HÔPITAL Glengarry Memorial HOSPITAL

BOARD QUALITY AND PATIENT SAFETY COMMITTEE MEETING AGENDA

Date: Wednesday, May 13, 2026
Time: 16:00 – 17:00
Location: Boardroom / Microsoft Teams

Time	Agenda Item	Board Item	Attachment
16:00	**1. Call to Order**		
(1 min)	1.1 Confirmation of Quorum		
(1 min)	1.2 Adoption of the agenda		P. 1-2
(1 min)	1.3 Declaration of Conflict of Interest		
16:03	**2.Report from Last Meeting**		
(1 min)	2.1 Approval of previous meeting report – April 8, 2026		P. 3-4
(1 min)	2.2 Business arising from the report		
(1 min)	2.3 Committee Work Plan Review		P. 5
16:06	**3. Education Session**		
(10 min)	3.1 Patient Story (R. Romany)		
16:16	**4. Matters for Decision**		
(5 min)	4.1 Review 2026-2027 Committee Workplan (H. Salib) **That the Quality & Patient Safety Committee recommend the 2026-2027 Quality & Patient Safety Committee Workplan to the Governance & Nominating Committee as presented.**		P. 6
(5 min)	4.3 Review Q4 2025-2026 Quality Improvement Plan Results (R. Romany) **That the Quality & Patient Safety Committee review and receive the Q4 quality improvement plan results for 2025-2026 as presented.**	D	P. 7-9
(5 min)	4.4 Review Q4 2025-2026 Quality & Safety Scorecard (R. Romany) **That the Quality & Patient Safety Committee review and receive the Q4 quality & safety scorecard results for 2025-2026 as presented.**	D	P. 10-11
(5 min)	4.5 Review Patient Satisfaction Survey Results (R. Romany) **That the Quality & Patient Safety Committee review and receive the patient satisfaction survey results as presented.**	D	P. 12-15
16:36	**5. Matters for Information**		
(2 min)	5.1 BPSO Updates (R. Romany)	C	P. 16
(5 min)	5.2 Review HIROC Report (R. Alldred-Hughes)	C	P. 17-22
(5 min)	5.3 Review Hospital Services (Dr. L. MacKinnon)	C	P. 23-26
(5 min)	5.4 Review Trillium Gift of Life Report (R. Romany)	C	P. 27-29
(5 min)	5.5 Review Professional Staff HR Plan (Dr. L. MacKinnon)	C	P. 30-31
(5 min)	5.6 Review Physician Engagement Survey Results (Dr. L. MacKinnon)	C	P. 32
17:03	**6. Date of Next Meeting**		
	TBC - September 2026		
17:04	**7. Adjournment**		

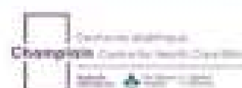
Board Item: Matters for Discussion/Decision (D) or Consent Agenda (C)
*Refer to the Accountability for Reasonableness (A4R) framework for organizational ethical issues.

Accountability for Reasonableness (A4R) Ethical Decision Making Framework Steps

Values that Optimize Fairness in the Process of Decision-Making

A4R Action Steps

Step	Actions
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.



HÔPITAL Glengarry Memorial HOSPITAL

REPORT OF THE BOARD QUALITY AND PATIENT SAFETY COMMITTEE MEETING

April 8, 2026 at 4:00PM Boardroom/MS Teams

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

Summary of Discussion

Approval of the Agenda:
The agenda was reviewed.

Moved By: C. Larocque
Seconded By: D. Elie
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 February 18, 2026, was approved as presented.

Moved By: G. Peters
Seconded By: D. Elie
THAT the report of February 18, 2026, be approved as presented.

CARRIED

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

Committee Work Plan
Things remain on track with the committee work plan.

Education - Quality Initiative

Education was done on pressure injuries and the boards role in monitoring these. One of our deliverables for our QIP is to build wound care capacity within the organisation to help support this initiative.

Matters for Discussion/Decision

Review Hospital Services
Deferred

Violent Incidents
The violent incidents were reviewed.

Moved By: C. Larocque
Seconded By: G. Peters

DRAFT

That the Quality & Patient Safety Committee review and receive the violent incidents report as presented.

After two reports of violent incidents from one patient, a care plan is put in place for that patient to determine what can be done to avoid any other incidents from happening. In Q4, the violent incidents that occurred were from the same patient, and that patient now has 24/7 security as per the patient care plan.

We are in the process of implementing nonviolent crisis intervention training, offered by the Canadian Patient Institute, to educate staff on how to address situations in a safe way for both the staff member and for the patient. This education will be starting with staff from the emergency department.

CARRIED

Emergency Preparedness

The emergency preparedness report was reviewed.

Moved By: C. Larocque
Seconded By: G. Peters
THAT the Quality & Patient Safety Committee review and receive the Emergency Preparedness report as presented.

The emergency preparedness program has been completely revamped, and we are looking at submitting it as an Accreditation Canada spotlight.

It was asked that the code colors be included on the report going forward.

CARRIED

Matters for Information

PFAC Updates

Updates on the work done by the committee were shared including that members continue to sit on internal committees, such as the Board of Directors, Ethics, Quality & Safety Advisory, and Product Evaluation.

The committee was once again asked to come up with an initiative as part of our strategic actions and they are also working on coming up with a question for interviews.

The committee is helping with patient experience week which is taking place at the end of the month, and they will be helping co-design a palliative care space.

Ethics Committee Updates

An ethics day took place in January in which education was done which included a presentation at the Board of Directors meeting. We now have a dedicated ethics email for anyone who has ethical questions. The ethics committee is split in two, in which a portion is allocated to an ethics case review where all staff and physicians are welcome to join followed by the regular committee meeting.

A case study will be prepared by the ethicist for the Board.

Date of Next Meeting: Wednesday, May 13, 2026

K-L. Massia, Recorder

DRAFT

Quality & Patient Safety Committee
Work Plan 2025-2026

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

Revisions since prior report:

Review Trillium Gift of Life Report – added January 2026
Review Physician Engagement Survey Results

March 30, 2026

Quality & Patient Safety Committee Work Plan 2026-2027

Deliverable	Legislation/Accountability	MRP	Occurrence	Sep	Nov	Jan	Feb	Apr	May
STRUCTURE/PROCESSES									
Review/Recommend Committee Terms of Reference		Chair	Annually	X					
Review Committee Effectiveness Survey Results		Chair	Annually	X					
Review/Recommend Annual Committee Work Plan to Governance		Chair	Annually						X
MEDICAL AFFAIRS									
Professional Staff Appointment and Re-appointment Process Review	*PHA*	COS	Annually		X				
Review Professional Staff HR Plan	*PHA*	COS	Annually		X				X
Appoint professional staff on recommendation of Medical Advisory Committee	*PHA*	COS	Annually			X			
Review Student/Resident Placement Report		COS	Annually				X		
Review Hospital Services		COS	Annually/As Occurs					X	
Review Physician Engagement Survey Results		COS	Annually					Survey to be sent	X
Medical Advisory Committee Recommendations	*PHA*	COS	As Occurs						
EDUCATION									
Patient Story		CNE			X		X		X
Quality Initiatives		CNE		X		X		X	
QUALITY OVERSIGHT AND IMPROVEMENT									
Review QIP Dashboard	ECFAA	CNE	Quarterly	Q1	Q2		Q3		Q4
Recommend QIP Dashboard 2027-2028	ECFAA	CNE	Yearly				X		
Quality & Safety Scorecard		CNE	Quarterly	Q1	Q2		Q3		Q4
Review Patient Satisfaction Survey Results	ECFAA	CNE	Quarterly	Q1	Q2		Q3		Q4
Review Life or Limb Results		CNE	When available						
Review Complaints & Compliments Report	ECFAA	CNE	Quarterly			X			
PFAC Updates	ECFAA	CNE	Quarterly	X		X		X	
Review Critical Events and Never Events Report	*PHA + Ontario Patient Safety Reporting requirements*	CNE	Yearly			X			
BPSO Update	RNAO BPSO	CNE	Quarterly	X	X		X		X
Review Patient Quality & Safety Plan	*ECFAA + Accreditation Canada Qmentum Standards*	CNE	Yearly				X		
Review Status of Patient Safety Plan Actions		CNE	Bi-Annual		X				
Review Provincial Stroke Report Card	OH	CNE	When available						
Review Ethics Committee Updates		CNE	Yearly					X	
Review Trillium Gift of Life Report	Trillium Gift of Life Network Act	CNE	Quarterly	Q1	Q2		Q3		Q4
SAFETY / RISK / OPERATIONS									
Violent Incidents Report	OHSA	CHRO	Yearly					X	
Review Emergency Preparedness		CHRO	Yearly					X	
Review Business Continuity Plan		CEO	Yearly		X				
Privacy & Confidentiality Overview	PHIPA	HIS	Yearly	X					
Review HIROC Report		CEO	Yearly						X
ACCREDITATION									
Accreditation Updates		CEO	Quarterly	X		X			
Accreditation Standard Review		CNE	Quarterly	X	X	X			
ESTIMATED PREPARATION TIME FOR MEETING:				1.5H	1.5H	1.5H	1.5H	1.5H	1.5H

Revisions since prior report:

April 21, 2026

HÔPITAL Glengarry Memorial HOSPITAL

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: May 1, 2026 Meeting Date Prepared for: May 13, 2026

Subject: Quality Improvement Plan (QIP) Results- Q4

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 Q4
- Discuss contributing factors and mitigation strategies for improvement

IMPLICATIONS TO OTHER STANDING COMMITTEES

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

SITUATION & BACKGROUND

A brief description of the background to the issue.

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

IMPACT ANALYSIS/RISK ASSESSMENT/DECISION CRITERIA

![Hôpital Glengarry Memorial Hospital]

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

Our QIP for Q4 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	Jan-26	Feb-26	Mar-26	Q4	YTD
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%	4.8%	4.5%	4.4%	4.6%	5.4%

- **Q4** ended with 4.6%, 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 helps 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	Jan-26	Feb-26	Mar-26	Q4
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	3.6	3.2	3.4	3.4

- **Q4** ended with 3.4 hours, which is positively below the target of 4.6 hours.
- **Strategy:** Continuous improvement through appropriate implementation of medical directives and active flow management, with a patient flow coordinator reallocating patients and staff as needed and coordinating with inpatient team on ED flow.

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	Jan-26	Feb-26	Mar-26	Q4	
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%	86.1%	86.1%	86.1%	86.1%	86.1%

- **Q4** ended with 86.1%, achieving the target of 25%.
- **Strategy:** IDEAA principles e-learning module provided to staff. This training helps staff provide respectful, unbiased, and inclusive 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	Jan-26	Feb-26	Mar-26	Q4	
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%	97.6%	97.2%	98.2%	96.9%	96.6%	97.2%	96.9%

- **Q4** ended with 97.2%, which is above the target of 89%.
- **Strategy:** Ongoing engagement of 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	Jan-26	Feb-26	Mar-26	Q4
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	0	0	0	0

- **Q4** 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 reported near misses related to controlled substances within the organization

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	Jan-26	Feb-26	Mar-26	Q4
Safety	Safe	Number of medication errors that reached the patient due to wrong drug/dose/patient (incident severity levels 2-5) Update: the target was originally 10 but it is now adjusted to an annual target of 24, monthly target of 2		10	Adjusted annual target 24 and 2 per month	2	0	1	3	5	1	2	8	2	2	2	6	0	1	0	1

- **Q4 ended at 1 incident, a total of 18 incidents which is below the annual target of 24 reported incidents.**
- 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.

Summary

- The Quality Improvement Plan 2025-26 highlights our achievements in all of our Q4 targets and emphasizes that ongoing teamwork, collaboration and shared accountability are essential for our continuous improvement as we tackle areas of opportunities.

HÔPITAL Glengarry Memorial HOSPITAL

Quality Improvement Plan (QIP)
Fiscal 2025/26

Print

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	Jan-26	Feb-26	Mar-26	Q4	YTD
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%	4.8%	4.5%	4.4%	4.6%	5.4%
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	3.6	3.2	3.4	3.4	4.3
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%	86.1%	86.1%	86.1%	86.1%	86.1%
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%	97.6%	97.2%	98.2%	96.9%	96.6%	97.2%	96.9%
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	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) Update: the target was originally 10 but it is now adjusted to an annual target of 24, monthly target of 2		10	Adjusted annual target 24 and 2 per month	2	0	1	3	5	1	2	8	2	2	2	6	0	1	0	1	18

Metric underperforming target by more than 25%

Metric within 25% of target

Metric equal or outperforming target

HÔPITAL Glengarry Memorial HOSPITAL

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared:	May 1, 2026	Meeting Date Prepared for:	May 13, 2026
Subject:	Quality and Safety Scorecard Q4 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 Q4 results 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
  - 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 (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:
  - Fall Rate- 17.7 % above the target of 12%, Falls with injury 31.25% which is above the target of 30%.
    - Strategy: Ongoing purposeful patient rounding and implementation of fall risk prevention strategies, with a focus on staff reminders on alarm equipment/use and early identification of high-risk patients.

- Incidents of Physical Violence- 20 incidents in Q4, yearly total of 41 which is above the target of 17 incidents
  - **Strategy:** Majority of the incidents were related to one patient who has cognitive issues. Goal was to reduce the frequency and severity of the incidents with an individualized behaviour support plan, clear de-escalation strategies, and engaging psychiatry and geriatrics for behavioural support while maintaining patient dignity, safety and staff well-being.
- Number of medication errors that reached the patient (severity levels 2-5) – Q4 was 1 incident, yearly total of 11, which did not meet the target of 8 incidents.
  - **Strategy:** Continue with safe medication practices such as bedside verification, administration checks and accountability for IV medications.
- Pressure injury development- Q4 result is 1, yearly total of 7, which does not meet the target of O.
  - **Strategy**: Ongoing reinforcement of repositioning schedules and wound care assessment and management. Discussion of pressure injury trends and prevention strategies in staff meetings and safety huddles.

SUMMARY

Monitoring quality indicators helps identify issues early and informs actions to improve patient care.

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 physician	hours	4.8	4.6	4.4	4.1	3.5	3.4	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%	97.2%	97.2%	96.9%	Above	
3. Safe & Effective Care											
	Fall Rate	# of incidents per 1000 patient days	14.2	12	19.5	9.6	8.2	17.7	13.7	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	31.25	30.14	Below	
	Incidents of Physical Violence	Actual number	17 (total)	17	15	4	2	20	41	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	1	11	Below	
	Pressure injury development rate (stage 2,3,4) during inpatient stays	Actual number	3	0	3	1	2	1	7	Below	
	Hand hygiene compliance rate (Moment 1)	# compliant activities / # of indicated activities	75.6%	92.0%	81.9%	79.8%	91.8%	94.1%	86.0%	Above	
	Hand hygiene compliance rate (Moment 4)	# compliant activities / # of indicated activities	93.3%	92.0%	93.4%	85.2%	90.6%	96.7%	91.1%	Above	
	C. difficile rate	# of incidents per 1000 patient days	0.52	0.00	0.00	1.11	0.00	0.00	0.28	Below	
	VRE Rate	# of incidents per 1000 patient days	0.00	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	0.00	2.34	Below	
4. Equity											
	Translation Services Usage	Number of minutes		50	49	54	70	247	120		

Metric underperforming target by more than 25%

Metric within 25% of target

Metric equal or outperforming target

HÔPITAL Glengarry Memorial HOSPITAL

DECISION SUPPORT DOCUMENT FOR

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

☐ Other *(please specify):*

Date Prepared: April 16, 2026 Meeting Date Prepared for:

Subject: Patient Satisfaction Surveys Q4

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

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

PURPOSE

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

IMPLICATIONS TO OTHER STANDING COMMITTEES

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

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

ANALYSIS

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

- Note: Q4 2026 column is the YTD average result for the indicator.

Quarterly Dashboard 1,356

	Q1 2026	Q2 2026	Q3 2026	Q4 2026
Care Rating	8.5	8.6	8.7	8.6
I did not have a long wait	60%	65%	71%	77%
During the visit, were you told the reason for the long wait?-1 to 3	24%	24%	34%	17%
Do you feel that there was good communication about your care between doctors?-1 to 4	98%	97%	96%	97%
How often did care providers treat you with courtesy and respect?	100%	99%	99%	99%
How often did care providers explain things in a way you could understand?	98%	98%	98%	99%
Did you get the emotional support you needed to help you with any anxieties?	95%	93%	90%	91%
Did care providers do everything they could to ease your discomfort?	90%	93%	94%	94%
Did you participate in your plan of care?-1 to 3	92%	93%	95%	93%

Gender Diverse Care Rating (16)	Sexual Orientation Care Rating (152)	Race Care Rating (100)	First Nation Care Rating (46)
6.9	8.5	8.5	8.8

HÔPITAL Glengarry Memorial HOSPITAL

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.

Satisfaction Indicators:

- Overall Care Rating: Consistent at 8.6, reflecting sustained high satisfaction.
- Wait time: Patient not having a long wait is continually increasing from 71% → 77%
- Courtesy and Respect: Near-perfect score 99% show consistent excellence in staff–patient interactions.
- Communication Among Providers: Very high and stable at 97% suggesting strong care coordination.
- Clarity of Explanations: Maintained at 99%, indicating providers explain conditions and treatments effectively.
- Participation in Care Planning: Steady at 93% reinforcing patient-centered care.
- Race & First Nation Care Ratings: High equity perceptions (8.5), demonstrating cultural sensitivity and inclusiveness.

Improvement Opportunities

While overall satisfaction is high, opportunity for targeted improvement:

- Communication of reason for the long wait –17% indicating room to continue to provide information to ED patients about long wait.

Strategy:

- Continue with proactive updates in the waiting room
- Continue to provide explanations with empathy, e.g. " I know this wait is frustrating and I appreciate your patience". Emphasize that acknowledging the wait is as important as explaining it.
- Continue to share survey results with staff and recognize improvements.

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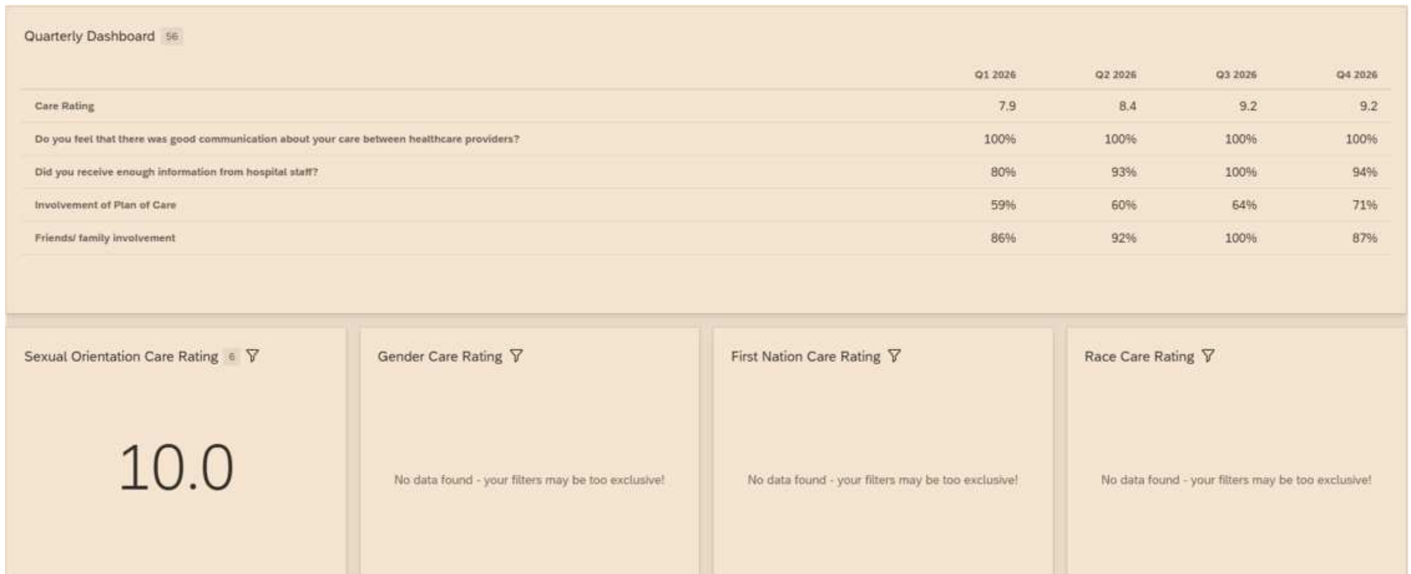
INPATIENT REHAB UNIT- 38 total respondents (cumulative for 3 quarters)



Quarterly Dashboard

	Q1 2026	Q2 2026	Q3 2026	Q4 2026
Care Rating	7.9	8.4	9.2	9.2
Do you feel that there was good communication about your care between healthcare providers?	100%	100%	100%	100%
Did you receive enough information from hospital staff?	80%	93%	100%	94%
Involvement of Plan of Care	59%	60%	64%	71%
Friends/ family involvement	86%	92%	100%	87%

Sexual Orientation Care Rating	Gender Care Rating	First Nation Care Rating	Race Care Rating
10.0	No data found - your filters may be too exclusive!	No data found - your filters may be too exclusive!	No data found - your filters may be too exclusive!

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: Steady at 9.2, 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 is at 94% rating
- Sexual Orientation Care Rating: Achieved a perfect 10.0, highlighting excellence in providing respectful, inclusive, and affirming care for this demographic group.

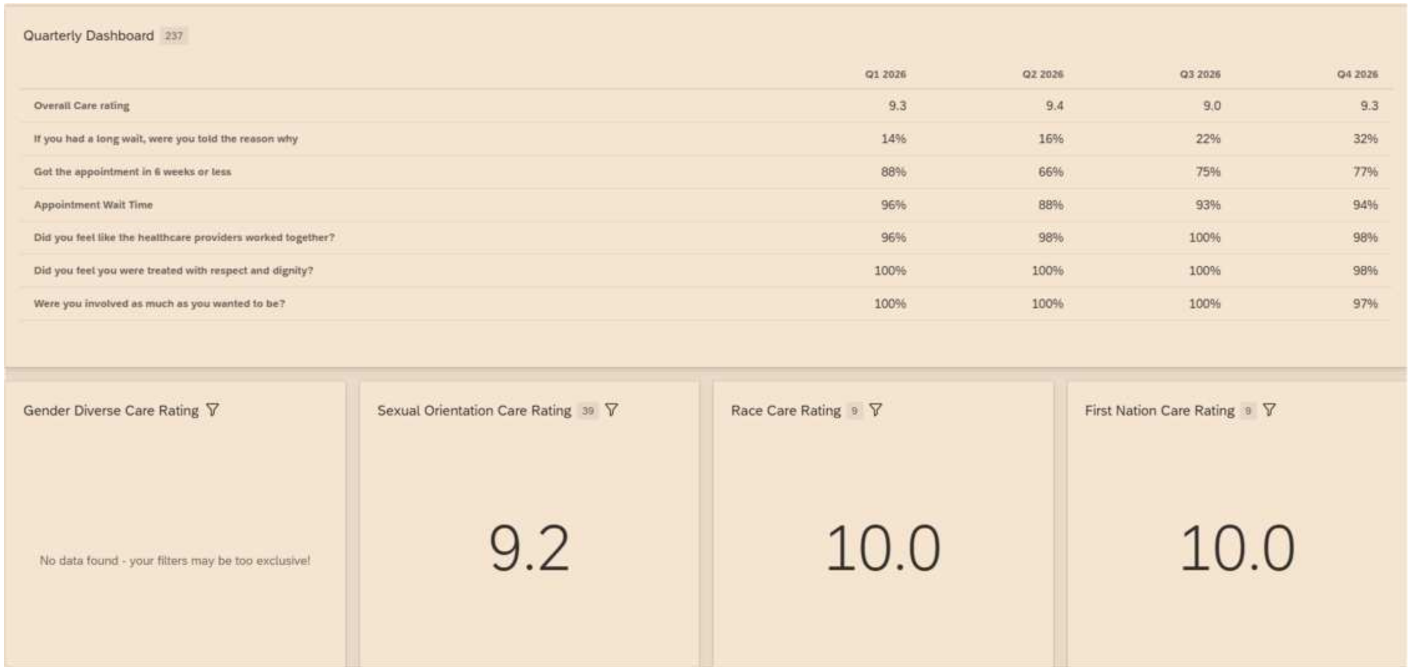
Improvement Opportunity

- Involvement in Plan of Care as well as Friends/Family Involvement can be improved at its current standing of 74% and 85%, respectively suggesting more communication with the patient on his/ her care plan.

Strategies

- Enhance Shared Decision-Making:
  - Continue to include family/friends to attend care conferences, therapy sessions or goal reviews.
  - Continue to review patient survey results at team huddles.

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



Quarterly Dashboard 237

	Q1 2026	Q2 2026	Q3 2026	Q4 2026
Overall Care rating	9.3	9.4	9.0	9.3
If you had a long wait, were you told the reason why	14%	16%	22%	32%
Got the appointment in 6 weeks or less	88%	66%	75%	77%
Appointment Wait Time	96%	88%	93%	94%
Did you feel like the healthcare providers worked together?	96%	98%	100%	98%
Did you feel you were treated with respect and dignity?	100%	100%	100%	98%
Were you involved as much as you wanted to be?	100%	100%	100%	97%

Gender Diverse Care Rating	Sexual Orientation Care Rating 39	Race Care Rating 9	First Nation Care Rating 9
No data found - your filters may be too exclusive!	9.2	10.0	10.0

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: Increased from 9.0 → 9.3.
- Respect & Dignity: Maintained at 98%, showing consistently compassionate, patient-centered care.
- Involvement in Care Decisions: Maintained at 97% indicating that patients feel fully included in care planning and decisions.
- Collaboration Between Providers: Achieved at 98% demonstrating highly coordinated, team-based care delivery.
- Equity Ratings:
    - Race Care: 10.0
    - First Nation Care: 10.0
    - Sexual Orientation Care: Strong at 9.2

Improvement Opportunity

- Timeliness of Care:
    - Appointment within 6 weeks is 77% this quarter, which includes appointments for diagnostic imaging, e.g. ultrasound. An extra weekend ultrasound day was added to manage high referral volumes and long wait times.

Summary

Q4 results reflect sustained performance with clear opportunities to further enhance communication, engagement and access. Overall satisfaction remains high across all departments, supported by strong provider communication, respect and dignity, and equity-related care indicators. Targeted improvement efforts will continue to focus on areas identified by patients to improve the overall patient experience.

HÔPITAL Glengarry Memorial HOSPITAL

DECISION SUPPORT DOCUMENT FOR

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

☐ Other *(please specify):*

Date Prepared:	May 1, 2026	Meeting Date Prepared for:	May 13, 2026
Subject:	RNAO- Best Practice Spotlight Organization (BPSO) Update		
Prepared by:	Rachel Romany- Vice President Clinical Services, Quality, Chief Nursing Executive		

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

PURPOSE

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

SITUATION & BACKGROUND

A brief description of the background to the issue.

- HGMH's focus for 2025-26:
  - RNAO's Evidence- based Best Practice Guideline (BPG): A Palliative Approach to Care in the Last 12 Months of Life
    - The guideline offers evidence-based recommendations to nurses and interprofessional teams for supporting adults in the last 12 months of progressive life-limiting illness, focusing on delivering psychosocial, spiritual, and culturally safe care, improving care coordination, and fostering supportive work environments.
  - BPSO Champion In-person Session by our trainer- Carissa Auger RPN
    - Target is to have 20% of staff complete the training. Additional 11 staff and 2 students became BPSO Champions as of April 1, 2026. Plan is to provide quarterly in-person sessions.
    - BPSO Champions support our hospital's commitment to excellence and contribute to a stronger, safer, and more consistent patient experience. This commitment is shared across the organization, with 100% participation from non-clinical teams including the Business Office, Pharmacy, and all members of the Senior Leadership Team.
    - Here is a picture of the recently certified champions (Keri M. is not in the picture but she is also certified!)

EVERY DAY EXCELLENCE
L'EXCELLENCE À TOUS LES JOURS

HÔPITAL Glengarry Memorial HOSPITAL

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared:	May 5, 2026	Meeting Date Prepared for:	May 13, 2026
Subject:	HIROC Claims History		
Prepared by:	Robert Alldred-Hughes, President & CEO		

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

PURPOSE

The purpose of this briefing note is to provide an overview of historical insurance file claims submitted to the Hospitals Insurance Reciprocal of Canada (HIROC) and to outline why the Board of Directors is reviewing this information.

RECOMMENDATION / MOTION

THAT the Quality & Patient Safety Committee review and receive the Hospitals Insurance Reciprocal of Canada historical claims submission.

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.

- Hôpital Glengarry Memorial Hospital (HGMH) has a longstanding relationship with HIROC, our insurance provider.
- Over the years, HGMH has submitted insurance claims for incidents ranging from professional liability to property damage.
- As part of our ongoing commitment to quality improvement and risk management, the Board of Directors conducts a thorough review of our historical insurance file claims.
- This review aims to identify trends, patterns, and areas for improvement in our operations, patient care, and risk mitigation strategies. By analyzing past claims data, we can gain valuable insights into potential areas of vulnerability and take proactive measures to prevent future incidents.

OPTIONS CONSIDERED & ANALYSIS

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

- HGMH conducts quality reviews related to critical events, or events involving the care of our patients where there is opportunity to learn. These reviews can also lead to root cause analysis, risk assessments, and actions plans.
- When a Quality Review is conducted by the care team, the recommendations do come to the Quality Committee of the Board for awareness.
- In addition, reviewing claims history can help with identification of trends which analyze the frequency and nature of past insurance claims to identify any recurring patterns or trends. This may include common types of incidents, departments or areas most frequently involved, and contributing factors such as human error or

system failures. Upon review of the most recent history, there has not been any trends identified, as the one submissions do not have common factors, nor do the submissions from recent years.

- By conducting this comprehensive review of our historical insurance file claims, we can enhance our risk management practices, improve patient safety, and ultimately enhance the overall quality of care provided at HGMH.

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- HIROC Claims Audit Report

HIROC

4711 Yonge Street, Suite 1600
Toronto, ON M2N 6K8
T: 416.733.2773
800.465.7357
F: 416.733.2438
800.668.6277

1200 Rotheasy Street
Winnipeg, MB R2G 1T7
T: 204.943.4125
800.442.7751
F: 204.949.0250

April 02, 2026

PRIVILEGED AND CONFIDENTIAL

Glengarry Memorial Hospital
20260 County Road 43
Alexandria ON K0C 1A0

Dear Subscriber,

2025-2026 HIROC Claims Listing for Audit

The HIROC Claims Audit report is a complete listing of all liability claims (excluding supplemental HIV employee payments) reported to HIROC by your institution as at the close of business on March 31, 2026.

HIROC's practice is to notify by special letter those Institutions which have reported matters that are being dealt with subject to a Reservation of Rights letter or Non-Waiver agreement. I am pleased to confirm that there have been no matters reported by your Institution with any reasonable chance, in HIROC's opinion, of settling at or above the applicable policy limits.

This report contains privileged and confidential commercial and financial information related to legal claims submitted to HIROC, the disclosure of which would be harmful to HIROC and your institution. Information in the report may also be subject to legal privilege. The report must therefore be kept confidential and not disclosed to anyone other than the hospital's auditor without HIROC's express written permission.

This letter and report must be forwarded to your Auditor by your institution. We recommend that you password protect them. HIROC does NOT provide the letter and report to your Auditors.

If you have any questions or concerns, please email us at claimsauditreport@hiroc.com.

Yours very truly,

Gareth Lewis
Vice President, Claims

Claims Audit Report

Accounting Date As Of: 31-Mar-2026

Glengarry Memorial Hospital - 107254

Risk Name	Claim No	Coverage	Policy Year	Date of Loss	Date Reported	Indemnity Paid	Expense Paid	Total Paid	Reserved	Total Incurred	Date Closed	Claim Status	Claim Type
Glengarry Memorial Hospital	254-10552	A:Bodily Injury	2006	04-Nov-2006	20-Nov-2006	$0.00	$2,006.57	$2,006.57	$0.00	$2,006.57	18-Dec-2007	CLOSED	Claim
Glengarry Memorial Hospital	254-11512	C: Prof Liab	2008	17-Jan-2006	05-Feb-2008	$0.00	$42,159.09	$42,159.09	$0.00	$42,159.09	05-Jul-2012	CLOSED	Suit
Glengarry Memorial Hospital	254-11711	C: Prof Liab	2008	07-Mar-2008	07-May-2008	$0.00	$431.60	$431.60	$0.00	$431.60	09-Jul-2009	CLOSED	Claim
Glengarry Memorial Hospital	254-12024	A:Bodily Injury	2008	28-Aug-2008	22-Sep-2008	$0.00	$1,737.96	$1,737.96	$0.00	$1,737.96	25-Nov-2009	CLOSED	Claim
Glengarry Memorial Hospital	254-12247	B:Property Dam.	2008	31-Dec-2008	06-Jan-2009	$634.13	$863.96	$1,498.09	$0.00	$1,498.09	17-Dec-2009	CLOSED	Claim
Glengarry Memorial Hospital	15548-01	C: Prof Liab	2009	03-Aug-2008	10-Nov-2009	$0.00	$5,259.91	$5,259.91	$0.00	$5,259.91	19-Jan-2011	CLOSED	Claim
Glengarry Memorial Hospital	254-13007	C: Prof Liab	2009	27-Dec-2007	30-Oct-2009	$0.00	$43,300.67	$43,300.67	$0.00	$43,300.67	27-Jul-2015	CLOSED	Suit
20260 County Road 43	15070-01	C: Prof Liab	2010	12-Jan-2010	13-Jan-2010	$0.00	$1,683.64	$1,683.64	$0.00	$1,683.64	07-Jan-2011	CLOSED	Claim
20260 County Road 43	16296-01	C: Prof Liab	2010	07-Oct-2010	13-Oct-2010	$0.00	$1,935.36	$1,935.36	$0.00	$1,935.36	28-Nov-2011	CLOSED	Claim
20260 County Road 43	17374-01	C: Prof Liab	2011	03-Feb-2009	07-Jun-2011	$0.00	$40,435.83	$40,435.83	$0.00	$40,435.83	17-Oct-2014	CLOSED	Suit
20260 County Road 43	18346-01	D:Conting.Empl.	2011	30-Sep-2011	16-Dec-2011	$0.00	$5,610.62	$5,610.62	$0.00	$5,610.62	26-Mar-2013	CLOSED	Suit
20260 County Road 43	20824-01	C: Prof Liab	2013	31-May-2013	03-Jun-2013	$0.00	$4,231.78	$4,231.78	$0.00	$4,231.78	30-Jan-2014	CLOSED	Claim
Glengarry Memorial Hospital	20831-01	A:Bodily Injury	2013	03-Jun-2013	04-Jun-2013	$0.00	$5,002.00	$5,002.00	$0.00	$5,002.00	03-Nov-2014	CLOSED	Claim
20260 County Road 43	22710-01	A:Bodily Injury	2014	19-Jul-2014	22-Jul-2014	$0.00	$2,146.57	$2,146.57	$0.00	$2,146.57	26-Oct-2016	CLOSED	Claim
20260 County Road 43	25260-01	C: Prof Liab	2016	02-Nov-2014	15-Jan-2016	$0.00	$2,794.43	$2,794.43	$0.00	$2,794.43	02-Jun-2017	CLOSED	Claim
20260 County Road 43	27445-01	C: Prof Liab	2017	10-Jun-2015	14-Mar-2017	$0.00	$2,549.58	$2,549.58	$0.00	$2,549.58	29-Jun-2018	CLOSED	Claim
20260 County Road 43	27806-01	C: Prof Liab	2017	12-Aug-2016	25-May-2017	$0.00	$4,224.71	$4,224.71	$0.00	$4,224.71	21-Feb-2019	CLOSED	Claim
20260 County Road 43	32563-01	C: Prof Liab	2019	30-Sep-2017	03-Sep-2019	$12,500.00	$20,493.76	$32,993.76	$0.00	$32,993.76	26-Jan-2021	CLOSED	Suit
20260 County Road 43	33454-01	C: Prof Liab	2020	07-Jan-2018	05-Feb-2020	$0.00	$45,667.46	$45,667.46	$0.00	$45,667.46	11-Oct-2023	CLOSED	Suit
20260 County Road 43	34382-01	C: Prof Liab	2020	26-Jun-2020	08-Jul-2020	$64,000.00	$7,563.42	$71,563.42	$0.00	$71,563.42	17-Mar-2022	CLOSED	Claim
20260 County Road 43	41037-01	C: Prof Liab	2023	18-Jan-2022	06-Feb-2023	$0.00	$27,191.83	$27,191.83	$17,808.17	$45,000.00		OPEN	Suit
20260 County Road 43	41242-01	C: Prof Liab	2023	03-Mar-2023	06-Mar-2023	$0.00	$5,721.10	$5,721.10	$0.00	$5,721.10	21-Mar-2025	CLOSED	Claim
20260 County Road 43	42527-01	C: Prof Liab	2023	27-Jul-2023	09-Aug-2023	$0.00	$1,720.00	$1,720.00	$0.00	$1,720.00	22-Jan-2025	CLOSED	Claim
20260 County Road 43	45615-01	A:Bodily Injury	2024	23-Aug-2024	09-Sep-2024	$0.00	$3,522.63	$3,522.63	$0.00	$3,522.63	19-Nov-2025	CLOSED	Claim

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Claims Audit Report

Accounting Date As Of: 31-Mar-2026

Glengarry Memorial Hospital - 107254

Risk Name	Claim No	Coverage	Policy Year	Date of Loss	Date Reported	Indemnity Paid	Expense Paid	Total Paid	Reserved	Total Incurred	Date Closed	Claim Status	Claim Type
Glengarry Memorial Hospital	47314-01	K3 EventSupExp	2025	03-Apr-2025	03-Apr-2025	$0.00	$0.00	$0.00	$0.00	$0.00	25-Nov-2025	CLOSED	Claim
20260 County Road 43	48225-01	A:Bodily Injury	2025	24-Jun-2025	14-Jul-2025	$0.00	$16,066.10	$16,066.10	$83,933.90	$100,000.00		OPEN	Claim
20260 County Road 43	48312-01	A:Bodily Injury	2025	25-Jun-2025	16-Jul-2025	$0.00	$46.30	$46.30	$49,953.70	$50,000.00		OPEN	Claim
20260 County Road 43	50063-01	C: Prof Liab	2026	05-Feb-2026	06-Feb-2026	$0.00	$0.00	$0.00	$22,000.00	$22,000.00		OPEN	Claim
Total						**$77,134.13**	**$294,366.88**	**$371,501.01**	**$173,695.77**	**$545,196.78**			

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Claims Audit Report

Accounting Date As Of: 31-Mar-2026

Claims Audit Report
Liability & Crime

Policy Year	Open	Closed	Total Claims	Total Reserve	Indemnity Paid (O)	Expense Paid (O)	Total Open	Total Closed	Total Incurred
2006	0	1	1	$0.00	$0.00	$0.00	$0.00	$2,006.57	$2,006.57
2008	0	4	4	$0.00	$0.00	$0.00	$0.00	$45,826.74	$45,826.74
2009	0	2	2	$0.00	$0.00	$0.00	$0.00	$48,560.58	$48,560.58
2010	0	2	2	$0.00	$0.00	$0.00	$0.00	$3,619.00	$3,619.00
2011	0	2	2	$0.00	$0.00	$0.00	$0.00	$46,046.45	$46,046.45
2013	0	2	2	$0.00	$0.00	$0.00	$0.00	$9,233.78	$9,233.78
2014	0	1	1	$0.00	$0.00	$0.00	$0.00	$2,146.57	$2,146.57
2016	0	1	1	$0.00	$0.00	$0.00	$0.00	$2,794.43	$2,794.43
2017	0	2	2	$0.00	$0.00	$0.00	$0.00	$6,774.29	$6,774.29
2019	0	1	1	$0.00	$0.00	$0.00	$0.00	$32,993.76	$32,993.76
2020	0	2	2	$0.00	$0.00	$0.00	$0.00	$117,230.88	$117,230.88
2023	1	2	3	$17,808.17	$0.00	$27,191.83	$45,000.00	$7,441.10	$52,441.10
2024	0	1	1	$0.00	$0.00	$0.00	$0.00	$3,522.63	$3,522.63
2025	2	1	3	$133,887.60	$0.00	$16,112.40	$150,000.00	$0.00	$150,000.00
2026	1	0	1	$22,000.00	$0.00	$0.00	$22,000.00	$0.00	$22,000.00
Total	**4**	**24**	**28**	**$173,695.77**	**$0.00**	**$43,304.23**	**$217,000.00**	**$328,196.78**	**$545,196.78**

Claim Type: Claim = non-litigated (no Statement of Claim served); Suit = litigated (Statement of Claim served)
Open claim status: includes Open, Re-open, Abeyance, Abeyance-Infant
*Total Reserve = Total Indemnity Reserve + Total Expense Reserve **
Expense Paid (O) = Paid Expense, for Open claims
Indemnity Paid (O) = Indemnity Paid, for Open claims
Total Open = Total Reserve + Paid Indemnity + Paid Expense, for Open claims
Total Closed = Total Reserve + Paid Indemnity + Paid Expense, for Closed claims
Total Incurred = Total Open + Total Closed

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DECISION SUPPORT DOCUMENT FOR

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

Date Prepared:	May 4, 2026	Meeting Date Prepared for:	May 13, 2026
Subject:	HGHM 2026 Hospital Services		
Prepared by:	Dr. Lisa MacKinnon, Chief of Staff		

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

PURPOSE

To provide the Board with an overview of current hospital services, recent service enhancements, and key service gaps impacting access, patient flow, and quality of care. This report is intended to support ongoing planning and inform future resource and service development decisions.

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.

HGMH currently delivers a range of acute, inpatient, outpatient, and diagnostic services supporting a broad patient population.

Core service areas include:

- Emergency Services
- Inpatient Care (Medicine and Rehabilitation)
- Outpatient and Ambulatory Clinics
- Diagnostic Imaging & Testing
  - Ultrasound
  - X-ray
  - Bone Mineral Density (BMD)
  - Pulmonary Function Testing
- Allied Health Services

Specialty and clinic-based services currently include:

- Minor Surgical Procedures
- Urology
- Gynecology
- Endoscopy
- Respirology
- Interventional Pain Services
- Telemedicine

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Recent Service Enhancements

Over the past year, targeted recruitment efforts have resulted in the addition of key specialty services, improving local access to care and supporting quality outcomes:

Hematology (Outpatient Clinics)

A hematologist was successfully credentialed to provide outpatient consultation and follow-up care. This service enhances local access to specialized care for patients with hematologic conditions and reduces the need for out-of-region referrals.

Preliminary impacts include:

- Improved access to timely specialist consultation
- Reduced patient travel burden
- Enhanced continuity of care through local follow-up
- Strengthened collaboration with primary care and internal medicine

Physiatry (Inpatient Services)

A physiatrist was recruited to support inpatient care, with a focus on rehabilitation and functional recovery.

Early benefits include:

- Improved functional assessment and rehabilitation planning
- Enhanced interdisciplinary collaboration
- More coordinated discharge planning
- Support for optimizing patient outcomes and appropriate length of stay

These additions align with organizational priorities to improve access, reduce fragmentation of care, and strengthen service delivery within the community.

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.

Despite the breadth of services available, there are some priority gaps that have been identified that may impact quality, access, and system efficiency. The organization continues to actively explore and implement strategies to address these pressures and strengthen patient care delivery.

Social Work Support

The absence of dedicated social work services presents challenges in:

- Discharge planning and care transitions
- Access to community and mental health supports
- Coordination for complex and vulnerable patients

Impact:

- Increased length of stay
- Delayed discharges
- Potential for avoidable readmissions
- Disproportionate impact on vulnerable populations

Current Mitigation Strategies:
To address this gap, the hospital is currently in the process of submitting a Health System Funding Proposal (HSFP) to Ontario Health to establish an integrated discharge planning team. The proposed model is intended to strengthen care coordination, support timely discharge planning, improve transitions to community care, and enhance support for patients with complex social and healthcare needs.

Diagnostic Imaging Capacity (CT Scanner)
The current absence of on-site CT imaging has been identified as a key limitation in timely diagnosis and clinical decision-making. Patients requiring CT imaging must be referred to external facilities, which can introduce delays in both inpatient and outpatient care.

Impact:
- Delays in diagnosis and initiation of treatment
- Extended length of stay for inpatients awaiting imaging
- Increased need for patient transfers or external referrals
- Added burden on patients and families

Current Mitigation Strategies:
The hospital recently received approval for the implementation of a CT scanner, representing a significant advancement in local diagnostic capacity. Planning activities are currently underway to support implementation, including infrastructure, operational, and staffing considerations. Once operational, on-site CT imaging is expected to improve timely access to diagnostics, enhance clinical decision-making, reduce patient transfers, and support more efficient patient flow throughout the organization.

Pain Services Capacity
While not a core hospital service, demand for interventional pain services continues to exceed current capacity, resulting in extended wait times for patients requiring assessment and treatment.

Impact:
- Extended wait times for pain management services, currently exceeding 18 months
- Delays in treatment and symptom management for patients with chronic pain conditions
- Potential negative impacts on patient quality of life and functional status

Current Mitigation Strategies:
The organization continues to monitor wait list volumes. Existing interventional pain services continue to be offered within current resource limitations.

Orthopedic Services
In and around 2021, the hospital no longer had a local orthopedic clinic, resulting in patients requiring referral to external organizations for orthopedic consultation and follow-up care.

Impact:
- Reduced local access to orthopedic assessment and specialist care
- Increased travel requirements for patients and families
- Potential delays in consultation and treatment planning
- Increased reliance on external healthcare partners

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Current Mitigation Strategies:
The organization continues to support patients through external referral pathways and partnerships with regional providers to facilitate access to orthopedic care. Opportunities to strengthen local musculoskeletal and rehabilitation supports continue to be explored as part of ongoing service planning discussions. Discussions continue with Dr. El Kurbo to potentially accommodate a return of this service.

Quality, Safety & Patient Experience Considerations

- Patient flow challenges, including delayed discharges due to higher ALC rates, may impact overall quality and patient experience
- Timely access to diagnostic imaging remains a key factor in clinical outcomes and care efficiency

No significant new service-related safety concerns have been identified; however, ongoing system pressures may elevate risk if not addressed.

SUMMARY

HGMH continues to provide a comprehensive range of hospital, diagnostic, and specialty services that support both acute and outpatient care needs within the community. Recent enhancements, including the addition of hematology and physiatry services, reflect ongoing efforts to improve local access to specialized care, strengthen interdisciplinary care delivery, and enhance patient outcomes.

At the same time, the organization continues to experience system pressures and identified service gaps that impact timely access to care, patient flow, and overall service efficiency. Key challenges include limited social work resources to support discharge planning and care transitions, the absence of on-site CT imaging, extended wait times for pain services, and the loss of local orthopedic clinic services.

The organization is actively pursuing strategies to address these gaps. Current initiatives include the submission of a Health System Funding Proposal to Ontario Health to establish an integrated discharge planning team, ongoing planning for implementation of an approved CT scanner, and continued collaboration with regional partners to support access to specialized services not currently available locally.

Continued focus on service enhancement, recruitment, and strategic partnerships will be essential to sustaining quality care, improving patient experience, and meeting the evolving healthcare needs of the population served.

CONSULTED WITH:

- R. Alldred-Hughes, President & CEO
- K. Duval, Manager Emergency Department and Respiratory Care

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DECISION SUPPORT DOCUMENT FOR

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

☐ Other *(please specify):*

Date Prepared: May 1, 2026 Meeting Date Prepared for: May 13, 2026

Subject: Trillium Gift of Life Network (TGLN) Q3 results Update

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

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

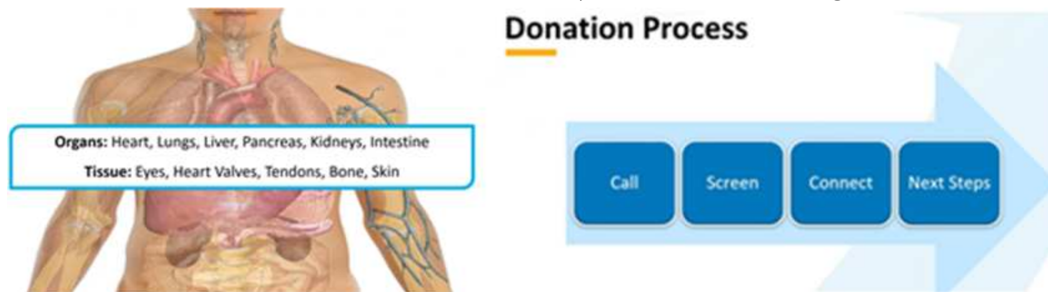
PURPOSE

- Provide an update on our TGLN program for Q3 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% for Q3 which is consistent with Q2 result.
  - There was one tissue donor. YTD total is 2 tissue donors.
- Routine Notification rate for Q3 is 100% which is improved from Q2 result of 88%.
  - Strategy that was implemented was staff reminder that the goal is to notify TGLN of all patients 79 years of age and younger within one hour of death.

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April is BeADonor Month and here is a sample toolkit from TGLN:

Trillium Gift of Life Network
Réseau Trillium pour le don de vie

BeADonor Month 2026
Le Mois Soyez un donneur 2026

Key Messages // Messages clés

These messages are intended to support your communications and outreach efforts during BeADonor Month. Contact us for stats related to your specific community.

Ces messages sont destinés à soutenir vos efforts de communication et de sensibilisation pendant le Mois Soyez un donneur. Contactez-nous pour des statistiques liées à votre communauté spécifique.

- Organ and tissue donation saves lives.
- One organ donor can save up to eight lives, and tissue donors can transform the lives of up to 75 more.
- In Ontario, thousands of people are waiting for a lifesaving transplant.
- Every three days, someone in Ontario dies waiting for an organ transplant.
- Everyone has the potential to be a donor. Medical conditions or age don't automatically prevent donation. Suitability is assessed by medical professionals at the time of donation.
- Most Ontarians support donation, yet only 35% of Ontarians have registered as organ and tissue donors.
- After registering as an organ and tissue donor, it's important to talk to your family so they can understand and honour your decision.
- Visit **www.beadonor.ca** to register or learn more about organ and tissue donation and transplantation.
- Visit **greenshirtday.ca** for resources specific to Green Shirt Day and learn about Logan Boulet's story.
- The success of organ and tissue donation in Ontario relies on the dedication and collaboration of our hospital partners.
- Together, with Trillium Gift of Life Network, healthcare teams ensure that a potential donor's wishes are honoured.
- Their commitment allows families the opportunity to save and transform lives through organ and tissue donation.

- *Le don d'organes et de tissus sauve des vies.*
- *Un donneur d'organe peut sauver jusqu'à huit vies, et les donneurs de tissus peuvent transformer la vie de 75 personnes.*
- *En Ontario, des milliers de personnes attendent une greffe qui pourrait leur sauver la vie.*
- *Tous les trois jours, une personne en Ontario meurt en attendant une transplantation d'organe.*
- *Tout le monde peut être donneur. Les conditions médicales ou l'âge n'empêchent pas automatiquement le don. L'aptitude est évaluée par des professionnels de la santé au moment du don.*
- *La plupart des Ontariens sont favorables au don, mais seulement 35% d'entre eux se sont inscrits comme donneurs d'organes et de tissus.*
- *Après vous être inscrit comme donneur d'organes et de tissus, il est important d'en parler à votre famille afin qu'elle comprenne et respecte votre décision.*
- *Visitez le site **www.soyezundonneur.ca** pour vous inscrire ou en savoir plus sur le don et la transplantation d'organes et de tissus.*
- *Visitez le site **greenshirtday.ca** pour obtenir des ressources spécifiques à la Journée du chandail vert et découvrir l'histoire de Logan Boulet.*
- *La réussite du don d'organes et de tissus en Ontario repose sur le dévouement et la collaboration de nos partenaires hospitaliers.*
- *En collaboration avec le Réseau Trillium pour le don de vie, les équipes de soins de santé veillent à ce que les souhaits d'un donneur potentiel soient respectés.*
- *Leur engagement permet aux familles de sauver et de transformer des vies grâce au don d'organes et de tissus.*

Donation Facts // Faits sur les dons

In the 2025 calendar year: // Au cours de l'année civile 2025 :

362 — deceased organ donors gave the gift of life
donneurs d'organes décédés ont fait le don de la vie

1088 — organs transplanted from deceased donors
organes transplantés de donneurs décédés

2051 — tissue donors enhanced the lives of thousands
donneurs de tissus ont amélioré la qualité de vie

Social media post on HGMH's participation for April BeADonor Month- LinkedIn

Hôpital Glengarry Memorial Hospital Hôpital Glengarry Memorial Hospital 663 followers663 followers3w • 3 weeks ago •
HGMH is proud to partner with the Trillium Gift of Life Network in support of organ and tissue donation.
On Green Shirt Day, we recognize the powerful legacy of Logan Boulet, whose decision to become an organ donor inspired a national movement across Canada. His story is a reminder of the profound impact one person can have. One donor can save up to 8 lives and enhance many more.
We encourage our community to learn more about organ and tissue donation and to register their consent: https://beadonor.ca/
Together, we can make a meaningful difference.

L'HGMH est fier d'être partenaire du Réseau Trillium pour le don de vie afin de soutenir le don d'organes et de tissus.
À l'occasion de la Journée du chandail vert, nous soulignons l'héritage marquant de Logan Boulet, dont la décision de devenir donneur d'organes a inspiré un mouvement national à travers le Canada. Son histoire nous rappelle l'impact profond qu'une seule personne peut avoir. Un donneur peut sauver jusqu'à 8 vies et en améliorer plusieurs autres.
Nous encourageons notre communauté à en apprendre davantage sur le don d'organes et de tissus et à enregistrer son consentement : https://beadonor.ca/
Ensemble, nous pouvons faire une réelle différence.

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DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: May 4, 2026 Meeting Date Prepared for: May 13, 2026

Subject: Professional Staff HR Plan

Prepared by: Dr. Lisa MacKinnon

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

PURPOSE

To provide an update on ongoing physician recruitment initiatives and outline current staffing needs for emergency and inpatient physician coverage, as well as efforts to attract family physicians to available practice opportunities within the hospital.

IMPLICATIONS TO OTHER STANDING COMMITTEES

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

SITUATION & BACKGROUND

The hospital continues to actively recruit 1–2 Emergency Department and 1-2 inpatient physicians to support shift coverage, vacation relief, and service sustainability. Due to fluctuating scheduling requirements, a guaranteed minimum number of monthly shifts cannot currently be offered, which may impact recruitment efforts for some candidates.

At present, the Emergency Department schedule is fully staffed through July 2026, while the inpatient schedule is filled through October 2026, with one week remaining vacant in September.

Recruitment efforts also remain focused on securing 1–2 family physicians to support continuity of care within the community. Two vacant physician office spaces within the hospital continue to be promoted as an attractive opportunity for prospective recruits.

Physician recruitment initiatives are being advanced through multiple regional and national partnerships and events. Suzanne Laframboise and the Dr. L. MacKinnon continue to represent the organization on the Health Human Resources (HHR) Regional Subcommittee and Workforce Attraction and Recruitment Working Group, with a focus on out-of-province and international physician recruitment. The GR OHT has also joined eOPRA (Eastern Ontario Physician Recruitment Alliance, and S. Laframboise is now a member of CaSPR (Canadian Society of Physician Recruitment).

Recent Recruitment Activities:

- Attendance at the Rural & Remote conference in Quebec City included staffing the GROHT-funded booth, reinforcing the importance of maintaining a strong presence at recruitment events. It was noted that while some learners were aware of the organization, others were unfamiliar with the hospital, highlighting ongoing visibility challenges for rural recruitment.
- S. Laframboise recently attended the CaSPR conference, which focuses on physician recruitment and retention strategies.
- S. Laframboise will represent the hospital at the GROHT booth at upcoming fall recruitment events, including:
    - FMF Conference (Family Medicine Forum),

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- FMRQ (Fédération des médecins résident-e-s),
- uOttawa Family Medicine Job Fair.

To further strengthen recruitment efforts, we are focusing on building our Medical Student/Resident program.

- From April 2025 to March 31, 2026, we hosted 14 different medical learners and residents, this was an impressive achievement! Feedback from the students/residents and universities has been very positive.
- We are currently preparing for the Rural Community/Discovery Weeks, May 25-29 and June1-5. We are working with ERMEP and are expecting 2 students each week from Ottawa and Queen's University combined.
- A third-year medical student from Queen's University will be with us from June 1-September 4, 2026. She will be completing her family practice component with Dr. Crevier.
- A medical resident who was with us for electives in family practice, inpatient and emergency experience, is scheduled to join us for her POCUS Fellowship from July 29-September 22, 2026. She has requested an application for privileges and is hoping to moonlight in ED or Inpatient on days where she is not scheduled for Fellowship hours.

SUMMARY

The organization continues to maintain stable short-term physician coverage while actively advancing recruitment efforts for Emergency Department, inpatient, and family medicine physicians. Recruitment initiatives, partnerships, and learner programs remain key strategies to support long-term workforce sustainability and continuity of care.

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DECISION SUPPORT DOCUMENT FOR

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

Date Prepared:	May 1, 2026	Meeting Date Prepared for:	May 13, 2026
Subject:	2025-2026 Physician Engagement & Wellness Survey Results		
Prepared by:	Dr. L. MacKinnon, Chief of Staff		

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

PURPOSE

To inform that the results of the recent Physician Engagement and Wellness Survey will be deferred due to insufficient participation and limited qualitative feedback.

SITUATION & BACKGROUND

A brief description of the background to the issue.

- The Physician Engagement and Wellness Survey is distributed annually to physicians who provide on-site services at HGMH. The purpose of the survey is to assess physician engagement, wellness, and opportunities for organizational improvement, while supporting ongoing dialogue regarding physician experience and well-being within the organization.
- Of the 32 physicians surveyed, only five physicians completed the survey, representing approximately 15% participation. In addition, only three respondents provided written comments or qualitative feedback.
- Given the limited response rate and minimal narrative input, the results are not considered sufficiently representative to provide an accurate or meaningful assessment of physician engagement and wellness across the organization.
- Next steps:
  - Medical Leadership will review opportunities to improve physician participation, including communication strategies and methods to encourage greater feedback and involvement. The survey will remain open for an extended period, and updated results and analysis will be brought forward in the fall once a more representative response rate has been achieved.