Executive Limitations Monitoring Report
EL- 4 Protection of Assets
Lake of the Woods District Hospital
For period ending March 31, 2017

Board policy is indicated in bold typeface throughout

I hereby present my monitoring report on the Executive Limitations Policy "Protection of Assets" according to the schedule set out. I certify that the information contained in this report is true, and represents compliance with a reasonable interpretation of all aspects of the policy unless specifically stated otherwise.

Signed C.M. Balcaen CEO Date: May 3, 2017

The CEO shall not allow corporate assets of the Lake of the Woods District Hospital to be unprotected, inadequately maintained or unnecessarily risked.

CEO Interpretation: (no change from previous report)

I interpret that the Board has, in the subsequent portions of this policy, comprehensively interpreted this broad policy provision. Therefore, my evidence for the numbered policy items following, taken collectively, constitutes evidence for compliance with the policy.

Further, without limiting the scope of the above statement by the following list, the CEO shall not:

1. **Fail to carry sufficient insurance against theft and casualty and liability losses for the organization.**

CEO Interpretation: (no change from previous report)

- I interpret "sufficient insurance" to mean an amount that is projected to be enough to cover against loss contingencies for accidental losses of physical assets, as well as loss contingencies to cover the potential for liability losses.
- I interpret "theft losses" to mean those losses that are as a result of intentional taking of cash or other hospital assets.
- I interpret "casualty losses" to mean losses that are a result of fire, flood or other physical cause of loss.
- I interpret "liability losses" to mean losses that are due to professional misconduct, malpractice, error or mistake causing bodily injury, including death.

Compliance will be achieved when it can be demonstrated through a review of the Hospital insurance policies that the amount of coverage is sufficient insurance in each area to cover any potential losses.

Evidence: **Compliant**

Insurance coverage is provided through two insurers, Healthcare Insurance Reciprocal of Canada (HIROC) for clinical/professional liability and crime insurance and Affiliated FM Insurance Company (co-brokers – Marsh & The Standard) for property, boiler, automobile and travel accident insurance. Insured amounts for liability meet industry norms as recommended by HIROC. HIROC is the largest healthcare liability insurer in Canada, and as such is able to provide well-informed guidance and information regarding insurance and claims trends for healthcare facilities. Similarly, Marsh is also one of the largest providers of Healthcare insurance in Canada and is well qualified to recommend coverage levels based on industry norms. Prior to renewal each year, both insuring agencies do detailed information updates to ensure that any material changes in operations or asset values are taken into account when determining coverage and premiums. The property insurer also does an onsite engineering inspection of the physical plant each year to identify potential risks. The Hospital participated in an RFP through the North West Supply Chain for the Property suite of insurance. Based on a comparison of coverage for other hospitals that participated in this RFP, the insured levels for LWDH are in line with our peer hospitals. Details of specific insurance policies,

comprehensive coverage information and results of engineering inspections are available through the office of the VP, Corporate Services.

2. Subject plant and equipment to improper wear and tear and insufficient maintenance.

CEO Interpretation*:*

- I interpret "improper wear and tear" to mean utilizing the plant, property and equipment without providing adequate maintenance on a rotating schedule. It is further interpreted to mean use for which the item was not designed, or use by persons not trained in the proper treatment of the asset.
- I interpret "insufficient maintenance" to mean a preventative maintenance schedule that is not in compliance with the manufacturer's recommended guidelines, lack of maintenance to keep the assets in good operating condition, or maintenance practice that puts the hospital at risk due to an increase in claims arising from injury to staff or patients.

Compliance will be demonstrated when:

a) There is documented evidence of regular maintenance of plant, property and equipment
b) There is a written record of preventative maintenance that is consistent with manufacturer's recommended guidelines
c) There are no patient or staff injuries attributed to faulty plant or equipment

Evidence: **Compliant**

Clinical Equipment

Some equipment is maintained internally by our internal Biomedical Technologists, and some equipment is maintained under annual contracts with equipment vendors. All hospital medical equipment has been tagged and entered into an electronic preventative maintenance (PM) schedule (Maintenance Connection) based on timelines recommended by Health Canada, (which is usually once per year), or more often if recommended by the equipment manufacturer. In the last EL-4 it was noted that although PM schedules were being adhered to for critical high risk areas such as OR, Lab, Ventilators, Cardiac & Anesthesia equipment, there was a concern that due to limited Tech resources PMs for lower risk clinical equipment were not always able to be completed as required. Subsequently, the hospital has hired a second Biomedical Technologist (November 2015) and based on discussions with the Biomed Tech and a review of the documentation logs, recommended preventative maintenance schedules are being met or exceeded for all critical equipment and approximately 85% of low risk, non-critical equipment. It is projected that we will be over 95% compliance in non critical equipment PMs this year.

Department Managers are responsible for ensuring that PMs are completed for those pieces equipment that are maintained by external contractors. For some of these clinical contracts, the Biomed Tech keeps a record of when maintenance is due. LWDH participates in a regionally coordinated equipment maintenance contract for Diagnostic Equipment Maintenance, which schedules regular PM on equipment and is available for emergency repairs when required.

Other Plant and Equipment

The Hospital utilizes software (Maintenance Connection) to track and schedule preventative maintenance and ongoing maintenance for plant equipment and buildings. Most assets have been entered into the database and scheduled preventative maintenance and ongoing maintenance associated with each piece of equipment are detailed in the equipment record. The hospital adheres to recommended guidelines for preventative maintenance and does our best to maintain equipment through ongoing repairs, however our aging plant systems (example, boilers, domestic hot water, steam systems) are nearing end of life and there is concern that there is a risk that ongoing repairs and preventative maintenance will escalate into a more urgent and expensive issue or in the worst case scenario, a system failure. As noted below, the Hospital performs regular testing of our critical building systems equipment and makes every effort to ensure that redundancies are in place to protect against system failure.

Copies of external equipment maintenance contacts are maintained in the "Contracts" binder in the Administration office. While the Biomed and or/maintenance department is aware of some of the required maintenance schedules in most cases the department manager initiates and retains record of the maintenance so there is no centralized tracking of completed maintnenance. Prior to the next monitoring

report a system will be developed to enter all equipment maintenance contracts into Maintenance Connection software in order to more effectively track external maintenance contracts to ensure that maintenance is being conducted in accordance with standards.

In order to protect patients and staff against faulty usage, all new equipment is tagged and checked by the maintenance department or biomedical technician to ensure its safety before it is deployed for usage. When new equipment is received, staff who will be using it are given the applicable training regarding its use, either by the equipment manufacturer or trained staff.

As noted above, we are seeing increased incidences of the plant breakdown due to our aging infrastructure. Although much of the current plant infrastructure is beyond its expected life, measures are taken to ensure the completion of any repairs and maintenance that are necessary to ensure patient, staff or public safety. Scheduled inspections and/or tests of the following are done in order to ensure compliance with legislation and safety standards:

Asset/Monitoring System	Frequency of inspection/servicing	Inspection Certificate or Visit Record Posted or Available?
Generator	Monthly testing (internal), additional semi-annual and annual inspection & load bank testing by contractor	Yes
Elevators	Monthly – contracted service. Full load test every 5 years	Yes
Fire Alarm and Sprinkler Systems	Annually through contracted service. Fire Department also does annual inspection of premises to identify any hazards and issues a written report	Yes
Fire Extinguishers	Monthly (internal) / Annually (contractor)	Yes
Boilers	Annually by insurance company and at least once annually (one boiler every 3 months) by contracted engineers. Boiler alarms tested and logged daily by maintenance staff Chemical testing daily, and verified monthly by contractor	Yes
Pressure Vessels	Annually by insurance company engineers Semi annually by contracted engineers. Also TSSA when they present.	Yes
Building Systems	Monitored daily by Delta maintenance system. Checked and serviced every three months by contractor	Yes
Cooling tower	Weekly checking of chilled water chemical content, verified monthly by contractor. Also tested semi-annually at change of season.	Yes
Natural Gas Systems	Union Gas does an annual walkabout to determine if any leaks exist	No. Union Gas advises if there are issues that need to be dealt with
Medical Gas System	Valve outlet testing and vacuum pump testing semi-annually and annually by contractors	Yes
Electrical	Annually by Technical Standards Safety Authority (TSSA). 3-4 times per year by Electrical Safety Authority	Yes
De-aerator Tanks	Annually	Yes
Mechanical rooms	Daily inspections by maintenance staff	Yes
Sterilizers	Daily test, Semi Annual by Vendor	Yes

Detailed logs or inspection reports are maintained onsite for timing and results of all inspections noted above. Follow-up action regarding any deficiencies noted is logged to ensure that they are rectified. All staff and patient injuries which can be attributed to faulty plant or equipment must be reported through the Risk Monitor software program. There were no incidents reported in Risk Monitor in 2016-17 as a result of malfunctioning of equipment that caused major or minor harm.

3. Unnecessarily expose the organization, its Board or staff to claims of liability.

CEO Interpretation**:** (no change from previous report)

- I interpret "unnecessarily expose to claims of liability" to mean not minimizing avoidable risks in the normal course of business. The most common risks for the hospital are potential patient safety issues, staff safety and wrongful treatment of patients or staff.

Compliance will be demonstrated when:

a) There is a comprehensive risk management program in place that provides for timely reporting of incidents or potential incidents and required documentation of follow-up investigation and resolution of incidents.
b) There are measures in place to identify and mitigate risk
c) There is sufficient liability insurance to offset liability arising from any potential claims against the Hospital

Evidence: **Compliant**

Measures to Limit Liability	Description	Process
Comprehensive risk management program	Online Risk Management reporting system (Risk Monitor Pro) provides for timely reporting of incidents	Incidents are reported via web based application. Risk Manager monitors responses to ensure incidents are followed up on a timely basis, and also provides an annual summary of incidents.
Regular Health & Safety Inspections	Internal Health & Safety inspections are conducted to identify areas which could pose a safety risk to patients, staff or the public. Monthly by JOHSC Quarterly by Dept. Mangers Semi-Annually by Sr. Managers	Findings of the inspectors are documented and forwarded to the applicable department manager. Major concerns must be rectified within a reasonable amount of time. Resolution is documented, and copies of all inspection reports are kept in Administration. Administration keeps a record to ensure compliance of submission and Senior Managers follow up with any departments that may not be submitting on a timely basis.
Risk Assessment Checklist	Developed by HIROC, this is a web based risk management self appraisal tool offering organizations the opportunity to identify risk areas requiring action and to prioritize action plans over a three year period. This is a hospital-wide team based approach whereby teams review existing procedures to identify risk areas and preventable issues. The objective is to prevent adverse incidents and claims and improve the overall safety of patients, staff and the organization as a whole. If HIROC is satisfied that standards are being met, a the hospital receives a reduction in insurance premiums	The latest annual assessment was done in June 2016 where HIROC reviewed our work performed on 3 selected modules. Each review identified minor areas for improvement which have subsequently been addressed. Overall the reviews were satisfactory and the premium discount was granted. 3 new areas of assessment for 2017-18 were chosen and submitted in April 2017.
Safe Operating Procedures	SOPs in place for all equipment.	SOPs maintained in all departments and are updated as new equipment is received. Compliance was tested through the Workwell Audit in 2012 and it was determined that proper SOPs were in place in all departments.
Ministry of Labour	Scheduled and impromptu inspections	Hospital reviews occupation health &

Measures to Limit Liability	Description	Process
Inspections	to ensure documented compliance with legislated safety standards in order to ensure staff, contractor, and ultimately patient safety	safety standards to ensure compliance. In June2017 the MOL will be conducting a3 day site inspection as part of a provincial initiative to inspect all hospitals in the province. Compliance in six specific areas will be tested. Policies and Procedures are being updated and education provided to ensure compliance for the inspection.
Respect in the Workplace Policy	Policy is in place	Policy is accessible to all staff in each department and on the internal website. Staff are educated with respect to the policy. Reported incidents are subject to documented follow-up investigation and resolution and are recorded in Risk Monitor. Violators are provided with a copy of the Policy as part of the investigation/resolution.
Workplace Conflict Resolution Policy	Implemented in 2014 to assist LWDH in maintaining s respectful and collegial work environment	All LWDH staff were required to review and familiarize themselves with this new policy and procedures which must be followed when workplace issues arising among staff
Disclosure of Critical Incident Policy	All critical incidents are disclosed and investigated	Every critical incident is reviewed by Senior Management and then referred to appropriate parties (legal counsel, department manager, board) as appropriate for resolution
Quality Reviews	Under the Quality of Care Information Act (QCIPA) critical incidents are reviewed by the Quality of Care Committee. Incidents associated with complaints regarding our hospital's service (non-QCIPA) are reviewed by an inter-professional team that may include the Manager of the department where the event occurred, the Risk Manager and/or the Quality of Care Committee.	25 non-QCIPA reviews were conducted during the 2016-17 year, No QCIPA reviews were conducted. Out of this process recommendations to improve processes and prevent similar incidents are formulated.
Quality Improvement Plan	Each year, in accordance with legislation, the Hospital implements a quality improvement plan which outlines improvement targets and initiatives to promote quality, effectiveness, efficiency and safety in delivery of patient care.	Met 10/11 quality improvement targets for 2015-16. The one measure not met was the balanced budget target.
Other Quality Committees	•Medical Advisory Committee •Medical QA •Quality Committee of the Board •Quality of Care Committee •Quality/Patient Safety and Risk Management Committee	Various committees in place to monitor and investigate practices and procedures to ensure legislation and best practices are adhered to
Patient and Family Advisory Committee	The Patient and Family Advisory Committee provides an opportunity for patients and families to provide feedback and input on hospital processes and programs	Committee meets quarterly.
Upgrade of Security	Hospital security systems (video	Positive response to staff concern re

Measures to Limit Liability	Description	Process
Systems	surveillance, electronic door access, infant abduction prevention systems) are all in the process of being upgraded	increasing incidences of violence
Crisis Prevention Intervention (CPI) Training	CPI Training is mandatory for all staff in specified areas where staff may be exposed to high risk or volatile situations or people	Mandatory bi-annual training.
Accreditation	Accreditation survey through Accreditation Canada tests the Hospital against various standards and Required Operating Procedures (ROPs) , many of which are related to risk reduction and patient safety.	The most recent Accreditation Survey was conducted at LWDH in October 2015

It is the practice of the hospital to report all incidents to our insurers which could potentially give rise to legal action. These incidents are reported to Senior Management by the Quality/Risk Manager, and discussed at their weekly meetings. Such incidents are also reported by the CEO or Chief of Staff in their monthly reports to the Board of Directors. There are no existing claims or potential claims that would not be covered through the Hospital's existing liability coverage.

4. Make any purchase wherein normally prudent protection has not been given against conflict of interest, or without due consideration to quality, value, after purchase service and consideration of local businesses.

CEO Interpretation: (no change from previous)

- I interpret "normally prudent protection" to mean steps that a reasonable person would make to ensure the hospital is protected.
- I interpret "conflict of interest" to mean to allow purchasing decisions to be biased in favour of a vendor who is a relative or close associate of an employee or board member in an influential decision making role.
- I interpret "without due consideration" to mean that all issues need to be considered when making a purchase. This involves ensuring the right goods are bought for the right price at the right time for the right purpose.
- I interpret "quality" to mean a product that is made for the purpose it was intended and a standard that meets at least the minimum requirements for its use.
- I interpret "value" to mean the economic value, i.e., the lowest cost provider taking quality into consideration.
- I interpret "after purchase service" to mean a service contract that provides adequate warranty and/or preventative maintenance programs as required
- I interpret "local businesses" to mean those that have an office located in Kenora and are competitive in their pricing.

Compliance will be demonstrated when: (see criteria under "criteria/procedure" column on the following chart.)

Evidence: **Compliant**

Criteria/Procedure	Evidence	Compliance
Policies clearly define: • A Supply Chain Code of Ethics •Purchasing Thresholds for RFP and tendering purposes •Authorization Thresholds	Purchasing policies have been reviewed to ensure that they remain in compliance with the Broader Public Sector (BPS) Procurement Directive which came into effect on April 1, 2011 for hospitals. These clearly define purchasing and authorization thresholds and conflict of interest guidelines.	Compliant

Criteria/Procedure	Evidence	Compliance
•Conflict of Interest Guidelines •Specific guidelines for capital purchasing.	Supply Chain Code of Ethics has been communicated to all staff and is posted on the internal website. Hard copies are posted in all departments responsible for purchasing activities.	Compliant
	The ORMED software system requires that a purchase order be prepared if items are processed through the purchasing system. Review of invoices indicates that items being ordered through the ORMED system are supported by authorized purchase order. Credit card purchases do not have a purchase order. Signature is evident on all POs to indicate proper authorization	Compliant - Continue to do periodic checks to ensure continued compliance.
	Major construction or consulting projects do not have or require a purchase order because they are supported by formal construction contracts. An examination of 100% of the major construction/consulting contracts entered into since the last report confirmed that all were signed by two authorized hospital signing officers.	Compliant – Continue to monitor for future reports
	100% of capital POs were examined and all are properly signed and are accompanied by supporting quotations and documentation	Compliant with respect to authorized signature however 11/56 did not have proper requisition attached, and 16/56 did not have a signed Hazard Assessment Form for New Equipment – Processes to improve compliance with these two requirements will be put in place immediately and will be reviewed again before the next monitoring report.
	Process and documentation was reviewed for all capital purchases to ensure approval has been signed off in accordance with authorization thresholds and that all contracts over $100,000 have been publicly tendered	Documentation indicated proper authorization sign off for all capital purchases. All contracts over $100,000 have been publicly tendered, either internally by LWDH or through the Northern Supply Chain.
2. A review of service contracts confirms that local suppliers were considered in cases where a local supplier existed	•Standard agreements are in place for local suppliers for certain groceries, wheelchair parts, and several other commodities/services. •Contracts are awarded through formal Requests for Proposals and comparative pricing – reviewed RFP processes – Local suppliers may be awarded contracts if they are very close to the lowest bid if they submit competitive bids and there is evidence that further efficiencies can be achieved through savings in travel costs, warranty or service response times.	Compliant – BPS requirements remove much of the flexibility to make local purchasing decisions unless local suppliers can be as competitive as all other suppliers. Some products from long standing local suppliers have begun to well exceed outside suppliers so in some cases we have no choice but to purchase from non local suppliers. Continue to monitor
3. Documented evidence is available to indicate	•Hospital is a member of the Northern Supply Chain Consortium (NSC) which is comprised of all	Compliant – continue to monitor for future reports and to

Criteria/Procedure	Evidence	Compliance
that products and services are sourced to achieve maximum quality at minimum cost	13 Northwestern Ontario hospitals and 23 Northeastern Ont hospitals •Hospital is a member of the MedBuy Purchasing Group through the NSC and is also a member of the HealthPro Purchasing Group. LWDH participates in these group purchasing organization (GPO) contracts for purchases of medical, pharmaceutical and other supplies. Contracts are provincially negotiated by the GPOs and access to the purchasing network is provided to all member hospitals. Pricing is very attractive for most commodities due to the expansive purchasing power of the GPOs •Hospital is a member of the Complete Purchasing Services Inc. for Nutrition & Food Services supplies •Hospital is a member of St. Joseph's Health System for purchase of capital supplies	participate in group purchasing efforts where beneficial for the hospital Membership in NSC has generated over $329,000 per year in annualized savings for LWDH
4. Documented evidence exists to indicate that as per our purchasing policies at least two and preferably three quotes have been obtained for all capital purchases and for contracted provision of supplies and services unless three qualified vendors are not available	A review of all capital purchases for the year and for contracted provision of supplies and services during the reporting period verified that in accordance with our purchasing policy, more than one quotation was received in the majority of cases. Exceptions noted were when only one viable supplier exists or for capital purchases where equipment is selected to maintain standardization with other equipment already being used in the hospital, a practice which is in compliance with our existing policies.	Continue ongoing monitoring to ensure compliance is maintained for future reports

5. Fail to protect intellectual property, information and files from loss or significant damage.

CEO Interpretation: (no change from previous)

- I interpret "intellectual property" to mean Patents, trademarks, copyrights, industrial designs.
- I interpret "information and files" to mean data, records and technology, whether it be paper or electronic version.
- I interpret "significant damage" to mean irreparable or considerable damage to data that has the potential for either lost data or recovered at a significant cost.

Compliance will be demonstrated when: (see criteria under "controls" column of the following chart)

Evidence: **Compliant**

Controls	Procedures/Compliance
•There are documented procedures in place, that are followed, to protect confidential information •There is compliance with the Personal Health Information Protection Act (PHIPA) in Ontario and the federal guidelines, Personal Information Protection and Electronic Documents Act (PIPEDA) . •Collection, use, disclosure and retention of a patient's personal and medical	•LWDH has data protection policies and processes that follow both the provincial and federal legislation •LWDH requires that a signed consent be obtained from all patients for use and disclosure of information. •Hospital policies and procedures are in place to comply with FIPPA. •All staff sign confidentiality agreements upon commencement of employment •All staff who use the Meditech patient information system have signed confidentiality agreements with the North West Health

Controls	Procedures/Compliance
information requires the patient or their legal representative's written consent •Policies, procedures and processes are in effect to ensure compliance with the Freedom of Information and Protection of Privacy Act (FIPPA) •There are physical safeguards in place to protect patient information and sensitive information	Alliance •Automatic audit procedures are in place which flag unauthorized access to Meditech for any patient files. All flags are investigated •The Hospital has recently updated all policies with respect to privacy and access to information •The use of personal electronic devices to record images or sound in the hospital is prohibited without the written permission of the person being recorded/photographed. Measures have recently been put in place to further educate and communicate on this policy •Reporting requirements under PHIPA and FIPPA have been met •Paper copies of patient charts are kept in locked storage rooms with keyed access granted only to applicable Health Records personnel, Nursing Supervisor and Maintenance on an as needed basis •Any violations with respect to privacy of patient information are dealt with immediately and offending staff are subject to discipline up to and including discharge •All staff are being required to review the Privacy module through the new Surge education program to reinforce importance and knowledge of obligations under PHIPPA.
Procedures are in place to protect electronic Information against unauthorized access and loss	•All incoming electronic traffic is monitored on-line and filtered by a firewall before it enters the hospital network to detect viruses and spam and to block unauthorized sites •Incoming and outgoing email is filtered to ensue all individual computers inside our network are also protected from viruses, hackers, network viruses and spy ware •All computers and systems require a user name and password for access. •All users of MediTech are required to sign Confidentiality Agreements with NWHA to protect privacy of patients •Users are only given permission for access appropriate to their job and function. •Computers are automatically locked out after 15 minutes of inactivity and may only be reactivated by the authorized user or administrator •Some backups are maintained on a server remote from the central IT server room but are not maintained offsite. Moving of backups to an offsite location will be investigated before the next monitoring report. •Backup systems are tested regularly to ensure viability
Physical safeguards are in place to protect computer equipment assets.	•The main computer server room is locked when IT personnel is not present in the room. •There is no signage displayed on the door so as not to draw attention to the location of the equipment. •Protective cabinets are used to house the servers to protect them from potential damage from water, accidental impact and static. •A risk has been identified in that although a protective trough exists above equipment in the server room to protect from water

Controls	Procedures/Compliance
	leakage if it should occur through the ceiling, the equipment is not elevated off of the floor so if a major flood were to occur there is a potential for damage. While there is a very low likelihood of this occurring, we will investigate the cost and feasibility of either elevating the equipment or installing a floor drain.
In the event that there should be a loss, LWDH is ensured against crime, property damage and business interruption losses.	•Coverage is reviewed annually to ensure it is adequate. A review of policies confirmed coverage against property loss/damage, crime and business interruption loss. (See #1)
Access to the Hospital logo is protected from unauthorized use	•Use of the Hospital's logo is restricted to those parties who have been given express permission to use it and only for specific purposes
The Hospital has sole ownership rights to drawings and design documents	•When the Hospital enters into contracts with consultants or suppliers to provide drawings or designs, a clause is included in the contract securing ownership to the intellectual property.

6. Fail to maintain and enforce internal control policies consistent with GAAP regarding receiving, processing or disbursing funds.

CEO Interpretation*:*
I interpret "GAAP" to mean Generally Accepted Accounting Principles, *being the standard framework of guidelines* for financial accounting as recommended in the Chartered Professional Accountants of Canada (CPA) Handbook

- I interpret "fail to maintain" to mean to not have adequate policies and procedures in place to comply with GAAP.
- I interpret "enforce internal control policies" to mean implement and make mandatory required policies and procedures which minimize or protect against waste, misuse and fraud in compliance with GAAP.
- I interpret "receiving ,processing or disbursing of funds" to mean the collection of funds, processing of invoices and the paying out of funds

Compliance will be demonstrated when:

a) All internal control policies are consistent with GAAP as evidenced by an unqualified audit.
b) Recommendations in the auditor's management letter which directly address internal control policies and compliance with GAAP are implemented prior to the end of the next fiscal year.

Evidence: **Compliant**

a) The external financial auditor notes all departures from GAAP in the annual audit report. All policies are consistent with GAAP as evidenced by an unqualified audit report for the year ending March 31, 2016.
b) The Hospital's auditors, Meyers Norris Penny LLP did not note any material concerns pertaining to internal controls and GAAP during the course of the 2015-16 audit.

7. Invest funds in investment vehicles prohibited under the Corporation by-laws.

CEO Interpretation:

- I interpret "investment vehicles" to mean GICs, bonds, securities and other forms of investments.
- I interpret "prohibited under the Corporation by-laws" to mean the Administrative By-laws of the Lake of the Woods District Hospital, dated November 2006.

Compliance will be demonstrated when 100% of investments are in compliance with the criteria in the corporate bylaws.

Evidence**: Compliant**

As can be verified by the investment certificates 100% of all investments as of March 31, 2017 are in instruments permitted by the corporate bylaws (i.e. GICs and term deposits).

7.1 Invest in unsecure instruments, including uninsured chequing accounts and bonds of less than AA rating at any time, or in non interest-bearing accounts.

CEO Interpretation:

- I interpret "unsecure instruments" to mean anything other than government-issued Treasury bills, Guaranteed Investment Certificates (GICs) federal or provincial government bonds.
- I interpret "uninsured chequing account" to mean those outside the Canadian Banking system.
- I interpret "bonds of less than AA rating" to mean high risk investments.
- I interpret "non-interest bearing accounts" to mean accounts that do not pay interest to the account holder

Compliance will be achieved when a review of the terms of the investment certificates and bank account agreements indicates that they bear interest and fall under the secure investments as noted in the interpretation above.

Evidence: **Compliant**

All Hospital investments held in low risk vehicles (bank or credit union GICs or other guaranteed interest bearing accounts). This can be verified by examination of the investment certificates.

Working capital for daily operational needs is all held in banks covered by depositor insurance. The operating chequing account provides for an interest rate on deposited funds.

8. Allow cheques to be drawn on Corporate accounts that do not bear the signatures of two authorized signors.

CEO Interpretation: (no change from previous)

- I interpret "corporate accounts" to mean the hospital bank accounts.
- I interpret" authorized signors" to mean those authorized as the designated signing officers for the LWDH as per the Hospital's By-Laws.

Compliance will be achieved when a review of cancelled cheques indicates that 100% of cheques bear the signature of two authorized signing officers.

Evidence: **Compliant**

A review of all cancelled cheques indicated that all cheques produced by the finance department bear two electronic signatures; that of the President & CEO and of the VP Corporate Services. The dual signature is built into the accounts payable software and is protected by the controls and permissions of the software usage and of the hospital's accounting internal control systems. The bank has not returned any cheques without proper signature. An increasing portion of payments are now being made by electronic funds transfer. This also involves a two stage approval process, with the EFT file having to be authorized and initialed prior to submission, and a second authorization required prior to having funds dispersed from the hospital bank account. The same person is not able to provide both authorizations.

9. Shall not endanger the Hospital's image or credibility, particularly in ways that would hinder its accomplishment of mission

CEO Interpretation: (no change from previous)

I interpret "endanger the Hospital's image or credibility" to mean to allow, or be perceived to allow, operational practices or implement decisions which could damage the reputation of the hospital in the eyes of the public, staff, or other partners and stakeholders.
I interpret "hinder its accomplishment of mission" to mean inhibit the hospital from ensuring that the people we serve receive optimal health care for a justifiable use of public resources.

Compliance will be achieved when it can be demonstrated that operations are directed in a manner that will not endanger the Hospital's image or credibility, nor inhibit the accomplishment of the mission.

Evidence: **Compliant**

One of the major causes of harm to the credibility or reputation of an organization arises from lack of accurate information or incorrect interpretation regarding its policies and practices and/or the reasoning behind various operational decisions. It is recognized that an effective communication strategy that promotes transparency, transmittal of accurate information and involvement of stakeholders is a crucial tool in preventing inaccurate rumours and in preserving the integrity of the hospital. The hospital strives to promote transparency in its operations and communications, in order that accurate information is disseminated to the public, our staff, our healthcare partners and other stakeholders. The LWHD 2014-17 Strategic Plan, identifies Communication and Engagement as an important component which will be incorporated into all Strategic Directions. Some specific actions which contribute to transparent communication by LWDH are as follows:

- Senior Management minutes and various committee minutes are posted on the internal website
- Board meetings are open to the public and are attended by media, who interview the CEO and Board Chair or their designates to clarify any items which may be reported in the media
- Internal & External website provide access to extensive information including the Quality Improvement Plan, Annual Financial Reports, Accessibility Plan, Executive Compensation, Executive Travel etc.
- Internal hospital newsletter is published monthly
- Community Partners newsletter sent semi-annually
- Board Ownership & Linkages Committee conducts community engagements to relay information and to obtain input from community and stakeholder groups
- Unions are kept apprised of activities through labour/management meetings and Fiscal Advisory Committee which meets at least twice per year, and more frequently if pertinent issues dictate
- Hospital management/staff is active on several advisory boards and committees which provides opportunity for exchange of information
- Patient safety information is available on the hospital external website and in the patient handbook
- External reviews are conducted to provide assurance regarding patient safety (ie accreditation) and results are published
- Internally developed patient satisfaction survey is administered annually and results are publicized
- Public reporting of safety indicators
- Patient and Family Advisory committee – provides opportunity to share information with former patients and/or family members and seek their input into hospital processes
- Met with staff and physician groups in March 2017 to advise of the upcoming Operational Review and to invite their input and suggestions into the Terms of Reference for the review.

9.1 Shall not cause or permit actions that are inconsistent with active partnership and positive relations with key stakeholders, including community partners, government and funders.

CEO Interpretation: (no change from previous)

- I interpret "inconsistent " to mean not keeping within the spirit of
- I interpret "active partnership" to mean working relationships between the Hospital and other health & community providers and stakeholders
- I interpret "key stakeholders" to mean those parties that have a direct involvement determining or supporting the services that the Hospital offers and provides
- I interpret " community partners" to mean community based health care and social services providers and other community groups whose operations directly or indirectly affect or are affected by the services that the hospital provides
- I interpret "government" to mean government and representatives of government at all levels, municipal, provincial and federal
- I interpret "funders" to mean the LHIN, MOHLTC and any other agencies or governments which provide financial support to the Hospital

Compliance will be demonstrated when:

(a) It can be demonstrated that the partners and key stakeholders and funders are satisfied with the level of, accuracy, timeliness and quality of information received by them from the Hospital, either at their request or as a result of voluntary information sharing by the Hospital, and
(b) Information regarding hospital issues that may have policy impact is sent to representatives of government where appropriate.

Evidence: **Compliant**

The Hospital meets regularly with key partners (ie. CCAC, nursing homes, police, community mental health organizations), to share and exchange information.

The Board of Directors has undergone community engagements with numerous partners, agencies and stakeholders over the past several years to communicate key priorities and to gather information regarding the expectations and priorities of the people the hospital serves.

There has been an expansion of legislated public reporting of key information, safety and performance indicators over the past two years, and the hospital has been compliant by posting this information on its external website in accordance with the required timeframes.

If the Hospital receives negative feedback, either privately or publicly, which appears to be related to misinformation or misunderstanding, efforts are made to respond in a prompt and respectful manner to correct misinformation and to dispel rumours.

A review of the submission of information and reports to our funders (LHIN and MOHLTC) revealed that all reports were filed on time. Late submission of some reports is subject to financial penalty. There were no incidences of financial penalties being assessed to the hospital for late submission of reports. Staff endeavour to respond quickly to ad hoc requests for information by our funders.

9.2 Shall not cause or permit hospital property to be used to promote causes that do not support the hospital mission.

CEO Interpretation: (no change from previous)

- I interpret “hospital property“ to mean hospital assets, including equipment, land and buildings, financial resources and human resources while on paid hospital time
- I interpret “promote causes” to mean endorse or sponsor activities
- I interpret the “hospital mission” to be “Lake of the Woods District Hospital exists so that: the people we serve receive optimal health care for a justifiable use of public resources”.

Compliance will be achieved when it can be demonstrated that activities which occur on hospital property or which use hospital resources are directly associated with the fulfillment of our Organizational End, which is to achieve the best possible health outcomes for the people we serve for a justifiable use of resources:

Evidence: **Compliant**

Prior to holding promotional events or activities on Hospital property, the CEO or another member of Senior Management is consulted to obtain permission. Permission is only granted if it is determined that the event is appropriate in nature and if it contributes directly to the hospital mission as interpreted above. This may include promotion of the mandate or mission of one of our direct healthcare partners.

Requests for advertising or donations are also vetted through Senior Management. Such expenditures are only committed if they are directly related to the mission of the Hospital.

Sale of goods or services on Hospital property (i.e. uniform sales, book sales etc) requires permission of the CEO and or a designated member of Senior Management In most cases, it is requested that a portion of the proceeds are donated to the LWDH Hospital Foundation.

Use of the Hospital email system to solicit support for causes or sales from employees is restricted by our “Use of Electronic Communications and Internet” Policy.