BOARD OF DIRECTORS

POLICY NO. 1

CODE OF CONDUCT

PURPOSE

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

APPLICATION

This policy applies to all Directors, including ex-officio Directors and non Board members of Board committees. Directors are also required to comply with the Hospital's policy on Code of Ethics and Code of Conduct, which applies to employees and professional staff.

DIRECTORS' DUTIES

- All Directors of the Hospital stand in a fiduciary relationship to the Hospital Corporation. As fiduciaries, Directors shall act honestly, in good faith, and in the best interests of the Hospital Corporation.
- Directors shall 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.
- Directors shall avoid situations where their personal interests will conflict with their duties to the Corporation. Directors shall also avoid situations where their duties to the Corporation may conflict with duties owed elsewhere.
- Directors shall NOT use their office to advance their personal interests or the interests of any person or organization with whom or with which they are associated.
- Directors shall respect the decisions of the Board but may make motion to reconsider any specific decision provided such motion is supported by another Board member. Any such proposal should be submitted to the Board Chair prior to a regularly scheduled Board meeting.
- Directors shall respect the confidentiality of information about the Corporation

BEST INTERESTS OF THE CORPORATION

Directors shall 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 nominee of a particular group must act in the best interests of the Corporation, even if this conflicts with the interests of the nominating party.

CONFIDENTIALITY

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, officer and employee of the corporation shall respect the confidentiality of information about the Hospital 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.

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.

BOARD SPOKESPERSON

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 President and Chief Operating Officer, or the Chief of Staff or their designates may speak on behalf of the organization.

No Director shall speak or make representations on behalf of the Board unless authorized by the Chair of the Board. When so authorized, the Director's representation must be consistent with accepted positions and policies of the Board.

MEDIA CONTACT AND PUBLIC DISCUSSION

News media contact and responses and public discussion of the Hospital Corporation'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 Corporation.

RESPECTFUL CONDUCT

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.

The authority of the Chair must be respected by all Directors.

OBTAINING ADVICE OF COUNSEL

Request to obtain outside opinions or advice regarding matters before the Board may be made through the Chair.

VACANCY AND TERMINATION

The office of a Director shall be vacated if a Director knowingly fails to comply with the Public Hospital Act, the Corporations Act, the Corporation's Letter Patent, Bylaw, Rules, Regulations, Policies and Procedures, including without limitation, the confidentiality, conflict of interest and standard of care requirement as set out in Bylaw, section 4.05.

AMENDMENT

This policy may be amended by the Board.

APPROVED BY: BOARD OF DIRECTORS

ISSUED: MAY 25, 2006; REVISED NOVEMBER 18, 2010; REVIEWED MAY 2017

RENFREW VICTORIA HOSPITAL

BOARD OF DIRECTORS

POLICY NO. 2

ROLES AND RESPONSIBILITIES OF THE BOARD

PURPOSE
To ensure that the Board has a shared understanding of its governance role, the Board has adopted this statement of roles and responsibilities of the Board.

APPLICATION
This policy applies to all Directors, including ex-officio Directors.

RESPONSIBILITY OF THE BOARD
The Board is responsible for the overall governance of the affairs of the Hospital.

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 Hospital in fulfilling its mission and discharging its accountabilities.

STRATEGIC PLANNING AND MISSION, VISION AND VALUES
- The Board participates in the formulation and adoption of the Hospital's mission, vision and values.
- The Board ensures that the Hospital develops and adopts a strategic plan that is consistent with the Hospital's mission and values, which will enable the Hospital to realize its vision. The Board participates in the development of and ultimately approves the strategic plan.
- The Board oversees hospital operations for consistency with the strategic plan and strategic directions.
- The Board receives regular briefings or progress reports on implementation of strategic directions and initiatives.
- The Board ensures that its decisions are consistent with the strategic plan and the Hospital's mission, vision and values.
- The Board annually conducts a review of the strategic plan as part of a regular annual planning cycle.

QUALITY AND PERFORMANCE MEASUREMENT AND MONITORING
- The Board is responsible for establishing a process and a schedule for monitoring and assessing performance in areas of Board responsibility including:
  - ❑ Fulfilment of the strategic directions in a manner consistent with the mission, vision and values
  - ❑ Oversight of management performance
  - ❑ Quality of patient care and hospital services
  - ❑ Financial conditions
  - ❑ External relations
  - ❑ Board's own effectiveness

- The Board ensures that management has identified appropriate measures of performance.
- The Board monitors Hospital and Board performance against Board approved performance standards and indicators
- The Board ensures that management has plans in place to address variances from performance standards indicators, and the Board oversees implementation of remediation plans.

FINANCIAL OVERSIGHT

- The Board is responsible for stewardship of financial resources including ensuring availability of, and overseeing allocation of, financial resources.
- The Board approves policies for financial planning and approves the annual operating and capital budget.
- The Board monitors financial performance against budget.
- The Board approves investment policies and monitors compliance.
- The Board ensures the accuracy of financial information through oversight of management and approval of annual audited financial statements.
- The Board ensures management has put measures in place to ensure the integrity of internals controls.

OVERSIGHT OF MANAGEMENT INCLUDING SELECTION, SUPERVISION AND SUCCESSION PLANNING FOR THE CEO AND CHIEF OF STAFF

- The Board recruits and supervises the CEO by:
    - Developing and approving the CEO job description
    - Undertaking a CEO recruitment process and selecting the CEO
    - Reviewing and approving the CEO's annual performance goals
    - Reviewing CEO performance and determining CEO compensation
- The Board ensures succession planning is in place for the CEO and senior management.
- The Board exercises oversight of the CEO's supervision of senior management as part of the CEO's annual review.
- The Board develops a process for selection and review of the Chief of Staff and ensures the process is implemented and following.
- The Board reviews Chief of Staff performance and sets Chief of Staff compensation.
- The Board develops, implements and maintains a process for the selection of Medical Directors and other medical leadership positions as required under the hospital's bylaw or the Public Hospitals Act.

RISK IDENTIFICATION AND OVERSIGHT

- The Board is responsible to be knowledgeable about risk inherent in Hospital operations and ensure that appropriate risk analysis is performed as part of Board decision-making.
- The Board oversees management's risk management process.
- The Board ensures that appropriate programs and processes are in place to protect against risk.
- The Board is responsible for identifying unusual risks to the organization for ensuring that there are plans in place to prevent and manage such risks.

STAKEHOLDER COMMUNICATION AND ACCOUNTABILITY

- The Board identifies hospital stakeholders and understands stakeholder accountability.
- The Board ensures the organization appropriately communicates with stakeholders in a manner consistent with accountability to stakeholders.
- The Board contributes to the maintenance of strong stakeholder relationships.
- The Board performs advocacy on behalf of the Hospital with stakeholders where required in support of the mission, vision and values and strategic directions of the Hospital.

GOVERNANCE

- The Board is responsible for the quality of its own governance
- The Board establishes governance structures to facilitate the performance of the Board's role and enhance individual Director performance.
- The Board is responsible for the recruitment of a skilled, experienced and qualified Board.
- The Board ensures ongoing Director training and education.
- The Board periodically assesses and reviews its governance through periodically evaluating Board structures including Director recruitment processes and Board composition and size, number of committees and the terms of reference, processes for appointment of committee chairs, processes for appointment of Directors and other governance processes and structures.

LEGAL COMPLIANCE

The Board ensures that appropriate processes are in place to ensure compliance with legal requirements.

AMENDMENT

This policy may be amended by the Board.

APPROVED BY: BOARD OF DIRECTORS

DATE: MAY 25, 2006; REVIEWED MAY 2017

BOARD OF DIRECTORS

POLICY NO. 3

CONFIDENTIALITY

PURPOSE
To ensure that confidential matters are not disclosed until disclosure is authorized by the Directors.

APPLICATION
This policy applies to all Directors, including ex-officio Directors and non Directors members of Board committees.

POLICY
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.

Every Director shall ensure that no statement not authorized by the Board is made by him or her to the press or public.

CONFIDENTIAL MATTERS
1. All matters that are the subject of closed sessions of the Board are confidential until disclosed in an open session of the Board.
2. All matters that are before a committee or task force of the Board are not confidential unless they have been determined to be confidential.
3. All matters that are the subject of open sessions of the Board are not confidential.

PROCEDURE FOR MAINTAINING MINUTES
1. 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.
2. All minutes of closed sessions of the Board shall be marked confidential and shall be handled in a secure manner.
3. Notwithstanding that information disclosed or matters dealt with in an open session are not confidential, no Director shall make any statement to the press or the public in his/her capacity as a Director unless such statement has been authorized by the Board.

VACANCY AND TERMINATION
Should a Director knowingly fail to comply to the above, Hospital Bylaw, Section 4.05, shall be enacted.

AMENDMENT
This policy may be amended by the Board.

APPROVED BY: BOARD OF DIRECTORS
DATE: MAY 25, 2006; REVIEWED MAY 2017

BOARD OF DIRECTORS

POLICY NO. 4

CONFLICT OF INTEREST

PURPOSE
All Directors have a duty to ensure that the trust and confidence of the public in the integrity of the decision-making processes of the Board are maintained by ensuring that they and other members of the Board are free from conflict or potential conflict in their decision-making. It is important that all Directors understand their obligations when a conflict of interest or potential conflicting interest arises.

APPLICATION
This policy applies to all Directors, including ex-officio Directors and non Directors members of Board committees.

POLICY
Directors and non-Directors committee members shall avoid situations in which they may be in a position of conflict of interest. The bylaw contains provisions with respect to conflict of interest that must be strictly adhered to. In addition to the bylaw, the process set out in this policy shall be followed when a conflict or potential conflict arises.

DESCRIPTION OF CONFLICT OF INTEREST
The situations in which potential conflict of interest may arise cannot be exhaustively set out. Conflicts generally arise in the following situations:

1. Interest of a Director "Wearing Two Hats"
When a Director transacts with the Corporation directly or indirectly. When a Director has a significant direct or indirect interest in a transaction or contract with the Corporation.

2. Interest of a Relative
When the Corporation conducts business with suppliers of goods or services or any other party of which a relative or member of the household of a Director is a principal, officer or representative.

3. Gifts
When a Director or a member of the Director's household or any other person or entity designated by the Director, accepts gifts, payments, services or anything else of more than a token or nominal value from a party with whom the Corporation may transact business (including a supplier of goods or services) for the purposes of (or that may be perceived to be for the purposes of) influencing an act or decision of the Directors.

4. Acting for an Improper Purpose
When Directors exercise their powers motivated by self-interest or other improper purposes. Directors must act solely in the best interest of the Corporation. Directors who are nominees of a

particular group must act in the best interest of the Corporation even if this conflicts with the interests of the nominating party.

5. Appropriation of Corporate Opportunity
When a Director diverts to his or her own use an opportunity or advantage that belongs to the Corporation.

6. Duty to Disclose Information of Value to the Corporation
When Directors fail to disclose information that is relevant to a vital aspect of the Corporation's affairs.

PROCESS FOR RESOLUTION OF CONFLICTS & ADDRESSING BREACHES OF DUTY

Disclosure of Conflicts
A Director who is in a position of conflict or potential conflict shall immediately disclose such conflict to the Directors by notification to the Chair or any Vice Chair of the Board. The disclosure shall be sufficient to disclose the nature and extent of the Director's interest. Disclosure shall be made at the earliest possible time and prior to any discussion and vote on the matter.

Abstain from Discussions
The Director shall comply with the requirements of the Bylaw. It is acknowledged that not all conflicts or potential conflicts may be satisfactorily resolved by strict compliance with the bylaw. There may be cases where the perception of a conflict of interest or breach of duty may be harmful to the corporation notwithstanding that there has been compliance with the bylaw.

A Director may be referred to the process outlined below in any of the following circumstances:

1. Circumstances for Referral
Where any Director believes that that Director or another Director:
a) has breached his or her duties to the Corporation;
b) is in a position where there is a potential breach of duty to the Corporation;
c) is in a situation of actual or potential conflict of interest; or,
d) has behaved or is likely to behave in a manner that is not consistent with the highest standards of public trust and integrity and such behaviour may have an adverse impact on the Corporation.

2. Process for Resolution
The matter shall be referred to the following process:
a) Refer matter to Chair or where the issue may involve the Chair, to any Vice Chair, with notice to the CEO.

b) Chair (or Vice-Chair as the case may be) may either (i) attempt to resolve the matter informally, or (ii) refer the matter to an ad hoc sub-committee of the Board established by the Chair which sub-committee shall report to the Board.

c) If the matter cannot be informally resolved to the satisfaction of the Chair (or Vice Chair as the case may be), the Director referring the matter and the Director involved then the Chair shall refer the matter to the process in (b) above.

It is recognized that if a conflict, or other matter referred cannot be resolved to the satisfaction of the Board (by simple majority resolution) or if a breach of duty has occurred, a Director may be terminated pursuant to the bylaw and the Corporations Act.

AMENDMENT
This policy may be amended by the Board.

APPROVED BY: BOARD OF DIRECTORS

DATE: MAY 25, 2006; REVIEWED MAY 2017

BOARD OF DIRECTORS

POLICY NO. 5

MEETING ATTENDANCE

PURPOSE

To ensure that Directors and committee members contribute their expertise and judgement to the business and affairs of the Hospital by attending and participating in Board and committee meetings.

APPLICATION

This policy applies to all Directors, including ex-officio Directors and non Directors members of Board committees.

POLICY

- Directors are expected to attend all Board meetings and all meetings of the committees to which they are assigned.
- It is recognized that Directors may be unable to attend some meetings due to conflicts with other commitments or other unforeseen circumstances. An attendance rate of at least 75% is acceptable.

PROCESS

Where a Director of committee member fails to attend 75% of the meetings of the Board or of a committee in a 12-month period, or is absent for three consecutive meetings, the Chair shall discuss the reasons for the absences with the member and may ask the individual to resign.

A member's record of attendance shall be considered with respect to renewal of Directors term or future assignment to a committee.

Where the Directors 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.

The Chair shall, in the Chair's sole discretion, determine if a Directors or committee member's absences are excusable and may grant a Directors 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.

AMENDMENT

This policy may be amended by the Board.

APPROVED BY: BOARD OF DIRECTORS

DATE: MAY 25, 2006; REVIEWED MAY 2017

RENFREW VICTORIA HOSPITAL

BOARD OF DIRECTORS

POLICY NO. 6

BOARD ORIENTATION AND CONTINUING EDUCATION PROGRAM

APPLICATION
This policy applies to all Directors, including ex-officio Directors and non Directors members of Board committees.

POLICY
All new members of the governing body shall participate in a Board orientation program. The orientation shall be co-ordinated by the President and CEO and completed in a timely manner.

Continuing education is available to all Directors and provides opportunities for members to expand their knowledge and understanding of governance and health care issues.

Evaluation of orientation and educational development activities through participant feedback and Board Evaluation Questionnaire shall be reviewed by the Governance Committee of the Board.

ORIENTATION PROGRAM
Upon election or appointment to the Board of Directors of Renfrew Victoria Hospital, a formal orientation is organized for the new Director who will receive:

- Welcome from the Board Chair
- Bylaw
- Public Hospital's Act
- Corporations Act
- Board Policies
- Hospital Code of Ethics
- Hospital Code of Conduct
- List and composition of the various committees of the Board and discussion of current issues
- List of senior administrative staff (departments within the hospital)
- A copy of the Annual Report including financial and statistical report for the preceding year
- Statement of Mission
- Organizational Chart
- A formal tour of the Hospital conducted by the President & CEO at a mutually convenience time preferably during the day to meet Nurse Managers/Department Heads and observe departments in operation.
- Informal sessions are held with new Directors members for further briefing depending on their background and committee membership.

CONTINUING EDUCATION

- Directors receive notices of the various Educational Seminars sponsored by the Ontario Hospital Association.
- Directors receive financial support and are encouraged to attend the Annual Ontario Hospital Convention.
- Individual Nurse Managers/Department Heads are invited from time to time to make presentations at the regularly scheduled Board meeting to outline the functions of their departments and assist with the long range planning process of the hospital.

AMENDMENT

This policy may be amended by the Board.

APPROVED BY: BOARD OF DIRECTORS

DATE: SEPTEMBER 26, 1991; REVISED: MAY 25, 2006; REVIEWED MAY 2017

BOARD OF DIRECTORS

POLICY NO. 7

PRESS ATTENDANCE AT BOARD MEETINGS

The Renfrew Victoria Hospital Board of Directors meets on a bi-monthly basis except for the months of July, August and December. These meetings are open to the public and the press.

The press will be provided with an agenda and appropriate information.

Matters dealing with labour relations, salaries, confidential patient and medical staff data will be deferred to a closed session.

Press code for media enquiries refer to General Administrative Policy No. 8.

AMENDMENT
This policy may be amended by the Board.

APPROVED BY: BOARD OF DIRECTORS

DATE: JANUARY 24, 199; REVISED MAY 25, 2006; REVIEWED MAY 2017

RENFREW VICTORIA HOSPITAL

ADMINISTRATIVE POLICY

GENERAL POLICY NO. 8

PRESS CODE FOR RENFREW VICTORIA HOSPITAL

Two of the most vital institutions in any community are its hospital and its news media. Co-operation between them should be strong and consistent, with understanding of each other's special needs.

Hospital representatives shall recognize the legal and ethical restrictions on the extent and type of information which may be released and will realize that the needs of the patient comes ahead of all others.

This news media code is a working guide for most institutions and will help to ensure an efficient working relationship between the Hospital and the news media.

The guidelines outlined here are appropriate whether the Hospital is responding to enquiries or initiating contact with the media.

CONFIDENTIALITY
Clinical records of a patient are classified "confidential" and cannot be divulged unless proper authorization from the patient or the President and Chief Executive Officer has been obtained.

Information acquired by employees, in the performance of their duties, regarding patients and their families must be held in strict confidence. Breaches of confidence or release of information by unauthorized personnel will result in disciplinary action. Information regarding the patient or family is NEVER given to the press or unauthorized persons. Such requests must be referred to the President and Chief Executive Officer or the Nursing Co-ordinator. Even the most innocent disclosure of information is an invasion of the privacy of patients and their families.

AUTHORIZED HOSPITAL SPOKES PERSONS FOR MEDIA ENQUIRIES
If it is decided that the information requested may be given by telephone, it is necessary to verify the enquirer's name and phone number by calling back.

a) Police and Accident Cases of Public Record
Cases which have been reported, or are reportable, to public authorities, such as police or fire departments. This would include cases of accidents occurring on the street or in other public places, or where a patient has been conveyed to Hospital by police or fire department transportation. Nursing Co-ordinator (in consultation with the investigating police force). (see Appendix A for procedural guidelines).

b) Cases Other Than Those of Public Record
Prominent personalities, deaths that may become coroner's cases. Nursing Co-ordinator unless specifically changed by the Chief Executive Officer in certain individual cases. (See Appendix B for procedural guidelines)

c) General News Coverage
All media enquiries of a general nature should be referred to the President & Chief Executive Officer, or designate. Normally, enquiries of a general nature fall within the following categories:

i) Board Policy Statements - Spokesperson: Chief Executive Officer (or delegate)
ii) General Hospital News - Spokesperson: Chief Executive Officer (or delegate)
iii) Departmental Function and Medical Activities - Procedure: Clearance by the Chief Executive Officer; Spokesperson: Vice-Presidentr or Department Head
iv) Contributions/Donations - Spokesperson: Chief Executive Officer (or delegate)

In all cases of media enquiries by telephone under "General News Coverage", these are best handled by written statement or a pre-arranged personal interview.

PHOTOGRAPHS AND INTERVIEWS OF PATIENTS

No interviews or photographs of patients in Hospital by media representatives can take place without the written consent of the patient or guardian and without authorization of the President and Chief Executive Director or the Nursing Co-ordinator. Pictures may not be taken of unconscious patients. Police cases related photographs and interviews are co-ordinated by the President and Executive Director or Nursing Co-ordinator.

GUIDELINES FOR PHYSICIANS IN THEIR RELATIONS WITH THE MEDIA

The College's position is that physicians are expected to comply with all of their existing professional expectations, including those set out in relevant legislation, codes of ethics, and College policies, when engaging in the use of social media platforms and technologies. The College of Physicians and Surgeons has formulated the following guidelines to be used by physicians.

These obligations are not unique to social media, but apply to medical practice in general, and must be met by all physicians. They are as follows:

- Comply with all legal and professional obligations to maintain patient privacy and confidentiality.
- Maintain appropriate professional boundaries with patients and those close to them.
- Maintain professional and respectful relationships with patients, colleagues, and other members of the health-care team.
- Comply with relevant legislation with respect to physician advertising.
- Comply with the law related to defamation, copyright, and plagiarism when posting content online.
- Avoid conflicts of interest.

In order to satisfy the above professional expectations while engaging in social media, it is recommended that physicians:

1. Assume that all content on the Internet is public and accessible to all.
2. Exercise caution when posting information online that relates to an actual patient, in order to ensure compliance with legal and professional obligations to maintain privacy and confidentiality. Bear in mind that an unnamed patient may still be identified through a range of other information, such as a description of their clinical condition, or area of residence
3. Refrain from providing clinical advice to specific patients through social media. It is acceptable, however, to use social media to disseminate generic medical or health information for educational or information sharing purposes.
4. Protect their own reputation, the reputation of the profession, and the public trust by not posting content that could be viewed as unprofessional.
5. Be mindful of their Internet presence, and be proactive in removing content posted by themselves or others which may be viewed as unprofessional.
6. Refrain from establishing personal connections with patients or persons closely associated with them online, as this may not allow physicians to maintain appropriate professional boundaries and may compromise physicians' objectivity. It is acceptable to create an online connection with patients for professional purposes only.
7. Refrain from seeking out patient information that may be available online without prior consent.
8. Read, understand, and apply the strictest privacy settings necessary to maintain control over access to their personal information, and social media presence undertaken for personal purposes only.

9. Remember that social media platforms are constantly evolving, and be proactive in considering how professional expectations apply in any given set of circumstances.

RESOLUTION

THIS POLICY ACCEPTED BY THE MEDICAL ADVISORY COMMITTE OCTOBER, 1994, ESTABLISHED BY MANAGEMENT COMMITTEE JULY 1984, REVIEWED JUNE 1991, AUGUST 2001, OCTOBER 2011, JANUARY 2017.

Randy V. Penney, Chief Executive Officer

PROCEDURAL GUIDELINES FOR NURSING CO-ORDINATOR
APPENDIX A

POLICE AND ACCIDENT CASES OF PUBLIC RECORD

NOTE: The following guidelines are to be followed for release of information in consultation with the investigating police force.

Provided the next-of-kin **have been notified**, the Hospital may release to the press the following information **without the consent** of the patient or guardian, except in the case of:

- sexual assault
- abortion
- drug addiction
- psychiatric problems
- emergency maternity cases

In these cases, the **general condition only** may be stated. **No identifying information** may be given.

1. **General Information**, if possible to obtain: address, age, time of arrival, sex, occupation

2. **General Condition, etc.**
   - **Good** – vital signs are stable; patient is conscious and comfortable – prognosis is either good or excellent
   - **Fair** – vital signs within normal limits; patient is conscious and may be uncomfortable – may have minor complications
   - **Serious** – acutely ill with questionable prognosis – vital signs may be unstable or not within normal limits.
   - **Critical** – questionable prognosis – there are major complications and death may be imminent.

3. **Nature of Accident** i.e. automobile, fire, fall may be stated if known – no comment will be made regarding the **cause.**

4. **Nature of Injury or Illness**
   - **Unconscious** - - May be stated if so, but no cause be given
   - **Fractures** - If confirmed may be described as left or right, arm or leg, simple or compound. If not confirmed, state "injuries" not "suspected fractures".
   - **Internal Injuries** - It may be stated that there are internal injuries, e.g., ruptured spleen, but not the nature of, unless confirmed by physician.
   - **Head Injuries** - If fracture of skull definite, this may be stated, otherwise state "undetermined injuries to head". Do not state severity of prognosis.
   - **Poisoning** - In case of accidental poisoning, it may be stated that a patient is being treated for symptoms of food poisoning, carbon monoxide poisoning, etc., if confirmed by physician. No cause as to how it occurred may be given.
   - **Burns** - It may be stated that the patient is suffering from burns and the parts and percentage of the body involved. The degree of burns may be stated, if physician agrees. The type of accident may be stated, if established.
   - **Shooting and/or Stabbing** - It may be stated that there is a gunshot or stab wound and the area affected, if agreed by physician. No cause may be given.

   If, in addition to injury or illness, there is suspicion or proof of intoxication by either alcohol or drugs, no mention may be made of this fact, especially if there is a possibility of legal proceedings.

5. **Name of the attending physician**

May be provided only after the consent of the physician has been obtained (this consent may be provided verbally).

6. **Any additional information sought by media** should be referred to the President & Chief Executive Officer.

PROCEDURAL GUIDELINES OTHER THAN POLICE AND ACCIDENT CASES

APPENDIX B

1. <u>BIRTHS AND DEATHS</u>

Permission to announce any birth should first be obtained by the Hospital from the mother.

In non-police cases, the attending physician is responsible for notifying the next-of-kin of a patient's death. When this has been done, the Hospital may, if requested by the press, confirm the fact of death.

<u>Coroner's Cases</u>: In cases where a death has been, or should be, reported to a coroner (including deaths resulting from accidents that may result in court cases), press enquiries as to the cause of death are referred to the coroner's office.

2. <u>PROMINENT PERSONALITIES AND CASES OF PUBLIC INTEREST</u>

If a patient is admitted to the Hospital, who is a prominent personality, specific steps will be taken to ensure privacy and confidentiality.

In such cases, the usual patient information will not be available at the Main Reception desk or in the Admitting Office, and no information will be released from the nursing unit.

Consent will be obtained from the family for the release of information to the press in accordance with the restrictions regarding police and accident cases (See Appendix A).

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BOARD OF DIRECTORS

POLICY NO. 8

DESTRUCTION OF HEALTH RECORDS

PURPOSE
The Hospital is committed to ensuring that in all aspects of its affairs it maintains the highest standards of public trust and integrity.

HEALTH RECORDS DESTRUCTION
Renfrew Victoria Hospital health records will be destroyed by shredding in accordance with the Public Hospitals Act of Ontario, Revised Statues of Ontario, 1990, Chapter P.40, Hospital Management (R.R.O. 1990, Reg. 965) as such:

Item	Retention Period
Records of inpatients and outpatients aged 18 years or older.	10 years after discharge, last visit or death.
Records of inpatients and outpatients under 18 years of age.	10 years after 18th birthday
Records of deceased inpatients and outpatients under 18 years of age.	10 years after death 10 years after 18th birthday

All records to be destroyed shall be documented with patient's last and first name, central patient index number and the date of destruction of the records.

An affidavit will be signed by the President and Chief Executive Officer as to the destruction of the health records, witnessed and stamped with the hospital corporate seal.

The Clinical Records Manager/Department will retain all Statements of Destruction as a record of the destruction process.

AMENDMENT
This policy may be amended by the Board.

APPROVED BY: BOARD OF DIRECTORS

DATE: JANUARY 28, 2010; REVIEWED MAY 2017

BOARD OF DIRECTORS

POLICY NO. 9

SIGNING AND APPROVAL AUTHORITY

PURPOSE

The Board of Directors is responsible for oversight of the Renfrew Victoria Hospital and its resources, and is accountable to the Province of Ontario through the Broader Public Sector Procurement Directive issued by the Management Board of Cabinet effective April 1, 2011.

The purpose of this policy is to define the levels of signing and approval authority delegated to the President and CEO, Vice Presidents, Directors, Managers and other staff. Vice Presidents, Directors, Managers and others are expected to manage their areas of responsibility in an efficient, effective and economical manner within the limits of their approved operating and capital budgets. Signing and approval authority limits are designed to assist in achieving this goal.

POLICY

The Hospital shall put in place controls that protect the Hospital from unauthorized purchase(s) or commitment(s) which are not in keeping with an overall financial plan.

PROCEDURE

A. Signing Authority – Bank Accounts

i) **Operating Bank Accounts** - Any two signatures from the following four positions:
- Chair Board of Directors
- Vice-Chair Board of Directors
- Treasurer Board of Directors
- President and CEO

Under the authority of the Vice-President Financial Services the hospital operates an electronic cheque signing device. Cheques are electronically signed by two of the three positions identified above. Cheques greater than $100,000 are initialed by the Vice-President, Financial Services or President & CEO, confirming authorization of release.

Renfrew Victoria Hospital promotes the benefits of ecommerce through electronic payments. Electronic payments must be duly authorized in accordance with the Signing Authority levels. Any electronic payment greater than $100,000 will be confirmed by the Vice-President of Financial Services or President and CEO.

ii) **Petty Cash Funds -** The Hospital supports the use of a Petty Cash Funds (100.00 or less) where appropriate. All Petty Cash Funds must be authorized by the department manager or Vice-President Financial Services.

B. Signing Authority – Contracts

All contracts which the Hospital enters into in the ordinary course of business must be signed by a person authorized to bind the Hospital. Within their respective signing authority levels, only the following positions have the authority to bind the Hospital to a contract:

Chair Board of Directors

- Vice-Chair Board of Directors
- Treasurer – Board of Directors
- President and CEO
- Vice-President Financial Services
- Vice-President Corporate Services
- Vice-President Patient Care Services

Managers and Directors will have the authority, under the direction of the President and CEO or their respective Vice President, to sign contracts up to their signing authority level.

Vendors offer the Hospital opportunities to participate in preferred pricing arrangements. The Manager, Materials Management has the authority to sign preferred pricing agreements where there is no commitment to meet purchase volumes or quota. When the pricing agreement is based on volume commitments, the Vice-President Financial Services or President and CEO must sign the agreement.

C. Signing Authority - Expenses

In addition to President & CEO, Vice President Financial Services, Vice President Corporate Services and Vice President Patient Care Services only individuals who have direct financial responsibility for a cost centre and are given authority pursuant to this policy shall authorize vendor invoices, purchase order requisitions, cheque requisitions or petty cash vouchers incurred by that cost centre.

No person can authorize an expenditure or payment to himself/herself.

Signing Authority Levels*

ITem	Dollar Limit	Positions Authorized to Approve
Goods, Non-Consulting Services	Up to $5,000	Departmental Managers/Director
Goods, Capital, Non-Consulting Services and contracts ≤ 5 years	Up to $100,000	Vice- Presidents
Goods, Capital, Consulting and Contracts	Up to $1,000,000	President & CEO
All items including Consulting, Capital, Construction and Contracts	>$1,000,000	Board of Directors

*Delegation of authority may be issued to other positions for different dollar limits

i) **Delegation of Authority** - In order to ensure efficient and effective management of the day to day operations, the Hospital provides for the delegation of authority to designated staff for specific dollar limits. An Authorization of Delegate form should be completed by the Department Head and approved by President & CEO, Vice President Financial Services, Vice President Corporate Services or Vice President Patient Care Services to assign approval authority for specific cost centre accounts and/or dollar thresholds to specific employees.

Finance maintains and makes available a register of authorized delegates and ensures expenditures are appropriately authorized. Materials Management ensures that purchase requisitions are appropriately authorized.

Authorization has been further delegated to specific departments as follows:

- To the Vice President Corporate Services for payments of payroll and related benefit expenses.
- To the Director of Pharmacy for the acquisition of pharmaceuticals
- To the Manager of Food Services Department for the acquisition of patient and non-patient food and related products
- To the Manager, Materials Management for the acquisition of Hospital stock and non stock items
- To the Manager, Plant Operations for the acquisition of supplies relating to plant operations and maintenance.

ii) **Goods and non-consulting services -** Any procurement of goods and non-consulting services must be approved by the appropriate authority according to the above Signing Authority Level.

iii) **Consulting services** - Any procurement of consulting services must be approved in accordance with Procurement Approval Authority Schedule for Consulting Services below**.**

Procurement Approval Authority Schedule for Consulting Services		
Procurement Method	**Procurement Value**	**Approval Authority**
Invitational Competitive	$0 up to $100,000	Vice President or President and CEO
Open Competitive	Any Value but mandatory >100,000	Board of Directors and President and CEO
Non-competitive*	$0 up to $100,000	President and CEO
	> $100,000	Board of Directors

*A sole or single source form must be completed for all Items procured in a Non Competitive manner.

D. <u>Signing Authority – Purchase Orders</u>

The Manager, Materials Management is authorized to sign all purchase orders under the direction of the Vice-President Financial Services, if supported by a signed and approved purchase requisition in accordance with Hospital's Signing Authority Policy.

The Director of Pharmacy, or designate(s) is authorized to sign all purchase orders for the acquisition of pharmaceuticals under the direction of the Vice-President Corporate Services and in accordance with Hospital's Signing Authority Policy.

The Manager of Food Services is authorized to sign all purchase orders for the acquisition of patient and non-patient food and related products under the direction of the Vice-President Corporate Services and in accordance with the Hospital's Signing Authority Policy.

The Director of Plant Services is authorized to sign all purchase orders for the acquisition of Plant Services approved expenses, under the direction of the Vice-President Corporate Services and in accordance with Hospital's Signing Authority Policy.

Other Managers as delegated by the respective Vice President responsible for departmental operations, in accordance with Hospital's Signing Authority Policy.

E. Signing Authority – Hospital Borrowing

Borrowing must be carried out in accordance with the Bylaw of Renfrew Victoria Hospital under the Canada Corporations Act.

F. Operating Expenditures

i) Operating Budget -Total Hospital operating expenditures and revenues are authorized by the Board of Directors through the approval of the annual operating budget as approved by the Board of Directors. Departmental Directors and Managers are authorized to spend up to the approved budgeted amounts subject to signing authority limits outlined in Section C.

ii) Reporting - Financial statements indicating actual and budgeted expenditures shall be prepared by the Finance Department for periodic review by the Board of Directors

G. Capital Expenditures

i) **Capital Budget -** Capital expenditures are those expenditures as authorized by the Board of Directors in the annual capital budget.

ii) **Contingency -** The annual capital budget may include a contingency. Departments are required to submit a request for use of the contingency fund to their respective Vice-President, illustrating need, other alternatives, why funds cannot be reprioritized in capital budget, etc. Final approval is required by either the President/CEO, Vice - President Financial Services, Vice - President Corporate Services or Vice – President Patient Care Services.

iii) **Reprioritization -** Reprioritization of items on the Approved Capital Budget may be authorized by the President and CEO or Vice - President Financial Services. It is expected that Senior Management review such reprioritization and any significant changes be reported to the Finance Committee of the Board at a subsequent meeting.

AMENDMENT

This policy may be amended by the Board.

APPROVED BY: BOARD OF DIRECTORS

DATE: FEBRUARY 2, 2012; REVIEWED MAY 2017

RENFREW VICTORIA HOSPITAL

BOARD OF DIRECTORS

POLICY NO. 10

PUBLIC ATTENDANCE AT BOARD MEETINGS

PURPOSE

The public and staff are welcome to observe the open portion of the board's meeting to:

- Facilitate the conduct of the board's business in an open and transparent manner;
- Ensure the hospital maintains a close relationship with:
  - the public
  - media
- Generate trust, openness and accountability.

POLICY

Members of the public are invited to attend the meetings of the board in accordance with the following policy:

- **Notice of Meeting**
  A schedule of the date, location and time of the board's regular meetings will be available from the office of the President & CEO and will be posted on the hospital's website. Changes will also be posted on the hospital website.

- **Attendance**
  To ensure adequate space is available; individuals wishing to attend are encouraged to give 24 hours' notice to the board secretary.

- **Conduct During the Meeting**
  Members of the public may be asked to identify themselves. Recording devices, videotaping and photography are prohibited. The chair may require anyone who displays disruptive conduct to leave.

- **Agendas and Board Materials**
  Agendas will be distributed at the meeting and may be obtained from the board secretary prior to the meeting. Supporting materials will be distributed only to the board.

- **In-Camera Session**
  The board may move in-camera or hold special meetings that are not open to the public where it determines it is in the best interest of the hospital to do so. The chair may order that the meeting move in-camera or any director may request a matter be dealt with in-camera in which case a vote will be taken and if a majority of the board decides the matter shall be dealt with in-camera.

  The following matters will be dealt with in-camera:
  - Matters involving property
  - Matters involving litigation

- Material contracts
- Human resource issues
- Professional staff appointments, re-appointments and credentialing issues
- Patient issues
- Matters dealing with the Foundation/donations
- Any matter that the board determines should be the subject of an in-camera session.

Guests or counsel may remain during an in-camera session with the permission of the chair or the consent of the meeting.

Requests for Interviews
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 raise questions with the board must contact the board secretary in advance of the meeting.

Committee Meetings
Meetings of committees are not open to the public.

PROCEDURE FOR MEMBERS OF THE PUBLIC ADDRESSING THE BOARD

Persons wishing to address the board concerning matters relevant to the hospital must do so following the procedures listed below.

1. Written notice of the request to address the board meeting must be provided to the secretary no later than 10 working days prior to the meeting date. A brief description of the specific matter to be addressed should be included in the request.
2. Requests to address the board on a specific item will be granted (generally in order of the receipt of the requests) if approved by the chair of the board. Persons not permitted to address the board shall be so notified.
3. The board may limit the number of presentations at any one meeting.
4. Persons addressing the board will be required to limit their remarks to five minutes. If a group wishes to make a submission, a spokesperson for the group should be identified.
5. Upon completion of the presentation, any dialogue shall be limited to Board members asking for clarification or obtaining additional relevant information only. There shall not be any debate.
6. Persons making presentations
   i) shall not speak disrespectfully of anyone,
   ii) shall not use offensive words or unparliamentary language,
   iii) shall not speak on any subject matter other than that which has been approved, and
   iv) shall not disobey the rules of procedure or a decision of the Chair.
7. The Chair may curtail any presentation as the result of disorder or any other breach of this Policy and ask the offending person to leave.
8. The chair is not obligated to grant a request to address the board and the board is not obligated to take any action on the presentation it receives.

Contact Information

Randy Penney, Board Secretary
Renfrew Victoria Hospital
499 Raglan Street, North
Renfrew, ON K7V 1P6
Telephone 613-432-4851 ext. 260
penneyr@renfrewhosp.com

AMENDMENT

This policy may be amended by the Board.

APPROVED BY: BOARD OF DIRECTORS
DATE: MAY 24, 2012; REVIEWED MAY 2017

BOARD OF DIRECTORS

POLICY NO. 11

CODE OF ETHICS

All Renfrew Victoria Hospital Board of Directors and lay committee members who sit on Board Committees are expected to be familiar with the Code of Ethics and adhere to this code as set forth in the Code of Ethics, General Administrative Policy No. 68.

AMENDMENT

This policy may be amended by the Board.

APPROVED BY: BOARD OF DIRECTORS
DATE: NOVEMBER 29, 2012; REVIEWED MAY 2017

ADMINISTRATIVE POLICY

GENERAL POLICY NO. 68

CODE OF ETHICS

The Board of Directors, Management and Staff of the Renfrew Victoria Hospital adopts the Canadian College of Health Service Executives' Standards of Ethical Conduct in its entirety as follows:

PREAMBLE

In fulfilling their responsibilities, RVH management and staff serve as moral agents. Every management decision affects the health and well being of individuals, organizations and communities, therefore management and staff must assess the consequences of their decisions and actions and accept responsibility for their results. As moral agents, RVH management and staff must speak out and strive for the most ethical course of action, both by themselves and by the organizations they lead.

All members of RVH are required to comply with the Standards of Ethical Conduct and follow their professional code of ethics. All members must also respect the patient declaration of values (Appendix A). Ethic decisions are also guided by the Mission, Vision and Values of the Renfrew Victoria Hospital (Appendix B).

ETHICAL PROBLEMS AND DILEMMAS

1. Responsibilities to Individuals

RVH Board of Directors, President and Chief Executive Officer, Management and Staff shall:

- Be exemplary, courteous and tactful in all interactions.
- Ensure the communication of rights, responsibilities and information to foster informed decision-making.
- Respect the customs and beliefs of others, consistent with the mission of the organization.
- Respect the confidentiality of information, unless it is in the public interest or required by law to divulge information or with the informed consent of the patient.
- Promote competence and integrity with individuals associated with the organization.

2. **Responsibilities to the Organization**

RVH Board of Directors, President and Chief Executive Officer, Management and Staff shall take a leadership role to ensure the organization:

- Serves the public interest in an ethical fashion.
- Strives to provide quality services.
- Communicates truthfully and avoids misleading or raising unreasonable expectations in others.
- Uses sound management practices and ethical use of resources.
- Promotes public understanding of health and health services.
- Conducts inter-organizational activities in a cooperative way that improves community health.

3. **Responsibilities to Community and Society**

RVH Board of Directors, President and Chief Executive Officer, Management and Staff shall:

- Abide by the laws of government, but seek changes by lawful means where needed.
- Contribute to improving the health of Canadians, including participating in public dialogue and recommending actions to enhance health and better health services.
- Strive to identify and meet the health needs of the community within the resources available and the mission of the organization.
- Consider the effects of management decisions on the community and society.

4. **Responsibilities t the Work Environment**

RVH Board of Directors, President and Chief Executive Officer, Management and Staff shall:

- Promote ethical conduct and best practices for discussing addressing ethical issues and concerns.
- Promote a healthy work environment that is safe and harassment-free, and that stimulates and makes the best use of employee skills, knowledge and experience.
- Promote a safe environment for disclosure of ethical issues.

5. **Conflict of Interest**

- Conflict of interest exists when RVH Board of Directors, President and Chief Executive Officer, Management and Staff uses position, authority or privileges information to:
  - Obtain an improper benefit, directly or indirectly, or
  - Obtain an improper benefit for a friend, relative or associate, or
  - Make decisions that will negatively affect the organization.

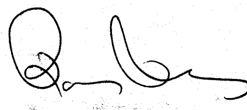
- RVH Board of Directors, President and Chief Executive Officer, Management and Staff shall:
  - Conduct all relationships in a way that assures those affected that decisions are not compromised by a conflict of interest.
  - Disclose to the appropriate authority any direct or indirect personal or financial interest, or appointment or election which might create a conflict of interest.
  - Neither accepts nor offer personal gifts or benefits with the expectation or appearance of influencing a decision.

The above is in addition to and does not in any way replace professional responsibilities of regulated professional as defined clinically by their respective code of ethics.

Adopted from the Canadian College of Health Leaders Code of Ethics.

RESOLUTION

THIS POLICY ESTABLISHED BY THE MANAGEMENT COMMITTEE ON MARCH 30, 2004 & REVISED SEPT. 15, 2010; REVISED OCT. 30, 2012; FEBRUARY 2017



Randy V. Penney, President & C.E.O.

RENFREW VICTORIA HOSPITAL

APPENDIX A

PATIENT DECLARATION OF VALUES/EXPECTATIONS

EXPECTATION	AS A PATIENT YOU HAVE THE RIGHT…	AS A PATIENT YOU HAVE A RESPONSIBLILITY TO…
PRIVACY	• To privacy, confidentiality and security of your personal health information. • To access your Medical Record.	• Respect the privacy of others.
QUALITY/SAFETY	• To excellence in the delivery of safe and high quality patient care services in a safe, accessible environment free of discrimination, harassment or abuse.	• Recognize that needs of others may sometimes be more urgent than your own. • Express opinions positive or negative about your healthcare experience. • Recognize your role in patient safety and safety of others.
RESPECT	• To be treated with dignity, courtesy and respect	• Respect and adhere to hospital policies. • Treat healthcare team members, other patients and families with dignity, courtesy and respect.
PATIENT FOCUS	• To have access to reliable and current information about your health care options. • To actively participate in decision-making/planning regarding diagnosis, treatment and discharge planning pertaining to your health care. • To have informed choices outlined in terms you understand.	• Identify a spokesperson or provide a Power of Attorney in the event you cannot make decisions for your care. • Ask questions and share relevant and accurate information with health care providers. • Make informed choices to consent or refuse treatment accepting responsibility for those decisions.

APPENDIX B

Mission, Vision and Values

MISSION:
To provide the best possible health care experience for our patients and their families.

VISION:
Renfrew Victoria Hospital will be a model of excellence in health care.

VALUES:
Quality
We are committed to continuously improving the quality of health care we provide.

Safety and Wellbeing
We make every effort to support the safety and wellbeing of all individuals within our environment.

Leadership and Accountability
We champion innovation and collaboration to anticipate and respond to the changing needs of our community in a fiscally-responsible manner.
We foster a culture that encourages everyone to embrace ownership, innovation and teamwork.

Respect
We respect the rights, dignity and values of each individual.

Engagement
We believe patients/caregivers should be active participants in their care.
We value the contribution of each individual in the organization.

2016

BOARD OF DIRECTORS

POLICY NO. 12

BOARD PERFORMANCE EVALUATION

PURPOSE
To assist the Board on its role of monitoring performance, the Board has undertaken to regularly evaluate the performance of the Board. The evaluations will occur in accordance with this policy.

EVALUATION
There will be a biennial evaluation of the performance of Board Directors, conducted in, or as close as possible to January/February.

The purpose of the evaluation is to evaluate how effective the Board, the Directors and the Committees are fulfilling their roles and duties.

The biennial review will commence in January/February, with the Chair requesting feedback at a meeting of the Board.

PROCESS
The process of the evaluation is to include written questions given to each Director for completion with respect to:

- The performance and functioning of the Board as a whole
- The performance and functioning of the Board's Committees
- Self –evaluation of the Director's own performance

OUTCOME OF EVALUATION
The review will be evaluated by the Governance Committee with recommendations to the Board for any required changes. Included will be an open discussion by the Board of the results of the evaluation.

If particular concerns arise from the evaluation in relation to any individual Director, or Committee, the Chair will meet with that Director, or Chair of that Committee, to discuss the concerns and any actions to be taken as a result. Discussions by the Chair with individual Directors on their performance will be held in strict confidence.

FEEDBACK
Directors will be encouraged to provide feedback on the conduct of Board meetings and other business, and the preparation for them, in order to assist in the continual improvement of the way the Board carries out its role.

AMENDMENT
This policy may be amended by the Board.

APPROVED BY: BOARD OF DIRECTORS
DATE: SEPTEMBER 26, 2013; REVIEWED MAY 2017

RVH RENFREW VICTORIA HOSPITAL

BOARD PERFORMANCE EVALUATION

This questionnaire is designed to assist RVH Board Directors to examine their approach to governance and identify areas of consensus related to RVH and the challenges that it faces.

The questionnaire will only take a few minutes to complete. Replies will remain completely anonymous and confidential. To be completed by all members of the Board of Directors.

Your responses should be received no later than ***date***

(If you are unsure, or feel you do not have enough information to answer any question, simply leave that item blank)

1. First, please rate the following aspects of the board's ongoing operations:

	Excellent	*Good*	*Fair*	*Poor*
a) Degree of organization at board meetings ....…..	☐	☐	☐	☐
b) Level of participation by directors …	☐	☐	☐	☐
c) Board director access to relevant Information in a timely manner..….........	☐	☐	☐	☐
d) Board director preparedness & knowledge of subject matter being discussed ……	☐	☐	☐	☐
e) Staff support ....…	☐	☐	☐	☐

2. Think now of your own involvement with the Board of Directors, and indicate your level of agreement or disagreement with each of the following statements:

	Agree Strongly	*Agree Somewhat*	*Disagree Somewhat*	*Disagree Strongly*
a) The board is dealing with important issues ....…	☐	☐	☐	☐
b) The board has a hard time focusing on issues	☐	☐	☐	☐
c) We spend too much time discussing things that have nothing to do with the agenda ....…	☐	☐	☐	☐
d) We have many good discussions and debates on this board ....….....	☐	☐	☐	☐

2. (Cont'd)

	Agree Strongly	*Agree Somewhat*	*Disagree Somewhat*	*Disagree Strongly*
e) The board seems to have a hard time making decisions ....…	☐	☐	☐	☐
f) Board directors represent a variety of backgrounds ....…..	☐	☐	☐	☐
g) The directors of this board work well together	☐	☐	☐	☐
h) I feel quite comfortable in "speaking my mind" at board meetings …............	☐	☐	☐	☐
i) Some directors tend to dominate board meetings ....…	☐	☐	☐	☐
j) I believe that my comments are respected by others ....…........	☐	☐	☐	☐
k) We tend to deal with a lot of issues that are outside our mandate ....….....	☐	☐	☐	☐
l) I believe that this board makes an important contribution to the mandate of RVH …...........................	☐	☐	☐	☐

3. What would you suggest to improve Board meetings?

____

____

____

____

4. What do you feel is the <u>single most important strength</u> of this board?

____

____

____

____

5. What do you feel is the <u>single most important weakness</u> of this Board?

____

____

____

____

6. This question pertains to the role of the board. For each item, Column 1 asks you to agree or disagree with a statement about what the role of the board should be. Column 2 asks you to indicate how your board actually behaves.

   For each item, circle the numbers which most closely correspond to your view:

   4 = Agree strongly   2 = Disagree somewhat
   3 = Agree somewhat   1 = Disagree strongly

	We should do this Column 1	*We actually do this* Column 2
a) Keeping up with relevant trends, events and emerging issues	4 3 2 1	4 3 2 1
b) Establishing strategic directions for the organization	4 3 2 1	4 3 2 1
c) Ensuring the needs of our customers are addressed i.e. patient safety, quality, risk management issues, etc…...	4 3 2 1	4 3 2 1
d) Providing directions to management on service priorities i.e. CT, Dialysis…..	4 3 2 1	4 3 2 1
e) Providing direction to management on human resource issues	4 3 2 1	4 3 2 1
f) Influencing social policy …………….	4 3 2 1	4 3 2 1
g) RVH communicates with the public and specific stakeholder groups …….	4 3 2 1	4 3 2 1
h) Overseeing financial matters	4 3 2 1	4 3 2 1
i) Overseeing operational matters ...…....	4 3 2 1	4 3 2 1
j) Evaluating health services	4 3 2 1	4 3 2 1
k) RVH has established community linkages …..	4 3 2 1	4 3 2 1

This next series of questions deals with the role of the RVH Board and some of the challenges that it faces in the next few years.

7. First, how would you rate RVH's overall effectiveness?

- ☐ Very effective
- ☐ Somewhat effective
- ☐ Not too effective
- ☐ Not at all effective

8. Please list one major <u>strength</u> and one major <u>weakness</u> of RVH.

Strength: ____

Weakness: ____

9. Now list one <u>opportunity</u> and one <u>threat</u> facing RVH.

Opportunity: ____

Threat: ____

10. What do you feel are <u>three most significant external challenges</u> confronting RVH in the next year?

(List them in order of priority)

(i) ____

(ii) ____

(iii) ____

11. Are there any other <u>important trends, issues or events</u> that the board should be considering?

____

____

____

12. Are there items that you feel need to be discussed at the Board:

____

____

____

13. Suggestions for Guest Speakers:

____

____

____

14. Feel free to make any other <u>comments or suggestions</u> to assist in future board planning and development initiatives:

____

____

____

____

____

15. Consideration is being given to a Board Retreat.

Are you in favour: ☐ Yes ☐ No

- One Day: ☐ Yes ☐ No ***OR*** One evening: ☐ Yes ☐ No
- Weekday: ☐ Yes ☐ No ***OR*** Weekend: ☐ Yes ☐ No
- Spring: ☐ Yes ☐ No ***OR*** Fall: ☐ Yes ☐ No

Please return the questionnaire to

Sandra Buttle
Renfrew Victoria Hospital
499 Raglan Street, North
Renfrew, ON K7V 1P6

Fax: 613-432-0711

buttles@renfrewhosp.com

RVH RENFREW VICTORIA HOSPITAL

BOARD COMMITTEE EVALUATION

Evaluate each Board Committee(s) you serve on:

Name of Committee: ____________________________ ___________________________

	Excellent	***Good***	***Needs Improvement***	***Excellent***	***Good***	***Needs Improvement***
1. Agenda Organization	☐	☐	☐	☐	☐	☐
2. Access to agenda/ information timely manner	☐	☐	☐	☐	☐	☐
3. Participation by committee members	☐	☐	☐	☐	☐	☐
	Agree	***Agree Somewhat***	***Needs Improvement***	***Agree***	***Agree Somewhat***	***Needs Improvement***
4. Committee deals with important issues	☐	☐	☐	☐	☐	☐
5. Good discussions and debates at this level	☐	☐	☐	☐	☐	☐
6. My comments are respected by others	☐	☐	☐	☐	☐	☐
7. Committee is effective in providing direction to the Board	☐	☐	☐	☐	☐	☐

Comments:

BOARD DIRECTOR SELF EVALUATION

Board Director Name: ______________________________ **Date:** ________________

1. How do you assess your contribution to the Board? (i.e. attendance at board meetings, participation on committees, do you add value and unique perspective)

2. What do you see as your strongest contribution to the Board?

2. How has RVH invested in your growth as a board director?

3. What would you like to contribute to or involve yourself in if you were to serve another term?

4. How would you like RVH to invest in and facilitate your personal development as a board director?

5. What changes would you suggest, as a board director, in the operation and involvement of the board?

BOARD OF DIRECTORS

POLICY NO. 13

BOARD CHAIR PERFORMANCE EVALUATION

FUNCTION

The Chair of the Board is responsible for the management, the development and the effective performance of the RVH Board of Directors, and provides leadership to the Board for all aspects of the Board's work.

The Chair acts in an advisory capacity to the President and Chief Executive Officer and to other Directors in all matters.

RESPONSIBILITIES

As set out in the RVH Bylaw (5.02), the duties of the Chair of the Board shall include, without limitation, the following:

a. When present, preside at all meetings of the Board;
b. Be Chair of the Governance Committee;
c. Be an ex officio member of all Committees of the Board;
d. In consultation with the President and Chief Executive Officer, develop the agenda for Board meetings;
e. Where possible, ensure that appropriate Board and Committee information and supporting materials are provided to Board and Committee members at least seven (7) business days prior to their meetings;
f. Ensure that the actions of the Board are in accordance with the Hospital's goals and priorities and the Board's own goals;
g. Report regularly and promptly to the Board on issues that are relevant to its governance responsibilities;
h. Set a high standard for Board conduct by modelling, articulating and upholding rules of conduct set out in Bylaw and Policies;
i. Intervene when necessary in instances involving conflict of interest, confidentiality and other Board Policies;
j. Be responsible for addressing issues associated with under performance of Directors including, if applicable, their removal from the Board;
k. Serve as the Board's central point of official communication with the President and Chief Executive Officer and, as such, develop a positive, collaborative relationship with the President and Chief Executive Officer, including acting as a sounding board for the President and Chief Executive Officer on emerging issues and alternative courses of action;
l. Ensure that the annual review of the President and Chief Executive Officer's and Chief of Staff's performance and compensation is done in accordance with Board approved policy;
m. Report to each annual meeting of Members of the Corporation concerning the operations of the Corporation;
n. Represent the Corporation at public or official functions; and
o. Perform such other duties as may from time to time be determined by the Board.

EVALUATION

There will be a biennial performance evaluation of the Board Chair in conjunction with the evaluation of the performance of Board Directors, conducted in, or as close as possible to January/February.

The purpose of the performance evaluation is to gather input from the Board concerning the Chair's performance in fulfilling his/her roles and duties.

PROCESS

The process of the review is to include written questions with respect to:

- Ethics/Values
- Competence
- Chairing Meetings
- Relationship with Other Directors
- Public Profile
- Relationship with the President and Chief Executive Officer
- Diligence
- Strengths
- How to Enhance Performance

OUTCOME OF EVALUATION

The evaluation will be reviewed by the Governance Committee with recommendations to the Board for any required changes. Included will be an open discussion by the Board of the results of the evaluation. If there are concerns with the Chair, the Chair will discuss the matter as appropriate with the Board.

AMENDMENT

This policy may be amended by the Board.

APPROVED BY: BOARD OF DIRECTORS
DATE: SEPTEMBER 26, 2013; REVIEWED MAY 2017

BOARD CHAIR PERFORMANCE EVALUATION

At least every two years, the RVH Board of Directors will evaluate the Board Chair.

Note that we welcome your written comments at the end, either elaborating on any of the specific questions or discussing any other topic you believe will be helpful in connection with the board chair evaluation.

ETHICS/VALUES	**Scale** 4 Exceptional; 3 Very Good 2 Acceptable; 1 Unsatisfactory NA No experience or opinion				
The Chair:	4	3	2	1	NA
1. Behaves in accordance with RVH's Mission, Vision and Values Statement.					
2. Is ethical.					
3. Encourages feedback on how the chair's performance could be enhanced.					
4. Encourages discussion on how the board's performance could be enhanced.					
5. Leads the board in its performance responsibilities					

Comments:

COMPETENCE	**Scale** 4 Exceptional; 3 Very Good 2 Acceptable; 1 Unsatisfactory NA No experience or opinion				
The Chair:	4	3	2	1	NA
1. Understands what is required of a Chair.					
2. Ensures that the board gets the right information.					
3. Ensures the board deals with the right matters.					
4. Leads the board in its compliance responsibilities.					
5. Leads the board in its performance responsibilities					

Comments:

CHAIRING MEETINGS	**Scale** 4 Exceptional; 3 Very Good 2 Acceptable; 1 Unsatisfactory NA No experience or opinion				
The Chair:	4	3	2	1	NA
1. Manages time well in chairing meetings.					
2. Sticks to the agenda.					
3. Brings minor matters to an early close.					
4. Draws out contributions from all directors.					
5. Encourages wider and deeper discussions of important issues.					
6. Encourages collegiately.					
7. Differentiates between management and governance functions in board discussion and refers operational issues to management.					
8. Is adept at summarizing outcomes from board discussion.					
9. Ensures clarity of decision making.					

Comments:

RELATIONSHIP WITH OTHER DIRECTORS	**Scale** 4 Exceptional; 3 Very Good 2 Acceptable; 1 Unsatisfactory NA No experience or opinion				
The Chair:	4	3	2	1	NA
1. Is an appropriate role model for Directors.					
2. Has a positive working relationship with other Directors.					
3. Acts as a sounding board for Directors.					
4. Has the support of other Directors.					

Comments:

PUBLIC PROFILE	**Scale** 4 Exceptional; 3 Very Good 2 Acceptable; 1 Unsatisfactory NA No experience or opinion				
The Chair:	4	3	2	1	NA
1. Chair acts as the public spokesperson for RVH.					
2. Enhances the public image of RVH.					
3. Is seen as a leader.					

Comments:

RELATIONSHIP WITH THE PRESIDENT & CHIEF EXECUTIVE OFFICER	Scale 4 Exceptional; 3 Very Good 2 Acceptable; 1 Unsatisfactory NA No experience or opinion				
The Chair:	4	3	2	1	NA
1. Has a positive working relationship with the CEO.					
2. Acts as a sounding board and mentor for the CEO.					
3. Demonstrates public support for the CEO.					
4. Works with the CEO to set the board agenda.					
5. Ensures board decisions are implemented properly.					
6. Leads an effective process for the performance evaluation of the CEO.					
7. Where necessary, provides constructive criticism to the CEO.					

Comments:

DILIGENCE	Scale 4 Exceptional 3 Very Good 2 Acceptable 1 Unsatisfactory NA No experience or opinion				
The Chair:	4	3	2	1	NA
1. Dedicates sufficient time to the Chair's role					
2. Is available to directors outside meetings.					
3. Ensures timely distribution of meeting information.					
4. Is well-prepared for chairing meetings.					
5. Makes contact with other directors outside meetings, where necessary.					
6. Makes time available to participate in RVH functions.					

Comments:

1. What are the Chair's strengths?

1.
2.
3.

2. Please state three areas in which you think the chair could enhance performance?

1.
2.
3.

Thank you for taking the time to complete this survey.

RENFREW VICTORIA HOSPITAL

BOARD OF DIRECTORS

POLICY NO. 14

INVESTMENTS

1.0 PURPOSE

This investment objectives and policy statement has been prepared to provide a framework within which to manage the Renfrew Victoria Hospital's (RVH) general investment fund and the RVH's relationship with its Investment Manager(s) and/or Advisor(s).

The policy details the roles and responsibilities of all parties relevant to investment management and the specific investment guidelines and procedural requirements deemed essential to effecting adequate asset growth, income generation and cash flow to meet RVH's needs, while assuring the safekeeping of RVH's funds.

This Policy is intended to provide an investment framework for the general investment fund. The RVH Board of Directors may set up different funds at its discretion and amend this policy to include the management of additional specific purpose funds.

1.1 Common Investment Policy and Investment Manager

As the objectives of the investment policy of RVH are similar to that of RVH Foundation, both organizations have adopted this investment policy for the management and direction of investments. In addition to the investment policy, for the purposes of consistency, both RVH and RVH Foundation have and will continue to employ a common investment manager/advisor.

2.0 INVESTMENT MANAGEMENT OBJECTIVES – GENERAL INVESTMENT FUND

Investment objectives are as follows:

- To ensure the preservation and security of capital.
- To provide steady, dependable and predictable generation of investment income and capital gains to meet fund requirements of RVH.
- To achieve overall time-weighted compound portfolio net returns that outperform a benchmark portfolio (as outlined in the asset management section of this policy) by at least 0.5% or 50 basis points over the most recent three year period.
- To achieve a total time-weighted compound net rate of return that, on a moving four-year basis, exceeds the rate of the Consumer Price Index.

3.0 RESPONSIBILITY

- The Board of Directors has overall responsibility for the security and management of all corporate assets. The Board appoints representatives from among its members to ensure that the care, skill, diligence and judgement that a prudent investor would exercise in making investments are being executed, as per the Trustee Act or successor acts. The Board must

ensure that the Investment Portfolio complies with all applicable legal and regulatory requirements and constraints.

- The Finance and Property Committee of the Board provides advice to the Board of Directors on all aspects of RVH's investment policy, including:

  - Any aspects of the Investment Fund performance, Investment Manager(s)/Advisor(s) service delivery and compliance by the Investment Manager(s)/Advisor(s) with the Investment Policy,
  - Liquidity requirements of the Portfolio and the timing and use of cash inflows and outflows from the Investment Portfolio.
  - Recommendations resulting from the committee's annual review of RVH's Investment Policy.
  - Recommendations resulting from the committee's annual meeting/conference with the Investment Manager(s).
  - The selection, engagement or dismissal of any Investment Manager or Advisor.

- RVH will monitor all aspects of the performance of the Investment Manager(s) on a consistent and ongoing basis. This process is to include a review of:
  - The financial stability of the Manager
  - Any impact derived from the rate of turnover of investment management personnel
  - The consistency of its investment style
  - Its compliance with this Investment Policy
  - The appropriateness and acceptability of management fees and the fee structure
  - Record of service to RVH.

  When one or more of these areas become subject to serious concern, RVH shall request a special meeting with the Investment Manager to discuss the issue(s). Evaluation of the matter may result in corrective action, which could include the termination of the services of the Investment Manager.

- The **Investment Manager(s)/Advisor(s)** are responsible for the daily management of the Investment Portfolio. The overall responsibilities of the Investment Manager(s) are to:
  - Manage the assets of the fund, subject to the criteria presented in the current Investment Policy.
  - Provide quarterly reports addressing the following matters:
    - Portfolio performance over various appropriate time periods
    - Analysis of fund performance against appropriate current benchmarks as agreed and prescribed in this policy, and as revised from time to time
    - Asset listings in comparative detail allowing the full reconciliation to Corporate financial statements and records
    - A perspective on all relevant securities and financial markets analysis, and an outlook on forward expectations
    - A commentary on the appropriateness of RVH's investment strategy.
  - Meet/conference with RVH when requested, with an update review at least annually.
  - Inform RVH if at any time they are unable to comply with the Investment Policy.
  - Exercise all voting rights acquired through the Portfolio's investments.

3.1 Compliance Certificate

The portfolio manager will prepare and forward a compliance certificate to RVH following each quarter. The certificate will indicate whether the portfolio has been invested in compliance with the investment guidelines at each month-end during the quarter.

4.0 ASSET MANAGEMENT

4.1 Portfolio Composition and Asset Mix

The investment portfolio will be subject to the following guidelines:

- The market value of the individual asset classes should be maintained within minimum and maximum aggregated investment limits:

	Asset Mix Range		
Asset Classes	**Minimum**	**Maximum**	**Target**
Benchmark Mix			
Cash and cash equivalents*	2%	20%	10%
Total Equities	10%	25%	20%
Canadian	10%	25%	15%
U.S. (Canadian $)	0%	10%	3%
International (Canadian $)	0%	5%	2%
Long Term Fixed-Income Securities	50%	80%	70%

* Cash equivalents less than one-year maturity

- There will be no borrowing from any source to make investments and no lending of securities unless approval in writing is obtained from RVH.
- Unless specifically approved in writing by RVH, the portfolio will not invest in derivatives.
- Except for government bonds, not more than 10% of the total market value of the portfolio will be invested in the securities of any one issuer.

4.2 Eligible Investments

Equities

- Unless specifically approved in writing by RVH, equities (including common shares, rights, preferred shares, warrants and securities convertible into common shares) must be listed on a recognized stock exchange or traded through an organized facility from which market prices are readily available.
- No one security shall represent more than 10% of the market value of total equity.
- Investment in preferred shares will be rated at least PFD-2 (low) by Dominion Bond Rating Services on an individual basis.
- Investments will not be made in entities which could damage the role or standing of RVH within the community or which could be construed to be at odds with RVH's Mission Statement. Additional restrictions may be communicated to the Investment Manager by RVH if required.

Fixed Income

a) Short-term Investments (up to 364 days in term):

(i) Canadian Government Treasury Bills;

(ii) Short-term obligations (including Bankers' Acceptances or Commercial Paper) of Canadian corporation rated at least R1 (low) by Dominion Bond Rating Services.

b) Bonds and Debentures:
   (i) Bonds issued or guaranteed by Government of Canada;
   (ii) Bonds issued or guaranteed by the government of a Province rated at least A (low) by Dominion Bond Rating Services and/or A- by Canadian Bond Rating Services;
   (iii) Canadian corporate bonds and debentures rated at least A (low) by Dominion Bond Rating Services and/or A- by Canadian Bond Rating Services.

- Investment in fixed-income securities in accordance with (a) and (b) above will be in Canadian dollar denominated securities with the exception that the portfolio manager may elect to invest up to 10% of the market value of total fixed-income in U.S. dollar denominated bonds and debentures (i.e. "U.S. pay" securities).
- At least 60% of the fixed-income portfolio must be in bonds issued or guaranteed by the Government of Canada or the Provinces.

4.3 Benchmark Portfolio

RVH has established the following table, which outlines by Asset Class the Benchmark Return deemed appropriate, as a guideline to meet its investment objectives. These Benchmarks are returns that could have been earned by the passive management of a Benchmark Portfolio assuming quarterly re-balancing. These return benchmarks are the sum of the appropriate asset class market index returns multiplied by the proportion of the Benchmark Portfolio allocated to each asset class.

Asset Class	Benchmark Weighting	Index of Investment Return
Cash and cash equivalents	10%	91-Day Canada Treasury Bill
Canadian Equities	15%	S&P/TSX Composite Return Index
U.S. Equities	3%	S&P 500 Total Return Index
International	2%	Morgan Stanley EAFE (Canadian $)
Long Term Fixed-Income	70%	Scotia Capital Universe Index

5.0 TREATMENT OF "IN KIND" DONATIONS

When "in kind" donations of marketable securities are received by RVH, either in person or via transfer of ownership, the securities will be sold by RVH immediately on a best efforts basis and in accordance with the guidelines of the Canada Revenue Agency ("CRA") unless in the view of investment counsel it is prudent to retain the securities as part of the investment portfolio.

An official tax receipt will be issued for an amount equal to the closing price on the date the gift of securities is received in good delivery form into our account in accordance with the guidelines of the CRA.

All other "in kind" donations i.e. land; artwork etc will be used or liquidated at the discretion of RVH unless otherwise expressly stated by the donor.

6. CONFLICT IN INTEREST

These guidelines apply to all Board Directors, Investment Manager, and RVH staff:

- Any of these persons must disclose any direct or indirect association or material interest or

involvement in aspects related to his/her role with regard to the Portfolio investments that would result in any actual or perceived conflict of interest.

- Actual or potential conflicts of interest shall be disclosed whenever any of these persons become aware of the perceived conflict.
- Disclosure must be included in the minutes of the Board.
- As soon as the actual or perceived conflict is disclosed, an officer of RVH shall decide upon a suitable course of action to resolve the conflict.
- All investment activities must be conducted in accordance with the CFA Institute (Certified Financial Analysts) Code of Ethics and Standards of Professional Conduct.

7. AMENDMENT

This policy may be amended by the Board.

APPROVED BY: BOARD OF DIRECTORS
DATE: JUNE 20, 2013; REVIEWED MAY 2017

BOARD OF DIRECTORS

POLICY NO. 15

CAPITAL PROJECT VARIANCE

This policy applies to all major capital projects that receive Board approval.

The status of all ongoing and completed capital projects is reported to the Finance Committee or Board of Directors on a regular basis.

If a project cost is forecasted to be more than 15% or $100,000 greater than the approved budget, management will provide the Finance Committee and the Board of Directors with a variance explanation and request appropriate funding approval prior to the completion of the project.

All approved capital projects will continue to be reported regularly to the Finance Committee or Board of Directors until the project is completed.

AMENDMENT
This policy may be amended by the Board.

APPROVED BY: BOARD OF DIRECTORS
DATE: MAY 26, 2016; REVIEWED MAY 2017