at the time. A complainant's allegation or concern is not in good faith if made with knowing or reckless disregard for information that would negate the allegation or concern. Good faith as applied to a committee member means carrying out the duties assigned impartially for the purpose of helping UHN meet its responsibilities under the applicable laws, rules, regulations and agency requirements regarding the responsible conduct of research. A committee member does not act in good faith if their acts or omissions on the committee are dishonest or influenced by personal, professional, or financial conflicts of interest with those involved in the matter under inquiry or investigation.

Inquiry: The informal process to determine whether a formal investigation of research misconduct allegations should be conducted.

Investigation: The formal process to make a determination of research misconduct in response to allegations.

Research misconduct: Any research practice that deviates materially from the commonly accepted ethics/integrity standards or practices of the relevant research community and includes, but is not limited to, intentional fabrication, falsification, plagiarism, and material non-compliance with accepted standards and regulations.

- **Fabrication:** Making up data, source material, methodologies, findings or results, including graphs and images, and recording or reporting them.

- **Falsification:** Manipulating, changing or omitting research materials, equipment, processes, data or results, including graphs and images, without proper acknowledgement such that the research is not accurately represented in the research findings, conclusions or records.

- **Plagiarism:** The appropriation of another person's ideas, processes, results, or words without giving appropriate credit; or the re-use of one's own work, ideas, processes, results, or words without proper acknowledgement of the previous use or without the permission of any person who may have acquired copyright or intellectual property rights by virtue of such previous use.

- **Material non-compliance with accepted standards and regulations** is the:

    a. Material failure to correct non-compliance with relevant federal or provincial statutes or regulations for the protection of researchers, human subjects, or the public or for the welfare of laboratory animals.

    b. Material failure to correct non-compliance with other legal or UHN requirements that relate to the conduct of research.

    c. Material failure to conform with accepted professional and academic

standards and practices with respect to scientific rigour, accountability, honesty, fairness and professional integrity.

Research personnel: All personnel paid by UHN or other sources involved in the conduct of research at UHN. This includes, but is not limited to, those personnel working in laboratory, administrative, clinical or support areas.

Respondent: An individual who is the subject of a concern regarding research misconduct or an allegation of research misconduct.

References

1. Tri-Agency Framework: Responsible Conduct of Research (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council, and Social Sciences & Humanities Research Council of Canada).

2. U.S. Department of Health and Human Services (2005). 42 CFR – Code of Federal Regulations, Parts 50 and 93, Public Health Service Policies on Research Misconduct.

Next Steps

Thank you for taking the time to review UHN Policies and Codes. **Once reviewed and by signing and returning your Offer Letter, you have agreed to adhere to all policies within.**

Once you commence your employment, you will be expected to be familiar with all of our Corporate and Departmental policies, which can be accessed via the UHN intranet in the top toolbar called “Policies” (click here).

We will also review some of these policies in New Employee Orientation, and you will be provided additional content when completing your legally mandated training (click here for the Legally Mandated Training Guide).

The links within the policies are only valid when the policy is being read and reviewed inside of UHN. Please refer to these links again once your employment has commenced (click here).