BOARD QUALITY AND PATIENT SAFETY COMMITTEE MEETING AGENDA

Date: Wednesday, September 10, 2025
Time: 16:00 – 17:H00
Location: Boardroom / Microsoft Teams

Time	Agenda Item	Board Item	Attachment
16:00	**1. Call to Order**		
(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		
16:03	**2. Report from Last Meeting**		
(1 min)	2.1 Approval of previous meeting report – May 14, 2025		P. 3-6
(1 min)	2.2 Business arising from the report		
16:05	**3. Education Session**		
(10 min)	3.1 Privacy and Confidentiality (RJ. Jarencio)		
16:15	**4. Matters for Discussion/Decision**		
(5 min)	4.1 Review Committee Effectiveness Survey Results (C. Larocque)	C	P. 7-10
(5 min)	4.2 Review and Recommend Annual Committee Work Plan (C. Larocque) **THAT the Quality and Patient Safety Committee review and approve the Annual Committee Work Plan for 2025-2026 as presented.**	C	P. 11-12
(5 min)	4.3 Review Terms of Reference (R. Alldred-Hughes/R. Romany) **THAT the Quality and Risk Management Committee recommend to the Board of Directors the approval of the Terms of Reference as presented.**	(goes to Governance)	P. 13-16
(5 min)	4.4 Review Q1 Quality Improvement Plan Results (R. Romany)	D	P. 17-19
(5 min)	4.5 Review Q1 Quality & Safety Scorecard Results (R. Romany)	D	P. 20-22
(5 min)	4.6 Review Q1 Patient Satisfaction Survey Results (R. Romany)	D	P. 23-27
16:45	**5. Matters for Information**		
(2 min)	5.1 Updates from Patient and Family Advisory Committee (R. Romany)	C	P. 28
(2 min)	5.2 Updates from Best Practice Spotlight Organization (R. Romany)	C	P. 29
(5 min)	5.3 Updates on Accreditation (R. Alldred-Hughes)	C	P. 30-31
(5 min)	5.4 Accreditation Standard Review (R. Romany)	C	P. 32
16:59	**6. Date of Next Meeting**		
	November 12, 2025		
17:00	**7. Adjournment**		

Board Item: Matters for Discussion/Decision (D) or Consent Agenda (C)
*Refer to the Accountability for Reasonableness (A4R) framework for organizational ethical issues.

Accountability for Reasonableness (A4R) Ethical Decision Making Framework Steps

Values that Optimize Fairness in the Process of Decision-Making

- Relevance
- Publicity/ Transparency
- Revision/ Appeals
- Enforcement
- Empowerment

A4R Action Steps

Determine and Identify

- Determine your mandate and the key question.
- Identify stakeholders and involve them in decision-making.
- Ensure alignment on the problem and question.

Clarify and Provide

- Clarify decision-making procedures (values, strategic priorities).
- Share how decisions will be made and revisited.
- Document rationale for decisions using value-based criteria.

Communicate

- Communicate decisions and their rationale with stakeholders.
- Seek input on communication strategy.

Revisit and Revise

- Revisit decisions as needed based on new evidence or stakeholder input.

Evaluate and Improve

- Evaluate success based on "accountability for reasonableness".
- Identify gaps and implement improvements for future processes.

Champlain

Glengarry Memorial

REPORT OF THE BOARD QUALITY AND PATIENT SAFETY COMMITTEE MEETING

May 14, 2025 at 6:00PM via MS Teams

Present:	G. Peters	Dr. S. Robertson	W. Rozon
	H. Salib	Dr. R. Cardinal (virtual 7:42)	R. Romany
	R. Alldred-Hughes		
Regrets:	C. Larocque	Dr. L. MacKinnon	

Summary of Discussion

Approval of the Agenda:
The agenda was reviewed. It was noted that the committee effectiveness survey and the Board Peer to Peer survey will be sent out tomorrow.

Moved By: H. Salib
Seconded By: W. Rozon
THAT the agenda be approved as presented.

CARRIED

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

Report from the Previous Meeting:
The report from the meeting of February 12, 2025, was approved as presented.

Moved By:
Seconded By:
THAT the report of February 12, 2025, be approved as presented.

CARRIED

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

Education – Quality Initiative

A new quality initiative was just launched whereas the hospital partnered with the Mohawk Council of Akwesasne to provide access to endoscopy services for Indigenous patients. This partnership enables patients to receive timely procedures and overcoming access challenges currently being faced by community members. This reflects the hospitals commitment to equitable care and strengthens our role as a partner in the provision of equitable health services.

Matters for Discussion/Decision

Review Q4 Quality Improvement Plan Results
The results of the Quality Improvement Plan for Q4 were shared.

Moved By: W. Rozon
Seconded By: H. Salib
THAT the Quality & Patient Safety Committee review and receive the Q4 Quality Improvement Plan results for 2024/2025 as presented.

All of the targets were positively achieved. These results are posted throughout the hospital on the quality boards where each department huddles and reviews the data.

CARRIED

Review Q4 Clinical Quality & Safety Scorecard
The results for the Q4 Clinical Quality & Safety Scorecard were shared.

Moved By: H. Salib
Seconded By: W. Rozon
THAT the Quality & Patient Safety Committee review and receive the Q4 Quality & Safety Scorecard results as presented.

The results are trending well. Translation service was discussed as the target level identified is low, however this was due to the service just being implemented and there was no baseline.

CARRIED

Review Q4 Patient Satisfaction Survey Results
The Q4 Patient Satisfaction Survey Results were shared.

Moved By: W. Rozon
Seconded By: H. Salib
THAT the Quality & Patient Safety Committee review and receive the Q4 Patient Satisfaction Survey results as presented.

IDEA was added to the review of patient satisfaction survey results to ensure cultural safety and gender sensitivity.

CARRIED

Review Q4 Violent Incidents Report
The violent incidents report for Q4 were shared.

Moved By: W. Rozon
Seconded By: H. Salib
THAT the Quality & Patient Safety Committee review and receive the Q4 violent incident results as presented.

There were a total of seven violent incidents in Q4. In March, the hospital received a threatening phone call as well as an aggressive social media posts which resulted in the implementation of effective preventative measures to ensure safety.

CARRIED

Review Q4 Complaints & Compliments Report
The Q4 complaints & compliments were reviewed.

Moved By: Dr. R. Cardinal
Seconded By: W. Rozon
THAT the Quality & Patient Safety Committee review and receive the Q4 Complaints & Compliments report as presented.

For Q4 there were a total of 5 compliments and 7 complaints mostly related to adequacy of service and the attitude an conduct of nursing staff and physicians. Work continues on addressing issues around attitude and conduct.

CARRIED

Review Recommendations from Quality Reviews
Examples were shared on what would come to the committee should quality reviews be done.

Moved By: H. Salib
Seconded By: W. Rozon

There was a review done in which it was identified that better communication within the team is needed. Work is being done on standardizing carts so that all carts are the same and people know where to look.

Privacy protocols are also being worked on.

Kudos were expressed to R. Romany and her teams for allowing teams to feel comfortable and safe with having quality reviews to allow for greater understanding of quality initiatives.

CARRIED

Kids Come First Regional Pediatric Surgery Update
An update was provided on the Kids Come First Regional Pediatric Surgery initiative.

Moved By: Dr. S. Robertson
Seconded By: Dr. R. Cardinal
That the Quality & Patient Safety Committee review and receive this update for information and continue to endorse HGMH's participation in the Kids Come First Health Team's efforts to regionalize pediatric surgical care.

This started with other regional hospitals providing pediatric surgeries in order to reduce wait times. We are not currently able to join this initiative as we do not have anesthetists as we do not have general surgery, however, we will continue to be involved in the dialogue and discussion as there may be opportunities in other fields such as pediatric mental health.

CARRIED

Surgical Report
This is part of the work in looking at increasing surgical services at the hospital.

Moved By: Dr. S. Robertson
Seconded By: H. Salib
That the Quality & Patient Safety Committee review and receive the Surgical Expansion Options Analysis Overview and support a phased advancement of surgical expansion opportunities, recognizing that implementation will be sequenced following the EPIC EMR go-live and stabilization period, and integrated with the future deployment of EPIC's surgical module.

Volumes around several surgical services were reviewed and the viability of general surgery is not one we want to chase down because the staff and surgeons wouldn't be doing these often which would mean the safety wouldn't be in line with what we would want to offer. Instead, we will look at what procedures can be done without anesthesia.

CARRIED

Quality & Patient Safety Framework Policy
The Quality & Patient Safety Framework policy was shared.

Moved By: Dr. R. Cardinal

Seconded By: Dr. S. Robertson
THAT the Quality & Patient Safety Committee recommend to the Board of Directors the approval and implementation of the Quality & Patient Safety Framework Policy as presented.

This is an Accreditation requirement and also identifies the definition of quality for the hospital. The appendix includes things that are already being done by the board to ensure that the quality of care is people centred.

CARRIED

HIROC Report
The latest HIROC claims submission was shared.

Moved By: W. Rozon
Seconded By: Dr. S. Robertson
THAT the Quality & Patient Safety Committee review and receive the Hospital Insurance Reciprocal of Canada historical claims submission.

These are the insurance claims that have been actioned over the past ten years. We notify HIROC when we think there could be a potential claim coming forward. There are currently two claims open.

CARRIED

Matters for Information

Report from VP Clinical Services, Quality & CNE on Quality Initiatives
Updates were provided on the work being done by the Patient & Family Advisory Committee, the work being done on Best Practice Guidelines, and the Patient Safety Plan Actions.

Patient rounding was launched and feedback received to date has been around whiteboards not being used in patient rooms and rounding not being done from staff in the evenings. Work will be done to improve on this.

Accreditation Updates
Great work is being done to gather evidence for Accreditation and update policies.

Accreditation Standard Review
The Accreditation standard was reviewed.

Ethics Committee Update
There were no ethical dilemmas in 2024, however, case studies were completed.

Emergency Preparedness Update
Emergency Preparedness updates were provided. Mock codes are done to ensure our staff are prepared should a code occur. Code of the month updates are provided to staff with scenarios and opportunities for reflection. Flipcharts are located throughout the hospital with cheat sheets on what to do in the event of a code. We are in the process of developing a business continuity plan which includes our core services and the expectations to continue operations.

Policy – Guidelines for Managing Physician Professional Behavior
Deferred – page 52 of 59, things are a little unclear and perhaps should be defined as level of behaviours.

Date of Next Meeting: September 2025

K-L. Massia, Recorder

HÔPITAL Glengarry Memorial HOSPITAL

BRIEFING NOTE FOR

☐ Board of Directors ☒ Board Committee – Quality & Patient Safety ☐ Senior Leadership Team

☐ Other *(please specify):*

Date Prepared: July 21, 2025 Meeting Date Prepared for: September 10, 2025

Subject: Quality & Patient Safety Committee Effectiveness Survey Results

Prepared by: Robert Alldred-Hughes, President & CEO

☐ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- To review the results of the Quality & Patient Safety Committee Meeting Effectiveness Survey completed at the end of the 2024-2025 Board Cycle, and determine any actions required on the part of the Committee to sustain positive results and identify opportunities for improvement in identified areas.

IMPLICATIONS TO OTHER STANDING COMMITTEES

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

- Board of Directors

SITUATION & BACKGROUND

A brief description of the background to the issue.

- The HGMH Committee Self-Assessment is one of the ways the committee can assess the degree to which its structure and processes are effective in supporting board performance.
- In the Spring of 2025, the Quality & Patient Safety Committee completed a self-assessment using the tool provided by the hospital.
- Based on the completed assessment process, the committee can develop a work plan to address areas for improvement or identified gaps.

OPTIONS CONSIDERED & ANALYSIS

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

- The committee self-assessment is structured to evaluate the following 5 domains:
    1. Terms of Reference and Composition
    2. Committee Management
    3. Committee Effectiveness
    4. Chair Effectiveness
    5. Overall Committee Performance

- The following tables provide the response data from all respondents to the survey:

Terms of Reference and Composition

	EXCELLENT (5)	VERY GOOD (4)	GOOD (3)	NEEDS IMPROVEMENT (2)	NO BASIS FOR JUDGEMENT (1)	NOT APPLICABLE (0)	TOTAL
The committee has clear and appropriate Terms of Reference.	80.00% 4	20.00% 1	0.00% 0	0.00% 0	0.00% 0	0.00% 0	5
The committee has the right number of members.	80.00% 4	20.00% 1	0.00% 0	0.00% 0	0.00% 0	0.00% 0	5
The committee has members with the skills and expertise that are needed by the committee.	60.00% 3	40.00% 2	0.00% 0	0.00% 0	0.00% 0	0.00% 0	5

RESPONSES

There are no responses.

Committee Management

	EXCELLENT (5)	VERY GOOD (4)	GOOD (3)	NEEDS IMPROVEMENT (2)	NO BASIS FOR JUDGEMENT (1)	NOT APPLICABLE (0)	TOTAL
The committee meets at the appropriate time of day.	40.00% 2	40.00% 2	20.00% 1	0.00% 0	0.00% 0	0.00% 0	5
I received orientation to the committee that was helpful to me as a member of the committee.	20.00% 1	60.00% 3	0.00% 0	0.00% 0	0.00% 0	20.00% 1	5
The committee is receiving the support from hospital management that it requires.	80.00% 4	20.00% 1	0.00% 0	0.00% 0	0.00% 0	0.00% 0	5
Information is received sufficiently in advance of the meeting.	80.00% 4	20.00% 1	0.00% 0	0.00% 0	0.00% 0	0.00% 0	5
The committee meets the right number of times over the year.	0.00% 0	40.00% 2	20.00% 1	40.00% 2	0.00% 0	0.00% 0	5

RESPONSES

The number of meetings is increasing which will allow time to cover all material so the meeting won't feel rushed.

The number of committee meetings with be increased to 6x/year in the next cycle which is needed.

Going to six meetings will make a huge difference

HÔPITAL Glengarry Memorial HOSPITAL

Committee Effectiveness

	EXCELLENT (5)	VERY GOOD (4)	GOOD (3)	NEEDS IMPROVEMENT (2)	NO BASIS FOR JUDGEMENT (1)	NOT APPLICABLE (0)	TOTAL
The committee is working effectively.	60.00% 3	40.00% 2	0.00% 0	0.00% 0	0.00% 0	0.00% 0	5
The committee performed its annual workplan.	40.00% 2	60.00% 3	0.00% 0	0.00% 0	0.00% 0	0.00% 0	5
The committee is eeffectively performing in the following areas:	50.00% 2	50.00% 2	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
- by developing components and indicators for its quality, patient safety, and risk management programs and monitoring the outcomes.	60.00% 3	40.00% 2	0.00% 0	0.00% 0	0.00% 0	0.00% 0	5
- by making recommendations to attempt to eliminate gaps idenfied for overall improvement.	40.00% 2	60.00% 3	0.00% 0	0.00% 0	0.00% 0	0.00% 0	5

RESPONSES

There are no responses.

Chair Effectiveness

	EXCELLENT (5)	VERY GOOD (4)	GOOD (3)	NEEDS IMPROVEMENT (2)	NO BASIS FOR JUDGEMENT (1)	NOT APPLICABLE (0)	TOTAL
The Chair is prepared for committee meetings.	60.00% 3	40.00% 2	0.00% 0	0.00% 0	0.00% 0	0.00% 0	5
The Chair keeps the meetings on track.	60.00% 3	40.00% 2	0.00% 0	0.00% 0	0.00% 0	0.00% 0	5
The Chair fairly reports the committee's work to the Board.	75.00% 3	25.00% 1	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
The Chair encourages participation and manages discussion.	60.00% 3	20.00% 1	20.00% 1	0.00% 0	0.00% 0	0.00% 0	5

RESPONSES

There really isn't a framework that has the Chair reporting back to the Board. Items voted at Committee are presented at the Board (usually by the cEO or CNE) but there is no presentation by Chair of this (or any Chair) of the Committee's workings, deliberations, etc., other than those items.

Overall Committee Performance

	EXCELLENT (5)	VERY GOOD (4)	GOOD (3)	NEEDS IMPROVEMENT (2)	NO BASIS FOR JUDGEMENT (1)	NOT APPLICABLE (0)	TOTAL
Overall, I am satisfied with my contribution to the committee.	20.00% 1	60.00% 3	20.00% 1	0.00% 0	0.00% 0	0.00% 0	5
Overall, I am satisfied with the committee's contribution to the Board.	60.00% 3	40.00% 2	0.00% 0	0.00% 0	0.00% 0	0.00% 0	5

RESPONSES

There are no responses.

Overview:

- Based on the results of the survey, the committee is satisfied with the current performance level, both from an individual and committee perspective, however there is room for improvement in which adding two committee meetings per year should help.

Actions for Consideration:

- Time will be provided at the Board meeting to ensure that committee Chair's can provide a report from the committee.

Questions for consideration:

- Based on the results of the survey, are there areas the Committee would like to explore alternate ways of accomplishing its work?
- Are there other areas the Committee would like to develop actions to support the Committees effectiveness?

IMPLEMENTATION & COMMUNICATION PLAN

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

- Results and associated actions to be shared with HGMH Board in October 2025, following review from the Governance Committee, along with all other committee results.

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Quality and Patient Safety ☐ Senior Leadership Team

☐ Other *(please specify):*

Date Prepared: August 13, 2025 Meeting Date Prepared for: September 10, 2025

Subject: 2025-2026 Quality and Patient Safety Committee Work Plan

Prepared by: Robert Alldred-Hughes, President & CEO

☒ DECISION SOUGHT* ☐ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- The purpose of this briefing note is to provide an overview of the 2024-2025 Quality and Patient Safety Committee Work Plan.

RECOMMENDATION / MOTION

That the Quality & Patient Safety Committee review and approve the Annual Committee Work Plan as presented.

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? ☐ *No* ☒ *Yes, please specify:*
Board of Directors

SITUATION & BACKGROUND

A brief description of the background to the issue.

- Feedback from previous committee assessment surveys highlighted the need for a more structured approach with the functioning of committee meetings. Respondents indicated a desire for increased clarity, accountability, and alignment of the committee's work with the organization's strategic objectives.
- In response to this feedback, the hospital developed and implemented annual work plans for all Board Committees. This plan outlines key activities, timelines, and responsibilities, ensuring that all critical governance and nominating tasks are addressed throughout the year.
- The annual work plan has become an essential tool for Board Committees and is reviewed annually.

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- 2025-2026 Quality and Patient Safety Committee Annual Work Plan

Quality & Patient Safety Committee
Work Plan 2025-2026

Deliverable	MRP	Occurrence	Sep	Nov	Jan	Feb	Apr	May
STRUCTURE/PROCESSES								
Review/Recommend Committee Terms of Reference	Chair	Annually	X					
Review Committee Effectiveness Survey Results	Chair	Annually	X					
Review/Recommend Annual Committee Work Plan to Governance	Chair	Annually						X
MEDICAL AFFAIRS								
Professional Staff Appointment and Re-appointment Process Review	COS	Annually		X				
Review Professional Staff HR Plan	COS	Annually		X				X
Appoint professional staff on recommendation of medical advisory committee	COS	Annually			X			
Review Student/Resident Placement Report	COS	Annually				X		
Hospital Services	COS	Annually/ As Occurs					X	
EDUCATION								
Patient Story	CNE		X		X		X	
Quality Initiatives	CNE			X		X		X
QUALITY OVERSIGNT AND IMPROVEMENT								
Review QIP Dashboard	CNE	Quarterly	Q1	Q2		Q3		Q4
Recommend QIP Dashboard 2026-2027	CNE	Yearly				X		
Quality & Safety Scorecard	CNE	Quarterly	Q1	Q2		Q3		Q4
Review Patient Satisfaction Survey Results	CNE	Quarterly	Q1	Q2		Q3		Q4
Violent Incidents Report	CNE	Yearly/ As Occurs					X	
Review Life or Limb Results	CNE	When available						
Review Complaints & Compliments Report	CNE	Quarterly			X		X	
PFAC Updates	CNE	Quarterly	X		X		X	
Review Critical Events and Never Events Report	CNE	Yearly			X			
BPSO Update	CNE	Quarterly	X	X		X		X
Review Patient Safety Plan	CNE	Yearly				X		
Review Status of Patient Safety Plan Actions	CNE	Bi-Annual		X			X	
Review Provincial Stroke Report Card	CNE	When available						
Review Ethics Committee Updates	CNE	Yearly					X	
Review HIROC Report	CEO	Yearly						X
Review Emergency Preparedness	CNE	Yearly					X	
Review Business Continuity Plan		Yearly		X				
Privacy & Confidentiality Overview		Yearly	X					
ACCREDITATION								
Accreditation Updates	CEO	Quarterly	X		X		X	
Accreditation Standard Review	CNE	Quarterly	X	X	X	X	X	X
ESTIMATED PREPARATION TIME FOR MEETING:			1.5H	1.5H	1.5H	1.5H	1.5H	1.5H

Revisions since prior report:

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Quality and Patient Safety ☐ Senior Leadership Team

☐ Other *(please specify):*

Date Prepared: August 13, 2025 Meeting Date Prepared for: September 10, 2025

Subject: Annual Review Committee Terms of Reference

Prepared by: Robert Alldred-Hughes, President & CEO

☒ DECISION SOUGHT* ☐ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- All committee Terms of Reference are to be reviewed on an annual basis.

RECOMMENDATION / MOTION

That the Quality and Patient Safety Committee recommend to the Governance and Nominating Committee the Quality and Patient Safety Terms of Reference 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.

- Terms of Reference are reviewed annually by all Board Committees to ensure they remain relevant and effective in guiding the committee's activities and responsibilities.
- To improve alignment of responsibilities, the responsibility for physician human resources planning in connection with the Medical Advisory Committee will be added to this committee. This duty was previously assigned to the Finance, HR and Audit Committee; however this better reflects the Quality & Patient Safety Committees oversight of medical and clinical matters.
- The meeting frequency was changed to six (6) meetings per board cycle.

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Quality and Patient Safety Committee Terms of Reference

TERMS OF REFERENCE QUALITY AND PATIENT SAFETY COMMITTEE OF THE BOARD

ROLE:	• The Quality and Patient Safety Committee operates under the authority of the Board and is the Quality Committee for the purposes of the Excellent Care for All Act, 2010 (the "Act"). The Quality and Patient Safety Committees role is to: • Assisting the Board in the performance of the Board's governance role for the quality of patient care and services; and • Performing the functions of the Quality Committee under the Act.

RESPONSIBILITIES:	The Quality Committee, in accordance with the responsibilities in the Act, shall:
	
	Quality Oversight and Quality Improvement
	1. Monitor and report to the Board on quality issues and on the overall quality of services provided in the hospital, with reference to appropriate data including:
	  • Performance indicators used to measure quality of care and services and patient safety;
	  • Reports received from the Medical Advisory Committee identifying and making recommendations regarding systemic or recurring quality of care issues;
	  • Publicly reported patient safety indicators;
	  • Critical incident and sentinel event reports;
	  • Patient Satisfaction Survey Results;
	  • Complaints, source of complaints, and interventions;
	  • Quality Indicator Dashboard.
	2. Consider and make recommendations to the board regarding quality improvement initiatives and policies;
	3. Ensure that best practices information supported by available scientific evidence is translated into materials that are distributed to employees, members of the professional staff and persons who provide services within the hospital, and subsequently monitor the use of these materials by such persons;
	4. Oversee preparation of the hospital's annual quality improvement plan; and
	5. Perform such other responsibilities as may be provided under regulations under the Act.
	
	Critical Incidents and Sentinel Events
	"Critical incident" means any unintended event that occurs when a patient receives treatment in the hospital:
	  a. That results in death, or serious disability, injury or harm to the patient; and
	  b. Does not result primarily from the patient's underlying medical condition or known risk inherent in providing treatment.
	
	In accordance with Regulation 965 under the Public Hospitals Act, receive from the Chief Executive Officer, at least twice a year, aggregate critical incident data related to critical incidents occurring at the hospital since the

previous aggregate data was provided to the quality committee.
Annually review and report to the board on the hospital's system for ensuring that, at an appropriate time following disclosure of a critical incident, there be disclosure as required by Regulation 965 under the Public Hospitals Act of systemic steps, if any, the hospital is taking or has taken to avoid or reduce the risk of further similar critical incidents.

The quality committee shall review reports of sentinel events and oversee any plans developed to address, prevent or remediate such events.

Compliance

- Monitor the hospital's compliance with legal requirements and applicable policies of funding and regulatory authorities related to quality of patient care and services.

Financial Matters

- As and when requested by the board, provide advice to the board on the implications of budget proposals on the quality of care and services.

Hospital Services Accountability Agreement and Hospital Annual Planning Submission (HAPS)

- As and when requested by the board, provide advice to the board on the quality and safety implications of the hospital annual planning submission and quality indicators proposed to be included in the hospital's service accountability agreement or in any other funding agreement.

Risk Management

Review and make recommendations with respect to:

- The hospital's standards on emergency preparedness;
- Policies for risk management related to quality of patient care and safety; and
- Areas of unusual risk and the hospital's plans to protect against, prepare for, and/or prevent such risks and services.

Accreditation

- Oversee the hospital's plan to prepare for accreditation.
- Review accreditation reports and any plans that need to be implemented to improve performance and correct deficiencies.

Professional Staff Process

- Annually review with the chief of staff/chair of the medical advisory committee the appointment and re-appointment processes for the professional staff, including:
    - Criteria for appointment;
    - Application and re-application forms;
    - Application and re-application processes; and
    - Processes for periodic reviews.
- Ensure coordination and alignment with the Corporation's

TERMS OF REFERENCE QUALITY AND PATIENT SAFETY COMMITTEE OF THE BOARD

	medical advisory committee for physician human resource planning. ***Policy Implementation*** • Oversee implementation of policies, processes and programs to ensure quality objectives are met and maintained. ***Other*** • Perform such other duties as may be assigned by the board from time to time.
CHAIR:	• A member of the Committee appointed by the Board on the recommendation of the Board Chair or a committee established by the Board for that purpose. • Term of office will be for a minimum of two (2) years.
MEMBERSHIP:	• The Chief of Staff • The Chief Executive Officer • The Chief Nursing Executive • One (1) health professional other than a nurse or doctor • Five (5) voting board members (minimum one bilingual Director in English and French), and • Such other persons as appointed by the hospital's board.
VACANCY:	• When a vacancy occurs among the appointed members, the Chair of the board may appoint a member to fill the vacancy for the unexpired portion of the term.
VOTING MEMBERS:	• Only Board Directors appointed to this committee may vote.
FREQUENCY OF MEETINGS AND MANNER OF CALL	• At least six (6) times annually, at the call of the committee chair.~~At minimum, quarterly.~~
QUORUM:	• 51% of voting members.
RESOURCES:	• VP of Clinical Services, Quality & Chief Nursing Executive
REPORTS TO	• Board of Directors
DATE OF LAST REVIEW	• ~~November 2024~~September 2025

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Quality & Patient Safety ☐ Senior Leadership Team

☐ Other *(please specify):*

Date Prepared: September 2, 2025 Meeting Date Prepared for: September 10, 2025

Subject: Q1- Quality Improvement Plan (QIP) results

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

☐ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- To review the results of the Quality Improvement Plan for Q2
- 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.

- 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 2025/26 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- 90th percentile ED wait time to physician initial assessment
    - Equity-Equitable - % of Full-time and Part-time staff who have completed relevant inclusion, diversity, equity and anti-racism (IDEA) education.
    - Experience- Patient-centered- % respondents who respond positively to the following question: Were you involved as much as you wanted to be in decisions about you or your family member's care and treatment?
    - Safety- Safe- Rate of workplace physical violence incidents resulting in lost time injury
    - Safety- Safe- Number of medication errors that reached the patient due to wrong drug/dose/ patient (incident severity levels 2-5)

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	DIMENSION	METRIC		YEAR END FISCAL 2024	TARGET PERFORMANCE	Apr-25	May-25	Jun-25	Q1
Access & Flow	Timely	Percent of patients who visited the ED and left without being seen by a physician	P4R	8.0%	7.7%	5.9%	5.6%	6.6%	6.1%

- Q1 ended with 6.1%, which is below the target of 7.69%.
- Strategy : ongoing ED initiative that was implemented July 2024 to have additional physician coverage (4 hours, MWF) during peak hours. 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 physician initial assessment

THEME	DIMENSION	METRIC		YEAR END FISCAL 2024	TARGET PERFORMANCE	Apr-25	May-25	Jun-25	Q1
Access & Flow	Timely	90th percentile emergency department wait time to physician initial assessment	P4R	4.8	4.6	4.5	4.6	4.1	4.6

- Q1 ended with 4.6 hours which meets the target of 4.6 hours.
- Strategy : ongoing work with ED patient flow including triage-to-physician efficiency. This demonstrates the strong collaboration between ED staff and physicians.

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

THEME	DIMENSION	METRIC		YEAR END FISCAL 2024	TARGET PERFORMANCE	Apr-25	May-25	Jun-25	Q1
Equity	Equitable	Percentage of Full-time and Part-time staff who have completed relevant inclusion, diversity, equity and accesibility (IDEA) education.	IDEA	n/a	25.0%	1.6%	0.0%	0.0%	1.6%

- Q1 ended with a completion rate of 1.6% that reflect the early stage of rollout as IDEA education modules were recently distributed to staff. Engagement is expected to increase as awareness and accessibility improve.
- Strategy : IDEA committee's initiative for this fiscal year is to embed IDEA principles among frontline staff to cultivate a workplace culture rooted in inclusivity, equity, and anti-racism.

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	DIMENSION	METRIC		YEAR END FISCAL 2024	TARGET PERFORMANCE	Apr-25	May-25	Jun-25	Q1
Experience	Patient-Centred	Percent of respondents answering yes to the question "were you involved as much as you wanted to be in decisions about you or your family member's care and treatment?"	nQuire	87.0%	89.0%	98.4%	96.2%	96.5%	96.9%

- Q1 ended with 96.9%, which is positively above the target of 89%.
- Strategy: Ongoing focus on clear, consistent discharge communication, patient and family engagement with care planning to help ensure safe transitions of care.

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

THEME	DIMENSION	METRIC		YEAR END FISCAL 2024	TARGET PERFORMANCE	Apr-25	May-25	Jun-25	Q1
Safety	Safe	Rate of workplace physical violence incidents resulting in lost time injury	RIMS	0	0	0	0	0	0

- Q1 ended with no physical violence incidents resulting in lost time injury.
- Strategy : Maintain a focus on proactive strategies to prevent and minimize violent incidents and sustain a culture of safety.

Safety- Safe- Number of medication errors that reached the patient due to wrong drug/dose/patient (incident severity levels 2-5)

THEME	DIMENSION	METRIC		YEAR END FISCAL 2024	TARGET PERFORMANCE	Apr-25	May-25	Jun-25	Q1
Safety	Safe	Number of medication errors that reached the patient due to wrong drug/dose/patient (incident severity levels 2-5)		10	8	2	0	1	3

- Q1 ended at 3, which is below the target of 8 reported incidents.
- Strategy: Strengthen medication safety through consistent double-checks, barcode scanning, targeted staff training, and regular incident reviews.

Summary

- The Quality Improvement Plan 2025-26 highlights our success in achieving most Q1 targets and our commitment to continuous improvement by addressing areas needing further development.

Quality Improvement Plan (QIP)
Fiscal 2025/26

THEME	DIMENSION	METRIC		YEAR END FISCAL 2024	TARGET PERFORMANCE	Apr-25	May-25	Jun-25	Q1
Access & Flow	Timely	Percent of patients who visited the ED and left without being seen by a physician	P4R	8.0%	7.7%	5.9%	5.6%	6.6%	6.1%
Access & Flow	Timely	90th percentile emergency department wait time to physician initial assessment	P4R	4.8	4.6	4.5	4.6	4.1	4.6
Equity	Equitable	Percentage of Full-time and Part-time staff who have completed relevant inclusion, diversity, equity and accesibility (IDEA) education.	IDEA	n/a	25.0%	1.6%	0.0%	0.0%	1.6%
Experience	Patient-Centred	Percent of respondents answering yes to the question "were you involved as much as you wanted to be in decisions about you or your family member's care and treatment?"	nQuire	87.0%	89.0%	98.4%	96.2%	96.5%	96.9%
Safety	Safe	Rate of workplace physical violence incidents resulting in lost time injury	RIMS	0	0	0	0	0	0
Safety	Safe	Number of medication errors that reached the patient due to wrong drug/dose/patient (incident severity levels 2-5)		10	8	2	0	1	3

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 – Quality & Patient Safety ☐ Senior Leadership Team

☐ Other *(please specify):*

Date Prepared: September 2, 2025 Meeting Date Prepared for: September 10, 2025

Subject: Quality and Safety Scorecard Q1 Results

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

☐ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- To review the Q1results of the Quality and Safety Scorecard 2025-26
- 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.

- The 2025/26 dashboard indicators are based on quality themes such as:
  - Timely and Efficient Transitions
    - 90th percentile ED wait time to physician initial assessment (PIA)
  - Service Excellence
    - Patients respond positively to the following question: Were you involved as much as you wanted to be in decisions about you or your family member's care and treatment?
  - Safety and Effective Care
    - Fall Rate, Falls with injury
    - Incidents of Physical Violence
    - Medication errors that reached the patient (incident severity levels 2-5)
    - Pressure Injury Development during inpatient stay
    - Hand Hygiene Compliance Rate for Moments 1 and 4
    - Hospital acquired infections (HAI) rates- C.Difficile, VRE, MRSA
  - Equity
    - Translation services usage- Language Line services

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.

- Areas of opportunities:
  - Fall Rate- Q1 rate is 19.5which is above the target of 12
    - **Strategy**: ongoing focus on staff education for falls reduction strategies, e.g. purposeful rounding, call bell placement, and bed alarms; ongoing review of high-risk patients and prevention plans.
  - Hand Hygiene Compliance rate for Moment 1- 81.9% which is 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. Increased the number of auditors, frequency of audits to monitor and reinforce these practices.
  - HAI rates- MRSA -2.34% which are above the target of 0%.
    - **Strategy:** Increasing hand hygiene compliance and provide Personal Protective Equipment (PPE) refresher education; ongoing collaboration between IPAC, nursing staff, housekeeping, Materials

management, and Eastern Ontario Health Unit to proactively address and manage inpatient outbreak concerns.

SUMMARY

Monitoring quality indicators is key to ensuring safe, high-quality care. Regular review of these measures allows us to identify gaps and take timely, effective action to improve outcomes.

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Board Scorecard

Fiscal 2025/26

Print

THEME	METRIC	MEASUREMENT	YEAR END FISCAL 2024	TARGET PERFORMANCE	Q1	Q2	Q3	Q4	YTD	AIM	Visualization
1.Timely & Efficient Transitions											
	90th percentile emergency department wait time to physician initial assessment (PIA)	hours	4.8	4.6	4.6				4.6	Below	
2. Service Excellence											
	Percent of respondents answering yes to the question "were you involved as much as you wanted to be in decisions about you or your family member's care and treatment?"	% of those who answered Positively/total surveys	87.0%	89.0%	96.9%				96.4%	Above	
3. Safe & Effective Care											
	Fall Rate	# of incidents per 1000 patient days	14.2	12	19.5				16.9	Below	
	Falls with Injury (any fall requiring intervention or treatment)	# of falls with injury/ # of falls *100	34.30	30.00	32.00				28.81	Below	
				numerator	16	0	0	0	17		
				denominator	50	0	0	0	59		
	Incidents of Physical Violence	Actual number	17 (total)	17	15				16	Below	
	Number of medication errors that reached the patient due to wrong drug/dose/patient (incident severity levels 2-5)	Actual number	10	8	3				3	Below	
	Pressure injury development rate (stage 2,3,4) during inpatient stays	Actual number	3	0	3				3	Below	
	Hand hygiene compliance rate (Moment 1)	# compliant activities / # of indicated	75.6%	92.0%	81.9%				81.7%	Above	
	Hand hygiene compliance rate (Moment 4)	# compliant activities / # of indicated	93.3%	92.0%	93.4%				93.0%	Above	
	C. difficile rate	# of incidents per 1000 patient days	0.52	0.00	0.00				0.57	Below	
	VRE Rate	# of incidents per 1000 patient days	0.00	0.00	0.00				0.00	Below	
	MRSA Rate	# of incidents per 1000 patient days	0.62	0.00	2.34				4.01	Below	
4. Equity											
	Translation Services Usage	Number of minutes		50	49				88	Above	

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 – Quality & Patient Safety ☐ Senior Leadership Team

☐ Other *(please specify):*

Date Prepared: September 2, 2025 Meeting Date Prepared for: September 10, 2025

Subject: Patient Satisfaction Surveys Q1

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

☐ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- Highlight top satisfaction indicators and identify areas for improvement to guide targeted service enhancements.
- In alignment with Accreditation standards, our team has enhanced the patient satisfaction survey to include ratings for gender diverse care, sexual orientation-related care, racialized care, and First Nations care, reflecting a deeper commitment to equity and inclusion.
- These updates enable us to better understand and respond to the expressed needs and diverse experiences of our clients, guiding more responsive, culturally safe, and community-informed service design.

IMPLICATIONS TO OTHER STANDING COMMITTEES

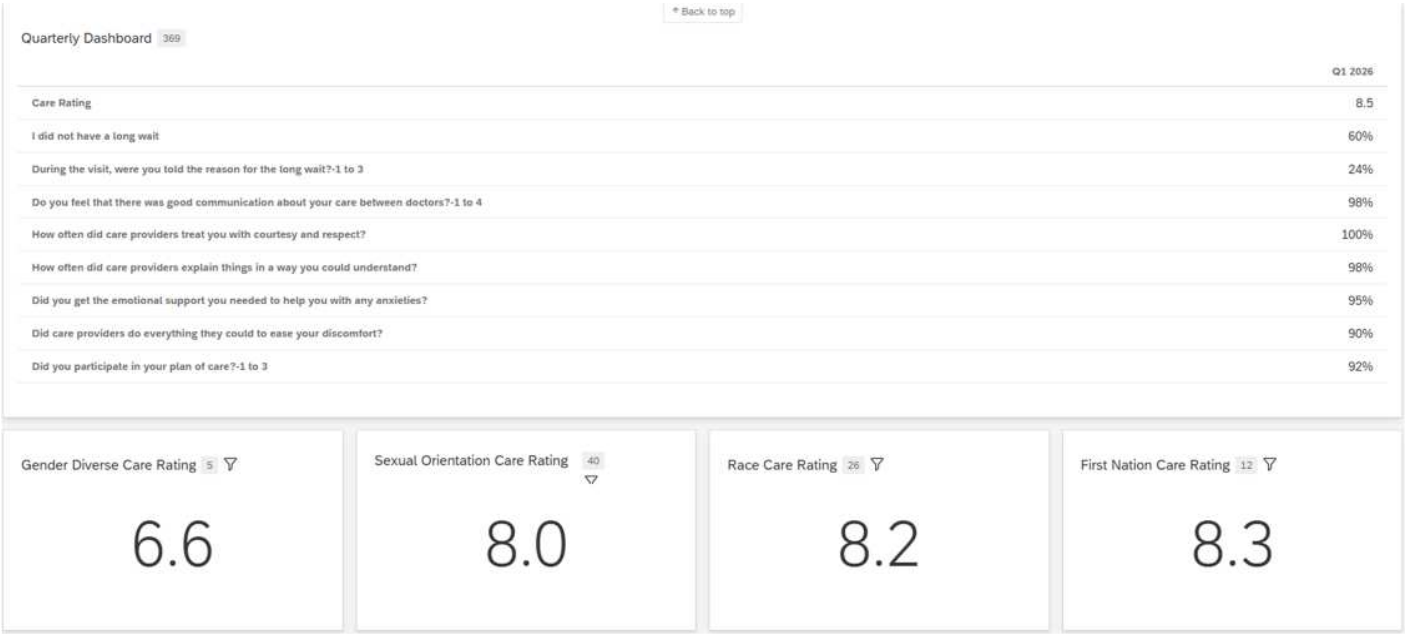
Are there any material or significant implications for other Standing Committees? ☐ *No* ☒ *Yes, please specify:*

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

ANALYSIS

EMERGENCY DEPARTMENT- *369 respondents*

- Note: Q1 2026 column is the YTD average result for the indicator.



Explanation of indicators and desired target (AIM):

THEME	AIM	Type of indication	Notes
Care Rating	Above	Patient Centered- Care	Average of the ratings given of the overall patient's
I did not have a long wait	Above	Access and Flow	Indicates if the patient had a long wait- the greater the percentage indicates a subjective feeling that patient did not wait long
During the visit, were you told the reason for the long wait?	Above	Access and Flow	Indication that if the patient had a long wait, there was a communication as to why there is a long wait
Do you feel there was good communication about your care between	Above	Patient Safety	Patient safety indication where the patient felt that the providers are **working together** to provide care
How often did care providers treat you with	Above	Patient Centered- Care	Indication on how the patient was treated while in
How often did care providers explain things in a way you could understand?	Above	Patient Centered- Care	Indicates if there was communication on the diagnosis and treatment of the patient in a way that the patient could understand (e.g. not using
Did you get the emotional support you needed to help you with any anxieties?	Above	Patient Centered- Care	Indication that the hospital is going the "extra mile" to make the patient feel comfortable
Did care providers do everything they could to ease your discomfort?	Above	Patient Centered- Care	Indication that the hospital is going the "extra mile" to make the patient feel comfortable
Did you participate in your plan of care?	Above	Patient Centered- Care	Indicator that signifies that there was the patient's active involvement during the encounter.

Top Satisfaction Indicators:

- Care rating out of scale of 10 = 8.5
- Communication about patient care between doctors = 98%
- Explanation of things that patients can understand = 98%
- Treated patients with courtesy and respect = 100%
- Patient participated in their plan of care = 92%

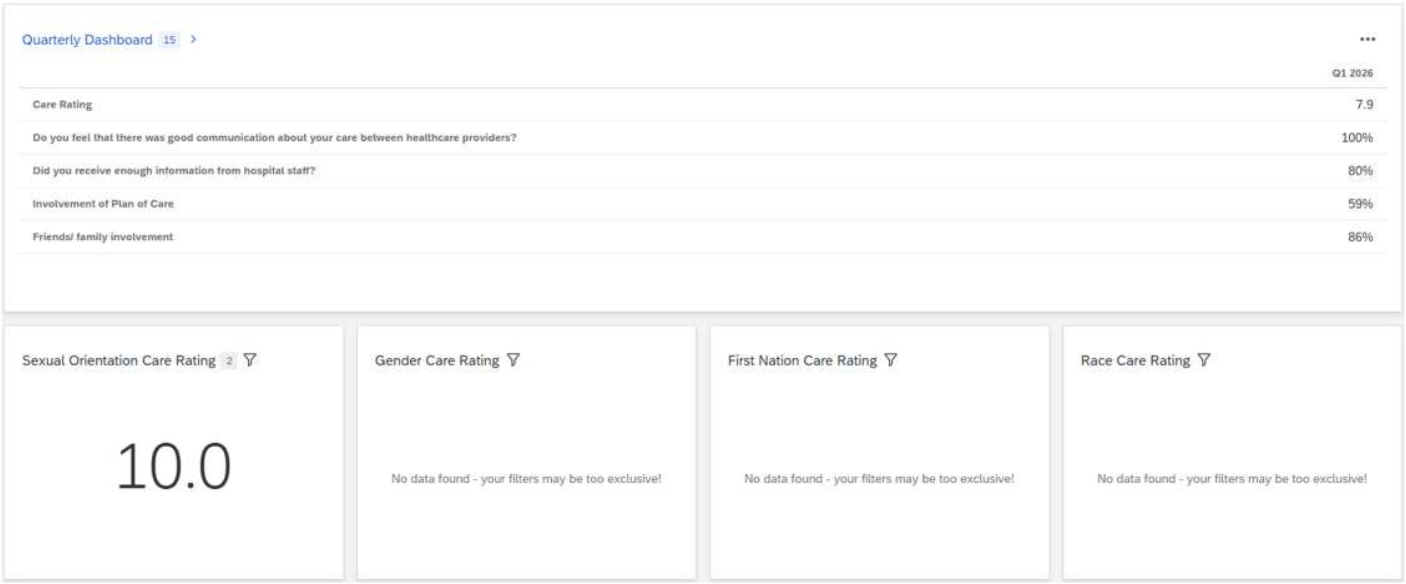
Improvement Opportunities

- The overall patient care experience remains positive, with a rating of 8.5, indicating high satisfaction among the general patient population.
- Care for gender-diverse patients received a notably lower score of 6.6, indicating significant concerns around inclusivity, cultural safety, and respectful treatment.
- First Nations patient care is rated at 8.3 slightly below the overall average, yet considerably higher than the gender-diverse care rating demonstrating progress, while underscoring the need for continued attention and improvement.

Strategy:

- Disparities in care suggest systemic issues in how equitable and culturally safe the ED environment feels for marginalized groups.
- Cultural Safety and Gender Sensitivity training-These results point to a need for staff training in gender diversity and Indigenous cultural safety, along with community consultation to better address unmet needs.
    - Cultural safety- staff to understand the impacts of history, practice trauma-informed care, communicate in respectful and culturally appropriate ways (e.g. open-ended questions, being comfortable with silence which can be a sign of respect or thoughtful listening in many First Nations cultures).
    - Gender sensitivity awareness- pronoun use, respectful interaction and reducing bias.

INPATIENT REHAB UNIT- *15 respondents*



Explanation of indicators and desired target (AIM):

THEME	AIM	Type of indication	Notes
Care Rating	Above	Patient Centered- Care	Average of the ratings given of the overall
Do you feel that there was good communication about your care	Above	Patient Safety	Patient safety indication where the patient felt that the providers are **working together** to
Did you receive enough information	Above	Patient Centered- Care	Indication that the patient had instructions
Involvement of Plan of Care	Above	Patient Centered- Care	Indicator that signifies that there was the patient's active involvement during the
Friends/ family involvement	Above	Patient Centered- Care	Indicator that signifies that there was an active family/friend involvement in the rehabilitation

Top Indicators

- Care rating out of scale of 10 = 7.9
- Communication about patient care between healthcare providers = 100%
- Received enough information from hospital staff = 80%
- Friends/family involvement in the patient's rehabilitation journey = 86%

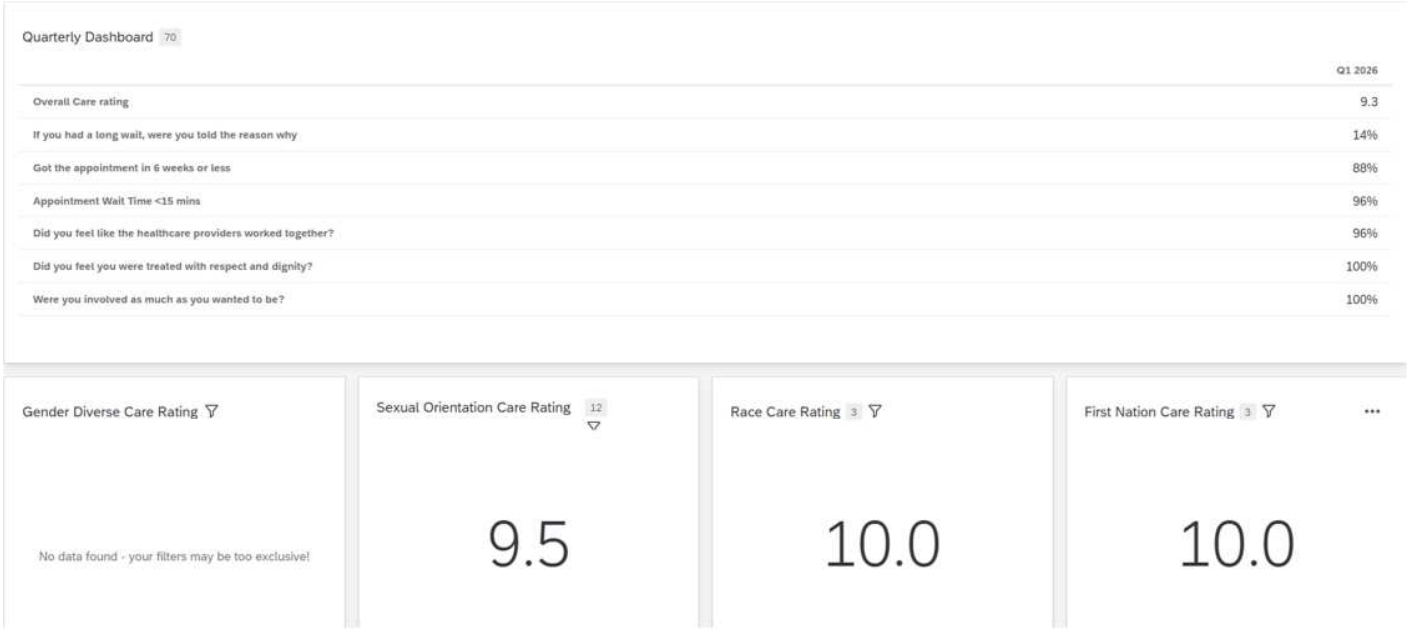
Improvement Opportunity

- Patient's active involvement during the rehabilitation journey = 59%

Strategies

- **Patient support-** continue to provide the necessary support and understanding for patients who may have limited ability to actively engage, e.g. offer information in a variety of formats- verbal, written, visual.
- **Equitable, gender-sensitive care**- implementation of gender sensitivity and inclusivity training including topics such as respectful language, pronoun use and unconscious bias.

OUTPATIENT DEPARTMENT- *70 respondents*



Explanation of indicators and desired target (AIM):

THEME	AIM	Type of indication	Notes
Care Rating	Above	Patient Centered- Care	Average of the ratings given of the overall
If you had a long wait, were you told the reason why?	Above	Access and Flow	Indication that if the patient had a long wait, there was a communication as to why there is a long wait time.
Got the appointment in 6 weeks of less	Above	Access and Flow	Indication if the patient got an appointment within 6 weeks from referral
Appointment wait time <15 minutes	Above	Access and Flow	Indication if the patient waited for less than 15 minutes when they checked-in for the
Did you feel like the healthcare providers worked together?	Above	Safety	Patient safety indication where the patient felt that the providers are **working together** to
Did you feel you were treated with	Above	Patient Centered- Care	Indication that the patient was treated well
Were you involved as much as you wanted to be?	Above	Patient Centered- Care	Indicator that signifies that there was the patient's active involvement during the

Top Indicators

- Care rating out of scale of 10 = 9.3
- Sexual orientation care 9.5
- Patient appointment's wait time is less than 15 minutes = 96 %
- Patients got the appointment in 6 weeks or less = 88%
- Patients felt the healthcare providers worked together = 96%
- Patients were treated with respect and dignity = 100%
- Patients felt they were involved in their care as much as they wanted to be = 100%

Improvement Opportunities

- Patients were told the reason for the long wait = 14%

Strategies

- Communication- ongoing staff reminders to proactively inform patients about delays and provide updates on expected wait times during appointments.

Summary

- Q1 survey results show generally positive care experiences, but highlight lower satisfaction among gender-diverse patients, underscoring gaps in inclusivity and cultural safety. These findings reinforce the relevance of the current quality improvement focus on relevant IDEA education for full-time and part-time staff.
- Future efforts will prioritize inclusive, affirming, and culturally safe care for gender-diverse individuals, racialized communities, and First Nations patients, reflecting the organization's commitment to advancing equity and responsiveness across all patient groups.

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Quality & Patient Safety ☐ Senior Leadership Team

☐ Other *(please specify):*

Date Prepared: September 2, 2025 Meeting Date Prepared for: September 10, 2025

Subject: Patient & Family Advisory Committee (PFAC) update

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

☐ DECISION SOUGHT* ☐ FOR DISCUSSION/INPUT ☒ FOR INFORMATION ONLY

PURPOSE

- To provide an update of the PFAC Aug 27, 2025 meeting.

SITUATION & BACKGROUND

A brief description of the background to the issue.

- Family Room Updates:
  - PFAC is actively involved in the design of the dedicated Family Room space in collaboration with the IDEA Committee.
- Patient and Family Handbook Revisions:
  - PFAC are engaged in the current review to the Patient and Family Handbook, providing feedback through a patient and family-centered lens.
- Senior Leader and PFAC Patient Rounding Updates:
  - Patient rounding began on April 28 and continued through August 6.
  - Senior Leadership Team (SLT) has interviewed approximately 30 patients during this period.
  - PFAC participation in rounding has been planned but delayed due to department outbreaks.
- Canadian Patient Safety Week (October 27-31, 2025):
  - PFAC is planning its recognition and participation in Canadian Patient Safety Week.
  - The theme for 2025 is "All Voices for Safer Care."
- Accreditation engagement
  - Accreditation Canada standards ask health organizations to engage patients and families in deciding what skills and experience are needed on care teams.
  - Currently, PFAC is gathering valuable feedback through a set of reflective discussion questions aimed at understanding care experiences, identifying skills and gaps, and improving communication and teamwork. These questions encourage patients and families to share their perspectives on:
    - Whether staff fully understood their needs or made a positive impact
    - Any gaps in support related to health conditions, cultural or language needs
    - Effectiveness of communication within the care team and with patients
  - Feedback collected will be reviewed and discussed at the upcoming PFAC meeting on October to guide ongoing improvements.

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DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Quality & Patient Safety ☐ Senior Leadership Team

☐ Other *(please specify):*

Date Prepared: September 2, 2025 Meeting Date Prepared for: September 10, 2025

Subject: RNAO- Best Practice Spotlight Organization (BPSO) Update

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

☐ DECISION SOUGHT* ☐ FOR DISCUSSION/INPUT ☒ FOR INFORMATION ONLY

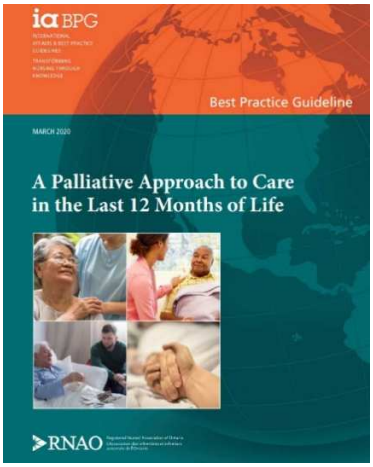
PURPOSE

- Provide an update on the Registered Nurses' Association of Ontario (RNAO) Best Practice Guideline (BPG) for 2025-2026.

SITUATION & BACKGROUND

A brief description of the background to the issue.

- HGMH's focus for 2025-26 is on the following RNAO's Evidence- based Best Practice Guideline (BPG):
  - A Palliative Approach to Care in the Last 12 Months of Life
    - The guideline offers evidence-based recommendations to nurses and interprofessional teams for supporting adults in the last 12 months of progressive life-limiting illness, focusing on delivering psychosocial, spiritual, and culturally safe care, improving care coordination, and fostering supportive work environments.
    - It addresses psychosocial and spiritual care domains, interprofessional care planning, and strategies to support healthcare providers.
- The team will conduct a gap analysis for this Best Practice Guideline (BPG), comparing current practices against evidence-based recommendations.
  - The review will identify key recommendations that support patient and staff safety, highlight quick wins to boost staff confidence, and outline partially implemented practices that can be further developed by the team.



BPSO Deliverables

- Ongoing collaboration with RNAO BPSO coaches
- Implementation of action items such as:
  - Review of order sets, electronic documentation worklists, assessment tools
  - Staff and physician training
  - Reporting requirements to RNAO

Summary

- HGMH, as a proud Best Practice Spotlight Organization (BPSO), is dedicated to embedding evidence-based practices into everyday care by strengthening patient safety, supporting staff confidence, and ensuring exceptional care for our patients and community.

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Quality & Patient Safety ☐ Senior Leadership Team

☐ Other *(please specify):*

Date Prepared: August 21, 2025 Meeting Date Prepared for: September 10, 2025

Subject: Accrediation Update

Prepared by: Robert Alldred-Hughes, President & CEO

☐ DECISION SOUGHT* ☐ FOR DISCUSSION/INPUT ☒ FOR INFORMATION ONLY

PURPOSE

To provide an update on preparations for HGMH's upcoming Accreditation Survey, scheduled for February 9–12, 2026, including progress to date.

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.

- Almost all Ontario Hospitals undergo an extensive accreditation process on a voluntary basis through Accreditation Canada who is a not-for-profit, independent organization accredited by the International Society for Quality in Health Care.
- They provide rigorous, evidence based, third-party evaluations, spanning a full spectrum of health and social services aligned with international leading practices and world class standards.
- HGMH completed the last accreditation in June of 2022, and was accredited with commendation. Following this survey, we took the approach in the spirit of continuous quality improvement that we would begin preparing for our next accreditation in the fall of 2022.
- The team leads and accreditation steering committee have been hard at work collecting evidence and ensuring the required organizational practices and standards are in place throughout the organization and doing so in a fun and interesting way with our theme of 'wizarding world'.
- As of Thursday, August 21, 2025, we are 171 days away from the survey. Preparations are intensifying with survey logistics. At this stage, we do not yet have the official survey schedule, the list of priority process reviews and tracers, or the names of the surveyors. These details are expected around November 2025. Importantly, one of the scheduled meetings will involve the Board of Directors, focusing on the Board's familiarity with HGMH's compliance with the Governance Standard.
- At this point, the team is on track with the established workplan. An overview of current challenges and successes is as follows:
    - The Accreditation SharePoint site is now open for uploading core documents, including:
        - Required Organizational Practice (ROP) compliance evidence
        - Instrument results and action plans
        - Overview documents (e.g., annual reports, operating plans)

- Additional evidence is being uploaded to HGMH's local Teams site, where surveyors will be added as guests to review data at their convenience.
- The tracker tool now includes a column for team leads to note the status of evidence uploaded to Teams. The progress dial has been updated with a new indicator for evidence uploads.

  Current compliance (self-assessed):
  - 96% – Required Organizational Practices (ROPs)
  - 92% – High priority criteria
  - 93% – Normal priority criteria
  - 0% – Evidence uploaded (in early stages)
- For comparison, in May 2025, compliance stood at 89% for ROPs, 90% for high priority, and 89% for normal priority criteria. Currently, only 136 criteria of 2,042 total remain pending. These results reflect strong progress and steady improvement. While compliance percentages are based on internal assessment, ultimate determinations will be made by surveyors during the onsite visit. Current activities remain focused on policy updates, documenting evidence for all standards, and ensuring accuracy in compliance reporting.

- Next steps with Accreditation are expected to be:
  - November/December: Submission of evidence to portal
  - November/December: Pre-survey logistics & planning
  - February 9-12, 2026: Onsite survey

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

HÔPITAL Glengarry Memorial HOSPITAL

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Quality Committee ☐ Senior Leadership Team

☐ Other *(please specify):*

Date Prepared: September 2, 2025 Meeting Date Prepared for: September 10, 2025

Subject: Accreditation Standard Feature

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

☐ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- As part of the hospital's efforts to embrace the new continuous model for Accreditation and embed it into our daily work, committees will feature 1-2 criteria from an Accreditation standard that applies to their committee's work at each meeting.
- These features will provide an opportunity for the committee to discuss the standard and how HGMH achieves compliance, identifies opportunities for improvement, while ensuring the committee is well-equipped to make informed decisions and recommendations related to quality.

STANDARD / CRITERIA FEATURED

Include the standard name, number(s), statement(s), guideline text, and other information if applicable

Service Excellence 4.3 Indicator data is collected and used to guide quality improvement activities.

- **Priority:** Normal **Quality Dimension:** Population Focus
- **4.3.10 The team leadership ensures that information about quality improvement activities, results and learnings are shared with staff, clients and families, organizational leaders, and partners, as appropriate.**
- **Guidelines**
  - Information is tailored to the audience and considers the messaging and language that is appropriate for each audience. Sharing the results of evaluations and improvements helps familiarize stakeholders with the philosophy and benefits of quality improvement and engage them in the process. It is also a way for the organization to spread successful quality improvement activities and demonstrate its commitment to ongoing quality improvement…

DISCUSSION QUESTIONS

- How would you respond to a surveyor asking you a question about this standard?
- What does the hospital already do to meet this standard?
  - Quality Improvement Plan
  - Quality and Patient Safety Dashboard, Patient Satisfaction Survey results
  - Operating Plan
  - RNAO BPG update
  - PFAC update