The Corporation of the County of Northumberland
Community Health Committee
Agenda

Tuesday, February 4, 2025, 9:00 a.m.
Council Chambers
555 Courthouse Road, Cobourg, ON K9A 5J6

Hybrid Meeting (In-Person and Virtual)
Zoom Information
Join Zoom Meeting
https://us06web.zoom.us/j/84824287491?pwd=5exFMnobZ7zi3ybHaxcs9Oh0uLMYPa.1
Meeting ID: 848 2428 7491
Passcode: 662177
Phone: 1-855-703-8985 Canada Toll-free

Pages

1. Notices

1.a Accessible Format

If you require this information in an alternate format, please contact the Accessibility Coordinator at accessibility@northumberland.ca or 1-800-354-7050 ext. 2327.

1.b Meeting Format

This Committee meeting will be held using a hybrid meeting model. The public is invited to attend in-person in Council Chambers. Alternatively, the public may view the Committee meeting via live stream, join online, or join by phone using Zoom Conference technology. If you have any questions, please email matherm@northumberland.ca.

- Attend in-person in Council Chambers, located at 555 Courthouse Road, Cobourg
- Watch a livestream by visiting Northumberland.ca/Council
- Join online using Zoom
- Join by phone using Zoom

2. Call to Order

2.a Territorial Land Acknowledgement

3. Approval of the Agenda

Recommended Motion:
"**That** the agenda for the February 4, 2025 Community Health Committee be approved."

4. Disclosures of Interest

5. Delegations

6. Business Arising from Last Meeting

7. Communications

7.a Correspondence, City of Toronto 'Opposition to Private For-Profit Blood and Plasma Collection' 5 - 7

Recommended Motion:
"**That** the Community Health Committee receive the correspondence from the City of Toronto regarding 'Opposition to Private For-Profit Blood and Plasma Collection' for information; and

Further That the Committee recommend that County Council receive this correspondence for information."

8. Staff Reports

8.a Report 2025-020, Golden Plough Lodge 'Ministry of Long-Term Care Inspection Update' 8 - 36

Alanna Clark, Administrator Golden Plough Lodge

Recommended Motion:
“**That** the Community Health Committee receive Report 2025-020 ‘Ministry of Long-Term Care Inspection Update’ for information; and

Further That the Committee recommend that County Council receive this report for information.”

8.b Report 2025-021, Northumberland Paramedics 'Vehicle Maintenance Cost Increases' 37 - 40

Keith Barrett, Deputy Chief of Operations
Susan Brown, Chief Northumberland Paramedics

Recommended Motion:
“**That** the Community Health Committee receive Report 2025-021 ‘Vehicle Maintenance Cost Increases’ for information; and

Further That the Committee recommend that County Council receive this report for information.”

9. Other Matters Considered by Committee

9.a Proclamation, 'Amyloidosis Awareness Month' - March 2025

41 - 41

Recommended Motion:
"**That** the Community Health Committee recommend that County Council proclaim the month of March 2025 as ‘Amyloidosis Awareness Month' in Northumberland County, at the February 19, 2025 County Council meeting."

9.b Haliburton, Kawartha, Pine Ridge (HKPR) District Health Unit - Board of Directors' Meeting Summary

42 - 46

Recommended Motion:
"**That** the Community Health Committee receive the meeting summaries from the November 21, 2024 and December 5, 2024 HKPR District Health Unit Board of Health meeting for information; and

Further That the Committee recommend that County Council receive the HKPR District Health Unit meeting summaries for information."

9.c Haliburton Kawartha Northumberland Peterborough (HKNP) District Health Unit - Board of Directors' Meeting Summary

47 - 50

Recommended Motion:
"**That** the Community Health Committee receive the meeting summary from the January 2, 2025 and January 16, 2025 HKNP District Health Unit Board of Health meeting for information; and

Further That the Committee recommend that County Council receive the HKNP District Health Unit meeting summaries for information."

10. Media Questions

11. Closed Session

N/A

12. Motion to Rise and Results from Closed Session

N/A

13. Next Meeting - Monday, March 4, 2025 at 9:00 a.m.

14. Adjournment

TORONTO

John D. Elvidge
City Clerk

City Clerk's Office

Secretariat
Sylwia Przezdziecki
Council Secretariat Support
City Hall, 12th Floor, West
100 Queen Street West
Toronto, Ontario M5H 2N2

Tel: 416-392-7032
Fax: 416-392-2980
e-mail:
Sylwia.Przezdziecki@toronto.ca
web: www.toronto.ca

In reply please quote:
Ref.: 24-MM23.1

(Sent by Email)

December 20, 2024

ALL ONTARIO MUNICIPALITIES:

Subject: **Member Motion Item 23.1**
Declaring Toronto a Paid-Plasma-Free Zone - by Councillor Chris Moise, seconded by Councillor Alejandra Bravo (Ward All)

City Council on November 13 and 14, 2024, adopted Item MM23.1 and in doing so, has forward this item to Canadian Blood Services, federal, provincial and territorial Ministers of Health, Grifols Pharmaceuticals, and all Ontario Municipalities and requested that they support only voluntary blood and plasma collection, where donors do not receive payment for their blood or plasma.

Yours sincerely,

Niko Markakis, for

for City Clerk

S. Przezdziecki/mp

Attachment

Sent to: All Ontario Municipalities
Chief Executive Officer, Canadian Blood Services
Chief Executive Officer, Grifols Canada

c. City Manager

City Council

Member Motions - Meeting 23

MM23.1	ACTION	Adopted		Ward: All

Declaring Toronto a Paid-Plasma-Free Zone - by Councillor Chris Moise, seconded by Councillor Alejandra Bravo

City Council Decision

City Council on November 13 and 14, 2024, adopted the following:

1. City Council express its opposition to the operation of private for-profit blood collection companies in the City.

2. City Council forward this item to Canadian Blood Services, federal, provincial and territorial Ministers of Health, Grifols Pharmaceuticals, and all Ontario Municipalities and request that they support only voluntary blood and plasma collection, where donors do not receive payment for their blood or plasma.

Summary

In the City of Toronto, we uphold the principle of voluntary blood and plasma donation, acknowledging its vital importance as a public good. Our commitment derives from the lessons of Canada’s tainted blood crisis, which tragically claimed approximately 8,000 lives. The subsequent Royal Krever Commission urged a fully voluntary, non-payment oriented blood and plasma donation system.

Within our Ontario healthcare system, we perceive blood donations as a priceless public resource, underscoring the need to safeguard the integrity of the public, voluntary donor system.

The Voluntary Blood Donations Act of Ontario strengthens this stance, legislating against the payment of donors and prohibiting donors from receiving financial compensation for their blood or plasma.

Canada Blood Services plans to open five paid plasma clinics, including one in Toronto, by 2025. This issue needs immediate attention and action. The public health community has raised concerns about Grifols Pharmaceuticals' plans to open a Toronto clinic. It's vital we protect vulnerable residents from exploitation by for-profit plasma collection companies offering cash for blood-plasma, a predatory practice.

In bringing this motion forward, we strive to reinforce the principles of voluntary, non-remunerated blood and plasma donation, protecting both the integrity of Canada’s public blood system and the dignity of blood donors.

Background Information (City Council)

Member Motion MM23.1
(https://www.toronto.ca/legdocs/mmis/2024/mm/bgrd/backgroundfile-249600.pdf)
Attachment 1 - Resolution to Declare the City of Hamilton a "No Paid Plasma Zone"
(https://www.toronto.ca/legdocs/mmis/2024/mm/bgrd/backgroundfile-250144.pdf)

If you require this information in an alternate format, please contact the Accessibility Coordinator at accessibility@northumberland.ca or 1-800-354-7050 ext. 2327

Report 2025-020

Report Title: **Ministry of Long-Term Care Inspection Update**

Committee Name: Community Health

Committee Meeting Date: February 4, 2025

Prepared by: Alanna Clark
Administrator
Golden Plough Lodge

Reviewed by: Glenn Dees
Director of Health and Human Services
Golden Plough Lodge

Approved by: Jennifer Moore, CAO

Council Meeting Date: February 19, 2025

Strategic Plan Priorities: ☐ Innovate for Service Excellence
☐ Ignite Economic Opportunity
☐ Foster a Thriving Community
☒ Propel Sustainable Growth
☒Champion a Vibrant Future

Information Report

"**That** the Community Health Committee receive Report 2025-020 'Ministry of Long-Term Care Inspection Update' for information; and

Further That the Committee recommend that County Council receive this report for information."

Purpose

This report for information will provide an overview of the most recent Golden Plough Lodge (GPL) Ministry of Long-Term Care Inspection Report dated September 9, 2024.

Background

The GPL is a municipally owned and operated long term care home. The Province mandates every upper tier municipality to have at least one long-term care home in operation. First

established in the 1850's as a County House of Refuge, the GPL has a long-established history of caring for others.

Today, the GPL serves others whose needs cannot be met in the community and require both personal care and nursing expertise. The GPL is first and foremost home to 151 residents, cared for and supported by 230 dedicated staff members providing Nursing Care, Dietary Services, Life Enrichment Programming, Environmental Services and Administration Support.

As an operating division of the Corporation of the County of Northumberland, the following core values are embedded in all facets of the GPL operations:

- Accountability
- Care & Support
- Collaboration/Communication
- Honesty & Integrity
- Innovation & Excellence
- Mutual Trust and Respect

The GPL operates on an annual budget of $23,945,474 (2024). Of that $13,312,827 is funded from Provincial subsidies, $6,982,034 County levy, $3,529,313 resident accommodation revenue and $121,300 other revenues. The bulk of the Provincial subsidies is in the form of a per diem based on occupied beds under various funding envelopes. The largest funding envelope is for nursing and personal care, and this is adjusted by a Case Mix Index factor dependent on the reported acuity levels of the resident population.

The Ministry of Long-term Care (MLTC) conducted an inspection which occurred onsite on the following date(s): August 20-23, 26-30, 2024. This was a follow up inspection related to a previous inspection that took place in May and June. The GPL received 15 written notifications and 9 compliance orders from the May and June inspections.

The following intake(s) were inspected:
• Intake: #00119791 - Follow-up #: 1 - CO #006, O. Reg. 246/22, s. 102 (2) (b) related to IPAC - CDD July 30, 2024.
• Intake: #00119792 - Follow-up #: 1 - CO #005, O. Reg. 246/22, s. 24 (4) related to air temperatures - CDD - August 9, 2024.
• Intake: #00119793 - Follow-up #: 1 - CO #007, O. Reg. 246/22, s. 102 (7) 11 related to hand hygiene program - CDD August 5, 2024.
• Intake: #00119794 - Follow-up #: 1 -CO #008, O. Reg. 246/22, s. 142 (1) related to recreational cannabis - CDD July 29, 2024.
Intake: #00119795 - Follow-up #: 1 - CO #009, O. Reg. 246/22, s. 252 (3) related to police record checks - July 30, 2024.
• Intake: #00119796 - Follow-up #: 1 - CO #001, O. Reg. 246/22, s. 23.1 (1) related to air conditioning (AC) requirements - CDD July 12, 2024.
• Intake: #00119797 - Follow-up #: 1 - CO #003, O. Reg. 246/22, s. 23.2 (4) related to uninstalling AC - CDD - July 15, 2024.
• Intake: #00119798 - Follow-up #: 1 -CO #004, O. Reg. 246/22, s. 23.2 (8) related to portable AC installed CDD July 15, 2024.
• Intake: #00119799 - Follow-up #: 1 - CO #002, FLTCA, 2021, s. 82 (2) related to training - CDD July 30, 2024.

During the inspection exit interview, the inspectors were complimentary of the home, stating that GPL staff were friendly and welcoming. They also stated information requested was provided in a timely manner which was appreciated.

For clarification, long-term care homes must report critical incidents to the Ministry as defined in legislation. Long-term care homes identify each critical incident using incident categories. If an incident appears to fall into more than one category, the most appropriate incident category is selected. A critical incident is completed for a variety of reasons including but not limited to a missing or unaccounted for controlled substance, contamination of drinking water supply, suspected neglect or abuse of a resident.

A Written Notification may be issued when a non-compliance is identified as low impact or risk to a resident. A Compliance Order will be issued when a non-compliance is identified as significant impact or risk to a single resident's health, safety or quality of life, or moderate impact or risk to multiple residents. If an inspector finds non-compliance with the Fixing Long-term Care Act (FLTCA) during an inspection, they are required by the Act to take the following factors into account:

- Severity
- Scope
- Compliance History.

Severity:

An inspector determines severity based on:

1. The impact to the resident(s) as a result of the finding of non-compliance.

2. The risk to the resident(s) at the time of the non-compliance.

3. The risk to the resident(s) at the time of the inspection (when relevant).

Scope:

An inspector determines scope based on how many residents were affected by the non-compliance. For example, is the finding of non-compliance an isolated incident or a broader issue in the home.

Compliance History:

A licensee is considered to have a history of non-compliance related to a finding if they have a previous finding of non-compliance on the same specific legislative reference (or equivalent in the Long-Term Care Homes Act, 2007) in the past 36 months.

To further explain compliance history, the GPL would have to have no findings for 36 months in an inspection protocol like, Infection Prevention and Control Program (IPAC), to be clear of repeat orders and AMP’s. A staff member could be found to be out of compliance by for example, missing one handwashing opportunity, forgetting a step in donning/doffing procedure, misreading a precautions sign and so on. These are important measures that GPL take seriously and when performed, minimize the spread of infectious diseases and provide a safe home for residents. Striving for continuous quality improvement is key and training, repetition

and on the spot audits reinforcing best practice behaviour and correcting mistakes are ways to improve IPAC practices within a long-term care home.

Consultations

The GPL senior management team routinely reviews all Inspection Reports upon receipt to initiate corrective actions if required. The GPL continues to work collaboratively and proactively with the HKPR District Public Health Unit to ensure IPAC protocols and mandates are followed

Consultations were completed with:

- leaders in other homes across the Eastern region of Ontario
- Northumberland County CAO and Director of Health and Human Services
- Ministry of Long-Term Care Inspection Manager

Legislative Authority / Risk Considerations

Ministry of Long-Term Care (MLTC)

Fixing Long-Term Care Act, 2021

Ontario Regulation 246/22

Discussion / Options

Ministry Findings

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s), based on the GPL's report from May/June inspections were found to be in compliance:

Order #006 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Karyn Wood (601)
Order #005 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 24 (4) inspected by Laura Crocker (741753)
Order #007 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 102 (7) 11. inspected by Karyn Wood (601)
Order #008 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 142 (1) inspected by Laura Crocker (741753)
Order #009 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 252 (3) inspected by Laura Crocker (741753)
Order #001 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 23.1 (1) inspected by Laura Crocker (741753)
Order #003 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 23.2 (4) inspected by Laura Crocker (741753)

The following previously issued Compliance Order was found not to be in compliance:

Order #002 from Inspection #2024-1553-0003 related to FLTCA, 2021, s. 82 (2)

Through comprehensive action planning, the GPL was able to comply with 8 of 9 orders received. There was a tremendous amount of planning and implementing from Senior Leadership and staff to accomplish compliance in these 8 areas. The Ministry was complimentary of GPL's accomplishment during the exit interview even stating they were surprised staff were able to complete such a large amount of work in a short period of time.

In addition to inspecting orders from a previous inspection to ascertain compliance, the Ministry also conducted an inspection using the following protocols:

- Safe and Secure Home
- Infection Prevention and Control
- Staffing, Training and Care Standards

This inspection resulted in 3 written notifications and 3 compliance orders which resulted in 2 Administrative Monetary Penalties totaling $2,200.00. 1 of the orders was an expansion of the initial order received in May/June. The other 2 are new orders to be addressed.

Orders

Protection from certain restraining

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 34 (1) 5. Protection from certain restraining
s. 34 (1) Every licensee of a long-term care home shall ensure that no resident of the home is: 5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than under the common law duty referred to in section 39.

Actions: Restraining -Order to comply by November 1, 2024

The Environmental Services Manager removed barriers, locks and controls to ensure that no resident is restrained from having access to resident dining room areas and designated cooling areas. The Senior Management team conducted audits twice a day, once on days and once on evenings for two weeks, then every other day for two weeks, to ensure that the dining room doors are open. If the dining room door was noted to be shut or locked the designate completing the audit provided education to the staff working on the unit. As per the order, audits were documented and include the name of the designate completing the audit, the date, the time, whether the dining room door was shut or locked, and the names of the staff educated and what education was provided when the dining room door was observed shut or locked. This information will be immediately available upon request of the Inspector.

Cooling Requirements

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 23 (2) (c) Cooling requirements
s. 23 (2) The heat related illness prevention and management plan must, at a minimum, (c) identify specific interventions and strategies that staff are to implement to prevent or mitigate the identified risk factors that may lead to heat related illness and to prevent or mitigate the identified symptoms of such an illness in residents.

Actions: Cooling – Order to comply by December 20, 2024

Currently providing Registered staff, PSW, all agency PSW and agency Registered staff and all Management staff education on the heat related illness and management plan identifying specific interventions and strategies that staff were to implement to prevent or mitigate the identified risk factors that may lead to heat related illness and to prevent or mitigate the identified symptoms of such an illness in residents. There will be a documented record of the date, staff names, staff signatures, the content of the education provided, and how this education was provided.

Nursing Staff will implement interventions identified on the care plan for all Residents identified as being at high or moderate heat risk as indicated by the Heat Risk Assessment (completed quarterly by the Resident Assessment Instrument (RAI) Coordinator and documented in the homes software Point Click Care). The acting Director of Care (DOC), within one week of receiving the Licensee Inspection Report, audited all resident care plans and ensured they are updated with resident specific interventions as per the Heat Related Illness and Prevention Plan. There is a documented record of the resident's name, the date, and indication if the care plan was up to date. These documents will be provided upon request of the Inspector.

The DOC is developing a process to ensure all resident care plans are updated prior to May 15 annually as per the home's Heat Prevention and Management Plan to include each resident has specific interventions and strategies implemented to prevent or mitigate the risk factors. The DOC will keep a documented record of the plan developed and provide the document upon request of the Inspector.

Training (previous training order expanded to include all staff)

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2. **Non-compliance with: FLTCA, 2021, s. 82 (2) 10.** Training s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person’s responsibilities.

The Licensee has failed to comply with FLTCA, 2021 **Notice of Administrative Monetary Penalty AMP #002 Related to Compliance Order CO #003**

Compliance History:

CO #002 issued on June 26, 2024 related to FLTCA, 2021, s. 82 (2) Orientation/Training in #2024-1553-0003 with a CDD of July 30, 2024.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Actions: Training – Order to comply by December 20, 2024

The management team, led by the Administrator, is currently providing training in all areas

required under FLTCA, 2021, s. 82 (2) to all staff working in the home. Written records of all general orientation training and department specific training along with a record of demonstrated knowledge of the training is being kept. This record includes what training was provided, who provided the training, a record of the knowledge test, the date and time the education was provided as well and the name and signature of the staff who received this training. These records will be made available to the inspector.

A process to ensure that the training for all staff meets the requirement for training under FLTCA, 2021, s. 82 (2), as well as any other required training specific to their role, prior to working in the home is being developed in collaboration with HR and internal scheduling. Further, the Administrator is conducting an audit of all staff working in the home to ensure that the required training under FLTCA, 2021, s. 82 (2) has been completed. The audit will include the name of the staff, date of hire, designated position, a list of all the training topics required specific to the staffs' role and responsibilities, and the date of the training for each topic completed by the staff. Any deficiencies identified will be recorded and those staff will be immediately trained in accordance with the legislated requirements. A documented record will be kept of this audit including the corrective action and made immediately available to the inspector upon request.

This revised training order has taken a tremendous amount of effort, developing and ensuring all staff attend a session. The senior leadership team has been working all shifts to make the training accessible to all staff, including those who regularly work evenings and nights. The Administrator recognizes the importance of ensuring all staff are trained appropriately and commends the senior leadership team for stepping up to the challenge.

Notifications

Training

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1. **Non-compliance with: FLTCA, 2021, s. 104 (4)** Conditions of licence s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject. The licensee has failed to comply with Compliance Order (CO) #002 from Inspection #2024-1553-0003 served on June 26, 2024, with a compliance due date of July 30, 2024.

Actions: Training – Written Notification

This written notification is in response to not meeting the training order requirements from a previous inspection as noted just above. A new training order was issued and expanded to include all staff, not just staff hired after January 1, 2023 as the original order required. Training is underway and it is anticipated that the GPL will meet this order by the new due date of December 20, 2024.

Communication and response system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1. **Non-compliance with: O. Reg. 246/22, s. 20 (g)** Communication and response system s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that, (g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

Actions: Communication and Response System- Written Notification

Based on this written notification, a new process has been established whereby when staff are on break on Blacklock House, a staff member from Symons House will come over to the Blacklock House area and attend to the call bells. This staff person will be required to sit in the nurse's station on Blacklock House and will not be able to assist on Symons House while covering Blacklock House. The Registered Nurses are responsible for creating a break/dinner coverage schedule and are conducting audits to ensure staff are following the schedule and responding to call bells in an appropriate manner. With the new build coming to completion in June 2025, procuring a new call bell system for the top floor isn't cost effective, however, the Administrator is looking into economical methods to ensure the call bell system is audible throughout the entire floor.

Infection Prevention and Control Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1. **Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)** Infection prevention and control program s. 102 (2) The licensee shall implement, (b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

Actions: Infection Prevention and Control program - Written Notification

All staff at the GPL have been retrained on proper IPAC Routine Practices and Additional Precautions specifically in proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal, and disposal for additional precautions. This was completed during the month of November 2024. Further, regular audits and on the spot corrections and training is conducted by the IPAC coordinator and those audits are documented and can be provided to an Inspector upon their request.

Financial Impact

Administrative Monetary Penalties totaling $2,200.00 were issued as follows:

Notice of Administrative Monetary Penalty AMP #002 Related to Compliance Order CO #003
Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1,100.00, to be paid within 30 days from the date of the invoice.

Notice of Administrative Monetary Penalty AMP #001 Related to Written Notification NC #001
Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1,100.00, to be paid within 30 days from the date of the invoice.

Member Municipality Impacts

N/A

Conclusion / Outcomes

GPL senior management request that the Community Health Committee and County Council receive this report for information.

Attachments

1. Report 2025-020 ATTACH 1 ‘Public Report – September 9, 2024’

Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: September 9, 2024	
Inspection Number: 2024-1553-0004	
Inspection Type: Follow up	
Licensee: The Corporation of the County of Northumberland	
Long Term Care Home and City: Golden Plough Lodge, Cobourg	
Lead Inspector The Inspectors	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 20-23, 26-30, 2024.

The following intake(s) were inspected:

- Follow-up #: 1 - CO #006, O. Reg. 246/22, s. 102 (2) (b) related to IPAC - CDD July 30, 2024.
- Follow-up #: 1 - CO #005, O. Reg. 246/22, s. 24 (4) related to air temperatures - CDD - August 9, 2024.
- Follow-up #: 1 - CO #007, O. Reg. 246/22, s. 102 (7) 11 related to hand hygiene program - CDD August 5, 2024.
- Follow-up #: 1 -CO #008, O. Reg. 246/22, s. 142 (1) related to recreational cannabis - CDD July 29, 2024.

- Follow-up #: 1 - CO #009, O. Reg. 246/22, s. 252 (3) related to police record checks - July 30, 2024.
- Follow-up #: 1 - CO #001, O. Reg. 246/22, s. 23.1 (1) related to air conditioning (AC) requirements - CDD July 12, 2024.
- Follow-up #: 1 - CO #003, O. Reg. 246/22, s. 23.2 (4) related to uninstalling AC - CDD - July 15, 2024.
- Follow-up #: 1 -CO #004, O. Reg. 246/22, s. 23.2 (8) related to portable AC installed CDD July 15, 2024.
- Follow-up #: 1 - CO #002, FLTCA, 2021, s. 82 (2) related to training - CDD July 30, 2024.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #006 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 102 (2) (b)
Order #005 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 24 (4)
Order #007 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 102 (7) 11.
Order #008 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 142 (1)
Order #009 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 252 (3)
Order #001 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 23.1 (1)
Order #003 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 23.2 (4)
Order #004 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 23.2 (8)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:

Order #002 from Inspection #2024-1553-0003 related to FLTCA, 2021, s. 82 (2)

The following **Inspection Protocols** were used during this inspection:

Safe and Secure Home
Infection Prevention and Control
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Licensee must comply

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with Compliance Order (CO) #002 from Inspection #2024-1553-0003 served on June 26, 2024, with a compliance due date of July 30, 2024.

The required staff education did not include training in all areas required under FLTCA, 2021, s. 82 (2) for all security staff, other agency staff and newly hired staff working in home.

Rationale and Summary

The written process developed and training provided to agency staff and all newly hired staff under FLTCA, 2021, s. 82 (2) did not include the required training according to all Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that were relevant to the person's responsibilities, prior to working in the home.

The documentation provided did not include the content of the training that was provided, a signature of the agency staff who received the training, a date the training was provided, and the results of the testing for staffs' knowledge of the training received.

The Associate Director of Care (ADOC) and the Administrator acknowledged the requirement for staffs' training under the FLTCA, 2021, s. 82 (2) was not completed for all security staff, other agency staff and newly hired staff working in home.

Failure to ensure that all security staff, other agency staff and newly hired staff completed the required training placed the residents at risk of harm.

Sources: CO #002, policies, New Employee Orientation Guide, staffs surge learning records, interviews with the ADOC and the Administrator.

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001

Related to Written Notification NC #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: Communication and response system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (g)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is

equipped with a resident-staff communication and response system that,
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

The licensee has failed to ensure that in the case of a system that uses sound to alert staff, was properly calibrated so that the level of sound was audible to staff.

Rationale and Summary

During a observation, Inspector noted a call bell was ringing. No staff could be found on the unit. A PSW indicated that they were off the unit and staff on a separate resident home area (RHA) were to answer the call bells when this occurred.

The Administrator confirmed the home's communication system was an audible system and that staff working on the other RHA could not hear the call bell if a resident was ringing for assistance.

There was an increased risk to the resident's safety as staff were not alerted to respond to the resident's needs increased risk to the resident's safety as staff were not alerted to respond to the resident's needs.

Sources: Observations, interviews with staff and the Administrator.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to implement the standard or protocol issued by the Director with respect to infection prevention and control (IPAC).

According to the IPAC Standard for Long-Term Care Homes (LTCHs) dated September 2023, section 9.1 directed the licensee to ensure that Routine Practices and Additional Precautions were followed in the IPAC program, specifically 9.1 (d) referring to proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal, and disposal for additional precautions.

Rationale and Summary

Two residents required additional precautions; staff were required to apply Personal Protective Equipment (PPE) when providing direct care.

A nurse was providing a resident's footcare. They were not wearing appropriate PPE. The nurse indicated they were not aware the resident required additional precautions and they should have been wearing the appropriate PPE.

A Personal Support Worker (PSW) was observed exiting a resident's room and removing their PPE incorrectly. The PSW acknowledged their technique for removing their PPE was not according to how they had been trained.

The IPAC lead indicated staff were required to perform hand hygiene, and apply the

appropriate PPE. They further indicated when exiting a resident's room staff were required to remove their PPE, and then perform hand hygiene.

There was a risk of transmission of infectious agents when staff did not apply and remove PPE correctly.

Sources: The IPAC Standard for LTCHs, observations, and interviews with staff, and interview with the IPAC lead.

COMPLIANCE ORDER CO #001 Protection from certain restraining

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 34 (1) 5.
Protection from certain restraining
s. 34 (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than under the common law duty referred to in section 39.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee shall:

The Administrator or Management designate will remove barriers, locks and controls to ensure that no resident is restrained from having access to resident dining room areas and designated cooling areas. The Administrator or Management designate will audit twice a day, once on days and once on evenings for two weeks, then every other day for two weeks, to ensure that the dining room doors are open. If the dining room door is noted to be shut or locked the designate completing the audit will provide education to the staff working on the unit. Keep a documented record of the audit including the name of the designate completing the audit, the date, the time, whether the dining room door was shut or locked, and the names of the staff educated and what education was provided when the dining room door was observed shut or locked. Provide this document immediately upon request of the Inspector.

Grounds

The licensee has failed to ensure that no resident in the home, was restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than under the common law duty referred to in section 39.

Rationale and Summary

During a tour of the home two resident dining rooms were locked, these areas were also the residents designated cooling areas. A Housekeeper confirmed the resident dining room should not be locked. The dining room door was locked the next day and a PSW opened the dining room door. The PSW reported the dining room was usually locked.

The Administrator confirmed that the dining room doors should not be locked, and residents should have access to them, and the dining rooms were also the designated cooling areas, except for one. The Administrator agreed there was a risk to resident safety when the dining room door was locked with a resident inside.

The following week, the doors of two of the dining areas that were also designated cooling areas were shut tight. Residents that were not cognitive or in wheelchairs would not have access to these areas. A Registered Practical Nurse (RPN) agreed the dining rooms were the residents designated cooling areas, and all residents should have access to this space.

The Acting Director of Care (DOC) agreed that when the doors to the dining room were shut this was a barrier and would prevent access to this area to residents in wheelchairs and residents that were not cognitive .

By failing to allow residents access to the home's dining rooms also the designated cooling areas, the licensee impacted the resident's quality of life by reducing their living space outside their home areas. When the resident was observed in the dining room and the door was locked the resident's health may have been at risk if there was a medical emergency and staff did not have the key to open the door.

Sources: Observations, interview with staff and the Administrator.

This order must be complied with by November 1, 2024

COMPLIANCE ORDER CO #002 Cooling requirements

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 23 (2) (c)
Cooling requirements
s. 23 (2) The heat related illness prevention and management plan must, at a minimum,
(c) identify specific interventions and strategies that staff are to implement to prevent or mitigate the identified risk factors that may lead to heat related illness and to prevent or mitigate the identified symptoms of such an illness in residents;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee shall:

1. Provide Registered staff, PSW, all agency PSW and agency Registered staff and all Management staff education on the heat related illness and management plan identifying specific interventions and strategies that staff were to implement to prevent or mitigate the identified risk factors that may lead to heat related illness and to prevent or mitigate the identified symptoms of such an illness in residents. Keep a documented record of the date, staff names, staff signatures, the content of the education provided, and how this education was provided.

2. As per the home's Heat Related Illness Plan which indicated the plan would be in effect in the months of May to September of each year and when the temperature was twenty-six (26) degrees Celsius or over. Nursing Staff shall implement interventions identified on the care plan for all Residents identified as being at high

or moderate heat risk as indicated by the Heat Risk Assessment (completed quarterly by RAI and found in PCC). The DOC or designate within one week of receiving the Licensee Report will audit all resident care plans to ensure they are updated with resident specific interventions as per the Heat Related Illness and Prevention plan. Keep a documented record of the resident's name, the date, and indicate if the care plan was up to date. Provide the documented records upon request of the Inspector.

3.The DOC or designate will develop a process to ensure all resident care plans are updated prior to May 15 annually as per the home's Heat Prevention and Management Plan to include each resident has specific interventions and strategies implemented to prevent or mitigate the risk factors. Keep a documented record of the plan developed and provide the document upon request of the Inspector.

Grounds

The licensee has failed to identify specific interventions and strategies that staff were to implement to prevent or mitigate the identified risk factors that may lead to heat related illness and to prevent or mitigate the identified symptoms of such an illness in residents.

Rationale and Summary

During an observation, a few resident portable air conditioning units were observed to be turned off.

The home's policy indicated that during the hot weather months all residents shall be monitored for signs of heat stress and dehydration. Nursing staff shall implement interventions identified on the care plan for all residents as being at high or

moderate risk as indicated by the heat assessment scale.

Review of the daily recorded air temperatures indicated the rooms air temperature was 26 degrees Celsius and above on multiple occasions, over a couple of weeks. Review of the residents care plans identified there were no interventions, or resident monitoring for signs of heat stress and dehydration as part of the heat related illness prevention and management plan.

The Acting DOC agreed that the residents should have individualized care plans as part of heat related illness prevention and management plan. The Acting DOC and Administrator indicated the care plans should have been updated to include interventions to be implemented, for monitoring signs of heat stress and illness, prior to May 15, 2024, as part of the heat related illness prevention and management plan.

Failing to ensure the residents care plans were updated with interventions and monitoring put the residents at risk for heat related illness, when the heat prevention management plan needed to be implemented due to an increase in air temperatures in the home.

Sources: the home's policy, resident's clinical records, interview with the Acting DOC, and the Administrator.

This order must be complied with by November 1, 2024

COMPLIANCE ORDER CO #003 Training

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 82 (2) 10.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee shall:

1. The management team, led by the Administrator, will provide training in all areas required under FLTCA, 2021, s. 82 (2) to all staff working in the home.

2. A written record of all training along with a record of demonstrated knowledge of the training is to be kept. This record will include what training was provided, who provided the training, a record of the knowledge test, the date and time the education was provided as well and the name and signature of the staff who received this training. These records are to be made available to the inspector immediately upon request.

3. The Administrator will develop a process to ensure that the training for all staff meets the requirement for training under FLTCA, 2021, s. 82 (2), as well as any other required training specific to their role, prior to working in the home.

4. The Administrator or a management designate will conduct an audit of all staff working in the home to ensure that the required training under FLTCA, 2021, s. 82 (2) has been completed. The audit will include the name of the staff, date of hire, designated position, a list of all the training topics required specific to the staffs' role and responsibilities, and the date of the training for each topic completed by the staff. Any deficiencies identified will be recorded and those staff are to be immediately trained in accordance with the legislated requirements. A documented record is to be kept of this audit including the corrective action and made immediately available to the inspector upon request.

Grounds

The licensee has failed to ensure that no person performed their responsibilities before receiving training in all Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that were relevant to the person's responsibilities.

Rationale and Summary

A follow up inspection related to s. 82 (2) of the FLTCA, 2021 identified that several staff working in the home had not received all the required training, including policies of the licensee that were relevant to the person's responsibilities, prior to working in the home.

The ADOC and the Administrator both reported that surge learning, and the New Employee Orientation Guide were considered the main source of staff education. They further acknowledged that the training requirements under the FLTCA, 2021, s. 82 (2) were not met when several policies of the licensee were not part of the staffs'

education.

Failure to ensure that all staff completed the required training placed the residents at risk of harm.

Sources: New Employee Orientation Guide, staffs surge learning records, interviews with the ADOC and the Administrator.

This order must be complied with by November 29, 2024.

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

CO #002 issued on June 26, 2024 related to FLTCA, 2021, s. 82 (2) Orientation/Training in #2024-1553-0003 with a CDD of July 30, 2024.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within

28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal

to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.

If you require this information in an alternate format, please contact the Accessibility Coordinator at accessibility@northumberland.ca or 1-800-354-7050 ext. 2327

Report 2025-021

Report Title: **Vehicle Maintenance Cost Increases**

Committee Name: Community Health

Committee Meeting Date: February 4, 2025

Prepared by: Keith Barrett
Deputy Chief of Operations
Northumberland Paramedics

Reviewed by: Susan Brown
Chief
Northumberland Paramedics

Approved by: Jennifer Moore, CAO

Council Meeting Date: February 19, 2025

Strategic Plan Priorities:
☐ Innovate for Service Excellence
☐ Ignite Economic Opportunity
☐ Foster a Thriving Community
☒ Propel Sustainable Growth
☐Champion a Vibrant Future

Information Report

"**That** the Community Health Committee receive Report 2025-021 'Vehicle Maintenance Cost Increases' for information; and

Further That the Committee recommend that County Council receive this report for information."

Purpose

The purpose of this report is to outline the increased expense of preventative maintenance, and repair costs of Northumberland Paramedics fleet.

Background

Northumberland Paramedics follow the Ministry of Health, Provincial Land Ambulance Certification Standard, LACS Section 3 – 11d (Each land ambulance and /or emergency

response vehicle used in the application / operator's service shall be maintained in a clean and sanitized condition, in safe operating condition according to manufactures specifications, and in proper working order). Each vehicle deployed by Northumberland Paramedics must be included in a preventative maintenance program. This program is regulated by mileage and is set in three (3) different categories.

"A" inspection is completed every 8,000 Km and this inspection includes but not limited to lube, oil and filter change.

"AB" inspection is completed every 24,000 Km and this inspection includes but not limited to everything included in the "A" inspection plus tire rotation, brake inspections and air filter change.

"ABC" inspection is completed every 48,000 Km and this inspection includes but not limited to everything included in the "AB" inspection plus, change transmission oil and filter, drain torque converter, change differential fluid, repack front and rear wheel bearings and check all tires.

Once a year a commercial safety inspection must be completed on all ambulances.

The cost to Northumberland County Paramedics for these maintenance inspections for 2024 can been seen in the table below.

Northumberland Paramedics Preventative Maintenance Costs

Shop price per hour	Inspection	Number of times complete 2024	Yearly cost to date	Average cost per vehicle	Average Cost per inspection	Total Yearly cost 2023	Total Yearly cost 2022
$120	A	5	$26,310.14	$1143.92	$226	33,907.60	18,881.17
$120	AB	3	$34,999.00	$1,521.70	$567.05	22,097.48	31,652.06
$120	ABC	2	$54,496.33	$2,369.41	$1,208.18	39,967.01	44,989.08
TOTAL			$115,805.47			$95,972.09	$95,522.31

Upon consultation with seven (7) of the Eastern Ontario Paramedic Services, it was determined that similar increased preventative maintenance costs (see table below).

Maintenance Cost Eastern Ontario Services January 2024

Type of Service	Highest Cost	Lowest Cost	Northumberland
Shop Cost Per Hour	$ 150	$ 60.38	$120.00
A Inspection	$ 299.38	$ 151.00	$226.00
AB Inspection	$ 889.15	$ 243.00	$567.05
ABC Inspection	$ 1234.80	$ 928.00	$1208.18

Along with the cost of completing the legislative preventative maintenance of our vehicles, Northumberland Paramedics have had some unexpected expenditures with the fleet. We have had to replace 2 engines as well as 2 transmissions in 2024.

Vehicle / Year	Date	Repair	Cost
4140	Mar 2024	Engine	$15,649.12
4143	Mar 2024	Engine	$16,313.58
4723	May 2024	Transmission	$10,312.47
4317	Nov 2024	Transmission	$8101.28

In consultation with seven (7) of the Eastern Ontario Services, it was discovered that seven (7) engines, and ten (10) transmissions were also replaced amongst them. Amongst those reported, it included both the GM and Ford chassis

Consultations

Eastern Ontario Paramedic Services

Legislative Authority / Risk Considerations

The Ministry of Health & Long-Term Care requires that all ambulances and ERV's be compliant and certified under the Land Ambulance Certification Standard Version 5.0 dated September 28, 2021. This standard recognizes that the appropriate life span of an Ambulance is fifty-four (54) months or 250,000 km whichever comes first. Northumberland Paramedics has adopted this life span and as such replaces vehicles on that schedule as part of the Long- Term Plan.

The replacement of this equipment as per the adopted schedule enhances paramedic and patient health and safety by reducing the risk of failure when performing critical work and responding to emergency calls.

Ambulances are subject to early wear and tear due to extreme operating conditions including exposure to all types of environmental conditions during emergency call responses.

Discussion / Options

There are no options available as Braun has consolidated with Crestline and Demers and are the only recognized and certified ambulance providers in Ontario.

Financial Impact

Delays in receiving our yearly order new ambulances, which could be anywhere between 16 – 18 months, increase maintenance and repair costs, maintaining older vehicles beyond the standard that recognizes that the appropriate life span of an Ambulance is fifty-four (54) months or 250,000 kms whichever comes first.

Increased “lost hours” of vehicles and replacements waiting for lengthy repairs and replacement parts.

Member Municipality Impacts

Potential for breakdowns of ambulances when responding to an emergency call.

Conclusion / Outcomes

Staff request that the Community Health Committee and County Council receive this report for information.

Attachments

N/A

If you require this information in an alternate format, please contact the Accessibility Coordinator at accessibility@northumberland.ca or 1-800-354-7050 ext. 2327

Proclamation

Event: Amyloidosis Awareness Month

Date: March 2025

“Whereas March is Amyloidosis Awareness Month, a month dedicated to raising awareness, funding research, and supporting those living with amyloidosis and their loved ones; and

Whereas Amyloidosis is a group of diseases that occurs when an abnormal protein, known as amyloid, builds up in the tissues and organs of the body. Left untreated, the disease can result in organ failure and can be fatal; and

Whereas Amyloidosis can mimic the signs and symptoms of more common medical conditions and the disease can be challenging to diagnose; and

Whereas Amyloidosis often affects people who are older or middle aged; however, younger people have been diagnosed with this disease; and

Whereas some of the signs and symptoms of amyloidosis can include shortness of breath, weight loss, fatigue, swelling in the ankles and legs, numbness in the hands and feet, foamy urine, carpal tunnel syndrome, bruising around the eyes, and an enlarged tongue; and

Whereas early diagnosis can lead to better outcomes for both patients and their families; and

Whereas raising awareness about all the amyloidosis diseases, including hereditary and non-hereditary forms of the disease, can contribute to the building of healthier communities across Canada;

Now Therefore Be It Resolved That I, Warden Brian Ostrander, on behalf of Northumberland County Council, do hereby proclaim the month of March 2025 to be ‘Amyloidosis Awareness Month’ in Northumberland County.”

Dated this 19th day of February, 2025

_____

Brian Ostrander, Warden

Date: November 21st, 2024 | Time: 9:30 a.m. – 11:30 a.m. | Location: 108 Angeline Street S, Lindsay

6. Medical Officer of Health Update
Presenter: Dr. Natalie Bocking, Medical Officer of Health and Chief Executive Officer

Dr. Bocking provided a brief update to the Board of Health during the November 21st, meeting. Information shared included that the Ministry of Health has shared an executive summary of feedback that health units provided on the initial draft of the updated Ontario Public Health Standards (OPHS). The next steps are to engage internally and reconvene with some stakeholder groups to incorporate feedback where appropriate, with no timeline for release of updated OPHS being communicated.

An update related to Fall Respiratory Season, where key messaging was reinforced, such as staying up to date with vaccinations, staying home when sick, and washing hands and high touch surfaces as much as possible. An update was shared related to the first human case of highly pathogenic avian influenza (HPAI) to be identified in Canada, specifically British Columbia. Board members were told that the strain of HPAI that has infected the human is similar to that which is causing outbreaks on poultry farms in British Columbia.

Dr. Bocking also shared an update related to the Association of Local Public Health Agencies (alPHa) Annual Fall Symposium, where presentations related to Artificial Intelligence (AI) use in Public Health, updates from Public Health Ontario, and presentations on public health workforce burnout and public recovery, renewal, and resilience building post pandemic.

The complete update can be watched here via Live Stream on HKPRDHU's YouTube channel

7. Report

Measuring the Pledge: Customer Experience Survey Update
Presenter: Fiona Kelly, Director of Foundational Standards

The Board of Health received a presentation related to updates on the Haliburton, Kawartha, Pine Ridge District Health Unit's (HKPRDHU) Customer Experience Survey. The survey is being promoted internally and externally and is ongoing to ensure data collection is fulsome. To date, 161 surveys have been started, with 97 surveys being completed. From those surveys there is a high percentage of clients indicating that they were satisfied with their overall experience, information was easy to find, they were assisted in a timely manner and treated with courtesy and respect. Some clients noted they were not able to find the information they were looking for, could not access a clinic in a timely fashion, and did not receive a response via email or phone in a timely manner.

The information from the completed surveys will help to shape program and service delivery to ensure clients are receiving the information and supports they need, enforcing HKPRDHU's Customer Service Pledge.

The presentation can be viewed here. The full presentation can be watched here.

8. New Business

Access to Dental Care for Seniors in Haliburton
Presenter: Dr. Natalie Bocking, Medical Officer of Health and Chief Executive Officer

A briefing note was shared with the Board of Health providing information and changes to the Ontario Seniors Dental Care Plan (OSDCP) delivery of services in the County of Haliburton. Recently, the Volunteer Dental Outreach (VDO) clinic in Haliburton has stated that as of January 2025 they will no longer be accepting clients on the OSDCP. This decision was made because of the changing landscape of dental care in Canada, mainly the availability of the new federal Canadian Dental Care Program (CDCP). Seniors, according to the VDO, make up one third of their clientele and most clients that qualify for the VDO qualify for the CDCP. Once on the CDCP, seniors can be seen by participating dental providers for treatment, and the VDO wants to avoid taking away patients from these practices. There are two dental practices in Haliburton Village, less than a five-minute drive from the VDO clinic, who are listed on the CDCP dental provider search tool, as accepting clients on this program.

The VDO stated that they are helping clients sign up for CDCP and has confirmed that legally all clients rostered with them will continue to receive services by VDO and will not be turned away.

The briefing note can be read here.

Corporate Services Updates
Presenter: Matthew Vrooman, Director, Corporate Services

An update was shared with the Board of Health in which a summary of finances was given. The results from current operations show that revenue received was approximately $373,841 less than the expected revenue at the end of October 31, 2024. It should be noted that of the $373,841 revenue shortfall, internal funding of $416,667 was not transferred into operations thus, revenue from operation is trending higher than expected. Similarly, expenditures for the equivalent period were approximately $99,000 less than the budgeted amount, after taking the merger related expenses into consideration. Overall year to date expenditures is on par or trending lower than the budgeted amounts with the exceptions being computer support, professional development, fees for service and equipment which are trending above the budgeted amounts; $22,189, $46,658, $51,872 and $56,201 respectively.

The Board of Health also received the unaudited operating statements for the ten-month period ending October 31st, 2024, in the amount of $ 18, 324, 998 for information.

The briefing note can be read here

2025 Budget Development
Presenter: Dr. Natalie Bocking, Medical Officer of Health and Chief Executive Officer

Dr. Bocking provided a briefing note with information related to the 2025 Budget Development of HKPRDHU. This budget was presented as a solo budget as part of scenario planning related to merger approval. HKPRDHU required the Board of Health to review and approve the solo budget, in the event that a merger with Peterborough Public Health is not approved.

The Board of Health received the briefing note and approved HKPRDHU's proposed 2025 budget in the total amount of $22,382,353.

The briefing note can be read here, and the full discussion can be watched here

Board of Health Q3 Summary
Presenter: Dr. Natalie Bocking, Medical Officer of Health and Chief Executive Officer

The Board of Health received a summary of the Q3 2024 Board of Health Quarterly Report for Programs and Services. The Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (Standards) outline the minimum requirements that boards of health must meet for mandatory health programs and services. There were no areas of concern presented to the Board related to requirements that were partially met.

The summary report can be viewed here

10. Correspondence

The following correspondence were shared with the Board of Health for information:

- Ontario Public Health Directory Update – alPHa
- Talk to a Stranger Week (November 18th – 24th)

Date of Next Meeting
December 5th, from 9:30 – 11:30am, at the Dalewood Golf and Country Club in Cobourg, and will include a recognition event for employees celebrating milestone Years of Service.

Date: December 5th, 2024 | Time: 10:30 a.m. – 11:30 a.m. | Location: Dalewood Golf & Country Club, Cobourg

7. Report

2019 – 2024 Strategic Plan Closure Report

Presenter: Dr. Natalie Bocking, Medical Officer of Health and Chief Executive Officer

Dr. Bocking presented an update related to the Strategic Plan of the Haliburton, Kawartha, Pine Ridge District Health Unit (HKPRDHU), and its closure in 2024. Developed in 2018, prior to Dr. Bocking assuming her role as the Medical Officer of Health, the Strategic Plan endured the test of a global pandemic, and was extended for an additional calendar year, resulting in its closure in 2024.

With each of the three core areas of focus - Lead, Partner and Deliver – goals and objectives were assigned. Dr. Bocking's presentation was able to highlight accomplishments under each area of focus, providing information related to the development and implementation of various strategies, tools, and engagement practices. Of note is the strong collaboration with HKPRDHU staff throughout the lifecycle of the Strategic Plan. From trainings, input sessions, working groups/committees and development of acronyms, the Strategic Plan was a living and evolving process over time.

In closing of the presentation, Dr. Bocking shared thoughts related to the upcoming opportunities based on the recently approved merger between HKPRDHU and Peterborough Public Health (PPH). A merger brings the work of both organizations together in a positive way, to take what has been accomplished and learned to develop and build together moving forward.

The Board of Health received the Strategic Plan Closure Report from Dr. Bocking and offered congratulations to the organization on the accomplishments attained, the use of key performance indicators, and using the results proactively.

The presentation slides can be viewed here. The full presentation can be watched here.

8. New Business

8.1 E-Cigarette Flavour Ban – Letter of Support

Presenter: Dr. Natalie Bocking, Medical Officer of Health and Chief Executive Officer

A letter of support was presented to the Board of Health for endorsement, with context being provided via the accompanying briefing note. The letter is in support of Health Canada's Order Amending Schedules 2 and 3 to the Tobacco and Vaping Products Act (Flavours) and Standards for Vaping Products' Sensory Attributes Regulation to ban all E-cigarette flavours. The Haliburton, Kawartha, Pine Ridge District Health Unit (HKPRDHU) feels strongly that the flavours to be banned

should also include mint and menthol flavours and has made such a recommendation in the letter. The Board of Health received the accompanying briefing note and approved the draft letter of support.

The briefing note can be read here for context, and the draft letter approved by the Board of Health can be viewed here.

Corporate Services Updates
Presenter: Matthew Vrooman, Director, Corporate Services

An update was shared with the Board of Health in which a summary of finances was given. The results from current operations show that revenue received was approximately $435,684 less than the expected revenue at the end of November 2024. It should be noted that the internal contribution of $458,333 has not been applied. Expenditures for the equivalent period were $284,563 less than the budgeted amount.

The Board of Health also received the unaudited operating statements for the eleven-month period ending November 30th, 2024, in the amount of $ 20,087,812 for information.

The un-audited operating statements can be read here and here.

10. Correspondence

The following correspondence were shared with the Board of Health for information:

- Realizing the Future of Vaccination for Public Health – Public Health Agency of Canada
- "A Time for Urgent Action" – The 2024 Report of the National Advisory Council on Poverty

Date of Next Meeting
December 5th, 2024, marks the final Board of Health meeting for the Haliburton, Kawartha, Pine Ridge District Health Unit (HKPRDU). The next Board of Health meeting will be held for the newly formed Board, consisting of members representing the new, merged entity of the HKPRDHU and Peterborough Public Health (PPH).

Haliburton Kawartha Northumberland Peterborough Board of Health Meeting Summary

Date: Thursday, January 2, 2025. | Time: 11 a.m.

The inaugural meeting of the Haliburton Kawartha Northumberland Peterborough Board of Health Meeting called to order at 11:02 a.m.

Election of Board of Health Chair and Vice-Chair

Two names were put forward for Chair of the HKPN Board and they were Deputy Mayor Ron Black, Selwyn Township, and Deputy Mayor Cecil Ryall, Highlands East. Both nominees put forward statements of interest and those were presented during the meeting. The votes were cast and Deputy Mayor Ron Black, Selwyn Township was elected as Chair of the Board of Health and Deputy Mayor Cecil Ryall elected as Vice-Chair.

By-Laws for Approval

By-Laws were reviewed individually and approved.

Committee Appointments

Members were polled for interest in servicing on the Board of Health Committees including the Indigenous Health Advisory Circle (IHAC) and Stewardship and appointed.

<u>Board Members of the Indigenous Health Advisory Circle (IHAC)</u>

Mayor John Logel, Township of Alnwick-Haldimand (Northumberland County)
Councillor Joy Lachica, City of Peterborough
Councillor Kathryn Wilson, Hiawatha First Nation,
Councillor Nodin Knott, Curve Lake First Nation,
Mr. Paul Johnston, Provincial Appointee

<u>Community Members of the Indigenous Health Advisory Circle (IHAC)</u>

Ashley Safar, Peterborough Community Health Centre
David Newhouse, Trent University
Executive Director (or delegate), Niijkiwendidaa Anishnaabekwewag Services Circle
Executive Director (or delegate), Nogojiwanong Friendship Centre
Elizabeth Stone, Fleming College
Representative, Alderville First Nation
Kristy Kennedy, Métis Nation of Ontario, Peterborough & District Wapiti Métis Council
Rebecca Watts, Lovesick Lake Native Women's Association

Board Members of Stewardship Committee
Deputy Mayor Cecil Ryall, Municipality of Highlands East
Mr. Daniel Moloney, Provincial Appointee
Mr. David Marshall, Provincial Appointee,
Dr. Hans Stelzer, Provincial Appointee,
Deputy Mayor Ron Black, Township of Selwyn
Councillor Kathryn Wilson, Hiawatha First Nation
Councillor Keith Riel, City of Peterborough
Councillor Tracy Richardson, City of Kawartha Lakes

2025 Meeting Schedule
The 2025 Board of Health meeting schedule has been deferred to the next meeting.

Next HKNP Board of Health Meeting
The next meeting of the Board of Health for the Haliburton Kawartha Peterborough Northumberland will take place on **Thursday, January 16, 2025, at 2 p.m.** at the Lindsay Office, located at 108 Angeline Street and will be an in-person/hybrid meeting.

View the HKNP Board of Health Agenda and Package
To view the Board of Health Meeting Summary, Agenda and Package please visit either the HKPR District Health Unit or Peterborough Public Health websites.

Media Contacts
Ashley Beaulac, Manager of Communication Services, HKPR District Health Unit, abeaulac@hkpr.on.ca, 1-866-888-4577 x 1212
Media Relations, Peterborough Public Health, media@peterboroughpublichealth.ca, 705-743-1000 x 352

We are committed to providing information in a format that meets your needs. To request information in an alternate format please speak to either media contacts listed above.

Haliburton Kawartha Northumberland Peterborough Board of Health Meeting Summary

Date: Thursday, January 16, 2025. | Time: 2 p.m.

The Haliburton Kawartha Northumberland Peterborough Board of Health Meeting was called to order at 2:01 p.m.

8.1 Report: Approval of Board Meeting Schedule

A rotating schedule of Wednesdays and Thursday meetings with both 1 and 5 p.m. start times was approved.

- Wednesday, February 19 – 5pm (Peterborough Office)
- Thursday, March 20 – 1pm (Port Hope Office)
- Wednesday, April 16 – 5pm (TBD)
- Thursday, May 15 – 1pm (TBD)
- Wednesday, June 18 – 5pm (TBD)
- Thursday, September 17 – 1pm (TBD)
- Wednesday, October 15 – 5pm (TBD)
- Thursday, November 20 – 1pm (TBD)
- Wednesday, December 17 – 5pm (TBD)

8.2 Report: Approval of Board Remuneration Policy and Rate

A remuneration amount of $100/meeting approved for Board of Health Members for 2025 was approved.

10.1 Presentation: HKNP Merger Briefing – Journey Towards Full Integration – Q1 2025

Tony Yu, Principal, Sense and Nous presented on merger successes that both legacy organizations have accomplished to date. Operational areas of review included Governance, Finance and Facilities, Legal, Information Technology, Branding and Communications, Human Resources, Change Management and Program Harmonization. A few operational examples include the near complete harmonization of the financial management systems, the bridging across two information technology systems to utilize cross tenant access, and the continued transparency of communications across both legacy organizations along with progress made with the new brand identity. The Senior Leadership Team continues to collaborate on an integration approach that's both organizational and regional in scope while ensuring the path forward is harmonious. Current priority focus remains on the leadership structure and when and how those decisions are to be made. The Senior Leadership Team will be providing an update to the Ministry on the 2025 budget.

10.2 Presentation: Partnering to Enhance Merger Success

Angela Burton, Principal Change Advisor, Prosci presented on change management practices and preparing both legacy organizations to be ready for change. A review of the 10 aspects of change management was presented along with a review of leadership capabilities. Change Management training has been delivered to the Senior Leadership Team as well as managers from both legacy organizations, and work is ongoing to support effective merger implementation through helping staff and stakeholders on their change journeys.

10.3 Legal Corporate Address

The Board of Health approved the 185 King Street Peterborough to be the legal corporate address for HKNP.

The Board discussed this legal/provincial requirement and recognized with current work approaches this represents a legal/mailing decision and does not change approaches to work design in our full region where offices in Peterborough, Port Hope, Lindsay and Haliburton are technically headquarters with rotating management/staff at each site.

10.4 Meeting Streaming

The Board of Health has requested staff to bring forward a report for the February 19th meeting on the different options available for a Board of Health decision regarding the public/media participation in meetings including live streaming, teleconference call-in, recording and posting Board of Health meeting, and meeting summary reports with no recording.

Board of Health Meeting adjourned at 4:36 p.m.

Next HKNP Board of Health Meeting

The next meeting of the Board of Health for the Haliburton Kawartha Peterborough Northumberland will take place on **Wednesday, February 19, 2025, at 5 p.m.** at the Peterborough Office, located at 185 King Street and will be an in-person/hybrid meeting.

View the HKNP Board of Health Agenda and Package

To view the Board of Health Meeting Summary, Agenda and Package please visit either the HKPR District Health Unit or Peterborough Public Health websites.

Media Contacts

Ashley Beaulac, Manager of Communication Services, HKPR District Health Unit, abeaulac@hkpr.on.ca, 1-866-888-4577 x 1212
Media Relations, Peterborough Public Health, media@peterboroughpublichealth.ca, 705-743-1000 x 352

We are committed to providing information in a format that meets your needs. To request information in an alternate format please speak to either media contacts listed above.