HÔPITAL Glengarry Memorial HOSPITAL

Governance and Nominating Committee Meeting Agenda

Date: Wednesday, October 8, 2025
Time: 17H00 – 18H00
Location: Boardroom / Microsoft Teams

Time	Agenda Item	Board Item	Attachment
17:00	**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 (Policy BOD.01.013.X.XX)		
17:03	**2. Report from the Last Meeting**		
(1 min)	2.1 Approval of Previous Meeting Report – June 4, 2025		P. 3
(1 min)	2.2 Business Arising from Report		
17:05	**3. Matters for Discussion/Decision**		
(5 min)	3.1 Review Committee Effectiveness Survey Results		P. 4-8
(5 min)	3.2 Review and Approve Annual Committee Work Plan **THAT The Governance and Nominating Committee review and approve the Annual Committee Work Plan for 2025-2026 as presented.**	D	P. 9-10
(5 min)	3.3 Review all Board Committee Terms of Reference **THAT the Governance and Nominating Committee recommend to the Board of Directors the Board Committee Terms of Reference as presented.**	C	P. 11-21
(5 min)	3.4 Review Q1 Strategic Actions **THAT the Governance and Nominating Committee review and receive the Q1 Strategic Actions report as presented.**	D	P. 22-26
(5 min)	3.5 Review the Revised Communication & Community Engagement Plan	D	P. 27-61
(10 min)	3.6 Documents for Review: (R. Alldred-Hughes)		
	3.6.1 Meetings of Directors Without Management Policy (New) **That the Governance and Nominating Committee recommend to the Board of Directors the approval of the Meetings of Directors Without Management Policy as presented.**	C	P. 62-64
	3.6.2 CEO and COS Performance Evaluation Policy (New) **That the Governance and Nominating Committee recommend to the Board of Directors the approval of the CEO and COS Performance Evaluation Policy as presented.**	C	P. 65-66
	3.6.3 Acts, Legislations, and Compliance Reporting Policy (New) **That the Governance and Nominating Committee recommend to the Board of Directors the approval of the CEO and COS Performance Evaluation Policy as presented.**	C	P. 67-69
17:40	**4. Matters for Information**		
(5 min)	4.1 Governance Accreditation Standard Review (R. Alldred-Hughes)		P. 70-71
(5 min)	4.2 Inclusion, Diversity, Equity & Anti-Racism Update (R. Alldred-Hughes)		P. 72-74
17:50	**5. Date of Next Meeting**		
(1 min)	November 12, 2025		
17:51	**6. Adjournment**		

Board Item: Matters for Discussion/Decision (D) or Consent Agenda (C)

Accountability for Reasonableness (A4R) Ethical Decision Making Framework Steps

Values that Optimize Fairness in the Process of Decision-Making

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.

Centre de bioéthique Champlain Centre for Health Care Ethics

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REPORT OF THE GOVERNANCE AND NOMINATING COMMITTEE

June 4, 2025 at 5:00PM MS Teams

Present:	L. Boyling, Chair	G. Peters	Dr. S. Robertson
	G. McDonald	C. Larocque	R. Alldred-Hughes, CEO
Regrets:	None		

Summary of Discussion

Approval of the Agenda

The agenda was reviewed.

Moved By: C. Larocque
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 14, 2025, was shared.

Moved By: C. Larocque
Seconded By: G. McDonald
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 Board Candidate

A candidate was interviewed and is well qualified for the Board. Mr. Elie recently moved to Alexandria and could bring a lot of value.

Moved By: Dr. S. Robertson
Seconded By: C. Larocque
THAT the Governance Committee recommend to the Board of Directors the nomination of Mr. Doug Elie for a three-year term at the Annual General Meeting.

CARRIED

Board Committee Membership

Mr. Elie was added to the Quality committee which meant a change in what had previously been agreed to for committee membership. Discussion ensued around the number of people per committee as we should not limit Directors who want to be involved on multiple committees. Terms of Reference are reviewed annually, and membership will be discussed in September at the committee meetings.

Next meeting: October, 2025

K-L. Massia, Recorder

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BRIEFING NOTE FOR

☐ Board of Directors ☒ Board Committee – Governance & Nominating Committee ☐ Senior Leadership Team

☐ Other *(please specify):*

Date Prepared: July 21, 2025 Meeting Date Prepared for: October 8, 2025

Subject: Governance & Nominating 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 Governance & Nominating Committee 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 Effectiveness 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 Governance Committee completed a committee effectiveness survey 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:

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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.	75.00% 3	25.00% 1	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
The committee has the right number of members.	75.00% 3	25.00% 1	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
The committee has members with the skills and expertise that are needed by the committee.	50.00% 2	50.00% 2	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4

For any answer above you marked as "needs improvement", please provide details below:

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.	50.00% 2	50.00% 2	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
I received orientation to the committee that was helpful to me as a member of the committee.	25.00% 1	50.00% 2	0.00% 0	0.00% 0	0.00% 0	25.00% 1	4
The committee is receiving the support from hospital management that it requires.	50.00% 2	50.00% 2	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
Information is received sufficiently in advance of the meeting.	50.00% 2	50.00% 2	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
The committee meets the right number of times over the year.	50.00% 2	50.00% 2	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4

For any answer above you marked as "needs improvement", please provide details below:

There are no responses.

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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.	50.00% 2	50.00% 2	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
The committee performed its annual workplan.	50.00% 2	50.00% 2	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
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 providing appropriate nominees for election to the Board of Directors.	25.00% 1	50.00% 2	25.00% 1	0.00% 0	0.00% 0	0.00% 0	4
- by ensuring an appropriate orientation and education program for members.	25.00% 1	75.00% 3	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
- by organizing, with the input of the CEO and Board Chair, the Board retreats.	50.00% 2	50.00% 2	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
- by selecting and recommending nominees for Chair, Vice-Chair, and Treasurer of the Board.	25.00% 1	50.00% 2	0.00% 0	0.00% 0	25.00% 1	0.00% 0	4
- by ensuring succession planning for the office of the Board.	25.00% 1	25.00% 1	25.00% 1	0.00% 0	25.00% 1	0.00% 0	4
- by ensuring periodic review and evaluation of committee performance and Terms of Reference.	50.00% 2	50.00% 2	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
- by recommending to the Board with the input of the Chair, nominees for all Board committees and Committee Chairs.	25.00% 1	75.00% 3	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
- by establishing a program to evaluate the performance of the Board, Board Chair, Board members, and Board Committees.	50.00% 2	50.00% 2	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
- by considering the results of Board evaluations in connection with renewal of terms of existing directors.	25.00% 1	50.00% 2	0.00% 0	0.00% 0	25.00% 1	0.00% 0	4

- by reviewing and making recommendations on Board composition, size, structure, policies and procedures, by-law amendments, and attendance.	50.00% 2	50.00% 2	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
- by developing a program to recruit, select, and appraise the CEO and, through annual reviews, to determine CEO compensation.	25.00% 1	50.00% 2	0.00% 0	0.00% 0	0.00% 0	25.00% 1	4
- by ensuring succession planning is in place for the CEO and senior management.	25.00% 1	75.00% 3	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4

For any answer above you marked as "needs improvement", please provide details below:

While noting that current incumbents are effective in their roles, it is not clear to me that there is in fact a process by which the Board or this Committee nominate or select the Chair, Vice or Treasurer.

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.	25.00% 1	50.00% 2	25.00% 1	0.00% 0	0.00% 0	0.00% 0	4
The Chair keeps the meetings on track.	25.00% 1	75.00% 3	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
The Chair fairly reports the committee's work to the Board.	25.00% 1	50.00% 2	0.00% 0	0.00% 0	0.00% 0	25.00% 1	4
The Chair encourages participation and manages discussion.	25.00% 1	50.00% 2	25.00% 1	0.00% 0	0.00% 0	0.00% 0	4

For any answer above you marked as "needs improvement", please provide details below:

While the results of the Committee's are tabled for consideration at the Board meetings (usually by the CEO), there is no framework for the Chair off this (or other Committees) to give an update of what the Committee is doing, broad directions, issues, etc. Perhaps there should be agenda items at the Board that ask Committee Chairs to give a Committee update.

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.	25.00% 1	75.00% 3	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
Overall, I am satisfied with the committee's contribution to the Board.	25.00% 1	75.00% 3	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4

For any answer above you marked as "needs improvement", please provide details below:

There are no responses.

Comments and suggestions for improvement to committee processes:

Hard working committee. Well done

Overview:

- Based on the results of the survey overall, the committee is satisfied with the current performance level, both from an individual and committee perspective.
- There appears to be some opportunity to increase the comfort level of the committee members and improve overall performance levels in the following areas:
    - Ensuring proper succession planning for the Board of Directors
    - Ensuring Committee Chair's are allotted time at Board meetings to 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, along with all other committee results.

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DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Governance & Nominating Committee ☐ Senior Leadership Team

☐ Other *(please specify):*

Date Prepared: August 13, 2025 Meeting Date Prepared for: October 8, 2025

Subject: 2025-2026 Governance & Nominating 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 2025-2026 Governance & Nominating Committee Work Plan.

RECOMMENDATION / MOTION

That the Governance & Nominating 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 prior 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 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 Governance & Nominating Committee Annual Work Plan

Governance and Nominating Committee
Annual Work Plan 2025-2026

Deliverable	MRP	Occurrence	OCT	NOV	JAN	MAR	MAY	JUN
STRUCTURE/PROCESSES								
Review Committee Effectiveness Survey Results	Chair	Annually	X					
Review/Recommend Governance Annual Committee Work Plan to BoD	Chair	Annually	X					
Review/Recommend Committee Terms of Reference to BoD	Chair	Annually	X					
Review Board Education Plan for following Board Cycle	Chair	Annually						X
Review/Revise Skills Matrix	Chair	Annually			X			
Review/Revise Corporate and Professional Staff Bylaws (as needed)	Chair	Annually		X				
Review Board Member Attendance	Chair	Twice yearly		X			X	
Plan AGM	Chair	Annually					X	
Review Board Orientation	Chair	Annually						X
Review CEO and COS Succession Plan	Chair	Annually			X			
DIRECTOR RECRUITMENT AND SELECTION								
Administer Board Personal Assessment Survey (results due in March)	Admin	Annually			X			
Review Board Succession Plan	Chair	Annually			X			
Identification of number of new members required	Chair	Annually				X		
Identification of selection criteria based on skills matrix	Chair	Annually				X		
Start recruitment process (April)	Admin	Annually				X		
Recommendation of New Directors to the Board		Annually						X
Review Following Years Committee Schedule and Membership		Annually						X
ACCREDITATION								
Governance Standards Review	Chair	Every meeting	X	X	X	X	X	X
Inclusion, Diversity, Equity & Anti-Racism Update	Chair	Bi-Monthly	X		X		X	
Review Communication Plan	Chair	Annually	X					
PERFORMANCE								
Review Performance Evaluation Questionnaire for CEO and COS	Chair	Annually		X				
Review Committee Effectiveness Survey Questions	Chair	Annually			X			
Administer Committee Effectiveness Survey	EA	Annually					X	
Review Peer to Peer Survey Questions	Chair	Annually				X		
Administer Peer to Peer Surveys	EA	Annually						X
STRATEGIC PLAN AND STRATEGIC DIRECTIONS								
Review Strategic Plan and Refresh	CEO	Annually		X				
Review Progress on Strategic Directions	CEO	Quarterly	X	X	X		X	
POLICY REVIEW								
CEO and COS Performance Evaluation (New)	CEO		X					
Meeting of Directors Without Management (New)	CEO		X					
Acts, Legislations, and Compliance Reporting (New)	CEO		X					
Patient and Family Engagement (New)	CEO			X				
Borrowing (New)	CEO			X				
Financial Planning and Performance (New)	CEO			X				
Signing Authority and Approval (BOD.04.005)	CEO				X			
Regular Meetings of the Board and Notice (BOD.05.013)	CEO					X		
Communication & Hospital Spokesperson (BOD.05.018)	CEO					X		
Minutes of Regular and In Camera Meetings (BOD.05.014)	CEO						X	
Board Award of Excellence (BOD.06.001)	CEO						X	
Board and Committee Expenses (BOD.04.001)	CEO							X
Board of Directors Orientation Program (BOD.05.015)	CEO							X
ESTIMATED PREPARATION TIME FOR MEETING			1H	1H	1H	1H	1H	1H

Revisions since prior report:

HÔPITAL Glengarry Memorial HOSPITAL

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Governance & Nominating Committee ☐ Senior Leadership Team

☐ Other *(please specify):*

Date Prepared: August 20, 2025 Meeting Date Prepared for: October 8, 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 Governance and Nominating Committee recommend to the Board of Directors the Governance & Nominating Committee Terms of Reference, the Finance, HR and Audit Committee Terms of Reference, and the Quality & Patient Safety Committee 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.

Governance and Nominating Committee:

- The existing Governance and Nominating Committee Terms of Reference continue to accurately reflect the role, responsibilities, and membership of the Governance and Nominating Committee. They provide clear guidelines on the committee's governance and nominating functions, ensuring that all essential duties are covered.
- DEI was changed to IDEA to keep language consistent throughout the organization.

Finance, HR, and Audit Committee:

- The Terms of Reference were reviewed by the Finance, HR, and Audit committee with a minor change under Human Resources which will now fall under the Quality & Patient Safety's responsibility.
- Meeting frequency was changed to six (6) meetings per year.

Quality & Patient Safety Committee:

- The statement around ensuring coordination and alignment with the Corporation's medical advisory committee for physician human resource planning was removed from the Terms of Reference of the Finance, HR, and Audit Committee and added to the Quality & Patient Safety Committee for better alignment.
- Meeting frequency was changed to six (6) meetings per year.

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Governance and Nominating Committee Terms of Reference
- Finance, HR and Audit Committee Terms of Reference
- Quality & Patient Safety Terms of Reference

TERMS OF REFERENCE

Governance and Nominating Committee

ROLE:	• To advise the Board on matters relating to the Board's governance structure and processes, evaluation of the Board's effectiveness, recruitment, education, and evaluation of Board members. • To advise the Board on the selection and recruitment, of the CEO and COS.
RESPONSIBIILITIES:	a) Board Recruitment • Develop for approval by the board a description of the skills, experience and qualities including diversity of the directors and ensure French-speaking representation as per bylaw 4(3)(e); • Consider skills, experience, qualities, and diversity of current directors to determine the Board's needs; and, • Oversee the Board's recruitment and nomination process and recommend to the Board candidates for election at the Annual Meeting. b) Board Education • Ensure a comprehensive orientation session is provided to all new Board members; • Oversee Board education sessions to ensure Board members receive periodic education on governance, health care issues and the hospital operations; and, • Organize with the input of the CEO and Board Chair, the Boards retreats. c) Board Chair • Ensure succession planning for the office of Board • Oversee and complement the Board's process for selecting a Board Chair and recommend an individual for election by the Board as Chair; and, • Make recommendations to the Board for Vice Chair and Treasurer. d) Board Committees • Ensure periodic review and evaluation of committee performance and Terms of Reference and make recommendations for the Board as required; and, • Recommend to the Board, with the input of the Chair, nominees for all Board Committees and Committee Chairs. e) Evaluations • Establish and implement a program to evaluate Board performance including individual director performance, performance of the Chair, Board Committees and Committee Chairs; • Consider the results of Board evaluations in connection with renewal of the terms of existing directors; and, • Review and make recommendations to the Board on Board composition, size, structure, board policies and procedures,

	by-law amendments and board attendance. f) Executive Management Performance • Developing and appraising the CEO and COS job descriptions; • Undertaking CEO and COS recruitment processes and selection of the CEO and COS or delegating to subcommittee; • Ensuring succession planning is in place for the CEO, COS. g) ~~Diversity, Equity, & Inclusion (DEI)~~Inclusion, Diversity, Equity & Anti-Racism (IDEA) • Ensure the hospital's strategic plan incorporates ~~DEI~~ IDEA principles. • Review and recommend policies that promote ~~DEI~~ IDEA within the organization, and holding leadership accountable for implementing and maintain these standards across the hospital. • Regular monitor progress on ~~DEI~~ IDEA initiatives and key performance measures.
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:	• Chair of the Board; • At least four Directors appointed by the Board (minimum one bilingual Director in English and French); • Chief Executive Officer as an *ex officio* member.
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 6 times per year, at the call of the chair
QUORUM:	• 51% of voting members.
RESOURCES:	• Chief Executive Officer • Guests, by invitation
REPORTS TO	• Board of Directors
DATE OF LAST REVIEW	• ~~September~~ October 2025~~4~~

Approved by: Corporation of l'Hôpital Glengarry Memorial Hospital

TERMS OF REFERENCE
FINANCE, HUMAN RESOURCES, AND AUDIT COMMITTEE OF THE BOARD

ROLE:	• Responsible on behalf of the board of directors (the "**Board**") for oversight of financial matters and the annual external audit. • To provide oversight over the planning of construction, renovation and maintenance of infrastructure and associated equipment. • Assist the Board in fulfilling its obligations relating to human resources and compensation matters.
RESPONSIBIILITIES:	***Budget Planning and Oversight*** • Ensure that there are processes in place for the development of an annual operating budget and capital budget. • Review and recommend to the board financial assumptions used to develop operating budget, capital budget and strategic plan. • Review and recommend to the board the annual operating plan and budget, and the capital plan and budget; • Review on a routine basis financial performance and compare actual performance against budget including year-end projections. • Review and recommend to the Board plans developed by management to address variances between budget and actual performance. • Oversee implementation of plans to address variances and report to the Board. ***Long-Term Planning*** • Oversee and assess achievement of the financial aspects of the strategic plan. • Review and recommend to the Board multi-year financial goals and long-term revenue and expense projections. • Review, with management, industry developments and legislative changes that may have an impact on financial resources or performance and report to the Board. ***Asset Management*** • Ensure there are processes in place to manage the assets of the Corporation. • Review and make recommendations on material asset acquisitions not contemplated in the annual capital plan. ***Financial Transactions*** • Review and make recommendations to the Board on

banking arrangements.
- Review and make recommendations to the Board on lines of credit and long-term debt.

Donations and Bequests
Advise the Board on major gifts that involve donor recognition agreements and related policies.

Investments
- Review and recommend to the Board the Corporation's investment policy.
- Oversee investment performance for compliance with the investment policy.

Internal Controls, Risk Management, and Oversight of Internal Audit
- Oversee, review, and make recommendations to the Board on management's risk management processes.
- Review and make recommendations on the adequacy of financial resources.
- Review and make recommendations on insurance coverage.
- Obtain reasonable assurance from management that the Corporation's financial accounting systems and financial reporting systems, including fraud prevention and risk management, are appropriately designed and that internal controls are operating effectively.
- Identify unusual risks and oversee management's plan to address unusual or unanticipated risks and make recommendations to the Board.
- Review and make recommendations on the quality and integrity of management's internal controls, including scope of work of the internal auditor and overseeing management's response and resulting action plans to address issues or deficiencies identified by internal auditor.

External Audit
- Recommend to the Board the external auditor for appointment or re-appointment by the members at the annual members' meeting.
- Annually review and make recommendations to the Board on the external auditor's remuneration.
- Meet with the external auditor to review the proposed scope of audit.
- Review, approve, and authorize management to execute

the external auditor's engagement letter.

- Oversee performance of the external audit as required, including ensuring the external auditor is receiving the assistance of management.
- Review audited financial statements and the external auditor's report and make recommendations to the Board.
- Meet with the external auditor and receive and review recommendations with respect to management, accounting systems, and internal control issues.
- At least annually, the elected director committee members shall meet with the external auditor without management present.
- Review non-audit services provided by the external auditor and other factors that might compromise the external auditor's independence and make recommendations to ensure independence.
- Review management's response to internal control recommendations of the external auditor and oversee implementation of internal control recommendations.

HUMAN RESOURCES

- Recommend an incentive-based compensation system for the chief of staff and the chief executive officer that is compliant with the legislative environment.
- Review, together with the chief executive officer and chief of staff, existing staff and physician management resources and plans, including recruitment and learning programs.
- Participate in the creation of the Corporation's strategic plan and provide input from a human resources perspective.
- Review on an annual basis the Corporation's human resources plan to ensure alignment with the strategic plan for the organization.
- ~~Ensure coordination and alignment with the Corporation's medical advisory committee for physician human resource planning.~~
- Receive and review on a periodic basis a report on the human resources' performance indicators.

BUILDING AND PROPERTY

- Make recommendations to the board for the purchase of equipment, property, renovations to existing building or construction of new buildings.
- Make such recommendations in conjunction with the annual capital budget with exceptions for emergency purchases.

	Compliance with Applicable Law • Oversee compliance with accounting and financial, legal, public disclosure, and regulatory requirements. • Approve material changes to accounting principles and practices as suggested by management with the concurrence of the external auditor. ***Other*** • Perform such other duties as may be requested by the Board from time to time.
CHAIR:	• Treasurer of the Board
MEMBERSHIP:	• The Treasurer • The Board Chair, or their designate • The Chief Executive Officer, ex officio • The VP of Support Services and Chief Financial Officer, ex officio • A minimum of three elected Directors of the Board (minimum one bilingual Director in English and French) • Invited guests may attend committee meetings at the invitation of the Chair • In accordance with the Ontario *Not-for-Profit Corporation Act*, 2010, the committee shall be comprised exclusively of directors of the Corporation, and the majority of committee members must not be officers or employees of the Corporation or any of its affiliates[1]
MEETING PARTICIPATIONG	• Notice of the time and place of committee meetings shall be given to the external auditor.[2] The external auditor shall be entitled to attend committee meetings and to be heard, and shall attend every committee meeting if requested to do so by a committee member.[3] • The Vice President of Support Services and Chief Financial Officer of the Corporation, *ex officio*, shall be invited to attend and participate in these meetings as a guest, but shall not have a vote. • The Chief Human Resources Officer, *ex officio*, shall be invited to attend and participate in these meetings as a guest,

[1] ONCA, s. 80(1), provides that a corporation may have an audit committee comprising one or more directors and the majority of the committee must not be officers or employees of the corporation or of any of its affiliates.

[2] ONCA, s. 80(2) provides that the corporation shall give the auditor notice of the time and place of any meeting of the audit committee. The auditor is entitled to attend the meeting at the expense of the corporation and be heard, and shall attend every meeting of the committee if requested to do so by one of its members.

[3] ONCA, s. 80(2).

	but shall not have a vote.
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 ~~eight~~six (~~8~~6) times annually, at the call of the committee chair. Meetings may also be held at the call of the external auditor or a committee member.[4]
QUORUM:	• 51% of voting members.
RESOURCES:	• VP of Support Services and Chief Financial Officer
REPORTS TO	• Board of Directors
DATE OF LAST REVIEW	• ~~November 2024~~September 2025

[4] ONCA, s. 80(3) provides that the auditor or a member of the audit committee may call a meeting of the committee.

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: • Assist~~ing~~ the Board in the performance of the Board's governance role for the quality of patient care and services; and • Perform~~ing~~ the functions of the Quality Committee under the Act. • Guide the strategic priority of Quality & Safety.
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.

TERMS OF REFERENCE QUALITY AND PATIENT SAFETY COMMITTEE OF THE BOARD

	• Ensure coordination and alignment with the Corporation's 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 - Governance ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: September 29, 2025 Meeting Date Prepared for: October 8, 2025

Subject: Q1 Strategic Actions Report

Prepared by: Robert Alldred-Hughes, President & CEO

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

PURPOSE

- The purpose of this briefing is to provide the Board of Directors with an update on the progress of the hospital's Q1 Strategic Action Report (2025–2026). Strategic actions are derived directly from our 2023–2028 Strategic Plan and are developed through consultation with senior leadership, physician leaders, and staff committees. Each action is designed to operationalize our four strategic priorities: Quality & Safety, People & Culture, Integration & Standardization, and Future Planning, and provides tangible milestones to measure progress toward our longer-term goals.
- Monitoring and reporting progress quarterly is critical to ensuring accountability, identifying early risks, and implementing mitigation strategies where required.

RECOMMENDATION / MOTION

THAT the Governance and Nominating Committee review and receive the Strategic Action Report of Q1.

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.

- All strategic actions for Q1 were assessed against established milestones and categorized as: Complete, On Track, Not on Track (mitigation plans in place), or At Risk.
- Quality & Safety: Actions focused on strengthening palliative care resources, expanding medical directives, and enhancing patient and family involvement in care are on track. Notably, the co-designed family spiritual and cultural care room, developed with the IDEA Committee and PFAC, is progressing with completion expected by October 2025.
- People & Culture: Efforts to enhance staff engagement through medical student placements, psychological safety training, and redesign of the performance evaluation process are on track.
- Integration & Standardization: The Epic EMR project through the Atlas Alliance is advancing as scheduled, with subject matter experts actively participating in workflow reviews. IT infrastructure upgrades required to support Epic are also on track. More detailed briefings regarding the EPIC implementation have been shared through the Finance, Human Resource & Audit Committee.
- Future Planning: The Board-approved pre-capital redevelopment submission was completed in June 2025. Foundation-led fundraising for the CT Scanner campaign is progressing, with $1M raised to date.

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.

Ongoing monitoring of strategic actions ensures that the hospital remains aligned with its long-term strategy and responsive to environmental and operational risks. Key impacts from Q1 include:

- **Enhanced Patient-Centered Care:** Direct patient feedback through leadership rounding is driving improvements such as consistent use of communication whiteboards.
- **Workforce Development:** Medical student placements and redesigned evaluation processes are positioning HGMH as both a teaching site and an employer of choice.
- **System Integration:** Engagement in the Epic EMR project is building regional standardization, which will improve quality, safety, and efficiency across the care continuum.
- **Future Sustainability:** Submission of the redevelopment proposal and progress toward CT fundraising demonstrate strong alignment with government and community priorities.

CONSULTED WITH:

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

- HGMH Senior Leadership Team

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Q1 Strategic Action Report

2025-2026 Strategic Action Report Q1

Strategic Dimension	Strategic Direction	Executive Lead	Action	Progress	Status
Quality & Safety	*Enrich the patient experience through quality, safe care that welcomes patients and families as partners in care.*	R. Romany	Implement Best Practice Guidelines to strengthen the tools and resources available to our palliative care team. This includes introducing assessment tools and reference sheets to support consistent, high-quality care across all touchpoints.	• Gap analysis of the Best Practice Guideline: Palliative Approach to Care in the Last 12 Months of Life has been completed. • A key recommendation is to ensure that nurses facilitate access to appropriate resources, spaces, and services to support the cultural, spiritual, and/or religious needs of patients and families. • A dedicated family/spiritual room is currently being co-designed by the IDEA Committee and the Patient and Family Advisory Council (PFAC) to reflect patient and family perspectives. The space is scheduled for completion by mid-October 2025. • Assessment tools and reference materials for staff and physicians are under review to evaluate their effectiveness and promote consistent usage across clinical teams.	On track
		R. Romany	Increase the use of medical directives for nursing staff, allowing for faster initiation of diagnostic tests and treatments before physician assessment. Undertake facility enhancements to support patient care and operational efficiency.	• There are 27 medical directives currently in place. • Medical directives are being utilized by staff, particularly for initiating diagnostic tests, helping to improve patient flow and reduce delays prior to physician assessment.	On track
		R. Romany	Enhance patient involvement in care decisions by implementing Leader and Patient and Family Advisory Committee (PFAC) patient rounding to engage directly with patients and	• Senior Leadership Team (SLT) Patient Rounds were initiated on April 28, with approximately 30 patients interviewed for real-time feedback on their care experience. • Patients report feeling cared for, safe, and checked on during evenings and nights.	On track

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

Updated August 14, 2025

			assess their level of involvement in their care before discharge.	• An area for improvement identified is the consistent completion of patient whiteboards as a key communication tool for patients and families regarding the care plan. • PFAC members to join SLT for patient rounds when appropriate.	
People & Culture	*Improve engagement by investing in the organizations people and empower a caring and positive culture for all.*	Dr. L. MacKinnon	Initiate a Medical Student and Resident Program to provide hands-on learning experiences within our medical community. By collaborating with the Rural Ontario Medical Program (ROMP) and other academic partners, we will support initiatives such as Discovery Week for medical students and structured resident placements	• In the spring, we successfully welcomed four first-year medical students—two from the University of Ottawa and two from the University of Toronto. • We are actively collaborating with ERMEP and ROMP to create our medical student and resident program. • Additionally, we will be hosting a third-year medical student from Queen's University for a 14-week generalist placement, scheduled from September 15 to December 19, 2025.	On track
		K. MacGillivray	As part of our ongoing commitment to health and safety, we are enhancing leadership training with a dedicated focus on psychological safety in addition to management responsibilities.	• The development of the psychological safety program is underway. • Training for the leadership team will be held at our annual Leadership retreat on March 5, 2026. We have reached out to a trainer and are exploring other training materials.	On Track
		K. MacGillivray	Redesign our performance evaluation process to create a more meaningful, transparent, and development-focused experience for our employees.	• Feedback survey on the current performance appraisal process has been sent to the leadership team with a deadline of September 12. From there, the redesign will begin.	On Track
Integration & Standardization	*Deliver standardized quality care in a cost-effective way through collaboration & integration opportunities.*	R. Romany	Continue the transition to a new Electronic Medical Record (EMR) system by joining the Atlas Alliance and implementing the EPIC EMR platform in the Fall of 2026.	• The implementation project officially launched on April 2, 2005. Go-live date is targeted for October 24, 2026. • Subject matter experts (SMEs) are actively engaged in various workgroups. • Workgroups are reviewing clinical and operational workflows, applications and systems functionality, order sets, data migration planning, etc.	On Track

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

Updated August 14, 2025

		L. Ramsay	Invest in critical upgrades to our information technology infrastructure. This year, we are enhancing system reliability and security by purchasing backup servers and an uninterruptible power supply (UPS) for our server environment.	• Looking at our current set-up and ensuring that it is lines with the requirements for our EPIC implementation.	On Track
Future Planning	*Invest in the sustainability of our equipment & infrastructure to support safe, quality care.*	R. Alldred-Hughes	Submit pre-capital submission to support the future redevelopment and revitalization of the hospital	• Board and Hospital Leadership completed Stage 1.1 of the Ministry Capital Redevelopment Planning Process, and received Board approval for submission in June 2025. The plan contains a new patient care tower, renovation of existing site, and a community health hub. • Hospital will continue to advocate for the proposal to move to stage 1.2 with Ministry of Health approval.	Complete
		R. Alldred-Hughes	Actively work with and support the HGMH Foundation in their efforts to fund our ability to bring CT to HGMH.	• Foundation has launched the their capital campaign, and continuous fundraising efforts. CEO has been meeting with donors as needed, providing hospital tours and context for our ask. In addition, the HGMH leadership team has been supporting fundraising events through volunteerism and attendance. • Foundation has raised $1M toward the CT Scanner at this time.	On Track

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

Updated August 14, 2025

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Governance ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: September 29, 2025 Meeting Date Prepared for: October 8, 2025

Subject: Communications and Community Engagement Plan

Prepared by: Robert Alldred-Hughes, President & CEO

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

PURPOSE

- To review the hospital Communications and Community Engagement Plan to ensure the plan aligns with organizational goals and communication needs and meets accreditation standards.

RECOMMENDATION / MOTION

That the Governance and Nominating Committee review and receive the Communications and Community Engagement Plan 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.

- Effective communication is essential to maintaining transparency both internally and externally to also help build and retain community trust.
- The hospital developed a communication plan in 2022.
- The communications plan serves as the framework for internal and external communications, guiding how and when we engage with staff, patients, families, community partners, and the public.
- The plan is reviewed annually to ensure compliance with legislative requirements (e.g., French Language Services Act, Accessibility for Ontarians with Disabilities Act, etc.), alignment with the hospital's strategic priorities and key initiatives, and the adaptation to changing circumstances such a media trends.
- Recent updates to the Communications and Community Engagement Plan include:
    - Title change to Communications and Community Engagement Plan
    - Inclusion of Community Engagement Strategies to support meaningful relationships with local stakeholders and partners
    - Addition of Crisis Communication protocols to ensure effective and timely communication during emergencies
    - Inclusion of Public Disclosure practices to reinforce transparency and accountability

IMPLEMENTATION & COMMUNICATION PLAN

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

- The communication plan was launched in 2022. The revised version will be used for Accreditation.

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Communications and Community Engagement Plan – Revised
- Communications and Community Engagement Plan - Clean

Communications & Community Engagement Plan

HÔPITAL Glengarry Memorial HOSPITAL

Effective: Oct 2022	**Last review/revision:** Aug 2025	Next Review: Aug 2026
Owner: Communications Officer	**Signing Authority:** Senior Leadership	

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Background

Established in 1965, Hôpital Glengarry Memorial Hospital has been a cornerstone of healthcare in Alexandria, Ontario. It provides acute care, 24-hour emergency services, outpatient services, and rehabilitation to over 41,000 residents annually. Our team of over 180 staff members, 50 Medical Staff members, and 100 volunteers are dedicated to delivering high-quality health care to our Eastern Ontario community.

~~Established in 1965, Hôpital Glengarry Memorial Hospital (HGMH) recently celebrated its 50th anniversary. Over the years, the hospital has grown to provide vital services to the community, including acute care, complex continuing care, emergency services, stroke and geriatric rehabilitation, specialist clinics, and more.~~

~~HGMH is a 37-bed hospital established in Alexandria, Ontario, for over 55 years. HGMH provides acute care, 24-hour emergency services, outpatient services and rehabilitation to over 41,000 residents every year. Our team includes over 180 staff members, 50 Medical Staff members and 100 volunteers who all take pride in bringing quality health care to our local Eastern Ontario community.~~

Our Mission

Delivering outstanding care for our communities.

Our Vision

Providing your care, your way with seamless integration, innovation, and equitable access for our communities.

Our Values

Our 'PACT' is our promise to have Passion, Accountability, Compassion & Teamwork at the heart of all we do, everyday.

Executive Summary

Effective communication is the process of sharing ideas and information in such a way that the content is received and understood in the way it was intended through a variety of channels to ensure understanding, collaboration, and trust among internal and external audiences. This includes day-to-day operational updates, announcements, crisis communication, health education, and promotional content.

~~Goals of effective communication could include creating a common perception, changing behaviours, and acquiring and disseminating information.~~

~~For HGMH, effective communication means conveying the information of our organization, our programs and services, the issues faced within the hospital, its accomplishments, etc. to our community.~~

HGMH's Communications & Community Engagement Plan is intended to guide the organization in communicating with its various stakeholders and ensure that the right people have the right information when they need it. This work requires that we provide information by the most appropriate method(s) to maximize clarity, conciseness, understanding, and transparency. All communication that is public facing will be available in both official languages (English and French) to align with the hospital's designation as a French Language Service hospital (as per the French Language Services policy BOD.01.002).

Community engagement refers to the process of building strong, reciprocal relationships with patients, families, and groups in the broader community. It involves listening, learning, and collaborating with stakeholders. The goal is to foster trust, reflect community voices, and ensure services and communications are culturally safe, inclusive, and responsive to community needs.

Stakeholders

The stakeholders listed below reflect the individuals, groups, and organizations with whom HGMH maintains strategic, operational, regulatory, and community relationships. Distribution ensures transparency, accountability, and engagement with those who have a vested interest in the hospital's performance and achievements.

Key themes that could be communicated are:

- **Strategic Direction & Accountability**: Annual Report; progress on Strategic Plan; governance and policy updates; hospital performance metrics
- **Clinical Excellence & Patient Care:** Accreditation readiness; patient safety initiatives; quality improvement updates; new/expanded services; recruitment successes
- **Workforce Engagement & Recognition**: recognition of staff, physicians and volunteers; milestones & retirements; professional development and training; IDEA initiatives
- **Community Impact & Partnerships:** partnerships within the community
- **Advocacy & Government Relations:** capital project needs; hospital funding priorities; alignment with municipal/federal priorities; small hospital advocacy
- **Education & Training Opportunities:** Student placement opportunities; partnerships with nursing/allied health institutions
- **Philanthropy & Fundraising:** Foundation campaign updates; impact of donations; capital equipment needs

- **Public Awareness & Media Relations:** Hospital news & service updates; health promotion & prevention campaigns; Care Champion stories; system updates of public interest

Stakeholder Group	Stakeholders	Key Themes for Communications & Engagement
Internal Governance & Leadership	• HGMH Board of Directors • HGMH Senior Leadership Team • HGMH Management Team • HGMH Medical Advisory Committee (MAC) • Department Chiefs	• Strategic Direction & Accountability • Clinical Excellence & Patient Care • Workforce Engagement & Recognition • Community Impact & Partnerships • Advocacy & Government Relations • Philanthropy & Fundraising
Hospital Staff, Physicians, and Volunteers	• All HGMH staff (via internal email and intranet) • Credentialed physicians and allied health professionals • Volunteer Auxiliary	• Strategic Direction & Accountability • Clinical Excellence & Patient Care • Workforce Engagement & Recognition • Community Impact & Partnerships • Education & Training Opportunities
Community Partners & Political Stakeholders	• Township of North Glengarry (Mayor, Council, CAO) • Township of South Glengarry (Mayor, Council, CAO) • United Counties of Stormont, Dundas, and Glengarry (Council, CAO) • Local First Nations leadership – Mohawk Council of Akwesasne • MPP Prescott, Russel, & Glengarry	• Community Impact & Partnerships • Advocacy & Government Relations (

	• MPP Cornwall, Stormont, Dundas, and South Glengarry • MP Cornwall, Stormont, Dundas, Glengarry • Local service clubs and community organizations (e.g., Rotary Club)	
Healthcare and System Partners	• Ontario Health East Region • Ministry of Health – Ontario • Eastern Ontario Health Unit • Great River Ontario Health Team (OHT) partners • Regional hospitals and healthcare alliances (e.g., Atlas Alliance members) • Champlain Alliance of Small Hospitals	• Strategic Direction & Accountability • Clinical Excellence & Patient Care • Advocacy & Government Relations
Educational & Training Partners	• Nursing and allied health educational institutions partnered with HGMH • Medical residency and student placement programs	• Education & Training Opportunities
Fundraising & Philanthropic Partners	• HGMH Foundation Board of Directors & Staff	• Strategic Direction & Accountability • Philanthropy & Fundraising
Public & Media	• Local and regional media outlets	• Strategic Direction & Accountability • Clinical Excellence & Patient Care • Workforce Engagement & Recognition

	• Posting on the HGMH public website and social media channels • Community members via newsletters and public engagement events	• Community Impact & Partnerships • Philanthropy & Fundraising • Advocacy & Government Relations • Public Awareness & Media Relations

This stakeholder distribution list will be reviewed annually by the Governance Committee to ensure accuracy, completeness, and alignment with Accreditation Canada requirements.

Distribution Method:

• Electronic: Email distribution to stakeholder mailing lists, posting on hospital website, and promotion via social media channels.
• Print (as required): Limited hard copies for stakeholders without reliable electronic access or upon request.

- ~~Patients and families (including Patient & Family Advisory Committee)~~
- ~~Staff~~
- ~~Credentialed professional staff~~
- ~~Board of directors~~
- ~~Volunteers~~
- ~~Donors (through the HGMH Foundation)~~
- ~~Healthcare community partners~~
- ~~General public~~
- ~~Media~~
- ~~Local government – Mayors, Councils, MPs, MPPs~~
- ~~Ontario Health East~~
- ~~Ministry of Health and Long-Term Care~~

Planning Communication

With each communication, the following questions should be considered:

- Why is this important to communicate? **(What is the purpose?)**
- With whom do we want to communicate? **(Who are the stakeholders?)**
- What do we want to communicate? **(What is the message?)**
- How do we want to communicate it and through which medium? **(What communication tools are to be used?)**
- What is the timeline of communications / presentations? **(Define when and who plans, prepares, and presents)**
- What needs to be developed? **(Develop material, ads, news articles, etc.)**

The answers to these questions will establish the Communication ~~a~~Action ~~p~~Plan (51-A-293) to communicate successfully with the intended audience. This action plan will focus on the messaging, making it possible to target the stakeholders accurately, providing structure to define who HGMH needs to reach and the medium. This process will make communication more efficient, effective, and long lasting. More importantly, flexibility is key in planning and being prepared to adapt messaging to ensure success.

Guiding Principles

The hospital's approach to communication and engagement is grounded in several core principles:

- **Transparency:** Communicate timely, accurate, and honest information.
- **Accessibility:** Ensure all communication meets accessibility standards and is available in both English and French, in accordance with the hospital's designation under the French Language Services Act (FLSA).
- **Cultural Sensitivity and Inclusion:** Reflect and respect the diversity of the communities we serve.
- **Engagement:** Foster meaningful, two-way communication with staff, patients, families, and community members.
- **Alignment:** Support the hospital's strategic goals, values, and vision.

Goals and Objectives

The overarching goal is to enhance hospital experiences and community trust through clear, consistent, and culturally respectful communication.

Objectives:

- Maintain public trust through proactive messaging.
- Keep staff informed and engaged.
- Promote hospital programs and achievements.
- Respond quickly and effectively in crisis or urgent situations.
- Foster meaningful staff participation in internal initiatives.
- Improve patient and family experiences by promoting two-way dialogue.
- Strengthen community partnerships through inclusive outreach and collaboration.

Key Messages

HGMH aligns its key messages with the four strategic priorities from its strategic plan:

- Quality and Safety
  - Enrich the patient experience through quality, safe care that welcomes patients and families as partners in care.
- People and Culture
  - Improve engagement by investing in the organizations people and empower a caring and positive culture for all.
- Integration and Standardization
  - Deliver standardized quality care in a cost-effective way through collaboration & integration opportunities.
- Future Planning
  - Invest in the sustainability of our equipment & infrastructure to support safe, quality care.

Communication Tools

HGMH uses several methods to communicate, including:

- Patient and Family Advisory Committee meetings
- Website – www.hgmh.on.ca
- Social Media (Facebook, LinkedIn, YouTube)
- Advertising (media releases, news stories, other publications)
- Community engagement / events
- Staff Forums
- Glentranet (Hospital Intranet)
- Town Hall Meetings
- Internal communications:
  - Bi-Weekly Blitz newsletter
  - Weekly Clinical Update newsletter
  - Monthly Physician newsletter

Corporate Publications

Annual Report

Following the Annual General Meeting, the hospital's annual report / update to the community is released electronically on the website and communicated via social media. The Annual Report includes a high-level overview of the hospital's achievements, financial performance, strategic initiatives, and community impact over the past year. Hard copies are available upon request.

Strategic Plan

The Hospital's Strategic Plan serves as a guiding framework for a five-year period, outlining the hospital's long-term vision, mission and values as well as the strategic priorities, and commitments to patients, families, staff, and the community. It reflects input from stakeholders across the organization and community, and is aligned with regional and provincial healthcare strategies.

The Strategic Plan is published on the hospital's website and shared with staff, physicians, partners, and the broader community through multiple communications channels including newsletters, media releases, and social media. Updates on progress toward Strategic Plan goals are integrated into the Annual Report and Annual Operating Plan. This ensures transparency and accountability, while keeping stakeholders informed of achievements and ongoing priorities.

Hard copies of the Strategic Plan are available upon request to ensure accessibility for all members of the community.

Annual Operating Plan

The Annual Operating Plan is released in May and outlines the hospital's strategic goals and operational priorities for the coming year. It serves as a roadmap for service delivery, quality improvement, and resource allocation, and it supports alignment with regional and provincial healthcare directives.

Patient Handbook

Our Patient Handbook is published annually at no cost to HGMH due to the sponsors who advertise in the publication. Hard copies are available for pick-up in high traffic areas (lobbies and waiting rooms), and electronically on the hospital's website. All admitted patients receive a copy of the Patient Handbook on admission as it outlines important information about patients' rights and responsibilities, hospital policies, services available, and what to expect during their stay.

Program / Service Brochures and Posters

HGMH develops various brochures and posters on an as needed basis to promote programs, services, or provide patient and family education.

Digital Media

Corporate Website

HGMH's website is used to outline programs and services offerings, sharing news updates, and to provide the community with feedback opportunities. The website is maintained by the Communications Officer and continues to evolve with new and improved content as needed.

Newsletters

Internal newsletters are produced and distributed to staff by email and on the intranet to ensure current information is disseminated on a regular basis. The Weekly Clinical Update includes up-to-the-minute information from the clinical managers, highlighting reminders about workflow changes, policy updates, upcoming education opportunities, etc. The Bi-Weekly Blitz is a general newsletter for all staff, which provides updates on internal wellness activities, community events, news from various departments, etc. The monthly physician newsletter is geared towards physicians and includes physician meeting dates, important departmental information, highlights around workflow changes, and policy updates.

Glentranet (intranet site)

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Crisis Communication Protocol

Purpose

To ensure that during any crisis, HGMH provides timely, accurate, clear, and bilingual information to all audiences, using coordinated communication strategies that maintain trust and reduce misinformation.

Definition of a Crisis

A crisis, for the purposes of this plan, is any event or situation that significantly disrupts the hospital's normal operations, poses a risk to safety, or threatens the hospital's reputation. Crisis can originate internally or externally and may include:

- Large-scale medical emergencies, such as mass casualty incidents or disease outbreaks.
- Facility issues, including fires, floods, or power outages.
- Medical errors or adverse events that draw public or media attention.
- Security threats, including active shooter situations or bomb threats.
- Cybersecurity breaches or loss of critical patient data.
- Labour actions or significant staff shortages.
- Natural disasters impacting hospital operations.

Objectives

- Maintain consistent, transparent communication during a crisis.
- Provide timely updates to internal and external audiences.
- Ensure communications are accessible, culturally sensitive, and bilingual.
- Fulfill requirements regarding system capacity, backup methods, reunification communications, community preparedness education, partner coordination, staff notification, and language accessibility.

Activation

The crisis communication protocol is initiated when a situation arises that has potential to significantly impact patient safety, staff operations, public perception, or media attention, and where rapid communication is necessary.

Roles in Communication

- **CEO:** Primary spokesperson (or delegate) for official public statements as per the Communications & Hospital Spokesperson policy (BOD.05.018.X.XX).

- **Communications Officer:** Coordinates all communication activities, drafts and distributes updates, manages website, media relations and social media as per the Social Media policy (COR.08.005.X.XX).
- **Managers**: Share approved messages with teams and gather feedback/questions for follow-up.
- **Administration On-Call**: Acts as the 24-hour contact point for the organization, ensuring stakeholder inquiries during emergencies are addressed or escalated to the appropriate lead as per the Administration On-Call policy (COR.01.005.X.XX)

Key Communication Actions

1. **Initial Holding Statement:** Release a brief, factual, and empathetic message acknowledging the situation and advising when further updates will follow.
2. **Audience Identification:** Determine priority audiences (staff, patients/families, media, community partners, public).
3. **Channel Selection:** Choose the most effective mix of channels (email, intranet, website banner, social media, media release).
4. **Update Frequency:** Commit to regular updates, even if the information is unchanged, to reinforce transparency.
5. **Message Consistency:** Ensure all public-facing channels deliver the same core messages.
6. Compliance with Legislation and Standards: All communications will comply with applicable laws, regulations, and quality standards, including:
    a) Accessibility Requirements: Ensure content is accessible in accordance with the Accessibility for Ontarians with Disabilities Act (AODA) and other relevant accessibility standards.
    b) Privacy laws: Protect personal and health information in compliance with applicable privacy legislation.
    c) French Language Services Requirements: Provide communications in both English and French, meeting obligations under the French Language Services Act (FLSA).
7. **Monitoring**: Track social media, media coverage, and public feedback to identify and correct misinformation quickly.

Media Management

During a crisis, all media inquiries will be directed to the Communications Officer, who will then report to the President & CEO as per the Communications & Hospital Spokesperson policy (BOD.05.018.X.XX). This ensures that the hospital speaks with one consistent voice and prevents misinformation from circulating. Press conferences will be held at designated safe locations, and media representatives will be informed of regular update times to avoid constant interruptions to hospital operations.

Social media will be monitored continuously for inaccurate or harmful information, and corrective statements will be issued promptly when needed, always in both English and French.

Staff and Physician Communication

In a crisis, HGMH will ensure that all staff and physicians, including those who are off duty, are kept informed as per the Automated Fanout Communication System policy (COR.02.019.X.XX).

- Automated Alerts: The system will send notifications via phone, text, and email to all staff in the database.
- Message Content: Updates will be concise, factual, and will specify whether staff are required to report to work, remain on standby, or take other action.
- Two-Way Capability: Where possible, the system will allow staff to confirm receipt or provide status updates back to the hospital.
- Redundancy: If the automated system fails, alternate channels such as phone trees, secure messaging apps, or public radio announcements will be used.

System Overload & Backup Communication

HGMH recognizes that communication systems may become overloaded during high-profile crises. To ensure continuity of communication, the hospital will:

- **Ensure Website Readiness:** The hospital's website will be prepared to handle increased traffic, with critical updates presented in simplified formats (minimal graphics/color) to reduce load time.
- **Provide FAQ Management:** A dedicated crisis FAQ page will be maintained to answer common questions and reduce phone/email inquiries.
- **Have a Website Downtime Plan:** If the website is unavailable, updates will be shared through:
  - Social media (Facebook, Instagram, LinkedIn)
  - Media briefings and releases
  - Recorded information on a dedicated public information phone line
- **Use Internal Communication Backup:** If internal email is unavailable, use the intranet (if functioning), secure messaging apps, or pre-printed memos for distribution in key staff areas.

Reunification Communication

HGMH will incorporate communication into its reunification strategy for families during emergencies or disasters. While the operational plan for reunification is covered in the Job Action Sheets under Family Information, the communications component will ensure:

- **Clear Instructions:** Families and friends seeking loved ones receive clear, bilingual directions on how to access reunification support.
- **Designated Updates:** A specific communication channel (e.g., website page, hotline, media briefings) will be used to share information on reunification procedures.
- **Partnership Messaging:** If reunification is coordinated with external organizations (e.g., local health partners, community agencies, emergency services), messaging will be consistent across all parties.
- **Privacy and Sensitivity:** Communications will protect personal health information while ensuring families receive the support and guidance they need.

Contact List for Key Emergency Communication Partners

To ensure seamless coordination during crises, the Communications Officer will maintain and

annually update the Emergency Partner Contact List (XX-XXX-XX). This list will be accessible in the EOC bins, and will include:

- Emergency Medical Services (EMS): Direct communications line and public information officer contact.
- Fire Services: Dispatch and designated communication liaison.
- Police Services: Community safety and public affairs contact.
- Regional Health Authorities & Ontario Health East: Emergency coordination contact.
- Local Government (Mayor's Office, Council): Official spokesperson and media relations contact.
- Neighboring Hospitals & Health Partners: Communications leads for mutual support.
- Community Support Agencies: Partners in reunification, shelter, and mental health support.

The contact list will include 24/7 phone numbers, email addresses, and alternate methods (e.g., encrypted messaging platforms) to ensure redundancy.

Communication in Non-Official or Minority Languages

HGMH recognizes that the community may speak languages beyond English and French. To ensure clear and accurate communications with patients, a professional interpretation services provider which offers interpretation services in all languages including American Sign Language (ASL). This service is offered in accordance with the hospitals Interpretation Service Request policy (COR.03.001.X.XX).

Transition and Recovery Communication

As services transition back to normal after the crisis, the EOC will conduct a full debrief within two weeks. This review will assess what communications strategies worked well, what challenges arose, and what improvements can be made. The findings will be documented, and the Communications and Community Engagements Plan will be updated accordingly.

Community Engagement Strategies

Engagement is embedded in everyday interactions with staff, patients, and the broader community. Internally, the hospital promotes engagement through staff recognition events, employee feedback surveys, town halls, committee participation, and small group sessions (Round Table with Rob). These channels allow staff to voice ideas, raise concerns, and contribute to shaping the work environment.

Patient and family engagement is facilitated through the Patient and Family Advisory Committee, bilingual satisfaction surveys, patient rounding, and the use of accessible education and orientation materials. The hospital is committed to involving patients

and families in the design and evaluation of care processes to enhance experience and outcomes.

Annual Community Engagement Sessions take place to promote two-way dialogue with the communities we serve. These sessions create space for open discussion and feedback.

Evaluation of Communications and Community Engagement

We acknowledge that it is extremely difficult to measure the impact of communications activities on stakeholders' perceptions, attitudes, and behaviours, and even more difficult to measure the impact of communications on HGMH's strategic goals. HGMH can look to other, more subtle, indirect ways of measuring the success of its communications efforts, including:

- Number and tone of media articles, editorials, and letters to the editor
- Feedback through the website, phone calls, and at meetings / presentations
- Employee feedback and employee surveys
- Input from our Patient & Family Advisory Committee
- Website visitors and monitoring hits on the pages that people visit
- Feedback from all stakeholders as part of regular meetings with these groups.

Strategies and tactics will be modified over time in response to these results and as new challenges and opportunities arise.

Roles and Responsibilities

The Communications Officer leads the implementation of this plan, supported by the Senior Leadership Team. Department managers are responsible for cascading messages and encouraging team feedback, while all staff are encouraged to participate in engagement initiatives and provide input. The plan is reviewed annually in collaboration with key committees, including the IDEAA Committee and the Patient and Family Advisory Committee, to ensure alignment with the hospital's strategic direction and community needs.

Cross-Referenced Policies:

Policy Number	Policy Name
BOD.05.018.X.XX	Communications & Hospital Spokesperson
COR.03.003.X.XX	Accessibility Multiple Format
COR.08.005.X.XX	Social Media
BOD.01.002.X.XX	French Language Services

Associated Forms:

Form Number	Form Name
51-A-293	Communications Action Plan

Communications & Community Engagement Plan

HÔPITAL Glengarry Memorial HOSPITAL

Effective: Oct 2022	**Last review/revision:** Aug 2025	Next Review: Aug 2026
Owner: Communications Officer	**Signing Authority:** Senior Leadership	
PLN-001-0-25		

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.

Table of Contents

Background

Established in 1965, Hôpital Glengarry Memorial Hospital has been a cornerstone of healthcare in Alexandria, Ontario. It provides acute care, 24-hour emergency services, outpatient services, and rehabilitation to over 41,000 residents annually. Our team of over 180 staff members, 50 Medical Staff members, and 100 volunteers are dedicated to delivering high-quality health care to our Eastern Ontario community.

Our Mission

Delivering outstanding care for our communities.

Our Vision

Providing your care, your way with seamless integration, innovation, and equitable access for our communities.

Our Values

Our 'PACT' is our promise to have Passion, Accountability, Compassion & Teamwork at the heart of all we do, everyday.

Executive Summary

Effective communication is the process of sharing ideas and information in such a way that the content is received and understood in the way it was intended through a variety of channels to ensure understanding, collaboration, and trust among internal and external audiences. This includes day-to-day operational updates, announcements, crisis communication, health education, and promotional content.

HGMH's Communications & Community Engagement Plan is intended to guide the organization in communicating with its various stakeholders and ensure that the right people have the right information when they need it. This work requires that we provide information by the most appropriate method(s) to maximize clarity, conciseness, understanding, and transparency. All communication that is public facing will be available in both official languages (English and French) to align with the hospital's designation as a French Language Service hospital (as per the French Language Services policy BOD.01.002).

Community engagement refers to the process of building strong, reciprocal relationships with patients, families, and groups in the broader community. It involves listening, learning, and collaborating with stakeholders. The goal is to foster trust, reflect community voices, and ensure services and communications are culturally safe, inclusive, and responsive to community needs.

Communications

Stakeholders

The stakeholders listed below reflect the individuals, groups, and organizations with whom HGMH maintains strategic, operational, regulatory, and community relationships. Distribution ensures transparency, accountability, and engagement with those who have a vested interest in the hospital's performance and achievements.

Key themes that could be communicated are:

- **Strategic Direction & Accountability**: Annual Report; progress on Strategic Plan; governance and policy updates; hospital performance metrics
- **Clinical Excellence & Patient Care:** Accreditation readiness; patient safety initiatives; quality improvement updates; new/expanded services; recruitment successes
- **Workforce Engagement & Recognition**: recognition of staff, physicians and volunteers; milestones & retirements; professional development and training; IDEA initiatives
- **Community Impact & Partnerships:** partnerships within the community
- **Advocacy & Government Relations:** capital project needs; hospital funding priorities; alignment with municipal/federal priorities; small hospital advocacy
- **Education & Training Opportunities:** Student placement opportunities; partnerships with nursing/allied health institutions
- **Philanthropy & Fundraising:** Foundation campaign updates; impact of donations; capital equipment needs
- **Public Awareness & Media Relations:** Hospital news & service updates; health promotion & prevention campaigns; Care Champion stories; system updates of public interest

Stakeholder Group	Stakeholders	Key Themes for Communications & Engagement
Internal Governance & Leadership	• HGMH Board of Directors • HGMH Senior Leadership Team • HGMH Management Team • HGMH Medical Advisory Committee (MAC) • Department Chiefs	• Strategic Direction & Accountability • Clinical Excellence & Patient Care • Workforce Engagement & Recognition • Community Impact & Partnerships • Advocacy & Government Relations • Philanthropy & Fundraising
Hospital Staff, Physicians, and Volunteers	• All HGMH staff (via internal email and intranet) • Credentialed physicians and allied health professionals • Volunteer Auxiliary	• Strategic Direction & Accountability • Clinical Excellence & Patient Care • Workforce Engagement & Recognition • Community Impact & Partnerships • Education & Training Opportunities
Community Partners & Political Stakeholders	• Township of North Glengarry (Mayor, Council, CAO) • Township of South Glengarry (Mayor, Council, CAO)	• Community Impact & Partnerships • Advocacy & Government Relations

	• United Counties of Stormont, Dundas, and Glengarry (Council, CAO) • Local First Nations leadership – Mohawk Council of Akwesasne • MPP Prescott, Russel, & Glengarry • MPP Cornwall, Stormont, Dundas, and South Glengarry • MP Cornwall, Stormont, Dundas, Glengarry	
Healthcare and System Partners	• Ontario Health East Region • Ministry of Health – Ontario • Eastern Ontario Health Unit • Great River Ontario Health Team (OHT) partners • Regional hospitals and healthcare alliances (e.g., Atlas Alliance members) • Champlain Alliance of Small Hospitals	• Strategic Direction & Accountability • Clinical Excellence & Patient Care • Advocacy & Government Relations
Educational & Training Partners	• Nursing and allied health educational institutions partnered with HGMH • Medical residency and student placement programs	• Education & Training Opportunities
Fundraising & Philanthropic Partners	• HGMH Foundation Board of Directors & Staff	• Strategic Direction & Accountability • Philanthropy & Fundraising
Public & Media	• Local and regional media outlets • Posting on the HGMH public website and social media channels • Community members via newsletters and public engagement events	• Strategic Direction & Accountability • Clinical Excellence & Patient Care • Workforce Engagement & Recognition • Community Impact & Partnerships • Philanthropy & Fundraising • Advocacy & Government Relations • Public Awareness & Media Relations

This stakeholder distribution list will be reviewed annually by the Governance Committee to ensure accuracy, completeness, and alignment with Accreditation Canada requirements.

Planning Communication

With each communication, the following questions should be considered:

- Why is this important to communicate? **(What is the purpose?)**
- With whom do we want to communicate? **(Who are the stakeholders?)**
- What do we want to communicate? **(What is the message?)**
- How do we want to communicate it and through which medium? **(What communication tools are to be used?)**
- What is the timeline of communications / presentations? **(Define when and who plans, prepares, and presents)**

- What needs to be developed? **(Develop material, ads, news articles, etc.)**

The answers to these questions will establish the Communications Action Plan (51-A-293) to communicate successfully with the intended audience. This action plan will focus on the messaging, making it possible to target the stakeholders accurately, providing structure to define who HGMH needs to reach and the medium. This process will make communication more efficient, effective, and long lasting. More importantly, flexibility is key in planning and being prepared to adapt messaging to ensure success.

Guiding Principles

The hospital's approach to communication and engagement is grounded in several core principles:

- **Transparency:** Communicate timely, accurate, and honest information.
- **Accessibility:** Ensure all communication meets accessibility standards and is available in both English and French, in accordance with the hospital's designation under the French Language Services Act (FLSA).
- **Cultural Sensitivity and Inclusion:** Reflect and respect the diversity of the communities we serve.
- **Engagement:** Foster meaningful, two-way communication with staff, patients, families, and community members.
- **Alignment:** Support the hospital's strategic goals, values, and vision.

Goals and Objectives

The overarching goal is to enhance hospital experiences and community trust through clear, consistent, and culturally respectful communication.

Objectives:

- Maintain public trust through proactive messaging.
- Keep staff informed and engaged.
- Promote hospital programs and achievements.
- Respond quickly and effectively in crisis or urgent situations.
- Foster meaningful staff participation in internal initiatives.
- Improve patient and family experiences by promoting two-way dialogue.
- Strengthen community partnerships through inclusive outreach and collaboration.

Key Messages

HGMH aligns its key messages with the four strategic priorities from its strategic plan:

- Quality and Safety
  - Enrich the patient experience through quality, safe care that welcomes patients and families as partners in care.
- People and Culture
  - Improve engagement by investing in the organizations people and empower a caring and positive culture for all.

- Integration and Standardization
  - Deliver standardized quality care in a cost-effective way through collaboration & integration opportunities.
- Future Planning
  - Invest in the sustainability of our equipment & infrastructure to support safe, quality care.

Communication Tools

HGMH uses several methods to communicate, including:

- Patient and Family Advisory Committee meetings
- Website – www.hgmh.on.ca
- Social Media (Facebook, LinkedIn, YouTube)
- Advertising (media releases, news stories, other publications)
- Community engagement / events
- Staff Forums
- Glentranet (Hospital Intranet)
- Town Hall Meetings
- Internal communications:
  - Bi-Weekly Blitz newsletter
  - Weekly Clinical Update newsletter
  - Monthly Physician newsletter

Corporate Publications

Annual Report

Following the Annual General Meeting, the hospital's annual report / update to the community is released electronically on the website and communicated via social media. The Annual Report includes a high-level overview of the hospital's achievements, financial performance, strategic initiatives, and community impact over the past year. Hard copies are available upon request.

Strategic Plan

The Hospital's Strategic Plan serves as a guiding framework for a five-year period, outlining the hospital's long-term vision, mission and values as well as the strategic priorities, and commitments to patients, families, staff, and the community. It reflects input from stakeholders across the organization and community and is aligned with regional and provincial healthcare strategies.

The Strategic Plan is published on the hospital's website and shared with staff, physicians, partners, and the broader community through multiple communications channels including newsletters, media releases, and social media. Updates on progress toward Strategic Plan goals are integrated into the Annual Report and Annual Operating Plan. This ensures transparency and accountability, while keeping stakeholders informed of achievements and ongoing priorities.

Hard copies of the Strategic Plan are available upon request to ensure accessibility for all members of the community.

Annual Operating Plan
The Annual Operating Plan is released in May and outlines the hospital's strategic goals and operational priorities for the coming year. It serves as a roadmap for service delivery, quality improvement, and resource allocation, and it supports alignment with regional and provincial healthcare directives.

Patient Handbook
Our Patient Handbook is published annually at no cost to HGMH due to the sponsors who advertise in the publication. Hard copies are available for pick-up in high traffic areas (lobbies and waiting rooms), and electronically on the hospital's website. All admitted patients receive a copy of the Patient Handbook on admission as it outlines important information about patients' rights and responsibilities, hospital policies, services available, and what to expect during their stay.

Program / Service Brochures and Posters
HGMH develops various brochures and posters on an as needed basis to promote programs, services, or provide patient and family education.

Digital Media

Corporate Website
HGMH's website is used to outline programs and services offerings, sharing news updates, and to provide the community with feedback opportunities. The website is maintained by the Communications Officer and continues to evolve with new and improved content as needed.

Newsletters
Internal newsletters are produced and distributed to staff by email and on the intranet to ensure current information is disseminated on a regular basis. The Weekly Clinical Update includes up-to-the-minute information from the clinical managers, highlighting reminders about workflow changes, policy updates, upcoming education opportunities, etc. The Bi-Weekly Blitz is a general newsletter for all staff, which provides updates on internal wellness activities, community events, news from various departments, etc. The monthly physician newsletter is geared towards physicians and includes physician meeting dates, important departmental information, highlights around workflow changes, and policy updates.

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- **Communications Officer:** Coordinates all communication activities, drafts and distributes updates, manages website, media relations and social media as per the Social Media policy (COR.08.005.X.XX).
- **Managers**: Share approved messages with teams and gather feedback/questions for follow-up.
- **Administration On-Call**: Acts as the 24-hour contact point for the organization, ensuring stakeholder inquiries during emergencies are addressed or escalated to the appropriate lead as per the Administration On-Call policy (COR.01.005.X.XX)

Key Communication Actions

1. **Initial Holding Statement:** Release a brief, factual, and empathetic message acknowledging the situation and advising when further updates will follow.
2. **Audience Identification:** Determine priority audiences (staff, patients/families, media, community partners, public).

3. **Channel Selection:** Choose the most effective mix of channels (email, intranet, website banner, social media, media release).
4. **Update Frequency:** Commit to regular updates, even if the information is unchanged, to reinforce transparency.
5. **Message Consistency:** Ensure all public-facing channels deliver the same core messages.
6. **Compliance with Legislation and Standards:** All communications will comply with applicable laws, regulations, and quality standards, including:
    a) Accessibility Requirements: Ensure content is accessible in accordance with the Accessibility for Ontarians with Disabilities Act (AODA) and other relevant accessibility standards.
    b) Privacy laws: Protect personal and health information in compliance with applicable privacy legislation.
    c) French Language Services Requirements: Provide communications in both English and French, meeting obligations under the French Language Services Act (FLSA).
7. **Monitoring**: Track social media, media coverage, and public feedback to identify and correct misinformation quickly.

Media Management

During a crisis, all media inquiries will be directed to the Communications Officer, who will then report to the President & CEO as per the Communications & Hospital Spokesperson policy (BOD.05.018). This ensures that the hospital speaks with one consistent voice and prevents misinformation from circulating. Press conferences will be held at designated safe locations, and media representatives will be informed of regular update times to avoid constant interruptions to hospital operations.

Social media will be monitored continuously for inaccurate or harmful information, and corrective statements will be issued promptly when needed, always in both English and French.

Staff and Physician Communication

In a crisis, HGMH will ensure that all staff and physicians, including those who are off duty, are kept informed as per the Automated Fanout Communication System policy (COR.02.019).

- Automated Alerts: The system will send notifications via phone, text, and email to all staff in the database.
- Message Content: Updates will be concise, factual, and will specify whether staff are required to report to work, remain on standby, or take other action.
- Two-Way Capability: Where possible, the system will allow staff to confirm receipt or provide status updates back to the hospital.
- Redundancy: If the automated system fails, alternate channels such as phone trees, secure messaging apps, or public radio announcements will be used.

System Overload & Backup Communication

HGMH recognizes that communication systems may become overloaded during high-profile crises. To ensure continuity of communication, the hospital will:

- **Ensure Website Readiness:** The hospital's website will be prepared to handle increased traffic, with critical updates presented in simplified formats (minimal graphics/color) to reduce load time.
- **Provide FAQ Management:** A dedicated crisis FAQ page will be maintained to answer common questions and reduce phone/email inquiries.
- **Have a Website Downtime Plan:** If the website is unavailable, updates will be shared through:
    - Social media (Facebook, Instagram, LinkedIn)
    - Media briefings and releases
    - Recorded information on a dedicated public information phone line
- **Use Internal Communication Backup:** If internal email is unavailable, use the intranet (if functioning), secure messaging apps, or pre-printed memos for distribution in key staff areas.

Reunification Communication

HGMH will incorporate communication into its reunification strategy for families during emergencies or disasters. While the operational plan for reunification is covered in the Job Action Sheets under Family Information, the communications component will ensure:

- **Clear Instructions:** Families and friends seeking loved ones receive clear, bilingual directions on how to access reunification support.
- **Designated Updates:** A specific communication channel (e.g., website page, hotline, media briefings) will be used to share information on reunification procedures.
- **Partnership Messaging:** If reunification is coordinated with external organizations (e.g., local health partners, community agencies, emergency services), messaging will be consistent across all parties.
- **Privacy and Sensitivity:** Communications will protect personal health information while ensuring families receive the support and guidance they need.

Contact List for Key Emergency Communication Partners

To ensure seamless coordination during crises, the Communications Officer will maintain and annually update the Emergency Partner Contact List (51-F-62). This list will be accessible in the EOC bins, and will include:

- Emergency Medical Services (EMS): Direct communications line and public information officer contact.
- Fire Services: Dispatch and designated communication liaison.
- Police Services: Community safety and public affairs contact.
- Regional Health Authorities & Ontario Health East: Emergency coordination contact.
- Local Government (Mayor's Office, Council): Official spokesperson and media relations contact.
- Neighboring Hospitals & Health Partners: Communications leads for mutual support.
- Community Support Agencies: Partners in reunification, shelter, and mental health support.

The contact list will include 24/7 phone numbers, email addresses, and alternate methods (e.g., encrypted messaging platforms) to ensure redundancy.

Transition and Recovery Communication

As services transition back to normal after the crisis, the EOC will conduct a full debrief within two weeks. This review will assess what communications strategies worked well, what challenges arose, and what improvements can be made. The findings will be documented, and the Communications and Community Engagements Plan will be updated accordingly.

Community Engagement Strategies

Engagement is embedded in everyday interactions with staff, patients, and the broader community. Internally, the hospital promotes engagement through staff recognition events, employee feedback surveys, town halls, committee participation, and small group sessions (Round Table with Rob). These channels allow staff to voice ideas, raise concerns, and contribute to shaping the work environment.

Patient and family engagement is facilitated through the Patient and Family Advisory Committee, bilingual satisfaction surveys, patient rounding, and the use of accessible education and orientation materials. The hospital is committed to involving patients and families in the design and evaluation of care processes to enhance experience and outcomes.

Annual Community Engagement Sessions take place to promote two-way dialogue with the communities we serve. These sessions create space for open discussion and feedback.

Evaluation of Communications and Community Engagement

We acknowledge that it is extremely difficult to measure the impact of communications activities on stakeholders' perceptions, attitudes, and behaviours, and even more difficult to measure the impact of communications on HGMH's strategic goals. HGMH can look to other, more subtle, indirect ways of measuring the success of its communications efforts, including:

- Number and tone of media articles, editorials, and letters to the editor
- Feedback through the website, phone calls, and at meetings / presentations
- Employee feedback and employee surveys
- Input from our Patient & Family Advisory Committee
- Website visitors and monitoring hits on the pages that people visit
- Feedback from all stakeholders as part of regular meetings with these groups.

Strategies and tactics will be modified over time in response to these results and as new challenges and opportunities arise.

Roles and Responsibilities

The Communications Officer leads the implementation of this plan, supported by the Senior Leadership Team. Department managers are responsible for cascading messages and encouraging team feedback, while all staff are encouraged to participate in engagement initiatives and provide input. The plan is reviewed annually in collaboration with key committees, including the IDEAA Committee and the Patient and Family Advisory Committee, to ensure alignment with the hospital's strategic direction and community needs.

CROSS-REFERENCED POLICIES:

Policy Number	Policy Name
BOD.05.018	Communications & Hospital Spokesperson
COR.03.003	Accessibility Multiple Format
COR.08.005	Social Media
BOD.01.002	French Language Services

ASSOCIATED FORMS:

Form Number	Form Name
51-A-293	Communications Action Plan
51-F-62	Emergency and Disaster Response Contacts

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Governance ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: September 29, 2025 Meeting Date Prepared for: October 8, 2025

Subject: Policy Review

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 three new policies that have been developed, one reflects best practices in governance and the other two of which were created to meet Accreditation requirements.

RECOMMENDATION / MOTION

That the Governance and Nominating Committee recommend to the Board of Directors the approval of the Meetings Without Management policy, the CEO and COS Performance Evaluation policy, and the Acts, Legislations, and Compliance Reporting policy 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.

Summary of Policies:

Meetings Without Management Policy

- This policy ensures that the Board of Directors has regular opportunities to meet independently of hospital management.
- Best practices in governance recommend that Boards hold sessions without management present in order to encourage open dialogue, strengthen Board cohesion, and provide a forum for directors to raise sensitive matters.
- This practice will enhance transparency, accountability, and the effectiveness of the Board's decision-making processes.

CEO and Chief of Staff (COS) Performance Evaluation Policy

- This policy was developed to establish a formal and consistent process for the annual evaluation of the CEO and COS.
- The policy was created to meet Accreditation Canada standards, which require defined evaluation mechanisms for senior leadership roles. (Governance Accreditation Criterion Statement 3.2.3)
- This process will ensure accountability, provide constructive feedback to leadership, align performance with the hospital's strategic goals, and demonstrate compliance with Accreditation requirements.

Acts, Legislations, and Compliance Reporting Policy

- This policy was developed to formalize the process by which the hospital ensures compliance with all applicable acts, regulations, and legislation.
- Also created to meet Accreditation Canada requirements, this policy establishes a clear framework for tracking, monitoring, and reporting compliance obligations to the Board. (Governance Accreditation Criterion Statement 3.5.1)
- This will strengthen oversight, reduce organizational risk, and provide the Board with assurance that the hospital remains compliant with its legislative and regulatory responsibilities.

IMPLEMENTATION & COMMUNICATION PLAN

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

- Obtain Board Approval – October 23, 2025
- Update Board Policy Online
- Include updates in Board Orientation Material

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Draft Meetings Without Management policy
- Draft CEO and COS Performance Evaluation policy
- Draft Acts, Legislations, and Compliance Reporting policy

MEETINGS OF DIRECTORS WITHOUT MANAGEMENT

Document Name:	Meetings of Directors Without Management	
Document Number:	BOD.0X.XXX.0.25	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Board Effectiveness	
Owner: Board Chair	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The purpose of this policy is to outline the procedure for meetings of the Board of Directors to be held without the presence of senior management. These in-camera sessions provide an opportunity for directors to engage in open and candid discussion on matters that may be sensitive or require confidentiality.

The Board of Directors recognizes the importance of holding regular meetings without directors to enhance governance effectiveness, promote accountability, and ensure an environment of trust among directors. These meetings are intended to:

- Ensure the Board exercises independent oversight of management;
- Discuss issues or concerns related to the hospital and/or the management thereof;
- Provide an opportunity to assess board processes and particularly the quality of material and information provided by management;
- Provide an opportunity for the Board Chair to discuss areas where their performance could be strengthened;
- Build relationships of confidence and cohesion among Board Directors.

PROCEDURE:

1. Such meeting shall not be considered to be a meeting of the Board but rather will be for information purposes only.

2. Minutes will not be kept, but the Chair may keep notes of the discussion.

3. The Chief Executive Officer (CEO) and the Chief of Staff (COS) may be invited by the Chair to participate in a part of the meeting without management before being excused.

4. The Chair shall immediately communicate with the CEO and, as appropriate, the COS any relevant matters raised in the meeting.

REFERENCES:

1. OHA Guide to Good Governance

Document Name:	CEO and COS Performance Evaluation	
Document Number:	BOD.02.XXX.0.25	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors		**Section:** Leadership
Owner: Board Chair		**Signing Authority:** Board of Directors

POLICY STATEMENT:

This policy outlines the process and responsibilities for the annual performance evaluation of the Chief Executive Officer (CEO) and the Chief of Staff (COS). The evaluation ensures accountability, alignment with strategic goals, and continuous leadership development. It reflects the Board's commitment to good governance, transparency, and performance excellence.

This policy applies to the performance evaluation of the CEO and COS of Hôpital Glengarry Memorial Hospital, overseen and conducted by the Executive Committee of the Board of Directors.

PROCEDURE:

The Executive Committee will annually review the process of soliciting input prior to the completion of the performance evaluation process. Each year, the committee will complete the evaluation using the following procedure:

1. The CEO and COSs personal business commitments will be established at the beginning of the year and reviewed bi-annually and prior to the completion of the performance evaluation.

2. The CEO and COS will complete a self-evaluation for the review with the committee.

3. The committee will determine the list of participants in the review. Each board member will have an opportunity for input.

4. The committee will meet to review all relevant factors that will go into the final evaluation. This will include:
    a. A review of the CEO and COSs annual goals and priorities.
    b. A review of the progress of strategic planning initiatives against approved targets.
    c. Input from stakeholders.
    d. An anecdotal review of major events and milestones of the past year.

5. Some of these items will be measurable, but many will require the exercise of judgment by the committee members. This judgment must be exercised in good faith in a manner consistent with the mission, vision and values.

6. At a final meeting with the CEO and COS, the committee will review its determinations, review the self-assessments, and finalize the evaluation.

7. At this point, the committee will meld the results of the evaluation with the incumbent's position relative to the target compensation peer market. A recommendation to the board will include this review and the comparison between relative market position and relative performance.

8. The report to the board will include a one-page summary of the process and outcomes and recommendations.

9. Following approval, the committee will work with the CEO and COS to set goals and priorities for the coming year.

REFERENCES:

1. OHA Guide to Good Governance
2. Executive Compensation Framework

Document Name:	Acts, Legislations, and Compliance Reporting	
Document Number:	BOD.0X.XXX.0.25	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Board Effectiveness	
Owner: Board Chair	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The purpose of this policy is to ensure that the Board of Directors fulfills its duty to oversee compliance with all applicable legislation, regulations, and contractual obligations, and to establish clear reporting requirements to support accountability, transparency, and risk management.

The Board of Directors has a fiduciary responsibility to ensure that the Corporation complies with all relevant federal, provincial, and municipal legislation, regulatory requirements, and contractual obligations.

The CEO is responsible for implementing processes and operating policies that ensure ongoing compliance. The CEO shall report regularly to the Board regarding statutory filings, compliance status, and any associated risks.

Where applicable laws or regulations conflict with the Corporation's mission, vision, and values, the Board will apply its decision-making framework to determine whether to pursue advocacy for exemptions or legislative change.

PROCEDURE:

1. *Responsibilities*

Board of Directors

- Ensures that compliance oversight is integrated into governance responsibilities.
- Reviews quarterly and annual reports from the CEO on compliance with statutory obligations, legislation, and regulatory requirements.
- Balances fiduciary duties with broader social responsibilities, ensuring alignment with organizational ethics and values while minimizing liability.
- Reviews and approves all required attestations under the Broader Public Sector Accountability Act, 2010 (BPSAA).
- Ensures Board-approved attestations are posted publicly in accordance with legislative requirements.

Chief Executive Officer

- Implements processes and operating policies to ensure compliance with federal, provincial, and municipal legislation and associated risks.
- Ensures timely completion of statutory filings and payments.

- Provides compliance reports to the Board as outlined under Reporting Requirements.
- Prepares CEO attestations as required under the BPSAA for Board review and approval.

2. *REPORTING REQUIREMENTS*

The CEO shall report to the Board regularly through the Finance, HR, and Audit Committee on the Corporation's compliance with:

- Employee remuneration;
- Statutory remittances (Receiver General, Ministry of Finance and Workplace Safety and Insurance Board);
- Healthcare of Ontario Pension Plan
- Bargaining Units (union dues)

The CEO shall report to the Board annually through the Finance, HR, and Audit Committee on:

- Compliance with occupational health and safety legislation, including:
  - i) a functioning safety committee with maintained meeting minutes;
  - ii) documentation of committee recommendations and management responses;
  - iii) appropriate corrective actions taken;
  - iv) up-to-date safety manuals;
  - v) identification of hazardous materials;
  - vi) proper maintenance of signage;
  - vii) ongoing staff training; and
  - viii) an established procedure for ongoing monitoring.
- Compliance with environmental legislation and regulations.
- Directors' and officers' liability insurance, including confirmation of:
  - i) suitable coverage in accordance with risk;
  - ii) sufficient indemnity amount;
  - iii) premiums paid and policy up-to-date.
- Compliance with the Broader Public Sector Accountability Act, 2010, including CEO attestations on:
  - i) the completion and accuracy of consultant use reports;
  - ii) compliance with prohibitions on engaging lobbyist services using public funds;
  - iii) compliance with expense claim directives;
  - iv) compliance with perquisite directives; and
  - v) compliance with procurement directives.

3. *Decision-Making in Conflict Situations*

When laws or regulations are at odds with the organization's vision, mission, and values, the Board will:

- Apply its established Framework for Ethical Decision-Making (BOD.03.003.X.XX)

- Consider whether to pursue advocacy for exemptions, amendments, or systemic change.

When conflicts arise between legal/fiduciary responsibilities and broader social responsibilities, the Board will:

- Balance the two obligations with fairness and accountability.
- Ensure decisions align with organizational ethics and values.
- Take measures to minimize liability while upholding the organization's integrity.

CROSS-REFERENCED POLICIES:

Policy Number	Policy Name
BOD.03.003.X.XX	Framework for Ethical Decision-Making

REFERENCES:

1. Trillium Health Partners, Board of Directors Policy Manua, Policy II-13 Reporting on Compliance (September 29, 2023)
2.

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee - Governance ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: September 30, 2025 Meeting Date Prepared for: October 8, 2025

Subject: Accreditation Standard Feature

Prepared by: Robert Alldred-Hughes, President & CEO

☐ 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

3.1.11 The governing body ensures that the organization has a comprehensive human resources strategy.

Priority: **High Priority** | Quality Dimension: **Worklife**

Guidelines

The governing body ensures that the organization keeps it informed about human resource risks and opportunities facing the organization to ensure the risks and opportunities are well-managed for a safe and effective workforce. The governing body ensures that the organization develops and regularly (at least annually) reviews its human resources strategy with the workforce. The governing body ensures that the organization has a human resources strategy that:

- Addresses recruitment of its workforce and volunteers
- Includes health and safety programs to manage the physical, psychological, and cultural health and safety of its workforce and volunteers
- Includes talent management systems to manage and improve staff performance, support professional development and build staff competencies, encourage staff retention, and support succession planning
- Reflects input from clients and families about the people-centred characteristics, competencies, and values that should be reflected throughout the organization's workforce
- Reflects an equity, diversity, and inclusion (EDI) approach. For example, it has equitable and evidence-informed recruitment and selection procedures that include steps to avoid unconscious bias in favour of or against a person, group, or attribute (e.g., age, gender identity, race, ethnicity) and to build an organizational workforce that reflects the diverse populations and groups that make up the organization's community
- Includes succession planning procedures to build capacity of diverse workforce members to fill critical and leadership roles through education, training, coaching, job rotation, and mentoring

- Ensures that the financial compensation model for its workforce, including senior leaders, is based on relevant laws, regulations, and contractual obligations.
- The compensation model is regularly reviewed and kept up to date, and takes into consideration job stresses and risks, pay equity, labour market, cost-of-living increases, bonuses, benefits, and allowances Includes continuous learning and improvement processes

The governing body ensures that the organization has an organizational structure in place that supports its human resources strategy. It ensures that the organization aligns its human resources strategy with the organization's planning for business continuity, whether in times of disruption or as part of long-term planning. Effective talent management contributes to business continuity by, for example, minimizing the impact of the departure of a senior leader or key operational workforce member by preparing internal candidates to step into the role.

DISCUSSION QUESTIONS

Choose 1-2 questions from the list below to guide discussion at your meeting, or create your own question(s)

- What does this standard mean to you / why is it important for this team?
- What does the hospital already do to meet this standard?
- What new things can the hospital implement to meet this standard?
- How does this team contribute to meeting this standard?
- What opportunities are there for this team to do things differently?
- How would you respond to a surveyor asking you a question about this standard?
- How can we best support staff awareness of the hospital's approach to this standard so they are prepared to answer surveyor questions?
- What evidence (i.e.: documentation) can support the hospital's compliance with this standard?

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Governance ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: September 30, 2025 Meeting Date Prepared for: October 8, 2025

Subject: Inclusion, Diveristy, Equity, & 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 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 Inclusion, Diversity, Equity, and Anti-Racism (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, lots of work has been 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 of 2024, an IDEA Framework was developed by HGMH, propelled by the Boards Policy related to IDEA, 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 last two years, 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.
- During September 30, 2024 National Truth and Reconciliation Day, HGMH held a series during the month of September to support Truth and Reconciliation, including a special on-site ceremony and social on September 17th from 1-3. Board Members were encouraged to attend, and invitations to MP's and MPP, including municipal officials have been issued.

- The IDEA Committee has selected cultural celebration days to be recognized through communication and special events. Recently those included Black History Month, and Pink Shirt Day.

- In October 2024 HGMH rolled out an education program for all leaders and Board Members at HGMH to complete through Culture Ally. There have been 13 educations sessions delivered in this online format, with regular discussions about the learnings occurring at Monthly Leadership and Board Meetings.

In 2025, further work has built upon these foundations:

- HGMH updated its Job Description Template to include an IDEA values statement:
  "We recognize the intrinsic value of every individual and the diversity they bring to our community. We are committed to fostering a sense of belonging and an environment that upholds principles of equity, diversity, inclusion and anti-racism in every facet of our operations. Our commitment is rooted in our belief that healthcare should be equitable, accessible and inclusive for all."

- The Committee is actively sharing information with respect to IDEA to all staff, physicians, PFAC, Auxiliary and Board in the bi-weekly blitz.

- Staff education on IDEA fundamentals was launched, exceeding the targeted completion rate within the first few weeks.

- The IDEA Committee identified inclusive spiritual care contacts from the broader community who are willing to provide care for patients, and these have been included in the new Palliative and End of Life Care handbook.

- Patient satisfaction survey data is also being reviewed to better understand and respond to the experiences of patients who self-identify as Indigenous and gender-diverse.

- Ongoing review of policies is being completed through an IDEA lens. Recently reviewed policies include Pastoral Care, Unidentified Patients, Accessibility, and Use of the Spiritual and Cultural Care Room.

- An education day to strengthen point-of-care staff knowledge about cultural safety in care is being supported by the Traditional Medicine Team in Akwesasne. This ensures staff have the knowledge and support needed to provide culturally safe care for First Nations, Inuit, and Métis patients. It is occurring on October 9th 2025.

- In September 2025, HGMH unveiled the Indigenous Art Installation with a special ceremony attended by the artist, Dawn Iehstoseranón:nha, the Department of Health Team from Akwesasne, and invited guests. Staff, physicians, and volunteers were also welcomed to take part in this meaningful event. The commissioned artwork now permanently displayed in the hospital stands as a symbol of our commitment to Indigenous patients and families, honoring the whole person and reinforcing our dedication to providing culturally safe and supportive care.

- On October 8, 2025, the new Spiritual and Cultural Care Room will open, designed in partnership with the Patient and Family Advisory Council (PFAC) and IDEA Committee, with sponsorship from the Auxiliary.
- 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.