BOARD QUALITY AND PATIENT SAFETY COMMITTEE MEETING AGENDA

Date: Thursday, September 10, 2026
Time: 16:00 – 17:15
Location: Boardroom / Microsoft Teams

Time	Agenda Item	Board Item	Attachment
16:00	**1. Call to Order**		
(1 min)	1.1 Confirmation of Quorum		
(1 min)	1.2 Adoption of the agenda		P. 1-2
(1 min)	1.3 Declaration of Conflict of Interest		
16:03	**2. Report from Last Meeting**		
(1 min)	2.1 Approval of previous meeting report – May 13, 2026		P. 3-5
	2.2 Business arising from the report		
(1 min)	2.3 Committee Work Plan Review		P. 6
16:05	**3. Education Session**		
(10 min)	3.1 Patient Story (R. Romany)		
16:15	**4. Matters for Decision / Discussion**		
(5 min)	4.1 Review Quality & Patient Safety Committee Effectiveness Survey Results (H. Salib)	C	P. 7-23
(5 min)	4.2 Review Quality & Patient Safety Committee Terms of Reference (H. Salib) **That the Quality & Patient Safety Committee recommend to the Governance & Nominating Committee the Terms of Reference as presented.**	C	P. 24-27
(10 min)	4.3 Review Q1 Quality Improvement Plan (R. Romany) **That the Quality & Patient Safety Committee review and receive the Q1 results of the Quality Improvement Plan for 2026-2027.**	D	P. 28-31
(5 min)	4.4 Review Q1 2025-2026 Quality & Safety Scorecard (R. Romany) **That the Quality & Patient Safety Committee review and receive the Q1 results of the Quality & Safety Scorecard for 2026-2027.**	D	P. 32-33
(10 min)	4.5 Review Patient Satisfaction Survey Results (R. Romany) **That the Quality & Patient Safety Committee review and receive the Q1 results of the Patient Satisfaction Survey Results for 2026-2027.**	D	P. 34-40
(5 min)	4.6 Review Q1 Trillium Gift of Life Report (R. Romany) **That the Quality & Patient Safety Committee review and receive the Q1 Trillium Gift of Life Report.**	D	P. 41
16:55	**5. Matters for Information**		
(5 min)	5.1 Review Professional Staff Appointment and Re-appointment Process (Dr. MacKinnon)	C	P. 42-44
(5 min)	5.2 Updates from the Patient and Family Advisory Committee (R. Romany)	C	P. 45
(5 min)	5.3 Privacy & Confidentiality Report (R. Jarencio)	C	P. 46-47
17:10	**6. Date of Next Meeting**		
	Thursday, November 12, 2026		
17:10	**7. Adjournment**		

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

Accountability for Reasonableness (A4R) Ethical Decision Making Framework Steps

Values that Optimize Fairness in the Process of Decision-Making

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

A4R Action Steps

Determine and Identify

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

Clarify and Provide

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

Communicate

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

Revisit and Revise

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

Evaluate and Improve

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

Champlain

Glengarry Memorial

REPORT OF THE BOARD QUALITY AND PATIENT SAFETY COMMITTEE MEETING

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 was done on Non-Violent Crisis Intervention (NVCI) including the purpose, 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 discussed 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

DRAFT

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 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 report was shared in which the hospital is at 100% for notification rates.

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 who 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

DRAFT

Quality & Patient Safety Committee
Work Plan 2026-2027

Deliverable	Legislation/ Accountability	MRP	Occurrence	Sep	Nov	Feb	Mar	May	Jun
STRUCTURE/PROCESSES									
Review/Recommend Committee Terms of Reference	Corporate By-law	Chair	Annually	X					
Review Committee Effectiveness Survey Results	Governance Best Practice	Chair	Annually	X					
Review/Recommend Annual Committee Work Plan to Governance		Chair	Annually						X
MEDICAL AFFAIRS									
Professional Staff Appointment and Re-appointment Process Review	*PHA*	COS	Annually	X					
Review Professional Staff HR Plan	*PHA*	COS	Annually		X				X
Appoint professional staff on recommendation of Medical Advisory Committee	*PHA*	COS	Annually			X			
Review Student/Resident Placement Report		COS	Annually				X		
Review Hospital Services		COS	Annually/As Occurs				X		
Review Physician Engagement Survey Results		COS	Annually					Survey to be sent	X
Medical Advisory Committee Recommendations	*PHA*	COS	As Occurs						
EDUCATION									
Patient Story / Quality Initiative		CNE		X	X	X	X	X	X
QUALITY OVERSIGHT AND IMPROVEMENT									
Review QIP Dashboard	ECFAA	CNE	Quarterly	Q1	Q2	Q3		Q4	
Recommend QIP Dashboard 2027-2028	ECFAA	CNE	Yearly			X	X		
Quality & Safety Scorecard		CNE	Quarterly	Q1	Q2	Q3		Q4	
Review Patient Satisfaction Survey Results	ECFAA	CNE	Quarterly	Q1	Q2	Q3		Q4	
Review Life or Limb Results		CNE	When available						
Review Complaints & Compliments Report	ECFAA	CNE	Quarterly				X		
PFAC Updates	ECFAA	CNE	Quarterly	X		X		X	
Review Critical Incident and Sentinel Event Report	*PHA (Regulation 965) + Ontario Patient Safety Reporting requirements*	CNE	Bi-Annually		X				X
BPSO Update	RNAO BPSO	CNE	Bi-Annually		X				X
Review Patient Quality & Safety Plan	*ECFAA + Accreditation Canada Qmentum Standards*	CNE	Yearly				X		
Review Status of Patient Safety Plan Actions		CNE	Bi-Annually		X				X
Review Provincial Stroke Report Card	OH	CNE	When available						
Review Ethics Committee Updates		CNE	Yearly				X		
Review Trillium Gift of Life Report	Trillium Gift of Life Network Act	CNE	Quarterly	Q1	Q2	Q3		Q4	
Review Compliance with Quality-Related Legislation		CEO	Yearly				X		
Policy Implementation		CEO	As Occurs						
SAFETY / RISK / OPERATIONS									
Violent Incidents Report	OHSA	CHRO	Yearly					X	
Review Emergency Preparedness		CHRO	Yearly						X
Review Business Continuity Plan		CEO	Yearly			X			
Privacy & Confidentiality Report	PHIPA	HIS	Yearly	X					
Review HIROC Report		CEO	Yearly						X
ACCREDITATION									
Accreditation Updates		CEO	Yearly					X	
ESTIMATED PREPARATION TIME FOR MEETING:				1.5H	1.5H	1.5H	1.5H	1.5H	1.5H

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BRIEFING NOTE FOR

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

Date Prepared: July 24, 2026 Meeting Date Prepared for: September 10, 2026

Subject: Quality & Patient Safety Committee Effectiveness Survey Results

Prepared by: Robert Alldred-Hughes, President & CEO

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

PURPOSE

- To review the results of the Quality & Patient Safety Committee Meeting Effectiveness Survey completed at the end of the 2025-2026 Board Cycle and determine any actions required on the part of the Committee to sustain positive results and identify opportunities for improvement in identified areas.

IMPLICATIONS TO OTHER STANDING COMMITTEES

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

- Board of Directors

SITUATION & BACKGROUND

A brief description of the background to the issue.

- The HGMH Committee Self-Assessment is one of the ways the committee can assess the degree to which its structure and processes are effective in supporting board performance.
- In the Spring of 2026, the Quality & Patient Safety Committee completed a self-assessment using the tool provided by the hospital.
- Based on the completed assessment process, the committee can develop a work plan to address areas for improvement or identified gaps.

OPTIONS CONSIDERED & ANALYSIS

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

- The committee self-assessment is structured to evaluate the following 5 domains:
    1. Terms of Reference and Composition
    2. Committee Management
    3. Committee Effectiveness
    4. Chair Effectiveness
    5. Overall Committee Performance

- The following tables provide the response data from all respondents to the survey:

Terms of Reference and Composition

	Fully Satisfactory	Could Improve	Unknown	Total
The committee has clear and appropriate Terms of Reference.	100.00% 3	0% 0	0% 0	3
The committee has the right number of members.	100.00% 3	0% 0	0% 0	3
The committee has members with the skills and expertise that are needed by the committee.	100.00% 3	0% 0	0% 0	3

RESPONSES

There are no responses.

Committee Management

	Fully Satisfactory	Could Improve	Unknown	Total
The committee meets at the appropriate time of day.	100.00% 3	0% 0	0% 0	3
I received orientation to the committee that was helpful to me as a member of the committee.	100.00% 3	0% 0	0% 0	3
The committee is receiving the support from hospital management that it requires.	100.00% 3	0% 0	0% 0	3
Information is received sufficiently in advance of the meeting.	100.00% 3	0% 0	0% 0	3
The committee meets the right number of times over the year.	100.00% 3	0% 0	0% 0	3

RESPONSES

The change to 6 meetings/year was a good decision. As a committee, I believe we are still adjusting to managing our time and the number of reports to review.

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Committee Effectiveness

	Fully Satisfactory	Could Improve	Unknown	Total
The committee is working effectively.	66.67% 2	33.33% 1	0% 0	3
The committee performed its annual workplan.	100.00% 2	0% 0	0% 0	2
The committee is effectively performing by developing components and indicators for its quality, patient safety, and risk management programs and monitoring the outcomes.	100.00% 3	0% 0	0% 0	3
The committee is effectively performing by making recommendations to attempt to eliminate gaps identified for overall improvement.	100.00% 3	0% 0	0% 0	3

RESPONSES

We often over-discuss some reports which causes a rush at the end of the meeting. The meetings will move to 90minutes next session. We will evaluate this improvement during the next session.

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Chair Effectiveness

	Fully Satisfactory	Could Improve	Unknown	Total
The Chair is prepared for committee meetings.	66.67% 2	33.33% 1	0% 0	3
The Chair keeps the meetings on track.	33.33% 1	66.67% 2	0% 0	3
The Chair fairly reports the committee's work to the Board.	66.67% 2	33.33% 1	0% 0	3
The Chair encourages participation and manages discussion.	33.33% 1	66.67% 2	0% 0	3

RESPONSES

As mentioned in previous questions, time in not always managed properly. The chair needs to move the meeting forward when required to avoid running overtime while allowing for an appropriate amount of discussion.

Very difficult to keep on track when some members are very very vocal. Chair is trying very hard to control the meeting while allowing members to participate. Getting much better

Overall Committee Performance

	Fully Satisfactory	Could Improve	Unknown	Total
Overall, I am satisfied with my contribution to the committee.	100.00% 3	0% 0	0% 0	3
Overall, I am satisfied with the committee's contribution to the Board.	100.00% 3	0% 0	0% 0	3

RESPONSES

There are no responses.

Comments and Suggestions for improvement to committee processes:

RESPONSES

There are no responses.

Overview:

Overall, the survey results show that the Quality & Patient Safety Committee is working well. Compared to last year's survey, members expressed greater satisfaction with the committee's meeting frequency, reflecting the decision to increase from four to six meetings annually in response to previous feedback. Members are also satisfied with the committee's structure, membership, the information they receive, and the committee's contribution to quality, patient safety, and the work of the Board.

This year's feedback identified meeting flow as the next opportunity for improvement. While members value the discussions that take place, some felt too much time is spent on certain reports, leaving less time for other agenda items. To help address this, committee meetings will increase by 15 minutes in the 2026–2027 Board cycle and the committee workplan will be reviewed to ensure agenda items are distributed more evenly throughout the year, helping balance workloads across meetings and allow adequate time for discussion. The committee will monitor whether this change, along with continued focus on effective agenda management, improves meeting efficiency.

Actions for Consideration:

- Improve meeting flow and time management by extending meetings. This year meetings will be 1 hour 15 minutes as the committee workplans have been rearranged for better agenda distribution throughout the year.

Questions for consideration:

- Based on the results of the survey, are there areas the Committee would like to explore alternate ways of accomplishing its work?
- Are there other areas the Committee would like to develop actions to support the Committees effectiveness?

IMPLEMENTATION & COMMUNICATION PLAN

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

- Results and associated actions to be shared with HGMH Board in October 2026, following review from the Governance Committee, along with all other committee results.

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- 2025-2026 Quality Committee Effectiveness Survey Results

Q1 3 responses

Terms of Reference and Composition

	Fully Satisfactory	Could Improve	Unknown	Total
The committee has clear and appropriate Terms of Reference.	100.00% 3	0% 0	0% 0	3
The committee has the right number of members.	100.00% 3	0% 0	0% 0	3
The committee has members with the skills and expertise that are needed by the committee.	100.00% 3	0% 0	0% 0	3
				9

Q2 For any answer above you marked as "could improve", please provide details below.

Answered: 0 Skipped: 3

#	RESPONSES	DATE
	There are no responses.	

Q3 3 responses

Committee Management

	Fully Satisfactory	Could Improve	Unknown	Total
The committee meets at the appropriate time of day.	100.00% 3	0% 0	0% 0	3
I received orientation to the committee that was helpful to me as a member of the committee.	100.00% 3	0% 0	0% 0	3
The committee is receiving the support from hospital management that it requires.	100.00% 3	0% 0	0% 0	3
Information is received sufficiently in advance of the meeting.	100.00% 3	0% 0	0% 0	3
The committee meets the right number of times over the year.	100.00% 3	0% 0	0% 0	3
				15

Q4 For any answer above you marked as "could improve", please provide details below.

Answered: 1 Skipped: 2

#	RESPONSES	DATE
1	The change to 6 meetings/year was a good decision. As a committee, I believe we are still adjusting to managing our time and the number of reports to review.	6/12/2026 4:12 PM

Q5 3 responses

Committee Effectiveness

	Fully Satisfactory	Could Improve	Unknown	Total
The committee is working effectively.	66.67% 2	33.33% 1	0% 0	3
The committee performed its annual workplan.	66.67% 2	0% 0	0% 0	2
The committee is effectively performing by developing components and indicators for its quality, patient safety, and risk management programs and monitoring the outcomes.	100.00% 3	0% 0	0% 0	3
The committee is effectively performing by making recommendations to attempt to eliminate gaps identified for overall improvement.	100.00% 3	0% 0	0% 0	3
				11

Q6 For any answer above you marked as "could improve", please provide details below.

Answered: 1 Skipped: 2

#	RESPONSES	DATE
1	We often over-discuss some reports which causes a rush at the end of the meeting. The meetings will move to 90minutes next session. We will evaluate this improvement during the next session.	6/12/2026 4:12 PM

Q7 3 responses

Chair Effectiveness

	Fully Satisfactory	Could Improve	Unknown	Total
The Chair is prepared for committee meetings.	66.67% 2	33.33% 1	0% 0	3
The Chair keeps the meetings on track.	33.33% 1	66.67% 2	0% 0	3
The Chair fairly reports the committee's work to the Board.	66.67% 2	33.33% 1	0% 0	3
The Chair encourages participation and manages discussion.	33.33% 1	66.67% 2	0% 0	3
				12

Q8 For any answer above you marked as "could improve", please provide details below.

Answered: 2 Skipped: 1

#	RESPONSES	DATE
1	As mentioned in previous questions, time in not always managed properly. The chair needs to move the meeting forward when required to avoid running overtime while allowing for an appropriate amount of discussion.	6/12/2026 4:12 PM
2	Very difficult to keep on track when some members are very very vocal. Chair is trying very hard to control the meeting while allowing members to participate. Getting much better	6/12/2026 10:18 AM

Q9 3 responses

Overall Committee Performance

	Fully Satisfactory	Could Improve	Unknown	Total
Overall, I am satisfied with my contribution to the committee.	100.00% 3	0% 0	0% 0	3
Overall, I am satisfied with the committee's contribution to the Board.	100.00% 3	0% 0	0% 0	3
				6

Q10 For any answer above you marked as "could improve", please provide details below.

Answered: 0 Skipped: 3

#	RESPONSES	DATE
	There are no responses.	

Q11 Comments and suggestions for improvement to committee processes:

Answered: 0 Skipped: 3

#	RESPONSES	DATE
	There are no responses.	

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: August 20, 2026 Meeting Date Prepared for: September 10, 2026

Subject: Annual Review Committee Terms of Reference

Prepared by: Robert Alldred-Hughes, President & CEO

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

PURPOSE

- All committee Terms of Reference are to be reviewed on an annual basis.

RECOMMENDATION / MOTION

That the Quality and Patient Safety Committee recommend to the Governance and Nominating Committee the Quality and Patient Safety Terms of Reference for 2026-2027 as presented.

IMPLICATIONS TO OTHER STANDING COMMITTEES

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

SITUATION & BACKGROUND

A brief description of the background to the issue.

- Terms of Reference are reviewed annually by all Board Committees to ensure they remain relevant and effective in guiding the committee's activities and responsibilities.
- No changes to the Terms of Reference are being proposed by management as part of this year's annual review. The current Terms of Reference are considered to continue to appropriately reflect the Committee's mandate and responsibilities.
- As part of the annual review, committee members are invited to consider whether the Terms of Reference continue to meet the Committee's needs and reflect how it carries out its oversight responsibilities. Members are encouraged to identify any areas that may benefit from clarification, modernization or adjustment based on the Committee's experience over the past year.

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- 2026-2027 Quality and Patient Safety Committee Terms of Reference

TERMS OF REFERENCE QUALITY AND PATIENT SAFETY COMMITTEE OF THE BOARD

ROLE:	• The Quality and Patient Safety Committee operates under the authority of the Board and is the Quality Committee for the purposes of the Excellent Care for All Act, 2010 (the "Act"). The Quality and Patient Safety Committees role is to: • Assist the Board in the performance of the Board's governance role for the quality of patient care and services; and • Perform the functions of the Quality Committee under the Act. • Guide the strategic priority of Quality & Safety.

RESPONSIBILITIES:	The Quality Committee, in accordance with the responsibilities in the Act, shall:
	
	Quality Oversight and Quality Improvement
	1. Monitor and report to the Board on quality issues and on the overall quality of services provided in the hospital, with reference to appropriate data including:
	  • Performance indicators used to measure quality of care and services and patient safety;
	  • Reports received from the Medical Advisory Committee identifying and making recommendations regarding systemic or recurring quality of care issues;
	  • Publicly reported patient safety indicators;
	  • Critical incident and sentinel event reports;
	  • Patient Satisfaction Survey Results;
	  • Complaints, source of complaints, and interventions;
	  • Quality Indicator Dashboard.
	2. Consider and make recommendations to the board regarding quality improvement initiatives and policies;
	3. Ensure that best practices information supported by available scientific evidence is translated into materials that are distributed to employees, members of the professional staff and persons who provide services within the hospital, and subsequently monitor the use of these materials by such persons;
	4. Oversee preparation of the hospital's annual quality improvement plan; and
	5. Perform such other responsibilities as may be provided under regulations under the Act.
	
	Critical Incidents and Sentinel Events
	"Critical incident" means any unintended event that occurs when a patient receives treatment in the hospital:
	  a. That results in death, or serious disability, injury or harm to the patient; and
	  b. Does not result primarily from the patient's underlying medical condition or known risk inherent in providing treatment.
	
	In accordance with Regulation 965 under the Public Hospitals Act, receive from the Chief Executive Officer, at least twice a year, aggregate critical

	incident data related to critical incidents occurring at the hospital since the previous aggregate data was provided to the quality committee.
	Annually review and report to the board on the hospital's system for ensuring that, at an appropriate time following disclosure of a critical incident, there be disclosure as required by Regulation 965 under the Public Hospitals Act of systemic steps, if any, the hospital is taking or has taken to avoid or reduce the risk of further similar critical incidents.
	
	The quality committee shall review reports of sentinel events and oversee any plans developed to address, prevent or remediate such events.
	
	Compliance
	• Monitor the hospital's compliance with legal requirements and applicable policies of funding and regulatory authorities related to quality of patient care and services.
	
	Financial Matters
	• As and when requested by the board, provide advice to the board on the implications of budget proposals on the quality of care and services.
	
	Hospital Services Accountability Agreement and Hospital Annual Planning Submission (HAPS)
	• As and when requested by the board, provide advice to the board on the quality and safety implications of the hospital annual planning submission and quality indicators proposed to be included in the hospital's service accountability agreement or in any other funding agreement.
	
	Risk Management
	Review and make recommendations with respect to:
	• The hospital's standards on emergency preparedness;
	• Policies for risk management related to quality of patient care and safety; and
	• Areas of unusual risk and the hospital's plans to protect against, prepare for, and/or prevent such risks and services.
	
	Accreditation
	• Oversee the hospital's plan to prepare for accreditation.
	• Review accreditation reports and any plans that need to be implemented to improve performance and correct deficiencies.
	
	Professional Staff Process
	• Annually review with the chief of staff/chair of the medical advisory committee the appointment and re-appointment processes for the professional staff, including:
	  ○ Criteria for appointment;
	  ○ Application and re-application forms;
	  ○ Application and re-application processes; and
	  ○ Processes for periodic reviews.

TERMS OF REFERENCE QUALITY AND PATIENT SAFETY COMMITTEE OF THE BOARD

	• Ensure coordination and alignment with the Corporation's medical advisory committee for physician human resource planning. ***Policy Implementation*** • Oversee implementation of policies, processes and programs to ensure quality objectives are met and maintained. ***Other*** • Perform such other duties as may be assigned by the board from time to time.
CHAIR:	• A member of the Committee appointed by the Board on the recommendation of the Board Chair or a committee established by the Board for that purpose. • Term of office will be for a minimum of two (2) years.
MEMBERSHIP:	• The Chief of Staff • The Chief Executive Officer • The Chief Nursing Executive • One (1) health professional other than a nurse or doctor • Five (5) voting board members (minimum one bilingual Director in English and French), and • Such other persons as appointed by the hospital's board.
VACANCY:	• When a vacancy occurs among the appointed members, the Chair of the board may appoint a member to fill the vacancy for the unexpired portion of the term.
VOTING MEMBERS:	• Only Board Directors appointed to this committee may vote.
FREQUENCY OF MEETINGS AND MANNER OF CALL	• At least six (6) times annually, at the call of the committee chair.
QUORUM:	• 51% of voting members.
RESOURCES:	• VP of Clinical Services, Quality & Chief Nursing Executive
REPORTS TO	• Board of Directors
DATE OF LAST REVIEW	• September ~~2025~~2026

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: July 16, 2026 Meeting Date Prepared for: September 20, 2026

Subject: Q1- Quality Improvement Plan (QIP) 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 results of the Quality Improvement Plan for Q1
- 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 2026/27 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 inpatient bed
  - **Equity-Equitable** - % of Full-time and Part-time staff who have completed relevant inclusion, diversity, equity and anti-racism (IDEA) education on gender identity.
  - **Experience- Patient-centered-** Reported patient care ratings related to being treated with courtesy and respect, regardless of gender identity
  - **Safety- Safe**- Number of hospital-acquired pressure injuries (Stage 2-4) during inpatient stay
  - **Safety- Safe-** Number of medication errors that reached the patient and resulting in harm (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 Q1 has yielded the following results:

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

THEME	DIMENSION	METRIC	UNIT/POPULATION	SOURCE/PERIOD	Year End Fiscal 25/26	TARGET PERFORMANCE	Apr-26	May-26	Jun-26	Q1
Access & Flow	Timely	Reduce the percentage of ED patients who left without being seen by a physician	%/ED patients	ERNI scorecard April 1- December 2025 (Q1-Q3)	6.0%	≤ 7.3%	4.0%	3.8%	5.1%	4.3%

- **Q1** ended with 4.3% , which is below the target of 7.3%.
- **Strategy :** ongoing ED initiative to have additional physician coverage (4 hours) every day during peak hours. New initiative is to have additional RN to support ED P4R physician on weekends. The goal is to support faster access for low-acuity ED visits, improve patient flow, reduce the number of patients leaving without being seen, and improve Physician Initial Assessment times.

Access & Flow- Timely transitions- Reduce the 90th percentile ED wait time to inpatient bed by 50%.

THEME	DIMENSION	METRIC	UNIT/POPULATION	SOURCE/PERIOD	Year End Fiscal 25/26	TARGET PERFORMANCE	Apr-26	May-26	Jun-26	Q1
Access & Flow	Timely	Reduce the 90th percentile emergency department wait time to inpatient bed by 50%	Hours/ED patients	ERNI scorecard April 1- December 2025 (Q1-Q3)	8.4	≤ 4.2	4.2	3.9	3.0	3.7

- **Q1** ended with 3.7 hours which meets the target of ≤ 4.2 hours.
- **Strategy :** focused work on improving timeliness of inpatient discharges and environmental services bed cleaning readiness so that admitted ED patients do not have a lengthy wait for a bed.

Equity-Equitable - % of Full and Part-time staff who have completed relevant inclusion, diversity, equity and anti-racism (IDEA) education on gender identity

THEME	DIMENSION	METRIC	UNIT/POPULATION	SOURCE/PERIOD	Year End Fiscal 25/26	TARGET PERFORMANCE	Apr-26	May-26	Jun-26	Q1
Equity	Equitable	Increase the percentage of Full-time and Part-time staff who have completed relevant inclusion, diversity, equity and accessibility (IDEA) education on gender identity to 50%.	%/applicable Staff	Quality scorecard April 1- December 2025 (Q1-Q3)	n/a	> 50.0%	33.3%	56.1%	57.7%	57.7%

- **Q1** ended with a completion rate of 57.7% which meets the target of ≥ 50%..
- **Strategy :** Online module on gender identity provided to staff. Lunch & Learn session also provided during Pride month on the Centretown Community Health Centre Trans Health clinic, gender affirming practice including language, space and administrative considerations, and social service and mental health resources for trans and gender diverse individuals.

Experience- Increase the reported patient care ratings related to being treated with courtesy and respect, regardless of gender identity by 5% on a scale of 0-10.

THEME	DIMENSION	METRIC	UNIT/POPULATION	SOURCE/PERIOD	Year End Fiscal 25/26	TARGET PERFORMANCE	Apr-26	May-26	Jun-26	Q1
Experience	Patient-Centred	Increase patient-reported care ratings related to being treated with courtesy and respect, regardless of gender identity by 5%.	scale out of 10	Quality scorecard April 1- December 2025 (Q1-Q3)	7.40	≥ 7.70	10.00	10.00	8.70	9.57

- **Q1** ended with 9.57, which is above the target of ≥ 7.7.
- **Strategy:** Ongoing process of asking and documenting preferred name and pronouns at registration and respectful communication practices across all clinical and registration staff.

Safety- Safe- Reduce the rate of hospital-acquired pressure injuries (Stage 2-4) during inpatient stays by 50%.

THEME	DIMENSION	METRIC	UNIT/POPULATION	SOURCE/PERIOD	Year End Fiscal 25/26	TARGET PERFORMANCE	Apr-26	May-26	Jun-26	Q1
Safety	Safe	Reduce the rate of hospital-acquired pressure injuries (Stage 2-4) during inpatient stays by 50%.	Number	Quality scorecard April 1- December 2025 (Q1-Q3)	6	≤ 3	0	0	0	0

- **Q1** ended with 0 incidents which meets the target of ≤ 3 incidents.
- **Strategy :** Implement a standardized interdisciplinary pressure injury (PI) prevention bundle that includes skin assessment on admission/every shift/ as necessary, repositioning schedule, use of

pressure-distributing surfaces, moisture management, and early dietitian referral. Establish unit level skin care champions to reinforce best practices and peer coaching.

Safety- Safe- Reduce the number of medication errors that reached the patient and resulting in patient harm (incident severity levels 2-5) by 4%.

Safety	Safe	Reduce the number of medication incidents reaching the patient and resulting in harm (severity levels 2-5) by 4%.	Number	Quality scorecard April 1- December 2025 (Q1-Q3)	25	≤ 24	0	0	0	0
THEME	DIMENSION	METRIC	UNIT/POPULATION	SOURCE/PERIOD	Year End Fiscal 25/26	TARGET PERFORMANCE	Apr-26	May-26	Jun-26	Q1

- **Q1** ended at 0, which meets the annual target of ≤ 24 incidents.
- **Strategy:** Strengthen medication safety through consistent double-checks, barcode scanning, targeted staff training, and regular incident reviews.

Summary

- The Quality Improvement Plan 2026-27 highlights our success in achieving most Q1 targets and our commitment to continuous improvement by addressing areas needing further development.

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- QIP

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Quality Improvement Plan (QIP)

Fiscal 2026/27

THEME	DIMENSION	METRIC	UNIT/POPULATION	SOURCE/PERIOD	Year End Fiscal 25/26	TARGET PERFORMANCE	Apr-26	May-26	Jun-26	Q1
Access & Flow	Timely	Reduce the percentage of ED patients who left without being seen by a physician	%/ED patients	ERNI scorecard April 1- December 2025 (Q1-Q3)	6.0%	≤ 7.3%	4.0%	3.8%	5.1%	4.3%
Access & Flow	Timely	Reduce the 90th percentile emergency department wait time to inpatient bed by 50%	Hours/ED patients	ERNI scorecard April 1- December 2025 (Q1-Q3)	8.4	≤ 4.2	4.2	3.9	3.0	3.7
Equity	Equitable	Increase the percentage of Full-time and Part-time staff who have completed relevant inclusion, diversity, equity and accessibility (IDEA) education on gender identity to 50%.	%/applicable Staff	Quality scorecard April 1- December 2025 (Q1-Q3)	n/a	> 50.0%	33.3%	56.1%	57.7%	57.7%
Experience	Patient-Centred	Increase patient-reported care ratings related to being treated with courtesy and respect, regardless of gender identity by 5%.	scale out of 10	Quality scorecard April 1- December 2025 (Q1-Q3)	7.40	≥ 7.70	10.00	10.00	8.70	9.57
Safety	Safe	Reduce the rate of hospital-acquired pressure injuries (Stage 2-4) during inpatient stays by 50%.	Number	Quality scorecard April 1- December 2025 (Q1-Q3)	6	≤ 3	0	0	0	0
Safety	Safe	Reduce the number of medication incidents reaching the patient and resulting in harm (severity levels 2-5) by 4%.	Number	Quality scorecard April 1- December 2025 (Q1-Q3)	25	≤ 24	0	0	0	0

Metric underperforming target by more than 25%

Metric within 25% of target

Metric equal or outperforming target

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: August 21, 2026 Meeting Date Prepared for: September 10, 2026

Subject: Quality and Safety Scorecard Q1 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 Q1 results of the Quality and Safety Scorecard 2026-2027
- 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 2026/27 dashboard indicators are based on quality themes such as:
  - Timely and Efficient Transitions
    - Reduce the 90th percentile ED wait time to inpatient bed by 50%.
  - Service Excellence
    - Patients respond positively to the following question: Were you involved as much as you wanted to be in decisions about you or your family member's care and treatment?
  - Safety and Effective Care
    - Fall Rate, Falls with injury
    - Incidents of Physical Violence
    - Medication errors that reached the patient (incident severity levels 2-5)
    - Pressure Injury Development rate (stage 2,3,4) during inpatient stay
    - Hand Hygiene Compliance Rate for Moments 1 and 4
    - Hospital acquired infections (HAI) rates- C. Difficile, MRSA
  - Equity
    - Care rating for Race, Indigenous, Sexual Orientation from patient satisfaction survey results

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.

- Celebrating 12 of 14 indicators that met targets for Q1.
- Areas of opportunities:
  - Falls with injury-41.38 % for Q1 is above the target of ≤ 30%.
  - Strategy: continue with purposeful patient rounds, proactive toileting, appropriate use of alarms and mobility supports, patient/family education, and post-fall learning
  - Incidents of Physical violence- Q1 result of 10, with the majority associated with one patient, which is above the annual target of 17, quarterly target of approximately 4 incidents.
    - Strategy: Continue with individualized care plan that includes early identification of triggers, proactive de-escalation, consistent team response plans, environmental and staffing considerations, security/clinical escalation pathways, and post-incident review.

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Board Scorecard
Fiscal 2026/2027

Print

THEME	METRIC	MEASUREMENT	Year End Fiscal 2025-2026	TARGET PERFORMANCE	Q1	Q2	Q3	Q4	YTD	AIM	Visualization (Monthly)
1.Timely & Efficient Transitions											
Reduce the 90th percentile emergency department wait time to inpatient bed by 50%		hours	8.4	≤ 4.2	3.7				3.4	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%	98.3%				97.3%	Above	
3. Safe & Effective Care											
Fall Rate		# of incidents per 1000 patient days	14.2	≤ 12	11.4				9.4	Below	
Falls with Injury (any fall requiring intervention or treatment)		# of falls with injury/ # of falls *100	34.30	≤ 30.00	41.38				41.94	Below	
Incidents of Physical Violence		Actual number	17 (total)	≤ 17	10				10	Below	
Number of medication errors that reached the patient due to wrong drug/dose/patient (incident severity levels 2-5)		Actual number	25	≤ 24	0				1	Below	
Pressure injury development rate (stage 2,3,4) during inpatient stays		Actual number	6	≤ 3	0				0	Below	
Hand hygiene compliance rate (Moment 1)		# compliant activities / # of indicated activities	75.6%	≥ 92.0%	95.6%				93.0%	Above	
Hand hygiene compliance rate (Moment 4)		# compliant activities / # of indicated activities	93.3%	≥ 92.0%	94.2%				90.9%	Above	
C. difficile rate		# of incidents per 1000 patient days	0.52	≤ 0.00	0.00				0.00	Below	
MRSA Rate		# of incidents per 1000 patient days	0.62	≤ 0.00	0.00				0.00	Below	
4. Equity											
Care Rating (Race)		Average score 1-10(highest)	8.2	≥ 8.2	9.17				9.25	Above	
Care Rating (Indigeneous)		Average score 1-10(highest)	7.5	≥ 7.5	9.10				9.15	Above	
Care Rating (Sexual Orientation)		Average score 1-10(highest)	8.3	≥ 8.3	9.10				9.00	Above	

Metric underperforming target by more than 25%

Metric within 25% of target

Metric equal or outperforming target

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: July 16, 2026 Meeting Date Prepared for: September 10, 2026

Subject: Patient Satisfaction Surveys Q1

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

EMERGENCY DEPARTMENT- *347 respondents*

- Note: Q1 2027 column is the YTD average result for the indicator.

Quarterly Dashboard 347

	Q1 2027
Care Rating	8.8
I did not have a long wait	73%
During the visit, were you told the reason for the long wait?-1 to 3	32%
Do you feel that there was good communication about your care between doctors?-1 to 4	98%
How often did care providers treat you with courtesy and respect?	100%
How often did care providers explain things in a way you could understand?	98%
Did you get the emotional support you needed to help you with any anxieties?	93%
Did care providers do everything they could to ease your discomfort?	93%
Did you participate in your plan of care?-1 to 3	94%

Gender Diverse Care Rating 4	Sexual Orientation Care Rating 45	Race Care Rating 32	First Nation Care Rating 6
9.0	8.4	8.8	8.7

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:

- Patient Experience
  - Overall Care Rating: Consistent at **8.8**, reflecting sustained high satisfaction.
- Wait Experience
  - Wait time: Patient not having a long wait dropped to 73%
- Respectful Care and Communication
  - Courtesy and Respect: Perfect score at 100%
  - Communication Among Providers: Very high and stable at **98%** suggesting strong care coordination.
  - Clarity of Explanations: Maintained at **98%**, indicating providers explain conditions and treatments effectively.
- Patient-centred Care
  - Participation in Care Planning: Steady at **94%** reinforcing patient-centered care.
- Equity-focused Care
  - Race & First Nation Care Ratings: High equity perceptions (**8.8, 8.7**), demonstrating cultural sensitivity and inclusiveness.
  - Sexual Orientation and Gender Rating: Consistent at 8.4 and 9.7
  - Note: Results have small sample sizes; trends should be interpreted cautiously and monitored over time.

Key Focus going forward:

- Continue to build on strengths in respectful, clear and collaborative care while sustaining improvements in wait-time communication and keeping patients and families informed about delays.

INPATIENT REHAB UNIT- *7 total respondents*

Quarterly Dashboard 7

	Q1 2027
Care Rating	8.7
Do you feel that there was good communication about your care between healthcare providers?	100%
Did you receive enough information from hospital staff?	71%
Involvement of Plan of Care	69%
Friends/ family involvement	100%

Sexual Orientation Care Rating 1

10.0

Gender Care Rating

No data found - your filters may be too exclusive!

First Nation Care Rating

No data found - your filters may be too exclusive!

Race Care Rating

No data found - your filters may be too exclusive!

Explanation of indicators and desired target (AIM):

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

Satisfaction indicators

- Patient experience
  - Overall Care Rating of 8.7/10
- Communication between healthcare providers
  - 100% of respondents felt that the communication was good and that the providers were working together.
- Patient-centred Care
  - Family and friend involvement is strong with 100% reporting involvement in their care.
- Equity-focused Care
  - The sexual orientation care rating was 10.0/10 *(n=1)*.
  - No data was available for gender, First Nation, or race in this quarter.
  - **Note:** these results should be interpreted cautiously.

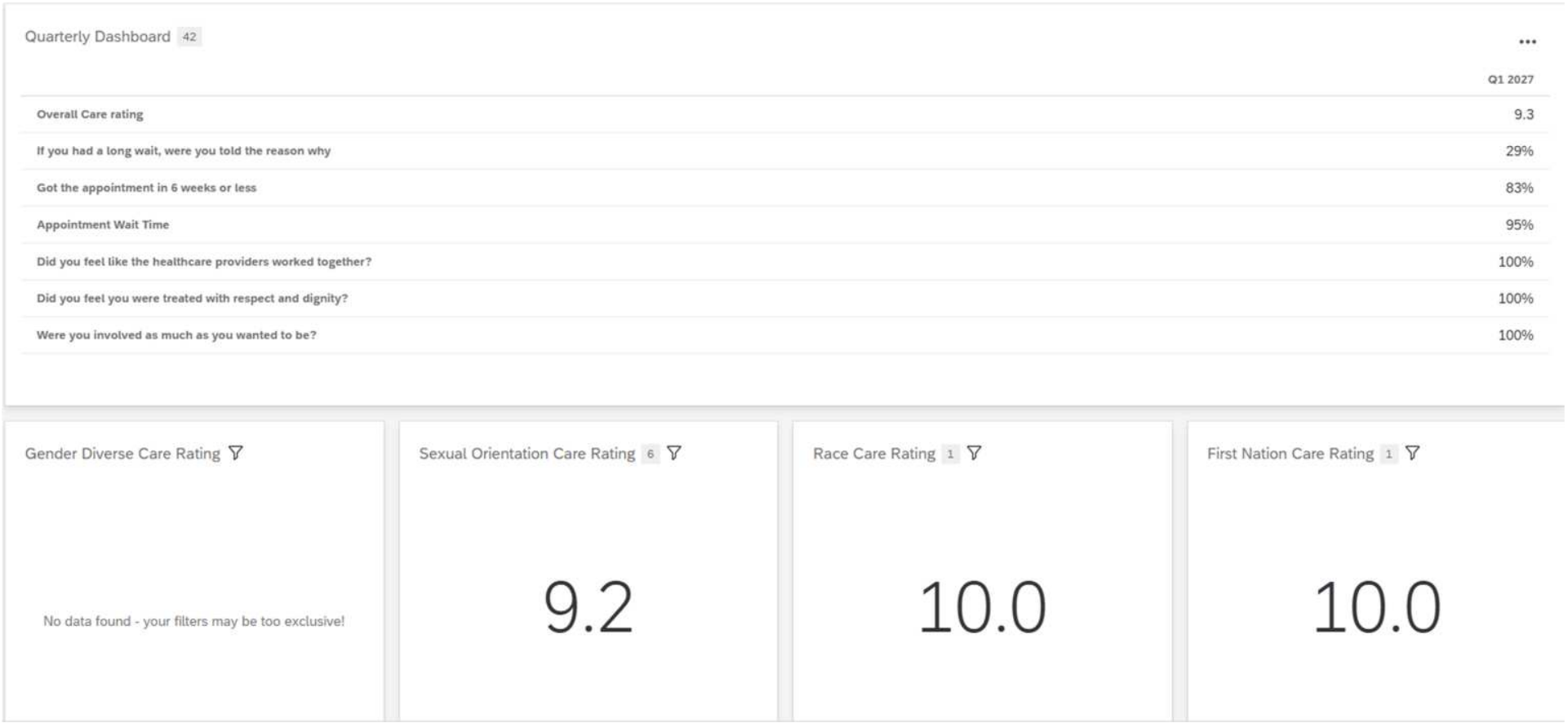
Opportunities

- Information sharing and patient involvement:
  - 71% reported receiving enough information from hospital staff.
  - 69% reported involvement in their plan of care
  - **Strategy:** Continue with activities that encourage patient participation as appropriate and strengthen shared decision-making

Key Focus going forward:

- Continue to build on strong communication and family engagement while strengthening information sharing and patient involvement in care planning.

OUTPATIENT DEPARTMENT- *42 total respondents*



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

Satisfaction Indicators

- Patient Care Experience
  - Overall Care Rating: Steady at 9.3.
- Collaboration and Respectful Care
  - Respect & Dignity: 100%
  - Providers Worked together: 100%
  - Involvement in Care Decisions: 100% felt they were fully included in care planning and decisions.
- Equity- focused Care:
  - Race, First Nation: 10.0
  - Sexual Orientation: 9.2
  - Note: Results have small sample sizes; trends should be interpreted cautiously and monitored over time.
- Timeliness of Care:
  - Appointment within 6 weeks increased from 77% → 83%
  - Wait time under 15 minutes: 95%

Key Focus going forward:

- Sustain the strong performance in collaborative, respectful and patient-centred care and continue with the improvements that were implemented to reduce wait times for ultrasound and outpatient clinic appointments.

HÔPITAL Glengarry Memorial HOSPITAL

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: August 21, 2026 Meeting Date Prepared for: September 10, 2026

Subject: Trillium Gift of Life Network (TGLN) Update

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

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

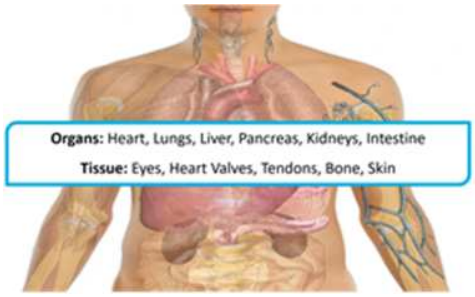
PURPOSE

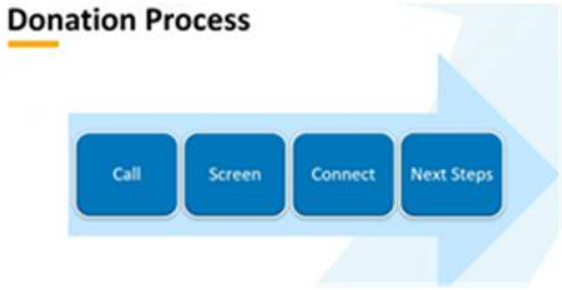
- Provide an update on our TGLN program Q4 2025-2026.

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.
- **Criteria for reporting**: aged 79 years and under; all deaths to be reported within one hour of death.

IMPACT ANALYSIS/RISK ASSESSMENT/DECISION CRITERIA

- **Tissue Notification timeliness is 86% for Q4 which was below the target of 100%.**
  - There were no donors for Q4. There were 2 donors in total for the year.
- **Routine Notification rate for Q4 is 87%, which is below the target of 100%.**
- There were 2 inpatient deaths (ages 76 and 79) that were not reported as required.
- **Strategy:** Reminder sent to staff to reinforce the criteria and timelines for reporting.

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: August 21, 2026 Meeting Date Prepared for: September 10, 2026

Subject: Professional Staff Appointment and Re-Appointment

Prepared by: Dr. Lisa MacKinnon, Chief of Staff

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

PURPOSE

To provide the Board with an annual overview of HGMH's Professional Staff appointment and re-appointment processes and provide assurance that appropriate credentialing, privileging and performance oversight processes are in place to support patient safety, quality of care and the Board's governance responsibilities.

SITUATION & BACKGROUND.

- Credentialing is an important governance responsibility of hospital boards. It includes the processes associated with initial appointment, verification of qualifications, identification of the scope and nature of privileges, granting of privileges, periodic review and annual re-appointment.
- Professional Staff includes physicians, dentists, midwives and extended class nurses who are granted privileges by the Board to practice within the Hospital. Privileges define the scope of an individual's authority to provide care and access Hospital resources, facilities, equipment, systems and supports.
- The Board has ultimate responsibility for the appointment of Professional Staff and the granting, modification, restriction or revocation of privileges. In fulfilling this responsibility, the Board relies on the review and recommendations of the Medical Advisory Committee (MAC) and Chief of Staff. Credentialing decisions must be based on fair, transparent and consistently applied processes, with patient safety and quality of care as paramount considerations.
- HGMH's credentialing processes are guided by applicable legislation, the Hospital's by-laws and established internal processes.

BOARD ROLE

- The Board is responsible for ensuring that an appropriate credentialing framework is in place and for making decisions regarding Professional Staff appointments and privileges based on recommendations received from MAC. In exercising this responsibility, the Board must be satisfied that appropriate due diligence has occurred and that recommendations are consistent with the Hospital's by-laws, identified clinical needs and its responsibility to provide safe, high-quality patient care.
- The Board is responsible for the appointment and re-appointment of Professional Staff, including approval of the applicable Professional Staff category and privileges, based on recommendations from MAC.
- The Board's role is not to repeat the detailed credentialing work undertaken by Medical Affairs, leadership and MAC, but rather to exercise appropriate governance oversight and satisfy itself that the process supporting the recommendation is robust, fair and consistently applied.
- Where an appointment, re-appointment or requested privilege is not recommended, applicable procedural fairness requirements, including rights to written reasons and a hearing where applicable, must be followed in accordance with the *Public Hospitals Act* and HGMH's by-laws.

INITIAL APPOINTMENT PROCESS

- Any physician is entitled to apply for hospital privileges and to have their application considered in accordance with the Hospital's by-laws and the *Public Hospitals Act*. For each application, the Medical Advisory Committee (MAC) considers the application and makes a written recommendation to the Board.
- A physician seeking an initial appointment requests an appointment package. The completed application is reviewed by Medical Affairs, the appropriate Chief of Department, the Chief of Staff and the CEO. The application then proceeds to MAC for review and recommendation, followed by the Board of Directors for approval.
- The initial appointment package includes:
    - completed application for appointment;
    - curriculum vitae;
    - certificate of registration with the applicable regulatory college;
    - Certificate of Professional Conduct or equivalent documentation confirming good standing;
    - professional references;
    - immunization record;
    - proof of appropriate professional liability protection or insurance;
    - confidentiality agreement and physician code of conduct; and
    - signed consents permitting the Hospital to verify information with regulatory colleges, previous hospitals, institutions and training organizations.

PROFESSIONAL STAFF CATEGORIES

- Professional Staff are appointed to a category of staff in accordance with HGMH's Professional Staff By-laws. Categories include **Active, Associate, Courtesy, Locum Tenens and Extended Class Nursing Staff**, with different rights, responsibilities and expectations associated with each category.
- The category of appointments and scope of privileges granted are considered as part of the credentialing process and approved by the Board based on the recommendation of MAC. New Professional Staff may be appointed to the Associate Staff category and undergo defined performance evaluations before being considered for advancement to Active Staff.

Annual Re-appointment Process

- The annual re-appointment process is initiated through CMARS in late November and is due in late December. Applications are reviewed by Medical Affairs, the Chiefs of Department, Chief of Staff and CEO before proceeding to MAC and the Board of Directors. Following Board approval, written confirmation of privileges is provided to physicians.
- Professional Staff are required to maintain appropriate documentation as part of re-appointment, including:
    - a completed CMARS re-appointment application;
    - pledge of confidentiality;
    - proof of appropriate professional liability protection or insurance
    - current certifications required depending on practice;
    - current N95 fit testing for on-site physicians; and
    - completion of required HGMH education and attestations.
- Re-appointment is not solely an administrative verification process. The annual re-appointment cycle also provides an opportunity to consider the Professional Staff member’s performance during the previous appointment period.

QUALITY AND RISK OVERSIGHT

- Credentialing, privileging and performance management are directly linked to patient safety and quality of care.
- HGMH’s credentialing process includes measures intended to reduce risk and support early identification of concerns, including:
    - six- and twelve-month performance evaluations, where applicable;
    - documentation of behavioral or professional concerns;

- early identification and mitigation of performance risks;
- verification of qualifications and professional standing;
- review of the privileges requested against the individual's qualifications; and
- escalation of significant concerns through the appropriate Medical Affairs, MAC and Board processes.

MEDICAL HR PLANNING

- An up-to-date Medical Human Resources (HR) Plan is an important component of HGMH's credentialing and recruitment framework. It helps ensure that Professional Staff recruitment and appointment decisions are aligned with the Hospital's current and anticipated clinical needs.
- The Medical HR Plan should be reviewed regularly to reflect changes in the Professional Staff complement and service needs, including anticipated retirements and vacancies, gaps in clinical coverage, specialist requirements, and Emergency Department and inpatient coverage. Maintaining a current plan supports proactive recruitment, succession planning, continuity of services and the early identification of potential workforce risks.
- For the Board, an updated Medical HR Plan provides assurance that Professional Staff appointments are considered within the context of HGMH's identified clinical needs and its ability to safely and sustainably provide patient care.

CONCLUSION

- HGMH's Professional Staff appointment and re-appointment processes provide an important mechanism for confirming that individuals granted privileges have the appropriate qualifications, professional standing and competencies to provide care within the scope of privileges granted by the Board.
- Ongoing credentialing, performance review, Medical HR planning and Medical Staff oversight provide the Board with assurance that Professional Staff continue to meet established requirements and that identified risks are appropriately managed in support of safe, high-quality patient care.

HÔPITAL Glengarry Memorial HOSPITAL

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: August 21, 2026 Meeting Date Prepared for: September 10, 2026

Subject: Patient and Family Advisory Committee (PFAC) Update

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

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

PURPOSE

- To provide an update of the Patient and Family Advisory Committee (PFAC).

SITUATION & BACKGROUND.

- Benefits of PFAC presence in hospital committees:
  - help identify areas of improvement in care delivery processes
  - ensure that patient and family voices are heard and considered in decision-making processes
  - foster a culture of collaboration and partnership to promote patient-centered and inclusive healthcare practices

IMPLEMENTATION & COMMUNICATION

- PFAC members are currently attending four hospital committees:
  - Board of Directors
  - Ethics
  - Product Evaluation
  - Quality and Safety Advisory
- PFAC members currently participate in patient rounds with the Senior Leadership team to get direct feedback and perspectives from patients and families on the care experience.
- Upcoming PFAC Activities
  - Co-design and launch a PFAC-led patient experience improvement initiative aligned with the 2026-2027 Strategic Actions
  - Expand PFAC membership and continue meaningful participation in initiatives, including engagement of patient advisors as appropriate.
  - Develop Terms of Reference for patient advisors participating in short-term initiatives, including expectations, roles, orientation, confidentiality and recognition.
  - Continue to strengthen PFAC integration with hospital committees and quality initiatives to ensure patient and family feedback informs improvements.
  - Provide input on the Patient and Family Handbook which is due for review.

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: September 1, 2026 Meeting Date Prepared for: September 10, 2026

Subject: Privacy and Confidentiality Report

Prepared by: Ryan Joseph Jarencio- HIS Manager and Privacy Officer

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

PURPOSE

The purpose of this report is to provide the Board Quality Committee with a governance-level overview of the organization's privacy and confidentiality activities during the reporting period.

The report provides assurance that:

- Patient and personal health information (PHI) continues to be protected in accordance with organizational policies and procedures.
- Privacy risks and concerns are being identified, assessed, documented, and managed.
- Privacy incidents are investigated and corrective actions implemented where required.
- The organization continues to meet its obligations under the Personal Health Information Protection Act, 2004 (PHIPA).
- Staff privacy awareness and education remain ongoing priorities.

Executive Summary / Overall Privacy Performance

Overall assessment: Green

For the reporting period of January 2026-August 2026, overall privacy performance is improving compared to January-December 2025.

Privacy incidents/concerns

1 reported concern, of which 1 was determined to constitute privacy breaches.

- This is compared to 5 privacy concerns constituting 3 minor and 2 major breaches in 2025

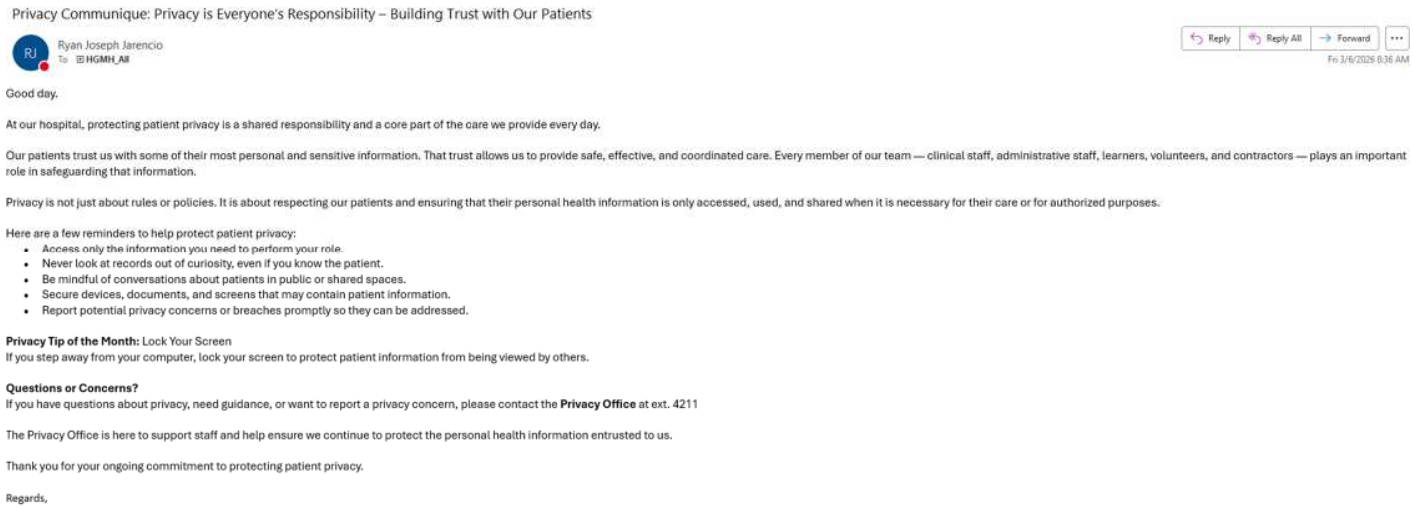
Significant breaches: none compared to (2 major breaches in 2025)
Risk level 2026: Low
Privacy audits: 6 random staff and 1 patient audit completed, with no significant findings
Staff training: 67% completion rate for required Annual privacy training.
PHIPA compliance: No significant compliance concerns identified

Ongoing initiatives:

Monthly Privacy Communications

The Privacy Office provides monthly privacy communications to staff to reinforce organizational expectations regarding the protection and appropriate use of personal health information (PHI). Communications address relevant privacy requirements, emerging risks, common privacy practices, and reminders regarding secure handling and disclosure of patient information.

The ongoing communiqué program supports a culture of privacy awareness and provides staff with regular, practical guidance to help maintain compliance with the **Personal Health Information Protection Act (PHIPA)** and organizational privacy policies.



Privacy Communique: Privacy is Everyone's Responsibility – Building Trust with Our Patients

Ryan Joseph Jarencio
To HGMH_All

Reply | Reply All | Forward | ...
Fri 3/6/2026 8:36 AM

Good day.

At our hospital, protecting patient privacy is a shared responsibility and a core part of the care we provide every day.

Our patients trust us with some of their most personal and sensitive information. That trust allows us to provide safe, effective, and coordinated care. Every member of our team — clinical staff, administrative staff, learners, volunteers, and contractors — plays an important role in safeguarding that information.

Privacy is not just about rules or policies. It is about respecting our patients and ensuring that their personal health information is only accessed, used, and shared when it is necessary for their care or for authorized purposes.

Here are a few reminders to help protect patient privacy:

- Access only the information you need to perform your role.
- Never look at records out of curiosity, even if you know the patient.
- Be mindful of conversations about patients in public or shared spaces.
- Secure devices, documents, and screens that may contain patient information.
- Report potential privacy concerns or breaches promptly so they can be addressed.

Privacy Tip of the Month: Lock Your Screen
If you step away from your computer, lock your screen to protect patient information from being viewed by others.

Questions or Concerns?
If you have questions about privacy, need guidance, or want to report a privacy concern, please contact the **Privacy Office** at ext. 4211

The Privacy Office is here to support staff and help ensure we continue to protect the personal health information entrusted to us.

Thank you for your ongoing commitment to protecting patient privacy.

Regards,

Staff and Patient Audits

The privacy office conducts quarterly privacy audits involving both staff access and patient records. These audits provide an additional monitoring mechanism to assess whether access to and use of personal health information is appropriate and consistent with the individual's role and legitimate business or care-related need.

There are also weekly audits on any unwarranted access of patient records who are employees of the hospital as well as any employees who accessed a high number of patient records and any patient of interest.

Audit findings are reviewed to identify inappropriate or unusual access patterns, potential privacy risks, and opportunities for improvement. Where concerns are identified, they are assessed and addressed in accordance with organizational policies and the applicable privacy requirements. The audit program supports proactive identification and management of privacy risks and provides ongoing assurance that appropriate safeguards are in place.

Privacy Training

Privacy education continues to be supported through the newly implemented organization's Learning Management System (LMS), providing staff with standardized privacy training and an accessible mechanism for monitoring training completion.

Training reinforces staff responsibilities related to the collection, use, disclosure, access, and protection of personal health information, as well as expectations for reporting privacy incidents and maintaining confidentiality. LMS-based tracking provides management with visibility into staff completion and supports organizational accountability for mandatory privacy education.

Collectively, the monthly privacy communications, quarterly privacy audits, and LMS-based training program provide complementary measures for **education, monitoring, and accountability**, supporting the organization's ongoing commitment to protecting patient information and meeting its obligations under PHIPA.

Overall, the privacy office, in coordination with hospital leadership continues to monitor privacy risks and has implemented appropriate processes to identify, investigate, and mitigate privacy concerns. No significant unresolved privacy risks requiring Board intervention were identified during the reporting period.