Thunder Bay Regional Health Sciences Centre

Board of Directors
Open Meeting
Wednesday, June 6, 2018 – 5:00 pm Boardroom, Level 3, TBRHSC
980 Oliver Road, Thunder Bay
AGENDA

Vision: *Healthy Together*
Mission: *We will deliver a quality patient experience in an academic health care environment that is responsive to the needs of the population of Northwestern Ontario*
Values: *Patients ARE First (Accountability, Respect and Excellence)*

#	Time	Presenter	Item & Purpose	Expected Outcome				
				Recommendation /Decision/Action	Education	Discussion	Strategic Progress	Fiduciary Information
1.0	2	**CALL TO ORDER and WELCOME**						
2.0	10	**PATIENT STORY** – *Ian McRae*						
3.1	1	N. Doucette	Quorum (9 members total required, 7 being voting)					
3.2	1	N. Doucette	Conflict of Interest					
3.3	1	N. Doucette	Approval of the Agenda	X				
3.4	3	N. Doucette	Chair's Remarks*					X
4.0	**PRESENTATIONS/EDUCATION**							
4.1	10	C. Freitag M. Del Nin	2020 Strategic Plan Update (Q4)*				X	
5.0	**CONSENT AGENDA**							
5.1	-		Board of Directors Open Meeting Minutes – May 2, 2018*	X				X
5.2	-		Governance and Nominating Committee Meeting Minutes – May 16 2018*					X
5.3	-		Broader Public Sector Travel and Expense Report 2017-18 *					X
5.4	-		Broader Public Sector Accountability Attestation Certificate*					X
5.5	-		H-SAA Declaration of Compliance Attestation*					X
5.6	-		M-SAA Declaration of Compliance Attestation*					X
5.7	-		Executive Committee Terms of Reference*					X
5.8	-		Audit Committee Terms of Reference*					X
5.9	-		Fiscal Advisory Committee Terms of Reference*					X
6.0	**REPORTS**							
6.1	20	J. Bartkowiak	Report from the President and CEO* 6.1.1 Current Challenges: a. Patient Flow b. Funding uncertainty c. Outcome of Provincial election on healthcare d. Organizational restructuring update e. Accreditation Survey Preliminary Report	X				
6.2	20	Dr. Porter	Report from the Chief of Staff* 6.2.1 Current Challenges: a. Overcapacity b. Outbreaks and infection control					X

#	Time	Presenter	Item & Purpose	Expected Outcome				
				Recommendation /Decision/Action	Education	Discussion	Strategic Progress	Fiduciary Information
			c. Accreditation and physician engagement d. Deputy COS e. Hospitalist program f. Locum dependency g. Opioid order sets					
6.3	5	DM. Perry	Report from the Chief Nursing Executive*					X
6.4	5	Dr. Moody-Corbett	Report from the Northern Ontario School of Medicine*					X
6.5	5	Dr. Davenport	Report from the Professional Staff Association					X
6.6	5	G. Craig	Report from the Foundation*					X
7.0	**FIDUCIARY MATTERS**							
7.1	10	A. Jean (for G. Whitney)	Report from the Chair of the Patient Safety and Quality of Care Committee on: a. Overcapacity Management tactics update b. Quality Based Procedure Progress Report c. Integrated Quality Framework d. Other Committee Matters or Comments				X	 X X
7.2	10	G. Walsh	Report from the Chair of the Resource Planning Committee on: a. Personal Emergency Leave b. 2016 Operational Review update c. Sale of Former PAGH Land update d. Other Committee Matters or Comments					 X X X
7.3	5	D. Mannisto	Recommendation and report from the Governance and Nominating Committee: 7.3.1 By-Law Approval* 7.3.2 Terms of Reference update 7.3.3 Other Committee Matters or Comments	X				X
7.4	10	J. Bartkowiak	OHA's Engagement Visit (Discuss responses to provide)*			X		
8.0	**FOR INFORMATION**							
8.1	-		Board and Committee Work Plans*					X
8.2	-		Webcast Statistics*					X
8.3	-		Report from the Health Research Institute*					X
8.4	-		Report from the Volunteer Association*					X
8.5	-		Article – Through the Eyes of the Patient and Caregivers*					X
9.0	**BOARD MEMBER COMMENTS**							
10.0	**DATE OF NEXT MEETING** – October, 2018							
11.0	**ADJOURNMENT**							

Ethical Framework

The Hospital is committed to ensuring decisions and practices are ethically responsible and align with our Vision, Mission and Values. Leaders should consider decisions from an ethics perspective including their implications on patients, staff and the community.

The following questions should be considered for each decision:

1. Does the course of action put 'Patients First' by responding respectfully to the needs, values, and expectations of our patients, their families, and the communities?
2. Does the course of action demonstrate 'Accountability' by advancing a quality patient experience that is socially and fiscally accountable?
3. Does the course of action demonstrate 'Respect' by honouring the uniqueness of each individual and his/her culture?

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4. Does the course of action demonstrate 'Excellence' by fostering an environment of innovation and learning to provide a quality patient experience?

For more detailed questions to use on difficult decisions, please refer to the Hospital's Framework for Ethical Decision Making

BOARD OF DIRECTORS (Open)
June 6, 2018 – DRAFT

Agenda Item	Committee or Report	Motion or Recommendation	Approved or Accepted by:
3.3	Agenda – June 6, 2018	"That the Agenda be approved as circulated."	Moved by: Seconded by:
5.0	Consent Agenda	"That the Board of Directors: 5.1 Approves the Board of Directors Minutes of May 2, 2018; 5.2 Accepts the Minutes of the Governance and Nominating Committee of May 16, 2018; 5.3 Approves the Broader Public Sector Travel and Expense Report, for the period October 1, 2017 to March 31, 2018, as recommended by the Resource Planning Committee, 5.4 Approves the Broader Public Sector Accountability Act Attestation Certificate, for the period April 1, 2017 to March 31, 2018, in accordance with Section 15 of the Broader Public Sector Accountability Act, 2010, confirming that the Hospital attests to: i. the completion and accuracy of reports required of the Hospital pursuant to section 6 of the BPSAA on the use of consultants; ii. the Hospital's compliance with the prohibition in section 4 of the BPSAA on engaging lobbyist services using public funds; iii. the Hospital's compliance with any applicable expense claims directives issued under section 10 of the BPSAA by the Management Board of Cabinet; iv. the Hospital's compliance with any applicable perquisite directives issued under section 11.1 of the BPSAA by the Management Board of Cabinet; v. the Hospital's compliance with any applicable procurement and directives issued under section 12 of the BPSAA by the Management Board of Cabinet; as recommended by the Resource Planning Committee 5.5 Approves the Hospital Service Accountability Agreement Declaration of Compliance for the period of April 1, 2017 to March 31, 2018 confirming that the Hospital has complied with the following: i. the HSP has complied with the provisions of the Local Health System Integration Act, 2006 and the Broader Public Sector Accountability Act	Moved by: Seconded by:

Agenda Item	Committee or Report	Motion or Recommendation	Approved or Accepted by:
		(the "BPSAA") that apply to the HSP; ii. the HSP has complied with its obligations in respect of CritiCall that are set out in the Agreement; iii. every Report submitted by the HSP is complete, accurate in all respects and in full compliance with the terms of the Agreement; and; iv. the representations, warranties and covenants made by the Board on behalf of the HSP in the Agreement remain in full force and effect, as recommended by the Resource Planning Committee 5.6 Approves the Multi Sector Service Accountability Agreement Declaration of Compliance for the period of April 1, 2017 to March 31, 2018 confirming that the Hospital has complied with the following: i. Article 4.8 of the M-SAA concerning applicable procurement practices; ii. The Local Health System Integration Act, 2006; and iii. The Public Sector Compensation Restraint to Protect Services Act, 2010; iv. The following specific performance requirements as outlined in Schedule E4 of the 2014-2017 M-SAA: a. "Home First" Philosophy; b. Diversity Planning requirement; c. Behavioural Supports Ontario Action Plan; d. Emergency Preparedness Plans; e. E-Health requirement; f. Information Technology requirement; g. Health Services Blueprint — Community Engagement, as recommended by the Resource Planning Committee, 5.7, 5.8, 5.9 Approves the Terms of References of the Executive, Audit and Fiscal Advisory Committee, as recommended by the Governance and Nominating Committee, as presented."	
6.0	Reports and Discussion	"That the Board of Directors accepts reports dated June 6, 2018 from the: 6.1 President and CEO; 6.2 Chief of Staff; 6.3 Chief Nursing Executive;	Moved by: Seconded by:

Agenda Item	Committee or Report	Motion or Recommendation	Approved or Accepted by:
		6.4 Northern Ontario School of Medicine; 6.5 Professional Staff Association; 6.6 Foundation, as submitted."	
7.3.1	By-Law Approval	"That upon recommendation from the Governance and Nominating Committee and the Medical Advisory Committee, the Board of Directors approves the proposed changes to the Thunder Bay Regional Health Sciences Centre Corporate By-Law to be confirmed at the Annual Meeting of the Corporation on June 21, 2018, as presented."	Moved by: Seconded by:

Thunder Bay Regional Health Sciences Centre

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Board of Directors
Conseil d'administration

Report from Nadine Doucette
Chair, Board of Directors
June 6, 2018

I am elated by comments made by the team of surveyors from Accreditation Canada during their recent site visit. They specifically discussed the high level of engagement of the Board of Directors at our Hospital. Our Board is comprised of dedicated and involved volunteers who contribute not only at Board meetings, but also at various committees. Their passion, initiative and expertise serves our Hospital well, and has impressed the surveyors. I thank my fellow Board members for making the care of others a priority.

I am also grateful to those who choose to guide our Hospital's strategic progress as members of our 5 Partners in Health. This includes the Policy Makers, Health Care Managers, Health Care Providers and representatives of Academic Institutions and the communities we serve. This group participated in the development of our Strategic Plan 2020, and provides annual input on our progress. On June 6, the 5 Partners will gather again to learn about the status of our Strategic Plan implementation, and provide feedback to ensure our initiatives are on track and relevant. Thunder Bay Regional Health Sciences Centre belongs to the community it serves, and engaging the 5 Partners ensures the priorities of the community and the Hospital are aligned. I look forward to a productive session.

There is opportunity for all community members to hear about our Hospital's activities and achievements. On June 21, our Hospital and its research arm, the Thunder Bay Regional Health Research Institute, will host annual general meetings, including a keynote presentation by Lee Fairclough, Vice President, Quality Improvement at Health Quality Ontario. Lee will present "Building a Quality-Driven Culture", with a focus on provincial developments in this area, what steps can be taken to support transformation, and how Quality enhances patient experiences and outcomes.

Quality is critical to the provision of safe care. This keynote address is a particularly valuable opportunity for health care providers, administrators and Board members to hear from and engage with a Quality expert. I invite anyone interested to attend any or all of the following activities on June 21 in the Hospital's Auditorium.
3:00 - 3:30 pm: Hospital Annual General Meeting
3:45 - 5:15 pm: Keynote speaker Lee Fairclough
5:30 - 6:00 pm: Health Research Institute Annual General Meeting

The Annual General Meeting will be my final meeting as Chair of the Board of Directors. I cannot adequately express my appreciation to the many people who have provided support, encouragement, guidance and hard work during the course of my terms as a Board member and Chair. I am proud of all that we have accomplished together, and leave my role with every confidence that the Board of Directors will continue to serve the community by delivering on the Hospital's Vision; Healthy Together.

BRIEFING NOTE

Thunder Bay Regional Health Sciences Centre

TOPIC	Q4 Strategic Progress Report
PREPARED BY	Carolyn Freitag, Director, Strategy & Performance, Michael Del Nin, Director, Decision Support
REVIEWED BY DECISION SUPPORT (if required)	<Does this have financial impacts to the hospital's budget? Has a Decision Support Analyst been consulted on this briefing note?> YES ☒ NO ☐ N/A ☐ Strategic initiative cost captured within the operational budget process.
APPROVED BY	Jean Bartkowiak, President & CEO
CO-SPONSER (if required)	<Does this impact another E/VP's portfolio/program? Have they been consulted on this briefing note?>
PREPARED FOR:	President &CEO ☒ Board of Directors ☐ Other:
DATE PREPARED	May 30, 2018

Our Hospital is committed to ensuring decisions and practices are ethically responsible and align with our Vision, Mission, and Values. Leaders should consider decisions from an ethics perspective including their implications on patients, staff and the community.

The reader considers the following questions to ensure each decision are ethically responsible by indicating with a √:

☐ 1. We put '**Patients First'** by responding respectfully to needs, values, & expectations of our patients, families, and communities?
☐ 2. We demonstrate '**Accountability**' by advancing a quality patient experience that is socially and fiscally responsible?
☐ 3. We demonstrate '**Respect**' by honouring the uniqueness of each individual and his or her culture?
☐ 4. Does the course of action demonstrate '**Excellence**' by fostering an environment of innovation and learning to advance a quality patient experience?

For more detailed questions to use on difficult decisions, please refer to the Hospital's Framework for Ethical Decision Making on the iNtranet under Quality and Risk Management>Ethics.

PURPOSE/ISSUE(S)

Highlight the 2017-18 Strategic Plan Q4 overall progress, tactics to achieve targets, strategic performance indicator results and associated improvement action plans.

BACKGROUND

The Strategic Quarterly report is formatted to provide a more comprehensive description of strategic tactics in each strategic direction to address the **achievement of the targets, the related strategic indicators, and any new tactics planned where targets fall short**. The Balanced Scorecard (BSC) attached provides a summary of the strategic indicators and trending.

ANALYSIS/CURRENT STATUS

Refer to the attached Q4 Strategic Progress Report and BSC.

RECOMMENDATION

None required for Quarterly Report.

NEXT STEPS

Present the Q4 Strategic Progress Report and BSC to 5 Partners on June 6, 2018, then the staff and the Annual General Meeting.

STAKEHOLDER REACTION

None expected.

COMMUNICATIONS

Success stories and profiles are communicated to staff, physicians, volunteers, patient and family advisors on unit posters, intranet and public bulletin board in the Hospital and to the community in Chronicle Journal articles.

All strategic project teams develop communication plans to ensure the progress, challenges and remedial actions are communicated in a timely manner to the appropriate audience/stakeholders.

FINANCIAL IMPACTS

Strategic initiatives that require investment are submitted to the operational budget process.

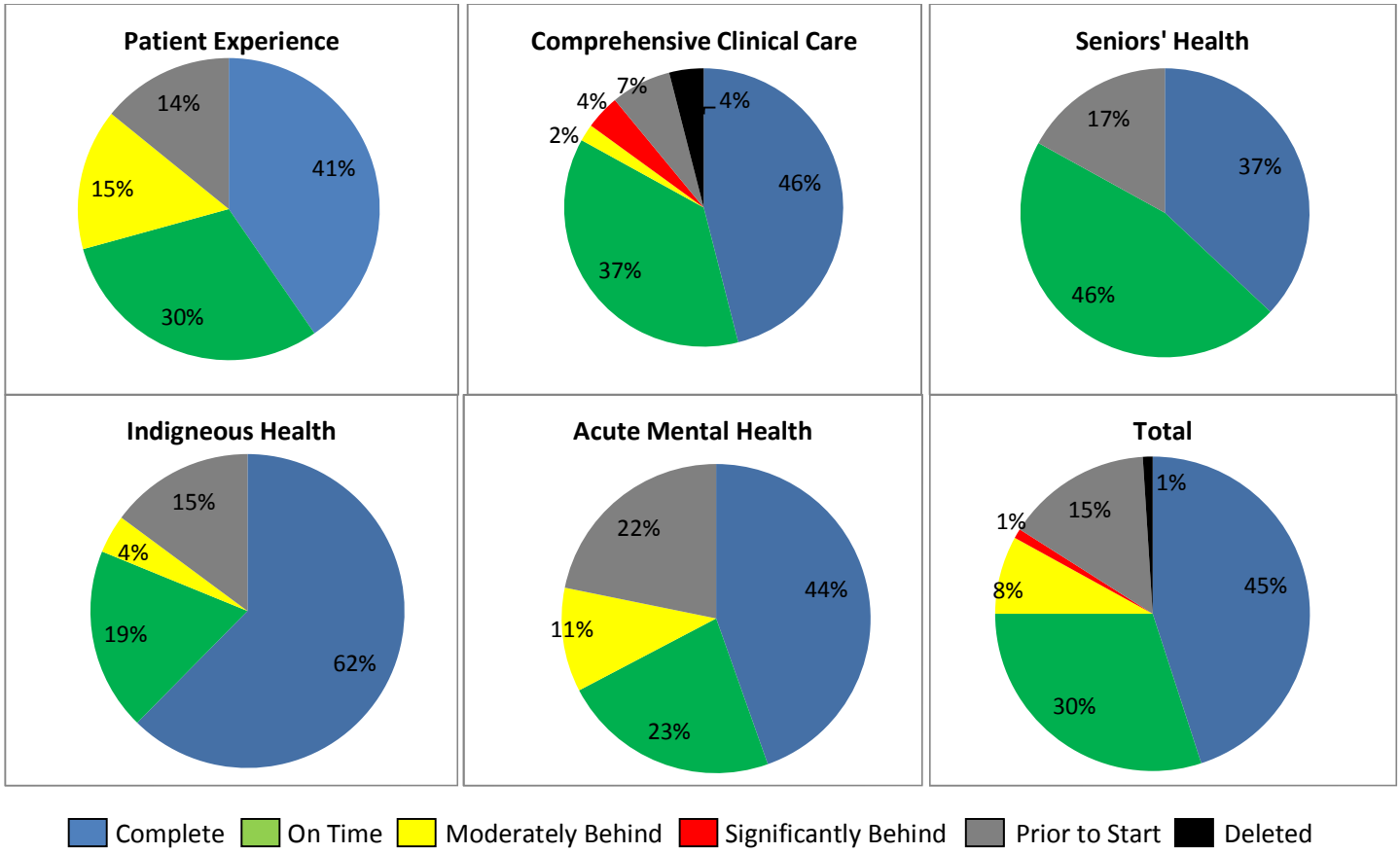
APPENDIX SECTION

2017-2018 Q4 Strategic Progress Report;

2017-2018 Q4 Balanced Scorecard - Strategic Indicators.

2017/18 Q4 Strategic Progress Report

Strategic Progress Summary



Strategic Direction 1: Patient Experience

Performance Measure	16-17 YTD Actual	Annual Target	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Actual
Rate of hand hygiene compliance before initial patient/environment contact	86.91%	93%	92.15%	82.40%	92.85%	83.96%
30-day in-hospital deaths following major surgery (risk-adjusted)	1.90	1.67	1.4	2.0	***2.9***	-
Number of critical events	6	0	0	0	1	1
Patient Satisfaction: All Dimensions - Inpatient	60.3%	61.8%	60.6%	67.2%	***69.3%***	***67.1%***
Learner Satisfaction	85.2%	87.0%	88.1%	86.7%	89.2%	81.7%

Total Researchers	316	301	276	311	325	364
Paid sick hours as a percentage of worked hours	3.53%	3.48%	4.49%	4.27%	4.21%	3.37%
Staff satisfaction	-	-	-	-	-	-
Physician satisfaction	-	-	-	-	-	-

Goal 1 - Develop a framework to deliver high quality care:

The Integrated Quality Framework development consists of three phases: the quality framework definition; the integrated quality committee structure; and the quality improvement model, resources and education. The quality framework definition was approved April 2017. Senior Leadership endorsed the integrated quality committee structure in March. The Quality Committee of the Board was consulted in May and Medical Advisory (MAC) to follow in June.

The Integrated Quality Framework committee structure promotes coordination and integration of quality improvement and clearly outlines accountabilities for quality improvement. The committee structure introduces a Quality Improvement (QI) committee that provides oversight for investigation and prioritization of quality improvement initiatives and ensures standardized methods are applied to improvement activities. This committee responds to and informs the Senior Leadership, Quality of Care Committee and EVP Portfolio Councils. The Senior Leadership reports to and responds to the Board's direction while providing guidance to direct reports. The EVP Portfolios identify corporate quality challenges and refers to the QI committee where a program/service cannot manage the issue, and in turn, the EVP Portfolio and related councils are responsible to support and encourage quality activity within programs and services. The implementation is expected in the fall.

The third phase in progress is to define the QI model, resources and required education to develop internal expertise and capacity to accelerate quality improvement process. Developing an Integrated Quality Framework is key to create a culture of quality and improve quality indicators not yet meeting the target.

The second wave of Quality Based Procedures (QBP) Patient Order Sets launched May 1st includes: Knee Arthroscopy; Orthopaedic Discharge; Prophylactic Breast Mastectomy; Lower Extremity Occlusive Disorder; and Stroke. In quarter three, 67% of patients had a digital order set completed, with 45% provider compliance.

Hand Hygiene compliance before initial patient/environment contact is currently performing at 83.96% for the first 2 months of Q4, which is below the 2018-19 target of 93.0%.

The following recommendations from the Public Health Organization (PHO) were adopted:

1. Processes for patient hand hygiene education including; increased signage in public and inpatient bathrooms, hand hygiene instructions included in Healthy Together patient directory and inclusion of content on public area screens.
2. Engage patients in using alcohol based hand rub prior to leaving room and sanitize hands before eating. Options include; hand sani-wipe provided on every meal tray and hand hygiene reminder printed on bottom of patient menus.

Goal 2 - Enhance understanding and continue to grow and embed our PFCC philosophy:

Presentations to all of the physician section meetings regarding patient experience results are complete. A presentation to MAC to gain input on an engagement strategy that links the physicians to the patient experience took place in May.

Patient Satisfaction scores continue to improve. A combination of priorities including Patient Oriented Discharge Summaries (PODS), implementation of patient experience action plans, and phone surveys have all contributed to this success. Staff should be commended for their engagement and focus on ensuring that patients have an optimal hospital experience, even when job demands and overcapacity are at its peak.

Goal 4 - Invest in staff development, engagement, and wellness:

Objective 4.1 - Develop and implement supports and structures for staff to participate in education that will allow them to excel:

The 2020 Strategic Plan includes objectives to evaluate and increase the knowledge and competency of staff in the areas of acute mental health, senior's health and patient experience overall. In addition, the plan aims to improve the sensitivity of care for acute mental health, the Indigenous population and seniors. The "Sensitivity" objective, now falling within the RESPECT Campaign, is currently rolling out education.

The education plan and training for the facilitator program is complete. Education occurred for managers and directors in the Leadership Enhancement and Performance sessions (LEAP) and Community Oncology Professional Education workshop (COPE). Future sessions are booked for Patient and Family-Centred Care, corporate services, mental health and the Operating Room.

The VP of People, Culture and Strategy participated in a retreat led by the Chief Nurse Executive (CNE) and Practice Leaders on March 5th. Its purpose was to identify the priorities for nursing and health professions 'clinical tactic' strategies. A three year practice plan resulted and the identified clinical tactics are the focus in the upcoming clinical leadership development. The plan will be validated following the organization restructure, phase two.

A formal Accredited Leadership 'Coach Training' Program (The Business Coaching Advantage™ Program) received Senior Leadership approval. The members of the LIFT (Leaders Influencing the Future, Today) committee are identified as the first group to take part in this five month intensive program beginning this summer. These leaders will gain expertise in the coaching approach to leadership and the coaching mindset and skills required to develop other leaders. This will effectively accelerate and spread leadership enhancement across the Hospital. A subsequent Coach Training Program will invite all leaders to participate in an application process for selection of the next group of Coaches in 2019. Developing effective leaders is important to improving staff job satisfaction and preparing our organization for the future.

Objective 4.3 - Increase organizational commitment to wellness:

The Healthy Work Environment model and three year action plan to enhance staff wellness is complete. The model supports a coordinated strategy to improve the health and wellness of staff. Activities in year one will focus on enhancements within current physical environment and budget. While activities in subsequent years require some investments, business plans will be prepared within the normal budget planning cycle.

Sick time decreased in Q4 compared to the prior year rate. The Nursing Resource Team and General Staffing Review Steering Committee and more recently the Q3 Financial review identify sick time as a priority issue. Our goal is to provide the resources and an environment that enhances our staff's physical

and psychological wellness. An action plan was developed and staff engaged in a Design Event to analyze the current Attendance Support Program.

Moving forward in Q1, the action plan includes:

- Engage members of the sick time working group to assist in root cause analysis and identification of improvements;
- Engage front line staff on what would improve culture and morale;
- Segment sick time use by short term episodic versus long term, analyze results and determine whether improvements are possible;
- Investigate additional physician and staff resources for Occupational Health to assess sick time and support staff and assist managers with their attendance management efforts.

The Workplace Violence Prevention will be integrated into the 2020 strategic plan to demonstrate the Hospital's commitment to adopt best practices to prevent violence in the workplace. Therefore, Goal 4: *Invest in staff engagement, development and wellness* now includes a new objective (4.5) to address this item. The objective aims to "Increase staff safety in the work environment'. The related actions include, but not limited to:

- Strengthen leadership and worker commitment to workplace violence prevention;
- Increase the spread of workplace violence prevention staff training;
- Develop a sustainability plan for the Acting Out Behaviour Intervention pilot study; and
- Improve staff awareness to create a safety culture.

Goal 5 - Use information technology to advance the patient experience:

The Northwest Health Alliance (NWHA) completed the draft business plan for an 'Advanced Clinical System' that is under review by the Senior Director of Informatics. A NWHA hosted a workshop in March, which focused on the fundamental elements of the large scale initiative to adopt 'Advanced Clinical System': physician engagement and funding sources. An estimated $30 million investment for technology upgrade and major enhancement to safe and quality practice is required. Over the next months the project team will make a decision regarding readiness and investment in a new Health Information System (HIS) based on the Healthtec recommendations and NWHA business plan.

Strategic Direction 2: Comprehensive Clinical Care

Performance Measure	16-17 YTD Actual	Annual Target	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Actual
Emergency Department length of stay (90th percentile in hours)	37.3	31.0	39.4	39.5	44.2	47.9

Goal 1- Adopt the Ontario Chronic Disease Prevention and Management framework:

The Chronic Disease Prevention and Management (CDPM) Framework was designed by the Ministry of Health and Long-Term Care as an evidence-based, population-based, and client centered approach. It supports health care system changes from one that is designed for episodic, acute illness to one that will support the prevention and management of chronic disease. Over the past two years, the group identified ongoing organizational initiatives that meet the requirements for success in each of the 8 elements of the

CDPM Framework. The work group is satisfied the Hospital designs care to support prevention and management of chronic diseases in the 8 elements as follows:

1. **Health Care Organizations:** The CDPM was formed to oversee, provide expert advice and monitor applicable indicators to ensure successful implementation. Ongoing monitoring and accountability of the CDPM Framework will be integrated into the Cardiovascular, Stroke & Medicine, Program portfolio;
2. **Delivery System Design:** Development and implementation of a patient-centric Inter professional Collaborative Care model. The Paediatric Team redesigned the daily patient rounds into inter professional collaborative rounds in Q2 and Adult Mental Health redesigned the same, in Q4. The care model has several benefits, the most important is the patient and family centeredness and care team communication;
3. **Provider Decision Supports:** QBP Patient Order Sets implementation organization-wide for patient diagnoses related to CHF, COPD and Community Acquired Pneumonia. These order sets ensure patients receive evidence-based, standardized and timely care;
4. **Information Systems:** A business case was developed for a patient portal and a Meditech upgrade is in the planning stages;
5. **Personal Skills and Self-Management Supports:** Standardized Patient Oriented Discharge Summaries (PODS) is an initiative within the Quality Improvement Plan. A number of PODS related to medical diagnosis are implemented. PODS ensure patients receive enough information on discharge, with recommendations on how to self-manage their disease;
6. **Healthy Public Policies:** Structures and processes exist including the Smoke Free and Eating Healthy Steering Committees which focus on respective, policy development to provide optimal supports;
7. **Supportive Environments:** The Healthy Workplace Model focuses on Physical Work Environment, Psychosocial Work Environment and Personal Health Resources. Several initiatives under each area were implemented based on feedback from staff. The Healthy Workplace model contributes to improved staff satisfaction and decreased sick time;
8. **Community Action:** Prevention & Screening Services collaborated with Fort Hope to increase cancer screening capacity and sustainability.

The sustainability plan is expected to be complete in Q2.

Goal 2 - Deliver comprehensive cardiovascular care in accordance with the Ministry of Health:

The second vascular surgeon, Dr. R. Osman, started at the Hospital in January. We eagerly await our third vascular surgeon, Dr. Matt Ingves, who is set to start this summer. A full complement of three vascular surgeons allows the Hospital to provide 24/7 emergency services and will also increase surgical case capacity, reducing wait times. This will bring the vascular program to maturity.

Dr. Barry Rubin, the TB UHN-PMCC Program Medical Director, presented the first Vascular Quality report to the Hospital Board in February. Monitoring, comparing, and reporting data from both the UHN and TBRHSC programs is a foundational element of the 'One Program Two Sites' model for the joint Cardiovascular Surgery Program to ensure the safety and quality of care are similar at both sites.

The ministry informed TBRHSC that our 2018-19 cardiovascular operational funding request was received and their response is pending.

Goal 3 - Enhance access to clinical services supported by patient flow efficiencies:

The Emergency Department and 1A In-Patient unit are trialing a new electronic transfer form. The form is intended to improve the timeliness and accuracy of patient information in nurse handover of care. All units will adopt the form by July.

A quality improvement Design Event was held with the physiotherapy & occupational therapy staff to improve issues related to interprofessional team collaboration and communication. Solutions were

developed including: daily team meetings to prioritize patients (based on best practice guidelines) and level workloads between staff; education materials for nurses and physicians to access physiotherapy & occupational therapy patient notes; a rehabilitation 'tab' in the Electronic Medical Records notes to help the team members access the notes easier; a summary report to communicate key messages to nursing. The changes are expected to be implemented in Q1, 2018/19.

Average Length of Stay excluding Alternative Level of Care for the first two months of Q4 is 5.47 days, which is above the target of 5.3 days for the 2017/18 fiscal year. In order to improve the negative results on length of stay, new tactics are planned that include:

1. Senior and operational leaders were tasked to complete action plans by May 2nd with priorities including:
    a. Ensure earlier placement on digital order sets for admitted patients in the emergency department;
    b. Distribute individual physician length of stay results vs the Expected Length of Stay;
    c. Ensure the electronic medical record can accommodate valid admitting diagnosis and Expected Length of Stay;
    d. Provide real time occupancy statistics;
    e. Implement discharge by 11am.
2. In March, a team from the Hospital attended the Ontario Hospital Association Conference 'Urgency in Overcapacity: Patient Flow Optimization', in Toronto. Key tactics included: full capacity protocol, 'smoothing' elective surgery demand, functioning as a 7 day a week operation and discharge before noon. Senior Leadership charged a Patient Flow sub-work group to identify the most relevant 'best practice' tactic for the Hospital by June 12th.
3. Although the Administrative Leadership for Patient Flow is in transition, the temporary Director collaborative with the medical leadership to manage the day to day overcapacity challenges. The focus is on a small group of diagnosis (CHF, COPD, Pneumonia) with longer stays where utilization coordinators monitor closely and participate in an escalation process to improve the gap between ALOS and ELOS. A Nurse Practitioner was recently hired to support the Hospitalist discharging patients.

Goal 4 - Develop formal partnerships to deliver comprehensive clinical services that support care in the appropriate location:

A number of value added partnerships are under development and/or maturing. The Regional Orthopeadic Program is established and has begun to explore with Neurosurgeons the integration of non-instrumental spinal surgery. The goal is to provide consistent service across the four dedicated regional site hospitals.

The Northern Supply Chain signed an agreement with the Ontario Association of Children's Aid Society (OACAS) inclusive of 37 agencies constituting a 143 million dollar annual contract spend. This expansion is directly related to the advocacy from a healthcare expert panel and the Ministry of Government and Consumer Services for Hospitals to play a larger role in shared services to maximize the benefit of public tax dollars. The benefits specific to the Hospital, include the creation of four full time jobs and demonstration of our commitment to the clustering concept and provincial collaboration between health and social services. The Hospital shared services agreements focus on medical surgical goods and capital to drive value based procurement.

The Hospital established a Strategic Alliance Agreement with the Nipigon District Memorial Hospital (NDMH). The new CEO is invited to the Senior Leadership Council, as a result of the agreement. The alliance between the two hospitals enhances the regional approach to health care and improves both effectiveness and efficiency in administrative operations. . As part of the agreement, the Hospital will provide IT/IS, human resources and finance support to NDMH.

The Emergency Department leadership engaged the Northwest Community Health Center (NWHC), St. Joseph's Care Group's Rapid Access Addiction Medicine (RAAM) clinic to care patients with addictions requiring long-term intravenous antibiotic therapy via peripheral intravenous central catheters (PICC) in the community. This initiative should ensure patient safety first and provide care by the right provider in the right place.

Emergency Department admitted length of stay (90%) for patients is 47.9 hours in the emergency department waiting for an inpatient bed, which is well above the target of 29.7 hours.

New tactics presented at the Ontario Hospital Association 'Urgency in Overcapacity' Conference to manage capacity will reframe and focus internal quality improvements. This coupled with additional tactics to reduce Alternative Level of Care and improve infection control practices is expected to improve the wait times in the Emergency over the next 6 months.

Strategic Direction 3: Seniors' Health

Performance Measure	16-17 YTD Actual	Annual Target	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Actual
Pressure Ulcer Incidence	3.70%	7.00%	-	2.8%	-	3.40%

Goal 2 - Adopt the Ontario Senior Friendly Hospital Framework:

Objective 2.1 - Deliver care designed from evidence and best practice for seniors (processes of care):

The MAC approved a medical directive for urinary incontinence developed to allow nurses to remove Foley catheters when it is longer medically required. This practice will improve timelessness of patient care. Education is scheduled on the in-patient units 2A and 2B in Q1.

Objective 2.3 - Deliver ethical care that protects the autonomy, choice, and diversity of senior patients (ethics in clinical care and research):

The Research Ethics Board (REB) conducted a review to determine whether seniors participating in research are sufficiently protected. It was found the Hospital is compliant with the national standards and upholds the principles, respect for persons, concern for welfare and justice. To further protect seniors participating in research, the Hospital's REB recommends:

1. Develop a guideline to recruit, consent, and include or exclude seniors in research;
2. Develop strategies for research clinicians to define and assess vulnerable seniors' to participate in research.
3. The Hospital's Research Ethics Office provides tools to prompt researchers to explain why seniors are excluded (if they are), and to prompt REB members to assess that the identification of a seniors as vulnerable and the exclusion or inclusion of seniors is ethically appropriate.

A literature review of best practices for seniors' Advanced Care Planning was completed and reviewed by the Ethics Committee in consultation with Patient and Family Advisors. The recommendations developed will ensure patients' values and wishes are respected in the formulation of their goals and care plans. Implementation is expected in 2018/19.

Strategic Direction 4: Indigenous Health

Performance Measure	16-17 YTD Actual	Annual Target	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Actual
Acute hospital admissions per 1,000 population for patients from Indigenous communities	249	-	266	273	270	-

Our focus on Indigenous Health has demonstrated the need for additional resources to address disparities in health status between Indigenous and non-Indigenous people in our region. The process to create and fill a permanent Senior Director, Indigenous Collaboration was initiated in Q4. Reporting to the President and CEO, this person will be responsible for forging and nurturing relationships and advising the Senior Leadership Council on strategies.

The Indigenous Health & Reconciliation Steering Committee (IHRSC) met on March 16 and finalized the Terms of Reference. The Committee addresses challenges with Indigenous Health disparities and barriers to equitable access to service for Indigenous patients at the Hospital. The IHRSC focuses on systemic and service advances through partnership and advocacy for funding. Examples of the steering committee activity include helping to prioritize Indigenous Health research priorities, facilitate partnerships, and consult on policies.

Indicators and targets are currently being investigated.

Strategic Direction 5: Acute Mental Health

Performance Measure	16-17 YTD Actual	Annual Target	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Actual
Psychiatrist full-time equivalent staffing as percentage of required full-time equivalent complement	55.70%	83.3%	58.3%	45.0%	41.7%	50.0%

Goal 2 - Enhance the delivery of mental health care to all patients at TBRHSC, outside of mental health services:

Objective 2.2 - Increase access to specialized and appropriate mental health services on all in-patient units:

The Consultation Liaison Service (CLS) provides psychiatric consult for off-unit mental health patients to ensure any mental health concerns are appropriately monitored. Dr. Hempe started the CLS Pilot on 1A in December and provided consultation to 64 patients, of which 14 were transferred to the Adult Mental Health Program for additional Inter professional team support.

Objective 2.5 - Expand Transitional Discharge Model (TDM) to include Child and Adolescent Mental Health Unit (CAMHU) patients and off-service mental health patients:

A new discharge sheet and checklist outlining requirements for Adolescent Psychiatric patient discharges from the paediatrics unit was implemented. This resource will ensure off-service mental health patients receive the appropriate supports on discharge.

Goal 4 - Enhance the delivery of acute mental health care within mental health:

Negotiations regarding allocation of psychiatrists at the Hospital are in the final stages with St. Joseph's Care Group. One of three newly recruited psychiatrists began in Adult Mental Health on April 16th.

The current 50.0% staffing translates to 3.0 FTE out of the required 6.0 FTE psychiatrists. Recruitment efforts are expected to show improvements in Q1.

Balanced Scorecard
Strategic Indicators
Report for 17-18 Q4
Updated 2018-05-30

				2017-18 Fiscal								
2020 alignment	**Domain**	**Indicators**	**Ind Type**	**Q1 Actual**	**Q2 Actual**	**Q3 Actual**	**Q4 Actual**	**Annual Target**	**YTD Target**	**YTD Actual**	**YTD Variance**	**Trending (last 6 or available quarters)**
Patient Experience	Quality & safety	Rate of hand hygiene compliance before initial patient/environment contact	Strat	92.15%	82.40%	92.85%	83.96%	93.00%	93.00%	87.39%	(5.61%)	
Patient Experience	Quality & safety	30-day in-hospital deaths following major surgery (risk-adjusted)	Strat	1.40	2.00	*2.90*		1.67	1.67	2.10	(0.43)	
Patient Experience	Quality & safety	Number of critical events	Strat	0	0	1	1	0	0	2	(2)	
Seniors' Health	Quality & safety	Pressure ulcer incidence	Strat		2.80%		3.40%	6.00%	6.00%	3.10%	2.90%	
Comprehensive Clinical Care	Quality & safety	90th Percentile ER length of stay (hours) for admitted patients	Strat	39.4	39.5	44.2	47.9	31.0	31.0	42.8	(11.8)	
Indigenous Health	Quality & safety	Acute hospital admissions per 1,000 population for patients from Indigenous communities	Strat	266	273	270				270		
Acute Mental Health	Quality & safety	Psychiatrist full-time equivalent staffing as percentage of required full-time equivalent complement	Strat	58.3%	45.0%	41.7%	50.0%	83.3%	83.3%	45.8%	(37.6%)	
Patient Experience	Customer	Patient satisfaction: All dimensions - Inpatients	Strat	60.6%	67.2%	*69.3%*	*67.1%*	61.8%	61.8%	66.2%	4.4%	
Patient Experience	Academics	Total researcher staff (CAHO definition)	Strat	276	311	325	364	301	301	364	63	
Patient Experience	Academics	Learner satisfaction	Strat	88.1%	86.7%	89.2%	81.7%	87.0%	87.00%	86.4%	(0.6%)	
Patient Experience	Financial	Paid sick hours as a percentage of worked hours	Strat	4.39%	4.27%	4.21%	3.37%	3.48%	3.48%	4.08%	(0.60%)	

At or better than target
Slightly (less than 5%) worse than target
Significantly (5% or more) worse than target
Data not expected for reporting period or too few results to be meaningful
Indicator has been discontinued and replaced
Blue text — Incomplete period or result not yet finalized

Thunder Bay Regional Health Sciences Centre

Board of Directors - *Open*

Wednesday, May 2, 2018

Boardroom – 5:00 p.m.

Action

***Present*:**

Gary Whitney (*Acting Chair*)	Dr. Eric Davenport*	Joy Wakefield
Jean Bartkowiak*	Matt Simeoni	Anita Jean
Dr. Gordon Porter*	Eric Zakrewski	Gordon Wickham
Dawna Maria Perry*	Patricia Lang	Micheal Hardy
Dick Mannisto	Dr. Penny Moody-Corbett *(tcon)*	
Grant Walsh		

By Invitation – Senior Leadership:

Dr. Rhonda Crocker Ellacott	Dr. Rami Rudnick	Peter Myllymaa
Kelly Meservia-Collins *(Dr. Kennedy)*	Glenn Craig	Amanda Björn

By Invitation:

Jessica Nehrebecky, *Rec. Sec.*	Kendra Walt	Tracey Hill

Regrets Board of Directors:

John Friday	Nadine Doucette

Regrets Senior Leadership:

Dr. Stewart Kennedy

1.0 CALL TO ORDER – The Chair called the meeting to order at 5:00 p.m.

The Chair welcomed Board members, the Senior Leadership Team, guests, and the webcast audience. As this was Dr. Rhonda Crocker Ellacott's last Board meeting before she begins her new role at the North West Local Health Integration (LHIN), she was thanked for her years of service at the Hospital.

2.0 PATIENT STORY

Dr. Gordon Porter, Chief of Staff, shared a patient story.

3.1 Quorum – Quorum was attained.

3.2 Conflict of Interest - None.

3.3 Approval of the Agenda

Moved by:	*Patricia Lang*	***Motion***
Seconded by:	*Anita Jean*	

"That the Agenda be approved, as presented."

CARRIED

3.4 Chair's Remarks – for information

3.4.1 CEO and COS Performance Assessment Process

The President & CEO and the EVP, People, Culture and Strategy, have revised the President & CEO performance assessment process and have provided the Governance and Nominating Committee with a long and short version. The Governance and Nominating Committee have recommended pursuing the long version of the assessment, which is essentially a 360° review. The assessment for the Chief of Staff will also be reviewed in the near future.

4.0 PRESENTATIONS

4.1 Respect Campaign

Ms. Kelly Meservia-Collins, Director, Academics and Interprofessional Education, Ms. Kendra Walt, Interprofessional Educator, and Ms. Tracey Hill, Interprofessional Educator provided an overview of the corporate Respect Campaign project.

Some of the goals within the 2020 Strategic Plan were aimed to develop sensitivity training for staff. One of the methods within the learning plan is to offer simulations, which provide hand-on training. Examples of measures that are in place to assess if the exercises are successful are through patient, employee and professional staff satisfaction surveys, and individual evaluations. In addition, the Hospital is involved in research projects in partnership with the Northern Ontario School of Medicine (NOSM) on this topic as it relates to resident satisfaction.

There are currently 25 trained Respect facilitators, who act as champions. Several groups in the Hospital have participated in the simulation training. The Senior Leadership Council is planning on participating in a full day session in the Fall.

Members of the Board endorsed this project with enthusiasm and expressed interest in participating in a team activity. Various training options are available, therefore the Governance and Nominating Committee will review the options and recommend the best ***Action***

course forward for the Board.

5.0 CONSENT AGENDA

Motion

Moved by: ***Eric Zakrewski***
Seconded by: ***Gordon Wickham***

"That the Board of Directors:
5.1 Approves the Board of Directors Minutes of April 4, 2018;
5.2 Accepts the Minutes of the Patient Safety and Quality of Committee meeting of April 11, 2018;
5.3. Accepts the Q4 2017-2018 Wages and Source Deduction Attestation, as recommended by the Resource Planning Committee,
5.4 Accepts the Minutes of the Fiscal Advisory Committee of April 9, 2018;
5.5 Accepts the Minuets of the Governance and Nominating Committee of April 18, 2018,

as presented."

CARRIED

A suggestion was made to have random audits on the attestations by a third party; the Audit Committee was tasked to investigate this practice further. ***Action***

Examples on which results have regressed with respect to the statement made under item 4.2 in the Fiscal Advisory Committee minutes were requested. The EVP, Corporate Services and Operations will provide this information at an upcoming Board meeting. ***Action***

6.0 REPORTS AND DISCUSSION

6.1 Report from the President & CEO

The President & CEO reported the following current challenges:

a. Patient Flow and Occupancy: The Hospital continues to experience a high number of repatriation cases, in which the President & CEO diligently calls upon his counterparts in the region for their assistance. The state of surge could possibly burn out the staff, fortunately sick time has decreased in Q4 of 2017-18, as compared to Q4 in 2016-17. Today, there were over 100 more patients than the allocated bed count.

b. CVS Project Progress: The capital project score for the Cardiovascular Surgery (CVS) Program is now confirmed. The Ministry of Health and Long-Term Care's Capital Branch

provided confirmation that upgrades to the Diagnostic Imaging angiography suite will not be considered in the CVS project. Instead, Diagnostic Imaging will submit a separate funding request.

c. Leadership Restructuring: After further engagement, the organizational structure has been revised. This is part one of a three phase restructuring approach.

6.2 Report from the Chief of Staff

The Chief of Staff (COS) was asked to comment on the impact of incomplete records; he clarified that it could have an impact on quality and safety, however it rarely does. The Medical Advisory Committee (MAC) has developed a process to deal with this.

The Length of Stay (LOS) has become a corporate strategic initiative and the MAC is focusing on two clinical programs which have the most impact: medical program, specifically, the hospitalists and the renal program.

6.3 Report from the Chief Nursing Executive

The Nursing Week activities will be held during the week of May 7, 2018. Board members are invited to participate in the activities to recognize the engagement of nurses.

6.4 Report from the Northern Ontario School of Medicine – For information.

6.5 Report from the Professional Staff Association (PSA) - None.

6.6 Report from the Foundation – For information.

Over $80K in grants have been made to the Hospitals in the region. Nearly $5M has been raised in support of the CVS Campaign so far.

Motion

Moved by: ***Dick Mannisto***
Seconded by: ***Grant Walsh***

"That the Board of Directors accepts reports dated May 2, 2018 from the:
6.1 President and CEO;
6.2 Chief of Staff;
6.4 Chief Nursing Executive;
6.5 Northern Ontario School of Medicine;
6.6 Professional Staff Association;
6.7 Foundation,

as submitted."

CARRIED

7.0 COMMITTEE MATTERS

7.1 Report from the Chair of the Patient Safety and Quality of Care Committee

The Chair of the Committee noted that a presentation was provided by the Infection Prevention and Control Department at their last meeting; he stated that seven units are in Vancomycin-Resistant Enterococci (VRE) outbreak. The Hospital invited the Public Health Ontario Infection Control Resource Team (ICRT) on March 28, 2018 to support our efforts to tackle the outbreaks. A fulsome report with recommendations is expected shortly. A preliminary report was submitted after the visit, and the Hospital has begun implementing some of its recommendations.

7.2 Report from the Chair of the Resource Planning Committee

The Chair of the Resource Planning Committee reported the following:

- The Harassment policy has now been approved by the President & CEO, after thorough vetting by the Senior Leadership, Leadership Staff, Union Leaders, the Joint Occupational and Safety Committee and legal counsel;
- The Committee closely monitors overtime with Leaders reviewing the functioning of the Nursing Resource Team (NRT);
- An update on the evolution of the Northern Supply Chain (NSC) was provided; it was suggested to have a presentation made to the entire Board to further explain the role the NSC plays in the province. ***Action***

7.3 Report from the Chair of the Fiscal Advisory Committee

The MOHLC announced an $800M for hospitals in the province for the 2018-19 fiscal year. It is anticipated the Hospital's share will be approximately $5-6M. Although this is good news, it is still far from the expected base funding allocation recommended following the 2016 Operational Review. The Hospital will resume its advocacy campaign with the North West Local Health Integration Network (NW LHIN) and the MOHLTC to address the chronic underfunding.

7.4 Report from the Chair of the Governance and Nominating Committee

The Chair of the Governance and Nominating Committee reported on the following:

a. Board agenda restructuring: Committee members discussed how to shift from an operational to a strategic agenda. As recommended by the Committee, changes on today's agenda were introduced, i.e. new agenda categories such as strategic, discussion or fiduciary. Also, the President & CEO will from now on, report on three current challenges. The Board will evaluate these changes in the In-Camera portion of the meeting.

b. Director recruitment Process: The Committee interviewed a prospective candidate.

c. By-Law review: Administration will be reviewing the By-Law and bring forth suggested amendments to the Governance and Nominating Committee at the May 16 meeting. The Medical Staff has already provided their suggested amendments. Those will be incorporated into the draft By-Law revisions for the Committee's consideration.

8.0 FOR INFORMATION

8.1 Board Comprehensive Work Plan - For information.

8.2 Webcast Statistics - For information.

8.3 Report from the Health Research Institute - For information.

8.4 Report from the Volunteer Association – For information.

8.5 Critical Incidents Update – For information.

8.6 Nursing Week Schedule – For information.

9.0 BOARD MEMBERS COMMENTS

The Accreditation Canada Surveyors will be onsite during the week of May 14, 2018. Board members are strongly encouraged to participate in the session on Monday.

10.0 DATE OF NEXT MEETING – June 4, 2018

11.0 ADJOURNMENT - The meeting adjourned at 6:32 p.m.

_____ _____

Chair Board Secretary

_____

Recording Secretary

Thunder Bay Regional Health Sciences Centre

Governance and Nominating Committee

Wednesday, May 16, 2018
Boardroom – 7:00 a.m.

***Present*:**

Dick Mannisto, *Chair*	Nadine Doucette	Gary Whitney
John Friday	Grant Walsh	Joy Wakefield
Jean Bartkowiak*		

By Invitation:

Angela Kutok, *Rec. Sec.*	Patricia Lang, *via t-con*

1.0 CALL TO ORDER – The meeting was called to order at 7:00 a.m.

1.1 Quorum – Quorum was achieved.

1.2 Conflict of Interest – None.

1.3 Approval of the Agenda

The agenda was amended as follows:

- 3.1 Research Ethics Board (REB) Terms of reference removed from consent agenda for discussion.
- 3.3 Governance and Nominating Committee Terms of Reference removed from consent agenda for discussion.
- 3.4 Resource Planning Terms of Reference removed from consent agenda for discussion.

Motion

Moved by: ***Nadine Doucette***
Seconded by: ***Joy Wakefield***

"That the Agenda be accepted, as amended."

CARRIED

2.0 PRESENTATIONS/EDUCATION – None.

3.0 CONSENT AGENDA

Motion

Moved by: ***Grant Walsh***
Seconded by: ***Gary Whitney***

"That the Governance and Nominating Committee recommend that the Board of Directors approves the Terms of Reference of:

3.2 Executive Committee;
3.5 Fiscal Advisory Committee;
3.6 Audit Committee,

as presented."

CARRIED

Dr. Peter Voros was welcomed to the meeting.

3.1 REB Terms of Reference

Dr. Peter Voros explained the rationale for moving several items from the REB Terms of Reference (TOR) into the Standard Operating Practice (SOP). As SOP's do not require Board approval, there was concern about the impact to the Board's responsibilities, authority, and potential liability resulting from the proposed changes.

Action

Dr. Voros was asked to provide further clarity regarding the areas from the previous TOR and whether they transferred to the new TOR, or are being left to the SOPs. In addition, a response was requested regarding the Board's liability. A summary will be developed and shared with the Governance Committee following the meeting.

Dr. Peter Voros was excused from the meeting.

3.3 Governance and Nominating Committee Terms of Reference

Action

The Terms of Reference (TOR) for the Governance and Nominating Committee was reviewed and discussed. It was suggested that the TOR be reviewed at the next Committee meeting in fall 2018, paying specific attention to the following areas:

- Review and update membership, for example, the community member; and
- Review the succession plan process and process for the recommendation for the slate of Officers.

3.4 Resource Planning Committee Terms of Reference

Action

The Terms of Reference for the Resource Planning Committee will be brought back to the resource Planning Committee in fall 2018, to provide more robust language in respect to the roles and responsibilities related to Human Resources oversight.

4.0 WORK PLAN

4.1 Review meeting evaluations for the quarter

The meeting evaluations for the quarter were reviewed. It was noted that the Patient Safety and Quality of Care Committee is currently reviewing their evaluation process and will provide recommendations for edits to the Governance committee in fall of 2018.

4.2 Review Board and Board Committee attendance

The Board of Directors' attendance at meetings was reviewed with some discrepancies noted. The attendance summary will be reviewed to ensure accuracy. ***Action***

4.3 Review team effectiveness scale summary

The Team Effectiveness Scale summary was reviewed with no concerns noted.

4.4 Review and recommend By-Law amendments

The Committee was presented with a preliminary review of By-Law revisions. Several revisions were recommended, and clarification was requested as follows:

- Page 8/9, Article 3, 3.8, (a), (b) – Review to determine if "Hospital" should be replaced with "Hospital Board" in this section;
- Page 20, Article 9, 10.4 Insurance - The use of the phrase from "time to time" was thought to be ambiguous. In order to provide more concise language it was recommended to strike this from the section;
- Page 22, Article 12, 12.1 – Update Quality Committee title to reflect new name of Patient Safety and Quality of Care Committee;
- Page 40, Article 17, 17.1, (a) (b), (vii) –It was noted that (a) and (b) were not grammatically correct. Clarification to be requested from Medical Affairs regarding the intent of the language;
- Page 48, Article 20, 20.1, (a), (iii) - Clarification to be requested from Medical Affairs regarding the removal of "all Chiefs of Departments"; and
- Ensure word "By-Law", without the "s" is consistent throughout the document.

Once clarification is received the amended By-Law will be forwarded to the Governance and Nominating Committee for an electronic vote prior to presentation at the June Board of Directors meeting. ***Action***

4.5 Review Board annual evaluation tool summary

The Annual Board Evaluation Summary was reviewed and discussed.

4.6 Review annual Directors' education summary

The Annual Education Session summary was reviewed with some discrepancies noted. The education summary will be reviewed to ensure accuracy. It was suggested that a list of potential courses and training opportunities be provided in advance. ***Action***

4.7 Plan Annual Board Retreat

A joint retreat will be planned for Thunder Bay Regional Health Sciences Centre (the Hospital), Thunder Bay Regional Health Research Institute (the Institute) and Thunder Bay Regional Health Sciences Foundation (the Foundation) in fall of 2018. Suggested topics include a focus on quality governance principals, ways to foster relationships, and sharing of priorities. Dr. Richard LeBlanc, Governance Professor at York University and leader in governance effectiveness, was suggested as a potential speaker.

Mr. Jean Bartkowiak suggested that although the Hospital is not scheduled to lead this year's retreat, an offer will be made to the other Boards for the Hospital to develop the framework and agenda for the retreat. ***Action***

Retreat planning will be added to the agenda for the upcoming meeting with the Hospital and Institute Executives. ***Action***

4.8 Review Board Orientation Program

The orientation program for new Board members was reviewed. Feedback from new Board members on how orientation could be improved included the following suggestions:

- A mandatory half day of orientation to be held in early September;
- Allow for more time for each of the scheduled meetings with executives and key stakeholders to allow for more robust discussion;
- Provide new Board members with orientation materials well in advance;
- Provide additional information that focuses on the liabilities pertaining to the Board;
- Provide orientation with Chair of the Board sub-committees for members who are new to the committee;
- Schedule time with the Board Chair;

- Provide tailored orientation and education as required for individual members; and
- Continue to have the First Vice Chair mentor new members as per policy BD-92, Board Mentorship Liaison.

5.0 COMMITTEE MATTERS

5.1 Closed Corporate Membership

A recommendation that the Hospital move from an open to a closed corporate membership model was proposed. A closed membership is where the Directors are the only corporate voting members. Historically, as with other hospitals in Ontario, the Hospital has functioned in an open corporate membership model. Based on the Ontario Hospital Association (OHA)'s Centre for Governance Excellence recommendation, several Ontario hospitals have moved to a closed membership model for a number of reasons including but not limited to:

- Helps the Hospital Board meet its significant legislated and contractual accountability requirements to the Government of Ontario, the LHIN, patients and the communities served;
- Helps to protect the Hospital from the risk of domination by a single special interest group and to better align the interests of the corporate membership with the best interests of the hospital; and
- Helps the Board discharge its responsibility for the quality of Board succession through a systematic and transparent nominations process.

Action

The Committee agreed to the following:

- Not admit any new Life Members going forward, recognize meritorious Member's contribution through other means;
- Ensure that the current Life Member, who will continue to be acknowledged as A Life Member, will not object to having his rights as a voting member terminated;
- Not admit any new Annual Members going forward, other than the Directors;
- Amend the Corporate By-Law; and
- Write a letter to last year's members from the Chair and President & CEO indicating the structure change while impressing on them the numerous other engagement available including access to audited financial information.

5.2 Good Governance Practice Tools

Deferred.

6.0 FOR INFORMATION

6.1 Committee Meeting Evaluation

Committee members were requested to complete the committee meeting evaluation.

7.0 BOARD MATTERS

7.1 Chair's Report to the Board

The Committee agreed that the Chair will provide an update of the following items at the June 6, 2018 Board of Directors meeting:

- Terms of Reference updates; and
- By-Law amendment update.

7.2 Recommendations to the Board – None.

8.0 BOARD MEMBER COMMENTS

9.0 DATE OF THE NEXT MEETING

The next Governance and Nominating Committee meeting date will be determined.

10.0 ADJOURNMENT - The meeting adjourned at 8:54 a.m.

EXPENSE REPORTING - OCTOBER 1, 2017 TO MARCH 31, 2018				
DATE	**DESCRIPTION**	**LOCATION**	**EXPENSE CATEGORY**	**AMOUNT**
Bartkowiak, Jean (President and CEO)				**11,023.13**
September 6-8, 2017	Healthcare Leadership Summit	Blue Mountain	Accommodation	669.37
			Incidentals	25.47
			Meals	213.75
			Taxi/Public Transport	35.16
			Vehicle Rental/Mileage	438.62
September 27, 2017	Partners in Reconciliation Summit	Ottawa	Air/Rail	147.45
			Meals	47.01
October 2-3, 2017	Meeting - LHIN & MOHLTC	Toronto	Accommodation	366.18
			Hospitality	122.17
			Incidentals	11.72
			Meals	44.72
			Taxi/Public Transport	18.03
October 23-30, 2017	CAHO - Queen's Park Meeting & CHSO	Toronto	Accommodation	277.18
			Air/Rail	198.24
			Meals	83.92
			Taxi/Public Transport	83.86
November 2-7, 2017	LEG, OHA, Rendez Vous	Toronto, Ottawa	Accommodation	1,138.15
			Meals	123.44
			Taxi/Public Transport	78.92
November 15, 2017	Meeting with NOSH CEO	Thunder Bay	Hospitality	42.47
November 16-17, 2017	HSFR, Meeting with MOH COS	Toronto	Accommodation	260.45
			Air/Rail	397.62
			Hospitality	75.71
			Incidentals	19.61
			Meals	45.16
			Taxi/Public Transport	21.64
November 23-24, 2017	CAHO & Meeting with HSN CEO	Toronto	Accommodation	192.98
			Air/Rail	841.35
			Hospitality	155.44
			Taxi/Public Transport	73.31
December 19, 2017	Meeting with Brian Ktyor, LHIN and Tracy Buckler, SJCG	Thunder Bay	Hospitality	89.08
January 26, 2018	CAHO	Toronto	Air/Rail	405.26
			Incidentals	11.49

EXPENSE REPORTING - OCTOBER 1, 2017 TO MARCH 31, 2018				
DATE	**DESCRIPTION**	**LOCATION**	**EXPENSE CATEGORY**	**AMOUNT**
January 26, 2018	CAHO	Toronto	Meals	37.66
January 31-February 5, 2018	Rural Road Map Collaborative Steering Committee	Toronto	Accommodation	243.52
			Air/Rail	396.91
			Incidentals	25.47
			Meals	46.35
			Taxi/Public Transport	27.34
March 12, 2018	Meeting with Health Sciences North	Sudbury	Air/Rail	284.67
			Meals	17.52
			Taxi/Public Transport	37.50
March 16, 2018	Lunch with CCO	Thunder Bay	Hospitality	69.48
March 27-April 2, 2018	OHA Confedrence - Urgency of Capacity Management	Toronto	Air/Rail	393.66
October 2017 to March 2018	Car Allowance	Thunder Bay	Vehicle Rental/Mileage	2,688.12

EXPENSE REPORTING - OCTOBER 1, 2017 TO MARCH 31, 2018				
DATE	**DESCRIPTION**	**LOCATION**	**EXPENSE CATEGORY**	**AMOUNT**
Bjorn, Amanda (EVP - People, Culture & Strategy)				**2,013.25**
November 5-8, 2017	OHA Health Achieve	Toronto	Accommodation	626.22
			Air/Rail	251.71
			Meals	20.38
			Taxi/Public Transport	39.68
October 2017 to March 2018	Car Allowance	Thunder Bay	Vehicle Rental/Mileage	1,075.26

EXPENSE REPORTING - OCTOBER 1, 2017 TO MARCH 31, 2018				
DATE	**DESCRIPTION**	**LOCATION**	**EXPENSE CATEGORY**	**AMOUNT**
Crocker-Ellacott, Rhonda (EVP - Patient Care Programs & Health Professions)				**2,676.75**
October 2017 to March 2018	Car Allowance	Thunder Bay	Vehicle Rental/Mileage	1,075.26
	Travel as CEO of Nipigon District memorial Hospital; reimbursed by NDMH	Nipigon	Vehicle Rental/Mileage	1,601.49

EXPENSE REPORTING - OCTOBER 1, 2017 TO MARCH 31, 2018				
DATE	**DESCRIPTION**	**LOCATION**	**EXPENSE CATEGORY**	**AMOUNT**
Henderson, Dr. Mark (EVP - Patient Services)				**5,150.24**
October 3-4, 2017	Ontario Palliative Care Network - CCO, RVPs, and LHIN CEOs	Toronto	Accommodation	208.74
			Air/Rail	555.95
			Incidentals	10.82
			Taxi/Public Transport	18.03
October 23, 2017	Ministry/UHN - CVS Budget	Toronto	Air/Rail	337.24
			Incidentals	10.60
			Taxi/Public Transport	29.30
November 9-12, 2017	CCO - Provincial Leadership Council Meeting	Toronto	Accommodation	208.74
			Air/Rail	474.29
			Incidentals	12.24
			Taxi/Public Transport	27.06
November 14, 2017	Meeting with regional CEOs	Thunder Bay	Hospitality	193.72
December 7-8, 2017	CCO - Provincial Leadership Council Meeting	Toronto	Air/Rail	404.14
January 8, 2018	Minimally Invasive Structural Heart Working Group Meeting	Toronto	Air/Rail	234.38
February 6, 2018	CVS Dinner Meeting	Thunder Bay	Hospitality	392.15
February 8, 2018	CCO - Provincial Leadership Council Meeting	Toronto	Accommodation	410.78
			Air/Rail	206.96
			Taxi/Public Transport	46.89
March 8-10, 2018	CCO - Provincial Leadership Council Meeting	Toronto	Accommodation	229.72
			Air/Rail	26.59
			Incidentals	13.19
			Taxi/Public Transport	23.45
October 2017 to March 2018	Car Allowance	Thunder Bay	Vehicle Rental/Mileage	1,075.26

EXPENSE REPORTING - OCTOBER 1, 2017 TO MARCH 31, 2018				
DATE	**DESCRIPTION**	**LOCATION**	**EXPENSE CATEGORY**	**AMOUNT**
Kennedy, Dr. Stewart (EVP - Medical, Academic & Regional Programs				**3,594.87**
October 3, 2017	Meeting - MOHLTC/LHIN	Toronto	Air/Rail	603.44
			Taxi/Public Transport	27.32
November 3-4, 2017	LEG Lead & Administrator's Meeting	Toronto	Air/Rail	634.01
December 20, 2017	NOAMA Presentation to OMA	Toronto	Air/Rail	625.86
			Incidentals	15.99
			Taxi/Public Transport	81.77
January 16, 2018	Presentation to WSIB	Toronto	Air/Rail	441.43
			Hospitality	63.87
			Incidentals	12.40
			Taxi/Public Transport	13.52
October 2017 to March 2018	Car Allowance	Thunder Bay	Vehicle Rental/Mileage	1,075.26

EXPENSE REPORTING - OCTOBER 1, 2017 TO MARCH 31, 2018				
DATE	**DESCRIPTION**	**LOCATION**	**EXPENSE CATEGORY**	**AMOUNT**
Lang, Patricia (Board of Directors)				**2,027.33**
September 14-16, 2017	OHA Conference	Toronto	Accommodation	740.59
			Incidentals	30.42
			Taxi/Public Transport	49.59
November 4-7, 2017	OHA Quality and OHA Health Achieve	Toronto	Accommodation	792.87
			Air/Rail	234.38
			Incidentals	86.09
			Meals	84.38
			Taxi/Public Transport	9.01

EXPENSE REPORTING - OCTOBER 1, 2017 TO MARCH 31, 2018				
DATE	**DESCRIPTION**	**LOCATION**	**EXPENSE CATEGORY**	**AMOUNT**
Mannisto, Richard (2nd Vice Chair, Regional Representative, Board of Directors)				**3,801.76**
September 18-19, 2017	Resource Planning Meeting	Thunder Bay	Accommodation	118.20
October 4-5, 2017	Board Meeting	Thunder Bay	Accommodation	118.20
			Meals	10.05
			Vehicle Rental/Mileage	232.90
October 11-13, 2017	Simulated Accreditation and Board Retreat	Thunder Bay	Accommodation	297.52
			Meals	60.38
			Vehicle Rental/Mileage	232.90
October 16-17, 2017	Board Interviews and Resource Planning Meeting	Thunder Bay	Accommodation	118.20
			Meals	18.30
			Vehicle Rental/Mileage	232.90
November 1, 2017	Board Meeting	Thunder Bay	Accommodation	118.20
			Vehicle Rental/Mileage	232.90
November 13-16, 2017	Resource Planning and Governance Meeting	Thunder Bay	Accommodation	236.38
			Meals	27.03
			Vehicle Rental/Mileage	232.90
December 18-19, 2017	Executive Meeting	Thunder Bay	Vehicle Rental/Mileage	232.90
February 27-March 1, 2018	Board Retreat	Thunder Bay	Accommodation	128.38
			Meals	9.02
			Vehicle Rental/Mileage	232.90
March 7-8, 2018	Board Meeting	Thunder Bay	Accommodation	121.25
			Meals	9.15
			Vehicle Rental/Mileage	232.91
March 19-21, 2018	Resource Planning, Audit, Executive, and Governance Meeting	Thunder Bay	Accommodation	242.50
			Meals	72.89
			Vehicle Rental/Mileage	232.90

EXPENSE REPORTING - OCTOBER 1, 2017 TO MARCH 31, 2018				
DATE	**DESCRIPTION**	**LOCATION**	**EXPENSE CATEGORY**	**AMOUNT**
Myllymaa, Peter (EVP - Corporate Services & Operations)				**2,559.60**
October 2-3, 2017	Meeting - NW LHIN/MOHLTC/TBRHSC	Toronto	Accommodation	366.18
			Incidentals	87.25
			Meals	9.16
			Taxi/Public Transport	18.03
November 16-17, 2017	Meeting - MOH ADM Chief of Staff; OHA HSFR Evolution Session	Toronto	Accommodation	260.45
			Air/Rail	428.18
			Incidentals	19.61
			Meals	26.72
March 12, 2018	Meeting with Health Sciences North	Sudbury	Air/Rail	232.46
			Incidentals	12.40
			Meals	23.90
October 2017 to March 2018	Car Allowance	Thunder Bay	Vehicle Rental/Mileage	1,075.26

EXPENSE REPORTING - OCTOBER 1, 2017 TO MARCH 31, 2018				
DATE	**DESCRIPTION**	**LOCATION**	**EXPENSE CATEGORY**	**AMOUNT**
Porter, Dr. Gordon (Chief of Staff)				**2,186.19**
September 7-8, 2017	Presentation at Huron Perth Health Care Alliance	Stratford	Incidentals	18.71
			Vehicle Rental/Mileage	96.53
February 8-9, 2018	Northern Lights	Toronto	Accommodation	266.05
			Air/Rail	729.64
October 2017 to March 2018	Car Allowance	Thunder Bay	Vehicle Rental/Mileage	1,075.26

EXPENSE REPORTING - OCTOBER 1, 2017 TO MARCH 31, 2018				
DATE	**DESCRIPTION**	**LOCATION**	**EXPENSE CATEGORY**	**AMOUNT**
Rudnick, Dr. Abraham (EVP - Research & Development)				**2,937.92**
October 16, 2017	Research Canada Caucus	Ottawa	Incidentals	5.41
			Meals	18.07
			Taxi/Public Transport	32.92
October 24-25, 2017	CAHO Research Day	Toronto	Accommodation	18.03
			Incidentals	7.10
			Meals	14.71
			Taxi/Public Transport	10.49
November 1-7, 2017	Techna 2017 and OHA Health Achieve	Toronto	Accommodation	155.87
			Meals	95.06
			Taxi/Public Transport	19.15
November 9-10, 2017	OPOP Annual Conference	Toronto	Accommodation	108.19
			Air/Rail	86.00
			Meals	41.59
			Taxi/Public Transport	10.14
November 14, 2017	Dinner - External Review Team	Thunder Bay	Hospitality	212.72
November 17-21, 2017	The Change Foundation Board of Directors & Bloorview Research Institute Symposium	Toronto	Accommodation	36.07
			Incidentals	23.78
			Taxi/Public Transport	51.17
February 14-20, 2018	Research Canada Caucus & CAHO Research Committee	Ottawa, Toronto	Accommodation	108.19
			Air/Rail	202.77
			Incidentals	63.14
			Taxi/Public Transport	53.98
February 7-12, 2018	N2 Network AGM & Sunnybrook Innovation Day	Toronto	Accommodation	36.07
			Air/Rail	63.36
March 12, 2018	Meeting with Health Sciences North	Sudbury	Air/Rail	304.14
			Incidentals	12.40
			Taxi/Public Transport	72.14
October 2017 to March 2018	Car Allowance	Thunder Bay	Vehicle Rental/Mileage	1,075.26

EXPENSE REPORTING - OCTOBER 1, 2017 TO MARCH 31, 2018				
DATE	**DESCRIPTION**	**LOCATION**	**EXPENSE CATEGORY**	**AMOUNT**
Whitney, Gary (Board of Directors)				**400.33**
September 6-7, 2017	OHA - Hospital Physican Relations	Toronto	Accommodation	339.58
			Meals	42.72
			Taxi/Public Transport	18.03

EXPENSE REPORTING - OCTOBER 1, 2017 TO MARCH 31, 2018				
DATE	**DESCRIPTION**	**LOCATION**	**EXPENSE CATEGORY**	**AMOUNT**
Grand Total				**38,371.37**

Thunder Bay Regional Health Sciences Centre

980 rue Oliver Road
Thunder Bay ON
P7B 6V4 Canada

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www.tbrhsc.net

ATTESTATION CERTIFICATE

Prepared in accordance with Section 15 of the Broader Public Sector Accountability Act, 2010 (BPSAA)

TO: The Board of Directors of Thunder Bay Regional Health Sciences Centre

FROM: Jean Bartkowiak, MHSc, CHE
President and Chief Executive Officer
Thunder Bay Regional Health Sciences Centre
Chief Executive Officer
Thunder Bay Regional Research Institute

Date: May 15, 2018

RE: April 1, 2017 to March 31, 2018

On behalf of the Thunder Bay Regional Health Sciences Centre I attest to:

- The completion and accuracy of reports required of the Hospital pursuant to section 6 of the BPSAA on the use of consultants;
- The Hospital's compliance with the prohibition in section 4 of the BPSAA on engaging lobbyist services using public funds;
- The Hospital's compliance with any applicable expense claims directives issued under section 10 of the BPSAA by the Management Board of Cabinet;
- The Hospital's compliance with any applicable perquisite directives issued under section 11.1 of the BPSAA by the Management Board of Cabinet; and
- The Hospital's compliance with any applicable procurement directives issued under section 12 of the BPSAA by the Management Board of Cabinet;
- The Hospital's compliance with any applicable business plans directives issued under section 13 of the BPSAA by the Management Board of Cabinet,

during the applicable period.

In making this attestation, I have exercised care and diligence that would reasonably be expected of a President/CEO in these circumstances, including making due inquiries of Hospital staff that have knowledge of these matters.

Thunder Bay Regional Health Sciences Centre

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P7B 6V4 Canada

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I further certify that any material exceptions to this attestation are documented in the attached Schedule A and Appendix B.

Dated at Thunder Bay, Ontario this May 15, 2018.

Jean Bartkowiak, MHSc, CHE
President and Chief Executive Officer
Thunder Bay Regional Health Sciences Centre
Chief Executive Officer
Thunder Bay Regional Research Institute

I certify that this attestation has been approved by the Board of the Thunder Bay Regional Health Sciences Centre on June 6, 2018.

Nadine Doucette
Chair, Board of Directors
Thunder Bay Regional Health Sciences Centre

Thunder Bay Regional Health Sciences Centre

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Schedule A to Attestation

MATERIAL EXCEPTIONS TO DECLARE

1. Exceptions to the completion and accuracy of reports required in section 6 of the BPSAA on the use of consultants;

   No Known Exceptions.

2. Exceptions to the Hospital's compliance with the prohibition in section 4 of the BPSAA on engaging lobbyist services using public funds;

   No Known Exceptions.

3. Exceptions to the Hospital's compliance with the expense claims directive issued under section 10 of the BPSAA by the Management Board of Cabinet;

   No Known Exceptions.

4. Exceptions to the Hospital's compliance with perquisites directive issued under section 11.1 of the BPSAA by the Management Board of Cabinet;

   No Known Exceptions.

5. Exceptions to the Hospital's compliance with the procurement directive issued under section 12 of the BPSAA by the Management Board of Cabinet;

   No Known Exceptions.

6. Exceptions to the Hospital's compliance with the business plans directive issued under section 13 of the BPSAA by the Management Board of Cabinet,

   As reported in Appendix B.

Jean Bartkowiak, MHSc, CHE
President and Chief Executive Officer
Thunder Bay Regional Health Sciences Centre
Chief Executive Officer
Thunder Bay Regional Research Institute

May 15, 2018

APPENDIX B- TBRHSC
BPSAA Exceptions 2017/2018

Procurement Initiative	Relevant Procurement Directives	Vendor	Rationale	Action Plan
Third Party Distribution Agreement	7.2.18 Term of Agreement Modifications	Medical Mart	An exception to the procurement directives occurred in the form of a 9 month extension to the 3rd Party Distribution Services contract with Medical Mart. This exception was carried out in order to align the close of the active contracts with that of other Northern Supply Chain peer hospitals for the purposes of entering a group procurement so that TBRHSC could achieve optimum value for money by pooling these opportunities into a single, competitive procurement.	Action was completed and a new contract was awarded January 1, 2018.

Schedule D — Form of Compliance Declaration

DECLARATION OF COMPLIANCE
Issued pursuant to the Hospital Service Accountability Agreement

To: **The Board of Directors of the North West Local Health Integration Network (the "LHIN"). Attn: Board Chair.**

From: **The Chair of the Board of Directors (the "Board') of Thunder Bay Regional Health Sciences Centre (the "HSP")**

Date: June 6, 2018

Re: April 1, 2017 — March 31, 2018 (the "Applicable Period")

The Board has authorized me, by resolution dated June 6, 2018, to declare and attest to you as follows:

After making inquiries of the HSP's Chief Executive Officer and other appropriate officers of the HSP and subject to any exceptions identified on Appendix 1 to this Declaration of Compliance, to the best of the Board's knowledge and belief, the HSP has fulfilled its obligations under the Hospital Service Accountability Agreement (the "Agreement") in effect during the Applicable Period.

Without limiting the generality of the foregoing, the Board confirms that:

(i) the HSP has complied with the provisions of the Local Health System Integration Act, 2006 and the Broader Public Sector Accountability Act (the "BPSAA") that apply to the HSP;
(ii) the HSP has complied with its obligations in respect of CritiCall that are set out in the Agreement;
(iii) every Report submitted by the HSP is complete, accurate in all respects and in full compliance with the terms of the Agreement; and
(iv) the representations, warranties and covenants made by the Board on behalf of the HSP in the Agreement remain in full force and effect.

Unless otherwise defined in this declaration, capitalized terms have the same meaning as set out in the Agreement.

This Declaration of Compliance, together with its Appendix, will be posted on the HSP's website on the same day that it is issued to the LHIN.

Nadine Doucette
Chair, Board of Directors

SCHEDULE G — FORM OF COMPLIANCE DECLARATION

DECLARATION OF COMPLIANCE

Issued pursuant to the M-SAA effective April 1, 2014

To: **The Board of Directors of the North West Local Health Integration Network (the "LHIN"). Attn: Board Chair.**

From: **The Chair of the Board of Directors (the "Board") of Thunder Bay Regional Health Sciences Centre (the "HSP")**

Date: **June 6, 2018**

Re: **April 1, 2017 — March 31, 2018 (the "Applicable Period")**

Unless otherwise defined in this declaration, capitalized terms have the same meaning as set out in the M-SAA between the LHIN and the HSP effective April 1, 2014.

The Board has authorized me, by resolution dated June 6, 2018, to declare to you as follows:

After making inquiries of the President and Chief Executive Officer and other appropriate officers of the HSP and subject to any exceptions identified on Appendix 1 to this Declaration of Compliance, to the best of the Board's knowledge and belief, the HSP has fulfilled, its obligations under the service accountability agreement (the "M-SAA") in effect during the Applicable Period.

Without limiting the generality of the foregoing, the HSP has complied with:

i. **Article 4.8 of the M-SAA concerning applicable procurement practices;**
ii. **The *Local Health System Integration Act, 2006*; and**
iii. **The Public *Sector Compensation Restraint to Protect Services Act, 2010*;**
iv. **The following specific performance requirements as outlined in Schedule E4 of the 2014-2017 M-SAA:**
    a. **"Home First" Philosophy**
    b. **Diversity Planning requirement**
    c. **Behavioural Supports Ontario Action Plan**
    d. **Emergency Preparedness Plans**
    e. **E-Health requirement**
    f. **Information Technology requirement**
    g. **Health Services Blueprint — Community Engagement**

_____

Nadine Doucette
Chair, Board of Directors

THUNDER BAY REGIONAL HEALTH SCIENCES CENTRE
EXECUTIVE COMMITTEE OF THE BOARD OF DIRECTORS

Terms of Reference

Duties/Responsibilities:

The Executive Committee shall:

(a) exercise the full powers of the Board in all matters of administrative urgency, reporting every action at the next meeting of the Board;

(b) study and advise or make recommendations to the Board on any matter as directed by the Board; and

In the event that one person holds two designated positions on the Executive Committee, the Board may elect a member of the Board to the Executive Committee and this member must be an elected member of the Board.

Given (a) ex-officio members are non-voting on the Executive Committee.

Membership and Voting:

The Executive Committee shall be comprised of the following Directors*:*

(a) Chair; (voting)
(b) First Vice-Chair; (voting)
(c) Second Vice-Chair; (voting)
(d) Chair of the Quality Management Committee; (voting)
(e) Treasurer; (voting)
(f) Chief of Staff; ex-officio (non-voting)
(g) President and CEO; ex-officio (non-voting)
(h) President – Professional Staff Association ex-officio (non-voting)

Chair:

The Board Chair will Chair the Executive Committee.

Frequency of Meetings and Manner of Call:

Quorum:
51% of the committee members and a majority of the voting members are present.

Resources:
The Board Liaison will provide support for the Executive Committee.

Reporting:
See Authority.

Authority:
Exercises the full powers of the Board in all matters of administrative urgency, reporting every action at the next meeting of the Board, and exercises the full powers of the Board between the last Board meeting in June and the first Board meeting in October, annually.

Date of Last Review:
May 11, 2018

THUNDER BAY REGIONAL HEALTH SCIENCES CENTRE
AUDIT COMMITTEE

Terms of Reference

Duties/Responsibilities:
The Audit Committee is responsible to oversee the financial management, reporting and internal controls of the Hospital. This is accomplished through direct communication with the external auditors and Hospital management. The Audit Committee reports to the Board of Directors of the Hospital.

The Audit Committee Shall:

General

(a) review, with the external auditors, the proposed scope of the current year's audit;
(b) review and approve the auditor's engagement letter including the audit fee and expenses;
(c) periodically review the need to tender audit services and recommend appointment of auditors to the Board. It is important to note the external auditors are accountable to the members ,and to the Audit Committee and the Board of Directors as their representatives
(d) Ensure the independence of the auditors and obtain a statement of independence from the auditors;
(e) maintain a high quality of financial reporting;
(f) assess whether appropriate assistance is being provided to the auditors by the organization's staff; and
(g) ensure finance staff have the appropriate qualifications and knowledge of internal control and financial management systems.

Policies for Financial Operations and Systems of Internal Control

(a) inquire about changes in the financial systems and control systems during the year;
(b) ensure appropriate systems are in place to identify, monitor and mitigate significant business risks;
(c) ensure appropriate financial policies and procedures are in place and operating effectively;
(d) ensure that systems of internal control are operating effectively;
(e) review control weaknesses detected in the prior year's audit and determine whether all practical steps have been taken to overcome them.
(f) supervise the investigation of any instances of non-compliance and make recommendations thereon;
(g) inquire into the major financial risks faced by the organization, and the appropriateness of related controls to minimize their potential impact;

Annual Financial Statements

(a) review audited financial statements, in conjunction with the report of the external auditor, and obtain an explanation from management of all significant variances between comparative reporting periods;
(b) recommend approval of the financial statements to the Board;

- inquire about changes in professional standards or regulatory requirements, and
- review the annual report for consistency with the financial statements

Audit Results

(a) review the report of the external auditors on the annual financial statements;
(b) review the external auditor's post-audit or management letter which may document weaknesses in the accounting system or in the internal control systems and which may contain recommendations of the external audit, and management's response and subsequent follow-up to any identified weaknesses;
(c) review the results of any requested special procedures performed by the auditors as identified in the scope of the engagement;
(d) review summary of legal claims and assess adequacy of disclosure;
(e) meet privately with the external auditors (without the presence of management) with regard to the adequacy of the internal accounting controls and similar matters, and review management responses to ascertain whether there are concerns that should be brought up to the Committee's attention;
(f) review any problems experienced by the external auditor in performing the audit, including any restrictions imposed by management or significant accounting issues on which there was a disagreement with management, or situations where management seeks a second opinion on a significant accounting issue; and
(g) meet privately with management to determine whether the external audit was performed in a professional manner, in accordance with the audit engagement letter and any other contractual agreement in place for these services, and to receive management's recommendation regarding the appointment or re-appointment of external auditors.

Duty to Report

(a) report to the Board discussing the actions it has taken and the assistance the Committee has had in fulfilling its duties;
(b) prepare a report to Members describing the Audit Committee activities during the past reporting period that identifies how it fulfilled its role and mandate.

Membership and Voting:

- Four (4) elected members of the Board (voting) ;
- Board Chair (voting);
  - One (1) member must possess an accounting designation, i.e. CA, CGA, CMA, CPA
  - If no member possesses an accounting designation, the Nominating Committee will recommend to the Board, a qualified individual from the community to serve a one year term as one of the five voting members of the Audit Committee.
- The President and CEO (non-voting);
- Members of the Committee should be financially literate and independent of the Hospital and External Auditors.

Chair:

The Committee will be chaired by the Treasurer.

Frequency of Meetings and Manner of Call:

- The Audit Committee will meet at least three times per year;

- The meetings will be scheduled to permit timely review of the interim audit plans and annual financial statements;
- Additional meetings may be held as deemed necessary by the Chair of the Committee or as requested by any member or the external auditors.

Quorum:
51% of the committee members, provided a majority of those present are voting members.

Resources:
The Executive Vice President, Corporate Services and Operations is assigned to the committee as a resource.

Reporting:
The Audit Committee reports to the Board of Directors

Authority:
n/a

Date of Last Review:
Reviewed at Audit Committee January 16, 2018
To Be Approved at Board of Directors June 6, 2018

` **THUNDER BAY REGIONAL HEALTH SCIENCES CENTRE**

FISCAL ADVISORY COMMITTEE

Terms of Reference

Duties and Responsibilities

The Fiscal Advisory Committee shall make recommendations to the Board with respect to the operation, use and staffing at the hospital.

The Fiscal Advisory Committee shall:

a) adhere to the Ministry's guiding principles during the Operating Plan process.
b) make recommendations to the Board with respect to the annual Operating Plan focusing on the Hospital's objectives. The Operating Plan will include the following three components:
    1. Program and Services Plan
    2. Human Resources Plan
    3. Financial Plan
c) evaluate programs and services relative to their impact on human, fiscal and physical resources;
d) ensure that equitable opportunity to participate exists;
e) ensure all recognizable internal stakeholders will be formally involved in the consultation process;
f) review the annual operating plan consistent with the Ministry's policies, guidelines and requirements;
g) review on a semi-annual basis, the Hospital's internal management financial statements and variance reports;
h) consult on the development of the plan with internal and external stakeholders, as determined by the Board; consults with the North West Local Health Integration Network on the process for external consultation;
i) monitor the implementation of the Operating Plan; identifies major variances and recommends in-year adjustments to the Board; and
j) address unresolved issues raised by committee members.

Membership and Voting:

The Fiscal Advisory Committee shall include:

a) Board Chair (voting);

b) President and CEO (non-voting);
c) Patient Family Advisor (voting);
d) one person representing both the medical staff and dental staff (voting);
e) one person representing nurses who are Managers (voting);
f) one staff nurse elected by his/her peers to represent O.N.A. (voting);
g) one staff person elected/appointed to represent C.O.P.E. (voting);
h) one staff person elected/appointed to represent S.E.I.U. (voting);
i) one staff person elected/appointed to represent O.P.S.E.U. Maintenance (voting);
j) one staff person elected/appointed to represent O.P.S.E.U. Paramedical (voting);
k) one staff person elected/appointed to represent P.I.P.S.C. (voting);
l) one staff person elected/appointed to represent P.I.P.S.C. Associates (voting);
m) one staff person representing non union staff (voting);
n) other individuals who by virtue of their position may make a contribution to the committee's deliberations (voting).

Chair:
The Fiscal Advisory Committee will be chaired by the President and CEO.

Frequency of Meetings and Manner of Call:
The frequency of meetings and number of calls are two times per year, at the call of the Chair, or as requested by the Board of Directors.

Quorum:
51% of the Committee members, provided a majority of those present are voting members.

Resources:
The Executive Vice President, Corporate Services and Operations and the Executive Vice President, Human Resources are assigned to the committee as resources.

Reporting:
The Fiscal Advisory Committee reports to the Board of Directors.

Authority:
n/a

Date of Last Review:
Reviewed at Fiscal Advisory Committee April 9, 2018
To be Approved at Board of Directors June 6, 2018

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**Report from the President & CEO
and Senior Leadership Team
June 6, 2018**

The following highlights priority operational activities only for the May 2 to June 5, 2018 period as the strategic update will be presented in the education session.

As you know, Accreditation Canada conducted a site survey at our Hospital from May 14 to 18; I was very impressed by the Surveyors' preliminary report. The Accreditation Canada surveyor team highlighted the Board's engagement, the quality of our communications, our impressive telemedicine program supporting regional clinical programs such as critical care for instance, the recognition our external clinical partners impressed on them on our achievements. The full report will be received in the coming weeks. However, comments from the surveyors indicate very positive results can be expected. I look forward to sharing details soon.

Accreditation involves all members of our organization, from board of directors to frontline staff as well as members of the community including patients and families and community partners. On behalf of the Senior Leadership Team, I want to convey our gratitude to all those who volunteered their time to contribute to our accreditation survey process.

In May, Dr. Rhonda Crocker Ellacott began her new position as CEO of the North West Local Health Integration Network (LHIN). Due to her departure, we began recruitment for a new Executive Vice President, In-Patient Care Programs; the position posting generated at lot of interest from very competent applicants. We have short listed the applicants that will be interviewed in June, and we anticipate that the successful candidate will begin in the fall at the latest. Ron Turner, Senior Director, Patient Services, has agreed to fill the role on an interim basis.

We are also regularly engaging our leadership team to monitor and evaluate the effectiveness of the revised organizational structure. Phase I has been implemented, and includes recruitment of a Senior Director, Indigenous Collaboration, who will build on our successes to date to advance Indigenous Health improvement initiatives. Interviews for this position will take place in June. Given our patient challenges, we developed a position description for a new Director, Medicine, Patient Flow and Partnerships. This person will play an integral role in addressing inpatient capacity challenges. It is anticipated that the position will be posted in early June. Phase II of the organizational restructure will introduce a revised Quality portfolio with a focus on sponsoring our Quality Framework throughout our Hospital. A review of other academic health sciences centres' Quality portfolios is underway to inform our approach.

The Vancomycin-Resistant Enterococci (VRE) outbreak continues to be a challenge; following the March site visit from Public Health Ontario (PHO) public health practitioners, we recently received their report and recommendations. Ron Turner has been designated to lead their implementation.

Recommendations include increasing Infection Prevention and Control staffing and providing after-hours and weekend coverage, enhance cleaning of in-patient rooms, using disposable urinal and bedpan liners, clarifying cleaning process for shared health care equipment, cohorting patients and staff to reduce transmission during outbreaks; and providing hand hygiene education aimed at patients, their families and visitors. Our Infection Prevention and Control team is diligently managing the outbreak and we commend them for their diligence and ongoing commitment.

Addressing the Hospital financial pressures translated in the following specific priority initiatives:

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Sick Time Usage:
The EVP, People, Culture & Strategy, struck a Sick Time Working Group to determine the root causes of sick time and identify improvement tactics such as:

- engaging frontline staff for input;
- investigating adding Occupational Health medical and other staff to support Managers and Directors managing attendance.

Concomitantly, the Director, Human Resources analyzed sick time use by stratifying short term episodic, frequent short term and long term sick leaves to identify potential improvements.

Finally, the EVP, Corporate Services & Operations is assessing the Staffing Office's scope, structure, alignment, effectiveness, and required changes to improve sick time replacement management process.

Length of Stay:
The Chief of Staff is investigating earlier use of order sets for admitted Emergency Department patients; following a data analysis was conducted, the digital order sets team outlined an adoption monitoring process and a non-compliance escalation procedure. Furthermore, the Chief of Staff received support from the Medical Advisory Committee to start distributing Average Length of Stay (ALOS) compared to Expected Length of Stay (ELOS) results for each admitting Physicians.

The EVP, Corporate Services & Operations will ensure that the electronic medical record system can accommodate valid admitting diagnosis and ELOS data. An initial meeting was held with the project team.

Nurse Resource Team
The Acting EVP, In-Patient Care Programs reviewed the Nursing Resource Team; 40 additional FTE Nursing positions were approved and posted.

Inpatient Units Alignment:
The Acting EVP, In-Patient Care Programs and the EVP, Medical, Academics & Regional Programs, are planning to right size inpatient units to accommodate volumes of surgical and medical patients.

Occupancy Management:
The EVP, Medical, Academics & Regional Programs is considering leveraging the Bed Board application in Meditech to support real time inpatient beds occupancy statistics. The Information Technology department is exploring expert staff implication to implement this project.

To improve patient flow and room cleaning, the EVP, Medical, Academics & Regional Programs is investigating the feasibility of an 11:00 am discharge. The initiative will begin with Hospitalists.

Isolations:
The EVP, Medical, Academics & Regional Programs has authorized increased use of swabbing and point of care testing to reduce or shorten patient isolations, which impact the number of blocked inpatient beds at any one time.

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On May 30, Jean Bartkowiak was joined by Fort William First Nation Chief Peter Collins and Hospital Board Director Michael Hardy to raise the Fort William First Nation flag at the Hospital. The flag will be a permanent symbol to recognize that the Hospital is in the Robinson-Superior Treaty territory on the traditional territory of the Ojibwe people of Fort William First Nation. The flag also signals our commitment to Indigenous Health, and advances awareness of the rich and important Indigenous history and culture of this region.

Also n May 30, Dominic Giroux, President & CEO of Health Sciences North in Sudbury, toured our Hospital with Jean Bartkowiak. Discussions centred around enhanced collaboration between our respective organizations, the Northern Supply Chain affiliation, matched funding challenges for research, drafting of a Northern Ontario Health Research Partnership to advocate to the provincial and federal governments for additional health research funding support, a common advocacy platform to ensure the new provincial government recognizes the need for appropriate financial support of our acute health sciences mission in Northern Ontario and the recruitment of the next Dean of the Northern Ontario School of Medicine (NOSM).

An external review of research at our Hospital and Thunder Bay Regional Health Research Institute was completed by an expert team from Health Sciences Centre Winnipeg. Eleven recommendations were provided, clustered primarily under governance, operations, and funding. Plans were initiated to report and action the recommendations, with leadership of the Hospital and Health Research Institute Boards and Senior Leadership.

The annual meeting of Cancer Care Ontario was held June 1. This provided opportunity for Regional Vice Presidents, including Dr. Stewart Kennedy and partner hospital CEOs, to discuss the performance of our provincial cancer care program and how the provincial standards have to be adapted to better reflect the unique geography of Northwestern Ontario; the region we serve extends from east of White River to the Manitoba border in the west and from Hudson Bay in the north to the United States border in the south, and encompasses 47% of Ontario's landmass with 2% of its population. The session allowed us to impress on CCO Leadership Team that the distribution of the population within this geography presents distinct challenges not faced by any other regional cancer care programs in the province.

The landscape also results in unique demands for patient transfers. Jean Bartkowiak, Chief of Staff Dr. Gordon Porter, and ORNGE CEO, Dr. Andrew McCallum and Chief of Staff, Dr. Homer Tien met on May 29 to discuss the best ways to address urgent transfers for patients who need special medical equipment, repatriation of patients, and the potential to employ ORNGE to accommodate visits to regional sites by our health care providers for service delivery. Our shared priority is effective and efficient patient care, and we look forward to further developments.

On June 3, President & CEO Jean Bartkowiak, along with Scott McIntaggart, Senior Vice President at the University Health Network (UHN) accepted an award in St. John's, Newfoundland. The award, presented by the Canadian College of Health Leaders, recognizes Delivering Value-based Healthcare. To significantly improve care for patients suffering from cardiovascular diseases in our region, our Hospital, in partnership with the UHN, developed a "One Program on Two Sites Model" for the provision of Vascular and Cardiac Surgery; already, we are well on our way to offering full coverage of vascular surgical services which has saved lives and limbs. In the next couple of years we will expand services to address the burden of cardiovascular disease, and improve access to open heart surgery in the region. We're very honoured to receive this award, as it recognizes our shared commitment to meeting the specialized acute care needs of Northwestern Ontario residents.

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We're very grateful to our UHN partner for collaborating so closely with us to advance this unique Canadian initiative.

Our Hospital celebrated National Nurses Week from May 7 - 13 to recognize the important contributions our nurses make 24 hours a day, 365 days a year. From the feedback of our patients and their families through satisfaction surveys, through patient stories we hear out in the community, we truly know our nurses are making the overall experience of care better by taking the time to listen, providing patient and family centred care and comfort measures, and taking the time to explain medications, anxieties, fears and discharge instructions. We are grateful to nurses for their continued engagement in providing empathic care even while operating in demanding conditions.

Indeed, as we were celebrating our nurses, our Hospital reached highest ever numbers of admitted patients, with inpatient census reaching as high as 479. While this number includes patients at our Transitional Care Unit at St. Joseph's Care Group's Hogarth Riverview Manor, pressures at our Hospital impact staff. Communications to staff, including a meeting with Hospitalists, focused on recognizing the extraordinary efforts put forth by the entire team.

We also celebrated our donors who contribute so generously to advance our clinical, academic and scientific mission. The Presidents' Reception, hosted on May 3 by the Hospital and our Health Sciences Foundation, honoured donors and the advances to safe, quality health care enabled by their generosity. It is always a pleasure to meet these special people to express gratitude in person.

Thunder Bay Regional Health Sciences Centre

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Chief of Staff
Médecin chef

Chief of Staff Report

to the
Board of Directors
Thunder Bay Regional Health Sciences Centre

June 2018

Quality Based Procedures (QBP) Digital Orders Sets

- The next set of digital order sets went live in May (Stoke, Prophylactic Mastectomy, Lower Extremity Occlusive Disease, Knee Arthroscopy and a Surgical Discharge set)
- Clinical leaders from the NW LHIN continue to meet regularly to develop provincial digital order sets based on the Opioid Quality Standards by Health Quality Ontario as well as a digital order set for opioid use in an acute care setting that will be piloted at the hospital

Length of Stay (LOS)

- New length of stay reports are being developed by Health Records which will be more succinct; a first draft is anticipated to be ready for dissemination in June
- Reports will be provided to Department Chiefs to share with their members as well as copies sent to Medical and Administrative Program Directors
- New reports will provide un-blinded individual physician length of stay data (previously this information was provided using dictation numbers)
- These will be circulated on a quarterly basis going forward

Department Chiefs

- Interviews for the position of Chief of General & Family Practice have been completed and a recommendation will be brought forward to the Medical Advisory Committee in June
- The Chief of Dentistry interviews are currently underway
- This is following the direction of the Medical Advisory Committee to consider both leadership renewal as well as engage interest in leadership roles by posting positions at the end of each term

Incomplete Health Records

- A new policy and procedure has been approved around expectations and the process for managing incomplete health records
- The new policy and procedure also includes updates to reflect our quality improvement plan to move towards discharge summaries completed within 48 hours of discharge
- Before implementing the new policy and procedure, it is necessary to close outstanding reports and this work will be completed in phases

Thunder Bay Regional Health Sciences Centre

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Chief Nursing Executive
Open Report
to the
Board of Directors
June 2018

Nurse Practitioner (NP) Scope of Practice:

Narcotics

- In April 2017, NP scope of practice was expanded to include prescribing of narcotics with a number of restrictions. In order to qualify for this privilege, NPs were required to complete a College of Nurses of Ontario approved controlled substance education program.
- On May 19, 2018, the Government of Canada made changes to the *Controlled Drug and Substances Act* (CDSA) giving NPs the authority to prescribe and administer Methadone without an exemption. NPs also gained the authority to prescribe Diacetylmorphine (commonly known as heroin).
- These changes will improve access for Canadians who require treatment for substance use disorder and is part of the Federal Government's response to the national opioid crisis.
- As with any other activity or procedure NPs engage in, they are expected to have the knowledge, skill and judgment to prescribe Methadone and Diacetylmorphine in a safe, competent and ethical manner. NPs are expected to understand the unique risks associated with prescribing any controlled substance and incorporate relevant evidence-informed strategies to mitigate these risks.

Diagnostics

- In January 2018, the Government made changes that allowed for the expansion of the NPs' scope of practice giving NPs the authority to order ultrasound and x-rays without restrictions, excluding computerized tomography (CT) scans.
- Previously, NPs could only order ultrasound and x-rays based on lists under the *Regulated Health Professions Act, 1991* and the *Healing Arts Radiation Protection Act* respectively. The new authority eliminates these lists.
- The College of Nurses of Ontario needed to clarity certain aspects of the new laws with the Government and, as such, did not update their NP authority and restrictions information until April 2018.

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- The next step is to present changes in NP authority to order ultrasound and x-rays to the Credentialing Committee for consideration (removal of current list associated with NP ordering).

Northern Ontario School of Medicine
École de médecine du Nord de l'Ontario

NOSM Activity Report

Dr. Roger Strasser, Dean-CEO
May - June 2018

NOSM Holds Board Retreat in Parry Sound

The Northern Ontario School of Medicine (NOSM) held its annual Board of Directors retreat in Parry Sound, Ontario on May 10 - 11, 2018.

During the two-day meeting, Board members participated in several presentations and interactive sessions which included topics relating to the School's mission of educating high quality physicians and health professionals, and achieving international recognition as a leader in distributed, learning-centred, community-engaged education and research.

Day one included updates on the School's MD program, the Academic Health Sciences Network, Research and the compendium of research activity in Northern Ontario, and highlights from the Indigenous Affairs and Francophone Affairs Units.

Dr. Sarah Newbery, rural physician, NOSM Associate Professor, and VP Clinical, North West Local Health Integration Network and Mr. Jim Whaley, provided an overview of work being done as a result of *Summit North: Building a Flourishing Physician Workforce* held in Thunder Bay on January 24, 2018.

In the evening, NOSM Board members enjoyed a Traditional Muskoka Dinner at the Rocky Crest Resort with local community members. Following dinner, Dr. Tim Redmond, Assistant Professor with the Northern Ontario School of Medicine and President of the Physician Clinical Teachers' Association (PCTA) spoke about the town of Parry Sound, and the importance of NOSM as a unifying agent for health care quality, accessibility and innovation in the North.

At the formal Board meeting on the second day, Directors received a Financial Report for the 11-month period ending March 31, 2018. In addition, the Board approved the proposed balanced budget of $46.22 million for the fiscal year May 1, 2018 to April 30, 2019.

Dr. Pierre Zundel, Chair of the Board of Directors, acknowledged the School's progress across Northern Ontario and said, "On behalf of the Board, we are grateful for the network of people, partnerships, communities and volunteers who have contributed to NOSM's achievement in providing access to health care."

NOSM Board members later joined members of the Federation of Northern Ontario Municipalities (FONOM) in a plenary session titled "2020 Vision, Reaching Beyond Extraordinary Together." Speakers included Dr. Catherine Cervin, NOSM Vice Dean, Academic; Dr. Penny Moody-Corbett, NOSM Senior Associate Dean, Associate Dean, Research and Interim Associate Dean, Community Engagement; and, Dr. Alex Anawati, Charter Class alumnus, ER Physician, faculty member, and NOSM Board member. The plenary was moderated by Dr. Roger Strasser, NOSM Dean and CEO.

The Board retreat ended with a tour of the of the West Parry Sound Health Centre (WPSHC) where Jim Hanna, Public Relations and Communications Director, explained why the community shares in the excitement of NOSM's academic success.

"Our community is fully engaged with NOSM and its learners because we will not be passive recipients of the School's many benefits," said Mr. Hanna. "We believe that social accountability is a shared responsibility, and this

approach has inspired the culture of learning within our community as we actively participate in the future of health care for our people."

The next meeting of the Board of Directors and the Annual Meeting of Members is scheduled to occur on September 19, 2018.

For a complete list of Board members, please visit our website at nosm.ca/board.

Séance de réflexion du conseil de l'EMNO à Parry Sound

Le conseil d'administration de l'École de médecine du Nord de l'Ontario (EMNO) a tenu sa séance annuelle de réflexion à Parry Sound (Ontario) les 10 et 11 mai 2018.

Au cours de ces deux jours, les membres ont assisté à plusieurs présentations et séances interactives portant sur des sujets liés à la mission de l'École qui est d'une part, de former des médecins et des professionnels de la santé hautement qualifiés et, d'autre part, de se faire connaître sur la scène internationale comme un chef de file de l'enseignement et de la recherche régionalisés faisant appel aux communautés.

Au programme du premier jour figuraient des mises à jour sur le programme de médecine de l'École, le Réseau universitaire des sciences de la santé et un résumé de l'activité de recherche dans le Nord de l'Ontario, ainsi que les faits saillants les bureaux des affaires autochtones et des affaires francophones.

La Dre Sarah Newbery, médecin rural, professeure agrégée à l'EMNO et vice-présidente des services cliniques du Réseau local d'intégration des services de santé du Nord-Ouest, et M. Jim Whaley, ont donné une vue d'ensemble du travail accompli à la suite de *Summit North: Building a Flourishing Physician Workforce* tenu à Thunder Bay le 24 janvier 2018.

Dans la soirée, les membres ont dégusté un dîner traditionnel des Muskokas au Rocky Crest Resort en compagnie de membres de la communauté locale. Après le dîner, le Dr Tim Redmond, professeur adjoint à l'École de médecine du Nord de l'Ontario et président de la Physician Clinical Teachers' Association, a parlé de la ville de Parry Sound et de l'importance de l'EMNO, un agent d'unification pour la qualité des soins, l'accessibilité et l'innovation dans les soins dans le Nord.

À la réunion officielle du conseil le lendemain, les membres ont reçu le rapport financier de la période de 11 mois terminée le 31 mars 2018. Ils ont aussi approuvé le budget équilibré proposé de 46,22 millions de dollars pour l'exercice du 1er mai 2018 au 30 avril 2019.

M. Pierre Zundel, président du conseil d'administration, a souligné les progrès de l'École dans tout le Nord de l'Ontario et a déclaré : « Au nom du conseil, je remercie le réseau de gens, de partenariats, de communautés et de bénévoles qui ont aidé l'EMNO à fournir l'accès aux soins de santé ».

Plus tard, les membres du conseil se sont joints à ceux de la Fédération des municipalités du Nord de l'Ontario pour une séance plénière intitulée *2020 Vision, Reaching Beyond Extraordinary Together* à laquelle les personnes suivantes ont fait des présentations : Dre Catherine Cervin, vice-doyenne responsable de l'enseignement à l'EMNO; Mme Penny Moody-Corbett, Ph. D., doyenne associée principale, doyenne associée responsable de la recherche et doyenne associée par intérim de l'engagement communautaire; Dr Alex Anawati, diplômé et membre de la toute première classe de l'EMNO, médecin-urgentiste, membre du corps professoral et membre du conseil de l'EMNO. Cette séance a été animée par le Dr Roger Strasser, doyen et PDG de l'EMNO.

La séance de réflexion du conseil s'est terminée avec une visite du West Parry Sound Health Centre où Jim Hanna, directeur des relations publiques et des communications, a expliqué pourquoi la communauté se réjouit elle

aussi du succès de l'EMNO en matière d'enseignement : « Notre communauté travaille pleinement avec l'EMNO et ses étudiants parce que nous ne voulons pas être des bénéficiaires passifs de ses nombreux bienfaits. Nous pensons que la responsabilité sociale est une responsabilité partagée, un point de vue qui a inspiré la culture d'apprentissage dans notre communauté qui participe activement à l'avenir des soins pour notre population ».

La prochaine réunion du conseil d'administration et l'assemblée générale annuelle des membres est prévue pour le 19 septembre 2018.

La liste complète des membres du conseil se trouve sur notre site Web à nosm.ca/board.

NOSM hosts annual Preceptor Awards and Recognition event

On Thursday, May 10 and Friday, May 11, NOSM hosted its annual Preceptor Awards and Recognition event. The event honoured preceptors in the Health Sciences and Interprofessional Education Unit at NOSM, including physiotherapists, occupational therapists, speech-language pathologists, audiologists and dietitians. This year's awards focused on preceptors working in Northwestern Ontario. The event also included a keynote address by Dr. Chris Mushquash titled Expanding Conceptual Models for Health Science Professionals: Indigenous Culture-Based Understandings of Wellness.

Read more.

Northern Ontario School of Medicine hosting a public information session on MD program admissions

The Northern Ontario School of Medicine (NOSM) will be hosting an information session for individuals interested in applying to the MD Program. These sessions are held annually, in conjunction with the opening of the new admission cycle. Learn about the admission requirements and application process at NOSM at Laurentian University Wednesday, June 20 at 6:30 p.m. or at NOSM at Lakehead University, Tuesday, June 26 at 6:30 p.m.

Learn more.

NOSM and the University of Manitoba Max Rady College of Medicine announce collaboration agreement

The Northern Ontario School of Medicine (NOSM) and the Max Rady College of Medicine at the University of Manitoba (U of M) have signed a collaboration agreement which will allow the two parties to collaborate on developing medical education programs that are socially accountable and responsive to patients in underserved, rural areas in both Manitoba and Northwestern Ontario. Through the collaboration, the two Schools hope to improve access to high-quality health care for patients across Manitoba and Northwestern Ontario, provide high-quality medical education and experience for learners in these communities, and collaborate on activities and programs that are relevant to the learners, patients and communities both Schools serve.

Learn more >>

Stay Connected

The Northern Ontario School of Medicine (NOSM) Executive Group has engaged an Expert Panel to provide advice on the relations, structures and policies that exist between NOSM and Indigenous Peoples including NOSM's Indigenous Reference Group, Elders' Council, the Indigenous Affairs Unit, Indigenous learners, Indigenous faculty members and staff, and Indigenous communities and organizations . **Learn more >>**

Northern Health Research Conference: Kenora, Ontario on September 21-22, 2018.

Join the Research Team for a virtual run to NHRC in Kenora!

The Northern Ontario School of Medicine's Northern Health Research Conference—more commonly known as the NHRC—has been held annually since 2006. It is hosted in communities across NOSM's wider campus of Northern Ontario and provides an opportunity for researchers in the region to present their research and exchange research ideas.

This conference demonstrates NOSM's commitment to research, health care, and education to the people of Northern Ontario and beyond. The NHRC explores research activities arising from community-based activities and highlights projects underway from students, residents, and community-based researchers. The conference provides opportunities for collaboration and networking.

Key Dates:
Registration Now Open:
Website: http://muster2018.com/

Northern Passages, is published twice yearly and conveys news about the School's activities. **Latest Issue - Volume 18, Issue 1 [English] [Français]**

Read your copy online: *https://www.nosm.ca/thescope/*

Respectfully submitted,

Dr Roger Strasser
Professor of Rural Health
Dean and CEO
Northern Ontario School of Medicine

Stay Connected

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Northern Cancer Fund
Northern Cardiac Fund
Health Sciences Discovery Fund

Report to the Thunder Bay Regional Health Sciences Centre Board of Directors June 2018

Who are you riding for?

Over 130 people are already registered for the 2018 **Tbaytel Motorcycle Ride for Dad presented by Winmar** in support of the prostate cancer diagnosis, treatment and research through the Northern Cancer Fund. Riders will all start their engines together on June 16/18 in a 'Roar for a Cure' and then head out on a day-long poker run in and around the city. Opening and closing ceremonies will take place at the Victoria Inn. Interested in participating (register online today at www.healthsciencesfoundation.ca) or volunteering for this fantastic event? Please contact Elaine Graydon at 684-7278. Everyone is welcome to come participate in the 'Roar for a Cure' which will happen at 9:00 A.M in the parking lot of the Victoria Inn.

Father's Day Jack Pot 50/50 Raffle: Tickets are $10 each or 3 for $20. Winner will be drawn on Father's Day, June 17th, at 3:00pm at Thunder Bay Harley Davidson.

Help kids get a spot on TeamStaal 2018

On May 3 the Foundation, through collaboration with the **Staal Foundation Open, presented by tbaytel** held a media conference to announce the TeamStaal Fundraising Contest and highlight the many family friendly events that will be happening at the Staal Foundation Open, presented by tbaytel from July 9-15. Kids age 7-12 are fundraising for the Northern Cancer Fund. The top 3 fundraisers will automatically win spots to play on Team Staal! 2 more spots will be randomly drawn from the remaining players, with each $20 they raise resulting in another ballot in the drum. The more they raise, the more chances they have to win. Every dollar raised will support the Northern Cancer Fund of the Thunder Bay Regional Health Sciences Foundation. Help make HOPE possible. Support a player today!

Media Coverage – Contact Heather ext. 7111

Planning your summer? Make your legacy.

You're finally grilling outside, planning vacations and soaking up some warm sunshine. With all this fun around the corner, it's time to plan in earnest for your future – near or far. Before you map out your herb garden, book an appointment to review your Will and consider a gift to the Health Sciences Foundation.

Every gift – regardless of size – impacts the care offered to all of us in Northwestern Ontario. Your Health Sciences Foundation helps make possible things like new infant warmers for the tiniest residents, just starting their lives, through to new vital signs monitors for patients receiving care here at the Health Sciences Centre and regional sites, including Marathon.

Every gift makes a difference and we hope that you've taken the time to think about what your legacy could be. Haven't had a chance? Want to know where your gift could make a difference? Please contact Terri Hrkac, Senior Director, Legacy and Major Gifts at 684-7109 for more information.

BY-LAW

OF

THUNDER BAY REGIONAL HEALTH SCIENCES CENTRE

Revised June ~~7, 2017~~6, 2018

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ADDENDA

PREAMBLE

WHEREAS Thunder Bay Regional Health Sciences Centre is an acute care academic hospital (the "Hospital") operating under the authority granted to it by the Province of Ontario. It functions under legislation contained in the *Public Hospitals Act* and all other pertinent and appropriate provincial and federal acts and regulations to provide care and treatment for those persons who require hospitalization or treatment. In addition to this "caring" function the Hospital has the following objects:

(a) In affiliation with Lakehead University, the Northern Ontario School of Medicine and other educational institutions to participate in programs for the contemporary training, education and qualification of undergraduate and graduate students in the health professions as may be considered necessary or advisable. In achieving this object the Hospital assumes its role as a University teaching, and research hospital;

(b) To encourage, promote and carry on medical and health care research. In addition, to encourage, promote support and carry on medical research in association with Thunder Bay Regional Health Research Institute, the Northern Ontario School of Medicine, Lakehead University, other academic hospitals and research funding agencies and other health science related agencies or institutions;

(c) To collaborate with community based health agencies so that a continuum of care is offered to patients;

(d) To assist in the promotion and maintenance of the health status of persons residing in the region served by the Hospital;

(e) To accept donations, gifts, legacies and bequests for use in promoting the objects and the carrying on of the work of the Hospital;

(f) To perform such lawful acts as are deemed necessary to promote the attainment of these objects;

AND WHEREAS the governing body of the Hospital deems it expedient that all By-Law of the Hospital heretofore enacted be cancelled and revoked and that the following By-Law No. 1 be adopted for regulating the affairs of the Hospital.

NOW THEREFORE BE IT ENACTED that all By-Law of the Hospital heretofore enacted be cancelled and revoked and that the following By-Law No. 1 be substituted in lieu thereof.

ADMINISTRATIVE PART

ARTICLE 1 - DEFINITIONS AND INTERPRETATION

1.1 Definitions

In this By-Law, the following words and phrases shall have the following meanings, respectively:

(a) "**Act**" means the *Corporations Act* (Ontario), and where the context requires, includes the Regulations made under it;

~~(b) "**Application**" means the application for membership prescribed by the Board;~~

~~(c)~~(b) "**Associates**" means the parents, siblings, spouse or common law partner or child of a Director, and includes any organization, agency, company, or individual (such as a business partner) with a formal relationship to a Director;

~~(d)~~(c) "**Board**" means the Board of Directors of the Hospital;

~~(e)~~(d) "**By-Law**" means any By-Law of the Hospital from time to time in effect;

~~(f)~~(e) "**Chief Financial Officer**" means the senior employee, responsible to the President and Chief Executive Officer for the treasury and controllership functions in the Hospital;

~~(g)~~(f) "**Chief Nursing Executive**" means the senior employee responsible to the President and Chief Executive Officer for the professional standards and quality of the nursing practice in the Hospital;

~~(h)~~(g) "**Chief of a Department**" means a member of the Medical, Dental, or Midwifery Staff appointed by the Board to be responsible for the professional standards and quality of medical, dental or midwifery care rendered by the members of his/her department to the Chief of Staff;

~~(i)~~(h) "**Chief of Staff**" means the member of the Medical Staff appointed by the Board to be responsible for the professional standards and the quality of Professional Staff care rendered at the Hospital and who shall be the Chair of the Medical Advisory Committee;

~~(j)~~(i) "**College**" means, as the case may be, the College of Physicians and Surgeons of Ontario (CPSO), the Royal College of Dental Surgeons of Ontario, the College of Nurses of Ontario, and/or the College of Midwives of Ontario;

~~(k)~~(j) **"Community"** means, the persons residing in the territory under the jurisdiction of the Ontario North West Local Health Integration Network ~~jurisdictional districts of Kenora, Rainy River, and Thunder Bay~~;

~~(l)~~(k) "**Conflict of Interest**" includes, without limitation, the following three areas that may give rise to a Conflict of Interest for the Directors of the Hospital, namely:

(i) "Pecuniary or Financial Interest": a Director is said to have a pecuniary or financial interest in a decision when the Director (or his/her Associates) stands to gain by that decision, either in the form of money, gifts, favours, gratuities, or other special considerations;

(ii) Undue Influence: a Director is said to have undue influence when his/her participation or influence in Board decisions selectively and disproportionately benefit particular agencies, companies, organizations, professional groups, or patients from a particular demographic, geographic, political, socio-economic, or cultural group; or

(iii) Adverse Interest: a Director is said to have an adverse interest to the Hospital when he/she is a party to or has an interest in a claim, application or proceeding against the Hospital.

~~(m)~~(l) "**Dental Staff**" means and includes all dentists and oral maxillofacial surgeons, who are appointed to attend patients in the Hospital;

~~(n)~~(m) "**Department**" means an organizational unit of the Professional Staff of which members of a similar discipline have been assigned;

~~(o)~~(n) "**Deputy Chief of Staff**" means the person appointed by the Board who supports the Chief of Staff, and who acts on behalf of the Chief of Staff in his/her absence;

~~(p)~~(o) "**Director**" means a member of the Board;

~~(q)~~(p) "**Excellent Care for All Act**" means the *Excellent Care for All Act* (Ontario), and where the context requires, includes the Regulations made under it;

~~(r)~~(q) "**Excluded Person**" means:

(i) Any member of the Professional Staff, other than the members of the Professional Staff appointed to the Board pursuant to the *Public Hospitals Act* and regulations thereunder;

(ii) Any employee other than the President and Chief Executive Officer; and Chief Nursing Executive;

(iii) Any spouse, dependent child, parent, brother or sister of an employee of the Hospital or member of the Professional Staff.

~~(s)~~(r) "**Executive Vice President, Medical and Academic Affairs**" means the senior employee responsible to the President and Chief Executive Officer for medical leadership in corporate visioning, planning, program development, human organizational development and for the academic mission of the Hospital.

~~(t)~~(s) "**Extended Class Nursing Staff**" means and includes all Registered Nurses in the extended class to whom the Board has granted Privileges with respect to the ordering of diagnostic procedures for out-patients in the Hospital;

~~(u)~~(t) "**Ex-officio**" means membership "by virtue of the office";

~~(v)~~(u) "**Hospital**" means the corporation created under the Act that operates the Thunder Bay Regional Health Sciences Centre having its head office at Thunder Bay, Ontario;

~~(w)~~(v) "**Foundation**" means the Thunder Bay Regional Health Sciences Foundation;

~~(x)~~(w) "**Impact Analysis**" means a process to assess the clinical and financial implications of a potential appointment to the Professional Staff;

~~(y)~~(x) "**Learner**" means a student, resident or graduate student participating in an educational program at the Hospital;

~~(z)~~(y) **"Medical Program Director"** means a member of the Medical Staff appointed by the Executive Vice President, Medical and Academic Affairs to be in charge of one organized program or service who reports to the Executive Vice President, Medical and Academic Affairs and the Chief of Staff on issues of quality and standards of care.

~~(aa)~~(z) "**Medical Staff**" means and includes all Physicians who are appointed to attend patients in the Hospital;

~~(bb)~~(aa) "**Member**" means member of the Hospital corporation;

~~(cc)~~(bb) "**Midwifery Staff**" means and includes all midwives who are appointed to attend patients in the Hospital;

~~(dd)~~(cc) **"Mission"** means the statement used to describe the founding purpose and major organizational commitments;

~~(ee)~~(dd) "**Northwest Regional Appointment and Credentialling Policy and Procedure**" means the policy endorsed and agreed upon by the participating organizations in North West Local Health Integration Network which outlines the standardized requirements and processes to be adhered to by each organization when considering an application for appointment or reappointment for hospital privileges;

~~(ff)~~(ee) "**Nurse**" means a holder of a current certificate of competence issued in Ontario as a Registered Nurse who is a staff nurse employed on a full time or part time basis by the Hospital

~~(gg)~~(ff) **"Officers"** means, the Chair, the Vice Chairs, the Treasurer, the Secretary and the President and Chief Executive Officer, as more particularly described in Article 9 of the By-law;

~~(hh)~~(gg) "**Patient**" means, unless otherwise specified, any in-patient, out-patient or other patient of the Hospital;

~~(ii)~~(hh) "**Person**" means and includes any individual, corporation, partnership, firm, joint-venture, syndicate, association, trust, government, government agency, board, commission or authority, or any other form of entity or organization;

~~(jj)~~(ii) "**President and CEO**" means, in addition to 'Administrator' as defined in section 1 of the *Public Hospitals Act*, the President and Chief Executive Officer of the Hospital;

~~(kk)~~(jj) "**Privileges**" mean those rights or entitlements conferred upon a Physician, Dentist, Midwife or Nurse in the Extended Class as a result of their appointment or re-appointment;

~~(ll)~~(kk) "**Professional Staff**" means a credentialed member of the Medical, Dental, Midwifery and Extended Class Nursing Staff who are appointed and granted privileges by the Board;

~~(mm)~~(ll) "**Professional Staff Officers**" means the President, Vice President and Secretary/Treasurer of the Professional Staff ;

~~(nn)~~(mm) "**Professional Staff Rules**" means provisions approved by the Board concerning the practice and professional conduct of the members of the Professional Staff;

~~(oo)~~(nn) "**Program and Service**" means an organized unit of a department which is based on a sub-specialty area of clinical practice;

~~(pp)~~(oo) "**Public Hospitals Act**" means the *Public Hospitals Act* (Ontario), and, where the context requires, includes the Regulations made under it;

~~(qq)~~(pp) "**Special Resolution**" means a resolution passed and confirmed with or without variation by at least a two-thirds (2/3) of the votes cast at a general meeting of the Members of the Hospital, an annual meeting of the Hospital or meeting of the Board.

~~(rr)~~(qq) **"Strategic Directions"** means course of action that leads to the achievement of the goals of the Hospital's strategy;

~~(ss)~~(rr) **"Vision"** means an aspirational description of what the Hospital would like to achieve or accomplish.

1.2 Interpretation

This By-Law shall be interpreted in accordance with the following unless the context otherwise specifies or requires:

(a) all terms which are contained in this By-Law of the Hospital and which are defined in the Act or the *Public Hospitals Act* or the Regulations made thereunder or the *Excellent Care for All Act* or the Regulations made thereunder , shall have the meanings given to such terms in the Act, *Public Hospitals Act* or the *Excellent Care for All Act* or the Regulations thereunder;

(b) the use of the singular number shall include the plural and vice versa, the use of any gender shall include the masculine, feminine and neuter genders;

(c) the headings used in the By-Law are inserted for reference purposes only and are not to be considered or taken into account in construing the terms or provisions thereof or to be deemed in any way to clarify, modify or explain the effect of any such terms or provisions; and

(d) any references herein to any law, by-law, rule, regulation, order or act of any government, governmental body or other regulatory body shall be construed as a reference thereto as amended or re-enacted from time to time or as a reference to any successor thereto.

ARTICLE 2 - MEMBERSHIP IN THE HOSPITAL

2.1 ~~Admission~~Members

(a) ~~Membership in the Hospital shall be limited to persons interested in furthering the Hospital's objects and shall consist of any person whose Application for admission as a Member has been approved by a resolution of the Board;~~The Members shall consist of the Directors from time to time of the Hospital, who shall be ex-officio Members for so long as they serve as Directors;

(b) ~~Membership in the Hospital shall include those persons who are Lifetime Members at the time this By-Law is revised and passed from time to time by the Board and who shall continue as Lifetime Members subject to Sections 2.4 and 2.5.~~Each Member shall be entitled to one vote;

(c) ~~The Secretary shall maintain a list of names and addresses of the Members of the Hospital and, the list as certified by the Secretary shall be conclusive evidence of such membership as of the date of such certificate.~~There shall be no dues payable by the Members.

2.2 Annual Membership

(a) Subject to Section 2.1, a person is eligible to be an Annual Member where he/she pays to the Hospital the annual membership fee for individuals, an amount to be determined from time to time by resolution of the Board;

(b) At the time of the payment of the fee in paragraph (a) above, the person must:

(i) be of the full age of eighteen (18) years;

(ii) have been either a resident, employee, or carry on a business in the jurisdictional districts of Kenora, Rainy River, or Thunder Bay for a continuous period of at least (3) months immediately prior thereto or such other location as may be approved by the Board;

(iii) support and promote the objects of the Hospital as determined by the Board; and

(iv) have completed, signed and submitted the Application as approved by the Board.

(c) Subject to Section 2.1 a person will be eligible for annual membership who is a member in good standing of the Volunteer Association to the Hospital or the Foundation Board;

(d) Any annual membership in the Hospital shall be effective from February 1st one year to January 31st in the following year;

(e) An Annual Member shall not be entitled to vote at any meetings of the Hospital unless the membership was approved by the Board and the membership fee was paid in full at least 60 days before any such meeting.

2.3 Application

Each application for a membership in the Hospital must be in a form prescribed by the Directors of the Hospital for the current year and must be received by the Board no later than sixty (60) days prior to the annual meeting in each year to be considered in time to allow the prospective applicant an opportunity to vote at the next annual meeting of the Hospital. The decision as to whether a prospective applicant will be admitted will be made by the Board in its sole discretion in accordance with Section 2.1. The Application shall contain:

(a) The membership qualifications set out in Section 2.2 of the By-Law;

(b) A statement by the applicant that he/she has read the membership qualifications and that he/she meets all of the requirements set forth therein; and

(c) The applicable membership fee for the upcoming year.

2.4 Withdrawal

A Member may withdraw from the Hospital by delivering a written resignation to the Secretary.

~~**2.5 Termination of Membership**~~

~~A person's membership in the Hospital shall terminate upon the happening of any of the following events:~~

~~(a) Upon the death, dissolution or resignation of the Member; or~~

~~(b) If the Member at any time fails to meet the qualifications as set out in Section 2.2;~~

~~(c) Where the Board passes a special resolution with respect to the removal of a Member's membership.~~

~~**2.6 Information Available to Members**~~

~~No Member may have access to information respecting the details of the business of the Hospital which, in the opinion of the Board, would be detrimental to the interests of the Hospital.~~

~~**2.7 Membership Dues**~~

~~Members shall be notified in writing of membership dues at any time payable by them.~~

ARTICLE 3 - ANNUAL AND SPECIAL MEETINGS OF THE MEMBERS OF THE HOSPITAL

3.1 Annual General Meeting of the Members of the Hospital

The annual meeting of Members shall be held on a date to be fixed by the Board between April 1st and July 31st in each year or as may otherwise be allowed by law.

3.2 Special Meetings of the Members of the Hospital

(a) The Board or the Chair may call a special meeting of the Hospital;

(b) Not less than twenty-five percent (25%) of the Members of the Hospital entitled to vote at a meeting proposed to be held may, in writing, requisition the Directors to call a special meeting of the Members for any purpose connected with the affairs of the Hospital which are properly within the purview of the Members' role in the Hospital and which are not inconsistent with the *Hospitals Act* (Ontario);

(c) The requisition shall be deposited at the Head Office of the Hospital and may consist of several documents in like forms signed by one or more requisitioners;

(d) Notice of a special meeting shall be given in the same manner as provided in Section 3.3 If the Directors, acting in their sole discretion, determine that the requisition meets the qualifications set out in paragraph (b) above, the Directors shall call and hold such meeting within fourteen (14) days from the date of the deposit of the requisition;

(e) The notice of a special meeting shall specify the purpose for which it has been called.

3.3 Notice

(a) At least ten (10) days' prior written notice of a meeting of the Members shall be given to each Member and such notice shall specify the business to be transacted at such meeting;

~~(b) In lieu of the written notice required under paragraph (a) above, it is sufficient notice of any annual or special meeting of Members of the Hospital if notice is given by publication at least once a week for two successive weeks next preceding the meeting in a newspaper or newspapers circulated in the municipalities in which Members of the Hospital reside as shown by their addresses in the records of the Hospital.~~

3.4 Omission of Notice

No unintentional or technical error or omission in giving notice of a meeting of Members of the Hospital may invalidate resolutions passed or proceedings taken at the meeting. Any Member may at any time waive notice of any such meeting and may ratify, approve and confirm any or all resolutions passed or proceedings taken at the meeting.

3.5 Location of Meeting

Meetings of the Hospital shall be held at the head office of the Hospital or at a location fixed by the Board within North Western Ontario

3.6 Voting

(a) At all annual or special meetings, resolutions shall be determined by a majority of affirmative votes cast by Members present at the meeting, unless otherwise required by statute or the By-Law. If there is an equality of votes, the Chair shall declare the motion lost;

(b) Pursuant to the *Public Hospitals Act*, no Member may vote by proxy;

(c) At any meeting, unless a poll is demanded, a declaration by the Chair of the meeting that a resolution has been carried or carried unanimously or by a particular majority, or lost or not carried by a particular majority, shall be conclusive of the fact;

(d) A poll may be demanded either before or after any vote by a show of hands by a member~~any person entitled to vote at the meeting~~. If at any meeting a poll is demanded on any other question or as to the election of Directors, the vote shall be taken by ballot in such manner as the Chair of the meeting directs. The result of a poll shall be deemed to be the resolution of the meeting at which the poll was demanded. A demand for a poll may be withdrawn.

3.7 Quorum

~~A quorum for any meeting of the Members of the Hospital shall be ten (10) Members.~~A majority of the Members must be present to constitute a quorum at a meeting of Members.

3.8 Chair of the Meeting

The Chair of a meeting of the members of the Hospital shall be:

(a) The Chair of the members of the Hospital; or

(b) The Vice-Chair of the members of the Hospital, if the Chair is absent or is unable to act; or

(c) A Chair elected by the Members present if the Chair and Vice-Chair are absent or are unable to act. The Secretary shall preside at the election of the Chair, but if the Secretary is not present, the Directors, from those present, shall choose a Director to preside at the election; or

(d) If no Director is present or if all the Directors present decline to take the Chair, then the Members who are present and entitled to vote shall, choose one of their number to be the Chair.

The Chair of the meeting shall not be entitled to vote, unless the vote is taken by written ballot.

3.9 Business at Annual Meetings

At each annual meeting, in addition to the other business identified by the published agenda for the meeting, the following reports, statements and actions shall be presented:

(a) the minutes of the previous annual meeting;

(b) the report of the Chair of the Board;

(c) the report of the Auditor including a presentation of the audited financial statements;

(d) the report of the President and Chief Executive Officer;

(e) the report of the Medical Advisory Committee;

(f) election of Board members; and

(g) appointment of the Auditors.

3.10 Adjourned Meeting

(a) If, within one-half hour after the time appointed for a meeting of the Hospital, a quorum is not present, the meeting shall stand adjourned until a day within two weeks to be determined by the Board;

(b) At least three days notice of the adjourned meeting shall be given in accordance to the provisions of Section 3.3 above.

3.11 Financial Year End

The financial year of the Hospital shall end with the 31st day of March in each year.

ARTICLE 4 - BOARD OF DIRECTORS

4.1 Nominations to Board

(a) Subject to this section and all other provisions of the By-law, nominations for election as Director at the annual meeting of the Hospital may be made only by

the Governance and Nominating Committee of the Board further to the Board's nominating policy as in place from time to time. For greater certainty, no nominations shall be accepted by the Members of the Hospital which are not submitted and approved by the Governance and Nominating Committee.

4.2 Board Composition

The affairs of the Hospital shall be governed by a Board consisting of:

(a) Elected Directors;

The affairs of the Hospital shall be managed by a Board of twelve (12) elected Directors, eligible to serve on the Board.

The terms of the elected Directors shall be staggered such that the term of at least one quarter of the elected Directors shall expire each year at the time of the annual general meeting of the Hospital, or until their successors are elected or appointed. The expiring terms shall be filled annually, for three (3) year terms, by election by the Members of the Hospital at the annual meeting of the Hospital in accordance with the provisions of the By-Law of the Hospital.

(b) Ex-Officio Directors (Non-Voting) :

(i) the President of the Professional Staff;

(ii) the Chief of Staff;

(iii) the President and CEO; and

(iv) the Chief Nursing Executive.

(c) Ex-Officio Directors (Voting):

The Dean of the Northern Ontario School of Medicine or designate. An Ex-Officio Director shall hold office until his/her successor is appointed in accordance with the By-Law of the Hospital.

4.3 Qualification of Directors

(a) Every Director shall be eighteen (18) or more years of age and shall be a voting Member in good standing of the Hospital, ~~or shall become a Member of the Hospital within ten (10) days~~ after election or appointment as a Director and no undischarged bankrupt shall become a Director;

(b) Save and except for the current Directors, no Excluded Person shall be eligible for election or appointment to the Board except where otherwise provided in this By-Law.

4.4 Honorary Directors

The Board may from time to time appoint Honorary Directors in recognition of contributions of long or special services to the Hospital considered worthy of such appointment. Honorary Directors may attend public meetings of the Board but do not have the right to vote. Honorary Directors do not have the rights and privileges of the Directors.

4.5 No Remuneration

The Directors shall serve as such without remuneration, and no Director shall directly or indirectly receive any profit from his or her position as such, provided that a Director may be paid reasonable expenses incurred by him or her in the performance of his or her duties as a Director. Members of the Professional Staff required to serve as Directors in accordance with the *Public Hospitals Act* shall be paid for their services to the Hospital in any other capacity, as approved by the Board.

4.6 Term of Office Restrictions

(a) No person may be elected or appointed a Director for more than nine (9) consecutive years of service, provided, however, that a Director completing nine years of service on the Board, may have his or her service as a Director extended so as to permit him or her to complete his or her terms as Chair, or Vice-Chair;

(b) A former Director restricted by paragraph (a) above may be re-elected or re-appointed a Director following a break in the continuous service of at least three (3) years;

(c) Save as otherwise provided in this By-Law, an Officer's term of office shall continue until his or her successor is elected or appointed;

(d) A Director may serve as Chair, Vice-Chair or Treasurer of the Board, for an initial term of one year renewable annually for a maximum of four (4) consecutive years in one office, provided, however, that following a break in the continuous service of at least one (1) year the same person may be re-elected or re-appointed to any office.

4.7 Vacancy and Termination of Office

(a) The office of a Director shall automatically be vacated:

~~(i) if the Director does not, within ten (10) days after election or appointment as a Director, become a Member, or ceases to be a Member of the Hospital;~~

~~(ii)~~(i) if the Director becomes bankrupt or suspends payment of debts generally or compounds with creditors or makes an assignment in bankruptcy or is declared insolvent;

~~(iii)~~(ii) if the Director is found to be a mentally incompetent person or becomes of unsound mind;

~~(iv)~~(iii) if the Director, by notice in writing to the Hospital, resigns office, which resignation shall be effective at the time it is received by the Secretary of the Hospital or at the time specified in the notice, whichever is later;

~~(v)~~(iv) if at a meeting of the Directors of the Hospital, a special resolution is passed by the Directors, removing a Director before the expiration of the Director's term of office; and

~~(vi)~~(v) if the Director dies.

(b) The office of a Director may be vacated by a simple majority resolution of the Board:

(i) if a Director is absent for seventy (70) percent of the meetings of the Board, in any twelve (12) month period; or

(ii) if a Director fails to comply with the *Public Hospitals Act*, the Act, the Hospitals Letters Patent, By-Law, Rules, Regulations, policies and procedures, including without limitation, the confidentiality and conflict of interest requirements.

(c) If a vacancy occurs at any time among the Directors either by a resignation, by death or removal by the Directors in accordance with paragraph (a) above, or by any other cause, such vacancy may be filled by a qualified person elected by the Board to serve until the next annual meeting;

(d) At the next annual meeting in addition to the election of Directors to fill the vacancies caused by expiry of Directors' terms, the Members shall also elect any additional Directors(s) to fill the unexpired term created by any vacancy referred to in paragraph (a) above.

ARTICLE 5 - CONFLICT OF INTEREST

(a) Every Director who, either directly or through one of his or her Associates, has, or thinks he or she may potentially have, a conflict of interest shall disclose the nature and extent of the interest at a meeting of the Board in accordance with Board policy on conflicts of interest, as set from time to time;

(b) If a Director believes that any other Director is in a conflict of interest position with respect to any contract, transaction, matter or decision, the Director shall have the concern recorded in the minutes in accordance with Board policy on conflicts of interest, as set from time to time;

(c) If a Director has made a declaration of conflict of interest in compliance with this By-Law the Director is not accountable to the Hospital for any profit he/she may realize from the contract, transaction, matter or decision;

(d) If a Director fails to make a declaration of his/her interest in a contract, transaction, matter or decision as required by this By-Law, this shall be considered grounds for termination of his/her position as a Director of the Hospital;

(e) The failure of any Director to comply with the Conflict of Interest By-Law of the Hospital does not, in or of itself, invalidate any contract, transaction, matter or decision undertaken by the Board of the Hospital.

ARTICLE 6 - PUBLIC STATEMENTS AND CONFIDENTIALITY

(a) Every Director, Officer and employee of the Hospital shall respect the confidentiality of matters brought before the Board, keeping in mind that unauthorized statements could adversely affect the interests of the Hospital;

(b) Unless the Board withholds such authority, the Chairperson, the Vice-Chairperson, in the absence of the Chairperson, and the President and Chief

Executive Officer have the authority to make statements to the news media, or public, on any matters concerning the Hospital. No other persons shall have the authority to comment to the news media or public on any matters concerning the Hospital unless authorized by the Chairperson or by the President and Chief Executive Officer.

ARTICLE 7 - STANDARDS OF CARE

Every Director and Officer of the Hospital in exercising his/her powers and discharging his/her duties shall:

(a) act honestly and in good faith with a view to the best interests of the Hospital; and

(b) exercise the care, diligence and skill that a reasonably prudent person would exercise in comparable circumstances;

(c) respect and abide by decisions of the Board;

(d) keep informed about:

(i) matters relating to the Hospital;

(ii) the community served;

(iii) necessary information and background preparation so as to participate effectively in meetings of the Board and its committees; and

(iv) other healthcare services provided in the region.

(e) participate in the initial orientation as a new Director and in ongoing Board education;

(f) participate in the annual evaluation of overall Board effectiveness; and

(g) represent the Board, when requested.

ARTICLE 8 - RESPONSIBILITIES OF THE BOARD

The Board shall govern and manage the affairs of the Hospital consistent with the *Public Hospitals Act*, the Hospital Management regulations thereunder and other applicable legislation and shall be responsible to:

(a) Develop and review on a regular basis the Vision, Mission, and Strategic Directions of the Hospital in relation to the provision, within available resources, of appropriate programs and services in order to meet the acute care needs of the region;

(b) Work collaboratively with other community agencies and institutions in meeting the health care needs of the community;

(c) Establish procedures for monitoring compliance with the requirements of the *Public Hospitals Act*, the Hospital Management Regulation thereunder, the By-Law of the Hospital and other applicable legislations;

(d) Establish policies and procedures to provide the general framework within which the President and Chief Executive Officer, the Medical Advisory Committee, the Professional Staff and the Hospital staff will establish procedures for the management of the day-to-day processes;

(e) Ensure that the President and Chief Executive Officer, Chief of Staff, Nurses and Health Professionals who are managers develop policies and plans to deal with:

(i) emergency situations that could place a greater than normal demand on the services provided by the Hospital or disrupt the normal routine;

(ii) the failure to provide services by persons who ordinarily provide services in the Hospital; and

(iii) situations, circumstances, conduct and behaviours which are or have the potential of resulting in a risk to the safety and wellbeing of patients, staff and/or other health professionals.

(f) Establish the selection process for the appointment of the President and Chief Executive Officer and the Chief of Staff and appoint the President and Chief Executive Officer and the Chief of Staff, in accordance with the process;

(g) Annually conduct the President and Chief Executive Officer's formal performance evaluation and review and approve his or her compensation and set his or her goals and objectives for the coming year;

(h) Delegate responsibility and concomitant authority to the President and Chief Executive Officer for the leadership, management, operation of programs, services and required accountability to the Board;

(i) Appoint the Chief of Staff in accordance with the provisions of the By-Law;

(j) Delegate responsibility and concomitant authority to the Chief of Staff for the medical quality of care of the operation of the clinical programs and departments of the Hospital, the supervision of the Professional Staff activities in the Hospital and require accountability to the Board;

(k) Appoint and re-appoint Physicians, Dentists, Midwives and Registered Nurses in the Extended Class to the Professional Staff of the Hospital and delineate the respective privileges after considering the recommendations of the Medical Advisory Committee, in accordance with legislative and By-law requirements and subject to the approval of relevant programs;

(l) Through the Medical Advisory Committee, assess and monitor the acceptance by each member of the Professional Staff of his or her responsibility to the patient and to the Hospital concomitant with the privileges and duties of the appointment and with the By-Law of the Hospital;

(m) Ensure that staff and facilities are appropriate and available, including an adequate supply of physicians and other professionals, for the services provided;

(n) Ensure that quality and improvement assurance, risk management and utilization review methods are established for the regular evaluation of the quality of care,

and that all Hospital services are regularly evaluated in relation to generally accepted standards and required accountability on a regular basis;

(o) Review regularly the functioning of the Hospital and all programs and services in relation to the objects of the Hospital as stated in the Letters Patent, Supplementary Letters Patent and the By-Law and demonstrate accountability for its responsibility to the annual meeting of the Hospital;

(p) Adhere to the attendance policy as established by the Board;

(q) Review on a regular basis the role and responsibility of the Hospital to its community in relation to the provision of services, within the means available, of appropriate types and amounts of services;

(r) Approve the annual budget for the Hospital;

(s) Establish an investment policy consistent with the provisions of the By-Law;

(t) Borrow money, from time to time, as may be authorized by resolution of the Board;

(u) Evaluate its own performance in relation to its responsibilities and periodically review and revise governance policies, processes and structures as appropriate;

(v) Ensure the establishment and provide for the operation of an Occupational Health and Safety program for the Hospital that shall include procedures with respect to:

(i) a safe and healthy work environment in the Hospital;

(ii) safe use of substances, equipment and medical devices in the Hospital;

(iii) safe and healthy work practices in the Hospital;

(iv) prevention of accidents to persons on the premises of the Hospital;

(v) elimination of undue risks and minimizing of hazards inherent in the Hospital environment; and

(vi) the establishment of and provision for the operation of a health surveillance program including a communicable disease surveillance program in respect of all persons carrying on activities in the Hospital.

(w) Establish a Fiscal Advisory Committee, the membership and purposes of which meet the requirements of the *Public Hospitals Act*;

(x) Establish a Quality Committee further to the *Excellent Care for All Act* to monitor and report on the overall quality of care and make recommendations to the Board regarding quality improvement initiatives and policies and to oversee the preparation of annual quality improvement plans. The Committee is comprised of:

(i) the President and CEO;

(ii) one member of the Medical Advisory Committee;

(iii) the Chief Nursing Executive;

(iv) one person who works in the Hospital and who is not a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario; and

(v) such other persons as are selected by the Board so as a third of the members of the Quality Committee shall be voting members of the Board

(y) Provide for:

(i) the participation of Nurses who are Managers and staff Nurses in decision making related to administrative, financial, operational and planning matters in the Hospital; and

(ii) the participation at the committee level of staff Nurses who are Managers, including the election of staff Nurse representatives to committees and the election or appointment to committees of Nurses who are Managers;

(z) Pursuant to the Hospital Management Regulations, provide for the establishment of procedures to encourage the donation of organs and tissues including:

(i) procedures to identify potential donors; and

(ii) procedures to make potential donors and their families aware of the options of organ and tissue donations;

and ensure that such procedures are implemented in the Hospital; and

(aa) Ensure that a system for the disclosure of every critical incident is established and that the President and Chief Executive Officer, the Chief of Staff and the Chief Nursing Executive will be responsible for the system.

ARTICLE 9 - OFFICERS OF THE BOARD AND OF THE HOSPITAL

9.1 Officers

(a) The Board shall elect the following Officers at a meeting immediately following the Annual Meeting, from among themselves:

(i) a Chair;

(ii) two Vice-Chairs;

(iii) a Treasurer.

(b) The President and Chief Executive Officer shall be the Secretary of the Hospital and Secretary of the Board;

(c) Ex-Officio Directors are ineligible for election as Chair or Vice-Chair;

(d) The Officers of the Hospital shall be responsible for the duties set forth in the By-Law and they are not necessarily required to perform such duties personally, but they may delegate to others the performance of any or all such duties;

(e) Any Officer of the Hospital shall cease to hold office upon resolution of the Board.

9.2 Duties of the Chair

The Chair of the Board shall:

(a) chair all meetings of the Board;

(b) be an ex officio member of all committees of the Board;

(c) report to each annual meeting of Members of the Hospital concerning the governance and operations of the Hospital;

(d) represent the Hospital at public or official functions; and

(e) perform such other duties as may from time to time be determined by the Board.

9.3 Duties of the Vice-Chairs

The Vice-Chairs of the Board shall have all the powers and perform all the duties of the Chair in the absence or disability of the Chair and any other duties assigned by the Board.

9.4 Duties of the Treasurer

The Treasurer shall:

(a) oversee the management of finances of the Hospital and ensure that appropriate reporting mechanisms and control systems as established by the Board are in place, and monitor such mechanisms and systems for compliance;

(b) ensure that appropriate banking resolutions and signing authority policies as established by the Board are in place and monitor for compliance with such resolutions and policies. Ensure that systems for control for regular review and revision as necessary of the banking resolutions and signing authority policies are in place, are adequate and functional, and monitor for compliance with such resolutions and policies;

(c) ensure that systems for control as established by the Board for the maintenance of books of account and accounting records required by the *Hospitals Act* are in place, are functional and adequate and monitor for compliance with such resolutions and policies;

(d) review the financial results and the budget submitted to the Resource Planning Committee by management and submit and recommend to the Board any changes to the budget;

(e) oversee the management of the investment policy as established by the Board, and ensure that the investment policy is in place, and monitor for compliance with the policy;

(f) review financial reports and financial statements and submit same at meetings of the Board, indicating the financial position of the Hospital;

(g) review and submit to the Board for approval, a financial statement for the past year;

(h) ensure systems as established by the Board for the preparation and submission to the Board of compliance certificates confirming that wages and source deductions have been accomplished, are functional and adequate and monitor for compliance with such systems;

(i) where there is concern with respect to any of the above, review the matter with the President and Chief Executive Officer and report to the Board the results of those deliberations; and

(j) perform such other duties as determined by the Board.

The Treasurer may delegate to employees of the Hospital those duties that he/she considers appropriate to delegate and that he is allowed by law to delegate.

9.5 Duties of the Secretary

The Secretary shall:

(a) attend all meetings of the Board and of Committees of the Board;

(b) keep a record of the minutes of all meetings;

(c) keep a roll of names and addresses of the Members;

(d) attend to correspondence;

(e) give such notice as required by the By-Law of the Hospital relating to all meetings of the Hospital, the Board and its Committees;

(f) prepare all reports required under any Act or regulation of the Province of Ontario;

(g) be the custodian of all minute books, documents and registers of the Hospital required to be kept by the provisions of the Act;

(h) be the custodian of the seal of the Hospital;

(i) keep copies of all testamentary documents and documents donating designated purpose funds by which benefits are given to the use of the Hospital and provide copies of same to the Office of the Public Guardian and Trustee in accordance to the provisions of the *Charities Accounting Act* (Ontario), and submit semi-annually a report to the Board with respect to such donations; and

(j) perform such other duties as may be determined by the Board.

The Secretary may delegate to employees of the Hospital those duties that he or she considers appropriate to delegate and that he/she is allowed by law to delegate.

9.6 President and Chief Executive Officer

(a) The President and Chief Executive Officer shall be appointed by the Board;

(b) The President and Chief Executive Officer shall be Secretary of the Hospital and Secretary of the Board;

(c) The duties of the President and Chief Executive Officer shall include the exercise of the authority delegated to the President and Chief Executive Officer by the Board through Board policies for the organization and operation of the Hospital and the President and Chief Executive Officer shall be accountable to the Board for the accomplishment of applicable Board policies and operation of the Hospital consonant with the reasonable interpretation of Board policies;

(d) The President and Chief Executive Officer shall be a non-voting member of the Board and a non-voting member of all committees of the Board;

(e) The President and Chief Executive Officer shall submit quarterly certificates to the Board in respect of the previous quarter that all wages owing to employees and source deductions relating to the employees that the Hospital is required to deduct and remit to the proper authorities pursuant to all applicable legislation, including without limitation, the *Income Tax Act* (Canada), the Canada Pension Plan (Canada), the *Unemployment Insurance Act* (Canada), and *Employer Health Tax Act* (Ontario), have been made and remitted to the proper authorities, and that all taxes collected pursuant to the goods and services tax and provincial sales tax have been collected and remitted to the proper authorities;

(f) The President and Chief Executive Officer shall submit semi-annual reports to the Board on the transfer of funds and payments made by the Hospital and the compliance of such transfers and payments with such policies as may be set by the Board from time to time;

(g) The President and Chief Executive Officer shall perform such other duties as may be determined from time to time by the Board.

ARTICLE 10 - PROTECTION OF DIRECTORS AND OFFICERS

10.1 Protection of Directors and Officers

Except as otherwise provided in any legislation or law, no Director or Officer of the Hospital shall be liable for the acts, receipts, neglects or defaults of any other Director or Officer or employee or for any loss, damage or expense happening to the Hospital through the insufficiency or deficiency of title to any property acquired by the Hospital or for or on behalf of the Hospital or for the insufficiency or deficiency of any security in or upon which any of the monies of or belonging to the Hospital shall be placed out or invested or for any loss or damage arising from the bankruptcy, insolvency or tortious act of any person including any person with whom or which any monies, securities or effects shall be lodged or deposited or for any loss, conversion, misapplication or misappropriation of or any damage resulting from any dealings with monies, securities or other assets belonging to the Hospital or for any other loss, damage or misfortune whatever which may happen in the execution of the duties of the Director's or Officer's respective office or trust or in relation thereto unless the same shall happen by or through the Director's or Officer's own failure to act honestly and in good faith in the performance of the duties of office, or other wilful neglect or default.

10.2 Pre-Indemnity Considerations

Before giving approval to the indemnities provided in section 10.3, or purchasing insurance provided in section 10.4, the Board shall consider:

(a) the degree of risk to which the Director or Officer is or may be exposed;

(b) whether, in practice, the risk cannot be eliminated or significantly reduced by means other than the indemnity or insurance;

(c) whether the amount or cost of the insurance is reasonable in relation to the risk;

(d) whether the cost of the insurance is reasonable in relation to the revenue available; and

(e) whether it advances the administration and management of the property to give the indemnity or purchase the insurance.

10.3 Indemnification of Directors and Officers

Upon approval by the Board from time to time, every Director and Officer of the Hospital and every member of a committee, or any other person who has undertaken, or is about to undertake, any liability on behalf of the Hospital or any Hospital controlled by it, and the person's respective heirs, executors and administrators, and estate and effects, successors and assigns, shall from time to time and at all times, be indemnified and saved harmless out of the funds of the Hospital, from and against:

(a) all costs, charges and expenses whatsoever which such Director, Officer, committee member or other person sustains or incurs in or in relation to any action, suit or proceeding which is brought, commenced or prosecuted against the Director, Officer, committee member or other person, for or in respect of any act, deed, matter or thing whatsoever, made, done or permitted by them, in or in relation to the execution of the duties of such office or in respect of any such liability; and

(b) all other costs, charges and expenses which the Director, Officer, committee member or other person sustains or incurs in or in relation to the affairs thereof, except such costs, charges or expenses as are occasioned by their own failure to act honestly and in good faith in the performance of the duties of office, or by other wilful neglect or default.

The Hospital shall also, upon approval by the Board from time to time, indemnify any such person in such other circumstances as any legislation or law permit or requires. Nothing in this By-Law shall limit the right of any person entitled to indemnity to claim indemnity apart from the provisions of this By-Law to the extent permitted by any legislation or law.

10.4 Insurance

Upon approval by the Board ~~and from time to time~~, the Hospital shall purchase and maintain insurance for the benefit of any Director, Officer or other person acting on behalf of the Hospital against any liability incurred in that person's capacity as a Director, officer or other person acting on behalf of the Hospital, except where the liability relates to that person's failure to act honestly and in good faith with a view to the best interests of the Hospital.

ARTICLE 11 - REGULAR AND SPECIAL MEETINGS OF THE BOARD

11.1 Regular Meetings

(a) There shall be at least eight (8) regular meetings of the Board each year, at such time and place as the Board may from time to time by resolution determine;

(b) The Secretary shall provide to each Director not less than five (5) days written notice of a regularly scheduled Board meeting. The notice may be delivered, mailed, emailed, or faxed;

(c) A meeting of the Board may be held without notice immediately following the Annual Meeting.

11.2 Special Meetings

(a) The Chair or Vice-Chair of the Board may call special meetings of the Board;

(b) The Secretary shall call a special meeting of the Board if three (3) Directors so request in writing;

(c) Notice of a special meeting of the Board shall specify the purpose of the meeting, shall be delivered, faxed, e-mailed or telephoned to each Director at least twenty-four (24) hours in advance of the meeting.

11.3 Procedures for Board Meetings

(a) The declaration of the Secretary or Chair that notice has been given pursuant to the By-Law, shall be sufficient and conclusive evidence of the giving of such notice;

(b) No error or omission in giving notice for a meeting of Directors shall invalidate such meeting or invalidate any proceedings at such meeting and any Director may at any time waive notice of any such meeting and may ratify and approve any or all proceedings;

(c) Meetings of the Board shall be open, but the Board may, at its discretion and without notice, hold all or part of any Board meeting in camera. Guests may participate in meetings of the Board and its Committees only by invitation or approval of the Chair or by resolution of the Board or Committee;

(d) If all the Directors present at or participating in the meeting consent and in accordance with the Board's policy on telephone meetings adopted from time to time by the Board, a meeting of Directors or a meeting of a committee of the Board may be held by such telephone, electronic or other communication facilities, and the Director or committee member participating in the meeting by those means is deemed to be present at the meeting;

(e) Minutes shall be kept for all meetings of the Board;

(f) Business arising at any meeting of the Board shall be decided by a majority of votes, provided that:

(i) except as provided by clause (ii) below, votes shall be taken in the usual way by a show of hands, in which case:

(A) The Chair of the meeting shall not have a vote;

(B) If there is an equality of votes, the Chair shall declare the motion lost.

(ii) votes shall be taken by written ballot if so demanded by any voting member present, in which case:

(A) The Chair shall have a vote;

(B) If there is an equality of votes, the motion is lost.

(iii) a declaration by the Chair that a resolution, vote or motion has been carried or defeated and an entry to that effect in the minutes shall be admissible in evidence as prima facie proof of the, fact without proof of the number or proportion of the votes recorded in favour of, or against such resolution, vote or motion.

11.4 Quorum

A quorum for any meeting of the Board shall be a majority of the Directors, provided that a majority of the Directors present are voting Directors. The Chair shall be included in the determination of a quorum.

11.5 Rules of Order

Any questions of procedure at or for any meetings of the Hospital, of the Board, of the Professional Staff, or of any committee, which have not been provided for in this By-Law or by the Act or by the *Public Hospitals Act* or Regulations thereunder, or the Professional Staff Rules and Regulations, shall be determined by the Chair in accordance with the rules of procedure adopted by resolution of the Board.

11.6 Rules

The Board may, from time to time, make such Rules as it may deem necessary or desirable for the better management, operation, and maintenance of the Hospital, provided however that any such rule shall conform with the provisions of this By-Law.

ARTICLE 12 - COMMITTEES OF THE BOARD

12.1 Establishment of Committees

(a) At the first meeting of the Board following the annual meeting of the Hospital, the Board shall establish the following standing committees:

(i) Executive Committee;

(ii) Audit Committee;

(iii) Governance and Nominating Committee;

(iv) ~~Quality Committee~~Patient Safety and Quality of Care Committee;

(v) Resource Planning Committee;

(vi) Medical Advisory Committee;

(vii) Research Ethics Board; and

(viii) Fiscal Advisory Committee;

(b) The Board may appoint such other committees as it sees fit from time to time;

(c) The composition and terms of reference for the standing and other committees shall be set out in a Board policy or, in the case of the Medical Advisory Committee, in the Hospital By-Law;

(d) Subject to the provisions of the By-Law, the Chair shall appoint the Chairs of the Committees of the Board and appoint the members of the Committees of the Board;

(e) The Board may appoint additional members who are not Directors to any committee of the Board except the Executive Committee and those persons shall be entitled to vote, but the number of non-Directors shall not exceed the number of Directors on a committee of the Board;

(f) Except for the Executive Committee, the Board shall encourage and promote the appointment of members who are not Directors to the standing and special committees of the Board. The Board shall ensure that committees reflect the community the Hospital serves;

(g) The membership formula for committees is designed on the basis of minimums and it is intended that the actual size of each committee should be determined by the need to ensure a breadth of perspectives;

(h) Subject to applicable law, the Board may, by resolution, dissolve any committee at any time;

(i) The Board Chair and President and Chief Executive Officer shall be ex-officio members of all committees;

(j) Members of the Board shall chair all standing committees, with the exception of the Research Ethics Board;

(k) A majority of voting members of a committee shall constitute a quorum so long as at any meeting a majority of those in attendance shall be Directors.

ARTICLE 13 - FINANCIAL

13.1 Bonding-Fidelity Insurance

(a) Directors, Officers and employees, as the Board may designate, shall secure from a guarantee company a bond of fidelity of an amount approved by the Board;

(b) At the discretion of the Board, the requirements of paragraph (a) above may be met by an alternative form of employee fidelity insurance such as, but not limited

to, a blanket position bond, a commercial blanket bond, or a comprehensive dishonesty, disappearance and destruction policy;

(c) The Hospital shall pay the expense of any fidelity bond or policy secured under paragraphs (a) or (b) above.

13.2 Signing Officers

The Board may be from time to time establish by policy, signing authority on behalf of the Hospital and may direct, by resolution, the manner in which and the person or persons by whom any particular instrument or class of instruments may or shall be signed. Any Signing Officer may affix the corporate seal thereto.

13.3 Banking and Borrowing

(a) The Board shall by resolution, from time to time, designate the Bank in which the bonds or other securities of the Hospital shall be placed for safekeeping.

(b) The Signing Officers designated by the Board are authorized for and in the name of the Board:

(i) to draw, accept, sign and make all or any bills of exchange, promissory notes, cheques, and orders for payment of money;

(ii) to receive and deposit all Hospital monies in the Bank above and give receipts for same;

(iii) subject to the approval of the Board, to assign and transfer to the Bank all or any stocks, bonds, or other securities;

(iv) from time to time, to borrow money from the Bank;

(v) to transact with the said Bank any business which they may think fit;

(vi) to negotiate with, deposit with, endorse or transfer to the Bank, but for the credit of the Hospital only, all or any bills of exchange, promissory notes, cheques; or orders for the payment of money and other negotiable paper;

(vii) from time to time, to arrange, settle, balance, and certify all books and accounts between the Hospital and the Bank designated by the Board under paragraph 13.3(a) above;

(viii) to receive all paid cheques and vouchers; and

(ix) to sign the Bank's form of settlement of balance and release.

13.4 Seal

The seal of the Hospital shall be in the form impressed hereon.

13.5 Investments

(a) Subject to paragraphs (b) and (c) below, the Board shall not be limited to investments authorized by laws for trustees provided their investments are

investments which are deemed reasonable and prudent under the circumstances;

(b) With respect to monies or property held in trust by the Hospital, the Board may invest only in securities authorized by the *Trustee Act* (Ontario), unless the trust instrument indicates otherwise;

(c) Notwithstanding the provisions of paragraphs (a) or (b) above, the Board may, in its discretion retain investments which are given to the Hospital in specie.

13.6 Endowment Benefits

(a) No benefit given in trust to or for the use of the Hospital for endowment purposes shall be hypothecated, transferred or assigned to obtain credit or to receive funds except as allowed by Section 13.5(a) above;

(b) The Secretary shall keep copies of all testamentary documents and trust instruments by which benefits are given, bequeathed or devised to, or to the use of, the Hospital;

(c) The Secretary shall give notice to the Office of the Public Guardian and Trustee, in accordance with the terms of the *Charities Accounting Act* (Ontario), of the benefits referred to in paragraph (b) above which come into the control or possession of the Hospital;

(d) The Hospital shall apply any trust funds of the Hospital only to the designated purpose(s) for which such funds were intended. Under no circumstances shall the Hospital transfer any funds held in trust by the Hospital to any other individual or entity, unless such transfer complies with all applicable law, including without limitation, the *Charities Accounting Act* (Ontario) and the *Trustee Act* (Ontario);

(e) The Secretary shall at least semi-annually provide an accounting to the Board with respect to all funds held in trust by the Hospital.

13.7 Auditor

(a) The Hospital shall at its Annual Meeting appoint an Auditor who shall not be a member of the Board or an Officer or employee of the Hospital or a business partner or employee of any such person, and who is duly licensed under the provisions of the *Public Accountancy Act* (Ontario), to hold office until the next Annual Meeting of the Hospital;

(b) The Auditor shall have all the rights and Privileges as set out in the Act and shall perform the audit function as prescribed therein;

(c) In addition to making the report at the Annual Meeting of the Hospital, the Auditor shall from time to time report through the Audit Committee to the Board on the audit work with any necessary recommendations.

ARTICLE 14 - VOLUNTARY ASSOCIATIONS

14.1 Authorization

The Board may sponsor the formation of a voluntary association(s) as it deems advisable.

14.2 Purpose

Such associations shall be conducted with the advice of the Board for the general welfare and benefit of the Hospital and the patients treated in the Hospital.

14.3 Control

Each such association shall elect its own Officers and formulate its own By-Law, but at all times the By-Law, objects and activities of each such association shall be subject to review and approval by the Board.

14.4 Auditor

(a) Each unincorporated voluntary association shall have its financial affairs reviewed for the purposes of assuring reasonable internal control.

(b) The Auditor for the Hospital shall be the Auditor for the voluntary association(s) under this section.

ARTICLE 15 - PROFESSIONAL STAFF

15.1 The Professional Staff Part of the By-Law

The By-Law:

(a) governs the appointment, organization, duties and responsibilities of the medical staff, dental staff, midwifery staff and registered nurses in the extended class all members of the Professional Staff, where not employed by the Hospital;

(b) recognizes that the Medical Advisory Committee is responsible to the Board of Directors for monitoring the safety and the quality of care provided by the Professional Staff practising in the Hospital and is hereby organized in conformity with the By-Law hereinafter stated;

(c) defines the roles, responsibilities, accountabilities and authority of the Professional Staff to the Management and Board;

(d) recognizes that members of the Active/Associate Professional Staff shall hold a Full-Time or such other Teaching appointment with the Northern Ontario School of Medicine and as such Members of the Professional Staff holding Full-Time or Adjunct Teaching appointments with the Medical School, shall be jointly appointed by the Medical School and the Hospital in accordance with the terms and conditions of the Affiliation Agreement between the parties;

(e) outlines how the requirements of the *Public Hospitals Act* and its regulations are put into force.

15.2 Purposes of the Professional Staff Portion of the By-Law

The purposes of the Professional Staff Part of the By-Law are:

(a) to outline clearly and succinctly the functions of the Professional Staff;

(b) to identify specific organizational units (departments, services, committees, programs, etc.) necessary to allocate the work of carrying out those functions;

(c) to designate a process for the selection of officials of the Professional Staff, including the Chief of Staff, Chiefs of Departments and Medical Programs or Service Directors;

(d) to assign clear roles, responsibility, define authority, and describe the manner of accountability to the Board of all officials, organizational units and each member of the Professional Staff for patient care and safety, and for professional and ethical conduct;

(e) to maintain and support the rights and privileges of the Professional Staff as provided herein;

(f) to provide clear direction to the Professional Staff that it must provide medical care to all patients within the Hospital, emphasizing evidenced based, patient and family centred care, interprofessional, academic and clinical team care;

(g) to define a Professional Staff Organization with roles, responsibility, authority and accountabilities so as to ensure that each Professional Staff member conducts themselves in a manner consistent with the requirements of law, the *Public Hospitals Act* and its regulations, the By-Law and such rules and regulations and policies, or any amendments thereto, which become effective when approved by the Board.

15.3 Purpose of the Professional Staff Organization

The purposes of the Professional Staff Organization are:

(a) to ensure input and advice with respect to the delivery of quality medical care to patients by the Professional Staff;

(b) to ensure a process and infrastructural organization whereby the members of the Professional Staff shall participate through the receipt of information and through input in the Hospital's planning, policy setting and decision making; and

(c) to maintain and support the rights and privileges of the Professional Staff.

15.4 Professional Staff Resource Plan

(a) The Executive Vice President, Medical and Academic Affairs, Chiefs and Medical Program or Service Directors will recommend to the Board for approval, on an annual basis, a Professional Staff Resource Plan for each department, service or program of the Professional Staff, as recommended by the Chief of the clinical department and Medical Program or Service Directors with the advice of the Administration of the Hospital and appropriate Regional Partners, where relevant and subject to available resources. This plan will be consistent with the strategic directions of the Hospital as established by the Board, and the *Public Hospitals Ac*t, Section 44(2) regarding cessation of services;

(b) A component of the Professional Staff Resource Plan shall be a recruitment plan, which shall include an impact analysis.

15.5 Appointment

(a) The Board shall appoint annually a Professional Staff for the Hospital;

(b) The Board shall establish from time to time criteria for appointment to the Professional Staff along with the form of application and reapplication after considering the advice of the Medical Advisory Committee. An application for appointment to the Professional Staff shall be processed in accordance with the Northwest Regional Appointment and Credentialing Policy and Procedure;

(c) In making an appointment or reappointment to the Professional Staff, the Board shall consider the recommendation of the Medical Advisory Committee, the Hospital's Professional Staff Resource Plan, the strategic directions of the Hospital, available human, physical and financial resources and whether there is a need for the services in the community;

(d) The Board shall grant privileges to members of the Professional Staff upon the recommendation of the Medical Advisory Committee;

(e) In addition to any other provisions of the By-Law, the Board may refuse to appoint any applicant to the Professional Staff on any of the following grounds:

(i) if applicable, the applicant is not eligible for or was not granted an academic appointment;

(ii) the appointment is not consistent with the need for service, as determined by the Board from time to time;

(iii) the Professional Staff Human Resources Plan of the Hospital and/or Department does not demonstrate sufficient resources to accommodate the applicant; and/or

(iv) the appointment is not consistent with the strategic plan of the Hospital or the academic plan of the Department, service or program.

(f) Where the Board of the Hospital determines that the Hospital shall cease to provide a service or the Minister directs the Hospital to cease to provide a service, the Board of Directors may:

(i) refuse the application of a member for appointment or reappointment to the Professional Staff;

(ii) revoke the appointment of any member; and

(iii) cancel or substantially alter the privileges of any member as long as such determination relates to the termination of the service.

15.6 Appointment to the Professional Staff

The Board shall appoint each member of the Professional Staff to the Hospital for up to a one year period, but such appointment shall continue beyond one year where the member has submitted an application for reappointment during the appointed year, except for Term Staff and Senior Staff who may be appointed for shorter specific time intervals without eligibility for reappointment.

15.7 Mid-Term Action Regarding Revocation, Suspension, Restriction of Privileges

In circumstances where there are concerns about the conduct, performance or competence of a member of the Professional Staff, the Board may, at any time, in a manner consistent with the *Public Hospitals Act* and in accordance with the regulations thereunder, the By-law, the Rules and Regulations of the Professional Staff, and policies of the Hospital, revoke or suspend any appointment of a member of the Professional Staff or revoke, suspend or restrict or otherwise deal with the Privileges of the member as follows:

(a) Immediate Action In Emergency Situations: In circumstances where, in the opinion of the Chief of Staff or delegate or the Chief of the relevant Clinical Department, the conduct, performance or competence of a member of the Professional Staff exposes or is reasonably likely to expose Patient(s), Staff or Learners to physical or emotional harm or injury and immediate action must be taken to protect the Patient(s) or Staff, and no less restrictive measure can be taken, the Chief of the Department or Chief of Staff or delegate will take action. This may require immediate and temporary suspension of the Privileges of the member of the Professional Staff by the Chief of Staff or delegate or Chief of the relevant Clinical Department with immediate notice to the President & Chief Executive Officer, the Executive Vice President, Medical and Academic Affairs and the President of the Professional Staff, pending the consideration of the suspension by the Medical Advisory Committee and the Board in keeping with the procedures outlined in Schedule A of the By-Law, respecting Mid-Term Action in an Emergency Situation.

(b) Non-Immediate Mid-Term Action: In circumstances where, in the opinion of the Chief of the relevant Clinical Department or the Chief of Staff, the conduct, performance or competence of a member of the Professional Staff:

(i) fails to comply with the criteria for annual reappointment;

(ii) exposes or is reasonably likely to expose patients, staff or learners to harm or injury;

(iii) is reasonably likely to be, detrimental to patients, staff or learners safety or to the delivery of quality Patient care within the Hospital;

(iv) results in the imposition of sanctions by the individual's professional college;

(v) has violated the By-Law, Rules and Regulations of the Professional Staff, policies of the Hospital, the *Public Hospitals Act*, the regulations made thereunder, or any other relevant law or legislated requirement;

(vi) constitutes abuse; or

(vii) is, or is reasonably likely to be, detrimental to the operations of the Hospital;

(viii) falls under the Hospital's guidelines for disruptive behaviour; and

where immediate action is not required to be taken, action may be initiated in keeping with the procedures in Schedule A of the By-law, respecting Non-Immediate Mid-Term Action.

15.8 Reappointment

(a) Each year, the Board shall require each member of the Professional Staff, save and except a member appointed to the Term Staff, to make a written application, on the prescribed form to the President and Chief Executive Officer, for reappointment to the Professional Staff;

(b) An application for reappointment to the Professional Staff shall be processed in accordance with the Northwest Regional Appointment and Credentialing Policy and Procedure;

(c) The Chief(s) of Department(s) shall review and submit a written report to the Credentials Committee concerning each application for reappointment within the Department. Each report shall include information concerning the knowledge and skill which has been shown by the Professional Staff member, the nature and quality of his/her work in the Hospital, including comments on the utilization of Hospital resources and the Professional Staff member's ability to function in conjunction with the other members of the Hospital staff and whether the member has maintained their academic appointment and responsibilities.

15.9 Refusal to Reappoint

Pursuant to the *Public Hospitals Act,* the Board may refuse to reappoint a member of the Professional Staff.

15.10 Revocation or Suspension of Appointment to the Professional Staff

Pursuant to the *Public Hospitals Act*, the Board may, at any time, revoke or suspend any appointment of a member of the Professional Staff. Where the Board revokes or suspends the appointment of a member of the Professional Staff at a time other than the annual reappointment to the Professional Staff, the Board will follow the procedure for Mid-Term Action respecting physicians' privileges, as identified in Schedule A, herein, which Schedule forms a part hereof.

The Board may revoke or suspend the appointment or privileges of a member of the Professional Staff where:

(a) The member fails to provide the agreed upon services in accordance with the *Public Hospitals Act*, the Hospital's By-Law, Rules and Regulations, Policies and Ethical Guidelines;

(b) The member fails to maintain an academic appointment where such academic appointment is a condition of the applicant's Hospital appointment.

15.11 Application for Change of Privileges

(a) Any change of privileges requested by a member of the Professional Staff shall be processed in accordance with the Northwest Regional Appointment and Credentialing Policy and Procedure;

(b) The Medical Advisory Committee is entitled to request any additional information or evidence that it deems necessary for consideration of the application for change in privileges.

ARTICLE 16 - CATEGORIES OF PROFESSIONAL STAFF

16.1 Professional Staff

The Professional Staff shall be divided into the following categories:

(a) Active;

(b) Associate;

(c) Supportive;

(d) Temporary;

(e) Resident Staff;

(f) Clinical Fellow Staff;

(g) Term Staff;

(h) Clinician Scientist;

(i) Senior Staff;

(j) Regional Staff.

16.2 Active Staff

(a) The Active Professional Staff shall consist of those members who have been appointed by the Board, following a period of Associate Professional Staff membership as provided for in this By-Law;

(b) All Active Professional Staff are responsible for assuring that professional care is provided to their patients in the Hospital;

(c) All Active Professional Staff must have admitting privileges unless otherwise specified in their appointment to the Professional Staff, or as directed within the service provision of individual Departments (Laboratory, Diagnostic Imaging, Emergency Department);

(d) Each member of the Active Professional Staff shall:

(i) Attend and act as Most Responsible Physician for patients admitted to Hospital by the member, and undertake necessary treatment and operative procedures only in accordance with the kind and degree of privileges granted by the Board and be subject to the rules and regulations of the Department to which he is assigned;

(ii) undertake such duties in respect of those patients classed as emergency cases as may be specified by the Chief of Staff, or by the Chief of the Department or their delegates to which the active staff member has been assigned;

(iii) participate in an on-call duty roster as directed by the Chief of Staff or Chief of Department, unless otherwise exempted by the Professional Staff Rules and Regulations;

(iv) act as a supervisor of a member of the Professional Staff as and when requested by the Chief of Staff or the Chief of Department;

(v) be eligible to vote at Professional Staff meetings and to hold office; and

(vi) attend no less than fifty percent (50%) of the regularly scheduled meetings of the Professional Staff and seventy percent (70%) of the meetings of the Department of which he/she is a member, annually.

(e) Be subject to a peer review process as directed by the Chief of Staff, the Medical Advisory Committee and/or the Chief of the Department. A Dentist in the Active Staff category, who is not an Oral and Maxillofacial Surgeon, may be granted admitting privileges in association with a Physician who is a member of the Professional Staff with active privileges.

16.3 Associate Staff

(a) The Associate Staff shall consist of Physicians, Dentists, or Midwives newly appointed to the Professional Staff by the Board. This shall be for a period of twelve (12) months;

(b) Each Associate Staff member must have admitting privileges unless otherwise specified in the appointment, or as directed within the service provision of individual Departments (Laboratory, Dentistry, Diagnostic Imaging, Emergency Department);

(c) An Associate Staff member shall work for a probationary period under the supervision of an Active Staff member named by the Chief of Staff or the Chief of Department to which the Associate Staff member has been assigned;

(d) At the end of twelve (12) months Associate staff appointment, the Department Chief may recommend a change of status to the Active Staff category. As part of the change of status process,the Associate Staff member shall be reviewed by the Department Chief who shall submit a written report to the Credentials Committee. Each report shall include information concerning the knowledge and skill which has been shown by the Associate Staff member, the nature and quality of his/her work in the Hospital, including comments on the utilization of Hospital resources, the Associate Staff member's ability to function in conjunction with the other members of the Hospital staff, and a statement indicating the category of Staff appointment for which the Physician, Dentist or Midwife is being recommended;

(e) Any such change of appointment status to the Active Staff will be in effect only for the period of time remaining in the current appointment year and may be carried out without requirement of a written application for reappointment by the Physician. Thereafter, the Physician will complete written application for all further reappointments at the regularly scheduled times;

(f) If the report and recommendation made as part of the change of status process are not favourable to the Associate Staff member, the Chief of the Department,

the Chief of Staff, the Executive Vice President, Medical and Academic Affairs, or the Medical Advisory Committee may recommend an extension of Associate Staff status not to exceed twelve (12) months or a denial of continued appointment;

(g) If the extension exceeds six (6) months, a formal review of the Associate Staff member with the Chief of the Department, the Chief of Staff and the member will be notified and placed on "probationary Associate Staff" status for the next six (6) months. If performance is not satisfactory after this, the Chief of the Department, the Chief of Staff and the Executive Vice President, Medical and Academic Affairs will not recommend reappointment to Active Staff. The Chief of Staff will provide written explanation to the Credentials Committee and to the Medical Advisory Committee, as per 16.3 (k);

(h) Should the extended period of the Associate Staff status be in effect beyond the date of the next annual reappointment time, the appointment as Associate Staff status shall be deemed to continue until completion of the extended period or unless revoked by the Board as per Section 16.3(f);

(i) Each report and recommendation as in subsection 16.3(d) shall be reviewed by the Credentials Committee of the Medical Advisory Committee;

(j) At any time, an unfavourable report may cause the Medical Advisory Committee to make a recommendation that the appointment of the Associate Staff member be terminated;

(k) The Chief of the Department, upon the request of an Associate Staff member or a supervisor, may assign the Associate Staff member to a different supervisor for a further probationary period after review by the Chief of Staff and/or the Executive Vice President, Medical and Academic Affairs;

(l) An Associate Staff member must:

(i) attend patients, and undertake treatment and operative procedures under supervision only in accordance with the kind and degree of privileges granted by the Board;

(ii) be subject to the Professional Staff By-Law, rules and regulations of the Department to which he is assigned, and Hospital policies;

(iii) undertake such duties in respect of those patients classed as emergency cases as may be specified by the Chief of Staff, or by the Chief of the Department to which the Associate Staff member has been assigned;

(iv) participate in an equitable manner in the on-call rota of the Department unless otherwise exempted by the Professional Staff Rules and Regulations;

(v) be entitled to vote at Professional Staff meetings;

(vi) be eligible to be elected a Professional Staff Officer, and appointed to a committee of the Professional Staff; and

(vii) attend no less than fifty percent (50%) of the regularly scheduled meetings of the Professional Staff and seventy percent (70%) of the meetings of the Department of which he is a member.

16.4 Supportive Staff

(a) The Supportive Staff shall consist of those members of the Professional Staff who are granted privileges by the Board to provide support to patients and/or members of patients' families and may not necessarily be required to hold a full-time or such other teaching appointment with the Northern Ontario School of Medicine;

(b) Supportive Staff:

(i) may provide patients and their families with information;

(ii) shall be eligible for annual reappointment as provided in the By-Law;

(iii) may review and receive the patient record and progress notes as well as out-patient records of their patients;

(iv) shall be eligible to attend Department, Service and Professional Staff meetings; and

(v) may utilize Ambulatory and Diagnostic Services if available, to support and advise on same, and after consideration and recommendations from the Credentials Committee.

(c) Supportive Staff shall not:

(i) have admitting privileges or provide direct patient care;

(ii) input information into the patient record and progress notes nor make or record any orders;

(iii) be eligible to hold an elected or appointed office or serve on committees of the Medical Advisory Committee; and

(iv) be eligible to vote or be bound by attendance requirements of Department, Service or Professional Staff meetings.

16.5 Temporary Staff

(a) Temporary staff shall be an appointment to the Professional Staff of the Hospital made only for one of the following reasons:

(i) to meet a specific singular requirement by providing a consultation and/or operative procedure; or

(ii) to meet an urgent unexpected need for a Professional service.

(b) Notwithstanding any other provision of this By-Law, the President and Chief Executive Officer, after consultation with and upon the advice of the Chief of Staff or his/her delegate, may:

(i) grant temporary Privileges to a Physician, Dentist, Midwife, or Extended Class Nurse who is not a member of the Professional Staff provided that such Privileges shall not extend beyond the date of the next meeting of the Medical Advisory Committee at which time the action taken shall be reported;

(ii) on the recommendation of the Medical Advisory Committee at its next meeting, continue the temporary Privileges until the next meeting of the Board; and

(iii) remove temporary Privileges at any time prior to any action by the Board.

(c) Temporary Staff shall not be eligible to:

(i) vote at Professional Staff meetings;

(ii) hold office; and

(iii) sit on a committee requiring Professional Staff.

16.6 Resident Staff

(a) Resident Staff privileges shall be granted to graduates in medicine who are registered in accredited university postgraduate programs, and as defined in the Thunder Bay Regional Health Sciences Centre – Northern Ontario School of Medicine Affiliation Agreement.

(b) Resident Staff:

(i) may attend and write orders for patients in the Hospital under the supervision and counsel of a member of the Active Staff;

(ii) may attend Professional Staff meetings; and

(iii) shall perform such other duties as specified by the Department, Program or Service to which the Resident Staff member is assigned.

(c) Resident Staff shall not:

(i) be eligible to hold an elected or appointed office or serve on committees of the Medical Advisory Committee;

(ii) be eligible to vote or be bound by attendance requirements of Department, Program or Service and Professional Staff meetings; and

(iii) have admitting privileges.

16.7 Clinical Fellow Staff

(a) Clinical Fellow Staff appointed by the Board shall include the graduates in medicine, appropriately qualified with an educational or independent licence issued by the College of Physician and Surgeons of Ontario (the College) and registered by the Post-Graduate Education Office, Northern Ontario School of Medicine, or by another accredited University;

(b) Clinical Fellow Staff who are part of the International Medical Graduates Program must undergo a Pre-Entry Assessment Program (PEAP) as outlined in the College certificate.

(c) Clinical Fellow Staff:

(i) may attend upon patients and write orders under the supervision of a designated Active Staff member;

(ii) shall perform such other duties as specified by the designated Active Staff member to which the Clinical Fellow Staff member is assigned; and

(iii) may attend Professional Staff meetings.

(d) Clinical Fellow Staff shall not:

(i) be eligible to hold an elected or appointed office or serve on committees of the Medical Advisory Committee;

(ii) be eligible to vote or be bound by attendance requirements of Department, Service and Professional Staff meetings; and

(iii) have admitting privileges.

16.8 Clinician Scientist

(a) Clinician Scientists are appointed by the Board, have an independent license, assist in the service of the Department and are required to do specific duties as designated by the particular Department involved. The specific role, privileges and scope of permissible activities of a Clinician Scientist shall be specifically identified and defined by the Medical Program or Service Director or Chief of Department and, where appropriate, the Chair of the appropriate Department of the Faculty of Health Sciences;

(b) Clinician Scientists shall:

i. be eligible to attend Department or Service meetings and meetings of the Professional Staff; and

ii. be required to work under the supervision of a member of the Active Staff.

(c). Clinician Scientists shall not:

i. be eligible to hold an elected or appointed office or serve on committees of the Medical Advisory Committee;

ii. be eligible to vote or be bound by attendance requirements of Department, Service and Professional Staff meetings; and

iii. have admitting privileges.

16.9 Term Staff

(a) Term staff consist of applicants who have been granted admitting and/or procedural privileges as approved by the Board having given consideration to the recommendation of the Chief of Department and the Medical Advisory Committee in order to meet a specific clinical need for a defined period of time not to exceed one (1) year. The specific clinical need(s) shall be identified by the Medical Advisory Committee and approved by the President and Chief Executive Officer of the Hospital. Appointments shall be for a period not to exceed one (1) year and such appointment does not imply or provide for any continuing Professional Staff appointment or right of renewal. Applicants to the Term Staff category may not necessarily be required to hold a full-time or such other teaching appointment with the Northern Ontario School of Medicine;

(b) Term staff:

(i) are required to work under the supervision of an Active Staff member designated by the Chief of Department;

(ii) are required to undergo a probationary period of six (6) months as appropriate and as determined by the Chief of Department;

(iii) shall, if replacing another member of the Professional Staff, attend that Professional Staff member's patient;

(iv) shall undertake such duties in respect of those patients classed as emergency cases, inpatients and of out-patient department clinics as may be specified by the Chief of Department;

(v) shall, unless otherwise specified in the grant of privileges by the Board, have admitting privileges and attend patients admitted to Hospital by the member, and undertake necessary treatment and operative procedures;

(vi) Privileges may be granted for specific purposes, and not be based solely on level of training or expertise.

(c) Term staff will not, subject to determination by the Board in each individual case:

(i) be eligible for re-appointment;

(ii) attend or vote at meetings of the Professional Staff or be an Officer of the Professional Staff or committee chair; and

(iii) be bound by the expectations for attendance at Professional Staff, Departmental and Service meetings.

16.10 Senior Staff

(a) The Senior Staff category has been created by the Board to allow the Hospital to, as required by its Professional Human Resource Plan, approve privileges beyond the Active Staff seventy (70) years of age or greater, provided that:

(i) the applicant's service is required;

(ii) they remain clinically competent; and

(iii) they are not otherwise represented in the Department.

(b) The Board's responsibility to ensure a succession plan for members of its Professional Staff, may require that from time to time and upon the recommendation of the Medical Advisory Committee, that a Senior Staff member's privileges may be reduced, revoked or not renewed in favour of granting privileges to a new or existing Associate or Active Staff member;

(c) Senior Staff:

(i) will consist of those members of the Active Staff previously appointed from time to time by the Board, who maintain clinical and/or academic activities within the Hospital and may not necessarily be required to hold a full-time or such other teaching appointment with the Northern Ontario School of Medicine;

(ii) may be subject to an enhanced performance review at the discretion of the Chief of Department and/or the Chief of Staff and approved by the Medical Advisory Committee with the express objective of ensuring the ongoing competency of the Senior Staff member;

(iii) will be granted privileges as approved by the Board having given consideration to the recommendation of the Chief of Department and the Medical Advisory Committee in consultation with the appropriate Medical Program or Service Director;

(iv) will be granted in-patient and/or out-patient admitting privileges, unless otherwise specified in their appointment to the Professional Staff;

(v) will be eligible to apply for annual reappointment;

(vi) will be eligible to attend and vote at meetings of the Professional Staff and to be an Officer of the Professional Staff or committee chair;

(vii) will be bound by the expectations for attendance at Professional Staff, Department and Service meetings.

16.11 Regional Staff

(a) The Regional Staff category shall consist of those members of the Professional Staff who are granted privileges by the Board to order or requisition outpatient diagnostics only. It is intended that a Regional Staff appointment shall facilitate the ordering of diagnostic tests for patient's care closer to their home or to allow for testing at another site where not otherwise available;

(b) Regional Staff:

(i) shall be eligible for annual reappointment provided they are credentialed at a primary organization;

(ii) may review and receive the out-patient records specific to the diagnostics ordered for their patients;

(ii)(iii) may write orders for inpatients admitted to their facility that are attending Thunder Bay Regional Health Sciences Centre for outpatient diagnostic tests and procedures.

(c) Regional Staff shall not:

(i) have admitting privileges or provide direct patient care;

(ii) input information into the patient record and progress notes nor make or record any orders with the exception of inpatients admitted to their regional facility that are attending Thunder Bay Regional Health Sciences Centre for outpatient diagnostic tests and procedures;

(iii) be eligible to hold an elected or appointed office or serve on committees of the Medical Advisory Committee; and

(iv) be eligible to vote or be bound by attendance requirements of Department, Service or Professional Staff meetings.

16.12 Rules of the Professional Staff

Members of the Professional Staff in their treatment and attendance upon patients within the Hospital shall be under the jurisdiction of the Chief of Staff or the Chief of the Department concerned and through him/her to the Medical Advisory Committee. They shall be required to conform with all general and departmental staff rules.

ARTICLE 17 - PROFESSIONAL STAFF DUTIES

17.1 Duties, General

(a) Each member of the Professional Staff is accountable to and shall recognize the authority of the Board through and with their Chief of Department and/or Medical Program or Service Director, the Chief of Staff, the Executive Vice President, Medical and Academic Affairs, and the President and Chief Executive Officer of the Hospital;

(b) Each member of the Professional Staff shall:

(i) attend and treat patients within the limits of the privileges granted by the Board, unless the privileges are otherwise restricted;

(ii) ensure a high professional standard of care is provided to patients under their care that is consistent with sound health care resource utilization practices, utilizing principles of evidence based best practice;

(iii) prepare and complete patient records in accordance with the Hospital's Policies as may be established from time to time, applicable legislation and accepted health sector standards;

(iv) participate in quality, safety and risk management initiatives by conducting all necessary and appropriate activities for assessing and improving the effectiveness and efficiency of care provided in the Hospital

as directed by Program, Service, Department, or academically directed standards;

(v) assist to fulfill the Mission of the Hospital through contributing to the strategic planning, community needs assessment, resource utilization management, quality management activities, quality improvement plans, and safety monitoring policies;

(vi) notify the President and Chief Executive Officer of the Hospital and/or the Chief of Staff of any change in the license to practice medicine made by Certificate of Registration in respective professional colleges;

(vii) notify the Chief of the Department and the Chief of Staff:

a) if one is the subject of an allegation that has been referred to the discipline committee;

b) if one is the subject of an investigation or proceeding by law enforcement, a court of tribunal or another hospital or healthcare facility;

c) of the findings of any completed reviews, investigations and proceedings by disciplinary panel reviews, law enforcement, a court or tribunal or another hospital or healthcare facility.

~~(vii)~~(viii) abide by the Policies and Procedures of the Hospital, and the Rules and Regulations of the Professional Staff, this By-Law, the Public Hospitals Act and the Regulations thereunder and all other legislated requirements and at all times maintain a professional and respectful workplace environment;

~~(viii)~~(ix) abide by the terms of any confidentiality agreement required to be signed by members of the Professional Staff with respect to the medical information systems;

~~(ix)~~(x) serve, if requested by the Medical Advisory Committee, on sub-committees of the Medical Advisory Committee;

~~(x)~~(xi) give such instruction as is required for the education and evaluation of other members of the Professional Staff, Hospital staff and Learners;

~~(xi)~~(xii) provide and maintain undergraduate and postgraduate medical education and health professional education where required in accordance with the Mission of the Hospital;

~~(xii)~~(xiii) provide, maintain and participate in medical, clinical health services and outcome research where required;

~~(xiii)~~(xiv) contribute to scholarly activities within the parameters of a mutual agreement as determined within the department in which the Professional Staff member is appointed;

~~(xiv)~~(xv) facilitate patients' relatives or other appropriate persons to authorize the direction of appropriate tissues and organs for transplantation;

~~(xv)~~(xvi) perform such other duties as may be prescribed from time to time by, or under the authority of the Board, the Medical Advisory Committee, the Chief of Staff, the Chief of Department, the President and Chief Executive Officer, and the Executive Vice President, Medical and Academic Affairs.

(c) Every member of the Professional Staff shall co-operate with:

(i) the Chief of Staff and the Medical Advisory Committee;

(ii) the Chief of the Department to which the Physician has been assigned and/or the Medical Program or Service Director of specific Services or Programs;

(iii) the Executive Vice President, Medical and Academic Affairs;

(iv) the President and Chief Executive Officer; and

(v) all other members of the interprofessional health team.

(d) Every member of the Professional Staff shall communicate immediately to the appropriate Department Chief or the Chief of Staff any situation where he believes a member of the Professional Staff is:

(i) attempting to exceed his/her privileges;

(ii) temporarily unable to perform his/her professional duties with respect to a patient in the Hospital;

(iii) demonstrating unprofessional conduct as defined by the professional College;

ARTICLE 18 - CHIEF OF STAFF

18.1 Chief of Staff

(a) The Board shall appoint a Physician who is a member of the Active staff to be the Chief of Staff after giving consideration to the recommendation of the Selection Committee.

(b) Subject to annual confirmation by the Board, an appointment made under subsection 18.1 (a) shall be for a term of three (3) years but the Chief of Staff shall hold office until a successor is appointed;

(c) The Chief of Staff shall be subject to an annual performance review by the Board of the Hospital with respect to issues related to quality and safety, performance review, competency, and credentialing, and shall be subject to an annual performance review by the President and Chief Executive Officer of the Hospital with respect to any leadership responsibilities arising out of the Chief of Staff's role as a member of the Senior Leadership Team.

(d) The membership of the Selection Committee to act in the selection of the Chief of Staff at the Hospital may be as follows:

(i) the Chair or delegate of the Board of the Hospital;

(ii) three (3) members of the Medical Advisory Committee, one of whom must be the President or Vice President of the Professional Staff Association or one (1) member at large;

(iii) the President and Chief Executive Officer, or his or her delegate;

(iv) the Chief Nursing Executive, or his or her delegate;

(v) such other members as may from time to time be selected by the Board;

(vi) the Executive Vice President, Medical and Academic Affairs; and

(vii) the Northern Ontario School of Medicine Dean or delegate.

18.2 Duties of the Chief of Staff

The Chief of Staff shall have the following duties to the Board and the Medical Advisory Committee as well as administrative duties;

(a) Duties to the Board and Medical Advisory Committee

The Chief of Staff shall be accountable to the Board of the Hospital through the Chair of the Hospital. The Chief of Staff shall:

(i) be responsible for establishing and monitoring the comprehensive credentialing and disciplining processes for the Professional Staff;

(ii) ensure that the process regarding credentialing of Professional staff is fair and executed in a timely manner;

(iii) be responsible for the disciplinary action or mediation of the Professional Staff in conjunction with the Department Chiefs and/or the Executive Vice President, Medical and Academic Affairs when appropriate;

(iv) be responsible for ensuring compliance with the provisions of the Public Hospitals Act, its Regulations and By-Law of the Hospital with respect to Professional Staff;

(v) be responsible to the Board for the supervision and quality of all the Professional Staff diagnosis, care and treatment given to patients within the Hospital according to the policies established by the Board. This will include quality improvement plans and patient safety monitoring;

(vi) through, and with the Department Chiefs, advise the Medical Advisory Committee and the Board of the Hospital, and the President and Chief Executive Officer of the Hospital with respect to the quality of medical diagnosis, care and treatment provided to the patients of the Hospital;

(vii) ensure that the Medical Advisory Committee fulfills its responsibility as defined in the Public Hospitals Act, and the By-Law;

(viii) be a member of, or delegate appropriate members to sit on all committees that report to the Medical Advisory Committee;

(ix) be a non-voting member of the Executive Committee of the Board as per the *Excellent Care for All Act*;

(x) be a non-voting member of the Quality Committee of the Board;

(xi) be a non-voting member of any committees of the Board as deemed reasonable and necessary;

(xii) assign, or delegate the assignment of, a member of the Professional Staff to supervise the practice of medicine, dentistry, midwifery, extended class nursing or other professional activities of any other member of the Professional Staff for any period of time;

(xiii) supervise and evaluate Chiefs of Department with respect to expected role. Under extraordinary conditions, the Chief of Staff may suspend the Chief of Department from the role of Chief of Department and, pending review, appoint an acting Chief of Department; and

(xiv) investigate, report and disclose critical incidents pursuant to the Hospital Management Regulation under the Public Hospitals Act and the *Excellent Care for All Act*; and

(xv) work with the Executive Vice President, Medical and Academic Affairs on peer review process as mandated by academic standards through the Council of Academic Hospitals of Ontario (CAHO).

18.3 Appointment of the Deputy Chief of Staff

The Board, in consultation with the Chief of Staff, may appoint a Physician with Active Staff privileges to be the Deputy Chief of Staff upon the recommendation of the Chief of Staff and after giving consideration to seek the advice of the Medical Advisory Committee. The Deputy Chief of Staff, if appointed, shall act in the place of the Chief of Staff if the Chief of Staff is absent or unable to act, and shall perform such duties as assigned from time to time by the Chief of Staff.

ARTICLE 19 - PROFESSIONAL STAFF DEPARTMENTS, PROGRAMS AND SERVICES

19.1 Departments

(a) The Professional Staff shall be divided into departments which shall include:

(i) Anaesthesia;

(ii) Dentistry;

(iii) Diagnostic Imaging;

(iv) Emergency;

(v) Family Medicine;

(vi) Internal Medicine;

(vii) Laboratory and Pathology Medicine;

(viii) Obstetrics and Gynecology;

(ix) Oncology;

(x) Pediatrics;

(xi) Psychiatry;

(xii) Surgery;

(xiii) Critical Care;

(xiv) Midwifery.

(b) Whenever a separate Department is established, Professional Staff and patients related to such a Department shall come under the jurisdiction of that department;

(c) The Board, after consultation and advisement from the Medical Advisory Committee, may at any time establish or disband Departments, Programs or Services of the Professional Staff.

19.2 Organization of Departments

(a) Each Department shall be organized as a division of the Professional Staff as a whole with a Chief of Department who shall be responsible to the Medical Advisory Committee on issues of quality and safety. All other issues would be reporting responsibilities to the Executive Vice President, Medical and Academic Affairs.

(b) The Clinical Departments of the Hospital shall ensure adequate coverage of the Emergency Department and the Hospital as per Hospital standards;

(c) Any Professional Staff with Active or Associate Staff privileges in the Clinical Department has a duty to take call in such a manner as is established within the Clinical Department concerned, in keeping with his/her privileges, or as recommended by governing professional institutions and academic guidelines;

(d) Any Department, Program or Service shall function in accordance with the Professional Rules and Regulations.

19.3 Division of Professional Staff

When a group of Professional Staff with a common interest indicate that its patients would be better served if they organized into a separate Department, Program or Service, and they are prepared to assume the responsibilities of operating as a separate Department Program or Service, they may make representation through their present Chief of Department, Chief of Staff, Executive Vice President, Medical and Academic Affairs, the Medical Advisory Committee and the President and Chief Executive Officer for the establishment of a separate Department, Program or Service. After due consideration and recommendation by the Chief of Department, Chief of Staff, Executive Vice President, Medical and Academic Affairs, the Medical Advisory Committee and the President and Chief Executive Officer, the application, together with their recommendations shall be submitted to the Board for a decision.

19.4 Programs and Services within Departments

a) When warranted by the professional resources of a Department, and after consultation with the Chief of the Department, the Chief of Staff and the Executive Vice President, Medical and Academic Affairs, the Board, on the advice of the Medical Advisory Committee, may divide a Department into Program or Services;

b) Reporting to the appropriate Executive Vice President Patient Care on administrative issues and the Chief of Department and Chief of Staff on quality and safety concerns.

c) Participation in the Medical Advisory Committee by a Medical Program or Service Director(s) will be by invitation at the request of the Chief of Department, the Chief of Staff or the Executive Vice President, Medical and Academic Affairs.

19.5 Changing a Department

If after a regular departmental survey, or at any time when requested by a Department, it becomes evident that a Department is considered too small to remain effectively autonomous, or is unable to acquire a Chief with the interest and capabilities of assuming the responsibilities of such a position, departmental members may make representation through their present Chief of Department, to the Chief of Staff, the Medical Advisory Committee and the President and Chief Executive Officer, that may recommend to the Board that such Department shall become temporarily or permanently a part of, or a division of the appropriate larger Department.

19.6 Departmental Meetings

(a) The essential purpose of staff and departmental meetings is to improve patient care by actions arising out of discussion of matters of scientific, educational, or clinical interests;

(b) Minutes shall be kept of each departmental meeting and shall be forwarded to the Medical Advisory Committee;l

(c) Attendance will be recorded for all meetings;

(d) Mortality and Morbidity Rounds shall be conducted quarterly.

19.7 Appointment of Chief of Department

(a) Appointments:

The Board shall appoint a Chief of Department for each of the Departments as set out in subsection 19.1(a). The Board may appoint a Chief of Department as follows:

(i) a member of the Active or Associate Staff from that Department, after consideration to the recommendations of a Selection Committee who shall seek the advice of the Medical Advisory Committee;

(ii) the membership of the Selection Committee to act in the selection of a Chief of Department at the Hospital in respect of those departments set out in subsection 19.1(a) may include:

(A) the Chief of Staff;

(B) the Executive Vice President, Medical and Academic Affairs or his/her delegate;

(C) a member of that Department;

(D) a member of the Medical Advisory Committee as appointed by the Chief of Staff;

(E) the Chief Nursing Executive of the Hospital where appropriate.

(b) The appointment of Chief of Department may be for a term of three (3) years, but the Chief of each Department shall hold office until his or her successor is appointed;

(c) The Board may at any time revoke or suspend the appointment of a Chief of Department upon recommendation of the Chief of Staff.

19.8 Duties of the Chief of Department

(a) The Chief of the Department shall:

(i) be a member of the Medical Advisory Committee and shall attend a minimum of seventy per cent (70%) of meetings;

(ii) through and with the Chief of Staff, fulfill the obligations set forth in the *Public Hospitals Act* ~~and in particular Section 31 thereof~~;

(iii) advise the Medical Advisory Committee through and with the Chief of Staff with respect to the quality of medical, and where appropriate dental and midwifery, diagnostic, care and treatment provided to the patients and outpatients of the Department;

(iv) advise the Chief of Staff and/or delegate, who will then advise the President and Chief Executive Officer and the Chair of the Board of Directors of the Hospital of any patient who is not receiving appropriate treatment and care;

(v) supervise the professional care provided by members of the Department;

(vi) under emergency conditions, and in consultation with the Chief of Staff or delegate and the Executive Vice President, Medical and Academic Affairs, restrict or suspend temporarily, any or all privileges of any members of his staff until such time as an emergency meeting of the Medical Advisory Committee and/or its Executive can be arranged in accordance with the By-Law;

(vii) report to the Medical Advisory Committee and to the Department on activities of the Department including utilization of resources and quality and safety management;

(viii) make recommendations to the Medical Advisory Committee and the Executive Vice President, Medical and Academic Affairs regarding Professional Staff Human Resource needs of the Department in accordance with the Hospital's strategic plan following consultation with Professional Staff of the Department, the Chief of Staff and, where appropriate, Medical Program or Service Directors;

(ix) participate in the development of the Department's mission, objectives and strategic plan;

(x) in collaboration with the Vice President Research, and the Executive Vice President, Medical and Academic Affairs, be accountable for the promotion of research within the department;

(xi) from a quality perspective, review and endorse all research being conducted within the department and provide recommendations to the Vice President, Research;

(xii) be responsible for providing to the Executive Vice President, Medical and Academic Affairs and the Medical Advisory Committee, for its review and approval, a report outlining the departmental clinical and academic responsibilities of the Credentialed Professional Staff as part of the annual work plan as required;

(xiii) participate in Department resource allocation decisions

(xiv) review or cause to be reviewed the privileges granted to members of the Department for the purpose of making recommendations for changes in the kind and degree of such privileges;

(xv) review and submit written recommendations regarding the performance of members of the Department to the Credentials Committee as part of the reappointment process;

(xvi) participate in the orientation of new members of the Medical, Dental and Midwifery Staff appointed to the Department;

(xvii) hold at least eight (8) regularly scheduled monthly departmental meetings in each year, including quarterly Mortality and Morbidity Rounds and report to the Medical Advisory Committee as per hospital policy;

(xviii) ensure minutes of each departmental meeting including attendance and Quality Management reports are kept and made available to the Medical Advisory Committee through the Chief of Staff;

(xix) delegate appropriate responsibility to the Medical Program or Service Directors within the department;

(xx) ensure there exists a process for the selection of representatives from the Department to those committees of the Medical Advisory Committee which name within their composition a member of that Department;

(xxi) notify the Chief of Staff and the Executive Vice President, Medical and Academic Affairs of the Chief of the Department's absence, and designate an alternate from within the Department; designate an alternate from within the department when the Chief of Department is absent but providing coverage by phone/email and situations arise where physical attendance is required; and when absent from Medical Advisory Committee meetings, appoint a delegate from within the Department to attend in Chief's absence;

(xxii) ensures timely completion of patient safety reports and responses to patient and family concerns.

(b) A Chief of Department wishing to resign from his or her appointment shall submit his or her resignation in writing to the Chief of Staff, and forward to the Chair of the Board of the Hospital; however, the resignation shall not be effective until sixty days (60) have passed since tendering resignation, and a replacement has been appointed.

ARTICLE 20 – MEDICAL ADVISORY COMMITTEE

20.1 Medical Advisory Committee

(a) Composition:

(i) the Chief of Staff who shall be Chair;

(ii) the President, Vice President, and Secretary/Treasurer of the Professional Staff;

(iii) the Chiefs of Departments who are physicians or dentists or delegates~~all Chiefs of Departments~~;

(b) The following shall have the right of attendance without vote:

(i) the President and Chief Executive Officer of the Hospital;

(ii) the Executive Vice President, Medical and Academic Affairs;

(iii) the Vice Presidents who are senior employees reporting to the President and Chief Executive Officer, responsible for patient care and clinical areas;

(iv) the Chief Nursing Executive;

(v) the Chief of Midwifery;

~~(v)~~(vi) Medical Program or Service Directors and other resource people may be invited to attend at the discretion of the Chair;

~~(vi)~~(vii) One (1) Patient Family Advisor.

(c) The term of the Patient Family Advisor is two (2) years, renewable for a maximum of three (3) consecutive terms or a total of six (6) years.

(d) In the absence of the Chair, the Deputy Chief of Staff shall serve as Chair; if no Deputy Chief of Staff is appointed, the members of the Medical Advisory Committee shall elect from amongst themselves a member to serve as Chair.

20.2 Duties of the Medical Advisory Committee

The Medical Advisory Committee is responsible for the following activities: credentials, recommendation with respect to the Professional Staff part of the By-Law, quality of education programs, quality of medical care and safety, ethics, discipline and conflict resolution. The Medical Advisory Committee shall establish Sub-Committees as directed by the Public Hospitals Act. Membership and duties of the Sub-Committees of the Medical Advisory Committee shall be set out in the Professional Staff Rules and Regulations.

The Medical Advisory Committee shall:

(a) report and make recommendations to the Board in writing on matters concerning the quality of professional care and the practice of Professional Staff or other professions licensed under the Regulated Health Professions Act, 1991 (Ontario) in the Hospital, in relation to the professionally recognized standards of Hospital professional care, including quality assurance, peer review, and critical incidents investigation;

(b) report and make recommendations to the Board concerning such matters as prescribed by the Public Hospitals Act and by the Hospital Management Regulations thereunder, including matters involving competence, conduct or physical or mental ability or capacity of a member of the Professional Staff;

(c) through the Chief of Department provide supervision over the practice of medicine, dentistry, midwifery, and extended class nursing in the Hospital when participating in Departments, Programs or Services;

(d) appoint such sub-committees as are required for the supervision, review and analysis of all the clinical work in the Hospital;

(e) name the Chair of each of the Sub-Committees it appoints and ensure that each meets and functions as required, and is keeping minutes of its meetings;

(f) receive, consider and act upon the report from each of its appointed committees;

(g) inform the Professional Staff at each regular meeting of the Professional Staff of any business transacted by the Medical Advisory Committee and refer to the Professional Staff such items as, in the opinion of the Medical Advisory Committee, require discussion and approval of the Professional Staff as a whole;

(h) advise and co-operate with the Board and the President and Chief Executive Officer in all matters relating to the professional, clinical, academic, scientific and technical services;

(i) recommend to the Board clinical and general rules respecting the Professional Staff as may be necessary under the circumstances;

(j) advise the Board on any matters referred to it by the Board;

(k) advise the Board on criteria for admission and discharge of patients; and

(l) advise the Board on recommendations resulting from quality improvement and risk management activities;

ARTICLE 21 – SUB-COMMITTEES OF THE MEDICAL ADVISORY COMMITTEE

21.1 Medical Advisory Sub-Committees

The Medical Advisory Committee will put in place standing and special sub-committees as may be necessary from time to time to comply with their duties under the *Public Hospitals Act* or the By-Law of the Hospital or as they deem appropriate from time to time. The duties of these sub-committees are outlined in the Professional Staff Rules. The Medical Advisory Committee shall appoint the following standing sub-committees following the annual meeting:

(a) Credentials Committee;

(b) Pharmacy and Therapeutics Committee;

(c) Medical Quality Improvement Committee;

(d) Medical Education Committee; and

(e) Laboratory Quality Utilization Committee.

21.2 Sub-Committees Established by the Medical Advisory Committee

(a) The Medical Advisory Committee may establish other sub-committees as required to fulfill its duties;

(b) Each sub-committee appointed by the Medical Advisory Committee shall work within a mandate described by the Medical Advisory Committee;

(c) The Medical Advisory Committee shall establish and revise the terms of reference for any Medical Advisory Committee sub-committee formed under section 19.2(a), which terms of reference shall be set forth in the Professional Staff Rules and Regulations. The Medical Advisory Committee shall present the revised terms of reference to the Board for approval;

(d) The Medical Advisory Committee may, at any meeting, appoint any special sub-committee, prescribe its terms of reference and name the Chair and Vice-Chair.

(e) The Medical Advisory Committee may, by resolution, at any time, dissolve and reconstitute the membership of any special sub-committee;

(f) Unless otherwise directed by the Medical Advisory Committee, each cub-committee of the Medical Advisory Committee shall meet as specified in its terms of reference and report to the Medical Advisory Committee;

(g) The Chair of each sub-committee of the Medical Advisory Committee will be appointed by the Medical Advisory Committee on an annual basis.

21.3 Appointment to Medical Advisory Committee Sub-Committees

Pursuant to the Hospital Management Regulation, the Medical Advisory Committee shall appoint the Physician members of all Medical Advisory Committee sub-committees provided for in this By-Law. Other members of Medical Advisory Committee sub-committees shall be recommended by the Medical Advisory Committee to the President and Chief Executive Officer and the Board. The Chief of Staff or delegate shall be an ex-officio member of all Medical Advisory Committee sub-committees, without vote.

21.4 Medical Advisory Committee Sub-Committees Duties

In addition to the specific duties of each Medical Advisory Committee sub-committee as set out in this By-Law and the Professional Staff Rules, all Medical Advisory Committee sub-committees shall:

(a) meet as directed by the Medical Advisory Committee;

(b) present a written report including any recommendations of each meeting to the next meeting of the Medical Advisory Committee;

(c) perform such other duties, not specified in this By-Law, as may from time to time be directed by the Medical Advisory Committee;

(d) review their terms of reference every three (3) years, or more frequently if necessitated by changing needs. Reviewed terms of reference will be submitted, with modifications if any, to the Medical Advisory Committee.

21.5 Medical Advisory Committee Sub-Committees Chairs

(a) The Medical Advisory Committee shall appoint a Physician as the Chair of each Medical Advisory Committee sub-committee where possible. Physicians named as Sub-Committee Chairs must be members of the Active or Associate Professional Staff;

(b) The Chair shall hold office for one year and may be reappointed annually by the Medical Advisory Committee.

21.6 Duties of the Chair of the Sub-Committees of the Medical Advisory Committee

Each Chair of a Sub-Committee of the Medical Advisory Committee shall:

(a) chair the sub-committee meetings;

(b) call meetings of the sub-committee;

(c) be a voting member of the sub-committee which they chair;

(d) report to the Medical Advisory Committee through the sub-committee minutes;

(e) at the request of the Medical Advisory Committee, be present to discuss all or part of any report of the Sub-Committee; and

(f) request meetings with the Medical Advisory Committee when appropriate.

21.7 Other Sub-Committee Duties

(a) The duties of all Professional Staff or Medical Advisory Committee sub-committees shall be as specified in the Rules and Regulations;

(b) Terms of Reference for all other Medical Advisory Committee sub-committees shall be developed by the sub-committee and approved by the Medical Advisory Committee.

21.8 Credentials Committee

(a) Composition:

(i) The Credentials Committee shall consist of:

(A) the Chief of Staff;

(B) the Chief Nursing Executive of the Hospital;

(C) such other Professional Staff members as appointed by the Medical Advisory Committee.

(b) Credentials Committee Duties:

(i) the Committee shall ensure that a record of the qualifications and professional career of every member of the Professional Staff is maintained;

(ii) the Committee shall establish the authenticity and investigate the qualifications of each applicant for appointment and reappointment to the medical, dental, midwifery and registered nurse extended class staff where not hospital employees, and each applicant for a change in privileges.

(iii) the Committee shall:

(A) ensure that each applicant for appointment to the Professional Staff meets the criteria as set out in the Northwest Regional Appointment and Credentialing Policy and Procedure;

(B) ensure that each applicant for a change in privileges continues to meet the criteria for reappointment set out in the Northwest Regional Appointment and Credentialing Policy and Procedure;

(iv) the Committee shall consider reports of the feedback from all stakeholders involved in the site visits and the standardized recruiting process;

(v) the Committee shall consult with the appropriate Chief of Department;

(vi) the Committee shall submit a written report to the Medical Advisory Committee at or before its next regular meeting. The report shall include the kind and extent of privileges requested by the applicant, and, if

necessary, a request that the application be deferred for further investigation;

(vii) the Committee shall perform any other duties prescribed by the Medical Advisory Committee.

ARTICLE 22 - MEETINGS – PROFESSIONAL STAFF ORGANIZATION

22.1 Annual Meeting

(a) An Annual Meeting of the Professional Staff shall be held at a date, time and place to be agreed upon and approved by the President of the Professional Staff;

(b) A written notice of each Annual Meeting shall be posted by the Secretary/Treasurer of the Professional Staff at least fourteen days (14) days before the meeting.

22.2 Quarterly Professional Staff Meetings

The meetings of the Professional Staff shall be held at least four (4) times in each fiscal year of the Hospital, one (1) of which shall be the Annual Meeting.

22.3 Notice of Regular Meetings

(a) Regular meetings of the Professional Staff shall be held at a date, time and place to be agreed upon and approved by the President of the Professional Staff;

(b) A written notice of each regular meeting shall be posted by the Secretary/Treasurer of the Professional Staff at least fourteen (14) days before the meeting.

22.4 Special Meetings

(a) In cases of emergency, the President of the Professional Staff may call a special meeting;

(b) Special meetings shall be called by the President of the Professional Staff on the written request of any ten (10) Active or Associate Staff members;

(c) Notice of such special meetings shall be as required for a regular meeting, except in cases of emergency, and shall state the nature of the business for which the special meeting is called;

(d) The usual time required for giving notice of any special meeting shall be waived in cases of emergency, subject to ratification of this action by the majority of those members present and voting at the special meeting, as the first item of business at the meeting.

22.5 Attendance at Meetings

(a) The Secretary/Treasurer of the Professional Staff shall:

(i) be responsible for the making of a record of the attendance at each meeting of the Professional Staff;

(ii) receive the record of attendance for each meeting of each Department of the Professional Staff; and

(iii) make such records available to the Medical Advisory Committee.

22.6 Quorum

(a) Thirty-five (35) Active and Associate Professional Staff members, of which fifty per cent (50%) must be Medical Staff, shall constitute a quorum at any general or special meeting of the Professional Staff;

(b) In any case where a quorum of the Professional Staff has not arrived at the place named for the meeting within thirty (30) minutes after the time named for the start of the meeting, those members of the Professional Staff who have presented themselves shall be given credit for attendance at the meeting for the purpose of satisfying the attendance requirement of this By-Law.

22.7 Voting

(a) There shall be only one (1) vote cast by any one such member on any question and the same shall be so cast by the member personally present;

(b) Unless as otherwise expressed by this By-Law, every question shall be decided by a majority vote;

(c) If there is an equality of votes, the Chair shall rule that the motion has been defeated;

(d) Unless a poll is demanded by ten percent (10%) of the members who can vote and who are present at any meeting, a declaration by the presiding officer thereat that a resolution is carried, or is not carried, by a particular majority shall be conclusive;

(e) If a poll be demanded as aforesaid, it shall be taken in such a manner as the presiding officer in such meeting directs;

(f) Voting at all elections shall be by secret ballots;

(g) No member of the Professional Staff shall vote by proxy.

22.8 Order of Business

The order of business at any meeting of the Professional Staff shall be as defined in the Professional Staff Rules and Regulations.

22.9 Election Procedure

(a) A Nominating Committee shall be appointed by the Professional Staff (at each Annual Meeting) and shall consist of three (3) members of the Active or Associate Staff appointed at the Hospital.

(b) The Nominating Committee shall undertake its selection activities further to the following criteria:

(i) an officer should have knowledge and understanding of the needs and operations of the Hospital;

(ii) a member nominated as President, or Vice President shall be a physician and member of the Active or Associate Staff, who shall have an understanding of their responsibility to act in good faith and in the best interest of the Hospital to avoid or declare situations of actual or perceived conflict of interest; and

(iii) a member nominated as Secretary/Treasurer may be an Active or Associate member of the Professional Staff

(c) At least thirty (30) days before the Annual Meeting of the Professional Staff, the Nominating Committee shall post a list of the names of nominated officers of the Professional Staff which are to be filled by election in accordance with this By-Law and the regulations under the *Public Hospitals Act*.

(d) Further nominations may be made, in writing, where signed by two (2) members of the Professional Staff entitled to vote, to the Secretary/Treasurer of the Professional Staff within fourteen (14) days of the posting referred to at subsection 22.9(c) and the nominee shall have signified in writing on the nomination his or her acceptance of it. Such nominations shall be posted or circulated in the same manner as above.

ARTICLE 23 - PROFESSIONAL STAFF ELECTED OFFICERS

23.1 Elected Officers

The elected Officers of the Professional Staff shall be President, Vice President, Secretary/ Treasurer. These officers shall be elected at the Annual Meeting of the Professional Staff. It is the intent of the By-Law that these officers hold office for one (1) year. Their term of office in each position shall not exceed two (2) years but they shall remain in office until their successors are elected.

23.2 Eligibility for Office

Only members of the Active or Associate Staff may be elected or appointed to any position or office.

23.3 Duties of the President of the Professional Staff

The President of the Professional Staff shall:

(a) preside at all meetings of the Professional Staff;

(b) call special meetings of the Professional Staff;

(c) be a voting member of the Medical Advisory Committee and its Executive;

(d) be a member of the Board without vote and as a Director, fulfill fiduciary duties to the Hospital;

(e) be a member of such other committees as may be deemed appropriate by the Board or through advisement and recommendation of the Medical Advisory Committee;

(f) report to the Medical Advisory Committee and the Board on any issues raised by the Professional Staff;

(g) be accountable to the Professional Staff and advocate fair process in the treatment of individual members of the Professional Staff;

(h) ensure that the Board is informed when a majority vote of the Professional Staff at any properly constituted meeting of the Professional Staff is opposed to a rule or rule change proposed by the Medical Advisory Committee;

(i) report to the Professional Staff at its regular meetings on all corporate issues, rules, new processes regarding quality and other issues from the Medical Advisory Committee which may affect a Professional Staff's practice;

(j) conduct the elections of Professional Staff Officers; and

(k) represent the Professional Staff on various task forces or at functions as may be requested from time to time.

23.4 Duties of the Vice President of the Professional Staff

The Vice President of the Professional Staff shall:

(a) act in the place of the President of the Professional Staff, perform the President's duties and possess the President's powers, in the absence or disability of the President;

(b) perform such duties as the President of the Professional Staff may delegate; and

(c) attend the Medical Advisory Committee meetings.

23.5 Duties of the Secretary/Treasurer of the Professional Staff

The Secretary/Treasurer of the Professional Staff shall:

(a) attend the Medical Advisory Committee meetings ;

(b) attend to the correspondence of the Professional Staff;

(c) give notice of Professional Staff meetings by posting a written notice thereof:

(i) in the case of a regular or special meeting of the Professional Staff, at least five (5) days before the meeting;

(ii) in the case of an Annual Meeting of the Professional Staff, at least ten (10) days before the meeting.

(d) ensure that minutes are kept of all Professional Staff meetings;

(e) ensure that a record of the attendance at each meeting of the Professional Staff is made;

(f) receive the record of attendance for each meeting of each Department of the Professional Staff, and provide copies to the Chief of Staff and the Executive Vice President, Medical and Academic Affairs;

(g) make the attendance records available to the Medical Advisory Committee;

(h) act in the place of the Vice President of the Professional Staff performing the Vice President's duties and possessing the Vice President's powers in the absence or disability of the Vice President;

(i) disburse Professional Staff funds at the direction of the Professional Staff as determined by a majority vote of the Professional Staff.

ARTICLE 24 - AMENDMENTS TO BY-LAW

24.1 Amendments to By-Law

~~(a) The Board may pass or amend the By-Law of the Hospital from time to time;~~

~~(b) Where it is intended to pass or amend the By-Law at a meeting of the Board, written notice of such intention shall be sent by the Secretary to each Director at his/her address as shown on the records of the Hospital by ordinary mail, email, or fax not less than ten (10) days before the meeting;~~

~~(c)~~(a) ~~Where the notice of intention required by clause 24.1(b) above is not provided, any proposed By-Law or amendments to the By-Law may nevertheless be moved at the meeting and discussion and voting thereon adjourned to the next meeting, for which no notice of intention need be given;~~Subject to applicable legislation the provisions of the by-Law of the Corporation may be repealed or amended by by-Law enacted by a majority resolution of the Directors at a meeting of the Board and sanctioned by at least a majority of the Members entitled to vote and voting at a meeting duly called for the purpose of the considering the said by-law.

~~(d)~~(b) Subject to paragraph 24.1(e) below, a By-Law or an amendment to a By-Law passed by the Board has full force and effect:

(i) from the time the motion was passed; or

(ii) from such future time as may be specified in the motion.

~~(e)~~(c) A By-Law or an amendment to a By-Law passed by the Board shall be presented for confirmation at the next annual meeting or to a special general meeting of the Members of the Hospital called for that purpose. The notice of such Annual Meeting or special general meeting shall refer to the By-Law or amendment to be presented.

~~(f)~~(d) The Members at the Annual Meeting or at a special general meeting may confirm the By-Law as presented or reject or amend them, and if rejected they thereupon cease to have effect and if amended, they take effect as amended.

~~(g)~~(e) In any case of rejection, amendment, or refusal to approve the By-Law or part of the By-Law in force and effect in accordance with any part of this section, no act

done or right acquired under any such By-Law is prejudicially affected by any such rejection, amendment or refusal to approve.

24.2 Amendments to Professional Staff Part of By-Law

Prior to submitting the Professional Staff part of the By-Law to the process established in Section 25.1, the following procedure shall be followed:

(a) a notice shall be sent to all voting members of the Professional Staff advising them of the proposed amendments to the Professional Staff part of the By-Law fourteen (14) days in advance of the matter being considered by the Board;

(b) a copy of the proposed Professional Staff part of the By-Law or amendments thereto shall be posted in the Professional Staff rooms and shall be made available on request fourteen (14) days in advance of the matter being considered by the Board;

(c) the Professional Staff shall be afforded an opportunity to comment on the proposed Professional Staff part of the By-Law or amendment thereto; and

(d) the Medical Advisory Committee may make recommendations to the Board, concerning the proposed Professional Staff part of the By-Law or amendment thereto.

ARTICLE 25 – PROFESSIONAL STAFF RULES AND REGULATIONS

25.1 Rules and Regulations

(a) The Board shall require that appropriate Professional Staff Rules and Regulations are formulated;

(b) The Board may establish, modify or revoke one or more Professional Staff Rules and Regulations;

(c) The Medical Advisory Committee may make recommendations to the Board for the establishment of one or more Professional Staff Rules and Regulations to be applicable to a group or category or to a specific Department of the Professional Staff or to all of the Professional Staff;

(d) The Medical Advisory Committee shall ensure that, prior to making any recommendation to the Board with respect to a Rule, the members of the Active Staff, or a specific Department when appropriate, have an opportunity to comment on the proposed recommendation;

(e) The President of the Professional Staff shall ensure that the Board is informed when a majority vote of the Professional Staff at any properly constituted meeting of the Professional Staff is opposed to a Rule or Rule change proposed by the Medical Advisory Committee.

SCHEDULE A
PROCEDURES REGARDING REAPPOINTMENTS, REQUESTS FOR CHANGES IN PRIVILEGES AND MID-TERM ACTION

1. PREAMBLE

This schedule outlines the procedures to be followed in three (3) different circumstances. Section 2 deals with Appointment, Reappointment and Requests for Changes in Privileges. Section 3 outlines the procedure when there is an immediate need to suspend privileges mid-term in an emergency situation. Section 4 is the procedure when mid-term action is required but not in an emergency situation.

It should be noted that a member's appointment and/or privileges shall continue throughout the review or investigation of circumstances relating to reappointment and until all appeals consistent with the *Public Hospitals Act* are completed.

The procedure for recommendations from the Medical Advisory Committee in respect of original Applications for Appointment shall be as set out in the By-Law and undertaken pursuant to the *Public Hospitals Act*.

2. RECOMMENDATION, APPOINTMENT, REAPPOINTMENT AND REQUESTS FOR CHANGES IN PRIVILEGES

(a) The Credentials Committee shall forward to the Medical Advisory Committee a report in respect of an appointment, a reappointment or request for change in privileges consistent with the Committee's terms of reference and such report shall be in writing and supported by references to the specific credentials, activities or conduct which may constitute the basis for the report;

(b) The Medical Advisory Committee may initiate further investigation, establish an ad hoc committee to conduct further investigation, refer the matter back to the Credentials Committee with direction or to an external consultant, or act upon the report and make recommendation to the Board;

(c) Where the Medical Advisory Committee makes recommendation to the Board, it should provide notice to the member in accordance with the *Public Hospitals Act* and the By-Law;

(d) Upon completion of its own investigation or upon receipt of the report of the body or consultant that conducted the investigation as the case may be, the Medical Advisory Committee shall make a recommendation to the Board in respect of the reappointment or privileges requested and provide notice to the member as set out at subsection 2(c);

(e) Service of a notice to the applicant or member may be made personally or by registered mail addressed to the person to be served at their last known address and, where notices served by registered mail, it shall be deemed that the notice was served on the third day after the day of mailing unless the person to be served establishes that they did not, acting in good faith, through absence, accident, illness or other causes beyond their control, receive it until a later date.

(f) If additional time is needed for review or the investigative process, the Medical Advisory Committee may defer its recommendation providing it indicates in

writing to the Board and the applicant or member that the recommendation cannot yet be made and gives reasons therefore, further to Section 37(5) of the *Public Hospitals Act*;

(g) The Medical Advisory Committee may, in its sole discretion, in the course of its review or investigation or in determining its recommendation, decide that there shall be a Special Meeting of the Medical Advisory Committee where the member shall be entitled to attend such Special Meeting;

(h) Where the Medical Advisory Committee considers a matter at a Special Meeting, the procedures set out below at Section 5 for Special Meetings of the Medical Advisory Committee are to be followed;

(i) The Medical Advisory Committee, when providing notice to the applicant or member as provided for in subsection 2(c) and subsection 2(d), shall advise the applicant or member that he or she is entitled to receive written reasons for the recommendation wherein a request therefore is received by the Secretary of the Medical Advisory Committee within seven (7) days from receipt by the applicant or member of the Medical Advisory Committee's recommendation and further that the applicant or member is entitled to a hearing before the Hospital's Board if a written request is received by the Board and the Medical Advisory Committee within seven (7) days from the receipt by the applicant or member of the Medical Advisory Committee's written reasons where requested;

(j) Where the applicant or member does not request written reasons for the Medical Advisory Committee's recommendation or where the applicant or member does not require a hearing by the Board, the Board may implement the recommendation of the Medical Advisory Committee;

(k) Where the applicant or member requires a hearing by the Board, the Board will appoint a time and place for the hearing and the procedures set out below at Section 6 for the Board hearing are to be followed.

3. IMMEDIATE MID-TERM ACTION IN AN EMERGENCY SITUATION

(a) The definition of mid-term action in an emergency situation is outlined in Article 15.7(a) of the By-Law.

(b) If at any time it becomes apparent that a member's conduct, performance or competence is such that it exposes, or is reasonably likely to expose patient(s), staff or others to harm or injury or is, or is reasonably likely to be detrimental to the safety of patient(s), staff or others or to the delivery of quality care, an immediate action must be taken to protect the patient(s), staff or others or to ensure the delivery of quality of care and the procedures set out herein relating to suspension or revocation of privileges shall be followed;

(c) In addition to the steps outlined in Article 15.7(a), the Chief of Department, or the Chief of Staff or the Executive Vice President, Medical and Academic Affairs will immediately notify the member, the Medical Advisory Committee, the President and Chief Executive Officer, the President of the Professional Staff and the Chair of the Board of their decision to suspend the member's privileges;

(d) Arrangements will be made by the Chief of Department or Chief of Staff for the assignment of a substitute to care for the patients of the suspended member;

(e) Within 24 hours of suspension, the individual who suspended the member will provide the Medical Advisory Committee, the President and Chief Executive Officer and the President of the Professional Staff with written reasons for the suspension and copies of any relevant documents or records;

(f) Upon receipt of the written reasons for suspension as described above, the Medical Advisory Committee will set a date for a Special Meeting of the Medical Advisory Committee to be held within five (5) days from the date of suspension to review the suspension and to make a recommendation to the Board;

(g) The Special Meeting of the Medical Advisory Committee shall be conducted further to the procedures set out below at Section 5 for the Special Meeting of the Medical Advisory Committee;

(h) The member may request and the Medical Advisory Committee may grant the postponement of the Special Meeting of the Medical Advisory Committee to a fixed date;

(i) The Medical Advisory Committee, when providing notice to the applicant or member as provided for in subsection 2(c) and subsection 2(d), shall advise the applicant or member that he or she is entitled to receive written reasons for the recommendation wherein a request therefore is received by the Secretary of the Medical Advisory Committee within seven (7) days from receipt by the applicant or member of the Medical Advisory Committee's recommendation and further that the applicant or member is entitled to a hearing before the Hospital's Board if a written request is received by the Board and the Medical Advisory Committee within seven (7) days from the receipt by the applicant or member of the Medical Advisory Committee's written reasons where requested;

(j) Where the applicant or member does not request written reasons for the Medical Advisory Committee's recommendation or where the applicant or member does not require a hearing by the Board, the Board may implement the recommendation of the Medical Advisory Committee;

(k) Where the applicant or member requires a hearing by the Board, the Board will appoint a time and place for the hearing and the procedure set out below at Section 6 for the Board Hearing are to be followed.

4. NON-IMMEDIATE MID-TERM ACTION

The definition of a non-immediate mid-term action is outlined in Article 15.7(b) of the By-Law. Procedure for a non-immediate mid-term action shall include:

(a) Information provided to the President and Chief Executive Officer or Chief of Staff by the Chief of Department which raises concerns about any of the matters in the By-Law relating to non-immediate mid-term action, shall be in writing and will be directed to the President and Chief Executive Officer and/or the Chief of Staff;

(b) Where either of the President and Chief Executive Officer, Chief of Staff, or Chief of Department receives information about the conduct, performance or

competence of a member, that person will provide a copy of the documentation to the other two;

(c) Upon receipt of information above, an interview will be arranged by the Chief of Staff or Chief of Department with the member, at which time the member will be advised of the information about their conduct, performance or competence and will be given a reasonable opportunity to present relevant information on their behalf;

(d) A written record will be maintained reflecting the substance of the aforementioned interview and copies will be sent to the member, the President and Chief Executive Officer, the Executive Vice President Medical and Academic Affairs, the Chief of Staff and the Chief of Department;

(e) Where the member fails or declines to participate in an interview as set out above, after being given a reasonable opportunity to so participate, appropriate action may be undertaken further to the procedure as outlined in this section;

(f) Following an interview as set out above, or where the member fails or declines to participate in an interview, the Chief of Staff, Chief of Department or President and Chief Executive Officer will determine whether further investigation of the matter is necessary;

(g) If further investigation is to be undertaken, the investigation may be assigned to individual or individuals within the Hospital, the Medical Advisory Committee, a body within the Hospital other than the Medical Advisory Committee or an external consultant;

(h) Upon the completion of the investigation contemplated by subsection 4(g), the individual or individuals or body who conducted the investigation will forward a written report to the President and Chief Executive Officer, Chief of Staff and Chief of Department. The member will be provided with a copy of the written report;

(i) The Chief of Staff, Chief of Department and President and Chief Executive Officer, upon further review of the matter and any report received, will determine whether further action may be required;

(j) Where it is determined that further action in respect of the matter may be required, the matter shall be referred to the Medical Advisory Committee along with a proposed recommendation with respect to mid-term action in writing and supported by references to specific activities or conduct along with any reports which constitute grounds for the proposed recommendation;

(k) The Medical Advisory Committee, in advance of considering the proposed recommendation, may initiate further investigation itself, in respect of such matters and in such a manner as it in, its sole discretion, deems appropriate;

(l) Upon completion of its own investigation or upon receipt of the proposed recommendation as set out above, the Medical Advisory Committee may determine that no further action need be taken in respect of the matter for lack of merit or determine to have a Special Meeting of the Medical Advisory Committee where the member is entitled to attend such Special Meeting;

(m) Where the Medical Advisory Committee considers the matter at a Special Meeting, then the procedure set out below at Section 5 for the Special Meeting of the Medical Advisory Committee is to be followed;

(n) The Medical Advisory Committee, following a Special Meeting of the Medical Advisory Committee, will provide the member with written notice of the Medical Advisory Committee's recommendation and the written reasons for the recommendation and the member's entitlement to a hearing before the Hospital's Board where a written request is received by the Board and the Medical Advisory Committee from the member within seven (7) days of the receipt by the member of the Medical Advisory Committee's recommendation and written reasons;

(o) Service of the notice of recommendation and written reasons to the member may be made personally or by registered mail addressed to the member at their last known address and, where notice is served by registered mail, it will be deemed that the notice was served on the third day after the day of mailing unless the member to be served establishes that they did not, acting in good faith, through absence, accident, illness or other causes beyond their control, receive it until a later date.

(p) Where the applicant or member does not require a hearing by the Board, the Board may implement the recommendation of the Medical Advisory Committee;

(q) Where the member requires a hearing by the Board, the Board will appoint a time and place for the hearing, such Board hearing to be undertaken pursuant to the procedures set out below at Section 6 for the Board Hearing.

5. SPECIAL MEETING OF THE MEDICAL ADVISORY COMMITTEE

In the event that a Special Meeting of the Medical Advisory Committee is required further to this schedule, such Special Meeting of the Medical Advisory Committee will be conducted pursuant to procedure as follows:

(a) The Medical Advisory Committee will give the applicant or member written notice of the Special Meeting, such notice to include:

(i) the time and place of the meeting;

(ii) the purpose of the meeting;

(iii) a statement that the applicant or member will be provided with a statement of the matter to be considered by the Medical Advisory Committee together with all relevant documentation;

(iv) a statement that the applicant or member is entitled to attend the Medical Advisory Committee meeting and to participate fully in all matters under consideration by the Medical Advisory Committee;

(v) a statement that the parties are entitled to bring legal counsel to the meeting and consult with legal counsel but that legal counsel shall not be entitled to participate in the meeting save and except in respect of making representation on behalf of the party;

(vi) a statement that, in the absence of the applicant or member, the meeting may proceed.

(b) The Medical Advisory Committee will provide the applicant or member with a statement of the particulars of the matter to be considered by the Medical Advisory Committee, including any proposed recommendation, together with all documentation and records collected by the Medical Advisory Committee or Credentials Committee pursuant to the performance of their duties;

(c) At the Special Meeting, a record of the proceedings will be kept in the minutes of the Medical Advisory Committee;

(d) The applicant or member involved will be given a full opportunity to answer each issue as well as to present documents and witnesses if so desired;

(e) Before deliberating on the matter or the recommendation to be made to the Board, the Chief of Staff will require the member involved and any other members present who are not Medical Advisory Committee members to retire for the duration of the discussion. The Medical Advisory Committee will not consider any matter, fact or documentation to which it did not give the member an opportunity to respond;

(f) No member of the Medical Advisory Committee will participate in a decision of the Medical Advisory Committee at a Special Meeting of the Medical Advisory Committee unless such member was present throughout the Special Meeting, except with the consent of the parties and no decision of the Medical Advisory Committee will be given unless all members so present participate in the decision. Where the Medical Advisory Committee determines that the matter is without merit and as such no decision of the Medical Advisory Committee is necessary, such determination will be noted in the minutes of the Special Meeting of the Medical Advisory Committee.

6. BOARD HEARING

In the event that a Board hearing is required pursuant to this schedule, such Board hearing will be conducted further to the following procedure:

(a) The Board will name a place and time for the hearing;

(b) The Board hearing will be held within thirty (30) days of the Board receiving the written recommendation and reasons for such recommendation from the Medical Advisory Committee unless such other time for the hearing is agreed to as by the parties;

(c) The Board will give written notice of the hearing to the applicant or member and to the Chief of Staff at least seven (7) days before the hearing date;

(d) The notice of the Board hearing will include:

(i) the place and time of the hearing;

(ii) the purpose of the hearing;

(iii) a statement that the applicant or member and Medical Advisory Committee will be afforded an opportunity to examine prior to the hearing all written or other documentary evidence to be ruled upon at the hearing and all reports which have been collected as part of the Credentials Committee and Medical Advisory Committee processes;

(iv) a statement that the applicant or member may be represented by counsel or agent, call witnesses, cross-examine witnesses and tender documents in evidence and present arguments and submissions in support of his or her case;

(v) a statement that the time for the hearing may be extended by the Board; and

(vi) a statement that if the applicant or member does not attend the hearing, the Board may proceed in the absence of the applicant or member and the applicant or member will not be entitled to any further notice in respect of the hearing.

(e) The parties to the Board hearing are the applicant or member, the Medical Advisory Committee and such other persons as the Board may specify;

(f) As soon as possible, and at least five (5) business days prior to the hearing, the parties will provide one another with copies of all written documentary material, along with the names, addresses and qualifications of all witnesses who will testify at the hearing and a detailed summary of the evidence they will give, along with reports that have been collected by the Credentials Committee or Medical Advisory Committee as part of the investigation process whether or not these materials will be used in evidence. The intent is that there should be full disclosure as between the parties to the Board hearing;

(g) The findings of fact of the Board pursuant to a hearing will be based exclusively on evidence admissible or matters that may be noted under the Statutory Powers Procedure Act. A party at a hearing may:

(i) be represented by counsel or agent;

(ii) call and examine witnesses and present arguments and submissions; and

(iii) conduct cross-examination of witnesses reasonably required for a full and fair disclosure of the facts in relation to which they have given evidence.

(h) The Board will consider the reasons for the Medical Advisory Committee that have been given to the applicant or member in support of its recommendations. Where through error or inadvertence, certain reasons have been omitted in the statement delivered to the applicant or member, the Board may consider those reasons only if those reasons are given by the Medical Advisory Committee in writing to both the applicant or member and the Board, and the applicant or member is given a reasonable time to review the reasons and to prepare a case to meet those additional reasons;

(i) No member of the Board will participate in a decision of the Board pursuant to a hearing unless they are present throughout the hearing and heard the evidence and argument of the parties and, except with the consent of the parties, no

decision of the Board will be given unless all members so present participate in the decision;

(j) The Board will make a decision to either follow or not follow the recommendation of the Medical Advisory Committee;

(k) A written copy of the decision of the Board and the written reasons for the decision will be provided to the applicant or member and to the Medical Advisory Committee within fifteen (15) days of the conclusion of the Hearing;

(l) Service on the applicant or member will be as set out in the By-Law.

CERTIFICATE OF ENACTMENT

THIS IS TO CERTIFY

(1) That the appended copy of the By-Law of the Thunder Bay Regional Health Sciences Centre is a true and complete copy of the By-law as amended by the Board of Directors of the Health Sciences Centre at a properly constituted meeting of the Board held on June6-7, 20187.

(2) That the amendments were confirmed at a properly constituted meeting of the general membership of the Health Sciences Centre Hospital held on the 21st2nd day of June 20178.

Dated at the City of Thunder Bay, the 21st2ne day of June 20187.

Jean Bartkowiak
President & CEO/Secretary

From: Sushma Khemani <skhemani@oha.com>
To: 'Jessica Nehrebecky' <nehrebej@tbh.net>
Date: 3/12/2018 11:30 AM
Subject: RE: OHA - Member Engagement Tour

>>> Sushma Khemani <skhemani@oha.com<mailto:skhemani@oha.com>> 3/6/2018 10:00 AM >>>
Good Morning Jean,

OHA's Learning and Engagement team, formerly Educational Services, is moving forward with a new vision, which will improve OHA's ability to provide even greater value for our hospital members, and their partners in what is now widely considered a complex, challenging and competitive learning space.

The new Learning and Engagement vision allows us to migrate away from a legacy portfolio grounded exclusively in individual skill development programming, to a more proprietary, innovative and future-oriented portfolio that fuels applied organization and system learning for OHA members. The new portfolio addresses current and emerging challenges, is driven and shaped by member need, and realizes clear learning objectives and outcomes.

With this vision, OHA will work closely and continuously with hospitals to ensure the development of programs that reflect their most critical learning needs.

Members of the Learning and Engagement team are planning a series of in-person meetings with members all over the province to explore the development of more comprehensive programs and services, specifically tailored to member needs and education requirements.

We are scheduling meetings with and conducting tours of our member organizations. Our goal is to engage the members, and conduct an organized briefing, where members can schedule as much or as little time as appropriate for Learning & Engagement. These meetings will identify the following:

* What is meeting their needs?
* What is not meeting their needs?
* What are their issues and challenges?
* What can we construct in learning to meet their needs?

Once a date is confirmed, I will send out a meeting invitation.

We look forward to hearing back from you soon.

Best regards,

Sushma Khemani
Coordinator, OHA Learning Portfolio

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APPENDIX B - Quality Committee of the Board - 2017-18

Colour Legend	
Completed by target	
In progress but not completed by target	
Not in progress, and not completed by target	

#	Accountability	Activity	As Needed	September	October	November	December	January	February	March	April	May	Presenter	Comments
1	Quality Oversight	Programs & Services Presentations		X	X	X	X	X	X	X	X	X	Dyad Leads	
2	Quality Oversight	Comments / Compliments / Complaints			X				X				C. Covino	
3	Quality Oversight	Credentialing and Licensing Processes for Professional Staff and Health Professionals			X								M. Addison / Dr. M. Langlois	
4	Quality Oversight	Critical Incidents / MAC Recommendations				X					X		C. Covino	
5	Quality Oversight	Emergency Preparedness					X					X	C. Covino /K. Bell/F. Pennie	
6	Quality Oversight	Financial Pressures Relating to Risk	X										P. Myllymaa	
7	Quality Oversight	Patient Safety		X			X			X	X		S. Craig	
8	Quality Oversight	Infection Prevention & Control Mandatory Patient Safety Indicators									X		H. McIver / R. Thompson	
9	Quality Oversight	Accreditation			X				X				G. Ferguson	
10	Quality Oversight	Quality and Risk Management Policies							X				C. Covino	
11	Quality Oversight	Quality Improvement Plan Excerpt from Balanced Scorecard			X		X			X			C. Freitag / M. Del Nin	
12	Quality Oversight	Quality Improvement Plan Updates / Approval						X	X				All	
13	Quality Oversight	Risk Management / Enterprise Risk Management			X								C. Covino /K. Bell/F. Pennie	
14	Quality Oversight	Terms of Reference Review		X				X					G. Whitney / C. Covino	
15	Quality Oversight	Terms of Reference Approval			X			X					G. Whitney / C. Covino	
16	Quality Oversight	Work Plan 2017-18 Review		X									G. Whitney / C. Covino	

17	Quality Oversight	Work Plan 2017-18 Approval			X	X						G. Whitney / C. Covino	
18	Quality Oversight	Ethics									X	M. Allain	
19	Quality Oversight	Litigation									X	X	C. Covino
20	Quality Oversight	Research Ethics Board					X					X	K. Bell (J. Wintermans)
21	Quality Oversight	Research Ethics Board Annual Report										X	K. Bell (J. Wintermans)
22	Quality Oversight	Annual Quality Research Report					X						Dr. A. Rudnick
23	Quality Oversight	Quality-Based Procedures									X		S. Craig
25	Quality Oversight	Accessibility						X					Ron Turner

Governance and Nominating Committee 2017-18

Updated: June 1, 2018

Colour Legend
Completed by target
In progress
Delayed

Committee legend:
G - Governance
N - Nominating business

Meetings Held:
Governance-September. November, February, May
Nominating-March, April (interviews)

#	Accountability	Activity	Committee	As Needed	September	October	November	December	January	February	March	April	May	July	Comments
1	Governance	Review Committee work plan for upcoming year	G		x										
2	Governance	Review Gov/Nom Committee terms of reference	G				x								Needs further revisions
3	Governance	Identify education needs and department tours for coming year	G		x										
4	Governance	Review Board vacancies	G							x					
5	Governance	Review Board forms	G		x										Forms to be reviewed every three years moving forward (last review in 2016)
6	Governance	Review Board policies	G				x								Only a portion of the policies to be reviewed annually on a three year rotation.
7	Governance	Plan annual Board retreat	G										x		Retreat to be held in September of each year
8	Governance	Review Board committees terms of reference	G		x										Some of the TOR need further review
9	Governance	Review meeting evaluations for the quarter	G				x						x		
10	Governance	Review Board and Board Committee attendance	G										x		

#	Accountability	Activity	Committee	As Needed	September	October	November	December	January	February	March	April	May	July	Comments
11	Governance	Review team effectiveness scale summary	G							x			x		Distributed to Board members at December/April Board meetings. February meeting canceled as there wasn't quorum.
12	Governance	Appoint community member on Board member interview panel	N							x					
13	Governance	Review Board member Selction and skills criteria (Policy BD-45)	N							x					
14	Governance	Review Board member skills matrix inventory	N							x					
15	Governance	Approve Application for Membership form	N							x					
16	Governance	Review Board of Directors recruitment ad, interview questions and schedule	N							x					
17	Governance	Review applications (Board and Community)									x				
18	Governance	Interview Board member candidates	N									x			
19	Governance	Propose slate of nominees	N									x			
20	Governance	Review By-Laws	G										x		
21	Governance	Review new Board member orientation program	G										x		
22	Governance	Review Board annual evaluation summary	G										x		Distributed at April Board meeting
23	Governance	Review annual education session summary	G										x		
24	Governance	AGM education theme	G									x			

#	Accountability	Activity	Committee	As Needed	September	October	November	December	January	February	March	April	May	July	Comments
25	Governance	Determine Board Committees membership	G											x	

ǧional Health Sciences Centre Board of Directors Work Plan
Revised: June 1, 2018

Colour Legend	
Completed by target	
In progress but not completed by target	
Not in progress, and not completed by target	

Legend:
BD: Board of Directors
EC: Executive Committee

#	Accountability	Activity	Responsible Body	As Needed	October	November	December	Februaary	March	April	May	June	Comments
2	Governance	Monthly education topics for the Board	BD		x	x	x	x	x	x	x	x	
3	Oversight of Management	Participate in CEO evaluation via website	BD							x			Names of respondants selected. Will email group via e-tool.
4	Oversight of Management	Participate in COS evaluation via website	BD							x			Process under review
5	Governance	Approval of By-Laws	BD								x		Will be approved at June meeting. Further review will be required in the fall.
6	Governance	Approve Slate of Nominees to fill Board vacancies	BD								x		
7	Oversight of Management	Approve CEO evaluation	BD									x	
8	Oversight of Management	Approve COS evaluation	BD									x	
9	Governance	Approval of Committee terms of reference and work plans	BD				x						Governnce reviewing in the new year

#	Accountability	Activity	Responsible Body	As Needed	October	November	December	February	March	April	May	June	Comments
10	Legal Compliance	Environmental compliance and fire safety update	BD		x		x		x			x	
11	Legal Compliance	Accessibility update	BD										
12	Quality Oversight	Critical Incidents Update	BD				x				x		
13	Oversight of Management	Physician recruitment plan update	BD					x					
14	Performance Measurement and Monitoring	Strategic plan update	BD						x				
15	Quality Oversight	Research Ethics Board appointments	BD	x									
16	Quality Oversight	Research Ethics Board report	BD									x	
17	Performance Measurement and Monitoring	Scorecard update	BD									x	
18	Governance	TBRHRI update	BD			x							
19	Governance	TBRHS Foundation update	BD		x								
21	Oversight of Management	Evaluation of CEO	EC								x		
22	Oversight of Management	Evaluation of COS	EC								x		

RESOURCE PLANNING COMMITTEE WORK PLAN

2017-2018

Colour Legend	
Completed by target	
In progress but not completed by target	
Not in progress, and not completed by target	

#	Accountability	Activity	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
1	Oversight of Management	2017-18 Work Plan for information only		x	x	x	x	x	x	x	x	x		
2	Financial Oversight	ALC, LOS and Emergency Admissions Monthly Report for information only		x	x	x	x	x	x	x	x	x		
3	Financial Oversight	Attestation: Wages and Source Deductions		x	x			x			x			
4	Financial Oversight	Financial Statements and Variance Report		x		x			x			x		
5	Financial Oversight	Financial Statements for information only		x	x		x	x		x	x			
6	Financial Oversight	Investment Policy Annual Review		x										
7	Financial Oversight	Investment Portfolio Reviews		x							x			
8	Financial Oversight	Northern Supply Chain Performance and Medbuy Update		x	x						x			Completed in October
9	Oversight of Management	Work Plan Review 2017-18		x										
10	Oversight of Management	Work Plan Approval 2018-19							x					
11	Governance	Terms of Reference Review 2017-18		x										
12	Governance	Terms of Reference Annual Approval 2018-19							x					
13	Performance Measurement and Monitoring	Corporate Balanced Scorecard			x			x		x				
14	Financial Oversight	H-SAA 2017-18 Operating Plan Agreement			x									
15	Financial Oversight	CAPS Approval					x	x						Completed in January
16	Performance Measurement and Monitoring	Human Resources and Organizational Development Update		x	x	x	x	x	x	x	x	x		
17	Financial Oversight	Broader Public Sector Travel & Expense Report				x						x		
18	Financial Oversight	Budget Planning Targets & Directives Report and Process Update				x								

#	Accountability	Activity	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
19	Financial Oversight	Funding HBAM and Quality Based Procedures Update				x								
20	Financial Oversight	HAPS 2018-19 Approval					x	x						Completed in January
21	Financial Oversight	TBRHRI and Sustainability Updates				x					x			
22	Financial Oversight	Capital Equipment and Capital Projects Update 2017-18						x			x	x		To be completed in May
23	Financial Oversight	Insurance Review						x						
24	Risk Identification and Oversight	Data Centre Disaster Recovery Plan Update								x				
25	Performance Measurement and Monitoring	Labour Relations, Grievances and Arbitrations Update								x				
26	Legal Compliance	Occupational Health and Safety Program Update								x				
27	Financial Oversight	Operating Plan Update 2018-19		x	x	x								
28	Financial Oversight	Operating Plan Approval 2018-19					x							
29	Legal Compliance	Public Sector Salary Disclosure								x				
30	Financial Oversight	Capital Budget Update 2018-19			x									
31	Financial Oversight	Capital Budget Approval 2018-19					x	x						Re-Approved in January
32	Legal Compliance	Broader Public Sector Accountability Attestation Certificate										x		
33	Legal Compliance	Broader Public Sector Use of Consultants Attestation										x		
34	Oversight of Management	H-SAA Declaration of Compliance Attestation										x		
35	Oversight of Management	M-SAA Declaration of Compliance Attestation										x		
36	Risk Identification and Oversight	Non Patient Legal Matters Annual Review										x		
37	Financial Oversight	Numbered Companies Unaudited Financial Statements 2017-18										x		
38	Risk Identification and Oversight	TBRHRI 2018-19 Operating and Capital Budget Report									x	x		Completed in April
39	Risk Identification and Oversight	TBRHRI 2017-18 Unaudited Financial Statements Review										x		
40	Financial Oversight	Unaudited Preliminary YE Financial Statements to 2018-03-31										x		

AUDIT COMMITTEE

2017-2018 WORK PLAN

Colour Legend	
Completed by target	
In progress but not completed by target	
Not in progress, and not completed by target	

#	Accountability	Activity	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
1	Oversight of Management	2017-2018 Work Plan for information only						x		x		x		
2	Financial Oversight	2017-2018 Audit Plan Overview - Grant Thornton						x						
3	Governance	Terms of Reference Annual Approval 2018-2019						x						
4	Performance Measurement and Monitoring	Review Results of May 2017 Evaluation of Auditors						x						
5	Financial Oversight	Independence Questionnaire 2017-2018						x						
6	Risk Identification and Oversight	Policy Reviews: Admin-19 & Admin-28						x						
7	Risk Identification and Oversight	Expense Test Audit						x						
8	Risk Identification and Oversight	Interim Audit Review 2017-2018								x				
9	Performance Measurement and Monitoring	Discussion of Year End Reporting Issues 2017-2018								x				
10	Financial Oversight	Audit Statement Review 2017-2018								x				
11	Financial Oversight	Individual Program Audit Reports								x				
12	Financial Oversight	Update on New Hospital Capital Audit								x				
13	Financial Oversight	Summary of Audit Fees Paid for 2017-2018								x				
14	Financial Oversight	2017-2018 Year End Financial statements for Board Approval										x		
15	Financial Oversight	2017-2018 Audit Results - Grant Thornton										x		
16	Oversight of Management	2017-2018 Management Letter										x		
17	Risk Identification and Oversight	2017-2018 Claims Summary										x		
18	Risk Identification and Oversight	Analysis of Legal Fees as at March 31, 2018										x		
19	Performance Measurement and Monitoring	Evaluation of Auditors for 2017-2018										x		
20	Performance Measurement and Monitoring	Recommend Appointment of Auditors for 2018-2019										x		
21	Oversight of Management	2018-2019 Work Plan Approval						x						

FISCAL ADVISORY COMMITTEE

2017-2018

Colour Legend	
Completed by target	
In progress but not completed by target	
Not in progress, and not completed by target	

#	Accountability	Activity	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
1	Stakeholder Communication and Accountability	Financial Statements and Variance Report				x								
2	Stakeholder Communication and Accountability	Operating Plan 2017-18				x								
3	Stakeholder Communication and Accountability	Q2 2017-18 Financial Review				x								
4	Stakeholder Communication and Accountability	Work Plan 2017-18 Review				x								
5	Stakeholder Communication and Accountability	Financial Statements as at 2017-08-31				x								
6	Stakeholder Communication and Accountability	Financial Statements and Variance Report									x			
7	Stakeholder Communication and Accountability	Operating Budget 2018-19									x			
8	Stakeholder Communication and Accountability	Q3 2017-18 Financial Review									x			
9	Stakeholder Communication and Accountability	Financial Statements as at 2018-02-28									x			
10	Stakeholder Communication and Accountability	Terms of Reference Annual Approval									x			
11	Stakeholder Communication and Accountability	Work Plan 2018-19 Approval									x			
12	Stakeholder Communication and Accountability	ALC, LOS and Emergency Admissions Monthly Report for information only				x					x			
13	Stakeholder Communication and Accountability	Vacancy, Overtime & Sick Time Report				x					x			

Page Views: Open Board Meeting Webcast

September 2017 – June 2018

Month	# of Page Views
September 2017	--
October 2017	18
November 2017	26
December 2017	17
January 2018	--
February 2018	15
March 2018	33
April 2018	13
May 2018	10
June 2018	
Yearly Total # of Page Views	

Thunder Bay Regional Health Research Institute

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Thunder Bay Regional Health Research Institute Report for TBRHSC Board – May, 2018

Submitted by: Jean Bartkowiak, CEO and Dr. Abraham Rudnick, EVP Research & Development and Chief Scientist May 28th, 2018. In alignment with the main directions of the Institute's *2020 Strategic Plan* we are pleased to share the following:

HEALTHIER: Improving the Health of People of NWO and Beyond

Currently the **Clinical Trials** department oversees the day-to-day operations of over 50 studies conducted by more than 20 physician investigators from 29 different sponsors (19 academic and 10 industry-sponsored). The majority of the open studies have a main focus on oncology or cardiology. This accounts for nearly one third of all open clinical research projects authorized by TBRHSC. A draft Business Plan for Clinical Trials has been developed with the goals: to attract industry and other sponsorships; to nurture clinical research; to create a human resources growth plan; and to enhance the quality management system. Attracting more trials will provide more opportunities for new patients, here and in our region, to participate in cutting edge trials. The draft plan is currently being presented to internal stakeholeders for feedback and will be finalized over the next few months.

Clinical Trials Patient Visits Q4 2017-18

Non-Oncology	January	February	March
Patients Screened	25	12	22
Patients Enrolled	3	1	3

Oncology	January	February	March
Patients Screened	79	81	218
Patients Enrolled	0	6	5

Physician-Initiated	January	February	March
Patients Screened	61	64	41
Patients Enrolled	53	53	32
Total Enrolled:	**56**	**60**	**40**

WEALTHIER: Generating Revenue through Science & Partnerships

Dr. Pichardo's **Ultrasound Transducer Project** is moving ahead with a second provisional patent application filed based on results from the first prototype developed by Sunnybrook and tested at TBRHRI. MaRS Innovation is considering commercialization potential.

As well, Dr. Alla Reznik and MaRS Innovation have identified a number of commercial partners and are engaged in dicussions regarding her **Glassy Lead Oxide Project**.

Thunder Bay Regional Health Research Institute

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SMARTER: Enhancing the Academic Environment

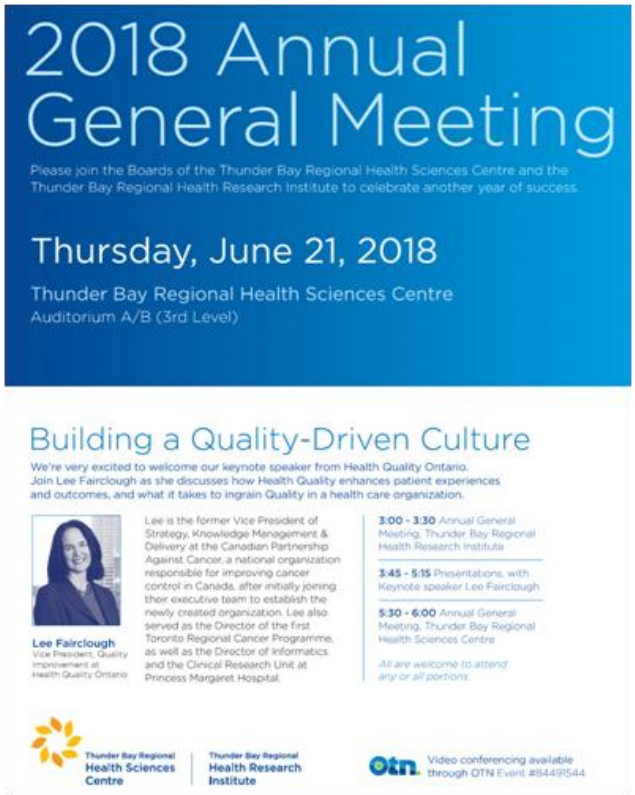
Interviews will be commencing in June for the three **new Joint LU/TBRHRI Research Chair** positions. A total of 30 applications were received for Research Chairs in the following areas:

- Smart Health Technology;
- Biophysics; and
- Radiochemistry.

As part of the interview process, each candidate will give a lecture, take part in tours of relevant LU and TBRHRI facilities, attend one-on-one meetings with select individuals from both organizations and participate in a formal interview with a department specific interview committee. It is hoped that the new recruits will be in place in the early fall.

We are proud to announce that **Robert Jackson**, PhD candidate with Dr. Ingeborg Zehbe, competed in Lakehead University's 3-minute thesis (3MT) competition during Research & Innovation week. His first place win led to the provincial event (3MT Ontario) at York University on April 19th where Rob competed with the winners from 19 other Ontario universities, presenting his PhD thesis work on human papillomavirus and biotechnology. Way to go Rob!

GENERAL:



The Institute and the Hospital will be holding their Annual General Meetings on June 21st in Auditorium A & B. The event commences with the Research Institute's AGM at 3:00 followed by a joint keynote speaker at 3:45. This year, the focus will be on *Building a Quality-Driven Culture.* Lee Fairclough from Health Quality Ontario will be speaking about how health quality enhances patient experiences and outcomes. The Hospital's AGM will follow at 5:30.

We hope you will be able to join us!.

Volunteer Association
to Thunder Bay Regional
Health Sciences Centre

SUPPORTING PATIENT FAMILY CARE

Report for May 2018

The Volunteer Association to TBRHSC hosted the 2018 HAAO Superior North Region Joint Spring Conference on April 28 & 29, 2018. Approximately 65 guests representing both the Superior North and the North West Regions attended the two day event. This year's theme was "This is Your Life". On Friday, four volunteers from Red Lake Margaret Cochenour District Hospital Auxiliary were inducted as Provincial Life Members (PLM). TBRHSC volunteer, Fin Selleck, was recognized for 60 years of volunteer service, she is already a PLM and has been recognized by the city and the province for this amazing achievement! We are very proud of her! We enjoyed a delicious dinner and were entertained by Thunder Bay's own Flamenco Caravan. Saturday, we had two informative and dynamic presentations. Michelle Allain, Bioethicist at TBRHSC spoke on MAiD (Medical Assistance in Dying) and Maggie Chicoine, who among many other things is a founding member of the Canadian Positive Psychology Association spoke to us about "Grins, Grit & Gratitude". Thank you very much to TBRHSC employees Mary Ann Porter, Dana Velgado and Donna Jeanpierre for their assistance. A special thanks to Glenn Craig and the TBRHS Foundation for the generous donation, that enabled us to provide breakfast and coffee breaks on Saturday.

On May 16th, we held our Annual General Meeting. Grant Thornton once again reviewed our books and Rosy Brizzi, presented the findings. Overall the report was favourable and no concerns were found. Sharron Detweiller, Past President and Pat Skula, Secretary were recognized for their contributions to the Board. Sharron will continue to oversee the Nevada licencing and reporting. The newly installed executive are Past President – Margaret Power, President – Cathy Britt, Vice-President – Shirley Wragg and Secretary – Mary Anne Fossum. Treasurer – Leshya Hunka is entering her second year in this position. Darlene Pyne and Pat Skula, will serve as Directors at Large. All positions are two year terms. We continue to search for a third Director at Large to bring the Board to the full complement of eight members, and have expanded the search to the broader community,

The primary focus of the Board is to be financially supportive of the hospital, its patients and its staff. We accomplish this mandate through our donations, scholarships and volunteering throughout the hospital. Our focus is centered on our goal of "Supporting Patient Family Care". The majority of funds are raised in Seasons Gift Shop, which is owned & operated by the Volunteer Association, and the largest share of the profits are returned to the Hospital and the Foundation. Additionally, we present a number of student and staff bursaries to support continuing education.

In addition to the donations noted in the April 2018 report, the Volunteer Association is donating $500 to the gardening volunteers. The gardens need quite a bit of work as they are now over ten years old; the soil needs replenishing and plants and shrubs are in need of replacement. The gardening volunteers are so appreciative of the new shed the Association purchased in 2017 and came to us in 2018 with a request to help them keep the gardens beautiful. Master Gardener, Carole McCollum is to develop a longer range plan for the garden and present her ideas to the Board in October.

Submitted by,

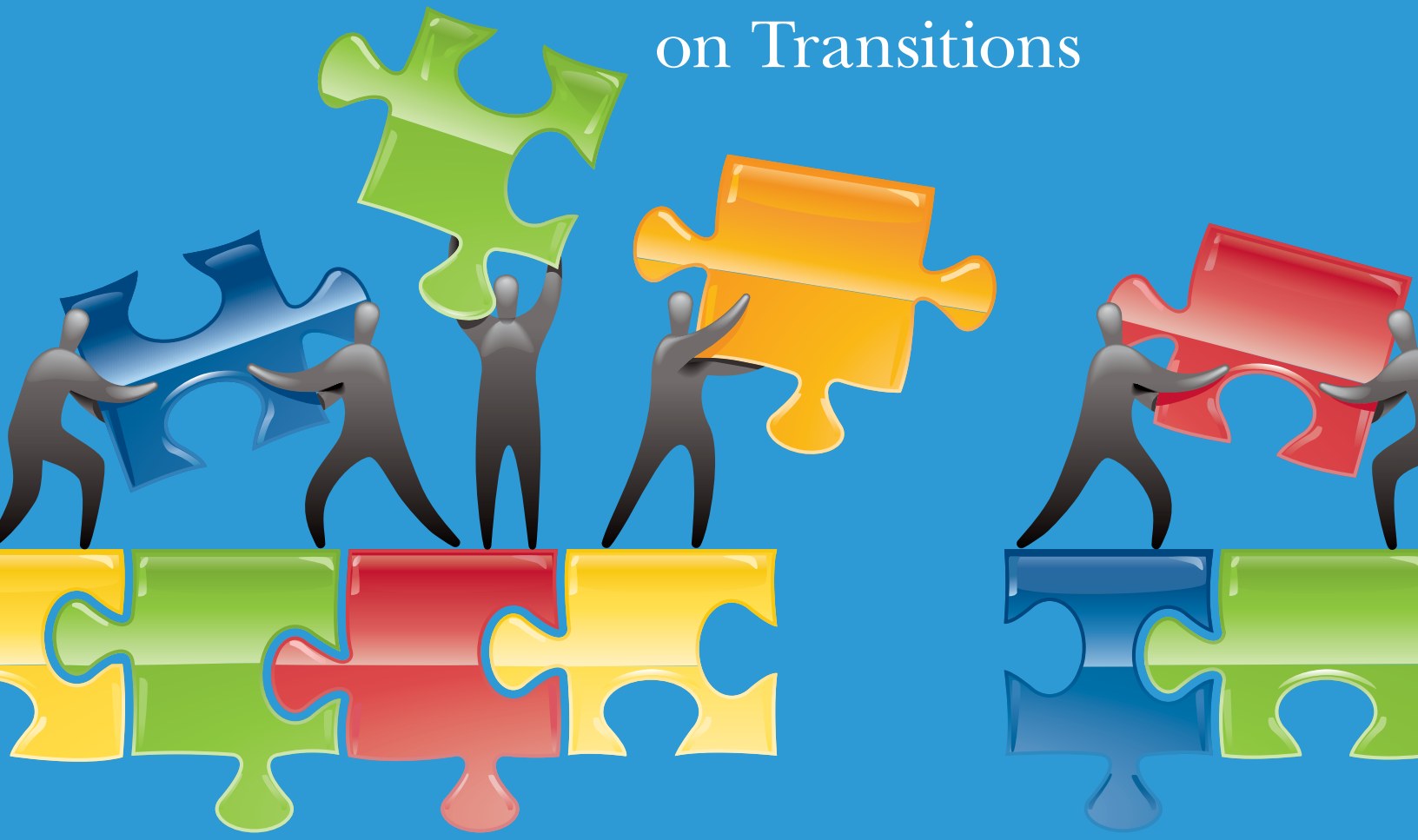
Cathy Britt, President

Issue 3 | April 2018

Redefining Health Care

A DIALOGUE ON HEALTH POLICY

Patient- and Family-Centred Care: Focus on Transitions



ONTARIO HOSPITAL ASSOCIATION

Through the Eyes of Patients and Caregivers: Jeannie Faubert

Redefining Health Care spoke to a number of former patients and caregivers to ask for their view about care transitions.

Jeannie is a retired elementary school teacher. She is a Patient and Family Advisor (PFA) at Thunder Bay Regional Health Sciences Centre (TBRHSC), which has been granted a Leading Practice Award in Patient Family Centred Care by Accreditation Canada, volunteers at the TBRHSC emergency department doing patient surveys, and is involved with various patient advisor initiatives. Jeannie continues to be inspired by the commitment of TBRHSC, and enjoys the many rewarding opportunities she has had as a PFA to contribute to quality improvement efforts in hospitals and research efforts in health care.

1. Can you describe an experience when you transitioned from one health care setting to another?

My father-in-law, Jerry, had a hemorrhagic stroke. He was transitioned from our acute care hospital to the regional stroke rehab unit. He was 79 years old. At that time, I had already been a patient/family advisor at the acute care hospital, and was well-versed in the patient- and family-centred care approach.

2. Can you reflect on how your transition impacted you and/or your caregiver?

Due to the timing of the transfer, Jerry was never oriented to the new ward nor was the family. We had no idea about meals, policies regarding physiotherapy, speech or occupational therapy assessments and programming, nor that there were laundry facilities in house for families to access. We felt that this information should have been shared via a tour, or at least, some kind of patient/family information paperwork.

In contrast, at the acute care hospital, we always knew what was on the daily schedule and who was looking after Jerry in terms of nursing because of the use of the white board.

It was a transparent system that worked well. At the rehabilitation facility, there was minimal communication with us – the family – or the patient. We also observed that physiotherapy schedules were not adhered to as announced on their boards. To go from feeling informed to being uninformed, raises anxiety needlessly.

As well, during the transition from one provider to another, I felt that we were not involved or consulted in the discussion. We were basically informed that when Jerry was in safe condition, he would be transferred from the acute care hospital to the special stroke rehab unit.

Looking back, we felt that there was no continuity of care between the two facilities. It was as if each organization was not particularly concerned about the care Jerry received outside of their facility, as long as they did the job they were supposed to do. In short, there was a lack of continuity between the two facilities about how patients were communicated with and treated, so we were left to adjust to each organization's way of doing things, rather than them meeting our expectations and needs using a more standardized approach.

3. What could have been done differently to make the experience better for you?

I feel that there should have been more of an orientation to specialty wards for patients/families. Someone at the receiving facility should have to sign off on this when a patient is admitted. In the same vein, facilities need to have similar, consistently used methods of communication with patients or families (e.g., white boards with an expectation and commitment to use them). Doing so would improve the process considerably, particularly in a community where facilities are working together regularly.

I also later learned that the rehabilitation hospital has a patient and family advisory council (PFAC). I discovered that the PFAC was not easy to join and had more staff than actual patient/family advisors. Membership was closed, meaning that at the time, they were not recruiting any new members. Members were also only accepted from certain practice areas (e.g., mental health services, chronic disease management). From my perspective, it seemed as though the PFAC was not empowered and set up to make meaningful changes that would support and improve the patient and family experience.

I had ideas for improvement, but I found it difficult to find someone who would listen.

We also feel that the organization could have done a much better job at addressing our complaints and needs. Instead, we felt as though we needed to take exceptional measures to have our needs heard. Interestingly, this experience was very different from the acute care facility where we felt that patient and family engagement was sincerely adhered to, and in fact, was part of the strategic plan.

I hope that patients and their families can come to expect standard treatment across the system, regardless of facility. I would also like to see a more universal desire to involve patients, listen to their concerns, and provide them with a more consistent experience, no matter where they are receiving care.