Board of Directors Meeting Agenda

Date: Thursday, February 26, 2026
Time: 5:00pm – 8:00pm
Location: Boardroom / Microsoft Teams

Time	Agenda Item	Attachment
5:00	**1. Call to Order (Dr. S. Robertson)**	
(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 (Policy BOD.05.003.X.XX)	
5:04	**2. Minutes (Dr. S. Robertson)**	
(1 min)	2.1 Approval of previous meeting minutes – January 29, 2026	P. 3-7
(1 min)	2.2 Business arising from minutes	
5:06	**3. Education**	
(15 min)	3.1 Open Wide Initiative (L. Hume)	
5:21	**4. Matters for Discussion/Decision**	
(5 min)	4.1 Report of the Board Chair (Dr. S. Robertson)	
(5 min)	4.2 Report of the President & CEO (R. Alldred-Hughes)	P. 8-12
(5 min)	4.3 Report of the Chief of Staff (Dr. L. MacKinnon)	P. 13
(5 min)	4.4 Report of the VP of Corporate Services & CFO (L. Ramsay)	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 Review 2025-2026 QIP for Q3 (H. Salib / R. Romany) **That the Board of Directors review and receive the 2025-2026 Quality Improvement Plan for Q3 as presented.**	P. 16-19
(5 min)	4.8 Review Q3 Patient Satisfaction Survey Results (H. Salib / R. Romany) **THAT the Board of Directors review and receive the Patient Satisfaction Survey Results for Q3 as presented.**	P. 20-24
(5 min)	4.9 Report of the Chair or Finance, HR and Audit Committee (C. Nagy)	
(5 min)	4.10 Financial Statements – November and December 2025 (C. Nagy / L. Ramsay) **THAT the Board of Directors review and receive the financial statements for November and December 2025 as presented.**	P. 25-30
(5 min)	4.11 Parking Increase (C. Nagy / L. Ramsay) **That the Board of Directors approve that parking rates for the public increase by 20% (from the daily rate of $ 5.00 to $ 6.00) effective April 1, 2026.**	P. 31-33
(5 min)	4.12 Review Draft Budget 2026-2027 (C. Nagy / L. Ramsay) **THAT the Board of Directors approve the draft budget for 2026-2027 as presented.**	P. 34-38
	5. Consent Agenda (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. 39-42
	5.2 Medical Student/Resident Placement Report	P. 43-44
	5.3 Q3 Quality & Safety Scorecard	P. 45-47
	5.4 BPSO Updates	P. 48
	5.5 Patient Safety Plan Review	P. 49-59
	5.6 Trillium Gift of Life Report	P. 60-61
	5.7 Draft Finance, HR & Audit Committee Report	P. 62-65
	5.8 Q3 HR Metrics Report	P. 66-68
	5.9 Review Strategic HR Plan	P. 69-82
	5.10 New Borrowing Policy	P. 83-86
	5.11 Electrical Service Capacity and Upgrade Strategy	P. 87-89
	5.12 Epic Project Updates **THAT the Board of Directors approve and receive all documents as presented in the consent agenda.**	P. 90-92
	6. Correspondence (Dr. S. Robertson)	P. 93
	7. Date of Next Meeting – Thursday, March 26, 2026 5:00pm	
	8. Closing Remarks & Adjournment (Dr. S. Robertson)	

**Meeting Moves to In Camera*

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.

Centre de bioéthique Champlain Centre for Health Care Ethics

HÔPITAL Glengarry Memorial HOSPITAL

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS

Date	Thursday, January 29, 2026
Time	5:00pm-8:00pm
Location	Boardroom / Microsoft Teams

Present:	Dr. S. Robertson, Chair	L. Boyling, Vice-Chair (v)	C. Nagy, Treasurer
	D. Elie	C. Larocque	G. Peters (v)
	Dr. R. Cardinal	F. Desjardins	Dr. G. Raby
	G. McDonald	R. Alldred-Hughes, CEO	R. Romany, CNE
	J. Shackleton, PFAC	K. MacGillivray, CHRO	L. Ramsay, CFO
	Dr. L. MacKinnon, COS		
Regrets:	Dr. D. Peffer	H. Salib	

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: C. Larocque
Seconded By: C. Nagy
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 November 27, 2025, were shared.

Moved By: C. Larocque
Seconded By: C. Nagy
THAT the minutes of the November 27, 2025 meeting be approved as presented.

CARRIED

2.2 Business Arising from the Minutes

Nothing to bring forward.

3 **Education**

3.1 Ethics Framework

A. Ladak, Champlain Centre for Health Care Ethics regional ethicist, and ethics fellow were introduced.

A. Ladak presented on Health Care Ethics, speaking about why we have ethics services and provided some data on regional consultation issues.

4 Matters for Discussion/Decision

4.1 Report of the Board Chair

An employee appreciation breakfast is taking place on March 6th from 6am-9am and Directors were asked to help serve is possible.

The new CEO was appointed for Maxville Manor.

Accreditation is coming up from February 9-12 whereas two surveyors will be on site. Directors will be asking questions during a group session where everyone will work together to answer questions. There is a document on the Board Portal with all of the standards which a great reference tool in preparation for Accreditation.

4.2 Report of the President & CEO

R. Alldred-Hughes sent an email to Board Directors today containing a document on the priority processes for Accreditation.

News was received before the holidays about an upcoming increase to our base funding which will be ongoing. This addresses this year's financial risk.

CT planning continues and an electrical study is to be done for the hospital to ensure capacity for the ct scanner, but also for the rest of the electrical capacity of the hospital. This is costly and work is being done to get funding for this. We were able to join an RFP of a hospital who just went through this process.

A celebration took place for our first cohort of LEADS graduates, and the call went out for applications for the second cohort.

Work continues on capital redevelopment in which we are still waiting on Ontario Health's letter of support. They have come back with a series of questions which have been answered.

Lots of wellness initiatives have been taking place including a puppy palooza where puppies were on site for staff to enjoy.

4.3 Report of the Chief of Staff

Recruitment remains ongoing with some physicians having sent in applications for credentialing.

We also have a number of medical learners and residents who have been doing placements at the hospital. There are currently two residents who are graduating shortly and could potentially be interested in working here.

The core shifts for the emergency department are all covered until end of April.

The influenza season was very heavy this year with a high census in the hospital and both the medical and clinical teams came together to ensure proper coverage in the departments.

ED P4R work continues with case reviews being done to see why patients are returning to the Emergency Department. Common themes are being reviewed and will be reviewed by the Quality & Safety Advisory committee to identify where the focus needs to be.

4.4 Report of the VP of Clinical Services, Quality & CNE
On December 10th, a wound care education day was held for staff and was well attended.

Audits are done within the hospital on hand hygiene and PPE by audit champions.

R. Romany updated on a course she is taking on artificial intelligence. This does not mean that the hospital is embarking in AI. R. Romany is to submit an AI transformation project which she agreed to also present to the board.

4.5 Report of the Patient and Family Advisory Committee
There is a session during Accreditation for PFAC in which they are well prepared for.

J. Shackleton reported that she was part of SLT rounding for the first time in which the responses were very positive.

4.6 Report of the Chair of Quality & Patient Safety Committee
In H. Salib's absence, G. Peters reported on work done at the last committee meeting. An education session was also received on the quality improvement plan.

4.7 Professional Staff Reappointment
The list of professional staff looking for reappointment was shared.

Moved By: Dr. R. Cardinal
Seconded By: C. Larocque
THAT the Board of Directors approve the reappointment of the Professional Staff for 2026 as presented.

Since this list was submitted, there has been update that Dr. DeYoung is looking for reappointment and follow up is still being done with Dr. El Kurbo. These will be brought forward following recommendation from MAC.

CARRIED

4.8 Accreditation Updates
Lots of preparation is being done for Accreditation. Leaders have been going around with snack carts and speaking with staff to prepare them for the survey. We also had a mock tracer done to help tighten up anything that may be missing for Accreditation. R. Alldred-Hughes thanked the core team leads as well as J. Mattice for the work done on Accreditation. A reminder to staff is being shared that it's ok not to know all of the answers, so long as they know where to get the information. A debrief will take place following the accreditation survey where lessons learned will be discussed so we can better ready ourselves for the next survey.

4.9 Report of the Chair of Governance & Nominating Committee
The committee proposed amendments to the Corporate Bylaws to include the PFAC Chair as an ad hoc non-voting member.

Changes were also proposed to the committee effectiveness survey in which alignment was made to the multiple-choice answers.

Strategic actions were reviewed which are moving in the positive direction.

4.10 Revised Corporate Bylaws

The proposed amendments to the Corporate Bylaws were shared.

Moved By: C. Larocque
Seconded By: Dr. G. Raby
THAT the Board of Directors recommend the amendment to the Corporate Bylaws at the Annual General Meeting.

Discussion ensued around whether the PFAC Chair would be appointed by the Board such as the CEO and COS are appointed, however the CNE is not appointed, and it was agreed that this would be the case for the PFAC Chair. This is based on the role and all PFAC members go through an application process. If there were performance concerns, they would be addressed from the CEO and the CNE.

CARRIED

4.11 Review Committee Effectiveness Survey Questions

The revised committee effectiveness survey questions were shared.

Moved By: C. Nagy
Seconded By: F. Desjardins
THAT the Board of Directors approve the Committee Effectiveness Survey questions as presented.

CARRIED

4.12 Review Q3 Strategic Actions

The Q3 strategic actions were shared.

Moved By: G. McDonald
Seconded By: Dr. R. Cardinal
THAT the Board of Directors review and receive the Q3 Strategic Actions as presented.

The Finance, HR & Audit committee will be providing oversight on the CT Scan project.

CARRIED

4.13 Report of the Chair of French Language Services

The main purpose of the meeting was to review the summary of the Annual French Language Report to the Ministry.

The hospital has a translation service which is very rarely used for French which means that the hospital is doing well with their HR plan in hiring bilingual staff members. The statistics presented are for the prior year.

The designation of French Language Services will help the hospital positively in the HSSP application.

4.14 Summary of the Annual French Language Report to the Ministry

The summary of the Annual French Language Report to the Ministry was shared.

Moved By: C. Larocque
Seconded By: F. Desjardins
That the Board of Directors review and receive the Summary of the Annual French Language Report to the Ministry as presented.

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 Professional Staff Appointment and Reappointment Process
5.3 Status of Patient Safety Plan Actions
5.4 Complaints and Compliments Report
5.5 Draft Governance & Nominating Committee Report
5.6 Succession Planning Overview
5.7 Board Member Attendance
5.8 IDEA Update
5.9 Draft French Language Services Committee Report
5.10 French Language HR Plan 2024-2025

Moved By: D. Elie
Seconded By: D. G. Raby
THAT the Board of Directors approve and receive all documents as presented in the consent agenda.

CARRIED

6 **Correspondence**

Correspondence was included in the meeting package.

Discussion ensued around the pool in which an article was shared in the news about the Township not being profitable with running community programming. The hospital runs 2-3 hydrotherapy classes per week with 4-5 patients in the pool as part of our rehab program.

7 **Date of Next Meeting**

Thursday, February 26, 2026, at 5:00pm

Meeting adjourned at 6:28pm

K-L. Massia, Recording Secretary

Report of the President & CEO

February 26, 2026 Board of Directors

Accreditation 2026

The Accreditation Canada survey was successfully completed last week, and we have now received the onsite report. Final results and our accreditation standing will be communicated in the coming months. The surveyors spent considerable time across the organization meeting with staff, physicians, volunteers, patients, partners, and Board members, and observing care and operations throughout the hospital. Their feedback reflected a strong, patient-centred culture, a committed and engaged workforce, and clear alignment with our strategic priorities in quality, safety, and integration.

I want to acknowledge how well the organization showed up throughout the process. From governance to the front line, there was a consistent demonstration of professionalism, transparency, and pride in the work being done every day. The preparation and participation of staff and leaders were exceptional, and the Board's engagement and readiness were noted and appreciated. While we will continue to review the onsite report in detail and act on opportunities for improvement, I am extremely proud of the team and the way the hospital represented itself and our community during the survey.

OHA Advocacy Information

Ontario's hospitals continue to face significant financial and operational pressures, a reality reinforced through the Ministry of Finance's recent pre-budget consultations. Sector leaders highlighted ongoing structural challenges, including rising costs, persistent deficits, erosion of working capital, and funding models that have not kept pace with current demand. While recent provincial investments have provided some relief, they have not yet created the level of stability or predictability required for long-term planning across the hospital system.

In this context, the OHA has advanced recommendations focused on addressing structural funding gaps and enabling more predictable, multi-year planning assumptions for hospitals. The association is also supporting members with resources to navigate the Hospital Sector Stabilization Plan and the upcoming Service Accountability Agreement process. I will include the OHA's formal release for the Board's information.

Hospital Governance Survey Results – Ontario Hospital Association & Ministry of Health

In August 2025, the Ontario Hospital Association, in partnership with the Ministry of Health's Health Sector Governance and Oversight Office, released a sector-wide survey examining hospital governance practices. Hôpital Glengarry Memorial Hospital participated in the survey, with input from our Board Chair and Vice Chair. The survey, aligned with the OHA's Guide to Good Governance, saw strong participation across the province, with 113 of 135 hospitals responding. Results demonstrated strong overall alignment with governance best practices, including structured recruitment, ongoing governance education, active oversight of quality, credentialing and strategy, and a continued commitment to board development and performance evaluation. Opportunities were also identified to further support boards in areas such as financial literacy, cybersecurity, artificial intelligence, and regional collaboration among board chairs.

Building on this work, the Ministry of Health is establishing a Hospital Governance Advisory Table, expected to launch in February 2026, which will bring together governance and management representatives alongside patient voices to inform future best practices. The OHA is also developing additional educational resources to

support boards in navigating an increasingly complex financial environment, with a focus on financial stewardship and oversight. These resources are anticipated to be available in Spring 2026.

Great River Ontario Health Team (GROHT) Update

The Great River Ontario Health Team continues to advance several priorities that support more integrated, patient-centred care across the region. Current work includes strengthening pathways to attach patients to primary care providers, expanding caregiver-inclusive practices to improve transitions and outcomes, and advancing regional health human resources initiatives, including coordinated recruitment efforts. The OHT is also enhancing its governance with broader representation from primary care, Indigenous partners, long-term care, and community and social services to ensure planning reflects the needs of the populations we serve.

In addition, there is continued progress in advancing equity and culturally appropriate care through initiatives supporting Francophone services, Indigenous engagement, and trauma-informed approaches, alongside new tools that elevate lived experience to inform system design and improvement. GROHT partners are also leveraging provincial performance and population health resources to strengthen integration and shared accountability across the region. This work remains important in ensuring coordinated access, improved patient and caregiver experience, and sustainable care models for our communities.

Site visit & advocacy at UOHI

I recently participated in a site visit to the University of Ottawa Heart Institute (UOHI), where I met with Dr. Rob Beanlands and his senior leadership team, alongside Fred Beauchemin, CEO of Hawkesbury, and MPP Stéphane Sarrazin. The visit focused on reinforcing the vital role the Institute plays in supporting patients from our communities and across the region, and the importance of continued collaboration to ensure timely access to specialized cardiac care close to home. We also had the opportunity to tour the facility, which provided a valuable, firsthand look at the exceptional clinical work underway and the impact it has on patients and families across Eastern Ontario.

Safety Star – Kaitlin MacLeod

I would like to recognize Kaitlin MacLeod RPN, as the recipient of our Q3 Safety Star. This recognition reflects her proactive approach to patient safety and her commitment to contributing to a culture where learning, accountability, and teamwork are at the forefront of how we provide care.
During routine wound care, Kaitlin identified a concern related to skin health and raised it with the team, helping to reinforce safer practices and strengthen the quality of care provided to patients. Her actions are a strong reminder of the impact that attentiveness and speaking up can have in preventing harm and supporting a safe care environment.

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:

- *Lyne Martineau – Executive Director of Centre de santé communautaire de l'Estrie*
- *UOHI Site visit – Dr. Rob Beanlands CEO of UOHI, Fred Beauchemin, CEO of Hawkesbury, and MPP Stéphane Sarrazin.*

Upcoming Events/Special Dates

February is Black History Month
February 20 – National Caregivers Day
February 25 – Pink Shirt Day
March 6 – Employee Appreciation Breakfast

Ontario Hospital Association

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MEDIA RELEASE

Ontario Hospitals Face Tough Choices as Economic and Financial Pressures Increase

January 16, 2026, Toronto, ON – At today's 2026/27 Pre-Budget Consultations, held by the Ministry of Finance in North York, Ontario Hospital Association (OHA) President and CEO Anthony Dale outlined the growing pressures facing the hospital sector and the need for stable, multi-year funding that will help hospitals plan as effectively as possible through the challenging years that lie ahead.

"As the voice of the province's public hospitals, the OHA is committed to working with government to ensure that the people of Ontario continue to have access to high-quality patient care," Dale said. "Ontario's hospitals support the government's ongoing investments in the health system. Investments in home care, primary care and long-term care help ensure that more people can receive the health and social services they need in settings that are more appropriate than hospitals."

Dale also recognized the extraordinary challenges ahead of the province, as the ongoing trade war with the United States threatens Ontario's future prosperity and the affordability of all public services.

"Unfortunately, many hospitals are also grappling with significant challenges. Many are projecting year-end deficits, have eroded their working capital, and in the absence of certainty about their revenues, cannot properly plan for the future," he said. "Costs for the sector have been rising by about 6% per year, primarily due to Ontario's growing population, its aging population and inflation, in general. In recent years, the sector has received annual increases of approximately 4%, leaving the sector with a persistent and deepening structural deficit of approximately $1 billion."

He added that long-standing issues such as unfunded beds and outdated funding rates have pushed hospitals into structural deficits that efficiencies cannot resolve. "Through the Hospital Sector Stabilization Plan (HSSP), hospitals have identified some initial clinical, operational and administrative cost savings and cost avoidance measures," Dale said. "Unfortunately, these measures alone won't address system pressures."

Hospitals are preparing for difficult decisions over the course of the next few years. Ontario hospitals are already the most efficient in Canada. The HSSP exercise proves that further significant cost-saving measures would likely include program consolidation with service impacts, closure of non-core inpatient services, and spending reductions in core inpatient services.

"There are no easy choices ahead," Dale said. Hospitals will also need to prioritize, make trade-off decisions, and above all, take action to operate with the more limited resources that are available.

Dale reaffirmed the OHA and its members' commitment to providing strong leadership and to continuing to work with the government to reduce the rate of cost growth in the hospital sector. "Hospitals need predictable, multi-year financial planning assumptions for the next three fiscal years in order to properly plan for the future and serve their communities despite the wider uncertainty," he said. "Hospitals are committed to doing everything possible to safeguard access to care."

Health care, anchored by hospitals, is foundational to a stronger competitive economy. And even under strain, hospitals continue to lead change and pursue innovation. Into the future, artificial intelligence, gene therapy, personalized medicine, and the emergent hospital-at-home model hold enormous promise. Ontario's hospitals and their partners are working hard to unlock the potential of the future – but it will also take time.

-30-

Ontario Hospital Association

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MEDIA RELEASE

Ontario Hospital Association
Established in 1924, the OHA serves as the voice of the province's public hospitals, supporting them through advocacy, knowledge translation and member engagement, labour relations, and data and analytics with the goal of helping hospitals build a better health system. The OHA is also attuned to the broader strategic questions facing the future of the province's health care system and we work to ensure Ontario's hospitals have a voice in shaping this longer-term vision.

For more information, please contact:

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Report of the Chief of Staff

February 2026

Physician Recruitment Update

Recruitment objectives remain unchanged:

- 1–2 part-time Emergency Department physicians to provide approximately 5–6 shifts per month, including vacation coverage.
- 1–2 part-time Inpatient physicians to ensure consistent coverage for Medicine and Rehabilitation services during vacation periods.

Expressions of Interest

- A physician with 19 years of Emergency Department experience has commenced the application process and is currently awaiting several required documents to finalize her submission.
- A second-year medical resident, Alexa Schryver that is currently completing a one-month elective with us, has verbally expressed interest in joining our hospital following graduation this summer. She intends to establish a family practice while also providing inpatient and Emergency Department services.

Scheduling Update

The *Emergency Department* schedule is covered through the end of May, with a few second-physician and back-up physician shifts remaining. These are often filled closer to the date as physician availability adjusts.

The *Inpatient Unit* remains fully covered through June 2026, and the July-September schedule is currently in progress.

Medical Learners

- We continue to receive positive feedback from and regarding the third-year medical student from Queen's University, Sara Marshall. She has been enthusiastic and a pleasure to work with.
- We are currently exploring options to accommodate two additional third-year medical students from Queen's University for Emergency Department experience. The primary challenge is scheduling, as they require two consecutive weeks each to facilitate securing accommodations.

Report of the VP of Corporate Services and CFO

February 26, 2026 Board Meeting

Facilities

Air balancing

The HVAC units servicing the Emergency department, Endoscopy suite and Medical Device Reprocessing (MDR) area underwent testing and balancing. This process measures, adjusts, and balances air and hydronic systems to ensure they operate according to design specifications. These areas have had some issues in the past and this was the first step in identifying the underlying cause.

New flooring

New flooring has been installed from the fire door at the laboratory through the hallway to the fire door near the Business Office. This includes the EMS entrance and both waiting room areas.

Flooring installation for Emergency Department and clinic areas is scheduled for April. During this period, the ER will temporarily relocate to the Endoscopy/OR area. This project is expected to take approximately one month.

Deluge shower in the MDR area

To ensure compliance with CSA and accreditation standards, an emergency drench (deluge) shower will be installed in the MDR area. This will allow for immediate decontamination in the event of exposure to harmful substances.

Dietary

Menu review

The comprehensive review of patient menus, which began in the fall, has been completed. Menus have been modified to balance food quality and patient satisfaction while achieving a cost reduction of approximately 30 % and 40 %.

Information Technology

Infrastructure improvements

The new dedicated backup server included in this year's capital plan has been purchased and deployed. Backups no longer impact our core systems, and recovery times have been significantly improved.

Both server room air conditioning units have been replaced and new temperature monitoring systems have been installed. These systems provide 24/7 alerts to IT personnel to ensure critical systems remain within safe operating temperatures.

EPIC preparation

All EPIC hardware purchased are currently being configured and rollout is underway. A new deployment server is operational, significantly reducing workstation setup for the EPIC implementation. Network mapping is also in progress to support re-IPing of infrastructure and ensure a smooth go-live.

Cyber security

A new phishing awareness and training campaign has been launched.

Finance

Quadrant Self Serve (QSS) and Time and Attendance (T & A)
QSS is now fully operational, and payroll processes are fully paperless. Key benefits include online access to paystubs, reduced administrative overhead, electronic vacation requests electronically and direct access to T4s through the portal.

Employees are now using the LGI application to manage schedules and receive notifications for available shifts. This enables the production of more detailed and comprehensive scheduling reports.

Health Information Services (HIS)

EPIC Conversion Validation
HIS is actively engaged in EPIC conversion validation activities to ensure the accuracy, completeness and integrity of data migrated from Meditech. Validation efforts focus on patient data, historical encounters, scans and notes. This work is essential to maintaining continuity of care, supporting clinical decision-making, and meeting regulatory and medico-legal requirements.

EPIC Working Group Participation
HIS staff continue to participate in EPCI attending group meetings. Through this participation, HIS provides input on documentation standards, information governance, workflow design, and privacy considerations. Early involvement ensures health information requirements are incorporated into system build decisions and supports alignment across clinical, operational and technical teams.

Enhanced Privacy Audits
HIS has strengthened its privacy audit program to reflect evolving privacy risks and regulatory expectations. Enhanced audits include targeted and proactive reviews of access to personal health information. Audit findings are reviewed, investigated, and addressed in collaboration with leadership and managers. These efforts reinforce accountability, support compliance with privacy legislation and promote a culture of privacy awareness across the organization.

ERP Strategy

Following the decision to transition the Electronic Health Record from Meditech (CHAMP) to EPIC (Atlas), QCH recognized that CHAMP partner organizations will likely need to consider an ERP solution in the coming years. This is due to Meditech financial modules (General Ledger, Accounts Receivable, Accounts Payables, Materials Management and Pharmacy Inventory) remaining in place post-EPIC go-live.

While the Ottawa Hospital continues to advance its own regional ERP business case, HGMH is closely monitoring both initiatives.

CFO meetings

Virtual meetings continue with the Atlas Alliance CFO group and the CHAMP Finance Sub-Committee. Additional participation includes meeting the OH Est Hospital CFOs, Champlain CFOs, the OHA Financial Leaders Network and the EORLA Pricing and Budgeting Committee.

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: February 5, 2026 Meeting Date Prepared for: February 18, 2026 – Quality
February 26, 2026 - Board

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

RECOMMENDATION AT QUALITY

That the Quality & Patient Safety Committee review and receive the 2025-2026 Quality Improvement Plan for Q3 as presented.
Moved By: D. Elie
Seconded By: G. Peters

CARRIED

RECOMMENDATION TO THE BOARD

That the Board of Directors review and receive the 2025-2026 Quality Improvement Plan for Q3 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.

- 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.

HÔPITAL Glengarry Memorial HOSPITAL

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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 – ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: Feb 5, 2026 Meeting Date Prepared for: February 18, 2026 – Quality February 26, 2026 - Board

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.

RECOMMENDATION AT QUALITY

THAT the Quality & Patient Safety Committee review and receive the Patient Satisfaction Survey Results for Q3 as presented.
Moved By: Dr. S. Robertson
Seconded By: G. Peters

CARRIED

RECOMMENDATION TO THE BOARD

THAT the Quality & Patient Safety Committee review and receive the Patient Satisfaction Survey Results for Q3 as presented.

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

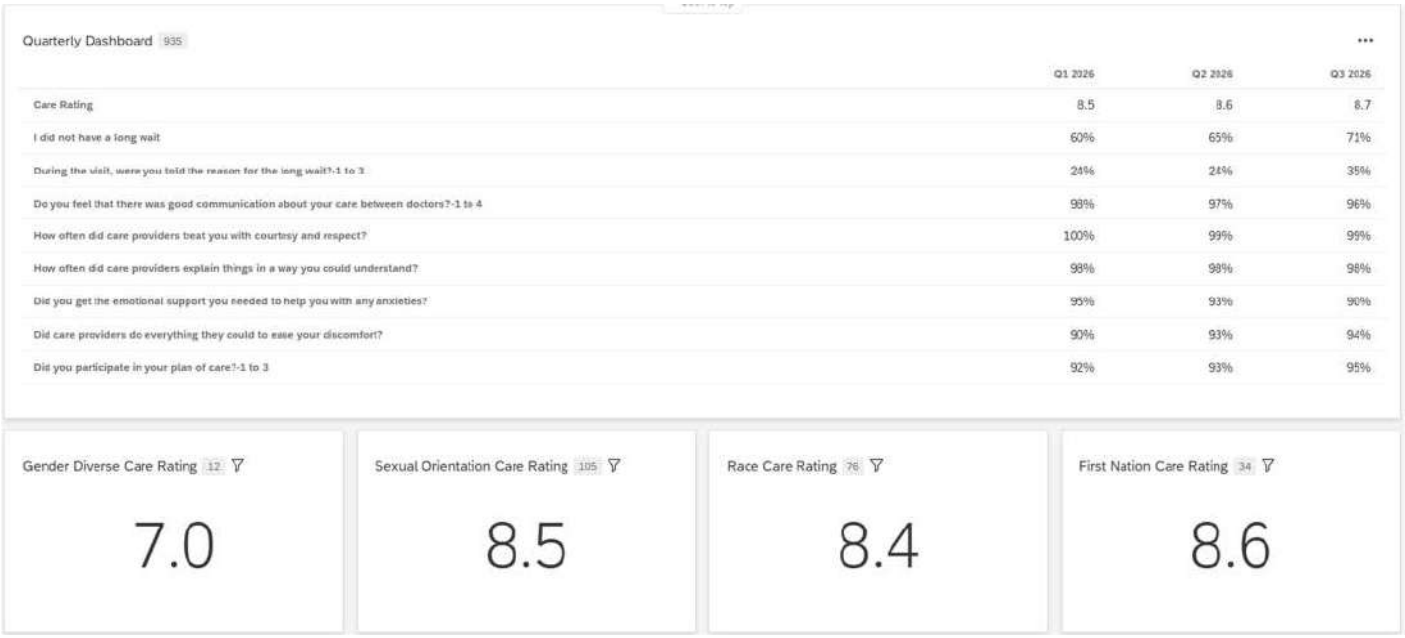
ANALYSIS

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.

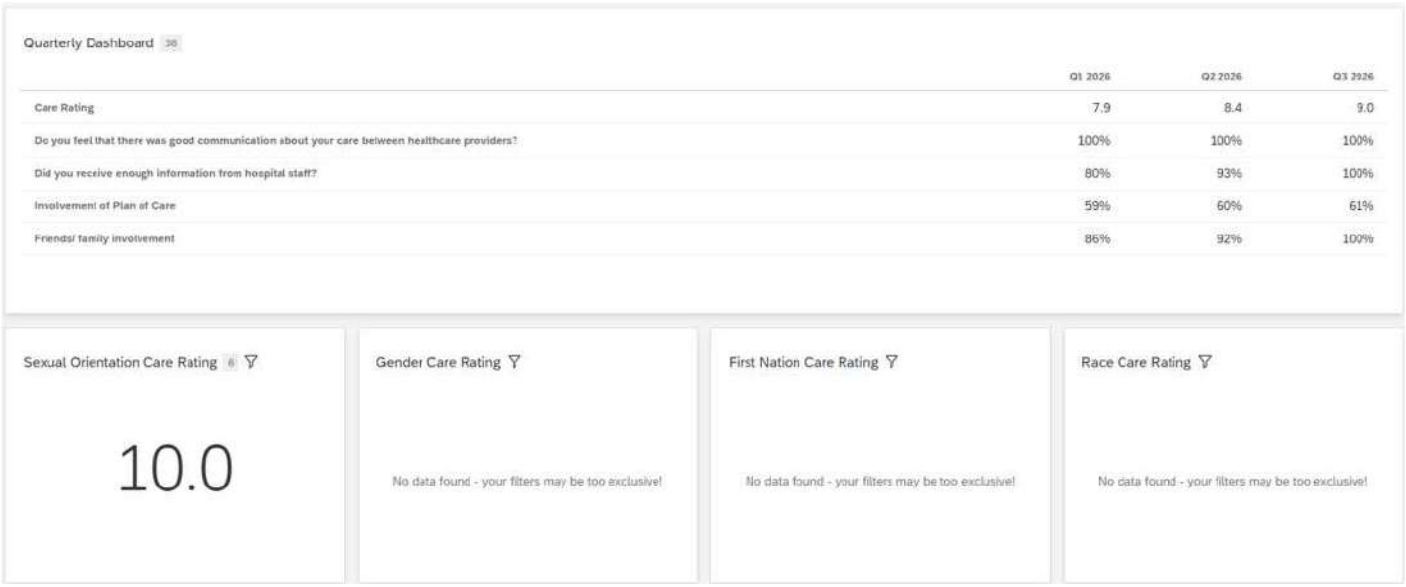
Top Satisfaction Indicators:

- 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.

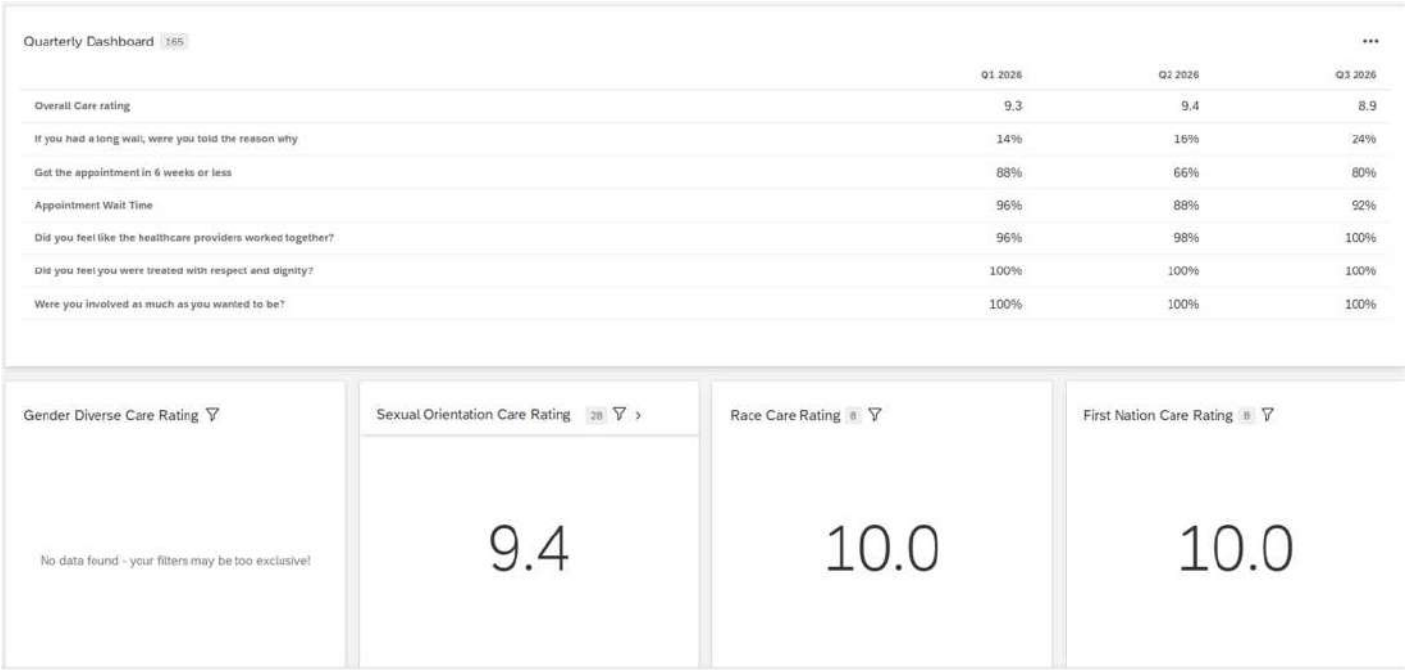
Improvement Opportunity

- 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 - ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: January 29, 2026 Meeting Date Prepared for: February 18, 2026 – Finance
February 26, 2026 - Board

Subject: November 2025 and December 2025 Financial Statements

Prepared by: Linda S. Ramsay

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

PURPOSE

- Financial Statement variance explanations between Actual and Budgeted amounts for the months of October 2025, November 2025 and December 2025. Note: Budget figures presented are based on the annual amount divided by 12 months.

RECOMMENDATION AT FINANCE

THAT the Finance, HR, and Audit Committee review and receive the financial statements for November and December 2025 as presented.

Moved By: G. McDonald
Seconded By: Dr. S. Robertson

CARRIED

RECOMMENDATION TO THE BOARD

THAT the Board of Directors review and receive the financial statements for November and December 2025 as presented.

ANALYSIS OF FINANCIAL INFORMATION

- The additional base funding of $ 527,000 announced just prior to Christmas was not deposited in December. However, it is expected to be recognized as revenue in January 2026.
- One time funding for HHR programs covering the period of October to December was recognized in December, in alignment with the Ministry's quarterly reporting schedule.
- Lower than budgeted volumes of out of province patients resulted in unrealized income for the 3 months period. Monthly visits were budgeted at 308.
- The CUPE Central Agreement was ratified in December. December financial statements include accrued costs for the period of September 29, 2025 to December 31, 2025.
- November included three pay periods. While the system accrued unpaid wages at month0end, it does not accrue the associate employer benefits costs (ie: employer portions of CPP, EI, EHT etc…) As a result, November reflects additional wage-related expenses.
- Emergency Room physicians and Hospital on call physicians received retroactive payments for the 2024-2025 fiscal year in November, resulting in increased AEF payments/Physician Payments revenue and higher Medical Staff Remuneration expenses.
- With winter conditions beginning in November, building and grounds expenses increased due to salting and snowplowing of parking areas.

ANALYSIS OF STATISTICAL INFORMATION

- Overall inpatient occupancy has been consistent with budget expectations. The Rehabilitation Unit continues to operate at high occupancy, supporting the overall occupancy rate for the first six months.

- ER volumes remain above budget, demonstrating sustained demand for emergency services. However, out of province ER visits continue to trend below expectations.

FUTURE ITEMS TO CONSIDER

- The CUPE collective agreement expired September 28, 2025. Negotiations are ongoing, with no arbitration referral to date.
- The ONA Central interest arbitration awarded wage increases of 3.0 % effective April 1, 2025 and 2.25 % effective April 1, 2026. These increases have been incorporated into projections moving forward.

SUPPORTING DOCUMENTS/ATTACHMENTS

- Statement of Operations
- Statistical Information

HOPITAL GLENGARRY MEMORIAL HOSPITAL
STATEMENT OF OPERATIONS
FOR THE PERIOD ENDING DECEMBER 31, 2025

ACTUAL Nov-25	BUDGET Nov-25	VARIANCE Nov-25	ACTUAL Dec-25	BUDGET Dec-25	VARIANCE Dec-25		ACTUAL YTD - DEC 2025	BUDGET YTD - DEC 2025	VARIANCE YTD - DEC 2025
						Revenue:			
1,570,994	1,572,330	(1,336)	1,453,152	1,572,330	(119,178)	MOHLTC Base Allocation	13,946,144	14,150,970	(204,826)
0		0	158,994		158,994	MOHLTC Base Allocation - one time funding	241,113	0	241,113
0		0	41,255		41,255	MOHLTC Special HHR programs	148,142	0	105,660
374,304	155,416	218,888	372,081	155,417	216,664	Alternate Emergency Funding Payments	2,305,269	1,398,750	906,519
73,992	32,500	41,492	35,205	32,500	2,705	Physician Payments	355,636	292,500	63,136
173,898	205,475	(31,577)	227,042	205,478	21,564	Patient revenues from other Payers	1,790,726	1,849,290	(58,564)
23,017	13,334	9,683	11,462	13,333	(1,871)	Differential and Co-Payment	164,773	120,000	44,773
(4,167)	(4,166)	(1)	(4,167)	(4,167)	0	Bad Debts	(39,977)	(37,500)	(2,477)
49,712	40,216	9,496	50,029	40,217	9,812	Recoveries and Miscellaneous	418,841	361,950	56,891
9,875	9,875	0	9,875	9,875	0	Amortization Grants/Donations - Equipment	88,875	88,875	0
2,271,625	2,024,980	246,645	2,354,928	2,024,983	329,945	Total Revenues	19,419,542	18,224,835	1,152,225
						Expenses			
1,146,172	1,063,426	82,746	1,102,656	1,063,426	39,230	Compensation - Salary and Wages	9,816,075	9,570,903	245,172
365,161	305,042	60,119	288,737	305,042	(16,305)	Employee Benefits	2,651,745	2,745,639	(93,894)
493,076	217,696	275,380	449,709	217,696	232,013	Medical Staff Remuneration	3,022,090	1,959,278	1,062,812
22,491	33,715	(11,224)	45,309	33,715	11,594	Medical and Surgical Supplies	299,145	303,464	(4,319)
27,316	24,853	2,463	21,927	24,853	(2,926)	Drugs and Medical Gases	207,614	223,122	(15,508)
374,327	379,725	(5,398)	396,509	379,725	16,784	Other Expenses	3,302,984	3,419,175	(116,191)
25,383	25,383	0	25,383	25,383	0	Amortization of Software License and Fees	228,447	228,448	(1)
23,871	23,871	0	23,871	23,871	0	Amortization of Equipment	214,839	214,841	(2)
2,477,797	2,073,711	404,086	2,354,101	2,073,711	280,390	Total Expenses	19,742,939	18,664,870	1,078,069
(206,172)	(48,731)	(157,441)	***827***	(48,728)	49,555	Surplus/(Deficit) From Operations	***(323,397)***	(440,035)	74,156

ACTUAL Nov-25	BUDGET Nov-25	VARIANCE Nov-25	ACTUAL Dec-25	BUDGET Dec-25	VARIANCE Dec-25	ACTUAL YTD - DEC 2025	BUDGET YTD - DEC 2025	VARIANCE YTD - DEC 2025

Loss of Revenues compared to Budget

Out of province							
108,351	139,506		96,778	139,510		1,048,960	1,255,573	(206,613)
In Patient O/P							
0	6,250		24,970	6,250		76,045	56,250	19,795
Rental Income							
4,196	4,809		4,202	4,809		41,056	43,275	(2,219)
Parking							
22,647	19,166		20,650	19,166		176,198	172,499	3,699

Details of Other Expenses

Supplies (4000)						
92,303	95,733	112,826	95,746	861,006	864,960	(3,954)
Services (6000)						
57,953	65,970	62,865	65,969	625,323	589,841	35,482
Equipment, R & M and software support (7100)						
106,626	100,793	97,169	100,787	781,920	909,348	(127,428)
Contracted Out services (8000)						
104,290	107,977	103,475	107,974	942,049	971,776	(29,727)
Building and grounds (9000)						
13,155	9,252	20,175	9,249	92,687	83,250	9,437
374,327	379,725	396,510	379,725	3,302,985	3,419,175	**(116,190)**

HOPITAL GLENGARRY MEMORIAL HOSPITAL
BALANCE SHEET
AS AT DECEMBER 31, 2025

	DECEMBER 31, 2025
Current Assets	
Cash and Investments	1,765,548
Accounts receivable	675,067
Inventory	159,585
Prepaid Expenses	310,617
	2,910,817
Capital assets minus accumulated depreciation	11,657,224
Total Assets	14,568,041
Current Liabilities	
Credit Line	0
Accounts payables and accrued liabilities	3,305,121
Employee future benefits	1,285,603
Deferred income	74,500
	4,665,224
Long-term debt	812,892
Deferred contributions	6,726,488
Net assets	
Restricted	898,041
Unrestricted	232,343
Capital Fund reserves	1,233,053
	2,363,437
	14,568,041

GLENGARRY MEMORIAL HOSPITAL
STATISCAL INFORMATION
December 2025

	April	May	June	July	August	September	October	November	December	January	February	March	Actual Total 2025/26	% as per Benchmark	BENCHMARKS 2025/26	Actual Total 2024/25
INPATIENTS																
OCCUPANCY RATE in %																
ACTIVE UNIT - 22 beds	51.21%	74.78%	78.03%	75.37%	78.45%	62.88%	78.89%	75.91%	80.79%				**73.01%**		**82.00%**	**59.19%**
(2024-2025)	69.09%	59.09%	47.27%	43.11%	67.16%	69.70%	70.23%	75.30%	73.61%	60.85%	70.62%	48.39%				
REHABILITATION - 15 beds	92.22%	89.03%	81.78%	89.46%	91.61%	90.44%	76.56%	80.67%	78.71%				**85.60%**		**80.00%**	**80.11%**
(2024-2025)	89.11%	85.81%	76.44%	77.63%	79.35%	72.22%	84.95%	91.56%	79.14%	92.04%	87.86%	90.32%				
OVERALL OCCUPANCY - 37 beds	67.84%	80.56%	79.55%	81.08%	83.78%	74.05%	77.94%	77.84%	79.95%				**78.11%**		**81.00%**	**67.67%**
(2024-2025)	77.21%	69.92%	59.10%	57.11%	72.10%	70.72%	76.20%	81.89%	75.85%	73.50%	77.61%	65.39%				
OUTPATIENTS																
EMERGENCY/OUTPATIENT																
# OF VISITS - Res.	1,304	1,347	1,347	1,520	1,490	1,320	1,316	1,214	1,497				**12,354**		**9,450**	**11,839**
Out of province	178 12%	225 14%	256 16%	303 17%	285 16%	274 17%	237 15%	221 15%	204 12%				**2,184**	15%	**3,375**	**2,723** 19%
	1,482	1,572	1,603	1,823	1,775	1,594	1,553	1,435	1,701				**14,538**		**12,825**	**14,562**
(2024-2025)	1,453	1,642	1,487	1,620	1,634	1,679	1,748	1,678	1,621				**14,562**			
SPECIALTY CLINICS																
# OF VISITS - Res.	246	190	214	177	152	192	242	170	201				**1,784**		**2,224**	**1,986**
Out of prov./country	0 0%	0 0%	0 0%	3 2%	2 1%	2 1%	1 0%	0 0%	1 0%				**9**	1%	**26**	**6** 0%
	246	190	214	180	154	194	243	170	202				**1,793**		**2,250**	**1,992**
(2024-2025)	250	248	227	191	202	225	270	184	195				**1,992**			
RADIOLOGY																
# OF STUDIES	1,087	1,156	1,159	1,063	1,074	1,112	1,162	1,120	1,182				**10,115**			**9,863**
(2024-2025)	1,117	1,119	932	947	973	1,048	1,228	1,222	1,277				**9,863**			
ULTRASOUND																
# OF STUDIES	201	203	191	228	175	210	239	218	213				**1,878**			**1,597**
(2024-2025)	192	205	166	185	166	160	217	148	158				**1,597**			
BONEDENSITOMETRY																
# OF STUDIES	38	38	19	56	18	80	56	39	38				**382**			**365**
(2024-2025)	39	39	39	51	39	53	48	20	37				**365**			

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: July 25, 2025 Meeting Date Prepared for: February 18, 2026 – Finance
February 26, 2025 - Board

Subject: Parking fees increase

Prepared by: Linda S. Ramsay, VP of Corporate Services and CFO

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

PURPOSE

To seek approval from the Board Committee to increase parking fees for both the public and employees.

RECOMMENDATION AT FINANCE COMMITTEE

That the Finance & Human Resources Committee recommends to the Board of Directors that parking rates for the public increase by 20% (from the daily rate of $ 5.00 to $ 6.00) effective April 1, 2026.
Moved By: Dr. S. Robertson
Seconded By: G. Peters

CARRIED

RECOMMENDATION TO BOARD

That the Board of Directors approve that parking rates for the public increase by 20% (from the daily rate of $ 5.00 to $ 6.00) effective April 1, 2026.

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.

Hopital Glengarry Memorial Hospital (HGMH) is projecting a deficit at the end of March 2026. In alignment with the Ministry of Health (MOH) and Ontario Health East (OHE) directives, hospitals are to pursue low-risk strategies to generate additional revenue or realize operational efficiencies before considering medium or high-risk approaches that could compromise clinical services.

Under the Hospital Parking Directives from the MOH, hospitals may increase daily maximum parking rates in accordance with cumulative CPI (Consumer Price Index) increases since April 1, 2019. HGMH has validated that it is in full compliance with this directive and may increase parking rates accordingly.

Currently:

Public parking is set at **$5.00 daily** (unchanged since 2015).
Staff parking is **$20.00 bi-weekly** (unchanged since 2011)

A survey of the OHE hospitals was sent in October 2024. The survey captured the public rates, staff rates, time of the last increase and if there were any planned increases, to ensure HGMH was following regional strategies and rates.

OPTIONS CONSIDERED & ANALYSIS

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

Option 1: Increasing parking rates as of January 1, 2026 (Recommended):

Public: Increase from **$5.00 to $6.00** daily

- Advantages:
  - Generates new revenue of $ $ 55,000 annually
  - Supports low-risk, sustainable strategies as mandated by the MOH and OHE
  - Ensures compliance with CPI-based rate increase guidelines
  - Provides funding for increased operational costs related to parking lot maintenance and infrastructure
- Disadvantages:
  - Potential dissatisfaction among visitors due to fee increases

Option 2: Maintaining status quo:

- Advantages:
  - Avoids negative reaction from staff and the public
  - Maintains current perception of affordability and accessibility
- Disadvantages:
  - Missed opportunity to generate revenue from an easy source
  - Not in alignment with low-risk revenue generation expectations
  - Weakens the case of additional funding requests from OHE

It was agreed at Senior Leadership, Leadership and PFAC that parking can be increased to the public.

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.

Risk Assessment:

- **Financial:** New recurring revenue to reduce operational deficit. Supports sustainability and efficient operations of the Hospital and generates funds for the upkeep of parking areas
- **Operational Risk:** Low-risk strategy as per Ministry criteria, missed opportunity if not implemented
- **Reputational Risk:** Demonstrates prudent fiscal management, but with possible short-term criticism from the public or staff.

Not acting on this low-risk option could reduce HGMH's credibility with the Ministry or OHE, who may expect hospitals to first exhaust internal measures prior to seeking further financial support

CONSULTED WITH:

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

- Senior Leadership
- Leadership
- Patient & Family Advisory Committee

IMPLEMENTATION & COMMUNICATION PLAN

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

- Contact parking software provider to modify programmed parking rates in pay stations
- Update parking policy
- Develop a communication plan for public, 1 month prior to effective date

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: January 15, 2026 Meeting Date Prepared for: February 18, 2026 – Finance
February 26, 2026 - Board

Subject: 2026-2027 Draft Budget

Prepared by: Linda S. Ramsay

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

PURPOSE

- Present the 2026-2027 draft budget

RECOMMENDATION AT FINANCE

THAT the Finance, HR & Audit Committee recommend to the Board of Directors the draft budget for 2026-2027 as presented.
Moved By: G. Peters
Seconded By: Dr. S. Robertson

CARRIED

RECOMMENDATION TO THE BOARD

THAT the Board of Directors approve the draft budget for 2026-2027 as presented.

IMPLICATIONS TO OTHER STANDING COMMITTEES

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

- To be presented to Finance, HR and Audit Committee of the Board and the Board of Directors

SITUATION & BACKGROUND

- Ontario Health has not given us any direction yet on the approach to be taken as it comes to the 2026-2027 budget. It seems that the current Hospital Service Accountability Agreement (HSAA) will be extended by another year to include 2026-27
- Meetings were held amongst the CFOs and Ontario Health to discuss common assumptions in November and December.
- Therefore, with no specific instructions by OH, the presented budget does not need to be approved at this time. However, to ensure financial oversight by the HGMH Board, the draft budget for 2026-27 is presented currently.

IMPACT ANALYSIS/RISK ASSESSMENT/DECISION CRITERIA

- All Central Collective Agreements have been arbitrated and ratified. Rates used in the preparation of the budget are the actual negotiated wages.
- Information Technology includes interest cost of +/- $ 65 K for the long-term debt acquired for EPIC
- EPIC operating expenses have been accounted for the period of November to March as per the Atlas Alliance CFO committee. The residual cost for CHAMP during that period has yet to be determined and has been estimated to 35 % of the current cost.
- Equipment Depreciation: Acquisitions of equipment has been limited to urgent or end of life basis due to cash flow issues over the past few years.

FUTURE ITEMS TO CONSIDER

- The hospital is still requesting additional funding from OHE, to compensate for the structural working capital deficit generated post-pandemic.

CONSULTED WITH:

- Department heads and senior management
- Fiscal Advisory Committee – February 4, 2026

SUPPORTING DOCUMENTS/ATTACHMENTS

- Draft Budget 2026-2027
- Assumptions

HÔPITAL GLENGARRY MEMORIAL HOSPITAL
BUDGET ANALYSIS

	2026-2027	2025-2026
REVENUE		
MOH Allocation	19,612,222	18,867,960
OHIP Revenues and other Payers	2,568,497	2,465,719
Differential and co-payment	160,000	160,000
Other Revenues	463,900	470,600
Capital Grants	120,000	118,500
EAF/HOCC Revenues	3,041,111	2,259,350
Total	25,965,730	24,342,129
EXPENSE		
Compensation	13,088,614	12,761,216
Benefits	3,852,921	3,660,914
Medical Staff Remuneration	432,375	382,375
Supplies and Other expenses	4,907,320	4,522,514
Medical/Surgical Supplies	399,500	404,625
Drugs	308,680	297,280
Bad Debts	50,000	50,000
Depreciation	470,005	591,050
EAF/HOCC Expenses	3,041,111	2,259,350
Total	26,550,526	24,929,324
Surplus/Deficit	(584,796)	(587,195)

HGMH 2026-2027 DRAFT BUDGET ASSUMPTIONS

Description	Assumptions	Details
Medicine Occupancy	82 %	Meaning 18 beds per day out of 22
Rehab Occupancy	80 %	Meaning 12 beds per day out of 15
Emergency Volumes	18,500	ON 14,800 (80 %) QC/Other 3,700 (20 %) for total visits of 18,500.
MOH Allocation	2.0 %	Assumption for small hospitals
Interprovincial Revenues	No rate increase	Rate increase at 0 %, but volumes set at 3,700 New rate as of April 1, 2025 was used $ 462/visit
Parking Revenue	From $ 5 to $ 6	Increase to public parking rate as proposed in Q4 2025-2026
Amortization of grants/donations		As per current listing and projected 25-26 acquisitions
Salary - ONA wage increase	2.25 %	This is the exact increase as of April 1, 2026 since the Central Collective Agreement was settled in September.
Salary - CUPE wage increase	2.25 % (6 months) and 2 % (6 months)	Rates as per the CUPE Central collective agreement that was ratified in December.
Salary -Non Union wage increase	2.625 % and step increases	To maintain parity with ONA
Benefits		Increases as per legislation (EI, CPP, WSIB). Other benefits LTD, Life and AD&D set at the 2024 rates, since no increase is anticipated. With the Healthcare EHC and Dental rates were increased due to new benefits negotiated by both ONA and CUPE. Dental and EHC rates with the Collaborative Provincial Benefits are currently being negotiated for April 1, 2026 and are expected to increase by 1.1 %.
Medical Remuneration		No increase to the CoS, CoE and CoM. Increase due to professional fees for Xray/US/Holters to be in correlation with volume increase trend from previous years.
Supplies	8.50 % average	Dietary: Increase to food 3 % IT: increase due to EPIC and multiple annual interface costs IT: Moving to the TOH tenancy increased our Microsoft licensing fees IT: Added $ 65 K of interest on long term debt. Estimated a full $ 4.0 M loan at 4 % interest. Laboratory: as per new developed funding model Mat. Management: increase to contracted services with QCH for purchasing services

HGMH 2026-2027 DRAFT BUDGET ASSUMPTIONS

		M/S and ER: increase to bio-medical maintenance services and repairs done by CHEO
Medical Supplies	1.00 %	Cost of Living % , but this is still 15 % higher than actual amount of 24-25
Drugs	3.83 %	Increase based on actuals of previous year. Increase in thrombolytics mostly.
Equipment depreciation		As per current equipment listing and projected 25-26 and 26-27 acquisitions

REPORT OF THE BOARD QUALITY AND PATIENT SAFETY COMMITTEE MEETING

February 18, 2026 at 4:00PM Boardroom/MS Teams

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

Summary of Discussion

Approval of the Agenda:
The agenda was reviewed.

Moved By: D. Elie
Seconded By: G. Peters
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 January 14, 2026, was approved as presented.

Moved By: G. Peters
Seconded By: Dr. R. Cardinal
THAT the report of January 14, 2026, be approved as presented.

CARRIED

Business Arising from Report:
There was no business arising from the report.

Committee Work Plan
There were no changes made to the committee work plan.

Education – Patient Story

R. Romany shared a patient story on a patient who was admitted and fell overnight. This patient had significant history of falls, and the key focus of the story was on transfer of accountability. Assessments and documentation are key. This is a sentinel event that will be reported back to the board through this committee.

Matters for Discussion/Decision

Medical Student/Resident Placement Report
The medical student and resident placement report was shared. We have significantly improved our capacity to take on medical students and residents which has helped get the hospital's name out there and draw in individuals who are looking at doing rural medicine in the future. The feedback received thus far has been quite positive from the learners with some of them scheduled to come back.

Learners have different permissions and access depending on the level they are at. Students are not permitted to order anything for patients however they can take history and physicals. Residents are able to put orders in, however the physician still reviews and signs off on this.

Review 2025-2026 QIP for Q3
The QIP was reviewed for Q3.

Moved By: D. Elie
Seconded By: G. Peters
That the Quality & Patient Safety Committee review and receive the 2025-2026 Quality Improvement Plan for Q3 as presented.

Targets have been met for most initiatives except for medication errors reaching the patient. Because we are working on continuous improvement and we went over the set target, changes were made to the target to two errors per month.

CARRIED

2026-2027 Quality Improvement Plan
The draft Quality Improvement Plan for 2026-2027 was reviewed.

Moved By: Dr. R. Cardinal
Seconded By: D. Elie
THAT the Quality & Patient Safety Committee recommend to the Board of Directors the 2026-2027 Quality Improvement Plan as presented.

The draft quality improvement plan for 2026-2027 was presented and discussed. The continued focus remains on the four province-wide priority issues which are Access and Flow, Equity, Experience, and Safety. As such, it was decided that several indicators remain the same but with a better target as we continuously strive to improve.

Discussion ensued around the target performance being set at 7.3 for the indicator on reducing the percentage of ED patients who left without being seen by a physician. While this is slightly higher than our current performance, it is still below the provincial average and the main driver for improvement in bringing this number down is having the second physician come in during the day which is made possible by using ED P4R funding. This funding is not guaranteed. Because of this, it was agreed that the target performance makes sense and is still lower than last years target performance.

The proposed QIP will be brought to the Board of Directors in March following final review from all key stakeholders.

CARRIED

Review Quality & Safety Scorecard
The quality & safety scorecard was reviewed.

Moved By: Dr. R. Cardinal
Seconded By: Dr. S. Robertson
THAT the Quality & Patient Safety Committee review and receive the Quality & Safety Scorecard as presented.

The areas for opportunity to improve were identified and strategies developed.

The falls with injury has exceeded the target performance for Q3. Purposeful patient rounding from clinical teams will continue to ensure patients have everything they need and patients will be reminded to use their call bells rather than attempting to get up without supervision.

While Q3 saw better results for number of medication errors that reached the patient in comparison with Q2, work will continue with safe medication practices such as order verification and consistent documentation during medication administration to help improve the rate of medication errors reaching patients.

CARRIED

Review Q3 Patient Satisfaction Survey Results
The patient satisfaction survey results for Q3 were reviewed.

Moved By: Dr. S. Robertson
Seconded By: G. Peters
THAT the Quality & Patient Safety Committee review and receive the Patient Satisfaction Survey Results for Q3 as presented.

The results from the survey continue to be positive overall.

There were some improvements seen from the survey for the Emergency Department where the overall care rating rose from 8.6 to 8.7. Work will be done on reminding staff about empathetic communication with patients and families as there was a decline in the emotional support response from 93% to 90%.

The inpatient and rehab unit also saw an increase in the overall care rating from 8.4 to 9.0. Work will be done on patients and family's involvement in plan of care in which the current standing is 61%.

The overall care rating for the outpatient care dropped from 9.4 to 8.9. There are currently long wait lists for the pain clinic which could be part of the reason for the drop. Work is being done on monitoring appointments to ensure patients are getting seen within 6 weeks.

Overall, there are high equity perceptions demonstrating cultural sensitivity and inclusiveness.

CARRIED

Matters for Information

BPSO Updates
An in-person session took place for those who wanted to become a BPSO champion. There is another session coming up in March in which Directors are welcome and encouraged to attend.

Patient Safety Plan Review
The Patient Safety Plan was reviewed and is now called the Patient Quality & Safety Plan. PFAC rounding on patients was included in the plan. The safety measures are reviewed yearly; however, the plan itself is from 2023-2028 to align with the strategic plan.

Trillium Gift of Life Report
The report for Trillium Gift of Life was shared in which improvement was seen with 100% tissue notification done. A reminder is being shared with staff to notify TGLN of all patients 79 years of age and younger within one hour of death as we are currently only at 88% for routine notification.

Accreditation Standard Review
The accreditation standard feature was discussed.

Date of Next Meeting: Wednesday, April 8, 2026

K-L. Massia, Recorder

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: January 22, 2026 Meeting Date Prepared for: February 18, 2026 – Quality
February 26, 2026 - Board

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.

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: February 11, 2026 Meeting Date Prepared for: February 18, 2026 – Quality February 26, 2026 - Board

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 – ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: February 10, 2026 Meeting Date Prepared for: February 18, 2026 – Quality
February 26, 2026 - Board

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 – ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: February 10, 2026 Meeting Date Prepared for: February 18, 2026 – Quality February 26, 2026 - Board

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.

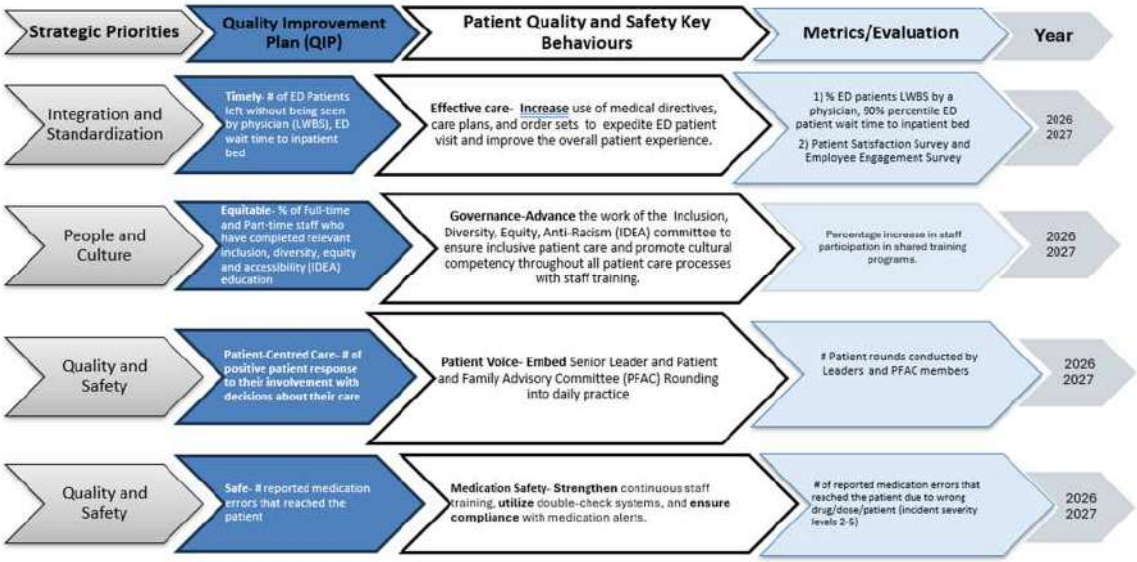
SITUATION & BACKGROUND

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

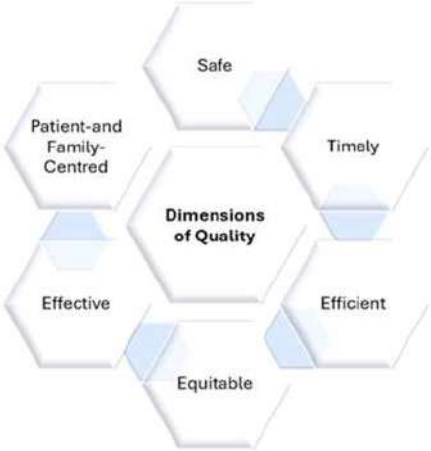
Patient Quality and Safety Plan

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.

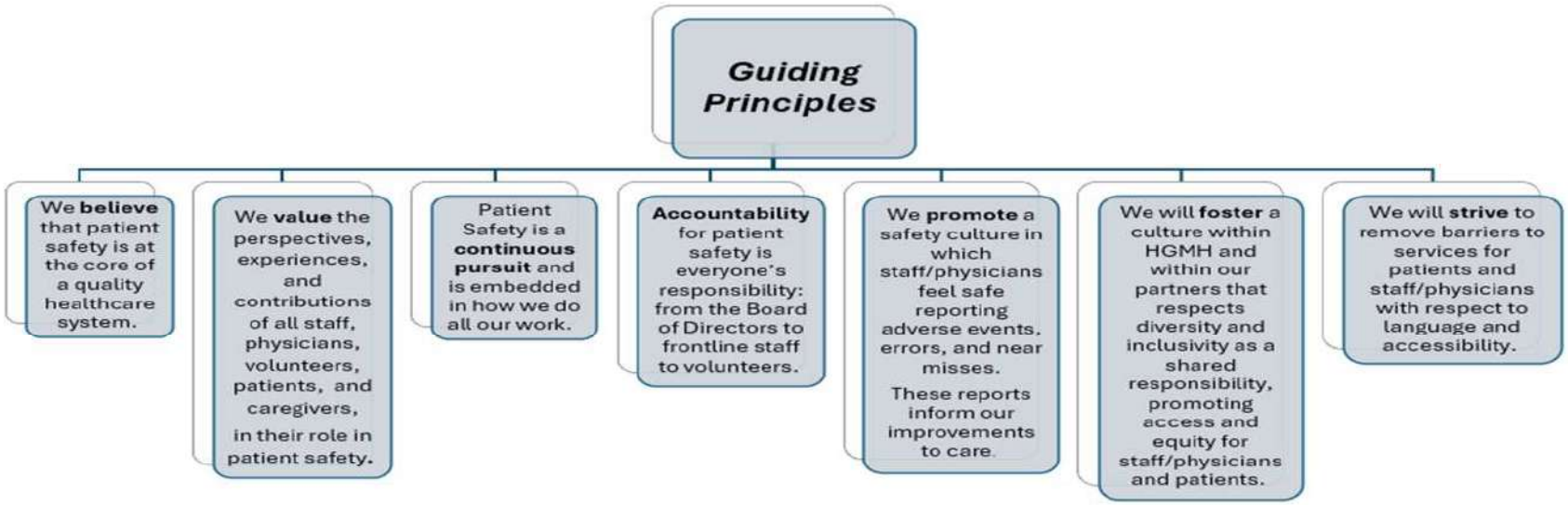
The intention of the Patient Quality and Safety Plan is to communicate and support our focus and commitment to providing safe, quality care while achieving optimal patient outcomes. It is designed to improve patient safety, reduce risk, and respect the dignity of our patients by assuring a safe environment.

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*.

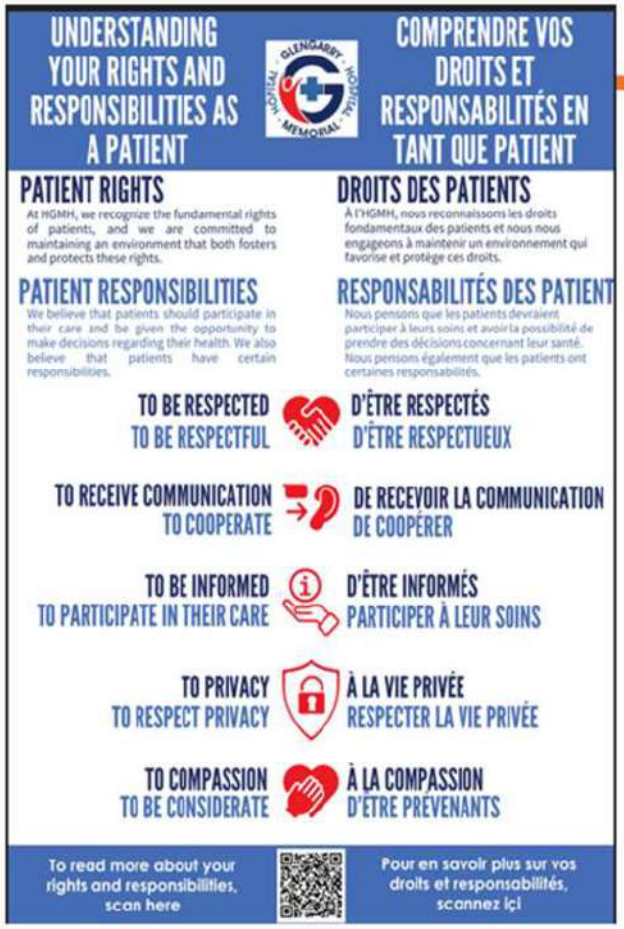


Patient Quality and Safety Plan Objectives

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

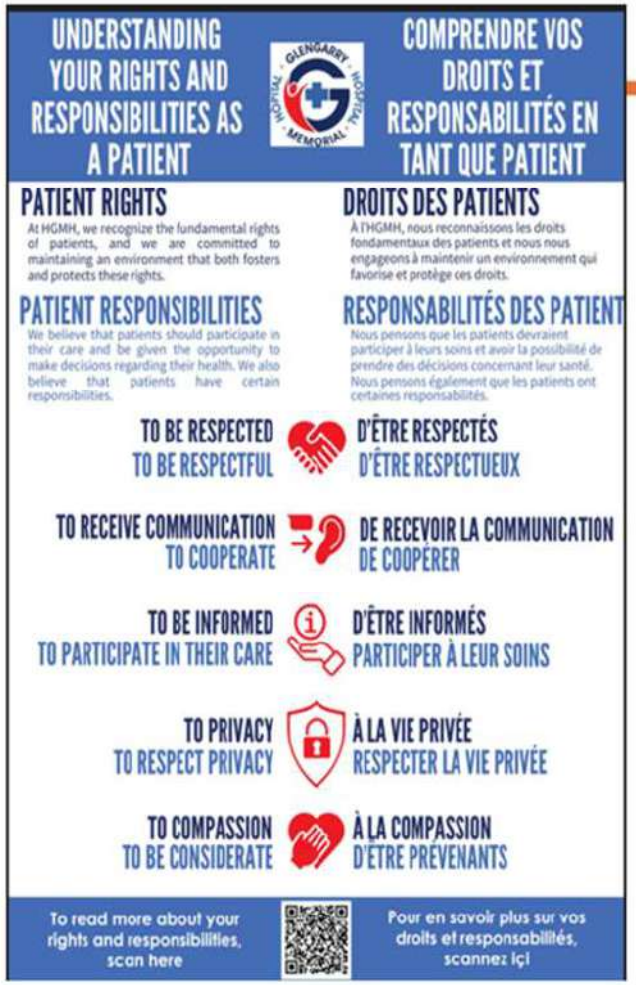
Privacy

- 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

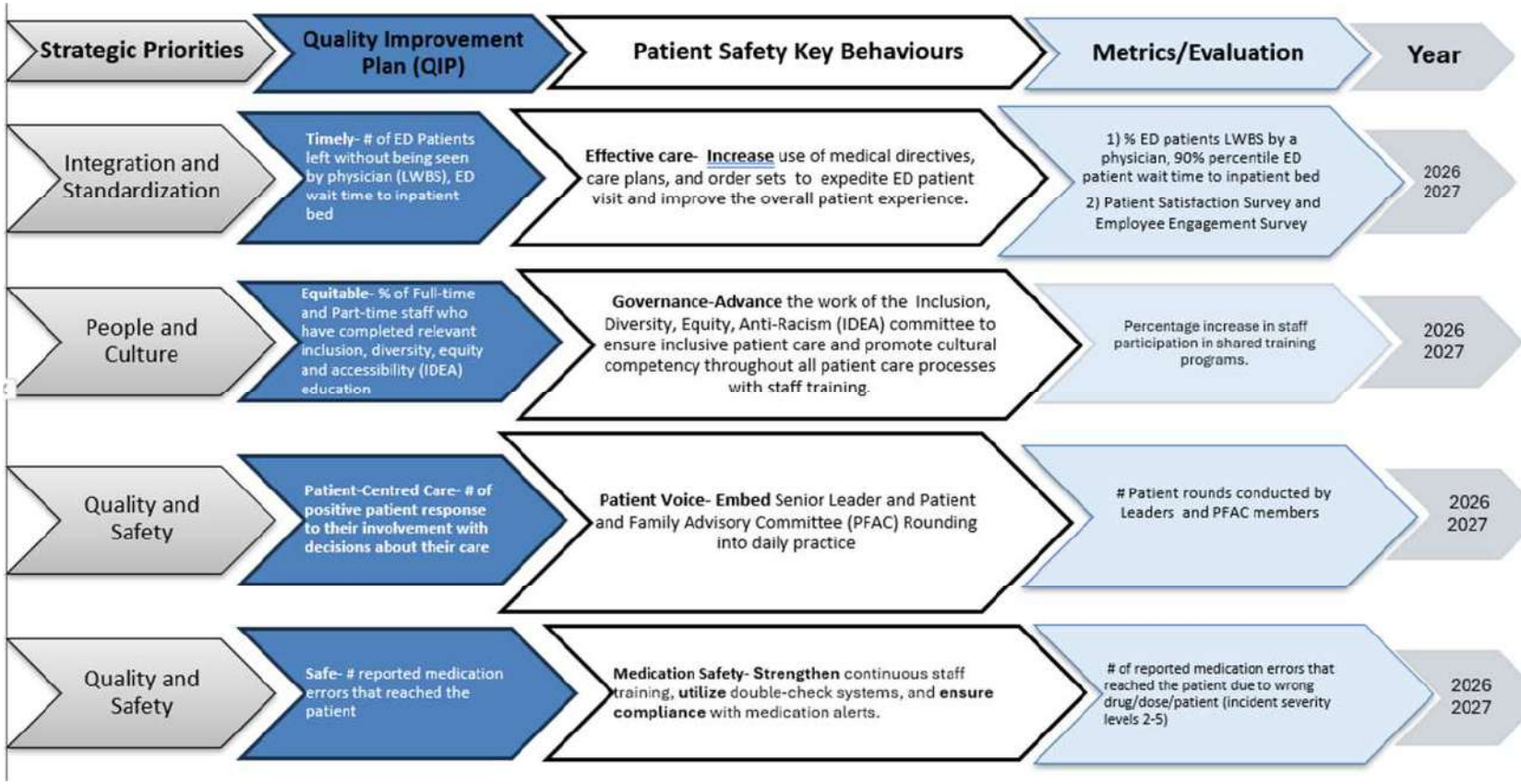
- To observe the hospital isolation and smoking restriction policies
- Follow instructions during emergency measures and outbreak of infections.
- Verbal and physical abuse will not be tolerated.

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.



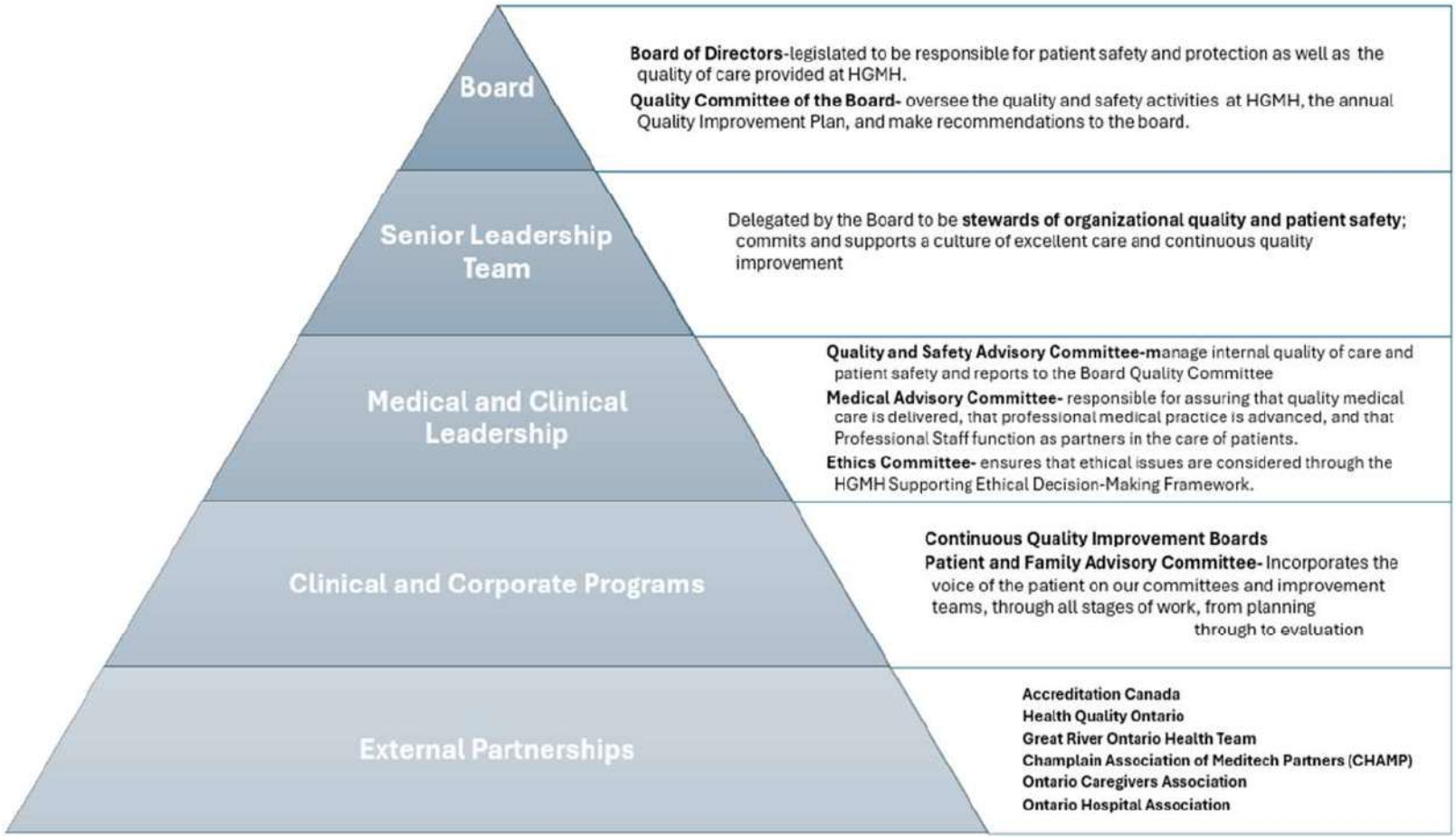
HGMH Patient Quality and Safety Program

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.

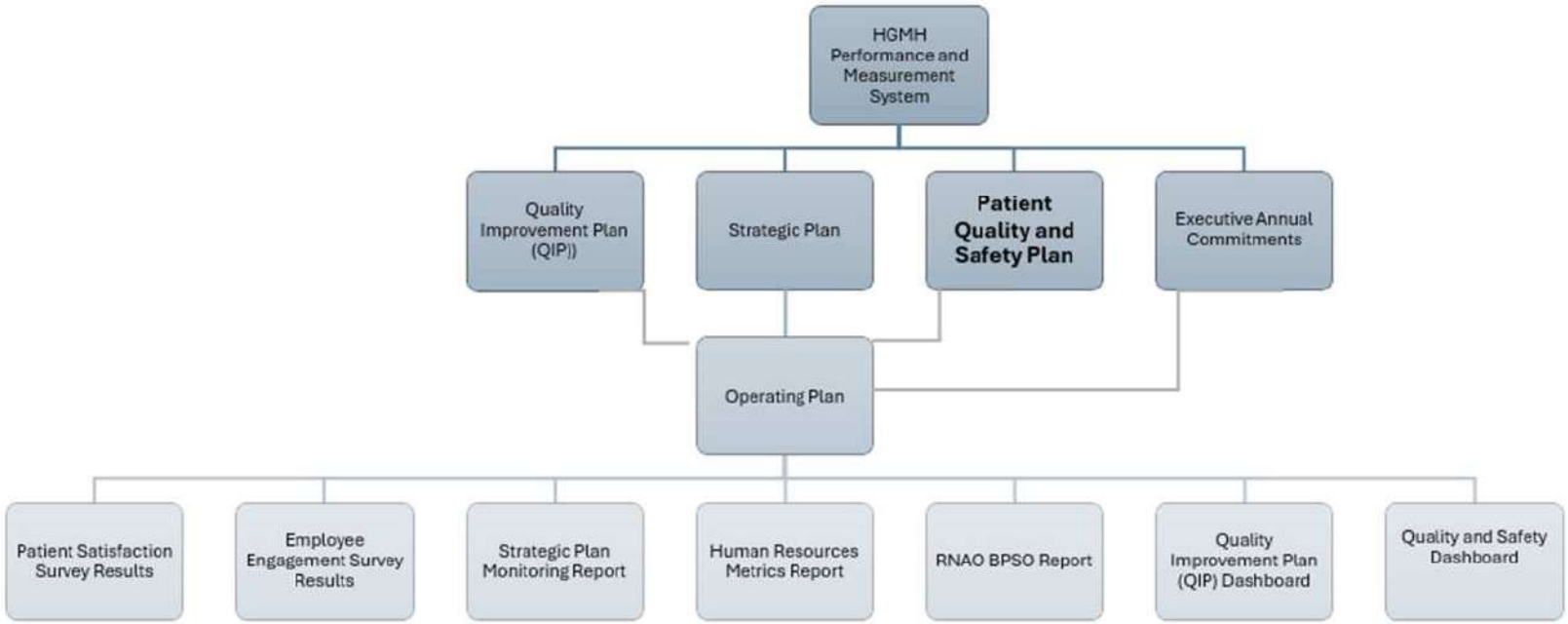
Ongoing Patient Safety Initiatives not limited to:

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 – ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: February 10, 2026 Meeting Date Prepared for: February 18, 2026 – Quality
February 26, 2026 - Board

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

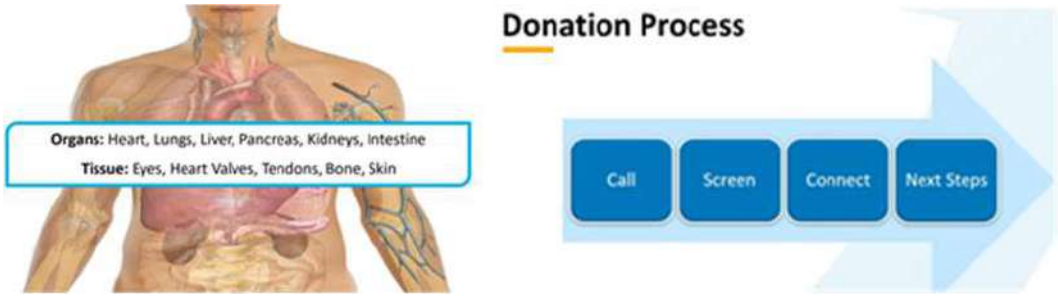
PURPOSE

- 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.



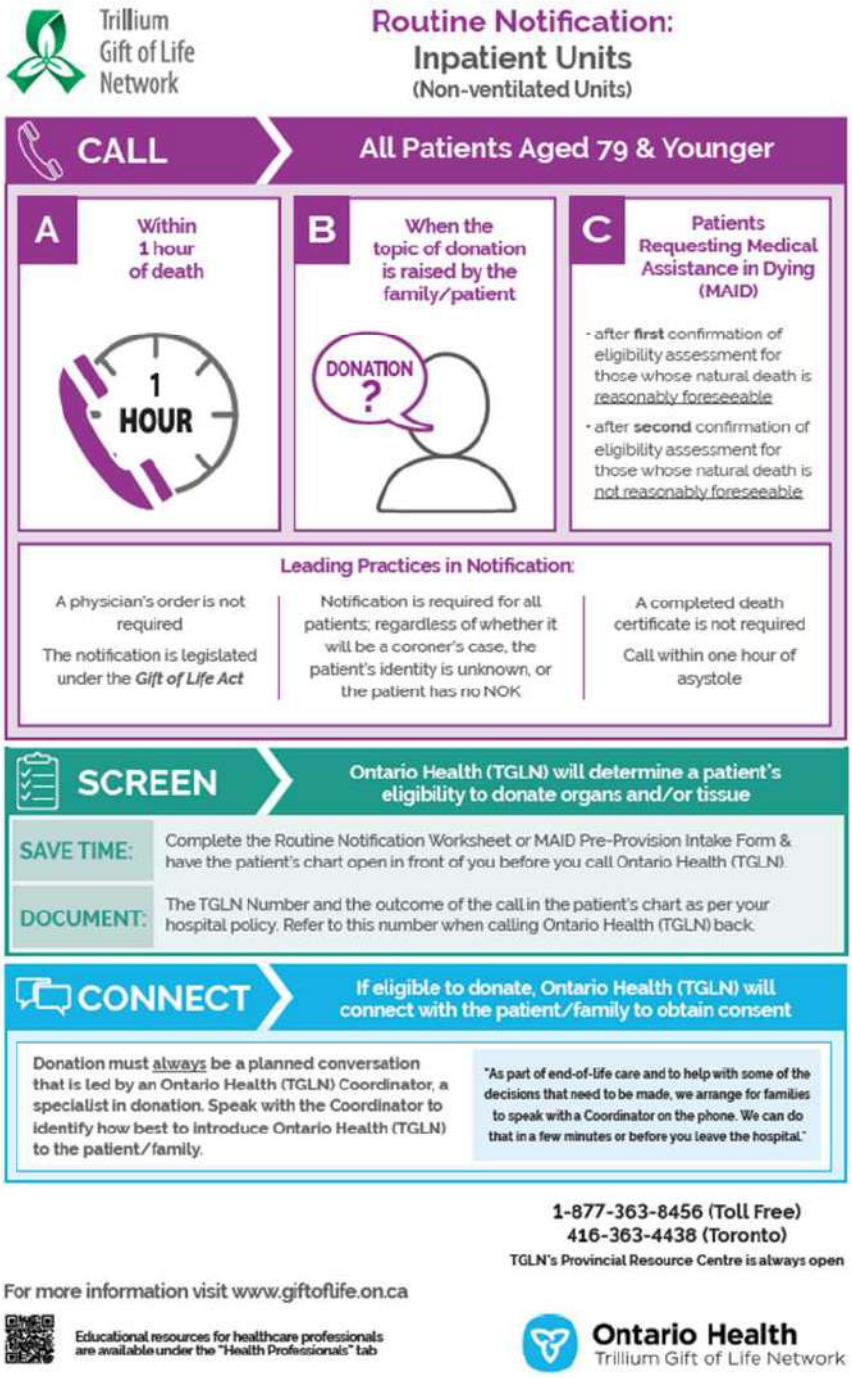
- HGMH is currently participating in voluntary notification/public reporting since October 2024.
- As a voluntary hospital, we are required to follow the Gift of Life Act.
- The Gift of Life Act requires hospitals to support organ and tissue donation by having appropriate policies, following routine 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.

HÔPITAL Glengarry Memorial HOSPITAL

TGLN poster for Inpatient Department



REPORT OF THE MEETING OF THE FINANCE, HR, AND AUDIT COMMITTEE

February 18, 2026 at 5:00PM in the Boardroom/MS Teams

Present:	C. Nagy, Chair	Dr. S. Robertson	
	G. McDonald	G. Peters	L. Ramsay
	K. MacGillivray, CHRO	R. Alldred-Hughes, CEO	

Regrets: F. Desjardins

Summary of Discussion of the meeting
Quorum achieved

Approval of Agenda

Agenda: The agenda was reviewed.

Moved By: G. McDonald
Seconded By: Dr. S. Robertson
THAT the agenda be approved as presented.

CARRIED

Declaration of Conflict of Interest: there were no conflicts declared.

Minutes

Report from the Previous Meeting: The report of the meeting of November 12, 2025, was shared.

Moved By: G. McDonald
Seconded By: G. Peters
THAT the report of the meeting of November 12, 2025, be approved as amended.

CARRIED

Committee Work Plan
The committee work plan was shared. It was agreed that CT Scan updates be added on an ad hoc basis until there is a project plan in place.

Business Arising:
There was no business arising from the minutes.

Matters for Discussion/Decisions

Financial Statements – November and December 2025
The financial statements were reviewed.

Moved By: G. McDonald
Seconded By: Dr. S. Robertson
THAT the Finance, HR, and Audit Committee review and receive the financial statements for November and December 2025 as presented.

We finished with a small surplus in December which brings us to a year end deficit of $323,397. Funding announced in December was received in January and will be reflected on the next financial statements.

Salting and sanding is included in the building and grounds category and is charged when used.

CARRIED

Parking Increase
A proposal to increase parking fees to the public was shared.

Moved By: Dr. S. Robertson
Seconded By: G. Peters
That the Finance & Human Resources Committee recommends to the Board of Directors that parking rates for the public increase by 20% (from the daily rate of $ 5.00 to $ 6.00) effective April 1, 2026.

In alignment with the Ministry of Health and Ontario Health East directives, hospitals are to pursue low risk strategies to help generate additional revenue. Since there are not many options available, it was agreed that a way to generate some revenue would be to increase parking fees which has not been changed since 2015. Through discussion with PFAC and the Leadership team, it was agreed that the raising the parking fee by $1 was reasonable.

Senior Leadership has made the decision to not increase staff parking fees to avoid decreasing moral during a time where cost of living is already going up.

CARRIED

Review Draft Budget 2026-2027
The draft budget for 2026-2027 was shared.

Moved By: G. Peters
Seconded By: Dr. S. Robertson
THAT the Finance, HR & Audit Committee recommend to the Board of Directors the draft budget for 2026-2027 as presented.

The draft budget was explained in detail. A deficit of $584,796 is being projected with this budget. The budget doesn't need to be submitted to Ontario Health through the HAPS process, however, the ask is that Board approves the budget for operational use. A request was made to break down the IT expenses in future budgets.

All hospitals are budgeting in the same manner and the regional CFO's meet and go through this exercise together.

The team continues to advocate for extra funding to compensate for the structural working capital deficit generated post-pandemic.

CARRIED

New Finance Policies
Two new policies were shared; Borrowing policy and Financial Objectives, Planning and Performance policy.

Moved By: Dr. S. Robertson
Seconded By: G. McDonald
THAT the Finance, HR & Audit Committee recommend to the Board of Directors the approval of the Borrowing policy and the Financial Objectives, Planning and Performance policy as presented.

Under paragraph 3 of the Financial Objectives, Planning and Performance policy statement, it says that the Board cannot approve a deficit budget however, this is not entirely true. The

third bullet under the Board of Directors responsibilities says the same thing. It was agreed that language be softened around this. This policy will be deferred and brought back to the next committee meeting.

The motion was amended:
THAT the Finance, HR & Audit Committee recommend to the Board of Directors the approval of the Borrowing policy as presented.

CARRIED

Matters for Information – Finance

Declaration of Compliance – October, November and December 2025

The declaration of compliance for October, November and December 2025 were included in the package.

Matters for Information – People & Partnerships

Q3 HR Metrics Report

The Q3 HR Metrics Report was shared. Overall, everything is going well, however there are several upcoming temporary vacancies coming up due to parental leaves. Work is being done in a proactive manner to fill these vacancies.

Discussion ensued around the benchmark for management voluntary separation in which there was none last year and the target is set at 0. This will be looked into for future reports as it is not realistic to include as a metric.

Review Strategic HR Plan

An update was shared on the strategic HR plan in which lots has already been achieved. The report will be revamped to include percentage of where things are at.

Matters for Information – Building, Property & Infrastructure

Electrical Service Capacity and Upgrade Strategy

A feasibility study was done by an electrical engineering firm in which it was determined that there is not enough power currently being delivered to the hospital. Adding the CT scan will increase the power demand and as such, something needs to be done to accommodate the growth of the hospital.

Three options were considered, in which option 2 is being explored. This option sees the installation of two transformers and would support current demand as well as CT implementation and 20% capacity for future growth. This option is considered the most appropriate balance of safety, compliance, program enablement, and financial stewardship.

The estimated cost for this option is approximately $3.08 million. Funding has been requested through Ontario Health and included as part of the hospital's Exceptional Circumstances submission under the Hospital Infrastructure Renewal program. Given the critical nature of the ask, there should be no issues with being approved from one of these funding programs however, if another path to fund this project is needed, it would be brought back to the Board for further discussion and decision on how to proceed.

Epic Project Updates

The project is moving along well. There are currently some risks to the project Atlas wide, however there are mitigation plans for all of these and there is no risk to not moving forward as scheduled.

Date of Next Meeting

Next meeting: March 11, 2026

K-L. Massia, Recorder

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: February 4, 2026 Meeting Date Prepared for: February 18, 2026 – Finance
February 26, 2026 - Board

Subject: Human Resources Q3 Scorecard

Prepared by: Kayla MacGillivray, Chief Human Resources Officer

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

PURPOSE

- The purpose of this report is to provide an overview of the human resources aspects of HGMH as it relates to key people metrics for Q3 of the 2025-2026 fiscal year.

SITUATION & BACKGROUND

A brief description of the background to the issue.

- HR metrics are important to review and track so the organization can address areas of concern in a timely fashion in order to contribute positively to organizational performance.
- We established a baseline performance for multiple metrics in 2022 in order to establish a year over year view to understand trends, opportunities for improvement and celebration.
- People & Culture is a strategic dimension of the HGMH strategic plan, and in an effort to address key performance indicators for this element of the strategy, a quarterly score card is being used to monitor.
- The HR metric report is set up to focus on four main areas of Human Resources: Recruitment & Retention, Professional Development, Employees Safety, and Labour Relations. Within each of these categories are specific metrics that the organization will work towards driving and sustain positive performance.
- The targets have been updated from prior year to use most current Ontario Hospital Association Data to inform the targets. The OHA updated their data in the winter and spring of 2024 to reflect 2023.

OPTIONS CONSIDERED & ANALYSIS

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

- Overall, workforce indicators demonstrate strong organizational stability, improving retention, and continued investment in staff development, while highlighting targeted opportunities in workplace injury prevention.
- **Recruitment & Retention:** All turnover indicators are below the OHA average, reflecting strong overall workforce stability. Voluntary separations and resignations have decreased in 2025–2026 compared to 2024–2025, indicating improved retention. We are contributing these trends to effective recruitment and scheduling practices and organizational retention initiatives (e.g., wellness, development, IDEA efforts).
- **Professional Development**: Education and development activity has increased in 2025–2026, with total training hours already exceeding the prior year's comparable reporting periods and trending toward (or surpassing) the 2024–2025 annual total. We have significantly surpassed the 25% Q4 target, with completion rising to 86.11%, substantially. These improvements are related to an increased organizational focus on education and professional development and alignment of training with organizational priorities such as equity, culture, and patient care quality.
- **Employee Safety**: Sick leave days per full-time employee in 2025–2026 (10.56) are trending below the OHA average (12.87) and lower than the 2024–2025 total (15.19). No reported lost-time incidents related to workplace violence across both fiscal years (0), indicating strong performance in this area.
- **Labour Relations:** Labour relations within the organization remain strong and collaborative, despite a small number of grievances progressing to arbitration. The referral of cases to arbitration does not reflect a breakdown in local labour relations; rather, it is partly attributable to broader, coordinated union initiatives to advance or clarify specific provisions of collective agreements across multiple organizations. At the local level, the organization continues to prioritize open dialogue, proactive issue resolution, and respectful partnership with union representatives. Efforts

remain focused on resolving concerns at the earliest possible stage while maintaining a fair, consistent, and transparent approach to collective agreement interpretation and application.

SUPPORTING DOCUMENTS/ATTACHMENTS: HR Metrics Dashboard

People Metrics Fiscal 2025-2026

2025-2026 Human Resources Dashboard Report	Dimension	Objective/Metric	Target	OHA Healthcare HR Benchmark 2024 (Average of all Participating Hospitals)	Quarterly	Q1	Q2	Q3	Q4	YTD	Trend
Recruitment and Retention	Turnover (excluding casual staff)	Voluntary Separation Rate (%)	Less than OHA Average	10.07%	2025-2026	2.22%	2.22%	1.67%		2.04%	
					2024-2025	5.26%	1.58%	0.53%	1.67%	2.26%	
		Resignation Rate (%)	Less than OHA Average	8.40%	2025-2026	1.70%	2.22%	0.55%		1.49%	
					2024-2025	4.21%	1.58%	0.53%	1.11%	1.86%	
		Retirement Rate (%)	Less than OHA Average	1.72%	2025-2026	1.10%	0.00%	1.10%		0.73%	
					2024-2025	1.05%	0.00%	0.00%	0.56%	0.40%	
		Management Voluntary Separation Rate (%)	HGMH Data	0.00%	2025-2026	0.00%	0.00%	0.00%		0.00%	
					2024-2025	0.00%	0.00%	0.00%	0.00%	0.00%	
	Permanent Vacancies	Total Vacancy Rate	Less than OHA Average	6.93%	2025-2026	1.68%	5.03%	3.91%		3.54%	
					2024-2025	4.47%	3.35%	2.79%	3.35%	3.49%	
	Student Placements	Total No. of New Student Placements Occurring During Reporting Period	HGMH Data	30 Students	2025-2026	4	6	16		26	
					2024-2025	6	8	1	15	30	
	Turnover in First 90 Days of Employment	Total Number of New Hire Departures within 90 Days of Hire	HGMH Data	3 Departures	2025-2026	1	0	0		1	
					2024-2025	2	0	0	1	3	
Professional Development	Education & Staff Development	Staff Training Hours	HGMH Data	1804	2025-2026	641.75	612.25	704.30		1958.30	
					2024-2025	433.80	388.30	139.85	842.09	1804.04	
		Front-line IDEA Training	HGMH Data	25% by Q4	2025-2026	0.00%	49.40%	86.11%		86.11%	
Employee Safety	Short Term Disability	All Full-time HGMH Staff (days per person based on 7.5 hour day)	Less than OHA Average	12.87	2025-2026	4.24	3.20	3.12		10.56	
					2024-2025	3.68	4.26	3.74	3.51	15.19	
	Workplace Illness or Injury	No. WSIB Lost Time Injuries/Illness Related to Workplace Violence (per OH&S Definition)	HGMH Data	0	2025-2026	0	0	0		0	
					2024-2025	0	0	0	0	0	
		Total No. WSIB Lost Time Injuries/Illness	HGMH Data	2	2025-2026	1	3	1		5	
					2024-2025	0	1	1	0	2	
		WSIB Lost Time Hours	HGMH Data	758	2025-2026	150.25	416.50	294.00		860.75	
					2024-2025	375.00	112.50	180.00	90.00	757.50	
Labour Relations	Grievance & Arbitration	Grievances Advanced to Arbitration	HGMH Data	1 Grievance	2025-2026	1	1	1		3	
					2024-2025	0	0	0	0	0	

Casual Staff excluded from data.

OHA Benchmarking Tool	
	Metric underperforming target by more than 25%
	Metric within 25% of target
	Metric equal or outperforming target

Q1	**April-June**
Q2	**July-Sep**
Q3	**Oct-Dec**
Q4	**Jan-Mar**

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: February 3, 2026 Meeting Date Prepared for: February 18, 2026 – Finance
February 26, 2026 - Board

Subject: HR Strategic Plan 2025 Progress Update

Prepared by: Kayla MacGillivray

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

PURPOSE

- To provide an update to the Finance & HR Committee of the Board and the Board of Directors on the HR Strategic Plan initiatives completed since it was launched in 2023.

SITUATION & BACKGROUND

A brief description of the background to the issue.

- The Human Resources Strategic Plan was launched in 2023 for the period of 2023-2025.
- The purpose of an HR strategic plan is to align the hospital's human capital with its overall strategic and operational goals. This allows is for HR to be a proactive driver of success.
- It was divided into five sections:
    - Recruitment & Retention
    - Inclusion, Diversity, Equity and Anti-Racism
    - Safety & Wellness
    - Professional & Leadership Development
    - Rewards & Recognition
- The metrics used to measure the effectiveness of these various initiatives are tracked in the HR Scorecard presented to the board quarterly.

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- HR Strategic Plan 2023-2028
- HR Strategic Plan Update

HÔPITAL
Glengarry
Memorial
HOSPITAL

Strategic Human Resources Plan

2023-2028

HGMH at a Glance

Our Mission

Delivering outstanding care for our communities.

Our Vision

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

Our Values

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

Passion for what we do
Accountability for our role
Compassion for those we serve
Teamwork for each other

Our Strategic Priorities

People & Culture

"Improve engagement by investing in the organization's people and empower a caring and positive culture for all."

-HGMH 2023-2028 Strategic Plan

About Our People

Number of Employees

186

Breakdown by Classification

Administration
Allied Health
Nursing
Support Staff

Unions

ONA

CUPE

Average Age of Employees

43

Strategic Priorities

1. Recruitment & Retention
2. Diversity, Equity, Inclusion & Accessibility
3. Safety & Wellness
4. Professional & Leadership Development
5. Rewards & Recognition

Recruitment & Retention

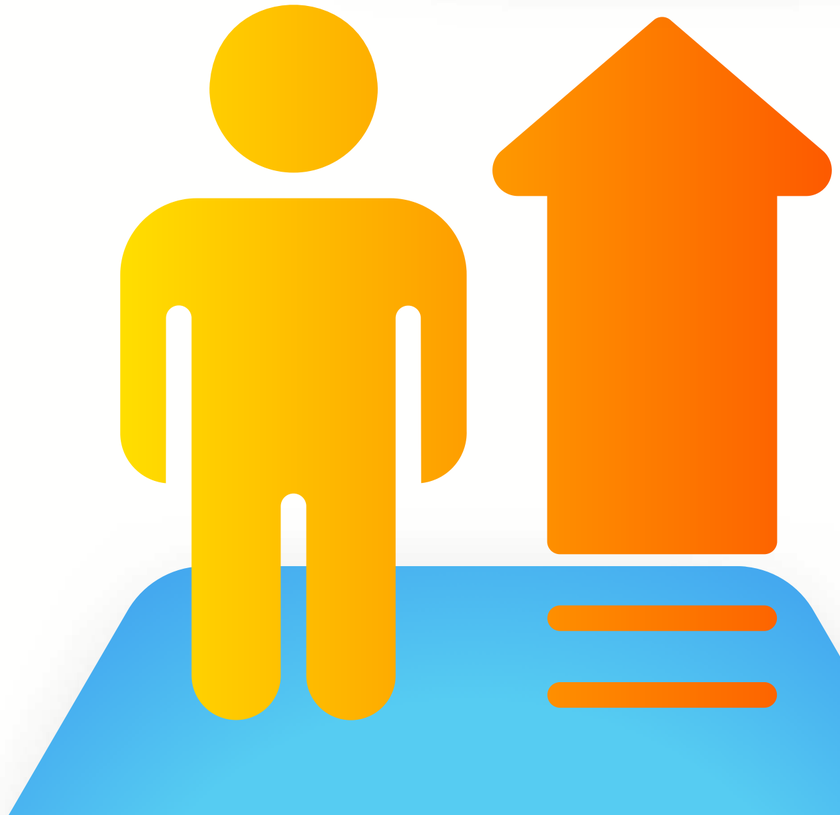
Develop and implement recruitment and retention initiatives to attract and retain high-performing employees that present the values of HGMH.

Here’s how we’ll make that happen:

- Develop Recruitment Branding
- Redesign Onboarding Process
- Explore Onsite Daycare
- Develop Student Relations

Measurements:

- Turnover rate
- Turnover first 90 days of employment
- Vacancy rate
- Time of application to time of offer



Diversity, Equity, Inclusion & Accessibility

Develop and implement an IDEA framework that aligns with the mission, vision and values of the organization and demonstrates that HGMH is an equitable provider of healthcare and employment.

Here's how we'll make that happen:

- Develop HGMH-IDEA Branding
- Create IDEA Committee
- Develop IDEA Framework
- Engage Community and Related Hospital Committees

Measurements:

- Targeted Engagement Questions
- Cultural Safety Training Completion %

Safety & Wellness

Develop and implement an updated Safety & Wellness program.

Here’s how we’ll make that happen:

- Implement Bi-Annual Fitness Challenges
- Explore Gym Membership Options
- Develop Workplace Inspections Platform
- Provide Regular Health & Safety Training to Leaders

Measurements:

- Employee Engagement Survey Results
- Safety Incidents
- Sick Time

Professional & Leadership Development

Cultivate a skilled and empowered workforce through continuous learning and leadership development.

Here’s how we’ll make that happen:

- Implement Leadership Development Programs
- Promote Professional Development for Staff
- Redesign Performance Evaluations

Measurements:

- Employee Engagement Survey Results
- Completion % of Performance Evaluations
- Training Hours

Rewards & Recognition

Reward and recognize the people of HGMH and celebrate their achievements.

Here's how we'll make that happen:

- Implement Standardized Recognition Weeks/Months
- Implement Standardized Retirement Recognition
- Develop & Implement Recognition for Quality & Service Excellence

  Measurements:
  - Employee Engagement Survey Results

Human Resources

By implementing this Human Resources strategic plan, HGMH aims to create a workplace that attracts, retains, and develops top talent while fostering a culture of diversity, equity, inclusion, safety, wellness and recognition.

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HUMAN RESOURCES STRATEGIC PLAN 2023-2028 UPDATE - February 2026

Priority	GOAL	PROGRESS
RECRUITMENT & RETENTION	Develop recruitment branding.	COMPLETE
	Redesign onboarding process.	COMPLETE
	Explore on-site daycare	COMPLETE
	Develop Student Relations	ON TRACK
DIVERSITY, EQUITY, INCLUSION & ACCESSIBILITY	Develop HGMH-IDEA Branding	COMPLETE
	Create IDEA Committee	COMPLETE
	Develop IDEA Framework	COMPLETE
	Engagement Community & Related Hospital Committees	ON TRACK
SAFETY & WELLNESS	Implement Bi-Annual Fitness Challenges	COMPLETE
	Explore Gym Membership Options	COMPLETE
	Develop Workplace Inspections Platform	NOT STARTED
	Provide Regular Health & Safety Training to Leaders	ON TRACK
PROFESSIONAL & LEADERSHIP DEVELOPMENT	Implement Leadership Development Programs	COMPLETE
	Promote Professional Development for Staff	ON TRACK
	Redesign Performance Excellence Program	ON TRACK
REWARDS & RECOGNITION	Implement Standardized Recognition Weeks/Months	COMPLETE
	Implement Standardized Retirement Recognition	COMPLETE
	Develop & Implement Recognition for Quality & Service Excellence	COMPLETE

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: February 4, 2026 Meeting Date Prepared for: February 18, 2026

Subject: New Policies Under Financial and Organizational Viability

Prepared by: Robert Alldred-Hughes

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

PURPOSE

To inform the Finance, HR and Audit Committee of a newly developed financial policies and seek endorsement for full Board for approval.

- Borrowing Policy

RECCOMENDATION AT FINANCE

The motion was amended:
THAT the Finance, HR & Audit Committee recommend to the Board of Directors the approval of the Borrowing policy as presented.
Moved By: Dr. S. Robertson
Seconded By: G. McDonald

CARRIED

RECCOMENDATION TO THE BOARD

That the Board of Directors approve the Borrowing Policy as presented.

SITUATION & BACKGROUND

A brief description of the background to the issue.

As part of ongoing efforts to strengthen financial governance, accountability, and long-term sustainability, a new policy was developed to formalize key financial practices. This policy aligns with best practices in healthcare financial management and support compliance with legislative, regulatory, and Ministry requirements. Should this be approved, the policy will be incorporated into the formal policy framework and subject to regular review through the established governance policy review cycle.

Overview of Policy

Borrowing Policy

The Borrowing policy establishes a formal framework for the authorization, management, and oversight of all borrowing activities. The policy is intended to ensure that borrowing decisions are prudent, transparent, and aligned with the organization's strategic and financial capacity.

Key elements include:

- Clear authority and approval requirements for borrowing
- Defined limits and conditions under which borrowing may occur
- Consideration of risk, affordability, and long-term financial impact
- Compliance with applicable legislation, funding agreements, and lender requirements
- Ongoing monitoring and reporting to the Board

Financial Implications

These policies do not introduce new financial commitments but strengthen governance and oversight of existing and future financial activities. Improved clarity and consistency in financial decision-making is expected to reduce risk and support long-term financial stability.

Implementation

As per the Developing, Reviewing and Revising Board Policies policy (BOD.05.001.X.XX), should this policy be approved, it will be reviewed one year after implementation and then every three years thereafter by the Governance & Nominating Committee.

SUPPORTING DOCUMENTS/ATTACHMENTS:

- Draft Borrowing Policy

Document Name:	Borrowing	
Document Number:	BOD.04.XXX.0.25	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Financial and Organizational Viability	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The Hospital is committed to maintaining prudent financial management and responsible use of debt to support its operational and strategic objectives. Borrowing will be undertaken only when necessary to ensure effective delivery of patient care, support capital development, or manage cash flow requirements. All borrowing must be approved by the Board of Directors and comply with applicable legislation, Ministry of Health requirements, and internal financial policies.

Guiding Principles

- Borrowing must not compromise the Hospital's ability to meet operational, capital, or regulatory requirements established by the Ministry of Health or other governing bodies.
- All borrowing must align with the Hospital's strategic plan, capital plan, and financial sustainability goals.
- The Hospital will seek the most cost-effective financing available while maintaining prudent risk management practices.

PROCEDURE:

1. Authorized Purposes for Borrowing

The Hospital may borrow funds or enter into lease or financing arrangements only for the following purposes:

- To secure bridge financing for working capital requirements;
- To secure operating financing (line of credit) to fund normal operating requirements arising from timing differences between cash inflows and expenditures;
- To secure capital project financing to support Board-approved capital initiatives;
- To lease or finance capital equipment that is part of the Hospital's approved capital expenditure plan;
- To lease or finance land or property consistent with the Hospital's Master Plan;
- To support an expenditure justified by a business case demonstrating acceptable financial return or operational necessity.

2. Procedures and Responsibilities

- The VP of Corporate Services & Chief Financial Officer (CFO) will
    - Prepare a detailed report for the Finance, HR and Audit Committee outlining:
        - The purpose of the borrowing;

        - Cash flow and balance sheet impacts;
        - Repayment capacity and terms of financing; and
        - Compliance with Board policies and Ministry requirements.
    - Seek financing from:
        - A Schedule I Canadian bank under the *Bank Act*;
        - The Ministry of Health or Ministry of Finance, where eligible; or
        - Reputable financial or leasing institutions offering competitive rates.

- All borrowing arrangements must be reviewed by the VP of Corporate Services & CFO and the CEO and be approved by the Board of Directors prior to execution.

- Designated Signing Authorities may execute Board-approved borrowing agreements in accordance with the Signing Authority and Approval Policy.

- The Hospital will adhere to any conditions or requirements stipulated by the Ministry of Health or other governing agencies when receiving financial assistance.

3. Reporting

An annual borrowing report will be presented to the Finance, HR and Audit Committee summarizing:

- The total outstanding debt and credit limits;
- Purpose and terms of all borrowings; and
- Any changes to existing financing arrangements.

REFERENCES:

1. Public Hospitals Act
2. Ministry of Health Guidelines on Borrowing and Financial Assistance
3. Mississippi River Health Alliance Borrowing Policy (IV-7 February 2023)
4. Health Sciences North Borrowing Policy (IV-4 September 2018)
5. Trillium Health Partners – Borrowing Policy (IV-5)

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: February 10, 2026 Meeting Date Prepared for: February 18, 2026 – Finance
February 26, 2026 - Board

Subject: Electrical Service Capacity and Upgrade Strategy

Prepared by: Robert Alldred-Hughes, President & CEO

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

PURPOSE

To inform the Board of the electrical capacity constraints at HGMH and seek alignment on proceeding with Option 2 (service upgrade to support current electrical needs, CT implementation, and future capacity), including the organization's requests to Ontario Health for capital support and inclusion within the Exceptional Circumstances stream of the Hospital Infrastructure Renewal Fund.

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.

A feasibility study completed by WSP (electrical engineering firm) identified that the hospital's existing electrical infrastructure is operating at or above its current capacity and requires upgrading to support safe operations and planned future initiatives.

The hospital's main electrical service is currently rated at 600A and supported by a 300kVA transformer. Actual peak demand has reached approximately 377kVA, which at times exceeds the transformer's capacity and creates risks to reliability and the lifespan of the equipment.

Looking ahead, planned initiatives such as the addition of a CT scanner and the systems required to operate it are expected to add roughly 141kVA of new electrical demand. When combined with current usage and a modest allowance for future growth, total projected demand is estimated at approximately 622kVA.

Hydro One has confirmed that the existing power line serving the hospital cannot support upgrades beyond 500kVA. Meeting future needs would therefore require connecting to a higher-capacity supply and installing new transformers and electrical infrastructure on site.

In practical terms, the hospital is already operating close to the limits of its electrical system. The addition of a CT scanner and future service growth will push demand beyond what the current infrastructure can safely sustain. These findings confirm that an electrical upgrade is required to maintain reliable operations today and to enable planned clinical expansion into the future.

OPTIONS CONSIDERED & ANALYSIS

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

Option 1 – Minimum Service Upgrade

- Upgrade to a 600A service and single transformer.
- Does not provide sufficient capacity for CT implementation and offers limited future growth.
- Does not provide transformer redundancy aligned with CSA healthcare facility standards.
- Estimated cost: approximately $1.74M.

Option 2 – Service Upgrade for CT Addition (Recommended)

- Installation of two 750kVA transformers connected to a 44kV supply with a new 1200A main switchgear configuration.
- Supports CT implementation, current demand, and minimum 20% capacity for future growth.
- Provides transformer redundancy consistent with CSA Z32 requirements for healthcare facilities.
- Estimated cost: approximately $3.08M.

Option 3 – Full Service and Emergency Power Redundancy

- Includes Option 2 plus full generator replacement and emergency power redundancy upgrades.
- Provides highest resilience but at significantly higher cost.
- Estimated cost: approximately $6.7M.

Option 2 is considered the most appropriate balance of safety, compliance, program enablement, and financial stewardship.

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.

Operational Impact

Implementing this upgrade will support the planned introduction of CT services and enable future clinical and program growth. It will reduce the risk of transformer overload and potential service disruptions while improving overall system reliability. The upgrade will also better align the hospital's electrical infrastructure with healthcare safety standards and expectations.

Strategic Impact

This work will enable continued progress on diagnostic expansion and broader redevelopment priorities. It also supports the hospital's long-term campus planning and ongoing efforts to modernize infrastructure in a way that meets future community needs.

Financial Impact

The estimated capital cost for the recommended option is approximately $3.08 million based on the construction estimate. Funding has been requested through Ontario Health and included as part of the hospital's Exceptional Circumstances submission under the Hospital Infrastructure Renewal program.

Risk if Not Proceeding

If the upgrade does not proceed, the hospital will continue operating beyond the intended capacity of its electrical infrastructure, increasing the likelihood of equipment failure or service disruption. This would limit the hospital's ability to safely implement CT services and support future program growth. It would also leave

the organization out of alignment with expectations for redundancy and reliability in healthcare electrical systems.

Decision Criteria

The recommended approach is guided by several key considerations, including ensuring patient and staff safety, improving infrastructure reliability and redundancy, enabling CT and future clinical services, aligning with provincial funding opportunities, and supporting responsible long-term stewardship of hospital assets.

CONSULTED WITH:

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

- Mathieu Bourbonnais – WSP, Senior Project Manager
- Julie Larose, Manager Support Services
- Linda Ramsay, VP Corporate Services & CFO

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: February 10, 2026 Meeting Date Prepared for: February 18, 2026 – Finance
February 26, 2026 - Board

Subject: EPIC Implementation Update

Prepared by: Robert Alldred-Hughes, President & CEO

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

PURPOSE

The purpose of this briefing is to update the Board of Directors on the status of Hôpital Glengarry Memorial Hospital's participation in the Atlas Alliance EPIC implementation, including progress achieved to date, emerging risks, and overall project readiness.

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.

Project Status: The Atlas Alliance Third Wave EPIC implementation remains satisfactory overall, with an overall project score of 8/10 and an average workflow walkthrough and configuration score of 7.38/10. The targeted go-live date remains October 24, 2026.

The regional EPIC implementation led by the Atlas Alliance continues to move forward as planned. The project has completed the final build wave and is transitioning into User and System Readiness, with application testing now underway and integrated testing scheduled to begin in March.

Hôpital Glengarry Memorial Hospital remains actively engaged in this work through participation in build, testing, and readiness activities across the Alliance. Local teams continue to support workflow design, application testing, and preparation for training and operational readiness. Recent milestones include migration of build environments to testing and continued involvement in Alliance-wide planning and readiness work.

While some components of the regional project are progressing more slowly than planned, this is typical for a project of this size and complexity. Areas such as Behavioral Health build, interface testing, and future appointment conversion are behind schedule across the Alliance but are being actively mitigated through additional planning, resourcing, and coordinated catch-up efforts to maintain the overall go-live timeline.

- **Budget**: The Atlas Alliance EPIC implementation project remains on track financially, with a $233,381 positive variance of budget over actual.

The HGMH Component of the is also on track as outlined below in an Epic Project Budget vs. Actual:

Timeline	Q1 (25/26)	Q2 (25/26)	Q3(25/26)	Q4(25/26)	Q1 (26/27)	Q2(26/27)	Q3(26/27)	Q4 (26/27)
Budget	$942,294	$144,587	$371,372	$178,056	$348,173	$272,115	$224,225	$152,792
Actual	$ 719,167	$134,333	$234,794					
Variance	$ 223,127	$10,254	$136,578					

Year to Date Spend: $1,088,294

Year to Date Budget Variance: $369,959

In addition to the above, we have built in a $500K contingency.

Overall, the project continues to progress satisfactorily, with an October 2026 go-live still targeted. Major build milestones have been achieved, testing is underway, and attention is now shifting toward readiness, training, and operational preparation in the months ahead.

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.

Current Risks and Mitigation Update

As part of the Atlas Alliance Third Wave EPIC implementation, there are a few areas where progress across the broader Alliance is not moving as quickly as originally planned. This is not unexpected in a project of this scale, and the work continues to move forward with active mitigation in place. Overall, the program remains stable, and HGMH is engaged and monitoring closely.

Build progress

Some of the Alliance build work is running behind schedule, with a portion of workgroups still completing earlier deliverables. This has the potential to put pressure on later phases such as testing if timelines are not recovered. The Alliance has increased oversight and prioritization, and HGMH continues to stay closely involved to ensure our needs are represented and local readiness planning stays aligned.

Operational readiness

A number of application areas are taking longer than anticipated to finalize decisions and configuration. This is being experienced across multiple partner organizations, not just HGMH. In the meantime, our clinical and operational teams are continuing their local planning so that workflows and readiness activities can progress in parallel.

Training preparation

Some training materials are still in development and not yet fully complete. While this creates some pressure on timelines, the education teams are actively working to close these gaps. Locally, the focus remains on early engagement with physicians and staff so that once training begins, adoption can move quickly.

Data and system readiness

Certain data conversion activities and interface testing steps are slightly behind across the Alliance. These are technical but important elements of readiness. Work is underway to bring these activities back on track, and HGMH is maintaining close coordination to ensure our systems and data remain prepared.

Patient record quality

Early work on consolidating patient records has identified a higher number of duplicate records across new partner organizations than expected. This is a known issue in large system transitions and is being actively addressed through Alliance-wide data cleanup and validation efforts ahead of go-live.

Overall perspective

These risks reflect the normal complexity of implementing a shared EPIC platform across multiple hospitals and care settings. They are not specific to HGMH, and there is active mitigation underway at both the Alliance and local levels. We are not in a position of concern with the project, but we are in a phase that requires continued attention, engagement, and steady execution. Leadership will continue to monitor progress and keep the Board informed as the program advances.

CONSULTED WITH:

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

- Jen Mattice, Manager of Projects, Emergency Preparedness & Security
- Dave Lorimer, Project Lead, and Manager of Information Technology
- Linda Ramsay, Vice President of Corporate Services & CFO

Correspondence

January 27, 2026 – Standard Freeholder – Hôpital Glengarry Memorial Hospital Foundation at $1.7 million raised for CT scanner

January 28, 2026 – Seaway News – Alexandria Moulding pledges $30K to HGMH

January 29, 2026 – The Review - $30,000 pledged for Glengarry hospital foundation

January 31, 2026 – The Review – MNP Contributes to CT campaign at Glengarry hospital

February 2, 2026 – Seaway News – Impact of expanded francophone services

February 11, 2026 – SDG & A Cornwall Seeker – Community Steps Up for HGMH CT Scanner with Business Pledge and Transformative Legacy Gift

February 12, 2026 – Standard Freeholder – Volunteer donates $100K to Hôpital Glengarry Memorial Hospital in memory of son and husband

February 13, 2026 - $100,000 donated to Glengarry CT campaign