HÔPITAL Glengarry Memorial HOSPITAL

Governance and Nominating Committee Meeting Agenda

Date: Wednesday, September 11, 2024
Time: 17H00 – 18H00
Location: Boardroom / Microsoft Teams

Time	Agenda Item	Attachment
17:00	**1. Call to Order**	
(1 min)	1.1 Confirmation of Quorum	
(1 min)	1.2 Adoption of the agenda	P. 1
(1 min)	1.3 Declaration of Conflict of Interest	
17:03	**2. Report from the Last Meeting**	
(1 min)	2.1 Approval of Previous Meeting Report – May 8, 2024	P. 2-4
(1 min)	2.2 Business Arising from Report	
17:05	**3. Matters for Discussion/Decision**	
(5 min)	3.1 Review Terms of Reference (L. Boyling) **THAT the Governance and Nominating Committee recommend to the Board of Directors the Governance and Nominating Committee Terms of Reference as presented.**	P. 5-7
(5 min)	3.2 Review Committee Effectiveness Survey Results (L. Boyling)	P. 8-12
(5 min)	3.3 Review Annual Committee Work Plan (L. Boyling) **THAT the Governance and Nominating Committee review and approve the Annual Committee Work Plan for 2024-2025 as presented.**	P. 13-14
(5 min)	3.4 Review Education Topics for Board of Directors – Approved May 2024 (R. Alldred-Hughes) **THAT the Governance and Nominating Committee accept the education sessions for 2024/2025 as presented.**	P. 15-16
(10 min)	3.5 Review Governance Accreditation Standard (R. Alldred-Hughes)	P. 17-18
(5 min)	3.6 Equity, Diversity & Inclusion Update (R. Alldred-Hughes)	P. 19-20
(10 min)	3.7 Documents for Review: (R. Alldred-Hughes)	P. 21-22
	3.7.1 Disclosure Protection (Whistleblower) (CO.01.018)	P. 23-32
	3.7.2 Board Attendance (GO.01.002) **THAT the Governance and Nominating Committee recommend to the Board of Directors the approval of the following policies as amended: Whistleblowing and Board Attendance.**	P. 33-34
17:50	**4. Date of Next Meeting**	
(1 min)	Wednesday, November 13, 2024	
17:51	**5. Adjournment**	

REPORT OF THE GOVERNANCE, NOMINATING & EXECUTIVE MANAGEMENT COMMITTEE

May 8, 2024 at 5:00PM Boardroom / MS Teams

Present:	L. Boyling, Chair R. Alldred-Hughes, CEO	C. Larocque	F. Wetering
Regrets:	J. Andrews	G. Peters	

Summary of Discussion

Approval of the Agenda
The agenda was approved as presented.

Moved By: C. Larocque
Seconded By: F. Wetering
THAT the agenda be approved as presented.

CARRIED

Declaration of Conflict of Interest
There were no conflicts declared.

Approval of Previous Meeting Report
The meeting report from April 10, 2024, was reviewed. There is a spelling mistake on page 2 of the report under the Accreditation Standard Review which will be corrected.

Moved By: F. Wetering
Seconded By: C. Larocque
THAT the meeting report be approved as amended.

CARRIED

Business Arising from Report
Discussion ensued on process when over budget based on a policy that was reviewed at Governance last month. There is another policy that states if items are to be replaced over $100,000 it requires Board approval. Different priorities can take precedence, therefor, the budget can be shifted to accommodate. This will be discussed further at the Finance & HR committee meeting.

Committee Workplan Review
The committee workplan is on track with no concerns reported.

Matters for Discussion/Decision

Review Board Member Attendance
Board attendance was reviewed, and discussion ensued on the Roles and Duties of Board Directors policy having an attendance requirement of 70%-80%. This range was included as not all meetings meet the same number of times throughout the year.

As per policy, Committee Chairs will speak with Directors who have lower attendance.

Recommendation for New Directors
The list of candidates was reviewed.

Moved By: C. Larocque
Seconded By: F. Wetering
THAT the Governance Committee recommend to the Board of Directors the nomination of the new Directors as presented, at the Annual General Meeting.

There was a great pool of candidates this year with five applications received. Four of the five are being recommended, with the fifth not being considered as it is a conflict of interest for a pharmacist who owns a community pharmacy due to the relationship with physicians.

Francois Desjardins for a 1-year term to complete the term of a parting Director
Wendy Rozon for a 2-year term to complete the term of a parting Director
Gerard McDonald for a 3-year term
Heidi Salib for a 3-year term

CARRIED

Assign Committee Membership
The proposed committee membership was reviewed.

Moved By: C. Larocque
Seconded By: F. Wetering
THAT the Governance Committee recommend to the Board of Directors the approval of the Committee Membership for 2024/2025 as amended.

Discussion ensued around the Quality Committee having all new Directors as membership. It was agreed that for this year, G. Peters should remain on Quality and can move to another committee next year.

CARRIED

Review Board Orientation
The orientation agenda was reviewed. It was agreed that Accreditation should be added as it is often discussed throughout the year. The tour will also be moved.

Review Governance Accreditation Standard
Accreditation standard 2.2.5 was reviewed – The governing body follows the organization's code of that includes procedures to address breaches of the code.

Discussion ensued around how this standard is exercised at the hospital to which it was acknowledged that all Directors sign the code of conduct yearly. The whistleblower policy is being updated this year and will be shared with the Board for information.

Equity, Diversity & Inclusion Update
The expression of interest was shared with the community to join the IDEA Committee. To date, there have been no external applicants so the plan is to get the committee up and running internally and work will continue on recruiting externally throughout the year. One of the first priorities of the committee will be to develop a land acknowledgment statement.

Board Committee Meeting Dates 2024/2025
With the majority of Directors being retired in the upcoming cycle, it was discussed moving Board meetings to day time rather than evenings. Dr. S. Robertson has reached out to the working Directors to ensure that they would be ok with this.

Moved By: C. Larocque
Seconded By: F. Wetering
THAT the Governance Committee recommend to the Board of Directors the Board and Committee Meeting Schedule for 2024/2025.

This will be discussed at the Board meeting in May.

CARRIED

Education Topics for Board of Directors 2024/2025
The proposed education topics for the 2024/2025 Board cycle were presented.

Moved By: C. Larocque
Seconded By: F. Wetering
THAT the Governance Committee accept the education sessions for 2024/2025 as presented.

Patient stories are required as education as per Accreditation. These will alternate with the subjects listed as proposed, in no particular order.

CARRIED

GR OHT Membership
The hospital is a member of the Great River Ontario Health Team.

Moved By: F. Wetering
Seconded By: C. Larocque
THAT the Governance Committee recommend to the Board of Directors the adoption of the new Great River Ontario Health Team Collaborative Decision Making Agreement.

This document was created by GR OHT. Core members of the group are still being established.

CARRIED

Documents for Review
Second Language Training (CO.07.023)

Moved By: F. Wetering
Seconded By: C. Larocque
THAT the Governance Committee cease reviewing the Second language Training Policy (CO.07.023) as it relates to corporate matters.

CARRIED

Next meeting: September 2024

K-L. Massia, Recorder

HÔPITAL Glengarry Memorial HOSPITAL

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Governance Committee ☐ Senior Leadership Team

☐ Other *(please specify):*

Date Prepared: August 16, 2024 Meeting Date Prepared for: September 11, 2024

Subject: Annual Review Committee Terms of Reference

Prepared by: Robert Alldred-Hughes, President & CEO

☒ DECISION SOUGHT* ☐ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- All committee Terms of Reference are to be reviewed on an annual basis.

RECOMMENDATION / MOTION

That the Governance and Nominating Committee recommend to the Board of Directors the Governance and Nominating Committee Terms of Reference as presented.

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? ☒ *No* ☐ *Yes, please specify:*

SITUATION & BACKGROUND

A brief description of the background to the issue.

- Terms of Reference are reviewed annually by all Board Committees to ensure they remain relevant and effective in guiding the committee's activities and responsibilities.
- The existing Terms of Reference continue to accurately reflect the role, responsibilities, and membership of the Governance and Nominating Committee. They provide clear guidelines on the committee's governance and nominating functions, ensuring that all essential duties are covered.
- The responsibility for Diversity, Equity and Inclusion (DEI) oversight was added for consideration based on last year's motion to oversee this work.
- The responsibility for overseeing the Chief Executive Officer (CEO) and Chief of Staff (COS) performance has been removed, as this is the responsibility of the Executive Committee.

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Governance and Nominating Committee Terms of Reference

TERMS OF REFERENCE

Governance and Nominating Committee

ROLE:	• To advise the Board on matters relating to the Board's governance structure and processes, evaluation of the Board's effectiveness, recruitment, education, and evaluation of Board members. • To advise the Board on the selection and recruitment, of the CEO and COS.
RESPONSIBIILITIES:	a) Board Recruitment • Develop for approval by the board a description of the skills, experience and qualities including diversity of the directors and ensure French-speaking representation as per bylaw 4(3)(e); • Consider skills, experience, qualities, and diversity of current directors to determine the Board's needs; and, • Oversee the Board's recruitment and nomination process and recommend to the Board candidates for election at the Annual Meeting. b) Board Education • Ensure a comprehensive orientation session is provided to all new Board members; • Oversee Board education sessions to ensure Board members receive periodic education on governance, health care issues and the hospital operations; and, • Organize with the input of the CEO and Board Chair, the Boards retreats. c) Board Chair • Ensure succession planning for the office of Board • Oversee and complement the Board's process for selecting a Board Chair and recommend an individual for election by the Board as Chair; and, • Make recommendations to the Board for Vice Chair and Treasurer. d) Board Committees • Ensure periodic review and evaluation of committee performance and Terms of Reference and make recommendations for the Board as required; and, • Recommend to the Board, with the input of the Chair, nominees for all Board Committees and Committee Chairs. e) Evaluations • Establish and implement a program to evaluate Board performance including individual director performance, performance of the Chair, Board Committees and Committee Chairs; • Consider the results of Board evaluations in connection with renewal of the terms of existing directors; and, • Review and make recommendations to the Board on Board composition, size, structure, board policies and procedures,

	by-law amendments and board attendance. f) Executive Management Performance • Developing and appraising the CEO and COS job descriptions; • Undertaking CEO and COS recruitment processes and selection of the CEO and COS or delegating to subcommittee; • ~~Reviewing the performance of the CEO and COS through the monitoring of clearly articulated performance measures;~~ • Ensuring succession planning is in place for the CEO, COS. ~~, and senior management staff.~~ g) Diversity, Equity, & Inclusion (DEI) • Ensure the organization the hospital's strategic plan incorporates DEI principles. • Review and recommend policies that promote DEI within the organization, and holding leadership accountable for implementing and maintain these standards across the hospital. • Regular monitor progress on DEI initiatives and key performance measures.
CHAIR:	• A member of the Committee appointed by the Board on the recommendation of the Board Chair or a committee established by the Board for that purpose. • Term of office will be for a minimum of two (2) years
MEMBERSHIP:	• Chair of the Board; • At least four Directors appointed by the Board (minimum one Francophone Director); • Chief Executive Officer as an *ex officio* member.
VACANCY:	• When a vacancy occurs among the appointed members, the Chair of the board may appoint a member to fill the vacancy for the unexpired portion of the term
VOTING MEMBERS :	• Only board directors appointed to this committee may vote.
FREQUENCY OF MEETINGS AND MANNER OF CALL :	• At least 6 times per year, at the call of the chair
QUORUM:	• 51% of voting members.
RESOURCES:	• Chief Executive Officer • Guests, by invitation
REPORTS TO	• Board of Directors
DATE OF LAST REVIEW	• September 2023

Approved by: Corporation of l'Hôpital Glengarry Memorial Hospital

HÔPITAL Glengarry Memorial HOSPITAL

BRIEFING NOTE FOR

☐ Board of Directors ☒ Board Committee – Governance ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: August 16, 2024 Meeting Date Prepared for: September 11, 2024

Subject: Governance Committee Self Assessment Results

Prepared by: Robert Alldred-Hughes, President & CEO

☐ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- To review the results of the Governance Committee Meeting Effectiveness Survey completed at the end of the 2023-2024 Board Cycle, and determine any actions required on the part of the Committee to sustain positive results and identify opportunities for improvement in identified areas.

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? ☐ *No* ☒ *Yes, please specify:*

- Board of Directors

SITUATION & BACKGROUND

A brief description of the background to the issue.

- The HGMH Committee Self-Assessment is one of the ways the committee can assess the degree to which its structure and processes are effective in supporting board performance.
- In the Spring of 2024, the Governance Committee completed a self-assessment using the tool provided by the hospital.
- Based on the completed assessment process, the committee can develop a work plan to address areas for improvement or identified gaps.

OPTIONS CONSIDERED & ANALYSIS

Outline alternatives that were contemplated in coming to a recommendation. If no viable alternatives exist, include that information as well.

- The committee self-assessment is structured to evaluate the following 5 domains:
    1. Terms of Reference and Composition
    2. Committee Management
    3. Committee Effectiveness
    4. Chair Effectiveness
    5. Overall Committee Performance

- The following tables provide the response data from all respondents to the survey:

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Terms of Reference and Composition

	EXCELLENT (5)	VERY GOOD (4)	GOOD (3)	NEEDS IMPROVEMENT (2)	NO BASIS FOR JUDGEMENT (1)	NOT APPLICABLE (0)	TOTAL
The committee has clear and appropriate Terms of Reference.	75.00% 3	25.00% 1	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
The committee has the right number of members.	50.00% 2	50.00% 2	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
The committee has members with the skills and expertise that are needed by the committee.	50.00% 2	25.00% 1	0.00% 0	25.00% 1	0.00% 0	0.00% 0	4

For any answer above you marked as "needs improvement", please provide details below:

Hard to judge skill levels of members who don't actively participate

Committee Management

	EXCELLENT (5)	VERY GOOD (4)	GOOD (3)	NEEDS IMPROVEMENT (2)	NO BASIS FOR JUDGEMENT (1)	NOT APPLICABLE (0)	TOTAL
The committee meets at the appropriate time of day.	50.00% 2	50.00% 2	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
I received orientation to the committee that was helpful to me as a member of the committee.	50.00% 2	25.00% 1	0.00% 0	0.00% 0	0.00% 0	25.00% 1	4
The committee is receiving the support from hospital management that it requires.	75.00% 3	25.00% 1	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
Information is received sufficiently in advance of the meeting.	75.00% 3	25.00% 1	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
The committee meets the right number of times over the year.	75.00% 3	25.00% 1	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4

Committee Effectiveness

	EXCELLENT (5)	VERY GOOD (4)	GOOD (3)	NEEDS IMPROVEMENT (2)	NO BASIS FOR JUDGEMENT (1)	NOT APPLICABLE (0)	TOTAL
The committee is working effectively.	50.00% 2	50.00% 2	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
The committee performed its annual workplan.	75.00% 3	25.00% 1	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4

The committee is eeffectively performing in the following areas:	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 1	1
- by providing appropriate nominees for election to the Board of Directors.	25.00% 1	50.00% 2	25.00% 1	0.00% 0	0.00% 0	0.00% 0	4
- by ensuring an appropriate orientation and education program for members.	25.00% 1	50.00% 2	25.00% 1	0.00% 0	0.00% 0	0.00% 0	4
- by organizing, with the input of the CEO and Board Chair, the Board retreats.	25.00% 1	75.00% 3	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
- by selecting and recommending nominees for Chair, Vice-Chair, and Treasurer of the Board.	25.00% 1	50.00% 2	0.00% 0	0.00% 0	25.00% 1	0.00% 0	4
- by ensuring succession planning for the office of the Board.	25.00% 1	50.00% 2	0.00% 0	0.00% 0	25.00% 1	0.00% 0	4
- by ensuring periodic review and evaluation of committee performance and Terms of Reference.	50.00% 2	50.00% 2	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
- by recommending to the Board with the input of the Chair, nominees for all Board committees and Committee Chairs.	25.00% 1	50.00% 2	0.00% 0	0.00% 0	25.00% 1	0.00% 0	4
- by establishing a program to evaluate the performance of the Board, Board Chair, Board members, and Board Committees.	50.00% 2	50.00% 2	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
- by considering the results of Board evaluations in connection with renewal of terms of existing directors.	25.00% 1	50.00% 2	0.00% 0	0.00% 0	25.00% 1	0.00% 0	4
- by reviewing and making recommendations on Board composition, size, structure, policies and procedures, by-law amendments, and attendance.	75.00% 3	25.00% 1	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
- by developing a program to recruit, select, and appraise the CEO and, through annual reviews, to determine CEO compensation.	25.00% 1	75.00% 3	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
- by ensuring succession planning is in place for the CEO and senior management.	25.00% 1	75.00% 3	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4

For any answer above you marked as “needs improvement”, please provide details below:

Annual compensation is by the Executive committee and is based mainly on quality parameters and strategic plan components.

Chair Effectiveness

	EXCELLENT (5)	VERY GOOD (4)	GOOD (3)	NEEDS IMPROVEMENT (2)	NO BASIS FOR JUDGEMENT (1)	NOT APPLICABLE (0)	TOTAL
The Chair is prepared for committee meetings.	25.00% 1	50.00% 2	25.00% 1	0.00% 0	0.00% 0	0.00% 0	4
The Chair keeps the meetings on track.	25.00% 1	50.00% 2	25.00% 1	0.00% 0	0.00% 0	0.00% 0	4
The Chair fairly reports the committee's work to the Board.	25.00% 1	50.00% 2	25.00% 1	0.00% 0	0.00% 0	0.00% 0	4
The Chair encourages participation and manages discussion.	50.00% 2	25.00% 1	0.00% 0	25.00% 1	0.00% 0	0.00% 0	4

For any answer above you marked as “needs improvement”, please provide details below:

While participation is welcomed by the Chair, there is very limited participation/engagement by several members. Chair could seek out participation from these members.

Overall Committee Performance

	EXCELLENT (5)	VERY GOOD (4)	GOOD (3)	NEEDS IMPROVEMENT (2)	NO BASIS FOR JUDGEMENT (1)	NOT APPLICABLE (0)	TOTAL
Overall, I am satisfied with my contribution to the committee.	25.00% 1	75.00% 3	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
Overall, I am satisfied with the committee's contribution to the Board.	25.00% 1	75.00% 3	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4

Comments and suggestions for improvement to committee processes:

This committee went above the call of duty this year with the update of the new bylaws. Well done.

As noted, explicitly seeking and encouraging input from all members might increase participation.

- Based on the results of the survey overall, the committee is satisfied with the current performance level, both from an individual and committee perspective.
- There appears to be some opportunity to increase the comfort level of the committee members and improve overall performance levels in the following areas:
    - Ensuring members are well oriented to the committee
    - Ensuring proper succession planning for the Board of Directors

Questions for consideration:

- Based on the results of the survey, are there areas the Committee would like to explore alternate ways of accomplishing its work?
- Are there other areas the Committee would like to develop actions to support the Committees effectiveness?

IMPLEMENTATION & COMMUNICATION PLAN

Consider how the recommendation will be rolled-out and communicated to all key stakeholders.

- Results and associated actions to be shared with HGMH Board in November 2024, along with all other committee results.

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DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Governance Committee ☐ Senior Leadership Team

☐ Other *(please specify):*

Date Prepared: August 16, 2024 Meeting Date Prepared for: September 11, 2024

Subject: 2024-2025 Governance Committee Work Plan

Prepared by: Robert Alldred-Hughes, President & CEO

☒ DECISION SOUGHT* ☐ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- The purpose of this briefing note is to provide an overview of the 2024-2025 Governance Committee Work Plan.

RECOMMENDATION / MOTION

That the Governance Committee review and approve the Annual Committee Work Plan as presented.

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? ☐ *No* ☒ *Yes, please specify:*
Board of Directors

SITUATION & BACKGROUND

A brief description of the background to the issue.

- Feedback from the committee assessment surveys highlighted the need for a more structured approach with the functioning of committee meetings. Respondents indicated a desire for increased clarity, accountability, and alignment of the committee's work with the organization's strategic objectives.
- In response to this feedback, the hospital developed and implemented annual work plans for all Board Committees. This plan outlines key activities, timelines, and responsibilities, ensuring that all critical governance and nominating tasks are addressed throughout the year.
- The annual work plan has become an essential tool for Board Committees.

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- 2024-2025 Governance and Nominating Committee Annual Work Plan

Governance and Nominating Committee
Annual Work Plan 2024-2025

Deliverable	MRP	Occurrence	SEP	NOV	JAN	MAR	APR	MAY
STRUCTURE/PROCESSES								
Review Committee Effectiveness Survey Results	Chair	Annually	X					
Review/Recommend Governance Annual Committee Work Plan to BoD	Chair	Annually	X					
Review/Recommend Committee Terms of Reference to BoD	Chair	Annually	X	X				
Review Board Education Plan	Chair	Annually	X					
Revise Skills Matrix	Chair	Annually		X				
Review/Revise Corporate and Professional Staff Bylaws (as needed)	Chair	Annually			X			
Review Board Member Attendance	Chair	Twice yearly			X			X
Plan AGM	Chair	Annually					X	
Recommend Directors and Assign Committee Membership	Chair	Annually						X
Review Board Orientation	Chair	Annually						X
Review CEO and COS Succession Plan	Chair	Annually			X			
DIRECTOR RECRUITMENT AND SELECTION								
Administer Board Personal Assessment Survey (results due in March)	Admin	Annually			X			
Identification of number of new members required	Chair	Annually				X		
Identification of selection criteria based on skills matrix	Chair	Annually				X		
Start recruitment process	Admin	Annually				X		
Interviews		Annually					X	
Recommendation to the Board		Annually						X
ACCREDITATION								
Governance Standards Review	Chair	Every meeting	X	X	X	X	X	X
Equity, Diversity & Inclusion Update	Chair	Bi-Monthly	X		X		X	
Review Communication Plan	Chair	Annually		X				
PERFORMANCE								
Review Performance Evaluation Questionnaire for CEO and COS	Chair	Annually			X			
Review Committee Effectiveness Survey Questions	Chair	Annually					X	
Administer Committee Effectiveness Survey	EA	Annually						X
Review Peer to Peer Survey Questions	Chair	Annually					X	
Administer Peer to Peer Surveys	EA	Annually						X
POLICY REVIEW								
Disclosure Protection (Whistleblower) (CO.01.018)	CEO		X					
Board Attendance (GO.01.002)	CEO		X					
Confidentiality for Board and Committee Members (GO.01.009)	CEO			X				
Education Conferences/Conventions (GO.02.001)	CEO			X				
Code of Conduct (GO.01.010)	CEO				X			
Board of Director Nomination and Election (GO.01.016)	CEO				X			
Signing Authority and Approval (GO.02.007)	CEO				X			
Board Mentorship Program (GO.01.020)	CEO					X		
Framework for Ethical Decision Making Process (GO.01.021)	CEO					X		
Donor Recognition (GO.01.003)	CEO					X		
Board Application for Membership Process (GO.01.022)	CEO						X	
Appointment of Auditor (GO.02.006)	CEO						X	
Fraud Prevention (CO.01.049)	CEO						X	
Active Service Offer – Personnel and Bilingual Services (CO.01.030)	CEO							X

Revisions since prior report:

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HÔPITAL Glengarry Memorial HOSPITAL

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Governance Committee ☐ Senior Leadership Team

☐ Other *(please specify):*

Date Prepared: August 16, 2024 Meeting Date Prepared for: September 11, 2024

Subject: Board Education Sessions – 2024/2025

Prepared by: Robert Alldred-Hughes, President & CEO

☒ DECISION SOUGHT* ☐ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- The Governance Committee is responsible for setting yearly Board education sessions in collaboration with the CEO. This decision support document outlines the education sessions that were recommended for the 2024-205 Board Cycle and approved by the committee in May 2024.

RECOMMENDATION / MOTION

That the Governance and Nominating Committee accept the education sessions for 2024/2025 as presented.

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? ☒ *No* ☐ *Yes, please specify:*

SITUATION & BACKGROUND

A brief description of the background to the issue.

- Directors have a responsibility to be knowledgeable about the environment in which the hospital operates, and to support this responsibility education sessions are a great way for Board of Directors to obtain knowledge of the health care environment, hospital programs and services, as well as governance responsibilities.
- The OHA guide to good governance outlines that Director education should be facilitated using multiple mechanisms, and education sessions at regular board meetings is one of those opportunities.
- Other means of encouraging Director education includes Board retreats, The Governance Centre of Excellence, Ontario Hospital Association educational programming, and establishing a policy that permits and encourages directors to attend educational programs.
- Patient stories are also an incredible way to provide education to hospital Boards of Directors. Often there is great learning that can be shared through patient feedback and experience. It is an opportunity to demonstrate the systems and processes that are in place or are put into place based on the experience of our patients receiving care in hospital. For this reason, providing Board education with patient stories is part of the consideration coming forward to the Governance committee as alternating between traditional education and patient story education.

OPTIONS CONSIDERED & ANALYSIS

- The following is an outline of the options for Board Education for the 2024/2025 Board Cycle in no particular order:
    - Emergency Preparedness
    - Accessibility
    - Inclusion, Diversity, Equity, and Anti-Racism
    - Ethics
    - BPSO Initiative being implemented throughout the year
    - Remote Care Monitoring

  These education sessions would alternate with a Patient Story every other month.

- The above sessions were approved as they support work being done in preparation for Accreditation Canada and sessions that support Director education in executing their role on the Board.

CONSULTED WITH:

Indicate those bodies and individuals who have been consulted with in the development of this decision support document

- HGMH Senior Leadership Team

HÔPITAL Glengarry Memorial HOSPITAL

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee - Governance ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: September 11, 2024 Meeting Date Prepared for: August 20, 2024

Subject: Accreditation Standard Feature

Prepared by: Robert Alldred-Hughes, President & CEO

☐ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- As part of the hospital's efforts to embrace the new continuous model for Accreditation and embed it into our daily work, committees will feature 1-2 criteria from an Accreditation standard that applies to their committee's work at each meeting
- These features will provide an opportunity for the committee to discuss the standard and how HGMH achieves compliance, identifies opportunities for improvement, while ensuring the committee is well-equipped to make informed decisions and recommendations related to quality

STANDARD / CRITERIA FEATURED

Include the standard name, number(s), statement(s), guideline text, and other information if applicable

High Priority

2.2 The operational conditions of the governing body are defined and documented.

2.2.1 The governing body defines its accountabilities in compliance with its jurisdictional obligations.

The governing body ensures that its accountabilities, including its roles and responsibilities, are defined in compliance with its obligations under relevant laws, regulations, and contractual arrangements as per its jurisdiction. It ensures that its roles, responsibilities, and accountabilities are aligned with the organization's vision, mission, and values, and reflect the organization's role in society.

The governing body's role includes guiding the organization to achieve its vision, mission, and values. The governing body is responsible and accountable for steering and overseeing the functions of the organization, including the quality, safety, legal, financial, technological, marketing, fundraising, and sustainability functions. The governing body must stay informed about the organization and represent the organization's interests. The governing body acts in the best interests of the organization and its stakeholders, including a commitment to financial and environmental stewardship, organizational health and safety, client outcomes, and the short- and long-term health of the community.

The governing body is also responsible for ensuring that relevant information flows in a timely, transparent, and coordinated manner between the governing body, its committees, the organizational leaders, and other stakeholders. Additionally, the governing body is accountable to follow the organization's code of conduct; comply with the organization's confidentiality agreements; participate in orientation and ongoing education; participate in self-evaluation and evaluation of the governing body; and prepare for and attend meetings.

The governing body ensures that it clearly outlines the division of roles, responsibilities, and accountabilities between the governing body and the organizational leaders. It ensures that the information on its roles, responsibilities, and accountabilities is understood by its members, its committees, the organizational leaders, and other stakeholders.

In some jurisdictions, government may be accountable for defining and updating the roles, responsibilities, and accountabilities of the governing body. In this case, the governing body works with government to inform and contribute to the process and participates to the fullest extent possible.

2.2.2 The governing body defines the accountabilities of each of its members, including the chair.

The roles, responsibilities, and accountabilities of each member of the governing body include attendance requirements, term lengths, and limits. Term lengths may be determined by regulations; if they are not, they should be established and included in the bylaws.

Governing body members may or may not be financially compensated for their time. When compensation is provided, the governing body ensures it is done transparently and does not create real or perceived conflicts of interest or interfere with the independence of its members.

Each member may fill a different position on the governing body (e.g., chair, vice-chair, secretary, treasurer, committee chair). The governing body documents each position or member's roles, responsibilities, and accountabilities in its operational documents (e.g., in its terms of reference or individual position descriptions). It ensures that the position information is written using neutral language that is not biased in favor of or against a person, group, or attribute (e.g., age, gender identity, race, ethnicity).

In some jurisdictions, government may be accountable for defining, updating the roles, responsibilities, and accountabilities of governing body members, including the chair. In this case, the governing body works with government to inform and contribute to the process and participates to the fullest extent possible.

2.2.4 The governing body ensures that each member acknowledges their accountabilities.

The governing body requires its members to acknowledge their individual roles, responsibilities, and accountabilities, as well as those of the governing body overall. This acknowledgement may be in the form of a signed statement.

2.2.5 The governing body follows the organization's code of conduct that includes procedures to address breaches of the code.

The organization's code of conduct describes the minimum behavior expectations of everyone working in or on behalf of the organization. The governing body holds itself accountable to the same behavior expectations as the organization's workforce. It also follows the organization's policies and procedures on addressing breaches of the code by its members including reporting, investigating, and resolving them. The governing body ensures that the organization shares the code of conduct with stakeholders.

DISCUSSION QUESTIONS

Choose 1-2 questions from the list below to guide discussion at your meeting, or create your own question(s)

- What does the hospital already do to meet this standard?
- How would you respond to a surveyor asking you a question about this standard?
- What evidence (i.e.: documentation) can support the hospital's compliance with this standard?

HÔPITAL Glengarry Memorial HOSPITAL

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Governance ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: August 20, 2024 Meeting Date Prepared for: September 11, 2024

Subject: Inclusion, Equity, Diveristy & Anti-Racism (IDEA) - Update

Prepared by: Robert Alldred-Hughes, President & CEO

☐ DECISION SOUGHT* ☐ FOR DISCUSSION/INPUT ☒ FOR INFORMATION ONLY

PURPOSE

- The purpose of this briefing note is to remind the Governance Committee of the requirements of Accreditation Canada Standards that are being overseen by this committee, in addition to provide an update on actions taken to date which support our policy on Inclusion, Diversity, Equity and Anti-Racism (IDEA) at HGMH.

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? ☐ *No* ☒ *Yes, please specify:*

- All Board Committees

SITUATION & BACKGROUND

A brief description of the background to the issue.

- In the Fall of 2023, the Board of Directors approved the recommendation that the Governance Committee take on a proactive role in leading, coordinating, and monitoring IDEA-related activities within HGMH. This includes ensuring compliance with Accreditation Canada Standards for IDEA and fostering a culture of inclusion, diversity, equity, and anti-racism throughout the organization.
- Since this recommendation was approved, there has been much work completed by the team at HGMH related to IDEA activities.
- HGMH, as a prominent organization and employer in our community, is committed to promoting an environment that is inclusive, diverse, and equitable, while actively combatting racism.
- In the winter/spring of 2024 an Inclusion, Diversity, Equity, and Anti-Racism Framework was developed by HGMH, which focuses our efforts on achieving meaningful actions to increase inclusion and celebrate diversity, while creating an overall sense of belonging.
- The advent of this framework helped kick off significant work that has been completed over the spring and summer, whereby:
  - an IDEA Committee has been formed consisting of leaders and staff with a passion for IDEA and lived experience.
  - A policy related to Land Acknowledgement has been created along with an official Land Acknowledgement statement for our hospital. The Land Acknowledgement has been endorsed by the senior leadership team, and reviewed by the Native North American Travelling College.
  - September 30th is National Truth and Reconciliation Day, and HGMH will be holding a series during the month of September to support Truth and Reconciliation, including a special on-site ceremony and social on September 17th from 1pm-3pm. All Board Members are encouraged to attend, and invitations to MP's and MPP, including municipal officials have been issued.

- Looking ahead, HGMH will be working on rolling out inclusion and diversity training for leadership and board members, including IDEA values statements in all job profiles, and connecting with community partners with lived experience as evidenced by the work we have done with the Native North American Travelling College.
- There are 10 new Governance related standards for IDEA and HGMH will be assessed against these standards in our next accreditation survey cycle of 2026. (*Attached*)

CONSULTED WITH:

Indicate those bodies and individuals who have been consulted with in the development of this decision support document

- Kayla MacGillivray, Chief Human Resources Officer

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Listing of Accreditation Canada Standards related to Governance
- IDEA Framework

Accreditation Canada Standards Related to Inclusion, Diversity, Equity, and Anti-Racism

The governing body uses a recognized framework for acknowledging systemic racism.
The governing body implements an action plan, in partnership with community partners, to address systemic racism in the organization.
The governing body provides its members with education and continuous learning on cultural safety and humility and systemic racism.
The governing body ensures the organization's policies reflect cultural safety and humility practices and encompass the culture and rights of the communities' receiving services from the organization.
The governing body monitors its action plan for addressing systemic racism.
The governing body uses a recognized framework for acknowledging Indigenous-specific systemic racism.
The governing body implements an action plan, in partnership with Indigenous partners, to address Indigenous-specific systemic racism in the organization.
The governing body provides its members with education and continuous learning on cultural safety and humility and Indigenous-specific systemic racism.
The governing body ensures the organization's policies reflect cultural safety and humility practices and encompass the culture and rights of the Indigenous peoples and communities receiving services from the organization.
The governing body monitors its action plan for addressing Indigenous-specific systemic racism.

HÔPITAL Glengarry Memorial HOSPITAL

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Governance ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: August 21, 2024 Meeting Date Prepared for: September 11, 2024

Subject: Policy Reviews

Prepared by: Robert Alldred-Hughes, President & CEO

☒ DECISION SOUGHT* ☐ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- The purpose of this briefing note is to provide an overview of the two policies up for review and highlight any material changes to each policy.

RECOMMENDATION / MOTION

That the Governance and Nominating Committee recommend to the Board of Directors the approval of the following policies as amended: Whistleblowing and Board Attendance.

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? ☒ *No* ☐ *Yes, please specify:*

SITUATION & BACKGROUND

A brief description of the background to the issue.

Summary of amendments:

Whistleblowing

- A review was completed of the current Whistleblowing Policy to align with industry standards.
- The amendments to the policy include an outline of the procedure set out if a complaint is filed, a named compliance officer for the organization, in addition to reporting requirements. The title of the policy was also amended for clarity.
- This policy will be renumbered to align with the new policy numbering system.

Board Attendance

- The review of this policy includes three main amendments: strengthening the reason why board attendance is important, removing the policy being applicable to non-board members of the committee, and what happens if a Board member refuses to resign after being asked to do so for reasons of poor attendance.
- The reason non-board members attendance was removed is, that would primarily consist of executive support, and this would not fall under the board policy, rather the employment relationship and performance improvement.
- If a Board member refuses to resign, if asked, outlining that the board may take action to terminate the Director in accordance with the by-laws.
- This policy will be renumbered to align with the new policy numbering system.

IMPLEMENTATION & COMMUNICATION PLAN

Consider how the recommendation will be rolled-out and communicated to all key stakeholders.

- Obtain Board Approval – September 26, 2024
- Update Board Policy Online
- Include updates in Board Orientation Material
- Include updates to whistleblower in General Orientation
- Post on our website

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- *Disclosure Protection (Whistleblower) Policy - Tracked Changes*
- *Whistleblower Policy - Clean Draft*
- *Board Attendance Policy – Tracked Changes*
- *Board Attendance Policy – Clean Draft*

POLICY NUMBER: CO.01.048.0.13

POLICY TYPE: CORPORATE (Administrative)

SUBJECT: ~~DISCLOSURE PROTECTION (WHISTLEBLOWER)~~Whistleblowing

POLICY: 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.

~~depends on the honesty and integrity of its employees to ensure that the Hospital's affairs are conducted in the best interests of the community it serves. HGMH is committed to a culture of open communication that supports and protects employees who come forward to disclose incidents of wrongdoing.~~

~~The purpose of this policy is to provide employees with a clear procedure to follow in the event that the employee witnesses an incident of wrongdoing and decides to come forward. This policy also serves to remind employees that they have a duty to come forward where they believe they have witnessed an act of wrongdoing. This policy applies to all employees of HGMH.~~

~~Employees should be aware that malicious or vexatious claims of wrongdoing, brought forward with the intent to harm an individual, can result in disciplinary measures up to and including termination of employment.~~

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. In circumstances where a conflict with the reporter exists for the Chief Human Resources Officer, the Chief Executive Officer 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.
- The compliance officer reserves the right to 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

If the report involves the Chief Executive Officer, that individual will not be informed in the ordinary course. The Compliance Officer shall report the matter as well as matters related to the Chief of Staff 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 Chief Executive Officer, the Chief of Staff, 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 A - 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. Internal reporters are free to bring reports to the attention of their Manager, Chief of Department, or the Human Resources Department, as they would any other workplace concern. The recipients of such reports shall forward them 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:

   2.1. an e-mail address to which reports may be forwarded and which is accessed exclusively by the Compliance Officer **compliance.officer@hgmg.on.ca**; and

   2.2. 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 Chief Executive Officer, 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.

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:

   4.1. **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.

   4.2. **Breach of Professional Behaviour:** The investigation should include a representative of the suspect's professional association.

4.3. **Unethical conduct:** The investigation should include a union representative or a Human Resources Representative for non-union staff.

4.4. **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 Committee

4.5. **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.

Procedure B – Fraud

1. It is the responsibility of the Finance & HR 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
   3.1. Consult with the CEO and CFO to determine the appropriate course of action which may or may not include an Investigation Task Force. Should the CEO ~~and/or CFO~~ be implicated, the Compliance Officer will consult with the Chair of the Finance & HR Committee;
   3.2. Advise the Finance & HR Committee immediately via email of the situation and the proposed course of action;
   3.3. 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 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 Chef Financial Officer, 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.

DEFINITIONS:

~~**Wrongdoing:** occurs when there is:~~

- A violation of any law or regulation; or
- Misuse of public funds or assets; or
- Gross mismanagement; or
- A substantial and specific danger to the life, health and safety of patients or the environment; or
- A serious breach of the values and ethics that guide HGMH.
- Wrongdoing is not a Labour Relations forum

Disclosure: is defined as bringing forward information within the organization and in good faith, based on a reasonable belief that wrongdoing has been, or is about to be, committed.

Disclosure Officer: is an appointed person responsible for supporting employees in the procedure.

PROCEDURE:

1. Where an employee believes and act of wrongdoing has been, or is about to be committed, the employee should approach the Disclosure Officer with the name or names of the individuals involved and the nature of the wrongdoing.

2. The Disclosure Officer reviews the information to determine if it constitutes wrongdoing as defined in the policy.

3. The Disclosure officer will then inform the employee as to whether there is sufficient information to warrant an investigation of wrongdoing.

4. Where the Disclosure Officer determines that the information does not constitute wrongdoing, the Officer may decide to refer the issue to the appropriate manager responsible for other policies (Canadian Human Rights, harassment, or abuse of authority) as necessary.

5. Where the information brought forward does indicate wrongdoing, the Disclosure Officer will conduct a full investigation into the matter.

6. Based on the results of the investigation, the Disclosure Officer will recommend appropriate disciplinary measures for either party.

7. In cases where the Disclosure Officer determines that the information brought forward does not constitute wrongdoing, but the employee does not agree with that finding, the employee has the option of raising the issue with the designated Board member with the Disclosure Officer present.

Protection from Retribution

1. Any employee who brings forward a good-faith complaint of wrongdoing is protected from retribution by the employee(s) named in the complaint, or by any other person representing the interests of that employee, irrespective of the outcome of the complaint. Any employee named in a wrongdoing complaint who then seeks retribution against the complainant may be subject to disciplinary measures up to and including termination of employment

2. The procedure to be followed in reporting retribution is the same as that for reporting wrongdoing.

Confidentiality

1. All information brought forward in a report of wrongdoing, including the names of the complainant and the named employee(s) and the nature of the complaint will be treated in confidence throughout the complaint and resolution procedure.

Complaints to External Sources

1. In all cases, employees who bring forward information related to wrongdoing are encouraged to make use of all internal mechanisms to resolve the issue. However, in the event that an employee complains to an external resource first, then the procedures outlined in this policy do not apply.

Annual Report

1. The Disclosure Officer will report annually to the HGMH Board of Directors on the number and nature of complaints (not including the names of the employees involved) and their disposition.

Document Name:	Whistleblowing	
Document Number:	COR.01.014.0.24	
Review Period:	☒3 years ☐1 year	**Manual:** Orientation
Classification: Corporate	**Section:** Administrative	
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. Internal reporters are free to bring reports to the attention of their Manager, Chief of Department, or the Human Resources Department, as they would any other workplace concern. The recipients of such reports shall forward them 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@hgmg.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.

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:
   - **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.

POLICY NUMBER: GO.01.002.5.21

POLICY TYPE: **GOVERNANCE (Administrative)**

SUBJECT: **BOARD ATTENDANCE**

POLICY: 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 ~~and committee members~~ 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.

PURPOSE:

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. ~~and non-board members of committees.~~

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

Where a director ~~or committee member~~ 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 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 ~~board or committee member's~~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.

Document Name:	Board Attendance	
Document Number:	BOR.01.014.0.24	
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Classification: Board of Directors	**Section:** Governance	
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.