

BOARD POLICY MANUAL

Original Issue April 1st 2017

Updated September 2018

Updated September 2019

Updated October 2019

Updated March 2020

Updated December 2020

Updated March 2022

Updated June 2022

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Preamble

Purpose:

The Board of Directors Policy Manual for the Kingston Health Sciences Centre (KHSC) provides the foundation for implementing effective governance of the Hospital.

Organization of Policies:

The policies are aligned with the OHA's Guide to Good Governance "Roles and Functions of a Board". The OHA's Guide states that there are a number of primary functions which should be performed by hospital boards. These include: approving strategic goals and directions; establishing a framework for performance oversight; overseeing quality; overseeing financial conditions and resources; ensuring enterprise risk management; providing for leadership; stakeholder relationships; board governance¹.

To ensure compliance with the Guide, the Board policies have been allocated in the following six categories:

- Establish Strategic Direction
- Provide for Excellent Leadership and Management
- Monitor Quality and Effectiveness
- Ensure Financial and Organizational Viability
- Ensure Board Effectiveness
- Build and Maintain Positive Relationships

Review of Policies:

It is anticipated that over time KHSC will develop other Board of Director policies that respond directly to changing circumstances of the Hospital. A policy guiding the process to review these Board Policies is included in this Manual (see Policy V-B-10).

Definitions:

The Hospital: Kingston Health Sciences Centre

The Board: Unless otherwise stated means the Board of the Kingston Health Sciences Centre

Member: A Member of the Corporation of the Kingston Health Sciences Centre

Director: A member of the Board of Directors of the Kingston Health Sciences Centre

¹OHA's Guide to Good Governance, Third Edition, page 39

ISSUED BY:	KHSC Board of Directors	NUMBER:	I-1
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Strategic Direction	REVIEW DATES:	April 2017, Sept 2018, September 2021
COMMITTEE:	Governance	REVISION DATE:	March 2022
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SUBJECT: VISION, MISSION AND VALUES

Our founding hospitals of Hotel Dieu Hospital (HDH) and Kingston General Hospital (KGH) both have long and distinguished histories of serving our community, providing caring and compassionate service to those needing health care and services.

Hotel Dieu Hospital was founded by the Religious Hospitallers of St. Joseph, whose philosophy and mission guided the development of the Hotel Dieu Hospital and its ongoing mission. Kingston General Hospital was founded by a community charity to provide food and shelter to the poor and the sick. Both hospitals are rooted in the community and have been committed to advancing health care to support patients and families. After a long and cooperative partnership, the two hospitals joined in 2017 through a legal integration to form Kingston Health Sciences Centre (KHSC).

Our Missions

Consistent with the *Kingston Health Sciences Centre Operating Agreement* (the “Operating Agreement”) dated March 30, 2017, KHSC is committed to recognizing the campus-specific missions of its founding Hospitals, Hotel Dieu Hospital and Kingston General Hospital on their respective sites. Specifically, the Operating Agreement **guarantees** the Catholic Mission at the HDH campus, and **guarantees** the secular mission at the KGH campus.

HDH Site

The mission of Hotel Dieu Hospital, rooted in the Gospel of Jesus Christ, is to make visible the compassionate healing presence of God to all persons. We share in this mission by being a caring and just community. This is expressed through the pursuit of excellence in health service, education, and research.

KGH Site

We are a community of people dedicated to transforming the experience of our patients and families through innovative and collaborative approaches to care, knowledge and leadership.

KHSC created a vision, mission and values shortly after its creation and through a broadly consultative process and as approved by the Board of Directors. All at KHSC strive to live this mission, while honouring the site-specific missions, as required through the Operating Agreement.

KHSC's Vision

Partnering in care, discovery and learning to achieve better health for our communities while transforming our health care system.

KHSC's Mission

We care for our patients, families and each other through everyday actions, significant moments and exciting breakthroughs.

KHSC's Values

At the heart of our values is **compassion**. We care for some of the sickest and most vulnerable people in our community.

We treat each person with **respect** and dignity. We do this by caring for the whole person, when and where they need it most.

Partnership is at the core of how we work. We empower patients, families and our teams to do great work together, and with our community.

The pursuit of **excellence** drives everything we do. We will be good stewards of resources while continually enhancing the quality of care, research and education we provide.

Research and **innovation** reflect our courage to try new things, challenge what we know, create new knowledge and transform health care.

Policy

1. Each person who works, learns, or volunteers at KHSC is responsible for living and honouring the missions of the Hospital and its sites (HDH and KGH), and for living KHSC's values.
2. The Hospital's missions and values are shared with all who seek care or visit our sites and the general public as appropriate. This occurs regularly in a variety of ways, including but not limited to:
 - a) Posted on the Hospital's website and corporate publications (e.g. included in the strategic plan, patient materials, and recruitment materials).
 - b) Through discussion and inclusion in orientation for all new employees, volunteers, and board members.
 - c) Through visible display in the organization (e.g. on posters, as signage, and/or through visible symbols.)
 - d) Through philosophy, mission and values-focused activities on each site (e.g Mission Week, Annual Food Blitz, Coat Drive, and Awards of Excellence). Through regular discussion and reflection by leaders at committees and hospital events.

ISSUED BY:	KHSC Board of Directors	NUMBER:	I-2
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Strategic Direction	REVIEW DATES:	April 2017. September 2021
COMMITTEE:	Governance	REVISION DATE:	March 2022
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SUBJECT: STRATEGIC PLANNING

The Board of Directors is responsible to establish the strategic goals and directions for the Hospital. The Vision and Mission for the Hospital provide the foundation upon which the strategic directions are developed, and are approved by the Board (see policy I-1)

Policy

The Board will:

1. Annually review the Corporation's mission, vision, values as an academic health sciences centre as part of a regular annual planning cycle.
2. Establish a process for engagement with patients and families, the communities served, representatives from Ontario Health-East (OH-E), other local/regional health service providers, Queen's University, University Hospitals Kingston Foundation, and the hospital Auxiliaries when developing plans and setting priorities.
3. Ensure establishment of the Corporation's strategic plan which is aligned with Ministry of Health (MOH) and OH-E's integrated health services plan; and reflects the Board's accountability to the MOH and OH-E through the Hospital Service Accountability Agreement (HSAA).
4. The President and Chief Executive Officer (CEO) is responsible to the Board for establishing the strategic planning process for approval by the Board. The Board, as a whole, will engage with the CEO and senior leadership team in developing the strategic plan.
5. Once the strategic plan has been developed, everything the organization currently does, undertakes as new, or stops doing, will be monitored and measured against whether or not it advances and aligns with the strategic plan, operating plans, and Board-approved performance metrics.
6. Ensure the establishment of an Integrated Annual Corporate Plan (IACP) to advance the strategic plan by addressing annual corporate goals and objectives, including key quality goals as may also be required by Ontario Health-Quality (OH-Q) as part of a Quality Improvement Plan (QIP). The IACP will be established by the CEO with Board approval.
7. On an annual basis, the Board of Directors will establish goals for the Board which are a priority for the Board in the coming year. These are consistent with the Mission and Vision, the Strategic Plan, and the IACP

ISSUED BY:	KHSC Board of Directors	NUMBER:	II-1
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Management & Leadership	REVIEW DATES:	April 2017, September 2021
COMMITTEE:	Governance	REVISION DATE:	March 2022
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SUBJECT: CHIEF EXECUTIVE OFFICER (CEO) SELECTION & SUCCESSION PLANNING

The Board of Directors is responsible for ensuring that provision is made for continuity of President and Chief Executive Officer (CEO) leadership for the Hospital and will have in place a documented process for potential internal succession should the CEO position become vacant. The succession plan will also specify the process for appointing an interim CEO should the CEO be absent from the Hospital for an extended leave of absence due to personal, health or other reasons. For relatively short scheduled absences (e.g. holidays, conferences) the CEO will appoint an Acting CEO and advise the Board Chair of the details.

In its annual work plan, the Board of Directors will include an action item for the CEO to report to the Governance Committee on the succession plan and related executive development. This report will include a review of internal candidates who have the potential to assume or apply for the position at the Hospital, and the associated development plans to enhance the capabilities of the internal candidate(s).

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

1. Annually the CEO will identify in writing to the Governance Committee, a successor recommended to fill the role of interim CEO if a sudden loss of the CEO occurs. The appointment of an interim CEO will be subject to approval by the Board.

Planning Vacancy (e.g. retirement)

The process to fill a planned vacancy will include:

2. The Board will establish a CEO Search Committee consisting of the Chair of the Board, at least two (2) elected Directors, the Chief of Staff, the President of the Medical Staff Association, and the Principal of Queen's University or his or her delegate and supported by the Chief Human Resources Officer (CHRO). The CEO Search Committee will be chaired by the Chair of the Board or a delegate appointed by the Chair.
3. The Search Committee may, at its discretion, select a search firm to assist with the process. The Search Committee will interview a shortlist of candidates and recommend to the Board its candidate of choice.
4. 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 to the Board.

SUBJECT: CHIEF EXECUTIVE OFFICER (CEO) SELECTION & SUCCESSION PLANNING

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POLICY NUMBER: II-1

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

ISSUED BY:	KHSC Board of Directors	NUMBER:	II-2
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Management & Leadership	REVIEW DATES:	April 2017, February 2022
COMMITTEE:	Governance	REVISION DATE:	March 2022
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SUBJECT: CHIEF EXECUTIVE OFFICER (CEO) DIRECTION

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 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.

ISSUED BY:	KHSC Board of Directors	NUMBER:	II-3
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Management & Leadership	REVIEW DATES:	April 2017, February 2022
COMMITTEE:	Governance	REVISION DATE:	March 2022
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**SUBJECT: CHIEF EXECUTIVE OFFICER (CEO) PERFORMANCE
MANAGEMENT AND EVALUATION**

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.

ISSUED BY:	KHSC Board of Directors	NUMBER:	II-4
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Management & Leadership	REVIEW DATES:	April 2017, February 2022
COMMITTEE:	Governance	REVISION DATE:	March 2022
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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, legislation¹, 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.

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

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.

ISSUED BY:	KHSC Board of Directors	NUMBER:	II-5
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Leadership & Management	REVIEW DATES:	April 2017; May 2022
COMMITTEE:	People, Finance & Audit	REVISION DATE:	
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SUBJECT: CHIEF EXECUTIVE OFFICER (CEO) EXPENSE REIMBURSEMENT AND TRAVEL POLICY

The responsibilities of the Chief Executive Officer (CEO) include duties that require commitments for the hospital, including attendance at hospital related events. It is expected that the CEO will discuss with the Board Chair the requirements associated with carrying out external duties, both in the community and outside Kingston area. The CEO will be compensated for reasonable expenses while carrying out such duties and while traveling on Hospital related business. With respect to fundraising, the CEO and Board Chair will review on an ongoing basis the listing of events to determine the costs which will be covered by the Hospital.

Such reimbursement and/or compensation will be consistent with the expense and travel policies and practices for other employee groups within the Kingston Health Sciences Centre.

The Board Chair, on the recommendations of the Chief Human Resources Officer or Chief Financial Officer, will approve allowable expenses and travel claims.

ISSUED BY:	KHSC Board of Directors	NUMBER:	II-6
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Leadership & Management	REVIEW DATES:	April 2017, February 2022
COMMITTEE:	Governance	REVISION DATE:	March 2022
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SUBJECT: CHIEF OF STAFF (COS) DIRECTION, SELECTION AND SUCCESSION PLANNING

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.

ISSUED BY:	KHSC Board of Directors	NUMBER:	II-7
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Leadership & Management	REVIEW DATES:	April 2017, February 2022
COMMITTEE:	Governance	REVISION DATE:	March 2022
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SUBJECT: CHIEF OF STAFF (COS) PERFORMANCE MANAGEMENT AND EVALUATION

Annually 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.

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 stake holders 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.

ISSUED BY:	KHSC Board of Directors	NUMBER:	II-8
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Leadership & Management	REVIEW DATES:	April 2017, February 2022
COMMITTEE:	Governance	REVISION DATE:	March 2022
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SUBJECT: CHIEF OF STAFF (COS) COMPENSATION

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.

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.

ISSUED BY:	KHSC Board of Directors	NUMBER:	II-9
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	Dec 2020
CATEGORY:	Leadership & Management	REVIEW DATES:	Dec 2020; May 2022
COMMITTEE:	People, Finance & Audit	REVISION DATE:	
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SUBJECT: WHISTLEBLOWING POLICY/REPORTING OF INAPPROPRIATE BEHAVIOUR

Introduction

This policy will assist persons, including physicians and residents, to report concerns regarding significant and serious matters related to the operations of KHSC. This policy endorses a proactive environment of disclosure and protection to ensure that Kingston Health Sciences Centre (KHSC) meets legislative requirements and aligns to the guiding principles of transparency and accountability.

Policy

KHSC is committed to operating in a manner that reflects honesty, integrity and ethical business practices and encourages good faith reporting of allegations of wrong doing in business conduct including but not limited to:

- Breach of the law and/or legal obligations,
- Gross mismanagement including omissions and/or neglect of duty,
- Breach of fiduciary responsibilities,
- Breach or inappropriate financial reporting and use of funds or organizational assets,
- Abuse of authority,
- Unethical business conduct,
- Endangering the health and safety of others.

KHSC is committed to protecting a person from inference, discrimination, harassment or retaliation for having made a good faith report of wrongdoing.

KHSC expects all persons to comply and act in accordance, at all times, with these values and principles.

One or more violations of this by a person may be grounds for disciplinary action up to and including termination of privileges, employment, and relationship with KHSC or the board directorship.

Persons who are members of a profession and/or discipline which is governed by standards and codes specific to their profession will be expected to adhere to those professional codes and standards in addition to KHSC's policies, codes and by-law.

Definitions

Affiliate: an individual who is not employed by KHSC but performs specific tasks at KHSC, including: learners, volunteers, contractors or employees of contractors who may be members of a third-party contractor or under direct contract to KHSC, and individuals working on KHSC premises, but funded/employed through an external source (i.e. research and university staff on site).

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Authorized Disclosure Officer: The delegated KHSC management staff responsible for receipt and management of the report of wrong doing.

By-Law: the by-law of KHSC.

Business Conduct: Way of acting, personal behaviour or how a person manages oneself related to non-clinical activities while performing duties for KHSC.

Complainant: Person or persons reporting inappropriate Business Conduct (wrongdoing), including retaliation after submission of the report.

Credentialed Staff: Physicians, residents, dentists, midwives, extended class nurses.

Disclosure: Report of a wrongdoing made in good faith by person(s) in accordance with this policy.

Employee: An individual, who is employed by KHSC, includes residents and is on KHSC's payroll.

Fiduciary Responsibilities: Refers to the duty to act in the best interest of KHSC.

Good Faith: Honestly and without deception. Good faith is evident when the report is made without malice or consideration of personal benefit, and that there is a reasonable basis to believe the report is true; however, a report does not have to be proven to be true to be in good faith. Good faith is lacking when the report is known to be malicious or false.

Governing Legislation: All legislation governing KHSC, including but not limited to the *Public Hospitals Act, Health Care Consent Act, Quality of Care Information Protection Act, Local Health System Integration Act, Substitute Decisions Act, Excellent Care for All Act, Public Sector Compensation Restraint to Protect the Public Services Act, Occupational Health and Safety Act and related Regulations, Regulated Health Professions Act, Transparency in Public Matters Act, Personal Health Information Protection Act, Criminal Code of Canada, and Human Rights Code* and regulations thereof.

Leader: A non-union supervisor, manager, director, executive, credentialed staff (i.e. physicians and residents) who provides supervision to employees, including residents.

Management: Those who have responsibility to hire, terminate, reorganize the workplace and provide supervision for others.

Officer of KHSC: A member of KHSC's executive.

Persons: Includes the Board of Directors and officers of KHSC, credentialed staff (i.e. physicians and residents), employees, management, contracted services, and people who do business at and on the premises of KHSC.

Policies: The Board, hospital and medical policies in place at KHSC.

Primary Hospital Contact: Volunteers: the Director of Volunteer Services; Credentialed Staff: Director, Medical Affairs or Executive Vice President and Chief of Staff; Students: Instructor or hospital educational supervisor, Contractors: the applicable hospital liaison and/or overseer of the contract.

Protected disclosure: A report about a wrongdoing. It is an admission or revelation that, when fulfilling certain requirements, entitles the person who made the disclosure to support and protection from reprisals, retaliation, victimization, or even prosecution.

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Receiver: A leader/representative of KHSC with accountability to respond to the disclosure.

Report: Written or verbal disclosure of allegations of inappropriate business conduct, including retaliation as defined in this policy (wrongdoing).

Reprisal: An act or instance of retaliation.

Respondent: The individual(s) alleged to have conducted a wrongdoing.

Retaliation: To take retribution, especially by returning some injury or wrong in kind, or to avenge.

Vexatious: An act done by a person in order to annoy, embarrass or otherwise aggravate another person.

Wrongdoing: A breach of the bylaw, practices, policies including without limitation, the contravention of an Act of Parliament or of the legislation of the province, the misuse of public funds or assets, an act or omission that creates a substantial and specific danger to the life, health and safety of persons or the environment, other than danger that is inherent in the performance of the duties or functions of an employee, credentialed staff and affiliate. (Judgment calls that result from a balance and informed decision-making process are not considered wrongdoing in the scope of this policy).

Workplace: All hospital premises, work assignments that occur off hospital property, off site work-related social events and functions, work-related seminars, conferences, travel and training, and other locations where work related responsibilities are carried out. Phone calls, communications, faxes, and electronic mail that are related to workplace activity made with communication devices are considered an extension of the workplace.

Procedure

1. Existing Policies and Procedures

- 1.1 This policy is not intended to replace existing KHSC policies and procedures that have a process that should be referenced and followed to resolve related concerns.
- 1.2 There are separate procedures outside this policy available for person(s) to raise issues relating to:
 - 1.2.1 grievances in respect of employment and the terms and conditions of employment;
 - 1.2.2 the quality of clinical care provided to KHSC's patients by those members of the credentialed staff;
 - 1.2.3 Workplace Harassment and Discrimination; Code of Behaviour (Be REAL), Workplace Violence Prevention, and Physician Behaviour policies; and Occupational health and safety concerns.

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2. Procedure for Reporting Allegations of Wrongdoing

2.1 Reporting. Each person has an obligation to report any good faith concern in respect of a wrongdoing. If a person reasonably believes that they have information about an inappropriate behaviour or activity that could show that a wrongdoing has been committed, or is about to be committed, the person may report this in accordance with the process set out below.

2.2 Submissions of Allegations of Wrongdoing

2.2.1 Any person may submit a report verbally or in writing, on a confidential basis, detailing any concerns regarding a wrongdoing to the applicable Authorized Disclosure Officer. In the event that a report is made to someone other than the applicable Authorized Disclosure Officer, the report will be forwarded to the Authorized Disclosure Officer by that individual.

Note: While KHSC trusts that current policies and procedures give persons the reassurance needed to report concerns regarding wrongdoing inside KHSC, it recognizes that there may be circumstances when a person(s) should properly report to outside bodies such as governmental authorities or the police.

2.2.2 The applicable Authorized Disclosure Officer is as follows:

If you are:	Applicable Authorized Disclosure Officer:
An Employee	The Chief Human Resources Officer
A Volunteer	
A Student	The Chief of Staff and Vice President Medical Affairs
A Physician, Midwife, Dentist or Extended Class Nurse	
A Researcher	The Vice President, Research
A member of the general public	The Chief Human Resources Officer

2.2.3 If the allegation of wrong doing alleges misconduct of the applicable Authorized Disclosure Officer identified above or of the President & Chief Executive Officer or if there is a real or perceived conflict of interest in reporting to the Authorized Disclosure Officer identified above, the following Authorized Disclosure Officer will apply:

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Alleged Wrongdoing by:	Authorized Disclosure Officer
The Chief Human Resources Officer	Chief Executive Officer
The Vice President, Medical Affairs	Chief Executive Officer
The Vice President, Research	Chief Executive Officer
The Chief Operating Officer	Chief Executive Officer
The Chief of Staff	Chair, People, Finance & Audit Committee
The President & Chief Executive Officer	Chair, People, Finance & Audit Committee

- 2.2.4 Any disclosure received regarding financial statements, accounting, internal accounting controls or auditing matters should be referred by the Authorized Disclosure Officer immediately to the Chief Operating Officer. Should the report be related to activities by the Chief Executive and/or Chief Operating Officer, it can be forwarded to the Chair of the People, Finance and Audit Committee.
- 2.2.5 Where the Authorized Disclosure Officer is the Chair of the People, Finance and Audit Committee, a written disclosure will be submitted c/o the Office of the Chief Operating Officer, in an envelope labelled, "To be opened by the Chair of the People Finance and Audit Committee only." If a person would like to discuss the matter with the Chair of the People, Finance and Audit Committee verbally, that person should indicate this and include a contact telephone number. If any such envelope is received by the management of KHSC, it shall be forwarded promptly and unopened to the Chair of the People, Finance and Audit Committee. A person can make a verbal report to the confidential telephone line direct to the Chair of the People, Finance & Audit Committee, by calling 613 544 3400 Ext 2657.
- 2.2.6 A report submitted hereinafter referred to as a disclosure made above must include the following information if known:
- 2.2.6.1 A description of the wrongdoing. Facts, not speculative information, must be provided and should contain as much detail as possible to allow for proper assessment. In addition, the disclosure should contain sufficient corroborating information to support the commencement of an investigation.
 - 2.2.6.2 The name of the person or persons alleged to have committed the wrongdoing, or planning to commit the wrongdoing.
 - 2.2.6.3 The dates of the wrongdoing;

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2.2.6.4 Whether the wrongdoing has already been disclosed to another representative of KHSC and a response received.

2.2.7 The Authorized Disclosure Officer must record date received, and issue a dated email or letter acknowledgement to the complainant.

2.3 Anonymous Disclosure of Wrongdoing

2.3.1 Any person may submit an anonymous report at any stage of the process detailed in 2.2.

2.3.2 Written acknowledgement under 2.2.5 will not be issued.

2.3.3 The seriousness of the allegation will, out of necessity, be determined based solely on the general merit and specific detail outlined in the disclosure. Follow-up for clarification and expansion of facts will not be possible, which may have the unintended consequence of limiting the effectiveness of any investigation or finding derived thereof.

2.3.4 In view of the investigation limitations outlined in 2.2.3, person(s) considering an anonymous report under this section are encouraged to review Section B, 4 & 5 of this policy. KHSC clearly prohibits retaliation, discrimination and harassment against any person(s) who reports, in good faith, what is reasonably believed to be a wrongdoing, and is fully committed to the safeguards outlined in Section B of this policy. Notwithstanding the foregoing, this in no way interferes or limits the right of person(s) who nevertheless choose to submit an anonymous report.

2.3.5 Any person submitting an anonymous report implicitly waives the protection afforded in Section B, 4 & 5.

2.4 Investigation of a Complaint

2.4.1 Following the receipt of a disclosure, including anonymous reports submitted hereunder, the disclosure shall be assessed promptly by the Authorized Disclosure Officer to determine if an investigation shall commence. This will include an assessment of the risks to the complainant(s), employees, credentialed staff, affiliates patients, the public and/or KHSC and immediately take appropriate preventative measures if required.

2.4.2 If the Authorized Disclosure Officer determines that the investigation is warranted, and with appropriate consultation of applicable subject matter experts they should determine who will conduct the investigation and facilitate the investigation process commencing in a timely fashion. The determination of the need for an investigation and who will conduct the investigation shall be communicated to the known complainant by the receiver.

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2.4.3 Where there are more specific policies which govern such investigations (for example KHSC By-law for Medical Staff or the KHSC Code of Behaviour – Be Real), the receiver will ensure that the more specific policy shall be followed.

2.5 Investigation Procedures, Reporting and Records

2.5.1 The investigation is to be conducted as expeditiously as possible. In conducting any investigation, the investigator shall use reasonable efforts to ensure that person(s) are treated fairly including the person(s) making the disclosure, witnesses, and the person(s) alleged to be responsible for the wrongdoing(s).

2.5.2 During the investigation, the Authorized Disclosure Officer and the investigator shall maintain neutrality and confidentiality. The investigator will ensure that the investigation is documented and that a written record of each step in the process including specifics like date, time, and place is completed. The investigator will interview witnesses and obtain applicable documentation and records as appropriate to review and analyze in order to reach a finding.

2.5.3 Upon completion of an investigation, a summary of investigation including the following information will be provided to the Authorized Disclosure Officer:

- Incident date;
- Disclosure date;
- Name and title of Authorized Disclosure Officer;
- Name and title of Investigator if applicable;
- Complainant name(s);
- Respondent name(s) and contact log;
- Summary of complaint;
- Summary of findings;
- Action(s) taken;
- Recommendations for preventative measures if applicable.

2.5.3.1 If the assessment concludes that the disclosure cannot be substantiated, no further action will be taken. The Authorized Disclosure Officer will discuss verbally with the complainant and respondent to recognize that they acted in good faith and that the process was followed.

2.5.3.2 If the assessment concludes that the disclosure was made in bad faith, the Authorized Disclosure Officer will follow-up with applicable parties for discipline and/or removal of access and privileges as applicable for the complainant.

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- 2.5.3.3 If the disclosure is substantiated, the Authorized Disclosure Officer will ensure that corrective action is taken immediately and consult with the Labour Relations or other appropriate management as applicable to determine if discipline or removal of access and/or privileges are warranted. The decision will be preferably conveyed in person to the respondent.
- 2.5.3.4 The Authorized Disclosure Officer will ensure that relevant information is shared for quarterly reporting to the People, Finance and Audit Committee. Where the Authorized Disclosure Officer is the Chair, People, Finance and Audit Committee, they will make reports on a quarterly basis to the Board of Directors, identifying any investigations undertaken, any findings arising from such investigations, and any disciplinary action taken as a result of such investigations.
- 2.5.3.5 Findings will be communicated to the known complainant.
- 2.5.4 The People, Finance and Audit Committee shall retain as a part of the records of the Committee any information and documentation pertaining to such reports for a period of no less than seven (7) years.
- 2.6 When Investigation Not Required. An Authorized Disclosure Officer may cease or decline to pursue an investigation upon review of all available relevant details if the receiver determines that:
- 2.6.1 the disclosure is frivolous or vexatious, or has not been made in good faith, or does not deal with a sufficiently serious subject matter;
- 2.6.2 the alleged conduct even if found to be true does not constitute inappropriate conduct;
- 2.6.3 the disclosure relates to a matter that could more appropriately be dealt with according to the procedures under a collective agreement, employment agreement, KHSC's by-law or a more appropriate and specific hospital policy, practice, procedure; so much time has elapsed between the date when the subject matter of the disclosure occurred and the date when the disclosure was made that investigating it would not serve a useful purpose;
- 2.6.4 the disclosure does not provide adequate facts about the wrongdoing to permit a proper investigation; or
- 2.6.5 there is another valid reason for not investigating the disclosure.
- 2.7 The decision not to investigate will be communicated to the known complainant.
- 2.8 Appeals to Decision Not to Investigate. A decision made not to investigate may be appealed in writing to an officer of KHSC. Decisions made by an officer of KHSC, including the Chief Executive Officer,

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may be appealed to the Chair of the People, Finance and Audit Committee. A written response will be provided to the complainant making the appeal at each level of the appeal process.

3. General Offences

- 3.1 False or misleading statements. No person shall, in seeking advice about making a disclosure, in making a disclosure, or during an investigation, knowingly, make a false or misleading statement, orally or in writing.
- 3.2 Obstruction in performance of duties. No person shall wilfully obstruct any person investigating and fulfilling the requirements under this policy. Such conduct will be deemed to be a reprisal.
- 3.3 Destruction, falsification or concealment of documents or things. No person shall, knowing that a document or material thing is likely to be relevant to an investigation under this policy:
 - 3.3.1 Destroy, mutilate or alter the document or material thing
 - 3.3.2 Falsify the document or make a false document
 - 3.3.3 Conceal the document or material thing; or
 - 3.3.4 Direct, counsel or cause, in any manner, a person to do anything mentioned in above clauses 3.3.1, 3.3.2, 3.3.3

4. Whistleblower Protection

- 4.1 Prohibition Against Interference, Discrimination, Harassment and/or Retaliation. KHSC prohibits interference, discrimination, harassment and/or retaliation against any person who reports, in good faith, what they reasonably believe to be a wrongdoing and any protected disclosures.
- 4.2 Protection. KHSC is committed to not discharging, demoting, suspending, threatening, harassing, prejudicially modifying the relationship of, or otherwise discriminating or retaliating against a person in the terms or conditions of their employment or relationship with KHSC as a result of a disclosure that was submitted in good faith in accordance with this policy and without malice of forethought.

Any person, who reports a wrongdoing, is protected by the safeguards set out in Article 5 & 6 unless the person remains anonymous.

- 4.3 Collective Responsibilities. All persons are responsible for ensuring that the workplace is free from all forms of discrimination, harassment and retaliation prohibited by this policy.

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5. Procedures for Breaches of Non-Retaliation

5.1 Any person who legitimately and in good faith believes that they have been the subject of retaliation, as defined in Article 4, or is aware of any conduct which may be prohibited by this policy is strongly encouraged to report immediately the facts forming the basis of that belief or knowledge to their leader or the hospital's primary contact (if not an employee). Any person who receives such a report or witnesses any conduct which they legitimately and in good faith believe may be prohibited by this policy must immediately notify their leader (or where a real or perceived conflict is believed to exist with their leader, to that individual's leader).

5.1.1 Upon receiving a report regarding retaliation, the receiver will promptly ascertain if an investigation is necessary, and if so lead an investigation or request another appropriate resources to conduct an investigation in accordance with the organization's normal practices for investigating allegations of misconduct. . It is the obligation of all persons to cooperate in such investigation. Those responsible for the investigation will maintain the confidentiality of the allegations of the complainant and the identity of the persons involved, subject to the need to conduct a full and impartial investigation, remedy any violations of policies, or monitor compliance with or administer the policies. If the report was made anonymously in writing or verbally, an investigation may not proceed.

5.1.2 The investigation generally will include, but will not be limited to, discussion with the subject of retaliation (unless the report was submitted on an anonymous basis), the person(s) against whom allegations have been made, and witnesses, if appropriate.

5.1.3 In the event that an investigation establishes that a person has engaged in conduct or actions constituting retaliation in violation of this policy, the receiver will ensure that KHSC takes appropriate corrective action up to and including termination of that person's employment or relationship with KHSC.

5.1.4 In the event that the investigation reveals that the report of retaliation was frivolously made or undertaken for improper motives or made in bad faith or without a reasonable basis, the receiver will ensure that the complainant's leader or applicable administrative lead will take whatever disciplinary action up to termination may be appropriate in the circumstances.

5.2 If there is a determination that a reprisal has been taken against the person making a protected disclosure, the receiver, in consultation with applicable hospital representative(s) may in accordance with the policy:

5.2.1 Return the complainant to their duties / activities; or

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- 5.2.2 Reinstatement the complainant or propose another remedy, if it is determined that the trust relationship between the parties cannot be restored; or
- 5.2.3 Rectify any situation resulting from the reprisal as deemed necessary; or
- 5.2.4 Do or refrain from doing anything in order to remedy any consequence of the reprisal.

Related Documents

02-143 Workplace Violence Prevention
12-320 Code of Behaviour (Be Real)
12-300 Workplace Harassment & Discrimination
12-140 Diversity
06-043 Accessibility
11-009 Physician Behaviour

References

- “Whistleblowing (Disclosure of Wrongdoing)”, Southlake Regional Health Centre
- “Whistleblower”, The Royal Ottawa Health Care Group
- “Professional Code of Conduct”, Yukon Health and Social Services Continuing Care
- “Disclosure of Wrongdoing”, Nova Scotia Health Authority
- “Whistleblower Policy”, London Health Sciences Centre Foundation
- “Whistleblower Policy”, Automotive Associate of Canada
- “Whistleblower Policy”, Duck Unlimited Canada
- “Whistleblower Policy”, NAV Canada
- “Whistleblower Policy”, The University of Adelaide
- “Whistleblower Policy”, Toronto 2015 Pan America and Parapan America Games
- “Hear that whistle blowing! Establishing an effective complaint-handling process”; Grant Thornton Corporate Governor Series, August 2006, Volume 2, Issue 2.
- “Understanding Disclosure Controls and Procedures: Helping CEOs and CFOs Respond to the Need for Better Disclosure”, A Risk Management and Governance Board Discussion Brief, The Canadian Institute of Chartered Accountants, Copyright 2005.
- Criminal Code of Canada and pertinent legislation.
- Verdict of Coroner’s Jury – Dupont/Daniel Inquest and the Dupont Inquiry Recommendations, December 11, 2007.
- “Guidebook for Managing Disruptive Physician Behaviour”, College of Physicians and Surgeons of Ontario, April 2008.
- “Audit Committee Whistleblower Policy”, Bennett Environmental Inc. Adopted March 2, 2005; modified November 17, 2005.

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- “Code of Conduct” Canada Line. Finalized April 22, 2008.
- “Whistleblower Policy”, Goldcorp Inc., August 2005.
- “Standards of Business Conduct”, London Health Sciences Centre, July 1, 2009.
- “Business Ethics in the Workplace – A Guide for Leaders, Physicians and Staff”, London Health Sciences Centre, May 2007.
- “Code of Conduct”, St. Joseph’s Health Sciences Centre, Toronto, Ontario.
- “Code of Ethical Conduct”, Mount Sinai Hospital, Toronto, Ontario
- “Code of Ethics and Business Conduct”, SNC-Lavalin, 2009-3.
- “Code of Conduct and Conflict of Interest”, Provincial Health Services Authority, February 13, 2003.
- “Whistleblower Policy”, Provincial Health Services Authority, August 25, 2005.
- “Code of Conduct”, Children’s Memorial Hospital”, Copyright 1999-2009.
- “Value Based Code of Conduct”, Hamilton Health Sciences, June 30, 2006.
- “Conflict of Interest and Conflict of Commitment”, Queens University, September 28, 2001.
- “Code of Conduct”, Queens University, July 1, 2008.
- “Conflict of Interest Rules for Public Servants”, Ontario Regulation 382/07.

Authorizing Signature:

Dr. David Pichora
President and Chief Executive Officer

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AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Quality & Effectiveness	REVIEW DATES:	April 2017, September 2021
COMMITTEE:	Patient Care & Quality	REVISION DATE:	March 2022
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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.

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SUBJECT: PERFORMANCE MONITORING

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 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 Governance Committee is responsible for reviewing and making recommendations to the Board on the overall performance management system.

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.

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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.

ISSUED BY:	KHSC Board of Directors	NUMBER:	III-5
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Quality & Effectiveness	REVIEW DATES:	April 2017, February 2022
COMMITTEE:	People, Finance & Audit	REVISION DATE:	March 2022
		PAGE:	1 OF 1

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.

ISSUED BY:	KHSC Board of Directors	NUMBER:	III-6
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Quality & Effectiveness	REVIEW DATES:	Sept 2017, November 2021
COMMITTEE:	Patient Care & Quality	REVISION DATE:	March 2022
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SUBJECT: PATIENT FEEDBACK

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 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 Patient Relations 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 Patient Relations and will provide notice of receiving the concern to the Board Chair. Thereafter, the concern will be addressed using the established resolution process.

ISSUED BY:	KHSC Board of Directors	NUMBER:	III-7
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Quality and Effectiveness	REVIEW DATES:	April 2017, January 2022
COMMITTEE:	Patient Care & Quality	REVISION DATE:	March 2022
		PAGE:	1 OF 1

SUBJECT: FRENCH LANGUAGE SERVICES

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 Affairs¹.

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
2. University of Ottawa Heart Institute Policy and Procedure Manual (2007). Official Languages /Services in French.

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 “

ISSUED BY:	KHSC Board of Directors	NUMBER:	IV-1
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Financial & Organizational Viability	REVIEW DATES:	April 2017, January 2022
COMMITTEE:	People, Finance & Audit	REVISION DATE:	March 2022
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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.

ISSUED BY:	KHSC Board of Directors	NUMBER:	IV-2
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Financial & Organizational Viability	REVIEW DATES:	April 2017, September 2021
COMMITTEE:	People, Finance & Audit	REVISION DATE:	March 2022
		PAGE:	1 OF 2

SUBJECT: FINANCIAL PLANNING AND PERFORMANCE

The Board of Directors approves the Hospital Annual Planning Submission (HAPS), and signs the Hospital Services Accountability Agreement (H-SAA) for submission to 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 (MOH) or 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.

ISSUED BY:	KHSC Board of Directors	NUMBER:	IV-3
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Financial & Organizational Viability	REVIEW DATES:	April 2017, February 2022
COMMITTEE:	People, Finance & Audit	REVISION DATE:	March 2022
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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 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].

ISSUED BY:	KHSC Board of Directors	NUMBER:	IV-4
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Financial & Organizational Viability	REVIEW DATES:	April 2017; May 2022
COMMITTEE:	People, Finance & Audit	REVISION DATE:	
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SUBJECT: SIGNING OFFICERS

In accordance with By-Law Articles 11.2 Execution of Documents, and Article 11.3 Other Signing Officers, the Board may by resolution, from time to time, designate the signing officers of the Hospital and authorize individuals to sign contracts, agreements, and carryout the business of the corporation.

Two signing officers shall be required to sign cheques, contracts, agreements, bills of exchange or other negotiable instruments and orders for payment, except as specifically provided for in a Board resolution. The Board by resolution, from time to time, will assign limits of authority to Signing Officers and clarify the incidences where Board Designated Signing Officers must be one of the signatories.

For further clarity, hospital employees are not authorized to bind the Hospital to contracts or incur expenditures unless they have been delegated that authority.

The CEO is accountable to the Board of Directors for ensuring that appropriate administrative policies and procedures are in place regarding signing authority, and that these policies and procedures are monitored for compliance and reviewed annually by the People, Finance & Audit Committee of the Board.

ISSUED BY:	KHSC Board of Directors	NUMBER:	V-1
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Board Effectiveness	REVIEW DATES:	April 2017, May 2022
COMMITTEE:	Governance	REVISION DATE:	June 2022
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SUBJECT: GOVERNANCE POLICY FRAMEWORK

As outlined in the OHA's Guide to Good Governance¹, *"as a general principle, the board governs, and management manages. Most governance models are based on the premise that the board's role is to approve overall direction, interpret the objects, and to see that the organization is well managed by monitoring performance and compliance with approved plans and policies. A key element of any governance model involves defining the line between board and management."*

The Guide goes on to say that *"while there is no one best model, typically, larger not-for-profit organizations will follow a form of 'the policy governance' model. Most hospitals have reached a relatively mature and stable state whereby the organization has highly developed policies and operating performance reporting with specialized and professional staff in most functions. The boards of these organizations do not need to be much involved in operations or give operational advice to management. These boards focus on policy direction and oversight of performance, plans and policy"*.

Pointer & Orlikoff's "Board Work" supports the above statement but further noting: *"Board policies perform two absolutely essential functions. First, they express Board expectations – of the organization as a whole, of itself, of management and the medical staff. Policies are the means by which Boards specify and convey what they want done (and what they want the organization to refrain from doing) in addition to the range of acceptable (and unacceptable) means for accomplishing specified goals. To lead rather than follow, policies must clarify and articulate Board expectations. Second, policy is the mechanism by which Boards direct and constrain as they delegate authority and tasks to management and the medical staff."*²

The policies are aligned with the OHA's Guide to Good Governance "Roles and Functions of a Board". The OHA's Guide states that there are a number of primary functions which should be performed by hospital boards. These include: approving strategic goals and directions; establishing a framework for performance oversight; overseeing quality; overseeing financial conditions and resources; ensuring enterprise risk management; providing for leadership; stakeholder relationships; board governance³. To ensure compliance with the Guide, the Board policies have been allocated in the following six categories:

- Establish Strategic Direction
- Provide for Excellent Leadership and Management
- Monitor Quality and Effectiveness
- Ensure Financial and Organizational Viability
- Ensure Board Effectiveness
- Build and Maintain Positive Relationships

¹OHA Guide to Good Governance, Third Edition, Page 29-30

²Pointer and Orlikoff. Board Work: Governing Health Care Organizations, Jossey Bass 1999

³OHA Guide to Good Governance, Third Edition, Chapter 4, Page 39

ISSUED BY:	KHSC Board of Directors	NUMBER:	V-2
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Board Effectiveness	REVIEW DATES:	April 2017, January 2022
COMMITTEE:	Governance	REVISION DATE:	March 2022
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SUBJECT: CONFLICT OF INTEREST PROVISIONS FOR DIRECTORS & EXTERNAL¹ MEMBERS

Preamble

The following definitions and procedures support the Declaration of Conflict provision in the By-law, Article 6. As part of the annual board member declaration process (see Board policy V-A-1), members are required to sign a form confirming that they have/will declare conflict of interest, consistent with this policy.

Definitions

“Conflict of Interest” includes, without limitation, the following four (4) areas that may give rise to a conflict of interest for the Directors of the Corporation, namely:

“Pecuniary or financial interest” – a Director is said to have a pecuniary or financial interest in a decision when the Director (or the Director’s Associates) stands to gain by that decision, either in the form of money, gifts, favours, gratuities or other special considerations;

“Undue influence” – participation or influence in Board decisions that selectively and disproportionately benefits particular agencies, companies, organizations, municipal or professional groups, or patients from a particular demographic, geographic, political, socio-economic or cultural group is a violation of the Director’s entrusted responsibility to the community at large;

“Adverse Interest” – a Director is said to have an adverse interest to the Corporation when the Director is a party to a claim, application or proceeding against the Corporation; or

“Personal Relationship” – a Director has or may be perceived to have personal interests that are inconsistent with those of the Corporation, creating conflicting loyalties.

“Associates” – in relation to an individual means the individual’s parents, siblings, children, spouse or common-law partner, and includes any organization, agency, company or individual (such as a business partner) with a formal relationship to the individual.

¹ An external member refers to community members on Board Committees, who are not directors of the Board, but are members of the Committee.

Procedure

- a)
 - i) The Conflict of Interest provision applies to every Director of the Corporation and its provisions apply at meetings of the Board of Directors and committees thereof.
 - ii) The Conflict of Interest provisions apply to every person who sits on a Board Committee (“External Member”) with necessary changes to the points of detail.
- b) Subject to paragraph c), every Director/external member who, either on their own behalf or while acting for, by, with, or through another, has any interest, direct or indirect, perceived or actual in any proposed matter, contract or transaction or a matter, contract or transaction with the Hospital shall declare their interest and the nature and extent of such interest at a meeting of the Directors or Committee at which the proposed matter, contract or transaction or a matter, contract or a transaction is the subject of consideration and shall not be present at, or take part in, the deliberations or vote on any question with respect to the proposed matter, contract or transaction or the matter, contract or transaction. The interests of any associate of the Director/external member shall be deemed for the purposes of this By-Law to be an interest of a Director/external member.
- c)
 - i) A Director/external member of the Hospital may have interests with stakeholders of the Hospital which may appear to be a Conflict of Interest. The Board recognizes that where the perceived conflicts relate to non-profit stake-holders/partners that share common goals with the Hospital, that the benefits of having such members on the Board outweigh the potential difficulties relating to the perceived or actual Conflict of Interest.
 - ii) The benefits include:
 - (A) reflection of the operational reality of the inter-relationship that the Hospital has with key stakeholders/partners that is critical to the Hospital achieving its mission and vision;
 - (B) increased capacity of the Board because it leads to fuller and more informed deliberation on issues that have cross-organizational implications.
- d) The disclosure requirements outlined in Article 6.1 of the By-Law state that disclosure shall be made:
 - i) at the meeting at which a proposed matter, contract or transaction is first considered if the Director is present, and otherwise, at the first meeting after the Director becomes aware of the contract, or transaction;
 - ii) if the director was not then interested in a proposed matter, contract, or transaction at the first meeting after such Director becomes so interested; or

- iii) if the Director becomes interested after a matter, contract or transaction is made, at the first meeting held after the Director becomes so interested.

- e) If a material matter, material contract or material transaction, whether entered into or proposed, is one that, in the ordinary course of the Corporation's activities, would not require approval by the Directors, a Director/external member shall, immediately after they become aware of the matter, contract or transactions, disclose in writing to the Corporation, or request to have entered in the minutes of meeting of Directors or Committee, the nature and extent of their interest.

- f) For the purposes of Article 6.1 of the KHSC By-law, a general notice to the Directors by a Director declaring that the person is a director of, officer of or has a material interest in a body corporate, business firm or organization and is to be regarded as interested in any contract made therewith, is a sufficient declaration of interest in relation to any contract so made.

- g) A Director/external member who has declared an interest in a proposed matter, contract or transaction or a matter, contract or transaction and who has otherwise complied with paragraphs 0 or b) hereof, shall not be accountable to the Hospital or its creditors for any profit resulting from such matter, contract or transaction. The matter, contract or transaction will not be voidable by reason only of the Director/external member belonging to the Board of Directors or of the fiduciary relationship established thereby.

- h) Every disclosure of interest under paragraphs 0 and b) hereof shall be recorded in the minutes of the meeting of the Board of Directors/Committee by the Secretary of the Board.

- i) The failure of a Director/external member to comply with paragraphs 0 or b) hereof does not itself invalidate any matter, contract or transaction or the proceedings in respect of any proposed matter, contract or transaction mentioned in paragraphs 0 or b), but the matter, contract or transaction, or the proceedings in respect of any proposed matter, contract or transaction are voidable at the instance of the Hospital.

ISSUED BY:	KHSC Board of Directors	NUMBER:	V-3
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Board Effectiveness	REVIEW DATES:	April 2017, January 2022
COMMITTEE:	Governance	REVISION DATE:	March 2022
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SUBJECT: BOARD CODE OF CONDUCT

The Kingston Health Sciences Centre is committed to ensuring that in all aspects of its affairs it maintains the highest standards of public trust and integrity.

This code of conduct applies to all directors, including *ex officio* directors, and external members of board committees. Directors are also required to comply with the hospital's policy on ethics and standards of business conduct, which applies to employees and professional staff.

1. All directors of the hospital stand in a fiduciary relationship to the hospital corporation. As fiduciaries, directors must act honestly, in good faith, and in the best interests of the hospital corporation.
2. Directors will be held to strict standards of honesty, integrity and loyalty. A director shall not put personal interests ahead of the best interests of the corporation.
3. Directors must avoid situations where their personal interests will conflict with their duties to the corporation. Directors must also avoid situations where their duties to the corporation may conflict with duties owed elsewhere. Where conflicts of interest arise, directors will comply with the requirements of the hospital's by-laws, policies and applicable legislation.
4. Directors must act solely in the best interests of the corporation. All directors, including *ex officio* directors, are held to the same duties and standard of care. Directors who are nominees of a particular group must act in the best interests of the corporation, even if this conflicts with the interests of the nominating party.
5. In addition, all directors must respect the confidentiality of information about the corporation.
6. Directors and committee members owe a duty to the corporation to respect the confidentiality of information about the corporation whether that information is received in a meeting of the board or of a committee or is otherwise provided to or obtained by the director or committee member. Directors and committee members shall not disclose or use for their own purpose confidential information concerning the business and affairs of the corporation unless otherwise authorized by the board.

¹ An external member refers to community members on Board Committees, who are not directors of the Board, but are members of the Committee.

7. It is recognized that the role of director may include representing the hospital in the community. However, such representations must be respectful of and consistent with the director's duty of confidentiality. In addition, the chair is the only official spokesperson for the board. Every director and committee member shall ensure that no statement not authorized by the board is made by him or her to the press or public unless authorized by the board.
8. A director is in breach of his or her duties with respect to confidentiality when information is used or disclosed for other than the purposes of the hospital corporation.
9. The board has adopted a policy with respect to designating a spokesperson on behalf of the board. Only the chair or designate may speak on behalf of the board. The chief executive officer or the chief of staff, or his or her designate may speak on behalf of the organization.
10. No director shall speak or make representations on behalf of the board unless authorized by the chair or the board. When so authorized, the board member's representations must be consistent with accepted positions and policies of the board.
11. News media contact and responses and public discussion of the hospital's affairs should only be made through the board's authorized spokespersons. Any director who is questioned by news reporters or other media representatives should refer such individuals to the appropriate representatives of the hospital.
12. It is recognized that directors bring to the board diverse background, skills and experience. Directors will not always agree with one another on all issues. All debates shall take place in an atmosphere of mutual respect and courtesy.
13. The authority of the chair must be respected by all directors.
14. Directors acknowledge that properly authorized board actions must be supported by all directors. The board speaks with one voice. Those directors who have abstained or voted against a motion must adhere to and support the decision of a majority of the directors.
15. Request to obtain outside opinions or advice regarding matters before the board may be made through the chair.

ISSUED BY:	KHSC Board of Directors	NUMBER:	V-4
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Board Effectiveness	REVIEW DATES:	April 2017, January 2022
COMMITTEE:	Governance	REVISION DATE:	March 2022
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SUBJECT: CONFIDENTIALITY

Article 13 of the KHSC by-law broadly describes aspects of confidentiality. The following policy defines a Director's role and handling of confidential matters before the Board and ensures that confidential matters are not disclosed until disclosure is authorized by the board. This policy applies to all board and external¹ committee members.

1. The directors owe to the hospital a duty of confidence not to disclose or discuss with another person or entity, or to use for their own purpose, confidential information concerning the business and affairs of the hospital received in their capacity as directors unless otherwise authorized by the board.
2. Every director shall ensure that no statement not authorized by the board is made by him or her to the press or public.
3. All matters that are the subject of closed sessions of the board are confidential until disclosed in an open session of the board.
4. All matters that are before a committee or task force of the board are confidential unless they have been determined not to be confidential by the chair of the relevant committee or task force or by the board.
5. All matters that are the subject of open sessions of the board are not confidential.
6. Minutes of closed sessions of the board shall be recorded by the secretary or designate or if the secretary or designate is not present, by a director designated by the chair of the board.
7. All minutes of closed sessions of the board shall be marked confidential and shall be handled in a secure manner.
8. All minutes of meetings of committees and task forces of the board shall be marked confidential and shall be handled in a secure manner.
9. Notwithstanding that information disclosed or matters dealt with in an open session of the board are not confidential, no director shall make any statement to the press or the public in his or her capacity as a director unless such statement has been authorized by the board.

¹ An external member refers to community members on Board Committees, who are not directors of the Board, but are members of the Committee.

ISSUED BY:	KHSC Board of Directors	NUMBER:	V-A-1
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Board Effectiveness	REVIEW DATES:	April 2017, May 2022
COMMITTEE:	Governance	REVISION DATE:	June 2022
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SUBJECT: DIRECTOR & EXTERNAL MEMBER¹ DECLARATION

The following is the declaration each Director or External Member will be required to sign on an annual basis before being accepted to serve on the KHSC Board or a Board Committee.

The declaration will be delivered to each Director and External Member following the annual general meeting for completion.

Annual Director Declaration and Consent

To: Kingston Health Sciences Centre
And to: The Directors thereof

Consent

- I am an individual elected or appointed to the Board and hereby acknowledge and declare that I:
- a) Consent to act as a director of the Corporation;
 - b) Am at least 18 years of age;
 - c) Have not been found under the Substitute Decision Act, 1992 or under the Mental Health Act to be incapable of managing property;
 - d) Have not been found to be incapable by any court in Canada or elsewhere;
 - e) Do not have the status of an undischarged bankrupt; and
 - f) Am not any "ineligible individual" as defined in the Income Tax Act (Canada) or any regulations made under it.
 - g) I have a Canadian Police Information Centre (CPIC) on record with the Secretary of the Board and confirm that there have been no changes to this record since I filed this information with KHSC.
- I am an individual appointed to a Board committee and consent to serve the Corporation as a non-director Board committee member.

Meeting Participation Consent

I consent to the holding of Board and Board Committee meetings by telephonic or electronic means that permit all persons participating in the meeting to communicate adequately with each other during the meeting. I also consent to the participation by any Director or Board Committee member at a Board or Board Committee meeting by such telephonic or electronic means.

¹ An external member refers to community members on Board Committees, who are not directors of the Board, but are members of the Committee.

I also understand that meetings I participate in may have my voice electronically captured by the recording secretary for the purpose of creating meeting minute documentation and that, once the minutes have been transcribed, the recording is deleted.

I hereby confirm that I have provided the CEO's office with a secure e-mail address/account to receive board information/materials which may be considered confidential. I will undertake to advise the Hospital in writing of any change of personal address/email as soon as possible after such change.

Compliance with Policies

I confirm that I have read and understand all of the Board-approved policies and codes of conduct and any other applicable KHSC policies, as amended or supplemented from time to time (the "**Policies**"), including but not limited to:

- a) III-6 Patient Feedback
- b) V-2 Conflict of Interest provisions for directors and external members
- c) V-3 Board Code of Conduct
- d) V-4 Confidentiality
- e) V-A-6 Position Description – Board of Directors
- f) V-B-7 Board & Committee Attendance

I agree and comply with the Not-for-Profit Corporations Act, 2010 (the "**Act**") and the Corporation's articles, by-laws, and Policies ("**Governance Documents**").

Conflicts

In accordance with the Act and the Corporation's Governance Documents, I make the following disclosure:

I have an interest, directly or indirectly, in the following entities or persons, or matters, which includes entities in which I am a director or officer:

- 1. (insert name)
- 2. (insert name)
- 3. (insert name)

This disclosure is a general notice of interest pursuant to Act and the Corporation's Governance Documents, and accordingly, I should be regarded as interested in any of the above entities, persons or matters.

I acknowledge that this disclosure is in addition to my obligations to comply with the ACT and the Corporation's Governance Documents in respect of any specific conflict that may arise.

I declare the above information to be true and accurate as of the date hereof.

Notice

Notice for Board and/or Board Committee meetings may be sent to me at the address set out below:

SUBJECT: DIRECTOR & EXTERNAL MEMBER DECLARATION

Page 2 of 3

POLICY NUMBER: V-A-1

Address: _____

Email: _____

Telephone: _____

Attention: _____

Dated this _____ day of _____, 20XX.

Signature

Name of Director (Please Print)

ISSUED BY:	KHSC Board of Directors	NUMBER:	V-A-2
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Board Effectiveness	REVIEW DATES:	April 2017, April 2022
COMMITTEE:	Governance	REVISION DATE:	March 2022; June 2022
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SUBJECT: STANDING AND SPECIAL COMMITTEES OF THE BOARD

This policy is intended to supplement Article 8 of the By-law on Committees of the Board.

Standing and Special Committees of the Board of Directors play an essential role in the Board's functioning. These bodies support the Board in fulfilling its defined roles and responsibilities by undertaking work and advising the Board within their Terms of Reference as defined by the Board. A Standing or Special Committee will assist the Board by preparing policy alternatives, identifying implications for Board deliberation and monitoring performance within its defined areas of responsibility. Recommendations will be made to the Board of Directors for discussion and, if appropriate, for ratification.

1. The Board of Directors will establish:
 - i) standing Committees, being those committees whose duties are normally continuous, by Board resolution;
 - ii) such other Committees as may be necessary to comply with the requirements of the Public Hospitals Act and the Hospital Management Regulation, as amended from time to time, or as the Board may from time to time deem necessary for the operation of the hospital.
2. The Board of Directors may establish Special Committees, being those Committees appointed for specific time-limited duties whose mandate shall expire with the completion of the tasks assigned. The terms of reference and membership of Special Committees will be approved by the Board and they will report to the Board at regular intervals during their mandate.
3. The Board of Directors will establish the necessary Standing Committees that are clearly tied to the Board's core responsibilities.
4. The Board of Directors will approve Terms of Reference and membership of the Standing Committees and Special Committees annually on the recommendation of the Governance Committee at the first regular meeting following the Annual General Meeting of the Board.
5. All Directors will be expected to serve on at least one Standing Committee. Initially, a Board Director's preference with respect to membership on the Standing Committees will be accommodated where possible, based on their areas of interest and expertise. However, in order to develop Director competency in the range of Board responsibilities, elected Directors are expected to serve on a variety of standing committees and representative roles over the course of their service as a Director.
6. The Board Chair shall be an Ex-officio member of each Standing Committee.

7. Each Standing Committee shall include at least three (3) elected Directors.
8. With the exception of the Governance Committee, each Standing Committee may also include up to two external members with appropriate skills and expertise to support the work of the Committee.
9. The Board, on the recommendation of the Governance Committee, will appoint the Chairs and members of the Board Standing Committees and Ad Hoc Committees.
10. The Board, on the recommendation of the Standing Committees, will approve the annual priorities and work plan of the Standing Committees.
11. The Board will monitor the performance of its Standing Committees at each regular meeting of the Board through a summary written report and/or a verbal report by the Committee Chair related to specific recommendations of the Standing Committee for approval by the Board of Directors.
12. Terms of Reference for all Standing Committees shall be reviewed annually by the respective Committees which shall make recommendations to the Governance Committee for revisions as appropriate.
13. Board Committees/Task Forces may not speak or act for the Board except when formally given such authority for specific and time-limited purposes. Such delegation will be framed so as to not conflict with the authority delegated to the Chief Executive Officer. Board Committees/Task Forces, unless otherwise specified, may not commit or bind the organization to any course of action.
14. Unless otherwise authorized to do so, a Committee/Task Force may not engage independent legal counsel or consulting advice without the prior approval of the Board.
15. Meetings of Committees are not open to the public.
16. Terms of Reference for the Medical Advisory Committee are included in Article 22 of the Bylaw.

This policy includes Terms of Reference for the following Board Standing Committees:

- Executive Committee
- People, Finance and Audit Committee
- Governance Committee
- Patient Care & Quality Committee
- Research Committee

ISSUED BY:	KHSC Board of Directors	NUMBER:	V-A-3
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Board Effectiveness	REVIEW DATES:	April 2017, November 2021
COMMITTEE:	Governance	REVISION DATE:	March 2022
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SUBJECT: POSITION DESCRIPTION FOR THE BOARD CHAIR

Article 10.1 of the By-law defines the Duties of the Board Chair. The skills, attributes and expertise of the Board Chair are defined below.

The role of the Chair is to:

1. Working collaboratively with the Chief Executive Officer and the Chief of Staff, provides leadership to the Board in fulfilling its accountabilities, roles and responsibilities and ensures the integrity of the Board's processes.
2. Facilitates co-operative relationships among Board members and between the Board and Chief Executive Officer and the Board and Chief of Staff.
3. Ensures that all matters relating to the Board's mandate are brought to the attention of, and discussed by, the Board.
4. The Chair is the official spokesperson on behalf of the Board of Directors unless otherwise delegated.
5. The Chair serves as an ex-officio member on all Board standing committees.

The responsibilities of the Chair are:

- a) **Board Meetings.** In collaboration with the Chief Executive Officer and Committee chairs, establish agendas that are aligned with the Board's roles and responsibilities, annual Board goals and work plan, and preside over meetings of the Board. Facilitate and advance the business of the Board, ensuring that meetings are effective and efficient for the performance of governance work. Utilize a practice of referencing Board Policies in guiding discussions in order to support the decision-making processes of the Board. Ensure that a schedule of Board meetings is prepared annually.
- b) **Direction.** Serve as the Board's central point of official communication with the Chief Executive Officer and the Chief of Staff; guide and counsel the Chief Executive Officer and the Chief of Staff regarding the Board's expectations and concerns. In collaboration with the Chief Executive Officer, develop standards for Board decision-support packages that include formats for reporting to the Board and the level of detail to be provided to ensure that Hospital management strategies and planning and performance information are appropriately presented to the Board.

- c) **Performance Appraisal.** Lead the Governance Committee in monitoring and evaluating the performance of the Chief Executive Officer and Chief of Staff and establishing compensation Policy through an annual process as outlined in the Board Policies re “President and Chief Executive Officer Performance Evaluation” and “ Chief of Staff Performance Evaluation” respectively.
- d) **Work Plan.** With the assistance of the Chief Executive Officer and the Governance Committee, ensure that a work plan is developed and implemented for the Board that includes annual goals for the Board and embraces continuous improvement.
- e) **Representation.** Ensure that members of the Board of Directors have the opportunity to represent the Board at hospital functions and in interactions with external partners and stakeholders.
- f) **Reporting.** Report regularly and promptly to the Board regarding issues that are relevant to its governance responsibilities. Report to the annual meeting of the Members concerning the operation of the Hospital.
- g) **Board Conduct.** Set a high standard for Board conduct and enforce Policies and By-Laws regarding Board member conduct.
- h) **Mentorship.** Serve as a mentor to the Vice-Chair and to other Board members. Ensure that all members of the Board contribute fully. Address issues associated with underperformance of individual Directors.
- i) **Succession Planning.** Participate in succession planning for the Chief Executive Officer, Chief of Staff and the Board of Directors.

The skills, attributes and expertise of the Board Chair are identified below.

The Board Chair should have the following personal qualities, skills, and experience:

- all of the personal attributes required of a Director;
- Leadership and management skills;
- Strategic and facilitation skills;
- Ability to effectively influence and build consensus within the Board;
- Ability to establish a trusted advisor relationship with the CEO, Chief of Staff and other Board Directors;
- Ability to make the necessary time commitment and required flexibility in schedule to meet the requirements of this leadership role;
- Ability to communicate effectively with the Board, hospital executives, the Ministry of Health and other government agencies, Ontario Health-East, other health service providers and stakeholders including Queen’s University;
- Record of achievement in one or several areas of skills and expertise required within the Board;
- Hospital Board experience.

ISSUED BY:	KHSC Board of Directors	NUMBER:	V-A-4
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Board Effectiveness	REVIEW DATES:	April 2017, November 2021
COMMITTEE:	Governance	REVISION DATE:	March 2022
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SUBJECT: POSITION DESCRIPTION FOR THE VICE CHAIR(S)

Article 10.2 of the By-law defines the Duties of the Vice- Chair(s). The skills, attributes and expertise of the Vice- Chair(s) are defined below.

The role of the Vice Chair is to:

The Vice-Chair works collaboratively with the Chair. He/she supports the Chair in fulfilling his/her responsibilities.

The responsibilities of the Vice-Chair are:

- a) **Chair Substitute.** Assume the duties of the Chair in his/her absence, as requested by the Chair, including representing the Board and the Corporation at official functions and to the public at large.
- b) **Board Conduct.** Maintain a high standard for Board conduct and uphold Policies and By-Laws regarding Board member conduct.
- c) **Mentorship.** Serve as a mentor to other Board members.
- d) **Succession Planning for Board Chair.** To ensure succession planning for leadership within the Board of Directors, under normal circumstances the Vice-Chair is expected to be subsequently elected by the Board of Directors as Chair. Consequently, the skills, attributes and experience are similar for the positions of Vice-Chair and Chair.

The Vice-Chair should have the following skills, attributes and experience:

- all of the personal attributes required of a Board director;
- leadership and management skills;
- strategic and facilitation skills;
- ability to effectively influence and build consensus within the Board;
- ability to establish trusted advisor relationship with the Chair, CEO, Chief of Staff and other Board Directors;
- ability to make the necessary time commitment and required flexibility in work schedule to meet the requirements of this leadership role;
- willingness and ability to assume the role of Chair;
- ability to communicate effectively with the Board, hospital executives, the Ministry of Health and other government agencies, Ontario Health-East, other health service providers and stakeholders including Queen's University;
- record of achievement in one or several areas of skills and expertise required within the Board;
- Hospital Board experience.

ISSUED BY:	KHSC Board of Directors	NUMBER:	V-A-5
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Board Effectiveness	REVIEW DATES:	April 2017, November 2021
COMMITTEE:	Governance	REVISION DATE:	March 2022
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SUBJECT: POSITION DESCRIPTION FOR BOARD STANDING AND SPECIAL COMMITTEE CHAIRS

Role Statement

A Committee Chair, working collaboratively with the Chair of the Board and with the assigned executive support, provides leadership to the committee. He/she ensures that the terms of reference of the committee are followed. He/she effectively manages issues to promote effective dialogue.

Responsibilities

Agendas. Establish agendas in collaboration with executive staff, usually in a pre-meeting, and preside over meetings of the committee.

Work Plan. With the assistance of executive staff support, develop a work plan for the committee which is aligned with and responsive to the Board work plan.

Leadership/Facilitation. Effectively lead/facilitate each committee meeting in a manner that encourages thoughtful participation and promotes understanding of complex issues. Ensure a fair discussion, especially when differences and conflicting opinions arise.

Expertise. Serve as a leader within the Board on the matters addressed in the committee's terms of reference.

Experience. Experience in and understanding of governance, including the roles and responsibilities of the Board and individual Directors and the difference between governance and management.

Effectiveness and Evaluation. A Committee Chair participates in the evaluation of the performance of the Committee as a whole and of their performance as Chair.

Advise Board Chair. Liaise with the Board Chair on key issues and recommendations from the Committee to be included in the Board agenda.

Report to the Board. With the assistance of staff support following each committee meeting, prepare a report and, where appropriate, recommendations for consideration by the Board of Directors. Review draft meeting minutes.

Mentorship. Serve as a mentor to committee members and develop a succession plan for the Chair.

Skills, Attributes and Experience

A Committee Chair will demonstrate the following personal qualities, skills and experience:

- i) all of the personal attributes required of a Director;
- ii) interest and experience related to the work of the committee;
- iii) ability to chair a meeting such that decisions are made in a manner that is respectful and efficient;
- iv) willingness and ability to commit time to the responsibilities of the Committee Chair.

Term

A Committee Chair shall be appointed by the Board of Directors on the recommendation of the Governance Committee annually.

ISSUED BY:	KHSC Board of Directors	NUMBER:	V-A-6
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Board Effectiveness	REVIEW DATES:	April 2017, June 2018, Nov 2019, November 2021
COMMITTEE:	Governance	REVISION DATE:	March 2022
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SUBJECT: POSITION DESCRIPTION – BOARD OF DIRECTORS

The following outlines the duties and expectations of a Kingston Health Sciences Centre Director. KHSC is committed to ensuring that it achieves standards of excellence in the quality of its governance and has adopted this policy describing the duties and expectations of directors.

This policy applies to all elected and *ex officio* directors and is provided to directors before they are recruited for appointment to the board. A director who wishes to serve on the board must confirm in writing that he or she will abide by this policy.

As a member of the board, and in contributing to the collective achievement of the role of the board, the individual director is responsible for the following:

1. Fiduciary Duties

- i) Each director is responsible to act honestly, in good faith and in the best interests of the hospital and, in so doing, to support the corporation in fulfilling its mission and discharging its accountabilities;
- ii) A director shall apply the level of skill and judgment that may reasonably be expected of a person with his or her knowledge and experience. Directors with special skill and knowledge are expected to apply that skill and knowledge to matters that come before the board.

2. Accountability

A director's fiduciary duties are owed to the corporation. The director is not solely accountable to any special group or interest and shall act and make decisions that are in the best interest of the corporation, as a whole. A director shall be knowledgeable of the stakeholders to whom the corporation is accountable and shall appropriately take into account the interests of such stakeholders when making decisions as a director, but shall not prefer the interests of any one group if to do so would not be in the best interests of the hospital.

3. Education

- i) A director shall be knowledgeable about:
 - o the operations of the hospital;
 - o the health care needs of the community served;

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

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

4. Board Policies and Corporation Policies

A director shall be knowledgeable of and comply with the policies that are applicable to the board including:

- the board's code of conduct;
- the board's conflict of interest policy;
- the board's confidentiality policy;
- the ethics and business conduct policy of the hospital; and
- expense reimbursement and perquisites policies.

5. Teamwork

A director shall develop and maintain sound relations and work cooperatively and respectfully with the board chair, members of the board and senior management.

6. Community Representation

A director shall represent the board and the hospital in the community when asked to do so by the board chair. Board members shall support the hospital and the foundation through attendance at hospital and foundation-sponsored events. Through active participation in hospital and Foundation activities, a director can then determine their support as a donor.

7. Time and Commitment

- i) A director is expected to commit the time required to perform board and committee duties. It is expected that a director will devote a minimum of between [10 and 15] hours per month.
- ii) The board meets approximately seven times a year and a director is expected to adhere to the board's attendance policy that requires attending at least 70% percent of board meetings.
- iii) A director is expected to serve on at least one standing committee. Committees generally meet approximately every second month (September to May).

8. Contribution to Governance

Directors are expected to make a contribution to the governance role of the board by:

- Reading materials in advance of meetings and coming prepared to contribute to discussions;
- Offering constructive contributions to board and committee discussions;
- Contributing his or her special expertise and skill;
- Respecting the views of other members of the board;
- Voicing conflicting opinions during board and committee meetings, but respecting the decision of the majority even when the director does not agree with it;
- Respecting the role of the chair;
- Respecting the role and terms of reference of board committees; and
- Participating in board evaluations and annual performance reviews.

9. Continuous Improvement

A director shall commit to be responsible for continuous self-improvement. A director shall receive and act upon the results of board evaluations in a positive and constructive manner.

10. Term and Renewal

- i) Directors shall be elected and shall retire in rotation as herein provided. The Directors referred to in subsection 4.1(a) of the by-law shall be elected for a term up to three (3) years provided that each such Director shall hold office until the earlier of the date on which their office is vacated pursuant to by-law provisions outlined in sections 4.4 or 4.5 or until the end of the meeting at which his or her successor is elected or appointed. Four (4) Directors shall retire from office each year subject to re-election as permitted by section 4.8 of the by-law. The Foundation Representative shall serve a term of one (1) year provided that such Foundation Representative shall hold office until the earlier of the date on which his or her office is vacated pursuant to sections 4.4 and 4.5 of until the end of the meeting at which his or her successor is elected or appointed.
- ii) Each Director referred to in subsection 4.1(a) of the by-law shall be eligible for re-election provided that such Director shall not be elected or appointed for a term that will result in the Director serving more than nine (9) consecutive years. Such Director may also be eligible for re-election for another term or terms (to a maximum of six (6) consecutive years) if two (2) or more years have elapsed since the termination of his or her last term. In determining a Director's length of service as a Director, service to another hospital corporation prior to the Effective Date shall be excluded and not considered. Despite the foregoing a Director may, by resolution of the Board, have their maximum term as a Director extended for the sole purpose of that Director succeeding to the office of Chair or serving as Chair. Despite the foregoing, where a Director was appointed to fill an unexpired term of a Director such partial term shall be excluded from the calculation of the maximum years of service.
- iii) A Director's renewal is not automatic and shall depend on the Director's performance.

ISSUED BY:	KHSC Board of Directors	NUMBER:	V-A-7
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	October 2019
CATEGORY:	Board Effectiveness	REVIEW DATES:	September 2019, November 2021
COMMITTEE:	Governance	REVISION DATE:	March 2022
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SUBJECT: POSITION DESCRIPTION FOR THE IMMEDIATE PAST CHAIR

The role of the Immediate Past Chair works collaboratively with the Chair and Vice Chairs. He/she is available to support the Chair in fulfilling his/her responsibilities in an advisory capacity at the request of the current Chair. The Immediate Past Chair position serves for one year only and the appointment is made at the special meeting following the annual general meeting.

The responsibilities of the Immediate Past Chair are:

- a) **Board Conduct.** Maintain a high standard for Board conduct and uphold Policies and By-Laws regarding Board member conduct.
- b) **Mentorship.** Serve as a mentor to other Board members at the request of the Board Chair. Facilitates the leadership transition of the Board.
- c) **Advice & Support.** Is available to provide advice and support to the Chair. Serves as an advisor to the incoming Board Chair.
- d) **Board & Committee Work.** Attends and participates fully in board and the quarterly board committee chair planning meetings as a resource to support the ongoing work of the board from the previous year.
- e) **Ambassador for the Organization.** Serves as an ambassador of the organization when requested by the Chair.

The Immediate Past Chair will have demonstrated the following skills, attributes and experience:

- has completed his/her term as Chair and is an active member;
- all of the personal attributes required of a Director;
- leadership and management skills;
- strategic and facilitation skills;
- ability to build consensus within the Board;
- ability to establish trusted advisor relationship with the Chair, Vice Chair(s), and other Directors as identified by the Board Chair;
- ability to make the necessary time commitment and required flexibility in work schedule to meet the requirements of this leadership role;
- record of achievement in one or several areas of skills and expertise required within the Board.

ISSUED BY:	KHSC Board of Directors	NUMBER:	V-B-0
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Board Effectiveness	REVIEW DATES:	April 2017; January 2022
COMMITTEE:	Governance	REVISION DATE:	March 2022
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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 publicly 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.

ISSUED BY:	KHSC Board of Directors	NUMBER:	V-B-1
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Board Effectiveness	REVIEW DATES:	April 2017, January 2022
COMMITTEE:	Governance	REVISION DATE:	March 2022
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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.

ISSUED BY:	KHSC Board of Directors	NUMBER:	V-B-2
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Board Effectiveness	REVIEW DATES:	April 2017, January 2022
COMMITTEE:	Governance	REVISION DATE:	March 2022
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SUBJECT: PROCESS FOR NOMINATION OF CHAIR, DIRECTORS, AND EXTERNAL MEMBERS¹ OF BOARD STANDING & SPECIAL COMMITTEES

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) balance of skills and expertise;
- ii) prior experience in relation to matters before the Committee;
- iii) the expectation that each Director serve on at least three Board Standing Committees over the course of their service as a Director
- iv) preferences of Directors; or
- v) other criteria as determined by the Board.

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

Governance Committee will review the skill requirements for external positions on the board standing committees annually.

¹ An external member refers to community members on Board Committees, who are not directors of the Board, but are members of the Committee.

ISSUED BY:	KHSC Board of Directors	NUMBER:	V-B-3
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Board Effectiveness	REVIEW DATES:	April 2017, May 2022
COMMITTEE:	Governance	REVISION DATE:	June 2022
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SUBJECT: BOARD ORIENTATION AND ONGOING DEVELOPMENT

Directors have a duty to be knowledgeable about the affairs of the hospital and their obligations as Directors. The hospital requires directors to demonstrate a firm commitment to continuing education by participating in board orientation, committee orientation, and ongoing board education. This commitment is a factor that is considered in the election or re-election of a Director of the Board.

New Directors are legally responsible to carry out their duties from the day they are elected or appointed to the Board of Directors. New Directors must be oriented to KHSC, current health care issues and their role as a Director.

Each Director is expected to participate in an initial orientation process and ongoing Board education events relating to Board roles and responsibilities.

The Board of Directors delegates responsibility to the Governance Committee for orientation of new Directors. The Chair of each Board Committee is expected to take an active role in the orientation process, specifically with respect to the mandate and Terms of Reference of the Committee for which they chair.

Orientation will take place in a timely manner as soon as possible after the appointment of a Director and will include:

- i) **Orientation** to KHSC within the context of Ontario Health and regional health system, an overview of Board and individual Director governance roles and responsibilities.
- ii) **Reference Manual/Board Portal:** Content will include: the KHSC By-law; KHSC Board Policy Manual; Board member contact listing; information on the Board Committee Structure; current Board work plan; current Board and Committee meeting schedule; a copy of the integrated annual corporate plan; KHSC's strategy performance index; the most recent Board agenda materials; and a user's guide to accessing the Board portal.
- iii) **Mentoring:** Each new Director may be paired with a mentor on the Board. The mentor will attend orientation sessions with the new Director, sit with them at Board meetings, ask if the information presented was clear, and answer any questions they may have about the meeting.
- iv) **Internal and External Resources:** Additional resources and expertise may be made available to support the orientation program e.g. KHSC staff present and provide an introduction to issues in their area; external speakers; attendance at Hospital sponsored events etc.
- v) **OHA Board Certification Program:** All new Board members will attend the OHA Board Certification program, preferably within the first year.
- vi) **Catholic Health Leadership Program:** All new Board members will attend Catholic Health Leadership program, preferably within the first year.
- vii) **OHA Guide to Good Governance:** New directors are encouraged to become familiar with this resource which is available from the Board Secretary.

Participants will evaluate the orientation program on completion.

A Board manual including all orientation materials, the KHSC By-law and Board of Directors Policies will be maintained by the Board Secretary.

An ongoing Board education program will be established each year that is consistent with the goals and objectives of the Board for that year. It is expected that each Director will participate in ongoing education.

Directors attend education events in accordance with board approved policies. Directors obtain prior approval to attend an education session. Such approvals will be coordinated through the CEO's office to ensure education budget funds are available.

Components of the ongoing education process may include:

- i) **Assessment of Development Needs:** Board Directors will be asked annually to identify their development needs. Mechanisms to identify those needs may include: survey of Board Directors; feedback on previous education sessions; diagnostic questionnaires; feedback from Board Directors' self-evaluations.
- ii) **Presentations at Board Meetings:** The Governance Committee, in consultation with the Chief Executive Officer, will develop an annual program of information/education presentations which may be included as part of the Board's regular meetings or presented at scheduled times as the Board may direct.
- iii) **Ontario Hospital Association sponsored Education Sessions and Programs:** Directors of the Board of Directors are encouraged to participate in educational opportunities offered by the Ontario Hospital Association. Reasonable expenses of attending and/or participating in such events may be reimbursed according to established policy.
- iv) **Other Relevant Education Programs:** Directors may attend relevant educational programs sponsored by organizations other than KHSC with the prior written approval of the Board Chair. Reasonable expenses of attending and/or participating in such approved programs will be reimbursed according to the established policy.
- v) **Knowledge Transfer/Reporting:** Directors are required to report back at the appropriate Board committee meeting to share information/best practice processes acquired at educational sessions.
- vi) **Annual Board Retreat:** An annual Board Retreat should be scheduled. At each retreat, the Strategic Plan will be reviewed to ensure that progress is being made toward its achievement. Additionally, the retreat should focus on other relevant areas within the Board Roles and Responsibilities, reflecting the Board's annual work plan. The retreat should be conducted at a reasonable cost, and with clear deliverables.

ISSUED BY:	KHSC Board of Directors	NUMBER:	V-B-4
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Board Effectiveness	REVIEW DATES:	April 2017, September 2021
COMMITTEE:	Governance	REVISION DATE:	March 2022
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SUBJECT: BOARD GOALS AND WORK PLAN

On an annual basis, the Board of Directors will establish Board goals consistent with the KHSC Mission and Vision, the Strategic Plan and Integrated Annual Corporate Plan, and key issues which are a priority for the Board in the coming year. The Board goals provide direction to and inform the work plans of the Board, its standing committees and any special committees. The Board will review its progress toward achieving the annual Board goals at least once at a mid-point during the year.

The Board will evaluate its success in achieving its work plan as part of the annual Board evaluation process and through discussion and reflection at a meeting of the Board of Directors prior to the Annual Meeting.

¹ An external member refers to community members on Board Committees, who are not directors of the Board, but are members of the Committee.

ISSUED BY:	KHSC Board of Directors	NUMBER:	V-B-5
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Board Effectiveness	REVIEW DATES:	April 2017; November 2020; May 2022
COMMITTEE:	Governance	REVISION DATE:	December 2020; June 2022
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SUBJECT: BOARD MEETINGS, BOARD AGENDA DEVELOPMENT, ELECTRONIC VOTES & USE OF THE CONSENT AGENDA

This policy supplements the By- Law by providing: more clarity on the role and responsibilities of the Board Chair, and on the Board's approach to regular and special meetings of the Board.

Board Meetings

In collaboration with the Chief Executive Officer and Committee Chairs, the Chair of the Board shall establish agendas that are aligned with the Board's role and responsibilities and annual Board goals and work plan and preside over meetings of the Board.

Board agenda packages should be accurate, timely, balanced, relevant and clear, sufficiently detailed and will ensure each Board meeting contributes effectively to the discharge of the Board's governance role.

Approximately 10 days prior to the distribution of an agenda package, the CEO will meet with the Board Chair to review the draft agendas for the upcoming meeting.

Use of the Consent Agenda

The Board elects to use a consent agenda for Board of Director open and closed meetings for the passage of non-controversial or routine board business, allowing more time for education and discussion of substantial and strategic issues. Consent items are those which usually do not require discussion or explanation prior to Board action or are items which have already been discussed or explained and not require further discussion.

Consent agenda items may include, but are not limited to: approval of the previous minutes, approval of routine policies and procedures, committee reports and minutes, correspondence.

Consent agenda items must be circulated with the agenda package (see Notice provisions below). Items may be moved out of the Consent agenda at the request of any member of the Board prior to approval of the agenda. No motion or vote of the board is required with respect to moving an item out of the Consent agenda. Where a member of the board requests that an item be moved out of the Consent agenda section, the Chair shall decide where to place that item on the agenda. Consent agenda items will be packaged with a single briefing note outlining the materials with applicable motion(s).

Open Board Meetings

The public, hospital staff and media are welcome to observe the open portion of the Board's meeting. The open part of Board meetings will be held at times generally recognized as convenient for the public to attend. Notice of the times and dates of such meetings will be provided annually to the public on the hospital website along with a copy of the approved open Board minutes

Recording devices, videotaping and photography are prohibited except for discretionary use by the Recording Secretary for the purposes of taking minutes of the meeting. If a device is used, the recording is deleted once the minutes have been transcribed.

Typically, open Board agenda packages are e-mailed to Directors seven (7) days in advance of the meeting date. If agenda materials are not ready within this time period, the Secretary will ensure notification is provided to Directors including the anticipate date of delivery of the materials.

In-Camera Board Meetings

The Board of Directors has the right to close to the public, hospital staff and media, any meeting or part of a meeting if the Board deems an in-camera session to be necessary to protect the interests of the public or a person. Matters that may generally be dealt with in an in-camera session include, but are not limited to:

- Matters involving property;
- Matters involving litigation;
- Material contracts;
- Human resources issues;
- Patient issues; and
- Any matters that the Board determines should be subject of a closed session.

A Board motion is required to move into, and to rise from, an in-camera session.

During an in-camera session, all persons who are not Board Members with the exception of the Chief Executive Officer will be excluded from the meeting; provided, however, Hospital personnel and others may be permitted to attend all or a portion of the In-Camera session upon the invitation of the Board as advised by the Chief Executive Officer.

All Hospital personnel including the Chief Executive Officer and the Chief of Staff will be excluded during discussion regarding the Performance Evaluation of the Chief Executive Officer and the Chief of Staff; however, the results of such discussion will be communicated to the Chief Executive Officer and the Chief of Staff immediately thereafter.

All matters brought before an in-camera session remain confidential until they are moved by the Board to an open session; the Board will pass a motion with respect to those items that are to be moved to an open session.

A separate agenda will be prepared for in-camera sessions indicating the items to be considered during the session. The agenda and any supporting materials will be clearly marked confidential and will be handled and secured in a manner that respects the nature of the material.

Typically, closed Board agenda packages are e-mailed to Directors seven (7) days in advance of the meeting date. If agenda materials are not ready within this time period, the Secretary will ensure notification is provided to Directors including the anticipated date of delivery of the materials.

Participation by Board Members by Telephone, Electronic or Other Communication Facilities

Directors and committee members may participate at a meeting of the board or a committee of the board by such telephone, electronic or other communications facilities as are permitted under applicable legislation so long as all persons participating in the meeting can communicate with each other simultaneously and instantaneously.

Electronic Voting Process

Appreciating that every effort is made to bring forward decision items in a timely manner based on the Board and committee meeting schedule, this may not always be possible due to timelines that are imposed by other agencies.

To address time sensitive issues, the Secretary, in consultation with the Chair, may recommend that an urgent board meeting be called and, if the Secretary is unable to secure quorum to complete the decision/discussion to meet the deadline, there is a provision in the KHSC By-law to bring the Executive Committee of the Board together to consider the matter.

If the matter is more routine in nature, the Secretary and Chair may determine that an electronic vote be considered via email. Board briefing materials would be prepared and circulated to all members of the Board. Directors have the right to request a constituted board meeting if they feel the matter requires further discussion prior to a decision being made.

For electronic votes, the following steps are recommended:

1. The Board Secretary ensures that materials are delivered as soon as possible in order to ensure reasonable notice.
2. Voting Directors will be asked to consider the matter and reply to the Secretary their decision on the matter. Directors have the right to respond to all who have received Notice, any concern or issue they have with the matter before them. To eliminate email volume, it is suggested that Directors simply reply to the Secretary with their decision. If one dissenting vote is received, the Secretary will then prepare and serve Notice for a meeting.
3. The Board Secretary will compile the results of the vote and circulate an electronic vote summary report to all Directors.
4. The report described in #3 will be brought forward to the next regular meeting of the Board to ensure it forms part of the corporate record.

Delegations and Presentations

Members of the public may not address the Board or ask questions of the Board without the permission of the Chair. Individuals who wish to address or raise questions with the Board must contact the Board Secretary, in writing, at least 24 hours in advance of the meeting and indicate the topic to be addressed.

**SUBJECT: BOARD MEETINGS, BOARD AGENDA DEVELOPMENT,
ELECTRONIC VOTES & USE OF CONSENT AGENDA**

Page 4 of 4

POLICY NUMBER: V-B-5

The Board Chair and the Chief Executive Officer will assess and prioritize the requests. Written confirmation of attendance, if approved, will be provided to the individual or group making the request. The Board Chair has the sole authority to confirm or deny the request.

Any one delegation or presentation will be limited to a maximum of ten minutes unless otherwise agreed by the Board Chair and Chief Executive Officer.

Board Standing and Special Committee Meetings

Board committee meetings shall be closed.

ISSUED BY:	KHSC Board of Directors	NUMBER:	V-B-6
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Board Effectiveness	REVIEW DATES:	April 2017, September 2021
COMMITTEE:	Governance	REVISION DATE:	March 2022
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SUBJECT: MEETING WITHOUT MANAGEMENT

The purpose of this policy is to ensure the board exercises independent oversight of management and to provide an opportunity to assess board processes, and particularly the quality of materials and information provided by management.

The policy provides the opportunity for the board chair to discuss areas where the performance of directors could be strengthened. It also allows board members to build relationships of confidence and cohesion.

A director who remains in the meeting without management is identified as an 'independent director' and is described as being free of any special relationship with the corporation. Members of the professional staff and employees shall be not considered independent directors for the purpose of this policy.

The independent directors shall meet without management at every regularly scheduled board meeting as determined by the board chair or at the request of any two members.

1. If a meeting without management is planned, the agenda of the meeting must include this information.
2. Timing of the session without management should be declared in the notice or agenda.
3. Such meeting shall not be considered to be meeting of the board, but rather, will be for information purposes only.
4. Minutes will not be kept, but the chair may keep notes of the discussion.
5. The CEO and COS may be invited by the chair to participate in part of the meeting without management before being excused.
6. The chair shall immediately communicate with the CEO and, as appropriate, the COS any relevant matters raised in the meeting.

ISSUED BY:	KHSC Board of Directors	NUMBER:	V-B-7
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Board Effectiveness	REVIEW DATES:	April 2017, November 2021
COMMITTEE:	Governance	REVISION DATE:	March 2022
		PAGE:	1 OF 1

SUBJECT: BOARD & COMMITTEE ATTENDANCE

To ensure that board and committee members contribute their expertise and judgment to the business and affairs of the corporation by attending and participating in board and committee meetings, board and committee members are expected to attend meetings to which they are assigned.

It is recognized that directors and committee members may be unable to attend some meetings due to conflicts with other commitments or other unforeseen circumstances. An attendance rate of at least 75% is required.

While participation by telephone or other electronic means is allowed, attending in-person when the meeting is scheduled as an in-person meeting is the preferred option.

1. Where a director or committee member is absent for 25% of the meetings of the board or of a committee in a 12-month period, or is absent for three consecutive meetings, the chair shall discuss the reasons for the absences with the member and may ask the individual to resign.
2. A member's record of attendance shall be considered with respect to renewal of a board term or future assignment to a committee.
3. Where the board or committee member is an *ex officio* member of the board, the chair may discuss the member's attendance with the organization the member is affiliated with, and such organization may be requested to remove the member and appoint a new *ex officio* member to the board.
4. The chair shall, at the chair's sole discretion, determine if a board or committee member's absences are excusable and may grant a board or committee member a limited period of time to rearrange their schedule so that there are no conflicts with regularly scheduled board or committee meetings.

¹ An external member refers to community members on Board Committees, who are not directors of the Board, but are members of the Committee.

ISSUED BY:	KHSC Board of Directors	NUMBER:	V-B-8
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Board Effectiveness	REVIEW DATES:	April 2017, November 2021
COMMITTEE:	Governance	REVISION DATE:	March 2022
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SUBJECT: BOARD OF DIRECTOR AND EXTERNAL MEMBER¹ EVALUATION

Each Director is required to participate in the evaluation of the performance of the Board as a whole and of their own performance as a Director. The scope of the evaluation will include an assessment of the effectiveness of the Board as a whole in fulfilling its roles and responsibilities and of the processes and structure of the Board and its committees. It will also include an assessment of the performance of individual Directors in fulfilling their responsibilities.

The purpose of evaluation is to:

- i) ensure continuous improvement of the Board, Committees and individual Directors and external members;
- ii) obtain input for succession planning for the Board and Board Officers and re-appointments of Directors and external members;
- iii) obtain input to guide the nomination of directors and external members to serve an additional term;
- iv) identify Directors' and external members' education and development needs; and
- v) provide an opportunity to provide feedback on effectiveness of Board and Committee meetings.

The Governance Committee will establish the annual process for evaluation of the Board and Individual Directors, The Governance Committee in coordination with Committee Chairs will establish a process for evaluation of Committee and Committee members (to include external members).

External resources may be used as appropriate to ensure an effective process.

The Governance Committee will provide a summary report of the evaluation of the Board as a whole to the Board of Directors including key issues to be addressed to ensure continuous improvement of the Board, as a whole.

The Governance Committee will develop a process to engage the Board Chair, Governance Committee Chair and Committee Chairs in providing feedback to individual Directors and committee members on their performance.

¹ An external member refers to community members on Board Committees, who are not directors of the Board, but are members of the Committee.

ISSUED BY:	KHSC Board of Directors	NUMBER:	V-B-9
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Board Effectiveness	REVIEW DATES:	April 2017; May 2022
COMMITTEE:	People, Finance & Audit	REVISION DATE:	Under review (pending)
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SUBJECT: REIMBURSEMENT OF DIRECTOR & EXTERNAL MEMBER¹ EXPENSES

Members of the Board of Directors and external members will be fairly and reasonably compensated for out-of-pocket expenses incurred while traveling on approved Kingston Health Sciences Centre-related business.

The CEO [or Designate] and Board Chair [or Designate] are required to pre-approve all travel requests and for the expenses of the Board Chair, the CEO [or Designate] and the Chair of Governance [or Designate] will approve.

Directors / external members will not be reimbursed for expenses associated with attendance at Board meetings or committee meetings held in Kingston except for requests that are pre-approved due to special circumstances.

Directors / external members are encouraged to attend meetings, conferences, and educational events as reasonably required to properly discharge their duties. Directors / External Members if authorized to attend such events based on the annual Board work plan for ongoing education, will be reimbursed for expenses associated with these events in accordance with this policy. In order to obtain reimbursement for cost, original receipts are required.

A Directors / External Members attending a meeting, convention or seminar will be reimbursed for all reasonable expenses while traveling to and from the event and during the event. Rules as outlined in KHSC's administrative travel policy for employees will apply.

In no case will reimbursement of expenses pursuant to this policy include reimbursement for personal services: alcoholic beverages; cigarettes; entertainment expenses (e.g. pay TV, movies, sporting events, and concerts); recreational expenses (e.g. fitness club); laundry and valet services; parking and traffic violations and other expenses resulting from unlawful conduct; or other expenses deemed unreasonable or unnecessary in the course of carrying out the business of the Hospital.

A Director / external member may be asked by KHSC to attend another organization's meetings. That Director may, upon Board approval, be reimbursed for expenses incurred to attend the meeting of that organization in accordance with this Policy providing the expenses are not covered by another organization.

¹ An external member refers to community members on Board Committees, who are not directors of the Board, but are members of the Committee.

ISSUED BY:	KHSC Board of Directors	NUMBER:	V-B-10
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Board Effectiveness	REVIEW DATES:	April 2017, April 2022
COMMITTEE:	Governance	REVISION DATE:	June 2022
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SUBJECT: REVIEW OF BOARD POLICIES

In keeping with best practices in governance, the Governance Committee will annually review Kingston Health Sciences Centre's Board Policies for relevance, to ensure compliance with By-Laws and applicable legislation, and will make recommendations to the Board for revisions as required.

The Board Secretary will be responsible for ensuring that all Board policies are reviewed annually and revised consistent with Board approval.

ISSUED BY:	KHSC Board of Directors	NUMBER:	V-B-11
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Board Effectiveness	REVIEW DATES:	April 2017, November 2021
COMMITTEE:	Governance	REVISION DATE:	March 2022
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SUBJECT: REMOVAL OF A DIRECTOR

In addition to the provisions in the Article 4.5 of the By-Law, the following will guide the process for removal of a Director.

Under extreme circumstances and in highly unusual situations, it may become necessary to remove a Director from the Board of Directors.

Reasons for removing a Director may relate to any of the following:

- i) breach of confidentiality, for all matters dealt with in camera or issues not discussed at the public meeting;
- ii) failure to meet obligatory procedures in the disclosure of interest;
- iii) failure to fulfill the fiduciary duties of a Director of the corporation;
- iv) failure to comply with the attendance policy for Directors' meetings; and
- v) inappropriate or lack of participation and contribution to effective discussion and Board decision making;
- vi) or as provided for in the By-Law and/or the Ontario and/or Canadian Corporations Acts.

The Governance Committee is responsible for recommending the removal of a Director to the Board of Directors based on the foregoing reasons. Prior to making a recommendation to the Board, the Governance Committee will adhere to the following principles and procedures:

- i) Directors will be treated fairly and with respect;
- ii) the Director in question will be given proper notification of the applicable reason for removal;
- iii) the Director will be given the opportunity to respond (for example, attendance can improve, conflict of interest can be examined and questions of conduct can be reviewed);
- iv) the Director should be clearly notified of the final consideration and action of the Board.

ISSUED BY:	KHSC Board of Directors	NUMBER:	V-C-0
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Board Effectiveness	REVIEW DATES:	April 2017, January 2022
COMMITTEE:	Governance	REVISION DATE:	March 2022
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**SUBJECT: PROCESS FOR SELECTION OF PATIENT EXPERIENCE ADVISORS TO
 KHSC BOARD AND COMMITTEES**

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 one year term with possibility of renewal twice for a maximum of three years in total.

¹An External Member refers to community members on Board Committees, who are not directors of the Board, but are members of the Committee.

**SUBJECT: PROCESS FOR SELECTION OF PATIENT EXPERIENCE
 ADVISORS TO KHSC BOARD AND COMMITTEES**

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POLICY NUMBER: V-C-0

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.

ISSUED BY:	KHSC Board of Directors	NUMBER:	VI-1
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Build & Maintain Position Relationships	REVIEW DATES:	April 2017, Feb 2020; April 2022
COMMITTEE:	Governance	REVISION DATE:	March 2020; June 2022
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**SUBJECT: SUPPORT AND RELATIONSHIP WITH UNIVERSITY HOSPITALS
 KINGSTON FOUNDATION (UHKF)**

A strong and positive relationship between the Kingston Health Sciences Centre and the University Hospitals Kingston Foundation (UHKF) is essential at several levels:

1. The Board of Directors will support the Foundation in their endeavours. The Board will be represented at the Foundation events when requested by the UHKF.
2. Individual Directors are expected to support the Foundation and are encouraged to contribute financially to the Foundation in their fundraising efforts.
3. Regular communications will be essential and achieved through a number of mechanisms:
 - (i) the President and CEO of UHKF will be invited to make a presentation to the KHSC Board of Directors annually on their activities on behalf of the hospital as well as providing regular updates at KHSC board meetings;
 - (ii) the KHSC Board shall annually appoint a member of its Board to serve as an ex officio voting member of the University Hospitals Kingston Foundation Board;
 - (iii) the UHKF Board shall annually appoint a member of its Board to serve as an ex officio voting member of the KHSC Board;
 - (iv) it is recognized that the cross appointees described in (ii) and (iii) shall not be Officers of their respective Boards due to conflict; the KHSC Board Chair and CEO or his/her delegate will meet and consult as required with their counterparts in the UHKF Foundation on strategic directions and priorities to ensure alignment of interests. The KHSC Board Chair will report to the KHSC Board on the conclusions and recommendations of these meetings; and
 - (v) as a result of the 2014 Amalgamation of the Kingston Hospital Foundation, the CEO holds the vote as a Class "B" membership which requires the KHSC Board to ratify the proposed slate of directors annually; approve changes to the charitable objects, letters patent and the by-law of corporation (UHKF).

ISSUED BY:	KHSC Board of Directors	NUMBER:	VI-2
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Build & Maintain Position Relationships	REVIEW DATES:	April 2017; April 2022
COMMITTEE:	Governance	REVISION DATE:	June 2022
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SUBJECT: CORPORATE COMMUNICATIONS

The Board of Directors is responsible to build and maintain positive relationships with the Corporation's stakeholders through a policy and plan for effective communications.

The Board will ensure that the CEO puts an effective communications and stakeholder- relations plan in place and will review this with the Board on an annual basis.

The Board Chair is the spokesperson on behalf of the Hospital for matters related to Board governance. The Chief Executive Officer (CEO) or his/her delegate is the spokesperson on behalf of the Hospital for all hospital matters. The CEO and Board Chair will mutually determine their respective roles as may be required from time to time. No Director will be a spokesperson for the Board unless specifically delegated by the Board Chair following consultation with the CEO.

The Board will ensure information on the hospital website is posted including:

- i) the membership of the Board of Directors
- ii) the nominations process for Board Directors and External Members¹ of Board Standing and Special Committees;
- iii) the Hospital By-laws;
- iv) Board Standing, Ad Hoc and Special committees, including terms of reference and membership.

Mechanisms for regular communication to the public on the activities of the Board may include but are not limited to:

- posting on the hospital website minutes/summaries of the open meetings of the Board of Directors; and
- periodic articles in the local media on matters of interest to the communities served by the hospital.

¹ An external member refers to community members on Board Committees, who are not directors of the Board, but are members of the Committee.

ISSUED BY:	KHSC Board of Directors	NUMBER:	VI-3
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Build & Maintain Position Relationships	REVIEW DATES:	April 2017; May 2022
COMMITTEE:	People, Finance & Audit	REVISION DATE:	
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SUBJECT: POLITICAL CONTRIBUTIONS

The Kingston Health Sciences Centre (KHSC) will not make direct contributions to political campaigns or to any elected official.

With the approval of the Board Chair, the Hospital may purchase tickets to events for a provincial political party, where the presence of the hospital management or the Board is deemed to be appropriate.

ISSUED BY:	KHSC Board of Directors	NUMBER:	VI-4
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Build & Maintain Position Relationships	REVIEW DATES:	April 2017; June 2017 April 2022
COMMITTEE:	Governance	REVISION DATE:	June 2022
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SUBJECT: NAMING OF KHSC ASSETS

Preamble

The mission of KHSC is fulfilled, in part, by the support it receives from society, volunteers and financial donors. The hospital welcomes the opportunity to recognize such support through the naming of buildings, facilities, programs and other components of its operation.

The philanthropic services and programs provided to the hospital are the responsibility of the University Hospitals Kingston Foundation.

This policy sets out guidelines for the granting of the honour of naming hospital assets for both philanthropic and other distinguished support. It sets out a consistent approach to the naming of Facilities, Major Equipment, Programs and Research/Academic positions entrusted to and operated by KHSC and referred to herein as “assets”.

Decisions regarding naming of assets shall be informed by this policy and the “Considerations for Naming Assets” (Appendix A) as well as the Common Core Donor Recognition and Naming Guidelines approved by the Board Members of University Hospitals Kingston Foundation.

Definitions

Assets: The term “Assets” includes and is limited to, Facilities, Programs, Major Equipment¹ and Research/Academic Positions, each of which is defined as follows:

Facilities: The term “Facilities” includes, but is not limited to, all buildings, internal building spaces, exterior grounds, landscaping materials and finishes.

Major Equipment: The term “Major Equipment” includes, but is not limited to single items with a unit value of \$50,000) or more or multiple units of a single item with a combined cost of \$50,000 or more.

Programs: The term “Programs” includes, but is not limited to, all programs, services and areas of care to patients.

Research/Academic Positions: The term “Research/Academic Positions” includes, but is not limited to, lead research positions, chairs, department heads, etc.

¹ Major equipment is defined as equipment valued at \$50,000 +

Authority

The **Board of Directors of KHSC** exercises the sole approval authority for naming – in honour of philanthropic gifts or distinguished service - any assets entrusted to the hospital subject to applicable federal and/or provincial laws. The Board may delegate to the CEO authority to approve naming of assets carrying a naming value of under \$100,000. In such cases the CEO shall report these to the Board at the next regular meeting. The CEO shall use his/her discretion in placing before the board any namings in this category that may be considered sensitive or controversial.

Policy Statement

1. KHSC retains the sole right to name its assets and will name assets only as it deems appropriate.
2. In the process of naming assets, KHSC shall consider factors which may affect the hospital's reputation and reserves the right to withdraw naming rights at its sole discretion
3. Naming shall not be bestowed in honour of any individual, group or organization linked to causes that could compromise health, the mission, vision or values of KHSC or the well-being of its staff, physicians, volunteers or patients it serves.
4. Prior to naming an asset, consideration shall be given to its full potential to generate revenue as donor naming opportunity while balancing other benefits and the current philanthropic environment.
5. Permanent named recognition will be provided only in circumstances where gift size and/or contribution to the organization are exceptional. When permanent named recognition has been extended for a gift received, it will be honoured in perpetuity. (This does not negate the hospital's authority as noted under item 2.) In the event of changed circumstances, e.g. a facility no longer exists or has been radically renovated, the hospital reserves the right to determine the form which the permanence will take.
6. KHSC will not name minor items that are replaced on a regular or scheduled basis such as minor equipment, furnishings or individual trees/shrubs.
7. Assets will not be named to honour outstanding service of members of staff, the Board of Directors of the hospital, the Foundation, any elected or appointed official concerned with the functions or control of the Hospital so long as their official relationship continues
8. For safety reasons, such as denoting the location of emergency codes, where naming rights bestowed to donors are not permanent, the hospital will continue to use an appropriate permanent wayfinding system to reference the specific geographic area. Naming signage will be designed in consultation with the planning and communications offices in keeping with the wayfinding signage.
9. The hospital reserves the right to decide on the nature of physical displays which may accompany named recognition while recognizing the value of donor or honouree input.

10. No name will be approved that will imply the hospital's endorsement of a partisan political or ideological position or of a commercial product. This does not preclude naming with the name of an individual or company that manufactures or distributes commercial products.
11. Provisions in this policy that refer to naming for a benefactor also in general apply to naming for a third party at the wish of a benefactor.
12. The proposed name of an asset shall comply with the Corporate Policies and Procedures of KHSC and with all applicable federal and provincial laws.

Procedure

1. KHSC shall, as appropriate, entertain proposals from and in consultation with the community, University Hospitals Kingston Foundation medical staff, management and staff, major corporate partners and other interest groups.
2. Recommendations are to be directed to the Chair of the Board of the hospital and should be addressed in the care of the President and Chief Executive Officer.
3. At the discretion of the Board Chair and President and Chief Executive Officer a group will be selected or delegated to review naming proposals according to this policy.
4. The Office of the Chair of the Board of Directors shall keep a permanent record of all approved naming of hospital assets.

Considerations for Naming Assets

Preamble

Proposals for the naming of KHSC assets will be evaluated and approved on an individual basis in accordance with the following criteria. These criteria, as approved by the Board of Directors, will be modified from time to time as the Board deems appropriate.

1. In general the name selected should not:
 - conflict with the clinical nature of the asset;
 - conflict with the asset's role in the community; and
 - conflict with the dominant views of the community.
2. Where buildings/spaces change their essential purpose, a name change may be in order. This change should occur using the process herein described.
3. There should be a widespread level of support for the proposed name. In addition, it should meet the standard of KHSC and community acceptability as perceived by the Board of Directors.
4. If the naming is associated with a gift or donation, the **Board of Directors** shall ensure that any established financial criteria are met and that an appropriate gift agreement is in place, and that a minimum of 25% of the pledge has been received, prior to announcing or bestowing the name. The board must exercise due diligence in ensuring the donor's good intentions to meet the full obligation, and may wish to place a higher requirement for pledge payment if deemed appropriate.
5. Donor naming opportunities for external and internal facilities will generally be offered for a specific duration. The following considerations should be taken into account in determining the appropriate duration for a naming opportunity: the visibility and profile of the named space; the frequency with which major capital upgrades will be required (necessitating additional fundraising); the likelihood of additional funders having an interest in the naming opportunity in future; the potential impact of renaming on the national and international profile of specific clinical or research programs; the costs associated with renaming.
6. Generally speaking, the duration of a donor naming will be associated with the level of the gift. For example, gifts made at a higher level (e.g. 50 per cent of cost) will be offered naming opportunities of a longer duration. Gifts at the minimum level (e.g. 30 per cent of cost) will be for a minimum duration. Naming will not be granted for gifts of less than \$50,000 or for a duration of less than 10years. Generally speaking, the maximum duration for a naming will be 25 years. Effective April 1, 2017, gifts directed to either site (HDH or KGH) will be treated as gifts to KHSC for the purposes of naming. Gifts made prior to April 1, 2017, and recognition for them will remain unchanged.

Considerations for Naming Assets

7. In certain, extraordinary circumstances, the hospital board may approve a permanent naming opportunity.
8. For the most part, the name being proposed must not be identical to that of another comparable asset in the region. Where appropriate, a name search should be conducted. Name choices may also need to be double-checked against other criteria, such as the profane expression of other languages or cultural groups in the region.
9. Where the proposed name is to honour an individual or individuals, the name(s) may be of a person(s) living or deceased, and the following facts should be considered:
 - a) The degree of involvement of that person with the facility, wing, space or item being named. There should be clear evidence that the person has made an exceptional and significant contribution to the essential purpose of the corporation/asset;
 - b) A background check of the person should be conducted to ensure that the proposal will meet current standards of propriety; and
 - c) The designated or proposed honouree or, if that person is deceased or no longer able, his/her family or legal representative should be approached regarding acceptance of the honour.
10. Where a name change is being considered:
 - a) Due consideration is to be given to the familiarity and acceptability of existing names.
 - b) A search of any record of incorporation or miscellaneous filing, deed, trust or bequest associated with the name or land, should be carried out for restrictions regarding the present name (e.g. was the bequest, deed or trust contingent upon the use of the specific name; and
 - c) An estimate of the cost to change the name should be put forward. Such an estimate should include the cost of new signage and other expenses such as replacing print materials, websites, recognition pieces, etc.

ISSUED BY:	KHSC Board of Directors	NUMBER:	VI-5
AUTHORIZED BY:	KHSC Board of Directors	ORIGINAL ISSUE:	April 2017
CATEGORY:	Build & Maintain Position Relationships	REVIEW DATES:	April 2017; April 2022
COMMITTEE:	Governance	REVISION DATE:	June 2022
		PAGE:	1 OF 2

SUBJECT: TEMPORARY REMOVAL OF RELIGIOUS ICONS AT PATIENT REQUEST

Guiding Principle

Guided by our mission(s) and values our Hospital cares for people of all religious faiths or creeds, and those with no religious belief or creed. From time to time some patients may experience discomfort in the presence of religious icons and request that they be removed. This policy was developed to ensure that there is a standardized process to guide staff to respond sensitively to these requests.

Policy

Upon the request of a patient or family member we will temporarily remove religious icons from the space within our sites, including Hotel Dieu Hospital in which that patient receives treatment. This policy does not apply to any public space, or to the Multi-faith room, or to any other worship space within the sites.

Definition

Religious icons include crucifixes and pictures or images signifying religious beliefs.

Procedure

1. In order to facilitate this process we ask that, wherever possible a patient submit a written request (email, letter, fax, or via the Patient Relations section of the hospital website) to the a Patient Relations Specialist at least one business day prior to the scheduled appointment. Verbal requests will be accepted if this is not feasible.
2. Requests must contain the following information:
 - a) Patient's name
 - b) Patient's date of birth (as a second identifier to verify the patient's identity)
 - c) Patient's telephone number or email address (if there is a need to clarify information)
 - d) Appointment date and time
 - e) Appointment location, if known
3. The Patient Relations Specialist will acknowledge the request and communicate it to the Program Manager.
4. If staff receives a verbal request from the patient/family member during the clinic or inpatient visit or stay, staff are asked to accommodate the request when it is feasible to do so, explain the request and resulting removal to staff in the area and to report the request to the Program Manager and to the Patient Relations Specialist.
5. When advance notice is provided the Program Manager requests that Facilities Management remove or temporarily cover the icons and replace them as soon as possible, no later than the start of the next business day.

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REQUEST**

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6. The Patient Relations Specialist tracks all requests of this nature and provides summary reports as required.

Related Document

Hospital Philosophy and Mission