

## Board of Directors Meeting Agenda

Date: Thursday, January 29, 2026  
 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.05.003.X.XX</a> )	
<b>5:04</b>	<b>2. Minutes (Dr. S. Robertson)</b>	
(1 min)	2.1 Approval of previous meeting minutes - November 27, 2025	P. 3-8
(1 min)	2.2 Business arising from minutes	
<b>5:06</b>	<b>3. Education</b>	
(15 min)	3.1 Ethics Framework (A. Ladak)	
<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. 9-12
(5 min)	4.3 Report of the Chief of Staff (Dr. L. MacKinnon)	P. 13
(5 min)	4.4 Report of the VP of Clinical Services, Quality & CNE (R. Romany)	P. 14-15
(5 min)	4.5 Report of the Patient and Family Advisory Committee (J. Shackleton)	
(5 min)	4.6 Report of the Chair of Quality & Patient Safety Committee (H. Salib)	
(5 min)	4.7 Professional Staff Reappointment (H. Salib/Dr. L. MacKinnon) <b>THAT the Board of Directors approve the reappointment of the Professional Staff for 2026 as presented.</b>	P. 16-20
(5 min)	4.8 Accreditation Updates (H. Salib/R. Alldred-Hughes)	P. 21-22
(5 min)	4.9 Report of the Chair of Governance & Nominating Committee (L. Boyling)	
(5 min)	4.10 Revised Corporate Bylaws (L. Boyling/R. Alldred-Hughes) <b>THAT the Board of Directors recommend the amendment to the Corporate Bylaws at the Annual General Meeting.</b>	P. 23-24
(5 min)	4.11 Review Committee Effectiveness Survey Questions (L. Boyling) <b>THAT the Board of Directors approve the Committee Effectiveness Survey questions as presented.</b>	P. 25-40
(5 min)	4.12 Review Q3 Strategic Actions (L. Boyling/R. Alldred-Hughes) <b>THAT the Board of Directors review and receive the Q3 Strategic Actions as presented.</b>	P. 41-45
(5 min)	4.13 Report of the Chair of French Language Services (Dr. G. Raby)	
(5 min)	4.14 Summary of the Annual French Language Report to the Ministry (Dr. G. Raby/L. Ramsay) <b>THAT the Board of Directors review and receive the Q2 Strategic Actions report.</b>	P. 46-50
<b>6:31</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 Quality & Patient Safety Committee Report	P. 51-53
	5.2 Professional Staff Appointment and Reappointment Process	P. 54-67
	5.3 Status of Patient Safety Plan Actions	P. 68-79
	5.4 Complaints and Compliments Report	P. 80-82
	5.5 Draft Governance & Nominating Committee Report	P. 83-84
	5.6 Succession Planning Overview	P. 85-94
	5.7 Board Member Attendance	P. 95-98
	5.8 IDEA Update	P. 99-101
	5.9 Draft French Language Services Committee Report	P. 102-103
	5.10 French Language HR Plan 2024-2025 <b>THAT the Board of Directors approve and receive all documents as presented in the consent agenda.</b>	P. 104
<b>6:32</b>	<b>6. Correspondence (Dr. S. Robertson)</b>	P. 105
	<b>7. Date of Next Meeting - Thursday, February 26, 2026 5:00pm</b>	
<b>6:33</b>	<b>8. Closing Remarks &amp; Adjournment (Dr. S. Robertson)</b>	

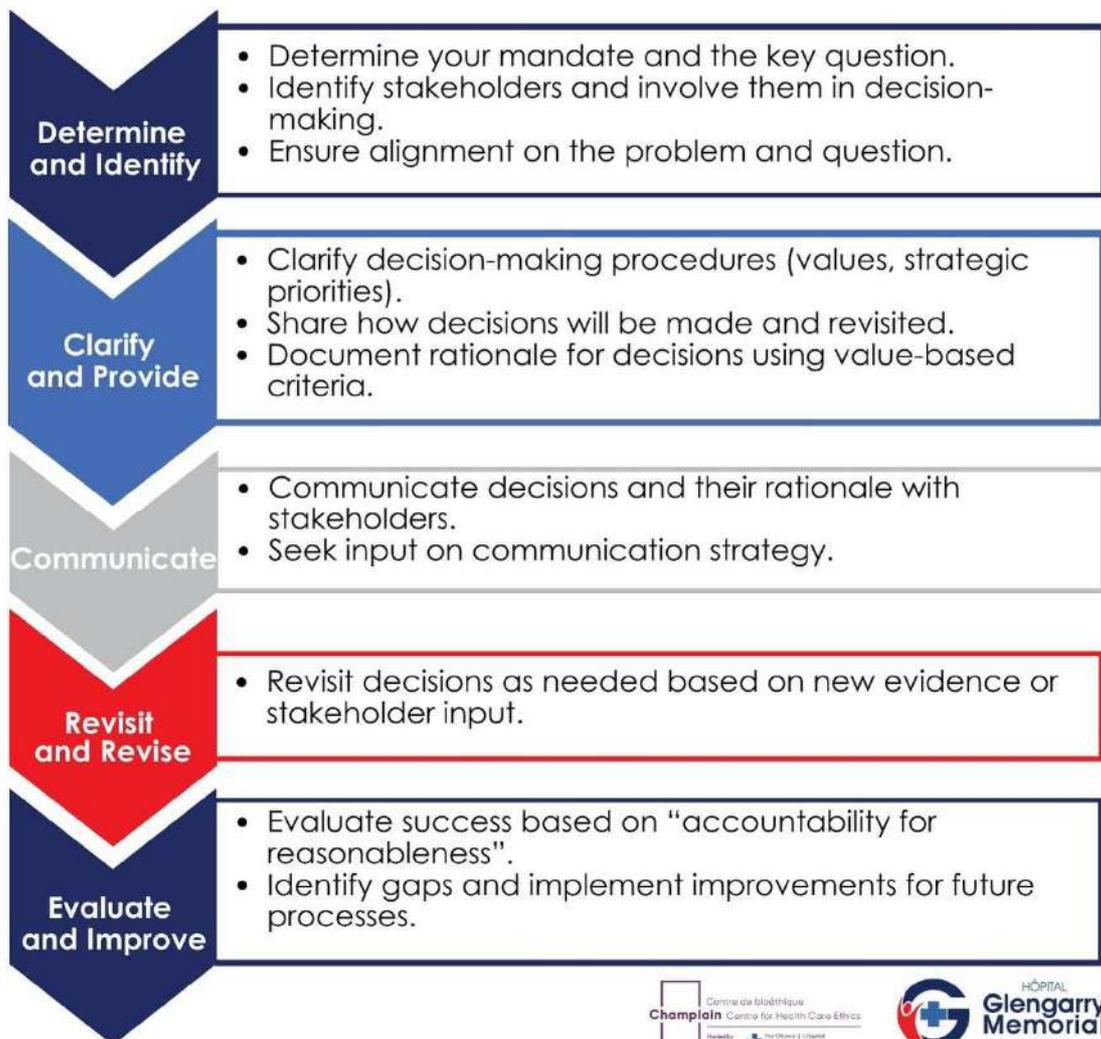
\*Meeting Moves to In Camera

# 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, 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
	G. McDonald	K. MacGillivray, CHRO	Dr. D. Peffer (v)
	J. Shackleton, PFAC	J. Mattice (guest presenter)	
Regrets:	Dr. L. MacKinnon, COS	L. Ramsay, CFO	
	Dr. R. Cardinal		

### 1. Call to Order

Dr. S. Robertson, Chair, called the meeting to order at 5:04.

#### 1.1 Quorum

A quorum was present.

#### 1.2 Land Acknowledgment

C. Naggy read the land acknowledgment.

#### 1.3 Adoption of the Agenda

The agenda was reviewed.

Moved By: F. Desjardins

Seconded By: G. McDonald

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 October 23, 2025, were shared.

Moved By: L. Boyling

Seconded By: C. Larocque

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

**CARRIED**

#### 2.2 Business Arising from the Minutes

Nothing to bring forward.

### **3 Education**

#### **3.1 Business Continuity Plan**

J. Mattice delivered education on the Business Continuity Plan and responded to questions from the Board members present. The Board expressed appreciation for the clarity and value of the information provided.

### **4 Matters for Discussion/Decision**

#### **4.1 Report of the Board Chair**

Dr. S Robertson reminded the Board member of the upcoming events that include:

- the Foundation Harley-Davidson Raffle, November 29<sup>th</sup>
- the HGMH Christmas Party, December 6<sup>th</sup>
- the Bonnie Glen Holiday Gala December 13<sup>th</sup>
- Baby, Please Come Home - Alexandria's Annual Evening Shopping Event tonight.
- CPKC Holiday Train will be in Finch November 28<sup>th</sup>

Wishing everyone a Merry Christmas a looking forward to next year with this Board.

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

Report was included in the package.

- University of Ottawa Heart Institute site visit: Special thanks to R. Romany for joining this meeting. It was a great discussion about their new strategic plan and we identified some actions we can implement in the near future to strengthen our collaboration moving forward.
- Patient Rounding with PFAC - Patient Safety Week.
- Regional Breach Coach Model: This approach provides a shared breach coach for a regional group. Whereas organizations often restrict information during a cyber-attack, this model encourages collective information sharing. Our previous experience utilizing two distinct breach coaches was discussed. It was also noted that cyber-attack attempts, particularly phishing, occur multiple times daily and are addressed by our IT department.
- EPIC Implementation - one year out celebration.
- CT Scanner Planning Update: We are actively exploring several alternatives, including the possibility of joining an existing RFP process, which could shorten the overall timeline by 2-3 months. David Price, who supported our business case, is serving as our Project Consultant Manager. There is increased confidence in the foundation's fundraising progress to date, and we want to avoid delays that could cause donors to question the status of the CT scanner project.
- Stakeholder Engagement Activities.

#### **4.3 Report of the Chief of Staff**

The report was included in the meeting package. Discussion took place regarding the section referencing the number of Quebec physicians interested in working in Ontario. The Board expressed appreciation for the physicians who have stepped up this year to ensure adequate coverage. Dr. Dale Peffer, President of the Professional Staff, was then introduced to the Board.

#### **4.4 Report of the Chief Human Resources Officer**

We hosted a chocolate fondue celebration for staff, which was very well received. Many staff members lined up enthusiastically to enjoy the sweet treat.

C. Maruno participated as a panel speaker at the *Breaking Barriers* event, supporting young people exploring career opportunities. She offered candid and straightforward responses to the questions asked.

C. Maruno and K. MacGillivray attended a free training session on psychological health and safety professional certification, offered by the Canadian Mental Health Association.

Management Bites sessions continue to provide not only snacks but also valuable dialogue, giving managers an opportunity to discuss and work through challenging issues they are facing.

Thank you to everyone who took part in the employee appreciation BBQ in September—your participation made the event meaningful, and staff truly appreciated it.

#### 4.5 Report of the Patient and Family Advisory Committee

J. Shackleton shared that the next meeting will take place next week. Two members participated in patient rounding last month, and she is set to complete their first rounding session next week and is looking forward to it. The group is preparing for accreditation and exploring plans for a Mental Health Day in the ED.

#### 4.6 Report of the Chair of Quality & Patient Safety

H. Salib reports as the new Chair to this committee, she is impressed with the committee itself, the reports shared, and discussions that R. Romany's team provide.

#### 4.7 Review Q2 Quality Improvement Plan Results

The Q2 QIP results were provided in the package. Current strategies are proving effective, and overall performance is positive. A goal of two medication errors per month has been set. No critical or adverse events were reported. The Board discussed the various types of reportable medication errors. The 2026-2027 QIP will be brought forward at the next meeting.

Moved By: C. Larocque

Seconded By: F. Desjardins

THAT the Board of Directors review and receive the Q2 Quality Improvement Plan results as presented.

**CARRIED**

#### 4.8 Review Q2 Patient Satisfaction Survey Results

Wait times remain a concern, but communication with patients regarding current wait times and their causes is improving. The Rehab team is recognized for actively involving patients and families in care planning.

Moved By: C. Naggy

Seconded By: G. McDonald

THAT the Board of Directors review and receive the Q2 Patient Satisfaction Survey results as presented.

**CARRIED**

4.9 Report of the Chair of Finance, HR and Audit Committee

C. Naggy reported that, arising from the Finance, HR, and Audit Committee meeting, three motions are scheduled for presentation today.

4.10 Financial Statements - July, August and September 2025

The July, August, and September 2025 financial statements were provided in the package. The Board discussed funding received, reduced Quebec patient visits, and budget variances. The supplementary graphics were particularly appreciated.

Moved By: F. Desjardins

Seconded By: G. McDonald

THAT the Board of Directors review and receive the financial statements for July, August, and September 2025 as presented.

**CARRIED**

4.11 Review Financial Projections

Financial projections were included in the meeting package. Discussion addressed the projected variance at year-end, highlighting ongoing efforts to identify and implement cost-saving measures wherever possible.

Moved By: F. Desjardins

Seconded By: G. Raby

THAT the Board of Directors review and receive the financial projections as presented.

**CARRIED**

4.12 Review Investments Q1 and Q2

It was noted that the attachment included in the package contains the Capital Fund Reserve on the first page and the Endowment Fund on the second page.

Moved By: C. Larocque

Seconded By: G. Peters

THAT the Board of Directors review and receive the Investments summary for Q1 and Q2 as presented.

**CARRIED**

4.13 Report of the Chair of Governance & Nominating Committee

L. Boyling reported that the Governance & Nominating Committee met two weeks ago. The skills matrix was reviewed, and it was decided to remove the diversity section, as it is not directly related to skills. The committee will determine the most appropriate way and location to capture this information.

4.14 Review Skills Matrix

The Governance Committee recommends to the HGMH Board of Directors an annual update process as part of the regular Board evaluation cycle.

Moved By: C. Larocque

Seconded By: F. Desjardins

That the Board of Directors approve implement an annual update process to the

skills matrix as part of the regular Board evaluation cycle.

**CARRIED**

**4.15 Review Q2 Strategic Actions**

The strategic action report was provided in the package. All initiatives are on track, PFAC has made a remarkable contributions of time and effort. The Board thanked the PFAC Committee. PFAC plans to expand its membership to up to six member, and capital redevelopment remains on schedule.

Moved By: G. McDonald

Seconded By: C. Naggy

THAT the Board of Directors review and receive the Q2 Strategic Actions report.

**CARRIED**

**5 Consent Agenda**

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

- 5.1 Draft Quality & Patient Safety Committee Report
- 5.2 Q2 Quality & Safety Scorecard Results
- 5.3 Business Continuity Plan
- 5.4 Updates from Best Practice Spotlight Organization
- 5.5 Trillium Gift of Life Report
- 5.6 Status of Patient Safety Plan Actions
- 5.7 Professional Staff HR Plan
- 5.8 Draft Finance, HR and Audit Committee Report
- 5.9 Q1/Q2 Executive Expense Report
- 5.10 Enterprise Risk Management
- 5.11 Q2 HR Metrics Report
- 5.12 IDEA Framework
- 5.13 Whistleblowing Report
- 5.14 Epic Implementation Updates
- 5.15 Energy Scorecard
- 5.16 Draft Governance and Nominating Committee Report
- 5.17 Patient and Family Engagement Policy (New)
- 5.18 Performance Evaluation Questionnaire for CEO and COS
- 5.19 Strategic Plan and Refresh

Moved By: G. Raby

Seconded By: G. Peters

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

**CARRIED**

It was acknowledged that Board Quality members have questions, and these will be further discussed at the next Board Quality Committee meeting.

6 **Correspondence**

Nothing noted this meeting.

7 **Date of Next Meeting**

Thursday, January 29, 2026, at 6:17

S. Laframboise, Recording Secretary

DRAFT

## Report of the President & CEO

January 14, 2026 Board of Directors

### Accreditation 2026

As we approach our upcoming Accreditation Canada survey, I want to acknowledge the significant work that has gone into our preparation to date. Accreditation reflects our day-to-day practices, and the progress achieved speaks to the focus, discipline, and consistency demonstrated across the organization. I would like to thank the leadership team and their respective teams for the time and effort invested in reviewing standards, strengthening processes, and addressing identified gaps.

Leadership presence and engagement are particularly important during the survey period. The Accreditation Canada survey will take place during the week of February 9–13. The Board of Directors' accreditation session is scheduled for February 9<sup>th</sup>, 2026 from 10am to 11:00am and Board participation will be an important opportunity to demonstrate governance oversight, leadership alignment, and our collective commitment to quality and continuous improvement.

The general debrief is on Thursday February 12, 2026 at 11:00am, and all staff, physicians, and Board of Directors are invited to attend. The location is in the Boardroom or via Teams.

Below are the Bio's of the surveyors who have been assigned to our hospital Accreditation Survey for your information.

**Marianne Walker:** *Marianne Walker has over 33 years of leadership experience. She was the President and CEO at the Guelph General Hospital, Ontario, and recently retired. Previously, she was the President of St. Joseph's Health Centre in Guelph, Ontario, and Senior Vice-President of Elder Care for St. Joseph's Health System, Hamilton.*

*The Guelph General Hospital is a large community acute care hospital. St. Joseph's Health System is a large corporation that provides academic, acute, mental health, rehabilitation, complex care, long term care, community support services, and home care services in five facilities throughout South-Western Ontario. She has led several integrated clinical programs that has resulted in improved patient outcomes.*

*Previously, Marianne held several senior positions including Chief Operating Officer, Chief Nursing Officer, and several clinical management positions in the areas of surgical services, mental health, pediatrics, maternal newborn, diagnostics, and infection control at a large acute care community hospital.*

*Marianne's expertise is in the areas of governance, leadership, strategic planning, mission integration, business planning, quality and risk management, elder care, and human resources.*

*Marianne holds a Bachelor of Science in Nursing from McMaster University and a Master of Health Sciences from the University of Toronto. She is a Certified Health Executive with the Canadian College of Health Leaders and Chartered Director(C.Dir)*

*Marianne is a past Board member of the Ontario Hospital Association and the Change Foundation. She is the past Chair of the Canadian College of Health Leaders and current Board member.*

**Annette Jones:** *Annette is a registered nurse, graduating from the University of Toronto where she completed both her Bachelor and Masters of Science in Nursing. She also completed a certificate of Acute Care Nurse Practitioner, specializing in Mental Health.*

*Annette worked at Scarborough Public Health, Hugh MacMillan Children's Rehabilitation Centre and Scarborough Centenary Hospital before she joined Southlake Regional Health Centre as a Clinical Nurse Specialist in the Mental Health Program. From there she moved into various roles including Director of*



*Mental Health, Maternal Child, and Emergency Department. For 18 years she held various senior executive positions at Southlake Regional Hospital including Vice President and Chief Nursing Executive from 2004 - 2021. Annette also held a joint role as the President and CEO at Stevenson Memorial Hospital from 2011 to 2013.*

*She is currently the Board Chair for the Addiction Services of Central Ontario.*

*Annette Jones is currently Vice President, Patient Experiences and Chief Nursing Officer/Professional Practice at Headwaters Health Care Centre in Orangeville, Ontario.*

### HGMH Operating Finances

I want to recognize the recent confirmation of an additional \$527,000 in base funding, bringing the total increase in annual operating revenue this year to approximately \$1.1 million. This adjustment reflects the collective work across the organization to clearly articulate our financial pressures, demonstrate responsible stewardship of resources, and advocate effectively for more sustainable base funding.

As we enter the final quarter of the fiscal year, a continued focus on planning, monitoring, and active financial management remains critical. Management is maintaining close oversight of departmental performance through regular financial dashboards and variance review. Sustained financial discipline over the coming weeks will be essential to closing the year in a stable and balanced position.

### Glengarry Mesonic Lodge host joint fundraiser

The Glengarry Masonic Lodge recently hosted a holiday meal in support of local healthcare, with the HGMH Foundation and Maxville Manor as joint beneficiaries. Greetings were brought on behalf of the hospital, along with remarks highlighting the importance of community engagement and philanthropic support through the HGMH Foundation.

Events such as this reflect the strength of regional partnerships and reinforce the important role community fundraising plays in supporting both hospital and long-term care services, complementing public funding and enhancing care for the communities we serve.

### CT Scanner Planning Update

Planning for the addition of a CT scanner at HGMH is underway as part of broader efforts to improve local access to diagnostic services and reduce the need for patients to travel outside the community for care. An initial planning meeting has taken place, supporting early alignment on timelines, infrastructure requirements, and implementation considerations.

Current planning is working toward an anticipated go-live of October 2027. The proposed approach includes joining an existing RFP, supporting procurement efficiency and alignment with regional partners. As part of this work, the hospital is undertaking a review of its electrical power supply and capacity to fully understand the infrastructure implications associated with bringing CT services on site. A more detailed update, including financial and risk considerations, will be brought forward through the Finance & Resources Committee as this work progresses, with subsequent updates to the Board as decisions move through the appropriate governance and approval processes.

### LEADS in a Caring Environment - Cohort 2 – Application

The application process is now underway for Cohort 2 of the LEADS leadership development program, an important component of leadership capacity-building at HGMH. This follows the successful completion of Cohort 1, with graduates representing a cross-section of clinical and administrative leaders across the organization. Their commitment to ongoing learning and leadership development reflects the hospital’s continued investment in building a strong and sustainable leadership pipeline. Congratulations to Annik Macleod - Manager of Pharmacy Operations, Julie Larose – Manager of Support Services, Jen Mattice – Manager of Emergency Preparedness & Projects, and Terri Courcy – Manager of Financial Services for completing the LEADS program.

Leaders interested in participating in Cohort 2 will be completing their application for participation with a November 2026 start date. Updates on participation and program outcomes will continue to be shared as the initiative progresses.



### HGMH Capital Redevelopment

Work on the hospital’s capital redevelopment continues within the Ministry of Health’s hospital capital planning process. Following submission, a series of follow-up questions were received from both the Ministry of Health and Ontario Health, which is a normal and expected part of this stage of review. All requested information has been provided, and discussions to date have been constructive in clarifying key elements of the proposal.

The project is currently awaiting the Ontario Health endorsement letter, which is the next required step before the Ministry can consider advancing the redevelopment to a subsequent phase of the capital planning process. Timelines at this stage remain largely dependent on external review processes. Regular contact is being maintained with Ontario Health and the Ministry, and updates will continue to be provided to the Board as further direction is received.

### Annual Strategic Action Planning Session

An annual strategic action planning session for the leadership team has been scheduled for February 26, with time held in calendars. The session will provide an opportunity to reflect on progress against the current Strategic Plan, confirm priorities already underway, and identify emerging needs and pressures as planning begins for 2026–2027.

The outputs from this session will inform the development of proposed strategic actions, which will be brought forward to the Board of Directors for review and approval, consistent with the Board’s governance role. The Medical Advisory Committee (MAC) and the Patient and Family Advisory Committee (PFAC) will also be engaged through discussions at their regular meetings to ensure clinical and patient perspectives inform this work. Key outcomes will be reported to the Board following these engagements.

### Wellness Activities

Wellness and staff engagement activities have continued to be an important focus at HGMH. Bella has resumed her regular wellness rounds, providing moments of connection and stress relief for staff across the organization. In recognition of Bell Let’s Talk Day, a series of wellness-focused activities were held, including guest speaker, Stephen Douris, from MenTALK support group, and a “Puppy Palooza,” where nine puppies visited the hospital

for staff to cuddle. These initiatives were well received and served as a reminder of the importance of mental health, psychological safety, and taking time to care for one another in a demanding healthcare environment.



### Medicine Wheel Friendship Circle gift for Spiritual & Cultural Care Room

HGMH was recently and unexpectedly gifted a hand-made ceramic Medicine Wheel Friendship Circle, received during the holiday season and now located in the hospital's Spiritual and Cultural Care Room. The Medicine Wheel carries important and diverse teachings across many Indigenous nations and is often understood as representing the balance and interconnectedness of emotional, physical, mental, and spiritual wellbeing.



This thoughtful and unanticipated gift reflects the relationships we have formed and aligns with the hospital's commitment to cultural safety, reconciliation, and inclusive spaces for patients, families, staff, and community members. Sincere appreciation is extended to Marleen Murphy of Millside Ceramics, located on Tyendingaga Mohawk Territory, and Dawn Iehstoseranón:nha of IndigenARTSY and Pass the Feather for their generosity and partnership. The Medicine Wheel Friendship Circle will remain a respected and meaningful presence within the hospital community.

### 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:

- Healthcare Infrastructure Forum
- Great River OHT – Primary Care Network Steering Committee – Pre-Capital Overview
- Site visit with Children's Hospital of Eastern Ontario CHEO, Chief Executive Officer, Vera Etches

### Upcoming Events/Special Dates

February 9-12 – Accreditation

February 25 – Pink Shirt Day

February 26 – 2026/2027 Strategic Action Planning Session

## Report of the Chief of Staff January 2026

### Physician Recruitment Update

Ongoing recruitment for:

- 1–2 part-time *ED physicians* to cover ~5–6 shifts/month plus vacation relief.
- 1–2 part-time *Inpatient physicians* to ensure consistent Medicine and Rehab coverage during vacation periods.

Following the partial repeal of Bill 2, interest from Quebec-based physicians has declined significantly; however, we remain in contact with three physicians from Quebec who have requested application packages.

- One physician with 19 years of Emergency Department experience has initiated the application process and is currently awaiting several required documents to complete her submission.
- One physician is in the process of completing an application for Inpatient Department coverage and is aiming for a start date toward the end of August 2026.
- One physician who has expressed interest in both Emergency and Inpatient Department coverage has received the application package but has not yet submitted any materials.

### Scheduling Update

The *Emergency Department* schedule is covered through the end of March, with 3 open shifts in March and a few optional second-physician and backup-physician shifts remaining. These are often filled closer to the date as physician availability adjusts.

The *Inpatient Unit* has full physician coverage secured through June 2026, and the July-December schedule will be worked on in February.

### Medical Learners

- We welcomed another third-year medical student from Queen's University who will be with us January 5-April 10, 2026 – Sara Marshall.
- Dr. Bilodeau mentored a second-year resident from Ottawa University – Alexa Schryver December 16, 2025-January 12, 2026. Alexa has requested another elective with us in the Emergency and Inpatient Departments February 10-March 9, 2026.
- Dr. Bilodeau is mentoring another second-year resident from Ottawa University – Cynthia Afeich January 19-February 9, 2026.
- We are working to support 2 third-year medical students from Queen's University who are currently placed in Akwesasne with Dr. Horne January 5-April 10, 2026 and looking to us for Emergency Department experience.

## Report of the VP Clinical Services, Quality & Chief Nursing Executive

January 29, 2026 Board Meeting

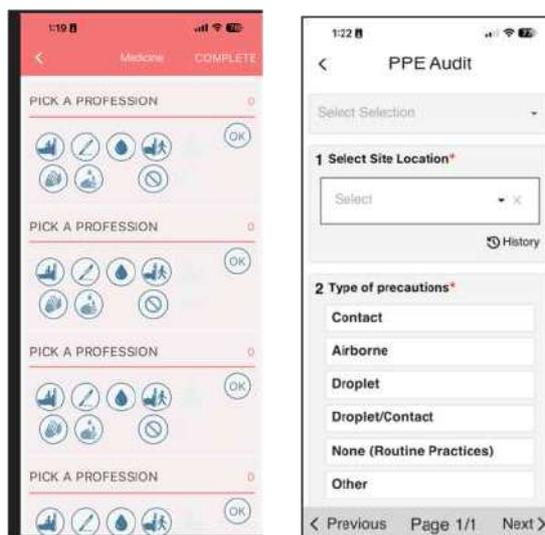
### December 10, 2025- Wound Care and Patient Safety Education Day

A practical, hands-on learning on wound care, patient safety and equipment was provided to all staff. The goal was to strengthen everyday practices that prevent patient harm, particularly skin breakdown, pressure injuries, and falls. The session was led by our Wound Care Nurse, supported by occupational and physiotherapy staff, and included education from specialized equipment vendors. Staff received direct instruction on wound care, safe patient repositioning, mobility techniques, use of pressure-relieving mattresses, and appropriate seating and wheelchair selection. This initiative supports safer care delivery by improving staff confidence, reinforcing best practices, and reducing the risk of preventable injuries for patients.



### IPAC Auditing Tool- SEMMEL Audting Tool App

As part of our ongoing focus on infection prevention and control (IPAC), we have **Semmel**, a digital auditing tools that improves how we monitor key safety practices. The app allows IPAC to electronically conduct and track hand hygiene audits ,proper use of personal protective equipment (PPE), such as gowns, gloves, and masks, and housekeeping cleaning audits (Glo- Germ Gel audits ). The app provides reliable data that helps identify trends, target education, and strengthen accountability. It enhances our ability to demonstrate compliance with infection control standards and supports continuous quality improvement.



### OHA and University of Waterloo Digital Education on Artificial Intelligence (AI)

HGMH is strengthening leadership capacity in digital health and innovation. The **Ontario Hospital Association**, in partnership with the **University of Waterloo**, is offering a complimentary executive education program titled **Building a Blueprint to Harness Artificial Intelligence in Healthcare**. This eight-week program begins in January 2026 and consists of weekly 2.5-hour sessions. The curriculum is designed for hospital leaders and focuses on understanding where artificial intelligence can safely and effectively support healthcare operations, clinical decision-making, and system efficiency. Topics include data privacy, risk management, ethical considerations, leadership, and change management, concluding with a practical project relevant to our hospital operations.

Together, these initiatives reflect continued progress in patient safety, workforce education, and leadership oversight and readiness.

It is important to note that HGMH is not advancing into AI innovation independently or implementing AI-driven clinical tools at this time. We are intentionally joining peer hospitals across Ontario in a shared learning journey, recognizing that AI is already influencing healthcare systems and will continue to do so.



## Program Outline

### Week 1: ONTARIO'S HEALTH CARE LANDSCAPE AND THE AI OPPORTUNITY

- January 13: 1630-1900
- Re-imagining Ontario's Health delivery landscape in the context of an AI enabled world

### Week 2: AI LITERACY: FOUNDATIONAL CONCEPTS AND USE CASES

- **January 20: 1630-1900**
- **January 21 - Working Group Session: 1630-1730**
- Tradeoffs and the cost benefits of Gen AI and how to balance these factors in the context of your hospital

### Week 3: DATA GOVERNANCE, MANAGEMENT, PRIVACY AND SECURITY

- January 27: 1630-1900
- AI Governance – Cultivating adoption, addressing security and privacy

### Week 4: ENHANCING OPERATIONAL EFFICIENCY WITH AI

- February 3: 1630-1900
- How to ensure you aren't measuring all the wrong things for the right reasons

### Week 5: ETHICAL, LEGAL, AND RISK MANAGEMENT CONSIDERATIONS

- February 10: 1630-1900
- Establishing trust in the use of AI applications by health providers

### Week 6: LEADERSHIP AND CHANGE MANAGEMENT

- February 17: 1630-1900
- February 19 - Post Module Spotlight: 1630-1730
- Setting the tone and driving culture within the organization to embrace AI

### Week 7: SCALING AND SUSTAINING AI INITIATIVES

- February 24: 1630-1900
- How AI changes traditional transformation

### March & April

- Post-module work group sessions
- Work Project: Exploring your AI transformation project with colleagues.

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: 2026 Medical Staff Reappointment Summary  
 Prepared by: Dr. Lisa MacKinnon, Chief of Staff

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

**PURPOSE**

To seek Board approval of medical staff reappointments and associated clinical privileges for the period January 1 to December 31, 2026, as recommended by the Medical Advisory Committee (MAC).

**RECOMMENDATION AT THE COMMITTEE MEETING**

**That the Quality & Patient Safety Committee recommend to the Board of Directors the reappointment of the Professional Staff for 2026 as presented.**

**RECOMMENDATION TO THE BOARD OF DIRECTORS**

**That the Board of Directors approve the reappointment of the Professional Staff for 2026 as presented.**

**IMPLICATIONS TO OTHER STANDING COMMITTEES**

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

**SITUATION & BACKGROUND**

As part of the annual credentialing and privileging process, physicians were invited to apply for reappointment to the Medical Staff for the 2026 calendar year.

- **46 physicians** completed the reappointment process and were reviewed and approved by the Medical Advisory Committee (MAC), with privileges recommended as submitted.
- **2 physicians** advised they are not seeking reappointment.
  - There is no operational or clinical impact to the hospital.
- **3 physicians** did not reapply:
  - **Internal Medicine:** Physician provides Holter monitor interpretation services. A reappointment application was not submitted, and confirmation is pending as to whether this was intentional. The physician may be retiring. A formal coverage plan has not yet been finalized and will require follow-up.
  - **Orthopedics:** Physician did not reapply pending an internal impact analysis and decision regarding an orthopedic clinic model. Reapplication may occur following that decision.
  - **Medical Biochemistry:** Physician is currently on maternity leave until May and an intention to reapply upon return is expected.

All reappointment applications were assessed in accordance with hospital bylaws, professional staff rules, and credentialing standards.

**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.*

**Clinical Impact**

- No immediate patient safety concerns identified.

- Potential service impact exists related to Holter monitor interpretation should the Internal Medicine physician confirm retirement or non-reapplication.

### **Operational Impact**

- Medical Affairs is actively following up to confirm the Internal Medicine physician's intent.
- A coverage plan will be developed and implemented as required, which may include redistribution of workload, temporary coverage, or external service arrangements.
- Orthopedic services continue to be reviewed as part of broader clinic planning.

### **Risk Assessment**

- Overall risk is low to moderate.
- Identified risk related to Holter monitor interpretation service coverage is pending confirmation and mitigation planning.

### **Decision Criteria**

- Compliance with Medical Staff Bylaws and credentialing policies
- MAC recommendation
- Ability to maintain safe, effective, and continuous patient care
- Proactive management of identified service coverage

### **SUMMARY**

The Medical Advisory Committee (MAC) recommends That the Board of Directors approve the reappointment and associated clinical privileges for the 46 physicians as recommended by the Medical Advisory Committee for the period January 1 to December 31, 2026, and note the identified coverage planning underway for services impacted by physicians who did not reapply.

2026 - HGMH Credentialing Period Summary - Board of Directors

Last Name	First Name	Reapplication Status Update	Department 1 Name	Department 1 Rank 1	Department 1 Specialty 1	Department 2 Name
<b>Not Seeking Reappointment = 2</b>						
Thomas	Gordon	Declined	Psychiatry	Courtesy		
Tsimiklis	Georgios	Not Submitted	Medicine	Courtesy	Medicine - Cardiology	
<b>Did Not Reapply = 3</b>						
DeYoung	J. Paul	Not Submitted	Medicine	Courtesy	Medicine - Internal Medicine	
Elkurbo	Mohamed	Not Submitted	Orthopedics	Courtesy		
Sant	Nadia	Not Submitted	Medicine	Courtesy	Medicine - Biochemistry, Transfusion Medicine	
<b>Reappointment List = 46</b>						
Assaly	Thomas	Complete	Medical Imaging	Courtesy		
Badawy	Wael	Complete	Emergency Medicine	Courtesy		
Bilodeau	Eric	Complete	General Medicine	Active		Emergency Medicine
Bishop	David	Complete	Medical Imaging	Courtesy		
Boubalos	Anastasios	Complete	Medical Imaging	Courtesy		
Bouka	Aimée	Complete	Emergency Medicine	Courtesy		
Buyukdere	Hakan	Complete	Medicine	Courtesy	Medicine - Biochemistry, Transfusion Medicine	
Cochrane	Jacqueline	Complete	Medicine	Courtesy	Physiatry	
Crevier	Julie	Complete	General Medicine	Associate		
Dabirzadeh	Hamidreza	Complete	Medical Imaging	Courtesy		
Dang	Yen	Complete	Surgery	Courtesy	Surgery - General Surgery	
Diaconescu	Ionut Marius	Complete	Medical Imaging	Courtesy		
El Salibi	Elias	Complete	Emergency Medicine	Active		
Farmer	Sara	Complete	Emergency Medicine	Active		General Medicine

Last Name	First Name	Reapplication Status Update	Department 1 Name	Department 1 Rank 1	Department 1 Specialty 1	Department 2 Name
Forbes	Jessica	Complete	Medicine	Courtesy	Medicine - Biochemistry, Transfusion Medicine	
Galley	Daniel	Complete	Medical Imaging	Courtesy		
Ghaly	Ezzat	Complete	Medicine	Courtesy	Medicine - Internal Medicine	
Grewal	Rasveg	Complete	Medicine	Courtesy	Medicine - Cardiology	
Isaac	Sandhya	Complete	General Medicine	Locum Tenens		
Kagoma	Peter	Complete	Medicine	Courtesy	Medicine - Hematology	
Kucherepa	Nadia	Complete	General Medicine	Active		
Lin	Charles	Complete	Medicine	Courtesy	Medicine - Cardiology	
Mackinnon	Lisa	Complete	Emergency Medicine	Active		General Medicine
McCudden	Chris	Complete	Medicine	Courtesy	Medicine - Biochemistry, Transfusion Medicine	
Meredith	Joel	Complete	Medicine	Courtesy	Medicine - Pain Management	
Miller	Claire	Complete	General Medicine	Courtesy		
Naoum	Serge	Complete	Surgery	Courtesy	Surgery - General Surgery	
Ojiaku	MacArinze	Complete	Medical Imaging	Courtesy		
Ourahma	Ziad	Complete	Emergency Medicine	Courtesy		
Peffer	Dale	Complete	General Medicine	Active		
Power	Ellen	Complete	Emergency Medicine	Active		
Read	Dale	Complete	General Medicine	Active		Emergency Medicine
Rivard	Marie-Hélène	Complete	Psychiatry	Courtesy		
Rivest-Gaudreault	Melissa	Complete	General Medicine	Active		
Rosenbloom	Alan	Complete	Emergency Medicine	Courtesy		

Last Name	First Name	Reapplication Status Update	Department 1 Name	Department 1 Rank 1	Department 1 Specialty 1	Department 2 Name
Ross	Anatoly	Complete	General Medicine	Active		
Rossbach	Valery	Complete	General Medicine	Courtesy		
Scharf	Lorne	Complete	Emergency Medicine	Courtesy		
Schneiderman	David	Complete	Medicine	Courtesy	Medicine - Respiriology	
Seid	Cherinet	Complete	Emergency Medicine	Active		
Sharda	Rajan	Complete	Surgery	Courtesy	Surgery - Urology	
Shirazi	Sahar	Complete	Surgery	Courtesy	Surgery - General Surgery	
Stephens	Leslie	Complete	Surgery	Courtesy	Surgery - General Surgery	
Vakili	Maryam	Complete	Medical Imaging	Courtesy		
Yuan-Innes	Melissa	Complete	Emergency Medicine	Active		
Ywakim	Fikry	Complete	Obstetrics	Courtesy	Obstetrics - Gynecology	

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: December 30, 2025 Meeting Date Prepared for: January 14, 2026 – Quality  
January 29, 2026 - Board  
 Subject: Accreditation Update  
 Prepared by: Robert Alldred-Hughes, President & CEO

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

**PURPOSE**

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

**IMPLICATIONS TO OTHER STANDING COMMITTEES**

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

**SITUATION & BACKGROUND**

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

- Almost all Ontario Hospitals undergo an extensive accreditation process on a voluntary basis through Accreditation Canada who is a not-for-profit, independent organization accredited by the International Society for Quality in Health Care.
- They provide rigorous, evidence based, third-party evaluations, spanning a full spectrum of health and social services aligned with international leading practices and world class standards.
- HGMH completed the last accreditation in June of 2022, and was accredited with commendation. Following this survey, we took the approach in the spirit of continuous quality improvement that we would begin preparing for our next accreditation in the fall of 2022.
- The team leads and accreditation steering committee have been hard at work collecting evidence and ensuring the required organizational practices and standards are in place throughout the organization and doing so in a fun and interesting way with our theme of ‘HGMH School of Accreditation Wizardry’.
- As of Monday, January 5, 2026, we are 35 days (25 workdays) away from the survey. Preparations are underway with pre-survey logistics and planning, including booking the priority processes and tracers with our teams according to the survey schedule.
- Importantly, one of the scheduled meetings will involve the Board of Directors, focusing on the Board’s familiarity with HGMH’s compliance with the Governance Standard. This session is booked for Monday, February 9, 2026 from 10:00-11:00 in the Boardroom. The general debriefing summarizing the surveyors’ unofficial findings will be on Thursday, February 12, 2026 from 11:00-12:00 in the Boardroom with an MS Teams link provided to all staff, physicians, and volunteers to enable remote attendance.
- The official report and Accreditation decision will not be received until 1-2 months after the survey is completed.
- Our lead surveyor will be Marianne Walker, recently retired from being President and CEO of Guelph General Hospital. Her expertise lies in the areas of governance, leadership, strategic planning, mission integration, business planning, quality and risk management, elder care, and human resources. Our second surveyor will be Annette Jones, a Nurse Practitioner who specialized in mental health and has expertise in emergency department care and clinical processes.
- At this point, the team is on track with the established workplan. An overview of current challenges and successes is as follows:

- Additional evidence is being uploaded to HGMH’s local Teams site, where surveyors will be added as guests to review data at their convenience during the survey.
  - Team leads are effectively using the tracker tool to note the status of evidence uploaded to Teams.
    - Current compliance (self-assessed):
      - 100% – Required Organizational Practices (ROPs)
      - 96% – High priority criteria
      - 97% – Normal priority criteria
      - 50% – Evidence uploaded
  - For comparison, in August 2025, compliance stood at 96% for ROPs, 92% for high priority, and 93% for normal priority criteria with no evidence uploaded at that time. Currently, only 60 criteria of 1,913 total remain pending completion. While compliance percentages are based on internal assessment, ultimate determinations will be made by surveyors during the onsite visit. Current activities remain focused on finalizing policy updates, and uploading documented evidence for all standards.
  - The team has been extremely engaged and effective in this Accreditation cycle, and lessons learned have been compiled throughout the process. These will be presented to the leadership team after this survey is complete to support an even better approach for our next cycle (2026-2030).
- Next steps with Accreditation are expected to be:
    - January: Finalization of pre-survey documentation on Accreditation SharePoint site
    - January 15, 2026: Pre-survey meeting for final logistics
    - February 6, 2026: Boardroom setup for surveyor’s arrival
    - February 9-12, 2026: Onsite survey

**CONSULTED WITH:**

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

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

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: December 30, 2025 Meeting Date Prepared for: January 14, 2026 – Governance  
January 29, 2026 - Board  
 Subject: Corporate Bylaw Review  
 Prepared by: Robert Alldred-Hughes, President & CEO

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

**PURPOSE**

- To conduct the annual review of HGMH’s corporate bylaws and seek input from the Governance Committee regarding any recommended amendments. As part of this year’s review, the Committee is asked to consider a proposed update to formally reflect the Patient and Family Advisory Committee (PFAC) Chair as a non-voting member of the Board of Directors.
- Committee members are encouraged to review the full bylaws in advance and come prepared to discuss this proposed update along with any other amendments they believe should be considered.

**RECOMMENDATION AT THE COMMITTEE MEETING**

**THAT the Governance and Nominating Committee recommend to the Board of Directors an amendment to the corporate bylaws as presented.**

**RECOMMENDATION TO THE BOARD OF DIRECTORS**

**THAT the Board of Directors approve the amendment to the Corporate Bylaws 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.*

- The Board previously endorsed the integration of patient and family engagement into governance through the recruitment of a non-voting patient or family member with lived experience at HGMH, as approved in September 2023.
- This direction aligns with HGMH’s ongoing commitment to People-Centred Care and embedding patient voice at all levels of the organization, including governance.
- To ensure alignment between governance practice and our governing documents, the corporate bylaws should be updated to specifically identify the PFAC Chair as a non-voting member of the Board. This formalizes the Board’s intent, strengthens patient engagement structures, and enhances clarity around Board composition and expectations.
- As part of standard governance practice, the Governance Committee also completes an annual review of the corporate bylaws. This is an opportunity for members to identify any additional updates required to ensure compliance with legislation, alignment with governance best practices, and support for HGMH’s ongoing accreditation readiness.

## OPTIONS CONSIDERED & ANALYSIS

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

- The bylaw section impacted by adding the PFAC Chair is found under Board composition in section 3.1 (**bold** indicates the proposed amendment):

### *3.1 Composition of Board*

*Subject to the Articles, the Board shall consist of:*

*(a) Ten (10) to twelve (12) Directors, who satisfy the criteria set out in section 3.3 and who are elected by the Members in accordance with sections 3.7 and 3.8 or appointed in accordance with section 3.10;*

*(b) The Past Chair as an ex-officio voting Director; and*

*(c) The following four (4) ex-officio non-voting Directors:*

*(i) Chief Executive Officer;*

*(ii) Chief of Staff;*

*(iii) President of the Medical Staff;*

*(iv) Chief Nursing Executive; **and***

*(v) **Patient and Family Advisory Committee Chair***

*There shall be no less than four (4) Francophone members on the Board. The number of Francophones on the Board of Directors must reflect the proportion of the Francophone population in the community served.*

- Please find the Corporate Bylaws for your review on the [hospitals website](#) or within the [Board Portal](#).
- Any further recommended amendments to the corporate bylaws will be incorporated into the motion presented to the Board of Directors at the January meeting.
- The finalized corporate bylaws will be brought forward for approval at the June 2026 Annual Meeting.

## SUPPORTING DOCUMENTS/ATTACHMENTS

*List any supporting documents or attachments*

- Links to Corporate Bylaws: [hospitals website](#) or [Board Portal](#)

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: December 18, 2025 Meeting Date Prepared for: January 14, 2026 – Governance  
January 29, 2026 - Board  
 Subject: Board Committee Effectiveness Surveys  
 Prepared by: Robert Alldred-Hughes, President & CEO

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

**PURPOSE**

The purpose of this briefing note is to provide an overview of the Board Committee Effectiveness Surveys which are completed annually. The Governance Committee annually reviews these questions and recommend any changes to the Board of Directors.

**RECCOMENDATION AT THE COMMITTEE MEETING**

**THAT the Governance and Nominating Committee approve the Committee Effectiveness Surveys as presented.**

**\*It was agreed that the categories in the Committee Effectiveness Surveys align with the Board Peer Assessment survey; Fully Satisfactory, Could Improve, and Unknown. The surveys were updated accordingly.**

**RECCOMENDATION TO THE BOARD OF DIRECTORS**

**THAT the Board of Directors approve the Committee Effectiveness Surveys 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.*

The Board Committee Effectiveness Surveys are an integral component of the Boards governing work, aimed at ensuring that Board committees are operating at their optimal level to fulfill their respective mandates and support strategic objectives of the hospital. Conducted annually, these surveys serve as a valuable tool for evaluating the strengths, weaknesses, and areas for improvement within each committee. The surveys are anonymous and completed by each committee member for the committee they sit on.

Key components of the surveys include:

- Terms of Reference and composition of the committees:** the surveys evaluate the clarity and relevance of the terms of reference for each committee, as well as the composition of the committee members in terms of number of members as well as skills and expertise on the committee. This helps ensure that the committees are well-equipped to fulfill their respective mandates.
- Committee management:** the surveys assess the effectiveness of the committees’ managements practices, including meeting time and frequency, and dissemination of materials and information. Efficient management ensures that committees can make informed decisions.

3. **Committee effectiveness:** this component evaluates the overall performance of each committee in fulfilling its objectives.
4. **Chair effectiveness:** the survey measures the effectiveness of committee chairs in facilitating discussions and fostering collaboration among members. Strong chair leadership is essential for driving committee effectiveness and ensuring productive meetings.
5. **Overall committee performance:** the survey measures overall satisfaction with the committees' performance and the contributions made to the Board.
6. **Comments and suggestions for improvement to committee processes:** committee members are invited to provide feedback on their overall satisfaction with the committee's functioning, as well as specific feedback on areas where improvements could be made.

Following completion of the surveys, the data is compiled and reviewed at each respective committee where key findings around trends, areas of strength, and opportunities for enhancement are discussed.

The Governance Committee oversees the review of survey questions annually to ensure their relevance and alignment with best practices in governance.

Please consider any feedback or adjustments to the questions being asked in the survey questions. An opportunity to share your thoughts will be provided at this Governance committee meeting.

#### **IMPLEMENTATION & COMMUNICATION PLAN**

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

- Review Survey Questions at Governance – January 14, 2026
- Email to be sent out for survey completion – May 15, 2026
- Surveys due June 12, 2026
- Survey results reviewed at first meeting of next Board cycle

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

*List any supporting documents or attachments*

- Governance Committee Meeting Effectiveness Survey
- Finance & HR Committee Meeting Effectiveness Survey
- Quality & Risk Management Meeting Effectiveness Survey



2025-2026 Governance and Nominating Committee Meeting Effectiveness Survey

\* 1. Terms of Reference and Composition

	Fully Satisfactory	Could Improve	Unknown
The committee has clear and appropriate Terms of Reference.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The committee has the right number of members.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The committee has members with the skills and expertise that are needed by the committee.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. For any answer above you marked as "could improve", please provide details below.

\* 3. Committee Management

	Fully Satisfactory	Could Improve	Unknown
The committee meets at the appropriate time of day.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I received orientation to the committee that was helpful to me as a member of the committee.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The committee is receiving the support from hospital management that it requires.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Information is received sufficiently in advance of the meeting.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The committee meets the right number of times over the year.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. For any answer above you marked as "could improve", please provide details below.

\* 5. Committee Effectiveness

	Fully Satisfactory	Could Improve	Unknown
The committee is working effectively.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The committee performed its annual workplan.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The committee is effectively performing by providing appropriate nominees for election to the Board of Directors.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The committee is effectively performing by ensuring an appropriate orientation and education program	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

for members.

The committee is effectively performing by organizing, with the input of the CEO and Board Chair, the Board retreats.

The committee is effectively performing by selecting and recommending nominees for Chair, Vice-Chair, and Treasurer of the Board.

The committee is effectively performing by ensuring succession planning for the office of the Board.

The committee is effectively performing by ensuring periodic review and evaluation of committee performance and Terms of Reference.

The committee is effectively performing by recommending to the Board with the input of the Chair, nominees for all Board committees and Committee Chairs.

The committee is effectively performing by establishing a program to evaluate the performance of the Board, Board Chair, Board members, and Board Committees.

The committee is effectively performing by considering the results of Board evaluations in connection with renewal of terms of

existing directors.

The committee is effectively performing by reviewing and making recommendations on Board composition, size, structure, policies and procedures, by-law amendments, and attendance.

The committee is effectively performing by developing a program to recruit, select, and appraise the CEO and, through annual reviews, to determine CEO compensation.

The committee is effectively performing by ensuring succession planning is in place for the CEO and senior management.

6. For any answer above you marked as "could improve", please provide details below.

\* 7. Chair Effectiveness

Fully Satisfactory

Could Improve

Unknown

The Chair is prepared for committee meetings.

The Chair keeps the meetings on track.

The Chair fairly reports the committee's work to the Board.

The Chair encourages participation and manages discussion.

8. For any answer above you marked as "could improve", please provide details below.

\* 9. Overall Committee Performance

	Fully Satisfactory	Could Improve	Unknown
Overall, I am satisfied with my contribution to the committee.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overall, I am satisfied with the committee's contribution to the Board.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. For any answer above you marked as "could improve", please provide details below.

11. Comments and suggestions for improvement to committee processes:



2025-2026 Quality and Patient Safety Committee Meeting Effectiveness Survey

\* 1. Terms of Reference and Composition

	Fully Satisfactory	Could Improve	Unknown
The committee has clear and appropriate Terms of Reference.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The committee has the right number of members.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The committee has members with the skills and expertise that are needed by the committee.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. For any answer above you marked as "could improve", please provide details below.

\* 3. Committee Management

	Fully Satisfactory	Could Improve	Unknown
The committee meets at the appropriate time of day.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I received orientation to the committee that was helpful to me as a member of the committee.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The committee is receiving the support from hospital management that it requires.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Information is received sufficiently in advance of the meeting.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The committee meets the right number of times over the year.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. For any answer above you marked as "could improve", please provide details below.

\* 5. Committee Effectiveness

	Fully Satisfactory	Could Improve	Unknown
The committee is working effectively.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The committee performed its annual workplan.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The committee is effectively performing by developing components and indicators for its quality, patient safety, and risk management programs and monitoring the outcomes.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The committee is effectively performing by making recommendations to attempt to eliminate gaps identified for overall improvement.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. For any answer above you marked as "could improve", please provide details below.

\* 7. Chair Effectiveness

	Fully Satisfactory	Could Improve	Unknown
The Chair is prepared for committee meetings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The Chair keeps the meetings on track.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The Chair fairly reports the committee's work to the Board.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The Chair encourages participation and manages discussion.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8. For any answer above you marked as "could improve", please provide details below.

\* 9. Overall Committee Performance

	Fully Satisfactory	Could Improve	Unknown
Overall, I am satisfied with my contribution to the committee.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overall, I am satisfied with the committee's contribution to the Board.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. For any answer above you marked as "could improve", please provide details below.

11. Comments and suggestions for improvement to committee processes:



2025-2026 Finance, HR and Audit Committee Meeting Effectiveness Survey

\* 1. Terms of Reference and Composition

	Fully Satisfactory	Could Improve	Unknown
The committee has clear and appropriate Terms of Reference.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The committee has the right number of members.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The committee has members with the skills and expertise that are needed by the committee.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. For any answer above you marked as "could improve", please provide details below.

\* 3. Committee Management

	Fully Satisfactory	Could Improve	Unknown
The committee meets at the appropriate time of day.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I received orientation to the committee that was helpful to me as a member of the committee.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The committee is receiving the support from hospital management that it requires.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Information is received sufficiently in advance of the meeting.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The committee meets the right number of times over the year.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. For any answer above you marked as "could improve", please provide details below.

\* 5. Committee Effectiveness

	Fully Satisfactory	Could Improve	Unknown
The committee is working effectively.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The committee performed its annual workplan.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The committee is effectively performing by ensuring processes are in place to prepare an annual operating and capital budget, reviewing it, and recommending it to the Board.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The committee is effectively performing by reviewing and			

monitoring the hospital's monthly financial performance and reviewing and recommending to the Board any plans developed to address variances between budget and actual performance.



The committee is effectively performing by reviewing and recommending to the Board long-term financial goals, and revenue and expense projections.



The committee is effectively performing by reviewing with management health care developments and legislative changes that may have an impact on financial resources or performance and report to the Board.



The committee is effectively performing by ensuring there is a process in place to manage the hospital's assets.



The committee is effectively performing by reviewing and making recommendations concerning material asset acquisitions not contemplated in the annual operating plan.



The committee is effectively performing by reviewing and recommending to the Board banking arrangements, including lines of credit and long-term debt.



The committee is effectively performing by advising the Board with respect to donations and the terms of any donor recognition agreements.

The committee is effectively performing by recommending an incentive-based compensation system for the CEO and COS that is compliant with the legislative environment.

The committee is effectively performing by reviewing with the CEO and COS existing staff and physician management resources and plans, including recruitment and learning programs.

The committee is effectively performing by reviewing on an annual basis the Human Resources Plan to ensure alignment with the strategic plan.

The committee is effectively performing by ensuring coordination and alignment with the Medical Advisory Committee for physician human resource planning.

The committee is effectively performing by receiving and reviewing on a period basis a report on human resources performance indicators.

6. For any answer above you marked as "could improve", please provide details below.

**\* 7. Chair Effectiveness**

	Fully Satisfactory	Could Improve	Unknown
The Chair is prepared for committee meetings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The Chair keeps the meetings on track.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The Chair fairly reports the committee's work to the Board.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The Chair encourages participation and manages discussion.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8. For any answer above you marked as "could improve", please provide details below.

**\* 9. Overall Committee Performance**

	Fully Satisfactory	Could Improve	Unknown
Overall, I am satisfied with my contribution to the committee.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overall, I am satisfied with the committee's contribution to the Board.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. For any answer above you marked as "could improve", please provide details below.

11. Comments and suggestions for improvement to committee processes:

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: December 30, 2025 Meeting Date Prepared for: January 14, 2026 – Governance  
January 29, 2026 - Board  
 Subject: Q3 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 Q3 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 AT THE COMMITTEE MEETING**

THAT the Governance and Nominating Committee review and receive the Q3 Strategic Actions for 2025-2026.

**RECOMMENDATION TO THE BOARD OF DIRECTORS**

THAT the Board of Directors review and receive the Q3 Strategic Actions for 2025-2026.

**SITUATION & BACKGROUND**

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

- All strategic actions for Q3 were assessed against established milestones and categorized as: Complete, On Track, Not on Track (mitigation plans in place), or At Risk.

**Quality & Safety:**

- Actions to strengthen palliative care resources has been completed. A gap analysis of the *Best Practice Guideline: Palliative Approach to Care in the Last 12 Months of Life* was completed, with key recommendations to enhance access to cultural, spiritual, and religious supports. The *Spiritual and Cultural Care Room*—a co-designed initiative between the PFAC and IDEA Committee—was officially opened on October 8, 2025.
- Medical directives continue to be used effectively by nursing staff, improving patient flow and reducing diagnostic delays. Twenty-seven directives are currently active, and Epic workflow reviews are underway to ensure continued functionality post go live. This action is now complete.
- Leadership and PFAC patient rounding remain consistent, with feedback confirming that patients feel cared for and safe. Continued focus is being placed on consistent whiteboard use. PFAC members joined Senior Leadership Team rounds during Canadian Patient Safety Week (October 27–31), and will continue to do so regularly. This action is complete.

### People & Culture:

- Four first-year medical students from the Universities of Ottawa and Toronto completed Discovery Week placements, and a third-year medical student from Queen’s University is completing a 14-week generalist placement (September 15 – December 19, 2025), we also have a medical resident who started with us in December, and another third-year medical student beginning in January. We now have set up a busy and robust medical learner program, as such, this action is now complete.
- Work on the *Psychological Safety Program* is advancing, with leadership training scheduled for the March 5, 2026, retreat.
- The *performance evaluation redesign* is progressing—feedback surveys have been completed, and results are being analyzed to shape a more meaningful, development-focused process. Current work is to test the new format within one department before finalizing.

### Integration & Standardization:

- The Epic EMR implementation through the Atlas Alliance officially launched April 2, 2025, with go-live targeted for October 24, 2026. Subject Matter Experts continue to participate in workflow design sessions.
- IT infrastructure improvements, including backup servers and a new uninterruptible power supply, are implemented. This action is now complete.

### Future Planning:

- Stage 1.1 of the Ministry’s Capital Redevelopment Planning Process was completed and approved by the Board in June 2025, outlining plans for a new patient care tower, renovations to the existing facility, and a community health hub. Advocacy continues for progression to Stage 1.2 with Ministry of Health approval.
- The HGMH Foundation has raised \$1.5 million toward the CT Scanner campaign. CEO and leadership continue to engage donors and participate in fundraising events. The CT project is planned to begin in early 2026, targeting a late 2027 go-live.

### 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 the hospital remains aligned with its long-term strategy and is responsive to operational and environmental risks. Key Q3 impacts include:

- **Enhanced Patient-Centred Care:** The completion of the Spiritual and Cultural Care Room and direct feedback through rounding reflect meaningful engagement with patients and families.
- **Workforce Development:** Expansion of medical student placements and continued emphasis on leadership and psychological safety training reinforce HGMH’s position as a teaching site and employer of choice.
- **System Integration:** Active engagement in the Epic EMR project and IT infrastructure readiness efforts will support regional standardization, quality, and safety.
- **Future Sustainability:** Progress in the capital redevelopment process and the Foundation’s CT campaign strengthen HGMH’s readiness for future growth and alignment with Ministry 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*

- Q3 Strategic Action Report

## Strategic Action Report Q3

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>Key focus for the team is to ensure that nurses and physicians facilitate access to appropriate resources, spaces, and services to support the cultural, spiritual, and/or religious needs of patients and families. The family guide for palliative care resources was developed and implemented.</li> <li>The Spiritual and Cultural Care Room is actively being used by families/patients as necessary. It was designed with PFAC, and IDEA Committee. Opened in Fall of 2025.</li> </ul>	Complete
		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>Use of the 27 medical directives by staff continues to help improve patient flow and reduce delays before physician assessment. The medical directives now form part of the standard workflow, and are consistently in use.</li> <li>Epic implementation activities also included completion of an order set review to ensure medical directives can be ordered effectively.</li> <li>A third Emergency Department treatment room was implemented to boost capacity, and an upgrade was completed to the Surgical Services decontamination room to improve infection prevention and control.</li> </ul>	Complete
		R. Romany	Enhance patient involvement in care decisions by implementing Leader and Patient and Family Advisory Committee (PFAC) patient rounding to	<ul style="list-style-type: none"> <li>Patient feedback consistently indicates that individuals feel cared for and safe.</li> </ul>	Complete

Fully complete

On track – no barriers for completion

Not on track – mitigation plans in place

Not on track – initiative at risk

			engage directly with patients and assess their level of involvement in their care before discharge.	<ul style="list-style-type: none"> <li>Strengthening consistency in patient whiteboard use remains an area of focus to enhance communication with patients and families regarding the plan of care.</li> <li>PFAC members partnered with Senior Leadership during Patient Safety Week patient rounds (Oct) and are scheduled to participate again in January 2026.</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	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	<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> <li>We have a 2<sup>nd</sup> Year Resident completing an elective from December 16<sup>th</sup>-January 12<sup>th</sup> with one of our Family Practice Physicians who also works in the Emergency and Inpatient Department.</li> <li>We are set to host a third-year medical student from Queen’s University for a 14-week generalist placement, scheduled from January 5 to April 10, 2026.</li> </ul>	<b>Complete</b>
		K. MacGillivray	As part of our ongoing commitment to health and safety, we are enhancing leadership training with a dedicated focus on psychological safety in addition to management responsibilities.	<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. Training with Dr. Dayna Lee-Briggs has been secured, specializing in Psychological Safety.</li> </ul>	<b>On Track</b>
		K. MacGillivray	Redesign our performance evaluation process to create a more meaningful,	<ul style="list-style-type: none"> <li>First draft of the new format has been developed and will be trialed on the Emergency Department staff.</li> </ul>	<b>On Track</b>

Fully complete

On track – no barriers for completion

Not on track – mitigation plans in place

Not on track – initiative at risk

			transparent, and development-focused experience for our employees.		
Integration & Standardization	<i>Deliver standardized quality care in a cost-effective way through collaboration &amp; integration opportunities.</i>	R. Romany	Continue the transition to a new Electronic Medical Record (EMR) system by joining the Atlas Alliance and implementing the EPIC EMR platform in the Fall of 2026.	<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>Workgroups actively reviewing clinical and operational workflows.</li> </ul>	On Track
		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>Uninterruptible Power Supply (UPS) was implemented in summer 2025.</li> <li>Backup servers have been installed in December 2025.</li> </ul>	Complete
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 \$1.5M toward the CT Scanner at this time. Based on these results, initial planning underway for CT implementation.</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

## Linda Ramsay

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**From:** BDSSEF FLHSD PROD (MPBSDP) <BDSSEF.FLHSD.PROD@ontario.ca>  
**Sent:** Tuesday, July 8, 2025 12:09 PM  
**To:** Linda Ramsay  
**Subject:** French Language Health Services - Your report has been accepted / Services de santé en français - Votre rapport a été accepté CRM:0724174

Hello,

Your annual French Language Health Services report has been reviewed and accepted. No further action is required on your part.

Please use this link to sign into the database: <https://flhsd.health.gov.on.ca/en-CA/>

Thank you,

The Portal Team

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Bonjour,

Votre rapport annuel sur les services de santé en français a été révisé et accepté. Aucune action n'est requise de votre part.

Veuillez utiliser ce lien pour accéder à la base de données: <https://flhsd.health.gov.on.ca/fr-FR/>

Merci,

L'équipe du portail

## FLHS Data Extract Report - Requirements for Compliance with the Designation Criteria

Submission Name	Reporting Period	OHFS Number	LHIN	OH Region	Agency Status	Requirement name	Activities	Person Responsible	Status	Start Date	Anticipated End Date	Additio
Glengary Memorial Hospital - 2024-2025	2024-2025	802	Champlain	East	Fully Designated	1. Board resolution to seek designation - Not required for FLHSD report 2. FLS Policy Framework	See policy COR.03.009.0.24 - French Language Services	Linda S. Ramsay	Completed	5/31/24	5/31/24	See do 2024.06 Board HGMH Extract Motion 2024
						3. Approved FLS responsibilities of the board and senior management team	See document - Responsibilities of the Board and Governing body (also attached to document Letter from the Board.	Linda S. Ramsay	Completed	5/31/24	5/31/24	See do CO.01.1 Service HGMH Extract new by approv upcomi 2024 2024.01 Board
						4. Telephone Services	Policy: CD.01.031.3.20 Communication	Linda S. Ramsay	Completed	5/31/24	5/31/24	See do Hospita 12, 202 Labora Script h
						5. FLS Active Offer and client identification	Policy CO.01.031.3.20 Communication	Linda S. Ramsay	Completed	5/31/24	5/31/24	See do ADM-0- registr Admiss Linguis
						6. Third party contracts	HGMH does not have a policy concerning contracts with third parties and the inclusion of obligations towards FLS.  However, HGMH currently has only one third party contractor working on its premises. Service Level agreement signed with EORLA, specifically states in clause 4.6 the obligation to provide FLS as we are designated.	Linda S. Ramsay	Completed	5/31/24	5/31/24	See do EORLA Extract

# FLHS Data Extract Report - Requirements for Compliance with the Designation Criteria

Submission Name	Reporting Period	OHFS Number	LHIN	OH Region	Agency Status	Requirement name	Activities	Person Responsible	Status	Start Date	Anticipated End Date	Additio
<b>Report Date:</b> 2025-06-09 <b>Report requested by:</b> Linda Ramsay												
						7. Complaints and client satisfaction survey	Policy CO.01.016.5.22	Linda S. Ramsay	Completed	5/31/24	5/31/24	See do ED Pati French Survey
						8. Organizational Website	Policy CO.01.031.3.20 Communication	Linda S. Ramsay	Completed	5/31/24	5/31/24	See do BOD.0 Commu Spokes COR.01 Media Informa Websit 2025 1
						9. Exterior Signage	Policy COR.01.007.0.23 Signage	Linda S. Ramsay	Completed	5/31/24	5/31/24	See do Outsid
						10. Interior Signage	Policy COR.01.007.0.23 Signage	Linda S. Ramsay	Completed	5/31/24	5/31/24	See do COR.1 ID bad Interior picture Mask s
						11. Documents intended for Clients	COR.01.009.0.23 Policy, Forms and SOP Process Policy	Linda S. Ramsay	Not Started	5/31/24	5/31/24	See do 51-E-0 Medica 491-15 disclos informa 810-01 Consul 810-01 Consul
						12. Correspondence in French	CO.01.031.3.20 Communication	Linda S. Ramsay	Not Started	5/31/24	5/31/24	See dc Letterh

# FLHS Data Extract Report - Requirements for Compliance with the Designation Criteria

Submission Name	Reporting Period	OHFS Number	LHIN	OH Region	Agency Status	Requirement name	Activities	Person Responsible	Status	Start Date	Anticipated End Date	Addit
						13. Communications and Publications Intended for the Public	CO.01.031.3.20 Communication	Linda S. Ramsay	Not Started	5/31/24	5/31/24	See do Depart Facebo Physio card SOP.0 Transl policy
						14. Senior Manager accountable for FLS	Responsibilities of the Board SLT and FLS SL	Linda S. Ramsay	Not Started	5/31/24	5/31/24	See do BOD.0 Manag skills VP of C CEO.11 See do
						15. Complaints management and FLS reporting	CO.01.016.5.22 Patient / Family Complaint Report to the Board of Directors - to be presented at June 5, 2024 FLS Committee and Board June 19, 2024 (with FLS Dashboard 2023-2024)	Linda S. Ramsay	Not Started	5/31/24	5/31/24	See do 2023.0 Directo submis commil Board FLS Cr 2023.0 FLS da and 20 June 8 Commi Respos SLT ar TOR - 2023 FLS Di to be p 2024 F meetin
						16. Human Resources Policy	COR.08.004.0.23 Staff Recruitment	Linda S. Ramsay	Not Started	5/31/24	5/31/24	See do 51-A-5 Proficiu 51-A-2 Positio CO.07 Langui COR.0 Interpr Reque HR.01 Design Positio

# FLHS Data Extract Report - Requirements for Compliance with the Designation Criteria

Submission Name	Reporting Period	OHFS Number	LHIN	OH Region	Agency Status	Requirement name	Activities	Person Responsible	Status	Start Date	Anticipated End Date	Addit
						17. Staffing of personnel and volunteers proficient in French	COR.08.004.0.23 Staff recruitment	Linda S. Ramsay	Not Started	5/31/24	5/31/24	See do 51-A-2 appoin staff 51-A-5 Proficie Auxilia FLS De JG.01.t HR.01. Design Positio HR.01. Profes HR.01. Postin J0223.J Medica
						18. Linguistic Training	HR.01.21.2.14 - Hiring - Professional Staff shortages CO.07.023.2.21 Second Language Training	Linda S. Ramsay	Not Started	5/31/24	5/31/24	See do Advert doctors French  2024.0 2024.0 Newsle
						19. Human Resources Plan	HR.01.018.2.14 Staffing HR .01.020.2.22 Hiring - Designated Bilingual Positions	Linda S. Ramsay	Not Started	5/31/24	5/31/24	See do 51-A-5 Proficie FLS HI Glenga 2023-2
						20. Letters of support - Not required for FLHSD report						

**REPORT OF THE BOARD QUALITY AND  
PATIENT SAFETY COMMITTEE MEETING**

January 14, 2026 at 4:00PM Boardroom/MS Teams

Present: C. Larocque                      Dr. S. Robertson                      G. Peters  
             D. Elie                                      H. Salib                                      Dr. R. Cardinal  
             R. Romany                                  R. Alldred-Hughes                      R.J. Jarencio  
             Dr. L. MacKinnon

Regrets:            None

**Summary of Discussion**

**Approval of the Agenda:**

The agenda was reviewed.

Moved By: C. Larocque

Seconded By: Dr. R. Cardinal

THAT the agenda be approved as presented.

**CARRIED**

**Declaration of Conflict of Interest:**

There were no conflicts declared.

**Report from the Previous Meeting:**

The report from the meeting of November 12, 2025, was approved as presented.

Moved By: Dr. S. Robertson

Seconded By: C. Larocque

THAT the report of November 12, 2025, be approved as presented.

**CARRIED**

**Business Arising from Report:**

**Review Status of Patient Safety Plan Actions**

Previously, there were two separate surveys to be completed, one for employee engagement, and one for patient safety. These have now been combined, and all staff are asked to complete the survey. 87 staff members completed the survey out of 180 hospital staff. The results were reviewed in which overall the answers were positive, and actions were developed where needed.

Work will be done on communicating with staff following debriefs from incidents so that everyone is on the same page and aware of new processes.

A safety star award has been created to recognize staff members who go above and beyond to flag safety issues. This is awarded on a basis. Incident reports can come from all staff members through RIMS and are then shared with department Managers for review.

**Education - Quality Initiative**

R. Romany educated on quality improvement and strategic alignment and the Board S role in the Quality Improvement Plan was discussed. The draft Quality Improvement Plan for 2026-2027 will be brought to the committee following review and input from internal hospital committees.

Discussion ensued around what factors should be looked at in the future that are not part of the Quality Improvement Plan.

### *Matters for Discussion/Decision*

#### Professional Staff Appointment and Re-Appointment Process

The process for the professional staff appointment and re-appointment was reviewed.

#### Professional Staff Reappointment 2026

The list of professional staff to be reappointed in 2026 was shared.

Moved By: C. Larocque

Seconded By: Dr. R. Cardinal

That the Quality & Patient Safety Committee recommend to the Board of Directors the reappointment of the Professional Staff for 2026 as presented.

Three physicians have not yet submitted their reapplications stating whether or not they are reapplying for privileges. There is a late fee should they decide to reapply.

**CARRIED**

#### Review Complaints and Compliments Report

The complaints and compliments were reviewed.

Moved By: Dr. S. Robertson

Seconded By: D. Elie

THAT the Quality & Patient Safety Committee review and receive the Q1-Q3 Complaints and Compliments report for 2025-2026 fiscal year as presented.

There were 14 formal complaints primarily related to the Emergency Department, and 12 formal compliments also primarily related to the Emergency Department. These numbers are good considering there were 14,547 emergency visits during this time.

**CARRIED**

#### Review Critical Events and Never Events Report

The critical and never events were reviewed.

Moved By: Dr. R. Cardinal

Seconded By: C. Larocque

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

There were no never events reported during this time however there was a critical event that resulted in a case and the patient had to be transferred out.

**CARRIED**

### *Matters for Information*

#### Updates from Patient and Family Advisory Committee

The Spiritual and Cultural Care Room officially opened in October and was co-lead by PFAC and patient rounding is being done with PFAC on a monthly basis.

Recruitment will begin for more PFAC members following Accreditation.

**Accreditation Standard**

The Accreditation Standard was reviewed and discussed.

**Accreditation Updates**

There are 18 working days left before Accreditation and the team is well positioned going into this Accreditation survey. The Board Governance Accreditation session is taking place on February 9<sup>th</sup> in the Boardroom and will also be available via MS Teams.

**Date of Next Meeting:** Wednesday, February 18, 2026

K-L. Massia, Recorder

DRAFT

~ 2026~

# HGMH Professional Staff

## Appointment and Re-appointment Review



**Board Quality**, January 14, 2026

**Presenter:**

Dr. Lisa MacKinnon, MD, Chief of Staff



# AGENDA

- What is “Credentialing”?
- Boards Obligation
- Medical HR
- Classifications of Professional Staff
- Process Flow
- Required Documentation for Application/Re-Application
- Common Credentialing
- Questions



# WHAT IS CREDENTIALING?

- Credentialing includes a range of activities and processes, such as reviewing applications for initial appointments, verifying qualifications, identifying the scope and nature of privileges, granting privileges, performing periodic reviews, and conducting annual reappointments.
- The term “privileges” is used because Professional Staff are given the privilege of using hospital resources in return for providing care to hospital patients.

Reference: [Professional Staff Credentialing Toolkit, 2021](#)



# WHO IS CREDENTIALLED?

- Although a variety of health care professionals work in hospitals, credentialing is only required for physicians, dentists, midwives, and extended class nurses.
- These professionals are not generally employed by the hospitals. They are usually independent contractors who bill the Ontario Health Insurance Plan for their services.



# BOARD OBLIGATIONS

- Under the Public Hospital's Act, only the hospital Board can grant, restrict or revoke physician privileges.
- The Board relies on the Chief of Staff (COS) and the Medical Advisory Committee (MAC) to make recommendations on privileges.
- Physicians are entitled to appeal to the board on privilege issues (e.g., restrictions, revocations, etc.).
- Procedural fairness is of utmost importance in this process.
- CEO & COS can temporarily grant, restrict or revoke privileges on an emergency basis, pending final approval at the next MAC and Board meetings.



# MEDICAL HR

Having a clear picture of the medical HR landscape assists the organization with purposeful retention, recruitment, and risk management.

Newly-credentialed staff must support organizational needs, such as:

- Current and future care gaps (retirements, vacancies, specialist support)
- FR-EN language needs
- Inpatient and ER roster coverage



# MEDICAL HR

Credentialing someone is easy. Revoking, restricting or not renewing privileges is more challenging!

Strategies for minimizing risk to HGMMH or patients:

- 6- & 12-month performance evaluations
- Strong record keeping of behavioral or professional misconduct
- Early risk identification and mitigation



# CLASSIFICATIONS OF PROFESSIONAL STAFF

- **Active Staff:** Can admit, diagnose, treat, vote and hold office. Cannot be designated as active at another hospital.
- **Associate Staff:** Can admit, diagnose, treat, vote. Cannot be designated as active at another hospital. Will undergo performance evaluations at six-month intervals following the initial appointment. Performance will be reviewed by MAC prior to recommending appointment to Active Staff.
- **Courtesy Staff:** Is active staff elsewhere or wants limited access to HGMH resources/programs/facilities. Not obliged to attend staff meetings. Cannot vote or hold office.



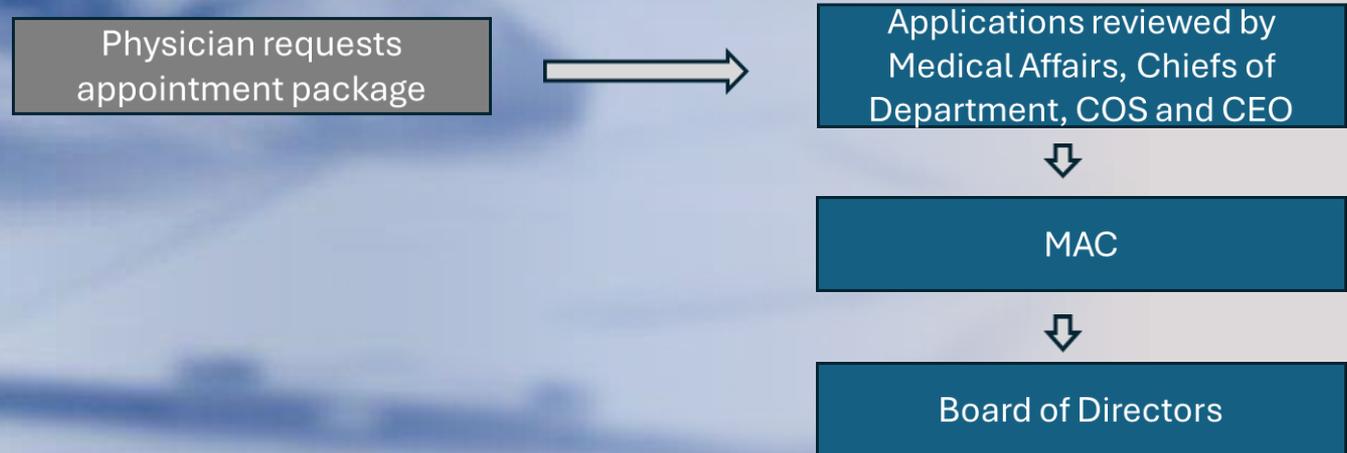
# CLASSIFICATIONS OF PROFESSIONAL STAFF

- **Locum Tenens Staff:** Can admit, diagnose, treat patients. Shall not attend or vote at Professional Staff meetings or be elected or appointed to any office of the Professional Staff. Meets specific clinical needs for a defined period of time in one or more of the following circumstances:
  - a) to be a planned replacement for a Physician, Dentist, or Midwife for a specified period of time; or
  - b) to provide episodic or limited inpatient, emergency or consulting services.
- **The Extended Class Nursing Staff:** The Board, having given consideration to the advice of the Medical Advisory Committee, will delineate the privileges for each member of the Extended Class Nursing Staff who is not an employee of the Hospital.



# PROCESS FLOW INITIAL APPOINTMENT

Every physician is entitled to apply for hospital privileges and have his or her application considered by the hospital in accordance with the hospital's by-laws and the Public Hospitals Act. With every application, the medical advisory committee must meet and make a written recommendation to the board.



# PROCESS FLOW RE-APPOINTMENT

CMARS email Invite for re-appointment  
(late November)



Final Notice  
(early December)



Deadline  
(late December)



Notice of Expiry  
(early January)

Applications reviewed by Medical Affairs,  
Chiefs of Department, COS and CEO



MAC  
(early January)



Board of Directors  
(early January/February)



Written Board Approval for privileges to  
physicians (after Board meeting)



## Required Documentation for RE-APPLICATION

- ✓ Re-appointment application - CMARS
- ✓ Pledge of confidentiality
- ✓ Proof of CMPA or other professional staff insurance coverage stating active coverage in Ontario
- ✓ Current ACLS/BLS certification (Emergency/Inpatient)
- ✓ Up to date N95 fit testing (all on-site physicians)
- ✓ Up to date HGMH education and attestations as required



# COMMON CREDENTIALING

- The process of common credentialing allows hospitals to pool their Professional Staff resources more easily.
- A letter of good standing is requested from the site the professional staff is applying too to the site they currently have privileges at.
- The letter of good standing acknowledges what the site has on file for the professional staff. Should some documentation be missing from our standard list, the request can be made that the professional staff provide such documentation.



# QUESTIONS?



DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: October 30, 2025 Meeting Date Prepared for: November 12, 2025 - Quality  
January 14, 2026 – Quality  
January 29, 2026 - Board  
 Subject: Global Workforce Survey - Patient Safety results  
 Prepared by: Rachel Romany VP Clinical Services, Quality and Chief Nursing Executive

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

**PURPOSE:**

To present the findings from the 2024 Global Workforce Survey results on Patient Safety, released Feb 2025 and identify key opportunities to strengthen the patient safety culture at HGMH.

**RECOMMENDATION AT THE COMMITTEE MEETING**

**That the Committee receive the survey results for information and support the continued efforts to strengthen a Just Culture and improve communication and learning following incidents.**

\*This was brought back to the Quality committee in January as there was not enough time for discussion in November. It was included in the consent agenda at the last Board meeting.

**RECOMMENDATION TO THE BOARD OF DIRECTORS**

**That the Committee receive the survey results for information and support the continued efforts to strengthen a Just Culture and improve communication and learning following incidents.**

**IMPLICATIONS TO OTHER STANDING COMMITTEES**

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

- Quality and Safety Advisory Committee- October 22, 2025 meeting
- MAC- November 4, 2025 meeting
- Leadership Team- Nov 12, 2025 meeting
- Board Quality and Safety Committee- November 12, 2025 meeting
- PFAC- November 26, 2025 meeting

**SITUATION & BACKGROUND**

- The Global Workforce Patient Safety Survey provides a snapshot of staff perceptions related to incident reporting, transparency, and overall safety culture.
- Results demonstrate strong engagement in patient safety but also highlight opportunities to enhance communication and reinforce a Just Culture framework that encourages reporting without fear of blame.
- **Key results include:**
  - **Transparency:** 65% agree patients are informed of incidents; 18% unsure.
  - **Learning from incidents:** 81% agree the organization prevents recurrence.
  - **Feedback loop:** 55% receive updates after incidents; 16% disagree.

- **Just Culture:** 59% feel mistakes are not held against them; 38% neutral.
- **Safety ratings:** 76% rated their unit “Very Good/Excellent”; 72% rated organizational safety “Very Good/Excellent”.

### OPTIONS CONSIDERED & ANALYSIS

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

- **Implement enhanced communication and learning strategy-** Strengthen Just Culture training, expand feedback mechanisms, and improve staff awareness of post-incident actions.

### IMPACT ANALYSIS/RISK ASSESSMENT/DECISION CRITERIA

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

#### Positive impacts:

- Reinforces a culture of safety, trust, and continuous improvement.
- Enhances compliance with Accreditation Canada standards.
- Improves staff engagement and patient outcomes through better communication.

#### Risks/Challenges:

- Requires sustained leadership engagement and communication planning.
- Potential perception gap if staff do not see visible changes following reporting.

### CONSULTED WITH:

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

- Senior Leadership
- Quality and Safety Advisory Committee
- MAC
- Leadership Team
- Board Quality and Safety Committee
- PFAC

### IMPLEMENTATION & COMMUNICATION PLAN

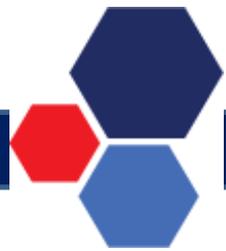
*Consider how the recommendation will be rolled-out and communicated to all key stakeholders.*

- Share results across units and committees via Weekly Clinical, Bi-Weekly Blitz, and town hall updates.
- Monitor progress through quarterly safety metrics, staff feedback surveys.

### SUPPORTING DOCUMENTS/ATTACHMENTS

*List any supporting documents or attachments*

- 2025 Global Workforce Survey Results on Patient Safety slide deck
- Safety Star Award briefing note



# 2025 Global Workforce Survey Results- Patient Safety

Rachel Romany  
VP Clinical Services, Quality, Chief Nursing Executive



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Memorial**  
HOSPITAL



# Purpose



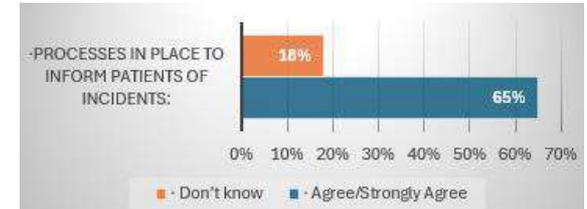
- Supports **Accreditation Canada** readiness by showing how staff input **drives continuous improvement**
- Provides insights into **staff experiences, incident reporting, and perceptions of patient safety**
- Identifies **strengths and opportunities** to enhance safety and quality of care

# What We Heard



## Transparency and Learning from Incidents

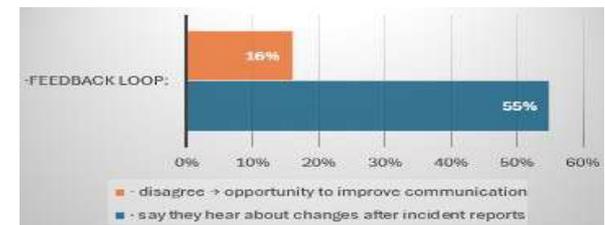
- **Processes in place to inform patients of incidents:**
  - 65% Agree/Strongly Agree
  - 18% Don't know
- **Learning from incidents:**
  - 81% Agree/Strongly Agree that we prevent mistakes from recurring
- **Feedback Loop:**
  - 55% say they hear about changes after incident reports
  - 16% disagree → opportunity to improve communication



### Learning from Incidents



81%



# What We Heard



## Just Culture

- 59% Agree/Strongly Agree mistakes will not be held against them
- 38% Neutral-> need to ensure strong communication of learnings from errors/mistakes



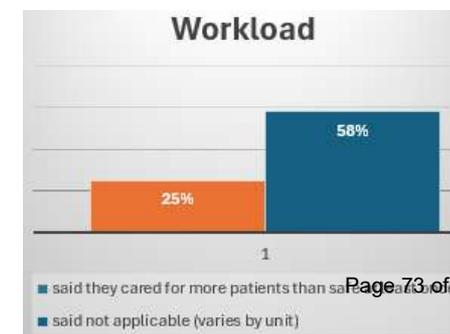
## Patient Safety Incidents reported (past 12 months)

- 53% reported none
- 20% reported 1-2



## Workload

- 58% said not applicable (varies by unit)
- 25% said they cared for more patients than safe at least once



# Just Culture in Healthcare



A **Just Culture** is a framework that balances accountability with learning when incidents occur in a hospital setting.

Instead of automatically blaming individuals, it distinguishes between:



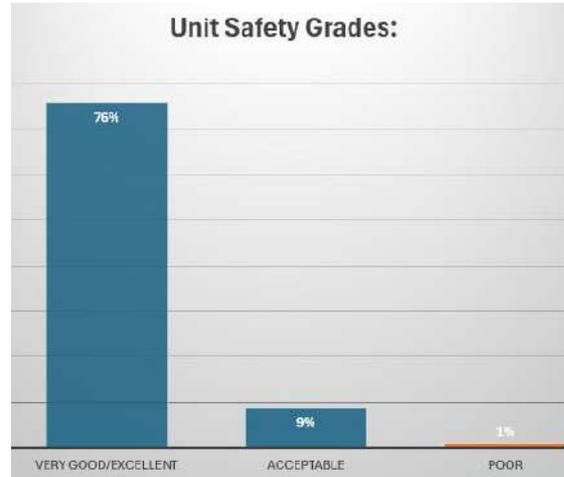
**Goal:** Create a **safe environment** where staff report incidents without fear, focusing on fairness, system improvement, and accountability for unsafe actions.

# Overall Safety Ratings



## Unit Safety Grades:

- 76% rated as **Very Good/Excellent**
- 9% rated as **Acceptable**
- 1% rated as **Poor**



## Organizational Safety Grades:

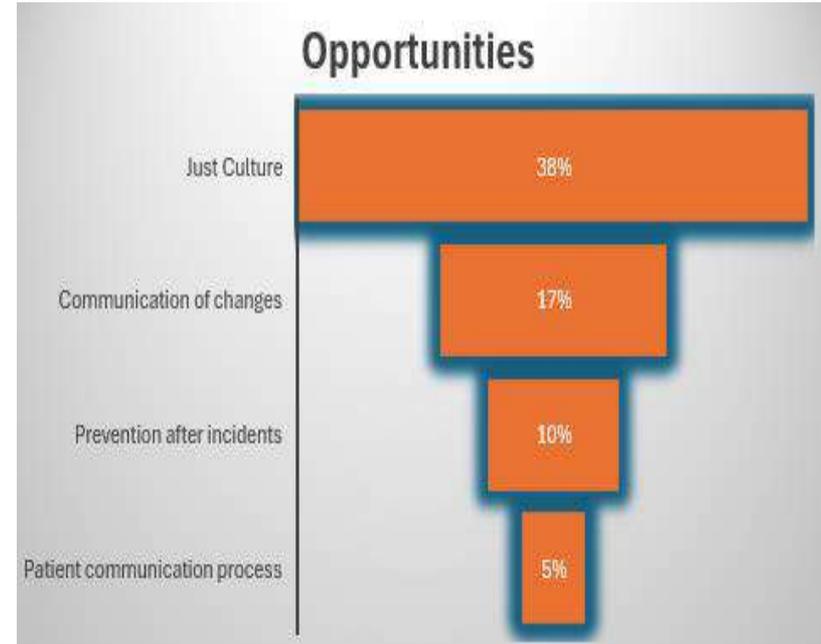
- 72% rated as **Very Good/Excellent**
- 24% rated as **Acceptable**
- 1% rated as **Failing/Poor**



# Moving Forward



- Staff see a **strong overall patient safety culture**
- **Opportunities** to strengthen:
  - **Just Culture (Q49)** – the *biggest opportunity* → 38% neutral.
  - **Communication of changes (Q50)** – medium opportunity → 17% neutral.
  - **Prevention after incidents (Q51)** – smaller but meaningful → 10% neutral.
  - **Patient communication process (Q48)** – minor opportunity → 5% neutral.



# Opportunities in Action



1

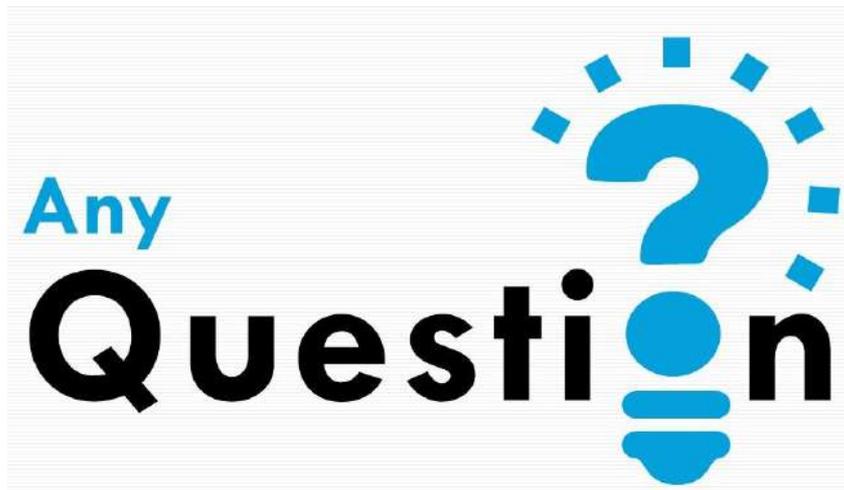
Strengthen a **learning culture** through regular **safety communication**.

2

Establish a Standard Process for **debrief and feedback loop with teams after** patient harm incidents.

3

**Safety Star Award** to celebrate staff who help prevent patient harm by reporting near misses or potential patient harm.



**Thank you**

# SAFETY STAR AWARD

THIS CERTIFICATE  
IS PROUDLY PRESENTED TO

**Employee Name**

**in recognition of exceptional  
commitment to patient safety. Your  
proactive efforts to report and prevent  
harm make a meaningful difference in  
keeping our patients safer each day.**

---

Robert Alldred-Hughes  
President & CEO

---

Rachel Romany  
VP Clinical Services, Quality & CNE



DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: January 5, 2026 Meeting Date Prepared for: January 14, 2026 – Quality  
January 29, 2026 - Board

Subject: Complaints and Compliments

Prepared by: R. Romany, VP Clinical Services, Quality & CNE

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

**PURPOSE**

- To provide the Quality & Patient Safety Committee with an overview of patient complaints and compliments received during Q1-Q3 of the 2025-2026 fiscal year and discuss contributing factors and mitigation strategies for improvement.

**RECOMMENDATION AT THE COMMITTEE**

**THAT the Quality & Patient Safety Committee review and receive the Q1-Q3 Complaints and Compliments report for 2025-2026 fiscal year as presented.**

**RECOMMENDATION TO THE BOARD**

**THAT the Board of Directors review and receive the Q1-Q3 Complaints and Compliments report for 2025-2026 fiscal year 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.*

- Reviewing complaints and compliments is a crucial component of our commitment to transparency, continuous improvement, and patient centered care.
- A summary of the complaints and compliments received will be reviewed at Internal Quality and brought to Board Quality quarterly to keep the committee apprised of any situations that may arise.
- This summary highlights key trends, areas of concern, and notable achievements related to the quality of care and services provided by the hospital.

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

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

Patient activity during the Q1-Q3 period:

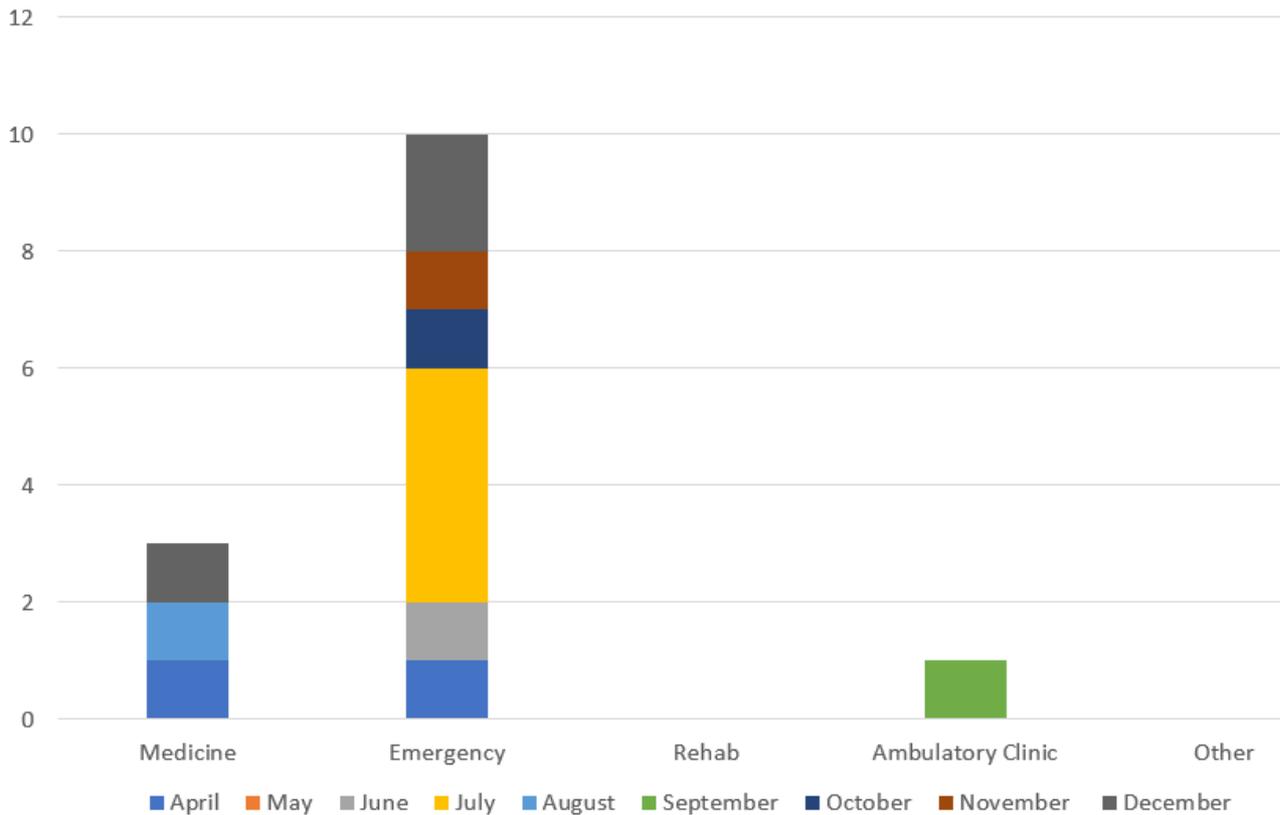
Quarter	Emergency Department Visits	Patient Admissions (inpatient and rehab units)
Q1	4,658	173
Q2	5,199	146
Q3	4,690	176
Total	14,547	495

**Complaints:**

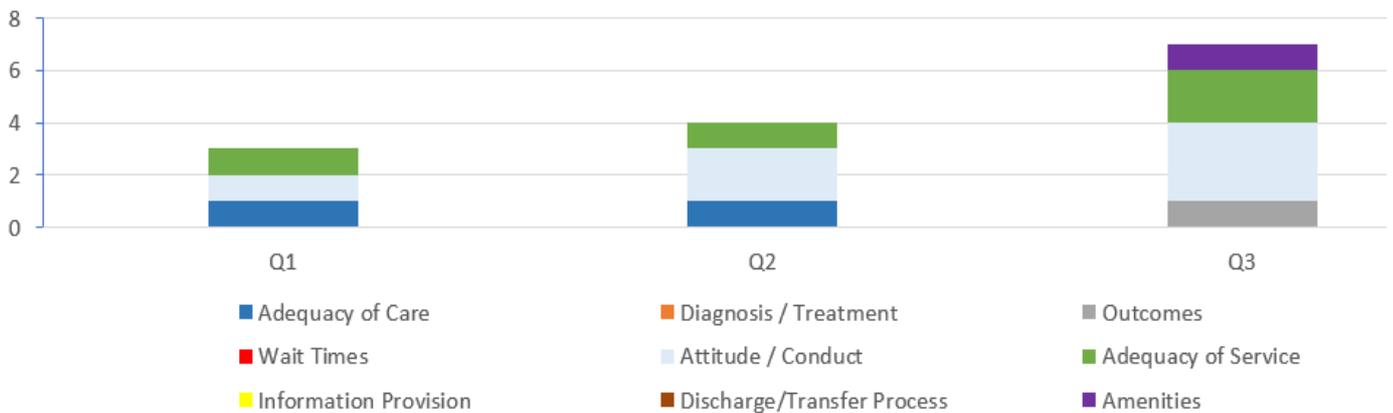
- There was a total of 14 formal complaints received in Q1-Q3
- The majority of complaints related to the Emergency Department
- Complaints themes included:
  - Adequacy of Care (2 complaints)

- Attitude and Conduct (6 complaints)
- Adequacy of Service (4 complaints)
- Amenities (1 complaint)
- When viewed in relation to overall ED volume and patient admissions, the number of formal complaints remains low.

### Complaints per Department



### Complaint Types

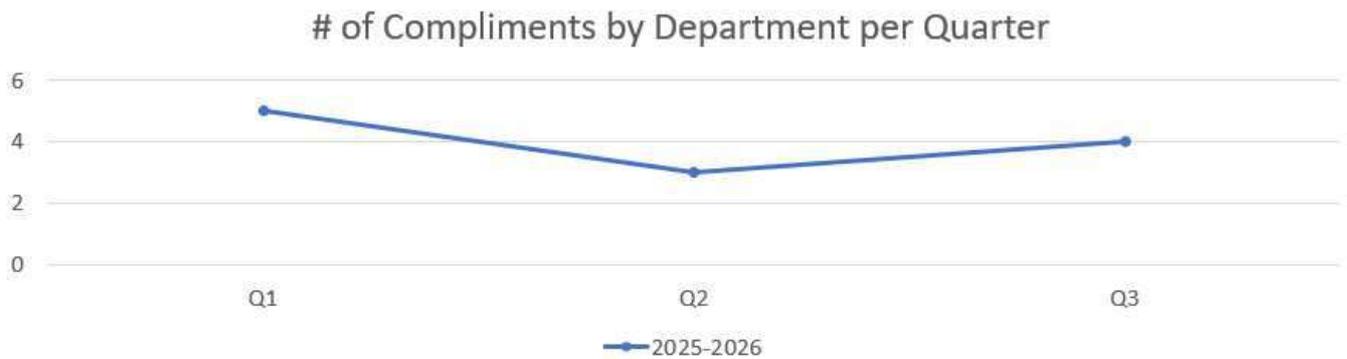


- All complaints were reviewed and followed up on with the people who submitted the complaints

- Follow-up discussions were held with staff where appropriate
- Staff were reminded that patients presenting to the hospital, particularly through the Emergency Department, may be experiencing heightened stress and emotions. Emphasis was placed on the importance of reassurance, empathy, and clear communication to support patient comfort and experience.

### Compliments:

- There were a total of 12 formal compliments received during Q1-Q3 of the 2025-2026 fiscal year.
- Compliments were primarily directed to the Emergency Department.
- Others who were complimented were from Medicine, Diagnostic Imaging as well as Food Services.
- Feedback highlighted positive patient experiences and staff contributions.
- Of these compliments, 4 of them were in form of Care Champion submissions which resulted in small donations to the Foundation.



### SUMMARY

- Overall patients seem appreciative of the service at HGMH with an overwhelming number of positive comments on the Hospital's social media channels.
- While we've received praise for our attentive care, there are areas for improvement highlighted in patient complaints, particularly regarding staff attitude/conduct in which we continue to work with staff, reminding them of our hospital values, which is our PACT (Passion, Accountability, Compassion, Teamwork).

## **REPORT OF THE GOVERNANCE AND NOMINATING COMMITTEE**

January 14, 2026 at 5:00PM Boardroom/MS Teams

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

Regrets: None

### **Summary of Discussion**

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

The agenda was reviewed.

Moved By: C. Larocque  
Seconded By: Dr. G. Raby  
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 November 12, 2025, was shared.

Moved By: Dr. S. Robertson  
Seconded By: C. Larocque  
THAT the meeting report be approved as presented.

**CARRIED**

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

There was no business arising from the report.

### **Committee Work Plan**

The work plan was reviewed in which the Signing Authority policy was deferred as it was reviewed earlier in the year with work done on Accreditation.

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

#### **Review and Revise Corporate and Professional Staff Bylaws**

The Corporate Bylaws were brought for revisions.

Moved By: G. McDonald  
Seconded By: Dr. G. Raby  
THAT the Governance and Nominating Committee recommend to the Board of Directors an amendment to the corporate bylaws as presented.

Recommendation was made to include the Patient and Family Advisory Committee (PFAC) Chair to the Board as an ex-officio non-voting member. PFAC recruitment is done through an application process and interviews are conducted. PFAC members sign confidentiality agreements, however there are no performance reviews done with PFAC members.

**CARRIED**

#### **Review Succession Planning Overview**

The overview of succession planning at the hospital was reviewed. The succession plan is a confidential process and is presented to the Executive Committee of the Board on an annual basis. Discussion ensued about the succession plan coming to the Governance Committee

rather than the Executive Committee, however, it was agreed that it does go to the Board through an In Camera session.

### **Review Committee Effectiveness Survey Questions**

The Committee Effectiveness Survey questions were shared.

Moved By: Dr. S. Robertson

Seconded By: G. McDonald

THAT the Governance and Nominating Committee approve the Committee Effectiveness Surveys as amended.

The committee agreed that the categories should align with the Board Peer Assessment survey; *Fully Satisfactory*, *Could Improve*, and *Unknown*. The surveys will be updated and brought to the Board.

**CARRIED**

### **Review Q3 Strategic Actions**

Progress made on strategic actions for Q3 was reviewed.

Moved By: C. Larocque

Seconded By: Dr. G. Raby

THAT the Governance and Nominating Committee review and receive the Q3 Strategic Actions for 2025-2026.

A number of actions have been moved to complete, and work continues to progress well. There are no concerns with the progress on actions identified as *On Track*.

**CARRIED**

### **Matters for Information**

#### **Review Board Member Attendance**

Board attendance was reviewed with no significant issues at the moment.

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

The list of Governance Accreditation Standards was shared with the evidence that was loaded into the portal for the surveyors. This document is now available on the Board Portal. It was agreed that this document be shared during Board Orientation.

#### **IDEA Update**

An update was provided on work done for inclusion, diversity, equity, and anti-racism in which the hospital continues to move in the right direction.

**Next meeting:** Wednesday, March 11, 2026

K-L. Massia, Recorder



# Succession Plan Overview

## *Creating the Leadership Pipeline*

*Presented By:*

Robert Alldred-Hughes M.HRM, CHRL, CHE  
President & CEO

January 14, 2026



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# Individual Succession Plan Profiles



- To develop the leadership pipeline at HGMH, we have focused on a four-step process to identify “high potential” or “fully competent” individuals to assume key positions when immediately or as the need arises.
- The four step process to succession planning at HGMH is as follows:



# Identification of Key Positions



- All Senior Leadership and Middle Management Positions have been identified as key positions for the purposes of HGMH's Succession Plan.



# Leadership Profiles



- Each member of the leadership team is provided with high level demographic information outlined in the chart below. This provides the ability to review current education levels, clinical designations (if applicable) and age.
- While age is not a determinant of a person's abilities, it will provide insight into years to earliest possible retirement.

Position	Professional Designation	Highest Level of Education	Age
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# Required Education & Certifications



- For each position within the portfolio of the senior leader, an outline of the required professional certifications and minimum education requirements are detailed.
- This will form the basis for which selection criteria or future development needs for high potential employees.

Position	Professional Certification	Minimum Education Required
----------	----------------------------	----------------------------



# Required Leadership Competencies



*The Canadian College of Health Leaders LEADS Competency Framework will set the stage for leadership competency evaluation & development*

**L**

**E**

**A**

**D**

**S**

## Lead self

- are self aware
- manage themselves
- develop themselves
- demonstrate character

## Engage others

- foster development of others
- contribute to the creations of healthy organizations
- communicate effectively
- build teams

## Achieve results

- set direction
- strategically align decisions with vision, values and evidence
- take action to implement decisions
- assess and evaluate

## Develop coalitions

- purposefully build partnerships and networks to create results
- demonstrate a commitment to customers and service
- mobilize knowledge navigate socio-political environments

## Systems transformation

- demonstrate systems /critical thinking
- encourage and support innovation
- orient themselves strategically to the future
- champion and orchestrate change

# Development Plan



Top Position

Identified Employee (Either Formal or Informal Leader)



# Individual Succession Plan Profiles



- Using “*Individual Succession Planning Profile*” the senior leader responsible for the position will evaluate current formal and informal leaders, using experience and historical data obtained through performance evaluations to complete the profile.
- This profile will form the basis of a development plan to ready a future candidate for the new role within HGMH.



# Individual & Bench-wide Plan



Role	Current Incumbent	Emergency Cover	Ready Now	Ready in 12-18 Months	Ready in 3-5 Years
CEO	Sarah	Fred	Gap	Gap	Fred

Upon identification of the High Potential and Ready candidates, the senior manager will prepare a development plan using some of the following methods:

1. Guiding Education & Professional Development
2. Providing experience in required areas of development (special projects/assignments)
3. Formalizing a mentorship arrangement
4. Continuous coaching

Where there are gaps – plans to recruit externally will be identified if no internal candidates will meet the requirements of the positions.





Questions,  
comments,  
feedback?



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## 2025-2026 Board of Directors Attendance



Name	2025				2026						Total	%
	*Jun	Sept	Oct	Nov	Jan	Feb	Mar	Apr	May	Jun		
Dr. Stuart Robertson, Chair	P	P	P	P							4	100%
Louise boyling, Vice Chair	P	P	P	P							4	100%
Charlotte Nagy, Treasurer	P	A	P	P							3	75%
Carole Larocque	P	P	P	P							4	100%
Doug Elie	P	P	P	P							4	100%
Francois Desjardins	P	P	P	P							4	100%
Dr. Genevieve Raby	P	A	P	P							3	75%
Gerard McDonald	P	P	A	P							3	75%
Gordon Peters	P	A	P	P							3	75%
Heidi Salib	P	P	P	P							4	100%
Dr. Raynald Cardinal	P	P	P	A							3	75%
<b>Total</b>	11	8	10	10	0	0	0	0	0	0	35	89%

\*Special Meeting

Attendance rate of 75% required for Board Directors as per the Board Attendance policy (BOD.05.004)

Name	2025				2026						Total	%
	*Jun	Sept	Oct	Nov	Jan	Feb	Mar	Apr	May	Jun		
Robert Alldred-Hughes, CEO	P	P	P	P							4	100%
Dr. Lisa MacKinnon, COS	P	P	P	A							3	75%
Rachel Romany, CNE	P	P	P	P							4	100%
<b>Total</b>	3	3	3	2	0	0	0	0	0	0	44	92%

## 2025-2026 Governance Attendance



Name	2025		2026				Total	%
	Oct	Nov	Jan	Mar	May	Jun		
Louise Boyling	P	P					2	100%
Carole Larocque	P	P					2	100%
Dr. Genevieve Raby	A	P					1	50%
Gerard McDonald	A	P					1	50%
Dr. Stuart Robertson	P	P					2	100%
<b>Total</b>	3	5	0	0	0	0	8	80%

Attendance rate of 75% required for Board Directors as per the Board Attendance policy (BOD.05.004)

Name	2025		2026				Total	%
	Oct	Nov	Jan	Mar	May	Jun		
Robert Alldred-Hughes, CEO	P	P					2	100%
<b>Total</b>	1	1	0	0	0	0	2	100%

## 2025-2026 Finance Attendance



Name	2025		2026				Total	%
	Sep	Nov	Feb	Mar	May	Jun		
Charlotte Nagy	P	P					2	100%
Francois Desjardins	P	P					2	100%
Gerard McDonald	P	P					2	100%
Gord Peters	P	P					2	100%
Dr. Stuart Robertson	P	P					2	100%
<b>Total</b>	5	5	0	0	0	0	10	100%

Attendance rate of 75% required for Board Directors as per the Board Attendance policy (BOD.05.004)

Name	2025		2026				Total	%
	Sep	Nov	Feb	Mar	May	Jun		
Robert Alldred-Hughes, CEO	P	P					2	100%
<b>Total</b>	1	1	0	0	0	0	2	100%

## 2025-2026 Quality Attendance



Name	2025		2026				Total	%
	Sep	Nov	Jan	Feb	Apr	May		
Carole Larocque	P	P					2	100%
Doug Elie	P	P					2	100%
Gord Peters	P	P					2	100%
Heidi Salib	A	P					1	50%
Dr. Raynald Cardinal	A	P					1	50%
<b>Total</b>	3	4	0			0	7	88%

Attendance rate of 75% required for Board Directors as per the Board Attendance policy (BOD.05.004)

Name	2025		2026				Total	%
	Sep	Nov	Jan	Feb	Apr	May		
Robert Alldred-Hughes, CEO	P	P					2	100%
Dr. Lisa MacKinnon, COS	A	A					0	0%
Rachel Romany, CNE	P	P					2	100%
<b>Total</b>	2	2	0			0	4	67%

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: December 31, 2025 Meeting Date Prepared for: January 14, 2026 – Governance  
January 22, 2026 - Board  
 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, there has been much work completed by the team at HGMH related to IDEA activities. HGMH, as a prominent organization and employer in our community, is committed to promoting an environment that is inclusive, diverse, and equitable, while actively combatting racism.

In the winter 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.
- 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. Recently a historical learning feature highlighting the history of Indian Hospitals in Canada was shared with staff through the bi-weekly Blitz and displayed on the Wellness Board to promote greater understanding of historical harms and their lasting impacts.
- Staff education on IDEA fundamentals was launched, exceeding the targeted completion rate within the first few weeks. The introductory DEI training module is ongoing, with current staff uptake at approximately 70%. Additional supports and reminders are planned to help reach even greater participation rates.
- 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.
- Diwali was recognized in November with traditional Indian refreshments served in the cafeteria, offering staff an opportunity to learn about and celebrate the festival together.
- 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.

## REPORT OF THE MEETING OF THE FRENCH LANGUAGE SERVICES COMMITTEE

January 14, 2026 at 6:00PM in the Boardroom / MS Teams

Present: Dr. G. Raby, Chair                      F. Desjardins                      Dr. S. Robertson  
            Dr. R. Cardinal                              L. Ramsay                              R. Alldred-Hughes, CEO

Regrets:              None

### Summary of Discussion of the meeting

#### 1.0 Approval of Agenda

Agenda: The agenda was reviewed.

Moved By: F. Desjardins  
Seconded By: Dr. S. Robertson  
THAT the agenda be approved as presented.

**CARRIED**

#### Declaration of Conflict of Interest:

There were no conflicts declared.

#### 2.0 Minutes

Approval of Previous Meeting's Minutes: The report of the meeting of June 4, 2025, was reviewed.

Moved By: Dr. S. Robertson  
Seconded By: F. Desjardins  
THAT the report of the meeting of June 4, 2025, be approved as presented.

**CARRIED**

#### Business Arising:

There was no business arising from the minutes.

#### 3.0 Matters for Information

##### 3.1 Summary of the Annual French Language report to the Ministry

The annual French language report is due at the beginning of June which is the reason that there will now be a meeting in September as well as May annually.

Discussion ensued around areas that are lacking within the hospital in terms of not having staff who can speak in French. The Auxiliary do not keep data on their members which makes it a challenge to report the number of Francophone speaking members. Work will be done on obtaining this information. Otherwise, the hospital is in good standing with an appropriate number of staff members who can speak French. French as a second language is also offered to staff and paid for by the hospital.

##### 3.2 HR Plan 2024-2025

The HR plan was presented and demonstrates the positions that are required to be bilingual in which we currently meet the requirements. The hospital does have a translation service available should we not have bilingual staff working during a shift; however, this is very minimally used for French.

#### 4.0 Matters for Discussion and/or Decision

##### 4.1 Review Terms of Reference

The French Language Services Committee terms of reference were reviewed.

Moved By: Dr. R. Cardinal

Seconded By: Dr. S. Robertson

THAT the French Language Services Committee recommend to the Governance Committee the Terms of Reference as amended for Board approval.

The role will be revised to better reflect the committee and the responsibilities will also be updated to include an element of recruitment of bilingual staff. This will be brought to Governance and then to the Board.

**CARRIED**

##### 5.0 Date of Next Meeting

Next meeting: June 3, 2026

K-L. Massia, Recorder

DRAFT

Department	Job Title	Required linguistic profile Oral	Required linguistic profile Written	Total employed FT	Total employed PT	Total employed CA	Required French Full Time	Required French Part Time	Required French Casual	Actual French FT	Actual French PT	Actual French CA	Non Evaluated FT	Non Evaluated PT	Non Evaluated CA
Administration	CFO	Superior	Superior	1	0	0	1	0	0	1	0	0	0	0	0
Administration	CEO	Undetermined	Undetermined	1	0	0	0	0	0	0	0	0	0	0	0
Administration	CNE	Undetermined	Undetermined	1	0	0	0	0	0	0	0	0	0	0	0
Administration	CHRO	Undetermined	Undetermined	1	0	0	0	0	0	1	0	0	0	0	0
Administration	Executive Assitant	Advanced Plus	Intermediate	1	0	0	1	0	0	1	0	0	0	0	0
Administration	Adm. Assistant Medical Affairs	Undetermined	Undetermined	1	0	0	0	0	0	1	0	0	0	0	0
Support Services	Mat. Management Manager	Undetermined	Undetermined	1	0	0	0	0	0	0	0	0	0	0	0
Support Services	Dietary and Housekeeping Manager	Advanced - Minus	Undetermined	1	0	0	0	0	0	1	0	0	0	0	0
Support Services	Bookkeepers - AR clerks - switchboard	Advanced Plus	Undetermined	1	0	1	2	0	0	1	0	1	0	0	0
Support Services	Cooks/Dietary Aides	Intermediate	Undetermined	0	12	1	0	2	0	0	5	0	0	3	1
Support Services	Filling Clerks	Advanced - Minus	Elementary	0	2	0	0	2	0	0	2	0	0	0	0
Support Services	Admitting/Ward Clerks (Medical Clerks)	Advanced Plus	Undetermined	4	6	5	4	6	5	4	5	5	0	1	0
Support Services	General Accounts (Payroll and AP)	Advanced Plus	Undetermined	1	0	0	1	0	0	1	0	0	0	0	0
Support Services	Coder	Undetermined	Undetermined	1	0	0	0	0	0	1	0	0	0	0	0
Support Services	Manager of Financial Services	Advanced - Minus	Undetermined	1	0	0	0	0	0	1	0	0	0	0	0
Administration	HR	Intermediate	Undetermined	1	0	0	0	0	0	0	0	0	0	0	0
Administration	IT	Undetermined	Undetermined	3	0	0	0	0	0	0	0	0	0	0	0
Support Services	HIS Manger	Undetermined	Undetermined	1	0	0	0	0	0	0	0	0	0	0	0
Clinical	Professional Practice/clinical managers	Elementary	Undetermined	3	0	0	1	0	0	2	0	0	0	0	0
Clinical	PSW - Acute	Advanced - Minus	Undetermined	2	1	2	0	1	0	1	1	0	1	0	2
Clinical	RN - Acute	Advanced - Minus	Undetermined	2	14	6	2	5	0	0	9	3	0	2	3
Clinical	RPN - Acute	Advanced - Minus	Undetermined	2	6	2	0	4	0	1	1	1	1	2	0
Clinical	Rehab/Physiotherapy Manager	Advanced - Minus	Undetermined	1	0	0	1	0	0	1	0	0	0	0	0
Clinical	Physiotherapists	Advanced - Minus	Undetermined	4	1	1	1	0	0	3	1	1	1	1	0
Clinical	OT and OT/PT Aides	Advanced - Minus	Undetermined	5	0	0	2	0	0	4	0	0	0	0	0
Clinical	SLP	Advanced	Undetermined	1	0	0	1	0	0	1	0	0	0	0	0
Clinical	PSW - Rehab	Advanced - Minus	Undetermined	0	4	2	0	2	0	0	3	1	0	0	1
Clinical	RPN - Rehab	Advanced - Minus	Undetermined	3	11	2	2	4	0	2	5	1	0	4	1
Clinical	RPN - ER	Advanced - Minus	Undetermined	3	0	0	1	0	0	2	0	0	0	0	0
Clinical	RT	Advanced - Minus	Undetermined	0	2	0	0	0	0	0	1	0	0	0	0
Clinical	RN - ER	Advanced - Minus	Undetermined	7	13	2	3	4	0	3	5	2	1	4	0
Clinical	Xray technologists	Advanced - Minus	Undetermined	1	5	1	1	3	0	1	3	0	0	1	1
Clinical	Ultrasonographers	Advanced - Minus	Undetermined	0	1	3	0	2	0	0	1	1	0	0	2
Clinical	Pharmacy Manager	Undetermined	Undetermined	1	0	0	0	0	0	1	0	0	0	0	0
Clinical	Registered Pharmacy Techs.	Intermediate	Undetermined	2	1	2	1	0	0	2	0	0	0	0	1

## Correspondence

December 25, 2025 – Seaway News – [Bonnie Glen Supports Hospital](#)

December 25, 2025 – Seaway News – [North Glengarry's pool cost running high](#)

January 5, 2025 – Standard Freeholder – [Costs of programming at Hôpital Glengarry Memorial Hospital pool concern North Glengarry council](#)

January 13, 2026 – Seaway News - [Glengarry Highland Masonic Lodge bash raises \\$71,000 for good causes](#)

January 15, 2026 – Seaway News – [Sabourins bolster CT scan drive](#)