HÔPITAL
Glengarry
Memorial
HOSPITAL

Board of Directors Policy Manual

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Document Name:	Inclusion, Diversity, Equity & Anti-Racism (IDEA)	
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Classification: Board of Directors	**Section:** Governance	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

Hôpital Glengarry Memorial Hospital (HGMH) recognizes that there are distinct racialized and marginalized groups that have long been disadvantaged both in employment and health care. In recognition of this and to achieve HGMH's vision of "providing your care, your way, with seamless integration, innovation, and equitable access for our communities", we have adopted the following policy.

HGMH is committed to advancing inclusion, diversity, equity & anti-racism, and addressing bias and discrimination, to achieve better outcomes for all patients, families, providers, and staff. All people will be treated with respect and dignity. Barriers to safe, and quality health care will be eliminated. We are committed to employing the right people to provide the best possible health care and encourage applicants from all genders, Indigenous peoples, persons with disabilities, members of visible minorities, and the 2SLGBTQ+ community, because we know the importance of reflecting the diversity of our community in our governance, leadership, and workforce.

PROCEDURE:

1. To create a sense of belonging, HGMH will nurture an inclusive and culturally safe environment for diverse, racialized, and marginalized staff, providers, volunteers, patients, and their families.

2. As partners in health care, we will support every patient's culture, history, and perspectives to advance safe, quality health care.

3. To ensure efforts to address inclusion, diversity, equity & anti-racism are a top priority for HGMH, the Board of Directors will ensure the organization has an Inclusion, Diversity, Equity & Anti-racism Framework that addresses, but is not limited to, systemic and structural racism, and the education needs specific to racism and cultural safety.

4. The Board will ensure that there are clear reporting procedures for any type of discrimination or harassment combined with follow-up procedures to prevent future incidents.

5. Through the Governance Committee, the Board of Directors will receive reports periodically regarding its activities specific to inclusion, diversity, equity & anti-racism work.

DEFINITIONS:

Discrimination: Any form of unequal treatment based on the *Ontario Human Rights Code*, whether imposing extra burdens or denying benefits. It may be intentional or unintentional. It may involve direct actions that are discriminatory on their face, or it may involve rules, practices or procedures that appear neutral, but have the effect of disadvantaging certain groups of people. Discrimination may take obvious forms, or it may occur in very subtle ways.

Diversity: Diversity is the presence of a wide range of visible or invisible human qualities and attributes within a group, organization, or society. The dimensions of diversity include, but are not limited to, ancestry, culture, ethnicity, gender, gender identity, race, language, physical and intellectual ability, religion, sex, sexual orientation, and socio-economic status.

Equity: Equity is a condition or state of fair, inclusive and respectful treatment of all people. Equity does not mean treating people the same without regard for individual differences. A level playing field among all individuals and communities. This requires recognizing and addressing barriers to opportunities for all to thrive in our society.

Harassment: A course of vexatious comments or actions that are known, or ought reasonably to be known, to be unwelcome. It can involve words or actions that are known or should be known to be offensive, embarrassing, humiliating, demeaning, or unwelcome, based on a ground of discrimination and workplace sexual harassment.

Inclusion: Inclusion is based on the principle of acceptance and inclusion of all employees, credentialed staff, volunteers, patients, and their families. They see themselves reflected in their physical surroundings and the broader environment, in which diversity is honoured and all individuals are respected.

REFERENCES:

1. Ontario Health Diversity, Equity & Inclusion Framework

Document Name:	French Language Services	
Document Number:	BOD.01.002.0.24	
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Classification: Board of Directors	**Section:** Strategic Direction	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

Hôpital Glengarry Memorial Hospital acknowledges that under the *French Language Services Act*, any person, in their interactions with staff or professionals with treatment right of designated programs, has the right to communicate and to receive services in French.

This policy applies to designated services by the Hôpital Glengarry Memorial Hospital as per the *French Language Services Act*.

Hôpital Glengarry Memorial Hospital is recognized as a designated Hospital under Ontario's *French Language Services Act (1986)*. Designation confers the following responsibilities to the Hospital as a designated provider of French language services:

- Offer quality services in French on a permanent basis; and
- Guarantee access to the designated services in French.

PROCEDURE:

1. Services in the Client's Official Language

1.1 A mechanism is in place to capture and record the linguistic identity of the client from the very first point of contact.

1.2 Management and staff are responsible for ensuring that clients receive the required services in French.

1.3 Contracts signed with third parties that offer services on behalf of the Hospital contain clauses stating their obligation to ensure the offer of French language services in designated programs.

2 Communications

2.1 Staff of the Hôpital Glengarry Memorial Hospital actively offer services in French when answering the telephone.

2.2 Interactive telephone response systems and voicemail are available in French.

2.3 Reception, intake services and the entire continuum of care provided by designated services are actively offered in French.

2.4 Staff members who are proficient in French are identified with identification badges, bilingual signage in offices, business cards and electronic signatures informing clients and their family of their ability to communicate in French.

2.5 Any client who sends a written communication in French to the Hospital will receive a response in French.

2.6 The Hospital ensures that its oral and written communications with clients and the public are available in both official languages simultaneously. This includes:

- 2.6.1 All temporary and permanent interior and exterior signage;
- 2.6.2 All admission and registration forms and other documents intended for clients; and
- 2.6.3 Press releases, letterhead, website, pamphlets, brochures, all advertising, educational and promotional materials, and other written and electronic communication produced by the Hospital.

3 Feedback Mechanisms

3.1 Clients have access to the complaint process, in both official languages. It is available through website, pamphlet, signage, etc.

3.2 Clients who wish to provide feedback on the quality of the services received in French may do so through the following options:

- 3.2.1 Complaints mechanism: Clients who are not satisfied with the quality of French language services they received (or did not receive) may submit a complaint by following the Hospital's complaint process – Patient Relations Policy (CO.01.016.X.XX).
- 3.2.2 Satisfaction survey: A survey evaluating the quality of French language services is offered to clients. The survey is available in both official languages.

3.3 Management of complaints about French language services will follow the Hospital's established procedures.

4 Professionals with Treatment Privileges

4.1 The following professionals have treatment privileges at Hôpital Glengarry Memorial Hospital:

- Physicians;
- Specialists/surgeons
- Nurse Practitioners

4.2 The Hospital maintains a list of professionals proficient in French for each specialty.

5 Recruitment and Staffing

5.1 The Hospital ensures access to French language services in all designated programs at all times.

5.2 The following criteria are used to identify positions designated as bilingual, the number of employees required to provide service in French and the linguistic profile of these positions:

- Client needs;
- Overall availability of staff able to provide service in French for the program during all business hours;
- Nature of contact with patients and public;
- Level of responsibility associated with the position in question;
- Identification of unique positions;
- Level of comprehension needed between employee and patient to ensure quality service; and
- Any specific funder requirements.

5.3 Each position designated as bilingual will have a linguistic profile corresponding to the level of language proficiency required in accordance with Government of Ontario standards.

5.4 When a position becomes vacant, the person in charge of the service reviews the position's linguistic profile. When creating new positions, a linguistic profile is defined.

5.5 When several candidates have equivalent qualifications, priority is given to candidates with the required language skills at time of hire.

5.6 When the ability to deliver services in both official languages is deemed essential for the position being staffed, candidates' language skills must be evaluated, prior to hiring, by an accredited language assessment service or the following internal mechanisms:

- Telephone interview in French (initial evaluation);
- Minimum of one member of the selection committee is bilingual and asks questions in French;
- If the position also has a written profile, include written questions in French;
- If the selection committee is uncertain that the candidate meets the linguistic requirements of the position, Hôpital Glengarry Memorial Hospital completes an external evaluation through an accredited Hospital.

5.7 If within the Hospital, there are no candidates with the required skills and the ability to deliver the services in French, the position is posted externally. When delivering services in French is an essential requirement to the position, the

position is posted again until a candidate meeting the language requirements can be hired.

5.8 If, after all reasonable efforts have been made to find a bilingual candidate with the required job skills, no candidate can be found, the Hospital hires the most qualified candidate and attempts to meet the missing qualification. These measures are reviewed at least annually to ensure they meet the needs of the community served.

5.9 Volunteer services within the Hospital are actively offered in French. If a volunteer does not have the necessary language skills, they will seek assistance to mee clients needs. The volunteer coordinator actively recruits bilingual volunteers.

6 Training Offer

6.1 For employees in a position designated as bilingual who do not meet the language requirements of their position, the Hospital will make available to its employees the following resources:

- Access to French language training outside work hours;
- Development opportunities available in the community;
- Information on language training reimbursement opportunities, either from the Hospital itself or from the Ontario government.

7 Accountability

7.1 The Board of Directors receives an annual report on the status of French language services.

8 Best practices

8.1 The Vice president of Corporate Services and Chief Financial Officer has been designated to oversee the delivery of French language services.

8.2 The Hospital is committed to having a representation of the francophone population on the Board of Directors, its committees and among senior management in order to sustain quality French language services in the organization.

DEFINITIONS:

Francophone: The Inclusive Definition of Francophone (IDF) used in Ontario reads as follows: "person whose mother tongue is French, plus those whose mother tongue is neither French nor English but have a particular knowledge of French as an Official Language and use French at home."[2]

Active Offer: refers to a series of measures that are taken in order to ensure that French language services are clearly communicated, available at all times, easily accessible and equivalent to the quality of services offered in English. This includes measures related to communications – signage, notices, social media and all other information on services – as well as at the time of initial contact with French speaking clients. [3]

Linguistic Identity: refers to the linguistic group to which a person belongs or with which a person identifies. This variable usually remains stable over time. [4]

Third Parties: contractors hired to provide some of the Hospital's services.

REFERENCES:

1. Ministry of Francophone Affairs. User guide — Designation of organizations under the French Language Services Act
2. Newsroom – Government of Ontario. (2009). Francophone Population Re-Defined
3. French Language Health Planning Entities and French Language Health Networks of Ontario. (2015). Joint Position Statement on the Active Offer of French Language Health Services in Ontario
4. Réseau des services de santé en français de l'Est de l'Ontario. (2016). Linguistic Data Collection – Réseau Recommandations

Document Name:	CEO and COS Succession Planning	
Document Number:	BOD.02.001.0.24	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Leadership	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

Given that it is the Board's responsibility to ensure that HGMH adheres to the goals of the corporation, the Board will ensure that at all times there is an incumbent assuming the role of Chief Executive Officer (CEO) and Chief of Staff (COS). To this end; it will have in place a documented process for succession should the CEO or COS position become vacant. The succession plan will include; sudden, temporary and permanent vacancy. For relatively short planned durations of absence (eg: holidays, conferences) the CEO or COS will appoint an Acting CEO or COS and advise the Board Chair.

The Board of Directors will establish as a requirement an annual report from the CEO and the COS to be presented to the governance committee, their succession plan and any related executive development. This report will include a review of internal candidates who have the potential to assume this role in addition to development plans to enhance the capabilities of internal candidates.

PROCEDURE:

Interim/Sudden Vacancy *(termination, death, sick, extended leave, short notice resignation)*

1. Annually, the CEO and COS will identify to the Governance Committee, a recommended successor to fill interim roles which may arise. The appointment of the interim CEO and interim COS will be subject to Board approval. At this point in time the Board will:
    a) Support any immediate development skills required
    b) Communicate decision to appropriate audiences
    c) Determine compensation

Permanent Vacancy *(resignation, death)*

2. At this point in time the Board will:

    a) Review the CEO or COS job description as per policy Roles and Responsibilities of the Board (BOD.05.009.X.XX)
    b) Appointment of CEO Selection Committee: the Chair of the Board, the Chief of Staff, plus a number of elected directors
    c) Appointment of the COS Selection Committee: the Chair of the Board, the Chief Executive Officer, plus a number of elected directors The board annually conducts a

review of the strategic plan as part of a regular annual planning cycle.
Request assistance from staff persons via CEO (e.g.: HR Manager/ Administrative Support)
e) The Board, at its discretion, may determine to use of a search firm to assist with the process.
f) Budget estimate
g) Review Compensation package and contract issues
h) In the event that a new CEO has not been appointed prior to the departure of the current CEO, the Board will appoint an interim CEO as per above section 1
i) In the event that a new COS has not been appointed prior to the departure of the current COS, the Board will appoint the Vice-Chair of MAC, Chief of Department or delegate as a replacement COS

CROSS-REFERENCED POLICIES:

Policy Number	Policy Name
BOD.05.009.X.XX	Roles and Responsibilities of the Board

SENIOR MANAGEMENT LANGUAGE SKILLS

Document Name:	Senior Management Language Skills	
Document Number:	BOD.02.002.0.23	
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POLICY STATEMENT:

The Hospital will ensure that at least one (1) of the members of the senior management team has a “superior” level of linguistic proficiency in French and English.

PROCEDURE:

In the event the Chief Executive Officer (C.E.O) is deemed to have limited French linguistic skills, the Board delegates the C.E.O. the responsibility to ensure one of the other senior positions is filled with a candidate with “superior” bilingual (French and English) language skills.

Document Name:	CEO and COS Position Description	
Document Number:	BOD.02.003.0.25	
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Classification: Board of Directors	**Section:** Leadership	
Owner: Board Chair	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

Given that President & Chief Executive Officer (CEO) and the Chief of Staff (COS) report to the Board of Directors, it is the Board's responsibility to ensure that the President & CEO position and the COS position are clearly defined in accordance with legislative, regulatory, contractual, and Accreditation requirements, and that the roles, responsibilities, and accountabilities are reviewed regularly and reflect the organization's commitment to quality, safety, equity, and people-centred care.

PROCEDURE:

The Board of Directors will ensure the ongoing development, maintenance, and review of comprehensive and current position descriptions for both the President & CEO and the COS, ensuring that:

- Each role's responsibilities and accountabilities are clearly defined.
- The descriptions clarify the separate responsibilities of governance and executive leadership while also outlining areas of collaboration between the two.
- Is written using inclusive, neutral, and non-discriminatory language.
- The descriptions reflect the hospital's mission, vision, values, and strategic direction.
- Is informed by input from the President & CEO and reflects collaboration between the executive and the governing body.
- Complies with all relevant laws, regulations, and contractual obligations.

Responsibilities of the Governing Body

The Board of Directors will:

- Approve and maintain up-to-date position descriptions for both the President & CEO and the COS.
- Review the Position Description at a minimum every three years or as required due to legislative or organizational changes.
- Seek and incorporate input from the President & CEO and the COS during development and revision.
- Ensure alignment with the organization's mission, vision, values, and strategic direction.

Position Description Requirements

Each position description will include:

a. General Role Summary

- A high-level overview of the role and its purpose within the organization.

b. Reporting Relationship

- Clarifies accountability to the Board of Directors and, where applicable, shared accountability with other system or medical oversight bodies.

c. Key Responsibilities and Accountabilities

- **President & CEO**: Organizational leadership; operational and financial oversight; strategic plan execution; system partnerships; people-centred care delivery; compliance with laws and regulations.
- **Chief of Staff**: Medical leadership; professional practice standards; credentialing and privileging; physician engagement and performance; quality of medical care; supporting a culture of clinical excellence.

d. Stakeholder Accountability

- Clear accountability to patients, families, the workforce, volunteers, and community partners for the delivery of safe, effective, and equitable care.

e. Governance Interface

- Role in supporting effective governance through communication, reporting, and collaboration with the Board.

f. Inclusion, Diversity, Equity, Anti-Racism, Accessibility (IDEAA)

- Responsibilities in advancing IDEAA values within the hospital and the broader health system.

Review and Revision Process

- The Board, in collaboration with the President & CEO and the COS, will review the Position Description during the CEO's performance review cycle or when significant changes occur in organizational structure, governance requirements, or external regulations.
- Revisions will be formally approved by the Board and documented.

REFERENCES:

1. HGMH Corporate Bylaws
2. Professional Staff Bylaws
3. Accreditation Canada

Appendix A – President & Chief Executive Officer Position Description

Accountabilities / Responsibilities:

Board of Directors

- Plans, organizes, assumes the preparation and participates in the Board of Directors meetings and its committees, provides the members with all of the elements necessary to the understanding of administrative issues directly or indirectly related to the missions and mandates of HGMH;
- Provides assistance to the members of the Board of Directors in the formulation of the Hospital directions, regulations, and policies;
- Assures the execution of all resolutions of the Board of Directors; provides pertinent information to the members of the different levels of the structure; assures follow-up of the directions and decisions of said Board;
- Assures the proper functioning of all the committees provided in the organizational plan and regional networks / committees;
- Forms all the internal committees necessary to the good functioning of the Hospital, determines their objectives, their authority, and their composition;
- Submits to the Board of Directors the organizational and functional structure of the Hospital, in relation with the missions and objectives to attain;
- On an annual basis or when necessary, provides the Board of Directors with a comprehensive report on its administration, stating, namely, the degree of achievement of the objectives set at the beginning of the year, and the difficulties encountered;
- Recommends the action plans as well as the implementation and assessment mechanisms regarding the outcome;
- Submits the Hospital operating plan to the Board of Directors for its approval and provides regular monitoring against the plan;
- On behalf of the Hospital, signs the contracts authorized by the Board of Directors and makes sure that they are respected;
- Informs the Board of Directors on the different policies and directives issued from the Ontario Ministry of Health MoH and Ontario Health (OH) that are pertinent to the Board of Director's deliberations and decisions;
- Complies with all applicable legislations.

Realization of the Hospital's Mission

- Defines the operational objectives of the Hospital which assure the realization of its mission;
- Sees that the policies and procedures of the Hospital respect the standards required by Accreditation Canada and other accreditation bodies or organizations recognized in Canada;
- On a periodical basis, assures that the assessment of the needs of the clientele and personnel is carried out, in order to re-adjust, when needed, the Hospital's programs and activities of care and services;
- Assures the quality of care and services provided to clientele.

Strategic Management / Leadership

- On a periodical basis, revises the Hospital's directions and priorities in the framework of a healthy strategic plan, taking into account the mission, the evaluation of the needs of the clientele and personnel, Ontario Health Strategic Priorities, and the MOH Action Plans;
- Assures the implementation of policies, procedures, and of integration and coordination mechanisms essential to the presentation of quality services, to a healthy resource management, and to the control of the professional act;
- Assures that the by-laws, regulations, and directives in effect at the Hospital are respected, as well as those pertaining to the collective agreements;
- Sets up problem solving and conflict management mechanisms; constantly sees to preserving balance in the work environment, favoring the autonomy of the members recognized corporations in their professional practice, while guaranteeing the respect due to each person, the pertinence and quality of services offered to the clientele, and the sound utilization of resources;

Management of Care and Services

- Institutes an ongoing care and services planning process, based on an evaluation of the clientele's needs, and on the complementarity with those services provided by the health care partners;
- Elaborates strategies for the upholding, development, or restructuring of care and services;
- Assures the actualization of care and services in accordance with the existing programs;
- Assures the implementation of a quality improvement program throughout the Hospital, by designating management staff for its coordination; ensures the participation of different professional groups and other works in the implementation of the program and of its quality improvement activities as regards care and services rendered to the clientele;
- Designates a member of the staff to be in charge for implementing the policy on users' complaints, and submits this designation to the Board of Directors;
- Transmits to the Board of Directors any recommendation or report addressed to him by the member of staff in charge for implementing the policy on users' complaints.
- Ensures the hospital operates in full compliance with all applicable laws, regulations, and healthcare standards.
- Provides oversight of the hospital’s enterprise risk management framework to proactively identify, assess, and mitigate organizational risks impacting safety, operations, and reputation.
- Champions the provision of bilingual services in alignment with the hospital’s designation and community needs, ensuring equitable access to care in both English and French.

Management of People

- Approves the human resources strategic plan;
- Sees to the selection and to the hiring of those reporting directly to the CEO;
- Favors mobilization, development, and expression of human resources as well as the development of an organizational culture;
- Identifies the measures to be taken in view of creating and maintaining a quality of life at work as well as a satisfying and stimulating environment amongst the Hospital in order to create a work environment conducive to staff retention;
- Sees to the elaboration, the implementation, and the follow-up of an evaluation process for management staff and non-management staff;
- Sees to the elaboration of an annual training plan for the personnel;
- Sees to the quality of the collective relations with the Hospital staff;
- Sees that a prevention program be implemented in order to protect the health and safety of the workers;

Management of Financial Resources

- Guides the budget planning process;
- Assures the parameters necessary to the preparation of the budget, recommends to the Board of Directors and sees to its execution;
- Assures the periodical evaluation of the global budget status of the Hospital;
- Foresees the strategies and the corrective measures, if necessary, in order to respect a balanced budget;
- Assures the preparation of the financial statements for the Board of Directors.

Management of Technical and Material Resources

- Sees that the Hospital Board be provided with a capital forecast;
- Assures the sound utilization and conservation of the Hospital's movables and immovable;
- Submits any urgent requests for capital worth $5,000 or more to the Board for approval;
- Acts for and on behalf of the Board of Directors during construction projects, major renovations, or building renting, within the respect of the laws and regulations.

Management of Informational Resources

- Ensures the development, implementation, and updating of clinical and management systems in compliance with Ministry directives;
- Sees that the Hospital be provided with efficient information management systems, as much on the clinical or department levels than on the financial or operational levels.

Management of Internal Communication

- Assures the preparation of an efficient internal communication plan, accepted by the Board of Directors, and followed-up so that the Board may make its decisions based on pertinent, reliable, and comprehensive information; assures that these decisions be communicated to the required instances of individuals, and that each

group or individual of the Hospital secures, at a timely moment, the information that is useful to them in order to play their role and perform efficiently in their functions.

Management of External Relations

- Assures the upholding of the necessary relations with the community, Ontario Health, and the MOH, as well as with all other institutions or bodies or organizations concerned by the Hospital's mission;
- Assures an active representation of the Hospital amongst bodies, organizations, or committees to which they are invited to participate on a consultation or complementarity basis and develops strategies in that respect;
- Assures that the competent authorities, such as the MOH, are aware of the needs of the Hospital's clientele and does the representations which are essential in order to secure the necessary resources;
- Assures the respect of the agreements with the different teaching institutions in relation with the Hospital;
- Elaborates, with a collaboration, in an external communication policy and assures its functioning on the local and regional levels, vis-à-vis the media, social groups, and the associations concerned by the Hospital's activities;
- Favors the upholding of good relations with the media so as to inform the population of the decisions that, in one way or another, might affect and/or interest them;
- Assures that pertinent information concerning the Hospital is communicated to the external instances and to the public.

In accordance with the Corporate By-law:

- serve as an *ex-officio* non-voting Director.
- serve as an *ex-officio* member of all Committees.
- serve as the Board Secretary, unless otherwise determined by the Board; and
- perform such other duties as directed by the Board from time to time.

Key Competencies:

- Innovative, strategic, and inspiring leadership;
- Ability to credibly communicate with individuals, committees, and larger groups;
- Ability to influence;
- Flexibility and versatility;
- Empathy and concern for people;
- Ability to speak publicly;
- Excellent communication skills in both English and French (written and spoken) preferred;

Appendix B – Chief of Staff Position Description

Accountabilities / Responsibilities:

Board of Directors

- Participates in the Board of Directors meetings and its committees;
- Report regularly to the Board on the work and recommendations of the Medical Advisory Committee and any other matters about which the Board should have knowledge;
- Be accountable to the Board for the organization of the Credentialed Staff, the quality of care given by such staff, and the appropriate utilization of resources by all Departments;
- Advise the Medical Advisory Committee and the Board with respect to the quality of medical, diagnosis, care, and treatment provided by Credentialed Staff members to patients;
- Develop, recommend for Board-approval, and implement a Clinical Services Resource Plan, that considers current and future requirements, the health system, and the community, and identify resource implications;
- Working with the Board, periodically review and recommend changes to the Professional Staff By-law.

Strategic Management/Leadership

- Serve as a member of the Corporation's senior leadership team.
- Establish and maintain a positive, accountable, and collegial working relationship with the Board and the President and Chief Executive Officer characterized by decisive leadership, candor, and transparency, that is aligned with the mission, vision and values of the Corporation.
- Report to the Medical Advisory Committee on the activities of the Corporation, including the utilization of resources and quality assurance.
- Participate in the development of the Corporation's mission, vision, and values, and strategic plan.
- Through the Chiefs of Department, ensure adequate orientation, supervision, and assessment of the Credentialed Staff.
- Working with the Chiefs of Department and the Credentialed Staff Association, ensure the development of a continuing education program for the Credentialed Staff.
- Lead the Credentialed Staff appointment, reappointment, and credentialing process, and be responsible for any complaints, mediation, or disciplinary action regarding the Credential Staff.
- Working with the Chief Nursing Executive, review and monitor Hospital committee structures and processes.
- Work in partnership with the President and Chief Executive Officer and the Medical Advisory Committee to ensure alignment of clinical programs with the Corporation's strategic plan.

- Ensure systems are in place, in consultation with the President and Chief Executive Officer, for the review, development, and implementation of new programs and services and/or changes to existing programs and services.
- Consult with the President and Chief Executive Officer with respect to clinical programs and services, including the introduction of any new clinical programs and services and/or changes to existing programs and services.
- Demonstrate fiscal responsibility and support the President and Chief Executive Officer in ensuring fiscal accountability in accordance with the Board-approved budget for the fiscal year, and report any serious or recurring misuse of Hospital resources to the President and Chief Executive Officer.
- Work in partnership with the President and Chief Executive Officer to ensure capital projects are strategically aligned with the Corporation's mission and vision and provide strategic oversight and support to enable effective implementation and evaluation.
- Ensure a process for the regular review of the performance of the Chiefs of Department.
- Receive and make written recommendations regarding the performance evaluations of the Chiefs of Department concerning annual re-appointments.
- Advise the Credentialed staff on current Hospital policies, objectives, and rules.
- Delegate appropriate responsibility to the Chiefs of Department.

In accordance with the Corporate Bylaws

- Serve as an ex-officio non-voting Director
- Perform such other duties as directed by the Board from time to time.

Key Competencies:

Though this position is grounded in understanding hospital governance, this role requires a high degree of emotional intelligence, professionalism, accountability, discretion, objectivity, demonstration of the ability to work well with others, follow-through, and performance management. Bilingualism is an asset.

Required Qualifications:

- Active Staff in good standing

Document Name:	CEO and COS Performance Evaluation	
Document Number:	BOD.02.004.0.25	
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Classification: Board of Directors	**Section:** Leadership	
Owner: Board Chair	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

This policy outlines the process and responsibilities for the annual performance evaluation of the Chief Executive Officer (CEO) and the Chief of Staff (COS). The evaluation ensures accountability, alignment with strategic goals, and continuous leadership development. It reflects the Board's commitment to good governance, transparency, and performance excellence.

This policy applies to the performance evaluation of the CEO and COS of Hôpital Glengarry Memorial Hospital, overseen and conducted by the Executive Committee of the Board of Directors.

PROCEDURE:

The Executive Committee will annually review the process of soliciting input prior to the completion of the performance evaluation process. Each year, the committee will complete the evaluation using the following procedure:

1. The CEO and COSs personal business commitments will be established at the beginning of the year and reviewed semi-annually and prior to the completion of the performance evaluation.

2. The CEO and COS will complete a self-evaluation for the review with the committee.

3. The committee will determine the list of participants in the review. Each board member will have an opportunity for input.

4. The committee will meet to review all relevant factors that will go into the final evaluation. This will include:
    a. A review of the CEO and COSs annual goals and priorities.
    b. A review of the progress of strategic planning initiatives against approved targets.
    c. Input from stakeholders.
    d. An anecdotal review of major events and milestones of the past year.

5. Some of these items will be measurable, but many will require the exercise of judgment by the committee members. This judgment must be exercised in good faith in a manner

consistent with the mission, vision and values.

6. At a final meeting with the CEO and COS, the committee will review its determinations, review the self-assessments, and finalize the evaluation.

7. At this point, the committee will meld the results of the evaluation with the incumbent's position relative to the target compensation peer market. A recommendation to the board will include this review and the comparison between relative market position and relative performance.

8. The report to the board will include a one-page summary of the process and outcomes and recommendations.

9. Following approval, the committee will work with the CEO and COS to set goals and priorities for the coming year.

REFERENCES:

1. OHA Guide to Good Governance
2. Executive Compensation Framework

Document Name:	Whistleblowing	
Document Number:	BOD.03.002.0.24	
Review Period:	☒3 years ☐1 year	**Manual:** Board and Employee Orientation
Classification: Board of Directors	**Section:** Program & Quality Effectiveness	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

HGMH is committed to conducting business with the highest standards of professional, ethical, financial, and legal behaviour as well as compliance with applicable laws and regulations. Recognizing the risk of illegal or unethical activity that all organization's face, the purpose of this Whistleblowing Policy is to outline the responsibilities and processes related to the disclosure of information related to any suspected wrongdoing.

This policy applies to all HGMH employees, medical staff, volunteers, and students. Its intent is to encourage the reporting of genuine, suspected wrongdoing on a timely basis and to provide assurance that concerns will be taken seriously, investigated as appropriate, confidentiality will be maintained and there is no risk of reprisal.

RESPONSIBILITY TO RAISE A WHISTLEBLOWING CONCERN

Any person who becomes aware of a breach of professional, ethical, financial, or legal behaviour, non-compliance with applicable laws and regulations, or contravention of any policy governing the conduct of persons associated with HGMH and attempts to conceal any such breach or contravention, is responsible for reporting this immediately.

- Whenever possible, the identity of the reporter will be protected, and will not be disclosed to anyone (other than those on the Investigation Task Force). The identity of the reporter will only be disclosed in connection with furthering the objectives of the investigation or if required by law to do so.
- There will be no retaliation, reprisals, or other action against anyone who reports a situation in good faith.
- Should any person be found to have made a maliciously motivated report which is proved to be unfounded will be subject to disciplinary action.

ROLE OF THE COMPLIANCE OFFICER

A Compliance Officer will be designated to address whistleblowing reports in a manner consistent with these procedures. The Compliance Officer shall be the Chief Human Resources Officer (CHRO). In circumstances where a conflict with the reporter exists for the CHRO, the Chief Executive Officer (CEO) will designate an alternate Compliance Officer to lead the investigation.

The Compliance Officer shall:

- Advise the CEO of all reports and the action plan for each report. The CEO will review the action plan which could include:
  - do nothing;

  - refer the report to the report process;
  - conduct a Compliance Officer investigation; or
  - constitute an Investigation Task Force.

  Action plans will consider the merit and severity of the report and the potential risk.
- Determine if a report is addressed under this policy, or addressed under an alternate administrative policy such as:
  - Patient and Family Feedback,
  - Harassment and Discrimination,
  - Disruptive Physician Policy,
  - Conduct Policy, etc.
- File a report with the CEO on a monthly basis. The monthly report shall include a summary of the reports received, the action plans and status, or state that no reports were received for the reporting period. (The CEO shall then report to the Finance, HR & Audit Committee of the Board through the monthly Compliance Report)
- Design, implement and oversee procedures to ensure that all reported whistleblowing concerns are investigated in full;
- Ensure that the reporter is advised when the investigation process has been completed.

REPORTS RELATED TO THE CEO OR CHIEF OF STAFF (COS)

If the report involves the CEO, that individual will not be informed in the ordinary course. The Compliance Officer shall report the matter as well as matters related to the COS immediately to the Chair of the Finance, HR, & Audit Committee and the Chair of the Board of Directors.

INVESTIGATION TASK FORCE

Should the Compliance Officer decide to refer a reported matter to a task force, an Investigation Task Force will be struck. The Investigation Task Force evaluates the merits of each allegation. The Compliance Officer, in consultation with the CEO, will appoint the Investigation Task Force to be comprised of appropriate individuals which may include but not limited to; the Compliance Officer, the CEO, the COS, the Senior Leader responsible for the area involved, and any other persons with a legitimate interest in the matter as outlined below in this policy. The Investigation Task Force shall evaluate all allegations referred to it by the Compliance Officer, investigate those deemed to have merit and shall make recommendations to the Compliance Officer on how to proceed.

PROCEDURE:

Ethical, Legal, Professional or Financial

1. Any person who witnesses or suspects that a criminal act, breach of professional or ethical behaviour or financial impropriety has occurred has the responsibility to

report this act or breach.

2. If the reporter brings forward a report to the attention of their Manager, Chief of Department, or the Human Resources Department, the recipient of the report shall forward the information promptly to the Compliance Officer. If the immediate supervisor may be implicated in the witnessed or suspected criminal act or breach of professional or ethical behaviour, the report should be made directly to the Compliance Officer.

   To ensure that reports can be submitted confidentially or anonymously when Internal Reporters so choose, HGMH shall maintain other formal means by which employees may communicate reports, which may include:
   - an e-mail address to which reports may be forwarded and which is accessed exclusively by the Compliance Officer **compliance.officer@hgmh.on.ca**; and
   - the interoffice mail (or regular mail or other means of delivery), by which reports may be submitted in a sealed envelope marked "Private and Strictly Confidential – Attention: Compliance Officer – Hôpital Glengarry Memorial Hospital", the envelope shall be forwarded unopened to the Compliance Officer.

   The Whistleblower designated e-mail address and the mail procedure will also be posted on the intranet.

3. If the suspicion of misconduct involves the CEO, that individual will not be informed or involved in the ordinary course. The Compliance Officer shall report the matter immediately to the Chair of the Finance, HR & Audit Committee and the Chair of the Board of Directors. The Board Chair shall assume the responsibility of the investigation with the support of the Compliance Officer.

4. The Compliance Officer shall investigate the circumstances, in consultation with the Investigation Task Force, and any other persons with a legitimate interest in the matter including external expertise if deemed appropriate:
   - **Criminal Activity:** In the case of suspected criminal activity, the CEO (or Board Chair should the CEO be implicated) should be involved in the investigation. If deemed necessary, legal counsel may be consulted. HGMH will at all times co-operate with the police.
   - **Breach of Professional Behaviour:** The investigation should include a representative of the suspect's professional association.
   - **Unethical conduct:** The investigation should include a union representative or a Human Resources Representative for non-union staff.
   - **Financial Impropriety:** Includes misuse or misappropriation of funds, improper expense account claims or patient billings. The investigation should include a representative of the Finance, HR, and Audit Committee

- **Witnesses:** If the person making the report and/or any other witnesses are unionized staff, a union representative should be present at all interviews.

5. The Compliance Officer shall make a recommendation to senior management on disciplinary action, up to and including termination and the laying of criminal charges.

Fraud

1. It is the responsibility of the Finance, HR, and Audit Committee to ensure that the organization has appropriate procedures for the receipt, retention, and treatment of reports about its accounting, internal accounting controls, or auditing matters.

2. Under NO circumstances, should employees, physicians, volunteers, or their supervisors initiate an investigation of alleged fraud. To do so may compromise any ensuing investigation.

3. Once the Compliance Officer has been notified of a possible fraudulent act, he/she will:
   - Consult with the CEO and Chief Financial Officer (CFO) to determine the appropriate course of action which may or may not include an Investigation Task Force. Should the CEO be implicated, the Compliance Officer will consult with the Chair of the Finance, HR, and Audit Committee;
   - Advise the Finance, HR, and Audit Committee immediately via email of the situation and the proposed course of action;
   - Should the Compliance Officer decide not to refer the matter to the Investigation Task Force, a full report including the rationale for the decision shall be forwarded to the Finance, HR, and Audit Committee immediately via email.

   The Compliance Officer shall ensure that all allegations brought to its attention are evaluated fully and make recommendations on how to proceed.

4. Where suspicion of fraud is substantiated, the CFO, shall, after the conclusion of the investigation, perform a thorough review of the existing internal controls, and shall present to the CEO a summary of internal control weaknesses and recommended internal control improvements required to minimize the likelihood of a recurrence.

FRAMEWORK FOR ETHICAL DECISION MAKING

Document Name:	Framework for Ethical Decision Making	
Document Number:	BOD.03.003.0.25	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Program & Quality Effectiveness	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

Hôpital Glengarry Memorial hospital is committed to conducting all of the hospital's administrative and governance affairs, activities, patient care, and treatments with the highest level of ethical conduct, simultaneously supporting a culture of trust, integrity, and openness.

The purpose of this policy is to outline the Accountability for Reasonableness (A4R) ethical decision-making framework that is used to inform decision making within the Corporation to support organizational ethical decision making.

In addition to abiding by several other existing policies which pertain to the promotion of Board ethical conduct: Governance and Accountability, Code of Conduct, Confidentiality, Conflict of Interest, and others pertaining to compliance with Federal and Provincial Law, to name a few.

PREAMBLE:

The purpose of this policy is to promote a culture of trust, integrity, and openness. HGMH's reputation for integrity and honesty is important; hence, our commitment to the realization of our vision, mission, through honesty, fairness, and respect of the individual and the community we serve is paramount. To achieve this goal, at all times we must be asking ourselves "Am I doing the right thing, or making the decision for the right reason?"

The framework incorporates the organization's mission, vision, and values as well as additional values/principles that are agreed upon by relevant stakeholders.

PROCEDURE:

1. The A4R Framework provides a step-by-step, fair process to help guide healthcare providers and administrators in working through ethical issues encountered in the delivery of healthcare.

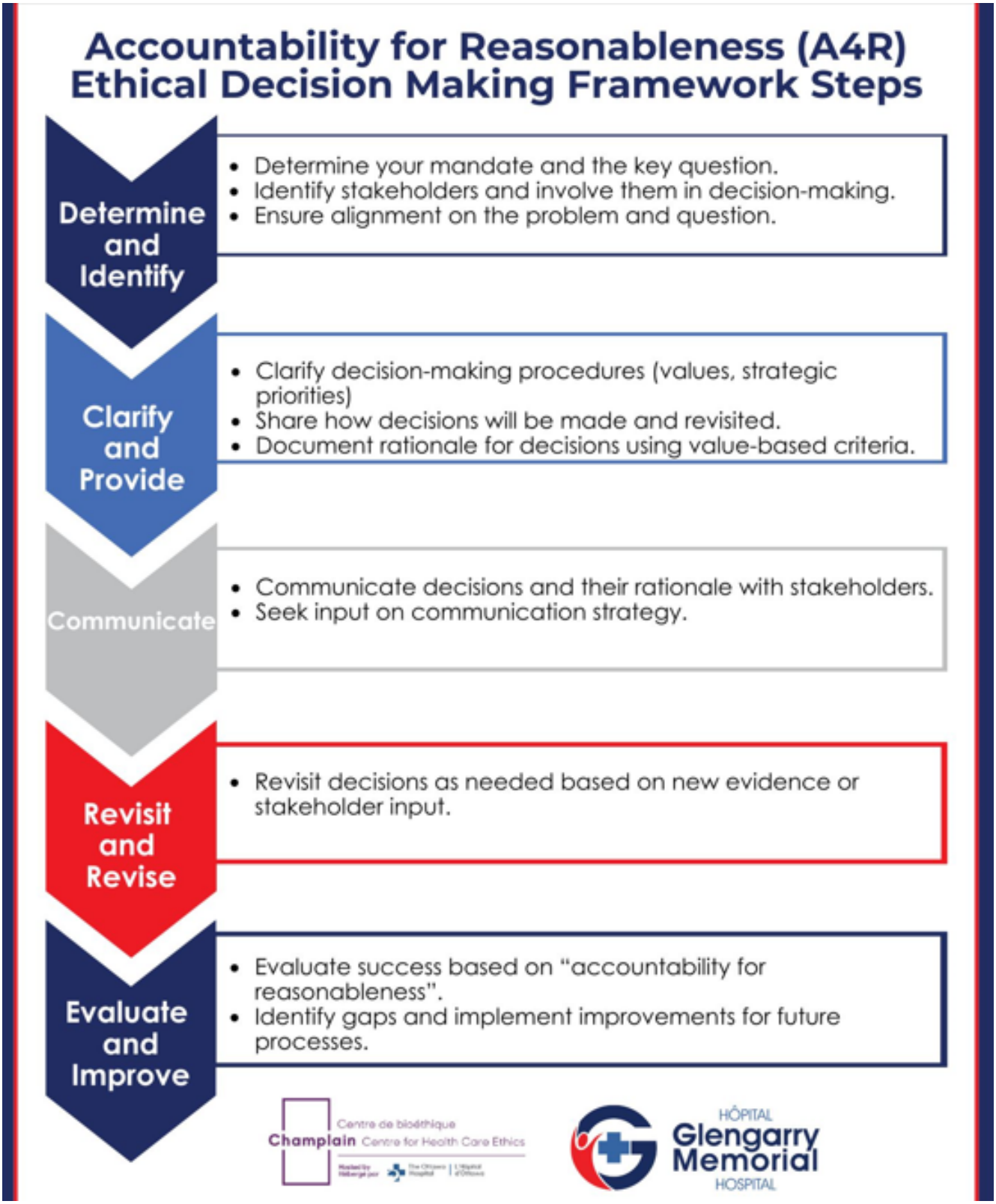
2. The A4R Framework incorporates the following steps:
   a) **Determine** your mandate and the question you are trying to answer as this will establish the type and scope of the answer you get. The goal is to ensure that the group is working on the same problem and asking the right question to solve it.

b) **Identify** your stakeholders (those who will be impacted by the decision) and **include** them in decision-making. Stakeholders may be involved as decision-makers or as consultants in decision-making. The aim is to ensure that decision-making includes a broad range of ideas and stakeholder perspectives. Consider who else needs to be consulted for their perspective after a draft decision is reached.
c) **Clarify** your decision-making procedure upfront (e.g., identify organizational values and strategic priorities, develop criteria from those values, prioritize the criteria, generate options, judge quality of your different options against those criteria, and select option).Decision-makers and stakeholders alike need to know and understand a) how decisions will be made and b) how and on what basis they can revisit decisions.
d) **Provide** a statement of rationale for each decision. It is not enough that a decision is made. Ethical decision-making requires that reasons be given to justify each decision utilizing value-based criteria.
e) **Communicate** the decision and its rationale to stakeholders. The key is access to information and this means *effective communication*. Knowing who your stakeholders are will help to identify who best to communicate with them and how (e.g., websites, email, forums, newsletters). Better yet, ask their input on how to develop an effective communication strategy.
f) **Revisit and revise** decisions on the basis of new evidence or argument brought forward either through a formal appeals mechanism or through consultation with stakeholders.
g) **Evaluate** how successfully the decision-making process met the conditions of 'accountability for reasonableness'. There may be gaps between *what you do* and *what you should be doing*. To close this gap, you need to be able to evaluate your success.
h) **Improve** the decision-making process to make it more ethical. The gaps you identify are areas of improvement for subsequent iterations of decision-making. Learning from experience demonstrates that you take seriously our corporate commitment to being publicly accountable and to seeking excellence in how we do business as a health care institution.

3. To further facilitate the process, the Regional Ethicist Program may be approached for input / leadership in the process.

4. In addition to Appendix A, HGMH uses the following graphic to depict the A4R ethical decision-making framework process.

APPENDIX A


Accountability for Reasonableness (A4R)
Ethical Decision Making Framework Steps
Determine and Identify
Determine your mandate and the key question.
Identify stakeholders and involve them in decision-making.
Ensure alignment on the problem and question.
Clarify and Provide
Clarify decision-making procedures (values, strategic priorities)
Share how decisions will be made and revisited.
Document rationale for decisions using value-based criteria.
Communicate
Communicate decisions and their rationale with stakeholders.
Seek input on communication strategy.
Revisit and Revise
Revisit decisions as needed based on new evidence or stakeholder input.
Evaluate and Improve
Evaluate success based on "accountability for reasonableness".
Identify gaps and implement improvements for future processes.
Centre de bioéthique
Champlain Centre for Health Care Ethics
HÔPITAL Glengarry Memorial HOSPITAL

DEFINITIONS:

Ethics: is about making "right" or "good" choices and the reasons that we give for our choices and actions. Ethics promotes reflective practice in the delivery of health care. Ethics can be described as a way of critically looking at issues in health care that encompasses:

- Deciding what we should do - what decisions are morally right or acceptable based on the values and principles we agree are relevant.
- Explaining why we should do it; justify our decision using language of values and principles to explain why
- Describing how we should do it - outlining an appropriate process of enacting the decision.

Document Name:	Enterprise Risk Management	
Document Number:	BOD.03.004.0.24	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Program & Quality Effectiveness	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The Board of Directors of the healthcare facility recognizes the primary purpose of the healthcare facility to provide for the safe, professional and quality care of patients, visitors, employees and other healthcare providers. The healthcare facility employs an enterprise risk management (ERM) framework in combination with a patient safety plan and quality improvement strategies to achieve this purpose and its desired results in alignment with the Mission, Vision and strategic priorities of Hôpital Glengarry Memorial Hospital (HGMH).

It shall be the policy of Hôpital Glengarry Memorial Hospital, in accordance with a Resolution of its Board of Directors, to develop, implement, support, monitor, and evaluate an Enterprise Risk Management Program. HGMH is committed to building an increased awareness and a shared responsibility for risk management at all levels of the organization through its ERM that includes:

- Clearly defined accountabilities and responsibilities
- A framework to analyze risk
- A risk register of key organizational risks
- A Board reporting schedule

PROCEDURE:

Accountabilities

1. Board of Directors:
   - The Board is accountable and responsible for the oversight of Enterprise Risk Management.
   - The Board ensures appropriate systems and processes are in place to identify and manage organizational-wide risks.
   - The Board delegates authority and responsibility to the CEO to ensure management of all aspects of the ERM process.

2. CEO:
   - The CEO supports the organization's risk management philosophy of open communication, knowledge sharing, best practices and transparent risk reporting.
   - Is accountable for ERM in the organization.
   - Ensures management implements and is accountable for the ERM program.

- Provides an annual report to the Board of the top organizational-wide risks and mitigation strategies in place for those risks.

DEFINITIONS:

Enterprise risk management: is a continuous, proactive and systematic process to understand, manage and communicate risk system-wide. It facilitates strategic decision-making that contributes to the achievement of overall corporate objectives.

Risk management: is a systematic approach to setting the best course of action under uncertainty by identifying, assessing, understanding, acting on and communicating risk issues. Risk management and quality improvement have a common goal to "do the right things well" and improve safety and quality throughout the organization. Both risk management and quality improvement use similar activities of data collection, evaluation and corrective action to evaluate care and improve patient safety. Patient safety is an imperative in the delivery of healthcare.

Quality improvement: is the organizational philosophy that seeks to meet clients' needs and exceed their expectations by using a structured process that selectively identifies and improves all aspects of service. It is used in planning or designing, monitoring, analyzing and improving processes and outcomes. Systematic quality improvement is achieved through the application of the Balanced Scorecard.

Document Name:	Quality & Patient Safety Framework	
Document Number:	BOD.03.005.0.25	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Program & Quality Effectiveness	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The Board is accountable for ensuring that the hospital establishes a clear definition of quality and adopts a quality framework to guide all activities related to the quality of care provided by the organization. This includes implementing appropriate structures, processes, and systems to support its responsibility for quality. Additionally, the Board must continuously monitor and exercise oversight of these frameworks and mechanisms to ensure they effectively uphold and enhance the delivery of safe, high-quality care.

DEFINITIONS:

Quality: For Hôpital Glengarry Memorial Hospital (HGMH), quality means delivering safe, effective, patient centered, efficient, timely, and equitable services resulting in optimal patient health outcomes, guided by Health Quality Ontario's definition of a high-quality health system. The following chart outlines these key dimensions, detailing what each element means from both the patient's perspective and the provider's perspective. This dual approach ensures that quality improvement efforts align with patient needs while supporting providers in delivering safe, effective, and compassionate care.

Element	Patient meaning	Provider meaning
Safe	*I will not be harmed by the health system*	*The care my patient receives does not cause the patient to be harmed*
Effective	*I receive the right treatment for my condition, and it contributes to improving my health*	*The care I provide is based on best evidence and produces the desired outcome*
Patient Centered	*My goals and preferences are respected. My family and I are treated with respect and dignity*	*Decisions about my patient's care reflect the goals and preferences of the patient and their family or caregivers*
Efficient	*The care I receive from all practitioners is well coordinated and efforts are not duplicated*	*I deliver care to my patients using available human, physical, and financial resources efficiently, with no waste to the system*
Timely	*I know how long I have to wait to see a doctor or for tests or treatments I need and why. I am confident this wait time is safe and appropriate*	*My patient can receive care within an acceptable time after the need is identified*
Equitable	*No matter who I am or where I live, I can access services that benefit me. I am fairly treated by the organization and health care system*	*Every individual has access to the services they need, regardless of his or her location, age, gender, or socio-economic status*

Quality Framework: The quality framework serves to ensure alignment and accountability for quality through the hospital and has been adopted from the Canadian Quality & Patient Safety Framework for Health Services.

The Framework's ultimate aims are:

1. Improving key quality and safety areas
2. Reducing unwarranted care variation
3. Strengthening high-quality health services that improve patient experiences and outcomes

The Board of Directors will apply this framework to guide the activities related to quality of care provided by HGMH. The following framework defines five goal areas designed to drive improvement and to align Canadian legislation, regulations, standards, organizational policies and public engagement on patient safety and quality improvement.

Goal 1 | People-Centred Care
People using health services are equal partners in planning, developing, and monitoring care to make sure it meets their needs and to achieve the best outcomes.

Goal 2 | Safe Care
Health services are safe and free from preventable harm.

Goal 3 | Accessible/Timely/Equitable Care
People have timely and equitable access to quality health services.

Goal 4 | Appropriate/Effective/Efficient Care
Care is evidence-based and people-centred.

Goal 5 | Integrated Care
Health services are continuous and well-coordinated, promoting smooth transitions.

PROCEDURE:

HGMH is committed to delivering high-quality, safe, and patient-centered care in alignment with the Canadian Quality & Patient Safety Framework for Health Services. This framework establishes five key goals to guide healthcare organizations in achieving excellence in quality and patient safety, which are:

- People-Centered Care
- Safe Care
- Accessible Care
- Appropriate Care
- Integrated Care

The Board of Directors plays a critical role in ensuring these principles are embedded in the organization's governance, strategic direction, and operational oversight.

To uphold ***People Centred Care***, the Board will:

- Set the expectation that the organization ensures patients and families have the information they need to make informed decisions about their care, improving patient experiences and outcomes.
- Ensure diverse populations, including Indigenous, Black, LGBTQ2S+, immigrant, and rural communities, receive culturally safe care by embedding respect for culture, values, and beliefs into strategic planning and policy development.
- Support and promote formal and informal partnerships with patients and healthcare providers to enhance service delivery and patient engagement.
- Regularly review patient-reported experience and outcome measures to assess whether hospital services are making a meaningful, positive impact on patient care and overall health outcomes.

To advance ***Safe Care***, the Board will:

- Ensure accountability for patient safety by overseeing that safety concerns and incidents are appropriately addressed.
- Support a psychologically and physically safe work environment by ensuring healthcare providers have access to staff wellness and retention programs.
- Regularly review safety outcomes and reported trends to proactively drive improvements in safe practices.
- Ensure the organization participates in accreditation processes where applicable, reinforcing a commitment to continuous quality and safety improvement.

To enhance ***Accessible Care***, the Board will:

- Ensure that diverse populations, including Indigenous, Black, LGBTQ2S+, immigrant, and rural communities, receive safe, equitable, and timely care by addressing barriers to access.
- Develop and implement needs-based human resource allocation strategies to ensure appropriate staffing levels and service availability that meet the needs of the communities served.

To ensure ***Appropriate Care***, the Board will:

- Encourage health promotion and disease prevention initiatives to improve overall community well-being.
- Ensure infrastructure and accountability measures are in place to support seamless care transitions across health services, particularly between urban, rural, and remote settings.
- Ensure health teams, including patients and families, have appropriate access to integrated electronic health records to enhance care coordination and decision-making.

REFERENCES:

1. Healthcare Excellence Canada. (2020). *Canadian Quality & Patient Safety Framework for Health Services*.
2. Health Quality Ontario. (2017). *Quality Matters: Realizing Excellent Care for All*.

APPENDIX A Activities the Board Undertakes to Support the Quality & Safety Framework	
People Centred	• Set expectations for active patient engagement throughout our organization. • Review patient experience data along with quality and patient safety action plans. • Regularly review patient feedback and learn about patient experiences through the use of patient stories at the Board. • Develop organizational policies, an Inclusion, Diversity, Equity, and Anti-Racism (IDEA) framework, and appropriate measures for addressing anti-racism, cultural safety and humility, in collaboration with diverse peoples. • Support and participate in anti-racism, cultural safety and humility training for board members and all staff. • Encourage membership of diverse peoples, including Indigenous, Black, LGBTQ2S+, immigrant, and people in rural and remote communities on the board. • Commit to establishing relationships with the communities our organization serves. • Establish mechanisms to engage with the Patient & Family Advisory Committee to incorporate their voices and perspectives in board initiatives. • Develop organizational strategic plans in collaboration with patient partners. • Include patient and family representative membership on our board and/or board committees. • Educate the Board about patient experience and outcome measures as part of our onboarding process. • Review qualitative and quantitative data about patient and staff experiences. • Seek updates from the patient and family advisory committee. • Provide feedback on targets, outcome indicators, and actions for improvement. • Review and approve quality, patient safety, and strategic plans.
Safe Care	• Prioritize quality and patient safety on the board's agenda. • Review reports on patient safety, recommended actions arising out of patient safety incident analyses, and resulting action plans for improvements. • Demonstrate accountability for our organization's quality and safety goals. • Foster psychological support programs for the health team. • Ensure that the health team is aware of available psychological support programs, turnover rates, and plans for improvement. • Review workplace health and safety information, turnover data, absenteeism rates, and mental health and workplace violence claims and use this information to assess improvement plans. • Review data on avoidable deaths and the implementation of relevant evidence-based practices. • Allocate resources for training, implementing evidence-based practices, and measuring outcomes. • Ensure actions are taken to improve patient outcomes. • Participate in accreditation for our organization and professionals. • Review the accreditation report and monitor actions that arise from it. • Share accreditation results internally and publicly. • Establish a process for publicly reporting data on patient harm and other indicators that reflect organizational safety.
Accessible Care	• Collect and review population data and consider the needs of diverse peoples in your strategic planning. • Identify health services that are monitored for access and review data on wait times to increase access to services. • Ensure that targets for access to services are measured and publicly reported and that actions are taken to drive improvement. • Ensure best practice for human resource strategic planning. • Evaluate the impact of human resource allocation decisions on quality, safety, and patient experience.

Appropriate Care	• Review population health outcomes and your organization's action plans for promoting health and preventing disease. • Participate in education on disease prevention and screening interventions and innovations.
Integrated Care	• Understand the challenges and solutions for electronic health record management and allocate resources for information systems implementation and improvement. • Advocate for an electronic health record to connect patients and providers and to give patients direct access to their personal health information.

QUALITY OF CARE INFORMATION PRIVACY ACT (QCIPA)

Document Name:	Quality of Care Information Privacy Act (QCIPA)	
Document Number:	BOD.03.006.0.25	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Program & Quality Effectiveness	
Owner: Chief Nursing Executive	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The purpose of this policy is to ensure the confidentiality, integrity, and security of all information related to the quality-of-care reviews conducted by the organization. The organization is committed to continuous improvement of care quality, while safeguarding the sensitive information generated and reviewed during the quality care evaluation processes. All reviews shall be conducted with due diligence, fairness, and in accordance with legal, ethical, and organizational standards.

This policy outlines the criteria for conducting quality care reviews, the responsibilities of stakeholders involved, and the procedures for protecting quality care-related information in compliance with the Quality-of-Care Information Protection Act, 2004 (QCIPA), the Personal Health Information Protection Act (PHIPA), and other relevant privacy and legal protections such as the Canada Health Act, Accreditation Canada standards, Evidence Act (Ontario) within the Canadian healthcare setting.

SCOPE:

This policy applies to all hospital staff, healthcare providers, and committees involved in the process of reviewing, analyzing, and improving the quality of patient care.

PROCEDURE:

1. **Initiation of Quality Care Review**:
   - A quality care review will be initiated by the Chief of Staff and VP Clinical Services, Chief Nursing Executive based on identified care gaps, patient complaints, or scheduled routine reviews.

2. **Criteria for Review**: Quality care reviews will focus on, but are not limited to, the following criteria:
   - **Patient Safety**: Evaluating incidents of harm, preventable errors, medication events, and near-misses, e.g. sentinel, serious or adverse events.
   - **Care Coordination**: Assess communication effectiveness, the smoothness of care transitions, and the adequacy of follow-up care.
   - **Patient -Centred Care:** Assessing patient satisfaction surveys, complaints and feedback regarding care delivery, and whether patients feel involved in their own care decisions.
   - **Documentation:** Review the accuracy and completeness of patient chart to ensure they reflect the patient's care appropriately

- **Clinical Outcomes**: Reviewing patient outcomes, including readmission rates, and treatment effectiveness to identify trends or areas needing improvement.
- **Performance**: Evaluate staff performance and adherence to best practices and protocols.
- **Compliance**: Ensuring that care delivery complies with relevant laws, regulations, accreditation standards and organizational protocols that impact quality and safety.
- **Resource Utilization**: Evaluating the efficiency of care delivery in relation to resource consumption, including staffing, equipment, and facilities.

3. **Conducting the Review**:
   - **Restricted Attendance**: The review is a focused, restricted meeting to ensure that only clinical team members, leadership and other relevant departments involved in the patient's care are present. This ensures the discussion remains relevant and efficient, centered around critical patient outcomes. Invitations are extended based on roles or areas of expertise within the care process.
   - **Inclusion of essential team members:** The review will include team members who directly contribute to the patient's care plan as their input is necessary for a comprehensive evaluation of the patient's care and progress, e.g., representatives from the clinical team, relevant leadership and other relevant departments (e.g., health information, pharmacy, IPAC).
   - **Data Collection and Review:** Reviews will involve data collection using the Quality of Care Review Meeting Template (51-A-290-XX), interviews with staff and patients, chart reviews, and analysis of relevant documentation.
   - **Confidential and Targeted Discussion:** All information gathered during the review will be confidential, and only authorized personnel will have access to sensitive data. Restricted access to meeting fosters a secure environment where challenges can be openly addressed and improvements in care delivery are proposed.

4. **Documentation and Reporting**:
   - All findings from the quality care review shall be documented in a formal report (Appendix A) The report will include identified areas of concern, recommendations for improvement, and a timeline for corrective action if applicable.
   - A summary of the findings will be shared with the management team and relevant stakeholders, ensuring that all actionable items are addressed promptly.
   - Recommendations for improvement will be submitted to the Board Quality committee and Quality and Safety Advisory committee to track progress, promote accountability and ensure patient safety care standards are met.
   - Documentation of the review process and final report will be securely stored and protected in accordance with QCIPA.

5. **Protecting Quality Care Information**:
   - All quality care review data, including patient records, staff information, and internal reports, will be handled in compliance with confidentiality protocols.
   - Access to review information will be restricted to authorized personnel only.

- Electronic records will be protected through encryption, password access, and other cybersecurity measures.

6. **Follow-up and Continuous Improvement**:
   - Once corrective actions have been implemented, follow-up reviews will be scheduled to assess the effectiveness of the changes and ensure continuous improvement in care quality.
   - Any recurring issues or trends identified during subsequent reviews will trigger further investigation and potential policy adjustments.

DEFINITIONS:

Quality of Care: The degree to which healthcare services provided to individuals increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Quality Care Review: A structured process used to assess and evaluate the performance of healthcare services, including safety, clinical outcomes, patient experience, and resource utilization.

Quality of Care Information Protection Act (QCIPA): A legal framework designed to protect sensitive information generated during quality care reviews to ensure patient privacy, organizational integrity, and compliance with regulatory standards.

Sensitive Information: Any data or documentation relating to patient care, staff performance, or organizational operations that is considered confidential and requires protection under QCIPA, e.g., information produced during a quality review such as opinions, audit results, interview reports, evaluations, and root cause analyses.

Sentinel /Serious/Adverse event: any unexpected occurrence or near miss occurrence involving death, serious physical or psychological injury, or risk thereof. Specific sentinel events include, but are not limited to:

- **Patient Deaths**:
  - Unanticipated deaths related to healthcare interventions or errors.
  - Deaths from complications of medical procedures or treatments.
- **Serious Physical or Psychological Injury**:
  - Permanent or significant disability.
  - Injury resulting from a healthcare error, including falls, infections, or surgical complications.
  - Events leading to long-term mental health issues or trauma.
- **Surgical or Procedural Errors**:
  - Wrong-site, wrong-procedure, or wrong-patient surgeries.
  - Retained surgical items (e.g., sponges, instruments).
  - Anesthesia-related errors or complications.

- **Medication Errors**:
  - Incorrect drug administration, including wrong dosage, wrong medication, or incorrect route.
  - Adverse drug reactions that result in severe harm or death.
- **Infection Control Failures**:
  - Outbreaks of infections that could have been prevented through proper hygiene or protocols.
  - Infection due to improper sterilization of medical equipment or lack of infection prevention measures.
- **Blood Transfusion Errors**:
  - Incorrect blood transfusions or mismatched blood types leading to severe reactions or death.
- **Elopement or Patient Absconding**:
  - Patients leaving care settings (especially in psychiatric or emergency settings) where their safety and well-being are at risk.
- **Falls Resulting in Serious Injury**:
  - Falls in hospital or care settings leading to fractures, neurological damage, or other severe injuries.
- **Loss of Organ Function**:
  - Instances where vital organ function is lost or severely compromised due to medical errors or negligence.
- **Restraint-Related Events**:
  - Patient injury or death related to the use of restraints, either physical or chemical.
- **Delayed Diagnosis or Misdiagnosis**:
  - Events where a delay or error in diagnosis results in significant harm or death.

CROSS-REFERENCED POLICIES:

Policy Number	Policy Name
COR.06.004.X.XX	Privacy Breach
COR.01.012.X.XX	Risk Incident Management System (RIMS)
CO.06.001.X.XX	Personal Health Information Protection
COR.12.009.X.XX	Disclosure of Harm
COR.12.010.X.XX	Adverse Drug Reaction Reporting (Vanessa's Law)

ASSOCIATED FORMS:

Form Number	Form Name
51-A-290-XX	Quality of Care Review Meeting Template

REFERENCES:

1. Canada Health Act (CHA), RSC 1985, c. C-6 https://laws-lois.justice.gc.ca/eng/acts/C-6
2. Personal Health Information Protection Act (PHIPA), 2004, S.O. 2004, c. 3 (Ontario) https://www.ontario.ca/laws/statute/04p03
3. PIPEDA – Personal Information Protection and Electronic Documents Act, SC 2000, c. 5. https://www.priv.gc.ca/en/privacy-topics/privacy-laws-in-canada/the-personal-information-protection-and-electronic-documents-act-pipeda/
4. Canadian Patient Safety Institute (CPSI) – Patient Safety and Quality Improvement Framework https://www.healthcareexcellence.ca/media/e3dkkwos/cpsi-10001-cqps-framework-english_fa_online-final-ua.pdf
5. The Accreditation Canada – Quality Standards https://accreditation.ca/standards/
6. The Office of the Privacy Commissioner of Canada (OPC) https://www.ipc.on.ca/en

BOARD AND COMMITTEE EXPENSES

Document Name:	Board and Committee Expenses	
Document Number:	BOD.04.001.0.23	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Financial & Organizational Viability	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

Board members required to travel outside the general Alexandria area on hospital business will be reimbursed for their travel following the submission of a claim for expenses in attending Board-approved meetings and events.

PROCEDURE:

1. Expenses shall be reimbursed consistent with the hospital policy entitled General Expense Policy (CO.02.022.0.11) and Gas/Travel Allowance Policy (CO.02.005.2.14):
    i. mileage will be reimbursed at a rate consistent with the rate established for staff mileage.
    ii. Using the most cost-effective form of travel is encouraged. Associated travel costs such as parking and taxi fare will be reimbursed.
    iii. Reasonable accommodation will be reimbursed.
    iv. All reasonable and customary meal expenses will be reimbursed. Costs incurred for alcoholic beverages will not be reimbursed. It is the responsibility of the person(s) approving the expenses to determine reasonableness.
    v. All out of pocket expenses shall be supported by receipts.
    vi. Registration fees for conferences, workshops and external meetings attended with Board approval will be reimbursed. Even in time-sensitive situations, approval of the Board Chair must be obtained.

2. The Board Chair shall approve board member expenses. The Vice-Chair shall approve the Board Chairs' expenses.

3. Payment of travel allowance will be paid to Board members on a quarterly basis upon submission of an approved *General Expense Statement for Staff and Board of Directors* (51-A-201-XX) approved and signed by the Board Chair.

CROSS-REFERENCED POLICIES:

Policy Number	Policy Name
CO.02.022.X.XX	General Expense
CO.02.005.X.XX	Gas/Travel Allowance

ASSOCIATED FORMS:

Form Number	Form Name
51-A-201-XX	General Expense Statement for Staff and Board of Directors

Document Name:	Investments	
Document Number:	BOD.04.002.0.24	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Financial & Organizational Viability	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The Chief Executive Officer, or their delegate, will be responsible for the day-to-day management of the investment portfolio of Capital Reserve Funds and Endowment Funds, subject to the oversight of the Finance and Human Resources Committee.

Investment activities are to be undertaken in a manner designed primarily to preserve and safeguard capital, and secondarily to optimize investment yield having regard to permissible investments. In all respects, maturity dates of investments must recognize the forecasted cash flow requirements of the Corporation.

This policy provides written guidelines for managing the investments of the Corporation and limits for the investment portfolio.

PROCEDURE:

1. Permissible investments will be restricted to:
    a) Canadian Government Debt Obligations
    b) Canadian Government Guaranteed Debt Obligations
    c) Province of Ontario Debt Obligations
    d) Province of Ontario Guaranteed Debt Obligations
    e) Term Deposits, Guaranteed Investment Certificates, and Interest Bearing Bank Accounts. The schedule of Banks are:
        i. Bank of Montreal
        ii. Bank of Nova Scotia
        iii. Canadian Imperial Bank of Commerce
        iv. Royal Bank of Canada
        v. TD Canada Trust

2. All investments will be in Canadian Dollars.

3. All investing must abide by the Public Hospital Act and Corporations Act.

4. Performance of the investment portfolio shall be reported to the Finance and Human Resources Committee on a quarterly basis, with detailed reporting at year end.

5. Capital Reserve Funds and Endowment Funds may be aggregated to improve the rate of return on investments.

6. The funds will be invested in the following time periods:
    a) Short Term (1 – 12 months): Funds required for operating expenses.
    b) Long Term (12 – 24 months)

7. Any investments in excess of $1,000,000, or for a period exceeding 24 months, shall require the prior approval of the Board, with the exception of funds on deposit in the Corporations interest bearing operating account.

CROSS-REFERENCED POLICIES:

Policy Number	Policy Name
BOD.04.003.X.XX	Management of Endowment Funds

MANAGEMENT OF ENDOWMENT FUNDS

Document Name:	Management of Endowment Funds	
Document Number:	BOD.04.003.0.24	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Financial & Organizational Viability	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The Hospital's Endowment fund is to be administered in accordance with guidelines as set by the Board of Directors in accordance with the Corporate Bylaw.

Governance

The Finance Committee, and aided as necessary by staff members, shall administer the ongoing activities of the Endowment Fund.

Funding

Donations to the Endowment Fund shall be considered unrestricted as to their end use, unless given with a purpose or time restriction by the donors. The Finance Committee shall ensure proper records and controls are maintained to comply with donors' specific conditions, and also that proper records are maintained.

It shall be the intent that unrestricted gifts from estates will go into the Endowment Fund rather than to operating funds.

Investments

Investing the funds of the Endowment Funds shall be done in accordance with the separate Investment policy.

Expenditures

The basic concept of endowments is to provide funding for long-term needs, whereby the fund contributed by donors are not spent immediately, but are invested to provide a stream of earnings which can then be used. The Board shall, at its discretion, recommend the amount to be transferred from the Endowment Fund for general corporate purposes. The Board shall make decisions on spending from restricted gifts and funds to the extent that donors' restrictions are met.

PROCEDURE:

1. The Finance and Human Resources Committee shall be responsible for reviewing the recommendation to use Endowment Funds, made by the CEO. If endorsed by the Committee, a recommendation will go before the Board.

2. Approval by the Board of Directors is required before funds are dispersed.

ACCEPTANCE OF A TENDER OVER A BOARD-APPROVED AMOUNT

Document Name:	Acceptance of Tender over a Board-Approved Amount	
Document Number:	BOD.04.004.0.24	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Financial & Organizational Viability	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

Additional specific approval from the Board of Directors is required whenever a Tender selected or recommended for a capital project is over the previously approved budget.

PROCEDURE:

1. Additional approval from the Board is required in the event all tenders for a capital project or equipment received or the tender recommended for acceptance is materially (greater than 10% above any capital project over $100,000) over the amount budgeted and previously approved by the Board.

2. Such additional approval may be done at the next Board meeting or may be obtained through telephone or electronic polling of Board members.

3. In seeking approval, management shall, in advance of the Board meeting, provide rational for the increase sought highlighting:
   a) The reason for requesting approval of an increase;
   b) Steps taken to mitigate/limit the increase
   c) Any financial impacts or risks to funds previously allocated to other approved capital projects, or, to the overall Board approved capital amount (working capital ratio).

Document Name:	Signing Authority and Approval	
Document Number:	BOD.04.005.0.25	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors		**Section:** Financial & Organizational Viability
Owner: President & CEO		**Signing Authority:** Board of Directors

POLICY STATEMENT:

The President and Chief Executive Officer shall ensure that the Corporation has in place policies and rules for the approval, purchasing, contracting, leasing, acquisition, or disposal of goods and services, capital, and real property. These policies will include identification of authorizations as required by legislation, accountability agreements, and/or service agreements with the Ministry of Health and Ontario Health. Such authorizations will be monitored for compliance and reviewed as recommended by the Finance, HR and Audit Committee.

PROCEDURE:

APPROVAL

The Board authorizes the President and Chief Executive Officer to make commitments contained within an approved operating plan or capital budget or as otherwise approved by the Board, including any and all: contracts, requisitions, purchase orders, travel authorizations, and any other agreement, financial or otherwise. If emergency expenditures or commitments are necessary, they must be subsequently submitted for approval at the next appropriate meeting.

Prior approval by Board resolution is required for any of the following:

- all contracts, agreements, and costs not included in the approved operating plan and capital budget involving liability on the part of the Corporation in excess of an unbudgeted amount of $100,000;
- the sale or transfer of any assets of the Corporation not included in the approved operating plan or capital budget, which individually or cumulatively exceeds $100,000;
- in the case of an acting President and Chief Executive Officer, any expense or cost not included in the approved operating plan or capital budget over $50,000;
- the taking or instituting of proceedings for the winding-up, reorganization or dissolution of the Corporation;
- the enactment, ratification, or amendment of any by-laws of the Corporation;
- the sale, lease, exchange or other disposition of all or substantially all of the assets or undertakings of the Corporation;
- the provision of financial assistance, whether by loan, guarantee, or otherwise to any person whatsoever;

- the mortgaging, pledging, charging or otherwise encumbering of any of the assets of the Corporation;
- all real estate purchases and sales; and
- all capital equipment, capital renovations, and capital projects not included in the approved operating plan and capital equipment budget.

SIGNING AUTHORITY

In accordance with the Corporate By-Law, any of the Chair, a Vice-Chair, or the Treasurer, together with either the President and Chief Executive Officer or their delegate may sign any deeds, transfers, assignments, contracts, mortgages, conveyances, obligations, certificates or any other instruments or documents requiring the signature of the Corporation, and all instruments or documents so signed shall be binding upon the Corporation without any further authorization or formality.

In addition, the Board may from time to time direct the manner in which and the person or persons by whom any particular document or class of documents may or shall be signed. Any signing officer may affix the seal of the Corporation to any instrument or document and may certify a copy of any document, resolution, by-law or other document of the Corporation to be a true copy.

In conjunction with the President and Chief Executive Officer, the Board will identify the designated signing officers of the Corporation and their authority and will review the designated signing officers at least annually and at the time of turnover of such designated Directors and staff.

The President and Chief Executive Officer shall ensure that adequate internal controls and processes are in place. Consistent with administrative policies and internal budgeting policies developed as part of the Corporation's system of internal control and which provide direction to staff for developing and managing the Corporation's budgets. Employees are not authorized to bind the Corporation to contracts or incur expenditures unless they have been delegated that authority. Where the President and Chief Executive Officer is appointed on an acting basis, the President and Chief Executive Officer's signing authority related to unbudgeted expenses shall not be delegated.

BANKING ARRANGEMENTS

Cheque Signing Authority is approved by the Board and generally includes, without limitation, the holders of the following positions:

- President & Chief Executive Officer
- Chief Financial Officer
- Board Chair
- Vice-chair
- Treasurer

All expenditures must be approved by any two of the above positions.

USE OF ELECTRONIC APPROVALS

This authority may not be delegated. All contracts, agreements and pre-approved payments may be signed by electronic signature.

Each electronic signature must be traceable to allow for the individuals signature to be authenticated.

Written authorization must be obtained to use the e-signature by someone else or the inclusion of an e-signature by the individual themselves in order to have a date stamped document.

REPORTING REQUIREMENTS

The Board will satisfy itself, through reporting from the President and Chief Executive Officer or their designate, that the Corporation is acting in accordance with rules as established. The reporting will be at least annually.

REFERENCES:

1. HGMH Corporate By-Law

APPOINTMENT OF AUDITOR

5Document Name:	Appointment of Auditor	
Document Number:	BOD.04.006.0.25	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Financial & Organizational Viability	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The Corporation will appoint an Auditor every year at the Annual Meeting. The Corporation will consider the recommendation of the Board.

PROCEDURE:

In addition to HGMH Corporate By-law 9.5, the Board of Directors will ensure the following actions related to the appointment of the auditor.

1. Every five years, tenders will be sought for auditors and reviewed by the Finance and Human Resources Committee who will recommend the auditor to the Board.

2. Every year, at the annual meeting, the membership of the Corporation will appoint the auditor as recommended.

INSURANCE COVERAGE AND ASSET PROTECTION

Document Name:	Insurance and Asset Protection	
Document Number:	BOD.04.007.0.25	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Financial & Organizational Viability	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The President and Chief Executive Officer (CEO) is accountable to the Board of Directors to ensure that the assets of Hôpital Glengarry Memorial Hospital (HGMH) are reasonably protected, adequately maintained, and not placed at unnecessary risk. HGMH will maintain appropriate insurance coverage to protect its assets, employees, Directors, officers, volunteers, students, visitors, and its day-to-day activities.

PROCEDURE:

The President and CEO shall:

- Review insurance requirements with the hospital's carrier annually to ensure that general liability insurance coverage is sufficient to protect staff, Directors, volunteers, visitors, and all assets.
- Review and evaluate the Corporation's comprehensive insurance policy annually.
- Review insurance coverage and requirements with the Finance and Audit Committee at least annually.
- Provide adequate notice to the insurance carrier to allow exploration of alternative options annually.
- Maintain, at a minimum, insurance policies covering:
    - Third-party liability
    - Property
    - Director, officer, and employee liability
    - Errors and omissions
    - Cyber Events

Insurance policies may be tendered every five years, or more frequently if determined by the Board.

Only the President and CEO or the Board shall initiate claims, settlements, or legal actions on behalf of HGMH.

Legal Liability:

The President and CEO shall:

- Maintain adequate liability insurance coverage for the Corporation, Directors, and officers to ensure indemnification.
- Insure against losses due to errors and omissions by Directors, officers, employees, and agents.
- Establish procedures to monitor legislative compliance.

- Provide the Board with opportunities to review internal controls, including key policies and procedures.

Financial Liability:
The President and CEO shall:

- Ensure appropriate and adequate financial internal controls are maintained, reviewed annually, and report any issues to the Finance and Audit Committee.
- Ensure financial reporting is consistent with Canadian Generally Accepted Accounting Principles.
- Ensure the Board reviews financial statements, internal control processes, risk management methods, audit processes, and management information systems for integrity and effectiveness.
- Ensure that access to funds aligns with the signing authority policy.

Asset Protection:
The President and CEO shall:

- Maintain reasonable insurance coverage against fire, theft, and casualty losses.
- Ensure property, boiler, and machinery insurance coverage is in place for all applicable assets.
- Implement a program for proper maintenance and renewal of equipment and systems, ensuring compliance with legal requirements and minimizing improper wear and tear.
- Maintain an up-to-date asset registry.

DEFINITIONS:

Comprehensive Insurance Policy: A policy that includes multiple types of insurance coverage under a single premium.

Errors and Omissions Insurance: Coverage that protects against claims of inadequate work or negligent actions.

REFERENCES:

1. Canadian Generally Accepted Accounting Principles (GAAP)
2. Relevant Ontario Health Insurance and Risk Management Guidelines

DEVELOPING, REVIEWING AND REVISING BOARD POLICIES

Document Name:	Developing, Reviewing and Revising Board Policies	
Document Number:	BOD.05.001.0.23	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Board Effectiveness	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

All Board policies are developed, approved, and reviewed through the process outlined in this document.

PROCEDURE:

Policy Development

1. New Board Policies shall be developed by the most appropriate Board Committee to address an identified need (e.g., change to applicable law, standardization, direction, etc.) and approved by the Board.

Policy Review

2. Board policies shall be reviewed one year after implementation and at least every three years thereafter. It is the responsibility of the President & Chief Executive Officer to ensure that Board policies are reviewed in a timely manner. Board policies requiring review shall be brought forward to the Governance Committee with recommendation to the Board. Board policies shall be reviewed for relevance, and to ensure compliance with applicable laws, the Corporation's Articles and By-laws, and governance best practice. Board Committee Terms of Reference must be approved annually by the Board.

Governance Review

3. The Board shall undertake a comprehensive review of its governance policies, practices, and structures every five years, or more frequently, if considered appropriate by the Board to ensure that they are contemporary and consistent with the needs of the Corporation.

Document Name:	Board Mentorship	
Document Number:	BOD.05.002.0.25	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Board Effectiveness	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The Board will provide governance development services for newly elected Board members through mentorship by existing Board members.

PROCEDURE:

1. A mentor for each new Board member will be named by the Governance Committee to become a resource for these new Board members for their first year, through peer-to-peer learning and to encourage the sharing of knowledge, experience, and productive involvement in Board matters.

2. Mentor assignments will be communicated to the new member at the time of their Committee assignments.

Role of the Mentor

3. A mentor is a trusted and experienced advisor who has direct interest in the development and education of a mentee. The mentor is guided by the following:
   - Meet face-to-face, or, virtually with your mentee within the first month of assignment
   - Discuss your goals and objectives as a mentor with your mentee within the first month of the relationship
   - Be accessible to your mentee (in person, phone and email)
   - Support and encourage the mentee's development
   - Acts as a role model, assisting in learning, accessing resources
   - Provides opportunities for discussion
   - Provides solid guidance and leadership to Director
   - Shares learning from own experiences with Director
   - Contact the Governance Committee Chair with any questions or concerns, or if you are unable to continue your commitment to your mentee for any reason
   - Plans the mentoring experience in conjunction with the Director based on their needs and goals
   - Maintains confidentiality
   - Communicates regularly with the Director regarding specific needs
   - Meets with the Director and the Board Chair when appropriate throughout the mentorship relationship

Role of the Mentee

4. A mentee is defined as someone who has a mentor, with the objective of developing their knowledge base to be an effective hospital board member. A mentee agrees to the following:
    - Meet face-to-face, or, virtually with your mentor within the first month of assignment
    - Define your mentorship goals. Share these with your mentor within the first month.
    - Be accessible to your mentor (in person, phone and email)
    - Be prepared for meetings with your mentor, to discuss questions that you may have
    - Remain open to advice
    - Owns the mentoring process and responsibility for its success
    - Contact the Governance Committee Chair with any questions or concerns, or if you are unable to continue your commitment to your mentor for any reason
    - Plans the mentoring experience in conjunction with the mentor based on their needs and goals
    - Maintains confidentiality
    - Communicates regularly with the mentor regarding specific needs
    - Meets with the mentor and the Board Chair when appropriate throughout the mentorship relationship

Selection of a Mentor

5. The following skills and experiences will be considered when selecting experienced board members to become mentors:
    - Minimum 1 year on the Board
    - Good knowledge of the strategic priorities of HGMH
    - Good knowledge and understanding of Governance
    - Experience in leadership role on the board or board committees
    - Ability to satisfy the necessary time commitment
    - Understanding the challenges faced by new Directors
    - Active participation in the Board activities
    - Effective communication skills
    - Critical thinking and problem solving skills
    - Willingness and ability to share knowledge and skills
    - Demonstrated commitment to the mission, vision and Values of HGMH

Document Name:	Conflict of Interest	
Document Number:	BOD.05.003.0.24	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Board Effectiveness	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

All directors have a duty to ensure that the integrity of the decision-making processes of the board of directors (the "**Board**") are maintained by ensuring that they and other directors are free from conflict or potential conflict in their decision making. It is inherent in a director's fiduciary duty that conflicts of interest be avoided. It is important that all directors and officers understand their obligations when a conflict of interest or potential conflict of interest arises.

This policy applies to all directors, including *ex-officio* directors, officers, and non-director Board committee members.

PROCEDURE:

Directors, officers, and non-director Board committee members shall avoid situations in which they may be in a position of a conflict of interest or perceived conflict of interest. In addition to the conflict of interest provisions in the Act and the by-laws, which must be strictly adhered to, the process set out in this policy shall be followed when a conflict or potential conflict arises.

Description of Conflict of Interest

A conflict of interest arises in any situation where a director's duty to act solely in the best interests of the Corporation and to adhere to their fiduciary duties is compromised or impeded by any other interest, relationship, or duty of the director. A conflict of interest also includes circumstances where the director's duties to the Corporation are in conflict with other duties owed by the director such that the director is not able to fully discharge the fiduciary duties owed to the Corporation.

The situations in which a potential conflict of interest may arise cannot be exhaustively set out. Conflicts generally arise in the following situations:

1. **Transacting with the Corporation**
   (a) When a director transacts with the Corporation directly or indirectly.
   (b) When a director has a material direct or indirect interest in a transaction or contract with the Corporation.

2. Interest of a Relative
When the Corporation conducts business with suppliers of goods or services or any other party of which a relative or member of the household of a director is a principal, officer, or representative.

3. Gifts
When a director or a member of the director's household or any other person or entity designated by the director, accepts gifts, payments, services, or anything else of more than a token or nominal value from a party with whom the Corporation may transact business (including a supplier of goods or services) for the purposes of (or that may be perceived to be for the purposes of) influencing an act or decision of the Board.

4. Acting for an Improper Purpose
When directors exercise their powers motivated by self-interest or other improper purposes. Directors must act solely in the best interest of the Corporation. Directors who are nominees of a particular group must act in the best interest of the Corporation even if this conflicts with the interests of the nominating party.

5. Appropriation of Corporate Opportunity
When a director diverts to their own use, an opportunity or advantage that belongs to the Corporation.

6. Duty to Disclose Information of Value to the Corporation
When directors fail to disclose information that is relevant to a vital aspect of the Corporation's affairs.

7. Serving on Other Corporations
A director may be in a position where there is a conflict of "duty and duty" This may arise where the director serves as a director of two corporations that are competing or transacting with one another. It may also arise where a director has an association or relationship with another entity. For example, if two corporations are both seeking to take advantage of the same opportunity, a director may be in possession of confidential information received in one boardroom or related to the matter that is of importance to a decision being made in the other boardroom. The director cannot discharge the duty to maintain such information in confidence while at the same time discharging the duty to make disclosure. The director cannot act to advance any interests other than those of the Corporation.

Process for Resolution of Conflicts and Addressing Breaches of Duty

8. Disclosure of Conflicts
A director or officer, who is in a position of conflict or potential conflict, shall immediately disclose such conflict to the Board by notification to the Board chair or

vice chair. Where the chair has a conflict, notice shall be given to the vice chair. A non-director Board committee member, who is in a position of conflict of potential conflict, shall immediately disclose such conflict to the Board by notification to the committee chair. The disclosure shall be sufficient to disclose the nature and extent of the interest. Disclosure shall be made at the earliest possible time and, where possible, prior to any discussion and vote on the matter.[1]

- In the case of a director, at a minimum the disclosure must be made:
  - at the meeting where a matter in which the director has a conflict is first considered;
  - if the director was not then interested in a matter, at the first meeting after the director becomes so interested;
  - if the director becomes interested after a matter has approved, at the first meeting after the director becomes so interested; or
  - if an individual who has a conflict in a matter later becomes a director, at the first meeting after the individual becomes a director.[2]
- In the case of an officer, at a minimum the disclosure must be made:
  - forthwith after the officer becomes aware that a matter in which the officer has a conflict is to be considered or has been considered by the Board;
  - if the officer becomes interested after a matter has been approved by the Board, forthwith after the officer becomes so interested; or
  - if an individual who has a conflict in a matter later becomes an officer, forthwith after the individual becomes an officer.[3]
- In the case of a non-director Board committee member, at a minimum the disclosure must be made:
  - at the committee meeting where a matter in which the Board committee member has a conflict is first considered; \
  - if the Board committee member was not then interested in a matter, at the first meeting after the Board committee member becomes so interested;
  - if the Board committee member becomes interested after a matter has been approved, at the first committee meeting after the Board committee member becomes so interested;
  - if an individual who has a conflict in a matter later becomes a Board committee member, at the first meeting after the individual becomes a Board committee member.[4]

[1] These disclosure obligations are more onerous than the obligations required by s. 41 of ONCA.

[2] ONCA, s. 41(2).

[3] ONCA, s. 41(3).

[4] ONCA, s. 41(2).

- If a director or officer has a conflict of interest in a matter that, in the ordinary course of the Corporation's business, would not require approval of the Board or members, the director or officer shall disclose the conflict of interest to the Board chair or vice chair, or request to have entered in the minutes of Board meetings, the nature and extent of their interest forthwith after the director or officer becomes aware of the matter.[5]

9. *Continuing Disclosure*

A director, officer, or non-director Board committee member may provide a general notice to the Board disclosing their relationships and interests in entities or persons that give rise to conflicts.[6]

10. *Leave the Meeting and Do Not Vote*

A director, officer, or non-director Board committee member who has declared a conflict shall not attend any part of a meeting during which the matter in which they have a conflict is discussed and shall not vote on any resolution to approve the matter.

Exceptions are made if the matter relates to a contract or transaction:

(a) primarily related to their remuneration as a director of the Corporation or an affiliate of the Corporation;[7]

(b) for indemnity or insurance under section 46 of the Act; or

(c) with an affiliate of the Corporation.[8]

If no quorum exists for the purposes of voting on a resolution to approve a matter only because one or more director(s) or Board committee member(s) are not permitted to be present at the meeting due to a conflict, the remaining directors or Board committee members(s) are deemed to constitute a quorum for the purpose of voting on the resolution.[9]

11. *Referral*

A director may be referred to the process outlined below where any director believes that they or another director:

(a) has breached their duties to the Corporation;

(b) is in a position where there is a potential breach of duty to the Corporation;

(c) is in a situation of actual or potential conflict of interest; or

[5] ONCA, s. 41(4).

[6] ONCA, s. 41(8).

[7] ONCA, s. 41(5).

[8] *Ibid.*

[9] ONCA, s. 41(6).

(d) has behaved or is likely to behave in a manner that is not consistent with the highest standards of trust and integrity and such behaviour may have an adverse impact on the Corporation.

12.*Process for Resolution*

(a) The matter shall be referred to the chair or where the issue may involve the chair, to the vice chair, with notice to the chief executive officer.

(b) The chair (or vice chair, as the case may be) may either:

(i) attempt to resolve the matter informally; or

(ii) (refer the matter to either the executive committee or to special committee of the Board established by the chair (or vice chair, as the case may be) which shall report to the Board.

(c) If the chair or vice chair elects to attempt to resolve the matter informally and the matter cannot be resolved to the satisfaction of the chair (or vice chair as the case may be), the director referring the matter, and the director involved, then the chair or vice chair shall refer the matter to the process in (a)(i) above.

(d) A decision of the Board by majority resolution shall be determinative of the matter.

It is recognized that if a conflict or other matter referred cannot be resolved to the satisfaction of the Board (by simple majority resolution) or if a breach of duty has occurred, a director may be asked to resign or may be subject to removal pursuant to the by-laws and the Act.

13.*Perceived Conflicts*

It is acknowledged that not all conflicts or potential conflicts may be satisfactorily resolved by strict compliance with the by-laws. There may be cases where the perception of a conflict of interest or breach of duty (even where no conflict exists, or breach has occurred) may be harmful to the Corporation notwithstanding that there has been compliance with the by-laws. In such circumstances, the process set out in this policy for addressing conflicts and breaches of duty shall be followed.

It is recognized that the perception of a conflict or breach of duty may be harmful to the Corporation even where no conflict exists, or breach has occurred and it may be in the best interests of the Corporation that the director be asked to resign.

***Note: This policy was reviewed by BLG in 2024 and meets all ONCA requirements.**

BOARD ATTENDANCE

Document Name:	Board Attendance	
Document Number:	BOD.05.004.0.24	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Board Effectiveness	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

Board members and committee members are expected to attend all Board meetings and all meetings of the committees to which they are assigned. It is recognized that directors may be unable to attend some meetings due to conflicts with other commitments or other unforeseen circumstances. An attendance rate of at least 75% is acceptable.

The Board of Directors and the Committees of the Board have been entrusted to direct and monitor hospital operations. Unreasonable Director absenteeism limits the full capability of the Board to fulfill its obligation to hospital stakeholders.

To ensure that board and committee members contribute their expertise and judgment to the business and affairs of the corporation by attending and participating in board and committee meetings. This policy applies to all Board members.

PROCEDURE:

The Governance and Nominating Committee shall review attendance twice a year and report to the Board of Directors.

Where a Director fails to attend 75% of the meetings of the Board or of a committee in a 12-month period, or is absent for three consecutive meetings, the Chair shall discuss the reasons for the absences with the member and may ask the individual to resign. Action leading to the termination of a Director will be in accordance with the Corporate By-laws.

A member's record of attendance shall be considered with respect to renewal of a Board term or future assignment to a committee.

The Chair shall, at the Chair's sole discretion, determine if a Director's absences are excusable and may grant a Board or Committee member a limited period of time to rearrange their schedule so that there are no conflicts with regularly scheduled Board or Committee meetings.

CONFIDENTIALITY FOR BOARD AND COMMITTEE MEMBERS

Document Name:	Confidentiality for Board and Committee Members	
Document Number:	BOD.05.005.0.24	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors		**Section:** Board Effectiveness
Owner: President & CEO		**Signing Authority:** Board of Directors

POLICY STATEMENT:

The directors owe to the hospital a duty of confidence not to disclose or discuss with another person or entity, or to use for their own purpose, confidential information concerning the business and affairs of the hospital received in their capacity as directors unless otherwise authorized by the board. Members will sign a Confidentiality Agreement.

Every director shall ensure that no statement not authorized by the board is made by him or her to the press or public.

This policy applies to all board and non-board committee members.

PROCEDURE:

Confidential Matters

1. All matters that are the subject of closed sessions of the board are confidential until disclosed in an open session of the board.

2. All matters that are before a committee or task force of the board are confidential unless they have been determined not to be confidential by the chair of the relevant committee or task force.

3. All matters that are the subject of open sessions of the board are not confidential.

4. Each member shall sign a Confidentiality Agreement (51-A-172-xx).

5. If an alleged breach occurs, the following steps will be taken:
   5.1 The breach will be investigated by the Governance Committee or an appointed representative to determine its nature, scope, and impact of the breach of confidentiality.
   5.2 If the allegation is founded, the Governance Committee will determine the appropriate course of disciplinary action up to and including the removal of the Director from the Board.

Procedure for Maintaining Minutes

1. Minutes of closed sessions of the board shall be recorded by the secretary or designate or if the secretary or designate is not present, by a director designated

by the chair of the board.

2. All minutes of closed sessions of the board shall be marked confidential and shall be handled in a secure manner.

3. All minutes of meetings of committees and task forces of the board shall be marked confidential and shall be handled in a secure manner.

4. Notwithstanding that information disclosed or matters dealt with in an open session are not confidential, no director shall make any statement to the press or the public in his capacity as a director unless such statement has been authorized by the board.

ASSOCIATED FORMS:

FORM NUMBER	FORM NAME
51-A-172-XX	Confidentiality Agreement

REFERENCES:

1. Guide for Good Governance, OHA

Document Name:	Nomination and Election	
Document Number:	BOD.05.006.1.25	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Board Effectiveness	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

Hôpital Glengarry Memorial Hospital is committed to a fair and equitable process for nominating and electing members to the Board of Directors such that the Board will continue to comprise members' representative of the diversity of the community we serve.

The purpose of this policy is to ensure that the Board is comprised of individuals who possess the skills, qualities, and experience to collectively contribute to effective Board governance and to assist the Board in identifying qualified individuals to become Board members.

PROCEDURE:

Composition of the Board

The composition of the Board will consist of 10 to 12 Directors, the Past Chair as an ex-officio voting Director and the following four *ex-officio* non-voting directors:
i) President and CEO,
ii) Chief of Staff,
iii) Chief Nursing Executive, and
iv) President of the Medical Staff (if one exists).

In alignment with the hospital's commitment to equity, diversity, and inclusion, the Board shall strive to reflect the diverse perspectives, backgrounds, and experiences of the community it serves. This includes, but is not limited to, consideration of gender, race, ethnicity, age, professional expertise, and lived experience. A broad range of viewpoints enhances decision-making, fosters innovation, and strengthens governance effectiveness.

Term of Office

An elected director is elected to the Board in accordance with the terms described in the HGMH Corporate By-Laws.

Ex-officio directors are members of the Board by virtue of their position within the organization and will serve on the Board according to the applicable terms of the particular office.

In order to adhere to the requirements of the *Public Hospitals Act*, in which four directors must retire (subject to re-election) each year, appointments to the Board will be staggered and any mid-term vacancy will be filled by the Board until the next annual general meeting.

Process for Nominations

a) Nominations Committee

The Board shall establish a Nominations Committee which shall be charged with the responsibility of identifying and recommending individuals to become Board members.

The size and composition of the Nominations Committee shall be determined by the Board from time to time and may include non-board members. The Board shall appoint the Chair of the Nominations Committee, who shall be a member of the Board.

The Nominations Committee will follow the Guidelines for Director Selection (see Appendix A).

b) Nomination Process

The *Public Hospitals Act* requires that four Board members retire each year. This means that four positions on the Board must be up for election or re-election each year. If a director has not yet completed his/her maximum number of terms, he or she may stand for re-election.

The Board shall identify qualified candidates through the following process:

- The number of vacancies will be determined each year and the necessary criteria to fill those vacancies will be identified by conducting a skill-set analysis. Directors will be evaluated based on their performance and renewal will not be automatic;
- A call for nominations will be made and interested parties will be encouraged to submit applications
- Vacancies will be advertised in the local newspapers, as well as on the hospital website;
- Applications will be submitted to the Chair of the Nominations Committee and reviewed by the Nominations Committee;
- A short-list of candidates will be developed by the Nominations Committee of those individuals who meet all of the criteria identified by the Board;
- Reference checks will be initiated before the annual general meeting at the call of the Chair of the Nominations Committee.

c) Election Process

The voting members of the corporation have the ultimate responsibility of approving the recommendation of the Nominations Committee; however only

nominees approved by the Nominations Committee through the nomination process set out in this policy shall be eligible for election.

Election of Board members is completed each year as part of the annual general meeting.

The Nominations Committee shall identify candidates to be brought forward to the voting membership for consideration.

Candidates recommended by the Nominations Committee will be presented to the voting members for election and approval.

The Nominations Committee may recommend more candidates than vacancies.

In the event that the number of candidates equals the number of vacancies, the voting members may be asked to vote for or against the slate and, if such a vote does not carry, the vote shall take place for or against each nominee individually.

In the event that one or more recommended candidates are not elected, the Board shall determine an appropriate process to bring new candidates forward for election.

In the event of a tie, the deciding vote will be cast by the Chair of the Board.

ASSOCIATED FORMS:

Form Number	Form Name
51-A-175-XX	Board Skills Matrix

REFERENCES:

1. Public Hospitals Act
2. Guide to Good Governance

Appendix A: Guidelines for Director Selection

Through the nomination and election process, the board selects directors according to their skills, experience, and personal qualities.

The board should seek a balance within the board concerning the skills and experience of directors, while considering any unique or special requirements of the corporation at the current time.

The board should ensure all directors possess the personal qualities necessary to perform their role as board members. The board should have the capacity to understand the diversity of the community served, including demographic, linguistic, cultural, economic, geographic, gender, ethnic and social characteristics of the communities served by the organization.

The skills, experience, knowledge, and personal qualities that the board will use to select potential directors are set out below.

Skills, Experience and Knowledge

The board is to reflect a complementary mixture of skills, experience and knowledge. The skills, experience and knowledge the board will consider in selecting members include the following:

- Accounting designation/financial expertise;
- Board and governance expertise;
- Business management;
- Clinical experience;
- Construction and project management;
- Education;
- Ethics;
- Government and government relations;
- Health care administration and policy and health system needs, issues and trends;
- Human resources management and labour relations;
- Information technology;
- Knowledge and experience in research;
- Legal expertise;
- Patient and health care advocacy;
- Performance management;
- Political acumen;
- Public affairs and communications;
- Quality and patient safety;
- Risk management;
- Diversity, Equity, & Inclusion
- Strategic planning; and
- Understanding of community/catchment area.

Personal Qualities

The board requires all of its board members to:

- Commit to adhere to the mission, vision and core values of the organization;
- Act with honesty and integrity;
- Understand a director's role and fiduciary duties, and the role of the board;
- Think strategically;
- Work as part of a team;
- Communicate effectively;
- Have, or commit to acquire, financial literacy appropriate for the organization's scope of activities;
- Be willing to devote the time and effort required to be an effective board member, including attendance at board orientation, board retreats, board meetings, committee meetings, and organization events;
- Be free of conflicts that would impede a director's ability to fulfill his or her fiduciary duties; and
- Demonstrate ability to recognize and manage specific conflicts of interest that arise from time to time.

Document Name:	Responsibilities as a Director and Code of Conduct	
Document Number:	BOD.05.007.1.25	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Board Effectiveness	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The hospital is committed to ensuring that it achieves standards of excellence in the quality of its governance and has adopted this policy describing the duties and expectations of directors.

A director who wishes to serve on the board must confirm in writing that they will abide by this policy by signing the Annual Declaration and Consent Form (51-A-215-XX) and must accept to have a criminal reference check.

This Code of Conduct applies to all directors, including *ex-officio* directors and non board members of board committees. Directors are also required to comply with the hospital's policy on Ethics and Standards of Business Conduct, which applies to employees and professional staff.

PROCEDURE:

The Hospital is committed to ensuring that, in all aspects of its affairs, it maintains the highest standards of public trust and integrity.

Directors' Duties

All directors of the hospital stand in a fiduciary relationship to the hospital corporation. As fiduciaries, directors must act honestly, in good faith, and in the best interests of the hospital corporation.

Directors will be held to strict standards of honesty, integrity, and loyalty. A director shall not put personal interests ahead of the best interests of the corporation.

Directors must avoid situations where their personal interests will conflict with their duties to the corporation. Directors must also avoid situations where their duties to the corporation may conflict with duties owed elsewhere as per the Conflict of Interest Policy (BOD.05.003.X.XX).

In addition, all directors must respect the confidentiality of information about the corporation.

Exercise of Authority
A Director carries out the powers of office only when acting as a member during a duty constituted meeting of the Board or one of its committees. A director respects the responsibilities delegated by the Board to the Chief Executive Officer (CEO) and Chief of Staff (COS), avoiding interference with their duties but insisting upon accountability to the Board and reporting mechanisms for assessing organizational performance.

Time and Commitment
A director is expected to commit the time required to perform board and committee duties including preparation for an attendance at Board meetings, assigned committee meetings and events.

The board meets approximately nine times a year and a director is expected to adhere to the Board's Attendance policy (BOD.05.004.X.XX) that requires attending at least 75 percent of board meetings.

A director is expected to serve on at least one standing committee.

Participation
A Director expects to receive relevant information in advance of the meetings and reviews pre-circulated material and comes prepared to Board and committee meetings and educational events, asks informed questions, and makes constructive contribution to discussions.

Education
A director shall be knowledgeable about:

- The operations of the hospital;
- The health care needs of the community served;
- The health care environment generally;
- The duties and expectations of a director;
- The board's governance role;
- Board's governance structure and processes;
- Board adopted governance policies; and,
- Hospital policies applicable to board members.

A director will participate in a board orientation session, orientation to committees, board retreats and board education sessions. A director should attend additional appropriate educational conferences in accordance with board approved policies.

Best Interests of the Corporation
Directors must act solely in the best interests of the corporation. All directors, including *ex-officio* directors, are held to the same duties and standard of care. Directors who are

appointed by a particular group must act in the best interests of the corporation, even if this conflicts with the interests of the nominating party.

Teamwork

A Director maintains effective relationships with Directors, management, and stakeholders by working positively, cooperatively, and respectfully with others in the performance of their duties while exercising independence in decision making.

Confidentiality

Directors and committee members owe a duty to the corporation to respect the confidentiality of information about the corporation whether that information is received in a meeting of the Board or of a committee or is otherwise provided to or obtained by the director or committee member as per the Confidentiality for Board and Committee Members Policy (BOD.03.001.X.XX). Directors and committee members shall not disclose or use for their own purpose confidential information concerning the business and affairs of the corporation unless otherwise authorized by the Board.

It is recognized that the role of director may include representing the hospital in the community. However, such representations must be respectful of and consistent with the director's duty of confidentiality. In addition, the chair is the only official spokesperson for the board. Every director, officer and employee of the corporation shall respect the confidentiality of information about the hospital whether that information is received in a meeting of the board or of a committee or is otherwise provided to or obtained by the director.

A director is in breach of his or her duties with respect to confidentiality when information is used or disclosed for other than the purposes of the hospital corporation.

Board Spokesperson

The board has adopted a policy with respect to designating a spokesperson on behalf of the board. Only the chair or designate may speak on behalf of the board. The CEO, or the Chief of Staff or their designates may speak on behalf of the organization as per the Communications and Hospital Spokesperson Policy (BOD.05.018.X.XX).

No director shall speak or make representations on behalf of the board unless authorized by the chair or the board. When so authorized, the board member's representations must be consistent with accepted positions and policies of the board.

Media Contact and Public Discussion

News media contact and responses and public discussion of the hospital corporation's affairs should only be made through the board's authorized spokespersons. Any director who is questioned by news reporters or other media representatives should refer such individuals to the appropriate representatives of the corporation.

Respectful Conduct
It is recognized that directors bring to the board diverse background, skills and experience. Directors will not always agree with one another on all issues. All debates shall take place in an atmosphere of mutual respect and courtesy.

The authority of the chair must be respected by all directors.

Community Representation and Support
A director shall represent the board and the hospital in the community when asked to do so by the board chair.

Board members shall support the hospital and the foundation through attendance at hospital and foundation sponsored events.

Corporate Obedience – Board Solidarity
Directors acknowledge that properly authorized board actions must be supported by all directors. The board speaks with one voice. Those directors who have abstained or voted against a motion must adhere to and support the decision of a majority of the directors.

Obtaining Advice of Counsel
Request to obtain outside opinions or advice regarding matters before the board may be made through the chair.

Evaluation and Continuous Improvement
A Director is committed to a process of continuous self-improvement as a Director. All Directors participate in the evaluation of the Board, and elected Directors participate in individual Director peer assessment and act upon results in a positive and constructive manner.

CROSS-REFERENCED POLICIES:

Policy Number	Policy Name
BOD.05.003.X.XX	Conflict of Interest
BOD.05.004.X.XX	Board Attendance
BOD.03.001.X.XX	Confidentiality for Board and Committee Members
BOD.05.018.X.XX	Communications & Hospital Spokesperson

ASSOCIATED FORMS:

Form Number	Form Name
51-A-172-24	Board Member Pledge of Confidentiality
51-A-215-XX	Annual Declaration and Consent Form

REFERENCES:

1. Guide to Good Governance
2. Trillium Health Partners – Board Effectiveness Governance Policy Framework, Responsibilities as an Elected and Ex-Officio Director Policy.

Document Name:	Roles and Responsibilities of the Board Chair, Vice Chair and Treasurer	
Document Number:	BOD.05.008.0.25	
Review Period:	☒3 years ☐1 year	**Manual:** Governance policy Manual
Classification: Board of Directors	**Section:** Board Effectiveness	
Owner: Chief Executive Officer	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

This policy defines the roles and responsibilities of the Board Chair, Vice Chair, and Treasurer to ensure effective governance and leadership of the hospital's Board of Directors.

The Board of Directors is responsible for the strategic oversight and governance of the hospital. The Board Chair, Vice Chair, and Treasurer play key leadership roles in fulfilling the Board's mandate.

PROCEDURE:

1. Role and Responsibilities of the Chair

The Board Chair is the leader of the board and is responsible for:

- Ensuring the integrity and effectiveness of the board's governance role and processes;
- Presiding at meetings of the board and members;
- Representing the board within the organization and the organization to its stakeholders; and
- Maintaining effective relationships with board members, management and stakeholders.

The responsibilities of the Board Chair include:

a) Board Governance

The Board Chair ensures the Board meets its obligations and fulfills its governance responsibilities. The Board Chair oversees the quality of the Board's governance processes including:

- Ensuring that the board performs a governance role that respects and understands the role of management;
- Ensuring that the board adopts an annual work plan that is consistent with the organization's strategic directions, mission and vision;
- Ensuring that the work of the board committees is aligned with the board's role and annual work plan and that the board respects and understands the role of board committees and does not redo committee work at the board level;
- Ensuring board succession by ensuring that there are processes in place to recruit, select and train directors with the skills, experience, background and personal qualities required for effective board governance;

- Ensuring that the board and individual directors have access to appropriate education;
- Overseeing the board's evaluation processes and providing constructive feedback to individual committee chairs and board members as required; and
- Ensuring that the board's governance structures and processes are reviewed, evaluated, and revised from time to time.

b) Presiding Officer

The Chair is the presiding officer at board and members' meetings. As the presiding officer at board and members' meetings, the Chair is responsible for:

- Setting agendas for board meetings and ensuring matters dealt with at board meetings appropriately reflect the board's role and annual work plan;
- Ensuring that meetings are conducted according to applicable legislation, by-laws and the board's governance policies and rules of order;
- Facilitating and forwarding the business of the board, including preserving order at board meetings;
- Encouraging input and ensuring that the board hears all sides of a debate or discussion;
- Encouraging all directors to participate and controlling dominant members;
- Facilitating the board in reaching consensus;
- Ensuring relevant information is made available to the board in a timely manner and that external advisors are available to assist the board as required; and
- Ruling on procedural matters during meetings.

c) Representation

- The Chair is the official spokesperson for the board;
- The Chair represents the organization in the community and to its various stakeholders;
- The Chair reports on behalf of the board to members at each annual meeting of members;
- The Chair represents the board within the organization, attending and participating in events as required; and
- The Chair represents the board in dealings with key stakeholders, as required.

d) Relationships

- The Board Chair facilitates relationships with, and communication among board members and between board members and senior management;
- The Chair establishes a relationship with individual directors, meeting with each director at least once a year to ensure that each director contributes his/her special skills and expertise effectively;
- The Chair provides assistance and advice to committee chairs to ensure that they understand board expectations and have the resources that are required for performance of their terms of reference; and

- The Chair maintains a constructive working relationship with the chief executive officer and chief of staff providing advice and counsel as required. In particular:
  - The Chair works with the Chief Executive Officer and Chief of Staff to ensure he or she understands board expectations; and
  - The Chair ensures that Chief Executive Officer and Chief of Staff annual performance objectives are established, and that an annual evaluation of the Chief Executive Officer and Chief of Staff is performed.

e) Other Duties

The Chair performs such other duties as the board determines from time to time.

Skills and Qualifications

The Board Chair will possess the following qualities, skills, and experience:

- Proven leadership skills;
- Good strategic and facilitation skills, ability to influence and achieve consensus;
- Ability to act impartially and without bias and display tact and diplomacy;
- Effective communicator;
- Political acuity;
- Must have the time to continue the legacy of building strong relationships between the organization and stakeholders;
- Ability to establish trusted advisor relationships with chief executive officer and chief of staff and other board members;
- Governance and board-level experience in the health sector;
- Understanding and appreciation of quality improvement and patient safety; and
- Outstanding record of achievement in one or several areas of skills and experience used to select board members.

Term

The Board Chair will serve an initial term of two years, renewable for an additional term of one year at the discretion of the board.

2. Roles and Responsibilities of the Vice-Chair

The responsibilities of the Vice Chair include:

- Assisting the Chair in executing their duties as required
- Assuming the role of Board Chair in their absence or incapacity
- Serving on the Executive Committee of the Board
- Supporting governance and strategic planning initiatives
- Participating in Board member development and succession planning

3. Roles and Responsibilities of the Treasurer

The responsibilities of the Treasurer include:

- The Treasurer provides oversight of the hospital's financial matters and ensures financial accountability with Executive Support
- Chairing the Finance, HR and Audit Committee

- Providing summary reports on financial matters to the Board of Directors
- Overseeing the annual audit of the hospital ensuring compliance with accepted accounting principles
- Presenting annual budget to the Board for approval
- Serving on the Executive Committee of the Board
- Overseeing matters related to Human Resources and labour relations of the hospital

REFERENCES:

1. Guide to good Governance

ROLES AND RESPONSIBILITIES OF THE BOARD

Document Name:	Roles and Responsibilities of the Board	
Document Number:	BOD.05.009.0.25	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Board Effectiveness	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

To ensure that the board has a shared understanding of its governance role, the board has adopted this Statement of the Roles and Responsibilities of the Board.

The board is responsible for the overall governance of the affairs of the hospital.

Each director is responsible to act honestly, in good faith and in the best interests of the hospital and in so doing, to support the hospital in fulfilling its mission and discharging its accountabilities. (Responsibilities as a Director and Code of Conduct BOD.05.007.X.XX)

PROCEDURE

1. Strategic Planning and Mission, Vision and Values

a) The board participates in the formulation and adoption of the hospital's mission, vision and values.
b) The board ensures that the hospital develops and adopts a strategic plan that is consistent with the hospital's mission and values, which will enable the hospital to realize its vision. The board participates in the development of and ultimately approves the strategic plan.
c) The board oversees hospital operations for consistency with the strategic plan and strategic directions.
d) The board receives regular briefings or progress reports on implementation of strategic directions and initiatives.
e) The board ensures that its decisions are consistent with the strategic plan and the hospital's mission, vision and values unless there is a sound rationale to do otherwise.
f) The board annually conducts a review of the strategic plan as part of a regular annual planning cycle.

2. Quality and Performance Measurement and Monitoring

a) The board is responsible for establishing a process and a schedule for monitoring and assessing performance in areas of board responsibility including:
   - Fulfillment of the strategic directions in a manner consistent with the mission, vision and values
   - Oversight of management performance

- Quality of patient care and hospital services
- Financial conditions and risks
- Stakeholder relations
- Board's own effectiveness

b) The board ensures that management has identified appropriate measures of performance.
c) The board is responsible for establishing policies and plans related to the quality improvement plan.
d) The board ensures that policies and improvement plans are in place related to quality of care, patient safety, consumer experience, and access.
e) The board monitors quality performance against the board-approved quality improvement plan, performance standards, and indicators.
f) The board ensures that management has plans in place to address variances from performance standards indicators, and the board oversees implementation of remediation plans.

3. Financial and Resources Oversight

a) The board acts in the best interest of the hospital and its stakeholders.
b) The board is responsible for stewardship of financial resources including ensuring availability of, and overseeing allocation of, financial resources.
c) The board approves policies for financial planning and approves the annual operating and capital budget.
d) The board monitors financial performance against budget.
e) The board approves investment policies and monitors compliance.
f) The board ensures the accuracy of financial information through oversight of management and approval of annual audited financial statements.
g) The board ensures management has put measures in place to ensure the integrity of internal controls.
h) The board oversees asset management.

4. Oversight of Management Including Selection, Supervision and Succession Planning for the CEO and Chief of Staff

(CEO and COS Succession Planning BOD.02.001.X.XX)

a) The board recruits and supervises the CEO and COS by:
   - Developing and approving the CEO and COS job descriptions
   - Undertaking a recruitment and selection process for the CEO and COS
   - Reviewing and approving the CEO and COS annual performance goals
   - Reviewing the performance of the CEO and COS and determining compensation

b) The board ensures succession planning is in place for the CEO and COS.
c) The board exercises oversight of the CEO's supervision of senior management as part of the CEO's annual review.
d) The board develops, implements and maintains a process for the selection of department chiefs and other medical leadership positions as required under the

hospital's by-laws or the *Public Hospitals Act*.

5. Enterprise Risk Management Oversight

a) The board is responsible to be knowledgeable about risks inherent in hospital operations and ensure that appropriate risk analysis is performed as part of board decision-making.
b) The board oversees management's risk management program including an assessment of risks relative to their probability and potential impact.
c) The board ensures that appropriate programs and processes are in place to protect against risk.
d) The board is responsible for identifying unusual risks to the organization for ensuring that there are plans in place to prevent and manage such risks.

6. Stakeholder Communication and Accountability

a) The board identifies hospital stakeholders and understands stakeholder accountability.
b) The board ensures the organization appropriately communicates with stakeholders in a manner consistent with accountability to stakeholders and to promote engagement.
c) The board contributes to the maintenance of strong stakeholder relationships.
d) The board performs advocacy on behalf of the hospital with stakeholders where required in support of the mission, vision and values and strategic directions of the hospital.

7. Governance

a) The board is responsible for the quality of its own governance.
b) The board establishes governance structures to facilitate the performance of the board's role and enhance individual director performance.
c) The board is responsible for the recruitment of a skilled, experienced and qualified board.
d) The board ensures ongoing board training and education.
e) The board assesses and reviews its governance by periodically evaluating board structures including board recruitment processes and board composition and size, number of committees and their Terms of Reference, processes for appointment of committee chairs, processes for appointment of board officers and other governance processes and structures. (Nomination and Election Policy BOD.05.006.X.XX)

8. Legal Compliance

a) The board ensures that appropriate processes are in place to ensure compliance with legal requirements.

9. Amendment

a) This statement may be amended by the board.

DEFINITIONS:

Hospital stakeholder: individuals or groups who are greatly influenced by the hospital and have a vested interest in its success. Examples of hospital stakeholders are patients, physicians, employees, the broader community, and legislative and regulatory bodies.

CROSS-REFERENCED POLICIES:

Policy Number	Policy Name
BOD.05.007.X.XX	Responsibilities as a Director and Code of Conduct
BOD.02.001.X.XX	CEO and COS Succession Planning
BOD.05.006.X.XX	Nomination and Election

ASSOCIATED FORMS:

Form Number	Form Name
51-A-215-XX	Annual Declaration and Consent Form

BOARD MEMBERSHIP APPLICATION PROCESS

Document Name:	Board Membership Application Process	
Document Number:	BOD.05.010.0.25	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Board Effectiveness	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The Board is a skills/knowledge-based Board with a passion to serve. Directors are chosen for their skill, competency, knowledge and experience, which will support the mission of HGMH. While in keeping with the objective of maintaining a skills/knowledge-based Board, Board membership should reflect the diversity of the Corporation's catchment area.

This policy outlines the application process members of the community use to apply to become a member of the Board of Directors.

PROCEDURE:

1. To apply for membership on the HGMH Board of Directors, the applicant must secure an application package from the HGMH website www.hgmh.on.ca or through administration which contains/requires the following:
    i) Covering letter
    ii) Conflict of interest disclosure
    iii) Skill matrix form
    iv) Vulnerable Sector check
    v) Updated resume
    vi) Interview (with panel to include CEO or delegate as non-voting member)

    Applications that are completed via an electronic submission process. Applicants that do not have access to electronic devises may submit hardcopy through the Board Liaison.

2. The application form will also include:
    a) Eligibility Criteria and Conditions of Appointment
    b) Duties and Expectations of a Director

3. If selected by the nominating committee, the applicant will be notified to be present at the Annual Meeting when/if voting is to take place. The applicant will also be notified if not selected, and applications will remain on file for one year at the candidate's request.

4. The Board of Directors continually strives to represent the diversity of voices and experiences in our community and strongly encourages Indigenous peoples, members of visible minorities, persons with disabilities, and people who identify as 2SLGBTQ+, to apply.

HOSPITAL EMAIL USAGE FOR BOARD DIRECTORS

Document Name:	Hospital Email Usage for Board Directors	
Document Number:	BOD.05.011.0.23	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Board Effectiveness	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

This policy outlines the requirement for all Board members of Hôpital Glengarry Memorial Hospital to use their official hospital-provided email address for communication related to hospital business. This policy is implemented to enhance security, confidentiality, and consistency in the exchange of sensitive and confidential information.

PROCEDURE:

Purpose of Hospital-Provided Email Addresses

Board members are required to use their designated hospital email addresses for official communications and activities related to the hospital. The purpose of these email addresses is to ensure the secure exchange of confidential information, promote consistency in communication, and support efficient collaboration among Board members.

Official Hospital Email Accounts

Board members will be provided with official hospital email accounts, which will be hosted by the hospital's secure email system.

Use of Hospital Email Addresses

Board members are expected to use their hospital-provided email addresses for all hospital-related communications. This includes, but is not limited to, correspondence with hospital Board Liaison, hospital Executives, and any other members of hospital committee or workgroup.

Confidential Information

Communications via hospital email addresses may contain confidential information. Board members are reminded to exercise the utmost discretion and adhere to hospital policies and legal requirements related to the handling and protection of sensitive data. The hospital's email system is equipped with encryption mechanisms to protect sensitive data during transmission.

Password Security

Board members are responsible for maintaining the security of their hospital email accounts. They should regularly update their passwords and follow hospital guidelines for password complexity. Sharing password is strictly prohibited.

DELEGATIONS OF AUTHORITY OF THE PRESIDENT AND CEO

Document Name:	Delegations of Authority of the President and CEO	
Document Number:	BOD.05.012.0.23	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Board Effectiveness	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The President and Chief Executive Officer (CEO) is accountable to the Board. The Board's sole official connection to the operations of the organization will be through the CEO.

The Board provides direction to the CEO in accordance with policies established by the Board. The Board hereby delegates to the CEO authority to:

- Manage and direct the business and affairs of the Corporation, except such matters and duties as must be transacted or performed by the Board by law or by the provisions of the Corporation's by-laws; and
- Employ and discharge agents and employees of Hôpital Glengarry Memorial Hospital as the CEO may from time to time decide is necessary.

PURPOSE:

In order to discharge its responsibility to provide for excellent management, the Board of Hôpital Glengarry Memorial Hospital selects and appoints the CEO and delegates responsibility and authority to the CEO for the management and operation of the Corporation. This policy sets out key parameters of that authority.

PROCEDURE:

The CEO shall:

- Ensure that the corporation's operations are conducted and that care to patients is provided in the Corporation in accordance with the organization's by-laws, policies established by the Board, and applicable legislation, including the *Public Hospitals Act*
- Ensure that the Corporation's practices, activities, and decisions are undertaken prudently, lawfully, and in an equitable and reasonable manner congruent with commonly accepted business practices and professional ethics
- Ensure that the Corporation's assets are protected, adequately maintained and not unnecessarily placed at risk
- Ensure that the Board-approved priorities are reflected in the allocation of resources
- Ensure that budgeting is based on generally accepted financial planning practices that balance expenditures in any fiscal year against expected revenues

- Promote a healthy work environment for staff and volunteers that is consistent with the Corporation's values
- Represent the Corporation externally to the community, government and media, and other organizations and agencies in ways that enhance the public image and credibility of the Corporation

The CEO shall provide leadership support to the Board in the discharge of its responsibilities and ensure that the Board is informed and supported in its work.

Document Name:	Regular Meetings of the Board and Notice	
Document Number:	BOD.05.013.0.23	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Board Effectiveness	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

Regular Board meetings will be held in accordance with corporate by-law 5.2 Regular Meetings. To ensure effective Board Meetings the following procedure will apply.

SCOPE:

The policy pertains to Hôpital Glengarry Memorial Hospital (HGMH) Board of Directors and any attendees at Board of Director meetings

PROCEDURE:

Notice of Meeting

A schedule of the date, location and time of the board's regular meetings will be available from the board liaison and will be posted on the hospital's website. Changes in the schedule will be posted on the website.

Conduct During the Meeting

- Members of the public will be asked to identify themselves
- Meetings may be recorded by the Corporation or the media for broadcast on radio, television, or the internet. Private photographs or recordings of proceedings are prohibited.
- The chair may require anyone who displays disruptive conduct to leave.

Agendas and Board Materials

The Chair, in consultation with the President & Chief Executive Officer, is responsible for developing and approving an agenda for each Board meeting that is aligned with the Board's roles and responsibilities, the Board's work plan, and the annual goals and objectives.

Agendas shall be divided into two sections: the main Agenda and the Consent Agenda. The Board shall use the consent agenda for the passage of non-controversial and/or routine matters. Consent agenda items may include, without limitations:

- approval of previous minutes
- routine Committee and/or other informational reports
- correspondence requiring no action; and
- actions that do not require a Director to disclose a potential conflict or otherwise abstain from voting

The Board meeting package will normally be sent to Directors five business days in advance of the meeting to allow for review and preparation, unless extenuating circumstances arise.

Open Board Meetings

The public and staff are welcome to attend the open portion of Board meetings in order to:

- facilitate the conduct of the Board's business in an open and transparent manner;
- ensure that the Corporation maintains a close relationship with the public, media, and stakeholder groups; and
- generate trust, openness, and accountability

To ensure adequate space is available, members of the public and media wishing to attend must give at least 24 hours' notice of their intent to attend a regular meeting of The Board. Attendees shall have observer status and may not provide comments or ask questions during the meeting. In the event the attending public or media have questions arising from a Board meeting, the Chair and/or President and Chief Executive Officer shall be available upon adjournment to address queries.

Attendees may be asked to leave at the discretion of the Chair.

Delegations and Presentations

Members of the public may not address the Board or ask questions of the Board without the permission of the Chair. Individuals who wish to address or raise questions with the Board must submit a Delegation Application to the office of the Secretary at least 15 business days in advance of the Board meeting.

The Chair and President & Chief Executive Officer will assess and prioritize the requests. Written confirmation of attendance, if approved, will be provided to the individual or group making the request. The Chair has the right to determine the appropriateness of any presentation. Any one delegation or presentation will be limited to a maximum of fifteen minutes unless otherwise agreed by the Chair and the President & Chief Executive Officer.

In-Camera Session

1. The board may move in-camera or hold special meetings that are not open to the public where it determines it is in the best interest of the corporation to do so. The chair may order that the meeting move in-camera or any director may request a matter be dealt with in-camera in which case a vote will be taken and if a majority of the board decides the matter shall be dealt with in-camera.

2. The following matters will be dealt with in-camera:
   a. matters relating to a Director or a prospective Director;
   b. matters involving property;
   c. patient issues;

d. Credentialed staff appointments, re-appointments, and credentialing issues
e. Items which are subject to solicitor/client privilege;
f. Items involving litigation affecting the Hôpital Glengarry Memorial Hospital;
g. Items where disclosure could prejudice an individual involved in a civil or criminal proceeding;
h. Items concerning negotiations or anticipated negotiations between the Hôpital Glengarry Memorial Hospital and any individual, corporation, or organization;
i. Matters involving material contracts;
j. Items concerning human resource or labour relations matters.

Document Name:	Minutes of Regular Meetings and In-Camera Meetings	
Document Number:	BOD.05.014.0.23	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Board Effectiveness	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The Board of Directors of the Hôpital Glengarry Memorial Hospital ("Board") shall keep minutes of its meetings as per Bylaw 10.5. Minutes need to be clear but brief, accurate, and objective. Minutes are no place for the expression of personal opinions, interpretations, or commentaries on the debates.

PROCEDURE:

Regular Meetings

1. The minutes of meetings shall, except in the case of *in camera* meetings:

    a) Be clear and neutral; and
    b) Contain sufficient detail to adequately inform the public of the main subject matters considered, any deliberations engaged in, and any decisions made.

2. The minutes of meetings shall not contain the names of any Board members or any other individuals, companies, or organizations, except in the following circumstances:

    a) The names of Board members shall be listed for attendance;
    b) The names of Board members whose comments are recorded in the minutes shall be listed where requested by one or more Board members;
    c) The names of Board members shall be recorded when a request to record the votes in favor and against the passing of motions is made;
    d) The names of individuals, companies, or organizations may be included where their inclusion is necessary to ensure that the minutes comply with the requirements in item 1 above.

3. Meeting minutes of the Regular Meeting of the Board of Directors shall be approved at the next Regular Meeting.

4. The Board of Directors shall make the minutes of its meetings available to the public upon request.

In Camera Meetings

1. Materials for distribution to the Board for *in camera* meetings are privileged and confidential and *in camera* discussions of the Board are confidential unless the

Board formally decides otherwise. Meeting minutes will follow the same standards as paragraph one (1), two (2) above.

2. Minutes of the *in-camera* meeting shall be approved at the next *in camera* meeting.

BOARD OF DIRECTORS ORIENTATION PROGRAM

Document Name:	Board of Directors Orientation Program	
Document Number:	BOD.05.015.0.23	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Board Effectiveness	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

Prior to the commencement of their first term, or as soon as is possible afterwards, each new Director is to be provided orientation by the Chief Executive Officer to their role as a member of the Board of Directors of Hôpital Glengarry Memorial Hospital.

PROCEDURE:

1. Each new Board will be provided electronic access to a shared drive with documentation that details of the Board Quality Program, Board Role, Board Structure and Process, The Hospital, and Hospital Partners and the Healthcare Environment. Should the Director require a device to access the material, a tablet will be loaned to the Director by the hospital.

2. Each new Board member shall attend a Board Orientation Session which includes a tour of the hospital and an overview of the purpose and functions of the Board, information about the hospital and our healthcare environment. During this session opportunities to ask questions pertaining to the hospital.

3. All Board members may attend educational seminars and hospital conventions as authorized by the Board.

4. All new Board members, during the orientation, are expected to sign a Board Member Pledge of Confidentiality (51-A-172-xx) and the Board Member Accountability Statement (51-A-174-xx).

5. Evaluation forms for the Orientation Program are to be completed by each new Trustee.

6. The Board may change the orientation Program for new Board members as required.

ASSOCIATED FORMS:

Form Number	Form Name
51-A-172-XX	Board Member Pledge of Confidentiality
51-A-175-XX	Board Member Accountability Statement

HÔPITAL Glengarry Memorial HOSPITAL

HONORARY MEMBERSHIP TO THE CORPORATION

Document Name:	Honorary Membership to the Corporation	
Document Number:	BOD.05.016.0.24	
Review Period:	☒3 years ☐1 year	**Manual:** N/A
Classification: Board of Directors	**Section:** Governance	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The Board will consider candidates for Honourary Membership to the Corporation as recommended by the Governance and Nominating Committee. Honorary membership is a symbolic recognition and does not confer any special privileges or rights within the corporation.

PROCEDURE:

Criteria for Honorary Membership

1. Individuals may be considered for honorary membership based on the following criteria:
   a) The nominee must have demonstrated exemplary contributions to the Board throughout their tenure.
   b) The nominee must have served a minimum of six (6) years on the Board of Directors, but the Board may suspend this requirement where circumstances warrant.
   c) The nominee cannot be a current Board member.

Nomination Process

2. Nominations for honorary membership may be submitted by any member of the Board of Directors to the Governance and Nominating Committee.

3. Nominations must be accompanied by a detailed justification outlining the nominee's exemplary contributions.

4. The Governance and Nominating Committee will review nominations during scheduled meetings and make recommendation to the Board of Directors should the majority vote in favor.

Recognition Process

5. Individuals granted honorary membership will be formally recognized at the Annual General Meeting where they receive a plaque and written acknowledgment.

Duration of Honorary Membership

6. Honorary membership is typically a lifetime recognition, however, the Board reserves the right to review and reassess honorary membership status if circumstances warrant.

Limitation on Privileges

7. Honorary members do not receive any special privileges, voting rights, or decision-making authority within the corporation. The honorary membership is a symbolic gesture of appreciation for their contributions.

ONGOING EDUCATION, CONFERENCES AND CONVENTIONS

Document Name:	Ongoing Education, Conferences and Conventions	
Document Number:	BOD.05.017.0.24	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Board Effectiveness	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

Board members are encouraged to attend educational conferences and conventions to enhance Board Governance. The Board recognizes that the continuing education of the Directors is an important requirement of effective governance and that it is essential that Directors be fully informed on the background and context of the issues they are called upon to address. A firm commitment to continuing education is the responsibility of each Director and a factor to be considered in the election or re-election of a Director.

PROCEDURE:

1. New Directors shall receive a complete orientation to ensure familiarity with the Corporation's issues and structure, the Board's process of governance, and the Board's policies; and Directors shall have ongoing opportunity for training and education to enhance their governance capabilities.

2. Directors who attend conferences or educational events will make available the materials and knowledge to the Board.

3. The Board will establish and be accountable for an annual budget for its own governance functions, which shall include, in addition to the costs of Board and Board Committee meetings, funds for:

   (i) director attendance at conferences and conventions;

   (ii) resources / expertise to assist in governance improvement;

   (iii) annual Board retreat and supporting costs; and

   (iv) self evaluation surveys.

4. Reasonable expenses of attending and/or participating in such events will be reimbursed according to established policy and with prior approval of the Chair.

5. All requests for education/conventions will be forwarded to the Board Chair and CEO for consideration.

Document Name:	Communications & Hospital Spokesperson	
Document Number:	BOD.05.018.0.23	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Board Effectiveness	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The Corporation will respond in a timely manner to media requests, complaints and concerns on the activities and operations of the Corporation.

PROCEDURE:

Spokesperson

1.1 **Board Communications:** The Board Chair is the spokesperson for Board communications and may delegate authority to one or more Directors, or Chief Executive Officer to make statements to the news media or public about matters that the Chair determines appropriate for disclosure. No Director will be a spokesperson for the Board unless specifically delegated by the Chair.

1.2 **Operational Communications:** The Chief Executive Officer is the spokesperson for the Corporation for all operational matters. From time to time, the Chief of Staff may be expected to speak on clinical and patient care issues.

Media Requests

2.1 Media queries regarding hospital matters should be referred to the Executive Assistant to the President & CEO, who will then report to the President & CEO. The President and CEO may exercise judgment in referring media inquiries to the Board Chair or designate and/or proper officers of the medical staff.

2.2 All official Board position statements must have approval of the Chair of the Board, or Executive Committee.

Patient Information/Confidentiality

3.1 The presence of the patient in the hospital is not confidential personal information under the Personal Health Information Protection Act (PHIPA), provided the patient or substitute decision maker has not requested that the patient's presence in hospital be confidential. The information provided in this matter should be confined to the response to the question "Is the patient in the hospital?". Confirmation of a YES or NO can be provided, as well as the general condition of the patient, i.e.: GOOD, STABLE, LIFE THREATENING upon determination by the most responsible provider. No other information regarding the patientmay be provided to the requester. This information shall only be provided by the official spokesperson.

3.2 **Exception**: The patient has indicated his/her refusal to permit this information from being released.

Communications Plan

3.1 Through the Chief Executive Officer, the Board will ensure that the Corporation establishes, maintains and supports a communications plan and related tactics to support effective and meaningful engagement and information sharing with the Corporation's stakeholder. The Hospital's Communications Plan will be reviewed and approved by Board on a regular basis.

3.2 Recognizing the breadth of the stakeholders, the Chief Executive Officer will ensure that information respecting the Corporation's activities is widely communicated to the public through the media throughout the catchment area. Mechanisms for broader ongoing communication to the public and key stakeholders may include:

- regular Board updates;
- an annual report to the stakeholders on the activities of the Corporation;
- periodic media briefings on the activities of the Corporation;
- periodic articles in the local media on matters of interest to the stakeholders served by the Corporation; and
- open opportunities for the purposes of consultation and engagement relating to key strategic priorities of the Corporation.

French/English Language Communications

4.1 All correspondence received in either official language will be answered to in the language of origin.

Document Name:	Meetings of Directors Without Management	
Document Number:	BOD.05.019.0.25	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Board Effectiveness	
Owner: Board Chair	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The purpose of this policy is to outline the procedure for meetings of the Board of Directors to be held without the presence of senior management. These in-camera sessions provide an opportunity for directors to engage in open and candid discussion on matters that may be sensitive or require confidentiality.

The Board of Directors recognizes the importance of holding regular meetings without directors to enhance governance effectiveness, promote accountability, and ensure an environment of trust among directors. These meetings are intended to:

- Ensure the Board exercises independent oversight of management;
- Discuss issues or concerns related to the hospital and/or the management thereof;
- Provide an opportunity to assess board processes and particularly the quality of material and information provided by management;
- Provide an opportunity for the Board Chair to discuss areas where their performance could be strengthened;
- Build relationships of confidence and cohesion among Board Directors.

PROCEDURE:

1. Such meeting shall not be considered to be a meeting of the Board but rather will be for information purposes only.

2. Minutes will not be kept, but the Chair may keep notes of the discussion.

3. The Chief Executive Officer (CEO) and the Chief of Staff (COS) may be invited by the Chair to participate in a part of the meeting without management before being excused.

4. The Chair shall immediately communicate with the CEO and, as appropriate, the COS any relevant matters raised in the meeting.

REFERENCES:

1. OHA Guide to Good Governance

Document Name:	Acts, Legislations, and Compliance Reporting	
Document Number:	BOD.0X.XXX.0.25	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Board Effectiveness	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The purpose of this policy is to ensure that the Board of Directors fulfills its duty to oversee compliance with all applicable legislation, regulations, and contractual obligations, and to establish clear reporting requirements to support accountability, transparency, and risk management.

The Board of Directors has a fiduciary responsibility to ensure that the Corporation complies with all relevant federal, provincial, and municipal legislation, regulatory requirements, and contractual obligations.

The CEO is responsible for implementing processes and operating policies that ensure ongoing compliance. The CEO shall report regularly to the Board regarding statutory filings, compliance status, and any associated risks.

Where applicable laws or regulations conflict with the Corporation's mission, vision, and values, the Board will apply its decision-making framework to determine whether to pursue advocacy for exemptions or legislative change.

PROCEDURE:

1. *Responsibilities*

Board of Directors

- Ensure that compliance oversight is integrated into governance responsibilities.
- Review quarterly and annual reports from the CEO on compliance with statutory obligations, legislation, and regulatory requirements.
- Balance fiduciary duties with broader social responsibilities, ensuring alignment with organizational ethics and values while minimizing liability.
- Reviews and approves all required attestations under the Broader Public Sector Accountability Act, 2010 (BPSAA).
- Ensure Board-approved attestations are posted publicly in accordance with legislative requirements.

Chief Executive Officer

- Implement processes and operating policies to ensure compliance with federal, provincial, and municipal legislation and associated risks.
- Ensure timely completion of statutory filings and payments.

- Provide compliance reports to the Board as outlined under Reporting Requirements.
- Prepare CEO attestations as required under the BPSAA for Board review and approval.

2. *REPORTING REQUIREMENTS*

The CEO shall report to the Board regularly through the Finance, HR, and Audit Committee on the Corporation's compliance with:

- Employee remuneration;
- Statutory remittances (Receiver General, Ministry of Finance and Workplace Safety and Insurance Board);
- Healthcare of Ontario Pension Plan
- Bargaining Units (union dues)

The CEO shall report to the Board annually through the Finance, HR, and Audit Committee on:

- Compliance with occupational health and safety legislation, including:
  - i) a functioning safety committee with maintained meeting minutes;
  - ii) documentation of committee recommendations and management responses;
  - iii) appropriate corrective actions taken;
  - iv) up-to-date safety manuals;
  - v) identification of hazardous materials;
  - vi) proper maintenance of signage;
  - vii) ongoing staff training; and
  - viii) an established procedure for ongoing monitoring.
- Compliance with environmental legislation and regulations.
- Directors' and officers' liability insurance, including confirmation of:
  - i) suitable coverage in accordance with risk;
  - ii) sufficient indemnity amount;
  - iii) premiums paid and policy up-to-date.
- Compliance with the Broader Public Sector Accountability Act, 2010, including CEO attestations on:
  - i) the completion and accuracy of consultant use reports;
  - ii) compliance with prohibitions on engaging lobbyist services using public funds;
  - iii) compliance with expense claim directives;
  - iv) compliance with perquisite directives; and
  - v) compliance with procurement directives.

3. *Decision-Making in Conflict Situations*

When laws or regulations are at odds with the organization's vision, mission, and values, the Board will:

- Apply its established Framework for Ethical Decision-Making (BOD.03.003.X.XX)

- Consider whether to pursue advocacy for exemptions, amendments, or systemic change.

When conflicts arise between legal/fiduciary responsibilities and broader social responsibilities, the Board will:

- Balance the two obligations with fairness and accountability.
- Ensure decisions align with organizational ethics and values.
- Take measures to minimize liability while upholding the organization's integrity.

CROSS-REFERENCED POLICIES:

Policy Number	Policy Name
BOD.03.003.X.XX	Framework for Ethical Decision-Making

REFERENCES:

1. Trillium Health Partners, Board of Directors Policy Manua, Policy II-13 Reporting on Compliance (September 29, 2023)

BOARD AWARD OF EXCELLENCE

Document Name:	Board Award of Excellence	
Document Number:	BOD.06.001.0.23	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Relationships	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The HGMH Board Award of Excellence recognizes the outstanding contributions of staff and physicians. This award provides an opportunity to promote the importance of celebrating excellence and the necessity of recognizing the work of the HGMH team.

PROCEDURE:

1. Each year, the Board will recognize up to two deserving recipients for the Board Award of Excellence. The award process is intended to support and enhance the recognition programs in existence at the hospital.

2. The Board will call for nominations from within the hospital.

3. The nominations will be required to support the criteria outlined below:
   - *significant achievement in person and family centred care, or service to a patient and family;*
   - *an extraordinary commitment to patient safety, has championed a new initiative or process, or has thought of an innovative solution to a patient safety concern;*
   - *significant accomplishment in the management of people, financial or material resources;*
   - *successful completion of a major project or special assignment in a manner beyond what would normally be expected; and,*
   - *an outstanding initiative which has resulted in significant monetary and/or non-monetary benefits to HGMH in regards to increasing efficiency, effectiveness, improving patient care or displaying innovation and creativity in their work environment.*

4. In April of each year, a call for nominations will be sent to all staff and physicians at HGMH. Nominations will be open for a period of three weeks.

5. The Finance and Human Resources Committee will be responsible for recommending to the Board of Directors up to two recipients.

6. Nominees will be published on the Intranet yearly in May, and the winner will be announced at the Board of Directors Annual General Meeting.

7. Winners of the Board Award of Excellence will receive a custom recognition plaque, and staff will receive one day off with pay.

FRAMEWORK FOR BOARD ACCOUNTABILITY & TRANSPARENCY

Document Name:	Framework for Board Accountability & Transparency	
Document Number:	BOD.06.002.0.25	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Relationships	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

This Policy sets out the accountability of the Board of Directors of Hôpital Glengarry Memorial Hospital (HGMH).

The duty of the board is to make decisions that are in the best interests of the corporation. Decisions that are in the best interests of the corporation will be decisions that further the hospital's mission, move it towards its vision, are consistent with its values, but also discharge its accountabilities.

PROCEDURE:

The Board governs the Corporation through the direction and supervision of the business and affairs of the Corporation in accordance with its By-Laws, vision, mission and core values, governance policies and applicable laws and regulations.

The Board adheres to a model of governance through which it provides strategic leadership and direction to the Corporation by establishing policies, making governance decisions, monitoring performance related to the key dimensions of the Corporation's mission, as well as evaluating its own effectiveness and by building relationships within the health system.

To guide the board in making decisions in the best interests of the corporation, the board has confirmed the following accountabilities of the corporation:

To patients and families	*For quality services, patient safety, patient and family-centered care and best practices.*
To the community we serve	*For efficient utilization of resources, clear communication, transparent processes, advocacy, and expectation management.*
To the Ministry of Health	*For compliance with applicable legislation, regulation and policies, including funding policies for capital.*
To the Ontario Health	*For performance of HSAA, participation in OH-led initiatives, expenditure management and performance management.*
To donors	*For financial stewardship.*
To staff and volunteers	*For establishing and communicating expectations and providing a safe work environment.*
To health system partners	*For cooperation and collaboration.*
To members of the corporation	*For complying with the by-laws and applicable legislation as it governs the corporation, and for the achievement of its mission and vision in a manner consistent with its values and accountabilities.*

Through the provision of outstanding healthcare and demonstrating our commitment to operate in a medically, socially and financially responsible manner HGMH shares our performance in an open and transparent manner.

To maintain HGMH's commitment to accountability and transparency, the Board adopts the framework below to earn the trust of those it is accountable.

Process or Action Required by Legislation	***Contributes to or Demonstrates***		
	Accountability	**Transparency**	**Engagement**
Entering into a Hospital Service Accountability Agreement (HSAA)	*X*		
Post HSAA in a conspicuous place and on website	*X*	*X*	
Public Reporting of Quality-of-Care Indicators (as required under the Public Hospitals Act, Regulation 965)	*X*	*X*	
Annual Audited Financial Statements	*X*	*X*	
Engage community of diverse persons and entities when setting plans and priorities (required under Local Health System Integration Act)	*X*	*X*	*X*
Public Sector Salary Disclosure Act compliance	*X*	*X*	
Quality Improvement Plans (required under Excellent Care for All Act)	*X*	*X*	
Quality Improvement Plan available to the public, and Ontario Health (Excellent Care for All Act)	*X*	*X*	*X*
Executive Compensation linked to Performance Improvement Targets in Quality Improvement Plan (Excellent Care for All Act) (pay for performance) and described in the Quality Improvement Plan	*X*	*X*	
Patient Declaration of Values/Rights and Responsibilities (Excellent Care for All Act) developed after consultation with the public and make publicly available	*X*	*X*	*X*
Patient Relations Process (Excellent Care for All Act) to reflect Patient Declaration Values and to be publicly available	*X*	*X*	*X*
Patient Satisfaction Surveys (Excellent Care for All Act)	*X*	*X*	*X*
Employee/Staff Satisfaction Surveys (Excellent Care for All Act)	*X*		*X*
Critical Incident Reporting (Public Hospitals Act, Regulation 965)	*X*	*X*	
Appointing investigator or supervisor under Public Hospitals Act	*X*	*X*	
Value for money audits by Auditor General	*X*	*X*	
Broader Public Sector Accountability Act and Directives requirements			
• *Not using public funds to engage lobbyists*	*X*		
• *Reporting on use of consultants*	*X*	*X*	
• *Managing expense claim reporting*	*X*	*X*	
• *Setting expense claim rules*	*X*	*X*	
• *Setting procurement standards*	*X*	*X*	
• *Establishing allowable perquisites rules*	*X*		
• *Creating compliance reports*	*X*	*X*	
Freedom of Information and Protection of Privacy Act		*X*	

Voluntary Processes			
Annual Reports	*X*	*X*	
Town Hall Forums or Targeted Focus Groups	*X*	*X*	*X*
Open Recruitment Process for Board	*X*	*X*	*X*
Open Board Meetings	*X*	*X*	*X*
Open Annual Meetings of Members	*X*	*X*	*X*
Policies for Responding to Media Enquiries	*X*	*X*	*X*
Website	*X*	*X*	*X*
Relationship-building with stakeholders (foundation, volunteers, Ontario Health, Ministry, local government, academic, partners, provincial and federal elected members of government)	*X*	*X*	*X*
Publications (such as information booklets, pamphlets, newsletters, including those issued by a hospital's foundation or volunteer organization)	*X*	*X*	
Community Advisory Councils or Committees (including community liaison committees or advisory committees for input from broader community or input based on stakeholders, services or special interest groups)	*X*	*X*	*X*
Patient & Family Advisory Committee member on Board of Directors	*X*	*X*	*X*
Presentations to Community and/or Stakeholder Groups	*X*	*X*	*X*
Accreditation Process through Accreditation Canada	*X*		

REFERENCES:

1. OHA Guide to Good Governance