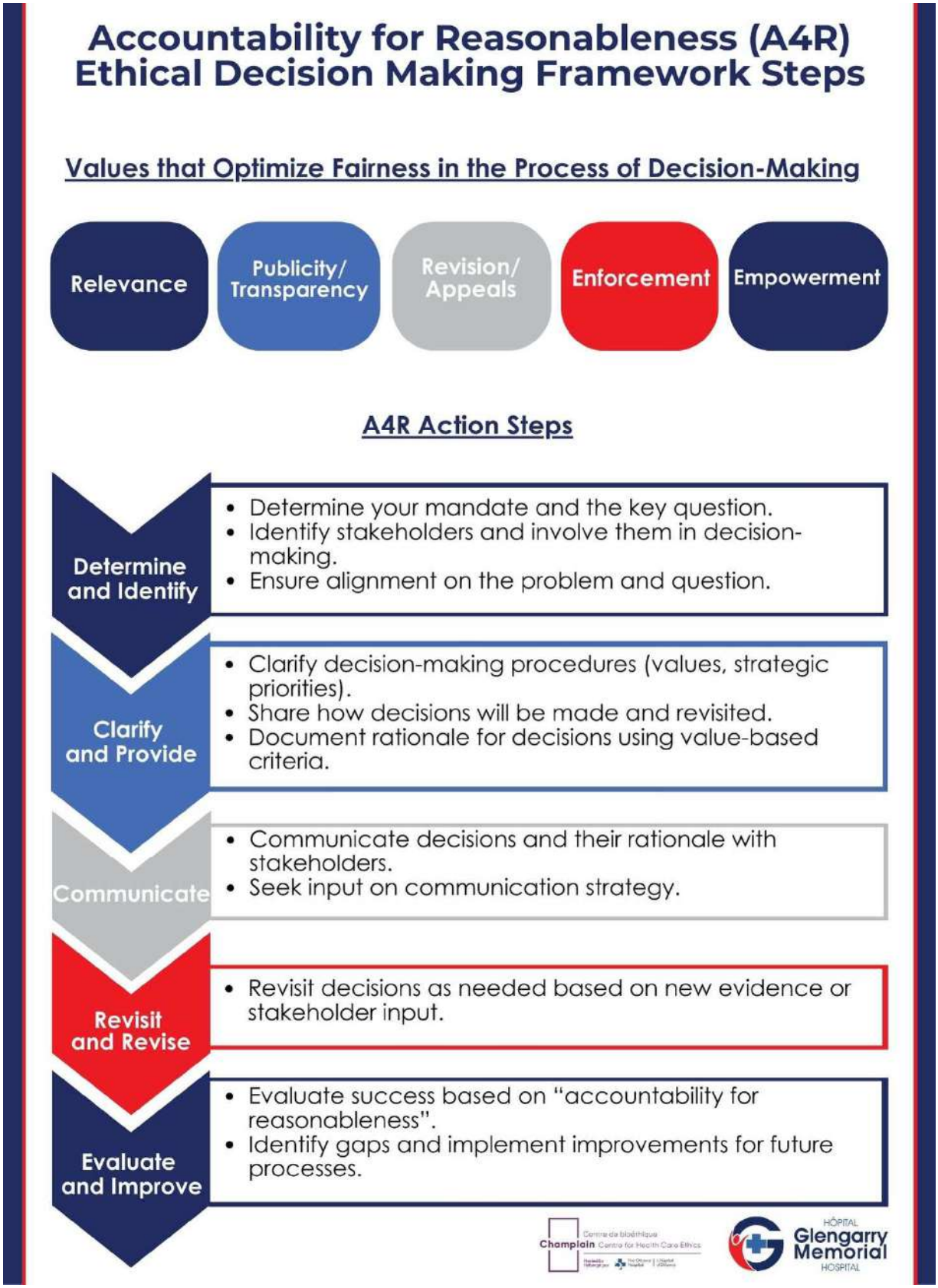
Board of Directors Meeting Agenda

Date: Thursday, May 28, 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 – March 26, 2026	P. 3-5
(1 min)	2.2 Business arising from minutes	
5:06	**3. Education**	
(10 min)	3.1 Key Take Aways from OHA Executive AI (R. Romany)	
5:16	**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. 6-8
(5 min)	4.3 Report of the VP Corporate Services & CFO (L. Ramsay)	P. 9-11
(5 min)	4.4 Report of the Patient and Family Advisory Committee (J. Shackleton)	
(5 min)	4.5 Report of the Chair of Quality & Patient Safety Committee (H. Salib)	
(5 min)	4.6 Q4 2025-2026 Quality Improvement Plan (H. Salib / R. Romany) **That the Board of Directors review and receive the Q4 quality improvement plan results for 2025-2026 as presented.**	P. 12-15
(5 min)	4.7 Q4 2025-2026 Quality & Safety Scorecard (H. Salib / R. Romany) **THAT the Board of Directors review and receive the Q4 quality & safety scorecard results for 2025-2026 as presented.**	P. 16-18
(5 min)	4.8 Patient Satisfaction Survey Results (R. Romany) **THAT the Board of Directors review and receive the patient satisfaction survey results as presented.**	P. 19-22
(5 min)	4.9 Report of the Chair of Finance, HR and Audit Committee (C. Nagy)	
(5 min)	4.10 Financial Statements and Statistical Information – February 2026 (C. Nagy/L. Ramsay) **THAT the Board of Directors review and receive the financial statements for February 2026 as presented.**	P. 23-27
(5 min)	4.11 Q3/Q4 Investments (C. Nagy/L. Ramsay) **THAT the Board of Directors review and receive the investments for Q3 and Q4 as presented.**	P. 28-32
(5 min)	4.12 Water Main Entrance Replacement (C. Nagy/L. Ramsay) **THAT Board of Directors approve that the capital plan item "Water Main Entrance Replacement" be replaced with "Electrical Upgrade Engineering Fees" in the amount of $ 200,000.**	P. 33-36
(5 min)	4.13 Psychological Safety Program (C. Nagy/K. MacGillivray)	P. 37-53
(5 min)	4.14 Epic Implementation Update (C. Nagy/R. Alldred-Hughes)	P. 54-55
(5 min)	4.15 Report of the Chair of Governance & Nominating Committee (L. Boyling)	
(5 min)	4.16 Q4 Strategic Actions (L. Boyling/R. Alldred-Hughes) **THAT the Board of Directors review and receive the Q4 Strategic Actions as presented.**	P. 56-61
6:46	**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. 62-64
	5.2 BPSO Updates	P. 65
	5.3 Trillium Gift of Life Report	P. 66-68
	5.4 Draft Finance, HR, and Audit Committee Report	P. 69-71
	5.5 Q3/Q4 Executive Expense Report	P. 72-76
	5.6 Talent Management Program	P. 77-87
	5.7 Draft Governance & Nominating Committee Report	P. 88-89
	5.8 Policy Review - Minutes of Regular and In Camera Meetings (BOD.05.014)	P. 90-92
	5.9 Policy Review - Board Award of Excellence (BOD.06.011)	P. 93-94
	5.10 Inclusion, Diversity, Equity & Anti-Racism Update	P. 95-98
	THAT the Board of Directors approve and receive all documents as presented in the consent agenda.	

Time	Agenda Item	Attachment
6:47	**6. Correspondence (Dr. S. Robertson)**	P. 99-100
6:48	**7. Date of Next Meeting – Thursday, June 18, 2026 5:00pm**	
	8. Closing Remarks & Adjournment (Dr. S. Robertson)	

**Meeting Moves to In Camera*



MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS

Date	Thursday, April 23, 2026
Time	5:00pm-8:00pm
Location	Boardroom / Microsoft Teams

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

1. Call to Order

Dr. S. Robertson, Chair, called the meeting to order at 5:01.

1.1 Quorum

A quorum was present.

1.2 Land Acknowledgment

L. Ramsay read the land acknowledgment.

1.3 Adoption of the Agenda

The agenda was reviewed.

Moved By: C. Larocque
Seconded By: G. McDonald
THAT the agenda be adopted as presented.

CARRIED

1.4 Declaration of Conflict of Interest

There were no conflicts of interest declared at this time.

2 Minutes

2.3 Approval of the Minutes

The minutes of the last meetings held on March 26, 2026, were shared.

Moved By: H. Salib
Seconded By: F. Desjardins
THAT the minutes of the March 26, 2026 meeting be approved as presented.

CARRIED

2.2 Business Arising from the Minutes

Nothing to bring forward.

3 Matters for Discussion/Decision

3.1 Report of the Board Chair

There was nothing to report on at this time.

3.2 Report of the President & CEO
The CEO report was shared in which it was highlighted that advocacy continues in efforts to advance capital priorities for the hospital including capital redevelopment and CT implementation work.

Discussion ensued on AI and what this could look like in the future, however, things change very quickly and the hospital is not in a position to implement AI at this time.

3.3 Report of the Chief of Staff
The report of the Chief of Staff was shared.

3.4 Report of the VP Clinical Services, Quality & CNE
The report was shared for information.

3.5 Report of the Patient and Family Advisory Committee
PFAC will be participating in patient experience week by handing out smile cookies to thank staff for providing good patient experiences. A basket was also put together by the committee and will be drawn for a lucky staff member.

Discussion ensued around increasing visibility for the hospital at different events within the community. This will be looked into.

3.6 Report of the Chair of Quality & Patient Safety Committee
The committee Chair reported on the reports that were reviewed by the committee at the last meeting including violent incidents and emergency preparedness as well as updates from PFAC and BPSO.

3.7 Violent Incidents
The violent incidents report was reviewed.

Moved By: C. Larocque
Seconded By: Dr. G. Raby
That the Board of Directors review and receive the violent incidents report as presented.

CARRIED

3.8 Emergency Preparedness Updates
The emergency preparedness report was reviewed.

Moved By: Dr. R. Cardinal
Seconded By: C. Nagy
THAT the Board of Directors review and receive the emergency preparedness report as presented.

CARRIED

4 **Consent Agenda**

The following were included in the meeting package under consent agenda and reviewed by members prior to the meeting:
4.1 Draft Quality & Patient Safety Committee Report
4.2 PFAC Updates
4.3 Ethics Committee Updates

Moved By: C. Larocque
Seconded By: G. Peters
THAT the Board of Directors approve and receive all documents as presented in the consent agenda.

CARRIED

5 **Correspondence**

Correspondence was included in the meeting package.

6 **Date of Next Meeting**

Thursday, May 28, 2026, at 5:00pm

Meeting adjourned at 5:38pm

K-L. Massia, Recording Secretary

Report of the President & CEO

May 28, 2026 Board of Directors

Ontario Hospital Association – Fundamentals of Financial Oversite for Hospital Boards

The Ontario Hospital Association (OHA) recently hosted two learning sessions for Hospital Boards focused on the Fundamentals of Financial Oversight for Hospital Boards on April 21 and 23, 2026. These sessions provided valuable insight into the governance role of Boards in financial stewardship, oversight, and accountability within Ontario's healthcare system. Thank you to all Board members who participated in the early morning sessions and for your continued commitment to ongoing learning and governance excellence. For ease of reference and future review, the presentation materials and related resources have been uploaded to the Board Portal.

Tim Horton's Smile Cookie Week a Success

During Smile Cookie Week, held the week of April 27, the Tim Hortons and Tim Hortons locations selected the HGMH Foundation as their charity of choice. The week was filled with community spirit, including visits from many special guest smile cookie decorators who helped support this important fundraiser. This year, over 900 Smile Cookies were sold in support of the Foundation. Final fundraising totals will be shared by the HGMH Foundation once all proceeds have been tallied. Special thanks to Kim Jarencio, Foundation Fundraising Coordinator, for all of her planning, coordination, and support in helping make this event such a success.

Journée de la femme/Women's Day Alexandria

On May 3, the annual Journée de la femme/Women's Day Alexandria event was held in support of patient comfort initiatives at Hôpital Glengarry Memorial Hospital. Once again, the organizers and community exceeded their fundraising goals, allowing for the purchase of additional equipment beyond what was originally planned from HGMH's capital equipment list. The event was a tremendous success and reflects the ongoing generosity and commitment of the community in supporting local healthcare. Special thanks to all of the organizers, volunteers, sponsors, and attendees whose efforts continue to make a meaningful impact for our patients and families.

Hospital Labour Disputes Arbitration Act – Charter Challenge

The Ontario Nurses' Association (ONA) has announced its intention to launch a Charter challenge related to the Hospital Labour Disputes Arbitration Act (HLDAA), the provincial legislation that currently prohibits strikes and lockouts in the hospital sector and instead requires unresolved collective bargaining disputes to proceed to binding interest arbitration. ONA's position is that the current framework infringes upon rights protected under the Canadian Charter of Rights and Freedoms, specifically the ability of workers to engage in meaningful collective bargaining, including access to strike action. The Ontario Hospital Association (OHA) has publicly expressed concern with the potential implications of this challenge, noting that the existing framework has historically been designed to balance fair dispute resolution with the need to ensure continuity of patient care and avoid labour disruptions within hospitals.

While this matter is expected to evolve over a potentially lengthy legal process, the challenge could have significant implications for labour relations across Ontario's hospital sector if successful. Any future move toward permitting strike activity in hospitals would represent a substantial shift in the healthcare labour relations environment and could create operational, financial, and patient care risks requiring provincial policy and contingency planning. At this time, there is no immediate operational impact to HGMH, and existing collective bargaining and labour relations processes remain unchanged. Leadership will continue to monitor developments through the OHA and legal counsel and will keep the Board informed as additional information becomes available.

Repatriation Direction for Acute Hospitals – Operational Direction from Ontario Health

From April 29 to May 1, 2026, Louise Boyling and I attended the Ontario Hospital Association Health Care Leadership Summit, which brought together healthcare Hospital CEO's and Board Chairs/Incoming Board Chairs across the province to explore emerging trends, system challenges, and innovative models of care. Sessions focused on topics including leadership wellness and psychological safety, the future role of hospitals as anchor institutions within their communities, upstream approaches to health and prevention, advancements in early cancer detection, and the evolution of hospital-at-home and virtual care models. Collectively, the presentations reinforced the increasing expectation that hospitals will play a broader role not only in delivering acute care, but also in supporting population health, workforce wellbeing, innovation, and community partnerships.

A consistent theme throughout the Summit was the need for healthcare organizations to continue adapting to growing patient complexity, workforce pressures, and evolving care expectations through greater integration, technology enablement, and community-based models of care. Discussions highlighted the importance of psychologically safe workplaces, data-informed decision-making, stronger partnerships across sectors, and designing healthcare delivery models that improve both patient outcomes and patient experience. The sessions also underscored how innovation in areas such as virtual care, home-based care, and early diagnostics may continue to shape the future sustainability and accessibility of healthcare delivery, particularly for rural and community hospitals.

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:

- *Northern, Small and Rural Hospital CEO's in person meeting*
- *Dr. Naoum – Lead Surgeon at HGMH for Endoscopy Service*

Upcoming Events/Special Dates

- June – Pride Month
- June 12 – Philippines Independence Day
- June 25 - AGM

Report of the VP of Corporate Services and CFO

May 28, 2026 Board Meeting

Support Services

Facilities

The new deluge shower installation in the MDR area was successfully completed on schedule, enhancing employee safety through the addition of an emergency shower station.

Phase 2 of the Emergency Department flooring project and surrounding areas was completed one week ahead of schedule. Installation of new ER cabinets and countertops is planned for completion by the end of May. All areas received new flooring, and new wall/door paint.

The CWS renovation project is currently underway and remains on target for completion by May 22. This renovation will improve patient registration flow and overall operational efficiency.

A comprehensive review of the facility's preventive maintenance program is in progress. This initiative will provide a full assessment of building infrastructure needs using a risk-based priority matrix to address the most critical areas first.

Dietary

Ongoing reviews of patient menus, patient satisfaction, and cost reduction strategies continue to support quality meal service and operational efficiency.

A new ice machine has been installed, and trials of new water cups are currently underway. This will improve Patient Hydration as well as remove 37,000 bottles from the land fill. It also reduces the work load on employees not having to handle all those water bottles.

Stores

A review and reorganization of supply storage within the Emergency Department and Medicine clean hold areas will begin in May. This initiative is intended to improve clinical workflow efficiency and support enhanced patient care.

Purchasing

Capital plan purchasing initiatives are currently in progress.

The electrical upgrade project has commenced and is presently under review by the engineering firm.

EVS- Housekeeping

The housekeeping staffing model has stabilized and is operating more efficiently, helping to reduce staff pressure, burnout, and workload concerns.

A review of product usage and policies is currently underway. This is to ensure we are meeting current standards to implement best practices

Information Technology

Infrastructure and Operations

Server room environmental controls and the dedicated backup server referenced in last quarter's report continue to perform as expected, with no critical temperature events and improved recovery time objectives maintained.

A major backend upgrade to the hospital's single sign-on authentication platform (Imprivata) has been completed. This update modernizes the authentication infrastructure and directly enables integration with Epic at go-live, reducing risk during conversion.

A new patient television platform has been deployed hospital-wide, improving the patient's experience while reducing ongoing maintenance overhead.

Epic Readiness

Epic hardware deployment is well underway across the organization. A centralized deployment server continues to accelerate workstation configuration, and network re-IPing in support of go-live is progressing on schedule.

Data migrations are actively underway for systems transitioning to The Ottawa Hospital and QCH as part of new partnership arrangements. These migrations support both financial and operational efficiencies by consolidating services with regional partners.

Cybersecurity

Multi-factor authentication has been fully implemented across the organization, covering all staff and physician access to hospital systems. This represents a significant reduction in the hospital's exposure to credential-based threats.

A new email security platform has been deployed, adding an additional layer of protection against phishing, spoofing, and malicious attachments beyond what the previous solution provided.

A formal Cybersecurity Incident Response Playbook has been developed and adopted, giving the organization documented and tested procedures for identifying, containing, and recovering from security incidents in alignment with Ontario Health requirements.

Role based Security training has been implemented to align with our regional Cybersecurity requirements.

Health Information Services (HIS)

EPIC Conversion Validation

Health Information Services (HIS) remains actively engaged in comprehensive validation activities to ensure the accuracy, completeness, and integrity of data being migrated from MEDITECH to Epic Systems. Current validation efforts focus on key data domains, including patient demographics, historical encounters, scanned records, and provider notes. This work is critical to preserving continuity of care, supporting informed clinical decision-making, and meeting regulatory, accreditation, and medico-legal requirements. Validation activities are progressing according to schedule and remain aligned with the overall Epic implementation timeline.

Cogito Training and Working Groups

We are participating in Epic Cogito training to strengthen internal reporting and analytics capabilities in preparation for the organization's transition to Epic. Cogito is Epic's enterprise analytics suite, which supports the development of operational, clinical, and quality dashboards and reports.

Through this training, we are building expertise in reporting tools, and dashboard design to support decision-making across the organization.

Privacy Works, and Artificial Intelligence Framework

Considering the tightening regulations of IPC and the institution of monetary penalties, privacy audits and training are more important than ever. There is continuing work to do privacy audit activities including targeted and proactive reviews of access to personal health information.

HIS also continues to distribute monthly privacy communications to all staff and physicians. These communications provide practical guidance on privacy best practices, highlight lessons learned from privacy incidents and regulatory decisions, and reinforce staff responsibilities in safeguarding personal health information.

In collaboration with Information Technology and clinical leadership, we are participating to develop a governance framework to assess privacy, security, and information management risks related to AI solutions. This framework is intended to guide the responsible evaluation, adoption, and oversight of AI tools while ensuring compliance with legislative requirements and organizational standards.

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: May 1, 2026 Meeting Date Prepared for: May 13, 2026 – Quality May 28 - Board

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

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	YTD
ccess & 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

- 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	YTD
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 92.2%, 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	YTD
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	YTD
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

- 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 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	Jan-26	Feb-26	Mar-26	Q4
iafety	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

- 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

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

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: May 1, 2026 Meeting Date Prepared for: May 13, 2026 – Quality May 28 - Board

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

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: April 16, 2026 Meeting Date Prepared for: May 13 – Quality
May 28 - Board

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

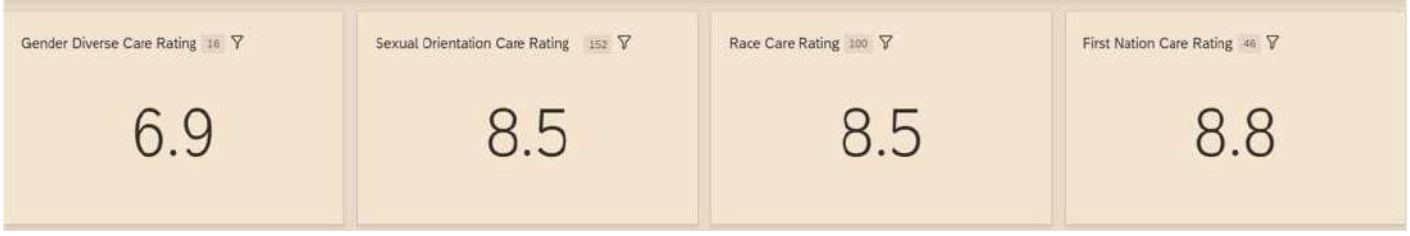
ANALYSIS

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%



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

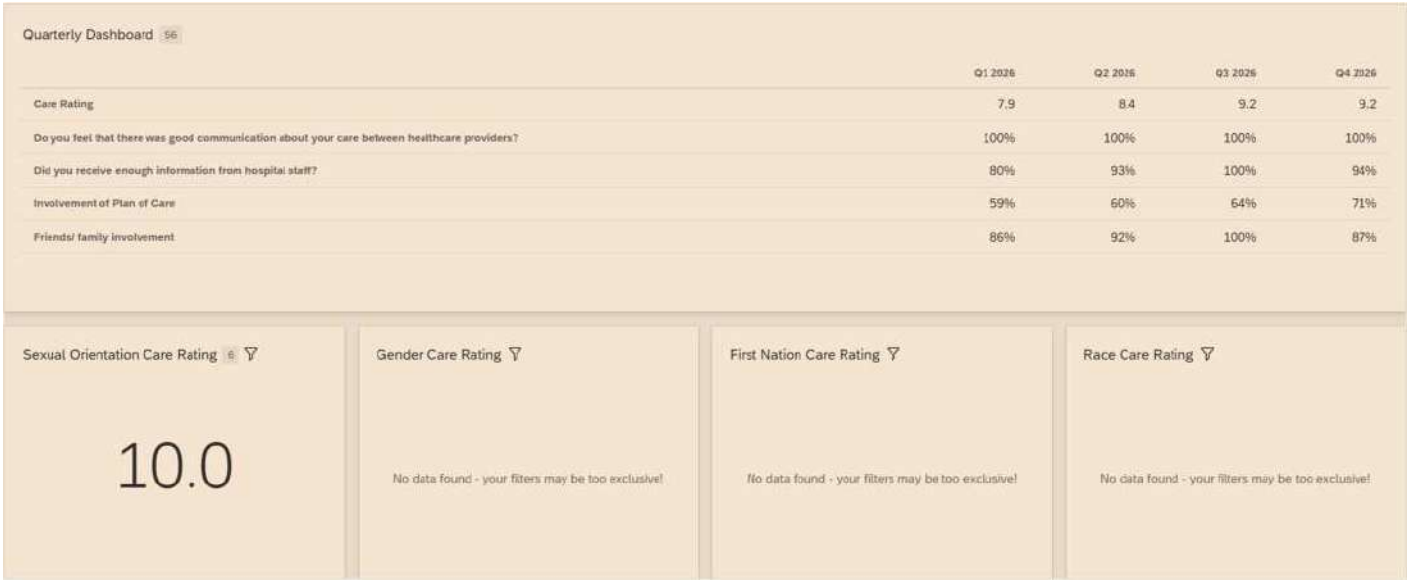
While overall satisfaction is high, opportunity for targeted improvement:

- **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.

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:** 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.

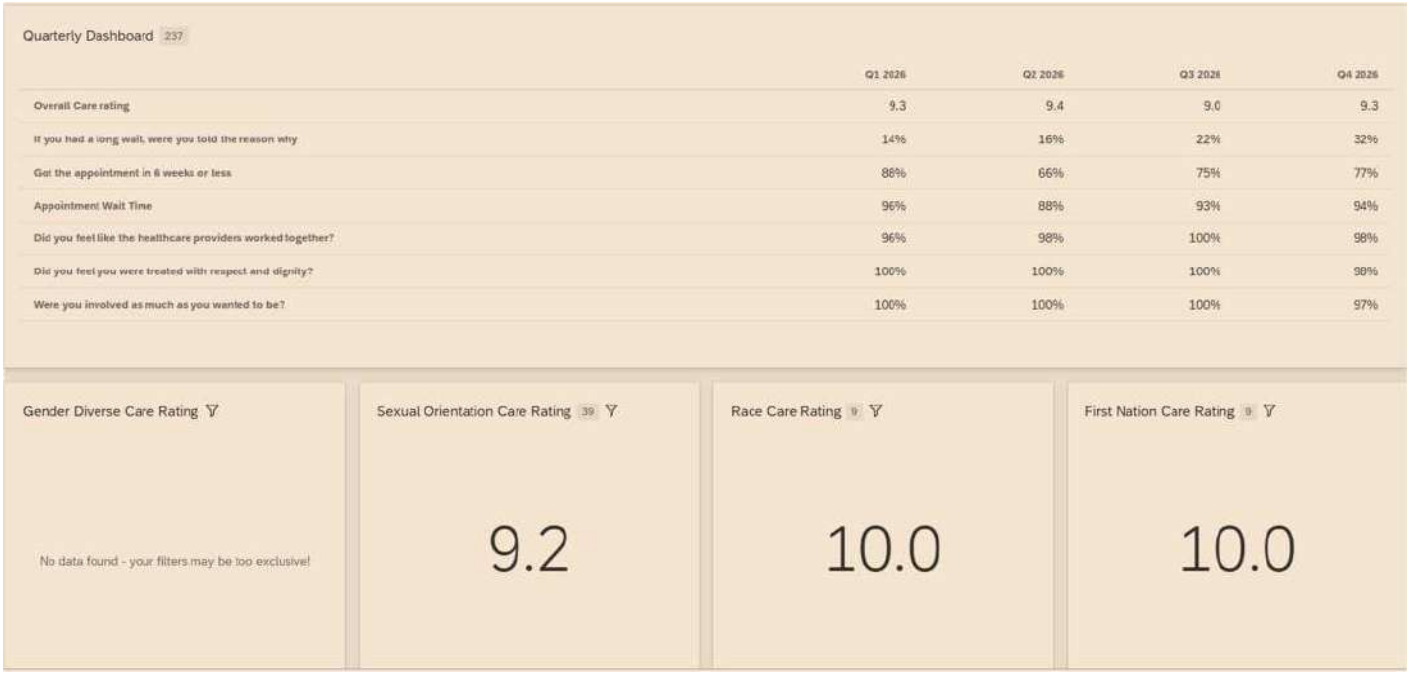
Improvement Opportunity

- **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)*



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.

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: May 6, 2026 Meeting Date Prepared for: May 13, 2026 - Finance, May 28 - Board

Subject: February 2026 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 month of February 2026. Note: Budget figures presented are based on the annual amount divided by 12 months.

ANALYSIS OF FINANCIAL INFORMATION

- February reflects a shorter operating period (28 days), resulting in lower wages and benefits expenses due to two fewer working days compared to longer months.
- The net loss for the month is primarily driven by a decline in out of province revenues, which continues to fall significantly below budget expectations.

ANALYSIS OF STATISTICAL INFORMATION

- Occupancy levels stabilized during the month, reaching an average of 72.68 %.
- Total ER volumes remain above budget, indicating contributed strong demand for emergency services.
- However, out of province ER visits are still trending below expected levels, contributing to revenue shortfalls.
- Overall, Ultrasound exam volumes have increased compared to prior years. This growth is partly due to the introduction of additional operating days on weekends, implemented in the fall aimed at reducing patient wait times.

SUPPORTING DOCUMENTS/ATTACHMENTS

- See financial statements in meeting package.

HOPITAL GLENGARRY MEMORIAL HOSPITAL
STATEMENT OF OPERATIONS
FOR THE PERIOD ENDING FEBRUARY 28, 2026

ACTUAL Jan-26	BUDGET Jan-26	VARIANCE Jan-26	ACTUAL Feb-26	BUDGET Feb-26	VARIANCE Feb-26		ACTUAL YTD - FEB 2026	BUDGET YTD - FEB 2026	VARIANCE YTD - FEB 2026
						Revenue:			
2,010,162	1,572,330	437,832	1,623,529	1,572,330	51,199	MOHLTC Base Allocation	17,579,835	17,295,630	284,205
		0			0	MOHLTC Base Allocation - one time funding	241,113	0	241,113
		0			0	MOHLTC Special HHR programs	148,142	0	105,660
217,361	155,417	61,944	292,508	155,416	137,092	Alternate Emergency Funding Payments	2,815,138	1,709,583	1,105,555
35,205	32,500	2,705	35,205	32,500	2,705	Physician Payments	426,046	357,500	68,546
219,572	205,476	14,096	155,534	205,478	(49,944)	Patient revenues from other Payers	2,165,832	2,260,244	(94,412)
11,497	13,333	(1,836)	5,577	13,334	(7,757)	Differential and Co-Payment	181,847	146,667	35,180
(4,167)	(4,167)	0	(4,167)	(4,166)	(1)	Bad Debts	(48,311)	(45,833)	(2,478)
47,672	40,217	7,455	41,227	40,216	1,011	Recoveries and Miscellaneous	507,740	442,383	65,357
9,875	9,875	0	9,875	9,875	0	Amortization Grants/Donations - Equipment	108,625	108,625	0
2,547,177	2,024,981	522,196	2,159,288	2,024,983	134,305	Total Revenues	24,126,007	22,274,799	1,808,726
						Expenses			
1,186,806	1,062,548	124,258	977,455	1,062,565	(85,110)	Compensation - Salary and Wages	11,980,336	11,696,016	284,320
266,855	302,237	(35,382)	287,319	302,237	(14,918)	Employee Benefits	3,205,919	3,350,113	(144,194)
295,780	217,699	78,081	368,798	217,696	151,102	Medical Staff Remuneration	3,686,668	2,394,673	1,291,995
35,400	33,546	1,854	37,502	33,560	3,942	Medical and Surgical Supplies	372,047	370,570	1,477
30,330	24,857	5,473	34,186	24,860	9,326	Drugs and Medical Gases	272,130	272,839	(709)
327,718	379,870	(52,152)	422,937	379,919	43,018	Other Expenses	4,053,639	4,178,964	(125,325)
25,383	25,383	0	25,383	25,383	0	Amortization of Software License and Fees	279,213	279,214	(1)
23,871	23,870	1	23,871	23,873	(2)	Amortization of Equipment	262,581	262,584	(3)
2,192,143	2,070,010	122,133	2,177,451	2,070,093	107,358	Total Expenses	24,112,533	22,804,973	1,307,560
355,034	(45,029)	400,063	***(18,163)***	(45,110)	26,947	Surplus/(Deficit) From Operations	***13,474***	(530,174)	501,166

ACTUAL Jan-26	BUDGET Jan-26	VARIANCE Jan-26	ACTUAL Feb-26	BUDGET Feb-26	VARIANCE Feb-26	ACTUAL YTD - FEB 2026	BUDGET YTD - FEB 2026	VARIANCE YTD - FEB 2026

Loss of Revenues compared to Budget

Out of province								
	108,951	139,510		100,658	139,509		1,258,569	1,534,592	(276,023)
In Patient O/P								
	15,890	6,250		0	6,250		91,935	68,750	23,185
Rental Income								
	4,770	4,809		4,196	4,809		50,022	52,893	(2,871)
Parking								
	23,237	19,166		22,751	19,166		222,186	210,831	11,355

Details of Other Expenses

Supplies (4000)								
	81,448	95,892		111,204	95,920		1,053,658	1,056,772	(3,114)
Services (6000)								
	41,868	65,963		64,432	65,972		731,623	721,776	9,847
Equipment, R & M and software support (7100)								
	91,077	100,792		115,180	100,798		988,177	1,110,938	(122,761)
Contracted Out services (8000)								
	94,011	107,974		112,176	107,977		1,148,236	1,187,727	(39,491)
Building and grounds (9000)								
	19,314	9,249		19,944	9,252		131,945	101,751	30,194
	327,718	379,870		402,992	370,667		4,053,639	4,178,964	**(125,325)**
Information technology (excluding Wages, Benefits and Depreciation)								
	59,288	65,040		67,280	65,041		605,218	715,442	(110,224)

Linda S Ramsay, GLENGARRY MEMORIAL H
Report Creation Date:Apr 01, 2026 09:07:35 AM ET

Date: From **Jun 01, 2025** To **Mar 31, 2026**
No of Loans:**2**
Transaction Amount: From To
Transaction Type:**All**

► Loan Calculator

Account: 14566 -47430021 -001 -GLENGARRY MEMORIAL H Currency: CAD

Description	Effective Date	Debits	Credits
WITHDRAWAL	Jun 11, 2025	-45,000.00	
PAYMENT	Jun 12, 2025		5,000.00
PAYMENT	Jun 13, 2025		40,000.00
INTEREST PAYMENT	Jun 23, 2025		11.53
WITHDRAWAL	Jun 27, 2025	-145,000.00	
PAYMENT	Jun 30, 2025		145,000.00
WITHDRAWAL	Jul 03, 2025	-5,000.00	
PAYMENT	Jul 04, 2025		5,000.00
WITHDRAWAL	Jul 07, 2025	-115,000.00	
WITHDRAWAL	Jul 09, 2025	-95,000.00	
WITHDRAWAL	Jul 10, 2025	-150,000.00	
PAYMENT	Jul 14, 2025		10,000.00
PAYMENT	Jul 15, 2025		350,000.00
INTEREST PAYMENT	Jul 21, 2025		362.10
Account Total :		**-555,000.00**	**555,373.63**

Account: 14566 -47430021 -002 -GLENGARRY MEMORIAL H Currency: CAD

Description	Effective Date	Debits	Credits
WITHDRAWAL	Jul 17, 2025	-665,106.00	
INTEREST PAYMENT	Jul 30, 2025		1,172.59
INTEREST PAYMENT	Sep 02, 2025		2,796.18
INTEREST PAYMENT	Oct 01, 2025		2,741.51
INTEREST PAYMENT	Oct 30, 2025		2,569.32
WITHDRAWAL	Nov 12, 2025	-147,785.92	
INTEREST PAYMENT	Dec 01, 2025		2,838.05
INTEREST PAYMENT	Dec 30, 2025		2,973.18
INTEREST PAYMENT	Jan 30, 2026		3,072.29
INTEREST PAYMENT	Mar 02, 2026		2,874.07
INTEREST PAYMENT	Mar 30, 2026		2,973.18
Account Total :		**-812,891.92**	**24,010.37**
CAD Total:		**-1,367,891.92**	**579,384.00**

HOPITAL GLENGARRY MEMORIAL HOSPITAL
BALANCE SHEET
AS AT FEBRUARY 28, 2026

	FEBRUARY 28, 2026
Current Assets	
Cash and Investments	2,254,478
Accounts receivable	624,810
Inventory	161,056
Prepaid Expenses	233,272
	3,273,616
Capital assets minus accumulated depreciation	11,772,121
Total Assets	15,045,737
Current Liabilities	
Credit Line	0
Accounts payables and accrued liabilities	3,446,952
Employee future benefits	1,289,668
Deferred income	74,500
	4,811,120
Long-term debt	812,892
Deferred contributions	6,718,710
Net assets	
Restricted	900,751
Unrestricted	569,211
Capital Fund reserves	1,233,053
	2,703,015
	15,045,737

GLENGARRY MEMORIAL HOSPITAL
STATISCAL INFORMATION
February 2026

	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%	95.45%	83.12%		**75.94%**		**82.00%**	**64.11%**
(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%	79.14%	57.38%		**82.63%**		**80.00%**	**83.25%**
(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%	88.84%	72.68%		**78.65%**		**81.00%**	**71.87%**
(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	1,177	1,104		**14,634**		**11,550**	**14,340**
Out of province	178 12%	225 14%	256 16%	303 17%	285 16%	274 17%	237 15%	221 15%	204 12%	226 16%	205 16%		**2,616**	15%	**4,125**	**3,240** 18%
	1,482	1,572	1,603	1,823	1,775	1,594	1,553	1,435	1,701	1,403	1,309		**17,250**		**15,675**	**17,580**
(2024-2025)	1,453	1,642	1,487	1,620	1,634	1,679	1,748	1,678	1,621	1,610	1,408		**17,580**			
SPECIALTY CLINICS																
# OF VISITS - Res.	246	190	214	177	152	192	242	170	201	201	198		**2,183**		**2,718**	**2,368**
Out of prov./country	0 0%	0 0%	0 0%	3 2%	2 1%	2 1%	1 0%	0 0%	1 0%	1 0%	0 0%		**10**	0%	**32**	**7** 0%
	246	190	214	180	154	194	243	170	202	202	198		**2,193**		**2,750**	**2,375**
(2024-2025)	250	248	227	191	202	225	270	184	195	192	191		**2,375**			
RADIOLOGY																
# OF STUDIES	1,087	1,156	1,159	1,063	1,074	1,112	1,162	1,120	1,182	1,189	962		**12,266**			**12,308**
(2024-2025)	1,117	1,119	932	947	973	1,048	1,228	1,222	1,277	1,285	1,160		**12,308**			
ULTRASOUND																
# OF STUDIES	201	203	191	228	175	210	239	218	213	214	200		**2,292**			**1,938**
(2024-2025)	192	205	166	185	166	160	217	148	158	165	176		**1,938**			
BONEDENSITOMETRY																
# OF STUDIES	38	38	19	56	18	80	56	39	38	58	54		**494**			**417**
(2024-2025)	39	39	39	51	39	53	48	20	37	25	27		**417**			

HÔPITAL Glengarry Memorial HOSPITAL

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: **November 3, 2025** Meeting Date Prepared for: **Finance, HR and Audit Committee – May 13, 2026**
Board of Directors – May 28, 2026

Subject: **Investments**

Prepared by: **Linda S. Ramsay**

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

PURPOSE

- To share details of the investments held by the hospital as of March 31, 2026.

ANALYSIS OF FINANCIAL INFORMATION

- Background of Investments
  - Until the summer of 2024, the Hospital maintained one investment account (505-13582-2-3) with RBC Dominion Securities Inc. This account held investments for both the Endowment Fund and the Capital Reserves Funds. At times, a single investment could be allocated to both funds.
  - In May 2024, the Finance, HR and Audit Committee recommended to the Board that the bank account and investments belonging to the endowment fund held at the Bank of Nova Scotia be closed, with the funds transferred to the Hospital's investment portfolio with the RBC Dominion Securities. This last transfer happened in May of 2025.
  - To improve the distinction between the Endowment Fund and the Capital Reserves Fund, a second investment account (505-19334-1-3) was opened at RBC Dominion Securities, and the transferred investments from the Bank of Nova Scotia were deposited in this new account. As investments belonging to the endowment fund, held in the (505-13582-2-3) account, mature, the redeemable value plus interest will be transferred to the 505-19334-1-3 account. By May 2029, all investments belonging to the endowment will have been transferred.
  - All investments are held in fixed income Guaranteed Investment Certificates (GICs).
  - The terms and rates of these investments are determined at the discretion of the CFO based on projected future cashflow needs, in consultation with the Hospital's investment advisor at the RBC Dominion Securities.

SUPPORTING DOCUMENTS/ATTACHMENTS

- Investment details of accounts # 505-13582-2-3 and account # 505-19334-1-3

Wealth Management
Dominion Securities

RBC Dominion Securities Inc.
CANADIAN DOLLAR ACCOUNT STATEMENT

MAR. 31 2026

Your Account Number: 505-13582-2-3

Date of Last Statement: DEC. 31, 2025

GLENGARRY MEMORIAL HOSPITAL
20260 COUNTY ROAD 43
ALEXANDRIA ON K0C 1A0

ADVISORY TEAM

Investment Advisor(s):
Blake Hambleton
(613) 933-2080

Team Member(s):
Jenna Garnier
(613) 930-2075

Branch Address:
10 3rd Street East
Cornwall, Ontario
K6H 2C7
Fax: 613-933-8475
Toll Free: 1-800-567-2127

Branch Manager:
Scott MacKinnon Matt Pestell
613-721-8035 - 613-749-3166

ASSET SUMMARY

	MARKET VALUE AT MAR. 31	PERCENTAGE OF MARKET VALUE
Cash	$633.36	0.11 %
Fixed Income	$598,747.42	99.89 %
Preferred Shares	$0.00	0.00 %
Common Shares	$0.00	0.00 %
Mutual Funds **	$0.00	0.00 %
Foreign Securities	$0.00	0.00 %
Managed Assets	$0.00	0.00 %
Other	$0.00	0.00 %
Total Value	**$599,380.78**	**100.00 %**

INCOME SUMMARY

	THIS MONTH	YEAR-TO-DATE
Dividends	$0.00	$0.00
Interest	$0.00	$0.00
Other	$0.00	$0.00
Total Income	**$0.00**	**$0.00**

CASH BALANCE

ACCOUNT TYPE	OPENING BALANCE AT FEB. 27	CLOSING BALANCE AT MAR. 31
Margin - Long	$633.36	$633.36

- CONTINUED ON NEXT PAGE -

ASSET REVIEW

(Exchange rate 1USD = 1.39275 CAD as of MAR. 31, 2026)

SECURITY SYMBOL	QUANTITY/ SEGREGATED	MKT. PRICE	BOOK COST	MARKET VALUE
FIXED INCOME				
EQUITABLE BANK	88,000	113.677	88,000.00	$100,035.85
GIC - ANNUAL COMPOUND	88,000			
DUE 05/04/2026 4.500%				
CANADIAN TIRE BANK	84,000	113.202	84,000.00	$95,090.10
GIC - ANNUAL COMPOUND	84,000			
DUE 05/03/2027 4.350%				
PC BANK	85,000	113.202	85,000.00	$96,222.13
GIC - ANNUAL COMPOUND	85,000			
DUE 05/03/2027 4.350%				
CDN WESTERN BANK	49,000	109.365	49,000.00	$53,589.24
GIC - ANNUAL COMPOUND	49,000			
DUE 05/03/2027 4.800%				
FAIRSTONE BANK	50,000	109.365	50,000.00	$54,682.90
GIC - ANNUAL COMPOUND	50,000			
DUE 05/03/2027 4.800%				
HOMEEQUITY BANK	80,000	114.061	80,000.00	$91,249.28
GIC - ANNUAL COMPOUND	80,000			
DUE 08/03/2028 5.070%				
GENERAL BANK OF CDA	49,000	108.967	49,000.00	$53,394.12
GIC - ANNUAL COMPOUND	49,000			
DUE 05/03/2029 4.600%				
HOME TRUST COMPANY	50,000	108.967	50,000.00	$54,483.80
GIC - ANNUAL COMPOUND	50,000			
DUE 05/03/2029 4.600%				
Total Value of Fixed Income			535,000.00	$598,747.42
Total Value of All Securities			535,000.00	$598,747.42

- CONTINUED ON NEXT PAGE -

Wealth Management
Dominion Securities

RBC Dominion Securities Inc.
CANADIAN DOLLAR ACCOUNT STATEMENT

MAR. 31 2026

Your Account Number: 505-19334-1-3

Date of Last Statement: DEC. 31, 2025

GLENGARRY MEMORIAL HOSPITAL
ENDOWMENT FUND
20260 COUNTY ROAD 43
ALEXANDRIA ON K0C 1A0

ADVISORY TEAM

Investment Advisor(s):
Blake Hambleton
(613) 933-2080

Team Member(s):
Jenna Garnier
(613) 930-2075

Branch Address:
10 3rd Street East
Cornwall, Ontario
K6H 2C7
Fax: 613-933-8475
Toll Free: 1-800-567-2127

Branch Manager:
Scott MacKinnon Matt Pestell
613-721-8035 - 613-749-3166

ASSET SUMMARY

	MARKET VALUE AT MAR. 31	PERCENTAGE OF MARKET VALUE
Cash	$74.29	0.03 %
Fixed Income	$229,690.23	99.97 %
Preferred Shares	$0.00	0.00 %
Common Shares	$0.00	0.00 %
Mutual Funds **	$0.00	0.00 %
Foreign Securities	$0.00	0.00 %
Managed Assets	$0.00	0.00 %
Other	$0.00	0.00 %
Total Value	**$229,764.52**	**100.00 %**

INCOME SUMMARY

	THIS MONTH	YEAR-TO-DATE
Dividends	$0.00	$0.00
Interest	$0.00	$0.00
Other	$0.00	$0.00
Total Income	**$0.00**	**$0.00**

CASH BALANCE

ACCOUNT TYPE	OPENING BALANCE AT FEB. 27	CLOSING BALANCE AT MAR. 31
Cash	$74.29	$74.29

- CONTINUED ON NEXT PAGE -

0025984 -DSC46

94226 (11/2019) 161-P9

ASSET REVIEW

(Exchange rate 1USD = 1.39275 CAD as of MAR. 31, 2026)

SECURITY SYMBOL	QUANTITY/ SEGREGATED	MKT. PRICE	BOOK COST	MARKET VALUE
FIXED INCOME				
B2B BANK	62,000	102.977	62,000.00	$63,846.05
GIC - ANNUAL COMPOUND	62,000			
DUE 05/28/2027 3.540%				
VERSA BANK	61,000	102.977	61,000.00	$62,816.28
GIC - ANNUAL COMPOUND	61,000			
DUE 05/28/2027 3.540%				
LAURENTIAN BANK	50,000	103.027	50,000.00	$51,513.95
GIC - ANNUAL COMPOUND	50,000			
DUE 05/29/2028 3.600%				
LBC TRUST	50,000	103.027	50,000.00	$51,513.95
GIC - ANNUAL COMPOUND	50,000			
DUE 05/29/2028 3.600%				
Total Value of Fixed Income			223,000.00	$229,690.23
Total Value of All Securities			223,000.00	$229,690.23

ENDOWMENT

- CONTINUED ON NEXT PAGE -

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: April 29, 2026 Meeting Date Prepared for: May 13, 2026 - Finance
May 28, 2026 - Board

Subject: Water main entrance replacement

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

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

PURPOSE

To request approval for a change in the 2026-2027 capital plan infrastructure request: specifically to replace the water main entrance replacement project ($ 200,000) with the Electrical Upgrade Engineering fees for the same amount.

RECOMMENDATION/MOTION

That the Finance, HR and Audit Committee recommend to the Board of Directors that the capital plan item "Water Main Entrance Replacement" be replaced with "Electrical Upgrade Engineering Fees" in the amount of $ 200,000.

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.

With the new fiscal year beginning April1, 2026, preparation commenced for the replacement of the water main entrance.

During this process, the Township attended on site to address a malfunction related to the water meter. While completing this work, Township representatives indicated that, in their option, the water main entrance did not appear to require replacement.

Subsequently, The Hospital engaged Adam MacDonald Plumbing Inc. to conduct an independent inspection and provide a report on the condition of the water main entrance. The findings were as follows:

- *Everything with the water main system including the gaskets and seals at the time of inspection appeared to be in good working condition, with no visual signs of leaks noted.*
- *There is minor rusting but this will occur on metal pipe from condensation that occurs during summer months (cold water running and hot temperatures) a proper clean up of the room, and cleaning the surface rust up while protecting it with a rust inhibitor would be beneficial.*

At this time there seems to be no need to replace the water entrance system coming in as everything is working as it should be. If a leak or repair is needed, it is best to address it on a case by case basis.

As previously discussed at Board meetings, the Hospital is planning an electrical infrastructure upgrade to support safe operations and planned future initiatives, including the implementation of CT scanning services.

To advance this project in a timely manner, WSP has provided a proposal for engineering services, including preparation of an RFP and partial project oversight in the amount of $ 286,000.

Funding has been requested through Ontario Health East under the Hospital Infrastructure Renewal Fund (HIRF) as part of the Exceptional Circumstances Program (ECP). A funding decision is anticipated in Q1, according to Ontario Health East.

Given the importance of maintaining project timelines, the Hospital is proposing to proceed with WSP's service prior to confirmation of funding.

Should ECP funding not be approved, preliminary discussions have already been initiated with the Hospital's banking institution regarding the potential for long-term debt financing to support the project.

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 – Wait for HIRF Funding decision

- Delays initiation of the electrical upgrade project.
- Delays implementation of CT scan services

Option 2 – Reallocate Capital Funds (Recommended)

- Advances project initiation ahead of funding confirmation
- Supports timely execution of the electrical upgrade
- Aligns with planned CT scan implementation timelines
-

Option 3 – Secure long term debt after funding decision

- Further delays project planning and initiation
- Postpones implementation of CT scan services

Option 2 is recommended as it best supports project timelines and alignment with planned clinical services expansion.

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

Proceeding at this time supports critical timelines for the introduction of the CT scan services. Reallocating the existing $ 200,000 within the capital plan allows the project to being without delay.

Strategic Impact

Advances the Hospital's diagnostic imaging capabilities and supports long-term service expansion.

Financial Impact

No net increase to the 2026-2027 capital plan, as the $ 200,000 allocation is being reallocated. The remaining balance of $ 86,000 (difference between $ 286,000 and $ 200,000) will be funded through ECP funding if approved, or alternatively through long-term debt.

The recommendation is based on the following key considerations:

- Ensuring patient and staff safety
- Improving infrastructure reliability and redundancy
- Enabling CT and future clinical services
- Aligning with provincial funding opportunities
- Supporting responsible long-term asset management

CONSULTED WITH:

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

- Robert Alldred-Hughes, President and CEO
- Julie Larose, Manager Support Services
- Linda Ramsay, VP Corporate Services & CFO

DOCUMENTS:

- Adam MacDonald Plumbing Inc. report

Adam MacDonald Plumbing Inc.
5357 County Road 27
Williamstown, ON K0C 2J0
Phone: 613-551-7238
info@adammacdonaldplumbing.ca
www.adammacdonaldplumbing.ca

April 22nd, 2026

20260 County Rd 43
Alexandria, ON K0C 1A0

To Whom it May Concern,

Re: Water Main Inspection Report

On April 21st, 2026, the plumber arrived, at, 20260 County Rd 43, Alexandria, ON, and proceeded with a to inspection the water main of the building;

- Everything with the water main system including the gaskets and seals at the time of inspection appeared to be in good working condition, with no visual signs of leaks noted.
- There is minor rusting but this will occur on metal pipe from condensation that occurs during summer months (cold water running and hot temperatures) a proper clean up of the room, and cleaning the surface rust up while protecting it with a rust inhibitor would be beneficial.

At this time there seems to be no need to replace the water entrance system coming in as everything is working as it should be. If a leak or repair is needed, it is best to address it on a case by case basis.

We trust this meets your requirements and if you have any questions, please contact us at info@adammacdonaldplumbing.ca

Sincerely,

Adam MacDonald, Master Plumber/Owner
Adam MacDonald Plumbing Inc.
5357 Country Road 27
Williamstown, ON K0C 2J0

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: May 6, 2026 Meeting Date Prepared for: May 13, 2026 – Finance
May 28, 2026 - Board

Subject: HGMH Psychological Safety Program

Prepared by: Kayla MacGillivray

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

PURPOSE

- To provide an overview of the Psychological Safety Program at HGMH and roll-out plan.

SITUATION & BACKGROUND

A brief description of the background to the issue.

- Healthcare workers face increasing psychological demands including workload pressures, exposure to trauma, workplace violence, burnout, and moral distress.
- These challenges can impact employee well-being, retention, absenteeism, engagement, and patient care.
- A psychologically safe workplace supports employees in speaking up, reporting concerns, and seeking support without fear of stigma or reprisal.
- Under Ontario's Occupational Health and Safety Act, employers are required to take every reasonable precaution to protect worker health and safety, including risks related to workplace harassment and violence.
- Psychological health and safety is increasingly recognized as a key component of occupational health, workplace culture, and quality patient care.
- The National Standard of Canada for Psychological Health and Safety in the Workplace (CAN/CSA-Z1003-13/BNQ 9700-803) provides a framework for addressing psychological hazards in the workplace.
- Implementing a Psychological Safety Program will help establish a proactive and sustainable approach to:
    - Promoting employee well-being
    - Preventing psychological harm
    - Supporting respectful workplace practices
    - Improving engagement, retention, and workplace culture
    - Supporting safe, high-quality patient care

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Psychological Safety Policy
- Psychological Safety Program

HGMH's Psychological Health & Safety Program

HÔPITAL Glengarry Memorial HOSPITAL

What is Psychological Safety?

The absence of harm and/or threat of harm to mental well-being that a worker might experience.

A psychologically health and safe workplace promotes workers' psychological

well-being and actively works to prevent harm to worker psychological health including in negligent,

reckless, or intentional ways

The National Standard of Canada for Psychological Health & Safety in the Workplace

Created in 2013, the Standard specifies requirements for a documented and systematic approach to develop and sustain a psychologically healthy and safe workplace.

This Standard provides a framework to create and continually improve a psychologically healthy and safe workplace, including:

a) the identification and elimination of hazards in the workplace that pose a risk of psychological harm to a worker;

b) the assessment and control of the risks in the workplace associated with hazards that cannot be eliminated;

c) implementing structures and practices that support and promote psychological health and safety in the workplace; and

d) fostering a culture that promotes psychological health and safety in the workplace.

Program Purpose & Guiding Principles

The purpose of this program is to create and sustain a psychologically safe workplace where employees feel respected, valued, and supported. This aligns with HGMH's commitment to patient-centered care, staff well-being, and compliance with the National Standard of Canada.

Guiding Principles

1. **Dignity & Respect** – All staff are treated fairly and inclusively.
2. **Equity & Accessibility** – Policies and supports are accessible to all employees.
3. **Collaboration** – Staff and leaders share responsibility for a safe, supportive environment.
4. **Prevention First** – Proactive measures to identify and address psychological hazards.
5. **Continuous Improvement** – Regular review and improvement of psychological health initiatives.

Objectives of the Program

- Promote a culture of trust, openness, and inclusion.
- Prevent workplace factors that can cause psychological harm (bullying, harassment, workload imbalance, stigma).
- Build organizational capacity to support resilience, engagement, and well-being.
- Provide clear processes for reporting, addressing, and resolving concerns.
- Support compliance with Occupational Health & Safety Act and the National Standard of Canada.

Program Components

1. Leadership Commitment
2. Policy Review
3. Risk Assessment & Prevention
4. Training & Awareness
5. Reporting & Support Systems
6. Employee Engagement & Collaboration
7. Monitoring & Continuous Improvement

Roles & Responsibilities

- **Senior Leadership**– Ensure resources, oversight, and accountability.
- **Managers** – Promote team well-being, address concerns early, lead by example.
- **Employees** – Engage respectfully, use support resources, contribute to a safe environment.
- **Joint Health & Safety Committee** – Monitor and review program outcomes, recommend improvements.

Metrics

- Staff engagement survey results.
- Rates of reported incidents (harassment, bullying, workload concerns).
- Utilization of EFAP and peer supports.
- Staff retention and absenteeism trends.

Program Roll Out

- Year 1: Build leadership commitment, establish policies and raise awareness.
- Year 2: Embed practices into daily operations and strengthen employee voice.
- Year 3: Institutionalize the program and ensure long-term sustainability.

Next Steps: 2026-2027

1. **Leadership Commitment & Endorsement**: Senior Leadership signs formal statements of commitment. Psychological safety is incorporated into strategic/operation plan (complete).

2. **Policy Alignment**: Update Workplace Violence and Harassment Prevention policy to include psychological safety. Ensure alignment with the Occupational Health & Safety Act and Human Rights Code.

3. **Baseline Assessment**: Conduct organization-wide psychological hazard and risk assessment (surveys, focus groups, incident reviews). Establish baseline measures: sick leave, staff turnover, engagement survey data.

4. **Awareness & Training**: Launch all-staff orientation module on psychological safety. Begin manager/supervisor training on supportive leadership and early intervention.

Next Steps: 2027-2028

1. **Expanded Training**: provide mandatory psychological safety training for all employees, integrated into onboarding and annual education. Leaders will receive targeted training focused on supportive leadership behaviours, respectful communication, and responding appropriately to psychological safety concerns.
2. **Reporting & Support Systems:** maintain a confidential and accessible process for reporting psychological safety concerns and will clearly communicate how concerns are reviewed and addressed. Employees will have access to timely, fair, and trauma-informed support following reported concerns or critical incidents. Mental health and wellness resources, including EFAP, will be actively promoted and made easy to access.
3. **Employee Engagement**: Actively engage employees in shaping a psychologically safe workplace through regular surveys, staff forums, and committee participation. Employees will be encouraged to share feedback and contribute to solutions at both the unit and organizational level. Input from staff will be used to inform continuous improvement efforts.

Next Steps: 2028-2029

1. **Embed in Leadership Performance:** Integrate psychological safety expectations into leadership performance evaluations, operational planning expectations, and the decision-making process.
2. **Evaluate:** Conduct a formal psychological health and safety evaluation aligned with the National Standard of Canada and use results to drive continuous improvement.
3. **Reporting:** Establish ongoing reporting to senior leadership to ensure accountability and sustainability.

Questions?

HÔPITAL Glengarry Memorial HOSPITAL

Document Name:	Psychological Safety Program	
Document Number:	COR.08.020.0.26	
Review Period:	☒3 years ☐1 year	**Manual:** N/A
Classification: Corporate	**Section:** Human Resources	
Owner: Human Resources	**Signing Authority:** Leadership	

POLICY STATEMENT:

The purpose of this program is to create and sustain a psychologically safe workplace where employees feel respected, valued, and supported. This aligns with HGMH's commitment to patient-centered care, staff well-being, and compliance with the National Standard of Canada.

DEFINITIONS:

Psychological Safety: The absence of harm and/or threat of harm to mental well-being that a worker might experience. A psychologically health and safe workplace promotes workers' psychological well-being and actively works to prevent harm to worker psychological health including in negligent, reckless, or intentional ways

PROCEDURE:

1. Leadership Commitment

- Senior Leadership will endorse and support the Psychological Health & Safety Program.
- Psychological safety principles will be integrated into strategic and operational planning.
- Oversight will be aligned with existing health and safety structures, including the Joint Occupational Health and Safety Committee (JOHSC), which also supports monitoring under the Workplace Violence & Harassment Prevention Policy (COR.11.003.X.XX).
- Regular reporting on psychological safety indicators will be provided to senior leadership.

2. Identification & Assessment of Psychological Hazards

- HGMH will identify and assess workplace factors that may pose a risk to psychological health, including but not limited to:
  - Workload demands and scheduling pressures
  - Incivility and interpersonal conflict
  - Role clarity and organizational change
  - Exposure to traumatic or distressing events
- Assessment methods may include staff surveys, focus groups, incident trend analysis, and workforce metrics.
- Findings that indicate potential violence or harassment risks will be escalated and managed in accordance with the Workplace Violence & Harassment Prevention Policy.

3. Prevention, Training & Awareness

- Psychological safety education will be provided to all employees through orientation and ongoing training.
- Leader training will reinforce:
  - Supportive and respectful leadership behaviours
  - Early identification of psychological safety risks
  - Appropriate referral to formal processes under the Workplace Violence & Harassment Prevention Policy when required
- Training will align with and reinforce expectations outlined in the Education, Training, and Development for Staff policy (COR.07.003.X.XX).

4. Reporting & Support Processes

- Employees may report psychological safety concerns using established reporting channels.
- Reports involving allegations of violence or harassment will be managed under the Workplace Violence & Harassment Prevention Policy, including investigation and resolution processes.
- Psychological safety concerns not meeting the definition of violence or harassment will be addressed through supportive, trauma-informed, and just culture approaches.
- Employees will have access to supports such as EFAP and critical incident debriefing, regardless of whether a formal complaint is initiated.

5. Employee Engagement & Collaboration

- Employees will be engaged through surveys, staff forums, and committee participation to identify risks and solutions related to psychological safety.
- Feedback trends that suggest systemic risks for violence or harassment will be shared with appropriate leadership and committees for action under both this procedure and the Workplace Violence & Harassment Prevention Policy.
- Shared responsibility for psychological safety will be reinforced across all levels of the organization.

6. Monitoring, Evaluation & Continuous Improvement

- Program effectiveness will be monitored using indicators such as:
  - Staff engagement and psychological safety survey results
  - Trends in reported concerns (psychological safety, violence, harassment)
  - Absenteeism, turnover, and EFAP utilization
- A formal psychological health and safety evaluation will be conducted periodically and aligned with the National Standard of Canada.
- Outcomes will inform updates to both this procedure and the Workplace Violence & Harassment Prevention Policy to ensure alignment and continuous improvement.

7. Documentation & Reporting

- Documentation related to assessments, actions, and improvements will be maintained in accordance with HGMH policy.
- Psychological safety data will be reported alongside workplace violence and harassment data to provide a comprehensive view of workplace health and safety.

ROLES & RESPONSIBILITES

Senior Leadership– Ensure resources, oversight, and accountability.

Managers – Promote team well-being, address concerns early, lead by example.

Employees – Engage respectfully, use support resources, contribute to a safe environment.

Joint Health & Safety Committee – Monitor and review program outcomes, recommend improvements.

CROSS-REFERENCED POLICIES:

Policy Number	Policy Name
COR.11.003.X.XX	Workplace Violence and Harassment Prevention
COR.07.003.X.XX	Education, Training and Development for Staff

REFERENCES:

1. Canadian Standards Association. (2022). *Psychological health and safety in the workplace* (CAN/CSA-Z1003-13/BNQ 9700-803/2013 [R2022]). CSA Group.

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: February 10, 2026 Meeting Date Prepared for: May 13, 2026 – Finane May 28, 2026 - Board

Subject: EPIC Implementation Update

Prepared by: Robert Alldred-Hughes, President & CEO

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

PURPOSE

To provide the Board of Directors with an update on the status of Hôpital Glengarry Memorial Hospital's participation in the Atlas Alliance Epic EMR implementation, including overall progress and readiness as the project advances toward go-live.

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 Atlas Alliance Epic EMR implementation continues to progress satisfactorily and remains on track for the planned October 24, 2026 go-live. The project has successfully completed core build activities and transitioned into the readiness phase, representing a significant shift from system design to operational implementation.
- Testing activities are well underway, with application testing complete and integrated testing in progress. At the same time, readiness work is advancing across clinical, operational, and technical areas, including data conversion, interface testing, and workflow validation.
- The project is now entering a critical stage focused on training and end-user readiness. Credentialed trainer programs and training registration are underway, with staff and physicians preparing to engage in training over the coming months. This phase represents the point at which the system becomes embedded into day-to-day operations.
- HGMH continues to be actively engaged across all aspects of the implementation and is aligned with regional planning and timelines.

Budget: The Atlas Alliance EPIC implementation project remains on track financially, with a $734,118 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	$1,130,753	$173,504	$445,646	$213,667	$417,807	$326,538	$257,556	$160,323
Actual	$ 719,167	$130,143	$234,794	$145,349				

Variance	$ 411,586	$43,361	$210,852	$68,319				

Year to Date Spend: $1,229,453

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.

Impact Analysis

The project continues to position HGMH for a successful transition to a modern, integrated electronic medical record. As the organization moves further into readiness and training, the impact is becoming more operational, with increased engagement from frontline teams and leaders.

Implementation of Epic will strengthen quality and safety through improved access to information, standardized workflows, and enhanced clinical decision support. It will also improve integration with regional partners, supporting more coordinated and seamless patient care.

In the near term, the shift to training and readiness will require focused organizational effort and coordination. This includes supporting staff through change, ensuring adequate training coverage, and maintaining operational stability while preparing for go-live.

Risk Assessment

At this stage, risks are consistent with a project of this scale and are being actively managed at both the Alliance and local levels. The overall program remains stable, with no issues requiring escalation.

Key areas of focus include maintaining momentum in testing and readiness activities, ensuring training capacity and participation, and advancing data and system readiness. Some elements of the broader Alliance work, such as order set development, data quality, and training coordination, require continued attention; however, mitigation strategies are in place and progress is being made.

Locally, efforts are focused on ensuring training readiness, supporting staff participation, and aligning workflows ahead of go-live. Continued engagement and oversight will be important as the project moves through this next phase.

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

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: May 5, 2026 Meeting Date Prepared for: May 13, 2026 – Governance
May 28, 2026 - Board

Subject: Q4 Strategic Actions Report

Prepared by: Robert Alldred-Hughes, President & CEO

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

PURPOSE

- The purpose of this briefing is to provide the Board of Directors with an update on the progress of the hospital's Q4 Strategic Action Report (2025–2026). Strategic actions are derived directly from our 2023–2028 Strategic Plan and are developed through consultation with senior leadership, physician leaders, and staff committees. Each action is designed to operationalize our four strategic priorities: Quality & Safety, People & Culture, Integration & Standardization, and Future Planning, and provides tangible milestones to measure progress toward our longer-term goals.
- Monitoring and reporting progress quarterly is critical to ensuring accountability, identifying early risks, and implementing mitigation strategies where required.

RECOMMENDATION / MOTION

THAT the Board of Directors review and receive the Q4 Strategic Action Report as presented.

SITUATION & BACKGROUND

A brief description of the background to the issue.

• All strategic actions for Q4 were assessed against established milestones and categorized as: Complete, On Track, Not on Track (mitigation plans in place), or At Risk.

Quality & Safety:

- Actions to strengthen palliative care resources have been completed. Implementation of Best Practice Guidelines included the development of a family guide to support access to cultural, spiritual, and religious resources. The Spiritual and Cultural Care Room, co-designed with PFAC and the IDEA Committee and opened in Fall 2025, is now actively being used by patients and families.
- Medical directives continue to be well embedded in clinical practice, with all 27 directives consistently supporting improved patient flow and reduced delays prior to physician assessment. As part of Epic implementation, order set reviews have been completed to ensure alignment and functionality within future workflows. Additional enhancements this quarter included the introduction of a third Emergency Department treatment room and upgrades to the Surgical Services decontamination room to strengthen infection prevention and control. This action is complete.
- Leadership and PFAC patient rounding remains well established, with patient feedback consistently indicating that individuals feel cared for and safe. PFAC members continue to participate in monthly rounding alongside the Senior Leadership Team. Ongoing focus remains on improving consistency of

whiteboard use to strengthen communication of care plans with patients and families. This action is complete.

People & Culture:

- The medical learner program is now fully established, with successful placements completed for first-year medical students, third-year clerks, and residents in collaboration with ROMP and ERMEP partners. This has created a structured and sustainable approach to supporting medical education at HGMH. This action is complete.
- The Psychological Safety Program has been completed and approved, with leadership training successfully delivered during the March 5, 2026 leadership retreat. This action is complete.
- The performance evaluation redesign has been completed and implemented across the organization. The new process is now in use, supporting a more meaningful, transparent, and development-focused approach to employee performance. This action is complete.

Integration & Standardization:

- The Epic EMR implementation through the Atlas Alliance remains on track, with a targeted go-live of October 24, 2026. Current efforts are focused on training readiness, including confirming trainer requirements, developing modules, and preparing for superuser and end-user training through the summer and early fall.
- IT infrastructure upgrades, including the implementation of an uninterruptible power supply and installation of backup servers, have been completed, strengthening system reliability and security. This action is complete.

Future Planning:

- Stage 1.1 of the Ministry's Capital Redevelopment Planning Process has been completed and approved by the Board, outlining a new patient care tower, renovations to the existing facility, and a community health hub. Advocacy efforts continue to advance the project to Stage 1.2 pending Ministry of Health approval. This action is complete.
- The HGMH Foundation has raised approximately $1.8 million toward the CT Scanner campaign. Strong fundraising momentum has supported the initiation of early implementation planning, with leadership continuing active engagement with donors and support of Foundation-led initiatives. This action remains on track.

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.

Completion of the 2025–2026 strategic actions reflects strong execution across all priority areas and positions HGMH well heading into the next fiscal year. The primary impact is increased organizational maturity, with several initiatives now embedded into standard practice rather than remaining project-based.

From a quality and patient experience perspective, these advancements support more consistent, person-centred care. From a people and culture lens, investments made this year strengthen recruitment, retention, and leadership capacity, which are critical in a constrained labour market.

Looking ahead, the organization will shift from implementation to sustainment and optimization. This introduces risk related to maintaining momentum, ensuring consistency in practice, and supporting teams through ongoing change, particularly as Epic implementation accelerates. In addition, future-facing initiatives such as capital redevelopment and CT implementation will require continued focus on external approvals, funding alignment, and infrastructure readiness.

Overall, the organization is well positioned; however, disciplined execution and continued monitoring will be required to sustain gains and manage the complexity of concurrent strategic initiatives.

CONSULTED WITH:

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

- HGMH Senior Leadership Team

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Q4 Strategic Action Report

Strategic Action Report Q4

Strategic Dimension	Strategic Direction	Executive Lead	Action	Progress	Status
Quality & Safety	*Enrich the patient experience through quality, safe care that welcomes patients and families as partners in care.*	R. Romany	Implement Best Practice Guidelines to strengthen the tools and resources available to our palliative care team. This includes introducing assessment tools and reference sheets to support consistent, high-quality care across all touchpoints.	• Key focus for the team is to ensure that nurses and physicians facilitate access to appropriate resources, spaces, and services to support the cultural, spiritual, and/or religious needs of patients and families. The family guide for palliative care resources was developed and implemented. • The Spiritual and Cultural Care Room is actively being used by families/patients as necessary. It was designed with PFAC, and IDEA Committee. Opened in Fall of 2025.	Complete
		R. Romany	Increase the use of medical directives for nursing staff, allowing for faster initiation of diagnostic tests and treatments before physician assessment. Undertake facility enhancements to support patient care and operational efficiency.	• Use of the 27 medical directives by staff continues to help improve patient flow and reduce delays before physician assessment. The medical directives now form part of the standard workflow, and are consistently in use. • Epic implementation activities also included completion of an order set review to ensure medical directives can be ordered effectively. • A third Emergency Department treatment room was implemented to boost capacity, and an upgrade was completed to the Surgical Services decontamination room to improve infection prevention and control.	Complete
		R. Romany	Enhance patient involvement in care decisions by implementing Leader and Patient and Family Advisory Committee (PFAC) patient rounding to engage directly with patients and assess their level of involvement in their care before discharge.	• Patient feedback consistently indicates that individuals feel cared for and safe. • Strengthening consistency in patient whiteboard use remains an area of focus to enhance communication with patients and families regarding the plan of care. • PFAC members continue to partner with Senior Leadership for patient rounds monthly.	Complete

Fully complete | On track – no barriers for completion | Not on track – mitigation plans in place | Not on track – initiative at risk

People & Culture	*Improve engagement by investing in the organizations people and empower a caring and positive culture for all.*	Dr. L. MacKinnon	Initiate a Medical Student and Resident Program to provide hands-on learning experiences within our medical community. By collaborating with the Rural Ontario Medical Program (ROMP) and other academic partners, we will support initiatives such as Discovery Week for medical students and structured resident placements	• In the spring, we successfully welcomed four first-year medical students—two from the University of Ottawa and two from the University of Toronto. • We are actively collaborating with ERMEP and ROMP to create our medical student and resident program. • Additionally, we will be hosting a third-year medical student from Queen's University for a 14-week generalist placement, scheduled from September 15 to December 19, 2025. • We have a 2nd Year Resident completing an elective from December 16th-Janaury 12th with one of our Family Practice Physicians who also works in the Emergency and Inpatient Department. • We are set to host a third-year medical student from Queen's University for a 14-week generalist placement, scheduled from January 5 to April10, 2026.	Complete
		K. MacGillivray	As part of our ongoing commitment to health and safety, we are enhancing leadership training with a dedicated focus on psychological safety in addition to management responsibilities.	• The development of the psychological safety program is complete and approved. • Training for the leadership team was completed on March 5, 2026.	Complete
		K. MacGillivray	Redesign our performance evaluation process to create a more meaningful, transparent, and development-focused experience for our employees.	• This process has been completed. We have launched the new process and are currently using it.	Complete
Integration & Standardization	*Deliver standardized quality care in a cost-effective way through collaboration & integration opportunities.*	R. Romany	Continue the transition to a new Electronic Medical Record (EMR) system by joining the Atlas Alliance and implementing the EPIC EMR platform in the Fall of 2026.	• The implementation project officially launched on April 2, 2005. Go-live date is targeted for October 24, 2026. • Focus this quarter is confirming training plans, e.g. # of trainers and modules to be completed by trainers and staff. Superuser training scheduled for July-Aug and end-user training Aug- Oct.	On Track

Fully complete | On track – no barriers for completion | Not on track – mitigation plans in place | Not on track – initiative at risk

		L. Ramsay	Invest in critical upgrades to our information technology infrastructure. This year, we are enhancing system reliability and security by purchasing backup servers and an uninterruptible power supply (UPS) for our server environment.	• Uninterruptible Power Supply (UPS) was implemented in summer 2025. • Backup servers have been installed in December 2025.	Complete
Future Planning	*Invest in the sustainability of our equipment & infrastructure to support safe, quality care.*	R. Alldred-Hughes	Submit pre-capital submission to support the future redevelopment and revitalization of the hospital	• Board and Hospital Leadership completed Stage 1.1 of the Ministry Capital Redevelopment Planning Process, and received Board approval for submission in June 2025. The plan contains a new patient care tower, renovation of existing site, and a community health hub. • Hospital will continue to advocate for the proposal to move to stage 1.2 with Ministry of Health approval.	Complete
		R. Alldred-Hughes	Actively work with and support the HGMH Foundation in their efforts to fund our ability to bring CT to HGMH.	• Foundation has launched the their capital campaign, and continuous fundraising efforts. CEO has been meeting with donors as needed, providing hospital tours and context for our ask. In addition, the HGMH leadership team has been supporting fundraising events through volunteerism and attendance. Working collaboratively with foundation on donor relations as needed. • Foundation has raised $1.8M toward the CT Scanner at this time. Based on these results, initial planning underway for CT implementation.	On Track

Fully complete | On track – no barriers for completion | Not on track – mitigation plans in place | Not on track – initiative at risk

REPORT OF THE BOARD QUALITY AND PATIENT SAFETY COMMITTEE MEETING

May 13, 2026 at 4:00PM Boardroom/MS Teams

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

Summary of Discussion

Approval of the Agenda:
The agenda was reviewed.

Moved By: C. Larocque
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 April 8, 2026, was approved as presented.

Moved By: G. Peters
Seconded By: Dr. S. Robertson
THAT the report of April 8, 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 on Non-Violent Crisis Intervention (NVCI) was shared and included the purpose of NVCI, what skills are taught, why NVCI matters, where it is used, and the policies associated with NVCI.

Discussion ensued around whether there could be a metric with the different interventions used for violent patients (ex: stopped X amount of incidents at level 1, and X amount at level 3). It was agreed that this could be easier to do with Epic.

Matters for Discussion/Decision

Review 2026-2027 Committee Workplan
The workplan was reviewed.

Moved By: C. Larocque
Seconded By: D. Elie

THAT the Quality & Patient Safety Committee recommend the 2026-2027 workplan to the Governance & Nominating Committee as presented.

Committee meetings next year will be one and half hours to allow for more discussion and not have to rush through meetings.

CARRIED

Review Q4 2025-2026 Quality Improvement Plan Results
The Quality Improvement Plan results for Q4 were reviewed.

Moved By: Dr. S. Robertson
Seconded By: G. Peters
That the Quality & Patient Safety Committee review and receive the Q4 quality improvement plan results for 2025-2026 as presented.

Q4 yielded positive results across all areas.

CARRIED

Review Q4 2025-2026 Quality & Safety Scorecard
The quality & safety scorecard results for Q4 were reviewed.

Moved By: C. Larocque
Seconded By: D. Elie
THAT the Quality & Patient Safety Committee review and receive the Q4 quality & safety scorecard results for 2025-2026 as presented.

Areas for opportunities are around fall rates as we continue to learn from every situation.

CARRIED

Review Patient Satisfaction Survey Results
The patient satisfaction survey results 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 as presented.

Signage is now in place asking patients to disclose their preferred name upon registration as there is no where to include this in our current system. This will be fixed once Epic is implemented.

CARRIED

Matters for Information

BPSO Updates
BPSO Champion training continues with members from all departments being involved.

Review HIROC Report
This is shared annually and identifies areas that need attention.

Moved By: C. Larocque
Seconded By: Dr. S. Robertson
THAT the Quality & Patient Safety Committee review and receive the HIROC report as presented.

CARRIED

Review Hospital Services
Hospital services were discussed including new services added over the last year and areas of focus for the future.

The pain clinic currently has an 18-month waitlist in which the team is working on managing as people are booking up to 6 appointments at a time.

Orthopedics is a service that used to be offered here which we are looking to bring back.

Because of the hospitals funding, adding procedures means having to look at the current budget to see how this can fit in.

Review Trillium Gift of Life Report
The Trillium Gift of Life report was shared for information.

Review Professional Staff HR Plan
A summary was shared on the professional staff human resources plan in which there is no urgency for recruitment within the hospital however recruitment does remain ongoing to help grow our teams.

We continue to accommodate medical students and residents as this is helpful for recruitment as well.

Review Physician Engagement Survey Results
With only 5 physicians having completed the survey, this will be deferred to try and get a higher response rate and the results will be brought back in the fall.

Date of Next Meeting: September 2026

K-L. Massia, Recorder

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: May 1, 2026 Meeting Date Prepared for: May 13, 2026 – Quality
May 28, 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. 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!)

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: May 1, 2026 Meeting Date Prepared for: May 13, 2026 – Quality
May 28, 2026 - Board

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

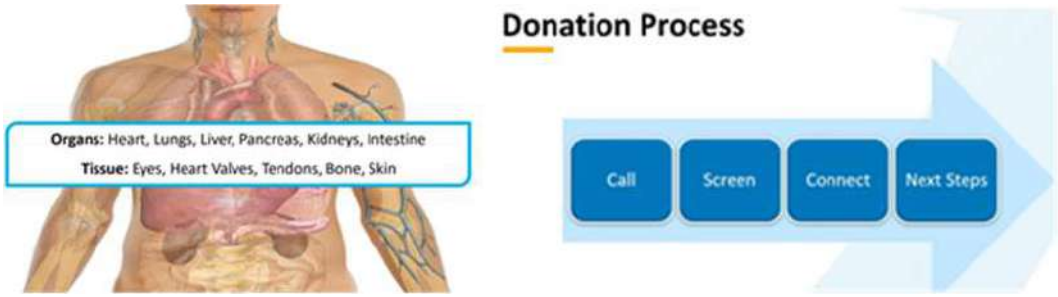
PURPOSE

- 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.

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

HÔPITAL Glengarry Memorial HOSPITAL

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.

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

May 13, 2026 at 5:00PM in the Boardroom/MS Teams

Present:	C. Nagy, Chair	Dr. S. Robertson	G. McDonald (v)
	G. Peters	L. Ramsay, CFO	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: Dr. S. Robertson
Seconded By: G. Peters
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 March 11, 2026, was shared.

Moved By: G. Peters
Seconded By: Dr. S. Robertson
THAT the report of the meeting of March 11, 2026, be approved as presented.

CARRIED

Committee Work Plan
The committee work plan was shared and remains on track.

Business Arising:
There was no business arising.

Matters for Discussion/Decisions

Review 2026-2027 Committee Workplan
The workplan for 2026-2027 was reviewed.

Moved By: G. Peters
Seconded By: Dr. S. Robertson
THAT the Finance, HR, and Audit Committee recommend the 2026-2027 workplan to the Governance & Nominating Committee as presented.

Discussion ensued around legislation requirements of the Board. This will be added to the Quality workplan.

CARRIED

Financial Statements and Statistical Information – February 2026
The financial statements for February 2026 were reviewed.

Moved By: G. McDonald
Seconded By: G. Peters
THAT the Finance, HR, and Audit Committee review and receive the financial statements for February 2026 as presented.

February ended with a small deficit of $18,163 bringing the year-to-date deficit to $13,474. The budget was updated for next year as the volumes for out of province patients has decreased. One time funding is never guaranteed for the following year so budgeting is done accordingly.

CARRIED

Q3/Q4 Investments
The investments for Q3/Q4 were reviewed.

Moved By: Dr. S. Robertson
Seconded By: G. Peters
That the Finance, HR, and Audit Committee review and receive the investments for Q3 and Q4 as presented.

A second investment account was opened last year for the endowment fund only. There is approximately 750K in investments. Discussion ensued around whether investments should remain in one account however, having two accounts makes it easier to manage as funds from the endowment are restricted.

CARRIED

Water Main Replacement
Discussion ensued around the water main replacement.

Moved By: Dr. S. Robertson
Seconded By: G. Peters
That the Finance, HR and Audit Committee recommend to the Board of Directors that the capital plan item "Water Main Entrance Replacement" be replaced with "Electrical Upgrade Engineering Fees" in the amount of $ 200,000.

A second opinion was received on the water main in which it was determined that it is not due to be replaced at this time. However, there is still the project for the electrical upgrade in which the quote came in at 286K. The water main was approved on the capital plan but the ask is to switch this project for the electrical upgrade project.

CARRIED

Matters for Information – Finance

Declaration of Compliance – February 2026
The declaration of compliance for February 2026 was included in the package.

Q3/Q4 Executive Expense Report
The executive expense report for Q3/Q4 was reviewed.

Matters for Information – People & Partnerships

Review Talent Management Program
The talent management program was reviewed in which there are 7 phases.

Changes to this program have been the integration of a new tracking system for applicants which is part of our current HR system and changing the performance evaluation from paper to electronic.

Review Psychological Safety Program
The psychological safety program was shared for information.

Matters for Information – Building, Property & Infrastructure

Epic Implementation Updates
Selected staff members were trained to become credentialed trainers. These will be the people who will train our staff on the systems in which a plan is being put together as to how we will go about this with the upcoming maternity leaves and vacation time.

Date of Next Meeting

Next meeting: June 3, 2026

K-L. Massia, Recorder

GLENGARRY MEMORIAL HOSPITAL
BROADER PUBLIC SECTOR EXPENSE REPORTING

REPORTING PERIOD: October 1, 2025 to March 31, 2026

NAME: Mr. Rob Alldred-Hughes

TITLE: President and Chief Executive Officer

Date(s)	Expense Amount by Category								Description
	Travel								
	Vehicle/Mileage	Train/Air	Taxi	Accomodation	Parking	Meal	Hospitality	Total	
October 1, 2025					20.3				Local meeting - regional initiatives (Ottawa)
November 13-14, 2025		$309.03		$1,266.94		$67.34		$1,643.31	Forum on Healthcare Infrastructure (Toronto)
February 5, 2026	$113.30							$113.30	Local meeting - regional initiatives (Ottawa)
TOTAL	**$113.30**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$113.30**	

GLENGARRY MEMORIAL HOSPITAL
BROADER PUBLIC SECTOR EXPENSE REPORTING

REPORTING PERIOD: October 1, 2025 to March 31, 2026

NAME: Dr. Lisa MacKinnon

TITLE: Physician, Chief of Staff

Date(s)	Expense Amount by Category								Description
	Travel								
	Vehicle/Mileage	Train/Air	Taxi	Accomodation	Parking	Meal	Hospitality	Total	
TOTAL	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	

GLENGARRY MEMORIAL HOSPITAL
BROADER PUBLIC SECTOR EXPENSE REPORTING

REPORTING PERIOD: October 1, 2025 to March 31, 2026

NAME: Ms. Linda S. Ramsay

TITLE: VP of Corporate Services and Chief Financial Officer

Date(s)	Expense Amount by Category								Description
	Travel								
	Vehicle/Mileage	Train/Air	Taxi	Accomodation	Parking	Meal	Hospitality	Total	
TOTAL	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	

GLENGARRY MEMORIAL HOSPITAL
BROADER PUBLIC SECTOR EXPENSE REPORTING

REPORTING PERIOD: October 1, 2025 to March 31, 2026

NAME: Mrs. Rachel Romany

TITLE: VP of Clinical Services, Quality and Chief Nursing Executive

Date(s)	Expense Amount by Category								Description
	Travel								
	Vehicle/Mileage	Train/Air	Taxi	Accomodation	Parking	Meal	Hospitality	Total	
Nov 24 2025	$128.70				$8.67	$56.33		$193.70	Local meeting - regional initiatives (Ottawa)
TOTAL	**$128.70**	**$0.00**	**$0.00**	**$0.00**	**$8.67**	**$56.33**	**$0.00**	**$193.70**	

GLENGARRY MEMORIAL HOSPITAL
BROADER PUBLIC SECTOR EXPENSE REPORTING

REPORTING PERIOD: October 1, 2025 to March 31, 2026

NAME: Mrs. Kayla MacGillvary

TITLE: Chief Human Resources Officer

Date(s)	Expense Amount by Category								Description
	Travel								
	Vehicle/Mileage	Train/Air	Taxi	Accomodation	Parking	Meal	Hospitality	Total	
TOTAL	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: May 6, 2026 Meeting Date Prepared for: May 13, 2026 – Finance
May 28, 2026 - Board

Subject: HGMH Talent Management Program

Prepared by: Kayla MacGillivray, CHRO

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

PURPOSE

- To present the HGMH Talent Management Program and actions taken to incorporate the program into operations of the hospital.

SITUATION & BACKGROUND

A brief description of the background to the issue.

- A talent management program is a comprehensive process used by organizations to attract, develop, and retain skilled employees, aligning their skills and abilities with the company's strategic goals. It focuses on improving employee performance, career development, and overall organizational agility.
- The HGMH Talent Management Program was updated in 2024.
- The HGMH Talent Management Program has 7 phases:
  a) Workforce planning and talent acquisition
  b) Performance management
  c) Employee development
  d) Succession planning
  e) Compensation and rewards
  f) Engagement and retention
  g) Employee transition
- Changes since the 2025 update include:
  - Purchase of a Learning Management System to be implemented in 2026.
  - Update performance excellence appraisal system.

Talent Management Program

May 2026 Update

HÔPITAL Glengarry Memorial HOSPITAL

April 22, 2025

What is a Talent Management Program?

A talent management program is a comprehensive process and strategy for attracting, developing, engaging, and retaining employees with the skills and knowledge needed to achieve organizational goals.

The HGMH Talent Management Program has 7 phases:

a) Workforce planning and talent acquisition
b) Performance management
c) Employee development
d) Succession planning
e) Compensation and rewards
f) Engagement and retention
g) Employee transition

Workforce Planning and Talent Acquisition

To ensure the hospital has the right people in the right roles to meet current and futures needs.

How do we accomplish this:

- Strategic Recruitment Initiatives
- Streamlined and Inclusive Hiring Practices
- Data-Driven Workforce Forecasting
- Integrated Planning Across Departments
- Implemented a new Applicant Tracking System that integrates with our current payroll and scheduling systems.

Performance Management

To establish clear performance expectations and provide feedback for continuous improvement.

How do we accomplish this:

- Probationary Evaluations
- Updated Digital Performance Excellence Program
- Executive Leadership Performance Excellence & Business Commitments
- As-needed Performance Management
- Attendance Management

Employee Development

To empower employees to enhance their skills and advance their careers within the organization.

How we accomplish this:

- Ongoing Education and Professional Development Support
- Leadership and Career Growth Opportunities
- Performance Development and Coaching Culture
- Implementation of a Learning Management System in 2026 will help track education hours and compliance.

Succession Planning

To ensure a pipeline of qualified talent for key positions within the organization.

How do we accomplish this:

- Partnerships with High Schools, Colleges, Universities
- Great River Ontario Health Team and Hospital Human Resource Ontario East collaborations
- All senior and leadership roles are key to HGMH's Succession Plan, using a four-step approach to identify high-potential or fully competent individuals for immediate or future needs. This allows us to support strategic priorities, workforce sustainability, and high-quality patient care continuity while nurturing internal talent

Compensation & Rewards

To attract, retain, and motivate employees through competitive compensation and recognition programs.

How we accomplish this:

- Maintaining Competitive Compensation
- Offering Comprehensive and Inclusive Benefits Packages
- Celebrating Excellence through Recognition Programs

Engagement & Retention

To create a positive work environment where employees feel valued, motivated, and committed to the organization.

How we accomplish this:

- Promoting a Culture of Respect, Inclusion, and Belonging
- Supporting Employee Wellness and Work-Life Balance
- Encouraging Transparent Communication and Staff Engagement

Employee Transition

To facilitate smooth transitions for employees entering new positions within the organization

How we accomplish this:

- Structured Onboarding and Orientation Programs
- Role-Specific Training and Mentorship
- Regular Check-ins During Transition Periods
- Assigning learning profiles for roles in a Learning Management System coming in 2026.

Questions?

HÔPITAL Glengarry Memorial HOSPITAL

REPORT OF THE GOVERNANCE AND NOMINATING COMMITTEE

May 13, 2026 at 6:00PM Boardroom/MS Teams

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

Regrets: Dr. G. Raby

Summary of Discussion

Approval of the Agenda

The agenda was reviewed.

Moved By: G. McDonald
Seconded By: L. Boyling
THAT the agenda be approved as presented.

CARRIED

Declaration of Conflict of Interest

There were no conflicts declared.

Approval of Previous Meeting Report

The meeting report from March 11 and April 9, 2026, were shared.

Moved By: Dr. S. Robertson
Seconded By: L. Boyling
THAT the meeting reports be approved as presented.

CARRIED

Business Arising from Report

There was no business arising from the report.

Committee Work Plan

The work plan was reviewed and remains on track.

Matters for Discussion/Decision

Annual General Meeting Preparation

Draft AGM Agenda

Re-election is for new members and those whose terms are up. The meeting following the AGM is where members are constituted.

Committee Chair Report

Last year, committee chairs were asked to report on the work that was done over the course of the board cycle. It was agreed that this was well received and that this process continue again this year.

Board Candidates

Five interviews took place in which three were selected. B. Pulice, M. Nichols, and K. McTaggart.

Moved By: L. Boyling
Seconded By: Dr. S. Robertson
THAT the Governance and Nominating Committee recommend to the Board of Directors the nomination of new Directors during the Annual General Meeting as presented.

CARRIED

Review Progress on Strategic Actions
The Q4 strategic actions were reviewed.

Moved By: Dr. S. Robertson
Seconded By: G. McDonald
THAT the Governance and Nominating Committee review and receive the Q4 Strategic Actions as presented.

Two items remain on track as the work remains ongoing. It has been a successful year with lots accomplished.

CARRIED

Policies for Review
Two policies were reviewed.

Minutes of Regular and In Camera Meetings (BOD.05.014)
The policy was reviewed

Moved By: Dr. S. Robertson
Seconded By: L. Boyling
THAT the Governance and Nominating Committee recommend to the Board of Directors the approval of the Minutes of Regular In Camera Meetings policy as presented.

There were no changes to the policy at this time.

CARRIED

Board Award of Excellence (BOD.06.011)
The policy was reviewed.

Moved By: Dr. S. Robertson
Seconded By: L. Boyling
THAT the Governance and Nominating Committee recommend to the Board of Directors the approval of the Board Award of Excellence policy as presented.

There were no changes to the policy at this time.

CARRIED

Matters for Information
Inclusion, Diversity, Equity & Anti-Racism Update
It was noted that the report is operational and doesn't include the items that the board undertook around IDEA.

Committee Effectiveness Survey to be sent out May 14, 2026
This will be delayed by one week and a two-week timeline will be given.

Next meeting: June 3, 2026

K-L. Massia, Recorder

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: May 5, 2026 Meeting Date Prepared for: May 13, 2026 – Governance May 28, 2026 - Board

Subject: Policy Reviews

Prepared by: Robert Alldred-Hughes, President & CEO

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

PURPOSE

The purpose of this briefing note is to provide an overview of the two policies up for review and highlight any material changes to each policy.

RECOMMENDATION / MOTION

THAT the Board of Directors approve of the Minutes of Regular In Camera Meetings policy as presented.

THAT the Board of Directors approve of the Board Award of Excellence policy 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.

Summary of amendments:

Minutes of Regular Meetings and In-Camera Meetings

- No amendments recommended

Board Award of Excellence

- No amendments recommended

IMPLEMENTATION & COMMUNICATION PLAN

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

- Obtain Board Approval – May 13, 2026
- Update Board Policy Online
- Include updates in Board Orientation Material

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Minutes of Regular Meetings and In-Camera Meetings Policy
- Board Award of Excellence Policy

MINUTES OF REGULAR MEETINGS AND IN-CAMERA MEETINS

Document Name:	Minutes of Regular Meetings and In-Camera Meetings	
Document Number:	BOD.05.014.0.26	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Board Effectiveness	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The Board of Directors of the Hôpital Glengarry Memorial Hospital ("Board") shall keep minutes of its meetings as per Bylaw 10.5. Minutes need to be clear but brief, accurate, and objective. Minutes are no place for the expression of personal opinions, interpretations, or commentaries on the debates.

PROCEDURE:

Regular Meetings

1. The minutes of meetings shall, except in the case of *in camera* meetings:
    a) Be clear and neutral; and
    b) Contain sufficient detail to adequately inform the public of the main subject matters considered, any deliberations engaged in, and any decisions made.

2. The minutes of meetings shall not contain the names of any Board members or any other individuals, companies, or organizations, except in the following circumstances:
    a) The names of Board members shall be listed for attendance;
    b) The names of Board members whose comments are recorded in the minutes shall be listed where requested by one or more Board members;
    c) The names of Board members shall be recorded when a request to record the votes in favor and against the passing of motions is made;
    d) The names of individuals, companies, or organizations may be included where their inclusion is necessary to ensure that the minutes comply with the requirements in item 1 above.

3. Meeting minutes of the Regular Meeting of the Board of Directors shall be approved at the next Regular Meeting.

4. The Board of Directors shall make the minutes of its meetings available to the public upon request.

In Camera Meetings

5. Materials for distribution to the Board for *in camera* meetings are privileged and confidential and *in camera* discussions of the Board are confidential unless the Board formally decides otherwise. Meeting minutes will follow the same standards as paragraph one (1), two (2) above.

6. Minutes of the *in-camera* meeting shall be approved at the next *in camera* meeting.

BOARD AWARD OF EXCELLENCE

Document Name:	Board Award of Excellence	
Document Number:	BOD.06.001.0.26	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Relationships	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The HGMH Board Award of Excellence recognizes the outstanding contributions of staff and physicians. This award provides an opportunity to promote the importance of celebrating excellence and the necessity of recognizing the work of the HGMH team.

PROCEDURE:

1. Each year, the Board will recognize up to two deserving recipients for the Board Award of Excellence. The award process is intended to support and enhance the recognition programs in existence at the hospital.

2. The Board will call for nominations from within the hospital.

3. The nominations will be required to support the criteria outlined below:
   - *significant achievement in person and family centred care, or service to a patient and family;*
   - *an extraordinary commitment to patient safety, has championed a new initiative or process, or has thought of an innovative solution to a patient safety concern;*
   - *significant accomplishment in the management of people, financial or material resources;*
   - *successful completion of a major project or special assignment in a manner beyond what would normally be expected; and,*
   - *an outstanding initiative which has resulted in significant monetary and/or non-monetary benefits to HGMH in regards to increasing efficiency, effectiveness, improving patient care or displaying innovation and creativity in their work environment.*

4. In April of each year, a call for nominations will be sent to all staff and physicians at HGMH. Nominations will be open for a period of three weeks.

5. The Finance and Human Resources Committee will be responsible for recommending to the Board of Directors up to two recipients.

6. Nominees will be published on the Intranet yearly in May, and the winner will be announced at the Board of Directors Annual General Meeting.

7. Winners of the Board Award of Excellence will receive a custom recognition plaque, and staff will receive one day off with pay.

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: May 5, 2026 Meeting Date Prepared for: May 13, 2026

Subject: Inclusion, Diveristy, Equity, & Anti-Racism (IDEA) - Update

Prepared by: Robert Alldred-Hughes, President & CEO

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

PURPOSE

- The purpose of this briefing note is to remind the Governance Committee of the requirements of Accreditation Canada Standards that are being overseen by this committee, in addition to provide an update on actions taken to date which support our policy on Inclusion, Diversity, Equity and Anti-Racism at HGMH.

IMPLICATIONS TO OTHER STANDING COMMITTEES

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

- All Board Committees

SITUATION & BACKGROUND

A brief description of the background to the issue.

In the Fall of 2023 the Board of Directors approved the recommendation that the Governance Committee take on a proactive role in leading, coordinating, and monitoring Inclusion, Diversity, Equity, and Anti-Racism (IDEA) related activities within HGMH. This includes ensuring compliance with Accreditation Canada Standards for IDEA and fostering a culture of inclusion, diversity, equity, and anti-racism throughout the organization.

Since this recommendation was approved, there has been much work completed by the team at HGMH related to IDEA activities. HGMH, as a prominent organization and employer in our community, is committed to promoting an environment that is inclusive, diverse, and equitable, while actively combatting racism.

Board of Directors level work and oversite included the following opportunities:

- Members of the Board of Directors participated in education and training modules related to Inclusion, Diversity, Equity, and Accessibility (IDEA), in addition to Indigenous Cultural Safety, to support ongoing learning and strengthen governance oversight through an IDEA lens.
- Board members were also active participants in a number of hospital and community events recognizing and celebrating IDEA-related initiatives throughout the year, demonstrating visible leadership and support for inclusion, belonging, and equity within the organization and broader community.
- The Board of Directors approved amendments to the Board recruitment application process to include the voluntary submission of equity-based demographic information. This enhancement is intended to support greater diversity and representation within Board composition over time.

- The Board of Directors oversaw the development and adoption of HGMH's first formal Land Acknowledgment, reflecting the organization's commitment to reconciliation, respect for Indigenous Peoples, and recognition of the traditional lands on which HGMH operates.

In the winter of 2024 an IDEA Framework was developed by HGMH, propelled by the Boards Policy related to IDEA, which focuses our efforts on achieving meaningful actions to increase inclusion and celebrate diversity, while creating an overall sense of belonging. The advent of this framework helped kick off significant work that has been completed over the last two years, whereby:

- An IDEA Committee has been formed consisting of leaders and staff with a passion for IDEA and lived experience.
- A policy related to Land Acknowledgement has been created along with an official Land Acknowledgement statement for our hospital. The Land Acknowledgement has been endorsed by the senior leadership team, and reviewed by the Native North American Travelling College.
- During September 30, 2024 National Truth and Reconciliation Day, HGMH held a series during the month of September to support Truth and Reconciliation, including a special on-site ceremony and social on September 17th from 1-3. Board Members were encouraged to attend, and invitations to MP's and MPP, including municipal officials have been issued.
- The IDEA Committee has selected cultural celebration days to be recognized through communication and special events.
- In October 2024 HGMH rolled out an education program for all leaders and Board Members at HGMH to complete through Culture Ally. There have been 13 educations sessions delivered in this online format, with regular discussions about the learnings occurring at Monthly Leadership and Board Meetings.

In 2025, further work has built upon these foundations:

- HGMH updated its Job Description Template to include an IDEA values statement:
  "We recognize the intrinsic value of every individual and the diversity they bring to our community. We are committed to fostering a sense of belonging and an environment that upholds principles of equity, diversity, inclusion and anti-racism in every facet of our operations. Our commitment is rooted in our belief that healthcare should be equitable, accessible and inclusive for all."
- The Committee is actively sharing information with respect to IDEA to all staff, physicians, PFAC, Auxiliary and Board in the bi-weekly blitz. Recently a historical learning feature highlighting the history of Indian Hospitals in Canada was shared with staff through the bi-weekly Blitz and displayed on the Wellness Board to promote greater understanding of historical harms and their lasting impacts.
- Staff education on IDEA fundamentals was launched, exceeding the targeted completion rate within the first few weeks. The introductory DEI training module is ongoing, with current staff uptake at approximately 70%. Additional supports and reminders are planned to help reach even greater participation rates.
- The IDEA Committee identified inclusive spiritual care contacts from the broader community who are willing to provide care for patients, and these have been included in the new Palliative and End of Life Care handbook.
- Patient satisfaction survey data is also being reviewed to better understand and respond to the experiences of patients who self-identify as Indigenous and gender-diverse.

- Ongoing review of policies is being completed through an IDEA lens. Recently reviewed policies include Pastoral Care, Unidentified Patients, Accessibility, and Use of the Spiritual and Cultural Care Room.
- An education day to strengthen point-of-care staff knowledge about cultural safety in care is being supported by the Traditional Medicine Team in Akwesasne. This ensures staff have the knowledge and support needed to provide culturally safe care for First Nations, Inuit, and Métis patients. It is occurring on October 9th 2025.
- In September 2025, HGMH unveiled the Indigenous Art Installation with a special ceremony attended by the artist, Dawn Iehstoseranón:nha, the Department of Health Team from Akwesasne, and invited guests. Staff, physicians, and volunteers were also welcomed to take part in this meaningful event. The commissioned artwork now permanently displayed in the hospital stands as a symbol of our commitment to Indigenous patients and families, honouring the whole person and reinforcing our dedication to providing culturally safe and supportive care.
- On October 8, 2025, the new Spiritual and Cultural Care Room will open, designed in partnership with the Patient and Family Advisory Council (PFAC) and IDEA Committee, with sponsorship from the Auxiliary.
- Diwali was recognized in November with traditional Indian refreshments served in the cafeteria, offering staff an opportunity to learn about and celebrate the festival together.

In 2026, the organization has continued its work to further the principals of IDEA with the following actions:

- The Psychological Safety Policy and associated action plan have been approved, establishing a structured approach to fostering a safe, inclusive, and supportive environment for staff and patients.
- Quarterly review of patient experience data for individuals who self-identify as part of diverse populations has been implemented. An additional survey question has been introduced to better capture opportunities to enhance inclusivity in care delivery.
- Training on sexual orientation, gender identity, and expression has been selected and launched as part of the organization's commitment to gender diversity. Participation is progressing, with approximately 28% of staff having completed the training to date.
- Development of an employment equity policy is underway, supporting a more structured and transparent approach to equity within recruitment and workforce practices.
- Work has been initiated to develop an IDEA lens to support the review of programs and policies, ensuring equity and inclusion considerations are embedded in organizational decision-making.
- The organization continues to recognize key awareness events with an educational focus, including Black History Month and Pink Shirt Day, and is actively planning for Pride Month.
- There are 10 new Governance related standards for IDEA and HGMH will be assessed against these standards in our next accreditation survey cycle of 2026. (*Attached*)

CONSULTED WITH:

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

- Kayla MacGillivray, Chief Human Resources Officer

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Listing of Accreditation Canada Standards related to Governance
- IDEA Framework

Accreditation Canada Standards Related to Inclusion, Diversity, Equity, and Anti-Racism

The governing body uses a recognized framework for acknowledging systemic racism.
The governing body implements an action plan, in partnership with community partners, to address systemic racism in the organization.
The governing body provides its members with education and continuous learning on cultural safety and humility and systemic racism.
The governing body ensures the organization's policies reflect cultural safety and humility practices and encompass the culture and rights of the communities receiving services from the organization.
The governing body monitors its action plan for addressing systemic racism.
The governing body uses a recognized framework for acknowledging Indigenous-specific systemic racism.
The governing body implements an action plan, in partnership with Indigenous partners, to address Indigenous-specific systemic racism in the organization.
The governing body provides its members with education and continuous learning on cultural safety and humility and Indigenous-specific systemic racism.
The governing body ensures the organization's policies reflect cultural safety and humility practices and encompass the culture and rights of the Indigenous peoples and communities receiving services from the organization.
The governing body monitors its action plan for addressing Indigenous-specific systemic racism.

Correspondence

April 28, 2026 – Glengarry Times

Setting the Gold Standard: HGMH Recognized for National Excellence

BY STEVE WARBURTON
Glengarry Times Editor

Hôpital Glengarry Memorial Hospital (HGMH) has achieved a 100 per cent compliance rating for all Required Organizational Practices (ROPs), giving it an Exemplary Accreditation Status by Accreditation Canada, the highest level of performance awarded through the national accreditation program.

The onsite survey took place in early February when Accreditation Canada surveyors conducted a comprehensive review of the organization's programs, services, and governance. Surveyors assessed the hospital against more than 1,900 national standards and ROPs, where they spent time speaking with staff, physicians, Board members, volunteers, community partners, patients, and families.

A press release from the hospital says that "this is a significant accomplishment that reflects the organization's commitment to delivering safe, high-quality care."

> "Achieving Exemplary Accreditation Status is a tremendous honour and a testament to the dedication of our entire team"

said Robert Alldred-Hughes, President and CEO of HGMH. "This recognition reflects years of hard work, collaboration, and commitment to patient safety and quality improvement. I am incredibly proud of our staff, physicians, volunteers, Board members, and community partners who contributed to this success."

Accreditation Canada's standards are grounded in best practices and evidence-based care, says the HGMH press release. The ROPs focus on high-priority areas essential to patient safety and quality, including medication safety, infection prevention and control, risk management, and governance. Preparation for the survey has been underway for the past four years and - as the Glengarry Times previously reported - the hospital used a Harry Potter-themed "Wizardry World" to keep staff emotionally vested in the campaign. Staff were sorted into "houses" and earned points by completing monthly quality improvement assignments and accreditation readiness activities.

"This achievement belongs to everyone," added Mr. Alldred-Hughes. "For a hospital our size to achieve this level of accreditation speaks volumes about the passion, teamwork, and dedication of our entire organization. Our community can be proud to know their hospital continues to deliver care that meets the highest national standards, ensuring their safety at every encounter".

According to the Accreditation Canada website, its evaluation strategy is based on "drawing on lessons learned from the past, insights from the pandemic crisis and emerging trends from around the world" and focuses on "the realities of what it will take to improve health care quality as we move into the future."

A spreadsheet on the website lists 8,364 different healthcare and similar institutions across the country. HGMH and The Palace were the only Glengarry institutions listed therein.

Casting into Spring

Jacob Emigh, 16, of North Lancaster, was at Alexandria's Island Park on Saturday, April 19, where he and nine-year-old brother, Finn, spent some time fishing off the dock. It was, perhaps, the first bona fide "really nice day" of 2026. The temperature was above 20 degrees for much of the day and several Glengarrians were spotted participating in warm weather activities, like fishing.

A Month for Community

Both North and South Glengarry have declared May to be Community Living Month. The two Townships both passed resolutions this month noting the work Community Living Ontario has done across the province. "Community Living Glengarry is promoting public awareness of the physical and social barriers that keep individuals with developmental challenges from participating in the social, recreational and economic world around them," the proclamation said. Community Living Glengarry has a building in Alexandria and carries on a number of initiatives throughout the year. Its biggest fundraiser is the annual Community Run, which takes place every September.

Correspondence

May 4, 2026 – Seaway News – Exemplary accreditation status for HGMH

May 6, 2026 – Seaway News – Knights of Columbus help HGMH campaign

May 9, 2026 – Seaway News – Tournament raises $4,500 for CT scanner

May 9, 2026 – Seaway news – A shining star in our community

May 11, 2026 – The Review – Hôpital Glengarry Memorial Hospital piloting oral care protocol for stroke patients

May 16, 2026 – Seaway News – HGMH pilot improves stroke recovery

May 18, 2026 – The Review – Dream Raffle returns to support Glengarry CT scanner campaign