



Board of Directors In Camera Meeting Agenda

Date: Thursday, January 29, 2026
Time: Following the Board meeting
Location: Boardroom / Microsoft Teams

| Agenda Item | Attachment |
|--|------------|
| 1. Call to Order (Dr. S. Robertson) | |
| 1.1 Confirmation of Quorum | |
| 1.2 Adoption of the agenda | P. 1-2 |
| 1.3 Declaration of Conflict of Interest | |
| 2. Minutes (Dr. S. Robertson) | |
| 2.1 Approval of previous meeting minutes - November 27 and December 17, 2025 | P. 3-6 |
| 2.2 Business arising from minutes | |
| 3. Matters for Discussion/Decision | |
| 3.1 Foundation Updates (L. Boyling) | |
| 3.2 Critical Events and Never Events Report (H. Salib/R. Romany) THAT the Board of Directors review and receive the Critical Events and Never Events report as presented | P. 7-8 |
| 4. Adjournment (Dr. S. Robertson) | |



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 IN CAMERA MEETING OF THE BOARD OF DIRECTORS

| | | | |
|----------|-----------------------------|---------------------------|-----------------|
| Date | Thursday, November 27, 2025 | | |
| Time | 5:00pm-8:00pm | | |
| Location | Boardroom / Microsoft Teams | | |
| Present: | Dr. S. Robertson, Chair | L. Boyling, Vice-Chair | |
| | D. Elie | H. Salib (v) | G. Peters (v) |
| | C. Larocque | F. Desjardins | Dr. G. Raby(v) |
| | C. Nagy | R. Alldred-Hughes, CEO | R. Romany, CNE |
| | Dr. D. Peffer (v) | K. MacGillivray, CHRO | G. McDonald |
| Regrets: | L. Ramsay, CFO | Dr. L. MacKinnon, COS (v) | Dr. R. Cardinal |

1. Call to Order

Dr. S. Robertson, Chair, called the meeting to order at 6:19pm.

1.1. Quorum

A quorum was present.

1.2. Adoption of the Agenda

The agenda was reviewed.

Moved By: L. Boyling

Seconded By: C. Naggy

THAT the agenda be adopted as presented.

CARRIED

1.3. Declaration of Conflict of Interest

There were no conflicts of interest declared at this time.

2. Minutes

2.1 Approval of previous meeting minutes

The previous meeting minutes were reviewed.

Moved By: G. McDonald

Seconded By: F. Desjardins

THAT the previous meeting minutes of October 23, 2025, be approved as presented.

CARRIED

3. Matters for Discussion/Decision

3.1 Foundation Updates

Dream Raffle ticket sales are lower than last year, possibly due to the number of other events happening this fall, including the Harley-Davidson raffle and the Holiday Gala. It was also noted that the Holiday Gala on the 13th is expected to have strong Board attendance.

3.2 CEO Report

A discussion took place regarding the Hospital Sector Stabilization Planning update. We continue to meet with Ontario Health as a Regional Group, and the focus appears to be shifting toward lower-risk items going forward. We are conducting a more in-depth review of administrative costs; our current admin cost benchmark is just slightly above the median.

4. Consent Agenda

4.1 Draft MAC Report

The meeting minutes were included in the package.

Moved By: C. Larocque

Seconded By: G. Raby

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

CARRIED

Adjournment

The meeting adjourned at 6:32pm.

S. Laframboise, Recording Secretary

MINUTES OF THE SPECIAL IN CAMERA MEETING OF THE BOARD OF DIRECTORS

| | | | |
|----------|------------------------------|------------------------|----------------|
| Date | Wednesday, December 17, 2025 | | |
| Time | 9:00am-9:45am | | |
| Location | Microsoft Teams | | |
| Present: | Dr. S. Robertson, Chair | L. Boyling, Vice-Chair | D. Elie |
| | H. Salib | G. Peters | G. McDonald |
| | R. Alldred-Hughes, CEO | L. Ramsay, CFO | R. Romany, CNE |
| | K. MacGillivray, CHRO | | |
| Regrets: | C. Nagy | Dr. L. MacKinnon, COS | F. Desjardins |
| | C. Larocque | Dr. G. Raby | |

1. Call to Order

Dr. S. Robertson, Chair, called the meeting to order at 9:02am.

1.1. Quorum

A quorum was present.

1.2. Adoption of the Agenda

The agenda was reviewed.

Moved By: L. Boyling

Seconded By: G. Peters

THAT the agenda be adopted as amended with the addition of item 2.1 Meeting Attendance. Item 2.1 was changed to 2.2

CARRIED

1.3. Declaration of Conflict of Interest

There were no conflicts of interest declared at this time.

2. Matters for Discussion/Decision

2.1 Meeting Attendance

Discussion ensued as to whether or not the Senior Leadership should remain present for the meeting. The meeting proceeded with all members of the team.

2.2 CEO Report

The briefing note titled *“Overview Continued Exploratory Dialogue with Maxville Manor Regarding a Shared CEO Model”* was presented for discussion.

Moved By: G. McDonald

Seconded By: L. Boyling

That the Board of Directors authorize management to continue exploratory discussions with Maxville Manor regarding the feasibility of a shared Chief Executive Officer model, with any proposed arrangement to be brought back to the Board for review and final approval.

A discussion ensued and a request for recorded vote occurred. H. Salib and L. Boyling in favor. G. McDonald, D. Elie, and G. Peters oppose.

The motion was **defeated**.

Adjournment

The meeting adjourned at 9:34am.

K-L Massia, Recording Secretary

DRAFT

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: January 6, 2026 Meeting Date Prepared for: January 14, 2026 – Quality
January 29, 2026 - Board
 Subject: Critical Events and Never Events Report
 Prepared by: Rachel Romany- Vice President Clinical Services, Quality, Chief Nursing Executive

- DECISION SOUGHT*
 FOR DISCUSSION/INPUT
 FOR INFORMATION ONLY

PURPOSE

- Critical events and never events are essential indicators of our operational safety and quality. To maintain our dedication to patient safety and quality care, it is important that the Quality Committee and Board of Directors are notified of any critical incidents that occur within the hospital.

RECOMMENDATION AT THE COMMITTEE

THAT the Quality & Patient Safety Committee review and receive the Critical Events and Never Events report as presented.

RECOMMENDATION TO THE BOARD OF DIRECTORS

THAT the Board of Directors review and receive the Critical Events and Never Events report as presented.

IMPLICATIONS TO OTHER STANDING COMMITTEES

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

SITUATION & BACKGROUND

Definitions:

Critical Event: An unintended event that occurs when a patient receives treatment in the hospital that results in death, or serious disability, injury or harm, and does not result primarily from the patient’s underlying medical condition or from a known risk inherent in providing treatment.

Never Events: Never events are patient safety incidents that results in serious harm or death, and that can be prevented by using organizational checks and balances.

Identification and Reporting:

- Critical events are identified and reported through various channels within the hospital, including incident reporting systems, patient complaints, staff reports, and regular safety audits.
- All reports are thoroughly investigated to determine the root causes and contributing factors.

Analysis of Critical Events and Never Events:

- Root Cause Analysis (RCA) and Failure Mode and Effects Analysis (FMEA) have been utilized to investigate the causes of critical events and never events.
- Common factors leading to critical events include communication breakdowns, medication errors, staff fatigue, equipment malfunctions, and process challenges.
- Every critical event is preventable, and it is essential to analyze these incidents to uncover opportunities for improvement and help prevent them from happening again.

Preventive Measures

- Building a culture where staff, patients and families feel safe to report and discuss adverse events or system failures.

- A comprehensive review of hospital policies and procedures is ongoing to address areas of vulnerability identified through event analysis.
- Staff training and education programs are being enhanced to improve skills and knowledge related to patient safety.
- Regular safety huddles and debriefings are held to discuss near misses and implement changes to prevent harm.
- Clinical newsletter shares safety matters and brings issues to the attention of the team on a weekly basis to ensure the safety of our patients.
- Quality reviews of critical events occur to learn from health care errors and identify opportunities to prevent the error from occurring again.

Critical Events and Never Events at HGMH

- Below is an overview of never events and critical events from October 1, 2025 to Dec 31, 2025 (Q3 period).
- There were zero never events.
- There is 1 critical event that occurred from a fall that resulted in serious disability.
- If an event had occurred, the hospital would have followed all protocols and reviewed the events, and adjusted process or procedures, or provided education as required.

| Critical Event Type | Number of Events |
|---|------------------|
| Surgery on the wrong body part or the wrong patient, or conducting the wrong procedure | 0 |
| Wrong tissue, biological implant or blood product given to a patient | 0 |
| Unintended foreign object left in a patient following a procedure | 0 |
| Patient death or serious harm arising from the use of improperly sterilized instruments or equipment provided by the health care facility | 0 |
| Patient death or serious harm due to a failure to inquire whether a patient has a known allergy to medication, or due to administration of a medication where a patient's allergy had been identified | 0 |
| Patient death or serious harm due to the administration of the wrong inhalation or insufflation gas | 0 |
| Patient death or serious harm as a result of one of five pharmaceutical events | 0 |
| Patient death or serious harm as a result of failure to identify and treat metabolic disturbances | 0 |
| Any stage III or stage IV pressure ulcer acquired after admission to hospital | 0 |
| Patient death or serious harm due to uncontrolled movement of a ferromagnetic object in an MRI area | 0 |
| Patient death or serious harm due to an accidental burn | 0 |
| Patient under the highest level of observation leaves a secured facility or ward without the knowledge of staff | 0 |
| Patient suicide, or attempted suicide that resulted in serious harm, in instances where suicide-prevention protocols were to be applied to patients under the highest level of observation | 0 |
| Infant abducted, or discharged to the wrong person | 0 |
| Patient death or serious harm as a result of transport of a frail patient, or patient with dementia, where protocols were not followed to ensure the patient was left in a safe environment | 0 |
| <i>Other Critical events not part of the never events</i> | 1 |

Summary

- Patient safety and high-quality care remain our highest priorities. Critical and never events are reviewed through a structured quality and safety framework to support organizational learning and continuous improvement.