

## Governance and Nominating Committee Meeting Agenda

Date: Wednesday, May 14, 2025  
 Time: 17H00 - 18H00  
 Location: Boardroom / Microsoft Teams

Time	Agenda Item	Board Item	Attachment
<b>17:00</b>	<b>1. Call to Order</b>		
(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 ( <a href="#">Policy BOD.01.013.X.XX</a> )		
<b>17:03</b>	<b>2. Report from the Last Meeting</b>		
(1 min)	2.1 Approval of Previous Meeting Report - April 9, 2025		P. 3-4
(1 min)	2.2 Business Arising from Report		
(1 min)	2.3 Committee Workplan Review		P. 5
<b>17:06</b>	<b>3. Matters for Discussion/Decision</b>		
(4 min)	3.1 Review Board Member Attendance (L. Boyling)	C	P. 6-9
(5 min)	3.2 Review Board Orientation (R. Alldred-Hughes)	C	P. 10-12
(5 min)	3.3 Board Candidates (L. Boyling)		
(5 min)	3.4 2025-2026 Meeting Schedule and Committee Membership	C	P. 13-14
(5 min)	3.5 Governance Accreditation Standard Review (R. Alldred-Hughes) <b>THAT the Governance and Nominating Committee recommend to the Board of Directors the approval of the new policies entitled "President &amp; Chief Executive Officer Position Description" and "Chief of Staff Position Description" as presented.</b>	C	P. 15-24
	3.6 Documents for Review: (R. Alldred-Hughes)		
(5 min)	3.6.1 Whistleblower and Fraud Prevention Policy <b>That the Governance Committee recommend to the Board of Directors the approval of the Whistleblowing &amp; Fraud Prevention Policy as presented, and retirement of the Fraud Prevention Policy.</b>	C	P. 25-30
(5 min)	3.6.2 Active Service Offer - Personal and Bilingual Services Policy <b>That the Governance Committee recommend to the Board of Directors the approval of the Active Service Offer Policy as presented.</b>	C	P. 31
<b>17:40</b>	<b>4. Matters for Information</b>		
(1 min)	4.1 Committee Effectiveness Survey and Peer to Peer Survey to be administered May 15 <sup>th</sup> , 2025, and completed by June 5 <sup>th</sup> , 2025.		
<b>17:41</b>	<b>5. Date of Next Meeting</b>		
(1 min)	October 2025		
<b>17:42</b>	<b>6. Adjournment</b>		

Board Item: Matters for Discussion/Decision (D) or Consent Agenda (C)

# 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

April 9, 2025 at 5:00PM Boardroom/MS Teams

Present: L. Boyling, Chair G. Peters Dr. S. Robertson  
G. McDonald C. Larocque R. Alldred-Hughes, CEO

Regrets: None

### Summary of Discussion

#### **Approval of the Agenda**

The agenda was reviewed.

Moved By: C. Larocque

Seconded By: G. McDonald

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 March 12, 2025, was shared.

Moved By: Dr. S. Robertson

Seconded By: G. Peters

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**

##### **Governance Accreditation Standard Review**

The Accreditation standard was reviewed in which a new policy was presented.

Moved By: C. Larocque

Seconded By: G. McDonald

THAT the Governance and Nominating Committee recommend to the Board of Directors the new policy entitled "Framework for Board Accountability & Transparency" as amended.

While doing Accreditation work, it was brought to our attention that we don't have a framework for Board accountability. As such, a policy was created formed from legislation and the Guide to Good Governance. The website is going to be updated to ensure transparency components are all outlined on our website and is publicly available. For the most part, it is all there, however there are a couple of things to be added.

It was suggested that the policy is the what and the procedure is the how and it seems to be the reverse here. He also suggested that there are X's missing or in the wrong place. This will

be adjusted. The first paragraph under procedure should be under the second paragraph of policy and moving the rest of policy under procedure.

The changes will be made to the policy and brought to the board as amended.

**CARRIED**

### **Equity, Diversity & Inclusion Update**

R. Alldred-Hughes gave an update on Equity, Diversity & Inclusion in which the Auxiliary will be sponsoring the Spiritual and Family Room. Survey responses are being pulled from diverse groups to analyze their responses and see what can be done to improve their experience at the hospital.

The committee would like to see a plan of what is being done and where we want to go with this.

### **Review Governing Body Assessment Results**

The Governing Body Assessment results were reviewed. Overall, the results are positive. Adjustments will be made based on these results in terms of the amount of time meetings are spent reviewing quality. This will take place with the Quality committee meeting 6 times per year as of next Board cycle.

Based on these results, it was questioned whether there were areas the committee would like to improve in order to enhance the work. The only area was around education in which it was agreed that education sessions be done at every board meeting to allow the board to learn about the hospital environment.

### **Documents for Review**

#### **Board Application for Membership Process Policy and Appointment of Auditor Policy**

These policies were due for regular review.

Moved By: C. Larocque

Seconded By: G. Peters

THAT the Governance & Nominating committee recommend to the Board of Directors the approval of the following policies as presented: Board Membership Application Process and Appointment of Auditor.

There were no changes proposed to the policies.

**CARRIED**

### **Fraud Prevention**

This policy was suggested to be archived.

Moved By: C. Larocque

Seconded By: G. McDonald

THAT the Governance & Nominating committee recommend to the Board of Directors the retirement of the Fraud Prevention Policy.

The recommendation for archiving this policy is due to the Whistleblower Policy being implemented and to eliminate duplicate policies. The Whistleblower Policy delineates who is responsible for what. It was agreed that the Whistleblower policy be renamed to include fraud prevention. The policy will be brought back to the next meeting with some revisions including title change.

**CARRIED**

**Next meeting:** Wednesday, May 14, 2025

K-L. Massia, Recorder

# Governance and Nominating Committee Annual Work Plan 2024-2025



Deliverable	MRP	Occurrence	SEP	NOV	JAN	MAR	APR	MAY
<b>STRUCTURE/PROCESSES</b>								
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					✓	
Review Board Orientation	Chair	Annually						X
Review CEO and COS Succession Plan	Chair	Annually			✓			
<b>DIRECTOR RECRUITMENT AND SELECTION</b>								
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	
Candidate Recommendation to the Board		Annually						X
Review Following Years Committee Schedule and Membership		Annually						X
<b>ACCREDITATION</b>								
Governance Standards Review	Chair	Every meeting	✓	✓	✓	✓	✓	X
Equity, Diversity & Inclusion Update	Chair	Bi-Monthly	✓		✓		✓	
Review Communication Plan	Chair	Annually		✓				
<b>PERFORMANCE</b>								
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
<b>POLICY REVIEW</b>								
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						✓	
Appointment of Auditor (GO.02.006)	CEO						✓	
Fraud Prevention (CO.01.049)	CEO						✓	
Active Service Offer – Personnel and Bilingual Services (CO.01.030)	CEO							X
<b>ESTIMATED PREPARATION TIME FOR MEETING</b>								

Revisions since prior report:

## 2024-2025 Board of Directors Attendance



Name	2024				2025						Total	%	
	*Jun	Sept	Oct	Nov	Jan	Feb	Mar	Apr	May	Jun			
Frank Wetering, Past Chair	P	P	P	P	P	P	P	P	P				
Dr. Stuart Robertson, Chair	P	P	P	P	P	P	P	P	P			8	100%
Louise Boyling, Vice Chair	P	P	P	P	P	P	P	P	P			8	100%
Charlotte Nagy, Treasurer	P	P	P	A	P	P	P	P	P			7	88%
Carole Larocque	P	P	P	A	P	P	P	P	P			7	88%
Francois Desjardins	A	P	P	P	P	P	P	P	P			7	88%
Dr. Genevieve Raby	P	P	P	A	P	P	P	P	P			7	88%
Gerard McDonald	P	P	P	P	P	P	P	P	P			8	100%
Gordon Peters	P	P	P	P	P	P	P	P	P			8	100%
Heidi Salib	P	P	P	P	P	P	P	P	P			8	100%
Dr. Raynald Cardinal	P	P	P	P	P	P	P	P	P			8	100%
Wendy Rozon	P	P	P	A	P	P	P	P	P			7	88%
<b>Total</b>	11	12	12	8	12	12	12	12	0	0	83	94%	

\*Special Meeting

## 2024-2025 Governance Attendance



Name	2024		2025				Total	%
	Sep	Nov	Jan	Mar	Apr	May		
Louise Boyling	P	P	P	P	P		5	100%
Carole Larocque	A	P	P	P	P		4	80%
Gerard McDonald	P	P	P	P	P		5	100%
Gordon Peters	P	P	P	P	P		5	100%
Dr. Stuart Robertson	P	P	P	P	P		5	100%
<b>Total</b>	4	5	5	5	5	0	24	96%

## 2024-2025 Finance Attendance



Name	2024			2025						Total	%
	Sep	Oct	Nov	Jan	Feb	Mar	*Apr	May	Jun		
Charlotte Nagy	P	P	P	P	P	P	P			7	100%
Francois Desjardins	P	A	P	P	P	P	P			6	86%
Dr. Genevieve Raby	P	P	P	P	A	P	P			6	86%
Louise Boyling	P	P	P	P	P	P	A			6	86%
Dr. Stuart Robertson	P	P	P	P	P	P	P			7	100%
<b>Total</b>	5	4	5	5	4	5	4	0	0	32	91%
*Special Meeting											

## 2024-2025 Quality Attendance



Name	2024		2025		Total	%
	Sep	Nov	Feb	May		
Carole Larocque	P	P	P		3	100%
Gordon Peters	P	P	P		3	100%
Heidi Salib	P	P	P		3	100%
Dr. Raynald Cardinal	P	P	P		3	100%
Wendy Rozon	P	P	A		2	67%
<b>Total</b>	5	4	4	0	12	100%

\*Special Committee Meeting

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: April 30, 2025                      Meeting Date Prepared for: May 14, 2025  
 Subject: Board Orientation  
 Prepared by: Robert Aلدred-Hughes, President & CEO

- DECISION SOUGHT\*                     
  FOR DISCUSSION/INPUT                     
  FOR INFORMATION ONLY

**PURPOSE**

The Governance Committee is responsible for ensuring that a comprehensive orientation session is provided to all new Board members. By periodically reviewing the board orientation, areas for improvement and optimization can be identified.

**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.*

The board orientation serves as a pivotal onboarding mechanism for new directors, offering them a comprehensive understanding of their roles, responsibilities, and the organization’s governance framework among other important information.

Based on conversations that took place throughout this board cycle, the orientation agenda was revised and includes information the was deemed to be important to discuss during orientation. These changes are highlighted in the agenda attached.

Please consider any other feedback or adjustments to the orientation agenda. An opportunity to share your thoughts will be provided at this Governance committee meeting.

**IMPLEMENTATION & COMMUNICATION PLAN**

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

- Review Orientation Agenda – May 14, 2025
- Orientation slide deck will be updated accordingly

**SUPPORTING DOCUMENTS/ATTACHMENTS**

*List any supporting documents or attachments*

- Board Orientation Agenda

<b>Agenda Item</b>	<b>Time</b>	<b>Responsibility</b>
<b>Welcome</b>	<b>12:00-12:15</b>	
<i>Introductions</i>		Dr. Stuart Robertson
<i>Hôpital Glengarry Memorial Hospital Overview</i>		Robert Alldred-Hughes
<b>HGMH Board of Directors</b>	<b>12:15-12:45</b>	
<i>Roles &amp; Responsibilities of the Board Chair, Vice Chair and Treasurer</i>		Dr. Stuart Robertson
<i>Roles and Responsibilities of the Board</i>		Dr. Stuart Robertson
<i>Responsibilities as a Director and Code of Conduct</i>		Dr. Stuart Robertson
<i>Board Structure &amp; Accountability</i>		Dr. Stuart Robertson
<i>Board Mentorship</i>		Dr. Stuart Robertson
<i>Board Portal and HGMH Email Usage</i>		Dr. Stuart Robertson
<i>Board and Committee Meeting Attendance Requirement</i>		Dr. Stuart Robertson
<i>Board Surveys</i>		Dr. Stuart Robertson
<b>Strategic Direction</b>	<b>12:45-13:15</b>	
<i>Governance &amp; Nominating Committee</i>		Louise Boyling
<i>Boards Role in Strategic Planning</i>		Robert Alldred-Hughes
<i>Strategic Plan Overview</i>		Robert Alldred-Hughes
<i>Strategic Plan Monitoring</i>		Robert Alldred-Hughes
<i>IDEAA Committee</i>		Robert Alldred-Hughes
<i>Ethical Decision-Making Framework</i>		
<b>Leadership</b>	<b>13:15-13:25</b>	
<i>Leadership Structure</i>		Robert Alldred-Hughes
<i>People Overview</i>		Robert Alldred-Hughes
<i>Talent Management &amp; Succession Planning</i>		Robert Alldred-Hughes
<b>Quality, Safety &amp; Effectiveness</b>	<b>13:25-14:00</b>	
<i>Quality &amp; Patient Safety Committee</i>		Dr. Stuart Robertson
<i>Medical Advisory Committee</i>		Robert Alldred-Hughes
<i>Boards Role in Credentialing and Re-Credentialing</i>		Robert Alldred-Hughes
<i>Quality Improvement Plan</i>		Rachel Romany
<i>Accreditation</i>		Rachel Romany
<i>Trillium Gift of Life Network (TGLN)</i>		Rachel Romany
<i>Whistleblowing and Fraud Prevention</i>		Robert Alldred-Hughes
<b>BREAK/HOSPITAL TOUR</b>	<b>14:00-14:20</b>	
<b>Relationships</b>	<b>14:20-14:40</b>	
<i>Ontario Health Teams</i>		Robert Alldred-Hughes
<i>Partnerships</i>		Robert Alldred-Hughes
<i>Communications</i>		Robert Alldred-Hughes
<b>Financial Viability</b>	<b>14:40-15:15</b>	
<i>Finance, HR, and Audit Committee</i>		Charlotte Nagy
<i>Finances Operating &amp; Capital</i>		Robert Alldred-Hughes
<i>Funding Committee of the Hospital</i>		Robert Alldred-Hughes
<i>Hospital Services Accountability Agreement</i>		Robert Alldred-Hughes
<i>Enterprise Risk Management</i>		Robert Alldred-Hughes
<i>Health Information Systems</i>		Robert Alldred-Hughes
<i>Capital Redevelopment Planning</i>		Robert Alldred-Hughes
<b>Other Board Committees</b>	<b>15:15-15:50</b>	
<i>Executive Committee</i>		Dr. Stuart Robertson



**BOARD OF DIRECTORS**  
**ORIENTATION 2025-2026**

**Monday, August 12<sup>th</sup>, 12:00pm - HGMH Boardroom**

<b>Agenda Item</b>	<b>Time</b>	<b>Responsibility</b>
<i>Executive Pay for Performance</i>		Robert Alldred-Hughes
<i>French Language Services Committee</i>		Carole Larocque
<i>Patient &amp; Family Advisory Committee</i>		Robert Alldred-Hughes
<b>Questions, Comments, Evaluation</b>	15:50-16:00	

Aug 2025						
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31						

Sept 2025						
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Oct 2025						
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Nov 2025						
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30						

Dec 2025						
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Jan 2026						
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Feb 2026						
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Mar 2026						
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Apr 2026						
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May 2026						
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31						

Jun 2026						
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Jul 2026						
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**Board of Directors**

5:00pm-7:30pm

**Board Committees**

5:00pm-8:30pm

**AGM**

Last Thursday of June

**Committee Schedule**

<b>Governance and Nominating:</b>	October, November, January, March (recruitment in April if needed), May, and June
<b>Finance, HR and Audit:</b>	September, November, February, March, May, and June
<b>Quality &amp; Patient Safety:</b>	September, November, January, February, April, and May
<b>Executive:</b>	October and April
<b>French Language Services:</b>	June

Board Retreat  
Board Open House (if recruitment is needed)

Board Orientation (if needed)

## 2025-26 BOARD COMMITTEE MEMBERSHIP



(X) = Minimum committee meetings / year	Governance (6)	Quality (6)	Finance & HR (6)	French Language Services (1)	Executive Com. (2)	Found. (10)	Past-Chair	Chair	Vice-Chair	Treasurer	Meetings per year (19)	Year Joined
Dr. S. Robertson	X by TOR		X by TOR		X			X				2021
L. Boyling	Chair				X	X			X			2021
C. Nagy			Chair		X					X		2022
C. Larocque	Backup	X										2022
Dr. G. Raby	X			Chair								2023
Dr. R. Cardinal		X		X								2023
G. Peters		Backup	X									2023
F. Desjardins			X	Backup								2024
W. Rozon		X										2024
G. McDonald	X		Backup									2024
H. Salib		Chair										2024
Members / TOR	5	5	5	3	3							
Quorum per TOR	3	3	3	2	2							

As per Bylaw the Vice-Chair shall at the discretion of the Board Chair or the Board shall serve on at least one key Board Committee as the committee chair.

Fiscal Advisory Committee: no board member unless asked by CEO (TOR)

Executive & Joint Conference Committees: Chair, Vice-Chair, Treasurer, CEO and COS (minimum 1 meeting per year)

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: April 30, 2025                      Meeting Date Prepared for: May 14, 2025

Subject: Accreditation Standard Feature 3.2.2

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 policies entitled “President & Chief Executive Officer Position Description” and “Chief of Staff Position Description” 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**

3.2.2 The governing body ensures that the accountabilities of the executive leader are defined.

Guidelines

The governing body ensures that the roles, responsibilities, and accountabilities of the executive leader are defined and kept up to date, in compliance with relevant laws, regulations, and contractual obligations. The governing body seeks input from the executive leader to inform the development and review of the roles, responsibilities, and accountabilities.

The governing body ensures that the roles, responsibilities, and accountabilities are described in an executive leader position description. It ensures that the position description is written using neutral language that is not biased in favour of or against a person, group, or attribute (e.g., age, gender identity, race, ethnicity).

The position description clarifies the division of roles, responsibilities, and accountabilities between the executive leader and the governing body. It includes the executive leader's accountabilities to the governing body and the organization's stakeholders (e.g., clients, families, workforce, volunteers, community groups, partner organizations) for the quality and safety of services provided by the organization; for advancing people-centred care in the organization and the health system; and for leading the workforce to achieve the organization's vision, mission, and values.

In some jurisdictions, the executive leader's roles, responsibilities, and accountabilities may be defined by government. In this case, the governing body provides input into defining, reviewing, and updating the roles, responsibilities, and accountabilities, and participates to the fullest extent possible.

Based on the above, the attached policies were developed for consideration and recommendation to the Board of Directors for adoption. If approved, these policies 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)*

**Do the new policy meet the Accreditation Standard from your perspective?**

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

<b>Document Name:</b>	Executive Leaders Position Description		
<b>Document Number:</b>	BOD.02.XXX.0.25		
<b>Review Period:</b>	<input checked="" type="checkbox"/> 3 years <input type="checkbox"/> 1 year	<b>Manual:</b> Governance Policy Manual	
<b>Classification:</b>	Board of Directors	<b>Section:</b> Leadership	
<b>Owner:</b> Board Chair	<b>Signing Authority:</b> Board of Directors		

### **POLICY STATEMENT:**

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

### **PROCEDURE:**

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

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

### ***Responsibilities of the Governing Body***

The Board of Directors will:

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

### ***Position Description Requirements***

Each position description will include:

#### **a. General Role Summary**

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

Effective: May 2025	Last review/revision: May 2025	Next review: May 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.

**b. Reporting Relationship**

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

**c. Key Responsibilities and Accountabilities**

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

**d. Stakeholder Accountability**

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

**e. Governance Interface**

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

**f. Equity, Diversity, Inclusion, and Accessibility (EDIA)**

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

***Review and Revision Process***

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

**REFERENCES:**

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

## **Appendix A – President & Chief Executive Officer Position Description**

### **Accountabilities / Responsibilities:**

#### *Board of Directors*

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

#### *Realization of the Hospital's Mission*

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

*Strategic Management / Leadership*

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

*Management of Care and Services*

- Institutes an ongoing care and services planning process, based on an evaluation of the clientele's needs, and on the complementarity with those services provided by the health care partners;
- Elaborates strategies for the upholding, development, or restructuring of care and services;
- Assures the actualization of care and services in accordance with the existing programs;
- Assures the implementation of a quality improvement program throughout the Hospital, by designating management staff for its coordination; ensures the participation of different professional groups and other works in the implementation of the program and of its quality improvement activities as regards care and services rendered to the clientele;
- Designates a member of the staff to be in charge for implementing the policy on users' complaints, and submits this designation to the Board of Directors;
- Transmits to the Board of Directors any recommendation or report addressed to him by the member of staff in charge for implementing the policy on users' complaints.

*Management of People*

- Approves the human resources strategic plan;
- Sees to the selection and to the hiring of those reporting directly to the CEO;
- Favors mobilization, development, and expression of human resources as well as the development of an organizational culture;
- Identifies the measures to be taken in view of creating and maintaining a quality of life at work as well as a satisfying and stimulating environment amongst the Hospital in order to create a work environment conducive to staff retention;

- Sees to the elaboration, the implementation, and the follow-up of an evaluation process for management staff and non-management staff;
- Sees to the elaboration of an annual training plan for the personnel;
- Sees to the quality of the collective relations with the Hospital staff;
- Sees that a prevention program be implemented in order to protect the health and safety of the workers;

*Management of Financial Resources*

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

*Management of Technical and Material Resources*

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

*Management of Informational Resources*

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

*Management of Internal Communication*

- Assures the preparation of an efficient internal communication plan, accepted by the Board of Directors, and followed-up so that the Board may make its decisions based on pertinent, reliable, and comprehensive information; assures that these decisions be communicated to the required instances of individuals, and that each group or individual of the Hospital secures, at a timely moment, the information that is useful to them in order to play their role and perform efficiently in their functions.

*Management of External Relations*

- Assures the upholding of the necessary relations with the community, Ontario Health, and the MOH, as well as with all other institutions or bodies or organizations concerned by the Hospital's mission;

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

*In accordance with the Corporate By-law:*

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

**Key Competencies:**

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

## **Appendix B – Chief of Staff Position Description**

### **Accountabilities / Responsibilities:**

#### *Board of Directors*

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

#### *Strategic Management/Leadership*

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

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

*In accordance with the Corporate Bylaws*

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

**Key Competencies:**

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

**Required Qualifications:**

- Active Staff in good standing
- Formal education related to Hospital Physician Leadership

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: May 6, 2025 Meeting Date Prepared for: May 14, 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 policies up for review and highlight any material changes to each policy.

**RECOMMENDATION / MOTION**

That the Governance Committee recommend to the Board of Directors the approval of the Whistleblowing & Fraud Prevention Policy as presented, and retirement of the Fraud Prevention Policy.

That the Governance Committee recommend to the Board of Directors the approval of the Active Service Offer Policy 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.*

Summary of amendments:

**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.

- Based on the feedback from the April 2025 Governance Committee meeting, the Whistleblower policy naming was amended to include the terms “Fraud Prevention” to ensure it was clear this is the policy used when there is suspicion of fraud.

#### **Active Service Offer Policy**

- This policy has not been amended, and is used to demonstrate the hospital commitment to providing services in the language of one's choice when accessing services at the hospital.

#### **IMPLEMENTATION & COMMUNICATION PLAN**

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

- Obtain Board Approval – May 22, 2025
- Update Board Policy Online
- Include updates in Board Orientation Material

#### **SUPPORTING DOCUMENTS/ATTACHMENTS**

*List any supporting documents or attachments*

- ***Whistleblower & Fraud Prevention Policy***
- ***Fraud Prevention Policy***
- ***Active Service Offer***

<b>Document Name:</b>	Whistleblowing & Fraud Prevention		
<b>Document Number:</b>	BOD.01.019.0.25		
<b>Review Period:</b>	<input checked="" type="checkbox"/> 3 years <input type="checkbox"/> 1 year	<b>Manual:</b> Board and Employee Orientation	
<b>Classification:</b>	Board of Directors	<b>Section:</b> Governance	
<b>Owner:</b> President & CEO	<b>Signing Authority:</b> 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 & Fraud Prevention 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;

Effective: Nov 2013	Last review/revision: May 2025	Next review: May 2028
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- refer the report to the report process;
  - conduct a Compliance Officer investigation; or
  - constitute an Investigation Task Force.
- Action plans will consider the merit and severity of the report and the potential risk.
- Determine if a report is addressed under this policy, or addressed under an alternate administrative policy such as:
    - Patient and Family Feedback,
    - Harassment and Discrimination,
    - Disruptive Physician Policy,
    - Conduct Policy, etc.
  - File a report with the CEO on a monthly basis. The monthly report shall include a summary of the reports received, the action plans and status, or state that no reports were received for the reporting period. (The CEO shall then report to the Finance, HR & Audit Committee of the Board through the monthly Compliance Report)
  - Design, implement and oversee procedures to ensure that all reported whistleblowing concerns are investigated in full;
  - Ensure that the reporter is advised when the investigation process has been completed.

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

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

### **INVESTIGATION TASK FORCE**

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

## **PROCEDURE:**

### ***Ethical, Legal, Professional or Financial***

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

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

To ensure that reports can be submitted confidentially or anonymously when Internal Reporters so choose, HGMH shall maintain other formal means by which employees may communicate reports, which may include:

- an e-mail address to which reports may be forwarded and which is accessed exclusively by the Compliance Officer **compliance.officer@hgmh.on.ca**; and
- the interoffice mail (or regular mail or other means of delivery), by which reports may be submitted in a sealed envelope marked "Private and Strictly Confidential – Attention: Compliance Officer – Hôpital Glengarry Memorial Hospital", the envelope shall be forwarded unopened to the Compliance Officer.

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

3. If the suspicion of misconduct involves the CEO, that individual will not be informed or involved in the ordinary course. The Compliance Officer shall report the matter immediately to the Chair of the Finance, HR & Audit Committee and the Chair of the Board of Directors. The Board Chair shall assume the responsibility of the investigation with the support of the Compliance Officer.
4. The Compliance Officer shall investigate the circumstances, in consultation with the Investigation Task Force, and any other persons with a legitimate interest in the matter including external expertise if deemed appropriate:
  - **Criminal Activity:** In the case of suspected criminal activity, the CEO (or Board Chair should the CEO be implicated) should be involved in the investigation. If deemed necessary, legal counsel may be consulted. HGMH will at all times co-operate with the police.
  - **Breach of Professional Behaviour:** The investigation should include a representative of the suspect's professional association.
  - **Unethical conduct:** The investigation should include a union representative or a Human Resources Representative for non-union staff.
  - **Financial Impropriety:** Includes misuse or misappropriation of funds, improper expense account claims or patient billings. The investigation should include a representative of the Finance, HR, and Audit Committee
  - **Witnesses:** If the person making the report and/or any other witnesses are unionized staff, a union representative should be present at all interviews.

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

***Fraud***

1. It is the responsibility of the Finance, HR, and Audit Committee to ensure that the organization has appropriate procedures for the receipt, retention, and treatment of reports about its accounting, internal accounting controls, or auditing matters.
2. Under NO circumstances, should employees, physicians, volunteers, or their supervisors initiate an investigation of alleged fraud. To do so may compromise any ensuing investigation.
3. Once the Compliance Officer has been notified of a possible fraudulent act, he/she will:
  - Consult with the CEO and Chief Financial Officer (CFO) to determine the appropriate course of action which may or may not include an Investigation Task Force. Should the CEO be implicated, the Compliance Officer will consult with the Chair of the Finance, HR, and Audit Committee;
  - Advise the Finance, HR, and Audit Committee immediately via email of the situation and the proposed course of action;
  - Should the Compliance Officer decide not to refer the matter to the Investigation Task Force, a full report including the rationale for the decision shall be forwarded to the Finance, HR, and Audit Committee immediately via email.

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

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

<b>Document Name:</b>	Active Service Offer – Personnel and Bilingual Services		
<b>Document Number:</b>	BOD.02.004.0.25		
<b>Review Period:</b>	<input checked="" type="checkbox"/> 3 years <input type="checkbox"/> 1 year	<b>Manual:</b> Governance Policy Manual	
<b>Classification:</b>	Board of Directors	<b>Section:</b> Leadership	
<b>Owner:</b>	President & CEO	<b>Signing Authority:</b> Board of Directors	

**POLICY STATEMENT:**

Patients are encouraged to communicate in the official language of their choice, and Hôpital Glengarry Memorial Hospital personnel will endeavor to provide the appropriate linguistic services within their language competency.

**PROCEDURE:**

When a patient has been identified to be French speaking, pro-active efforts to address the patient in their language will be made.

Effective: Nov 2002	Last review/revision: May 2025	Next review: May 2028
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