SUBJECT: PROCESS FOR NOMINATION OF DIRECTORS

Article 4.7 of the By-law outlines the nomination for Directors to ensure a systematic, transparent, accountable and fair process is in place by which the Board of Directors, with the advice and assistance of the Governance Committee, will recommend a slate of candidates for approval by the voting Members of the Corporation at the annual meeting.

Role

The Governance Committee supports the Board of Directors in fulfilling its responsibilities to recruit Directors who are skilled, experienced and able to provide leadership to KHSC. The Governance Committee also supports the Board of Directors in the annual process to approve non-Director members of Board Standing Committees.

Reporting Relationship

To the Board of Directors with respect to the nomination of Directors and to the Governance Committee with respect to the nomination of non-Director members of Board Standing Committees.

Responsibilities

The Governance Committee shall:

1. be bound by the Guidelines for the Selection of Directors, as amended by the Board from time to time;

2. recommend annually to the Board of Directors individuals to fill vacancies on the Board of Directors as a result of a systematic and transparent nominations process as outlined below;

3. recommend at least annually to the Board of Directors potential candidates to fill non-Director positions on Board Standing and Ad Hoc Committees.

The Nominations Process for Elected Directors:

The Nomination Process sets out a systematic, transparent, accountable and fair process by which the Board of Directors with the advice and assistance of the Governance Committee will recommend a slate of candidates for approval by the Voting members of the Corporation at the Annual General Meeting.
1. Each year, at least five (5) months before the Annual General Meeting, the Board of Directors shall:

(a) request the Governance Committee to determine the number of vacancies in the office of Directors and shall include in this number incumbent Directors who are eligible for re-election. The Governance Committee shall then, using the Guidelines for the Selection of Directors, review the Board profile of skills and expertise of incumbent Directors and identify the specific skills and expertise, which are required to fill vacancies. Where an incumbent director is seeking re-election, in addition to the foregoing criteria, the Governance Committee shall take into consideration that individual’s self-evaluation of their own performance as a Board member, their history as a Board member and the contributions that they have made to KHSC;

(b) the Governance Committee will undertake a systematic and transparent process of recruitment for nomination of potential candidates based on the Guidelines for Selection of Directors and current Board profile as compiled by the Governance Committee.

2. The Governance Committee shall:

(a) review the vacancies and specific skills and expertise which are required on the Board of Directors and non-Director positions on Board Standing Committees;

(b) advertise vacancies on the Board of Directors in the regional daily and weekly paperspublicly accessible local and/or regional locations and/or media and on the KHSC website, including a summary of the responsibilities as a Director and the Guidelines for Selection of Directors. Where an incumbent director’s term is up for renewal and the director is seeking re-election, that fact shall be indicated on the KHSC website;

(c) advertise vacancies in non-Director external positions on Board Standing Committees where desired or where a specific skill set or affiliation is required on the committee for which a broader recruitment strategy is indicated;

(d) invite formal applications by interested individuals on a standard form to be provided by KHSC, which shall be submitted to the Secretary of KHSC and forwarded to the Chair of the Governance Committee for review. Applicants who do not meet the basic qualifications set out in section 4.3 of the by-law shall be advised of their ineligibility to serve as directors;

(e) identify a short-list of candidates for interview evaluation by the Governance Committee and interview and confirm the process to evaluate the short-listed candidates in accordance with the criteria for the selection of directors;

(f) obtain and check references for the candidates selected for nomination as Directors and non-Director members of Board Standing Committees;
(g) recommend to the Board of Directors a slate of candidates for Director equal to the number of vacancies for approval by the Board of Directors and for subsequent ratification by the Voting members of the Corporation at the Annual General Meeting.
SUBJECT: PROCESS FOR SELECTION OF BOARD OFFICERS

This Policy is intended to supplement By-Law Articles 9 and 10 related to Board Officers. In the event of conflict between this Policy and the By-Law, the By-Law provision(s) will apply.

The selection process for Board Officers will be a systematic, transparent, accountable and fair process.

The Governance Committee is responsible for ongoing succession planning for leadership on the Board and the recommendation of a slate of Officers including Board Chair and Vice-Chair. Under normal circumstances, the by-law provides for succession from the position of Vice-Chair to Chair. Therefore, under normal circumstances, the Governance Committee process for selection of Board officers is focused on the position of Vice-Chair.

Selection Process

The following process will be followed by the Governance Committee:

1. No later than four months prior to the completion of the second one-year term of the incumbent Vice-Chair(s), the Governance Committee will canvass the Directors for expressions of interest in being considered for the position of Vice-Chair(s) or nomination of another Director, based on the position description and qualifications for Vice-Chair(s) and Board Chair.

2. Based on the information received from Directors, the Governance Committee will develop an inventory of candidates for Vice-Chair(s).

3. The Governance Committee Chair will interview potential candidates, having regard for the position description and qualifications for Board Chair and Vice Chair(s) and the results of their Director evaluations.

4. In the event that members of the Governance Committee are also seeking election as Vice-Chair(s), the Committee will pursue one of the following processes:
   
i) conduct the selection process and make recommendations to the Board of Directors; OR

ii) exclude potential candidates from Committee deliberations in relation to this position.
5. Where there are multiple candidates for the position of Vice-Chair, the Governance Committee will:

   i) provide a list of the candidates to the Board of Directors for a vote by secret ballot at the first meeting of the Board following each Annual General Meeting; OR

   ii) canvass the Board of Directors on the perceived strengths and weaknesses of the potential candidates and agree on a nominee to recommend for election by the Board of Directors at the first meeting of the Board following the Annual General Meeting.

6. No later than four months prior to the completion of the initial one year term of the Vice-Chair, the Governance Committee will confirm with the Vice-Chair that he/she wishes to be elected for a second one year term and canvass the Board of Directors to confirm their support for the Vice-Chair to be elected for a second one-year term on the understanding that he/she would subsequently be elected by the Board of Directors to the position of Chair.

7. In the event that the Vice-Chair does not wish to/does not have the support of the Board of Directors to be elected for a second one year term, the Governance Committee will initiate the process for selection of a Vice-Chair outlined above. In this event, the new Vice-Chair would serve a one year term, prior to standing for election as Chair.
The nominations process for the Director and Non-Director Members of Board Standing Committees will be a systematic, transparent, accountable and fair process.

All Directors of the Board will be expected to serve on at least one Board Committee. The Board Chair will be an ex-officio member of every Board Committee. Each Standing Committee will include at least three other elected Directors.

Guidelines for the Assignment of Directors to Standing and Special Committees

Annually, as part of the nominations process for Directors, the Governance Committee will canvass each Director to obtain expressions of interest in specific Standing and Special Committee assignments for the coming year including interest in assuming responsibilities as Committee Chairs.

In nominating specific Directors for assignment to Standing Committees, the Governance Committee will have regard for:

i) preferences of Directors;

ii) balance of skills and expertise;

iii) prior experience in relation to matters before the Committee;

iv) the expectation that each Director serve on at least three Board Standing Committees over the course of their service as a Director

or:

v) preferences of Directors;

vi) other criteria as determined by the Board.

Guidelines for the Assignment of External Members to Standing and Special Committees

1 An external member refers to community members on Board Committees, who are not directors of the Board, but are members of the Committee.
Governance Committee will review the skill requirements for external positions on the board standing committees annually.
The nominations process for the Director and external members¹ of the Board and Standing Committees will be a systematic, transparent, accountable and fair process.

Guidelines for the Assignment of Patient Experience Advisors to the Board

Annually, as part of the nominations process, the Governance Committee will review the committee compositions and term expirations for members serving on the Board and its committees.

Selection Process

The Governance Committee shall:

1. Review the vacancies and specific skills and expertise which are required for the positions on the Board and its committees.

2. Identify Patient Experience Advisor appointments that are expiring or that may be renewed.

3. Invite Patient Experience Advisors through an Expression of Interest form to confirm their interest in serving on the Board or specific Board committee.

4. Interested Patient Experience Advisors will need to meet the basic qualifications outlined in Article 4.3 of the By-law; individuals who do not meet the basic qualifications will be advised of their ineligibility to serve as a Board and/or committee member.

5. Short-list of candidates for interview will be identified by the Chair and Vice Chair or Governance Chair and Vice-Chair and arrangements for interview will be confirmed by the CEO’s office.

6. Patient Experience Advisors will be interviewed by a small panel of board members.

7. The Board Chair or Governance Committee Chair will follow up with all candidates interviewed; reference checks will be completed and CPICs confirmed to be on file.

8. Appointments are for a two-year term or a one year term with possibility of renewal twice for a maximum of three years in total.

¹ An External Member refers to community members on Board Committees, who are not directors of the Board, but are members of the Committee.
9. Recommendation to the Board for Patient Experience Advisor appointments will normally be completed at the June board meeting.

10. Patient Experience Advisors appointed will participate in an orientation program.

11. Board committee chairs will serve as mentors to the Patient Experience Advisors.
The Board delegates responsibility and authority to the President & Chief Executive Officer (CEO) for the management and operation of the Corporation. As such, the CEO is accountable and require accountability to the Board.

The Board’s sole official connection to the operational organization, its achievements and conduct will be through the Chief Executive Officer (CEO). The Board provides direction to the CEO in accordance with policies established by the Board. The Board delegates responsibility and authority to the CEO for the overall operation of the Hospital.

Only decisions of the Board acting as a body are binding on the CEO. When Directors or Committees make requests without Board authorization, such requests can be declined when in the CEO’s opinion, a material amount of staff time or funds are required. The matter, if appropriate, may be referred to the Board for discussion.

The CEO will report to and be responsible to the Kingston Health Sciences Centre Board of Directors for implementing the Hospital’s Strategic Plan, operating and capital plan, and for the day-to-day operation of the facilities of the Hospital in a manner consistent with policies established by the Board.

The CEO shall not cause or, with the CEO’s knowledge, allow any practice, activity, decision or organizational circumstance that is either unlawful, imprudent, or in violation of commonly accepted business and professional ethics.
Annually the Board of Directors will: establish measurable performance expectations for the President & Chief Executive Officer (CEO), in cooperation with the CEO; assess CEO performance; and determine CEO compensation consistent with the Ontario Regulation 304/16: Executive Compensation Framework. The performance review process provides an opportunity to recognize the CEO’s level of performance, to collaboratively develop the CEO’s priorities for the next fiscal year, and to plan strategies to support the CEO and the organization’s continuing growth.

Guiding Principles

1. Performance management supports, reinforces and integrates the achievement of strategic and annual business plan results with individual performance goals. It provides recognition and input from key stakeholders of performance outcomes.

2. Performance standards, measures and indicators should be established in the Performance Agreement to appropriately assess CEO performance. Performance commitments and measures should be set at a level which reflects the high level of performance expected.

3. Performance pay (pay at risk) is directly linked to the achievement of key results in specified performance areas, including building for the longer term (multi-year goals).

4. The Performance Agreement should include reference to the CEO’s expectations for executives within the organization, thereby promoting a consistent and continuous approach to talent development succession planning, and performance measurement across the executive leadership group.

5. The Performance Agreement will be aligned with the fiscal year.

Process

a) The CEO will provide the Governance Committee with progress reports 6 weeks after the end of each quarter so that results reporting is aligned with corporate planning and performance cycle. The Governance Committee will review the CEO’s performance against the Plan and report to the board on a quarterly basis.

b) The Governance Committee will conduct an annual review of CEO performance against the established Performance Agreement and report to the board within 10 weeks following the end of
the Fiscal Year. This review will include input from members of the board and major external stakeholders and will be structured around the agreed upon Performance Agreement.

c) At the end of the review period, the board chair provides the CEO with a written performance evaluation and meets with the CEO to discuss the board’s evaluation and pay at risk award.
SUBJECT:  CHIEF EXECUTIVE OFFICER (CEO) COMPENSATION

The Board is responsible for establishing a fair compensation package for the position of President & Chief Executive Officer (CEO) in order to:

i) attract and retain a highly skilled CEO with the requisite competencies.

ii) reward meritorious performance.

The key elements of the CEO total compensation structure will include base salary, pay at risk and a competitive suite of insured and non-insured benefits, all in accordance with terms of the employment agreement, legislation\textsuperscript{1}, and industry guidelines.

The Governance Committee (voting members) shall be responsible for determining the CEO base salary and parameters for performance payment and shall bring forward a recommendation to the Board of Directors. Upon mutual agreement between the Governance Committee and the CEO, or at least every three years, total compensation will be reviewed and a report and/or recommendation shall be brought forward to the Board of Directors.

NOTE: The CEO is considered a conflicted party in relation to his/her remuneration package and is required to absent him/herself from any Board meeting or committee meeting when such matters are discussed or any other matter addressed in their employment agreement.

\textit{It is understood that any contractual agreements between the Chief Executive Officer and the Board of Directors shall supersede this policy.}

\textsuperscript{1} Established under the Broader Public Sector Executive Compensation Act, 2014, the Executive Compensation Framework regulation sets out requirements that designated broader public sector (BPS) employers must meet when setting executive compensation.
The Board must ensure that provision is made for continuity of leadership of the professional staff (as defined in the By-Law, Article 23) of the Hospital. The Board will have in place a documented process for succession should the Chief of Staff (COS) position become vacant due to sudden loss, resignation, retirement or termination. The succession plan should also specify the process for appointing an interim COS, should the COS be absent from the hospital for an extended leave of absence due to personal, health or other reasons. For relatively short durations of absence (e.g. holidays, conferences) the COS will appoint an Acting COS and advise the Board Chair.

During the annual COS evaluation period, the COS will report to the Governance Committee on the succession plan and related physician development. This report will include a review of internal candidates who have the potential to assume the COS position at the hospital. This review will include development plans to enhance the capabilities of the internal candidates.

**Sudden Vacancy (e.g. death, resignation, termination, extended leave)**

The COS will identify to the Medical Advisory Committee and to the Governance Committee, at the beginning of each fiscal year, which member of the Medical Staff is recommended to fill the role of interim COS, if a sudden loss of the COS occurs. The appointment of an interim COS will be subject to approval by the Board.

**Planned Vacancy (e.g. retirement)**

1. As specified in the By-Law (Article 23), the appointment of the COS will be made with consideration being given to the advice of a Selection Committee appointed for the express purpose of recommending a candidate for the position to the Board, following consultation with the Medical Advisory Committee.

2. The Chair of the Selection Committee will be a Director of the Board and membership will include the President or Vice-President of the Medical Staff Association, and two (2) members of the Medical Advisory Committee, supported by the Chief Human Resources Officer.

3. The work of the Selection Committee will include, but not be limited to, establishing and clarifying criteria to be used in the selection, overseeing the process to obtain candidates, interviewing candidates and agreeing on a process by which to make a final recommendation.
4. An offer will be subject to submission of a declaration that the candidate has no conflict of interest consistent with hospital policy and in a form as required by the Board, and satisfactory results of a criminal reference check as determined in the sole discretion of the Board.

5. An agreement to support the terms and conditions of employment will be consistent with the policy on COS Compensation in a form determined by the Board and will be executed by the Board Chair and the candidate accepting the position.

6. In the event a new COS has not been appointed prior to the departure of the current COS, the Board will appoint an interim COS in accordance with policy statement 1 above.

Refer to the By-Law (Article 23.4) for the role of the COS, and to the By-Law (Article 23.5) for the COS responsibilities and duties.
Anually the Board of Directors will establish measurable annual performance expectations, in cooperation with the Chief of Staff (COS), assess COS performance, and provide input on COS compensation to the CEO. The performance review process provides an opportunity to recognize the COS’s level of performance, to collaboratively develop the organization’s priorities for the next fiscal year, and to plan strategies to support the COS and the organization's continuing growth.

Guiding Principles

1. Performance management supports, reinforces and integrates the achievement of strategic and annual business plan results with individual performance goals. It provides recognition and input from key stakeholders of performance outcomes.

2. Performance standards, measures and indicators should be established in the Performance Agreement to appropriately assess COS performance. Performance commitments and measures should be set at a level which reflects the high level of performance expected.

3. Performance management focuses both on improving organizational processes and structure and on enhancing the COS’s performance. There will be recognition and reward for performance against established targets and commitments.

4. The annual Performance Agreement should include reference to the COS’s expectations for senior physician leaders within the organization, thereby promoting a consistent and continuous approach to talent development succession planning, and performance measurement across the executive leadership group.

5. The Performance Agreement will be aligned with the fiscal year-end.

Process

a) The COS will provide the Governance Committee with progress reports 6 weeks after the end of each quarter so that results reporting is aligned with corporate planning and performance cycle. The Governance Committee will review the COS performance against the Plan and report to the board on a quarterly basis.

b) The Governance Committee will conduct an annual review of COS performance against the Performance Agreement as it relates to COS accountabilities and report to the board within 10
weeks following the end of the Fiscal Year. This review will include input from members of the board and major external stakeholders and will be structured around the agreed Performance Agreement as it relates to COS accountabilities. This assessment will be provided to the CEO to include in the COS overall yearly assessment and pay at risk award.

c) The Governance Committee will conduct a leadership competency assessment of the COS on behalf of the board in consultation with the CEO, every two years, at a time separate from the annual performance review.
The Chief of Staff reports jointly to the President & CEO and the Board of Directors.

The Board and CEO are responsible for establishing a fair compensation package for the position of Chief of Staff in order to:

i) attract and retain a highly skilled Chief of Staff with the requisite competencies.

ii) reward meritorious performance.

The key elements of the COS total compensation structure will include base salary, pay at risk, benefits, all in accordance with terms of the employment agreement, hospital policies, legislation1 and industry guidelines.

The Governance Committee (voting members) shall be responsible for working with the CEO to determine the COS base salary, pay at risk and parameters for performance payment and shall bring forward a recommendation to the Board of Directors. Upon mutual agreement between the Governance Committee and the COS, or at least every three years, total compensation will be reviewed and a report and/or recommendation shall be brought forward to the CEO and Board of Directors.

NOTE: The COS is considered a conflicted parties in relation to his/her remuneration package and is required to absent him/herself from any Board meeting or committee meeting when such matters are discussed or any other matter addressed in their employment agreement.

It is understood that any contractual agreements between the Chief of Staff and the Board of Directors shall supersede this policy.

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1. Established under the Broader Public Sector Executive Compensation Act, 2014, the Executive Compensation Framework regulation sets out requirements that designated broader public sector (BPS) employers must meet when setting executive compensation.
There are three main roles for the Board with respect to performance monitoring and assessment:

i) Ensuring that management has identified appropriate performance metrics (measures of performance);

ii) Monitoring hospital and board performance against board approved performance targets and performance metrics; and

iii) Ensuring that management has plans in place to address variances from performance targets and overseeing implementation of remediation plans.

The Board will ensure that the President & Chief Executive Officer (CEO) implements an effective performance management system, based on performance metrics for measuring and continuously improving the Hospital’s performance. The Board will approve the targets and performance metrics for monitoring organization performance in achieving financial, quality, safety, and human resource targets using best practices and benchmarks.

The CEO will establish an annual schedule of specific performance reports to the Board of Directors and appropriate Board Standing Committees. These performance reports are intended to support the Board in its responsibility to monitor and assess the organization’s performance related to the established targets and performance metrics.
People, Finance & Audit Committee
Proposed Policy Revisions
March 2022 Board
The Board of Directors approves the Hospital Annual Planning Submission (HAPS), and signs the Hospital Services Accountability Agreement (H-SAA) for submission to the South East Local Health Integration Network (SE LHIN) Ontario Health East (OH-E) by a date in compliance with its requirements. The Board will not approve an annual budget that projects a deficit position, unless explicitly directed or permitted to do so by the Ministry of Health and Long-term Care (MOHLTC) or the SE LHIN OH-E.

The Hospital Accountability Planning Submission (HAPS) will be aligned with the Board’s established priorities, and will not place the organization at financial risk. The Board will require that the operating plan address the working capital needs of the organization.

The CEO is responsible for preparing the HAPS for each fiscal year. Prior to the Board granting its approval, the People, Finance & Audit Committee will review and recommend these documents for presentation to the Board.

The Chief Executive Officer (CEO) will ensure that appropriate and effective administrative policies and procedures exist to manage operating expenses within the annual budget plan, and that these policies and procedures are monitored for compliance and reviewed periodically.

**Monitoring of Financial Performance**

On a regularly reported basis, determined by terms of reference, the Board of Directors will conduct a thorough assessment of the organization’s financial statement and performance of indicators.

The CEO is responsible to ensure that the Hospital establishes and maintains financial reporting systems in accordance with generally accepted accounting principles and its accountability agreements. Financial statements will be prepared in conformance with generally accepted accounting principles. The statements will include statements of:

i) financial position;

ii) revenues and expenditures, including approved fiscal budget, actual expenditures to date, and analysis of variances; and

iii) statement of cash flows.
Capital Plan

The annual capital budget will be recommended for approval to the Board of Directors aligned with the capacity and requirements of the HAPS. In addition, the Board may consider approval of capital equipment/projects, as may be required outside of these timelines, based on appropriate information.
SUBJECT: ENTERPRISE RISK MANAGEMENT

The Board of Directors is accountable for ensuring that organizational risk is monitored and that appropriate risk mitigation plans are developed to address these risks.

The Board of Directors must be knowledgeable about risks inherent in hospital operations and ensure that appropriate risk analyses are performed as part of its decision-making. The Board of Directors is responsible for ensuring that appropriate risk management practices are in place in the organization, and reviewing and approving the Hospital's variance and risk tolerance levels.

In particular, the Board:

i) ensures that appropriate programs and processes are in place to control risk;

ii) requires management to identify and assesses the associated risks to the organization when reviewing and approving resource allocation decisions;

iii) requires management to identify unusual risks to the organization and ensure that there are plans in place to prevent and manage such risks;

iv) works with the CEO to reduce risks to the organization and promote ongoing quality improvement.

Each Board Standing Committee will review the risks related to its mandate at least annually.

The Chief Executive Officer is accountable for: identifying the principal risks of the Hospital's business; determining the organization's exposure to risk; and developing and implementing an integrated risk management framework.

The Board of Directors of the Hospital will annually monitor and assess the Hospital's quantification of risks and how those risks are addressed.
SUBJECT: FINANCIAL OBJECTIVES

The Board will ensure that the Hospital is operated and managed in an efficient and effective manner according to accepted business and financial practices and approved policies, and that the Hospital operates within its approved funding and in alignment with the Hospital Services Accountability Agreement (H-SAA). The CEO is accountable to the Board for ensuring that these objectives are achieved, that the fiscal position of the organization is not placed at risk, and that adequate internal controls and processes are in place, monitored for compliance, and periodically reviewed by the People, Finance & Audit Committee of the Board.

A material deviation of actual expenditures from Board approved priorities will not properly occur without prior approval of the Board. Accordingly, the CEO will not:

i) direct or approve the expenditure of designated revenue for other than its intended purpose;

ii) direct or approve the expenditure of more funds than have been budgeted, or expend more funds than have been received or reasonably forecast to be received;

iii) use any reserves except as provided in the approved budget;

iv) direct or approve the accumulation of debt for operational requirements in an amount greater than provided within the budget and indicated by the cash flow projections associated with the budget;

v) direct or approve the cash position falling, at any time, below the amount needed to settle payroll and all other obligations in a timely manner, in accordance with generally accepted good business practices or the agreed terms inherent with the obligation; or

vi) knowingly allow any payments or filings to be overdue or inaccurately filed.
SUBJECT: PRIVACY AND SECURITY OF INFORMATION

Article 13 of the By-law requires a Director to respect the confidentiality of Board discussions and information.

In compliance with the Public Hospitals Act and other relevant legislative requirements, the Board of Directors of the KHSC recognizes the importance of respecting and ensuring the confidentiality of all patient and employee-related information.

Every Director, officer, employee, physician, volunteer and student of the Hospital will respect the confidentiality of matters brought before the Board, or before any Board committee.

All Directors must adhere to the by-laws, policies and procedures regarding confidentiality of information. These policies, without limitation, include confidential information, release of patient information, facsimile of patient information, release of information to the media and personnel records.

The Chief Executive Officer (CEO) is responsible for ensuring that policies and practices are in place for the protection of the personal information of patients and their families, staff, physicians, volunteers, and students, and all corporate and business information.

The CEO will take all reasonable steps to ensure that such organizational policies are implemented consistent with legislative requirements and enable the Hospital to handle such information in a secure and confidential manner.
SUBJECT: PURCHASING AND LEASING

The Chief Executive Officer (CEO) is accountable to the Board of Directors of the KHSC to ensure that the Hospital has in place administrative policies and procedures for the acquisition of goods and services and real property and that these policies and procedures adhere to legislated or agreements with the Ministry of Health (MOH) and Long-Term Care and the South East Local Health Integration Network Ontario Health East (OH-E). The practices established by the Hospital for the leasing, acquisition or disposal of real property, must comply with the Board Policy IV-5 and any Board resolution for Signing Officers, which is passed from time to time.

The Board authorizes the CEO to initiate any commitments contained within an approved Operating or Capital Plan or otherwise approved by motion of the Board or its delegated authorities, including any and all: contracts, requisitions, purchase orders, travel authorizations and any other agreement, financial or otherwise. If emergency expenditures or commitments are necessary, they must be subsequently submitted for approval at the next appropriate meeting.

Compliance with this policy will be monitored and reviewed annually by the People, Finance & Audit Committee of the Board.

For greater clarity, it is the CEO’s responsibility to ensure appropriate practices are followed in competitive tendering or invitation for proposal in all purchases of supplies, services, capital, leases, or agreements and such practices are in compliance with appropriate legislation [including the Broader Public Sector Procurement Directive].
Patient Care & Quality Committee
Proposed Policy Revisions
March 2022 Board
SUBJECT: QUALITY IMPROVEMENT AND SAFETY

The Board of Directors is responsible for overseeing quality and safety for the Hospital. The Board approves goals and performance metrics for quality, effectiveness, and patient/staff safety.

The Board of Directors of the Kingston Health Sciences Centre defines quality as doing the right thing at the right time, in the right way, for the right reason – and having the best possible results.

The Hospital will meet or exceed established and evolving standards of quality and patient/staff safety. The Hospital is committed to addressing quality issues, and identifying and acting upon opportunities to continuously improve patient care and service delivery.

The Board recognizes the importance of the safe delivery of its services, as well as the importance of reducing or preventing the potential for injury or loss to its patients, visitors, staff, physicians, volunteers and learners, and damage to or loss of the Hospital’s assets.

The Board will:

i) implement effective processes for reviewing and recommending policies and standards;
ii) implement effective processes for monitoring patient outcomes and safety and patient flow and access;
iii) comply with quality and safety related issues, including requirements set out by legislation and accreditation;
iv) ensure the hospital has effective processes for monitoring patient experience and responding to identified improvement opportunities; and
v) ensure the hospital has an effective process for reviewing and responding following adverse events.

The Board, with the assistance of the Patient Care & Quality Committee, will annually establish performance targets and performance metrics related to clinical quality and safety for monitoring by the Patient Care & Quality Committee. Quarterly, the Patient Care & Quality Committee will monitor the Hospital’s quality of patient care and safety against the defined performance targets and performance metrics and report to the Board.

The Board will discuss issues related to quality of patient care and safety and meeting time is dedicated to this focus.
The identification, investigation and management of individual patient feedback or concerns which, in part, form the basis of this trend analysis, are addressed by hospital staff through a process for which the CEO bears responsibility.

The Board also encourages feedback from staff, patients, and families as a key instrument to continuous improvement to achieving the goal of outstanding care always quality in every patient experience. To optimize the usefulness of feedback provided to Board members, members will refer such feedback to be addressed within the hospital staff, patient and community relations processes. The Board will not review individual concerns.

Should a concern relating to a patient’s situation be addressed to Director of the Board or Board committee member verbally, that member should accept such feedback with thanks and, to avert the potential for unintended errors in message transmission by the member, encourage the complainant to forward it directly to the Patient Relations Specialist whose responsibility it is to ensure that it is addressed using the established resolution process.

If the concern is addressed to either a Director of the Board or member of a Board committee in writing, he/she will forward a copy of the letter to the Patient Relations Specialist and will provide notice of receiving the concern to the Board Chair. Thereafter, the concern will be addressed using the established resolution process.
Kingston Health Sciences Centre (KHSC) has been identified under the provincial French Language Services Act (FLSA) as a Health Service Provider (HSP) that will develop and implement a French Language Services Implementation Plan in accordance with requirements set out by the South East Local Health Integration Network (SE LHIN). The goal is to work toward becoming a designated Hospital Service Provider (HSP) as defined under the French Language Services Act. The Board of Directors and Executive team are responsible for oversight of the French Language Services (FLS) Implementation Plan and for moving KHSC toward designation.

At the point of designation, the Board will be responsible for maintaining and monitoring the availability and effective delivery of quality services in both English and French. For clarity, designation is achieved when there is legal recognition, by the government of Ontario, of the ability of an organization to offer French-language services according to criteria set by the Office of Francophone Affairs.¹

To support the designation of KHSC the Board of Directors will:
- Ensure the existence of a policy and a committee on French language services (FLS);
- Review and approve an annual report on the status of French language services;
- Support effective representation of Francophones within the leadership team;
- Ensure that a senior manager has been designated to assume responsibility for the delivery of French language services;
- Ensure that a mechanism has been put in place to manage complaints concerning French language services

REFERENCES

1. French Language Services Act, R.S.O. 1990

¹ Ref. SELHIN Guide to FLS – “To be designated, an agency must demonstrate that it meets the following conditions:
- It offers quality French-language services on a permanent basis;
- It guarantees access of its French-language services;
- Its Board of Directors and management team both include some Francophones;
- It has explicit written policies that define its responsibilities regarding French-language services, and those policies have been ratified by its Board of Directors”