Board of Directors Meeting Agenda

Date: Thursday, October 22, 2026
Time: 5:00pm – 8:00pm
Location: Boardroom / Microsoft Teams

Time	Agenda Item	Attachment
5:00	**1. Call to Order (L. Boyling)**	
(1 min)	1.1 Land Acknowledgment	
(1 min)	1.2 Confirmation of Quorum	
(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 (L. Boyling)**	
(1 min)	2.1 Approval of previous meeting minutes – September 24, 2026	P. 3-6
(1 min)	2.2 Business arising from minutes	
5:06	**3. Education**	
(10 min)	3.1 Cyber Security (D. Lorimer)	
5:16	**4. Matters for Discussion/Decision**	
(5 min)	4.1 Report of the Board Chair (L. Boyling)	
(5 min)	4.2 Report of the President & CEO (R. Alldred-Hughes)	P. 7-8
(5 min)	4.3 Report of the VP Clinical Services, Quality & CNE (R. Romany)	P. 9-10
(5 min)	4.4 Report of the Patient and Family Advisory Committee (J. Shackleton)	
(5 min)	4.5 Report of the Executive Committee (L. Boyling)	
(5 min)	4.6 Report of the Chair of the French Language Services Committee (C. Larocque)	
(5 min)	4.7 Annual French Language Services Report to the Ministry (C. Larocque/L. Ramsay) **THAT the Board of Directors review and receive the French Language Services Report as presented.**	P. 11
(5 min)	4.8 Report of the Chair of Governance & Nominating Committee (G. McDonald)	
(5 min)	4.9 Q1 Strategic Actions (G. McDonald/R. Alldred-Hughes) **THAT the Board of Directors review and receive the Q1 Strategic Actions Report as presented.**	P. 12-16
(5 min)	4.10 Communication and Community Engagement Plan (G. McDonald/R. Alldred-Hughes) **THAT the Board of Directors review and receive the Communication and Community Engagement Plan as presented.**	P. 17-32
5:56	**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 Update on Personal Business Commitments of the CEO and COS	P. 33-37
	5.2 Draft Governance & Nominating Committee Report	P. 38-40
	5.3 Committee Terms of Reference	P. 41-51
	5.4 Policy Review	P. 52-54
	5.5 Inclusion, Diversity, Equity & Anti-Racism Update	P. 55-56
	5.6 Draft French Language Services Committee Report	P. 57
	THAT the Board of Directors approve and receive all documents as presented in the consent agenda.	
5:58	**8. Date of Next Meeting – Thursday, November 26, 2026 5:00pm**	
	9. Closing Remarks & Adjournment (L. Boyling)	

**Meeting Moves to In Camera*

Accountability for Reasonableness (A4R) Ethical Decision Making Framework Steps

Values that Optimize Fairness in the Process of Decision-Making

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

A4R Action Steps

Determine and Identify

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

Clarify and Provide

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

Communicate

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

Revisit and Revise

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

Evaluate and Improve

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

Centre de bioéthique Champlain Centre for Health Care Ethics

HÔPITAL Glengarry Memorial HOSPITAL

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS

Date	Thursday, September 24, 2026
Time	5:00pm-8:00pm
Location	Boardroom / Microsoft Teams

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

1. Call to Order

L. Boyling, Chair, called the meeting to order at 5:00.

1.1 Quorum

A quorum was present.

1.2 Land Acknowledgment

L. Boyling read the land acknowledgment.

1.3 Adoption of the Agenda

The agenda was reviewed.

Moved By: C. Larocque
Seconded By: B. Pulice
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

2.1 Approval of the Minutes

The minutes of the meetings held on June 18 and June 25, 2026, were shared.

Moved By: G. Peters
Seconded By: C. Larocque
THAT the minutes of the June 18 and June 25, 2026, meeting be approved as presented.

CARRIED

2.2 Business Arising from the Minutes

There was no business arising to discuss.

3 Education

K. Duval presented an overview of the Emergency Department Pay for Results (P4R) Program, including its funding structure and performance measures. The presentation outlined the stages of the emergency department patient journey and measures related to

length of stay, time to physician assessment, time to an inpatient bed, and ambulance offload time.

HGMH's emergency department scorecard and performance against P4R targets were reviewed. Findings from 40 chart audits completed through the Emergency Department Return Visit Quality Program identified opportunities to improve discharge vital sign documentation and discharge instructions, formalize morbidity and mortality rounds, and address return visits related to diagnostic imaging. The presentation also highlighted opportunities associated with Epic, ultrasound expansion, and planned CT acquisition in 2027.

4 **Matters for Discussion/Decision**

4.1 Report of the Board Chair

L. Boyling shared some words as her first meeting as the Chair and highlighted that she would like to focus over the next two years on the implementation of the CT Scanner as well as the Health Hub, which will be discussed at the Board Retreat.

4.2 Report of the VP of Corporate Services & CFO

L. Ramsay provided updates on facility improvements, information technology, and Health Information Services' preparations for Epic.

Discussion took place regarding the future implementation of AI, and it was noted that this would follow a global governance approach.

4.3 Report of the Patient and Family Advisory Committee

A report was provided on work being done by the Committee in which they will be participating in Canadian Patient Safety Week at the end of October by doing a walkthrough of the hospital with a patient lense to look at wayfinding, and patient rounding will be done as well to hear firsthand from patients during the week.

4.4 Report of the Chair of Quality & Patient Safety Committee

With the QIP and scorecard results performing well, the Committee noted an opportunity to devote more meeting time to other priorities, including accreditation and patient satisfaction survey results.

4.5 Q1 Quality Improvement Plan

The results of the Quality Improvement Plan for Q1 were reviewed.

Moved By: C. Nagy
Seconded By: C. Larocque
That the Board of Directors review and receive the Q1 quality improvement plan results as presented.

All items are in green for Q1 with things going really well.

CARRIED

4.6 Q1 Quality & Safety Scorecard

The results of the Quality & Safety Scorecard for Q1 were reviewed.

Moved By: R. Cardinal
Seconded By: M. Nichols

That the Board of Directors review and receive the Q1 quality & safety scorecard results as presented.

It was acknowledged that 12 of 14 indicators are currently meeting targets. Falls with injury and incidents of physical violence were identified as areas requiring improvement. Strategies will focus on fall prevention, individualized care planning, de-escalation, and learning from incidents.

CARRIED

4.7 Q1 Patient Satisfaction Survey Results

The patient satisfaction survey results were reviewed for Q1.

Moved By: C. Larocque
Seconded By: R. Cardinal
THAT the Board of Directors review and receive the Q1 patient satisfaction survey results as presented.

The results reflect high overall satisfaction across departments. Opportunities for improvement include communication about emergency department wait times and strengthening inpatient information sharing and involvement in care planning. The survey now includes additional equity and inclusion measures, with small sample sizes requiring cautious interpretation.

CARRIED

4.8 Report of the Chair of Finance, HR, and Audit Committee

The committee reviewed the workplan and good discussions took place throughout the meeting.

4.9 Financial Statements and Statistical Information – April-July

The financial statements and statistical information from April to July 2026 were reviewed.

Moved By: C. Larocque
Seconded By: R. Cardinal
THAT the Board of Directors review and receive the financial statements for April to July 2026 as presented.

A year-to-date deficit of $332,033 was reported end of July 2026. Delayed recognition of base funding affected the reported results. Including this funding would result in a very small year-to-date surplus.

CARRIED

4.10 Annual Borrowing Report

The annual borrowing report was reviewed.

Moved By: B. Pulice
Seconded By: K. McTaggart
THAT the Board of Directors review and receive the annual borrowing report as presented.

No changes to financing arrangements were reported. Borrowing and cash flow continue to be monitored. It was also noted that wages for some managers with significant involvement in the Epic project are being allocated to the project. Epic hours are identified on their pay stubs to track these costs.

CARRIED

4.11 Epic Implementation Update

There are 30 working days left to go-live and lots of work continues to be done in preparation for implementation day.

5 **Consent Agenda**

The following were included in the meeting package under consent agenda and reviewed by members prior to the meeting:

5.1 Draft Quality & Patient Safety Committee Report
5.2 Q1 Trillium Gift of Life Report
5.3 Professional Staff Appointment and Reappointment Process
5.4 Updates from the Patient and Family Advisory Committee
5.5 Draft Finance, HR, and Audit Committee Report
5.6 CT Scan Update

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

CARRIED

6 **Correspondence**

Correspondence was included in the meeting package.

7 **Date of Next Meeting**

October 22, 2026

Meeting adjourned at 6:26pm

K-L. Massia, Recording Secretary

DRAFT

Report of the President & CEO

October 22, 2026 Board of Directors

Countdown to EPIC Go Live

HGMH is entering the final stages of preparation for our transition to Epic as part of the Atlas Alliance, with go live scheduled for October 24, 2026. The focus has now shifted almost entirely to final readiness activities, including completion of staff and physician training, dry runs, workflow practice, cutover preparation and validation of go live support plans.

Recent readiness walk arounds have been positive, with teams demonstrating a strong understanding of new workflows and increasing confidence in the transition. Staff have been actively participating in practice sessions and dry runs, helping identify and resolve issues before go-live. Cutover activities are also being rehearsed to ensure a coordinated transition from our existing systems to Epic.

While the final days leading to go live will remain busy, HGMH is well positioned for the transition. Management is encouraged by the readiness, engagement and positive approach demonstrated by our teams. Significant onsite and Alliance support will be in place throughout go live and the stabilization period that follows.

Capital Redevelopment Planning

Work continues to advance HGMH's long term capital redevelopment planning following discussions with Ontario Health and the Ministry of Health regarding our Stage 1.1 Pre Capital Submission, and subsequent need for a resubmission. Recent engagement has provided an opportunity to further clarify HGMH's future service needs.

Discussions have also continued regarding the future of inpatient rehabilitation services. Management's current approach is to maintain HGMH's existing 15 rehabilitation beds within the redevelopment plan, while recognizing that future growth in rehabilitation capacity should be considered through broader regional planning. This approach supports the continued program at HGMH while supporting a collaborative discussion about how additional capacity should be planned as regional demand grows. This approach was accepted by Ontario Health. The other area where we are providing additional clarity is with respect to the Transitional and Restorative Care Unit, along with providing additional detail on our outpatient and program growth volume.

Management continues to refine the redevelopment proposal and supporting evidence based on feedback received through these discussions. Engagement with Ontario Health will continue as we work toward a path forward for HGMH's long term redevelopment and Community Health Hub and will bring a resubmission forward through appropriate committees for review, discussion, and finalization.

Respiratory Illness Season - Influenza & COVID-19 Immunization

HGMH is preparing for the upcoming respiratory illness season, with early activity suggesting that respiratory viruses may begin circulating sooner than in some previous years. Preparations are underway to support the health and safety of our patients, teams and hospital operations throughout the fall and winter.

Once our supply is received, HGMH will begin offering both influenza and COVID 19 immunizations to staff, physicians and volunteers. We will continue to monitor respiratory illness activity and adjust infection prevention and operational measures as required throughout the season.

Traditional Healing Knowledge Exchange

From October 13 to 15, I will participate in the Ontario Hospital Association's Traditional Healing Knowledge Exchange on Manitoulin Island. The gathering brings together Indigenous Elders, Knowledge Keepers,

Traditional Healers, Indigenous communities and health system leaders for three days of ceremony, storytelling and dialogue focused on Traditional Healing, Indigenous health and culturally safe care.

I am looking forward to participating in this gathering and the opportunity for shared learning and discussion about how hospitals can better recognize and support Traditional Healing and Indigenous approaches to health and well-being. I will bring perspectives from the gathering back to HGMH as we continue our work in cultural safety and strengthen our relationships with Indigenous communities, including Akwesasne.

Emergency Department Action Team (EDAT) Webinar

On October 7, Board Chair Louise Boyling and I participated in a Ministry of Health webinar focused on the province's Emergency Department Action Team initiative. Premier Doug Ford, Deputy Premier and Minister of Health Sylvia Jones, Ontario Health President and CEO Matt Anderson, Deputy Minister of Health Deb Richardson, and Associate Deputy Minister Catherine Wang participated in the session to provide an overview of the initiative, early results and next steps.

The initiative began with three hospitals, where teams worked directly with emergency departments to improve patient flow, reduce unnecessary processes and waste, and improve wait times using LEAN methodology. The Ministry reported positive early results, including a 50 percent improvement in wait times for admitted patients.

Building on this initial work, the initiative is now expanding to 26 hospitals across the province, with a continued focus on improving emergency department performance, operational efficiency and hospital sustainability. Small hospitals are not currently included in the scope of the initiative, although there may be opportunities for broader application of the work in the future.

HGMH will continue to follow the initiative and consider how emerging approaches and lessons may be relevant to our own Emergency Department.

Stakeholder Engagement

Ongoing engagement with health system partners, government, community organizations and sector leaders remains an important part of the CEO role. These discussions provide opportunities to advance HGMH's priorities, strengthen partnerships, understand emerging system issues and ensure the perspectives of small and rural hospitals are represented in broader health system conversations. Since the last meeting of the Board of Directors, CEO stakeholder engagement has included:

- Mohawk Council of Akwesasne Department of Health
- Meeting with North Glengarry CAO (Michael Fawthorp), Mayor (Jamie McDonald), and Deputy Mayor (Carma Williams)
- Kinsmen Club of Cornwall, jointly with Kim Jarencio, HGMH Foundation Fundraising Manager

Upcoming Events/Special Dates

- November is Fall Prevention Month
- November 2-6 – MRT Week and National Health Ethics Week
- November 8 - Diwali
- November 10 – International Accounting Day
- November 15 – National Philanthropy Day

Report of the VP Clinical Services, Quality & Chief Nursing Executive

October 22, 2026 Board Meeting

May 2026 – Present
Clinical Services continues to focus on patient safety, quality improvement, workforce engagement, and readiness for major clinical transformation.

Recognition
During Nursing Week in May, Ninon Jearound, received the Mrs. Oma Nursing Commitment Award, recognizing her compassion, responsiveness, leadership, and commitment to patients and colleagues. The Safety Star Award continues to recognize staff and physicians who proactively identify risks and contribute to a strong culture of safety and continuous improvement. Recent recipients included the Diagnostic Imaging team (Dr. Vakili, J.Duperron, T. Belanger) and nurse K. MacLeod for patient advocacy and identifrying opportunities for quality improvement.

Medication Safety
The inpatient Omnicell automated dispensing unit (ADU) was delivered in July and is being implemented for go-live in October prior to EPIC go-live. The ADU provides secure, controlled access to medications at the point of care, supports standardized workflows, nursing practice and helps establish a safer foundation for the transition to EPIC.





Regional and System Collaboration
Since May, I have continued to represent HGMH and Clinical Services through a range of regional and provincial forums, supporting collaboration, information sharing, and alignment of clinical priorities across the health system.

Key committees and communities of practice include:

- Champlain Hospital Access Table
- ED Community of Practice
- Alternative Level of Care (ALC) Community of Practice
- RNAO Best Practice Spotlight Organization (BPSO) Community of Practice
- Great River Ontario Health Team Collaboration Council
- Regional Cancer Program Partner Council
- Regional Acute Care Medicine Steering Committee
- Chief Nursing Executives Committee
- Rehab Advisory Council
- Champlain Regional Stroke Network
- Ontario Health Champlain Critical Care Network

These forums provide opportunities for networking, advance regional coordination, share best practices, address system capacity and patient flow, and ensure HGMH's clinical priorities remain aligned with broader health-system planning.

EPIC Readiness

A significant focus for Clinical Services is EPIC go-live. Teams across clinical services are actively completing the preparation required for implementation, including workflow readiness, education and training, testing, and change management, with a strong focus on supporting staff through the transition.

Key Clinical Priorities

- **Wound Care & Pressure Injury Prevention**: Established the Wound Care Team and goal is to standardize best practices to support consistent prevention, assessment, and treatment.
- **Discharge Process and Patient Flow**: Advancing Conservable Bed Days (CBD) and Expected Date of Discharge (EDD) to reduce avoidable hospital days, support earlier discharge planning, and improve access to inpatient beds.
- **Staff Safety & Education**: Continuing Non-Violent Crisis Intervention (NVCI) training along with Learning Management System- Dual Code post-rollout focus on supporting centralized staff education, training completion and ongoing competency requirements.
- **Outpatient Physiotherapy and Ambulatory Care clinics**: Optimizing scheduling and staffing to improve patient access and use of available capacity.
- **Diagnostic Imaging Services**: Reviewing hours of operation, equipment, space/renovation requirements, and workflows to optimize services and support future CT implementation.
- **Quality & Patient Safety**: Continuing to strengthen a culture of safety through frontline staff reporting, learning from events, standardization of practice, and staff engagement in quality improvement.



Looking Ahead

The immediate priority is supporting a successful EPIC implementation on Saturday, October 24. Following go-live, the focus will shift to staff support, stabilization, and maintaining continuity of safe, high-quality patient care. Recognizing the sustained effort required of our teams, we will continue to support staff as we move through the transition while keeping our clinical priorities moving forward.

FLHS Data Extract Report - Identified

Report Date: 2026-06-23

Report requested by Linda Ramsay

Submission Name	Reporting Period	OH Region	Agency Status	1.1 - Letter Patent:	1.5 Organizational type or category (AKA Sector of Care):	1.6 - Clientele:	1.7 - Brief description of the background of the agency or organization:	2.1 - Type of application:	2.2 - List of all programs/services offered by the agency:	3.1 - Name of the city(its) and/or region(s) served:		3.3 - Clientele		5.1 - How do you identify Francophone clients	5.2 - What do you do when you receive a request for services in French?	5.3 - If you chose "The client is referred to another provider who offers French language services", please list these providers.	5.4 - How do you measure client satisfaction with the French language services offered by your organization?	5.5 - Does your organization have a policy or guidelines on active offer?	5.6 - If your organization has a policy or guidelines on active offer, how do you inform people in your organization (employees, management, board members) about your policy or guidelines on active offer?
Glengarry Memorial Hospital - 2025-2026	2025-2026	East	Fully Designated	Hopital Glengarry Memorial Hospital	Hospital Services	A Francophone minority: 49% and less of clients are Francophone	Glengarry Memorial Hospital is a patient-centered primary care hospital that has been established in Alexandria, Ontario for over 50 years. It has 37 beds in 2 units: Acute and Rehabilitation. HGMH provides acute care, 24-hour emergency services, and rehabilitation to over 23,000 residents every year. Our team includes 200 staff members, who all take pride in bringing quality health care to our local Eastern Ontario community. Other services include: laboratory (inpatient and community), ultrasound, radiology, bone mineral densitometry, cardiac stress testing, physiotherapy and rehabilitation, pulmonary function testing laboratory. We also have six family physicians with offices onsite and host a variety of patient clinics by onsite specialists, including gastroenterology, urology, internal medicine, respirology, endoscopy, OB/GYN, and neurology.	Full designation	Ambulatory clinics: cardiology, minor and general surgery, gastroenterology, gynecology/obstetrics, internal medicine, family medicine, neurology, orthopedics, respirology, urology, telemedicine and pain. Departments: Diagnostics (x-ray, bone mineral densitometry, ultrasound), Laboratory, Pharmacy, Physiotherapy and Rehabilitation, Medicine Unit (22 inpatient beds), General Rehabilitation and Post Acute Stroke Rehabilitation Unit (15 inpatient beds), Emergency Department (open 24/7/365), Health Information Services, Community Wide Scheduling	City / Region 1:	Township of North Glengarry	Total Number of Visits:	43,321	Clients self-identify as Francophone Mother Tongue Official language spoken Official language in which are most comfortable	A caregiver, volunteer or staff member acts as interpreter Professional interpretation service is offered We match clients with staff members who have French Language Skills		We use a survey of overall client satisfaction with services rendered	Yes	Orientation Package
										City / Region 2:	Township of South Glengarry	# of visits by francophone clients:	12,820						
										City / Region 3:		French Visits Percent:	29.59%						
												Total number of unique clients:							
												# of Francophone clients:							
												French Percent:							

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: September 30, 2026 Meeting Date Prepared for: October 8, 2026 – Governance
October 22, 2026 - Board

Subject: Q1 Strategic Actions Report – 2026/2027

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 Governance Committee with an update on progress against HGMH's Strategic Action Report for Q1 2026/2027.

Strategic actions are developed annually to advance HGMH's 2023–2028 Strategic Plan and provide measurable actions under our four strategic priorities: Quality & Safety, People & Culture, Integration & Standardization, and Future Planning.

Quarterly reporting provides the Board with oversight of progress, identifies emerging risks or barriers, and supports accountability for implementation.

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 Q1 Strategic Action Report represents the first formal progress update against the 2026/2027 annual priorities established to advance HGMH's 2023–2028 Strategic Plan.
- Overall, implementation is progressing as planned. All strategic actions have advanced during the first quarter, with no actions currently identified as at risk or requiring a formal mitigation plan.
- The first quarter has largely focused on establishing the foundations required for implementation throughout the remainder of the year. Several initiatives have moved from planning into active implementation, while others have established the teams, partnerships, education and operational structures required to support further progress.
- Q2 will represent an important period of execution for the organization. In particular, preparations for the October 24, 2026 Epic go live will require significant organizational attention alongside continued advancement of the CT project and other strategic commitments.
- Management will continue to monitor progress, organizational capacity and emerging risks throughout the year and will bring forward any material issues that may affect achievement of the Strategic Action Plan.

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.

- The 2026/2027 Strategic Action Plan includes several significant initiatives being advanced concurrently with day to day hospital operations. While individual actions are progressing, the cumulative demands on leadership and staff capacity will require continued attention as implementation activity increases through the year.
- The most significant near term organizational impact will be the Epic go live in October. Training, scheduling, backfill and operational readiness will place additional demands on teams and may temporarily affect the pace of other strategic work.
- Several actions also depend on factors outside of HGMH's direct control, including external approvals and partnership activities. The CT project in particular will continue to require coordination with other partners as it moves from planning toward implementation.
- Management will balance these competing priorities through the year and adjust sequencing where necessary to protect operational capacity while continuing to advance the commitments established in the Strategic Action Plan. Material changes to timelines, scope or risk will be identified through subsequent quarterly reporting.

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

- Q1 Strategic Action Report

2026-2027 Strategic Action Report Q1

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.*	Robert Alldred-Hughes	Advance CT implementation by completing detailed planning for infrastructure, equipment procurement, clinical model design, staffing strategy, and operational integration to support service launch readiness.	Q1	RFP and space design process has been completed for both the CT Equipment and Turnkey Construction. Submission made to MOH Capital Branch to support approval to proceed.	**10%**
				Q2		
				Q3		
				Q4		
		Rachel Romany	Implement the RNAO Best Practice Guideline for wound care to strengthen evidence-based assessment, prevention, and management practices across the organization.	Q1	Established a dedicated wound care team led by the IPAC Nurse with RPN support. Team members have applied to complete a five-month wound care course starting in August to build expertise and support implementation of the RNAO Best Practice Guideline.	25%
				Q2		
				Q3		
				Q4		
		Robert Alldred-Hughes	Collaborate with PFAC to co-design and implement a priority improvement initiative that enhances the patient and family experience.	Q1	PFAC meeting has occurred to determine which initiative they would like to advance this year. Focus has been determined to support the development of a patient advisor framework and role description.	**25%**
				Q2		
				Q3		
				Q4		
People & Culture	*Improve engagement by investing in the organizations people and empower a caring and positive culture for all.*	Kayla MacGillivray	Advance implementation of an organization-wide Learning Management System to standardize training delivery, monitor mandatory education compliance, and enhance workforce development.	Q1	Vendors were met with and the project team selected Dual Code, an Ottawa-based organization. The project was kicked off in June.	**70%**
				Q2	The platform has a soft go-live on August 10, 2026 as we continue to populate the education programs.	

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

Updated August 18, 2026

				Q3		
				Q4		
		Rachel Romany	Advance comprehensive NVCI training across patient-facing teams to enhance de-escalation capability and reduce workplace violence risk.	Q1	An internal NVCI instructor has been certified, with staff training beginning July 23. Phase 1 includes ED, Diagnostic Imaging, and Registration staff, followed by inpatient and Allied Health teams. NVCI training will be added to new staff orientation in January 2027.	25%
				Q2		
				Q3		
				Q4		
		Kayla MacGillivray	Execute priority IDEA initiatives, including gender identity education, integration of patient voice in committee governance, cultural safety learning experiences, and implementation of an anti-racism lens in organizational policy review.	Q1	Gender-identity training was launched on the intranet. A corporate IDEA policy has been developed and is currently going through the approval processes.	30%
				Q2		
				Q3		
				Q4		
		Kayla MacGillivray	Advance implementation of the psychological safety strategy by delivering targeted training and reinforcing leadership accountability.	Q1	Commitment from Senior Leadership was signed. The Program was shared with all staff. Guarding Minds at Work survey was launched.	**20%**
				Q2		
				Q3		
				Q4		
Integration & Standardization	*Deliver standardized quality care in a cost-effective way through collaboration & integration opportunities.*	Rachel Romany	Achieve successful Epic EMR go-live by executing required clinical, operational, and technical readiness activities across the organization.	Q1	Achieved 56% end-user training registration against the initial 50% target. Current focus is coordinating staff schedules and backfill, with a goal of reaching 100% registration by August 21 to support Epic readiness with a go-live date of October 24, 2026.	25%
				Q2		
				Q3		
				Q4		
		Robert Alldred-Hughes	Advance Endoscopy Program expansion through targeted business development, partnership engagement, and operational capacity planning.	Q1	Opportunity is progressing well. The surgeons are supportive of the opportunity to increase endoscopy. Working through billing support, and requisition	25%

					development. Referring physicians supportive of new referral pattern.	
				Q2		
				Q3		
				Q4		
Future Planning	*Invest in the sustainability of our equipment & infrastructure to support safe, quality care.*	Linda Ramsay	Implement an Infrastructure Renewal Strategy to ensure infrastructure investments are sequenced, risk-informed, and aligned with the hospital's long-term redevelopment direction.	Q1	Infrastructure Renewal Strategy Executive Summary and a Facilities Operations and Maintenance Operational Plan have been drafted.	25 %
				Q2		
				Q3		
				Q4		
		Linda Ramsay	Develop and implement an Environmental Stewardship Plan to guide energy efficiency, waste reduction, and sustainable operations.	Q1	First meeting of the committee was held in July. Terms of reference were drafted and reviewed by the committee members.	25 %
				Q2		
				Q3		
				Q4		

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: September 18, 2026 Meeting Date Prepared for: October 8, 2026 – Governance
October 22, 2026 - Board

Subject: Communications and Community Engagement Plan

Prepared by: Robert Alldred-Hughes, President & CEO

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

PURPOSE

- To review the hospital Communications and Community Engagement Plan to ensure the plan aligns with organizational goals and communication needs and meets accreditation standards.

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.

- Effective communication is essential to maintaining transparency both internally and externally to also help build and retain community trust.
- The hospital developed a communication plan in 2022. The plan has since evolved into the Communications and Community Engagement Plan, reflecting the hospital's broader approach to both communication and stakeholder engagement.
- The plan serves as the framework for internal and external communications and guides how the hospital communicates and engages with staff, physicians, patients, families, community partners, stakeholders and the public.
- The plan is reviewed annually to ensure continued alignment with applicable legislative requirements, including the French Language Services Act and Accessibility for Ontarians with Disabilities Act, as well as the hospital's strategic priorities, key initiatives, accreditation requirements and evolving communication needs.
- Upon review of the Communications and Community Engagement Plan, Management is not recommending any major changes at this time. Town Hall sessions were updated to be quarterly to allow for more conversation with staff and physicians on key initiatives throughout the year.
- Management completed its annual review of the Communications and Community Engagement Plan. No substantive changes are recommended at this time. Minor administrative and editorial updates have been incorporated to ensure the plan remains accurate and current. The plan is presented to the Governance and Nominating Committee for review and feedback.

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Communications and Community Engagement Plan

Communications & Community Engagement Plan

HÔPITAL Glengarry Memorial HOSPITAL

PATIENT & FAMILY SEAL OF APPROVAL ADVISORY COMMITTEE

Effective: Oct 2022	**Last review/revision:** Oct 2026	Next Review: Oct 2027
Owner: Communications Officer	**Signing Authority:** Senior Leadership	
PLN-001-0-26		

Note: This is a controlled document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the Intranet prior to use.

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Background

Established in 1965, Hôpital Glengarry Memorial Hospital has been a cornerstone of healthcare in Alexandria, Ontario. It provides acute care, 24-hour emergency services, outpatient services, and rehabilitation to over 41,000 residents annually. Our team of over ~~180~~ 220 staff members, 50 Medical Staff members, and 100 volunteers are dedicated to delivering high-quality health care to our Eastern Ontario community.

Our Mission

Delivering outstanding care for our communities.

Our Vision

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

Our Values

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

Executive Summary

Effective communication is the process of sharing ideas and information in such a way that the content is received and understood in the way it was intended through a variety of channels to ensure understanding, collaboration, and trust among internal and external audiences. This includes day-to-day operational updates, announcements, crisis communication, health education, and promotional content.

HGMH's Communications & Community Engagement Plan is intended to guide the organization in communicating with its various stakeholders and ensure that the right people have the right information when they need it. This work requires that we provide information by the most appropriate method(s) to maximize clarity, conciseness, understanding, and transparency. All communication that is public facing will be available in both official languages (English and French) to align with the hospital's designation as a French Language Service hospital (as per the French Language Services policy BOD.01.002).

Community engagement refers to the process of building strong, reciprocal relationships with patients, families, and groups in the broader community. It involves listening, learning, and collaborating with stakeholders. The goal is to foster trust, reflect community voices, and ensure services and communications are culturally safe, inclusive, and responsive to community needs.

Communications

Stakeholders

The stakeholders listed below reflect the individuals, groups, and organizations with whom HGMH maintains strategic, operational, regulatory, and community relationships. Distribution ensures transparency, accountability, and engagement with those who have a vested interest in the hospital's performance and achievements.

Key themes that could be communicated are:

- **Strategic Direction & Accountability**: Annual Report; progress on Strategic Plan; governance and policy updates; hospital performance metrics
- **Clinical Excellence & Patient Care:** Accreditation readiness; patient safety initiatives; quality improvement updates; new/expanded services; recruitment successes
- **Workforce Engagement & Recognition**: recognition of staff, physicians and volunteers; milestones & retirements; professional development and training; IDEA initiatives
- **Community Impact & Partnerships:** partnerships within the community
- **Advocacy & Government Relations:** capital project needs; hospital funding priorities; alignment with municipal/federal priorities; small hospital advocacy
- **Education & Training Opportunities:** Student placement opportunities; partnerships with nursing/allied health institutions
- **Philanthropy & Fundraising:** Foundation campaign updates; impact of donations; capital equipment needs
- **Public Awareness & Media Relations:** Hospital news & service updates; health promotion & prevention campaigns; Care Champion stories; system updates of public interest

Stakeholder Group	Stakeholders	Key Themes for Communications & Engagement
Internal Governance & Leadership	• HGMH Board of Directors • HGMH Senior Leadership Team • HGMH Management Team • HGMH Medical Advisory Committee (MAC) • Department Chiefs	• Strategic Direction & Accountability • Clinical Excellence & Patient Care • Workforce Engagement & Recognition • Community Impact & Partnerships • Advocacy & Government Relations • Philanthropy & Fundraising
Hospital Staff, Physicians, and Volunteers	• All HGMH staff (via internal email and intranet) • Credentialed physicians and allied health professionals • Volunteer Auxiliary	• Strategic Direction & Accountability • Clinical Excellence & Patient Care • Workforce Engagement & Recognition • Community Impact & Partnerships • Education & Training Opportunities
Community Partners & Political Stakeholders	• Township of North Glengarry (Mayor, Council, CAO) • Township of South Glengarry (Mayor, Council, CAO)	• Community Impact & Partnerships • Advocacy & Government Relations

	• United Counties of Stormont, Dundas, and Glengarry (Council, CAO) • Local First Nations leadership – Mohawk Council of Akwesasne • MPP Prescott, Russell, & Glengarry • MPP Cornwall, Stormont, Dundas, and South Glengarry • MP Cornwall, Stormont, Dundas, Glengarry	
Healthcare and System Partners	• Ontario Health East Region • Ministry of Health – Ontario • Eastern Ontario Health Unit • Great River Ontario Health Team (OHT) partners • Regional hospitals and healthcare alliances (e.g., Atlas Alliance members) • Champlain Alliance of Small Hospitals	• Strategic Direction & Accountability • Clinical Excellence & Patient Care • Advocacy & Government Relations
Educational & Training Partners	• Nursing and allied health educational institutions partnered with HGMH • Medical residency and student placement programs	• Education & Training Opportunities
Fundraising & Philanthropic Partners	• HGMH Foundation Board of Directors & Staff	• Strategic Direction & Accountability • Philanthropy & Fundraising
Public & Media	• Local and regional media outlets • Posting on the HGMH public website and social media channels • Community members via newsletters and public engagement events	• Strategic Direction & Accountability • Clinical Excellence & Patient Care • Workforce Engagement & Recognition • Community Impact & Partnerships • Philanthropy & Fundraising • Advocacy & Government Relations • Public Awareness & Media Relations

This stakeholder distribution list will be reviewed annually by the Governance Committee to ensure accuracy, completeness, and alignment with Accreditation Canada requirements.

Planning Communication

With each communication, the following questions should be considered:

- Why is this important to communicate? **(What is the purpose?)**
- With whom do we want to communicate? **(Who are the stakeholders?)**
- What do we want to communicate? **(What is the message?)**
- How do we want to communicate it and through which medium? **(What communication tools are to be used?)**
- What is the timeline of communications / presentations? **(Define when and who plans, prepares, and presents)**
- What needs to be developed? **(Develop material, ads, news articles, etc.)**

The answers to these questions will establish the Communications Action Plan (51-A-293) to communicate successfully with the intended audience. This action plan will focus on the messaging, making it possible to target the stakeholders accurately, providing structure to define who HGMH needs to reach and the medium. This process will make communication more efficient, effective, and long lasting. More importantly, flexibility is key in planning and being prepared to adapt messaging to ensure success.

Guiding Principles

The hospital's approach to communication and engagement is grounded in several core principles:

- **Transparency:** Communicate timely, accurate, and honest information.
- **Accessibility:** Ensure all communication meets accessibility standards and is available in both English and French, in accordance with the hospital's designation under the French Language Services Act (FLSA).
- **Cultural Sensitivity and Inclusion:** Reflect and respect the diversity of the communities we serve.
- **Engagement:** Foster meaningful, two-way communication with staff, patients, families, and community members.
- **Alignment:** Support the hospital's strategic goals, values, and vision.

Goals and Objectives

The overarching goal is to enhance hospital experiences and community trust through clear, consistent, and culturally respectful communication.

Objectives:

- Maintain public trust through proactive messaging.
- Keep staff informed and engaged.
- Promote hospital programs and achievements.
- Respond quickly and effectively in crisis or urgent situations.
- Foster meaningful staff participation in internal initiatives.
- Improve patient and family experiences by promoting two-way dialogue.
- Strengthen community partnerships through inclusive outreach and collaboration.

Key Messages

HGMH aligns its key messages with the four strategic priorities from its strategic plan:

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

Communication Tools

HGMH uses several methods to communicate, including:

- Patient and Family Advisory Committee meetings
- Website – www.hgmh.on.ca
- Social Media (Facebook, Instagram, LinkedIn, YouTube)
- Advertising (media releases, news stories, other publications)
- Community engagement / events
- Staff Forums
- Glentranet (Hospital Intranet)
- Town Hall Meetings
- Internal communications:
    - Bi-Weekly Blitz newsletter
    - Weekly Clinical Update newsletter
    - ~~Monthly~~ Quarterly Physician newsletter

Corporate Publications

Annual Report

Following the Annual General Meeting, the hospital's annual report / update to the community is released electronically on the website and communicated via social media. The Annual Report includes a high-level overview of the hospital's achievements, financial performance, strategic initiatives, and community impact over the past year. Hard copies are available upon request.

Strategic Plan

The Hospital's Strategic Plan serves as a guiding framework for a five-year period, outlining the hospital's long-term vision, mission and values as well as the strategic priorities, and commitments to patients, families, staff, and the community. It reflects input from stakeholders across the organization and community and is aligned with regional and provincial healthcare strategies.

The Strategic Plan is published on the hospital's website and shared with staff, physicians, partners, and the broader community through multiple communications channels including newsletters, media releases, and social media. Updates on progress toward Strategic Plan goals are integrated into the Annual Report and Annual Operating Plan. This ensures transparency and accountability, while keeping stakeholders informed of achievements and ongoing priorities.

Hard copies of the Strategic Plan are available upon request to ensure accessibility for all members of the community.

Annual Operating Plan

The Annual Operating Plan is released in May and outlines the hospital's strategic goals and operational priorities for the coming year. It serves as a roadmap for service delivery, quality improvement, and resource allocation, and it supports alignment with regional and provincial healthcare directives.

Patient Handbook
Our Patient Handbook is published annually at no cost to HGMH due to the sponsors who advertise in the publication. Hard copies are available for pick-up in high traffic areas (lobbies and waiting rooms), and electronically on the hospital's website. All admitted patients receive a copy of the Patient Handbook on admission as it outlines important information about patients' rights and responsibilities, hospital policies, services available, and what to expect during their stay.

Program / Service Brochures and Posters
HGMH develops various brochures and posters on an as needed basis to promote programs, services, or provide patient and family education.

Digital Media
Corporate Website
HGMH's website is used to outline programs and service offerings, sharing news updates, and to provide the community with feedback opportunities. The website is maintained by the Communications Officer and continues to evolve with new and improved content as needed.

Newsletters
Internal newsletters are produced and distributed to staff by email and on the intranet to ensure current information is disseminated on a regular basis. The Weekly Clinical Update includes up-to-the-minute information from the clinical managers, highlighting reminders about workflow changes, policy updates, upcoming education opportunities, etc. The Bi-Weekly Blitz is a general newsletter for all staff, which provides updates on internal wellness activities, community events, news from various departments, etc. The monthly physician newsletter is geared towards physicians and includes physician meeting dates, important departmental information, highlights around workflow changes, and policy updates.

Glentranet (intranet site)
The Glentranet site is the go-to place for staff and physicians to find information including memos, reports, hospital committee information, policies and forms, etc., as well as newsletters.

Social Media
Rapid information delivery on a 24/7 news cycle has moved us beyond traditional media to a vastly expanding social media reality. Guided by an internal social media policy, HGMH creates and maintains our presence on Facebook, LinkedIn, and YouTube. Pages are regularly updated with timely content, photographs, and videos related to hospital activities, services, disruptions, provincially recognized health topics, and wellness content.

Visual media has proven an excellent support to ensure the broadest possible reach to our stakeholders, including photographs, infographics, and videos.

Media Relations
We recognize that timely and accurate media attention can support recruitment and retention, employee and community engagement, and fundraising and funding.

HGMH aims to communicate with media in a proactive rather than a reactive manner via designated spokespersons as per the Communications & Hospital Spokesperson policy (BOD.05.018). Planned media briefings occur during times of significant announcements to ensure local media has timely and accurate information available to report to the community.

CEO Communications

CEO communications with stakeholders is an important component to the HGMH communications plan which is designed to provide opportunities to increase stakeholder engagement.

Communication initiatives will allow for both two-way and one-way communication, centered around an approach to ensure CEO communications are a*ccessible, timely, relevant, and meaningful*. The following communication strategies will be used:

Communication Tactic	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
~~Twice~~ Quarterly ~~Annual Virtual~~ Town Hall – (and as needed)	✓		✓	✓			✓			✓		
CEO Vlog (video blog)		✓			✓			✓			✓	
Round Table with Rob	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Regular Rounding on Units	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Bi-Weekly Blitz CEO Corner		✓		✓		✓		✓		✓		✓
Bi-Weekly Blitz Board of Directors Updates	✓		✓		✓		✓		✓		✓	
Annual Community Engagement Session							✓					
Twice Annual Meeting with Political Leaders	✓						✓					
SLT Patient Rounding	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Annual Report			✓									
Annual Operating Plan		✓										

Public Disclosure

Purpose

HGMH is committed to maintaining transparency, accountability, and trust through proactive public disclosure of information that is of interest and relevance to our patients, families, staff, partners, and community. Public disclosure is a cornerstone of good governance and demonstrates the hospital's commitment to engaging stakeholders in meaningful ways.

Scope of Disclosure

Public disclosure includes, but is not limited to, the following areas:

- Quality and Safety Indicators: Regular posting of quality improvement metrics and patient safety indicators in alignment with provincial reporting requirements.
- Financial Information: Annual audited financial statements and operating plan updates, made available to the public following approval by the Board of Directors.
- Executive Compensation: Disclosure of executive compensation in compliance with the Public Sector Salary Disclosure Act.
- Board Governance: Posting of Board meeting highlights, annual reports, bylaws, and strategic priorities.

- Accreditation and Compliance: Publicly sharing results of Accreditation Canada surveys and compliance with relevant healthcare legislation and standards.
- Policies of Public Interest: Ensuring public access to key hospital policies, such as accessibility, privacy, and French Language Services policies.

Channels of Disclosure

Public disclosure will be carried out through the following methods:

- Corporate website (www.hgmh.on.ca) as the primary platform for publicly available documents and updates.
- Annual Report and Annual Operating Plan, distributed electronically and in print upon request.
- Media releases and social media updates for timely, high-profile announcements.
- Community engagement sessions, which provide opportunities for open dialogue and questions regarding disclosed information.

Guiding Principles

- Transparency: Disclose timely, accurate, and honest information to stakeholders.
- Accessibility: Ensure all disclosure materials are available in both English and French and meet Accessibility for Ontarians with Disabilities Act (AODA) standards.
- Clarity: Use plain language to ensure information is understandable to a broad audience.
- Accountability: Align disclosures with legislation, accreditation requirements, and best practices in healthcare governance.
- Engagement: Provide opportunities for community members, patients, and families to participate in governance-related discussions.

Communication in Non-Official or Minority Languages

HGMH recognizes that the community may speak languages beyond English and French. To ensure clear and accurate communications with patients, a professional interpretation services provider which offers interpretation services in all languages including American Sign Language (ASL). This service is offered in accordance with the hospital's Interpretation Service Request policy (COR.03.001.X.XX).

Crisis Communication Protocol

Purpose

To ensure that during any crisis, HGMH provides timely, accurate, clear, and bilingual information to all audiences, using coordinated communication strategies that maintain trust and reduce misinformation.

Definition of a Crisis

A crisis, for the purposes of this plan, is any event or situation that significantly disrupts the hospital's normal operations, poses a risk to safety, or threatens the hospital's reputation. Crises can originate internally or externally and may include:

- Large-scale medical emergencies, such as mass casualty incidents or disease outbreaks.
- Facility issues, including fires, floods, or power outages.
- Medical errors or adverse events that draw public or media attention.
- Security threats, including active shooter situations or bomb threats.
- Cybersecurity breaches or loss of critical patient data.
- Labour actions or significant staff shortages.
- Natural disasters impacting hospital operations.

Objectives

- Maintain consistent, transparent communication during a crisis.
- Provide timely updates to internal and external audiences.
- Ensure communications are accessible, culturally sensitive, and bilingual.
- Fulfill requirements regarding system capacity, backup methods, reunification communications, community preparedness education, partner coordination, staff notification, and language accessibility.

Activation

The crisis communication protocol is initiated when a situation arises that has potential to significantly impact patient safety, staff operations, public perception, or media attention, and where rapid communication is necessary.

Roles in Communication

- **CEO:** Primary spokesperson (or delegate) for official public statements as per the Communications & Hospital Spokesperson policy (BOD.05.018.X.XX).
- **Communications Officer:** Coordinates all communication activities, drafts and distributes updates, manages website, media relations and social media as per the Social Media policy (COR.08.005.X.XX).
- **Managers**: Share approved messages with teams and gather feedback/questions for follow-up.
- **Administration On-Call**: Acts as the 24-hour contact point for the organization, ensuring stakeholder inquiries during emergencies are addressed or escalated to the appropriate lead as per the Administration On-Call policy (COR.01.005.X.XX).

Key Communication Actions

1. **Initial Holding Statement:** Release a brief, factual, and empathetic message acknowledging the situation and advising when further updates will follow.
2. **Audience Identification:** Determine priority audiences (staff, patients/families, media, community partners, public).

3. **Channel Selection:** Choose the most effective mix of channels (email, intranet, website banner, social media, media release).
4. **Update Frequency:** Commit to regular updates, even if the information is unchanged, to reinforce transparency.
5. **Message Consistency:** Ensure all public-facing channels deliver the same core messages.
6. **Compliance with Legislation and Standards:** All communications will comply with applicable laws, regulations, and quality standards, including:
    a) Accessibility Requirements: Ensure content is accessible in accordance with the Accessibility for Ontarians with Disabilities Act (AODA) and other relevant accessibility standards.
    b) Privacy laws: Protect personal and health information in compliance with applicable privacy legislation.
    c) French Language Services Requirements: Provide communications in both English and French, meeting obligations under the French Language Services Act (FLSA).
7. **Monitoring**: Track social media, media coverage, and public feedback to identify and correct misinformation quickly.

Media Management

During a crisis, all media inquiries will be directed to the Communications Officer, who will then report to the President & CEO as per the Communications & Hospital Spokesperson policy (BOD.05.018). This ensures that the hospital speaks with one consistent voice and prevents misinformation from circulating. Press conferences will be held at designated safe locations, and media representatives will be informed of regular update times to avoid constant interruptions to hospital operations.

Social media will be monitored continuously for inaccurate or harmful information, and corrective statements will be issued promptly when needed, always in both English and French.

Staff and Physician Communication

In a crisis, HGMH will ensure that all staff and physicians, including those who are off duty, are kept informed as per the Automated Fanout Communication System policy (COR.02.019.X.XX).

- Automated Alerts: The system will send notifications via phone, text, and email to all staff in the database.
- Message Content: Updates will be concise, factual, and will specify whether staff are required to report to work, remain on standby, or take other action.
- Two-Way Capability: Where possible, the system will allow staff to confirm receipt or provide status updates back to the hospital.
- Redundancy: If the automated system fails, alternate channels such as phone trees, secure messaging apps, or public radio announcements will be used.

System Overload & Backup Communication

HGMH recognizes that communication systems may become overloaded during high-profile crises. To ensure continuity of communication, the hospital will:

- **Ensure Website Readiness:** The hospital's website will be prepared to handle increased traffic, with critical updates presented in simplified formats (minimal graphics/color) to reduce load time.
- **Provide FAQ Management:** A dedicated crisis FAQ page will be maintained to answer common questions and reduce phone/email inquiries.
- **Have a Website Downtime Plan:** If the website is unavailable, updates will be shared through:
    - Social media (Facebook, Instagram, LinkedIn)
    - Media briefings and releases
    - Recorded information on a dedicated public information phone line
- **Use Internal Communication Backup:** If internal email is unavailable, use the intranet (if functioning), secure messaging apps, or pre-printed memos for distribution in key staff areas.

Reunification Communication

HGMH will incorporate communication into its reunification strategy for families during emergencies or disasters. While the operational plan for reunification is covered in the Job Action Sheets under Family Information, the communications component will ensure:

- **Clear Instructions:** Families and friends seeking loved ones receive clear, bilingual directions on how to access reunification support.
- **Designated Updates:** A specific communication channel (e.g., website page, hotline, media briefings) will be used to share information on reunification procedures.
- **Partnership Messaging:** If reunification is coordinated with external organizations (e.g., local health partners, community agencies, emergency services), messaging will be consistent across all parties.
- **Privacy and Sensitivity:** Communications will protect personal health information while ensuring families receive the support and guidance they need.

Contact List for Key Emergency Communication Partners

To ensure seamless coordination during crises, the Communications Officer will maintain and annually update the Emergency Partner Contact List (51-F-62). This list will be accessible in the EOC bins, and will include:

- Emergency Medical Services (EMS): Direct communications line and public information officer contact.
- Fire Services: Dispatch and designated communication liaison.
- Police Services: Community safety and public affairs contact.
- Regional Health Authorities & Ontario Health East: Emergency coordination contact.
- Local Government (Mayor's Office, Council): Official spokesperson and media relations contact.
- Neighboring Hospitals & Health Partners: Communications leads for mutual support.
- Community Support Agencies: Partners in reunification, shelter, and mental health support.

The contact list will include 24/7 phone numbers, email addresses, and alternate methods (e.g., encrypted messaging platforms) to ensure redundancy.

Transition and Recovery Communication

As services transition back to normal after the crisis, the EOC will conduct a full debrief within two weeks. This review will assess what communications strategies worked well, what challenges arose, and what improvements can be made. The findings will be documented, and the Communications and Community Engagement Plan will be updated accordingly.

Community Engagement and Consultation Strategies

Engagement is embedded in every day interactions with staff, patients, and the broader community. Internally, the hospital promotes engagement through staff recognition events, employee feedback surveys, town halls, committee participation, and small group sessions (Round Table with Rob). These channels allow staff to voice ideas, raise concerns, and contribute to shaping the work environment.

Patient and family engagement is facilitated through the Patient and Family Advisory Committee, bilingual satisfaction surveys, patient rounding, and the use of accessible education and orientation materials. The hospital is committed to involving patients and families in the design and evaluation of care processes to enhance experience and outcomes.

Consultation is an integral component of community engagement at HGMH. The hospital actively seeks input from community members, local organizations, healthcare partners, and municipal representatives to guide planning, programs, and decision-making. Consultation may occur through surveys, focus groups, or public meetings, and ensures that the voices and perspectives of those we serve are reflected in hospital priorities and strategic initiatives. This collaborative approach supports transparency, strengthens trust, and ensures services remain responsive to community needs.

Annual Community Engagement Sessions take place to promote two-way dialogue with the communities we serve. These sessions create space for open discussion and feedback.

Evaluation of Communications and Community Engagement

We acknowledge that it is extremely difficult to measure the impact of communications activities on stakeholders' perceptions, attitudes, and behaviours, and even more difficult to measure the impact of communications on HGMH's strategic goals. HGMH can look to other, more subtle, indirect ways of measuring the success of its communications efforts, including:

- Number and tone of media articles, editorials, and letters to the editor
- Feedback through the website, phone calls, and at meetings / presentations
- Employee feedback and employee surveys
- Input from our Patient & Family Advisory Committee
- Website visitors and monitoring hits on the pages that people visit
- Feedback from all stakeholders as part of regular meetings with these groups.

Strategies and tactics will be modified over time in response to these results and as new challenges and opportunities arise.

Roles and Responsibilities

The Communications Officer leads the implementation of this plan, supported by the Senior Leadership Team. Department managers are responsible for cascading messages and encouraging team feedback, while all staff are encouraged to participate in engagement initiatives and provide input. The plan is reviewed annually in collaboration with key committees, including the IDEAA Committee and the Patient and Family Advisory Committee, to ensure alignment with the hospital's strategic direction and community needs.

CROSS-REFERENCED POLICIES:

Policy Number	Policy Name
BOD.05.018.X.XX	Communications & Hospital Spokesperson
COR.03.003.X.XX	Accessibility Multiple Formats
COR.08.005.X.XX	Social Media
BOD.01.002.X.XX	French Language Services
COR.02.019.X.XX	Automated Fanout Communications System

ASSOCIATED FORMS:

Form Number	Form Name
51-A-293-XX	Communications Action Plan
51-F-62	Emergency and Disaster Response Contacts

Personal Business Commitments (2026 - 2027)

Robert Alldred-Hughes, President & Chief Executive Officer

OCTOBER 2026 – Update on Progress

Introduction

The Ontario Government passed the Excellent Care For All Act (ECFAA) and Bill 16 in 2010 which required Hospital Boards to establish a pay for performance component of executive compensation and achieve targets tied to a Quality Improvement Plan.

My Personal Business Commitments are tied to Hôpital Glengarry Memorial Hospital's (HGMH) Quality Improvement Plan (QIP), the HGMH Strategic Plan, our Accreditation, directive from the Ontario Health and Ministry of Health and any impacting factors that have been identified through an environmental scan. These form the context that has shaped the 2026-2027 Personal Business Commitments. Clearly, health funding and its emphasis on cost efficiency and quality outcomes (value for money), the focus on clinical performance, the patient experience, patient and family centered care and the need for integration and partnerships are key drivers to positioning, not only HGMH, but the health system as a whole for continued high performance and success.

In order to ensure that expected levels of performance are clearly articulated and understood, measures have been aligned with three performance assessment categories – Quality, Financial and Strategic / Significant Initiatives as per HGMH's Executive Compensation Philosophy, Strategy and Policy. The performance assessment categories will be rated on the following scale:

Quality: 50% weighting
Financial: 30% weighting
Strategic: 20% weighting

Although selected commitments have been identified in this document for the performance pay component of executive compensation determination, it is important to note that an unrelenting focus will also be placed on other areas such as those identified in the QIP, the Patient Safety Plan, the Strategic Plan, Enterprise Risk Management and so forth.

Finally, my Personal Business Commitments serve as the framework and the priorities for all leaders within HGMH. Each senior leader is expected to develop their Personal Business Commitments to align with the Chief Executive Officer's, support the Strategic Plan, the Quality Improvement Plan as well as align with corporate metrics/balanced scorecard.

	Goal	2025/2026 Performance	2026/27 Target	Current Performance	Quality Improvement Plan	Strategic Plan	Accreditation	OH/ MOH
QUALITY	Reduce the time to inpatient bed from the Emergency Department by 50%.	8.4 hours	4.2 hours	April to August: 3.9 Hours	✓			✓
	Increase pateint-reported care ratings related to being treated with courtesy and respect from those patients who identify as gender diverse.	7.4/10	7.7/10	Q1: No Responses However 9.0/10 for Emergency Department Care	✓	✓	✓	✓
	Reduce the number of medication incidents reaching the patient and resulting in harm (severity levels 2-5) by 5%	25	24	Q1: 0	✓		✓	

FINANCIAL	Ensure financial stability by proactively engaging with Ontario Health and government stakeholders to secure funding, advocate for sustainable reimbursement models, and align resources with HGMH's strategic priorities to support high-quality, sustainable care.	*$35K Surplus*	On Budget	YTD results: $100K surplus		✓	✓	✓
	Increase endoscopy service days to expand procedural volumes and generate additional revenue.	-	Increase Revenue by $25,000 in year 1	Currently in planning and pre-implementation phase – project February for additional volume.		✓		✓

STRATEGIC	Lead coordinated advocacy efforts with the Ministry of Health and Ontario Health, including scheduled engagement meetings, formal follow-ups, and documentation updates, to position HGMH for progression to Stage 1.2 of the Hospital Capital Planning Process.	-	All requested documentation submitted within established timelines and advocacy meetings held as opportunities arise, with quarterly progress tracking reported to the Board.	Currently engaged in a resubmission of pre-capital. Continuous engagements with Ontario Health on planning for future healthcare services.		✓	✓	✓
	Establish project governance, finalize infrastructure requirements, and initiate operational and clinical readiness planning for CT implementation.	-	Project governance structure established, infrastructure requirements confirmed, and a documented CT readiness plan approved	Currently project governance is in place, and planned contract finalization in progress. September 16th MOH approved HGMH to continue to construction. Comprehensive CT implementation plan in place.		✓		
	Advance comprehensive Non-violent crisis intervention training across patient-facing teams to enhance de-escalation capability and reduce workplace violence risk.		30 staff members receive NVCI training	As of September 21, 2026: 26 Employees received NVCI training.		✓	✓	✓
	Achieve successful EPIC EMR go live by executing required clinical, operational, and technical readiness activities across the organization.	-	EPIC EMR Launched on time and on budget	As of September 30: Go live is still on target, and overall project under budget.		✓		✓

Personal Business Commitments (2026 - 2027)

Dr. Lisa MacKinnon, Chief of Staff

Introduction

The Ontario Government passed the Excellent Care For All Act (ECFAA) and Bill 16 in 2010 which required Hospital Boards to establish a pay for performance component of executive compensation and achieve targets tied to a Quality Improvement Plan.

My Personal Business Commitments are tied to Hôpital Glengarry Memorial Hospital's (HGMH) Quality Improvement Plan (QIP), the HGMG Board Strategic Plan, our Accreditation, directive from the Ontario Health and Ministry of Health and any impacting factors that have been identified through an environmental scan. These form the context that has shaped the 2023-2024 Personal Business Commitments. Clearly, health funding and its emphasis on cost efficiency and quality outcomes (value for money), the focus on clinical performance, the patient experience, patient and family centered care and the need for integration and partnerships are key drivers to positioning, not only HGMH, but the health system as a whole for continued high performance and success.

In order to ensure that expected levels of performance are clearly articulated and understood, measures have been aligned with three performance assessment categories (PAC) – Quality, Financial and Strategic / Significant Initiatives as per HGMH's Executive Compensation Philosophy, Strategy and Policy. The performance assessment categories will be rated on the following scale:

Quality: 50% weighting
Financial: 30% weighting
Strategic: 20% weighting

Although selected commitments have been identified in this document for the performance pay component of executive compensation determination, it is important to note that an unrelenting focus will also be placed on other areas such as those identified in the QIP, the Patient Safety Plan, the Strategic Plan, Enterprise Risk Management and so forth.

	Goal	2025/2026 Performance	2026/27 Target	Current Performance	Quality Improvement Plan	Strategic Plan	Accreditation	OH/ MOH
QUALITY	Reduce the time to inpatient bed from the Emergency Department by 50%.	8.4 hours	4.2 hours	On-going current YTD= 3.91 hours	✓			✓
	ED P4R Action & Goal - Access and Flow - Timely transitions – Reduce the 90th percentile ED wait time to Physician Initial Assessment.	4.3 hours	3.2 hours	On-going current YTD= 3.27 hours		✓		
FINANCIAL	Increase endoscopy service days to expand procedural volumes and generate additional revenue.	-	Increase Revenue by $25,000 in year 1	On-going		✓		✓
STRATEGIC	Advance comprehensive non-violent crisis intervention training across patient - facing teams to enhance de-escalation capability and reduce workplace violence risk	-	8 trained physician staff members	On-going Current YTD= 0		✓	✓	✓
	Create a comprehensive physician recruitment strategy		Completed by Q4	Initiated and progressing toward Q4 completion.		✓	✓	

REPORT OF THE GOVERNANCE AND NOMINATING COMMITTEE

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

Present:	L. Boyling	G. McDonald (v)	C. Larocque
	K. McTaggart	R. Alldred-Hughes, CEO	
Regrets:	M. Nichols		

Summary of Discussion

Approval of the Agenda

The agenda was reviewed.

Moved By: L. Boyling
Seconded By: K. McTaggart
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 June 3, 2026, were shared.

Moved By: L. Boyling
Seconded By: G. McDonald
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.

Matters for Discussion/Decision

Review Governance & Nominating Committee Effectiveness Survey Results

The committee effectiveness survey results were reviewed.

The Committee reviewed the self-assessment results, which reflected strong overall effectiveness, and discussed suggestions for improvement. Committee-specific orientation was identified as a gap. As this concern arose only within this Committee, no changes will be implemented at this time. Emerging orientation needs will be captured throughout the cycle. Succession planning will be discussed in March as part of the Board Succession Plan review.

Review Committee Terms of Reference

The committee terms of reference were reviewed.

Moved By: L. Boyling
Seconded By: K. McTaggart
THAT the Governance and Nominating Committee recommend to the Board of Directors the committee terms of reference as amended.

Revisions to the Finance, HR and Audit Committee's terms clarified that the Hospital has no internal auditor position but has a process to arrange an internal audit if required and updated the VP and CFO title.

It was agreed to remove "performance" under item f) of the responsibilities from the Governance and Nominating Committee's terms, as this responsibility rests with the Executive Committee.

No changes were proposed to the Quality and Patient Safety Committee's terms following the committee's review.

CARRIED

Q1 Strategic Actions
The strategic actions for Q1 were reviewed.

Moved By: K. McTaggart
Seconded By: G. McDonald
THAT the Governance and Nominating Committee recommend to the Board of Directors receipt of the Q1 2026-2027 strategic actions report

Progress was noted across all four strategic priorities, with no actions identified as at risk during the quarter. It was acknowledged that the report reflects Q1 only and that additional work has since been completed. Management continues to monitor progress and organizational capacity while advancing Epic, CT planning, and other strategic commitments.

CARRIED

Communications and Community Engagement Plan Review
The Communications and Community Engagement Plan was reviewed.

Moved By: K. McTaggart
Seconded By: G. McDonald
THAT the Governance and Nominating Committee review and receive the Communications and Community Engagement Plan as presented.

Discussion ensued around the challenges of evaluating communication effectiveness, to which it was noted that social media engagement is monitored as one measure of reach and interaction.

CARRIED

Policy Review
Two policies were reviewed; Senior Management Language Skills (BOD.02.002) and Developing, Reviewing, and Revising Board Policies (BOD.05.001).

Moved By: L. Boyling
Seconded By: K. McTaggart
THAT the Governance and Nominating Committee recommend to the Board of Directors the approval of the Senior Management Language Skills policy and the Developing, Reviewing, and Revising Board Policies policy as presented.

There were no proposed amendments to either policy. Discussion clarified that French-language proficiency is assessed through self-assessment and conversations with the CFO. Written French is not tested, as the Hospital's operating language and clinical charting are

done in English.

CARRIED

Inclusion, Diversity, Equity & Anti-Racism Update
The Committee reviewed progress on Inclusion, Diversity, Equity and Anti-Racism.

Moved By: L. Boyling
Seconded By: K. McTaggart
THAT the Governance & Nominating Committee approve the transition of oversight of HGMH's Inclusion, Diversity, Equity and Anti Racism Framework to the Finance, HR and Audit Committee, with formal reporting on progress against the Framework occurring at least twice annually.

Oversight, previously shared between Governance and Finance, HR and Audit, will transition to the Finance, HR and Audit Committee, where the CHRO participates and provides updates. Formal reporting on progress will occur at least twice annually.

CARRIED

Next meeting: November 12, 2026

K-L Massia, Recorder

DRAFT

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: September 30, 2026 Meeting Date Prepared for: October 8, 2026 – Governance
October 22, 2026 - Board

Subject: Annual Review of Committee Terms of Reference

Prepared by: Robert Alldred-Hughes, President & CEO

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

PURPOSE

- To review the Terms of Reference as recommended by the Board Committees and make recommendation to the Board of Directors.

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.

Governance and Nominating Committee:

- The existing Governance and Nominating Committee Terms of Reference continue to accurately reflect the role, responsibilities, and membership of the Governance and Nominating Committee. They provide clear guidelines on the committee's governance and nominating functions, ensuring that all essential duties are covered.
- At the committee meeting, it was agreed to remove the word *Performance* from Executive Management as that is the responsibility of the Executive Committee.
- It was also agreed to remove monitoring of IDEA initiatives as this is reported at the Finance, HR, and Audit Committee meetings. Those terms of reference were updated accordingly as well.

Finance, HR, and Audit Committee:

- The Terms of Reference were reviewed by the Finance, HR, and Audit committee with a minor change to make it clear that there is no internal auditor position at the hospital.
- The title of the VP & CFO was also updated.

Quality & Patient Safety Committee:

- The existing Quality & Patient Safety Committee Terms of Reference continue to accurately reflect the role, responsibilities, and membership of the committee. There were no suggested changes from the committee.

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Governance and Nominating Committee Terms of Reference
- Finance, HR and Audit Committee Terms of Reference
- Quality & Patient Safety Terms of Reference

TERMS OF REFERENCE OF THE GOVERNANCE & NOMINATING COMMITTEE

ROLE:	• To advise the Board on matters relating to the Board's governance structure and processes, evaluation of the Board's effectiveness, recruitment, education, and evaluation of Board members. • To advise the Board on the selection and recruitment, of the CEO and COS.
RESPONSIBIILITIES:	a) Board Recruitment • Develop for approval by the board a description of the skills, experience and qualities including diversity of the directors and ensure French-speaking representation as per bylaw 4(3)(e); • Consider skills, experience, qualities, and diversity of current directors to determine the Board's needs; and, • Oversee the Board's recruitment and nomination process and recommend to the Board candidates for election at the Annual Meeting. b) Board Education • Ensure a comprehensive orientation session is provided to all new Board members; • Oversee Board education sessions to ensure Board members receive periodic education on governance, health care issues and the hospital operations; and, • Organize with the input of the CEO and Board Chair, the Boards retreats. c) Board Chair • Ensure succession planning for the office of Board • Oversee and complement the Board's process for selecting a Board Chair and recommend an individual for election by the Board as Chair; and, • Make recommendations to the Board for Vice Chair and Treasurer. d) Board Committees • Ensure periodic review and evaluation of committee performance and Terms of Reference and make recommendations for the Board as required; and, • Recommend to the Board, with the input of the Chair, nominees for all Board Committees and Committee Chairs. e) Evaluations • Establish and implement a program to evaluate Board performance including individual director performance, performance of the Chair, Board Committees and Committee Chairs; • Consider the results of Board evaluations in connection with renewal of the terms of existing directors; and, • Review and make recommendations to the Board on the Board composition, size, structure, board policies and procedures, by-law amendments and board attendance.

TERMS OF REFERENCE OF THE GOVERNANCE & NOMINATING COMMITTEE

	f) Executive Management ~~Performance~~ • Developing and appraising the CEO and COS job descriptions; • Undertaking CEO and COS recruitment processes and selection of the CEO and COS or delegating to subcommittee; • Ensuring succession planning is in place for the CEO, COS. g) Inclusion, Diversity, Equity & Anti-Racism (IDEA) • Ensure the hospital's strategic plan incorporates IDEA principles. • Review and recommend policies that promote IDEA within the organization, and holding leadership accountable for implementing and maintain these standards across the hospital. ~~• Regular monitor progress on IDEA initiatives and key performance measures.~~ •
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:	• Chair of the Board; • At least four Directors appointed by the Board (minimum one bilingual Director in English and French); • Chief Executive Officer as an *ex officio* member.
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 6 times per year, at the call of the chair
QUORUM:	• 51% of voting members.
RESOURCES:	• Chief Executive Officer • Guests, by invitation
REPORTS TO	• Board of Directors
DATE OF LAST REVIEW	• October ~~2025~~2026

Approved by: Corporation of l'Hôpital Glengarry Memorial Hospital

TERMS OF REFERENCE
FINANCE, HUMAN RESOURCES, AND AUDIT COMMITTEE OF THE BOARD

ROLE:	• Responsible on behalf of the board of directors (the "**Board**") for oversight of financial matters and the annual external audit. • To provide oversight over the planning of construction, renovation and maintenance of infrastructure and associated equipment. • Assist the Board in fulfilling its obligations relating to human resources and compensation matters.
RESPONSIBIILITIES:	***Budget Planning and Oversight*** • Ensure that there are processes in place for the development of an annual operating budget and capital budget. • Review and recommend to the board financial assumptions used to develop operating budget, capital budget and strategic plan. • Review and recommend to the board the annual operating plan and budget, and the capital plan and budget; • Review on a routine basis financial performance and compare actual performance against budget including year-end projections. • Review and recommend to the Board plans developed by management to address variances between budget and actual performance. • Oversee implementation of plans to address variances and report to the Board. ***Long-Term Planning*** • Oversee and assess achievement of the financial aspects of the strategic plan. • Review and recommend to the Board multi-year financial goals and long-term revenue and expense projections. • Review, with management, industry developments and legislative changes that may have an impact on financial resources or performance and report to the Board. ***Asset Management*** • Ensure there are processes in place to manage the assets of the Corporation. • Review and make recommendations on material asset acquisitions not contemplated in the annual capital plan.

Financial Transactions

- Review and make recommendations to the Board on banking arrangements.
- Review and make recommendations to the Board on lines of credit and long-term debt.

Donations and Bequests

- Advise the Board on major gifts that involve donor recognition agreements and related policies.
-

Investments

- Review and recommend to the Board the Corporation's investment policy.
- Oversee investment performance for compliance with the investment policy.

Internal Controls, Risk Management~~, and Oversight of Internal Audit~~

- Oversee, review, and make recommendations to the Board on management's risk management processes.
- Review and make recommendations on the adequacy of financial resources.
- Review and make recommendations on insurance coverage.
- Obtain reasonable assurance from management that the Corporation's financial accounting systems and financial reporting systems, including fraud prevention and risk management, are appropriately designed and that internal controls are operating effectively.
- Identify unusual risks and oversee management's plan to address unusual or unanticipated risks and make recommendations to the Board.
- Review and make recommendations on the quality and integrity of management's internal controls, ~~including scope of work of the internal auditor and~~ overseeing management's response and resulting action plans to address issues or deficiencies identified by ~~internal auditor~~any internal audit as required.

External Audit

- Recommend to the Board the external auditor for appointment or re-appointment by the members at the annual members' meeting.
- Annually review and make recommendations to the Board on the external auditor's remuneration.

- Meet with the external auditor to review the proposed scope of audit.
- Review, approve, and authorize management to execute the external auditor's engagement letter.
- Oversee performance of the external audit as required, including ensuring the external auditor is receiving the assistance of management.
- Review audited financial statements and the external auditor's report and make recommendations to the Board.
- Meet with the external auditor and receive and review recommendations with respect to management, accounting systems, and internal control issues.
- At least annually, the elected director committee members shall meet with the external auditor without management present.
- Review non-audit services provided by the external auditor and other factors that might compromise the external auditor's independence and make recommendations to ensure independence.
- Review management's response to internal control recommendations of the external auditor and oversee implementation of internal control recommendations.

Human Resources

- Review, together with the chief executive officer and chief of staff, existing staff and physician management resources and plans, including recruitment and learning programs.
- Participate in the creation of the Corporation's strategic plan and provide input from a human resources perspective.
- Review on an annual basis the Corporation's human resources plan to ensure alignment with the strategic plan for the organization.
- Receive and review on a periodic basis a report on the human resources' performance indicators.
- Regular monitor progress on IDEA initiatives and key performance measures.

Building and Property

- Make recommendations to the board for the purchase of equipment, property, renovations to existing building or construction of new buildings.
- Make such recommendations in conjunction with the annual capital budget with exceptions for emergency

	purchases. ***Compliance with Applicable Law*** • Oversee compliance with accounting and financial, legal, public disclosure, and regulatory requirements. • Approve material changes to accounting principles and practices as suggested by management with the concurrence of the external auditor. ***Other*** • Perform such other duties as may be requested by the Board from time to time.
CHAIR:	• Treasurer of the Board
MEMBERSHIP:	• The Treasurer • The Board Chair, or their designate • The Chief Executive Officer, ex officio • The VP of ~~Support~~ Corporate Services and Chief Financial Officer, ex officio • A minimum of three elected Directors of the Board (minimum one bilingual Director in English and French) • Invited guests may attend committee meetings at the invitation of the Chair • In accordance with the Ontario *Not-for-Profit Corporation Act*, 2010, the committee shall be comprised exclusively of directors of the Corporation, and the majority of committee members must not be officers or employees of the Corporation or any of its affiliates[1]
MEETING PARTICIPATIONG	• Notice of the time and place of committee meetings shall be given to the external auditor.[2] The external auditor shall be entitled to attend committee meetings and to be heard, and shall attend every committee meeting if requested to do so by a committee member.[3] • The Vice President of Support Services and Chief Financial Officer of the Corporation, *ex officio*, shall be invited to attend and participate in these meetings as a guest, but shall not have a vote. • The Chief Human Resources Officer, *ex officio*, shall be

[1] ONCA, s. 80(1), provides that a corporation may have an audit committee comprising one or more directors and the majority of the committee must not be officers or employees of the corporation or of any of its affiliates.

[2] ONCA, s. 80(2) provides that the corporation shall give the auditor notice of the time and place of any meeting of the audit committee. The auditor is entitled to attend the meeting at the expense of the corporation and be heard, and shall attend every meeting of the committee if requested to do so by one of its members.

[3] ONCA, s. 80(2).

	invited to attend and participate in these meetings as a guest, but shall not have a vote.
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. Meetings may also be held at the call of the external auditor or a committee member.[4]
QUORUM:	• 51% of voting members.
RESOURCES:	• VP of Support Services and Chief Financial Officer
REPORTS TO	• Board of Directors
DATE OF LAST REVIEW	• ~~September 2025~~September 2026

[4] ONCA, s. 80(3) provides that the auditor or a member of the audit committee may call a meeting of the committee.

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

Date Prepared: September 30, 2026 Meeting Date Prepared for: October 8, 2026 – Governance October 22, 2026

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.

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:

Senior Management Language Skills Policy

- No amendments recommended

Developing, Reviewing, and Revising Board Policies

- No amendments recommended

IMPLEMENTATION & COMMUNICATION PLAN

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

- Obtain Board Approval – October 22, 2026
- Update Board Policy Online
- Include any applicable updates in Board Orientation Material

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Senior Management Language Skills Policy
- Developing, Reviewing, and Revising Board Policies Policy

Document Name:	Senior Management Language Skills	
Document Number:	BOD.02.002.0.~~23~~26	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Leadership	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The Hospital will ensure that at least one (1) of the members of the senior management team has a “superior” level of linguistic proficiency in French and English.

PROCEDURE:

1. In the event the Chief Executive Officer (C.E.O) is deemed to have limited French linguistic skills, the Board delegates the C.E.O. the responsibility to ensure one of the other senior positions is filled with a candidate with “superior” bilingual (French and English) language skills.

Document Name:	Developing, Reviewing and Revising Board Policies	
Document Number:	BOD.05.001.0.~~23~~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:

All Board policies are developed, approved, and reviewed through the process outlined in this document.

PROCEDURE:

Policy Development

1. New Board Policies shall be developed by the most appropriate Board Committee to address an identified need (e.g., change to applicable law, standardization, direction, etc.) and approved by the Board.

Policy Review

2. Board policies shall be reviewed one year after implementation and at least every three years thereafter. It is the responsibility of the President & Chief Executive Officer to ensure that Board policies are reviewed in a timely manner. Board policies requiring review shall be brought forward to the Governance Committee with recommendation to the Board. Board policies shall be reviewed for relevance, and to ensure compliance with applicable laws, the Corporation's Articles and By-laws, and governance best practice. Board Committee Terms of Reference must be approved annually by the Board.

Governance Review

3. The Board shall undertake a comprehensive review of its governance policies, practices, and structures every five years, or more frequently, if considered appropriate by the Board to ensure that they are contemporary and consistent with the needs of the Corporation.

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: September 30, 2026 Meeting Date Prepared for: October 8, 2026 – Governance
October 22, 2026 - Board

Subject: IDEA – Transition to Governance Oversite

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 update on HGMH's IDEA Framework and recommend an ongoing approach to Board oversight.

Over the past several years, HGMH has moved from establishing its IDEA commitments and foundational activities to embedding IDEA within the organization's policies, practices, patient care and governance. Management is recommending that oversight of the IDEA Framework now become part of the Board of Directors' regular governance responsibilities, with formal reporting to the Board at least twice annually.

IMPLICATIONS TO OTHER STANDING COMMITTEES

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

- Finance, Human Resources and Audit

SITUATION & BACKGROUND

A brief description of the background to the issue.

- In Fall 2023, the Board of Directors approved a recommendation that the Governance Committee take a proactive role in leading, coordinating and monitoring IDEA related activities at HGMH. This included oversight of Accreditation Canada requirements and supporting a culture of inclusion, diversity, equity and anti racism throughout the organization.
- Since that time, considerable work has been completed to establish the foundations for this work. HGMH developed its IDEA Framework in 2024 to provide greater structure and focus to the organization's efforts and has continued to advance actions under the Framework.
- The Board has also become increasingly involved in this work. Board members have participated in IDEA and Indigenous Cultural Safety education, supported IDEA related hospital and community activities, introduced voluntary equity based demographic information into the Board recruitment process, and overseen the development and adoption of HGMH's Land Acknowledgment.
- At the organizational level, IDEA considerations are increasingly being incorporated into regular operations. This includes patient experience monitoring, staff education, policy review, psychological safety, employment equity work and development of an IDEA lens for organizational decision making.
- Should the Governance Committee agree with the recommendation, a decision as to weather the oversite responsibilities will be overseen by the Finance, Human Resources, and Audit Committee or the Governance Committee of the Board of Directors. Please consider this question in advance of the meeting.

OPTIONS CONSIDERED & ANALYSIS

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

- As this work has matured, there is an opportunity to transition IDEA from a developing initiative overseen primarily through the Governance Committee to an established area of Board oversight.
- This approach is consistent with Accreditation Canada's governance standards, which establish specific responsibilities for the governing body related to systemic racism, Indigenous specific systemic racism, cultural safety and humility, organizational policies, education and monitoring of organizational action plans.
- Management recommends that the Board receive an update on the IDEA Framework at least twice annually. Reporting would provide the Board with an opportunity to:

✓ Review progress against the IDEA Framework and associated action plans
✓ Monitor key measures and organizational activities
✓ Consider patient, staff and community perspectives where available
✓ Ensure continued alignment with Accreditation Canada governance requirements
✓ Identify opportunities for continued Board education and governance action
✓ This would embed IDEA within the Board's regular oversight responsibilities while allowing management and the IDEA Committee to continue leading the operational work associated with the Framework.

REPORT OF THE MEETING OF THE FRENCH LANGUAGE SERVICES COMMITTEE

October 8, 2026 at 3:30PM in the Boardroom / MS Teams

Present: C. Larocque, F. Desjardins, R. Cardinal, L. Ramsay, R. Alldred-Hughes, CEO

Regrets: None

Summary of Discussion of the meeting

1.0 Approval of Agenda

Agenda: The agenda was reviewed and the addition of item 3.2 CPSSF Strategic Planning Session was recommended.

Moved By: F. Desjardins
Seconded By: R. Cardinal
THAT the agenda be approved as amended.

CARRIED

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

2.0 Minutes

Approval of Previous Meeting's Minutes: The report of the meeting of June 3, 2026, was reviewed.

Moved By: R. Cardinal
Seconded By: F. Desjardins
THAT the report of the meeting of June 3, 2026, be approved as presented.

CARRIED

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

3.0 Matters for Information

3.1 Summary of the Annual French Language report to the Ministry
The submitted report was reviewed and it was acknowledged that we meet the requirements for designation in all categories based on the total number of employees.

3.2 CPSSF Strategic Planning Session
A new organization was created in 2025 with the mandate to improve services for francophones. A report will come from this organization and will be shared at the next committee meeting in June.

4.0 Date of Next Meeting

Next meeting: June 3, 2027

K-L. Massia, Recorder

DRAFT