

## Board of Directors Meeting Agenda

Date: Thursday, October 23, 2025  
 Time: 5:00pm - 8:00pm  
 Location: Boardroom / Microsoft Teams

Time	Agenda Item	Attachment
<b>5:00</b>	<b>1. Call to Order (Dr. S. Robertson)</b>	
(1 min)	1.1 Confirmation of Quorum	
(1 min)	1.2 Land Acknowledgment	
(1 min)	1.3 Adoption of the agenda	P. 1-2
(1 min)	1.4 Declaration of Conflict of Interest ( <a href="#">Policy BOD.01.013.X.XX</a> )	
<b>5:04</b>	<b>2. Minutes (Dr. S. Robertson)</b>	
(1 min)	2.1 Approval of previous meeting minutes - September 25, 2025	P. 3-7
(1 min)	2.2 Business arising from minutes	
<b>5:06</b>	<b>3. Education</b>	
(15 min)	3.1 Cyber Security (D. Lorimer)	
<b>5:21</b>	<b>4. Matters for Discussion/Decision</b>	
(5 min)	4.1 Report of the Board Chair (Dr. S. Robertson)	
(5 min)	4.2 Report of the President & CEO (R. Alldred-Hughes)	P. 8-10
(5 min)	4.3 Report of the Chief of Staff (Dr. L. MacKinnon)	P. 11
(5 min)	4.4 Report of the VP Clinical Services, Quality & CNE (R. Romany)	P. 12-13
(5 min)	4.5 Report of the Patient and Family Advisory Committee (J. Shackleton)	
(5 min)	4.6 Report of the Executive Committee Chair (Dr. S. Robertson)	
(5 min)	4.7 Report of the Governance & Nominating Committee Chair (L. Boyling)	
(5 min)	4.8 Q1 Strategic Actions (L. Boyling/R. Alldred-Hughes) <b>THAT the Board of Directors review and receive the Q1 Strategic Action results as presented.</b>	P. 14-18
(5 min)	4.9 Review Revised Communication & Community Engagement Plan (L. Boyling/ R. Alldred-Hughes) <b>THAT the Board of Directors review and receive the revised Communication &amp; Community Engagement Plan as presented.</b>	P. 19-34
<b>6:27</b>	<b>5. Consent Agenda</b> (a formal request is to be made with the Board Chair to move an item out of the consent agenda for it to be discussed)	
	5.1 Draft Executive Committee Report	P. 35-36
	5.2 CEO Personal Business Commitment Update	P. 37-41
	5.3 COS Personal Business Commitment Update	P. 42-44
	5.4 Updated Executive Committee Terms of Reference	P. 45-47
	5.5 Draft Governance and Nominating Committee Report	P. 48-50
	5.6 Governance & Nominating Committee Work Plan	P. 51
	5.7 Board Committee Terms of Reference	P. 52-62
	5.8 Meetings of Directors Without Management Policy	P. 63-65
	5.9 CEO and COS Performance Evaluation Policy	P. 66-67
	5.10 Acts, Legislations, and Compliance Reporting Policy	P. 68-70
	5.11 Inclusion, Diversity, Equity & Anti-Racism Update	P. 71-73
	<b>THAT the Board of Directors approve and receive all documents as presented in the consent agenda.</b>	
<b>6:28</b>	<b>6. Correspondence (Dr. S. Robertson)</b>	P. 74
	<b>7. Date of Next Meeting - Thursday, November 27, 2025 5:00pm</b>	
<b>6:29</b>	<b>8. Closing Remarks &amp; Adjournment (Dr. S. Robertson)</b>	

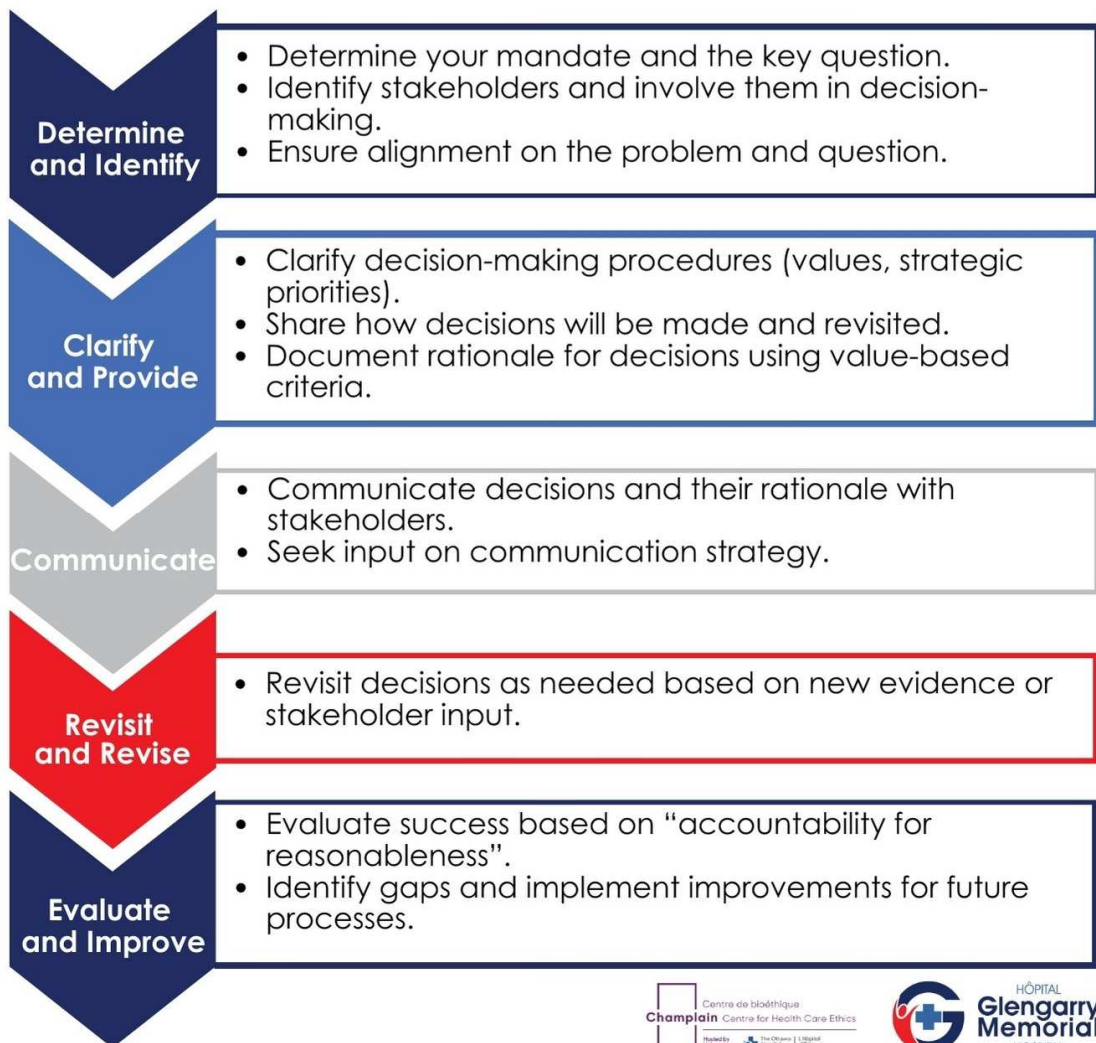
\*Meeting Moves to In Camera

# Accountability for Reasonableness (A4R) Ethical Decision Making Framework Steps

## Values that Optimize Fairness in the Process of Decision-Making



## A4R Action Steps



## MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS

Date Thursday, September 25, 2025  
 Time 5:009m-8:00pm  
 Location Boardroom / Microsoft Teams  
 Present: Dr. S. Robertson, Chair L. Boyling, Vice-Chair Dr. R. Cardinal  
 D. Elie H. Salib G. McDonald  
 C. Larocque F. Desjardins R. Romany, CNE  
 R. Alldred-Hughes, CEO K. MacGillivray Dr. L. MacKinnon, COS

Regrets: Dr. G. Raby G. Peters C. Nagy  
 L. Ramsay

### 1. Call to Order

Dr. S. Robertson, Chair, called the meeting to order at 5:01pm.

#### 1.1 Quorum

A quorum was present.

#### 1.2 Land Acknowledgment

G. McDonald read the land acknowledgment.

#### 1.3 Adoption of the Agenda

The agenda was reviewed

Moved By: C. Larocque

Seconded By: L. Boyling

THAT the agenda be adopted as presented.

**CARRIED**

#### 1.4 Declaration of Conflict of Interest

There were no conflicts of interest declared at this time.

### 2. Minutes

#### 2.3 Approval of the Minutes

The minutes of the last meetings held on June 19, 2025, and June 26, 2025, were shared.

Moved By: Dr. R. Cardinal

Seconded By: H. Salib

THAT the minutes of the June 19, 2025, and June 26, 2025 meeting be approved as presented.

**CARRIED**

#### 2.2 Business Arising from the Minutes

There was no business arising from the minutes.

### 3. Equity, Diversity & Inclusion

The mini training for EDI was assigned, titled Disability Awareness. The Board discussed their thoughts on the training.

#### **4 Education**

##### **4.1 Occupational Health & Safety**

D. Eastwood, Occupational Health & Safety Coordinator, presented on health & Safety within the hospital including the duties of the employer, managers, and workers as well as work done by the Joint Occupational Health and Safety Committee. Progress on health and safety was acknowledged, and D. Eastwood was thanked for her contributions to the organization.

#### **5 Matters for Discussion/Decision**

##### **5.1 Report of the Board Chair**

The Board will have to recruit next year as one Director resigned due to health issues.

Reminder was made on the upcoming Board Retreat, taking place on October 4<sup>th</sup> at the Sandfield Center.

The Foundation Chair, Mark Adam, was introduced to the Board and roundtable was done.

##### **5.2 Report of the President & CEO**

R. Alldred-Hughes reported on delegation in which he attended at the Association of Municipalities of Ontario Conference. A follow up was requested in which Ontario Health has notified us that the submission is likely to be reviewed early October.

Gratitude was expressed to all those who helped out at the Foundation gold tournament.

A Code Orange tabletop took place today and J. Mattice was thanked for her hard work on this initiative which also saw external partners participate around the table.

K. MacGillivray, C. Maruno and the IDEA committee were thanked for their work on the unveiling of the Indigenous Art which is now hanging in the Main Entrance. The ceremony took place earlier this week in which the artist attended and was very appreciative.

##### **5.3 Report of the Chief of Staff**

All physicians pulled together to ensure that shifts were all covered throughout the summer and a new physician, Dr. W. Badawy, recently started in the Emergency Department. A physiatrist has also joined the medical staff and is providing physiatry services on the inpatient unit.

Medical learners continue to show lots of interest in doing a placement at the hospital and work is being done to try and accommodate as many of these students as possible.

The portal to complete the chart reviews has now been setup however, the charts to be reviewed have not yet been assigned.

Leadership for the Professional Staff Association remains unchanged for the year following the Annual General Meeting which took place in August. The President of the Professional Staff Association has been invited to the Board meeting as per the Bylaws.

5.4 Report of the VP of Corporate Services and CFO

The report was shared in the package for information.

5.5 Report of the Patient and Family Advisory Committee

The Patient and Family Advisory Committee have been busy over the summer with working on the Spiritual Care Room. The opening of the room is set to take place on October 8<sup>th</sup>.

5.6 Report of the Quality and Patient Safety Backup Chair

At the committee meeting, results of the QIP were reviewed as well as the Quality & Safety Dashboard.

5.7 Q1 Quality Improvement Plan Results

The Q1 Quality Improvement Plan results were reviewed.

Moved By: L. Boyling

Seconded By: G. McDonald

THAT the Board of Directors review and receive the Q1 Quality Improvement Plan results as presented.

The left without being seen rate is currently lower than the target and is at half of what was reported last year at this time which indicates great work being done in the department.

The IDEA education is currently in red however, the roll out was just being done and Q2 will see a much higher percentage.

**CARRIED**

5.8 Q1 Quality & Safety Scorecard Results

The Q1 Quality & Safety Scorecard results were reviewed.

Moved By: G. McDonald

Seconded By: F. Desjardins

THAT the Board of Directors review and receive the Q1 Quality Improvement Plan results as presented.

Overall, the results are positive, however the inpatient unit has been on outbreak for 15 weeks now. The Health Unit has come on site and provided some recommendations.

**CARRIED**

5.9 Q1 Patient Satisfaction Survey Results

The Q1 Patient Satisfaction Survey results were reviewed.

Moved By: F. Desjardins

Seconded By: H. Salib

THAT the Board of Directors review and receive the Q1 Patient Satisfaction Survey results as presented.

The survey results are very positive and there is a large number of respondents answering the surveys.

**CARRIED**

5.10 Report of the Finance, HR and Audit Committee Chair  
The report was deferred in the absence of the Chair.

5.11 Financial Statements - April, May and June 2025  
The financial statements were reviewed.

Moved By: F. Desjardins

Seconded By: L. Boyling

THAT the Board of Directors review and receive the Financial Statements for April, May, and June 2025 as presented.

June ended with a deficit of \$240,000 which is over and above the projected \$146,000 deficit. Funding letters were received in August and will be reflected on later statements.

5.12 Q1 HR Metrics Report  
The Q1 HR Metrics were reviewed.

Moved By: L. Boyling

Seconded By: H. Salib

THAT the Board of Directors review and receive the Q1 HR Metrics Report as presented.

It was noted that while the metric on Management Voluntary Separation was red, this represents just one Manager who retired.

Generally, a higher volume of students is seen in fall and winter. A facility tour as done with the coordinator of St Lawrence College in hopes of having them send more students here.

The metric on IDEA education is currently red, however a change will be noted in Q2 as the education was just being rolled out in Q1.

5.13 Epic Implementation Update

The Atlas Alliance sends out a report on how each site is doing in which we are currently scoring 8 out of 10. Progress is moving along well and work is now being done on identifying trainers including physicians in training roles. The planned go live is set for October 2026.

## 6 Consent Agenda

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

6.1 Report of the Auxiliary President

6.2 Draft Quality and Patient Safety Committee Report

6.3 Quality and Patient Safety Committee Work Plan

6.4 Draft Finance, HR and Audit Committee Report

7 Finance, HR and Audit Committee Work Plan

Moved By: C. Larocque

Seconded By: F. Desjardins

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

**CARRIED**

**8 Correspondence**

Correspondence was shared.

**9 Date of Next Meeting**

Thursday, October 23, 2025, at 17:00

K-L Massia, Recording Secretary

DRAFT

## Report of the President & CEO

*October 23, 2025 Leadership Team Meeting*

### Capital Redevelopment – Update

I received an update from Ontario Health East regarding our pre-capital submission. The proposal is currently under review by their cross-functional teams, and a decision from the Regional Leadership Team is expected in early October. At this stage, no additional information has been requested from HGMH, but Ontario Health has confirmed they will reach out if needed.

This is a positive sign that our submission is moving forward in the process. I will keep you updated once the Regional Leadership Team has made its decision, as this will be a key step in advancing our redevelopment journey.

### Round Table with Rob

As part of my ongoing “Round Tables with Rob” sessions, I’ve had the opportunity to sit down with some of our new team members and hear directly about their experiences since joining HGMH. The feedback has been very encouraging. Several have highlighted how welcoming the environment has been and how quickly they’ve felt a sense of belonging. They also spoke positively about the teamwork and supportive culture they are seeing across departments. It’s reassuring to know that the efforts we are all making to strengthen our workplace culture are being noticed and appreciated by those newest to our organization.

### Senior Leadership Patient Rounding – Update

During Patient Experience Week in April, the Senior Leadership Team launched a new patient rounding initiative aimed at deepening our understanding of the patient experience at HGMH. To date, we have talked to over 32 patients. These rounds have provided valuable opportunities to hear directly from patients about their feelings of safety in the hospital, their involvement in care decisions, and to recognize staff who have made a meaningful impact during their stay. The feedback received so far has been overwhelmingly positive, with many patients expressing their appreciation for the kindness and professionalism of our staff, as well as the quality of our food services. One area for continued improvement identified through these conversations is the consistent use of patient room whiteboards. Work is underway to ensure whiteboards are updated regularly throughout each shift to enhance communication and keep patients and families informed about their care.

### QCH Strategic Plan Refresh

Queensway Carleton Hospital is currently undertaking a refresh of their strategic plan, and I was pleased to attend one of their recent sessions to support them in this important work. It was a valuable opportunity to hear how they are engaging their teams and community partners in shaping future priorities, and to share insights from our own planning journey at HGMH. Participating in these conversations not only strengthens our partnership with QCH but also helps align our efforts across the region as we work collectively to address the evolving healthcare needs of our communities.

### University of Ottawa Heart Institute (UOHI) Site Visit – October 28, 2025

We are looking forward to welcoming Rob Beanlands, CEO, and Erika MacPhee, Chief Nursing Executive, from the University of Ottawa Heart Institute for a visit in the coming weeks. The Heart Institute has recently launched their new strategic plan, which places a strong emphasis on outreach and supporting rural communities. This aligns closely with our priorities at HGMH, and the visit will provide an opportunity to explore how we can strengthen our collaboration, enhance access to specialized cardiac care for our patients, and build on the important relationship we already share with UOHI.

### Code Orange – Table Top

Our recent Code Orange exercise was an excellent demonstration of teamwork, planning, and preparedness across the hospital. The scenarios were engaging, realistic, and truly tested our ability to respond effectively under pressure. I want to extend a special thank you to Jen Mattice, Manager of Emergency Preparedness, Security, & Projects for her outstanding leadership in planning and facilitating the exercise. Jen’s thoughtful approach, attention to detail, and ability to bring together partners from Cornwall Community Hospital, Emergency Management Ontario, and Paramedic Services made this a highly valuable learning experience for all involved.

### Cultural Safety Training for Point of Care Staff

Hôpital Glengarry Memorial Hospital is proud to partner with the Akwesasne Department of Health’s Land-Based Healing team to advance learning and understanding around Indigenous culture and care. Earlier this month, the team hosted an immersive education day for HGMH staff on Thompson Island. The experience centered on learning about Indigenous history, the intergenerational impacts of the past on present-day realities, and how healthcare providers can best support Indigenous peoples in a culturally safe and respectful way.



It was a meaningful and eye-opening experience that deepened staff understanding and strengthened our commitment to equitable and compassionate care. Our sincere thanks to the Akwesasne Department of Health’s Land-Based Healing team for their generosity, guidance, and wisdom, and to Courtney Maruno, Manager of Human Resources, for organizing this impactful learning opportunity. Plans are already underway to bring this important education onsite so that more staff can benefit from this valuable partnership and experience.

### Board Retreat



Thank you to all Board members who participated in our recent Board Retreat. The day was filled with thoughtful discussion, meaningful reflection, and valuable insights that will continue to strengthen our governance and strategic focus as we move forward. Each year our retreats build on the last, showing how we continue to grow and evolve together as a Board. A reminder that the post-retreat survey link was shared following the session. Your feedback is important and helps us continue to improve the experience and value of these sessions. Thank you again for your engagement and commitment to continuous improvement.

### Stakeholder Engagement Activities

To strengthen relationships and foster collaboration, key meetings have been held with external partners and stakeholders. These engagements are essential for sharing information about our hospital's performance, discussing future plans, and aligning efforts to better support the needs of our patients and community. Building strong partnerships in this way helps ensure transparency, trust, and coordinated progress toward shared healthcare goals. This past month I had the opportunity to conduct the following stakeholder meetings/initiatives:

- QCH Strategic Planning Session
- UOHI Strategic Plan Launch
- Donor meeting
- Medical Student Learner Lunch
- Meeting with Suzanne Medore, CEO of Renfrew Victoria Hospital

### **Upcoming Events/Special Dates**

- October 27-31 – Patient Safety Week
- November 2-8 – MRT Week
- November 10<sup>th</sup> – International Accounting Day
- November 15<sup>th</sup> – National Philanthropy Day

## Report of the Chief of Staff October 2025

### Physician Recruitment Update

#### *Area Job Fairs:*

- ❖ **Best Places to Work – Ottawa (October 7, 2025):** HGMH recruitment poster provided to the event representative from the Workforce Attraction Working Group.
- ❖ **Salon de l'emploi – Montreal (October 7–9, 2025):** HGMH recruitment poster shared with the Workforce Attraction Working Group representative attending the event.
- ❖ **uOttawa Family Medicine Event – Ottawa (October 24, 2025):** Suzanne will attend as the designated representative from the Workforce Attraction Working Group.

As a result of these ongoing efforts, we have established one connection with an International Medical Graduate (IMG) currently based in the Ottawa area, who has expressed interest in relocating to a rural community.

This month, Dr. Rivest-Gaudreault, the Alexandria FHO Lead, will be shadowed for a day by a physician from Valleyfield who is exploring the possibility of setting up a practice in Ontario near the Quebec border. She previously toured our hospital in September with Suzanne, and met with Dr. Rivest-Gaudreault and myself. Her goal is to gain a deeper understanding of the care delivered in our inpatient medicine unit and to observe the rounding process firsthand. She has also expressed strong interest in touring our available family practice spaces.

### Scheduling Update

The Emergency Department schedule has been completed through the end of January 2026, with only two open shifts remaining in December. We are optimistic that these remaining shifts can be filled through schedule adjustments by mid-November.

The Inpatient schedule remains fully staffed through to the end of June 2026.

### Medical Learners

#### **Queen's University:**

We continue to support the third-year medical students from Queen's University. Since September 15th, we've had one student with us, who has provided very positive feedback about her experience to date. Additionally, we have agreed to take on two more third-year students in November, who will be gaining experience in both Inpatient and Emergency care. They are currently placed with Dr. Horn in Akwesasne for their Family Practice rotation.

If everything proceeds as planned, we will have hosted a total of seven medical learners at various stages of their training, including first- and third-year medical students, as well as first- and second-year medical residents, at our hospital during this fiscal year.

## Report of the VP Clinical Services, Quality & CNE

October 25, 2025 Board Meeting

### Enhancing Patient Access Through Weekend Ultrasound Services- September 14, 2025

As of September 14, 2025, ultrasound services have expanded to six days per week to improve patient access and support weekday workflow. Weekend service (Saturday or Sunday, depending on schedule) now provides additional booked appointments, with one time slot reserved for urgent inpatient or Emergency Department cases.






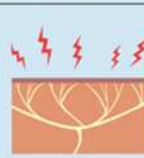
This expansion enhances timely access to diagnostic imaging, helping reduce wait times and supporting earlier diagnosis and treatment. The added availability benefits both patients and the broader community by improving continuity of care and overall service responsiveness.



### Physiatry Clinic Services for Inpatients

Physiatrist

A physiatrist is a doctor who diagnoses and treats conditions affecting your:

 <p><b>Joints.</b></p>	 <p><b>Bones.</b></p>
 <p><b>Muscles.</b></p>	 <p><b>Brain.</b></p>
 <p><b>Spinal cord.</b></p>	 <p><b>Nerves.</b></p>

On September 15, 2025, physiatry clinic services were introduced for inpatients under the care of Dr. Jacqueline Cochrane, Physiatrist. At this time, the clinic will operate once a month and will be available to inpatients only.

Dr. Cochrane's specialty and primary areas of interest include stroke care and spasticity management. In addition, the clinic will provide consultation and management for other neurological disorders, fatigue, mood and behavioral issues, swallowing difficulties, pain management, return-to-driving assessments, and return-to-work planning.

The addition of these services enhances our capacity to provide comprehensive, multidisciplinary rehabilitation and recovery care for our inpatient population.

This initiative aligns with our priority to bring care closer to home, as patients will no longer need to travel to Ottawa for these specialized services. Expansion to outpatient services may be considered in the future based on demand and resource availability.

### Methicillin- Resistant *Staphylococcus aureus* (MRSA) Outbreak Update

The MRSA outbreak in the inpatient department, which lasted over 17 weeks, was declared over on October 2, 2025.

A range of strategies were implemented to reduce the bacterial burden and prevent transmission, including **patient-specific measures** such as antibacterial wipes bathing for positive patients, enhanced hand hygiene for patients leaving their bed space.

**Staff-focused measures** reinforced adherence to policies on fingernails and jewelry and strengthened housekeeping oversight, while environmental cleaning was increased and dedicated equipment and new disinfection technologies were implemented to support infection control.

These combined efforts successfully contained and resolved the outbreak. A review is underway to update policies and improve future readiness.

The leadership team extends appreciation to all staff for their diligence, adaptability, and commitment to patient safety throughout this prolonged event.

## Type Of MRSA

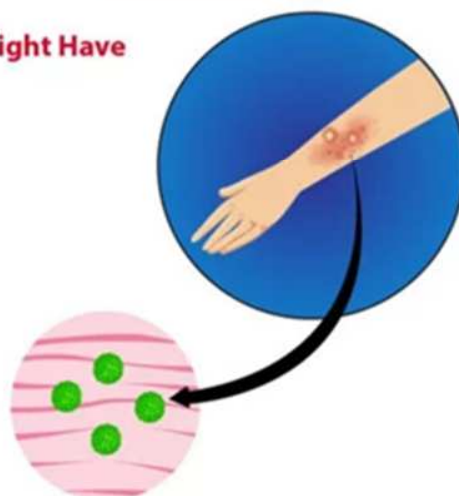


## Symptoms

**MRSA infections often appear as a skin infection**

### Affected Area Might Have

- Swelling
- Redness
- Tenderness
- Pus formation



### Other Symptoms

- Chest pain
- Chills
- Fatigue
- Rash
- Headache

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	<i>Enrich the patient experience through quality, safe care that welcomes patients and families as partners in care.</i>	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.	<ul style="list-style-type: none"> <li>Gap analysis of the Best Practice Guideline: Palliative Approach to Care in the Last 12 Months of Life has been completed.</li> <li>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.</li> <li>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.</li> <li>Assessment tools and reference materials for staff and physicians are under review to evaluate their effectiveness and promote consistent usage across clinical teams.</li> </ul>	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.	<ul style="list-style-type: none"> <li>There are 27 medical directives currently in place.</li> <li>Medical directives are being utilized by staff, particularly for initiating diagnostic tests, helping to improve patient flow and reduce delays prior to physician assessment.</li> </ul>	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	<ul style="list-style-type: none"> <li>Senior Leadership Team (SLT) Patient Rounds were initiated on April 28, with approximately 30 patients interviewed for real-time feedback on their care experience.</li> <li>Patients report feeling cared for, safe, and checked on during evenings and nights.</li> </ul>	On track

■ Fully complete

■ On track – no barriers for completion

■ Not on track – mitigation plans in place

■ Not on track – initiative at risk

			<p>assess their level of involvement in their care before discharge.</p>	<ul style="list-style-type: none"> <li>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.</li> <li>PFAC members to join SLT for patient rounds when appropriate.</li> </ul>	
<b>People &amp; Culture</b>	<i>Improve engagement by investing in the organizations people and empower a caring and positive culture for all.</i>	Dr. L. MacKinnon	<p>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</p>	<ul style="list-style-type: none"> <li>In the spring, we successfully welcomed four first-year medical students—two from the University of Ottawa and two from the University of Toronto.</li> <li>We are actively collaborating with ERMEP and ROMP to create our medical student and resident program.</li> <li>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.</li> </ul>	On track
		K. MacGillivray	<p>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.</p>	<ul style="list-style-type: none"> <li>The development of the psychological safety program is underway.</li> <li>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.</li> </ul>	On Track
		K. MacGillivray	<p>Redesign our performance evaluation process to create a more meaningful, transparent, and development-focused experience for our employees.</p>	<ul style="list-style-type: none"> <li>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.</li> </ul>	On Track
<b>Integration &amp; Standardization</b>	<i>Deliver standardized quality care in a cost-effective way through collaboration &amp; integration opportunities.</i>	R. Romany	<p>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.</p>	<ul style="list-style-type: none"> <li>The implementation project officially launched on April 2, 2005. Go-live date is targeted for October 24, 2026.</li> <li>Subject matter experts (SMEs) are actively engaged in various workgroups.</li> <li>Workgroups are reviewing clinical and operational workflows, applications and systems functionality, order sets, data migration planning, etc.</li> </ul>	On Track

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

		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.	<ul style="list-style-type: none"> <li>Looking at our current set-up and ensuring that it is lines with the requirements for our EPIC implementation.</li> </ul>	On Track
Future Planning	<i>Invest in the sustainability of our equipment &amp; infrastructure to support safe, quality care.</i>	R. Alldred-Hughes	Submit pre-capital submission to support the future redevelopment and revitalization of the hospital	<ul style="list-style-type: none"> <li>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.</li> <li>Hospital will continue to advocate for the proposal to move to stage 1.2 with Ministry of Health approval.</li> </ul>	Complete
		R. Alldred-Hughes	Actively work with and support the HGMH Foundation in their efforts to fund our ability to bring CT to HGMH.	<ul style="list-style-type: none"> <li>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.</li> <li>Foundation has raised \$1M toward the CT Scanner at this time.</li> </ul>	On Track

■ Fully complete

■ On track – no barriers for completion

■ Not on track – mitigation plans in place

■ Not on track – initiative at risk

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 Aldred-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 - Clean

# Communications & Community Engagement Plan



HÔPITAL  
**Glengarry  
Memorial**  
HOSPITAL

<b>Effective:</b> Oct 2022	<b>Last review/revision:</b> Aug 2025	<b>Next Review:</b> Aug 2026
<b>Owner:</b> Communications Officer	<b>Signing Authority:</b> 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.

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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.

### *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	<ul style="list-style-type: none"> <li>• HGMH Board of Directors</li> <li>• HGMH Senior Leadership Team</li> <li>• HGMH Management Team</li> <li>• HGMH Medical Advisory Committee (MAC)</li> <li>• Department Chiefs</li> </ul>	<ul style="list-style-type: none"> <li>• Strategic Direction &amp; Accountability</li> <li>• Clinical Excellence &amp; Patient Care</li> <li>• Workforce Engagement &amp; Recognition</li> <li>• Community Impact &amp; Partnerships</li> <li>• Advocacy &amp; Government Relations</li> <li>• Philanthropy &amp; Fundraising</li> </ul>
Hospital Staff, Physicians, and Volunteers	<ul style="list-style-type: none"> <li>• All HGMH staff (via internal email and intranet)</li> <li>• Credentialed physicians and allied health professionals</li> <li>• Volunteer Auxiliary</li> </ul>	<ul style="list-style-type: none"> <li>• Strategic Direction &amp; Accountability</li> <li>• Clinical Excellence &amp; Patient Care</li> <li>• Workforce Engagement &amp; Recognition</li> <li>• Community Impact &amp; Partnerships</li> <li>• Education &amp; Training Opportunities</li> </ul>
Community Partners & Political Stakeholders	<ul style="list-style-type: none"> <li>• Township of North Glengarry (Mayor, Council, CAO)</li> <li>• Township of South Glengarry (Mayor, Council, CAO)</li> </ul>	<ul style="list-style-type: none"> <li>• Community Impact &amp; Partnerships</li> <li>• Advocacy &amp; Government Relations</li> </ul>



	<ul style="list-style-type: none"> <li>• United Counties of Stormont, Dundas, and Glengarry (Council, CAO)</li> <li>• Local First Nations leadership - Mohawk Council of Akwesasne</li> <li>• MPP Prescott, Russel, &amp; Glengarry</li> <li>• MPP Cornwall, Stormont, Dundas, and South Glengarry</li> <li>• MP Cornwall, Stormont, Dundas, Glengarry</li> </ul>	
<b>Healthcare and System Partners</b>	<ul style="list-style-type: none"> <li>• Ontario Health East Region</li> <li>• Ministry of Health - Ontario</li> <li>• Eastern Ontario Health Unit</li> <li>• Great River Ontario Health Team (OHT) partners</li> <li>• Regional hospitals and healthcare alliances (e.g., Atlas Alliance members)</li> <li>• Champlain Alliance of Small Hospitals</li> </ul>	<ul style="list-style-type: none"> <li>• Strategic Direction &amp; Accountability</li> <li>• Clinical Excellence &amp; Patient Care</li> <li>• Advocacy &amp; Government Relations</li> </ul>
<b>Educational &amp; Training Partners</b>	<ul style="list-style-type: none"> <li>• Nursing and allied health educational institutions partnered with HGMH</li> <li>• Medical residency and student placement programs</li> </ul>	<ul style="list-style-type: none"> <li>• Education &amp; Training Opportunities</li> </ul>
<b>Fundraising &amp; Philanthropic Partners</b>	<ul style="list-style-type: none"> <li>• HGMH Foundation Board of Directors &amp; Staff</li> </ul>	<ul style="list-style-type: none"> <li>• Strategic Direction &amp; Accountability</li> <li>• Philanthropy &amp; Fundraising</li> </ul>
<b>Public &amp; Media</b>	<ul style="list-style-type: none"> <li>• Local and regional media outlets</li> <li>• Posting on the HGMH public website and social media channels</li> <li>• Community members via newsletters and public engagement events</li> </ul>	<ul style="list-style-type: none"> <li>• Strategic Direction &amp; Accountability</li> <li>• Clinical Excellence &amp; Patient Care</li> <li>• Workforce Engagement &amp; Recognition</li> <li>• Community Impact &amp; Partnerships</li> <li>• Philanthropy &amp; Fundraising</li> <li>• Advocacy &amp; Government Relations</li> <li>• Public Awareness &amp; Media Relations</li> </ul>

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](http://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 \(intranet site\)](#)

The Glentranet site is the go-to place for staff and physicians to find information including memos, reports, hospital committee information, policies and forms, etc., as well as newsletters.

### [Social Media](#)

Rapid information delivery on a 24/7 news cycle has moved us beyond traditional media to a vastly expanding social media reality. Guided by an internal social media policy, HGMH creates and maintains our presence on Facebook, LinkedIn, and YouTube. Pages are regularly updated with timely content, photographs, and videos related to hospital activities, services, disruptions, provincially recognized health topics, and wellness content.

Visual media is has proven an excellent support to ensure the broadest possible reach to our stakeholders, including photographs, infographics, and videos.



## Media Relations

We recognize that timely and accurate media attention can support recruitment and retention, employee and community engagement, and fundraising and funding.

HGMH aims to communicate with media in a pro-active rather than a reactive manner via designated spokespersons as per the Communications & Hospital Spokesperson policy (BOD.05.018). Planned media briefings occur during times of significant announcements to ensure local media has timely and accurate information available to report to the community.

## CEO Communications

CEO communications with stakeholders is an important component to the HGMH communications plan which is designed to provide opportunities to increasing stakeholder engagement. Communication initiatives will allow for both two-way and one-way communication, centered around an approach to ensure CEO communications are *accessible, timely, relevant, and meaningful*. The following communication strategies will be used:

<b>Communication Tactic</b>	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Twice Annual Virtual Town Hall - (and as needed)			✓							✓		
CEO Vlog (video blog)		✓			✓			✓			✓	
Round Table with Rob	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Regular Rounding on Units	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Bi-Weekly Blitz CEO Corner		✓		✓		✓		✓		✓		✓
Bi-Weekly Blitz Board of Directors Updates	✓		✓		✓		✓		✓		✓	
Annual Community Engagement Session							✓					
Twice Annual Meeting with Political Leaders	✓						✓					
SLT Patient Rounding	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Annual Report			✓									
Annual Operating Plan		✓										

## Public Disclosure

### Purpose

HGMH is committed to maintaining transparency, accountability, and trust through proactive public disclosure of information that is of interest and relevance to our patients, families, staff, partners, and community. Public disclosure is a cornerstone of good governance and demonstrates the hospital's commitment to engaging stakeholders in meaningful ways.

### Scope of Disclosure

Public disclosure includes, but is not limited to, the following areas:

- **Quality and Safety Indicators:** Regular posting of quality improvement metrics and patient safety indicators in alignment with provincial reporting requirements.
- **Financial Information:** Annual audited financial statements and operating plan updates, made available to the public following approval by the Board of Directors.



- Executive Compensation: Disclosure of executive compensation in compliance with the Public Sector Salary Disclosure Act.
- Board Governance: Posting of Board meeting highlights, annual reports, bylaws, and strategic priorities.
- Accreditation and Compliance: Publicly sharing results of Accreditation Canada surveys and compliance with relevant healthcare legislation and standards.
- Policies of Public Interest: Ensuring public access to key hospital policies, such as accessibility, privacy, and French Language Services policies.

### *Channels of Disclosure*

Public disclosure will be carried out through the following methods:

- Corporate website ([www.hgmh.on.ca](http://www.hgmh.on.ca)) as the primary platform for publicly available documents and updates.
- Annual Report and Annual Operating Plan, distributed electronically and in print upon request.
- Media releases and social media updates for timely, high-profile announcements.
- Community engagement sessions, which provide opportunities for open dialogue and questions regarding disclosed information.

### *Guiding Principles*

- Transparency: Disclose timely, accurate, and honest information to stakeholders.
- Accessibility: Ensure all disclosure materials are available in both English and French and meet Accessibility for Ontarians with Disabilities Act (AODA) standards.
- Clarity: Use plain language to ensure information is understandable to a broad audience.
- Accountability: Align disclosures with legislation, accreditation requirements, and best practices in healthcare governance.
- Engagement: Provide opportunities for community members, patients, and families to participate in governance-related discussions.

### *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 hospital's Interpretation Service Request policy (COR.03.001.X.XX).

## **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). 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



## MINUTES OF THE MEETING OF THE EXECUTIVE COMMITTEE

Date Wednesday, October 8, 2025  
Time 4:30PM  
Location Boardroom / Microsoft Teams  
Present: Dr. S. Robertson, Chair L. Boyling C. Nagy  
R. Alldred-Hughes, CEO  
Regrets: Dr. L. MacKinnon, COS

### 1. Call to Order

L. Boyling, Vice Chair, called the meeting to order at 4:30pm.

#### 1.1. Quorum

1.2. A quorum was present.

#### 1.3. Adoption of the Agenda

The agenda was reviewed and approved.

Moved By: C. Nagy

Seconded By: Dr. S. Robertson

THAT the agenda be adopted as presented.

**CARRIED**

#### 1.4. Declaration of Conflict of Interest

There were no conflicts of interest declared at this time.

### 2. Minutes

#### 2.1. Approval of the Minutes

The minutes from the meeting held on April 9, 2025, were reviewed.

Moved By: Dr. S. Robertson

Seconded By: C. Nagy

THAT the minutes of the meeting of April 9, 2025, be approved as presented.

**CARRIED**

### 3. Matters for Discussion/Decision

#### 3.1 Review Terms of Reference

No revisions were made to the Terms of Reference.

Moved By: Dr. S. Robertson

Seconded By: C. Nagy

THAT the Executive Committee recommend to the Board of Directors the Terms of Reference as presented.

**CARRIED**

#### 3.2 Review Personal Business Commitments of the CEO and COS

3.2.1 Personal Business Commitments of the CEO

The personal business commitments of the CEO were reviewed and discussed in which all items are on track.

Moved By: Dr. S. Robertson

Seconded By: C. Nagy

THAT the Executive Committee of the Board receive the CEO Personal Business Commitments for information, acknowledging the progress to date on the CEO's Personal Business Commitments, and provide feedback or direction as appropriate.

The target around a balanced budget was discussed to which the committee finds it unrealistic to achieve a balanced budget when the hospital is projecting a deficit. This performance target was established 6-months ago and as such, would not be realistic to change now, however R. Alldred-Hughes is committed to finding efficiencies within the hospital and revenue generation ideas.

**CARRIED**

3.2.2 Personal Business Commitments of the COS

The personal business commitments of the COS were reviewed.

Moved By: Dr. S. Robertson

Seconded By: C. Nagy

THAT the Executive Committee of the Board receive the COS Personal Business Commitments for information, acknowledging the progress to date on the COS' Personal Business Commitments, and provide feedback or direction as appropriate.

**CARRIED**

4. Date of Next Meeting

April 8, 2025

DECISION SUPPORT DOCUMENT FOR

Board of Directors

Board Committee – Executive Committee

Senior Leadership Team

Other (please specify):

Date Prepared: September 24, 2025

Meeting Date Prepared for: October 8, 2025

Subject: Update – CEO Personal Business Commitments

Prepared by: Robert Aldred-Hughes, President & CEO

DECISION SOUGHT\*

FOR DISCUSSION/INPUT

FOR INFORMATION ONLY

### PURPOSE

The purpose of this briefing is to provide the Executive Committee of the Board with an update on the CEO’s 2025–2026 Personal Business Commitments. This update outlines progress achieved to date across the three performance assessment categories: Quality, Financial, and Strategic/Significant Initiatives.

### RECOMMENDATION / MOTION

That the Executive Committee of the Board receive the CEO Personal Business Commitments for information, acknowledging the progress to date on the CEO’s personal business commitments, and provide feedback or direction as appropriate.

### IMPLICATIONS TO OTHER STANDING COMMITTEES

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

### SITUATION & BACKGROUND

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

- In alignment with the Excellent Care for All Act (ECFAA), and the HGMH Board’s Executive Compensation Philosophy, the CEO’s commitments are tied to the hospital’s Quality Improvement Plan (QIP), Strategic Plan, Accreditation readiness, Ontario Health/Ministry directives, and environmental factors. These commitments also serve as the framework for senior leadership’s own business commitments and align with corporate metrics and the balanced scorecard.

#### Quality (50% weighting)

- **Accreditation Readiness:** Standards continue to be embedded into daily operations through training and policy improvements. Evidence submission monitoring suggests a promising outlook toward achieving
- **Patient & Family-Centered Care:** Leader rounding, launched in May 2025, has resulted in a 96.5% year-to-date positive score for patient involvement in care decisions (surpassing the 89% target).
- **Partnership with Mohawk Nation of Akwesasne:** Concrete progress achieved, including the Endoscopy and Hematology partnerships and the September unveiling of Indigenous art, reinforcing equitable access and cultural collaboration.

#### Financial (30% weighting)

- **Financial Stability:** Despite efforts, the hospital is projecting a \$500K deficit for 2025/26, compared to a target balanced budget. Ongoing engagement with Ontario Health and the Ministry of Health continues, with active participation in the HSSP process to secure sustainable funding.

- **Revenue Generation:** Initiatives implemented include increasing cafeteria prices and planning for higher parking rates. Discussions are underway with a business development professional to identify additional opportunities for non-ministry revenue growth.

#### **Strategic / Significant Initiatives (20% weighting)**

- **Capital Redevelopment:** The Pre-Capital Proposal was successfully submitted to the Ministry in July. Continued stakeholder engagement is underway to advance visioning for future redevelopment.
- **Healthcare Capacity & Training:** HGMH participated in Rural Week and Community Week, hosting 4 first-year students. A third-year medical student is currently completing a 14-week placement, with additional requests in progress—strengthening recruitment and rural healthcare exposure.
- **Equity, Diversity & Inclusion (EDI):** As of this update, 33.9% of staff have completed assigned EDI training, exceeding the 25% goal. Leadership training remains at 100%.
- **Epic EMR Implementation:** All milestones within HGMH’s control remain on track for October 2026 go-live. Staff readiness and regional collaboration continue to be key areas of focus.

#### **SUPPORTING DOCUMENTS/ATTACHMENTS**

*List any supporting documents or attachments*

- 2025/2026 Personal Business Commitment Mid-Year Update



## **Personal Business Commitments (2025 - 2026)**

**Robert Alldred-Hughes, President & Chief Executive Officer**

### **Introduction**

The Ontario Government passed the Excellent Care For All Act (ECFAA) and Bill 16 in 2010 which required Hospital Boards to establish a pay for performance component of executive compensation and achieve targets tied to a Quality Improvement Plan.

My Personal Business Commitments are tied to Hôpital Glengarry Memorial Hospital's (HGMH) Quality Improvement Plan (QIP), the HGMG Board Strategic Plan, our Accreditation, directive from the Ontario Health and Ministry of Health and any impacting factors that have been identified through an environmental scan. These form the context that has shaped the 2025-2026 Personal Business Commitments. Clearly, health funding and its emphasis on cost efficiency and quality outcomes (value for money), the focus on clinical performance, the patient experience, patient and family centered care and the need for integration and partnerships are key drivers to positioning, not only HGMH, but the health system as a whole for continued high performance and success.

In order to ensure that expected levels of performance are clearly articulated and understood, measures have been aligned with three performance assessment categories (PAC) – Quality, Financial and Strategic / Significant Initiatives as per HGMH's Executive Compensation Philosophy, Strategy and Policy. The performance assessment categories will be rated on the following scale:

Quality: 50% weighting

Financial: 30% weighting

Strategic: 20% weighting

Although selected commitments have been identified in this document for the performance pay component of executive compensation determination, it is important to note that an unrelenting focus will also be placed on other areas such as those identified in the QIP, the Patient Safety Plan, the Strategic Plan, Enterprise Risk Management and so forth.

Finally, my Personal Business Commitments serve as the framework and the priorities for all leaders within HGMH. Each senior leader is expected to develop their Personal Business Commitments to align with the Chief Executive Officer's, support the Strategic Plan, the Quality Improvement Plan as well as align with corporate metrics/balanced scorecard.

	Goal	2024/2025 Performance	2025/26 Target	Current Performance	Quality Improvement Plan	Strategic Plan	Accreditation	OH/ MOH
Q u a l i t y	Accreditation standards will be embedded into daily operations through enhanced staff training, policy improvements, and readiness initiatives, driving measurable gains in quality and patient care.	2022 Accreditation – Accredited with Commendation	Accreditation with Exemplary Status	Team continues to ensure standards are met. Promising outlook based on self monitoring of evidence submission.	✓		✓	
	Patient involvement in care decisions will be strengthened through Leader and PFAC patient rounding, ensuring real-time feedback is gathered and acted upon to enhance communication, patient satisfaction, and person- and family-centered care.	<i>Percent positive score on the question – related involvement in care: 87%</i>	89% positive score	Leader rounding launched in May 2025. Current percent positive score on involvement in care is: 96.5% YTD	✓	✓	✓	✓
	Strengthen relationships with the Mohawk Nation of Akwesasne to advance equitable access to care and foster collaboration in meeting community healthcare needs.	-	Implement one partnership action	Implemented Endoscopy Partnership, and Hematology. Art Installation occurred in September.		✓		✓
F I N A N C I A L	Ensure financial stability by proactively engaging with Ontario Health and government stakeholders to secure funding, advocate for sustainable reimbursement models, and align resources with HGMH's strategic priorities to support high-quality, sustainable care.	<i>\$150K Surplus</i>	Balanced Budget	Currently projecting \$500K deficit. Meetings with OH, and MOH occur. Working through MOH HSSP Process.				✓
	Assess and explore feasible revenue generation opportunities within the constraints of Ontario's hospital funding model, identifying sustainable strategies to enhance HGMH's financial resilience while maintaining alignment with our mission and regulatory requirements.	-	Increase non-ministry revenue growth	Increased cafeteria prices. Propose to increase parking rates. Connecting with business development professional to discuss options.				✓

<b>STRATEGIC</b>	Drive the pre-capital submission and visioning process for HGMH's redevelopment, ensuring that our hospital's infrastructure aligns with evolving healthcare needs and supports the delivery of innovative, high-quality, and accessible rural healthcare.	-	Submit Pre-Capital Proposal to MOH	Pre-capital proposal submitted in July. Continued and ongoing engagement occurs with stakeholders.		✓	✓	✓
	Healthcare capacity will be strengthened through a Medical Student and Resident Program, leveraging partnerships with ROMP/ERMEP and academic institutions to provide hands-on learning, enhance recruitment, and promote rural healthcare careers.	-	Participate in Discovery Week. Bring at least one Medical Resident to Learn at HGMH	Participated in Rural Week and Community week. 4 first year students came. Currently have a 3 <sup>rd</sup> year medical student for 14 week placement. Additional requests coming in to support.		✓		
	Cultural safety will be advanced through organization-wide DEI training, equipping staff with the knowledge and tools to provide equitable, patient-centered care and foster an inclusive, respectful workplace.	100% of Leaders Trained	25% of Staff Trained	Current performance has 33.90% of staff having completed assigned EDI training.		✓	✓	✓
	Lead the launch of the EPIC EMR system by ensuring staff readiness, optimizing clinical workflows, and strengthening regional collaboration to enhance patient care and interoperability, maintaining key milestones.	-	100% of project milestones completed on schedule that are within HGMH's control	Milestones currently on track for an October 2026 Go live.		✓		✓



## **Personal Business Commitments (2025 - 2026)**

**Dr. Lisa MacKinnon, Chief of Staff**

### **Introduction**

The Ontario Government passed the Excellent Care For All Act (ECFAA) and Bill 16 in 2010 which required Hospital Boards to establish a pay for performance component of executive compensation and achieve targets tied to a Quality Improvement Plan.

My Personal Business Commitments are tied to Hôpital Glengarry Memorial Hospital's (HGMH) Quality Improvement Plan (QIP), the HGMG Board Strategic Plan, our Accreditation, directive from the Ontario Health and Ministry of Health and any impacting factors that have been identified through an environmental scan. These form the context that has shaped the 2023-2024 Personal Business Commitments. Clearly, health funding and its emphasis on cost efficiency and quality outcomes (value for money), the focus on clinical performance, the patient experience, patient and family centered care and the need for integration and partnerships are key drivers to positioning, not only HGMH, but the health system as a whole for continued high performance and success.

In order to ensure that expected levels of performance are clearly articulated and understood, measures have been aligned with three performance assessment categories (PAC) – Quality, Financial and Strategic / Significant Initiatives as per HGMH's Executive Compensation Philosophy, Strategy and Policy. The performance assessment categories will be rated on the following scale:

Quality: 50% weighting  
Financial: 30% weighting  
Strategic: 20% weighting

Although selected commitments have been identified in this document for the performance pay component of executive compensation determination, it is important to note that an unrelenting focus will also be placed on other areas such as those identified in the QIP, the Patient Safety Plan, the Strategic Plan, Enterprise Risk Management and so forth.

	Goal	2024/2025 Performance	2025/26 Target	Current Performance	Quality Improvement Plan	Strategic Plan	Accreditation	OH/ MOH
QUALITY	% of patients who left without being seen (LWBS)  *Regional Provincial Avg = 8.2% *Provincial Avg = 5%	7.6%	7.4%	On Track ~ 6.3% moving closer to the provincial average.	✓	✓	✓	
FINANCIAL	Ensure 40 return visit chart reviews are completed annually from the Emergency Department to maintain Emergency Department pay For Results (ED P4R) funding levels.	N/A	40 annually	On Track ~ K. Duval has now been granted access to the portal, and the case list has recently been released. I will be working with K. Duval to organize and initiate the review process to ensure we meet the annual target.	✓	✓		

STRATEGIC	Expand medical professional staff recruitment efforts by developing relationships with ROMP and other educational institutions, while also motivating our current physician group to embrace mentoring more students.	-	Participate in Rural Week. Bring at least one Medical Resident to Learn at HGMH	On Track ~ We've initiated a new partnership with Queen's University/ER MEP, hosting our first 3rd-year medical student this fall. Discussions are underway to potentially add two more Queen's students and two 4th-year students from Quebec.		✓		
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DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: September 30, 2025                      Meeting Date Prepared for: October 8, 2025 – Executive  
October 23, 2025 - Board

Subject: 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 Board of Directors approve the Executive 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.
- There were no changes to the Executive Committee Terms of Reference.

**SUPPORTING DOCUMENTS/ATTACHMENTS**

*List any supporting documents or attachments*

- Executive Committee Terms of Reference

# TERMS OF REFERENCE EXECUTIVE COMMITTEE OF THE BOARD



<p><b>ROLES AND RESPONSIBILITIES:</b></p>	<ul style="list-style-type: none"> <li>● Act as a body with delegated authority to make certain decisions binding on the Corporation on matters of administrative urgency where the board of directors of the Corporation (the “<b>Board</b>”) is unable to convene; provided that, in accordance with the <i>Not-for-Profit Corporations, 2010</i>, the Executive Committee may not exercise any of the following Board powers:           <ul style="list-style-type: none"> <li>○ submitting to the members any question or matter requiring the approval of the members;</li> <li>○ filling a vacancy among the directors or in the position of auditor;</li> <li>○ appointing additional directors;</li> <li>○ issuing debt obligations, except as authorized by the directors;</li> <li>○ approving the financial statements of the Corporation;</li> <li>○ adopting, amending, or repealing the by-laws of the Corporation; and</li> <li>○ establishing contributions to be made, or dues to be paid, by the members.<sup>1</sup></li> </ul> </li>   <li>● Develop a process to oversee performance, compensation, and succession planning for the chief executive officer and chief of staff by:           <ul style="list-style-type: none"> <li>○ developing a position description for the chief executive officer and chief of staff for Board approval;</li> <li>○ overseeing and recommending to the Board the chief executive officer and chief of staff recruitment, selection, and succession planning;</li> <li>○ reviewing and recommending to the Board the chief executive officer’s and chief of staff’s annual objectives;</li> <li>○ developing and conducting a process to review the performance of the chief executive officer and chief of staff and reporting the results to the Board; and</li> </ul> </li> </ul>
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<sup>1</sup> ONCA, s. 36(2).

# TERMS OF REFERENCE EXECUTIVE COMMITTEE OF THE BOARD



	<ul style="list-style-type: none"> <li>o recommending chief executive officer and chief of staff compensation for Board approval.</li> <li>● Oversee the chief executive officer's and chief of staff's supervision of management and management succession plans.</li> <li>● Undertake such other activities as may be authorized by the Board, from time to time.</li> </ul>
<b>CHAIR:</b>	<ul style="list-style-type: none"> <li>● Chair of the Board</li> </ul>
<b>MEMBERSHIP:</b>	<ul style="list-style-type: none"> <li>● Chair</li> <li>● Vice-Chair</li> <li>● Treasurer</li> <li>● Chief of Staff, and</li> <li>● Chief Executive Officer</li> <li>● Invited guests may attend committee meetings at the invitation of the Chair but shall not have a vote.</li> <li>● One of the Board members sitting on this committee must be bilingual in English and French</li> </ul>
<b>VOTING :</b>	<ul style="list-style-type: none"> <li>● Only Members of the board may vote</li> </ul>
<b>FREQUENCY OF MEETINGS AND MANNER OF CALL:</b>	<ul style="list-style-type: none"> <li>● At the call of the Chair or direction of the Board</li> </ul>
<b>QUORUM:</b>	<ul style="list-style-type: none"> <li>● Shall be a majority of the members entitled to vote (2)</li> </ul>
<b>RESOURCES:</b>	<ul style="list-style-type: none"> <li>● The Chief Executive Officer shall provide the Executive Committee with appropriate resources to perform its mandate.</li> </ul>
<b>REPORTS TO:</b>	<ul style="list-style-type: none"> <li>● Board of Directors</li> </ul>
<b>DATE OF LAST REVIEW</b>	<ul style="list-style-type: none"> <li>● October 2025</li> </ul>

## REPORT OF THE GOVERNANCE AND NOMINATING COMMITTEE

October 8, 2025 at 5:00PM BOARDROOM / MS Teams

Present: L. Boyling, Chair C. Larocque Dr. S. Robertson  
R. Alldred-Hughes, CEO

Regrets: G. McDonald Dr. G. Raby

### Summary of Discussion

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

The agenda was reviewed.

Moved By: C. Larocque  
Seconded By: Dr. S. Robertson  
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 June 4, 2025, was shared.

Moved By: C. Larocque  
Seconded By: Dr. S. Robertson  
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 Committee Effectiveness Survey Results**

Over, the survey results indicate that the committee is performing well. Chair of each committee are now provided time at the Board meeting to provide a report. Ensuring proper succession planning for Board Directors will be worked on.

#### **Review and Approve Annual Committee Work Plan**

The draft committee work plan was reviewed and revision was made.

Moved By: Dr. S. Robertson  
Seconded By: C. Larocque  
THAT the Governance and Nominating Committee review and approve the Annual Committee Work Plan for 2025-2026 as amended.

Under Director Recruitment and Selection, review of the skills matrix will be added annually, and Directors will be asked to update their skills matrix.

CARRIED

#### **Review all Board Committee Terms of Reference**

The committee Terms of Reference were reviewed.

Moved By: C. Larocque  
Seconded By: Dr. S. Robertson

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

**CARRIED**

#### **Review Q1 Strategic Actions**

The results of the strategic actions for Q1 were reviewed.

Moved By: C. Larocque

Seconded By: Dr. S. Robertson

THAT the Governance and Nominating Committee review and receive the Q1 Strategic Actions report as presented.

All items are on track and the team is progressing well with the actions identified.

**CARRIED**

#### **Review the Revised Communication & Community Engagement Plan**

The Accreditation standards were reviewed and the Communication & Community Engagement Plan was updated to ensure standards are met. Rather than having multiple policies, all information pertaining to communication was pulled into this document.

There is a section under CEO Communications which pertains to the Board of Directors and will be renamed Board of Directors Updates in Bi-Weekly Blitz.

#### **Documents for Review**

Meetings of Directors Without Management Policy (New)

The Meeting of Directors Without Management Policy was reviewed.

Moved By: C. Larocque

Seconded By: Dr. S. Robertson

THAT the Governance and Nominating Committee recommend to the Board of Directors the Meeting of Directors Without Management policy as presented.

No changes were made to the policy.

**CARRIED**

CEO and COS Performance Evaluation Policy (New)

The policy was reviewed and minor revision was made, changing the bi-annually to semi-annually.

Moved By: C. Larocque

Seconded By: Dr. S. Robertson

THAT the Governance and Nominating Committee recommend to the Board of Directors the CEO and COS Performance Evaluation policy as amended.

**CARRIED**

Acts, Legislations, and Compliance Reporting Policy (New)

The policy was reviewed.

Moved By: Dr. S. Robertson

Seconded By: C. Larocque

That the Governance and Nominating Committee recommend to the Board of Directors the

approval of the Acts, Legislations, and Compliance Reporting Policy as presented.

**CARRIED**

**Matters for Information**

**Governance Accreditation Standard Review**

The Accreditation Standard was reviewed and discussion ensued around the process for Accreditation.

**Inclusion, Diversity, Equity & Anti-Racism Update**

An update was shared on IDEA in which it was noted that the hospital has come a long way in terms of IDEA.

**Next meeting:** November 12, 2025

K-L. Massia, Recorder

DRAFT

# Governance and Nominating Committee Annual Work Plan 2025-2026



Deliverable	MRP	Occurrence	OCT	NOV	JAN	MAR	MAY	JUN
<b>STRUCTURE/PROCESSES</b>								
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			
<b>DIRECTOR RECRUITMENT AND SELECTION</b>								
Administer Board Personal Assessment Survey/Board Succession	Admin	Annually			X			
Review Board Succession Plan	Chair	Annually				X		
Review Skills Matrix	CEO	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
<b>ACCREDITATION</b>								
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					
<b>PERFORMANCE</b>								
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
<b>STRATEGIC PLAN AND STRATEGIC DIRECTIONS</b>								
Review Strategic Plan and Refresh	CEO	Annually		X				
Review Progress on Strategic Directions	CEO	Quarterly	X	X	X		X	
<b>POLICY REVIEW</b>								
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
<b>ESTIMATED PREPARATION TIME FOR MEETING</b>			1H	1H	1H	1H	1H	1H

Revisions since prior report:

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

<p><b>ROLE:</b></p>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• To advise the Board on the selection and recruitment, of the CEO and COS.</li> </ul>
<p><b>RESPONSIBILITIES:</b></p>	<ul style="list-style-type: none"> <li>a) Board Recruitment             <ul style="list-style-type: none"> <li>• 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);</li> <li>• Consider skills, experience, qualities, and diversity of current directors to determine the Board’s needs; and,</li> <li>• Oversee the Board’s recruitment and nomination process and recommend to the Board candidates for election at the Annual Meeting.</li> </ul> </li> <li>b) Board Education             <ul style="list-style-type: none"> <li>• Ensure a comprehensive orientation session is provided to all new Board members;</li> <li>• Oversee Board education sessions to ensure Board members receive periodic education on governance, health care issues and the hospital operations; and,</li> <li>• Organize with the input of the CEO and Board Chair, the Boards retreats.</li> </ul> </li> <li>c) Board Chair             <ul style="list-style-type: none"> <li>• Ensure succession planning for the office of Board</li> <li>• Oversee and complement the Board’s process for selecting a Board Chair and recommend an individual for election by the Board as Chair; and,</li> <li>• Make recommendations to the Board for Vice Chair and Treasurer.</li> </ul> </li> <li>d) Board Committees             <ul style="list-style-type: none"> <li>• Ensure periodic review and evaluation of committee performance and Terms of Reference and make recommendations for the Board as required; and,</li> <li>• Recommend to the Board, with the input of the Chair, nominees for all Board Committees and Committee Chairs.</li> </ul> </li> <li>e) Evaluations             <ul style="list-style-type: none"> <li>• Establish and implement a program to evaluate Board performance including individual director performance, performance of the Chair, Board Committees and Committee Chairs;</li> <li>• Consider the results of Board evaluations in connection with renewal of the terms of existing directors; and,</li> <li>• Review and make recommendations to the Board on Board composition, size, structure, board policies and procedures,</li> </ul> </li> </ul>

# TERMS OF REFERENCE



	<p>by-law amendments and board attendance.</p> <p>f) Executive Management Performance</p> <ul style="list-style-type: none"> <li>• Developing and appraising the CEO and COS job descriptions;</li> <li>• Undertaking CEO and COS recruitment processes and selection of the CEO and COS or delegating to subcommittee;</li> <li>• Ensuring succession planning is in place for the CEO, COS.</li> </ul> <p>g) <del>Diversity, Equity, &amp; Inclusion (DEI)</del><u>Inclusion, Diversity, Equity &amp; Anti-Racism (IDEA)</u></p> <ul style="list-style-type: none"> <li>• Ensure the hospital's strategic plan incorporates <del>DEI</del><u>IDEA</u> principles.</li> <li>• Review and recommend policies that promote <del>DEI</del><u>IDEA</u> within the organization, and holding leadership accountable for implementing and maintain these standards across the hospital.</li> <li>• Regular monitor progress on <del>DEI</del><u>IDEA</u> initiatives and key performance measures.</li> </ul>
<b>CHAIR:</b>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Term of office will be for a minimum of two (2) years</li> </ul>
<b>MEMBERSHIP:</b>	<ul style="list-style-type: none"> <li>• Chair of the Board;</li> <li>• At least four Directors appointed by the Board (minimum one bilingual Director in English and French);</li> <li>• Chief Executive Officer as an <i>ex officio</i> member.</li> </ul>
<b>VACANCY:</b>	<ul style="list-style-type: none"> <li>• 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</li> </ul>
<b>VOTING MEMBERS :</b>	<ul style="list-style-type: none"> <li>• Only board directors appointed to this committee may vote.</li> </ul>
<b>FREQUENCY OF MEETINGS AND MANNER OF CALL :</b>	<ul style="list-style-type: none"> <li>• At least 6 times per year, at the call of the chair</li> </ul>
<b>QUORUM:</b>	<ul style="list-style-type: none"> <li>• 51% of voting members.</li> </ul>
<b>RESOURCES:</b>	<ul style="list-style-type: none"> <li>• Chief Executive Officer</li> <li>• Guests, by invitation</li> </ul>
<b>REPORTS TO</b>	<ul style="list-style-type: none"> <li>• Board of Directors</li> </ul>
<b>DATE OF LAST REVIEW</b>	<ul style="list-style-type: none"> <li>• <del>September-October</del> <u>2025</u><sup>4</sup></li> </ul>

Approved by: Corporation of l'Hôpital Glengarry Memorial Hospital

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



<b>ROLE:</b>	<ul style="list-style-type: none"> <li>• Responsible on behalf of the board of directors (the “<b>Board</b>”) for oversight of financial matters and the annual external audit.</li> <li>• To provide oversight over the planning of construction, renovation and maintenance of infrastructure and associated equipment.</li> <li>• Assist the Board in fulfilling its obligations relating to human resources and compensation matters.</li> </ul>
<b>RESPONSIBILITIES:</b>	<p><b><i>Budget Planning and Oversight</i></b></p> <ul style="list-style-type: none"> <li>• Ensure that there are processes in place for the development of an annual operating budget and capital budget.</li> <li>• Review and recommend to the board financial assumptions used to develop operating budget, capital budget and strategic plan.</li> <li>• Review and recommend to the board the annual operating plan and budget, and the capital plan and budget;</li> <li>• Review on a routine basis financial performance and compare actual performance against budget including year-end projections.</li> <li>• Review and recommend to the Board plans developed by management to address variances between budget and actual performance.</li> <li>• Oversee implementation of plans to address variances and report to the Board.</li> </ul> <p><b><i>Long-Term Planning</i></b></p> <ul style="list-style-type: none"> <li>• Oversee and assess achievement of the financial aspects of the strategic plan.</li> <li>• Review and recommend to the Board multi-year financial goals and long-term revenue and expense projections.</li> <li>• Review, with management, industry developments and legislative changes that may have an impact on financial resources or performance and report to the Board.</li> </ul> <p><b><i>Asset Management</i></b></p> <ul style="list-style-type: none"> <li>• Ensure there are processes in place to manage the assets of the Corporation.</li> <li>• Review and make recommendations on material asset acquisitions not contemplated in the annual capital plan.</li> </ul> <p><b><i>Financial Transactions</i></b></p> <ul style="list-style-type: none"> <li>• Review and make recommendations to the Board on</li> </ul>

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



	<p>banking arrangements.</p> <ul style="list-style-type: none"><li>• Review and make recommendations to the Board on lines of credit and long-term debt.</li></ul> <p><b><i>Donations and Bequests</i></b></p> <p>Advise the Board on major gifts that involve donor recognition agreements and related policies.</p> <p><b><i>Investments</i></b></p> <ul style="list-style-type: none"><li>• Review and recommend to the Board the Corporation's investment policy.</li><li>• Oversee investment performance for compliance with the investment policy.</li></ul> <p><b><i>Internal Controls, Risk Management, and Oversight of Internal Audit</i></b></p> <ul style="list-style-type: none"><li>• Oversee, review, and make recommendations to the Board on management's risk management processes.</li><li>• Review and make recommendations on the adequacy of financial resources.</li><li>• Review and make recommendations on insurance coverage.</li><li>• 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.</li><li>• Identify unusual risks and oversee management's plan to address unusual or unanticipated risks and make recommendations to the Board.</li><li>• 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.</li></ul> <p><b><i>External Audit</i></b></p> <ul style="list-style-type: none"><li>• Recommend to the Board the external auditor for appointment or re-appointment by the members at the annual members' meeting.</li><li>• Annually review and make recommendations to the Board on the external auditor's remuneration.</li><li>• Meet with the external auditor to review the proposed scope of audit.</li><li>• Review, approve, and authorize management to execute</li></ul>
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# TERMS OF REFERENCE FINANCE, HUMAN RESOURCES, AND AUDIT COMMITTEE OF THE BOARD



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.

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



	<p><b><i>Compliance with Applicable Law</i></b></p> <ul style="list-style-type: none"> <li>• Oversee compliance with accounting and financial, legal, public disclosure, and regulatory requirements.</li> <li>• Approve material changes to accounting principles and practices as suggested by management with the concurrence of the external auditor.</li> </ul> <p><b><i>Other</i></b></p> <ul style="list-style-type: none"> <li>• Perform such other duties as may be requested by the Board from time to time.</li> </ul>
<b>CHAIR:</b>	<ul style="list-style-type: none"> <li>• Treasurer of the Board</li> </ul>
<b>MEMBERSHIP:</b>	<ul style="list-style-type: none"> <li>• The Treasurer</li> <li>• The Board Chair, or their designate</li> <li>• The Chief Executive Officer, ex officio</li> <li>• The VP of Support Services and Chief Financial Officer, ex officio</li> <li>• A minimum of three elected Directors of the Board (minimum one bilingual Director in English and French)</li> <li>• Invited guests may attend committee meetings at the invitation of the Chair</li> <li>• In accordance with the Ontario <i>Not-for-Profit Corporation Act</i>, 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<sup>1</sup></li> </ul>
<b>MEETING PARTICIPATION</b>	<ul style="list-style-type: none"> <li>• Notice of the time and place of committee meetings shall be given to the external auditor.<sup>2</sup> 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.<sup>3</sup></li> <li>• The Vice President of Support Services and Chief Financial Officer of the Corporation, <i>ex officio</i>, shall be invited to attend and participate in these meetings as a guest, but shall not have a vote.</li> <li>• The Chief Human Resources Officer, <i>ex officio</i>, shall be invited to attend and participate in these meetings as a guest,</li> </ul>

<sup>1</sup> 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.

<sup>2</sup> 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.

<sup>3</sup> ONCA, s. 80(2).

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



	but shall not have a vote.
<b>VACANCY:</b>	<ul style="list-style-type: none"> <li>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.</li> </ul>
<b>VOTING MEMBERS :</b>	<ul style="list-style-type: none"> <li>Only board directors appointed to this committee may vote.</li> </ul>
<b>FREQUENCY OF MEETINGS AND MANNER OF CALL:</b>	<ul style="list-style-type: none"> <li>At least <del>eightsix</del> (86) 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.<sup>4</sup></li> </ul>
<b>QUORUM:</b>	<ul style="list-style-type: none"> <li>51% of voting members.</li> </ul>
<b>RESOURCES:</b>	<ul style="list-style-type: none"> <li>VP of Support Services and Chief Financial Officer</li> </ul>
<b>REPORTS TO</b>	<ul style="list-style-type: none"> <li>Board of Directors</li> </ul>
<b>DATE OF LAST REVIEW</b>	<ul style="list-style-type: none"> <li><del>November 2024</del><u>September 2025</u></li> </ul>

<sup>4</sup> 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



<b>ROLE:</b>	<ul style="list-style-type: none"> <li>• 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”).</li> </ul> <p>The Quality and Patient Safety Committees role is to:</p> <ul style="list-style-type: none"> <li>• Assisting the Board in the performance of the Board’s governance role for the quality of patient care and services; and</li> <li>• Performing the functions of the Quality Committee under the Act.</li> <li>• <u>Guide the strategic priority of Quality &amp; Safety.</u></li> </ul>
<b>RESPONSIBILITIES:</b>	<p>The Quality Committee, in accordance with the responsibilities in the Act, shall:</p> <p><b>Quality Oversight and Quality Improvement</b></p> <ol style="list-style-type: none"> <li>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:             <ul style="list-style-type: none"> <li>• Performance indicators used to measure quality of care and services and patient safety;</li> <li>• Reports received from the Medical Advisory Committee identifying and making recommendations regarding systemic or recurring quality of care issues;</li> <li>• Publicly reported patient safety indicators;</li> <li>• Critical incident and sentinel event reports;</li> <li>• Patient Satisfaction Survey Results;</li> <li>• Complaints, source of complaints, and interventions;</li> <li>• Quality Indicator Dashboard.</li> </ul> </li> <li>2. Consider and make recommendations to the board regarding quality improvement initiatives and policies;</li> <li>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;</li> <li>4. Oversee preparation of the hospital’s annual quality improvement plan; and</li> <li>5. Perform such other responsibilities as may be provided under regulations under the Act.</li> </ol> <p><b>Critical Incidents and Sentinel Events</b></p> <p>“Critical incident” means any unintended event that occurs when a patient receives treatment in the hospital:</p> <ol style="list-style-type: none"> <li>a. That results in death, or serious disability, injury or harm to the patient; and</li> <li>b. Does not result primarily from the patient’s underlying medical condition or known risk inherent in providing treatment.</li> </ol> <p>In accordance with Regulation 965 under the Public Hospitals Act, receive from the Chief Executive Officer, at least twice a year, aggregate critical</p>

# TERMS OF REFERENCE QUALITY AND PATIENT SAFETY COMMITTEE OF THE BOARD



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



	<ul style="list-style-type: none"> <li>• <u>Ensure coordination and alignment with the Corporation's medical advisory committee for physician human resource planning.</u></li> </ul> <p><b>Policy Implementation</b></p> <ul style="list-style-type: none"> <li>• Oversee implementation of policies, processes and programs to ensure quality objectives are met and maintained.</li> </ul> <p><b>Other</b></p> <ul style="list-style-type: none"> <li>• Perform such other duties as may be assigned by the board from time to time.</li> </ul>
<b>CHAIR:</b>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Term of office will be for a minimum of two (2) years.</li> </ul>
<b>MEMBERSHIP:</b>	<ul style="list-style-type: none"> <li>• The Chief of Staff</li> <li>• The Chief Executive Officer</li> <li>• The Chief Nursing Executive</li> <li>• One (1) health professional other than a nurse or doctor</li> <li>• Five (5) voting board members (minimum one bilingual Director in English and French), and</li> <li>• Such other persons as appointed by the hospital's board.</li> </ul>
<b>VACANCY:</b>	<ul style="list-style-type: none"> <li>• 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.</li> </ul>
<b>VOTING MEMBERS:</b>	<ul style="list-style-type: none"> <li>• Only Board Directors appointed to this committee may vote.</li> </ul>
<b>FREQUENCY OF MEETINGS AND MANNER OF CALL</b>	<ul style="list-style-type: none"> <li>• <u>At least six (6) times annually, at the call of the committee chair.</u> <del>At minimum, quarterly.</del></li> </ul>
<b>QUORUM:</b>	<ul style="list-style-type: none"> <li>• 51% of voting members.</li> </ul>
<b>RESOURCES:</b>	<ul style="list-style-type: none"> <li>• VP of Clinical Services, Quality &amp; Chief Nursing Executive</li> </ul>
<b>REPORTS TO</b>	<ul style="list-style-type: none"> <li>• Board of Directors</li> </ul>
<b>DATE OF LAST REVIEW</b>	<ul style="list-style-type: none"> <li>• <del>November 2024</del> <u>September 2025</u></li> </ul>

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: September 29, 2025 Meeting Date Prepared for: October 8, 2025 – Governance  
October 23, 2025 - Board  
 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 Board of Directors approve 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

<b>Document Name:</b>	Meetings of Directors Without Management		
<b>Document Number:</b>	BOD.0X.XXX.0.25		
<b>Review Period:</b>	<input checked="" type="checkbox"/> 3 years <input type="checkbox"/> 1 year	<b>Manual:</b> Governance Policy Manual	
<b>Classification:</b>	Board of Directors	<b>Section:</b> Board Effectiveness	
<b>Owner:</b>	Board Chair	<b>Signing Authority:</b> 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

Effective: May 2025	Last review: May 2025	Next review: May 2028
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Note: This is a controlled document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the Intranet prior to use.

<b>Document Name:</b>	CEO and COS Performance Evaluation		
<b>Document Number:</b>	BOD.02.XXX.0.25		
<b>Review Period:</b>	<input checked="" type="checkbox"/> 3 years <input type="checkbox"/> 1 year	<b>Manual:</b> Governance Policy Manual	
<b>Classification:</b>	Board of Directors	<b>Section:</b> Leadership	
<b>Owner:</b>	Board Chair	<b>Signing Authority:</b> 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 semi-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.

Effective: May 2025	Last review: May 2025	Next review: May 2028
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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

<b>Document Name:</b>	Acts, Legislations, and Compliance Reporting		
<b>Document Number:</b>	BOD.0X.XXX.0.25		
<b>Review Period:</b>	<input checked="" type="checkbox"/> 3 years <input type="checkbox"/> 1 year	<b>Manual:</b> Governance Policy Manual	
<b>Classification:</b>	Board of Directors	<b>Section:</b> Board Effectiveness	
<b>Owner:</b>	Board Chair	<b>Signing Authority:</b> 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.

Effective: Oct 2025	Last review: Oct 2025	Next review: Oct 2028
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- 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:**

<b>Policy Number</b>	<b>Policy Name</b>
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.

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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 education 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 9<sup>th</sup> 2025.
- In September 2025, HGMH unveiled the Indigenous Art Installation with a special ceremony attended by the artist, Dawn lehstoseranón: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.

## Correspondence

September 24, 2025 – The Review – [Indigenous art unveiled at Alexandria Hospital](#)

September 29, 2025 – Seaway News – [HGMH unveils Indigenous artwork in honor of Truth and Reconciliation Month](#)

September 30, 2025 – Seaway News - [B&B Market hosts fundraising barbeque for Glengarry Memorial Hospital](#)

October 5, 2025 – Seaway News – [HGMH Welcomes New Emergency Physician](#)

October 6, 2025 – The Review – [Glengarry memorial Hospital hires two new doctors to boost ER, offer new physical medicine service](#)