BOARD QUALITY AND PATIENT SAFETY COMMITTEE MEETING AGENDA

Date: Wednesday, February 18, 2026
Time: 16:00 – 17:00
Location: Boardroom / Microsoft Teams

Time	Agenda Item	Board Item	Attachment
16:00	**1. Call to Order**		
(1 min)	1.1 Confirmation of Quorum		
(1 min)	1.2 Adoption of the agenda		P. 1-2
(1 min)	1.3 Declaration of Conflict of Interest		
16:03	**2. Report from Last Meeting**		
(1 min)	2.1 Approval of previous meeting report – January 14, 2026		P. 3-5
(1 min)	2.2 Business arising from the report		
(1 min)	2.3 Committee Work Plan Review		P. 6
16:06	**3. Education Session**		
(10 min)	3.1 Patient Story (R. Romany)		
16:16	**4. Matters for Discussion/Decision**		
(5 min)	4.1 Medical Student/Resident Placement Report (Dr. L. MacKinnon)	D	P. 7-8
(5 min)	4.2 Review 2025-2026 QIP for Q3 (R. Romany) **That the Quality & Patient Safety Committee review and receive the 2025-2026 Quality Improvement Plan for Q3 as presented.**	D	P. 9-12
(5 min)	4.3 2026-2027 Quality Improvement Plan (R. Romany) **THAT the Quality & Patient Safety Committee recommend to the Board of Directors the 2026-2027 Quality Improvement Plan as presented.**	D	P. 13-23
(5 min)	4.4 Review Quality & Safety Scorecard (R. Romany) **THAT the Quality & Patient Safety Committee review and receive the Quality & Safety Scorecard as presented.**	C	P. 24-26
(5 min)	4.5 Review Q3 Patient Satisfaction Survey Results (R. Romany) **THAT the Quality & Patient Safety Committee review and receive the Patient Satisfaction Survey Results for Q3 as presented.**	D	P. 27-31
16:41	**5. Matters for Information**		
(5 min)	5.1 BPSO Updates (R. Romany)	C	P. 32
(5 min)	5.2 Patient Safety Plan Review (R. Romany)	C	P. 33-43
(5 min)	5.3 Trillium Gift of Life Report (R. Romany)	C	P. 44-45
(5 min)	5.4 Accreditation Standard Review (R. Romany)	C	P. 46-47
17:01	**6. Date of Next Meeting**		
	Wednesday, April 8, 2026		
17:02	**7. Adjournment**		

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

Accountability for Reasonableness (A4R) Ethical Decision Making Framework Steps

Values that Optimize Fairness in the Process of Decision-Making

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

A4R Action Steps

Determine and Identify

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

Clarify and Provide

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

Communicate

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

Revisit and Revise

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

Evaluate and Improve

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

Champlain

Glengarry Memorial

REPORT OF THE BOARD QUALITY AND PATIENT SAFETY COMMITTEE MEETING

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	RJ. 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 9th in the Boardroom and will also be available via MS Teams.

Date of Next Meeting: Wednesday, February 18, 2026

K-L. Massia, Recorder

Quality & Patient Safety Committee
Work Plan 2025-2026

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

Revisions since prior report:

Review Trillium Gift of Life Report – added January 2026

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: January 22, 2026 Meeting Date Prepared for: February 18, 2026

Subject: Medical Student & Resident Plaement Report 2025-26 (Q1-Q4)

Prepared by: Dr. Lisa MacKinnon

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

PURPOSE

- To provide an overview of medical student and resident placements hosted during the 2025–26 academic year, outlining quarterly activity for information and situational awareness.

IMPLICATIONS TO OTHER STANDING COMMITTEES

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

SITUATION & BACKGROUND

The organization continues to support medical education through clinical placements, electives, and observerships across multiple departments, including Emergency, Inpatient, Family Practice, and specialty clinics. In addition to fulfilling an educational mandate, supporting medical students and residents serves as an important physician recruitment strategy. Learners who have positive clinical and community experiences are more likely to return to practice at the hospital following graduation and completion of their training.

The following summarizes placement activity by quarter.

Quarterly Placement Summary

Q1 (April–June 2025)

- 4 first-year medical students
  - 2 from University of Ottawa
  - 2 from University of Toronto

Q2 (July–September 2025)

- 1 third-year medical student from Queen's University
- 1 University of Ottawa observership (1 day) in the Hematology clinic

Q3 (October–December 2025)

- 3 third-year medical students
  - 2 completed two-week placements focused on Emergency Department and Inpatient experience only
  - These students completed their Family Medicine rotations in Akwesasne

Q4 (January–March 2026)

- 3 third-year medical student from Queen's University
  - 2 third-year medical students
    - Two-week Emergency Department–only placements
    - Family Medicine completed in Akwesasne
- 2 second-year residents from uOttawa
  - One-month Family Practice electives in January
- 1 second-year resident returning for a repeat elective
  - February–March placement in Inpatient and Emergency Departments

IMPACT ANALYSIS/RISK ASSESSMENT/DECISION CRITERIA

Overall Impact

- Maintains strong academic relationships with uOttawa, University of Toronto, Queen's University, and affiliated training programs.
- Provides consistent exposure to Emergency and Inpatient care, particularly for learners completing Family Medicine rotations in Akwesasne.
- Supports physician recruitment efforts by creating early, positive exposure to the hospital and community, increasing the likelihood that learners may return to practice post-graduation.
- Encourages repeat electives and return learners, strengthening continuity and recruitment potential.

Risks & Considerations

- Increased learner volume in certain quarters may place additional demands on preceptors and clinical services.
- No decision required at this time; information presented for planning and monitoring purposes.

SUMMARY

During the 2025–26 academic year, the hospital hosted multiple medical student and resident placements across Emergency, Inpatient, Family Practice, and specialty services. These placements supported medical education, strengthened academic partnerships, and contributed to physician recruitment efforts by providing learners with positive clinical experiences that may encourage them to return to practice at the hospital following graduation. No decisions are required at this time.

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DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: February 5, 2026 Meeting Date Prepared for: February 18, 2026

Subject: Quality Improvement Plan (QIP) Results- Q3

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

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

PURPOSE

- To review the results of the Quality Improvement Plan for Q3
- Discuss contributing factors and mitigation strategies for improvement

IMPLICATIONS TO OTHER STANDING COMMITTEES

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

SITUATION & BACKGROUND

A brief description of the background to the issue.

- In June 2010, the Ontario Government passed the Excellent Care for All Act. This legislation was designed to put patients first with a focus on the health care sector's accountability for delivering high quality patient care.
- One of the ways this accountability is being made transparent is through the requirement that all hospitals create and make public their annual Quality Improvement Plan (QIP).
- A QIP is a formal, documented set of Quality commitments aligned with system and provincial priorities that a health care organization makes yearly to its patients, staff, and community to improve quality through focused targets and actions.
- Each year, four themes are chosen and targets are established for each indicator to be achieved.
- The 2025/26 QIP themes, quality dimension and six (6) indicators are as follows:
    - Access & Flow- Timely transitions- % of patients who visited the ED and left without being seen by the physician
    - Access & Flow- Timely transitions- 90th percentile ED wait time to physician initial assessment
    - Equity-Equitable - % of staff who have completed relevant inclusion, diversity, equity and anti-racism, and accessibility (IDEA) education.
    - Experience- Patient-centered- % respondents who respond positively to the following question: Were you involved as much as you wanted to be in decisions about you or your family member's care and treatment?"
    - Safety- Safe- Rate of workplace physical violence incidents resulting in lost time injury
    - Safety- Safe- Number of medication errors that reached the patient due to wrong drug/dose/patient (incident severity levels 2-5)

IMPACT ANALYSIS/RISK ASSESSMENT/DECISION CRITERIA

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

Our QIP for Q3 has yielded the following results:

Access & Flow- Timely transitions- % of patients who visited the ED and left without being seen by the physician

THEME	DIMENSION	METRIC		YEAR END FISCAL 2024	TARGET PERFORMANCE	Apr-25	May-25	Jun-25	Q1	Jul-25	Aug-25	Sep-25	Q2	Oct-25	Nov-25	Dec-25	Q3
Access & Flow	Timely	Percent of patients who visited the ED and left without being seen by a physician	P4R	8.0%	7.7%	5.9%	5.6%	6.6%	6.1%	6.5%	6.8%	5.2%	6.2%	4.7%	3.8%	4.7%	4.4%

- Q3 ended with 4.4%, achieving the target of staying below 7.7%..
- **Strategy:** Current ED initiative to have additional physician coverage (4 hours, everyday) during ED visit peak hours to support faster access for low-acuity ED visits, improve patient flow, reduce the number of patients leaving without being seen, and improve Physician Initial Assessment times.

Access & Flow- Timely transitions- 90th percentile ED wait time to physician initial assessment

THEME	DIMENSION	METRIC		YEAR END FISCAL 2024	TARGET PERFORMANCE	Apr-25	May-25	Jun-25	Q1	Jul-25	Aug-25	Sep-25	Q2	Oct-25	Nov-25	Dec-25	Q3
Access & Flow	Timely	90th percentile emergency department wait time to physician initial assessment	P4R	4.8	4.6	4.5	4.6	4.1	4.4	4.1	4.4	3.9	4.1	3.0	3.4	4.2	3.5

- Q3 ended with 3.5 hours, which is positively below the target of 4.6 hours.
- **Strategy:** continuous improvement processes such as clear communication protocols between ED and inpatient team to ensure seamless transitions and quick responses.

Equity-Equitable - % of full-time and part-time staff who have completed relevant inclusion, diversity, equity, anti-racism and accessibility (IDEAA) education.

THEME	DIMENSION	METRIC		YEAR END FISCAL 2024	TARGET PERFORMANCE	Apr-25	May-25	Jun-25	Q1	Jul-25	Aug-25	Sep-25	Q2	Oct-25	Nov-25	Dec-25	Q3
Equity	Equitable	Percentage of Full-time and Part-time staff who have completed relevant inclusion, diversity, equity and accessibility (IDEA) education	IDEA	n/a	25.0%	1.7%	0.0%	0.0%	1.7%	33.9%	33.9%	33.9%	33.9%	33.9%	33.9%	33.9%	33.9%

- Q3 ended with 33.9%, achieving the target of 25%.
- **Strategy:** IDEAA principles e-learning module provided to staff. This training helps staff provide respectful, unbiased, and accessible care, leading to better communication and trust between patients and providers. This improves patient safety, satisfaction, and health outcomes.

Experience- Patient-centered- % respondents who respond positively to the following question: Were you involved as much as you wanted to be in decisions made about you or your family member's care and treatment

THEME	DIMENSION	METRIC		YEAR END FISCAL 2024	TARGET PERFORMANCE	Apr-25	May-25	Jun-25	Q1	Jul-25	Aug-25	Sep-25	Q2	Oct-25	Nov-25	Dec-25	Q3
Experience	Patient-Centred	Percent of respondents answering yes to the question "were you involved as much as you wanted to be in decisions about you or your family member's care and treatment?"	nQuire	87.0%	89.0%	98.4%	96.2%	96.5%	96.9%	94.5%	97.0%	97.3%	96.3%	96.2%	97.9%	97.0%	97.0%

- Q3 ended with 97%, which is well above the target of 89%.
- **Strategy:** Consistently involve patients and families in establishing goals of care and support their understanding of shared information.

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

THEME	DIMENSION	METRIC		YEAR END FISCAL 2024	TARGET PERFORMANCE	Apr-25	May-25	Jun-25	Q1	Jul-25	Aug-25	Sep-25	Q2	Oct-25	Nov-25	Dec-25	Q3
Safety	Safe	Rate of workplace physical violence incidents resulting in lost time injury	RIMS	0	0	0	0	0	0	0	0	0	0	0	0	0	0

- Q3 ended at 0, which is favorably below our target of 0.
- Strategy : Emphasis on proactive approaches to avoid or reduce violent incidents, creating a safer and more supportive environment for both patients and staff.

Safety- Safe- Number of medication errors that reached the patient (severity levels 2-5)

THEME	DIMENSION	METRIC		YEAR END FISCAL 2024	TARGET PERFORMANCE	Apr-25	May-25	Jun-25	Q1	Jul-25	Aug-25	Sep-25	Q2	Oct-25	Nov-25	Dec-25	Q3
Safety	Safe	Number of medication errors that reached the patient due to wrong drug/dose/patient (incident severity levels 2-5)		10	2 per month	2	0	1	3	5	1	2	8	2	2	2	6

- Q3 ended at 6 incidents, which met the adjusted target of 2 per month. YTD total number of incidents is 17 which is above the target of 12 incidents for the year.
- Strategy:
  - Continuous evaluation of dispensing and documentation processes, including narcotic counts, investigations of potential losses, and gathering feedback from staff.
  - Pharmacy providing constructive feedback and additional training where necessary.
  - Diversion prevention education included in the orientation session for new employees.

Summary

The 2025–26 Quality Improvement Plan demonstrates success in achieving most Q3 objectives while reinforcing the need for ongoing collective efforts to address remaining improvement priority.

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Quality Improvement Plan (QIP)

Fiscal 2025/26

THEME	DIMENSION	METRIC		YEAR END FISCAL 2024	TARGET PERFORMANCE	Apr-25	May-25	Jun-25	Q1	Jul-25	Aug-25	Sep-25	Q2	Oct-25	Nov-25	Dec-25	Q3
Access & Flow	Timely	Percent of patients who visited the ED and left without being seen by a physician	P4R	8.0%	7.7%	5.9%	5.6%	6.6%	6.1%	6.5%	6.8%	5.2%	6.2%	4.7%	3.8%	4.7%	4.4%
Access & Flow	Timely	90th percentile emergency department wait time to physician initial assessment	P4R	4.8	4.6	4.5	4.6	4.1	4.4	4.1	4.4	3.9	4.1	3.0	3.4	4.2	3.5
Equity	Equitable	Percentage of Full-time and Part-time staff who have completed relevant inclusion, diversity, equity and accesibility (IDEA) education.	IDEA	n/a	25.0%	1.7%	0.0%	0.0%	1.7%	33.9%	33.9%	33.9%	33.9%	33.9%	33.9%	33.9%	33.9%
Experience	Patient-Centred	Percent of respondents answering yes to the question "were you involved as much as you wanted to be in decisions about you or your family member's care and treatment?"	nQuire	87.0%	89.0%	98.4%	96.2%	96.5%	96.9%	94.5%	97.0%	97.3%	96.3%	96.2%	97.9%	97.0%	97.0%
Safety	Safe	Rate of workplace physical violence incidents resulting in lost time injury	RIMS	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Safety	Safe	Number of medication errors that reached the patient due to wrong drug/dose/patient (incident severity levels 2-5)		10	2 per month	2	0	1	3	5	1	2	8	2	2	2	6

Metric underperforming target by more than 25%

Metric within 25% of target

Metric equal or outperforming target

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Quality ☐ Senior Leadership Team
☐ Other *(please specify): Quality and Safety Advisory Committee*

Date Prepared: Feb 5, 2026 Meeting Date Prepared for: February 18, 2026

Subject: Quality Improvement Plan (QIP) 26/27

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

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

PURPOSE

- To determine the recommended QIP Indicators for 2026-2027 and submit recommendations to the Board Quality and the Board of Directors for approval.

RECOMMENDATION / MOTION

- That the Quality and Safety Advisory Committee review the Quality Improvement Plan for 2025-26 as presented and provide recommendations.

IMPLICATIONS TO OTHER STANDING COMMITTEES

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

- Quality and Safety Advisory –January 28, 2026
- Senior Leadership Team- February 2026
- MAC – February 2026
- PFAC – March 2026
- Board Quality- February 2026
- Board of Directors- March 26, 2026
- Submission due to OH on April 1, 2026

SITUATION & BACKGROUND

A brief description of the background to the issue.

- Continued focus on four province-wide priority issues: (1) Access and flow, (2) Equity, (3) Experience, and (4) Safety which means priority and optional indicators are the same as those of last year.
- See attached 2026/27 Quality Improvement Plan Program: Indicator Matrix for review of indicators.
- To ensure alignment with the strategic and operating plans, as well as Accreditation Standards, specific indicators were selected to be incorporated into the Quality Improvement Plan.

Draft 2026-2027 QIP

		DRAFT Quality Improvement Plan 2026-2027				
THEME	QUALITY DIMENSION	MEASURE/INDICATOR	UNIT/POPULATION	SOURCE/PERIOD	CURRENT PERFORMANCE	TARGET PERFORMANCE
Access & Flow	Timely	Reduce the percentage of ED patients who left without being seen by a physician	%/ED patients	ERNI scorecard April 1- December 2025 (Q1-Q3)	6%	7.3%
Access & Flow	Timely	Reduce the 90th percentile emergency department wait time to inpatient bed by 50%	Hours/ED patients	ERNI scorecard April 1- December 2025 (Q1-Q3)	8.4	4.2
Equity	Equitable	Increase the percentage of Full-time and Part-time staff who have completed relevant inclusion, diversity, equity and accessibility (IDEA) education on gender identity to 50%.	%/applicable Staff	Quality scorecard April 1- December 2025 (Q1-Q3)	n/a	50%
Experience	Patient-Centred	Increase patient-reported care ratings related to being treated with courtesy and respect, regardless of gender identity by 5%.	scale out of 10	Quality scorecard April 1- December 2025 (Q1-Q3)	7.4	7.7
Safety	Safe	Reduce the rate of hospital-acquired pressure injuries (Stage 2-4) during inpatient stays by 50%.	Number	Quality scorecard April 1- December 2025 (Q1-Q3)	6	3
Safety	Safe	Reduce the number of medication incidents reaching the patient and resulting in harm (severity levels 2-5) by 4%.	Number	Quality scorecard April 1- December 2025 (Q1-Q3)	25	24

- Access and Flow – ED Patients Leaving Without Being Seen
  - This indicator is proposed for 2026 based on demonstrated improvement in 2024 (9%) and the 2025 target of 7.5%. Continued focus is required to sustain progress and further improve access.
- Access and Flow – ED Wait Time to Inpatient Bed (90th Percentile)
  - Inclusion of this indicator in 2026 is informed by 2024 performance (3.5 hours) and the 2025 target (3.1 hours), reinforcing accountability for reducing prolonged ED stays and improving patient flow.
- Equity and Patient-Centred Experience: Gender identity education for staff and Patient care rating
  - These indicators are proposed for 2026 to build on prior work in 2024, 2025 and to maintain accountability for equitable, inclusive care, staff education, and improved patient experience.
- Patient Safety: Pressure injuries and medication-related incidents that reached the patient
  - Patient safety indicators are included in the 2026 QIP to sustain oversight and accountability, building on existing efforts to prevent pressure injuries and medication-related incidents.

IMPLEMENTATION & COMMUNICATION PLAN

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

- Communication at each committee as above.
- Quality and Safety Advisory committee will be accountable to track/trend and implement strategies to achieve targets.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

3/26/2026

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

Hôpital Glengarry Memorial Hospital (HGMH) is a designated bilingual (French, English) hospital in Alexandria, Ontario. HGMH provides acute care, 24-hour emergency services, inpatient medicine services, outpatient services and sub-acute rehabilitation services to residents in our local Eastern Ontario community.

HGMH is an organization committed to the **Mission** of *delivering outstanding care for our communities*, which fuels the **Vision** of *providing your care, your way, with seamless integration, innovation, and equitable access for our communities.*

HGMH team continues to advance the organization forward with four strategic priorities:

- **Quality and Safety:** enrich the patient experience through quality, safe care that welcomes patients and families as partners in care.
- **People and Culture:** improve engagement by investing in the organization's people and empower a caring and positive culture for all.
- **Integration and Standardization**: deliver standardized quality care in a cost-effective way through collaboration and integration opportunities.
- **Future Planning**: invest in the sustainability of equipment and infrastructure to support safe, quality care.

HGMH is pleased to present its 2026-27 Quality Improvement Plan (QIP). It is one component of the overall organizational approach to quality and safety, with initiatives selected that are consistent with the Strategic Plan, Patient Safety Plan, Hospital Service Accountability Agreement, Accreditation standards, and informs our operating plan. In addition, input on this plan is sought from the Quality and Safety Advisory Committee, and from the Board of Directors, the Leadership Team, the Medical Advisory Committee, and the Patient and Family Advisory Committee.
HGMH is committed to focus on indicators that Ontario Health has identified as priorities for hospitals.

Hôpital Glengarry Memorial Hospital

Quality Improvement Plan 2026-2027

THEME	QUALITY DIMENSION	MEASURE/INDICATOR	UNIT/POPULATION	SOURCE/PERIOD	CURRENT PERFORMANCE	TARGET PERFORMANCE
Access & Flow	Timely	Reduce the percentage of ED patients who left without being seen by a physician	%/ED patients	ERNI scorecard April 1- December 2025 (Q1-Q3)	6%	7.3%
Access & Flow	Timely	Reduce the 90th percentile emergency department wait time to inpatient bed by 50%	Hours/ED patients	ERNI scorecard April 1- December 2025 (Q1-Q3)	8.4	4.2
Equity	Equitable	Increase the percentage of Full-time and Part-time staff who have completed relevant inclusion, diversity, equity and accessibility (IDEA) education on gender identity to 50%.	%/applicable Staff	Quality scorecard April 1- December 2025 (Q1-Q3)	n/a	50%
Experience	Patient-Centred	Increase patient-reported care ratings related to being treated with courtesy and respect, regardless of gender identity by 5%.	scale out of 10	Quality scorecard April 1- December 2025 (Q1-Q3)	7.4	7.7
Safety	Safe	Reduce the rate of hospital-acquired pressure injuries (Stage 2-4) during inpatient stays by 50%.	Number	Quality scorecard April 1- December 2025 (Q1-Q3)	6	3
Safety	Safe	Reduce the number of medication incidents reaching the patient and resulting in harm (severity levels 2-5) by 4%.	Number	Quality scorecard April 1- December 2025 (Q1-Q3)	25	24

Access and Flow

Maximizing hospital capacity, ensuring timely access to care, and optimizing patient flow contribute to better patient outcomes and enhance the overall patient experience.
At HGMH, these strategies are in place to support access and flow, including:

- **Enhanced Emergency Department (ED) Capacity**: A strategic initiative aimed at reducing the number of patients who leave the ED without being seen by a physician, as well as decreasing wait times for the physician's initial assessment (PIA). This is achieved by adding an additional ED physician daily during peak hours of high ED activity.
- **Multidisciplinary Rounds**: Daily rounds involving healthcare professionals from various disciplines to efficiently coordinate care, assess patient statuses, facilitate and expedite discharges, and ensure a collaborative team approach to treatment.
- **Bedboard Tool**: The Daily Bedboard Tool is used to optimize bed utilization, reduce wait times, and ensure that patients receive appropriate care based on their needs and the resources available.
- **Regional Bed Planning**: Daily coordination of bed planning across the region to ensure the most efficient use of available beds and resources.
- **Collaboration with Great River Ontario Health Team (GROHT)**: Active partnerships with GROHT and local community agencies to ensure patients have timely and adequate access to care.
- **Ongoing Partnerships with Ontario Health and The Ottawa Hospital (TOH)**: Continued collaboration through the ED Peer-to-Peer Program and the TOH Virtual Critical Care initiative to enhance care coordination and access to specialized services.

Equity and Indigenous Health

HGMH is a designated agency under the French Language Services Act (FLSA). We are committed to providing our French-speaking population with access in French to the full range of quality care and services being offered. This includes access to French-speaking health care professionals as well as providing all patient educational materials in both official languages.
As part of our commitment to health equity, HGMH is actively engaged in several initiatives:

- **IDEA Committee**: The Inclusion, Diversity, Equity, and Anti-Racism (IDEA) Committee has been established to promote diverse and inclusive care. The committee oversees the development and implementation of a framework focused on ensuring inclusiveness, diversity, equity, and anti-racism within the organization.
- **IDEA Framework**: This framework guides our practices and policies to ensure they are aligned with the principles of fairness and equitable opportunity for all.
- **Partnerships for Culturally Safe Care**: Formal and informal partnerships with external agencies are established to provide culturally safe care for Indigenous patients and their families. This includes collaborating with individuals with lived experience to create training opportunities for staff.
- **Patient Satisfaction Surveys**: We have incorporated diversity-related questions into our patient satisfaction surveys to help us better understand the needs of our diverse population. This data helps identify areas for improvement and guides targeted actions.

- **Indigenous Healthcare Training**: Collaborating with a Diversity, Equity, and Inclusion (DEI) training provider to offer tailored DEI learnings for our leadership team and staff, empowering our teams with the knowledge, strategies, and interventions necessary to ethically and effectively meet the needs of diverse clients.
- **On-Demand Medical Translation**: HGMH has maintained on-demand medical translation services, covering over 240 languages and dialects, including American Sign Language. This service ensures that language barriers do not hinder access to quality care.

Patient/Client/Resident Experience

HGMH is committed to a patient and family-centered approach to health care. Our patients and their families play a vital role in improving the patient's experience at our hospital. The Patient and Family Advisory Committee (PFAC) provide a way for staff and leadership to connect with patients and family members, share perspectives, and provide advice on how to continue to improve how care is delivered.
Patient feedback is gathered through observations, compliments and feedback from patients, families/caregivers, and Patient Satisfaction surveys. Ongoing initiatives have been introduced to recognize the importance of having a loved one or support person present during a patient's hospital stay for healing and recovery, in alignment with guidelines developed by the Registered Nurses Association of Ontario (RNAO). These initiatives include:

- **Essential Care Partner Program**: presence of a support person is essential to the safety and well-being of a patient during their hospital stay and is a valued member of the care team.
- **Hospital Elder Life Program**: with the support of trained team of volunteers, this patient care program provides support to older patients and conducts activities that help keep patients mentally and physically active and help prevent delirium and reduce the risk of functional decline.
- **Purposeful Hourly Rounding Program:** proactively and promptly identify any emerging concerns, fostering trust by ensuring patients feel heard and supported throughout their hospital stay.
- **Supportive Communication for Adults with Aphasia (SCA):** trains staff and caregivers on how to assist patients with aphasia, a language impairment that affects an individual's ability to express themselves or understand spoken and written language.

Senior leaders and PFAC Patient Rounding are regularly conducted to engage directly with patients, ask for feedback on their experience, and gather actionable feedback related to safety, care, and communication. The process includes asking targeted questions, ensuring follow-up on concerns raised, and providing patients with contact information to support ongoing communication.

Provider Experience

HGMH is committed to providing a positive and caring culture for all staff. Prioritization of staff and physician well-being and support of a better work-life balance enable them to provide the best possible care to our patients. These initiatives include:

- **Online health and wellness resources**: 24/7 access to Employee Assistance Program (EAP)
- **Strategic Human Resources Plan**: focus on optimizing workforce, recruitment and retention of top talent, positive work environment and employee engagement
- **Social Club Committee**
- **Care Champion Program**: platform for patients and families to express their gratitude for exceptional patient experiences.
- **Employee Satisfaction and Engagement Survey**
- **Staff Town Halls and Department meetings**: addressing issues and conveying concerns
- **Roundtable conversations with the CEO and CEO quarterly VLOGs (Video Blogs)**
- **Weekly Clinical Leadership newsletter & Biweekly Corporate Newsletter**
- Quality Board Huddles
- Bi-annual Departmental Inspections
- Physician newsletter update
- Monthly Occupational Health and Safety Talks
- Individual and Team recognition for demonstrating excellence in safe, high-quality patient care, leadership, and meaningful impact through their work: Board Award of Excellence, Mrs. Oma Award, Annual Team Award, Annual Dr. Govan Award, Safety Star Award

Physician recruitment efforts are ongoing, with job postings actively maintained on Health Force Ontario to ensure visibility and attract interested applicants. Current strategies focus on broad engagement with stakeholders and partners to build awareness and generate interest locally, provincially, and internationally. Our priorities remain focused on maintaining staffing stability, supporting employee development, and ensuring compliance.

Safety

Never events are serious patient safety incidents that are preventable through the consistent use of evidence-based practices. Our organization addresses the prevention of never events as part of its overall patient safety strategy through risk awareness, staff education, and standardized clinical practices.

Pressure injury prevention is supported through focused, interdisciplinary training that reinforces safe daily care. Education from the wound care nurse consultant, with support from occupational and physiotherapy staff and equipment specialists, emphasize early risk identification, safe repositioning, mobility, appropriate use of pressure-relieving surfaces, and proper seating and mobility equipment. These measures promote consistent practice and reduce the risk of preventable skin breakdown.

Medication safety is another key priority area. To support safe medication management, a monthly “Pharm Facts” communication is distributed to all staff. These updates provide targeted guidance on medication safety topics, including high-alert medications, high-concentration and high-total-dose opioid formulations, and controlled substances diversion prevention. This ongoing education reinforces safe medication handling and administration practices.

Together, these initiatives demonstrate our organization’s commitment to preventing never events through education, interdisciplinary collaboration, and consistent reinforcement of safe clinical practices.

Palliative Care

Our dedication to providing high-quality palliative care is in alignment with the RNAO Best Practice Guidelines (BPG) for End-of-Life Care and Palliative Care with the corresponding action measures in the following areas:

- Early initiation of palliative care
- Ongoing staff education and training
- Utilization of assessment tools for comprehensive symptom and spiritual care evaluation
- Development and implementation of a palliative care handbook to support patients, families, and care partners during end-of-life care
- Psychological and social support for patients and families navigating end-of-life decisions, the grieving process, and care coordination and transitions
- Mental and emotional wellness resources for staff to ensure sustained delivery of high-quality palliative care

Population Health Approach

HGMH plays a vital role in improving population health outcomes and helps reduce health disparities and inequities within the community with approaches such as:

- Preventative Care programs- to promote early disease detection and prevention with screenings and education.
- Chronic Disease management- utilization of coordinated care plans for heart disease led regionally by the University of Ottawa Heart Institute with provision of Cardiac Rehabilitation services and standardized discharge planning.
- Community partnerships- collaboration with public health agencies, primary care, local organizations, and social services to help address social determinants of health and improve continuity of care and patient outcomes.
- Telehealth and remote monitoring device (Holter monitor) to expand access to care and provide proactive and preventative patient care.
- Rehabilitation beds to address increasing general, post stroke, and geriatric rehabilitation access needs in the region

Quality Improvement and Emergency Department Return Visit Quality Program

Emergency department return visit audits identified key factors contributing to returns, including clinical management and follow-up access. A primary strength was the physician-led review of full clinical charts, which moved beyond administrative data to uncover meaningful clinical trends and actionable opportunities for system improvement.

Challenges included limited staffing, competing clinical priorities, and variable documentation. Additionally, selection bias hindered analysis; without a control group, it is difficult to determine if a return represents a true system failure versus a statistical inevitability.

Audit findings highlighted rural system constraints specifically limited diagnostics and primary care as significant contributors. While many returns were planned reassessments, a clinical subset demonstrated abnormal pre-discharge vitals, signaling a need for standardized pre-discharge reassessment for those patients with abnormal triage vital signs. High volume of returns involved chronic or palliative patients who preferred to remain at home but lacked adequate community-based symptom management and social supports.

Quality improvement initiatives prioritize clinical standardization and diagnostic access. To enhance safety, we will look into implementing EMR alerts to prompt review of abnormal vital signs prior to discharge and mandating printed care summaries for complex patients. Operationally, we have increased ultrasound availability to six days per week and are fundraising for a CT scanner to reduce regional reliance. We are strengthening support for vulnerable patients through partnerships with our local Community Health Centre to match these patients with primary care providers, and establishing M&M rounds within our hospital to facilitate provider education.

Executive Compensation

The Excellent Care for All Act (ECFAA, 2010) mandates that executive compensation be tied to the Quality Improvement Plan (QIP).

HGMH is dedicated to rewarding the CEO, COS, and Executive Team for their strategic leadership with an incentive plan that drives engagement, results orientation, and commitment to achieving key goals.

The plan focuses on quality performance and promotes a team-oriented approach to organizational success, ensuring that compensation reflects their contributions to the organization’s overall goals.

Executive Team Member	Compensation
President and Chief Executive Officer	1.5% of annual executive compensation is linked to achieving the targets set out in our QIP
Chief Financial Officer	1.5% of annual executive compensation is linked to achieving the targets set out in our QIP
Chief Nursing Executive	1.5% of annual executive compensation is linked to achieving the targets set out in our QIP
Chief Human Resources Officer	1.5% of annual executive compensation is linked to achieving the targets set out in our QIP
Chief of Staff	1.5% of annual executive compensation is linked to achieving the targets set out in our QIP

Contact Information

Rachel Romany
Vice-President Clinical Services, Quality & Chief Nursing Executive
613-525-2222 ext. 4110

Sign-off

I have reviewed and approved our organization's Quality Improvement Plan on March 26, 2026.

Stuart Robertson, Board Chair _____

Heidi Salib, Board Quality and Safety Committee Chair _____

Robert Alldred-Hughes, President and CEO Click here to enter text._____

Dr. Lisa MacKinnon, EDRVQP Lead _____

HÔPITAL Glengarry Memorial HOSPITAL

Quality Improvement Plan 2026-2027

THEME	QUALITY DIMENSION	MEASURE/INDICATOR	UNIT/POPULATION	SOURCE/PERIOD	CURRENT PERFORMANCE	TARGET PERFORMANCE	2025 Target
Access & Flow	**Timely**	Reduce the percentage of ED patients who left without being seen by a physician	%/ED patients	ERNI scorecard April 1-December 2025 (Q1-Q3)	6%	7.3%	7.7%
Access & Flow	**Timely**	Reduce the 90th percentile emergency department wait time to inpatient bed by 50%	Hours/ED patients	ERNI scorecard April 1-December 2025 (Q1-Q3)	8.4	4.2	3.1
Equity	**Equitable**	Increase the percentage of Full-time and Part-time staff who have completed relevant inclusion, diversity, equity and accessibility (IDEA) education on gender identity to 50%.	%/applicable Staff	Quality scorecard April 1- December 2025 (Q1-Q3)	n/a	50%	n/a
Experience	**Patient-Centred**	Increase patient-reported care ratings related to being treated with courtesy and respect, regardless of gender identity by 5%.	scale out of 10	Quality scorecard April 1- December 2025 (Q1-Q3)	7.4	7.7	6.2
Safety	**Safe**	Reduce the rate of hospital-acquired pressure injuries (Stage 2-4) during inpatient stays by 50%.	Number	Quality scorecard April 1- December 2025 (Q1-Q3)	6	3	3
Safety	**Safe**	Reduce the number of medication incidents reaching the patient and resulting in harm (severity levels 2-5) by 4%.	Number	Quality scorecard April 1- December 2025 (Q1-Q3)	25	24	10

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: February 11, 2026 Meeting Date Prepared for: February 18, 2026

Subject: Quality and Safety Scorecard Q3 Results

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

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

PURPOSE

- To review the Q3results of the Quality and Safety Scorecard 2025-26
- Discuss contributing factors and mitigation strategies for improvement

IMPLICATIONS TO OTHER STANDING COMMITTEES

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

SITUATION & BACKGROUND

A brief description of the background to the issue.

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

IMPACT ANALYSIS/RISK ASSESSMENT/DECISION CRITERIA

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

- Areas of opportunities:
  - Falls with injury- Q3 result is 40.91 which does not meet the target of 30.00.
    - **Strategy**: Continue with purposeful patient rounding and reinforce fall prevention strategies including reminding patients to use call bell rather than attempting to get up without supervision.
  - Number of medication errors that reached the patient- Q3 result is 6, which is in line with monthly target of 2.
    - **Update**: the target was originally 10; it is now adjusted to an annual target of 24, monthly target of 2
    - **Strategy:** Continue with safe medication practices such as order verification and consistent documentation standard during medication administration.

- Hand Hygiene Compliance rate for Moment 1- 91.8% and Moment 4- 90.6% which are below the target of 92%.
  - **Strategy**: Continue targeted feedback and education for physicians, nurses, and other patient care staff, such as housekeeping, to improve hand hygiene compliance.
- HAI rate: MRSA – 0.75% which is above the target of 0%.
  - **Strategy:** Q3 coincided with an MRSA outbreak period in the inpatient department. To reduce bacterial burden, ongoing measures include antibacterial wipe bathing for positive patients, enhanced hand hygiene practices for both staff and patients, reinforcement of policies related to fingernails and jewelry, updates to environmental cleaning products and procedures, and the use of enhanced disinfection technology.

SUMMARY

Monitoring quality indicators supports continuous improvement by identifying gaps early and guiding evidence-based actions to strengthen care quality and safety.

HÔPITAL Glengarry Memorial HOSPITAL

HÔPITAL Glengarry Memorial HOSPITAL

Board Scorecard

Fiscal 2025/26

Print

THEME	METRIC	MEASUREMENT	YEAR END FISCAL 2024	TARGET PERFORMANCE	Q1	Q2	Q3	Q4	YTD	AIM	Visualization
1.Timely & Efficient Transitions											
	90th percentile emergency department wait time to	hours	4.8	4.6	4.4	4.1	3.5		4.3	Below	
2. Service Excellence											
	Percent of respondents answering yes to the question "were you involved as much as you wanted to be in decisions about you or your family member's care and treatment?"	% of those who answered Positively/total surveys	87.0%	89.0%	96.9%	96.3%	97.0%		96.7%	Above	
3. Safe & Effective Care											
	Fall Rate	# of incidents per 1000 patient days	14.2	12	19.5	9.6	8.2		12.3	Below	
	Falls with Injury (any fall requiring intervention or treatment)	# of falls with injury/ # of falls *100	34.30	30.00	32.00	15.38	40.91		29.59	Below	
	Incidents of Physical Violence	Actual number	17 (total)	17	15	4	2		21	Below	
	Number of medication errors that reached the patient due to wrong drug/dose/patient (incident severity levels 2-5)	Actual number	10	8	3	8	6		11	Below	
	Pressure injury development rate (stage 2,3,4) during inpatient stays	Actual number	3	0	3	1	2		6	Below	
	Hand hygiene compliance rate (Moment 1)	# compliant activities / # of indicated	75.6%	92.0%	81.9%	79.8%	91.8%		84.7%	Above	
	Hand hygiene compliance rate (Moment 4)	# compliant activities / # of indicated	93.3%	92.0%	93.4%	85.2%	90.6%		90.1%	Above	
	C. difficile rate	# of incidents per 1000 patient days	0.52	0.00	0.00	1.11	0.00		0.38	Below	
	VRE Rate	# of incidents per 1000 patient days	0.00	0.00	0.00	0.00	0.00		0.00	Below	
	MRSA Rate	# of incidents per 1000 patient days	0.62	0.00	2.34	6.27	0.75		3.15	Below	
4. Equity											
	Translation Services Usage	Number of minutes		50	49	54	70		120		

Metric underperforming target by more than 25%

Metric within 25% of target

Metric equal or outperforming target

DECISION SUPPORT DOCUMENT FOR

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

☐ Other *(please specify):*

Date Prepared: Feb 5, 2026 Meeting Date Prepared for: February 18, 2026

Subject: Patient Satisfaction Surveys Q3

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

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

PURPOSE

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

IMPLICATIONS TO OTHER STANDING COMMITTEES

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

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

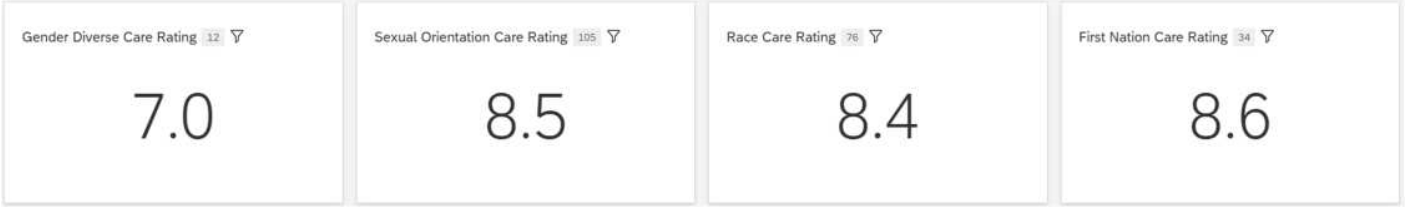
ANALYSIS

EMERGENCY DEPARTMENT- *935 total respondents (cumulative for 3 quarters)*

- Note: Q3 2026 column is the YTD average result for the indicator.

Quarterly Dashboard 935

	Q1 2026	Q2 2026	Q3 2026
Care Rating	8.5	8.6	8.7
I did not have a long wait	60%	65%	71%
During the visit, were you told the reason for the long wait?-1 to 3	24%	24%	35%
Do you feel that there was good communication about your care between doctors?-1 to 4	98%	97%	96%
How often did care providers treat you with courtesy and respect?	100%	99%	99%
How often did care providers explain things in a way you could understand?	98%	98%	98%
Did you get the emotional support you needed to help you with any anxieties?	95%	93%	90%
Did care providers do everything they could to ease your discomfort?	90%	93%	94%
Did you participate in your plan of care?-1 to 3	92%	93%	95%



Explanation of indicators and desired target (AIM):

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

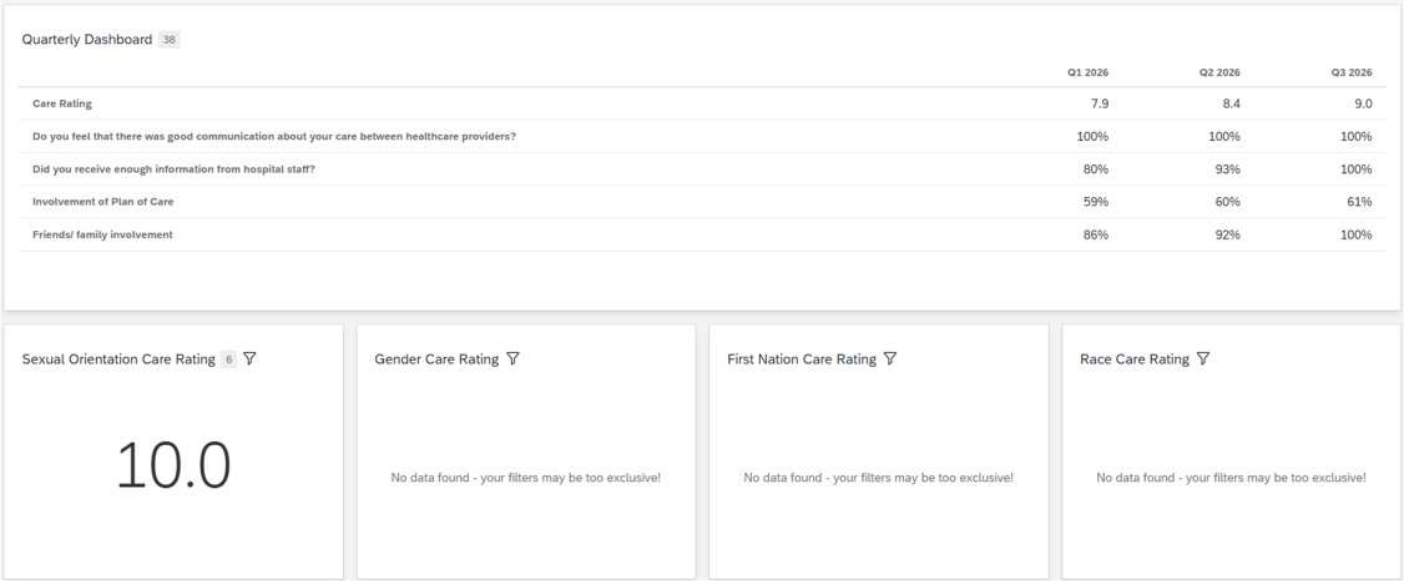
Top Satisfaction Indicators:

- Overall Care Rating: Rose slightly from 8.6 to 8.7, reflecting sustained high satisfaction.
- Courtesy and Respect: Near-perfect scores show consistent excellence in staff–patient interactions.
- Communication Among Providers: Very high and stable at 96% suggesting strong care coordination.
- Clarity of Explanations: Maintained at 98%, indicating providers explain conditions and treatments effectively.
- Participation in Care Planning: Improved (93% → 95%), reinforcing patient-centered care.
- Race & First Nation Care Ratings: High equity perceptions (8.4 and 8.6, respectively), demonstrating cultural sensitivity and inclusiveness.
- Wait time: Perception improved from 65% to 71% as well as explaining the reason for the wait dramatically improved by 11 points (24% -> 35%)

Improvement Opportunity:

- Emotional Support –Decline (93% → 90%), indicating room to strengthen psychosocial support during visits.
    - Strategy: Reminder to staff about empathetic communication with patients and families.

INPATIENT REHAB UNIT- *38 total respondents (cumulative for 3 quarters)*



Explanation of indicators and desired target (AIM):

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

Top Indicators

- **Overall Care Rating:** Continually increasing from 8.4 to 9.0, showing stronger patient satisfaction with overall care.
- **Provider Communication:** A perfect 100% score maintained, indicating excellent coordination between healthcare providers and clear communication with patients.
- **Information from Hospital Staff:** Discharge planning significantly improved with a 100% rating
- **Family/Friends Involvement:** Improved to a 100% positive score
- **Sexual Orientation Care Rating**: Achieved a perfect 10.0, highlighting excellence in providing respectful, inclusive, and affirming care for this demographic group.

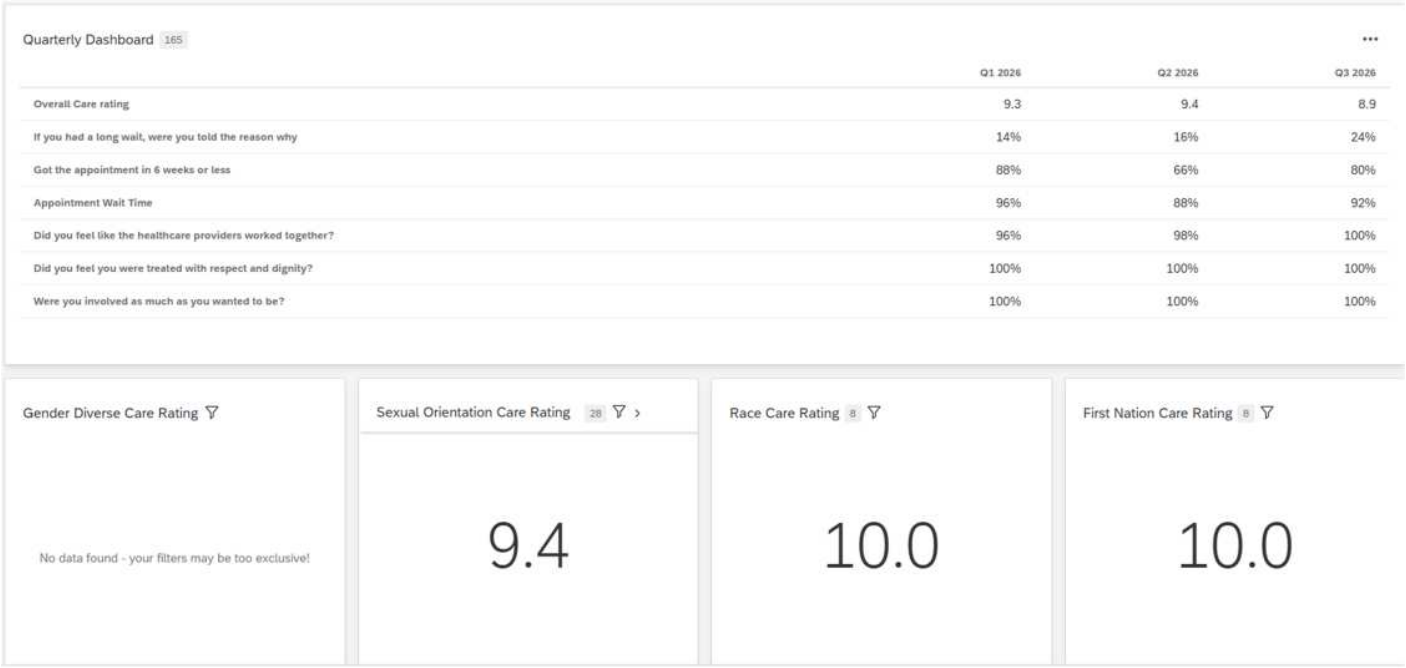
Improvement Opportunity

- Involvement in Plan of Care can be improved with its current standing of 61%.

Strategy:

- Care Team Visibility
  A wall-mounted visual board identifying the rehabilitation team was installed to help patients understand who is involved in their care, especially for patients experiencing memory challenges.

OUTPATIENT DEPARTMENT- *165 total respondents (cumulative for 3 quarters)*



Explanation of indicators and desired target (AIM):

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

Top Indicators

- Overall Care Rating: Dropped from 9.4 to 8.9.
- Respect & Dignity: Achieved a perfect 100% for three consecutive quarters, showing consistently compassionate, patient-centered care.
- Involvement in Care Decisions: Also maintained 100%, indicating that patients feel fully included in care planning and decisions.
- Collaboration Between Providers: Achieved a perfect 100%, demonstrating highly coordinated, team-based care delivery.
- Equity Ratings:
    - Race Care: 10.0
    - First Nation Care: 10.0
    - Sexual Orientation Care: Strong at 9.4

Improvement Opportunity

- Timeliness of Care:

- Appointment within 6 weeks rose back from 66% to 80% this quarter.

Strategy: Continue to monitor scheduling to ensure patients are getting seen in 6 weeks or less.

Summary

- Consistent High Care rating

  Despite the wait time issues, we are still consistent with a satisfied overall care rating range of 8.6-8.8 with increasing quarter by quarter.

DECISION SUPPORT DOCUMENT FOR

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

☐ Other *(please specify):*

Date Prepared: February 10, 2026 Meeting Date Prepared for: February 18, 2026

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

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

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

PURPOSE

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

SITUATION & BACKGROUND

A brief description of the background to the issue.

- HGMH's focus for 2025-26:
    - RNAO's Evidence- based Best Practice Guideline (BPG): A Palliative Approach to Care in the Last 12 Months of Life
        - The guideline offers evidence-based recommendations to nurses and interprofessional teams for supporting adults in the last 12 months of progressive life-limiting illness, focusing on delivering psychosocial, spiritual, and culturally safe care, improving care coordination, and fostering supportive work environments.
    - BPSO Champion In-person Session by our trainer- Carissa Auger RPN
        - Target is to have 20% of staff complete the training. We are currently at 19%.
        - BPSO Champions support our hospital's commitment to excellence, and contribute to a stronger, safer, and more consistent patient experience.

HÔPITAL Glengarry Memorial HOSPITAL

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: February 10, 2026 Meeting Date Prepared for: February 18, 2026

Subject: Updated Patient Quality and Safety Plan 2022-2028

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

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

PURPOSE

- To provide an update on the Patient Quality and Safety Plan.

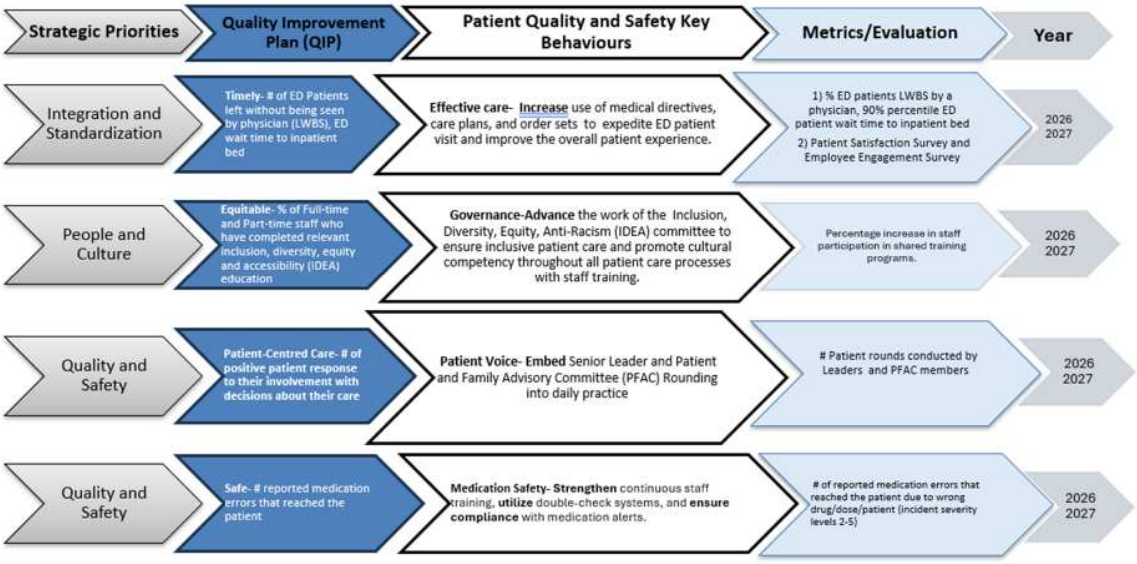
SITUATION & BACKGROUND

A brief description of the background to the issue.

- The Patient Quality and Safety Plan is to communicate and support our focus and commitment to the provision of safe, quality patient care.

IMPLEMENTATION & COMMUNICATION

- The Patient Safety Plan has been renamed as the **Patient Quality and Safety Plan** to demonstrate that high-quality care cannot exist without safe practices.
- **Patient Quality and Safety Key behaviors remain the same for 2026-2027:**
  - **People and Culture**: Senior Leader and PFAC patient rounds will continue.
  - **Patient Centred Care**: Quality and Safety questions will continue to be asked in huddles/ committees for open communication of concerns.
  - **Equitable**: Relevant IDEA education will be completed by leadership team and staff.
  - **Patient Voice and Engagement**: PFAC members will continue to participate in the Ethics, Product Evaluation, and Quality and Safety Advisory committees to offer input from a patient/ family perspective.
  - **Safety**: continuous assessment of reported near misses involving controlled substances and medication errors that reached the patient.



HÔPITAL Glengarry Memorial HOSPITAL

PATIENT QUALITY AND SAFETY PLAN

2022-2028

Table of Contents

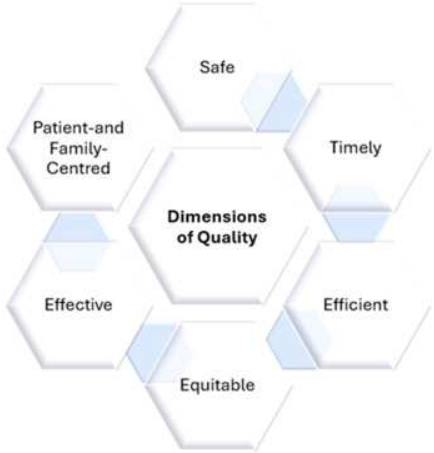
Patient Quality and Safety Plan

The **Mission** at Hôpital Glengarry Memorial Hospital (HGMH) is *delivering outstanding care for our communities*, which fuels the **Vision** of *providing your care, your way, with seamless integration, innovation, and equitable access for our communities*.

We envision being a recognized leader in the delivery, promotion, and integration of health care services. It is our aim that everyone accessing care at our hospital receives an exceptional patient experience delivered by staff and physicians who consistently demonstrate our **Values**, our "PACT" to have **P**assion, **A**ccountability, **C**ompassion & **T**eamwork at the heart of all we do, everyday.

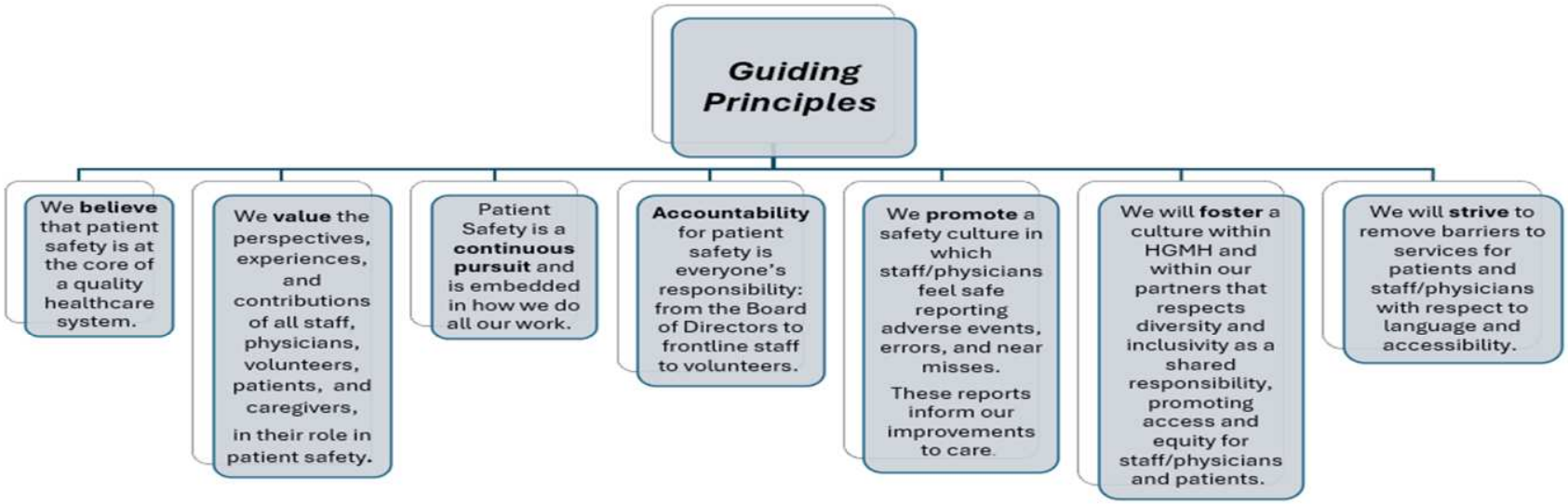
The intention of the Patient Quality and Safety Plan is to communicate and support our focus and commitment to providing safe, quality care while achieving optimal patient outcomes. It is designed to improve patient safety, reduce risk, and respect the dignity of our patients by assuring a safe environment.

Our Patient Quality and Safety Plan aligns with the **Ontario Health Quality model** that views quality through six dimensions*: safe, timely, effective, patient-centred, efficient, and equitable*.

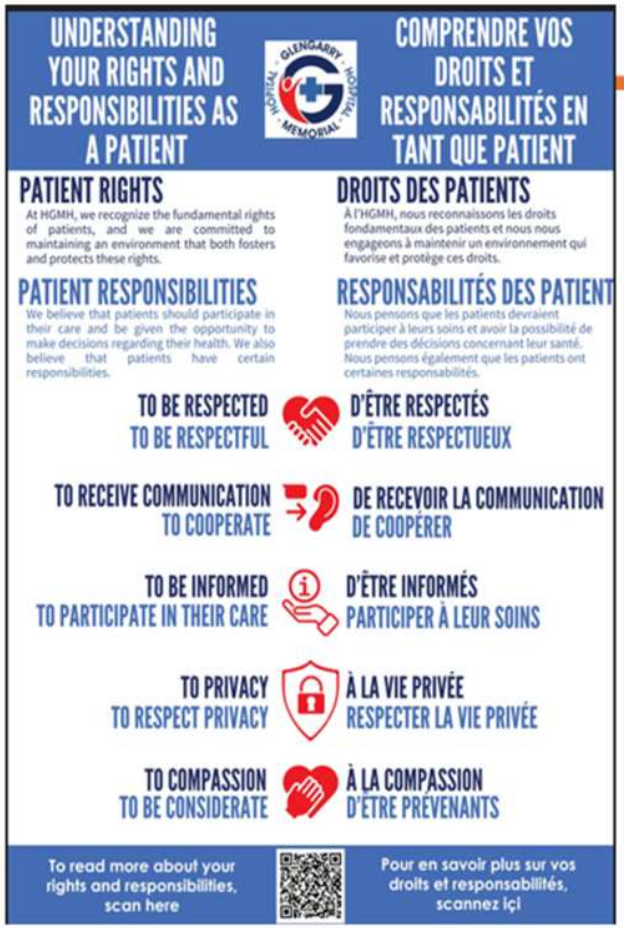


Patient Quality and Safety Plan Objectives

Patient Quality and Safety Plan Guiding Principles



Patient Rights and Responsibilities



Patient Rights

When you are in our hospital, we recognize the fundamental rights of patients and we are committed to maintaining an environment that both fosters and protects these rights.

Respect

- Every patient has the right to be treated with courtesy and dignity in a way that recognizes individuality and is free of prejudice.
- Accommodation in a safe and clean environment that is free from abuse.

Communication

- To have your condition, care, and treatment explained to you or to your substitute decision maker in simplified terms to the best of the health care provider's ability; and to participate in one's care plan in either official language.
- To be introduced to and informed of the professional status of individuals providing care and service.

To be informed

- To receive ongoing information concerning your diagnosis, treatment, and any known prognosis and to consent to service knowing the consequence of refusal.
- To receive information regarding available healthcare services and options when planning for admission, discharge, or transfer from the hospital

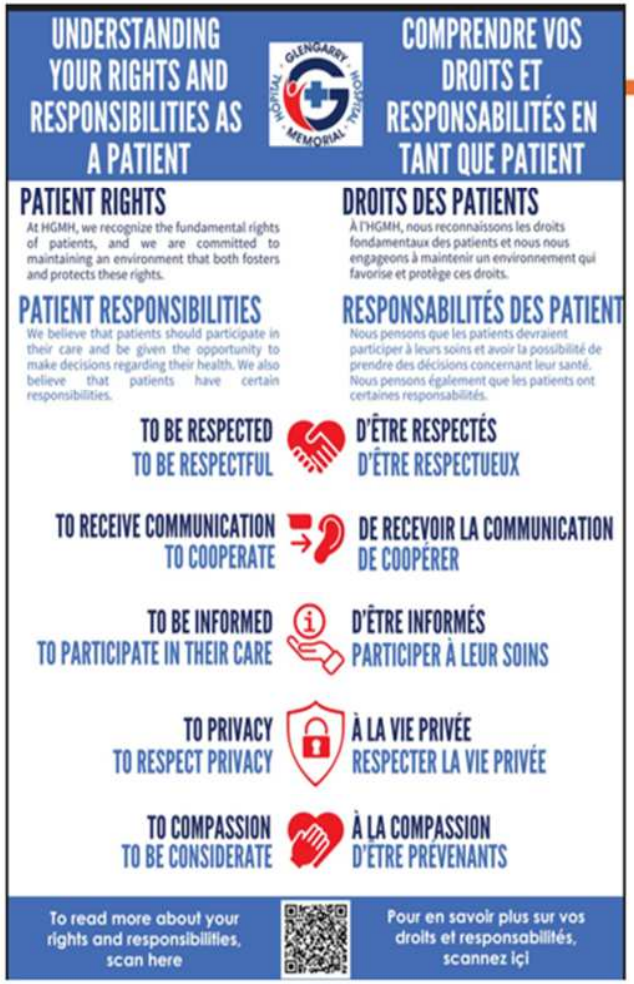
Privacy

- To have your personal health information kept private in accordance with the Privacy Act.
- To request that your admission to the hospital not be disclosed to certain individuals.

Compassion

- To have a parent, guardian, family member, essential care partner, or friend stay with you 24 hours per day in special circumstances.
- Pastoral and palliative care services

Patient Rights and Responsibilities



Patient responsibilities

Hôpital Glengarry Memorial Hospital believes that patients should participate in their treatments and be given the opportunity to make decisions regarding their health. We also believe that patients have certain responsibilities.

Respect

- Every person working, volunteering, visiting, or receiving services from HGMH has the right to be treated with courtesy, dignity and respect.

Consideration

- Be considerate and respectful of health care providers and other patients and families.
- Be considerate of other patients and respect their privacy.

Cooperation

- To provide accurate information about your past illnesses, previous hospitalizations, and medications and to report any unexpected changes in your condition.
- To follow the treatment plan as discussed and mutually agreed by you and your physician.
- To keep appointments or to contact the hospital when this is not possible.

Safety for Everyone

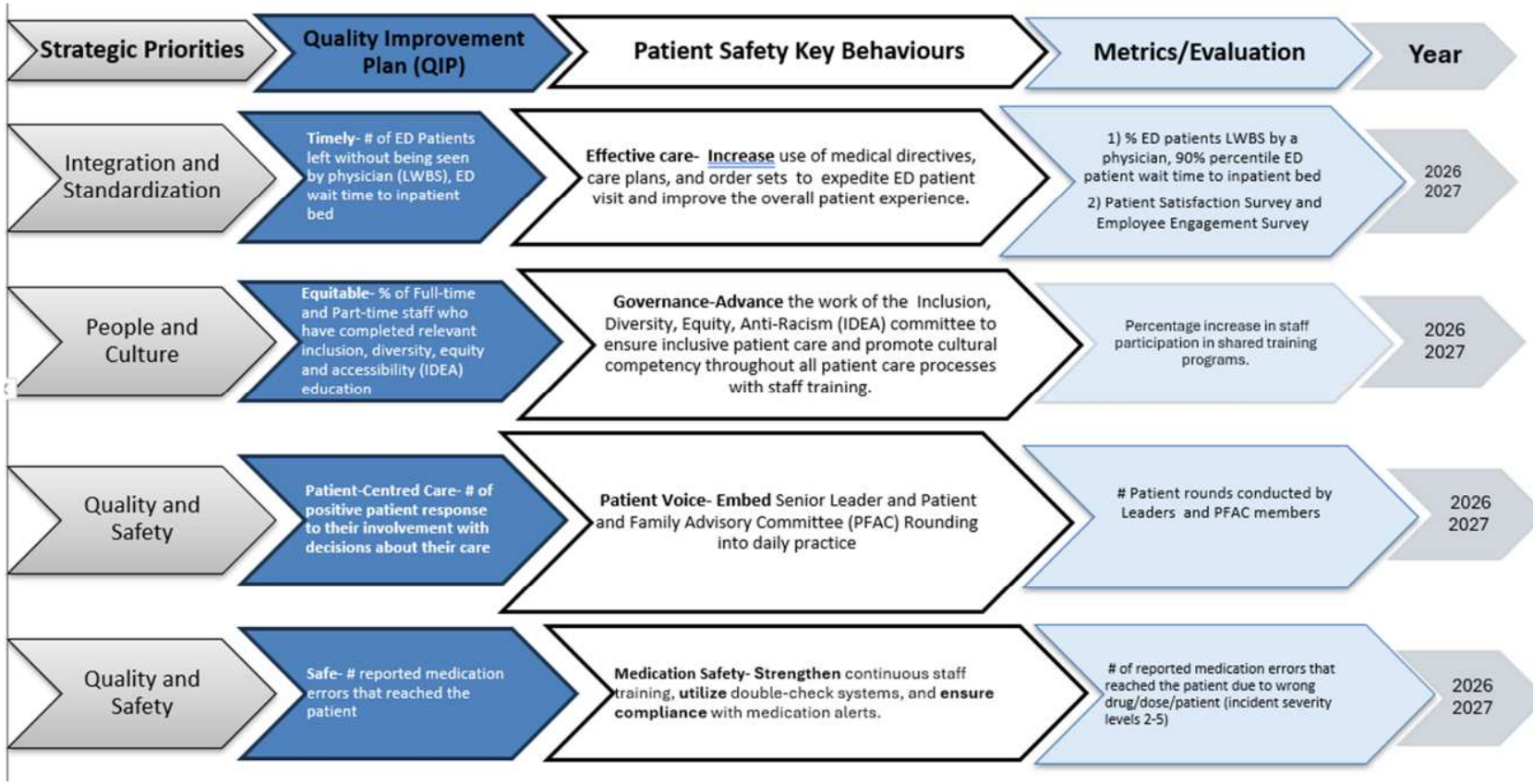
- To observe the hospital isolation and smoking restriction policies
- Follow instructions during emergency measures and outbreak of infections.
- Verbal and physical abuse will not be tolerated.

Participation

- To make appropriate and timely arrangements for leaving the hospital upon discharge by your physician.

Patient Quality and Safety Plan- Safety Behaviours for Improved Quality Care

This plan is in alignment with the Quality Improvement Plan and is updated annually to ensure continuous improvement of patient outcomes and quality of care.



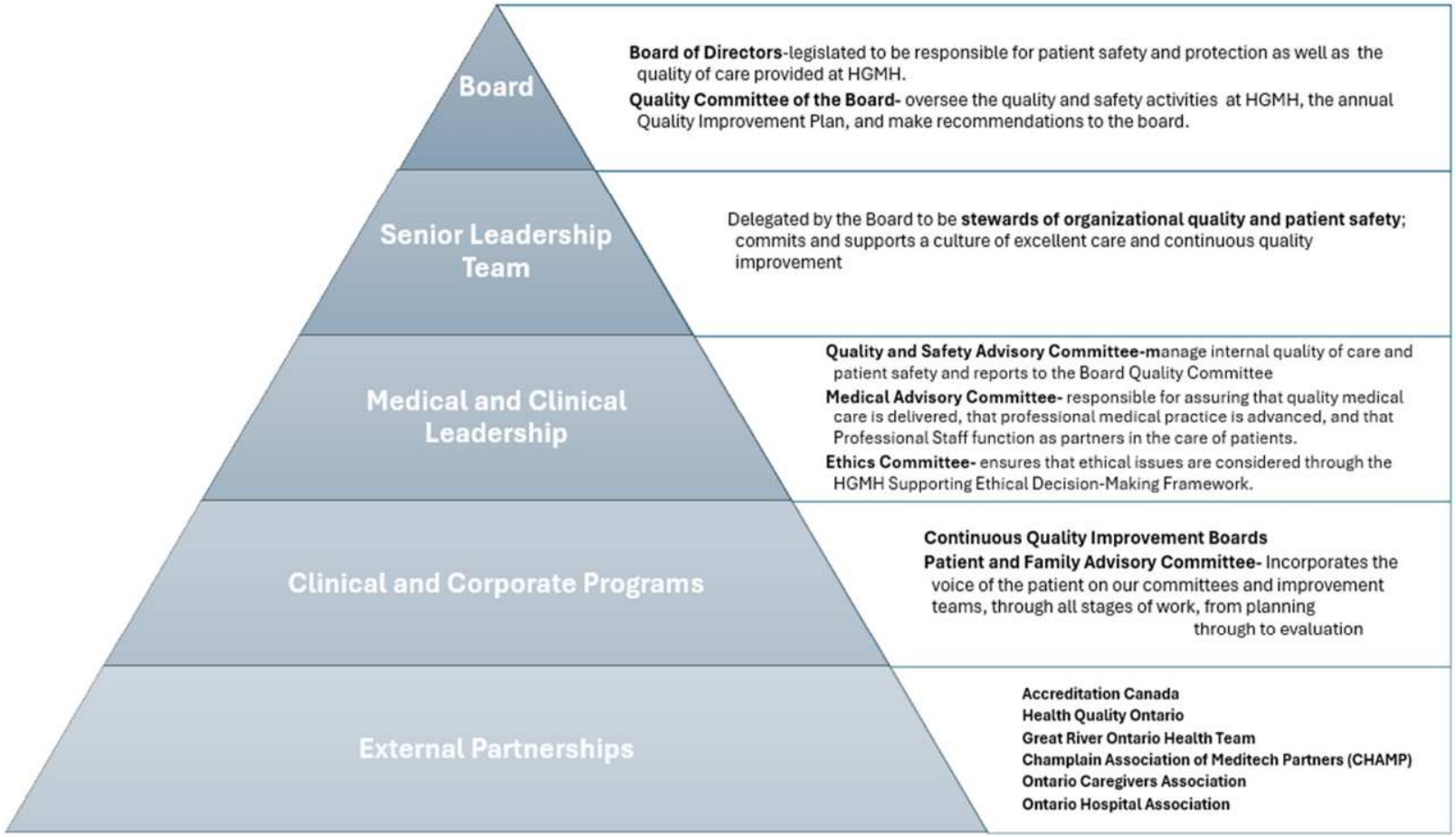
HGMH Patient Quality and Safety Program

HGMH is committed to providing the best possible care and ensuring patient safety through the integration of both internal and external systems and processes. Our Patient Quality and Safety Plan is designed to support and align with our Strategic Plan priorities, Quality Improvement Plan, Operating Plan, and ongoing quality and patient safety initiatives. It is guided by compliance with Accreditation Canada's Required Organizational Practices, while also recognizing the contributions of other professional regulatory authorities and accreditation bodies, such as the Institute for Quality Management in Healthcare (IQMH) for Laboratory Accreditation and the Ontario College of Pharmacists Accreditation Program.

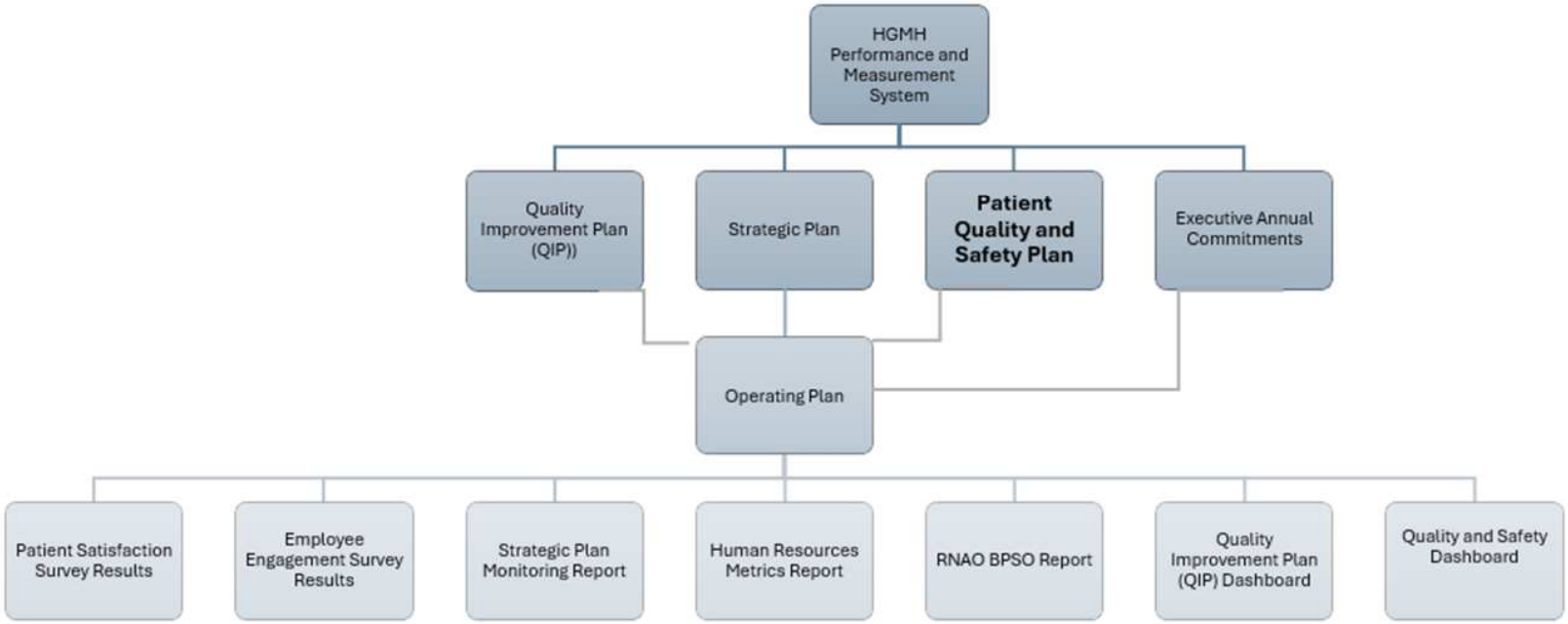
Ongoing Patient Safety Initiatives not limited to:

Safety Culture and Communication	Quality and Workforce Indicators	Risk and Safety Programs	Environmental Safety
• Huddles- Quality Boards • Discharge Rounds • Orientation • Monthly Safety Talks • Purposeful Hourly Rounding • Bedside Medication Verification • Clinical Education Support • Clinical Informaticist Support • Reporting of Adverse Drug Reactions and Medical Device Incidents under Vanessa's Law	• Hand Hygiene Compliance Audits • Medication Errors • Measures for Antibiotic Resistant Organisms and Healthcare Associated Infections • Blood Product Transfusion Reactions • Use of Restraints • Staff Retention and Workforce Stability • Workforce Efficiency and Resource Utilization	• Immunization Programs • Emergency Preparedness Program • Infection Prevention and Control Program • Preventative Maintenance Program • Occupational Health and Safety • Antimicrobial Stewardship Program • Accreditation Canada • Violence Prevention Program	• Departmental Inspections • Product Recalls • Product/Equipment malfunction • Drug Recalls • WHMIS Training for all Staff/ Physicians • Air Quality • Cyber Security

Governance Structure that Supports Patient Quality and Safety



HGMH Performance and Measurement System



HGMH Patient Quality and Safety Plan provides a framework for action in our quality care journey. We are committed to ongoing dialogue and co-creation of initiatives with patients and families. We are confident that the priorities and commitments identified provide clear direction and enhances our partnership with patients and their families to optimize quality and patient safety at HGMH.

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: February 10, 2026 Meeting Date Prepared for: February 18, 2026

Subject: Trillium Gift of Life Network (TGLN) Q2 results Update

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

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

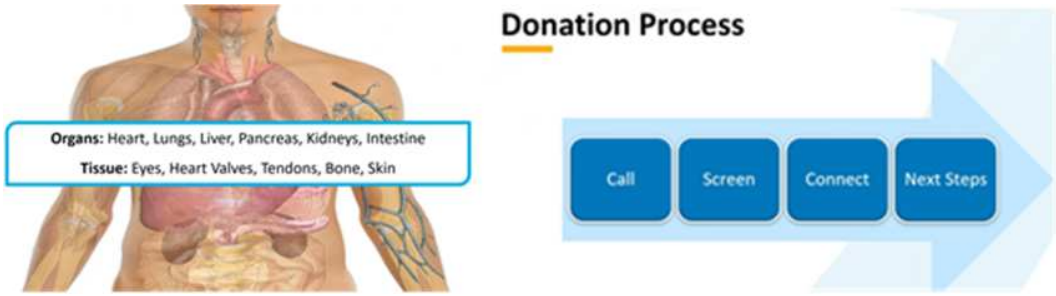
PURPOSE

- Provide an update on our TGLN program for Q2 2025-2026

SITUATION & BACKGROUND

A brief description of the background to the issue.

- Ontario Health (Trillium Gift of Life Network) is responsible for delivering and coordinating organ and tissue donation and coordinating transplantation services across the province.
- Currently Ontario Health (TGLN) works with over 90 hospitals (mandated and voluntary) through Routine Notification to ensure that deaths are screened for the potential to donate organs and/or tissue.



- HGMH is currently participating in voluntary notification/public reporting since October 2024.
- As a voluntary hospital, we are required to follow the **Gift of Life Act**.
- The **Gift of Life Act** requires hospitals to support organ and tissue donation by having appropriate policies, following routine notification practices, allowing Ontario Health (TGLN) to collect necessary patient and family information, and working collaboratively with TGLN to ensure proper consent procedures.
- Ontario Health (TGLN) publicly reports performance metrics for voluntary sites: Routine Notification rate. Data is obtained through the hospital mortality list submission.

IMPACT ANALYSIS/RISK ASSESSMENT/DECISION CRITERIA

- **Tissue Notification timeliness is 100% which is improved from Q1 rate of 67%.**
  - There was one tissue donor.
- **Area of opportunity**: **Routine Notification rate 88% which is below the target of 100%.**
  - **Strategy**: Reminder to staff that the goal is to notify TGLN of all patients 79 years of age and younger within one hour of death.

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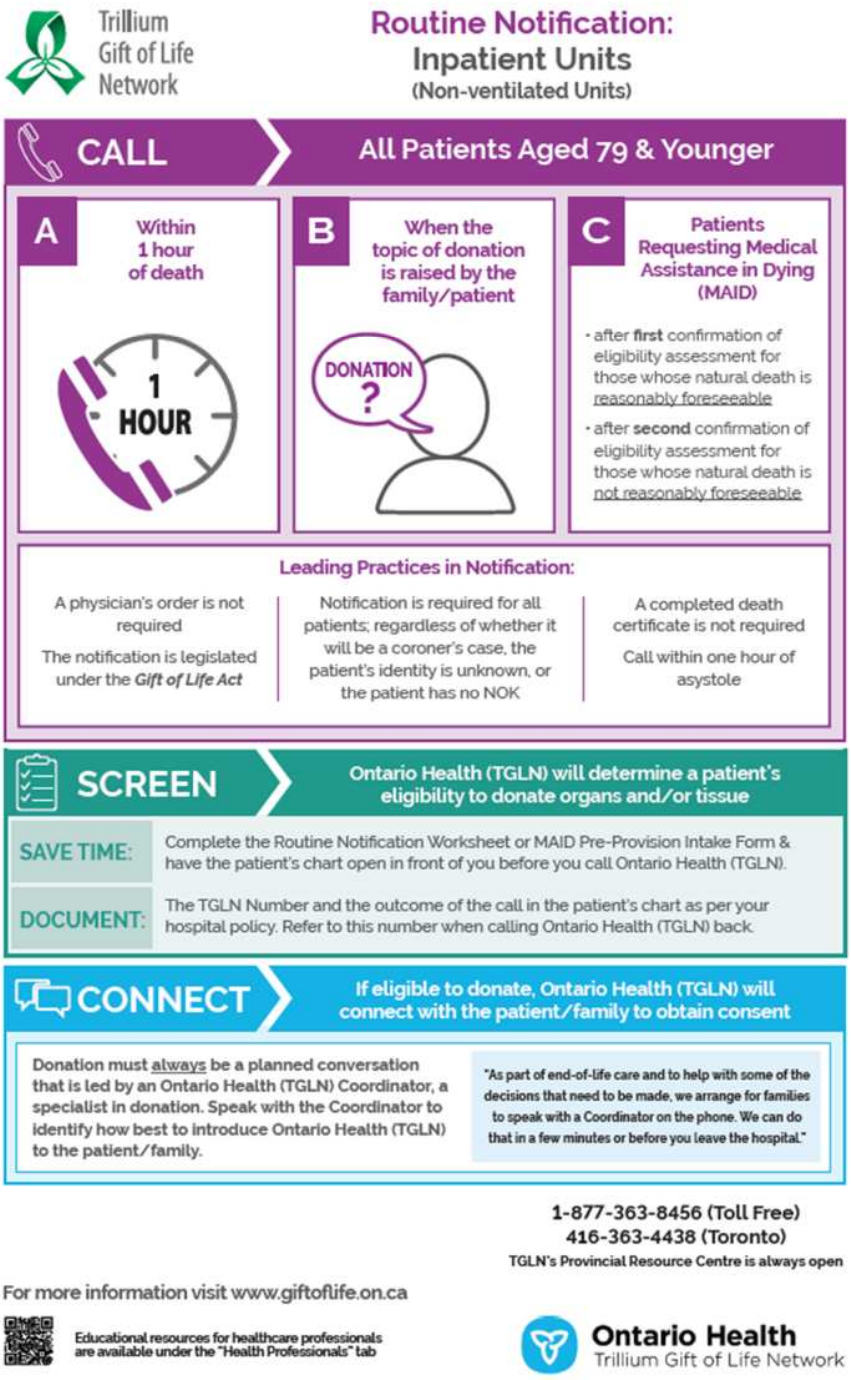
TGLN poster for Inpatient Department



DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: February 10, 2026 Meeting Date Prepared for: February 18, 2026

Subject: Accreditation Standard Feature

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

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

PURPOSE

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

STANDARD / CRITERIA FEATURED

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

Governance 3.5 The governing body ensures that the organization operates responsibly.

- **Priority:** High **Quality Dimension:** Safety
- 3.5.7 The governing body ensures that the organization protects the privacy and confidentiality of all stakeholder information.

Guidelines:

The governing body ensures that the organization's policies, procedures, and other protections related to privacy and confidentiality of information comply with relevant laws, regulations, and contractual obligations, including those related to the collection, use, storage, access, and disclosure of client, workforce, volunteer, and other stakeholder information. It also includes policies restricting client, workforce volunteer, and other stakeholders' use of personal information technology, the internet, and social media. The policies, procedures, and other protections should address both normal operations and emergencies and disasters, and the management of privacy incidents including breaches. The governing body ensures that it is kept informed by the organization about high-risk privacy issues like privacy breaches. The governing body ensures that the organization has measures to monitor the effectiveness of its privacy and confidentiality protections.

DISCUSSION QUESTIONS

- How would you respond to a surveyor asking you a question about this standard?
- What does the hospital already do to meet this standard?
    - Board-related policies
        - Hospital Email Usage for Board Directors policy (BOD.05.011)
        - Confidentiality for Board and Committee Members policy (BOD.05.005)
        - Responsibilities as a Director and Code of Conduct (BOD.05.007)
        - Social Media policy (COR.08.005)
        - Hospital AI Usage Policy (COR.10.006)

- Corporate Policies
  - Quality of Care Information Privacy Act (QCIPA) Policy
  - Privacy Inquiries and Complaints Policy
  - Privacy- Confidentiality and Disclosure of Patient Health Information to Law Enforcement
  - Privacy Breach Policy
  - Patient Relations
  - Use and Disclosure of Health Information
  - Disclosure of Patient Harm
  - Code of Conduct