

## Board of Directors Meeting Agenda

Date: Thursday, September 26, 2024

Time: 9:15am - 12:00pm

Location: Boardroom / Microsoft Teams

Time	Agenda Item	Attachment
<b>9:15</b>	<b>1. Call to Order (Dr. S. Robertson)</b>	
(1 min)	1.1 Confirmation of Quorum	
(1 min)	1.2 Adoption of the agenda	P. 1-2
(1 min)	1.3 Declaration of Conflict of Interest	
<b>9:18</b>	<b>2. Minutes (Dr. S. Robertson)</b>	
(1 min)	2.1 Approval of previous meeting minutes - June 19, 2024, and June 26, 2024	P. 3-9
(1 min)	2.2 Business arising from minutes	
<b>9:20</b>	<b>3. Education Session</b>	
(15 min)	3.1 Emergency Preparedness (J. Mattice)	
<b>9:35</b>	<b>4. Strategic Actions Review</b>	
(5 min)	4.1 Q1 Strategic Actions Review (R. Alldred-Hughes) THAT the Board of Directors review and receive the Q1 Strategic Actions Report.	P. 10-14
<b>9:40</b>	<b>5. Matters for Discussion/Decision</b>	
(5 min)	5.1 Report of the Board Chair (Dr. S. Robertson)	
(5 min)	5.2 Report of the President & CEO (R. Alldred-Hughes)	P. 15-17
(5 min)	5.3 Report of the Vice President of Support Services & CFO (L. Ramsay)	P. 18-19
(5 min)	5.4 Report of the Patient and Family Advisory Committee (J. Shackleton)	
(5 min)	5.5 BPSO Champion (Dr. G. Raby)	
(5 min)	5.6 Financial Statements - April, May and June 2024 (C. Nagy/L. Ramsay) THAT the Board of Directors review and receive the financial statements for April, May, and June as presented.	P. 20-26
(10 min)	5.7 Capital Redevelopment Planning (L. Boyling/R. Alldred-Hughes) THAT the Board of Directors approve the recommendation of the Finance, HR, and Audit Committee with the issuance of a Request for Proposal (RFP) to hire a consultancy firm to support the development of a Pre-Capital Submission for Hôpital Glengarry Memorial Hospital.  THAT the Board of Directors approve the recommendation of the Finance, HR, and Audit Committee to use the Endowment fund to pay for the required fees associated with developing a Pre-Capital Submission for Hôpital Glengarry Memorial Hospital, if the fees cannot be covered by current operational dollars.	P. 27-29
(10 min)	5.8 Q1 Quality Improvement Plan Results 2024/2025 (C. Larocque/R. Romany) THAT the Board of Directors review and receive the results of the Q1 Quality Improvement Plan for 2024/2025.	P. 30-33
<b>10:30</b>	<b>6. Consent Agenda</b> (a formal request is to be made with the Board Chair to move an item out of the consent agenda for it to be discussed)	
	6.1 Auxiliary Report	P. 34
	6.2 Draft Governance and Nominating Committee Meeting Report	P. 35-37
	6.3 Education Topics for Board of Directors	P. 38-39
	6.4 Equity, Diversity & Inclusion Update	P. 40-41
	6.5 Revised Disclosure Protection (Whistleblower) Policy (CO.01.018)	P. 42-53
	6.6 Revised Board Attendance Policy (GO.01.002)	P. 54-55
	6.7 Draft Finance, HR, and Audit Committee Meeting Report	P. 56-58
	6.8 Q1 HR Metrics Report	P. 59-60
	6.9 Project Updates	P. 61-62
	6.10 Draft Quality and Risk Management Meeting Report	P. 63-66
	6.11 Q1 Quality & Safety Scorecard Results	P. 67-69
	6.12 Q1 Patient Satisfaction Survey Results	P. 70-73
	6.13 Q1 Violent Incident Report	P. 74-75

Time	Agenda Item	Attachment
	6.14 Q1 Complaints and Compliments Report	P. 76-78
	6.15 Patient Safety Actions Report	P. 79-80
	THAT the Board of Directors approve and receive all documents as presented in the consent agenda.	
10:31	7. Correspondence (Dr. S. Robertson)	P. 81
	8. Date of Next Meeting - October 24, 2024, 9:00am	
10:32	9. Closing Remarks & Adjournment (Dr. S. Robertson)	

*Meeting moves to In Camera*

## MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS

Date Wednesday, June 19, 2024  
 Time 18:15  
 Location Boardroom/Microsoft Teams  
 Present: F. Wetering, Chair Dr. S. Robertson, Vice-Chair C. Nagy, Treasurer  
 Dr. R. Cardinal L. Cardinal Dr. G. Raby  
 C. Larocque L. Boyling G. Peters  
 K. MacGillivray, CHRO R. Alldred-Hughes, CEO Dr. L. MacKinnon, COS  
 R. Romany, CNE J. Shackleton (PFAC)

Regrets: J. Andrews L. Ramsay, CFO

### 1. Call to Order

F. Wetering, Chair, called the meeting to order at 18:15.

#### 1.1. Quorum

A quorum was present.

#### 1.2. Adoption of the Agenda

The agenda was reviewed. Item 3.4 will be moved to the beginning of the meeting as J. Shackleton is to leave early.

Moved By: C. Larocque

Seconded By: L. Cardinal

THAT the agenda be adopted as amended.

CARRIED

#### 1.3. Declaration of Conflict of Interest

There were no conflicts of interest declared at this time.

### 2. Minutes

#### 2.1. Approval of the Minutes

The minutes of the last meetings held on May 22, 2024, were presented.

Moved By: G. Peters

Seconded By: C. Nagy

THAT the minutes of the May 22, 2024, meeting be approved as presented.

CARRIED

#### 2.2 Business Arising from the Minutes

There was no business arising from the minutes.

### 3. Matters for Discussion/Decision

#### 3.0 Patient and Family Advisory Committee Report (J. Shackleton)

In April, members of PFAC completed the Essential Care Partner program training. This was done to help identify any gaps there might be when becoming an Essential Care Partner. J. Shackleton noted that this training is very easy to understand, even from a non-clinical perspective and will have great impact on patients.

At the meeting in June, the committee reviewed draft posters for Patient Rights and Responsibilities. These will eventually be placed in all patient waiting areas and will serve as a good reminder for patients that they have a right to be respected but also the responsibility to be respectful.

As part of the Strategic Actions for 2024-2025, the committee was asked to come up with an initiative that could positively impact patient care. The idea of a possible library was brought up as reading is very therapeutic for some. The committee will be exploring a potential partnership with the library in order to offer books to patients. Because of infection prevention measures, physical books would be a challenge and as such, eBooks will be explored instead.

#### 3.1. Chair Report (F. Wetering)

F. Wetering reported that the hospital will be holding its annual Staff BBQ on September 12<sup>th</sup> in which he asked Board Directors to be present and serve the food.

#### 3.2 President & CEO Report (R. Alldred-Hughes)

R. Alldred-Hughes updated on the Strategic Plan of the Great River Ontario Health Team which was presented at the Collaboration Council last week.

On June 11<sup>th</sup>, R. Alldred-Hughes presented at the St. Joseph's Healthcare Hamilton Medical Leadership Retreat on Psychological Safety. This presentation will be offered to the Leadership team in the coming weeks.

June is pride month and staff, physicians, volunteers, and Board members are taking a pledge to support the 2SLGBTQ+ community at the hospital. This is a great step forward for diversity, equity, and inclusion at the hospital.

One of the major initiatives of the capital plan this year are for the parking lot. The hospital received notice that it will be getting HIRF allocation to cover all three phases of the project. Planning will now commence for this work and will go through RFP.

The hospital will be receiving the RNAO BPSO tomorrow at the RNAO Annual General Meeting. This is a great accomplishment for the hospital.

#### 3.3 Chief Human Resources Officer Report (K. MacGillivray)

K. MacGillivray advised that as part of the annual Staff BBQ this year, retirement recognition will be done for those who retired throughout the pandemic. Long service pin recipients will also be recognized at this event. Going forward, a separate event will take place for retirement recognition.

Recruitment is going well with 21 people hired since January. The presence on social media has significantly increased which is believed to be part of the success in recruiting as the hospital name is becoming more present. A question was added during the interview to find out how people are hearing about HGMH to better understand where we need to focus advertisement.

The team continues to compete in the Health Workforce Innovation Challenge in which another 5K was recently won, bringing the total to 26K won so far for the daycare initiative. Work is currently being done with GIAG to secure a location.

The hospital participated in a Benefits Collaborative initiative with the OHA and as a result, the benefits provider for the hospital will be changing to Medavie Blue Cross. A projection was done and this is expected to bring approximately 50K in savings per year.

K. MacGillivray was invited to speak at the Cornwall & SDG Employer Seminar about recruitment and retention. She sat on the panel with four other local organizations to answer questions about competitive hiring and retention practices in 2024. R. Alldred-Hughes thanked K. MacGillivray for well representing the hospital at this event.

The first IDEA committee meeting took place last week in which some very engaged members are excited about the opportunity to bring positive change to the hospital. The next meeting is scheduled in July.

#### 3.4 Audited Financial Statements 2023-2024 (C. Nagy)

The audited financial statements for 2023-2024 were shared.

Moved By: Dr. R. Cardinal

Seconded By: L. Cardinal

THAT the Board of Directors approve the audited financial statements for 2023-2024 as presented.

The legal name of the hospital was questioned as on some documentation, the full bilingual name is spelt out and other places it just says Glengarry Memorial Hospital. The legal name is actually Glengarry Memorial Hospital. In order to change this, would have to start by contacting the Ministry. R. Alldred-Hughes will look into this.

**CARRIED**

3.5 French Language Services Policy Framework / Cadre politique détaillé sur les Services en Français (C. Larocque)

The new policy, recommended by the French Language Services Committee was shared.

Moved By: Dr. S. Robertson

Seconded By: G. peters

THAT the Board of Directors approve the French Language Services Policy Framework (BOR.04.002) as presented.

**CARRIED**

3.6 Resolution from the Board to Maintain the Provision of French Language Services Across HGMH / Résolution du Conseil qui vise à maintenir la prestation des services en français dans l'ensemble de l'HGMH (C. Larocque)

The Board is fully supportive in maintaining the provision of French language services at HGMH.

Moved By: L. Boyling

Seconded By: C. Nagy

THAT the Board of Directors approve that the provision of French language services across HGMH be maintained as presented.

**CARRIED**

**4. Consent Agenda**

The following were included in the meeting package under consent agenda and reviewed by members prior to the meeting:

4.1 Draft Finance and Human Resources Committee Report of June 5, 2024

4.2 HSAA Declaration of Compliance

4.3 Attestation of the Broader Public Sector Accountability Act

4.4 Draft French Language Services Committee Report of June 5, 2024

4.5 French Language Services Annual Dashboard 2023/2024 *Tableau de bord annuel 2023-2024 du comité des services en français*

4.6 Summary of the Annual French Language report to the Ministry / *Sommaire du rapport annuel au Ministère sur les services de santé en français*

4.7 Letter to be sent to the Ministry of Health / Ministry of Long-Term Care on the Full designation under the FLSA / *Lettre à faire parvenir au Ministère de la Santé / Ministère de soins de longue durée*

Moved By: C. Larocque

Seconded By: Dr. R. Cardinal

THAT the Board of Directors approve and receive all documents as presented in the consent agenda.

**CARRIED**

**5. Correspondence**

Correspondence was shared.

6. Date of Next Meeting

Thursday, September 26, 2024, at 9:00am

7. Closing Remarks & Adjournment

The meeting adjourned at 18:57.

K-L. Massia, Recording Secretary

DRAFT

## MINUTES OF THE SPECIAL MEETING OF THE BOARD OF DIRECTORS

Date Wednesday, June 26, 2024  
 Time 19:00  
 Location Island Park Sandfield Centre

Present: Dr. S. Robertson, Chair L. Boyling  
 F. Wetering, Past Chair Dr. R. Cardinal  
 C. Larocque G. Peters  
 C. Nagy Dr. G. Raby  
 H. Salib R. Alldred-Hughes (CEO)  
 W. Rozon  
 G. McDonald

Regrets: F. Desjardins

### 1. Call to Order

Dr. S. Robertson, Board Chair, called the meeting to order at 19:07.

#### 1.1 Confirmation of Quorum

A quorum was present.

#### 1.2 Approval of Agenda

The agenda was reviewed.

Moved By: C. Larocque

Seconded By: L. Boyling

THAT the agenda be adopted as presented.

**CARRIED**

Dr. S. Robertson welcomed the new members to the Board and then handed the Chair of the meeting to L. Boyling for election of the officers.

### 2. Election of Officers

L. Boyling presented the recommendation from the Governance Committee that Dr. S. Robertson be appointed as the Board Chair, L. Boyling be appointed as Vice-Chair and C. Nagy be reappointed as Treasurer. With no additional nominations, the positions were acclaimed.

Moved By: C. Larocque

Seconded By: Dr. G. Raby

THAT the Board of Directors approve the elected officers as presented.

**CARRIED**

The Board agreed on consensus that R. Alldred-Hughes, CEO, be appointed Secretary.

The committee membership was set for 2024-2025.



Moved By:

Seconded By:

THAT the Board of Directors approve the committee membership as presented.

**CARRIED**

3. **Adjournment**

Dr. S. Robertson adjourned the meeting at 19:13.

K-L. Massia, Recorder

DECISION SUPPORT DOCUMENT FOR

- Board of Directors                       Board Committee                       Senior Leadership Team  
 Other (please specify):

Date Prepared: September 17, 2024                      Meeting Date Prepared for: September 26, 2024  
 Subject: Q1 Strategic Action Report  
 Prepared by: Robert Alldred-Hughes, President & CEO

- DECISION SOUGHT\*                       FOR DISCUSSION/INPUT                       FOR INFORMATION ONLY

**PURPOSE**

- The purpose of this briefing note is to present the Q1 Strategic Plan Action Monitoring Report for Hôpital Glengarry Memorial Hospital (HGMH). The report outlines the progress and status of actions undertaken to achieve our strategic priorities: Quality & Safety, People & Culture, Integration & Standardization, and Future Planning. Monitoring these actions allows us to ensure alignment with our strategic goals and make informed decisions to drive the organization forward effectively.

**RECOMMENDATION / MOTION**

- THAT the Board of Directors review and receive the Q1 Strategic Action Report.

**IMPLICATIONS TO OTHER STANDING COMMITTEES**

Are there any material or significant implications for other Standing Committees?  No     Yes, please specify:

**SITUATION & BACKGROUND**

*A brief description of the background to the issue.*

- HGMH has established strategic priorities in line with its vision and mission: Quality & Safety, People & Culture, Integration & Standardization, and Future Planning. These priorities guide our actions and initiatives each year. The actions are determined annually to align with the strategic priorities and move the organization towards its long-term vision. The Strategic Plan Action Monitoring Report provides a comprehensive view of the progress made in implementing these actions.

**IMPACT ANALYSIS/RISK ASSESSMENT/DECISION CRITERIA**

*Outline both the positive and negative consequences of the recommendations in terms of financial, mission, quality, risk and other.*

- Q1 saw actions completed and significant progress towards implementing remaining actions.
- The actions that have been completed include recruitment branding, standardized retirement and recognition program, and Computerized Tomography (CT) approval.
- There are no actions currently at risk or not on track, and all initiatives have started and are underway.
- An adjustment has been made to the following action "Implement a virtual care model to support reduced wait times and enhance physician initial assessment times in the emergency department during peak periods." The hospital continues to explore the virtual option, however, unless targeted funding is provided from Ontario Health to support this strategy, its implementation is cost prohibitive. In order to support a different care model, HGMH has temporarily implemented added physician coverage during peak periods through the week, and having positive results on wait times, left without being seen, and physician initial assessment times.

**SUPPORTING DOCUMENTS/ATTACHMENTS**

*List any supporting documents or attachments*

- Strategic Action Report Q1

## Strategic Action Report Q1

Strategic Dimension	Strategic Direction	Executive Lead	Action	Progress	Status
Quality & Safety	<i>Enrich the patient experience through quality, safe care that welcomes patients and families as partners in care.</i>	K. MacGillivray	Implement at least two actions from the Inclusion, Diversity, Equity, and Anti-Racism framework that support equitable access and/or culturally safe care.	<ul style="list-style-type: none"> <li>The IDEA Committee has now met four times and identified three actions from the framework:               <ol style="list-style-type: none"> <li>Job descriptions to include the hospital's value statement of IDEA and cultural safety.</li> <li>Employees have multiple trainings in IDEA and cultural safety.</li> <li>Connect with community partners with expertise and lived experience for training.</li> </ol> </li> <li>The value statement has been added to the job description template and will be included in all updated job descriptions.</li> <li>A twelve-session series on IDEA micro-trainings has been secured for the leadership team, IDEA committee and Board of Directors. A grant has been submitted to plan the training of all employees.</li> <li>An event will be held on September 17 with the Native North American Travelling College- smudging and social.</li> <li>The HGMH land acknowledgement has been developed and reviewed by two members of the Indigenous community.</li> </ul>	OnTrack

■ Fully complete

■ On track – no barriers for completion

■ Not on track – mitigation plans in place

■ Not on track – initiative at risk

		R. Romany	Implement at least two Best Practice Guidelines (BPG) aligned with the Registered Nurses Association of Ontario, Best Practice Spotlight Organization.	<ul style="list-style-type: none"> <li>The two BPGs that the team will focus on: <ul style="list-style-type: none"> <li>End-of-Life Care: During the last days and hours</li> <li>Oral Health: Supporting Adults who require assistance</li> </ul> </li> <li>The team is currently evaluating the existing processes and workflows for these two BPGs and identifying gaps and opportunities for improvement.</li> </ul>	On track
		R. Romany	Develop a business case for Surgical Services at HGMH to support care close to home and wait time reduction in the region.	<ul style="list-style-type: none"> <li>Work is currently underway to assess options related to utilization of HGMH surgical operating room to support our business case development.</li> <li>Working groups will meet in Q2 that will include clinical, physicians, admin and other stakeholders.</li> </ul>	On track
		R. Alldred-Hughes	The Patient & Family Advisory Committee (PFAC) will develop and implement two initiatives to continue advancing person and family centred care.	<ul style="list-style-type: none"> <li>The first initiative was for PFAC to complete training on Essential Care Partners (ECP) and provide feedback to HGMH for opportunities to better support ECP's. Complete.</li> <li>The second initiative is a collaborative effort with the Library, to support patient access to books and entertainment. This partnership has a planned launch in October 2024.</li> </ul>	On track
People & Culture	<i>Improve engagement by investing in the organizations people and empower a caring and positive culture for all.</i>	K. MacGillivray	Develop a creative recruitment brand that markets the hospital to prospective talent in a meaningful way.	<ul style="list-style-type: none"> <li>Branding has been developed and implemented. We worked with a marketing and media development firm to support this work, giving it a professional look and feel.</li> </ul>	Complete
		K. MacGillivray	Redesign and validate adjustments to the onboarding process for new hires, to ensure the new employee experience is seamless and positive.	<ul style="list-style-type: none"> <li>Work is underway with the IT department to develop a new ticketing system. Work is also underway with a new applicant tracking system that would ease the</li> </ul>	On Track

Fully complete
 On track – no barriers for completion
 Not on track – mitigation plans in place
 Not on track – initiative at risk

				onboarding process and collection of paperwork from new recruits. Next step will be to streamline the orientation education process.	
	K. MacGillivray	Develop and implement a standardized retirement recognition program that celebrates staff members who are retiring from the hospital in a meaningful way.		<ul style="list-style-type: none"> <li>The policy and program has been developed and implemented to ensure consistent recognition of retirements across the organization. The program includes certificate and gift of recognition, in addition to an annual retiree celebration event.</li> </ul>	Complete
Integration & Standardization	<i>Deliver standardized quality care in a cost-effective way through collaboration &amp; integration opportunities.</i>	R. Romany	Collaborate with the Great River Ontario Health Team to develop a plan and proposal that would see Enhanced Remote Care Monitoring by Ontario Health at Home integrated into our discharge process.	<ul style="list-style-type: none"> <li>Proposal developed in collaboration with GROHT and was submitted to Ontario Health for funding and now awaiting approval</li> <li>Working group continues to meet to review processes and workflows.</li> </ul>	On Track
		R. Alldred-Hughes	Explore the viability of a Health Hub in Alexandria in collaboration with the Great River Ontario Health Team, to support Primary Care, Emergency Department diversion, and sustainable physician recruitment and retention.	<ul style="list-style-type: none"> <li>Two meetings have taken place with the Family Health Organization, Eastern Ontario Health Unit, Community Mental Health, Great River OHT, and HGMH. Partners are working together to explore what may best support primary care providers, and support future recruitment efforts of physicians to the community.</li> </ul>	On Track
		R. Romany	Implement a virtual care model to support reduced wait times and enhance physician initial assessment times in the emergency department during peak periods.	<ul style="list-style-type: none"> <li>Implemented additional physician coverage during peak periods in July to improve patient flow, reduce the number of patients left without being seen and improve overall ED performance.</li> </ul>	On track
Future Planning	<i>Invest in the sustainability of our equipment &amp; infrastructure to support safe, quality care.</i>	L. Ramsay/R. Alldred-Hughes	Begin the capital redevelopment planning process that supports the development of a plan that meets the needs of the communities we serve.	<ul style="list-style-type: none"> <li>Plans to complete a pre-capital submission to the Ministry of Health Capital Branch has begun. The first step will be to issue an</li> </ul>	On Track

Fully complete
  On track – no barriers for completion
  Not on track – mitigation plans in place
  Not on track – initiative at risk

			RFP for a consultant to support the Board and Leadership in this work.	Complete
	R. Alldred-Hughes	Continue to work collaboratively the Ministry of Health and the HGMH Foundation to bring Computerized Tomography (CT) to HGMH, with the goal of obtaining approval for implementation.	<ul style="list-style-type: none"> <li>HGMH received Ministry of Health Capital Branch approval for CT in May 2024. We continue to work closely with the HMGH Foundation to help support the launch of their capital campaign.</li> </ul>	Complete
	L. Ramsay	Implement at least two projects that support the sustainability of the hospital's infrastructure.	<ul style="list-style-type: none"> <li>The parking lot resurfacing will begin in late September.</li> <li>The window on the south side of the hospital has been installed.</li> </ul>	On Track

■ Fully complete

■ On track – no barriers for completion

■ Not on track – mitigation plans in place

■ Not on track – initiative at risk

## Report of the President & CEO

*September 26, 2024 Board Meeting*

### Staff and Family BBQ



I would like to extend my sincere thanks to the members of the HGMH Board of Directors who attended and generously volunteered their time to help cook and serve at the Staff and Family BBQ. Your support and involvement made the event truly special and highlighted the strong sense of community we have at HGMH. Your commitment to fostering connections and showing appreciation for our staff is deeply appreciated by all. Thank you for helping to make the evening a success.

### System Planning for Mental Health across the Region

On July 3rd, I attended a meeting on systems planning for mental health across the region. Discussions focused on key areas such as patient access, systems integration, and substance use disorder services. The three breakout groups provided valuable insights, but the most notable outcome was the convergence on several core themes. Patient access, particularly ensuring patients find the "right door" for care and the need for after-hours services, which was a top priority across all groups. Geographic disparities, especially for rural communities, were also highlighted as critical concerns.

Another shared theme was the importance of data and knowledge sharing. Participants emphasized the need for accurate and standardized data collection, with a focus on equity-deserving populations, to ensure no group is left behind. Standardized assessment tools and care models were proposed to enhance collaboration and integration across systems, highlighting the need for more than just cooperation but full system-wide integration to truly address the mental health care challenges. Dialogue continues to occur among service providers with the Royal Ottawa taking a lead role in this work.

### CHAMP Value Analysis Update

CHAMP's member hospitals recently developed a 3-year strategic plan that begun with a critical member-by-member decision to either reaffirm their commitment to the CHAMP partnership and Meditech instance or to explore other potential partnerships with alternative HIS options. This Value Analysis was conducted to help the current CHAMP members determine the HIS path forward that best satisfies their organizations' future state needs.

The value analysis has been completed, and the CEOs of the CHAMP hospitals are working collaboratively to determine the next steps, including stakeholder engagement, prior to bringing a recommendation to our respective Boards of Directors. The value analysis has demonstrated that changes will need to occur, which will come at a significant cost to each hospital.

### Surgical Business Case

HGMH is currently collaborating with Deloitte to conduct an options analysis aimed at increasing surgical capacity at our facility. The analysis is focused on five potential areas of expansion: General Surgery, Pediatric Surgery, Urology, Gynecology, and Ophthalmology. As part of this work, we will be holding stakeholder engagement sessions with front-line care providers, including physicians, to ensure that their insights and perspectives are integral to the decision-making process. This comprehensive review will help inform our business case for submission to Ontario Health and the Ministry of Health, positioning HGMH to better meet the growing needs of our community.

### July 19 Code Grey

On June 19th, at 9:00am HGMH experienced a Code Grey: Electrical incident due to a malfunction in the Main Transfer Switch, which routes power to the hospital. The malfunction posed an imminent risk of failure, prompting an immediate shutdown of the switch and rerouting of power to a backup panel. Staff were alerted, and critical equipment was transferred to emergency power outlets. Electricians arrived quickly to implement a bypass of the faulty switch, ensuring power restoration without overloading the system.

During the outage, multiple departments worked together to manage the situation. The IT team addressed network issues, clinical services adapted to the limitations, ensuring patient care continued with minimal disruption, and maintenance worked quickly and diligently to implement a plan to restore power. By 9:55 AM, power was gradually restored, and the Code Grey was cleared at 10:00 AM. Steps were taken to secure a new transfer switch and improve emergency power protocols.

I would like to express my sincere thanks to the entire team for working through this difficult situation.

### Truth and Reconciliation

On September 17th, 2024, HGMH hosted a special ceremony in partnership with the Native North American Travelling College. Held at the hospital, the event brought together staff, board members, and community members, along with elected officials, in the spirit of reconciliation, cultural exchange, and community healing. The ceremony featured a smudging ceremony, providing a moment of reflection and honoring the cultural heritage of Indigenous communities. Following the ceremony, attendees participated in a social gathering, enjoying traditional dances and



engaging with local community members to further strengthen ties and celebrate Indigenous culture. This meaningful event reaffirmed our commitment to inclusivity and community connection.



#### Mayor's Task Force on Medical Recruitment

The City of Cornwall has struck a Mayor's Task Force to support work related to medical recruitment. As part of this task force mandate, they have reached out to health service providers in Cornwall and SD&G and sought responses to a series of questions. I was invited to attend the task force on September 18<sup>th</sup>, 2024, to present information pertinent to our hospital and rural context. HGMH has expressed our commitment to work collaboratively with the Mayor's Task force and regional partners to strengthen healthcare recruitment and retention strategies.

#### Foundation Dream Vacation & Harvest Tasting at the North

The HGMH Foundation has launched a Dream Vacation Raffle. Tickets are \$100, and the draw will take place at the Harvest Tastings at the North on October 28<sup>th</sup>, 2024. The prizes are as follows:

Grand Prize: \$15,000

Second Prize: \$3,000

Third Prize: \$2000

Contact the HGMH Foundation to get your tickets: [info@hgmhfoundation.org](mailto:info@hgmhfoundation.org) or 613-525-2222 ext. 4138

#### Upcoming Events/Special Dates

September 12: Staff and Family BBQ

September 8-14: International Housekeeping & Environmental Services Week

September 15-21 National Security Officer Appreciation Week

September 17: Indigenous Ceremony – Smudging and Social Dance

September 17: IT Professionals Day and Special Ceremony

September 25: World Pharmacist Day and Journée Franco-Ontarien

September 26: HR Professional Appreciation Day

September 30: National Day of Truth and Reconciliation (Orange Shirt Day)

October 22: Board Retreat

November 30: Hospital Christmas Party



## Report of the VP of Corporate Services and CFO

September 26, 2024 Board Meeting

### Health Information Services

#### **Winrecs 3.0 upgrade**

The Health Information Services department will be upgrading to a new version of Winrecs 3.0 (our coding and abstracting software). This enhancement has a more user-friendly interface and comes with the Edit Management Tool. This new tool provides more accurate and real time corrections in coding and abstracting of patient charts and minimizes errors in submissions.

#### **Fairwarning**

The Privacy Officer will be using Fairwarning a software that monitors any suspicious access to specific medical records. The system uses an algorithm that flags access to records by certain individuals who were not part of the patient's "circle of care." Policies and procedures will be published in the upcoming weeks.

### Maintenance

#### **Parking resurfacing and sidewalks**

Our parking lot will be resurfaced in phases starting with Phase one on Sept 23. This will be done hopefully with minimal disruptions to patients, visitors and staff. Completion date of all phases to be in the spring of 2025.

#### **Door Locks**

The new door access system is underway. Handles are being changed and new badges are being created on an ongoing basis.

#### **New ATS switch**

The main ATS switch that failed in June has now been replaced. The work was successfully completed over a 2-day span without any major impact.

#### **Rehab and Medicine unit renovation**

The nursing station on medicine will receive a facelift. Creating a better workflow with new workstations, file systems and computer placements to ensure enough space is available for all staff. To better accommodate dementia patients, wayfinding signage, murals and door wraps will also be installed. Renovations to three (3) rooms will be done to create a home-like setting for patients hopefully to bring them a bit more comfort. In addition, the Inpatient shower on the Medicine Unit will receive a facelift with a spa like setting. Additional seating will also be added for patients and families to sit and visit.

### Housekeeping

#### **Celebration week**

Last week was International Housekeeping and Environmental Services week. Each staff member received an HGMH tuque and were treated to ice cream, pizza and Tim's throughout the week.



## Information Technology

### **Infrastructure upgrade**

We are implementing new switches and access points to enhance security and improve internet speed and reliability. This project will significantly increase the reliability of our infrastructure, greatly assisting with security, monitoring, network organization, and usability. These upgrades will benefit all users.

### **Community Engagement**

We are expanding our relationship with Community Living, assisting them in achieving better security and usability. We are working collaboratively with them to upgrade their hardware and software, helping them strengthen their IT infrastructure and provide them with IT support.

### **Enhanced Security**

Multi-Factor Authentication (MFA) is being introduced to provide better protection for remote users. Additionally, we are partnering with a new Security Operations Center (SOC) and building relationships with The Ottawa Hospital (TOH) to enhance our own security measures. This will ensure that all parties attempting to access the hospital's IT infrastructure remotely will have to verify their identity with a secondary app in addition to their password, significantly reducing the risk of unauthorized access.

### **Super Ops ticketing system**

A new ticketing system will be launched to increase traceability, security, and automate processes, leading to quicker resolutions and better service. This project will make contacting IT much easier, introduce improved documentation, remote management, exploit patching, updates, and standard operating procedures (SOPs) for common issues. The new system will streamline IT support, making it more efficient and user-friendly.

### **Downtime solution**

We are implementing a more robust downtime solution to ensure patient care remains unaffected during any system outages. This is highly beneficial to patient safety and reduces the workload on staff. By minimizing downtime, we can maintain high standards of care and ensure that our systems are always available when needed.

## Finance

### **Redesigning receivable invoices and statements**

We are in the beginning stages of redesigning the receivable invoices and statements produced by the system. The redesign will include enlarging the current font to make it more senior friendly, reorganizing the way the information is presented to make it less confusing and modernizing the look to promote our own branding.

### **Employee portal for payroll**

HR and Finance are working collaboratively to implement the employee portal for payroll. Once implemented employees will be able to access their payroll information online. This will save time for our payroll clerk and paper.

DECISION SUPPORT DOCUMENT FOR

- Board of Directors                       Board Committee –                       Senior Leadership Team  
 Other (please specify):

Date Prepared: August 26, 2024                      Meeting Date Prepared for: September 11 – Finance  
September 26 - Board of Directors

Subject: April, May, and June 2024 Financial Statements

Prepared by: Linda S. Ramsay

- DECISION SOUGHT\*                       FOR DISCUSSION/INPUT                       FOR INFORMATION ONLY

**PURPOSE**

- Financial Statement explanations of variances between Actual and Budgeted amounts for the months of April 2024, May 2024 and June 2024. Note: Budget figures presented are based on the annual amount divided by 12 months.

**RECOMMENDATION / MOTION**

- THAT the Board of Directors review and receive the financial statements of April, May, and June 2024.

**ANALYSIS OF FINANCIAL INFORMATION**

- April/May/June 2024:
  - Year to date (YTD) Out of province volumes were lower than predicted by 9 %. Even though the interprovincial rate in effect as of April 1, 2024 (\$ 440 per visit), is up from April 1, 2023 (\$ 361). The increase in rate was offset by a decrease of volumes.
  - The Ministry announced in May that it would extend the Temporary Summer Locum Program to September 30, 2024, retroactive to April 2024. This explains the variance between actual and budgeted amounts for both the Emergency Funding and Staff Remuneration each month by about \$ 50,000.
  - Recoveries and Miscellaneous: Most of the variance is related to the parking revenue.
  - The ONA wage rate in effect as of April 1, 2024 (3 %) is the exact same rate as the assumptions in the budget. CUPE rate assumption was the same as ONA (3 %) however, the arbitration award was announced on April 22. Actual rate adjustments for CUPE employees were modified in May and retro payments were issued in June. June was a month that had 3 pay periods. The systems calculates an accrual for the unpaid wages at the end of every month. However, it does not calculate the related accrued benefits (ie: employer portions of CPP, EI, EHT etc.) Meaning that for June we have an additional cost related to wages.
  - The proceeded with its first phase of duct cleaning. The north end (ER/DI/lab area) was done at a cost of \$ 15,000.

**ANALYSIS OF STATISTICAL INFORMATION**

- The overall census for both inpatient units has been on the decline since April. This enables us to reduce staffing levels, often times sending staff home after 4 hours or limiting the use of agency nurses.
- Overall ER volumes are higher than budgeted, but our Out of province volume are lower than budgeted.

**FUTURE ITEMS TO CONSIDER**

- Our funding announcement was received at the end of May, but the funding was not received until July.



#### SUPPORTING DOCUMENTS/ATTACHMENTS

- Financial Statements: April, May, and June 2024
- Statistical information

HOPITAL GLENGARRY MEMORIAL HOSPITAL  
STATEMENT OF OPERATIONS  
FOR THE PERIOD ENDING APRIL 30, 2024

ACTUAL Apr-24	BUDGET Apr-24	VARIANCE Apr-24
1,327,184	1,353,683	(26,499)
193,377	152,083	41,294
16,885	16,667	218
186,160	199,269	(13,109)
16,211	16,666	(455)
(5,333)	(3,333)	0
50,112	40,023	10,089
14,167	17,917	(3,750)
<b>1,800,763</b>	<b>1,792,975</b>	<b>7,788</b>
941,212	1,011,579	(70,367)
247,392	274,847	(27,455)
254,459	197,210	57,249
21,734	32,851	(11,117)
26,958	21,683	5,275
338,924	347,002	(8,078)
18,167	18,167	0
32,291	32,293	(2)
<b>1,881,137</b>	<b>1,935,632</b>	<b>(54,495)</b>
<b>(80,374)</b>	<b>(142,657)</b>	<b>62,283</b>

Revenue:  
MOHLTC Base Allocation  
MOHLTC Base Allocation - one time funding  
MOHLTC Special HHR programs  
Alternate Emergency Funding Payments  
Physician Payments  
Patient revenues from other Payers  
Differential and Co-Payment  
Bad Debts  
Recoveries and Miscellaneous  
Amortization Grants/Donations - Equipment

Total Revenues

Expenses

Compensation - Salary and Wages  
Employee Benefits  
Medical Staff Remuneration  
Medical and Surgical Supplies  
Drugs and Medical Gases  
Other Expenses  
Amortization of Software License and Fees  
Amortization of Equipment

Total Expenses

Surplus/(Deficit) From Operations

ACTUAL YTD - APR 2024	BUDGET YTD - APR 2024	VARIANCE YTD - APR 2024
1,327,184	1,353,683	(26,499)
0	0	0
0	0	0
193,377	152,083	41,294
16,885	16,667	218
186,160	199,269	(13,109)
16,211	16,666	(455)
(3,333)	(3,333)	0
50,112	40,023	10,089
14,167	17,917	(3,750)
<b>1,800,763</b>	<b>1,792,975</b>	<b>7,788</b>
941,212	1,011,579	(70,367)
247,392	274,847	(27,455)
254,459	197,210	57,249
21,734	32,851	(11,117)
26,958	21,683	5,275
338,924	347,002	(8,078)
18,167	18,167	0
32,291	32,293	(2)
<b>1,881,137</b>	<b>1,935,632</b>	<b>(54,495)</b>
<b>(80,374)</b>	<b>(142,657)</b>	<b>62,283</b>

ACTUAL Apr-24	BUDGET Apr-24	VARIANCE Apr-24
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ACTUAL YTD - APR 2024	BUDGET YTD - APR 2024	VARIANCE YTD - APR 2024
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**Loss of Revenues compared to Budget**

<b>Out of province</b>				
	108,357	136,939		
			108,357	136,939
				(28,582)
<b>In Patient O/P</b>				
	0	6,250		
			0	6,250
				(6,250)
				<b>(34,832)</b>
<b>Rental Income</b>				
	3,922	4,667		
			3,922	4,667
				(745)
<b>Foundation</b>				
	0	0		
			0	0
				0
<b>Interest - income</b>				
	4,598	0		
			4,598	0
				4,598
<b>Parking</b>				
	24,602	19,167		
			24,602	19,167
				5,435
				<b>5,288</b>

**Details of Other Expenses**

<b>Supplies (4000)</b>				
	84,136	90,276		
			84,136	90,276
				(6,140)
<b>Services (6000)</b>				
	43,263	58,593		
			43,263	58,593
				(15,330)
<b>Equipment, R &amp; M and software support (7100)</b>				
	98,555	95,484		
			98,555	95,484
				3,071
<b>Contracted Out services (8000)</b>				
	97,073	95,795		
			97,053	94,940
				2,113
<b>Building and grounds (9000)</b>				
	15,896	6,854		
			15,896	6,854
				9,042
	<b>338,923</b>	<b>347,002</b>		
			<b>338,903</b>	<b>346,147</b>
				<b>(7,244)</b>

HOPITAL GLENGARRY MEMORIAL HOSPITAL  
STATEMENT OF OPERATIONS  
FOR THE PERIOD ENDING JUNE 30, 2024

ACTUAL May-24	BUDGET May-24	VARIANCE May-24	ACTUAL Jun-24	BUDGET Jun-24	VARIANCE Jun-24
1,327,138	1,353,682	(26,544)	1,327,138	1,353,683	(26,545)
200,499	152,084	48,415	197,745	152,083	45,662
48,077	16,666	31,411	32,483	16,667	15,816
218,740	199,267	19,473	215,935	199,269	16,666
16,200	16,668	(468)	16,016	16,666	(650)
(3,328)	(3,334)	6	(3,333)	(3,333)	0
53,598	40,073	13,525	52,719	40,076	12,643
14,167	17,916	(3,749)	14,167	17,917	(3,750)
<b>1,875,091</b>	<b>1,793,022</b>	<b>82,069</b>	<b>1,852,870</b>	<b>1,793,028</b>	<b>59,842</b>
1,065,936	1,011,555	54,381	1,104,843	1,011,579	93,264
251,106	274,805	(23,699)	367,434	274,847	92,587
266,311	197,205	69,106	258,326	197,210	61,116
74,243	32,839	(41,404)	18,358	32,851	(14,493)
24,801	21,681	3,120	26,681	21,683	4,998
367,684	346,984	20,700	349,469	347,002	2,467
18,167	18,166	1	18,167	18,167	0
32,291	32,289	2	32,291	32,293	(2)
<b>2,050,539</b>	<b>1,935,524</b>	<b>115,015</b>	<b>2,175,569</b>	<b>1,935,632</b>	<b>239,937</b>
<b>(175,448)</b>	<b>(142,502)</b>	<b>(32,946)</b>	<b>(322,699)</b>	<b>(142,604)</b>	<b>(180,095)</b>

ACTUAL YTD - JUNE 2024	BUDGET YTD - JUNE 2024	VARIANCE YTD - JUNE 2024
3,981,460	4,061,048	(79,588)
0	0	0
0	0	0
591,621	456,250	135,371
97,445	50,000	47,445
620,835	597,805	23,030
48,427	50,000	(1,573)
(9,994)	(10,000)	6
156,429	120,225	36,204
42,501	53,750	(11,249)

Total Revenues

ACTUAL YTD - JUNE 2024	BUDGET YTD - JUNE 2024	VARIANCE YTD - JUNE 2024
3,111,991	3,034,713	77,278
865,932	824,499	41,433
779,096	591,625	187,471
64,335	98,541	(34,206)
78,440	65,047	13,393
1,056,077	1,040,988	15,089
54,501	54,500	1
96,873	96,875	(2)

Total Expenses

Surplus/(Deficit) From Operations

ACTUAL YTD - JUNE 2024	BUDGET YTD - JUNE 2024	VARIANCE YTD - JUNE 2024
5,528,724	5,379,078	149,646
6,107,245	5,806,788	300,457
<b>(578,521)</b>	<b>(427,710)</b>	<b>(150,811)</b>

ACTUAL May-24	BUDGET May-24	VARIANCE May-24	ACTUAL Jun-24	BUDGET Jun-24	VARIANCE Jun-24
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ACTUAL YTD - JUNE 2024	BUDGET YTD - JUNE 2024	VARIANCE YTD - JUNE 2024
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**Loss of Revenues compared to Budget**

<b>Out of province</b>									
	136,066	138,739	113,124	138,739		357,547	416,217		(58,670)
<b>In Patient O/P</b>									
	3,942	6,250	34,164	6,250		38,106	18,750		19,356
									<b>(39,314)</b>
<b>Rental Income</b>									
	3,917	4,666	3,917	4,666		11,756	13,999		(2,243)
<b>Foundation</b>									
	0	0	0	0		0	0		0
<b>Interest - income</b>									
	1,619	0	859	0		7,076	0		7,076
<b>Parking</b>									
	23,432	19,166	24,027	19,166		72,061	57,499		14,562
									<b>19,395</b>

**Details of Other Expenses**

<b>Supplies (4000)</b>									
	96,995	90,267	73,988	90,276		255,119	270,819		(15,700)
<b>Services (6000)</b>									
	60,495	58,580	62,953	58,593		166,711	175,766		(9,055)
<b>Equipment, R &amp; M and software support (7100)</b>									
	94,567	95,484	104,670	95,484		297,792	286,452		11,340
<b>Contract</b>									
	109,970	95,798	98,774	95,795		305,817	287,388		18,429
<b>Building and grounds (9000)</b>									
	5,657	6,855	9,084	6,854		30,637	20,563		10,074
	<b>367,684</b>	<b>346,984</b>	<b>349,469</b>	<b>347,002</b>		<b>1,056,076</b>	<b>1,040,988</b>		<b>15,088</b>

**GLENGARRY MEMORIAL HOSPITAL  
STATISTICAL INFORMATION  
June 2024**

	April	May	June	July	August	September	Actual Total 2024/25	% as per Benchmark	BENCHMARKS 2024/25	Actual Total 2023/24
<b><u>INPATIENTS</u></b>										
<b><u>OCCUPANCY RATE in %</u></b>										
<b>ACTIVE UNIT - 22 beds</b> (2023-2024)	69.09% 96.82%	59.09% 65.98%	47.27% 66.82%				<b>58.49%</b>		<b>82.00%</b>	<b>76.42%</b>
<b>REHABILITATION - 10 beds</b> (2023-2024)	89.11% 91.67%	85.81% 81.61%	76.44% 112.00%				<b>83.81%</b>		<b>80.00%</b>	<b>94.95%</b>
<b>OVERALL OCCUPANCY - 37 beds</b> (2023-2024)	77.21% 82.34%	69.92% 61.29%	59.10% 70.00%				<b>68.76%</b>		<b>81.00%</b>	<b>71.10%</b>
<b><u>OUTPATIENTS</u></b>										
<b>EMERGENCY/OUTPATIENT</b>										
<b># OF VISITS - Res.</b>	1,214	1,333	1,234				3,780		3,150	4,016
<b>Out of province</b>	239	309	253	16%	19%	17%	802	17%	1,125	771
(2022-2023)	1,453	1,642	1,487				<b>4,582</b>		<b>4,275</b>	<b>4,787</b>
	1,473	1,650	1,684				4,787			
<b>SPECIALTY CLINICS</b>										
<b># OF VISITS - Res.</b>	250	248	227				725		741	760
<b>Out of prov./country</b>	0	0	0	0%	0%	0%	0	0%	9	1
(2022-2023)	250	248	227				<b>725</b>		<b>750</b>	<b>761</b>
	202	325	234				761			
<b>RADIOLOGY</b>										
<b># OF STUDIES</b>	1,117	1,119	932				<b>3,168</b>			<b>2,950</b>
(2022-2023)	949	1,016	985				2,950			
<b>ULTRASOUND</b>										
<b># OF STUDIES</b>	192	205	166				<b>563</b>			<b>564</b>
(2022-2023)	174	192	198				564			
<b>BONEDENSITOMETRY</b>										
<b># OF STUDIES</b>	39	39	39				<b>117</b>			<b>137</b>
(2022-2023)	49	37	51				137			



DECISION SUPPORT DOCUMENT FOR

- Board of Directors, Board Committee, Senior Leadership Team, Other

Date Prepared: August 12, 2024 Meeting Date Prepared for: September 11 - Finance, September 26 - Board of Directors
Subject: Pre-Capital Submission
Prepared by: Robert Alldred-Hughes, President & CEO

- DECISION SOUGHT, FOR DISCUSSION/INPUT, FOR INFORMATION ONLY

PURPOSE

To seek approval from the Board Committee to initiate a Request for Proposal (RFP) for the development of a Pre-Capital Submission for Hopital Glengarry Memorial Hospital (HGMH).

RECOMMENDATION / MOTION

- 1. THAT the Board of Directors approve the recommendation of the Finance, HR, and Audit Committee with the issuance of a Request for Proposal (RFP) to hire a consultancy firm to support the development of a Pre-Capital Submission for Hôpital Glengarry Memorial Hospital.
2. THAT the Board of Directors approve the recommendation of the Finance, HR, and Audit Committee to use the Endowment fund to pay for the required fees associated with developing a Pre-Capital Submission for Hôpital Glengarry Memorial Hospital, if the fees cannot be covered by current operational dollars.

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? No Yes, please specify:

SITUATION & BACKGROUND

A brief description of the background to the issue.

Hopital Glengarry Memorial Hospital (HGMH) is at a pivotal point where long-term planning is essential to address evolving healthcare needs, technological advancements, and demographic changes within our service area.

Stage 0 - Pre-Capital Submission is the first step in submitting an application for a capital project. The Pre-Capital Stage articulates the capital proposal and describes how it will meet local health system needs and priorities.

The development of a Pre-Capital Submission is a critical component of the hospital's capital planning process as outlined in the Hospital Capital Planning and Policy Manual for Ontario.

This step is a step prior to completing a Master Program & Master Plan (phase one of the planning process). As part of the pre-capital submission to the Ministry of Health, HGMH would highlight the need for a planning grant to enter

phase one of the capital development process. It is possible to complete phase 1 of the process using our own funds, however, for a hospital our size we would be looking at a cost of approximately \$1.5 Million to complete this work. Given our financial constraints, completing a pre-capital submission to create a case for the ministry to support this work with a planning grant is advisable. The cost to do phase 0 – pre capital submission is likely going to be \$200K (*estimation & approximation*).

## OPTIONS CONSIDERED & ANALYSIS

*Outline alternatives that were contemplated in coming to a recommendation. If no viable alternatives exist, include that information as well.*

Proceed with the RFP for a Pre-Capital Submission (Recommended):

- Advantages:
  - Provides a clear roadmap for the future development of HGMH.
  - Ensures alignment with Ministry of Health requirements and access to capital planning funding.
  - Supports evidence-based decision-making for infrastructure investments.
  - Enhances the hospital’s ability to meet community needs and integrate services effectively.
- Disadvantages:
  - Requires an upfront investment of time and resources.
  - Potential delays if the RFP process is not managed efficiently.

Maintain Current Infrastructure and Services without a Formal Plan:

- Advantages:
  - Immediate cost savings by avoiding the expense of developing a Master Plan.
  - Allows for a focus on short-term operational goals.
- Disadvantages:
  - Increased risk of misalignment with future community needs and provincial requirements.
  - Potential missed opportunities for funding and development support from the Ministry.
  - Lack of a cohesive strategy may lead to inefficiencies and fragmented service delivery.

Develop an Internal Pre-Capital Submission without an RFP:

- Advantages:
  - Cost savings by using internal resources.
- Disadvantages:
  - Potential lack of expertise and objectivity.
  - May not meet the rigorous standards required for Ministry approval and capital funding.
  - Could lead to an incomplete or biased plan, limiting the hospital’s long-term success.
  - Slower turnaround time compared to an RFP process.

## IMPACT ANALYSIS/RISK ASSESSMENT/DECISION CRITERIA

*Outline both the positive and negative consequences of the recommendations in terms of financial, mission, quality, risk and other.*

**Impact:**

- The development of a Pre-Capital Submission will significantly enhance HGMH’s ability to deliver on its vision of providing care in a seamless, innovative, and equitable manner. It will position the hospital to respond proactively to changes in healthcare delivery and population health needs.
- Aligning the hospital’s strategic direction with provincial guidelines will improve the likelihood of securing capital planning funding and support for future projects.

**Risk Assessment:**

- **Financial Risk:** There is an initial financial commitment associated with the RFP process; however, the long-term benefits of having a strategic plan outweigh the short-term costs.
- **Operational Risk:** Failure to proceed with a Pre-Capital Submission could lead to suboptimal service delivery and missed opportunities for funding.



- **Reputational Risk:** Not engaging in this planning process could undermine stakeholder confidence in HGMH’s ability to plan for and manage future challenges.

**CONSULTED WITH:**

*Indicate those bodies and individuals who have been consulted with in the development of this decision support document*

- Linda Ramsay, Vice President of Corporate Services & CFO

**IMPLEMENTATION & COMMUNICATION PLAN**

*Consider how the recommendation will be rolled-out and communicated to all key stakeholders.*

- Develop and Issue an RFP by November 2024
- Submit Pre-Capital Submission by March 31, 2025

DECISION SUPPORT DOCUMENT FOR

- Board of Directors                     
  Board Committee –                     
  Senior Leadership Team  
 Other (please specify):

Date Prepared: August 28, 2024                      Meeting Date Prepared for: September 11 – Quality  
September 26 – Board of Directors

Subject: Q1 Quality Improvement Plan 2024/25 results

Prepared by: Rachel Romany

- DECISION SOUGHT\*                     
  FOR DISCUSSION/INPUT                     
  FOR INFORMATION ONLY

**PURPOSE**

- To review the results of the Quality Improvement Plan for Q1
- Discuss contributing factors and mitigation strategies for improvement

**RECOMMENDATION/MOTION**

- THAT the Board of Directors review and receive the results of the Q1 Quality improvement Plan for 2024/2025.

**IMPLICATIONS TO OTHER STANDING COMMITTEES**

Are there any material or significant implications for other Standing Committees?  No     Yes, please specify:

**SITUATION & BACKGROUND**

*A brief description of the background to the issue.*

- In June 2010, the Ontario Government passed the Excellent Care for All Act. This legislation was designed to put patients first with a focus on the health care sector’s accountability for delivering high quality patient care.
- One of the ways this accountability is being made transparent is through the requirement that all hospitals create and make public their annual Quality Improvement Plan (QIP).
- A QIP is a formal, documented set of Quality commitments aligned with system and provincial priorities that a health care organization makes yearly to its patients, staff, and community to improve quality through focused targets and actions.
- Each year, four themes are chosen and targets are established for each indicator to be achieved.
- The 2024/25 QIP themes, quality dimension and six (6) indicators are as follows:
  - Access & Flow- Timely transitions- % of patients who visited the ED and left without being seen by the physician
  - Access & Flow- Timely transitions- 90<sup>th</sup> percentile ED wait time to inpatient bed
  - Equity-Equitable - % of executive and management staff who have completed relevant inclusion, diversity, equity and anti-racism (IDEA) education.
  - Experience- Patient-centered- % respondents who respond positively to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?
  - Safety- Safe- Rate of workplace physical violence incidents resulting in lost time injury
  - Safety- Safe- Number of reported near misses related to controlled substances within the organization

**IMPACT ANALYSIS/RISK ASSESSMENT/DECISION CRITERIA**

*Outline both the positive and negative consequences of the recommendations in terms of financial, mission, quality, risk and other.*

Our QIP for Q1 has yielded the following results:

Access & Flow- Timely transitions- % of patients who visited the ED and left without being seen by the physician

THEME	QUALITY DIMENSION	MEASURE/INDICATOR	TYPE	UNIT/POPULATION	SOURCE/PERIOD	CURRENT PERFORMANCE	TARGET PERFORMANCE	LEADER	24Apr	24May	24Jun	Q1
Access & Flow	Timely	Percent of patients who visited the ED and left without being seen by a physician	F	ED patients	CHAMRC/Quality Improvement 1-2023 to September 30th, 2023 Q1 and Q2	8.30%	7.69%	Manager, Health Information Services	8.8%	12.3%	10.0%	10.8%

- Q1 ended with 10.8%, which is above the target of 7.69%.
- **Strategy** : current ED initiative to have additional physician coverage (4 hours, MWF) during peak hours implemented July 2024. The goal is to support faster access for low-acuity ED visits, improve patient flow, reduce the number of patients leaving without being seen, and improve Physician Initial Assessment times.

Access & Flow- Timely transitions- 90th percentile ED wait time to inpatient bed

THEME	QUALITY DIMENSION	MEASURE/INDICATOR	TYPE	UNIT/POPULATION	SOURCE/PERIOD	CURRENT PERFORMANCE	TARGET PERFORMANCE	LEADER	24Apr	24May	24Jun	Q1
Access & Flow	Timely	90th percentile emergency department wait time to inpatient bed	D	ED patients	Little Ausley/Scott Hospital (December 1, 2022 to November 30, 2023) Non-ESR Renalists April 1, 2023 to September 30, 2023 Q1 & Q2	4.63 hrs	6 hrs	Manager, Health Information Services	3	3	3	3

- Q1 ended with 3 hours which is positively above target of 6 hours.
- **Strategy** : ongoing work with discharge processes and workflows to ensure appropriate education and communication are provided at discharge.

Equity-Equitable - % of executive and management staff who have completed relevant inclusion, diversity, equity and anti-racism (IDEA) education.

THEME	QUALITY DIMENSION	MEASURE/INDICATOR	TYPE	UNIT/POPULATION	SOURCE/PERIOD	CURRENT PERFORMANCE	TARGET PERFORMANCE	LEADER	24Apr	24May	24Jun	Q1
Equity	Equitable	Percentage of executive and management staff who have completed relevant inclusion, diversity, equity and anti-racism (IDEA) education.	D	%Applicable Staff	Human Resources collection/feedback annual 12-month period	31%	100%	Chief, Human Resources	0%	25%	0%	31%

- Q1 ended with 31%, which is positively above the quarterly target of 25% to achieve 100% at Q4.
- **Strategy** : IDEA committee started in June 2024 and outlining strategies that will ensure to embed IDEA principles within our leadership operations, and cultivate a culture of inclusivity and equity that drives organizational excellence.

Experience- Patient-centered- % respondents who respond positively to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?

THEME	QUALITY DIMENSION	MEASURE/INDICATOR	TYPE	UNIT/POPULATION	SOURCE/PERIOD	CURRENT PERFORMANCE	TARGET PERFORMANCE	LEADER	24Apr	24May	24Jun	Q1
Experience	Patient-Centered	Percentage of respondents who respond positively to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	C	%Survey respondents	Outreach data collection/2023 Q1	84%	90%	Manager, Health Information Services	86%	87%	88%	84%

- Q1 ended with 87%, which is positively above the target of 86%.
- **Strategy:** Continuously enhance patient communication to ensure it is clear and thorough, facilitating a complete understanding of patients' discharge needs.

**Safety- Safe- Rate of workplace physical violence incidents resulting in lost time injury**

THEME	QUALITY DIMENSION	MEASURE/INDICATOR	TYPE	UNIT/POPULATION	SOURCE/PERIOD	CURRENT PERFORMANCE	TARGET PERFORMANCE	LEADER	28-Apr	28-May	28-Jun	Q1
Safety	Safe	Rate of workplace physical violence incidents resulting in lost time injury	O	% Staff	HRIS data collection/most recent consecutive 13 work weeks	0.6%	0.5%	Manager Human Resources	0%	0%	0%	0%

- Q1 ended at 0% which is positively above our target of 0.5%.
- **Strategy :** Maintain a focus on proactive strategies to prevent and minimize violent incidents which creates a safer and more supportive environment for both patients and staff.

**Safety- Safe- Number of reported near misses related to controlled substances within the organization**

THEME	QUALITY DIMENSION	MEASURE/INDICATOR	TYPE	UNIT/POPULATION	SOURCE/PERIOD	CURRENT PERFORMANCE	TARGET PERFORMANCE	LEADER	28-Apr	28-May	28-Jun	Q1
Safety	Safe	Number of reported near misses related to controlled substances within the organization	C	Number	Hospital Collected Data April 1 - December 30 2023 Q1-Q2 Q3	19.7	12.0	Manager Pharmacy Operations				

- Q1 ended at 25 incidents which is negatively above the target of 12 reported incidents.
- **Strategy:**
  - Analyze dispensing and documentation workflows such as narcotic counts, potential losses investigation, and monitoring use /distribution of prescription pads, based on nursing feedback.
  - Pharmacy providing individual staff feedback to address errors.
  - Additionally, plan diversion prevention education for staff orientation in Fall 2024.

**Summary**

- The Quality Improvement Plan 2024-25 showcases our achievements in meeting the majority of Q1 targets and underscores our commitment to ongoing enhancement as we address opportunities for improvement.

**SUPPORTING DOCUMENTS/ATTACHMENTS:**

- Quality Improvement Plan 2024/2025



**2024-25 QUALITY IMPROVEMENT PLAN (QIP) [Org ID 802]**

AIM			MEASURE				DATA				Visualization	Comments		
ID	THEME	QUALITY DIMENSION	MEASURE/INDICATOR	TYPE	UNIT/POPULATION	CURRENT PERFORMANCE	TARGET PERFORMANCE	LEADER	24-Apr	24-May			24-Jun	Q1
7	Access & Flow	Timely	Percent of patients who visited the ED and left without being seen by a physician	P	%/ED patients	8.10%	7.85%	Manager, Health Information Services	9.8%	12.3%	10.0%	10.8%		
5	Access & Flow	Timely	90th percentile emergency department wait time to inpatient bed	O	Hours/ED patients	6.63 hrs	6 hrs	Manager, Health Information Services	7.3	8.1	9.2	9.0		
12	Equity	Equitable	Percentage of executive and management staff who have completed relevant inclusion, diversity, equity and anti-racism (IDEA) education.	O	%/applicable Staff	N/A	100%	Chief, Human Resources	0%	81%	0%	11%		
9	Experience	Patient-Centred	Percentage of respondents who respond positively to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	O	%/Survey respondents	84%	86%	Manager, Health Information Services	80%	81%	85%	87%		Methodology: Responses were extracted based on the Discharge Date of the Patient Positive Responses included the following choices (Yes, as much as I wanted to and Sometimes, but not as much as I wanted to) Blank responses were included in the Total Number of Survey Responses
16	Safety	Safe	Rate of workplace physical violence incidents resulting in lost time injury	O	%/Staff	0.6%	0.5%	Manager, Human Resources	0%	0%	0%	0%		
15	Safety	Safe	Number of reported near misses related to controlled substances within the organization.	C	Number	19.7	12.0	Manager, Pharmacy Operations	21	21	21	21		

M = Mandatory; P = Priority; O = Optional; C = Custom

## REPORT OF THE HOSPITAL AUXILIARY

September 2024

To start, I'd like to thank management and staff for all the assistance they provide to the auxiliary. Their input makes our task so much easier than it might be otherwise.

The 4 programs of the Auxiliary are in full operation although there is a need for a few additional volunteers, particularly in the winter months, when some of our members follow the migrating birds on their southern journey.

The Information Desk operates Monday to Friday from 8:00 to 16:00 and provides assistance to patients and visitors when they present to the hospital. They also assist people navigate the intricacies of the parking machines as required.

The Gift Shop, offers a great selection of merchandise and is open 5 days per week from 11:00 to 15:00.

The Hospital Elder Life Program (HELP), now in its second year of operation, and has a full contingent of volunteers dedicated to enhancing the quality of life for in-patients during their stay at HGMH.

The Pastoral care group caters to the religious needs of the patients by delivering the Eucharist to patients of the Catholic faith. The team also assists patients of other faiths if they require the services of a spiritual counsellor that corresponds to their personal beliefs.

In addition, student volunteers, under the direct supervision of an adult volunteer, provide their time in both the Information Desk and the Gift Shop.

You might have noticed the colourful flower boxes by the main entrance and along the east wall. This is an initiative of the CEO managed and built by the Auxiliary. The "Independent" and Pierre Brunet donated the flowers, and Pierre also watered and cared for the flowers over the summer.

Mario Riggio  
Auxiliary President

## REPORT OF THE GOVERNANCE AND NOMINATING COMMITTEE

September 11, 2024 at 5:00PM Boardroom / MS Teams

Present: L. Boyling, Chair  
G. McDonald  
G. Peters  
R. Alldred-Hughes, CEO  
Dr. S. Robertson

Regrets: C. Larocque

### Summary of Discussion

#### **Approval of the Agenda**

The agenda was reviewed.

Moved By: Dr. S. Robertson

Seconded By: G. Peters

THAT the agenda be approved as presented.

**CARRIED**

#### **Declaration of Conflict of Interest**

There were no conflicts declared.

#### **Approval of Previous Meeting Report**

The meeting report from May 8, 2024, was shared.

Moved By: Dr. S. Robertson

Seconded By: G. Peters

THAT the meeting report be approved as presented.

**CARRIED**

#### **Business Arising from Report**

There was no business arising from the report.

### Matters for Discussion/Decision

#### **Review Terms of Reference**

The Terms of Reference were reviewed.

Moved By: G. Peters

Seconded By: G. McDonald

THAT the Governance and Nominating Committee recommend to the Board of Directors the Governance and Nominating Committee Terms of Reference as presented.

Amendments were made to the Terms of Reference, removing the review of the performance of the CEO and COS as this is now under the responsibility of the Executive Committee. Diversity, Equity, & Inclusion were added as a responsibility to this committee.

**CARRIED**

#### **Review Committee Effectiveness Survey Results**

The committee effectiveness survey results were reviewed. It was noted from the survey that

Directors would like the Chair to ask for more participation as well as to ensure that new Directors are well oriented to committees.

To help with that, new Directors have now been paired with a Mentor to ensure they have full support.

Discussion ensued on the lack of understanding around ensuring proper succession planning for the Board. This process takes place in the spring each year through a survey in which Directors respond whether or not they will remain on the Board and what committees they are interested in being part of.

#### **Review Annual Committee Work Plan**

The committee work plan was reviewed.

Moved By: Dr. S. Robertson

Seconded By: G. McDonald

THAT the Governance and Nominating Committee review and approve the Annual Committee Work Plan for 2024-2025 as presented.

It was agreed that this is a great tool for committees to better understand what work is to be done throughout the year and remain on track. There have been some comments around the Peer-to-Peer survey questions, as such, this will be reviewed in January and finalized in March.

**CARRIED**

#### **Review Education Topics for Board of Directors**

The education topics were approved in the spring by the committee. These were brought back to see if any changes were wanted.

Moved By: G. Peters

Seconded By: Dr. S. Robertson

THAT the Governance and Nominating Committee accept the education sessions for 2024/2025 as presented.

It was agreed that the education topics selected will be interesting for the Board. Discussion ensued around wanting to see the bigger picture of how these all tie together, especially with Accreditation. Education sessions were changed last year following feedback received from the Board, however, it was agreed that macro education can be included as well.

**CARRIED**

#### **Review Governance Accreditation Standard**

The Accreditation standard 2.2, The operational conditions of the governing body are defined and documented, was reviewed and discussed. It was agreed that the review of the Corporate By-laws last year was great education for the Board. Committee work plans could be used as evidence to show what the Board reviews in a year. The Board signs off on the Confidentiality agreement yearly as well as the Code of Conduct. The committee would like to see crosswalks to Accreditation standards included in policies.

#### **Equity, Diversity, & Inclusion Update**

The IDEA committee has been hard at work and have developed a Land Acknowledgement statement with the help of the Native American Travelling College. This will be read for the first time on September 17<sup>th</sup> at the Indigenous ceremony which was also planned by the committee. This event will be open to the public. Micro trainings for the Board and Leadership team will commence in October and there will be a discussion period at each Board meeting on the trainings.

#### **Documents for review**

##### **Disclosure Protection (Whistleblower) Policy:**

The Disclosure Protection (Whistleblower) policy was due for review. Amendments were made to the policy to align with industry standards. The amendments include an outline of the procedure set out if a complaint is filed and there will now be a named compliance officer for the organization in addition to the reporting requirements. The title of the policy was amended for clarity. The policy will be renumbered to align with the new policy numbering system.

Discussion ensued and additional amendments will be made. Under item 2 of the procedure, it was agreed that it could be hard to differentiate staff following normal procedure by going to their Manager as opposed to whistleblowing. The first sentence will be reworded as follows: *If the reporter brings forward a report to the attention of their Manager, Chief of Department, or the Human Resources Department, the recipient of the report shall forward the information promptly to the Compliance Officer.*

The policy will also be changed to reflect that the Board Chair will assume the responsibility of the investigation with the support of the Compliance Officer if the suspicion of misconduct involves the CEO. The taskforce may require external expertise to undertake the investigation if deemed appropriate.

The Board Attendance policy was also due for review in which there were three main amendments. These included strengthening the reason why board attendance is important, removing the policy being applicable to non-board members of the committee, and what happens if a Board member refuses to resign after being asked to do so for reasons of poor attendance.

Moved By: Dr. S. Robertson

Seconded By: G. Peters

THAT the Governance and Nominating Committee recommend to the Board of Directors the approval of the following policies as amended: Whistleblowing and Board Attendance.

**CARRIED**

**Next meeting:** November 13, 2024

Directors were asked to let L. Boyling know if they are interested in sitting on the Foundation Committee as Board representation as the current Director has had to step down from that committee.

K-L. Massia, Recorder

DECISION SUPPORT DOCUMENT FOR

- Board of Directors                     
  Board Committee –                     
  Senior Leadership Team  
 Other (please specify):

Date Prepared: August 16, 2024                      Meeting Date Prepared for: September 11 – Governance  
September 26 – Board of Directors

Subject: Board Education Sessions – 2024/2025

Prepared by: Robert Alldred-Hughes, President & CEO

- DECISION SOUGHT\*                     
  FOR DISCUSSION/INPUT                     
  FOR INFORMATION ONLY

**PURPOSE**

- The Governance Committee is responsible for setting yearly Board education sessions in collaboration with the CEO. This decision support document outlines the education sessions that were recommended for the 2024-2025 Board Cycle and approved by the committee in May 2024.

**RECOMMENDATION / MOTION**

THAT the Board of Directors approve the recommendation of the Governance and Nominating Committee to accept the education sessions for 2024/2025 as presented.

**IMPLICATIONS TO OTHER STANDING COMMITTEES**

Are there any material or significant implications for other Standing Committees?  No     Yes, please specify:

**SITUATION & BACKGROUND**

*A brief description of the background to the issue.*

- Directors have a responsibility to be knowledgeable about the environment in which the hospital operates, and to support this responsibility education sessions are a great way for Board of Directors to obtain knowledge of the health care environment, hospital programs and services, as well as governance responsibilities.
- The OHA guide to good governance outlines that Director education should be facilitated using multiple mechanisms, and education sessions at regular board meetings is one of those opportunities.
- Other means of encouraging Director education includes Board retreats, The Governance Centre of Excellence, Ontario Hospital Association educational programming, and establishing a policy that permits and encourages directors to attend educational programs.
- Patient stories are also an incredible way to provide education to hospital Boards of Directors. Often there is great learning that can be shared through patient feedback and experience. It is an opportunity to demonstrate the systems and processes that are in place or are put into place based on the experience of our patients receiving care in hospital. For this reason, providing Board education with patient stories is part of the consideration coming forward to the Governance committee as alternating between traditional education and patient story education.



#### OPTIONS CONSIDERED & ANALYSIS

- The following is an outline of the options for Board Education for the 2024/2025 Board Cycle in no particular order:
  - Emergency Preparedness
  - Accessibility
  - Inclusion, Diversity, Equity, and Anti-Racism
  - Ethics
  - BPSO Initiative being implemented throughout the year
  - Remote Care Monitoring

These education sessions would alternate with a Patient Story every other month.

- The above sessions were approved as they support work being done in preparation for Accreditation Canada and sessions that support Director education in executing their role on the Board.

#### CONSULTED WITH:

*Indicate those bodies and individuals who have been consulted with in the development of this decision support document*

- HGMH Senior Leadership Team

DECISION SUPPORT DOCUMENT FOR

- Board of Directors                       Board Committee –                       Senior Leadership Team  
 Other (please specify):

Date Prepared: August 20, 2024                      Meeting Date Prepared for: September 11 – Governance  
September 26 – Board of Directors

Subject: Inclusion, Equity, Diveristy & Anti-Racism (IDEA) - Update

Prepared by: Robert Alldred-Hughes, President & CEO

- DECISION SOUGHT\*                       FOR DISCUSSION/INPUT                       FOR INFORMATION ONLY

**PURPOSE**

- The purpose of this briefing note is to remind the Governance Committee of the requirements of Accreditation Canada Standards that are being overseen by this committee, in addition to provide an update on actions taken to date which support our policy on Inclusion, Diversity, Equity and Anti-Racism (IDEA) at HGMH.

**IMPLICATIONS TO OTHER STANDING COMMITTEES**

Are there any material or significant implications for other Standing Committees?  No  Yes, please specify:

- All Board Committees

**SITUATION & BACKGROUND**

*A brief description of the background to the issue.*

- In the Fall of 2023, the Board of Directors approved the recommendation that the Governance Committee take on a proactive role in leading, coordinating, and monitoring IDEA-related activities within HGMH. This includes ensuring compliance with Accreditation Canada Standards for IDEA and fostering a culture of inclusion, diversity, equity, and anti-racism throughout the organization.
- Since this recommendation was approved, there has been much work completed by the team at HGMH related to IDEA activities.
- HGMH, as a prominent organization and employer in our community, is committed to promoting an environment that is inclusive, diverse, and equitable, while actively combatting racism.
- In the winter/spring of 2024 an Inclusion, Diversity, Equity, and Anti-Racism Framework was developed by HGMH, which focuses our efforts on achieving meaningful actions to increase inclusion and celebrate diversity, while creating an overall sense of belonging.
- The advent of this framework helped kick off significant work that has been completed over the spring and summer, whereby:
  - an IDEA Committee has been formed consisting of leaders and staff with a passion for IDEA and lived experience.
  - A policy related to Land Acknowledgement has been created along with an official Land Acknowledgement statement for our hospital. The Land Acknowledgement has been endorsed by the senior leadership team, and reviewed by the Native North American Travelling College.
  - September 30<sup>th</sup> is National Truth and Reconciliation Day, and HGMH will be holding a series during the month of September to support Truth and Reconciliation, including a special on-site ceremony and social on September 17<sup>th</sup> from 1pm-3pm. All Board Members are encouraged to attend, and invitations to MP’s and MPP, including municipal officials have been issued.



- Looking ahead, HGMH will be working on rolling out inclusion and diversity training for leadership and board members, including IDEA values statements in all job profiles, and connecting with community partners with lived experience as evidenced by the work we have done with the Native North American Travelling College.
- There are 10 new Governance related standards for IDEA and HGMH will be assessed against these standards in our next accreditation survey cycle of 2026. *(Attached)*

**CONSULTED WITH:**

*Indicate those bodies and individuals who have been consulted with in the development of this decision support document*

- Kayla MacGillivray, Chief Human Resources Officer

**SUPPORTING DOCUMENTS/ATTACHMENTS**

*List any supporting documents or attachments*

- Listing of Accreditation Canada Standards related to Governance
- IDEA Framework

**Accreditation Canada Standards Related to Inclusion, Diversity, Equity, and Anti-Racism**

The governing body uses a recognized framework for acknowledging systemic racism.
The governing body implements an action plan, in partnership with community partners, to address systemic racism in the organization.
The governing body provides its members with education and continuous learning on cultural safety and humility and systemic racism.
The governing body ensures the organization’s policies reflect cultural safety and humility practices and encompass the culture and rights of the communities’ receiving services from the organization.
The governing body monitors its action plan for addressing systemic racism.
The governing body uses a recognized framework for acknowledging Indigenous-specific systemic racism.
The governing body implements an action plan, in partnership with Indigenous partners, to address Indigenous-specific systemic racism in the organization.
The governing body provides its members with education and continuous learning on cultural safety and humility and Indigenous-specific systemic racism.
The governing body ensures the organization’s policies reflect cultural safety and humility practices and encompass the culture and rights of the Indigenous peoples and communities receiving services from the organization.
The governing body monitors its action plan for addressing Indigenous-specific systemic racism.





## IMPLEMENTATION & COMMUNICATION PLAN

*Consider how the recommendation will be rolled-out and communicated to all key stakeholders.*

- Reviewed at Governance and additional amendments made September 11, 2024
- Obtain Board Approval – September 26, 2024
- Update Board Policy Online
- Include updates in Board Orientation Material
- Include updates to whistleblower in General Orientation
- Post on our website

## SUPPORTING DOCUMENTS/ATTACHMENTS

*List any supporting documents or attachments*

- *Disclosure Protection (Whistleblower) Policy - Tracked Changes*
- *Whistleblower Policy - Clean Draft*
- *Board Attendance Policy – Tracked Changes*
- *Board Attendance Policy – Clean Draft*

## POLICY & PROCEDURE

Disclosure Protection (Whistleblower) Whistleblowing

Gtengarry Memorial Hospital  
Hôpital Gtengarry Memorial



**POLICY NUMBER: CO.01.048.0.13**

**POLICY TYPE: CORPORATE (Administrative)**

**SUBJECT: DISCLOSURE PROTECTION  
(WHISTLEBLOWER) Whistleblowing**

**POLICY:** HGMH is committed to conducting business with the highest standards of professional, ethical, financial and legal behaviour as well as compliance with applicable laws and regulations. Recognizing the risk of illegal or unethical activity that all organization's face, the purpose of this Whistleblowing Policy is to outline the responsibilities and processes related to the disclosure of information related to any suspected wrongdoing.

This policy applies to all HGMH employees, medical staff, volunteers and students. Its intent is to encourage the reporting of genuine, suspected wrongdoing on a timely basis and to provide assurance that concerns will be taken seriously, investigated as appropriate, confidentiality will be maintained and there is no risk of reprisal.

~~depends on the honesty and integrity of its employees to ensure that the Hospital's affairs are conducted in the best interests of the community it serves. HGMH is committed to a culture of open communication that supports and protects employees who come forward to disclose incidents of wrongdoing.~~

~~The purpose of this policy is to provide employees with a clear procedure to follow in the event that the employee witnesses an incident of wrongdoing and decides to come forward. This policy also serves to remind employees that they have a duty to come forward where they believe they have witnessed an act of wrongdoing. This policy applies to all employees of HGMH.~~

~~Employees should be aware that malicious or vexatious claims of wrongdoing, brought forward with the intent to harm an individual, can result in disciplinary measures up to and including termination of employment.~~

### RESPONSIBILITY TO RAISE A WHISTLEBLOWING CONCERN

Any person who becomes aware of a breach of professional, ethical, financial or legal behaviour, non-compliance with applicable laws and regulations, or contravention of any policy governing the conduct of persons associated with HGMH and attempts to conceal any such breach or contravention, is responsible for reporting this immediately.

- Whenever possible, the identity of the reporter will be protected, and will not be disclosed to anyone (other than those on the Investigation Task Force). The identity of

Reference: Federal Bridge Corporation Ltd.

Approved by:

Effective Date: November 7, 2013

Reviewed: \_\_\_\_\_

Revised



the reporter will only be disclosed in connection with furthering the objectives of the investigation or if required by law to do so;

- There will be no retaliation, reprisals, or other action against anyone who reports a situation in good faith;
- Should any person be found to have made a maliciously motivated report which is proved to be unfounded will be subject to disciplinary action.

### ROLE OF THE COMPLIANCE OFFICER

A Compliance Officer will be designated to address whistleblowing reports in a manner consistent with these procedures. The Compliance Officer shall be the Chief Human Resources Officer. In circumstances where a conflict with the reporter exists for the Chief Human Resources Officer, the Chief Executive Officer will designate an alternate Compliance Officer to lead the investigation. The Compliance Officer shall:

- Advise the CEO of all reports and the action plan for each report. The CEO will review the action plan which could include: do nothing; refer the report to the report process; conduct a Compliance Officer investigation; or constitute an Investigation Task Force. Action plans will consider the merit and severity of the report and the potential risk.
- The compliance officer reserves the right to determine if a report is addressed under this policy, or addressed under an alternate administrative policy such as: Patient and Family Feedback, Harassment and Discrimination, Disruptive Physician Policy, Conduct Policy, etc.
- file a report with the CEO on a monthly basis. The monthly report shall include a summary of the reports received, the action plans and status, or state that no reports were received for the reporting period. (The CEO shall then report to the Finance, HR & Audit Committee of the Board through the monthly Compliance Report)
- design, implement and oversee procedures to ensure that all reported whistleblowing concerns are investigated in full;
- ensure that the reporter is advised when the investigation process has been completed.

### REPORTS RELATED TO THE CEO OR CHIEF OF STAFF

If the report involves the Chief Executive Officer, that individual will not be informed in the ordinary course. The Compliance Officer shall report the matter as well as matters related to the Chief of Staff immediately to the Chair of the Finance, HR, & Audit Committee and the Chair of the Board of Directors.

### INVESTIGATION TASK FORCE

Should the Compliance Officer decide to refer a reported matter to a task force, an Investigation Task Force will be struck. The Investigation Task Force evaluates the merits of each allegation. The Compliance Officer, in consultation with the CEO, will appoint the Investigation Task Force to be comprised of appropriate individuals which may include but not limited to: the Compliance Officer, the Chief Executive Officer, the Chief of Staff, the Senior Leader responsible for the area involved, and any other persons with a legitimate interest in the matter as outlined below in this policy. The Investigation Task Force shall evaluate all allegations referred to it by the



Compliance Officer, investigate those deemed to have merit and shall make recommendations to the Compliance Officer on how to proceed.

**Procedure A - Ethical, Legal, Professional or Financial**

1. Any person who witnesses or suspects that a criminal act, breach of professional or ethical behaviour or financial impropriety has occurred has the responsibility to report this act or breach.
2. If the reporter brings forward a report to the attention of their Manager, Chief of Department, or the Human Resources Department, the recipient of the report shall forward the information promptly to the Compliance Officer. If the immediate supervisor may be implicated in the witnessed or suspected criminal act or breach of professional or ethical behaviour, the report should be made directly to the Compliance Officer.

To ensure that reports can be submitted confidentially or anonymously when Internal Reporters so choose, HGMH shall maintain other formal means by which employees may communicate reports, which may include:

- 2.1. an e-mail address to which reports may be forwarded and which is accessed exclusively by the Compliance Officer [compliance.officer@hgmh.on.ca](mailto:compliance.officer@hgmh.on.ca) and
- 2.2. the interoffice mail (or regular mail or other means of delivery), by which reports may be submitted in a sealed envelope marked "Private and Strictly Confidential – Attention: Compliance Officer – Hôpital Glengarry Memorial Hospital", the envelope shall be forwarded unopened to the Compliance Officer.

The Whistleblower designated e-mail address and the mail procedure will also be posted on the intranet.

3. If the suspicion of misconduct involves the Chief Executive Officer, that individual will not be informed or involved in the ordinary course. The Compliance Officer shall report the matter immediately to the Chair of the Finance, HR & Audit Committee and the Chair of the Board of Directors. The Board Chair shall assume the responsibility of the investigation with the support of the Compliance Officer.
4. The Compliance Officer shall investigate the circumstances, in consultation with the Investigation Task Force, and any other persons with a legitimate interest in the matter including external expertise if deemed appropriate:
  - 4.1. **Criminal Activity:** In the case of suspected criminal activity, the CEO (or Board Chair should the CEO be implicated) should be involved in the investigation. If deemed necessary, legal counsel may be consulted. HGMH will at all times co-operate with the police.
  - 4.2. **Breach of Professional Behaviour:** The investigation should include a representative of the suspect's professional association.



- 4.3. **Unethical conduct:** The investigation should include a union representative or a Human Resources Representative for non-union staff.
  - 4.4. **Financial Impropriety:** Includes misuse or misappropriation of funds, improper expense account claims or patient billings. The investigation should include a representative of the **Finance & HR Committee**
  - 4.5. **Witnesses:** If the person making the report and/or any other witnesses are unionized staff, a union representative should be present at all interviews.
5. The Compliance Officer shall make a recommendation to senior management on disciplinary action, up to and including termination and the laying of criminal charges.

### **Procedure B – Fraud**

1. It is the responsibility of the **Finance & HR Committee** to ensure that the organization has appropriate procedures for the receipt, retention, and treatment of reports about its accounting, internal accounting controls, or auditing matters.
2. Under NO circumstances, should employees, physicians, volunteers or their supervisors initiate an investigation of alleged fraud. To do so may compromise any ensuing investigation.
3. Once the Compliance Officer has been notified of a possible fraudulent act, he/she will
  - 3.1. Consult with the CEO and CFO to determine the appropriate course of action which may or may not include an Investigation Task Force. Should the CEO and/or CFO be implicated, the Compliance Officer will consult with the **Chair of the Finance & HR Committee**;
  - 3.2. Advise the **Finance & HR Committee** immediately via email of the situation and the proposed course of action;
  - 3.3. Should the Compliance Officer decide not to refer the matter to the Investigation Task Force, a full report including the rationale for the decision shall be forwarded to the **Finance & HR Committee** immediately via email.

The Compliance Officer shall ensure that all allegations brought to its attention are evaluated fully and make recommendations on how to proceed.

4. Where suspicion of fraud is substantiated, the Chief Financial Officer, shall, after the conclusion of the investigation, perform a thorough review of the existing internal controls, and shall present to the CEO a summary of internal control weaknesses and recommended internal control improvements required to minimize the likelihood of a recurrence.

### **DEFINITIONS:**

**Wrongdoing:** ~~occurs when there is:~~



- ~~A violation of any law or regulation; or~~
- ~~Misuse of public funds or assets; or~~
- ~~Gross mismanagement; or~~
- ~~A substantial and specific danger to the life, health and safety of patients or the environment; or~~
- ~~A serious breach of the values and ethics that guide HGMH.~~
- ~~Wrongdoing is not a Labour Relations forum~~

~~**Disclosure:** is defined as bringing forward information within the organization and in good faith, based on a reasonable belief that wrongdoing has been, or is about to be, committed.~~

~~**Disclosure Officer:** is an appointed person responsible for supporting employees in the procedure.~~

#### **PROCEDURE:**

- ~~1. Where an employee believes an act of wrongdoing has been, or is about to be committed, the employee should approach the Disclosure Officer with the name or names of the individuals involved and the nature of the wrongdoing.~~
- ~~2. The Disclosure Officer reviews the information to determine if it constitutes wrongdoing as defined in the policy.~~
- ~~3. The Disclosure officer will then inform the employee as to whether there is sufficient information to warrant an investigation of wrongdoing.~~
- ~~4. Where the Disclosure Officer determines that the information does not constitute wrongdoing, the Officer may decide to refer the issue to the appropriate manager responsible for other policies (Canadian Human Rights, harassment, or abuse of authority) as necessary.~~
- ~~5. Where the information brought forward does indicate wrongdoing, the Disclosure Officer will conduct a full investigation into the matter.~~
- ~~6. Based on the results of the investigation, the Disclosure Officer will recommend appropriate disciplinary measures for either party.~~
- ~~7. In cases where the Disclosure Officer determines that the information brought forward does not constitute wrongdoing, but the employee does not agree with that finding, the employee has the option of raising the issue with the designated Board member with the Disclosure Officer present.~~

#### **Protection from Retribution**



- ~~1. Any employee who brings forward a good faith complaint of wrongdoing is protected from retribution by the employee(s) named in the complaint, or by any other person representing the interests of that employee, irrespective of the outcome of the complaint. Any employee named in a wrongdoing complaint who then seeks retribution against the complainant may be subject to disciplinary measures up to and including termination of employment.~~
- ~~2. The procedure to be followed in reporting retribution is the same as that for reporting wrongdoing.~~

### **Confidentiality**

- ~~1. All information brought forward in a report of wrongdoing, including the names of the complainant and the named employee(s) and the nature of the complaint will be treated in confidence throughout the complaint and resolution procedure.~~

### **Complaints to External Sources**

- ~~1. In all cases, employees who bring forward information related to wrongdoing are encouraged to make use of all internal mechanisms to resolve the issue. However, in the event that an employee complains to an external resource first, then the procedures outlined in this policy do not apply.~~

### **Annual Report**

- ~~1. The Disclosure Officer will report annually to the HGMH Board of Directors on the number and nature of complaints (not including the names of the employees involved) and their disposition.~~

<b>Document Name:</b>	Whistleblowing		
<b>Document Number:</b>	COR.01.014.0.24		
<b>Review Period:</b>	<input checked="" type="checkbox"/> 3 years	<input type="checkbox"/> 1 year	<b>Manual:</b> Orientation
<b>Classification:</b> Corporate	<b>Section:</b> Administrative		
<b>Owner:</b> President & CEO	<b>Signing Authority:</b> Board of Directors		

### **POLICY STATEMENT:**

HGMH is committed to conducting business with the highest standards of professional, ethical, financial, and legal behaviour as well as compliance with applicable laws and regulations. Recognizing the risk of illegal or unethical activity that all organization's face, the purpose of this Whistleblowing Policy is to outline the responsibilities and processes related to the disclosure of information related to any suspected wrongdoing.

This policy applies to all HGMH employees, medical staff, volunteers, and students. Its intent is to encourage the reporting of genuine, suspected wrongdoing on a timely basis and to provide assurance that concerns will be taken seriously, investigated as appropriate, confidentiality will be maintained and there is no risk of reprisal.

### **RESPONSIBILITY TO RAISE A WHISTLEBLOWING CONCERN**

Any person who becomes aware of a breach of professional, ethical, financial, or legal behaviour, non-compliance with applicable laws and regulations, or contravention of any policy governing the conduct of persons associated with HGMH and attempts to conceal any such breach or contravention, is responsible for reporting this immediately.

- Whenever possible, the identity of the reporter will be protected, and will not be disclosed to anyone (other than those on the Investigation Task Force). The identity of the reporter will only be disclosed in connection with furthering the objectives of the investigation or if required by law to do so.
- There will be no retaliation, reprisals, or other action against anyone who reports a situation in good faith.
- Should any person be found to have made a maliciously motivated report which is proved to be unfounded will be subject to disciplinary action.

### **ROLE OF THE COMPLIANCE OFFICER**

A Compliance Officer will be designated to address whistleblowing reports in a manner consistent with these procedures. The Compliance Officer shall be the Chief Human Resources Officer (CHRO). In circumstances where a conflict with the reporter exists for the CHRO, the Chief Executive Officer (CEO) will designate an alternate Compliance Officer to lead the investigation.

The Compliance Officer shall:

- Advise the CEO of all reports and the action plan for each report. The CEO will review the action plan which could include:
  - do nothing;

Effective: Nov 2013	Last review/revision: Sep 2024	Next review: Sep 2027
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Note: This is a controlled document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the Intranet prior to use.

- refer the report to the report process;
- conduct a Compliance Officer investigation; or
- constitute an Investigation Task Force.

Action plans will consider the merit and severity of the report and the potential risk.

- Determine if a report is addressed under this policy, or addressed under an alternate administrative policy such as:
  - Patient and Family Feedback,
  - Harassment and Discrimination,
  - Disruptive Physician Policy,
  - Conduct Policy, etc.
- File a report with the CEO on a monthly basis. The monthly report shall include a summary of the reports received, the action plans and status, or state that no reports were received for the reporting period. (The CEO shall then report to the Finance, HR & Audit Committee of the Board through the monthly Compliance Report)
- Design, implement and oversee procedures to ensure that all reported whistleblowing concerns are investigated in full;
- Ensure that the reporter is advised when the investigation process has been completed.

#### **REPORTS RELATED TO THE CEO OR CHIEF OF STAFF (COS)**

If the report involves the CEO, that individual will not be informed in the ordinary course. The Compliance Officer shall report the matter as well as matters related to the COS immediately to the Chair of the Finance, HR, & Audit Committee and the Chair of the Board of Directors.

#### **INVESTIGATION TASK FORCE**

Should the Compliance Officer decide to refer a reported matter to a task force, an Investigation Task Force will be struck. The Investigation Task Force evaluates the merits of each allegation. The Compliance Officer, in consultation with the CEO, will appoint the Investigation Task Force to be comprised of appropriate individuals which may include but not limited to; the Compliance Officer, the CEO, the COS, the Senior Leader responsible for the area involved, and any other persons with a legitimate interest in the matter as outlined below in this policy. The Investigation Task Force shall evaluate all allegations referred to it by the Compliance Officer, investigate those deemed to have merit and shall make recommendations to the Compliance Officer on how to proceed.

### **PROCEDURE:**

#### ***Ethical, Legal, Professional or Financial***

1. Any person who witnesses or suspects that a criminal act, breach of professional or ethical behaviour or financial impropriety has occurred has the responsibility to

report this act or breach.

2. If the reporter brings forward a report to the attention of their Manager, Chief of Department, or the Human Resources Department, the recipient of the report shall forward the information promptly to the Compliance Officer. If the immediate supervisor may be implicated in the witnessed or suspected criminal act or breach of professional or ethical behaviour, the report should be made directly to the Compliance Officer.

To ensure that reports can be submitted confidentially or anonymously when Internal Reporters so choose, HGMH shall maintain other formal means by which employees may communicate reports, which may include:

- an e-mail address to which reports may be forwarded and which is accessed exclusively by the Compliance Officer **compliance.officer@hgmh.on.ca**; and
- the interoffice mail (or regular mail or other means of delivery), by which reports may be submitted in a sealed envelope marked "Private and Strictly Confidential – Attention: Compliance Officer – Hôpital Glengarry Memorial Hospital", the envelope shall be forwarded unopened to the Compliance Officer.

The Whistleblower designated e-mail address and the mail procedure will also be posted on the intranet.

3. If the suspicion of misconduct involves the CEO, that individual will not be informed or involved in the ordinary course. The Compliance Officer shall report the matter immediately to the Chair of the Finance, HR & Audit Committee and the Chair of the Board of Directors. The Board Chair shall assume the responsibility of the investigation with the support of the Compliance Officer.
4. The Compliance Officer shall investigate the circumstances, in consultation with the Investigation Task Force, and any other persons with a legitimate interest in the matter including external expertise if deemed appropriate:
  - **Criminal Activity:** In the case of suspected criminal activity, the CEO (or Board Chair should the CEO be implicated) should be involved in the investigation. If deemed necessary, legal counsel may be consulted. HGMH will at all times co-operate with the police.
  - **Breach of Professional Behaviour:** The investigation should include a representative of the suspect's professional association.
  - **Unethical conduct:** The investigation should include a union representative or a Human Resources Representative for non-union staff.
  - **Financial Impropriety:** Includes misuse or misappropriation of funds, improper expense account claims or patient billings. The investigation should include a representative of the Finance, HR, and Audit Committee

- **Witnesses:** If the person making the report and/or any other witnesses are unionized staff, a union representative should be present at all interviews.
5. The Compliance Officer shall make a recommendation to senior management on disciplinary action, up to and including termination and the laying of criminal charges.

***Fraud***

1. It is the responsibility of the Finance, HR, and Audit Committee to ensure that the organization has appropriate procedures for the receipt, retention, and treatment of reports about its accounting, internal accounting controls, or auditing matters.
2. Under NO circumstances, should employees, physicians, volunteers, or their supervisors initiate an investigation of alleged fraud. To do so may compromise any ensuing investigation.
3. Once the Compliance Officer has been notified of a possible fraudulent act, he/she will:
  - Consult with the CEO and Chief Financial Officer (CFO) to determine the appropriate course of action which may or may not include an Investigation Task Force. Should the CEO be implicated, the Compliance Officer will consult with the Chair of the Finance, HR, and Audit Committee;
  - Advise the Finance, HR, and Audit Committee immediately via email of the situation and the proposed course of action;
  - Should the Compliance Officer decide not to refer the matter to the Investigation Task Force, a full report including the rationale for the decision shall be forwarded to the Finance, HR, and Audit Committee immediately via email.

The Compliance Officer shall ensure that all allegations brought to its attention are evaluated fully and make recommendations on how to proceed.

4. Where suspicion of fraud is substantiated, the CFO, shall, after the conclusion of the investigation, perform a thorough review of the existing internal controls, and shall present to the CEO a summary of internal control weaknesses and recommended internal control improvements required to minimize the likelihood of a recurrence.

**POLICY NUMBER: GO.01.002.5.21**

**POLICY TYPE: GOVERNANCE (Administrative)**

**SUBJECT: BOARD ATTENDANCE**

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

**PURPOSE:**

The Board of Directors and the Committees of the Board have been entrusted to direct and monitor hospital operations. Unreasonable Director absenteeism limits the full capability of the Board to fulfill its obligation to hospital stakeholders.

To ensure that board and committee members contribute their expertise and judgment to the business and affairs of the corporation by attending and participating in board and committee meetings. This policy applies to all Board members, ~~and non-board members of committees.~~

**PROCEDURE:**

The Governance and Nominating Committee shall review attendance twice a year and report to the Board.

Where a director ~~or committee member~~ fails to attend 75% of the meetings of the Board or of a committee in a 12-month period, or is absent for three consecutive meetings, the Chair shall discuss the reasons for the absences with the member and may ask the individual to resign. Action leading to the termination of a Director will be in accordance with the by-laws.

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

The chair shall, at the chair's sole discretion, determine if a ~~board or committee member's~~ Director's absences are excusable and may grant a board or committee member a limited period of time to rearrange their schedule so that there are no conflicts with regularly scheduled board or committee meetings.

<b>Document Name:</b>	Board Attendance		
<b>Document Number:</b>	BOR.01.014.0.24		
<b>Review Period:</b>	<input checked="" type="checkbox"/> 3 years <input type="checkbox"/> 1 year	<b>Manual:</b> Board Orientation	
<b>Classification:</b>	Board of Directors	<b>Section:</b> Governance	
<b>Owner:</b>	President & CEO	<b>Signing Authority:</b> Board of Directors	

**POLICY STATEMENT:**

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The Governance and Nominating Committee shall review attendance twice a year and report to the Board of Directors.

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

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

The Chair shall, at the Chair's sole discretion, determine if a Director's absences are excusable and may grant a Board or Committee member a limited period of time to rearrange their schedule so that there are no conflicts with regularly scheduled Board or Committee meetings.

Effective: Apr 2010	Last review/revision: Sep 2024	Next review: Sep 2027
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## REPORT OF THE MEETING OF THE FINANCE, HR AND AUDIT COMMITTEE

September 11, 2024 at 6:00PM in the Boardroom / MS Teams

Present: C. Nagy, Chair                      L. Boyling                      Dr. S. Robertson  
          Dr. G. Raby                              F. Desjardins                L. Ramsay  
          R. Alldred-Hughes, CEO              K. MacGillivray, CHRO

Regrets:        None

### Summary of Discussion

#### 1.0 Approval of Agenda

Agenda: The agenda was reviewed.

Moved By: L. Boyling  
Seconded By: Dr. G. Raby  
THAT the agenda be approved as presented.

**CARRIED**

Declaration of Conflict of Interest: there were no conflicts declared.

#### 2.0 Minutes

Report from the Previous Meeting: The report of the meeting of June 5, 2024, was shared.

Moved By: F. Desjardins  
Seconded By: Dr. S. Robertson  
THAT the report of the meeting of June 5, 2024, be approved as presented.

**CARRIED**

#### Business Arising:

There was no business arising from the minutes.

#### 3.0 Matters for Discussion/Decisions

##### 3.1 Review Terms of Reference

The committee terms of reference were reviewed. No changes were proposed with having just been reviewed with BLG.

Moved By: Dr. S. Robertson  
Seconded By: L. Boyling  
THAT the Finance, HR, and Audit Committee recommend to the Governance and Nominating Committee, the Finance, HR, and Audit Committee Terms of Reference as presented.

**CARRIED**

##### 3.2 Review Committee Effectiveness Survey Results

The results from the committee effectiveness survey were reviewed. It was noted that members did not feel well oriented to the committees. A new process was put together this

year as part of the Board Mentorship program whereas all new Directors were assigned a mentor for direct support. Mentors will take a proactive approach. It was agreed that since Dr. G. Raby is new to this committee, C. Nagy would mentor her as well.

There is a guide on the Board Portal on how to read the financial statements.

### 3.3 Review Annual Committee Work Plan

The committee work plan was reviewed.

Moved By: Dr. G. Raby

Seconded By: F. Desjardins

THAT the Finance, HR, and Audit Committee review and approve the Annual Committee Work Plan for 2024-2025 as presented.

**CARRIED**

### 3.4 Financial Statements - April, May, and June 2024

The financial statements for April, May, and June 2024 were reviewed.

Moved By: Dr. S. Robertson

Seconded By: L. Boyling

THAT the Finance, HR, and Audit Committee review and receive the financial statements for April, May, and June 2024 as presented.

The year-to-date as of June 30, 2024, reported a deficit of \$578,521.00.

Volumes from out-of-province patients were lower than forecasted by 9%. Despite the increase in the interprovincial rate from \$361 in 2023 to \$440 as of April 1, 2024, the increase in rate was offset by a decrease of volumes.

The variance noted under recoveries and miscellaneous revenue was primarily attributed to parking revenue, which performed below budgeted expectations.

The ONA wage rate increase of 3%, effective April 1, 2024, aligned with budget assumptions. CUPE wage adjustments, also budgeted at 3%, were impacted by an arbitration award on April 22, which led to retroactive payments being issued in June.

**CARRIED**

## **4.0 Matters for Information**

### 4.1 Statistical Information - April, May, and June 2024

The statistical information was reviewed for the months of April-June 2024. Occupancy was lower during these months.

### 4.2 Declaration of Compliance - April, May, and June 2024

The declaration of compliance for April, May, and June 2024 were included in the package.

## **5.0 Matters for information - People & Partnerships**

### 5.1 Q1 HR Metrics Report

K. MacGillivray presented the HR metrics for Q1 with things going very well and no concerns to report. Going forward, turnover in the first 90 days of employment will be tracked.

It was noted that there is an error on the report under number of students. This will be corrected.

## 6.0 Matters for information - Building & Property

### 6.1 Capital Redevelopment Planning

R. Alldred-Hughes explained the process for the pre-capital submission.

Moved By: L. Boyling

Seconded By: Dr. G. Raby

That the Finance, HR, and Audit Committee recommends to the Board of Directors the issuance of a Request for Proposal (RFP) to hire a consultancy firm to support the development of a Pre-Capital Submission for Hôpital Glengarry Memorial Hospital.

Moved By: L. Boyling

Seconded By: Dr. G. Raby

That the Finance, HR, and Audit Committee recommends to the Board of Directors to use the Endowment fund to pay for the required fees associated with developing a Pre-Capital Submission for Hôpital Glengarry Memorial Hospital, if the fees cannot be covered by current operational dollars.

Future planning is one of the pillars of the Strategic Plan. Certain areas of the hospital are starting to show their age and more space is needed as the hospital grows its services. This proposal would allow to complete the pre-capital submission at our cost, and in the submission, make it clear that we require a planning grant in order to move to phase 1.

This entire process can take up to 10 years to complete. The hope is to have an RFP issued by November 2024. **CARRIED**

### 6.2 Project Updates

R. Alldred-Hughes updated that the fire sprinkler system project is now complete and came in slightly over budget by 17K.

The electrical switch was replaced this morning following a code grey that took place in June where power to the hospital was lost. This project was not in the budget.

Funding was secured from HIRF to complete the entire parking lot resurfacing. Sidewalks will be redone as well. This project will be done in a phased approach.

## 7.0 Date of Next Meeting

Next meeting: October 9, 2024

Directors were asked to let L. Boyling know if they are interested in sitting on the Foundation Committee as Board representation as the current Director has had to step down from that committee.

K-L. Massia, Recorder

DECISION SUPPORT DOCUMENT FOR

- Board of Directors                     
  Board Committee –                     
  Senior Leadership Team  
 Other (please specify):

Date Prepared: August 28, 2024                      Meeting Date Prepared for: September 11 – Finance  
September 26 – Board of Directors

Subject: Human Resources Q1 Scorecard

Prepared by: Kayla MacGillivray, Chief Human Resources Officer

- DECISION SOUGHT\*                     
  FOR DISCUSSION/INPUT                     
  FOR INFORMATION ONLY

**PURPOSE**

- The purpose of this report is to provide an overview of the human resources aspects of HGMH as it relates to key people metrics for Q1 of the 2024-2025 fiscal year.

**SITUATION & BACKGROUND**

*A brief description of the background to the issue.*

- HR metrics are important to review and track so the organization can address areas of concern in a timely fashion in order to contribute positively to organizational performance.
- We established a baseline performance for multiple metrics in 2022 in order to establish a year over year view to understand trends, opportunities for improvement and celebration.
- People & Culture is a strategic dimension of the HGMH strategic plan, and in an effort to address key performance indicators for this element of the strategy, a quarterly score card is being used to monitor.
- The HR metric report is set up to focus on four main areas of Human Resources: Recruitment & Retention, Professional Development, Employees Safety, and Labour Relations. Within each of these categories are specific metrics that the organization will work towards driving and sustain positive performance.
- The targets have been updated from prior year to use most current Ontario Hospital Association Data to inform the targets. The OHA updated their data in the winter and spring of 2024 to reflect 2023.

**OPTIONS CONSIDERED & ANALYSIS**

*Outline alternatives that were contemplated in coming to a recommendation. If no viable alternatives exist, include that information as well.*

- **Recruitment & Retention:** Recruitment over the last several months has been very successful. We no longer have any Registered Practical Nurse vacancies and only two part-time Registered Nurse Vacancies. Struggles for allied health; specifically, physiotherapy and ultrasound technician recruitment remain challenging. We have implemented targeted social media campaigns for these two positions. Please note that we have added a turnover in the first ninety days of employment in order to monitor the success of our onboarding.
- **Professional Development:** Training hours remain consistent. We had 6 RPN students in the spring from St. Lawrence College.
- **Employee Safety:** We currently have one employee on a long-term WSIB leave which is the reason for the consistent lost time hours. Sick leave remains low during the summer months.
- **Labour Relations:** Labour relations remain consistent and positive. We are moving in to negotiations with CUPE.

**SUPPORTING DOCUMENTS/ATTACHMENTS:** HR Metrics Dashboard



## People Metrics Fiscal 2024-2025

2023-2024 Human Resources Dashboard Report	Dimension	Objective/Metric	Target	OHA Healthcare HR Benchmark 2023 (Average of all Participating Hospitals)	Quarterly	Q1	Q2	Q3	Q4	YTD	Trend	
Recruitment and Retention	Turnover (excluding casual staff)	Voluntary Separation Rate (%)	Less than OHA Average	15.28%	2024-2025	5.28%					5.28%	
					2023-2024	4.85%	0.54%	1.06%	1.00%	6.45%		
		Resignation Rate (%)	Less than OHA Average	10.42%	2024-2025	4.21%					4.21%	
					2023-2024	4.32%	0.54%	1.05%	1.00%	5.91%		
		Retirement Rate (%)	Less than OHA Average	4.86%	2024-2025	1.05%					1.05%	
					2023-2024	0.54%	0.00%	0.00%	0.00%	0.54%		
		Management Voluntary Separation Rate (%)	Less than Prior year	NA	2024-2025	0.00%					0.00%	
					2023-2024	0.00%	5.86%	0.00%	0.00%	5.86%		
	Permanent Vacancies	Total Vacancy Rate	Less than OHA Average	10.84%	2024-2025	4.47%					4.47%	
					2023-2024	10.81%	5.03%	6.49%	5.02%	6.84%		
Student Placements	Total No. of New Student Placements Occurring During Reporting Period	HGMH Data	N/A	2024-2025	6					6		
				2023-2024	3	5	5	12	25			
Turnover in First 90 Days of Employment	Total Number of New Hire Departures within 90 Days of Hire	HGMH Data	Creating baseline	2024-2025	14.28%					14.28%		
				2023-2024	N/A	N/A	N/A	N/A	N/A	N/A		
Professional Development	Education & Staff Development	Staff Training Hours	HGMH Data	N/A	2024-2025	433.80				433.80		
				2023-2024	105.00	626.30	448.30	413.54	1593.14			
Employee Safety	Short Term Disability	All Full-time HGMH Staff (days per person based on 7.5 hour day)	Less than OHA Average	16.48%	2024-2025	1.30%				1.30%		
					2023-2024	4.44	3.66	6.35	2.23	16.70		
	Workplace Illness or Injury	No. WSIB Lost Time Injuries/Illness Related to Workplace Violence (per OH&S Definition)	HGMH Data	N/A	2024-2025	0					0	
					2023-2024	0	0	0	0	0		
		Total No. WSIB Lost Time Injuries/Illness	HGMH Data	N/A	2024-2025	0					0	
				2023-2024	4	3	1	3	11			
	WSIB Lost Time Hours	HGMH Data	N/A	2024-2025	375.00					375.00		
				2023-2024	950.00	231.50	262.50	757.50	2270.50			
Labour Relations	Grievance & Arbitration	Grievances Advanced to Arbitration	HGMH Data	N/A	2024-2025	0				0		
				2023-2024	0	0	0	1	1			

The 2023 Health Care HR Benchmarking data represents 105 (75%) of the 140 OHA hospital members for a total of 186,360 employees (131,382 full-time and 54,978 part-time). Casual Staff excluded from data.

Dark Benchmarking Trend	Metric underperforming target by more than 25%
	Metric within 25% of target
	Metric equal or outperforming target



- Some electrical downtime will be needed; details to be determined and communicated as appropriate

#### **Point of Care Testing Room**

- Background and scope:
  - The Eastern Ontario Regional Lab Association Accreditation identified issues with humidity and temperature control in the Point of Care Testing (POCT) room in the Emergency Room (ER)
  - One treatment room was renovated to bring POCT space into alignment with the lab's Accreditation standards
- Status:
  - Renovation complete, equipment moved and quality validated; space opened for use August 14, 2024

#### **Parking Lot**

- Background and scope:
  - Majority of the hospital parking lots are very old and in need of replacement; about 50% of sidewalks are cracked/broken and pose trip hazards
  - HIRF funding acquired in June 2024
- Status:
  - Call for tenders closed on Friday, August 30, 2024; RFP evaluations currently being conducted.
  - Project will proceed in four phases:
    - Phase 1: back parking lot and 'heavy duty' laneway that cuts through the east lot down to the back
    - Phase 2: west lot and north lot
    - Phase 3: east lot and sidewalk replacements
    - Phase 4: removal of old unused parking area north of ER

#### **CONSULTED WITH:**

*Indicate those bodies and individuals who have been consulted with in the development of this decision support document*

- Jennifer Mattice, Manager of Emergency Preparedness, Projects, & Security

**REPORT OF THE BOARD QUALITY AND  
RISK MANAGEMENT COMMITTEE MEETING**

September 11, 2024 at 7:00PM in the Boardroom / MS Teams

Present: C. Larocque Dr. S. Robertson G. Peters  
W. Rozon H. Salib R. Romany  
R. Alldred-Hughes Dr. L. MacKinnon

Regrets: C. Mageau-Pinard

**Summary of Discussion**

**Approval of the Agenda:**  
The agenda was reviewed.

Moved By: G. Peters  
Seconded By: W. Rozon  
THAT the agenda be approved as presented.

**CARRIED**

**Report from the Previous Meeting:**  
The report from the meeting of May 8, 2024, was shared.

Moved By: Dr. S. Robertson  
Seconded By: G. Peters  
THAT the report be approved as presented.

**CARRIED**

**Business Arising from Report:**  
There was no business arising from the report.

**Education - Patient Story (R. Romany)**

R. Romany presented a patient story about a patient who was admitted for urinary tract infection which led to come confusion and weakness and the patient was assessed as high risk for falls. Precautions were implemented to ensure the patients safety and purposeful rounding is done hourly on all patients, however, during an evening shift, the patient was found sitting between the bed and commode. The patient was assessed for injuries and helped back in bed. The patient had attempted to use the commode without assistance. Even with purposeful rounding, it appears the timing of rounding did not align with the patient's needs and that staff did not respond soon enough to the bed alarm as the patient was falling.

To reduce the likelihood of recurrence, purposeful rounding will be enhanced, ensuring that patients are being checking in with at appropriate times and also ensuring prompt response to bed alarms. Patient education will also be done on the importance of using the call bells when needing assistance.

### Matters for Discussion/Decision

#### Review Terms of Reference

The Terms of Reference were reviewed.

Moved By: G. Peters

Seconded By: W. Rozon

THAT the Quality and Risk Management Committee recommend to the Board of Directors the approval of the Terms of Reference as presented.

There was a minor change to the name of the committee from Quality & Risk Management to Quality & Patient Safety to better reflect the purpose of the committee.

**CARRIED**

#### Review Committee Effectiveness Survey Results

The results of the committee effectiveness survey were reviewed and one of the comments of the survey was that no orientation was provided. A thorough orientation is conducted yearly, however, when Directors join later in the year, they do not get the same orientation which is why this year a different approach was taken with the Board Mentorship program and all new Directors were assigned to a mentor.

#### Review Annual Committee Work Plan

The committee work plan was reviewed.

Moved By: H. Salib

Seconded By: W. Rozon

THAT the Quality and Risk Management Committee review and approve the Annual Committee Work Plan for 2024-2025 as presented.

There were no concerns with the work plan.

**CARRIED**

#### Review Q1 Quality Improvement Plan Results 2024/2025

The results of the Quality Improvement Plan for Q1 were reviewed.

Things are going well under all the themes with work needing to be focused on in two areas.

Under Access & Flow, the percentage of patients who visited the ED and left without being seen by a physician for Q1 ended with 10.8% which is above the target of 7.69%. An initiative was implemented in the Emergency Department whereas additional physician coverage is added on certain days of the week for 4-hour blocks to support faster access for low-acuity emergency visits, improve patient flow, reduce the number of patients leaving without being seen, and improve Physician Initial Assessment times.

The other area of focus is under Safety in which the number of reported near misses related to controlled substances within the organization is being measured. Any controlled substance that cannot be accounted for has to be reported. Controlled substances are counted daily at shift change to better identify when a near miss occurred. Q1 ended at 25 incidents which is above the target of 12 reported incidents. The strategy to help with this based on nursing feedback is to analyze dispensing and documentation workflows such as narcotic counts, potential losses investigation, and monitoring use and distribution of prescription pads.

Pharmacy will also provide individual staff feedback to address errors. A diversion prevention education will be coordinated for staff orientation in Fall 2024.

#### **Review Q1 Quality & Safety Scorecard Results**

The Q1 results were overall good for the Quality & Safety Scorecard. There are some indicators which are to be improved, such as Hand Hygiene compliance rates for moment 1 and moment 4 which have come in under target. Targeted feedback and education for staff and physicians will be done to improve these numbers. The frequency of audits will be increased to monitor and reinforce these practices.

This also ties in with the MRSA and C. difficile rates which came in above target. By increasing hand hygiene compliance, these rates should also improve. New patient furniture was also purchased to help with this.

#### **Review Q1 Patient Satisfaction Survey Results**

The Patient Satisfaction Survey results were reviewed for Q1. These questions are standard questions to allow for benchmarking with peer hospitals. Surveys are sent out 24 hours following a patient's discharge and are sent electronically.

While only 8 surveys were received for the inpatient unit and the results were overall positive, there was indication that work needs to be done around enhancing communication with the patient.

The results from the Emergency Department were very good overall.

#### **Review Q1 Violent Incident Report**

There were 4 violent incidents reported across various departments, mostly verbal. There were no patient cognitive issues noted from these incidents.

#### **Review Q1 Complaints and Compliments Report**

In Q1, 458 patients were seen in the Emergency Department. Only 3 formal complaints were received during that time, 2 within the Emergency Department and 1 in the Ambulatory Clinic. These complaints were primarily around the attitude of staff as well as the treatment received at the hospital. All patients who submitted a complaint received a follow up from management.

There was a total of 6 formal compliments received in Q1, with 5 of them for the Emergency Department, and one for Rehab. This demonstrates the ongoing efforts of the team in making a positive difference with patient care.

#### **Review Patient Safety Plan Actions**

The Patient Safety Plan includes the Patient Rights and Responsibilities as per Accreditation recommendations. A poster was created and will be displayed in waiting rooms to help patients understand their rights and responsibilities.

R. Romany shared the initiatives being conducted under the patient safety plan which include conducting leader rounds, asking a safety question in team huddles, engaging the IDEA committee, having PFAC members participate on internal hospital committees, and review policy and procedures with staff to increase awareness.

### **Matters for Information**

#### **Patient & Family Advisory Committee Update**

R. Romany updated on the work being done by the very engaged PFAC committee. They have come up with the idea of bringing in a library for patients and are leading the project with the SD&G library. Communication is being worked on to start advertising this service.

#### **Best Practice Spotlight Organization Update**

Designation was received in June and now 2 new best practice guidelines are being worked on; oral health and end of life care. These are currently in place, however, work will be done to ensure there are no gaps in the process.

#### **Accreditation Update**

The team has been doing great work in order to keep staff engaged in Accreditation with new assignments every month that have a Wizardry theme. The portal will open end of next year where we can start uploading evidence for the surveyors to review.

#### **Accreditation Standard Review**

R. Romany presented the Accreditation standard 3.1 The governing body provides guidance and engages in oversight to ensure the organization achieves its mandate. The committee discussed the standard.

**Date of Next Meeting:** November 13, 2024

Directors were asked to let L. Boyling know if they are interested in sitting on the Foundation Committee as Board representation as the current Director has had to step down from that committee.

K-L. Massia, Recorder



INDICATOR	MEASURE	SOURCE	REFERENCE	TARGET 24/25	LEADER	2023/24 YEAR END	24-Apr	24-May	24-Jun	Q1
<b>SAFETY</b>										
Fall Rate	per 1000 patient days	RIMS	NQUIRE	12.00	Managers, HIS	13.00	16.90	7.50	13.70	17.00
Falls with Injury (any fall requiring intervention or treatment)	per 1000 patient days	RIMS	BPSO	2.00	Managers, HIS	2.00	1.20	0.00	1.50	0.90

- Hand Hygiene Compliance rate for Moment 1- 70% and Moment 4- 84% which are below the target of 92%.
  - Strategy: Emphasize targeted feedback and education for physicians, nurses, and other patient care staff, such as lab personnel, to improve hand hygiene compliance. Increase the frequency of audits to monitor and reinforce these practices.

INDICATOR	MEASURE	SOURCE	REFERENCE	TARGET 24/25	LEADER	2023/24 YEAR END	24-Apr	24-May	24-Jun	Q1
Hand hygiene compliance rate (Moment 1)	# compliant activities / # of indicated activities	HandiAudit	MOH	92%	Manager, Professional Practice	79%	75%	66%	69%	70%
Hand hygiene compliance rate (Moment 4)	# compliant activities / # of indicated activities	HandiAudit	MOH	92%	Manager, Professional Practice	88%	78%	80%	93%	84%

- HAI rates- MRSA- 2 and C. Difficile- 0.78, which are above the target of 0.
  - Strategy: Increasing hand hygiene compliance and provide Personal Protective Equipment (PPE) refresher education

INDICATOR	MEASURE	SOURCE	REFERENCE	TARGET 24/25	LEADER	2023/24 YEAR END	24-Apr	24-May	24-Jun	Q1
C. difficile rate	# cases / 1000 patient days	Hospital Collected Data	MOH	0	Manager, Professional Practice	3.00	2.34	0.00	0.00	0.78
MRSA rate	# cases / 1000 patient days	Hospital Collected Data	MOH	0	Manager, Professional Practice & IPAC	4.00	2.00	2.00	2.00	2.00

## SUMMARY

Monitoring quality indicators is essential to uphold high standards of care and ensure safe, quality patient care. This involves regularly assessing these performance metrics and implementing strategies to address any performance gaps.



THEME	METRIC	MEASURE	YEAR END FISCAL 2023	TARGET PERFORMANCE	Q1
<b>1. Timely &amp; Efficient Transitions</b>					
	90th percentile emergency department wait time to inpatient bed	hours	5.8	6.0	1.0
<b>2. Service Excellence</b>					
	Percentage of respondents answering yes to the question "did you participate in your plan of care?"	% of those who answered Positively/total surveys	78.0%	80.0%	55.4%
	Number of compliments received	Actual number	13	15	6
	Number of complaints received	Actual number	21	10	3
<b>3. Safe &amp; Effective Care</b>					
	Rate of delirium onset during hospitalization	%/Hospital admitted patients		20%	0.0
	Fall Rate	# of incidents per 1000 patient days	13	12	12.5
	Falls with Injury (any fall requiring intervention or treatment)	# of incidents per 1000 patient days	2.00	2.00	0.86
	Incidents of Physical Violence	Actual number	84	75	5
	Medication Errors (reaching the patient secondary to wrong	Actual number	59	52	8
	Pressure injury development rate (stage 2,3,4) during inpatient stays	Actual number	0	0	0
	Hand hygiene compliance rate (Moment 1)	# compliant activities / # of indicated activities	79.0%	92.0%	70.0%
	Hand hygiene compliance rate (Moment 4)	# compliant activities / # of indicated activities	88.0%	92.0%	83.7%
	C. difficile rate	# of incidents per 1000 patient days	3.00	0.00	0.78
	VRE Rate	# of incidents per 1000 patient days	0.00	0.00	0.0
	MRSA Rate	# of incidents per 1000 patient days	4	0.00	2.0
<b>4. Equity</b>					
	Translation Services Usage	Number of minutes		5	4

Metric underperforming target by more than 25%

Metric within 25% of target

Metric equal or outperforming target

DECISION SUPPORT DOCUMENT FOR

- Board of Directors                     
  Board Committee –                     
  Senior Leadership Team  
 Other (please specify):

Date Prepared: August 28, 2024                      Meeting Date Prepared for: September 11 – Quality  
September 26 – Board of Directors

Subject: Patient Satisfaction Surveys

Prepared by: Rachel Romany - VP Clinical Services, Quality, Chief Nursing Executive

- DECISION SOUGHT\*                     
  FOR DISCUSSION/INPUT                     
  FOR INFORMATION ONLY

**PURPOSE**

- To outline patient satisfaction survey indicators for Emergency Department and Inpatient/Rehab.
- To celebrate the top patient satisfaction indicators and to outline the lowest scoring indicators that can be improved.

**IMPLICATIONS TO OTHER STANDING COMMITTEES**

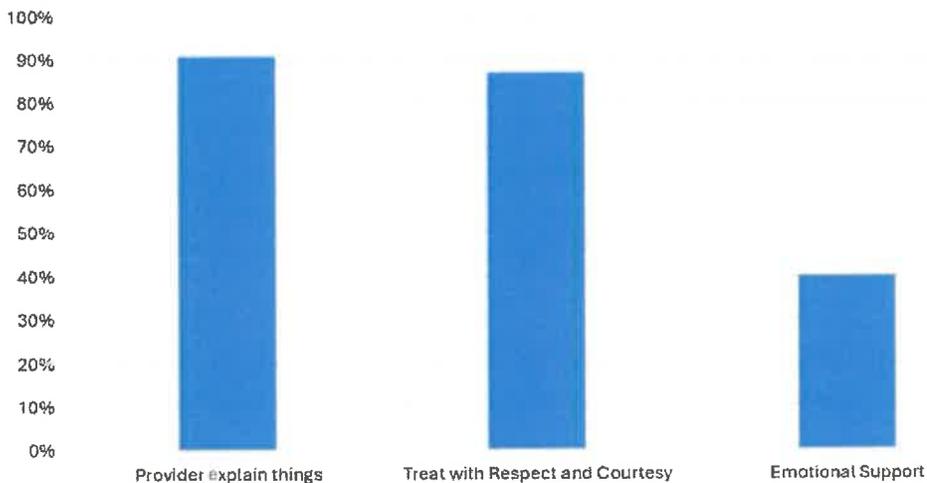
Are there any material or significant implications for other Standing Committees?  No     Yes, please specify:

- Quality and Safety Advisory Committee
- Patient & Family Advisory Committee

**ANALYSIS**

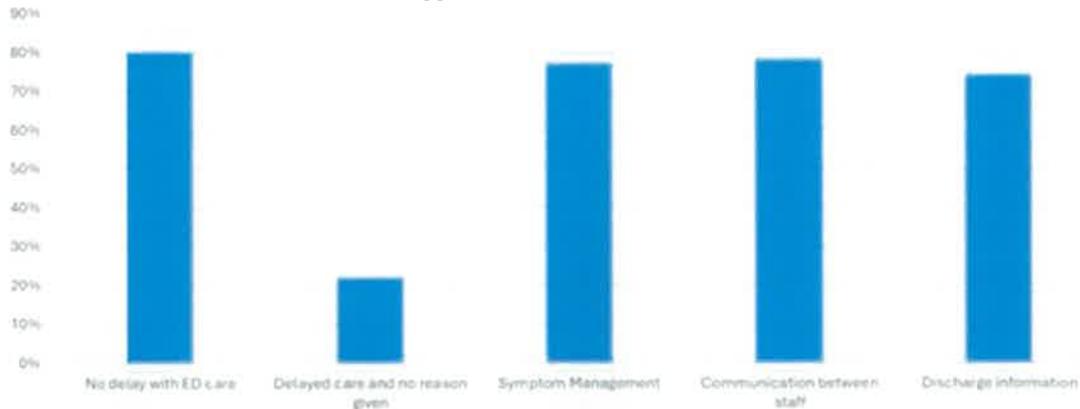
**EMERGENCY DEPARTMENT:** n=426

Information, Emotional Support, Respect, & Courtesy



- Most patients felt well-informed (91%) and treated with respect and courtesy (87%).
- Opportunity: providing emotional support, as 40% received it and 44% sometimes felt/did not feel fully supported.
- Strategy: Empathy, active listening, emotional support techniques

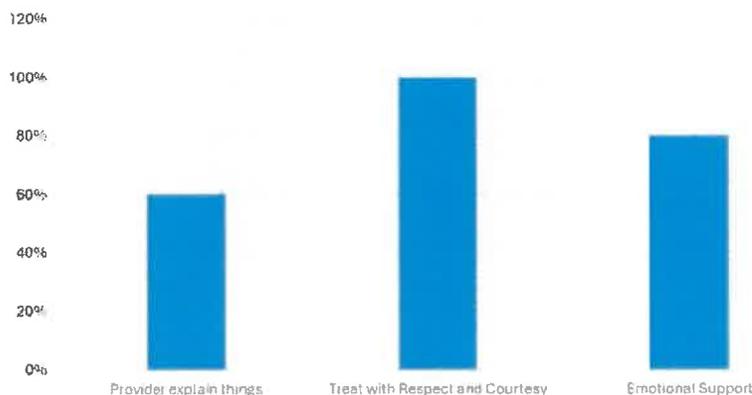
### ED Wait, Support, Communication, Information



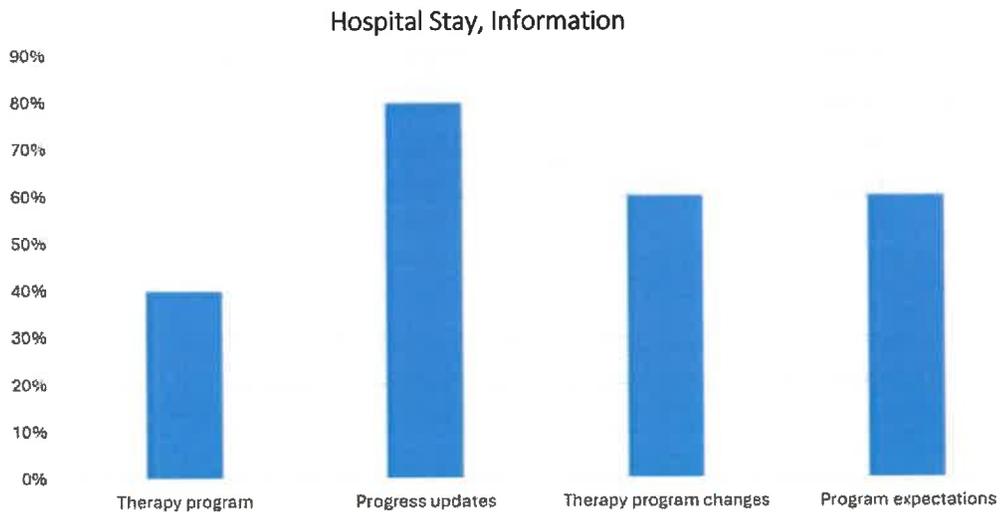
- **ED Wait**
  - The majority (52%) did not experience long waits, which is positive.
  - Opportunity: explanation of wait time to those who did wait (22%).
  - Strategy: Transparent, clear language, signage to explain delays and reasons for waiting
- **Symptom Management**
  - Most patients felt that their discomfort and symptoms were well-managed (77%)
  - Opportunity: enhance patient care for the 12% who felt staff did not adequately address their needs.
  - Strategy: improve communication, enhance patient engagement, optimize response times to patient requests and discomfort
- **Communication between staff**
  - The majority felt that there was good communication between staff (78%).
- **Discharge Information**
  - Over half of the respondents felt they received adequate information about their discharge (74%)
  - Opportunity: better discharge planning and communication for nearly 26% who felt they did not receive enough information.
  - Strategy: Discharge checklist, discharge instructions with diagrams to make it clearer and more comprehensible for patients. This approach aims to enhance patient understanding of their post-discharge care, reduce the risk of misunderstandings or errors, and improve overall patient satisfaction and outcomes.

### Inpatient/Rehab Department: n=8

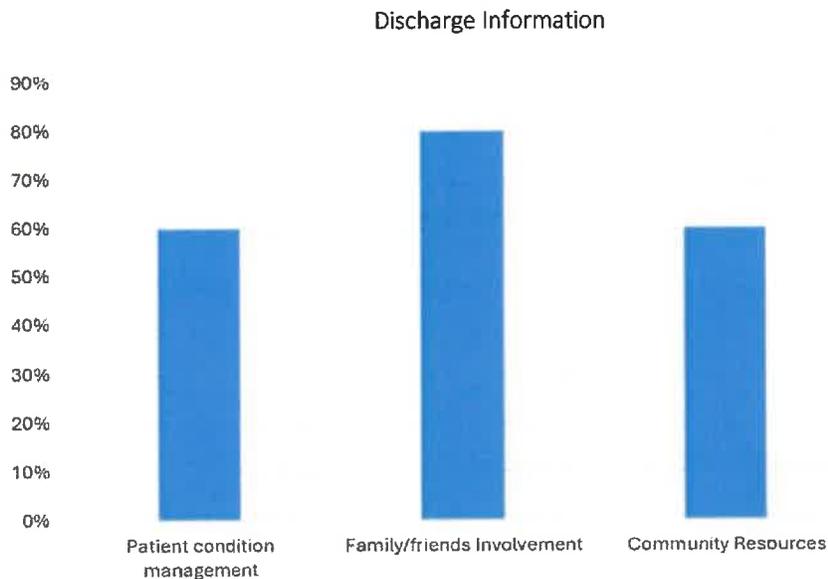
#### Information, Emotional Support, Respect, & Courtesy



- All patients felt they were treated with respect and courtesy (100%), and 80% felt they received the emotional support they needed.
- Opportunity: Provider information- 40% of patients felt that the provider did not explain things clearly.
- Strategy: Effective communication skills, focusing on clarity, simplicity, patient engagement, and checking patient understanding.



- 80% of individuals felt they were given adequate information about their progress.
- Opportunities: Patient information on the therapy program itself (40%), changes to the program (60%), and setting clear patient expectations (60%).
- Strategy: Improve communication regarding the therapy program, any changes to it, and setting clear expectations for patient progress.



- **Patient Condition Management**: 60% of patients feel they received adequate information on effectively managing their condition.



- **Family/Friends Involvement:** 80% of patients are highly satisfied with the involvement of their family and friends in their care, indicating that support systems are generally effective.
- **Community Resources:** 60% of patients are satisfied with the information provided about community resources. However, it is unclear whether this satisfaction reflects a lack of resources in the community or unmet needs.
- **Opportunities:** Patient communication about managing their condition and accessing community resources
- **Strategy:** Clear and comprehensive communication regarding patient condition management and solicit regular patient feedback to understand their discharge needs.

A summary of patient satisfaction survey results highlights key areas for improvement to ensure high-quality and safe patient care. Regularly reviewing and responding to patient feedback is vital for upholding these high standards and ensuring that all patients receive safe, effective, and compassionate treatment.

DECISION SUPPORT DOCUMENT FOR

- Board of Directors                     
  Board Committee –                     
  Senior Leadership Team  
 Other (please specify):

Date Prepared: August 28, 2024                      Meeting Date Prepared for: September 11 – Quality  
September 26 – Board of Directors

Subject: Violent Incidents Review

Prepared by: Rachel Romany- Vice President Clinical Services, Quality and Chief Nursing Executive

- DECISION SOUGHT\*                     
  FOR DISCUSSION/INPUT                     
  FOR INFORMATION ONLY

**PURPOSE**

- Provide an overview of the violent incidents for Q1 and the measures taken to mitigate and address these incidents.

**IMPLICATIONS TO OTHER STANDING COMMITTEES**

Are there any material or significant implications for other Standing Committees?  No     Yes, please specify:

**SITUATION & BACKGROUND**

*A brief description of the background to the issue.*

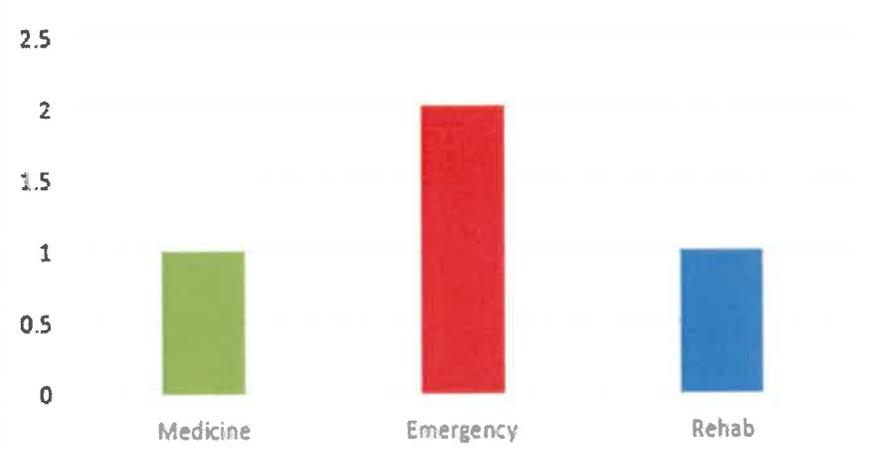
- Violence within healthcare settings is a concern, impacting the safety and well-being of both our staff and patients.
- Understanding root causes of these incidents is crucial to implementing effective preventative measures.

**IMPACT ANALYSIS/RISK ASSESSMENT/DECISION CRITERIA**

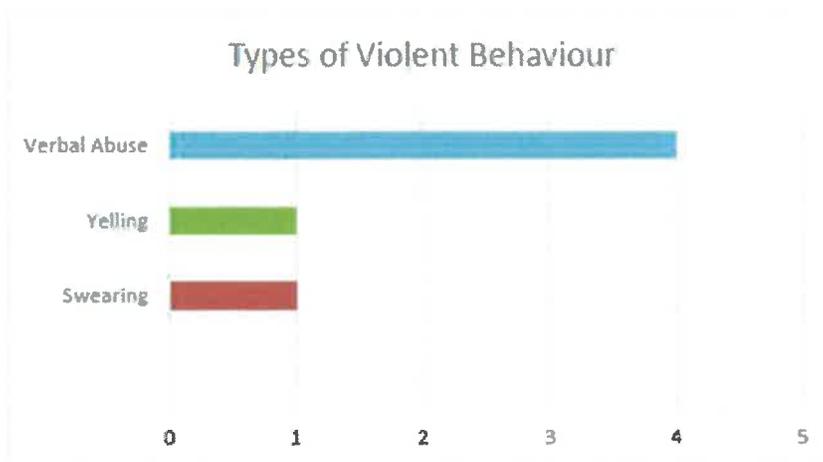
*Outline both the positive and negative consequences of the recommendations in terms of financial, mission, quality, risk and other.*

A total of 4 violent incidents were reported in Q1.

**Violent Reports/RIMS for July 2024**



- These incidents occurred across various departments.
- For all four incidents, there were no patient cognitive issues noted .
- None of these incidents required First Aid or Medical Aid (ED physician).



- Most of the incidents are classified as verbal abuse and verbal conflicts.
- Handling verbal conflicts with patients requires a combination of empathy, communication skills, and de-escalation techniques.
- We continue to focus on proactive strategies to prevent and reduce violent incidents, while ensuring a safer and more supportive environment for both patients and staff.

DECISION SUPPORT DOCUMENT FOR

- Board of Directors                       Board Committee –                       Senior Leadership Team  
 Other (please specify):

Date Prepared: August 9, 2024                      Meeting Date Prepared for: September 11 – Quality  
September 26 – Board of Directors

Subject: Complaints and Compliments

Prepared by: Rachel Romany- Vice President Clinical Services, Quality and Chief Nursing Executive

- DECISION SOUGHT\*                       FOR DISCUSSION/INPUT                       FOR INFORMATION ONLY

**PURPOSE**

- To review the complaints and compliments received for Q1 and discuss contributing factors and mitigation strategies for improvement

**IMPLICATIONS TO OTHER STANDING COMMITTEES**

Are there any material or significant implications for other Standing Committees?  No     Yes, please specify:

**SITUATION & BACKGROUND**

*A brief description of the background to the issue.*

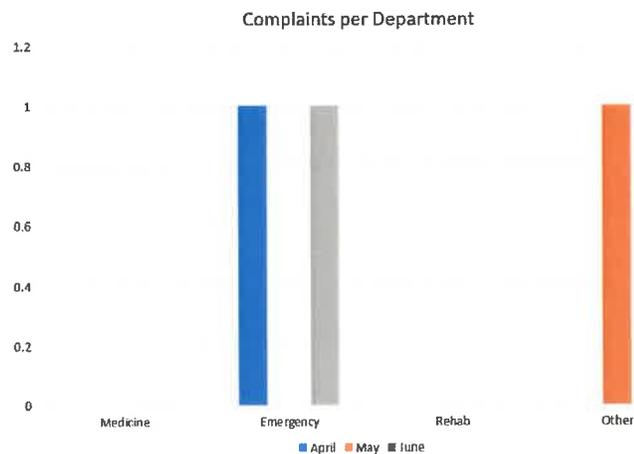
- Reviewing complaints and compliments is a crucial component of our commitment to transparency, continuous improvement, and patient centered care.
- This summary highlights key trends, areas of concern, and notable achievements related to the quality of care and services provided by the hospital.

**IMPACT ANALYSIS/RISK ASSESSMENT/DECISION CRITERIA**

*Outline both the positive and negative consequences of the recommendations in terms of financial, mission, quality, risk and other.*

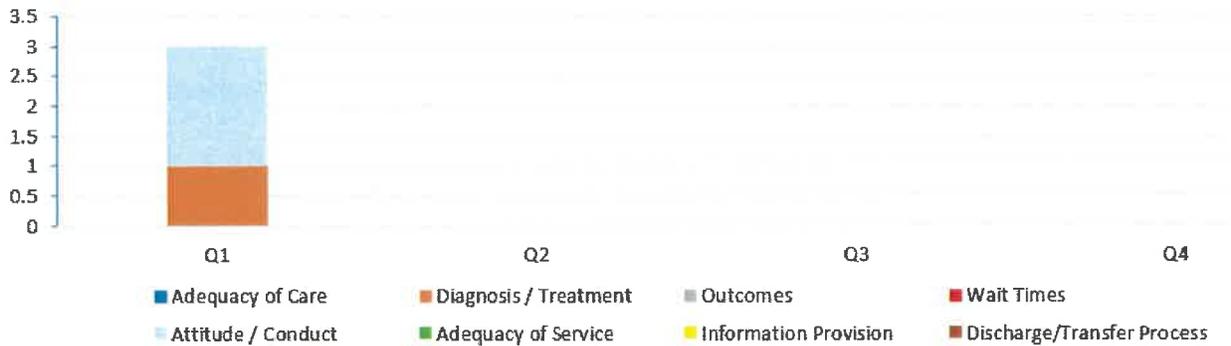
**Complaints:**

- In Q1, HGMH saw 4,582 patients in the emergency department.
- There was a total of 3 formal complaints received, two within the Emergency Department and one from the Ambulatory Clinic.



- Of the three complaints, one was related to the treatment received and the other two were related to the attitude/conduct of staff.
- While the overall number of complaints remains relatively low for the number of patients seen in the quarter, there were no complaints made about wait times which can be seen as improvement. Timely access to care is a cornerstone of patient satisfaction, and the Quality and Safety Advisory Committee continues to look at ways to address this issue to help enhance the overall patient experience.

### Complaint Types



- All patients who have submitted a formal complaint have had initial follow up from management. One of the three complaints has been closed, and the remaining two are pending information from physicians.

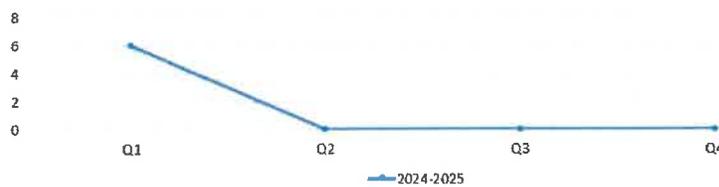
### Complaint Status



### Compliments:

During Q1, there were a total of 6 formal compliments received, five of them for the Emergency Department and one for Rehab. This demonstrates the ongoing efforts of the team to make a positive difference with patient care.

# of Compliments by Department per Quarter





## SUMMARY

- Overall patients seem fairly appreciative of the service at HGMH.
- While we've received praise for our attentive care and knowledgeable staff, there are areas for improvement highlighted in patient complaints, particularly regarding staff attitude/conduct.
- Ongoing strategies to address these opportunities can enhance the quality of the care we provide and ensure overall patient satisfaction and experience.

DECISION SUPPORT DOCUMENT FOR

- Board of Directors
  Board Committee –
  Senior Leadership Team
- Other (please specify):

Date Prepared: August 29, 2024 Meeting Date Prepared for: September 11 – Quality  
September 26 – Board of Directors

Subject: Patient Safety Plan 2022-2028 Actions

Prepared by: Rachel Romany - Vice President Clinical Services, Quality, Chief Nursing Executive

- DECISION SOUGHT\*
  FOR DISCUSSION/INPUT
  FOR INFORMATION ONLY

**PURPOSE**

- To provide an update of the Patient Safety Plan actions.

**SITUATION & BACKGROUND**

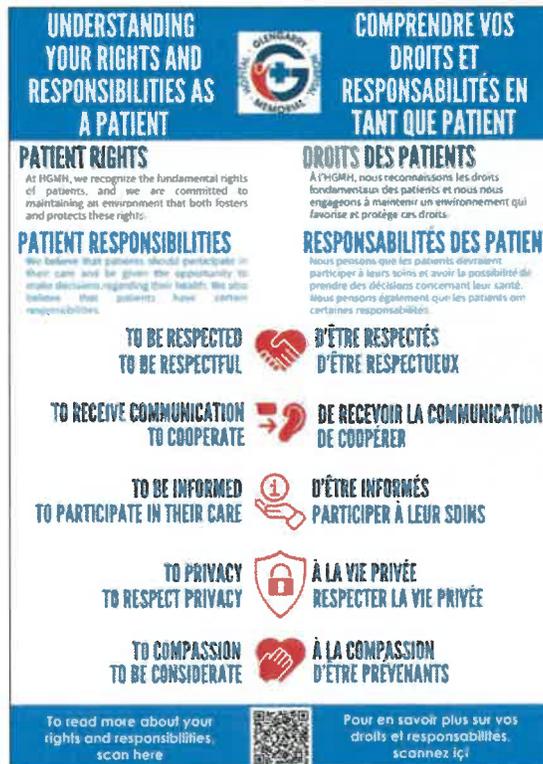
A brief description of the background to the issue.

- The Patient Safety Plan is to communicate and support our focus and commitment to the provision of safe, quality patient care.

**IMPLEMENTATION & COMMUNICATION**

Consider how this will be rolled-out or shared as information

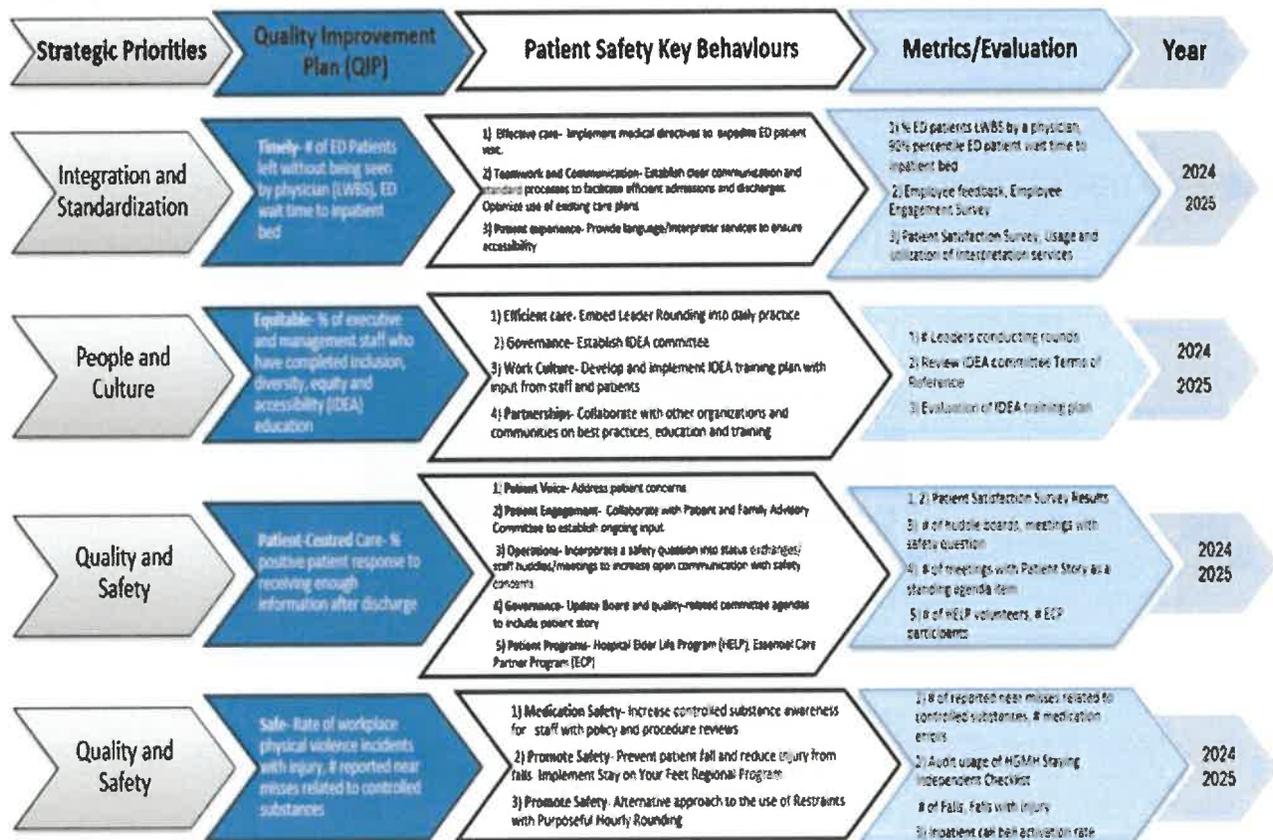
- The Patient Safety Plan includes the Patient rights and responsibilities as per Accreditation recommendations.
- Patient Rights and Responsibilities poster



- **Patient Safety Key behaviors:**
  - **People and Culture:** Leader rounds are being conducted
  - **Patient Centred Care:** Safety question is included in huddles/ committees
  - **Equitable:** IDEA Committee held its first meeting in June 2024.
  - **Patient Voice and Engagement:** PFAC members are participating in the Ethics, Product Evaluation, and Quality and Safety Advisory committees to offer input from a patient perspective.
  - **Safety:** Policy and procedure reviews with staff to increase controlled substance awareness, including diversion education.

### Patient Safety Plan- Safety Behaviours for Improved Quality Care

This plan is in alignment with the Quality Improvement Plan and is updated annually to ensure continuous improvement of patient outcomes and quality of care.



## Correspondence

June 20 - [Power failure at Alexandria hospital - The Review Newspaper](#)

June 20 - [Fondation de l'Hôpital Glengarry Memorial Hospital Foundation Welcomes New Executive Director \(cornwallseawaynews.com\)](#)

July 12, 2024 Seaway News - [Glengarry Memorial Hospital Awarded Best Practice Spotlight Organization \(BPSO\) Designation by the Registered Nurses Association of Ontario \(RNAO\)](#)

July 14, 2024 – Seaway News - [Hôpital Glengarry Memorial Hospital \(HGMH\) Announces New Slate of Directors and Celebrates Excellence in Healthcare](#)

August 6, 2024 – Seaway News - [Outbreak](#)

August 6, 2024 – The SDG & A Cornwall Seeker – [Yes, COVID-19 is still a thing: outbreak at HGMH](#)

September 16, 2024 – Seaway News – [HGMH Receives Health Infrastructure Renewal Fund \(HIRF\) to Restore Hospital Parking Lot and Sidewalks](#)