

Governance and Nominating Committee Meeting Agenda

Date: Wednesday, April 9, 2025
 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. 1-2
(1 min)	1.3 Declaration of Conflict of Interest (Policy BOD.01.013.X.XX)	
17:03	2. Report from the Last Meeting	
(1 min)	2.1 Approval of Previous Meeting Report - February 12, 2025	P. 3-5
(1 min)	2.2 Business Arising from Report	
(1 min)	2.3 Committee Workplan Review	P. 6
17:06	3. Matters for Discussion/Decision	
	3.1 Governance Accreditation Standard Review (R. Alldred-Hughes) THAT the Governance and Nominating Committee recommend to the Board of Directors the new policy entitled "Framework for Board Accountability & Transparency" as presented.	P. 7-11
	3.2 Equity, Diversity & Inclusion Update (R. Alldred-Hughes)	P. 12-29
	3.3 Review Governing Body Assessment Results (R. Alldred-Hughes)	P. 30-32
	3.4 Documents for Review: (R. Alldred-Hughes)	P. 33-34
	3.4.1 Board Application for Membership Process	P. 35-38
	3.4.2 Appointment of Auditor That the Governance and Nominating Committee recommend to the Board of Directors the approval of the following policies as amended: Board Membership Application Process, and Appointment of Auditor.	P. 39-40
	3.4.3 Fraud Prevention That the Governance and Nominating Committee recommend to the Board of Directors the retirement of the Fraud Prevention Policy.	P. 41-45
17:56		
(1 min)	Wednesday, May 14, 2025	
17:57	5. Adjournment	

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.



REPORT OF THE GOVERNANCE AND NOMINATING COMMITTEE

March 12, 2025 at 5:00PM MS Teams

Present: L. Boyling, Chair
G. McDonald

G. Peters
C. Larocque

Dr. S. Robertson
R. Alldred-Hughes, CEO

Regrets: None

Summary of Discussion

Approval of the Agenda

The agenda was reviewed.

Moved By: G. Peters

Seconded By: C. Larocque

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 January 15, 2025, was shared.

Moved By: Dr. S. Robertson

Seconded By: G. McDonald

THAT the meeting report be approved as presented.

CARRIED

Business Arising from Report

There was no business arising from the report.

Committee Workplan Review

There were no changes to the committee workplan, and things are on track.

Matters for Discussion/Decision

Board Recruitment

Last year, the Corporate Bylaws were amended and now state that the Board shall consist of a minimum of ten (10) and a maximum of twelve (12) directors. With the current Past Chair not returning next Board cycle, there is the opportunity to recruit for one Director as the Past Chair is an ex-officio voting Director.

Moved By: G. Peters

Seconded By: Dr. S. Robertson

THAT the Governance and Nominating Committee commence the recruitment process for the recruitment of one (1) Director for the 2025-2026 Board Cycle.

To increase efforts in recruiting a diverse Director, it was agreed to reach out to the community of Akwesasne since lots of work is being done with them. An application has already been received, and the candidate will be interviewed, however, this person works at a neighbouring hospital which could be perceived a conflict of interest. This will be looked into further should this be the successful candidate. Interviews will aim to be scheduled April 23-25, 2025.

CARRIED

Board and Committee Meeting Schedule

After reviewing the questions from the Governing Body Assessment survey, it was identified that Quality is not on the agenda often enough as the committee only meets four times per Board cycle. Recommendation is being made to change committee meeting frequency so that all committees meet six (6) times per year. This would even out the workload and ensure equal distribution of meeting times as currently the Quality meeting has a heavier workload and Finance often has a shorter workload as they meet eight (8) times per year.

Moved By: C. Larocque

Seconded By: G. McDonald

THAT the Governance & Nominating Committee recommend to the Board of Directors the proposed adjustment to the committee meeting schedule as presented.

The revised workplans were mapped out to list out the even workload for all committees. At the French Language Services meeting in June, the question will be raised as to whether this committee should meet more frequently.

Workplans are discussed and approved at the first committee meeting of the Board cycle, however, it was agreed that the Epic project be added to the Finance, HR and Audit committee work plan. The committees can decide whether anything else should be added at that time.

CARRIED

Governance Accreditation Standard Review

Work is being done on ensuring all Accreditation standards are met for the upcoming Accreditation cycle. As such, it was noted that there was opportunity to amend some of the policies recently reviewed to ensure standards are met.

Moved By: Dr. S. Robertson

Seconded By: C. Larocque

THAT the Governance & Nominating committee recommend to the Board of Directors the approval of the Roles and Responsibilities of the Board Policy, the Nominating and Election Policy, the Responsibilities as a Director and Code of Conduct Policy, and the Responsibilities of the Board Chair, Vice Chair, and Treasurer Policy as amended.

The composition listed in the Nominating and Election Policy will be corrected to reflect the language used in the Corporate Bylaws.

CARRIED

Review Peer-to-Peer Survey Questionnaire

Revisions were made to the Peer-to-Peer survey following discussion from the last meeting.

Moved By: C. Larocque

Seconded By: G. Peters

THAT the Governance & Nominating committee approve the Peer-to-Peer survey questionnaire as amended.

Discussion ensued around the objective of the survey which is to identify whether Directors are good performers or lack thereof. It was agreed that there is no need to have multiple categories in the survey, these should just be Fully Satisfactory, Could Improve and Unknown. The open text box language will be changed to say *Please explain with examples if choosing could improve.*

CARRIED

Documents for Review

Framework for Ethical Decision-Making Policy

This policy was due for regular review.

Moved By: G. Peters

Seconded By: G. McDonald

THAT the Governance & Nominating committee recommend to the Board of Directors the approval of the Framework for Ethical Decision-Making Policy as presented.

A number of changes were required to reflect the requirements of Accreditation and to align with the framework used at the hospital. The policy now outlines the ethical decision-making steps.

A visual was created to help identify the steps for ethical decision-making and will be included at the end of all meeting agendas going forward and will also be displayed in the Boardroom.

CARRIED

Board Mentorship

This policy was due for regular review.

Moved By: G. Peters

Seconded By: G. McDonald

THAT the Governance & Nominating committee recommend to the Board of Directors the approval of the Board Mentorship Policy as presented.

This policy was revised to ensure that both the mentor and the mentee understand what is required of them in Board of Director mentorship. Criteria was included for selecting a mentor for new Board members.

CARRIED

Donor Recognition

This policy was due for regular review.

Moved By: G. Peters

Seconded By: G. McDonald

THAT the Governance & Nominating committee retire the Donor Recognition Policy.

This policy is to be retired as the HGMH Foundation is developing a comprehensive donor recognition policy and all donations should be directed toward the Foundation.

CARRIED

Next meeting: Wednesday, April 9, 2025

K-L. Massia, Recorder

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	✓					
Review/Recommend Governance Annual Committee Work Plan to BoD	Chair	Annually	✓					
Review/Recommend Committee Terms of Reference to BoD	Chair	Annually	✓	✓				
Review Board Education Plan	Chair	Annually	✓					
Revise Skills Matrix	Chair	Annually		✓				
Review/Revise Corporate and Professional Staff Bylaws (as needed)	Chair	Annually			✓			
Review Board Member Attendance	Chair	Twice yearly			✓			X
Plan AGM	Chair	Annually					X	
Review Board Orientation	Chair	Annually						X
Review CEO and COS Succession Plan	Chair	Annually			✓			
DIRECTOR RECRUITMENT AND SELECTION								
Administer Board Personal Assessment Survey (results due in March)	Admin	Annually			✓			
Identification of number of new members required	Chair	Annually				✓		
Identification of selection criteria based on skills matrix	Chair	Annually				✓		
Start recruitment process	Admin	Annually				✓		
Interviews		Annually					X	
Recommendation to the Board		Annually						X
Review Following Years Committee Schedule and Membership		Annually						X
ACCREDITATION								
Governance Standards Review	Chair	Every meeting	✓	✓	✓	✓	X	X
Equity, Diversity & Inclusion Update	Chair	Bi-Monthly	✓		✓		X	
Review Communication Plan	Chair	Annually		✓				
PERFORMANCE								
Review Performance Evaluation Questionnaire for CEO and COS	Chair	Annually			✓			
Review Committee Effectiveness Survey Questions	Chair	Annually			✓	✓		
Administer Committee Effectiveness Survey	EA	Annually						X
Review Peer to Peer Survey Questions	Chair	Annually			✓	✓		
Administer Peer to Peer Surveys	EA	Annually						X
POLICY REVIEW								
Disclosure Protection (Whistleblower) (CO.01.018)	CEO		✓					
Board Attendance (GO.01.002)	CEO		✓					
Confidentiality for Board and Committee Members (GO.01.009)	CEO			✓				
Education Conferences/Conventions (GO.02.001)	CEO			✓				
Code of Conduct (GO.01.010)	CEO				✓			
Board of Director Nomination and Election (GO.01.016)	CEO				✓			
Signing Authority and Approval (GO.02.007)	CEO				✓			
Board Mentorship Program (GO.01.020)	CEO					✓		
Framework for Ethical Decision Making Process (GO.01.021)	CEO					✓		
Donor Recognition (GO.01.003)	CEO					✓		
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
ESTIMATED PREPARATION TIME FOR MEETING								

Revisions since prior report:

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: March 28, 2025 Meeting Date Prepared for: April 9, 2025
 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

MOTION

THAT the Governance Committee recommend to the Board of Directors the new policy entitled “Framework for *Board Accountability & Transparency*” as presented.

STANDARD / CRITERIA FEATURED

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

Priority **High Priority** Guidelines Quality Dimension: **Efficiency**

3.1.3 The governing body applies the organization’s accountability framework to ensure the organization is well-managed and accountable to its stakeholders.

Guidelines

An accountability framework specifies the evidence-informed approach and mechanisms (e.g., criteria, guidelines, plans, procedures) that the governing body can use to set expectations for strong organizational management practices and performance. The governing body uses the framework to oversee and guide the organization’s achievement of its strategic goals and objectives and establish the organization’s accountability to its stakeholders, including workforce, volunteers, clients, and families. The framework aligns with the organization’s ethics and values. It may be developed in collaboration with stakeholders or may be adopted from existing frameworks.

Based on the above, HGMH does not currently have an Accountability Framework, however, our orientation materials do speak to who the Board of Directors is Accountable to.

To support the Board in ensuring we have a documented framework that demonstrates our accountability and transparency practices, the attached policy has been developed for consideration, and recommendation to the Board of Directors for adoption. If approved, this policy will be added to the list of policies to be reviewed on a rotational basis.



DISCUSSION QUESTIONS

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

Does the new policy meet the Accreditation Standard from your perspective?

Are there opportunities for enhancement, or elements you believe should be added or removed?

Document Name:	Framework for Board Accountability & Transparency		
Document Number:	BOD.01.XXX.0.25		
Review Period:	<input checked="" type="checkbox"/> 3 years <input type="checkbox"/> 1 year	Manual: Governance	
Classification:	Board of Directors	Section:	
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 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.

PROCEDURE:

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.

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

<i>To patients and families</i>	<i>For quality services, patient safety, patient and family-centered care and best practices.</i>
<i>To the community we serve</i>	<i>For efficient utilization of resources, clear communication, transparent processes, advocacy, and expectation management.</i>
<i>To the Ministry of Health</i>	<i>For compliance with applicable legislation, regulation and policies, including funding policies for capital.</i>
<i>To the Ontario Health</i>	<i>For performance of HSAA, participation in LHIN-led initiatives, expenditure management and performance management.</i>
<i>To donors</i>	<i>For financial stewardship.</i>
<i>To staff and volunteers</i>	<i>For establishing and communicating expectations and providing a safe work environment.</i>
<i>To health system partners</i>	<i>For cooperation and collaboration.</i>
<i>To members of the corporation</i>	<i>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.</i>

Effective: Apr 2025	Last review/revision: Apr 2025	Next review: Apr 2028
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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	Contributes to or Demonstrates		
	Accountability	Transparency	Engagement
Required by Legislation			
<i>Entering into a Hospital Service Accountability Agreement (HSAA)</i>	X		
<i>Post HSAA in a conspicuous place and on website</i>	X	X	
<i>Public Reporting of Quality of Care Indicators (as required under the Public Hospitals Act, Regulation 965)</i>	X	X	
<i>Annual Audited Financial Statements</i>	X		
<i>Engage community of diverse persons and entities when setting plans and priorities (required under Local Health System Integration Act)</i>	X	X	X
<i>Public Sector Salary Disclosure Act compliance</i>		X	
<i>Quality Improvement Plans (required under Excellent Care for All Act)</i>	X		
<i>Quality Improvement Plan available to the public, and Ontario Health (Excellent Care for All Act)</i>	X	X	X
<i>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</i>	X	X	
<i>Patient Declaration of Values/Rights and Responsibilities (Excellent Care for All Act) developed after consultation with the public and make publicly available</i>	X	X	X
<i>Patient Relations Process (Excellent Care for All Act) to reflect Patient Declaration Values and to be publicly available</i>	X	X	X
<i>Patient Satisfaction Surveys (Excellent Care for All Act)</i>			X
<i>Employee/Staff Satisfaction Surveys (Excellent Care for All Act)</i>			X
<i>Critical Incident Reporting (Public Hospitals Act, Regulation 965)</i>	X	X	
<i>Appointing investigator or supervisor under Public Hospitals Act</i>	X		
<i>Value for money audits by Auditor General</i>	X	X	
<i>Broader Public Sector Accountability Act and Directives requirements</i>			
• <i>Not using public funds to engage lobbyists</i>	X		
• <i>Reporting on use of consultants</i>	X	X	
• <i>Managing expense claim reporting</i>	X	X	
• <i>Setting expense claim rules</i>	X		

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**FRAMEWORK FOR BOARD
ACCOUNTABILITY & TRANSPARENCY**

• <i>Setting procurement standards</i>	X		
• <i>Establishing allowable perquisites rules</i>	X		
• <i>Creating compliance reports</i>	X	X	
<i>Freedom of Information and Protection of Privacy Act</i>		X	
Voluntary Processes			
<i>Annual Reports</i>	X	X	
<i>Town Hall Forums or Targeted Focus Groups</i>	X	X	X
<i>Open Recruitment Process for Board</i>	X	X	
<i>Open Board Meetings</i>	X	X	
<i>Open Annual Meetings of Members</i>	X	X	
<i>Policies for Responding to Media Enquiries</i>	X	X	X
<i>Website</i>	X	X	X
<i>Relationship-building with stakeholders (foundation, volunteers, Ontario Health, Ministry, local government, academic, partners, provincial and federal elected members of government)</i>	X	X	
<i>Publications (such as information booklets, pamphlets, newsletters, including those issued by a hospital's foundation or volunteer organization)</i>	X	X	
<i>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)</i>	X	X	X
<i>Patient & Family Advisory Committee member on Board of Directors</i>	X	X	X
<i>Presentations to Community and/or Stakeholder Groups</i>	X	X	X
<i>Accreditation Process through Accreditation Canada</i>	X		

REFERENCES:

1. OHA Guide to Good Governance

DECISION SUPPORT DOCUMENT FOR

- Board of Directors
 Board Committee – Governance
 Senior Leadership Team
 Other (please specify):

Date Prepared: March 31, 2025 Meeting Date Prepared for: April 9, 2025
 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 and Nominating 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 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 1-3. All Board Members are encouraged to attend, and invitations to MP's and MPP, including municipal officials have been issued.
- In October 2024 HGMH rolled out an education program for all leaders and Board Members at HGMH to complete through Culture Ally. To date the following education topics have been delivered:
 - Foundations of Diversity, Equity, and Inclusion
 - Truth and Reconciliation

- *Anti-Sexual Harassment*
- *LGBTQ+ Awareness*
- *Unconscious Bias*
- *Microaggressions*
- *Inclusive Hiring*
- *Allyship*
- *Cultural Competency*
- The hospital has commissioned artwork by indigenous artist Dawn lehstoseranonhha from Akwesasne to be installed at our hospital. The art is a symbol for indigenous patients and family who access our services that we care deeply about the whole person and providing care that is culturally safe and supportive.
- HGMH Update Job Description Template now includes and IDEA values statement: *“We recognize the intrinsic value of every individual and the diversity they bring to our community. We are committed to fostering a sense of belonging and an environment that upholds principles of equity, diversity, inclusion and anti-racism in every facet of our operations. Our commitment is unwavering, rooted in our belief that healthcare should be equitable, accessible and inclusive for all”*.
- The IDEA Committee has selected cultural celebration days to be recognized through communication and special events. Recently those included Black History Month, and Pink Shirt Day.
- Looking ahead, adding an IDEA corner to the bi-weekly blitz.
- IDEA committee found inclusive spiritual care contacts from the broader community willing to provide care for our patients, for inclusion in the new Palliative and End of Life Care handbook.
- IDEA committee partnering with PFAC to co-design the new Family and Spiritual Care Room.
- Ongoing review of policies, recently involved in a review of the following policies with a IDEA lens, Pastoral Care, and Unidentified Patients
- Review results and feedback from Patient Satisfaction Survey data regarding patients who self-identify as Indigenous and Gender-diverse.
- 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

Creating a Sense of Belonging

Inclusion, Diversity, Equity & Anti-Racism
Framework

2024-2028



Message from the President & CEO



Robert Alldred-Hughes
President & CEO

As we embark on a new chapter in our journey toward excellence in healthcare, I am delighted to introduce the Inclusion, Diversity, Equity & Anti-Racism (IDEA) Framework for HGMH, a critical and important document that holds the promise of fostering a more inclusive, supportive, and thriving environment for all.

At HGMH, we understand that diversity is a strength, and by embracing a culture of equity and inclusion, we not only enhance the well-being of our staff but also improve the quality of care we provide to the community we proudly serve. This framework represents our commitment to creating a workplace where every voice is heard, every perspective is valued, and every individual, regardless of background, feels a sense of belonging.

Why is this important to us? The answer lies in the very essence of our mission – delivering outstanding care for our communities. By championing equity, diversity, and inclusion, we are better equipped to understand, respect, and respond to the unique requirements of our patients. As we strive for to be outstanding at every patient and family encounter, it is imperative that our hospital reflects the community it serves, ensuring that our practices and policies align with the principles of fairness and equitable opportunity.

This framework is not just a set of guidelines; it is a pledge to weave IDEA into the very fabric of HGMH. It is a commitment to fostering an environment where differences are celebrated, where barriers are dismantled, and where every member of our team feels empowered to contribute their best.

As we embark on this transformative journey, I invite each and every one of you to actively participate, share your insights, and champion the cause of equity, diversity, and inclusion. Together, we can provide care that reflects and respects the mosaic of our community.

Thank you for your dedication and commitment to being better together.

Our Commitment to Truth and Reconciliation

We recognize the profound impact that historical injustices, including but not limited to colonialism, systemic racism, and discrimination, have had on Indigenous peoples, marginalized communities, and individuals. We acknowledge the enduring trauma and intergenerational effects that continue to reverberate through society.

We commit ourselves to the principles of truth and reconciliation and pledge to actively engage in truth, healing, education and awareness, collaboration and accountability.

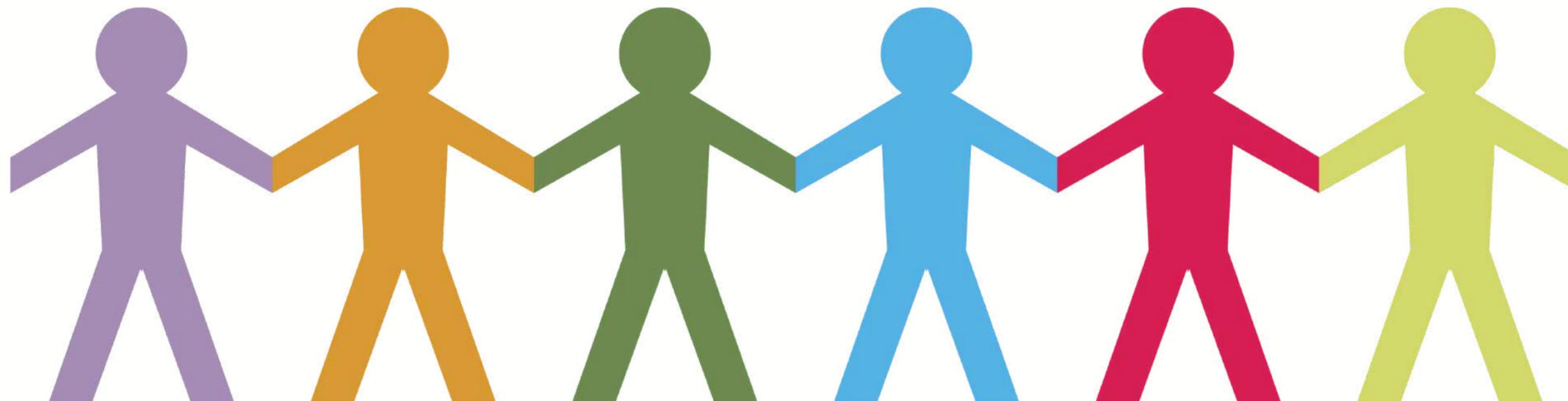
We affirm our dedication to fostering a healthcare environment that is inclusive, respectful, and just for all. We recognize that the journey towards reconciliation is ongoing and complex, but we are steadfast in our determination to contribute to a future where equity, dignity, and healing prevail.



Our Commitment to Inclusion, Diversity, Equity & Anti-Racism

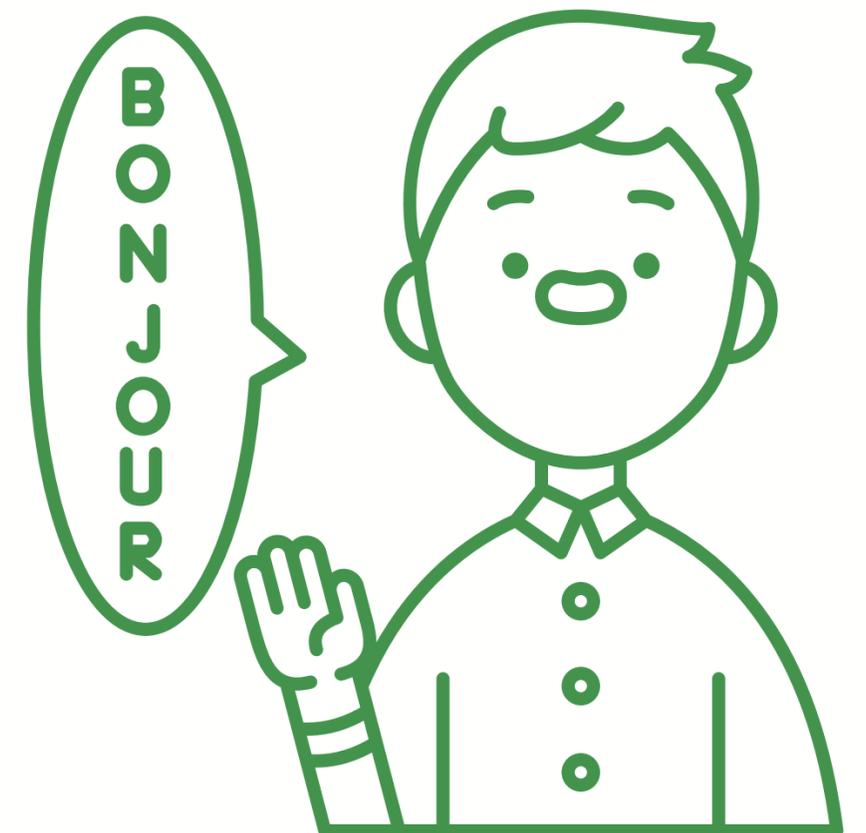


We recognize the intrinsic value of every individual and the diversity they bring to our community. We are dedicated to fostering an environment that upholds principles of equity, diversity, inclusion, and anti-racism in every facet of our operations. Our commitment is unwavering, rooted in our belief that healthcare should be equitable, accessible, and inclusive for all.



Our Commitment to French Language Services

En tant qu'établissement de santé, nous nous engageons à respecter et à promouvoir la langue française dans tous les aspects de nos services et de nos interactions. Nous reconnaissons l'importance de la langue française pour la communication efficace et le bien-être des patients francophones. Par conséquent, nous nous engageons à fournir des services de haute qualité en français, à garantir l'accès à des interprètes si nécessaire et à favoriser un environnement inclusif où la diversité linguistique est valorisée. Nous nous efforçons continuellement d'améliorer nos pratiques linguistiques pour répondre aux besoins de la communauté francophone que nous servons.



Our Path to Change

- Create a common understanding of IDEA
- Create an IDEA Committee
- Meet Accreditation Canada requirements
- Train and educate staff
- Implement equity indicators to support the pillars of Accountability, Human Resources, Leadership and Decision Making, Partnerships and Strategic Planning.
- Engage with community partners and people with lived experience.



Inclusion, Diversity, Equity & Anti-Racism Pillars



1

Leadership & Decision-Making

2

Strategic Planning

3

Human Resources

4

Accountability

5

Partnerships

Strategic Planning

The strategic plan has goals and/or targets that reflect the needs of the community.

The strategic plan is created, decided on, and reflects the values of those affected by the organization.

The staff and board are invited to participate in the creation of the strategic plan.

Action indicators and measurements will be identified and monitored by the IDEA Committee.



Human Resources

Job descriptions include the hospital's value statement of IDEA and cultural safety.

The employment equity policy is developed, and IDEA and cultural safety are considered a job competency.

Employees have multiple trainings in IDEA and cultural safety.

We celebrate cultural diversity in our organization.

Action indicators and measurements will be identified and monitored by the IDEA Committee.



Accountability

Policies are created using an anti-racism lens. Existing policies are reviewed to ensure cultural safety.

There is active and consistent enforcement of policies that meaningfully deal with cultural safety.

There is transparency about cultural safety policies, practices and planning.

Action indicators and measurements will be identified and monitored by the IDEA Committee.



Partnerships

Partner with local indigenous communities to support culturally safe care for indigenous patients and their families.

Connect with community partners with expertise and lived experience for training opportunities.

Actively engage with community partners and the Great River Ontario Health Team to support equitable care in our communities.

Action indicators and measurements will be identified and monitored by the IDEA Committee.

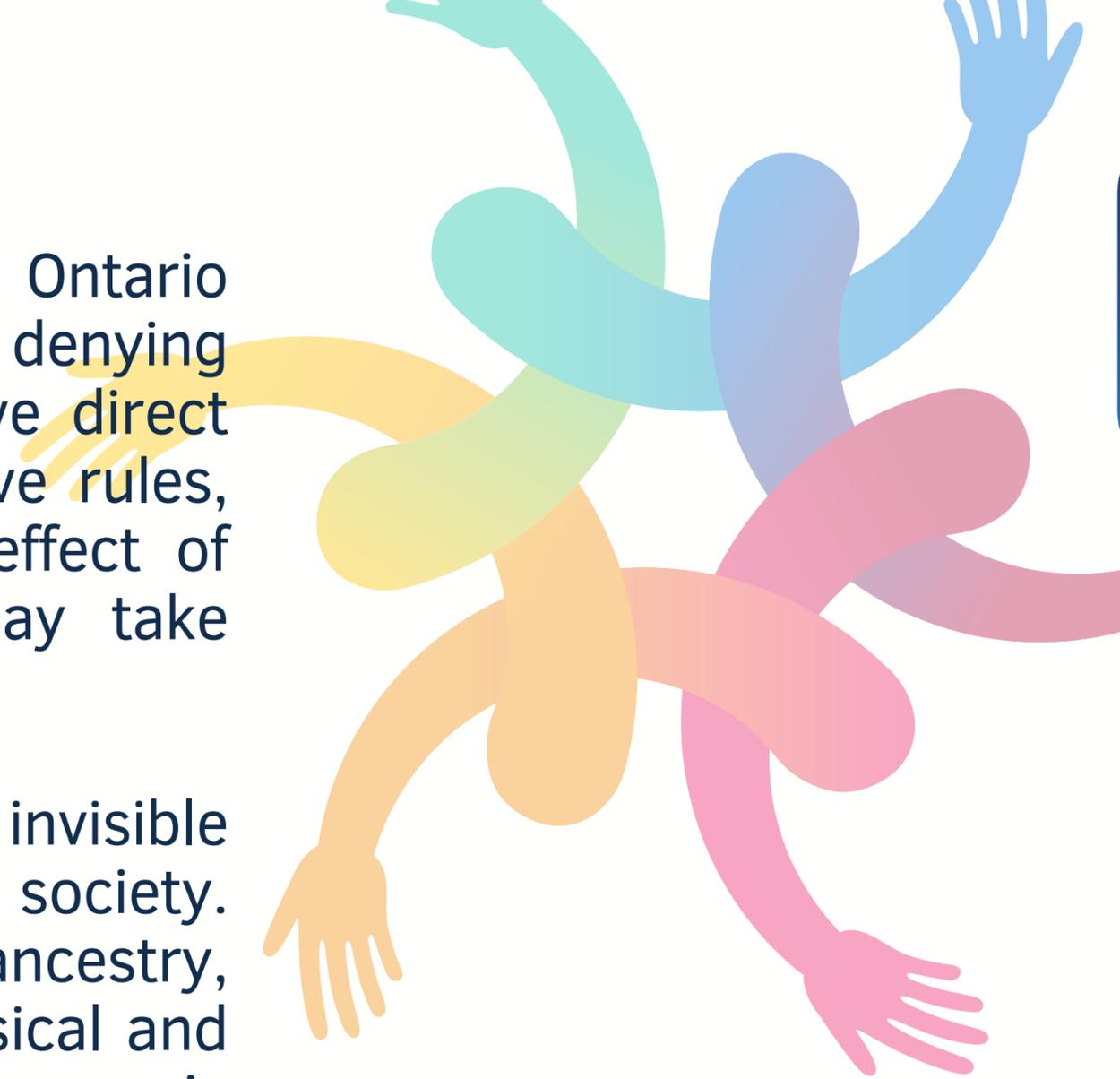


Key Terms

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.

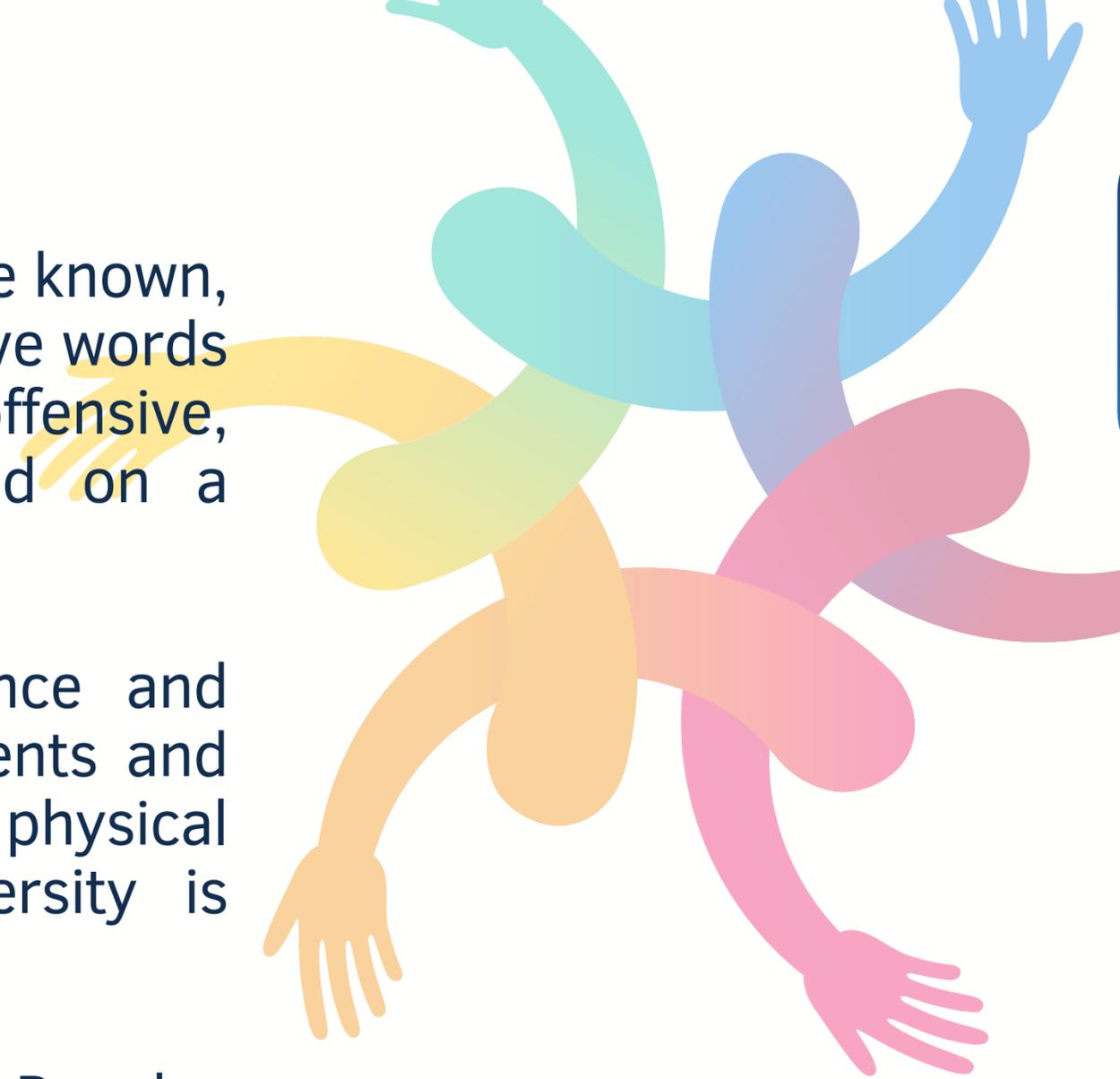


Key Terms

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.

Reconciliation: Building a renewed relationship with Indigenous Peoples based on the recognition of rights, respect and partnership.





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Inclusion
Diversity
Equity
Anti-racism

Inclusion
Diversité
Équité
Anti-racisme



BRIEFING NOTE FOR

- Board of Directors
 Board Committee – Governance
 Senior Leadership Team
 Other (please specify):

Date Prepared: March 4, 2025 Meeting Date Prepared for: April 9, 2025
 Subject: HSO Governing Body Assessment Results
 Prepared by: Robert Alldred-Hughes, President & CEO

- DECISION SOUGHT*
 FOR DISCUSSION/INPUT
 FOR INFORMATION ONLY

PURPOSE

- To review the results of the Health Standards Organization (HSO) Governing Body Assessment as part of the hospital's Accreditation process and to outline key findings and next steps for review and improvement.

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.

- As part of the Accreditation process, the Board was asked to complete the HSO Governing Body Assessment to evaluate its governance practices, effectiveness, and alignment with accreditation standards. This assessment serves as a critical tool for identifying strengths and areas requiring improvement to ensure the hospital continues to uphold high standards of governance and accountability.

Key Findings:

The assessment results highlight the following key areas:

- Strengths:** The Board demonstrated strong governance practices in some of the following areas which all received 100% positive responses:
 - Clear understanding of roles and responsibilities.
 - Confidence in raising difficult issues.
 - Access to necessary information for decision-making.
 - Alignment with the hospital's mission and vision.
 - Clear understanding of what quality means for the organization.
 - Ability to monitor the organization's actions to improve the quality of care and services for patients/residents/clients.
 - Received education or participated in continuous learning sessions
 - Meetings are conducted in the spirit of open, constructive discussions.
 - Strong collaboration with executive leadership and respect amongst each other.
- Opportunities for Improvement:** While the results were generally positive, some areas showed lower confidence:
 - Supporting the organization to reduce its carbon footprint (54.60%)** – Improving knowledge and training in these areas.
 - % of governing body's meeting time spent on the organization's quality performance (27.3%)** – increasing meeting frequency for Quality & Patient Safety to allow for more discussions around quality to take place at the Board level.

- Actively engage external stakeholders in reviewing the organization's performance and ensure that the quality-of-care action plan is co-developed with internal and external stakeholders (81.8%) – increase communication around efforts to engage external stakeholders.

Next Steps:

- **Ongoing Monitoring:** Regular progress updates will be provided to the Board to ensure continuous improvement in governance practices.
- **Integration with Accreditation Preparation:** The insights gained from this assessment will be integrated into our broader Accreditation readiness efforts to strengthen compliance with HSO standards.

OPTIONS CONSIDERED & ANALYSIS

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

- 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:
 - Increasing communication efforts
 - Increase discussions around quality

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 to be shared with HGMH Board in April 2025

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- HSO Governing Body Assessment Results

HSO Governing Body Assessment Results

Questions - How much do you agree or disagree with the following statements about your role on the governing body?	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Positive	Neutral	Negative	
01. I have a clear understanding of my role on the governing body.	90.9%	9.1%				100%			
02. I am confident in raising difficult issues during governing body meetings.	81.8%	18.2%				100%			
03. I can get the information I need to make informed decisions at governing body meetings.	90.9%	9.1%				100%			
04. I fully understand the organization's mission, vision, and values.	90.9%	9.1%				100%			
05. I have a clear understanding of what quality means for the organization.	100%	0.0%				100%			
06. I can monitor the organization's actions to improve the quality of care and services for patients/residents/clients.	63.6%	36.4%				100%			
07. I was provided with comprehensive new member orientation when I joined this governing body.	63.6%	27.3%	9.1%			90.9%	9.1%		
Questions - In the past 12 months have you received education or participated in continuous learning on any of the following topics as a member of this governing body? If a statement does not apply to you select 'Not Applicable (N/A)' or 'Don't Know'.	Yes	No	Don't Know	Not Applicable		Positive	Neutral	Negative	
08. How this organization is addressing systemic racism.	90.9%		9.1%			90.9%	9.1%		
09. The importance of the cultural safety in the organization's approach to addressing Indigenous-specific systemic racism.	90.9%		9.1%			90.9%	9.1%		
10. How to interpret quality and patient/resident/client safety performance information.	90.9%		9.1%			90.9%	9.1%		
11. How to be an effective member of this governing body.	90.9%		9.1%			90.9%	9.1%		
12. How the organization takes a people-centered care approach to providing care and services.	90.9%		9.1%			90.9%	9.1%		
13. Have you received constructive feedback from the chair on your contributions as a governing body member in the past 12 months?	72.7%	9.10%		18.20%		72.7%	18.2%	9.1%	
Questions - How much do you agree or disagree with the following statements about the organization and the governing body you participate on? If a statement does not apply to you select 'Not Applicable (N/A)' or 'Don't Know'.	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Not applicable	Don't Know	Positive	Neutral	Negative
14. Our meetings are conducted in the spirit of open, constructive discussions.	90.9%	9.1%					100%		
15. At our meetings, governing body members show respect to each other.	90.9%	9.1%					100%		
16. We ensure that all governing body members participate in decision making.	72.7%	27.3%					100%		
17. We have an effective quality sub-committee.	72.7%	18.2%			9.1%		90.9%	9.1%	
18. We ensure that the organization's executive leader(s) who report to the governing body have accountability for the quality of care in their performance objectives.	81.8%	18.2%					100%		
19. We actively engage internal stakeholders in reviewing the organization's performance.	72.7%	18.2%				9.1%	90.9%	9.1%	
20. We actively engage external stakeholders in reviewing the organization's performance.	36.4%	45.5%				18.2%	81.8%	18.2%	
21. We ensure that the organization's quality-of-care action plan is co-developed with internal and external stakeholders.	63.6%	18.2%				18.2%	81.8%	18.2%	
22. We support the organization's executive leader(s) to develop a strategy for improving cultural safety for Indigenous patients/clients/residents.	81.8%	18.2%					100%		
23. We support the organization's executive leader(s) on a strategy to address Indigenous-specific racism.	72.7%	27.3%					100%		
24. We support the organization's executive leader(s) to publicly review the organization's quality and safety performance annually.	81.8%	18.2%					100%		
25. We support the organization to reduce its carbon footprint.	36.4%	18.2%	9.1%			34.4%	54.60%	43.5%	
26. We regularly review data documenting the experiences of patients/residents/clients and their families.	90.9%	9.1%					100%		
27. We regularly review data from the organization's workforce documenting their health, safety, and overall work experiences.	54.5%	27.3%				18.2%	81.8%	18.2%	
28. We regularly review data showing the organization's performance.	72.7%	18.2%				9.1%	90.9%	9.1%	
29. We regularly evaluate how we can improve our effectiveness as a governing body.	36.4%	54.5%				9.1%	90.9%	9.1%	
30. We do not become directly involved in the day-to-day operations of the organization.	90.9%	9.1%					100%		
31. We have a collaborative relationship with the organization's senior leaders.	90.9%	9.1%					100%		
32. We have a collaborative relationship with the organization's clinical management.	72.7%	27.3%					100%		
Question - This question asks for your assessment of the governing body's focus on the organization's quality performance over the past 12 months. If a statement does not apply to you select 'Not Applicable (N/A)' or 'Don't Know'.	In Every Meeting	In Most Meetings	Not Applicable			Positive	Neutral	Negative	
33. How frequently was the organization's quality performance on the governing body's agenda?	45.5%	45.5%	9.0%			91%	9.0%		
Question - This question asks for your assessment of the governing body's focus on the organization's quality performance over the past 12 months. If a statement does not apply to you select 'Not Applicable (N/A)' or 'Don't Know'.	More than 40%	31-40%	21-30%	10-20%		Positive	Neutral	Negative	
34. Approximately what percentage of the governing body's meeting time was spent on the organization's quality performance?	18.2%	9.1%	36.4%	36.4%		27.3%	36.4%	36.4%	
Questions - How would you rate the governing body's impact on the following? If a statement does not apply to you select 'Not Applicable (N/A)' or 'Don't Know'.	Excellent	Very Good	Good	Don't Know		Positive	Neutral	Negative	
35. Improving the quality of care?	18.2%	63.6%	18.2%			100%			
36. Improving patient/resident/client safety?	18.2%	63.6%	18.2%			100%			
37. Improving occupational health and safety?	18.2%	63.6%	18.2%			100%			
38. Addressing systemic racism in the organization?	18.2%	63.6%	18.20%			100%			
39. Addressing Indigenous-specific systemic racism in the organization?	18.2%	63.6%	18.2%			100%			
40. Ensuring the security of the organization's information management systems?	27.3%	63.6%	9.10%			100%			
41. Improving the sharing of patient/resident/client information with them and their care providers?	9.10%	54.50%	18.20%	18.20%		81.8%	18.2%		

DECISION SUPPORT DOCUMENT FOR

- Board of Directors
 Board Committee – Governance
 Senior Leadership Team
 Other (please specify):

Date Prepared: March 31, 2025 Meeting Date Prepared for: April 9, 2025
 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 three 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: Board Membership Application Process, and Appointment of Auditor.

That the Governance and Nominating Committee recommend to the Board of Directors the retirement of the Fraud Prevention Policy.

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:

Board Membership Application Process

- The policy was reviewed and revised to clearly articulate its focus on the application process for prospective Board members.
- A Diversity, Equity, and Inclusion (DEI) lens was applied to emphasize the Board’s commitment to recruiting members who reflect the diversity of the community it serves. The policy now explicitly encourages applications from diverse candidates, reinforcing this commitment. Codifying this language ensures consistency in recruitment practices across the organization.

Appointment of Auditor

- Since the HGMH Corporate By-laws include provisions regarding the appointment of the auditor, this policy and procedure serve as a supplementary requirement of the Board of Directors. Accordingly, a cross-reference to the By-laws is included to ensure the Board adheres to its prescribed duties in this matter.

Fraud Prevention Policy

When reviewing the Fraud Prevention Policy, it became clear that we had HGMH have already rolled out the Whistleblowing Policy and Program, and for the reasons below recommend the retirement of the Fraud Prevention Policy.

- The Whistleblower Policy already encompasses fraud prevention by providing a clear mechanism for reporting unethical or illegal activities, including fraud.
- Maintaining a separate Fraud Prevention Policy creates redundancy, as the key principles and protections are already embedded in the Whistleblower Policy.
- Retiring the Fraud Prevention Policy streamlines governance by reducing policy duplication and ensuring a more concise and effective policy framework.
- The Whistleblower Policy offers a stronger protection framework, as it includes safeguards against retaliation and encourages employees to report concerns confidentially and without fear.
- The Board’s commitment to fraud prevention remains intact through the Whistleblower Policy, which aligns with best practices for transparency and accountability.
- Organizations with a single, well-communicated reporting mechanism improve organizational trust and effectiveness in addressing fraud-related concerns.

IMPLEMENTATION & COMMUNICATION PLAN

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

- Obtain Board Approval – April 24, 2025
- Update Board Policy Online
- Include updates in Board Orientation Material

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Board Member Application Process Draft with tracked changes
- Board Member Application Process Clean
- Appointment of Auditor Draft with tracked changes
- Appointment of Auditor Clean
- Fraud Prevention Policy

Document Name:	Board Membership Application Process		
Document Number:	BOD.01.XXX.0.25		
Review Period:	<input checked="" type="checkbox"/> 3 years <input type="checkbox"/> 1 year	Manual: Governance	
Classification:	Board of Directors	Section:	
Owner:	President & CEO	Signing Authority: Board of Directors	

POLICY STATEMENT:

HGMH is committed to fair and equitable process for seeking applications to the Board of Directors. 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 purpose of this policy outlines the application process is to guide members of the community use who wish to apply to become a member of the Board of Directors member.

PROCEDURE:

1. In order 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:

1. _____

a. Secure an application package from the HGMH website www.hgmh.on.ca or through administration which contains/requires:

- i) Covering letter
- ii) Conflict of interest disclosure
- iii) Skill matrix form
- iv) Criminal reference 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 devices 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.

Effective: Jan 2015	Last review/revision: Apr 2025	Next review: Apr 2028
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Note: This is a controlled document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the Intranet prior to use.

- 3.4. 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.

DRAFT

Document Name:	Board Membership Application Process		
Document Number:	BOD.01.XXX.0.25		
Review Period:	<input checked="" type="checkbox"/> 3 years <input type="checkbox"/> 1 year	Manual: Governance	
Classification:	Board of Directors	Section:	
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) Criminal reference 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 devices 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,

Effective: Jan 2015	Last review/revision: Apr 2025	Next review: Apr 2028
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BOARD MEMBERSHIP APPLICATION PROCESS

members of visible minorities, persons with disabilities, and people who identify as 2SLGBTQ+, to apply.

DRAFT

Note: This is a controlled document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the Intranet prior to use.

Document Name:	Appointment of Auditor		
Document Number:	BOD.01.XXX.0.25		
Review Period:	<input checked="" type="checkbox"/> 3 years <input type="checkbox"/> 1 year	Manual: Governance	
Classification:	Board of Directors	Section:	
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.

Effective: Apr 2025	Last review/revision: Apr 2025	Next review: Apr 2028
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Note: This is a controlled document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the Intranet prior to use.

Document Name:	Appointment of Auditor		
Document Number:	BOD.01.XXX.0.25		
Review Period:	<input checked="" type="checkbox"/> 3 years <input type="checkbox"/> 1 year	Manual: Governance	
Classification:	Board of Directors	Section:	
Owner:	President & CEO	Signing Authority: Board of Directors	

POLICY STATEMENT:

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PROCEDURE:

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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.
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DRAFT

Effective: Apr 2025	Last review/revision: Apr 2025	Next review: Apr 2028
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Note: This is a controlled document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the Intranet prior to use.

POLICY NUMBER: CO.01.049.0.13

POLICY TYPE: CORPORATE (Administrative)

SUBJECT: FRAUD PREVENTION POLICY

POLICY: HGMH is committed to protecting its revenues, property, proprietary information, and other assets. HGMH will not tolerate any misuse or misappropriation of those assets.

The HGMH Fraud Prevention Policy is established to provide guidance to its directors, officers, and employees when misuse or misappropriation of HGMH's assets is suspected. HGMH values the integrity of its directors, officers, and employees and recognizes that they have a key role to play in the prevention, detection, and reporting of fraud. They are therefore expected to be vigilant at all times and to report concerns they may have at the earliest opportunity.

This corporate policy is meant to augment other corporate policies or any applicable law and is not intended to replace or preclude them. Should an overlap arise between the application of this policy and any other policy, the policy most specific to the situation will apply.

1. GUIDING PRINCIPLE:

It is HGMH's intent to fully investigate any suspected acts of "fraud", as it is defined in this policy, in an impartial manner regardless of the suspected wrongdoer's position, title, length of service, or relationship with HGMH.

Any act of fraud that is detected or suspected must be reported immediately and investigated in accordance with this policy.

HGMH will make every reasonable effort, including seeking court ordered restitution, to recover or receive compensation from any appropriate source in respect of HGMH's assets obtained by fraud.

2. SCOPE:

This policy applies to the directors, officers, and employees of HGMH.

Reference: Federal Bridge Corporation Ltd.

Approved by: _____

Effective Date: _____

Reviewed: _____

Revised _____

3. DEFINITIONS:

There are many definitions of "fraud" in the *Criminal Code* of Canada. At its most basic, fraud is the act of using dishonesty as a tool for personal gain. For the purposes of this policy, the definition includes any misuse or attempt to misuse an HGMH asset for personal gain or purpose unrelated to HGMH's business or undertaking. Examples of fraud include, but are not limited to, the following:

- Stealing or removing HGMH's assets;
- Using HGMHs' equipment, facilities, supplies, or funds for purposes unrelated to HGMH's business;
- Obtaining HGMH's funds or compensation through dishonesty; and
- Forgery or alteration of any document.

Areas of HGMH's business where risks of fraud may be particularly high include:

- Letting or managing of external contracts;
- Handling cash, invoices, receipts, or accounts;
- Expense claims;
- Payroll including the reporting of flexible hours;
- Handling sensitive information; and
- Overseeing high-volume, high-value or high-risk assets.

If you have any questions as to whether an action constitutes fraud, contact the CEO.

4. AUTHORITY AND RESPONSIBILITY:

Directors:

The Board of Directors is responsible to review and amend this policy, as may be required, from time to time. Also, the Board of Directors is responsible to oversee the management of the Corporation and the risk of fraud.

President and Chief Executive Officer:

The President and Chief Executive Officer (CEO) is responsible to implement this policy.

Management:

Management, including the officers of the corporation, is responsible for establishing and maintaining a system of internal controls to ensure the prevention, detection, and reporting of fraud, waste, abuse, and other irregularities (confirmed during audit). Management is expected to be reasonably familiar with the types of fraud that might occur within their area of responsibility and be alert for any indication of fraud.

Management has the same responsibility with respect to reporting fraud as do all other employees of HGMH, as outlined below.

Management will support and cooperate with the CEO, other involved managers, and law enforcement agencies in the detection, reporting, and investigation of suspected fraudulent acts, including the prosecution of offenders.

Employees:

Any employee of HGMH who knows or has reason to believe that a fraud has occurred, is responsible for immediately notifying his/her immediate manager. If the employee has reason to believe that the employee's immediate manager may be involved, the employee shall immediately notify the CEO. The CEO may be contacted via telephone or any other means of communication. Employees may choose to remain anonymous when reporting a suspected fraud but must maintain strict confidentiality concerning a reported fraud at all times.

It is expected that employees will fully cooperate with the CEO, other involved managers, and law enforcement agencies during the course of an investigation and will make all reasonable efforts to be available to assist the above noted persons with the investigation. Employees should not attempt to personally conduct investigations or interviews/interrogations related to any suspected fraudulent act so as not to prejudice the investigation.

5. INVESTIGATION AND OTHER RESPONSIBILITIES

Investigation Responsibilities

The CEO has primary responsibility for the investigation of all suspected fraud. Great care must be taken in the investigation of suspected fraud or wrongdoing so as to avoid mistaken accusation or alerting suspected individuals that an investigation is underway. This is important in order to avoid damaging the reputations of persons suspected but subsequently found innocent of wrongful conduct and to protect the hospital from potential civil liability.

Within the scope of the investigation as set out above, the CEO will have:

- Free and unrestricted access to all HGMH records, employees, and premises, whether owned or rented; and
- The authority to examine, copy, or remove all or any portion of the contents of files, desks, cabinets, and other HGMH facilities without prior knowledge or consent of any individual who may have use or custody of any such items.

The CEO will, as appropriate, consult with the Chief Financial Officer and Chief Nursing Officer.

The CEO may delegate responsibility for the investigation of suspected fraud to an outside consultant, as appropriate depending on the nature and scope of the suspected fraud. In this regard, the CEO will continue to monitor and provide advice as requested.

Decisions to prosecute or refer the investigation results to law enforcement agencies or other regulatory agencies for independent investigation will be made by the CEO.

Upon conclusion of an investigation, recommendations may be made by the CEO where required in order to minimize future risk. The CEO is responsible for implementing the appropriate controls to prevent reoccurrence.

The CEO will prepare an annual report on the status of any suspected fraud and related matters for review by the Finance Committee and will also recommend any necessary changes to policies and procedures that need to take place immediately to prevent similar frauds from happening again.

Special Investigations

Where it is suspected that fraud may have been committed by a director or an officer of HGMH, the CEO will conduct an initial review and report the results to the Chair of the Finance Committee. Where appropriate, the results may be reported to the Board Chair and/or the CEO. Where it is suspected that fraud may have been committed by the CEO, the Chair of the Finance Committee and the Board Chair will conduct an initial review.

Confidentiality

The CEO and all participants in a fraud investigation shall treat all information received as confidential. Investigation results will not be disclosed or discussed with anyone other than those who have a legitimate need to know. To the extent possible by law, the identity of the individuals involved in an investigation, including the identity of an individual alleged to have committed fraud, will be protected.

Any director, officer, or employee contacted by the media with respect to a fraud investigation shall refer the media person to the CEO. The alleged fraud or investigation shall not be discussed with the media by any person other than the CEO.

Whistle-Blower Protection

No person covered by the policy shall:

- Dismiss or threaten to dismiss an employee;
- Discipline or suspend or threaten to discipline or suspend an employee;
- Impose any penalty upon an employee; or
- Intimidate or coerce an employee,

because an employee has acted in accordance with the requirements of the policy.

Disciplinary Action

The CEO is solely responsible for discipline of employees in consultation with the Director of Human Resources. Employees who have committed fraud will be subject to disciplinary action up to and including dismissal.

Where fraud is suspected of any director, officer, or employee, the individual will be given notice of the essential particulars of the allegations following the conclusion of the investigation and prior to final disciplinary action. The individual against whom allegations are being made will be given the opportunity to respond.