HANOVER & DISTRICT HOSPITAL

Operational Plan

Reviewed 2026-27

Operational Plan Overview

Annual Strategic Initiatives

- Equity, Diversity and Inclusion Strategy & Implementation Plan
- Quality Improvement Plan
- Operating Budget/Capital Planning
- Risk Management Plan
- Patient Safety Plan
- Human Resources Plan
- Engagement & Communications Plan
- Infection Prevention and Control Plan
- Accessibility Plan
- Conservation & Demand Management Plan

Executive Summary: Hanover & District Hospital Operational Plan

The Hanover and District Hospital (HDH) Operational Plan serves as a dynamic roadmap guiding the organization in achieving its Strategic Goals and Objectives while upholding its Mission, Vision and Values of "*Partnering for Excellence in Rural Health Care"*. This plan aligns closely with the hospital's Strategic Plan and underscores its commitment to *Providing Exceptional Care* to the communities it serves.

Strategic Initiatives:

The Operational Plan supports HDH in achieving four key strategic drivers:

1. **Caring for our Patients:**
   Delivering safe, effective, and equitable patient care that is responsive to the diverse needs of our region. HDH remains committed to continuously improving the quality of care and ensuring that patients receive compassionate services close to home.
2. **Valuing our People & Teams:**
   Supporting and empowering our healthcare professionals by fostering a culture of well-being, equity, diversity and inclusion. HDH prioritizes professional growth and teamwork to build a resilient healthcare workforce.
3. **Innovating for a Sustainable Future:**
   Advancing innovative practices and leveraging technology to enhance healthcare services while ensuring financial sustainability. HDH will continue to seek new approaches that optimize resource utilization and improve operational efficiency**.**
4. **Anticipating and Responding**
   Strengthening partnerships and community engagement to foster collaboration, inclusivity, and adaptability. HDH will proactively address emerging healthcare needs and trends, ensuring we remain a trusted partner in the regional health system.

Annual Review and Collaboration:

The plan will be reviewed annually under the leadership of the President & CEO and the Senior Leadership group. Collaborating with managers, frontline staff, patient and family advisors and physicians, the team will identify strategic priorities, opportunities for improvement, and areas of focus for the year. These will be formalized into the annual Strategic Goals, Objectives, and Quality Improvement Plan Initiatives, with final approval from the Board of Directors.

Key Objectives:

The Operational Plan is designed to:

- Promote quality patient care using performance metrics and innovation.
- Deliver patient care that is evidence-based, accessible, and culturally responsive.
- Enhance patient satisfaction, safety, and program delivery.
- Develop and sustain inclusive partnerships that address health disparities and reflect the region's diversity.
- Consistently deliver outcomes that meet the diverse needs of the community.
- Maintain a healthy, equitable, and skilled workforce.

- Uphold fiscal responsibility while ensuring equitable access to care.

Through this framework, the Operational Plan ensures HDH remains a leader in rural health care excellence, prioritizing quality, equity, and community engagement.

Land Acknowledgment:
We recognize that Hanover & District Hospital provides care on the traditional, ancestral and unceded lands of the Anishinabewaki and is home to Chippewas of Nawash Unceded First Nation and Saugeen First Nation within Grey and Bruce County.

Commitment to Indigenous Sovereignty, Truth and Reconciliation:
Hanover & District Hospital recognizes and respects Indigenous sovereignty in Canada as recognized and affirmed in Section 35 of Constitution Act, 1982, and is committed to truth and reconciliation with Indigenous Peoples, HDH will recognize and respect Indigenous Peoples' right to self-governance and ways of knowing.

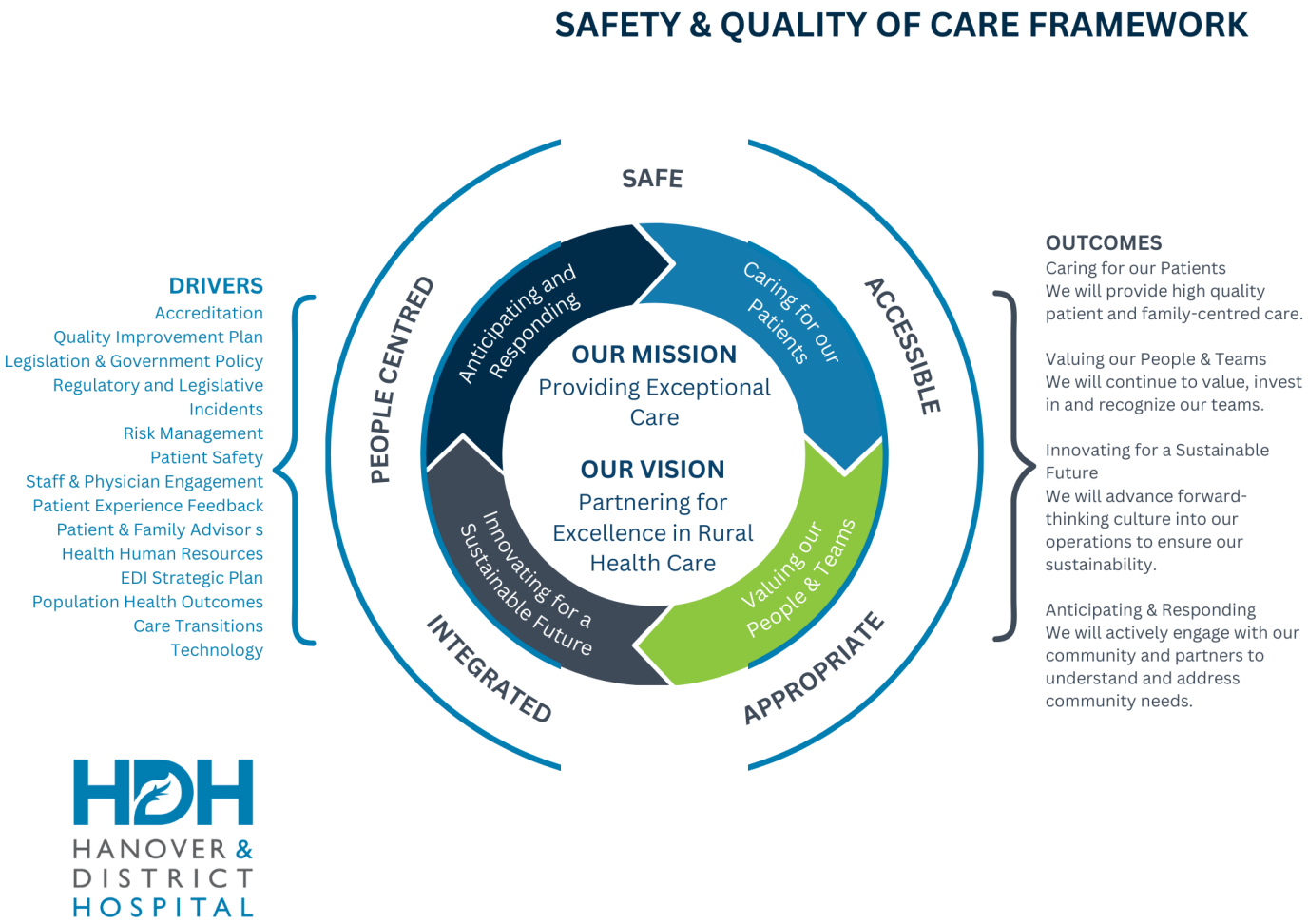
Our approach will be informed by collaborating with Indigenous Leaders to increase Indigenous cultural safety within Hanover and District Hospital. HDH will reflect and respond to the needs of the Indigenous communities we serve including Chippewas of Nawash Unceded First Nation and Saugeen First Nations, as well as urban Indigenous Peoples. We will also seek to respond to the distinct needs of both on-territory and urban-residing Indigenous Peoples. Our plan for Indigenous truth and reconciliation will intersect with and be in addition to the objectives outlined in our Equity, Diversity and Inclusion (EDI) Strategy.

We are committed to hearing, understanding and responding to the concerns of Indigenous Peoples in order to co-create a new path forward that is grounded in respect, reconciliation and partnership.

Safety & Quality of Care Framework
The Safety & Quality of Care Framework will serve as a compass for Hanover & District Hospital, ensuring all operational initiatives align with its strategic vision and mission of exceptional care. This framework will drive decision-making, resource allocation, and performance measurement across departments, guided by the principles of people-centred care, safe care, accessible care, appropriate care and continuous improvement. (Refer to Board Policy # 208 – Safety and Quality of Care Plan)

HDH will embed these principles into daily operations by aligning departmental goals, integrating data-driven decision-making, and prioritizing continuous improvement. The framework will guide investments in staffing, technology, and infrastructure while ensuring compliance with accreditation and regulatory standards. (Refer to Administrative Policy # 1-102 – Safety and Quality of Care Framework)

By fully integrating this framework, HDH will strengthen its commitment to safe, high-quality, and patient-centred care, reinforcing its role as a leader in rural healthcare.



HDH
HANOVER & DISTRICT HOSPITAL

Specific Components

The following components of the plan are as follows:

Equity, Diversity and Inclusion (EDI) Strategy and Implementation Plan:

The EDI Strategy and Implementation Plan serves as a guiding framework to foster an inclusive, equitable, and culturally responsive environment. It supports the organization's Mission, Vision, and Values by embedding EDI principles into all aspects of care delivery, workforce development, and community engagement. The plan focuses on providing equitable access to safe and effective patient care, strengthening partnerships that reflect and serve the diverse needs of the region, and ensuring financial sustainability through inclusive practices. Collaboratively developed and reviewed annually, the EDI Plan prioritizes fostering a healthy, diverse workforce and addressing systemic barriers to equity. By

integrating EDI into its strategic priorities, HDH is committed to creating a healthcare environment where all individuals feel valued, respected, and empowered to thrive.

Quality Improvement Plan (QIP)

A Quality Improvement Plan (QIP) is a formal, documented set of quality commitments aligned with system and provincial priorities that a health care organization makes to its patients/clients/residents, staff and community to improve quality through focused targets and actions. Annually, HDH staff, physicians, patient and family advisors, and Board of Directors in concert with our strategic plan and the priority indicators as identified by Health Quality Ontario, develop a comprehensive QIP that supports staff and patients.

Operating Budget and Capital Planning

The budgeting process is integral to ensuring the financial sustainability of the hospital, delivering safe and patient-centred care within the available resources. The operating budget is developed annually in collaboration with managers, patient and family advisors and physicians, to align with and support our strategic initiatives. The operating budget is presented to the Finance/Audit and Property Committee of the Board of Directors for approval, and the process is managed through the Hospital Annual Planning Submission (HAPS) and the Hospital Service Accountability Agreement (HSAA). The hospital's Vice President of Finance & Operations is responsible for the ongoing monitoring and implementation of the operating budget, with the support of the hospital's leadership and management team. Financial results are reported monthly to Senior Leadership, and the Finance/Audit and Property Committee of the Board of Directors. Financial results are reported quarterly to the Ministry of Health, as required by the HSAA.

The capital budget is developed annually in collaboration with managers, patient and family advisors and physicians and presented to the Finance/Audit and Property Committee who make a recommendation to the Board of Directors for approval. Resource allocation is determined based on the priorities identified in the HDH Strategic Plan. The hospital's Vice President of Finance & Operations is responsible for the ongoing monitoring and implementation of the capital plan with the support of the hospital's management team.

The annual operating and capital budgets are also presented to the hospital's Fiscal Advisory Committee, as required by the Public Hospitals Act.

Risk Management Plan

The Risk Management Plan is a primary tool for implementing the organization's overall risk management strategies. It is designed to provide guidance and structure for the hospital's clinical and administrative services that drive quality patient care while fostering a safe environment for staff and patients.

This risk management plan is reviewed annually by the Patient Safety and Risk Management Committee and is presented to the Quality Governance and Risk Management Committee of the Board of Directors for approval. The hospital's Risk Manager is responsible for the ongoing monitoring and implementation of the plan with the support of the hospital's leadership and management group.

Patient Safety Plan

The Patient Safety Plan outlines a comprehensive approach that ensures that quality and safety driven initiatives are in place to support patients. Further, the Patient Safety Plan supports initiatives of the QIP. It is a living plan that is continuously being modified to reduce patient safety breeches.

While ensuring the safe care of patients is everyone's responsibility, the Risk Manager in collaboration with the Patient Safety and Risk Management Committee will lead the Patient Safety Plan with support from the Senior Leadership and management groups. The Patient Safety Plan is reviewed annually.

Human Resources Plan

The Human Resources Plan is a vital component to support and advance the HDH Strategic Plan. The Human Resources Plan provides important framework and guides the organization' recruitment and retention activities. This plan outlines the needs of the organization to enable proactive planning to ensure the hospital attracts, develops and nurtures our workforce, and is able to respond to the changing landscape.

The Manager of Human Resources and Physician Recruitment is responsible for the ongoing monitoring and implementation of the Human Resources Plan, with support from the hospital's leadership and management group. This plan is reviewed annually.

Engagement and Communications Plan

The Engagement and Communication Plan for Internal and External Stakeholders is an essential element in upholding the hospital's Strategic Plan from year to year. Effective communication with not only our internal team members, but also our external stakeholders and the patients that we serve is paramount in our delivery of safe and effective care. The plan speaks to the Patient Engagement Framework that promotes and supports active patient engagement. Conveying the information of our organization, the programs and services, challenges encountered and the accomplishments to our staff, physicians, our Board of Directors, our Patient and Family Advisory Committee, Auxiliary, Foundation and community is vital to ensuring confidence in our organization.

Infection Prevention and Control Plan

The Infection Prevention and Control (IPAC) Plan is paramount in ensuring the health and safety of patients, physicians, staff, and volunteers. Under the direction of the Infection Control Manager, the infection control program fosters a culture of accountability, education, and continuous improvement. The plan is reviewed annually by the Infection Control Manager and IPAC Committee.

Accessibility Plan

The Accessibility Plan is a commitment to upholding the standards outlined in the province's *Accessibility of Ontarians with Disabilities Act, 2005.* The plan describes the measures taken in the past and plans for the future to identify, remove and prevent barriers for staff, patients, family members, health care practitioners, volunteers and members of the community.

The Accessibility Plan is reviewed and updated annually by the Health Equity Committee and provided annually to the Board of Directors.

Conservation & Demand Management Plan

The Conservation and Demand Management (CDM) Plan outlines Hanover & District Hospital's commitment to energy efficiency and environmental stewardship. Under the direction of the Senior Team, the plan integrates conservation considerations into infrastructure renewal, strategic policies, and operational practices. Progress is tracked through regular reporting to ensure advancement toward energy reduction goals.

Annual Deliverables

ACTION ITEM	WHAT	WHO	WHEN
Committees *(Patient Safety, Professional Practice/ Product Evaluation, Ethics, Occupational Health & Safety, Patient & Family Advisory Committee, Health Equity, Code Team, Wellness & Mental Health)*	• Quality Metrics • Quality Initiatives & Projects	• Committee Chair • Committee Members • VP Patient Care Services/CNE	• Monthly to quarterly or as needed
Departmental Goals & Quality Initiatives	• Quality Metrics	• PCMs • VP Patient Care Services/CNE • VP Operations & Finance	• Quarterly
Data Utilization	• Population, program, disease specific data	• Manager of Health Records & Privacy Officer – reports to Medical Advisory Committee	• Quarterly or as needed
Environmental Scan & Service Delivery	• Health Equity, Mental Health & Addictions, Diversity, Ambulatory Clinics	• VP Patient Care Services/CNE • Manager of Health Records, Registration & Privacy Officer • Leadership • Board of Directors	• Quarterly/Annually or as needed
Finance & Operational Planning	• H-SAA metrics (current ratio, gross margin) • Budget variances	• VP of Finance & Operations • Leadership	• Monthly
Human Resources Plan	• Global Workforce Survey Results • Turnover • Absenteeism	• Manager, Human Resources	• Quarterly or as needed
Patient Satisfaction	• Satisfaction survey results • Patient Complaints	• VP of Patient Care Services/CNE	• Monthly/Quarterly
Partnerships	• Internal and external partnerships	• Leadership	• Ongoing

Appendices:

Appendix A: Equity, Diversity and Inclusion (EDI) Strategy & Implementation Plan
Appendix B: Quality Improvement Plan
Appendix C: Annual Strategic Plan Quality Goals & Objectives
Appendix D: Quality Goals & Objectives
Appendix E: Risk Management Plan
Appendix F: Patient Safety Plan
Appendix G: Quality of Care: Patient Quality Safety Metrics
Appendix H: Human Resources Plan
Appendix I: Engagement & Communications Plan for Internal & External Stakeholders
Appendix J: Infection Prevention & Control Plan
Appendix K: Accessibility Plan
Appendix L: Conservation and Demand Management Plan

HANOVER & DISTRICT HOSPITAL

Equity, Diversity and Inclusion (EDI) Strategy and Implementation Plan

2025-2030

Revised February 2026

Equity, Diversity and Inclusion (EDI) Strategy and Implementation Plan

At Hanover & District Hospital, we are deeply committed to fostering an environment where equity, diversity, and inclusion (EDI) are fundamental to everything we do. Our comprehensive EDI Strategy, developed through extensive consultations with staff and physicians between October 2024 and January 2025, reflects our unwavering dedication to embedding these principles across all aspects of our operations. Under the leadership of our President & CEO and Vice Presidents, and guided by our Health Equity Committee, we strive to create a healthcare environment that celebrates diversity, promotes equity, and ensures inclusion for all our patients, staff, and community members. This strategy represents not just a plan, but our collective promise to drive meaningful change through measurable actions, clear accountability, and continuous evaluation. As we move forward, every member of our hospital community plays a vital role in bringing this vision to life, ensuring that EDI becomes intrinsic to our organizational culture and healthcare delivery.

A More Equitable, Diverse and Inclusive Hospital

Equity, Diversity and Inclusion (EDI) are critical concepts that hospitals must consider when delivering health care services.

Equity means that all people can participate or engage equally based on a fair distribution of opportunities and resources regardless of who they are and where they come from.

Diversity refers to the fact that people come from different backgrounds and experiences, including, but not limited to age ability, gender, identity, language, ethnicity, religion, socioeconomic status, experiences related to use and more.

Inclusion refers to the extent to which people feel included, welcomed, valued and respected. An inclusive culture is on that embraces diversity in all of its forms.

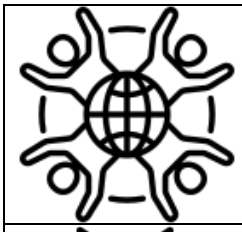
The goal of this EDI Strategy is to enhance delivery of equitable and culturally safe health care services, regardless of the dimensions of diversity of the people served by the hospital. It will allow us to live up to our mission of providing exceptional care and address inequities that disproportionally affect equity-seeking populations.[1]

The EDI Strategy and Implementation Plan for HDH will serve as the foundation for many hospital initiatives aimed at creating an environment where all people feel welcomed, safe and respected. The EDI Strategy complements initiatives including those relating to Indigenous Health[2], fostering respectful environments[3], and building capacity.

[1] Groups of individuals or communities that have been historically marginalized, underrepresented or discriminated against in health care settings.
[2] 2024 Indigenous Cultural Safety Plan
[3] 2024 Code of Conduct

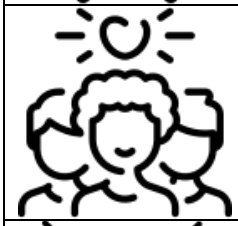
Strategy Pillars and Action Zones

The Strategy aims to help HDH meet our goals of providing equitable health service delivery for all community members and actively address systemic barriers and biases. Implementation of the Strategy will help HDH create inclusive diverse health care environments that foster trust, respect and understanding. To move towards achieving these goals, the Strategy is designed around four pillars and associated action zones. These four Strategy pillars and related Action Zones are outlined below.



Inclusive HDH

1.1 Implement anti-discrimination practices
1.2 Incorporate inclusive design in our environments
1.3 Promote diversity and inclusion



Enhancing EDI Learning Culture

2.1 Mandate EDI education
2.2 Support meaningful engagement with diverse communities
2.3 Establish tools to foster culturally sensitive communication

Equitable Care

3.1 Advance targeted actions for equity-seeking populations
3.2 Optimize use of Language Service Programs
3.3 Improve access to care

Incorporating EDI into Hospital Systems

4.1 Collect EDI data to inform decision-making
4.2 Ensure a diverse workforce
4.3 Promote open and honest communication around EDI

The Implementation Plan outlines prioritized initiatives to implement under each Action Zone, key steps to ensure that reflection and adaptation occur as lessons are learned, and circumstances change in our communities and environments.

The Strategy represents a significant step forward in our ongoing journey to create a more diverse, equitable and inclusive health care system. To be truly responsive to community needs, we recognize that the work is ongoing and that continued collaboration with our staff, physicians, patients and community partners is required to ensure that we meet the needs of those who serve and are served by Hanover & District Hospital.

Core Commitments

HDH has in place five (5) overarching core commitments that describe what we should live up to, and what those served by us can expect to experience. The commitments are reflected in HDH's policies, procedures and other actions, including this Strategy, to address discrimination and inequity. These commitments are:

1. **Respect for Indigenous Peoples**
   At HDH, we will specifically focus on the rights of all Indigenous Peoples – First Nations, Métis and Inuit – to ensure cultural safety and practice cultural humility. See HDH's Indigenous Cultural Safety Plan (Appendix B) which includes Indigenous Cultural Safety Principles and guides three areas for implementation to transform the culture of care delivery and improve health outcomes for Indigenous People. These three areas include; 1) Inclusion of Indigenous knowledge and expertise in health care, 2) Welcoming and land acknowledgment of traditional territory, and 3) Right to traditional medicines.

2. **Equal Respect, Anti-Discrimination, and Health Equity for All**
   At HDH, we are dedicated to treating everyone with equal respect, fostering a discrimination-free environment, and advancing health equity for all. We stand against all forms of bias and are committed to providing compassionate, inclusive care to every patient, ensuring that everyone has access to the highest quality healthcare, regardless of their background.

3. **Understanding, Compassion and Collaboration**
   At HDH, we seek understanding of diverse perspectives, show compassion by valuing each individual's unique experiences, and foster collaboration to build an inclusive, equitable environment. We will establish a shared approach to seek to understand the complex questions we face together.

4. **Health and Well-Being for All**
   At HDH we will protect and support the mental, physical, spiritual, and emotional health and well-being of those we serve and those providing services within, or on behalf of the hospital.

5. **Accountability, Growth and Excellence**
   At HDH, we will take responsibility for living up to these commitments. We will continuously improve the environment within the organization.

STRATEGY PILLAR ONE:
Inclusive Hanover & District Hospital

CREATING EQUITABLE AND INCLUSIVE SURROUNDINGS WHERE EVERYONE FEELS RESPECTED, HEARD AND VALUED.

Hanover & District Hospital is dedicated to implementing anti-discrimination actions into our practices, incorporating inclusive designs in our collective environments, and promoting diversity. These steps will help ensure that all individuals, including those that serve at or are served by HDH, regardless of their diverse backgrounds, experiences and abilities, have access to save and inclusive environments, services and programs at HDH.

ACTION ZONES:

1.1 Implement anti-discrimination practices
Implementing anti-discrimination practices including building on existing workplace policies and an anti-discrimination policy, is crucial in promoting inclusivity and respect for all individuals. An anti-discrimination policy communicates a strong message to staff, physicians and patients that any form of discrimination is unacceptable. It ensures that everyone will be treated with dignity and respect. It outlines expectations for all members of the hospital, establishes procedures to address discrimination incidents and defines consequences for policy violations.

1.2 Incorporate inclusive design in our environments
Hanover & District Hospital is committed to incorporating inclusive and equitable design into their environment. This is applied to both new and existing spaces, as well as virtual environments, ensuring accessibility and fostering an inclusive culture throughout the hospital. HDH recognizes the importance of considering the linguistic, accessibility and cultural requirements of the diverse communities we serve.

1.3 Promote diversity and inclusion
Hanover & District Hospital recognizes the importance of promoting and respecting diversity and committing to cultivating welcoming and inclusive environments. We will incorporate meaningful ways to acknowledge and recognize diverse communities, fostering a sense of belonging and creating inclusive environments for both staff and individuals served by the hospital. This includes meaningfully acknowledging and recognizing diverse communities and creating spaces for individuals to participate in what is important to them.

STRATEGY PILLAR TWO:
Enhancing EDI Learning Culture

CREATING A SUPPORTIVE LEARNING CULTURE THAT ENABLES VALUE-BASED DECISION-MAKING AND WELCOMES DIFFERENCES.

Hanover & District Hospital is dedicated to building capacity to support our strong commitment to equity, diversity and inclusion. We will continue to invest in learning opportunities for staff, through professional and resources development, ensuring that each employee possesses the necessary knowledge, skills and qualities to serve diverse communities with integrity and compassion. We also recognize the importance of community engagement and will develop resources to enhance our abilities in this area, valuing the voices of the communities we serve.

ACTION ZONES:

2.1 Mandate EDI education
Hanover & District Hospital recognizes the importance of developing EDI knowledge among staff. This knowledge provides the necessary skills to integrate EDI principles into daily work. HDH leadership are responsible for addressing learning needs and providing opportunities for staff to build knowledge. We are dedicated to the ongoing development of EDI learning opportunities and resources.

2.2 Support meaningful engagement with diverse communities
Hanover & District Hospital recognizes the importance of developing community engagement resources to effectively involve the diverse communities that we serve. Through continued and meaningful engagement, these resources will help in building and nurturing relationships of trust and respect with individuals, organizations and communities from various backgrounds. This approach will identify systemic barriers, address inequities, and improve the effectiveness and impact of service delivery.

2.3 Establish tools to foster culturally sensitive communication
Communication plays a crucial role in creating an environment where everyone feels safe, valued and respected. Culturally sensitive communication ensures that language is inclusive, uses plain language principles and is accessible for diverse individuals and communities through multiple mediums and languages. It includes messaging and materials that align with HDH's commitment to EDI and prevents unintended harm. Resources will be developed to raise awareness about the significance of safer and inclusive language and culturally relevant materials. Education will be offered to support the implementation of safer language, fostering a culture of respect and inclusivity.

STRATEGY PILLAR THREE:
Equitable Care

DELIVER EQUITABLE CARE THAT IS ACCESSIBLE, CULTURALLY SAFE AND RESPONSIVE TO THE DIVERSE COMMUNITIES WE SERVE.

Hanover & District Hospital is committed to providing equitable and accessible care that is culturally safe and responsive to the diverse communities we serve. We acknowledge the existence of health inequities and aim to address them through tailored actions supporting equity-seeking groups, and collaborating and co-creating solutions with community and client partners. We will use evidence-informed and innovated approaches, strive to overcome barriers to care and deliver programs and services that cater to the unique needs of diverse communities.

ACTION ZONES:

3.1 Advance targeted actions for equity-seeking populations
Hanover & District Hospital recognizes that there are continued challenges faced by communities that have been historically excluded due to systemic inequities. To address these inequities and provide more equitable health care, HDH implements targeted interventions for specific populations that consider broader determinants of health. These interventions include community outreach programs, health promotion campaigns and collaborations with community organizations. New and existing programs will identify the needs of equity-seeking groups and tailor their programs accordingly. Ongoing monitoring, evaluation and adjustments will be conducted to improve health outcomes over time. The goal is to ensure that everyone regardless of background or circumstances, can access quality health care services.

3.2 Optimize the use of Language Services Programs

Language barriers pose significant challenges for limited English proficient, Deaf, Deaf-blind and Hard of Hearing patients, leading to misunderstandings, miscommunication and negative health outcomes. Language services programs aim to meet the communication needs of individuals regardless of their linguistic backgrounds, enabling full participation in their care. We will continue to grow this service by increasing ease of access and use of translation and interpretation services, and improving the experiences of people receiving these services. Staff and physicians will receive additional training on accessing and effectively utilizing translation and interpretation services.

3.3 Improve access to care

We are committed to improving access to care by using data-driven and evidence-based approaches to better support vulnerable populations in our community. Our efforts will be guided by patient and staff feedback, ensuring that services are responsive, equitable, and focused on delivering the best possible outcomes. By continuously reviewing and renewing protocols, we will enhance the quality and availability of care while addressing emerging needs.

STRATEGY PILLAR FOUR:
Incorporating EDI into Hospital Systems

INCORPORATE EQUITY, DIVERSITY AND INCLUSION PRINCIPLES IN POLICIES, PROGRAMS AND SERVICE DELIVERY ACROSS ORGANIZATIONAL STRUCTURES AND SYSTEMS.

Hanover & District Hospital will integrate an EDI lens into our policies, programs and service delivery. By implementing data collection to monitor and evaluate our progress, taking steps towards ensuring workforce diversity, and strengthening communication practices around EDI, we are committed to being accountable to our pursuit of providing the highest quality healthcare services. We are also committed to addressing institutional, structural and systemic barriers through actions that further embed EDI into our hospital systems.

ACTION ZONES:

4.1 Collect EDI data to inform decision-making

Hanover & District Hospital recognizes the importance of collecting data to inform decisions and resource allocations. By capturing disaggregated EDI specific data in a safe and respectful and purposeful manner, the data can inform the development of new and existing evidence-based programs, policies and service deliver, and facilitate ongoing monitoring and evaluation to measure our progress. Developing protocols and educating those serving at HDH on the appropriate and meaningful collection of EDI related data is a vital step in capturing EDI data.

4.2 Ensure a diverse workforce

Hanover & District Hospital recognizes the benefits of workforce diversity. We will ensure a diverse workforce by collecting workforce diversity data to identify potential barriers and guide the development of targeted initiatives to address any gaps. We will conduct a review of current hiring practices to identify barriers to equity and inclusivity in the hiring process.

4.3 Promote open and honest communication around EDI

Hanover & District Hospital recognizes the importance of clear and effective communication in fostering an inclusive culture. We will create safe spaces for discussion to hear about the work and experiences of those working at HDH, and expand on opportunities for communication with leadership. By prioritizing open and honest communication among those working at HDH, we will build trust, promote collaboration and establish a strong reputation as a hospital that values and meets the needs of the communities we serve.

Our Implementation Approach

The implementation plan (Appendix A) illustrates the priorities to enable implementation each Action Zone of the EDI Strategy. To ensure the Strategy remains adaptive while adhering to established directions for the future, implementation will be gradual and intentional. This will encourage an environment of continual learning, adaptations and improvement. Simultaneously, this approach provides the necessary flexibility for implementation to reflect changing priorities and conditions within the hospital and unexpected challenges and opportunities outside of it.

Implementation will include four distinct steps: **ACT, REPORT, ASSESS and ADJUST**.

1. **ACT**
   Through key initiatives listed in the implementation plan and developing opportunities. Hanover & District Hospital will build on existing momentum, learn from implementation and adjust as needed.

2. **REPORT**
   Deliver annual progress report to ensure transparency and accountability. These reports will provide updates on progress on each of the Strategy Pillars and Action Zones.

3. **ASSESS**
   For each of the Strategy Pillars and Action Zones, assessments will occur on an annual basis. This includes reviewing shared efforts and identifying difficult challenges that remain unresolved as well as available and emerging resources. It will also address outcomes from previous year's assessments. This will ensure challenges can be mitigated, opportunities may be enacted upon and progress may continue.

4. **ADJUST**
   Hanover & District Hospital has a diverse portfolio of responsibilities which are subject to many outside influences. As part of a successful EDI strategy, the ability to remain open to new challenges and emerging opportunities is important.

We're on a Path of Continuous Learning, Improvement and Impact

This Strategy and Implementation Plan represents an important milestone, but we know there is always more that can be done to address systemic issues, ensuring that every patient receives the care they deserve, and create an environment where employees feel like they belong, are heard and respected. As we begin to implement this EDI Strategy and Implementation Plan for Hanover & District Hospital, it is important to remember that the work is never truly done. It is up to all of us at HDH to continuously learn and improve, bringing a spirit of humility to our work. Think of the patients and families whose

lives will be positively impacted by the changes we can implement together. Creating a hospital that truly works for everyone.

What Success Looks Like

The objectives and deliverables outlined in our 2025-2030 EDI Plan are things we believe must be addressed first in order to position HDH for future progress. We will know we have been successful when:

- Care at HDH is more patient-centered, culturally informed, equitable and accessible for all patients and families.
- Our workforce and leadership reflect the diverse communities we serve.
- Sustainable EDI infrastructure exists across HDH, and we have even stronger, more authentic partnerships with our community
- Equity-deserving patients have better health outcomes and health inequities are reduced.

This is the future we are working towards – one that brings to life our Mission of *Providing Exceptional Care*, and Vision of *Partnering for Excellence in Rural Health Care*

Appendix A: EDI Implementation Plan
Appendix B: Indigenous Cultural Safety Plan

HANOVER & DISTRICT HOSPITAL

EDI Implementation Plan 2025-2030

STRATEGY PILLAR ONE: **Inclusive Hanover & District Hospital**		
1.1 Implement anti-discrimination practices		
INITIATIVES:	**Progress**	**Stop Light**
1.1.1 Implement anti-discrimination policy with clear set of commitments and a culturally safe process for resolving discrimination complaints in a timely manner.	Year 1	
1.1.2 Explore inclusive benefit options (Substituting another day for a Statutory Holiday).	Year 1	
1.1.3 Evaluate the current EDI plan (2025-2030) and prepare a new EDI plan	Year 5	
1.1.4 Include an EDI lens into procurement processes and ensure vendors are aligned with Hanover & District values and commitments to EDI and Reconciliation.	Year 3/4	
1.1.5 Update performance evaluation template to include EDI accountabilities for Leadership and frontline staff.	Year 3/4	
1.1.6 Develop and implement decision making matrix for innovation projects that prioritize EDI.	Year 4/5	
1.2 Incorporate inclusive design in our environments		
INITIATIVES:	**Progress**	**Stop Light**
1.2.1 Establish a regular review of the Accessibility Plan as per AODA requirements.	Year 1-5	
1.2.2 Annually assess built environments and virtual spaces and develop plans to improve spaces for patients and staff.	Year 1-5	
1.2.3 Incorporating Inclusive signage in our waiting rooms and common areas to create a more welcoming environment	Year 1	
1.2.4 Incorporate our Land Acknowledgement in our front lobby	Year 1	
1.3 Promote diversity and inclusion		
INITIATIVES:	**Progress**	**Stop Light**
1.3.1 Promote the diversity of Hanover and District Hospital's region by sharing statistics show casing the region's diversity.	Year 5	
1.3.2 Create an EDI awards program to recognize individuals, programs, and services that have gone above and beyond advancing EDI and Reconciliation.	Year 5	
1.3.3 Adopt a diversity calendar to raise awareness of days of significance for diverse communities and create safe spaces for interested groups to celebrate them.	Year 1-5	

1.3.4 Review HDH's strategic plan, mission, vision and values to ensure the organization's commitment to EDI and its EDI Plan is well represented.	Year 1	
1.3.5 Create a method for patients, families and staff can provide feedback on our EDI plan, or their lived experience	Year 1-2	
1.3.6 Ensure the annual Quality Improvement Plan (QIP) includes equity dimensions and improvements to reduce harm for equity deserving communities.	Year 1-5	
STRATEGY PILLAR TWO: Enhancing EDI Learning Culture		
2.1 Mandate EDI education		
INITIATIVES:	**Progress**	**Stop Light**
2.1.1 Provide ongoing EDI capacity building opportunities using various modalities and learning options.	Year 1-5	
2.1.2 Develop a broad regional EDI curriculum and implement plan for all staff and physicians, Board of Directors, volunteers and PFAC including Culturally Safe Indigenous training.	Year 1	
2.1.3 Encourage participation on the Health Equity Committee at discuss EDI initiatives at huddles.	Year 1-5	
2.1.4 Achieve 75% initial EDI training completion rate for staff and board	Year 1-5	
2.1.5 Achieve 100% initial EDI training for Executive Leadership Team	Year 1-5	
2.2.5 Present learnings back to Health Equity Committee from community leaders (e.g. Mennonite, Indigenous).	Year 1-5	
2.2 Support meaningful engagement with diverse communities		
INITIATIVES:	**Progress**	**Stop Light**
2.2.1 Build strategic partnerships with community partners, and build capacity to engage with the diverse communities we serve.	Year 1-5	
2.2.2 Support meaningful engagements with equity-seeking populations by including representatives of diverse groups within patients and family advisory committees.	Year 1-5	
2.2.3 Engage community leaders, healthcare organizations and academic institutions in meaningful conversations on EDI issues including research opportunities.	Year 1-5	
2.2.4 Incorporate EDI in HDH Engagement and Communications Plan and Social Media Calendar.	Year 1	
2.2.5 Create opportunities for Indigenous Elders to teach and share knowledge at HDH.	Year 1-5	
2.3 Establish tools to foster culturally sensitive communication		
INITIATIVES:	**Progress**	**Stop Light**
2.3.1 Develop and adopt a communications guide, including an inclusive and culturally responsive language guide plain language tools and translated patient education materials.	Year 3	
2.3.2 Audit and revise corporate policies to align with culturally sensitive language and minimize unintended harms.	Year 3-5	

2.3.3 Include regular EDI updates in hospital communication tools.	Year 1	
STRATEGY PILLAR THREE: Equitable Care		
3.1 Advance targeted actions for equity-seeking populations		
INITIATIVES:	**Progress**	**Stop Light**
3.1.1 Embed EDI and Indigenous Cultural Safety in the policies and decisions support tools process and assess for quality improvement on an ongoing basis.	Year 2-5	
3.1.2 Implement a health equity checklist considering the social determinants of health when planning or developing new or existing programs/services.	Year 3-5	
3.1.3 Explore the enhancement of diverse food services offerings in alignment with patient centered care considering patient length of stay and logistics.	Year 3-4	
3.1.4 Add EDI question to the patient satisfaction surveys to determine any trends of dissatisfaction of cultural needs being met	Year 1	
3.1.5 Collect patient EDI data utilizing the patient registration kiosk and posters.	Year 3-5	
3.2 Optimize use of Language Service Programs		
INITIATIVES:	**Progress**	**Stop Light**
3.2.1 Optimize offerings of Language Services for all clinical settings by leveraging technology and innovations.	Year 3	
3.2.2 Enhance access to language and interpretation services for limited English proficient, Deaf, Hard of Hearing and Deaf-Blind patients and families.	Year 3	
3.2.3 Track how often language service are being accessed to determine if proper resources are available.	Year 2	
3.2.4 Explore website translation and accessibility options.	Year 3	
3.2.5 Translation of patient consent forms and other required information for patients.	Year 4	
3.3 Improve access to care for inequitable groups visiting the hospital		
INITIATIVES:	**Progress**	**Stop Light**
3.3.1 Age Friendly Recognition from the town of Hanover	Year 2	
3.3.2 Wayfinding project	Year 3	
STRATEGY PILLAR FOUR: Incorporating EDI into Hospital Systems		
4.1 Collect EDI data to inform decision-making		
INITIATIVES:	**Progress**	**Stop Light**
4.1.1 Create a patient-centered and culturally safe process to collect disaggregated EDI data to improve patient and family experience and health outcomes.	Year 2	
4.1.1 (a) Provide training to registration staff to ensure they are comfortable to collect EDI data from patients.	Year 1-2	

4.1.2 Transparently show data, progress and impact related to EDI efforts and invite community feedback and collaboration.	Year 4	
4.1.3 Collect data on workforce diversity to improve representation of equity-seeking staff and physicians at all levels of the hospital.	Year 1	
4.1.4 Create dashboards for leaders to evaluate and improve health equity indicators.	Year 5	

4.2 Ensure a diverse workforce

INITIATIVES:	**Progress**	**Stop Light**
4.2.1 Conduct a review of current hiring practices (e.g. recruitment, on-boarding, compensation, promotion, retention) to identify barriers to equity and inclusivity in hiring.	Year 2	
4.2.2 Expand representation of equity-deserving groups on patient and family advisory committees, volunteers and Board of Directors.	Year 3	
4.2.3 Partner with Project Search to provide training and potential employment opportunities for individuals with physical and intellectual disabilities	Year 1	

4.3 Promote open and honest communication around EDI

INITIATIVES:	**Progress**	**Stop Light**
4.3.1 Support inclusive employee affinity groups that are open to anyone to join.	Year 1-5	
4.3.2 Establish an EDI Committee with accountability to senior executive team.	Year 1	

References:

1. Fraser Health Equity, Diversity and Inclusion Strategy and Action Plan 2023-2028
2. Our Journey from Complacency to Change, 5-Year Equity Diversity and Inclusion Plan, Hamilton Health Science

HANOVER & DISTRICT HOSPITAL

Indigenous Cultural Safety Plan

Intent and Purpose

Health Care Institutions have not always been the safest places for Indigenous Peoples to access and participate in, as providers and receivers. Systems that were supposed to protect have resulted in harm.

Systemic racism occurs when an institution or set of institutions working together maintain racial inequity. To create change it has to be on the individual and organizational level. Systemic racism is often caused by hidden biases, resulting in doing things the way they have always been done.

It is essential that organizations acknowledge that systemic racism exists and actively confront that unequal power dynamic between groups sustains it. Thus organizations have to consistently assess systems to monitor that outcomes ensure fairness and equity.

To combat racism successfully, it takes a collective effort to acknowledge it exists and design strategies that promote equity and inclusion.

Cultural Safety can only be defined by an Indigenous person receiving care. Culturally safe care does not profile or discriminate but is experienced as respectful and safe and allows meaningful communication and service. To be culturally safe requires positive anti-racism stances, tools and approaches, and the continuous practice of cultural humility. This is why we need to connect to local Indigenous populations.

A culturally competent approach should consider:

- **Holistic Well-being**: Recognizing that health is interconnected—mentally, physically, emotionally, and spiritually.
- **Trauma-Informed Care**: Acknowledging historical and intergenerational trauma and its impact on health-seeking behaviors.
- **Communication Barriers**: Ensuring medical terminology is explained in an accessible way and respecting traditional knowledge and healing practices.
- **Trust and Relationship-Building**: Understanding the importance of relationships, community, and traditional healing in Indigenous cultures.

In order for this plan to be successful it has to be modeled by the workforce and a whole system approach is required. This is going to make some people uncomfortable, unless we are Indigenous we are not going to understand how they feel or think. Stating we welcome everyone is not enough; we need to understand their needs are unique and different.

Hanover & District Hospital's Indigenous Cultural Safety Plan

Indigenous Cultural Safety (ICS) is a long term and continuous development process that is linked to Hanover & District Hospital goals and objectives.

Hanover & District Hospital (HDH) is committed to ensuring the ICS plan is embedded throughout the hospital. HDH is committed to addressing and decreasing health inequalities for Indigenous Peoples by providing culturally safe and responsive services. Cultural safety reduces barriers to care, increases the quality and safety of services, positively impacts patterns of service utilization, improves clinical outcomes and leads to fewer disparities in health status between Indigenous and non-Indigenous people.

The purpose of this plan is to provide direction to HDH regarding the organization's approach to ICS by informing the hospital change that will enhance service user experience, include service users as partners in their own care and improve service delivery and health service user outcomes.

Indigenous Cultural Safety Principles

1. Indigenous culturally competent and responsive health care practices are embedded throughout HDH.

2. Indigenous communities are central in the identification, development, delivery and evaluation of health services for Indigenous Peoples.

3. Indigenous cultural practices are included in culturally competent health care delivery for Indigenous Peoples.

4. Indigenous Peoples have an inherent and recognized right to access cultural practices as part of their health care plan.

5. Indigenous Peoples connection to traditional and unceded territories is recognized as an integral component to Indigenous health, well-being and care.

6. Indigenous beliefs are diverse amongst Indigenous Peoples and therefore traditional medicines and health care practices will vary by individual.

We recognize that Hanover and District Hospital lies on the traditional homelands of the Saugeen First Nations and the Chippewas of Nawash Unceded First Nation.

Becoming a Culturally Safe Organization

This plan guides HDH to become a Culturally Safe hospital and inform health care provision. It identifies the following three areas for implementation to transform the culture of care delivery and improve health outcomes for Indigenous Peoples.

1. ***Inclusion of Indigenous knowledge and expertise in health care***
   HDH will actively bring in Indigenous knowledge and expertise at all levels of health service delivery. This will reflect in engagement with Indigenous Leadership, communities and clients, staff education, recruitment and retention and health service delivery.

2. ***Welcoming and land acknowledgement of traditional territory***
   As official HDH protocol, staff will give a land acknowledgment at all public meetings, public events and conferences.

3. ***Right to traditional medicines***
   HDH staff will facilitate the inclusion and access to traditional medicines in health care planning on request.

Responsibilities

Executive Leadership will:

- Lead and demonstrate the overall hospital commitment to delivering Indigenous Cultural Safety;
- Endorse and support hospital initiatives and the development of practice guidelines that strengthen Indigenous Cultural Safety;
- Support the meaningful engagement of Indigenous groups in governance and decision making; and
- Plan and deliver services that meet the health care needs of Indigenous Peoples.

Management will:

- Support the meaningful engagement and partnership with Indigenous Elders and Knowledge Keepers in the planning and delivery of services;
- Allow Indigenous Peoples to be a part of the decision making regarding overall hospital care.
- Facilitate the development of policies, procedures and other changes in HDH's operations to enhance Indigenous Cultural Safety;
- Plan and deliver services that meet the health care needs of Indigenous Peoples;
- Respond to practices and barriers that hinder Indigenous Cultural Safety. These practices and barriers may be identified by staff, external agencies or communities;
- Provide on-going professional development opportunities and resources for staff to build Indigenous Cultural Safety; and
- Support staff to incorporate Indigenous Cultural Safety into the delivery of services and to put knowledge and skills into practice.

Front Line Employees will:

- Provide appropriate, equitable and culturally safe care;
- Support Indigenous clients to engage in decision-making around their own care;
- When possible and requested, integrate traditional Cultural Practices into client care plans based on safety and benefit;
- Develop personal and professional knowledge and skills in Indigenous Cultural Safety;
- Identify barriers to services whenever possible and report barriers to management

1. Inclusion of Indigenous Knowledge and Expertise in Health Care

HDH will include Indigenous knowledge and expertise in all levels of health service delivery. This will be reflected in engagement of Indigenous Leadership, communities, and clients, staff education, recruitment and retention and health service deliver.

Key guidelines and recommendations to implement Indigenous knowledge and expertise in health care:

Recruitment and Retention

- HDH will ensure all staff will have on-going education and training
- HDH will actively work to increase employment and career opportunities for Indigenous people at all levels of the hospital,
- HDH will seek out and prioritize candidates of Indigenous ancestry for positions that required Indigenous knowledge and expertise
- Hiring Indigenous candidate(s), visibility helps First Nations to be comfortable knowing they are not alone.

Engagement

- HDH will engage and consult with Indigenous Knowledge Keepers in the development of health programs and services for Indigenous clients.
- HDH will create opportunities to Indigenous Staff, Knowledge Keepers, Traditional Practitioners and Elders to share their expertise on health matters for Indigenous Peoples.
- HDH understands the practice of offer a Tobacco Tie and honorariums.

Education

- HDH recommends Indigenous Cultural Safety training for staff.
- HDH provides on going Indigenous Cultural Safety training for staff
- HDH will provide local Indigenous training whenever possible to staff

Practice

- Indigenous service users have a way to identify health options for their care.
- HDH staff will consult and include culturally-specific health care options in health care planning for Indigenous service users.

- HDH staff will include Indigenous Health Care Navigators, Traditional Practitioners or Elders when possible to facilitate the inclusion of cultural support.
- Indigenous cultural practices provide with HDH are conducted by Indigenous Peoples when possible.
- HDH physicians and staff will consult with the Indigenous Navigators when support is requested, understanding they act as a spokesperson for the Indigenous patient.

Documenting Cultural Practices

- Cultural practices and consultation with Indigenous Health Care Navigators and Practitioners will be documented in the patient's care notes.
- The following information will be documented:
    - The name of the navigator, practitioner or traditional knowledge keeper
    - The type of ceremony i.e smudging, birthing, end of life, etc.
    - Details of ceremonies are not included.

2. Welcoming and Acknowledgment of Traditional Territory

As official HDH protocol, staff will give a land acknowledgement at formal meetings, public events or conferences.

Key Guidelines and recommendation to implement Land Acknowledgement

Application

- Recognition of the First Nations unceded homelands where we are conducting business is respectful and is supported by HDH. When holding formal meetings, public events or conferences, recognition will be stated at the beginning.

Land Acknowledgement

- HDH staff will recognize the unceded homelands
- The land acknowledgement can be done by the emcee, speakers and/or HDH staff

3. Right to Traditional Medicines

HDH staff will facilitate the inclusion and access to traditional medicines in health care planning on request. Recognizing each Knowledge Keeper/Elder may follow different traditions for each patient. Staff will consult with them and support them. HDH staff will have access to some traditional medicine (located in medication rooms) if requested by patient or family member.

Some examples of traditional medicine ceremonies: smudging, cedar baths, and sweat lodges.

References:

1. *Indigenous Cultural Safety Policy*, Vancouver Coastal Health
2. *NE'IIKAANIGAANA Toolkit, Guidance for Creating Safer Environments for Indigenous Peoples,* Indigenous Primary Health Care Council, 2021
3. Kewaquom, Lori (December 19, 2024) Personal Communication
4. John, Shirley (February 24, 2025) Personal Communication

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 26, 2026

HANOVER & DISTRICT HOSPITAL

Ontario Health

OVERVIEW

Hanover and District Hospital (HDH) remains committed to delivering exceptional patient care. Guided by our vision, "Partnering for Excellence in Rural Health Care," we uphold our core values of integrity, compassion, and collaboration in everything we do. As a small and rural hospital that provides essential 24/7 Emergency and Acue Care services, HDH continues to experience system pressures related to patient flow, fiscal constraints, and regional gaps in emergency service availability. Despite these challenges, HDH has maintained strong patient satisfaction and has demonstrated adaptability, collaboration, and resilience in supporting our community.

For 2026-27, HDH's Quality Improvement Plan (QIP) aligns with Ontario Health's system-wide priorities: Access and Flow, Equity, Patient Experience, and Safety. HDH's QIP indicators, targets and improvement activities are grounded in the organization's Strategic Plan and informed by date from the Emergency Department Pay-for-Results (P4R) Program, patient feedback, and staff and physician engagement.

Key improvement priorities this year include:
- Reducing the 90th percentile ED wait time to physician initial assessment to Ontario Health's recommended 3.4 hours target.
- Reducing the number of admitted patients waiting in the ED at 8 a.m. by the OH – recommended 25% reduction.
- Strengthening oversight and audit-driven improvements to maintain or improve the percentage of patients who leave without being seen (LWBS).
- Supporting equity through Indigenous Canada cultural safety education for executive-level leadership.

- Enhancing patient experience by improving clarity and consistency of discharge information.
- Advancing patient safety through implementation of the Delirium Aware Safer Healthcare (DASH) program.

HDH's approach reflects strong collaboration across teams, reliance on evidence-based practices, and a commitment to improving care experiences and outcomes for patients, families, and staff.

ACCESS AND FLOW

Improving access and flow remains one of HDH's highest priorities and aligns directly with Ontario Health's system requirements for emergency department performance. HDH's QIP includes three ED-related Access & Flow indicators: the 90th percentile ED wait time to physician initial assessment (PIA), the daily average number of admitted patients waiting in the ED at 8 a.m., and the percentage of ED patients who leave without being seen (LWBS). Each indicator includes Ontario Health's recommended targets where required.

Key strategies include strengthening ED documentation accuracy, reinforcing early assessment processes, and optimizing internal patient-flow workflows. HDH will continue to improve the completeness and reliability of time-stamp data and reinforce consistent use of standardized processes to reduce variation in PIA documentation.

HDH's Utilization Committee plays a central role in Access & Flow improvements by reviewing ED P4R data quarterly, analyzing trends, identifying contributing factors, and submitting formal recommendations to the Medical Advisory Committee (MAC) for oversight and follow-up. This governance structure ensures HDH maintains continuous and transparent monitoring of ED performance and aligns organizational decision-making with P4R metrics.

HDH will also complete 40 Emergency Department Return Visit Quality Program (EDRVQP) audits, including development and implementation of corresponding quality improvement action plans. These audits directly support improvements in ED flow, LWBS mitigation, and provider education related to unplanned return visits.

For admitted patients, HDH will improve overnight flow through policy review, earlier discharge planning processes, and enhanced surge capacity planning. Collaboration with South Bruce Grey Health Centre and regional partners supports timely interfacility transfers and shared resource use, reducing bottlenecks across the system.

Through these targeted, data-driven initiatives, HDH aims to ensure patients receive the right care in the right place at the right time.

EQUITY AND INDIGENOUS HEALTH

Ontario Health has emphasized the importance of reducing health inequities and advancing Indigenous health across care settings. HDH continues to prioritize equity, diversity, inclusion, and anti-racism (EDI/AR) as organizational commitments embedded within both the Strategic Plan and the Health Equity Committee's workplan.

HDH's 2026–27 QIP includes one equity indicator: the percentage of executive-level staff completing relevant EDI/AR training, with a target of 100% completion. This year, HDH has adopted a focused learning requirement using the Indigenous Canada course offered through Coursera by the University of Alberta's Faculty of Native Studies. Completion of this education supports leadership in strengthening cultural safety, improving understanding of Indigenous histories and contemporary realities, and advancing reconciliation within healthcare.

This focused, mandatory education enhances leadership competency and informs policy, resource development, and organizational decision-making, contributing to an increasingly equitable and culturally safe care environment for patients, families, and staff.

PATIENT/CLIENT/RESIDENT EXPERIENCE

Ontario Health requires hospitals to demonstrate how patient experience feedback informs quality improvement. HDH collects experience data through the Ontario Hospital Association's patient satisfaction surveys and unit-based feedback mechanisms. One of HDH's strengths is the active participation of the Patient and Family Advisory Committee (PFAC), who co-design and review patient communication materials, processes and policies.

The patient experience indicator for 2026–27 is the percentage of respondents who report "Completely" to the question:
"Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?"

HDH's target is 95%, consistent with prior QIP targets and reflective of the hospital's commitment to clear, consistent, and patient-centred discharge communication.

Planned improvement activities will support patients in understanding their care, managing their recovery at home, and knowing when and how to seek follow-up support.

PROVIDER EXPERIENCE

HDH recognizes that creating a positive workplace culture is essential for delivering high-quality, safe care and supporting staff retention. Ontario Health encourages organizations to describe initiatives that address recruitment, retention, workplace culture, and staff experience.

We prioritize staff education and development, offering training, workshops, and continuing education opportunities to ensure our team has the tools and knowledge needed to deliver exceptional care. This investment in professional growth not only enhances care quality but also cultivates a culture of continuous learning, making our staff feel valued and empowered.

SAFETY

At HDH, ensuring safety is integral to our mission of delivering exceptional care. Our approach is guided by Healthcare Excellence Canada's Quality Care and Patient Safety Framework, which supports alignment with evidence-informed safety practices across all care settings. HDH continues to participate in Ontario Health's Never Events program, reinforcing our commitment to preventing avoidable, serious incidents through focused education and shared learning.

Our incident management system remains a critical tool for ensuring timely reporting and follow-up of all safety events. Each report triggers a structured review, enabling early identification of contributing factors and supporting targeted quality improvement actions. The Patient and Medication Safety Committee review all medication-related, falls, and miscellaneous incidents to identify opportunities for improvement and prevent recurrence. HDH also maintains robust patient safety policies, subject to annual review to ensure their effectiveness.

Furthermore, HDH's active Joint Health and Safety Committee continues to play a key role in maintaining a safe workplace environment. Regular safety inspections and follow-up processes help safeguard both staff and patients and reinforce proactive hazard identification.

A key enhancement of this past year was the introduction of a new security services provider, which strengthened safety practices throughout the hospital. This upcoming year, working with this security provider, HDH will implement MORB (Management of Resistive Behaviour) training and PINEL restraint training for staff. This partnership will enhance staff competency, confidence, and preparedness when managing behavioural escalations, ensuring responses prioritize patient dignity, therapeutic communication and staff and patient safety.

Together, these initiatives demonstrate HDH's strong commitment to fostering a safe, supportive, and high-quality environment for patients, staff, physicians and visitors.

EMERGENCY DEPARTMENT RETURN VISIT QUALITY PROGRAM (EDRVQP)

In its inaugural year participating in the Emergency Department Return Visit Quality Program (EDRVQP), Hanover and District Hospital (HDH) gained meaningful experience conducting structured return-visit audits and integrating findings into quality improvement activities. During the audited period, HDH had 19,219 ED visits, with 56 return visits within 72 hours meeting criteria for review and one

sentinel event, which was audited thoroughly and found to have no quality-of-care concerns, with the patient experiencing a positive outcome.

HDH successfully completed the required 40 return-visit audits, strengthening staff familiarity with the program's methodology and reinforced a consistent approach to case review, documentation, and learning. Audit findings are shared with the Patient Safety Committee, Utilization Committee, Medical Advisory Committee, and the Board Quality Governance and Risk Management Committee, enhancing organizational oversight and promoting shared learning across departments.

Two themes consistently emerged through the audit process. The first involved seniors living alone, who comprised 60% of return-visit patients, often experiencing challenges with follow-up care or managing symptoms independently. In response, HDH will implement the Identification of Seniors at Risk (ISAR) tool at triage and develop standardized pathways for engaging community partners in earlier intervention.

The second theme involved patients who left without being seen (LWBS). Audit findings identified the need for deeper analysis of LWBS characteristics and underlying causes. HDH will undertake a comprehensive review of LWBS patterns and develop a follow-up process for highest-risk LWBS patients, supporting safe transitions and timely care re-engagement.

EXECUTIVE COMPENSATION

Ontario Health requires clarity on how executive compensation is linked to QIP performance. At HDH, this includes tying 5% of the President & CEO's base salary to achievement of QIP targets, in alignment with Board Policy #502. This linkage supports strong accountability for quality improvement at the senior leadership level.

SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on **March 26, 2026**

Tina Shier, Board Chair

Pamela Matheson, Board Quality Committee Chair

Dana Howes, Chief Executive Officer

Saskia MacMillan, EDRVQP lead, if applicable

Access and Flow

Measure - Dimension: Timely

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of patients who visited the ED and left without being seen by a physician	O	% / ED patients	CIHI NACRS / April 1, 2024, to March 31, 2025 (i.e., FY 2024)	4.16	4.16	LWBS in Ontario was 5.3%. HDH will strive to maintain or improve as this rate is below the Ontario average.	

Is this indicator related to:	
Emergency Department Return Visit Audits	Yes
Executive Compensation	Yes
Pay-for-Results Action Plan	Yes

Change Ideas

Change Idea #1 Strengthen ED Oversight, Early Assessment and Audit-Driven Improvements to Reduce LWBS

Methods	Process measures	Target for process measure	Comments
- Complete 40 audits including the development and implementation of a Quality Improvement action plan as part of the Emergency Department Return Visit Quality Program (EDRVQP) requirements. - The Utilization Committee will conduct quarterly analyses of LWBS patterns using P4R data to help guide the implementation of mitigation strategies.	- Number of EDRVQP audits completed and % of audit-generated action items implemented. - Completion of quarterly Utilization Committee review of ED P4R indicators, included recommendations to Medical Advisory Committee.	- 40 audits completed with 100% corresponding QI action plans and Quarterly review of LWBS cases with flagged return visits. - 100% completion of all four quarterly Utilization Committee meetings.	

Measure - Dimension: Timely

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department wait time to physician initial assessment	P	Hours / ED patients	CIHI NACRS / December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program	3.70	3.40	Ontario Health recommended target for ED PIA is 3.4 hours or less.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	Yes

Change Ideas

Change Idea #1 Ensure the accuracy, completeness, and timeliness of data regarding ED wait times to Physician initial assessment.

Methods	Process measures	Target for process measure	Comments
- Continue to conduct regular data audits to identify inaccuracies or missing data in ED wait time logs. - Utilize standard process for recording wait times to reduce data entry errors.	- Data Accuracy - Audit frequency	- Data accuracy: Collect baseline accuracy in recorded ED wait times to physician initial assessment. - Audit frequency: Target quarterly audits to review and correct data entry issues.	

Change Idea #2 Reinforce the importance of accurate data and reducing wait times to ensure consistent adherence to timeliness guidelines for initial assessments.

Methods	Process measures	Target for process measure	Comments
The Utilization Committee, reporting to MAC, will review P4R data quarterly, identify contributing factors to delays, and recommend actions to improve PIA timelines.	Completion of quarterly Utilization Committee review of ED P4R indicators, included recommendations to Medical Advisory Committee	100% completion of all four quarterly Utilization Committee meetings.	

Measure - Dimension: Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m.	P	Number / ED patients	CIHI NACRS / April 1, 2024, to March 31, 2025 (i.e., FY 2024)	0.44	0.33	Ontario Health recommended target is a 25% reduction from baseline.	South Bruce Grey Health Centre

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	Yes

Change Ideas

Change Idea #1	Optimize internal processes for overnight admissions to ensure timely patient placement and reduce wait times in the ER.		
Methods	Process measures	Target for process measure	Comments
Review patient flow process daily	Continue to reinforce internal policies	Education and implementation of policy and process.	

Change Idea #2	Continue to expand and enhance internal surge capacity to accommodate a higher number of patients during peak periods, reducing ER wait times for inpatient beds.		
Methods	Process measures	Target for process measure	Comments
- Regularly review surge protocols to quickly increase inpatient capacity during periods of high ED patient volume. - Increase flexibility in bed assignment.	- Surge protocol review - Flexibility in bed usage.	- Target activation of surge protocol within 4 hours of identifying high patient volume.	

Change Idea #3	Work with regional partners to coordinate bed leveling efforts and share resources, improving bed availability across the system and reducing ER wait times.		
Methods	Process measures	Target for process measure	Comments
- Work with the SW Situational Surge Group - Continue collaboration with South Bruce Grey Health Centre in meeting regularly around interfacility transfers	Frequency of meetings	- SW Situational Surge Group meetings attended (Meetings occur weekly during surge.) - Bi-weekly interfacility transfer meeting touch bases with South Bruce Grey Health Centre	

Change Idea #4	Ensure the accuracy, completeness, and timeliness of data on inpatient bed availability to enable better decision-making and more efficient bed management.		
Methods	Process measures	Target for process measure	Comments
- Standardize data collection practices across departments and facilities to improve consistency. - Reinforce with staff on the importance of accurate data entry and the impact it has on patient flow. - The Utilization Committee, reporting to MAC, will review admission related P4R metrics for recommended improvements.	- Data Accuracy - Staff Training - Completion of quarterly Utilization Committee review of ED P4R indicators, included recommendations to Medical Advisory Committee	- Target quarterly audits to ensure accurate data. - Target 95% of relevant staff trained on data entry protocols. - 100% completion of all four quarterly Utilization Committee meetings.	

Equity

Measure - Dimension: Equitable

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	100.00	100.00	% of executive-level staff	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Support equity and reconciliation through Indigenous Canada Training for Executive-level Staff

Methods	Process measures	Target for process measure	Comments
Executive-level staff will participate in Indigenous Canada online course with Coursera offered by the Faculty of Native Studies at the University of Alberta.	Documentation of training completion submitted.	100% of executive-level staff completing required training components by fiscal year-end.	

Experience

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of respondents who responded “completely” to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	O	% / Survey respondents	Local data collection / Most recent consecutive 12-month period	92.11	95.00	Consistent with HDH prior QIP target	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Audit and improve discharge information materials with the guidance of the Patient and Family Advisors.

Methods	Process measures	Target for process measure	Comments
- Work with PFAC to develop standardized discharge packages to support informational needs. - Continue to monitor patient responses/satisfaction surveys indicating that they have received sufficient information prior to discharge.	- Completion status of standardized discharge packages. - Monitoring of Patient Satisfaction survey responses.	- Completion of standardized discharge packages with the input of PFAC. - Achieve 95% positive “Completely” responses for the patient satisfaction survey question, "Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital.	Total Surveys Initiated: 1128

Safety

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of delirium onset during hospitalization	O	% / Hospital admitted patients	CIHI DAD / April 1 to September 30, 2025 (Q1 and Q2), based on the discharge date (Discharge Date/Time)	2.57	2.57	The Ontario Hospital average is 8.2% of all hospitalizations. HDH is striving to improve or maintain current performance.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1	Utilize the Health Quality Ontario Delirium Aware Safer Healthcare (DASH) program to improve delirium screening, documentation, and early intervention practices across the hospital.		
Methods	Process measures	Target for process measure	Comments
- Utilize the DASH (Delirium Assessment Screening and Hospitalization) program into daily clinical practices for all hospitalized patients, especially those at higher risk for delirium. - Participation in DASH Community of Practice (CoP) to engage Care Partners in recognizing early signs of delirium.	- Screening completion rate - Implement 1-2 DASH CoP ideas	- Collect the number of at-risk patients screened for delirium using the DASH tool within 24 hours of admission. - Completion of 1-2 CoP changes.	

Strategic Plan Quality Goals & Objectives 2026-27

HANOVER & DISTRICT HOSPITAL

Caring for our Patients

We will provide high quality patient and family-centred care.

- Provide exceptional care for all who come through our doors.
- Monitor and measure our performance using quality metrics.
- Be laser-focused about caring for our patients, their families and our community.

EMBRACING EQUITY, DIVERSITY, AND INCLUSION IN EVERYTHING WE DO

	ANNUAL INITIATIVES (WHAT WE WILL ACHIEVE)	SUCCESS METRICS (HOW WE WILL MEASURE SUCCESS)	SUPPORTING PARTNERS (WHO DRIVES RESULTS)
1	Continue to monitor and measure our performance through the Pay for Results (P4R) Funding Model	• 90th percentile emergency department wait time to physician initial assessment **(QIP)** • Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m. **(QIP)** • Percentage of patients who visited the ED and left without being seen. **(QIP)** • 90th percentile ambulance offload time • 90th percentile emergency department length of stay for nonadmitted patients with high acuity • 90th percentile emergency department length of stay for nonadmitted patients with low acuity • 90th percentile emergency department length of stay for admitted patients • 90th percentile emergency department wait time to inpatient bed • Reduce Emergency Department time to bed for admitted patients by improving discharge efficiency, by re-enforcing an 11 a.m. discharge time. • Complete 40 audits including the development and implementation of a Quality Improvement action plan as part of the Emergency Department Return Visit Quality Program (EDRVQP) requirements	Senior Leader: VP of Patient Care Services/CNE Staff & Physicians Patient and Family Advisors Emergency Services

2	Progress towards a long-term target of achieving a 25% reduction in Conservable Bed Days, defined as bed days saved by reducing avoidable admissions, unnecessary length of stay, and non-clinical discharge barriers	• Improved accuracy and utilization of Estimated Date of Discharge (EDD) through spot audits. • Achieve ALC target (OH West Target = 6) by using a standard escalation process and checklist. • Interdisciplinary bed rounds involving community partners (Ontario Health atHome/Home and Community Support Services) • Collecting and monitoring baseline of delirium onset during hospitalization. **(QIP)** • Implementation of evidence-informed order sets for high-impact case groups (HIG) including Heart Failure without Coronary Angiogram and Arrhythmia without Coronary Angiogram • Strengthen Home First approach to discharge planning beginning at admission to support safe, timely transitions to the most appropriate next level of care. • Improvement in patient-reported experience: Did Acute Care patients feel they received adequate information about their health their and their care at discharge in? **(QIP – will include Acute Care, ED, Surgical Services and OB)**	Senior Leader: VP of Patient Care Services/CNE Staff & Physicians Patient and Family Advisors Ontario Health atHome Home and Community Support Services

Valuing our People & Teams

We will continue to value, invest in and recognize our teams.

- Continue to value, invest in and recognize our people and teams.
- Prioritize the growth and well-being of our people and teams.
- Strategically use our resources to achieve our goals.

EMBRACING EQUITY, DIVERSITY, AND INCLUSION IN EVERYTHING WE DO

	ANNUAL INITIATIVES (WHAT WE WILL ACHIEVE)	SUCCESS METRICS (HOW WE WILL MEASURE SUCCESS)	SUPPORTING PARTNERS (WHO DRIVES RESULTS)
1	Embracing Equity, Diversity, and Inclusion in everything we do	• 100% of executive-level who have completed relevant equity, diversity, inclusion, and antiracism education **(QIP)**	Senior Leader: President & CEO

		• Increased staff awareness and engagement in EDI through participation in learning opportunities, events or initiatives.	Health Equity Committee Staff & Physicians PFAC
2	Encourage a culture of listening through intentional engagement and information-gathering	• 95% of full-time and part-time staff will be rounded on quarterly by the management team. • Support a culture of continuous improvement by systematically tracking staff-driven initiatives identified through rounding and team huddles. • Enhanced feedback loop including refreshed education on effective rounding, quarterly "Rounding Round-Up" featuring staff-initiated improvement projects.	Senior Leader: President & CEO Staff
3	Create an organizational mindset that values openness, reflection and shared learning	• Improvement in the Global Workforce Survey question, "My manager considers my suggestions for improving patient safety?" (Increase positively by 5%) • Rebranding of incident reporting to emphasize learning and growth by reframing shared reports as *Learning Moments* with a positive, improvement-focused tone.	Senior Leader: JHSC Patient Safety Committee PFAC

Innovating for a Sustainable Future

We will advance a forward-thinking culture into our operations to ensure our sustainability.

- Ensure fiscal responsibility and financial stability.
- Identify innovative solutions to ensure our sustainability.
- Advocate for enhanced resources to strengthen our ability to care for our patients and community.

EMBRACING EQUITY, DIVERSITY, AND INCLUSION IN EVERYTHING WE DO

	ANNUAL INITIATIVES (WHAT WE WILL ACHIEVE)	SUCCESS METRICS (HOW WE WILL MEASURE SUCCESS)	SUPPORTING PARTNERS (WHO DRIVES RESULTS)
1	Strengthening cybersecurity to protect information, systems, and organizational trust	• Development of comprehensive cybersecurity plan outlining organizational priorities, risks, safeguards and response process. • Formalize relationship with the LDG - Cybersecurity Southwest. • Completion of required cybersecurity training for all full-time and part-time staff to promote safe digital practices and reduce preventable cyber risks.	Senior Leader: VP of Finance and Operations IT Manager All Staff and Physicians
2	Align financial performance with planned operational budget	• Report actual budget compared to planned budget.	Senior Leader: VP of Finance and Operations All Staff and Physicians
3	Advance revenue-generating initiatives to strengthen financial sustainability by optimizing existing assets, expanding service offerings and pursuing new funding opportunities.	• Implementation and optimization of parking lot revenues through new parking gates and layout. • Launch Bone Density services to increase clinical revenue and fill a need in the community. • Offer external partners training conducted by HDH inhouse trainers. • Apply to all applicable grants and one time funding opportunities. • Increase Non-OHIP Uninsured Fees and Supplies to align with regional and provincial benchmarks.	Senior Leader: VP of Finance and Operations All Staff and Physicians PFAC

Anticipating & Responding

We will actively engage with our community and partners to understand and address community needs.

- Lead with purpose.
- Align our efforts with those of Ontario Health and our local health care partners.
- Anticipate and respond to the needs of our community through active engagement and partnerships.

EMBRACING EQUITY, DIVERSITY, AND INCLUSION IN EVERYTHING WE DO

	ANNUAL INITIATIVES (WHAT WE WILL ACHIEVE)	SUCCESS METRICS (HOW WE WILL MEASURE SUCCESS)	SUPPORTING PARTNERS (WHO DRIVES RESULTS)
1	Enhance Senior Friendly Care by strengthening partnerships and increasing community engagement to better support older adults.	• Exploration of an Age Friendly Certification in collaboration with the Town of Hanover • Participation in select Town of Hanover Seniors' Events to provide education and promote hospital services. • Implementation of the Identifying Seniors at Risk (ISAR) tool in the Emergency Department and develop associated action plan to improve early identification and support for at-risk seniors.	Senior Leader: President & CEO Human Resources Manager Town of Hanover PFAC Health Equity Committee

2	Advocating for resources, policies, and partnerships that enable care close to home	• Continued advocacy for the ED Renovation Project. • Ongoing communication with the local MPP, Ontario Health and Ministry of Health to ensure HDH priorities remain visible and understood. • Sustained collaboration with the Grey Bruce Ontario Health Team to advance shared regional initiatives	Senior Leader: President & CEO Grey Bruce OHT Local MPP and government partners Community and Municipal Leaders

2026/27 QUALITY GOALS & OBJECTIVES

HANOVER & DISTRICT HOSPITAL

EMBRACING EQUITY, DIVERSITY, AND INCLUSION IN EVERYTHING WE DO

Caring for our Patients

- Progress towards a long-term target of achieving a 25% reduction in Conservable Bed Days
- Did Acute Care patients feel they received adequate information about their health and their care at discharge? (Goal 95%) ***(QIP)***

Valuing our People & Teams

- Full-time and part-time staff will be rounded on quarterly by the management team. (Goal 95%)
- Improvement in the Global Workforce Survey question, "My manager considers my suggestions for improving patient safety?" (Increase positively by 5%)

Innovating for a Sustainable Future

- Align financial performance with planned operational budget
- Number of revenue-generating initiatives implemented to strengthen financial sustainability.

Anticipating & Responding

- Number of engagements and initiatives to enhance Senior Friendly Care.

ED P4R SCORECARD	Units	Q1 Result	Q2 Result	Q3 Result	Q4 Result	TOTAL
QIP Initiative: 90th percentile emergency department wait time to physician initial assessment.	Hours					
QIP Initiative: Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m.	Patients					
QIP Initiative: % of patients visiting the ED and left without being seen by a physician.	%					
90th percentile ambulance offload time.	Minutes					
90th percentile ED length of stay for non-admitted patients with low acuity.	Hours					
90th percentile ED length of stay for non-admitted patients with high acuity.	Hours					
90th percentile emergency department length of stay for admitted patient	Hours					
90th percentile ED wait time to inpatient bed.	Hours					

HANOVER & DISTRICT HOSPITAL

Risk Management Plan

2026-27

Reviewed January 2026

Risk Management Plan

The purpose of the risk management plan is to protect patients, staff members and visitors from inadvertent injury. The plan is also designed to protect the organization's financial assets and intangibles, such as reputation and standing in the community.

The risk management plan is a primary tool for implementing the organization's overall risk management strategies. It is designed to provide guidance and structure for the hospital's clinical and administrative services that drive quality patient care while fostering a safe environment for staff and patients.

The focus of the risk management plan is to provide an ongoing, comprehensive, and systematic approach to reducing risk exposures. Risk management activities include identifying, investigating, analyzing, and evaluating risks, followed by selecting and implementing the most appropriate methods for correcting, reducing, managing, transferring and/or eliminating them.

Under the direction of the risk manager, the risk management program provides for collaboration among all departments, services, and patient care professionals within the hospital. Hanover and District Hospital's risk management plan provides policies, procedures and protocols to address events which may include organizational-related liability, professional liability, general liability and workers' compensation. The identification, investigation and management of accidents, injuries and other potentially compensable events are a primary responsibility under the risk management plan. This process is directed by the risk manager and others who are delegated to participate in the various components of managing adverse events occurring with patients, staff, visitors and organizational assets.

Risk management will influence, persuade and educate leaders within the following departments in order to achieve quality care in a safe environment and protect the organization's resources:

- Administration including Human Resources
- Allied Health and Adjunct Professional Services (Laboratory, Diagnostic Imaging, Infection Control, Rehab Services)
- Health Records & Data/Health Information and Privacy Management
- Maintenance
- Clinical (Surgical Services, Emergency Department, Acute Care, Obstetrics, Dialysis)
- Employee Health
- Environmental Services, Dietary, Medical Device Reprocessing
- Medical Staff

Objectives of the Risk Management Plan

The objectives of the risk management program include, but are not limited to:

- Promoting the quality of patient care, in collaboration with quality/performance improvement activities;

- Enhancing patient satisfaction;
- Minimizing the frequency and severity of adverse events;
- Supporting a culture of just-cause; non-punitive culture that promotes awareness and empowers staff to identify risk-related issues;
- Enhancing patient safety through participation in organizational safety strategies and other patient safety initiatives;
- Enhancing environmental safety for patients, visitors and staff through participation in environment of care-related activities;
- Utilizing risk management strategies to identify and minimize the frequency and severity of near misses, incidents and claims;
- Managing adverse events and injuries;
- Evaluating systems that can contribute to patient care, error or injury;
- Educating stakeholders on emerging and known risk exposures and risk reduction initiatives;
- Achieving requirements promulgated by Accreditation Canada; and
- Complying with provincial mandates, applicable laws, regulations and standards.

Specific Components

The risk management plan will include the following components:

Incident Reporting

Incident reporting is intended to provide a systematic, organization-wide program of reporting risk exposures to identify potential future liability. The risk management program includes an event reporting system that is used to identify, report, track, and trend patterns of events with the potential for causing adverse patient outcomes or other injuries to people, property or other assets of the organization. It is designed to reduce or ameliorate preventable injuries and property damage, and minimize the financial severity of claims.

The risk manager tracks and trends event data in order to report those findings to the following committees: Patient Safety and Risk Management, Professional Practice, Patient and Family Advisory Committee and, the Board of Directors quarterly.

Certain specific events (i.e. – missing narcotics) must be reported to governmental agencies through delineated methods. This is often a responsibility of the risk manager and a senior leader, and compliance within established guidelines and time frames is critical.

Reporting Risk Management Activities as Part of the Quality/Performance Improvement Process

Recognizing that the effectiveness of risk management activities is contingent upon collaboration and integration with the quality/performance improvement activities, the risk manager will work with various hospital committees such as Patient Safety and Risk Management, Professional Practice, Occupational Health and Safety, and Senior Administration.

Monthly summaries of incidents and their resolutions are circulated throughout the organization via eBlast, and posted on huddle boards. It is reported to the Board quarterly.

Educational Activities

The risk manager will provide or facilitate orientation programs for all new employees and contracted staff. Annually activities will include:

- Code review and mock code events scheduled annually;
- Ongoing Non-Violent Crisis Intervention Training;
- Annual CBRNE Training;
- Brain Train for all staff (occupational health and safety/infection control, emergency codes and (patient safety protocols and policies) and Clinical Brain Train (RNs, RPNs, laboratory staff and diagnostic imaging staff);
- Annual infusion device training;
- Annual certification training as needed (Advanced Cardiac Life Support, Neonatal Resuscitation, Pediatric Cardiac Life Support); and
- Timed Code-Red and Green exercise annually.

Management of Patient and Family Complaints/Grievances

The management and resolution of patient and family complaints will be managed in accordance with hospital policy. Complaints are reported to the Board two times per year.

Patient Satisfaction

The organization will measure patient satisfaction and respond to issues identified in patient satisfaction surveys. The results are reviewed quarterly and presented to Patient Safety and Risk Management, Professional Practice, Patient and Family Advisory Committee.

HIROC Risk Assessment and Claims Management

Risk Assessment (3-Year Plan)

Hanover and District Hospital collaborates with Healthcare Insurance Reciprocal of Canada (HIROC) to assist the hospital with ongoing risk assessment via checklists. The hospital engages in 3-year long risk assessment and improvement cycles. Risk Assessment Checklists, also referred to as RAC, is a tool that enables the hospital to systematically self-assess compliance with evidence-based mitigation strategies for HIROC's top risks. The top risks are ranked by those which lead to significant medical malpractice claims. The following areas completed a RAC assessment:

- Failure to Pay Benefits/Overtime;
- Client Falls and Handling and Transfer Injuries;
- Employee Fraud;
- Healthcare Acquired Infections;
- Mismanagement of Wounds and Pressure Injuries;
- Failure to Identify/Manage Neonatal Hyperbilirubinemia and Hypoglycemia;
- Fire Losses;
- Failure to Appreciate Status Changes/Deteriorating Patients;
- Death by Suicide and/or Attempts While In-Care;
- Medication Adverse Events;
- Diagnostic Errors;
- Cyber Security & Privacy Breaches;

- Mismanagement of Neonatal Resuscitation;
- Inappropriate Credentialing, Re-appointment and Performance Management;
- Mismanagement of Shoulder Dystocia;
- Retained Foreign Items;
- Assisted Vaginal Birth;
- Windstorms;
- Water and Sewage Losses;
- Delayed Decision to Delivery Time for Caesarean Sections;
- Mismanagement of Client and Family Complaints;
- Wrongful Dismissal;
- Visitor and Ambulatory and Community-Based Falls;
- Wrong Client, Site, and/or Procedure;
- Inadequate Mental Health Facility and Space Design;
- Mismanagement of Client's Rights
- Failure to Appreciate Deterioriating Pregnant and Postpartum Persons
- Mismanagement of Induction and Augmentation of Labour
- Mismanagement of Intrapartum Fetal Monitoring
- Mismanagement of Trial of Labour After Caesarean (TOLAC)
- Abuse of Clients

Claims Management:

- Reporting potentially compensable events, unexpected outcomes or patient complaints to the involved department manager, the insurance carrier as appropriate and the organization's risk manager;
- Performing initial and ongoing investigation and interviews;
- Documenting activities and correspondence related to the investigation of the event;
- Protecting and preserving the patient health information record and/or other documents and evidence for potential future litigation;
- Organizing, managing and maintaining claim files;
- Limiting access to claim files to only authorized individuals under direct supervision of the risk manager;
- Coordinating activities with the defense team and providing input into the strategy for each claim;
- Reporting claim management activity to quality/performance improvement and appropriate organizational leaders;
- Participating in establishing defense/settlement posture;
- Resolving claims within established limits of authority;
- Maintaining confidentiality of protected documents;
- Reviewing, vetting and accepting legal service as appropriate; and
- Timely forwarding subpoenas, summons and complaints to legal counsel.

Legal

HDH retains Miller Thomson Advocates as the legal counsel.

Reports to the Governing Body via Quality Governance and Risk Management Committee

The risk manager will provide the following reports quarterly to the Quality Governance and Risk Management Committee:

- Patient Safety/Risk Management Report
- Staff Safety Report
- Patient Quality Safety Metrics Report
    - Hospital Acquired Infections
    - Hand Hygiene
    - Surgical Safety Checklists

Adverse advents or any other risk-related item that affects the hospital will be brought to the Board's attention promptly. The Board Chair will determine if a special meeting of the Board needs to be called.

The annual HIROC Risk Management report will also be shared with the Board.

Review of the Risk Management Plan

The risk management plan will be reviewed, updated, and approved annually, or as needed. Dated signatures and titles from appropriate parties should be obtained at the time of the approval.

Annual Evaluation of the Risk Management Program

The risk management program will be evaluated by the governing body annually.

Tina Shier, Board Chair	March 24, 2026 Date
Dana Howes, President & CEO	March 24, 2026 Date

HANOVER & DISTRICT HOSPITAL

Patient Safety Plan

2026-27

Introduction

Hanover and District Hospital (HDH) is strongly committed to ensuring that patient safety is the underpinning of all of our programs and services in our goal to deliver exceptional patient care. Patient safety is paramount, and HDH promotes a culture of patient safety.

The notion of ensuring patient safety begins with HDH's Strategic Plan. The strategic direction to *Provide High Quality Patient and Family-Centered Care* is at the forefront of operations and initiatives. For HDH, providing high quality patient and family-centered care means:

- We will provide exceptional care for all who come through our doors;
- We will monitor and measure our performance using quality metrics; and
- We will be laser-focused about caring for our patients, their families and our community.

Through this strategic direction, as well as the development of the Quality Improvement Plan and Risk Management Plan, annual safety goals are identified in collaboration with our staff, physicians, and patient advisors and through analysis of data. Each year, HDH strives to make continuous and sustainable safety and quality improvements.

Guiding Principles and Framework for Patient Safety at HDH

HDH will refer to the Patient Safety Guiding Principles and Framework outlined in ADM 1-102: Safety & Quality of Care Framework.

HDH's Commitment to Patient Safety

1. **Structures that Support Patient Safety at HDH**

   a. ***Board of Directors and the Quality Governance & Risk Management Committee of the Board***
   In accordance with the *Excellent Care for All Act (ECFAA)* the Board of Directors is legislated to be responsible for patient safety and protections, and quality care. The Quality Governance & Risk Management Committee of the Board reviews patient safety metrics, safety initiatives, and safety related incidents and provides oversight of the annual strategic plan initiatives and the Quality Improvement Plan.

   b. ***Senior Leadership, Risk Manager and the Achieving Excellence Leadership Group***
   Senior Leadership, Risk Manager and the Achieving Excellence Leadership Group are stewards of patient safety and quality across the organization; they are responsible for promoting a culture of safety and a no blame approach. The CEO is responsible to the Board for ensuring that patient safety measures and quality are upheld.

   c. ***Committees at HDH:***
   The following Committees at HDH support patient safety;
   - Patient Safety and Risk Management Committee;
   - Infection Prevention and Control;
   - Professional Practice & Product Evaluation Committee;
   - Ethics;
   - Patient and Family Advisory;

- Code Team Committee;
- Medical Advisory Committee;
- Occupational Health and Safety; and
- Medical Devices Reprocessing Committee.

d. Risk Management Plan and HIROC Risk Management Assessment Plan

HDH's Risk Management Plan promotes continuous, proactive and systematic processes to understand, manage and communicate risk from an organization-wide perspective in a cohesive and consistent manner.

HIROC's Risk Management Assessment Plan tracks and monitors associated risks in HDH's operations by determining the probability of a risk occurring multiplied by the impact should that risk occur. The resulting risk scores inform priorities for action to mitigate risk.

e. RL6 Patient Safety Incident System Incident

Incident reporting and management is integral to HDH's approach to patient safety. It is the responsibility of all staff, physicians, and volunteers, who observe, are involved in, or are made aware of an adverse event or near miss to ensure the incident is reported. Our RL6 system supports the documentation and tracking of patient safety incidents, findings, recommendations and actions/improvements. The RL6 system also allows for reporting of and follow through on feedback from staff, patients and caregivers.

All incidents and good catches are discussed/analyzed monthly at the Patient Safety and Risk Management Meeting. Quality Improvement projects are then developed to address patient safety issues and reduce the incidence of further occurrence. An incident report is then disseminated widely across the organization for all staff, physicians and volunteers and to The Board monthly for review. The Board receives quarterly reports on patient safety metrics via various reports.

f. Violence Reporting Hotline

Recognizing that it is important to report all incidents that breech patient safety in a timely manner, HDH has created a Violence Reporting Hotline so that staff can report incidents in a timely fashion. The incidents will then be entered into the RL6 system.

g. Scope of Internal Safety Initiatives – Ongoing Patient Safety Programs and Initiatives

HDH Patient Safety Programs:	
• Huddles	• Rounding – staff and patients
• Daily Discharge Rounds	• Leadership Patient Rounding
• Quality Safety Metrics	• Bedside Transfer of Accountability (TOA)
• Choosing Wisely	• Corporate and Unit Based Orientation
• Hand Hygiene Audits	• Clinical Education Calendars
• Patient and Family Advisory Committee	• Arm banding in ER

• Vanessa's Law • Falls Prevention Program • Audits: Documentation, Arm banding, PPE Donning & Doffing, Falls, Bedside Whiteboards • Newborn Wellness Check-ups • Pharmacy Medication Reviews	• Senior Friendly Framework • Pressure Ulcer Prevention • Enhanced Observation Policy • Discharge Planning – Family conferences • Violence Reporting Hotline • Patient Alerts – Cerner • Medication Reconciliation
Patient Quality Metrics:	
• RL6 Incident Reporting (Med Errors, Falls, Good Catches, Hospital Acquired Pressure Ulcers) • Medication Reconciliation at Admission & Discharge • Medication Reconciliation – transfer to surgical services • Hospital Acquired Infections (MRSA, C-Diff) • Surgical Site Infections • Surgical Safety Checklist	• Hand Hygiene Compliance • Patient Safety Culture Survey • Hospital Acquired Pressure Ulcers • Blood Bank – Routine Transfusions • Blood Bank – Urgent Transfusions • Laboratory Turn Around Time • Patient Infection Rates (MRSA & C-Diff) • Venous Thromboembolic Prophylaxis (VTE)- Admission • Laboratory Turn Around Time – ER
Safety Program:	
• Immunization Programs • Emergency Preparedness Plan • Infection Prevention and Control Program • Preventative Maintenance Program	• Antimicrobial Stewardship • Accreditation Canada • Employee Safety/EFAP
Environmental Safety Issues:	
• Product Recalls • Drug Recalls • Product/equipment malfunction	• Air Quality Reports • Infection Control Audits (ATP testing) • Workplace Violence (RL6) • Security Incidents (RL6)

h. **External – Accreditation Canada Required Organization Practices (ROPs/RSPs) Examples of HDH's Performance Related to 6 Patient Areas of ROPs include:**

Safety Culture	• Measurement of Quality Indicators • Program Councils focus on quality of care and patient safety • RL6 Incident Reporting System • Integrated Risk Management Program and risk assessment • Surgical Safety Checklist before and after procedures • Patient Safety Culture Survey
Communications	• Medication Reconciliation on Admission • Transfer of Accountability and Standardized Shift report

	• Staff and Patient Rounding • Patient Quality Metrics • Secure "Connect MyHealth", "PocketHealth" and process allowing patients to access their medical record • Discharge Summaries – sent to Primary Care Provider
Medication Use	• 90 Day medication reviews on long stay patients • Audits of VTE (Venous Thromboembolism Prophylaxis) • Antibiotics prophylaxis in surgery • Audits of safety reports for medications and Do Not Use abbreviations • Infusion Pump Training
Infection Control	• Monthly Hand Hygiene audits • Orientation and Staff/Volunteer education • PPE Audits • ATP Audits
Risk Assessment	• Falls and Medication error reporting (RL6) • Quality Reviews and Quality of Care reviews (under Quality of Care Information Protection Act [QCIPA] for high risk and critical incidents • Risk Management Program • Risk assessments for falls, pressure ulcers, and medication reconciliation
Worklife/Workforce	• Workplace Violence Program • Workplace Violence During Care Transitions Policy • Grey-Bruce Police-Hospital Protocol • Non-Violent Crisis Intervention Program and training • Responsive Behaviour education (Gentle Persuasive Approach, Delirium, Dementia)

i. **Additional Accreditation Bodies**

The HDH Laboratory is regularly assessed and accredited by the Institute for Quality Management in Hospitals (IQMH). Their mission is to elevate the integrity of the medical diagnostic testing system by providing rigorous, objective, third-party evaluation according to international standards.

In Diagnostic Imaging, the Mammography Accreditation program is reviewed and accredited by the Canadian Association of Radiologists. The following areas are assessed: personnel requirements, quality control, equipment specifications and breast image quality.

The Ontario College of Pharmacists has an accrediting arm that is tasked with ensuring the HDH pharmacy meets the requirements as outlined in the Drug and Pharmacies Regulation Act (O.Reg.264/16).

j. External Partnerships

HDH is committed to addressing Patient Safety at the system level, including working with our regional healthcare partners to develop a comprehensive Ontario Health Team that is capable of addressing patient safety and improving the quality of care.

HDH works closely with police services throughout the Grey-Bruce region. Most recently working together to create the Grey-Bruce Police-Hospital Protocol. This protocol ensures that patients are transitioned utilizing patient-centered approach that promotes safety from one provider group to another.

HDH has contracted an outside security firm to provide on-site security services in our Emergency Department on both a regularly schedule shift and as needed on a call-in basis. Security is often brought in to ensure the safety of patients experiencing a mental health crisis.

Infection Control consultant services is a partnership that was pursued to ensure patient safety. Dr. Michael Gardam provides infection control consultative support on an as needed basis.

HANOVER & DISTRICT HOSPITAL

QUALITY OF CARE: Patient Quality Safety Metrics 2026/2027

Indicator	Reported Frequency	1st Quarter (Q1)	2nd Quarter (Q2)	3rd Quarter (Q3)	4th Quarter (Q4)	YTD 2026/27	Benchmark Value	Benchmark Source	2025/26
Date		Apr '26 June '26	July '26 Sept '26	Oct '26 Dec '26	Jan '27 Mar '27				
MEDICATION ERRORS									
Omission	Q								
Wrong Patient									
Wrong Medication									
Wrong Route									
Wrong Time									
Wrong Dose									
Miscellaneous									
Total									
Medication Good Catches									
ACTION PLAN SUMMARY									
MEDICATION RECONCILLIATION		Q1	Q2	Q3	Q4	YTD 2026/27			2025-26
Medication Reconciliation (Admission)	Q						100%		
Medication Reconciliation (Discharge)	Q						100%		
Medication Reconciliation (Internal transfer to Surgical Services)	Q						100%		
ACTION PLAN SUMMARY	No action required.								
PATIENT FALLS		Q1	Q2	Q3	Q4	YTD 2026/27			2025-26
Total	Q								
Patient Falls Causing Significant Harm	Q						0	Internal	
Patient Fall Good Catches	Q								
ACTION PLAN SUMMARY									
LABORATORY/IPAC		Q1	Q2	Q3	Q4	YTD 2026/27			2025-26
Patient Infection Rates (per 1000 patient days) MRSA C-Diff	Q						 0.30 0.33	 Safer Healthcare Now (SHCN)	
Surgical Safety Checklist (Ministry)	Q						100%		
VTE screening in admission	Q						100%		
Pressure Wound • Hospital Acquired • HR Coded	Q								
Laboratory Turn Around Time – ER Patient (CBC, INR, BUN, Troponin 1)	Q	)					1 hour TAT	IHLP	
Blood Bank - Routine Transfusion	Q						Within 8 hours	IHLP	
Blood Bank - Urgent Transfusion	Q						Within 4 hours	IHLP	
ACTION PLAN SUMMARY									
HAND HYGIENE		Q1	Q2	Q3	Q4	YTD 2026/27			2025-26
Hand Hygiene Compliance (Acute) • Before Pt./Environ Contact • After Pt./Environ Contact	Q						Before/After = 100%		
Hand Hygiene Compliance (ER) • Before Pt/Environ Contact • After Pt/Environ Contact	Q						Before/After = 100%		
Overall Hand Hygiene Compliance • Before Pt/Environ Contact • After Pt/Environ Contact	Q						Before/After = 100%	QIP	

HANOVER & DISTRICT HOSPITAL

Human Resource Plan
2025-2030

Introduction

HDH's Human Resources Service Mission is focused on attracting, hiring, and retaining a vibrant, inclusive workforce who possess a spirited capacity of compassion, for continuous improvement and for contributing to the development of a strong collaborative culture in order to consistently meet and exceed the evolving needs and performance objectives of the hospital.

We are aware of the Health Human Resourcing challenges that are facing all Canadian providers of health care. The competition for Registered Nurses, Lab Technicians, and other roles is becoming fiercer. HDH needs to be competitive and chosen to be the employer of choice. Therefore, we must remind the people we wish to attract and/or retain of the very real opportunity that a career with HDH presents for making a difference in the lives of others.

The Human Resource Plan guides the development and helps with the availability of that workforce. This will ensure that we maintain our ability to deliver high quality services to Hanover and surrounding communities. Today's workers place a higher value on balancing their home and work lives; where employees seek meaningful and rewarding work.

The focus in this Human Resource Plan are the following areas:

1) Recruitment;
2) Creating a diverse and inclusive workplace
3) Enhance employee engagement and wellness

Strategic Goals vs. Human Resource Goals

The Human Resources Plan is based on the organization's strategic goals and objectives.

These are:

1) Caring for our Patients
2) Valuing our People and Teams
3) Innovating for a Sustainable Future
4) Anticipating & Responding

These strategic goals will be supported by the Human Resource goals and objectives presented and analyzed in the Human Resource Plan.

Values

HDH provides patient care and client services based on the following values:

- Integrity – to make decisions in a manner that is consistent, professional fair and balanced;
- Compassion – sympathetic consciousness of others' distress together with a desire to alleviate it;
- Collaboration – to enhance efficiency and credibility of our clients and staff;

To complement these core values expressed in the Strategic Plan, it is important to identify corporate human resource values that will guide our decision-making and actions, as well as the way we interact with one another and with those, we seek to serve. These values are:

- Respect: We value a workplace culture where people respect one another in their interactions with co-workers and clients.

- Integrity: We value a workplace culture where personal and professional integrity cause us to behave in an ethical and balanced way.
- Diversity: We value a workplace where diversity, in all its forms, is encouraged and recognized for its contribution to a more creative, rewarding, and productive workplace.
- Accountability: We value a workplace where accountability for our actions, our interactions, the objective and wise use of resources, and responsibilities for our successes and failures is reflected in how we conduct ourselves.

Human Resource Goals, Objectives and Strategies

This Human Resource Plan has numerous goals, which we will work on to achieve in a five-year period, between 2025 and 2030.

Goal 1: **All performance reviews for full time and part time employees are completed every two years.**

Objectives:

- **Fairness:** HDH wants to ensure that decision-making process associated with its human capital is aligned with related policies, and is entirely objective and consistent.
- **Providing exceptional care**: HDH aims at having the right employees with the right skills in the right place at the right time, and at ensuring the consistent application of human resource policies and practices throughout HDH.

Strategies:

- **Service excellence**: We must ensure the health care service we provide the community, and the way we deliver the service, is continually monitored for its value. The following initiativere reviewed and updated: *Performance management* (employees need to know how their efforts affect the business goals of HDH. Performance management will continue to highlight the relationship between individual performance, rewards and recognition, and HDH's objectives.)
- **360 Reviews**: HDH will source 360 reviews for leadership performance, to create a more well-rounded performance review process.

Goal 2: **Overall how you would you rate your organization as a place to work?" Achieve rating of 85-90% for "excellent", "very good", and "good" in Global Workforce Survey.**

Objectives:

- **Committed employees**: HDH wants to ensure that recruitment and orientation programs support the hiring of all employees who are personally committed to providing a high-quality of care.
- **Welcoming culture**: HDH will provide equitable and easy access to employment opportunities, and will foster a culture where new workers are welcomed, and oriented to achieve their career goals in health care.
- **Career advancement**: HDH wants to raise awareness about the many challenging and rewarding opportunities available within the hospital.

Strategies:

- **Regular Recognition and Feedback:** HDH will foster a culture of appreciation for individual and team accomplishments. Review and enhance the recognition program and create an action plan from feedback provided through the Global Workforce Survey.
- **Enhance wellness programs***:* HDH aims at promoting well-being of its employees through development of new and implementation of current wellness programs that assist in the well-being of employees both on and off the job.
- **Work-Balance:** HDH promotes a healthy work-life balance through flexible work arrangements and time off policies. While encouraging employees to take advantage of wellness programs.
- **Professional Development:** HDH will provide on-going training opportunities and mentorship programs and help develop personalized career paths for employees.

Goal 3: **Recruit and retain a diverse workforce that meets the needs of the organization.**

Objectives:

- **Increase the percentage of active open positions filled within the targeted deadline**: The objective is to fill positions in a timely fashion, ensuring key positions are filled.
- **To maximize hiring effectiveness and reduce cost-to-hire:** The objective is to ensure there are no delays, keeping candidates engaged and ultimately reduce the cost in hiring, by hiring star employees.

Strategies:

- **Recruitment:** HDH must develop outreach initiatives that will help us look for potential candidates. It is no longer enough to expect potential employees to come looking for us; we must develop outreach initiatives that will help us look for them. Strategies to address these essential needs include the following: *Ongoing job postings; Word of mouth strategies; Referral programs; Cooperation with Universities and Colleges.*
- **Employer Branding:** Enhance the organization's online presence and showcase a positive work culture.
- **Continuous Training for Recruiters:** Keep Human Resources and hiring managers updated on best practices, diversity and inclusion and interview techniques.
- **Define Talent Needs:** Work closely with department heads to identify current and future skill requirements and forecast workforce needs based on growth and changes.

Goal 4: **To enhance the volunteer program.**

Objectives:

- **Improving HDH's volunteer program**: The objective is to create a diverse program that welcomes all individuals from our community who wish to give their time to make HDH a better hospital.
- **Create a Volunteer Recognition Program**: The objective is to attract and retain our volunteers, and provide them a voice to enhance our programs and services.

Strategies:

- **Partnering with local high schools and youth groups**: HDH will partner with local high schools to create a program which will allow students to complete their volunteer hours while learning about the different opportunities within the hospital.
- **Improve Orientation and Support**: HDH will improve the volunteer orientation program, creating both in person and virtual options. Review technological options for scheduling.

Goal 5: **To support an EDI (Equity, Diversity & Inclusion) culture.**

Objectives:

- **Adopting an EDI culture**: HDH aims at creating programs, which recognize all aspects of equity, diversity and inclusion among its workers, and communities the hospital serves.
- **Diversity Training**: Conduct diversity and inclusion training for all employees.
- **Inclusive Policies:** Review and update Human Resources policies to ensure inclusivity and continue with a zero-tolerance policy for discrimination and harassment.
- **Employee Resource Groups:** HDH encourages the formation of employee resource groups, and support initiatives that celebrate various cultures and identities.

Strategies:

- **Recruitment and Hiring**: Develop inclusive hiring practices to attract diverse talent. Expand outreach efforts to underrepresented communities. Building relationships/partnerships with Indigenous Leaders and key community-based groups to promote a diverse and inclusive workplace.
- **Employee Development and Retention**: Provide equitable access to training, leadership development, and career advancement. Conduct regular pay equity audits and address any disparities.
- **Workplace Culture and Inclusion**: Foster an inclusive culture through ongoing EDI training and education. Support employee resource groups to promote a sense of belonging. Implement feedback mechanisms to assess inclusion efforts. The Health Equity Committee working in partnership both internally and externally, to make recommendations and initiate strategies to remove barriers of accessing healthcare to enhance the patient and workplace experience.
- **Policies and Accountability**: Ensure HDH policies promote equity and address discrimination, bias and harassment. Establish transparent reporting and accountability structures for EDI progress.

HDH strives to be a workplace that is reflective of the growing diversity within our community and to create a more respectful and inclusive workplace. HDH will be an organization where valuing diversity is a positive choice, not an obligation.

Action Plan

The following plan begins the process of identifying measures of success against which HDH will assess the company's progress. This latter task will also be a key part of the development and implementation of the strategies described within this plan. Some of these strategies will evolve as the plan itself is implemented and tested over the next five years.

HDH will need to regularly assess the company's progress towards achieving objectives identified in this Human Resource Plan. The development of these measures of success and indicators will be an evolving and continuous process throughout the life of this plan.

Goal # 1	Critical Actions to Take	Next Five Years	Outcomes	Measurements/ Indicators
All employee performance reviews are completed every two years.	Performance evaluations 360 Reviews	Review Annual and probationary performance appraisal process currently in place and working; Research 360 performance reviews for managers and senior leaders. Research on line platform for performance reviews.	100% of new full time and part time workers evaluated in the probationary performance appraisal process. 100% of full time and part time workers undergoing the bi-annual performance appraisal process 80% of staff highly satisfied with performance evaluation process	Number and percentage of performance evaluations completed each year (includes bi-annual performance appraisal process as well as the probation performance appraisal process)

Goal #2	Critical Actions to Take/ Strategies	Next Five Years	Outcomes/ Results	Measurements
Overall how you would you rate your organization as a place to work?" Achieve rating of 85-90% for "excellent", "very good", and "good".	Orientation Talent Management Process Exit Interview Enhancements Retention Strategies Enhanced Learning and Development Strategy – Reviewing both Clinical and Non Clinical roles	Develop Talent Management Process Enhance Corporate Orientation Enhance Recognition Program (staff, physicians and volunteers) Ongoing communication initiatives leading to fair treatment of workers based on dignity, respect, open communication and loyalty Improve Exit Interview process and reporting Enhance Employee Wellness Program, different ways of recognizing staff while promoting healthy living	100% of new workers undergoing the corporate orientation after being hired 80% of workers satisfied with the orientation program Overall, 40% of workers recognized by the management annually Newsletters/Eblasts sent weekly No complaints on lack of clear patterns of communication and lack of support by the management 85-90% positive responses related to working at HDH on survey	Global Workforce survey Level of employee engagement (measured by a number of responses for all, sent by HDH, surveys, questionnaires, etc.) Number of HDH workers recognized by the management for their contributions and achievements Management's commitment to staff well-being, health and safety

Goal #3	Critical Actions to Take/ Strategies	Next Five Years	Outcomes/ Results	Measurements
Recruit and retain a diverse workforce that meets the needs of the organization	Recruitment of staff Employee Value Proposition (EVP) Enhance partnerships with colleges and universities.	Implement strategies to attract talent from various sources, including job boards, social media and industry events Create a Referral Program Establish partnerships with universities, community organizations and diversity focused job platforms. Leverage technology for applicant tracking and assessment. Continuous training for management – best practices, diversity and inclusion and interview techniques. Optimize the recruitment process to minimize time to hire. Review Job Descriptions to ensure they avoid gendered language or jargon that may deter candidates Provide mentorship and sponsorship programs to support underrepresented groups	Equitable and accessible employment opportunities (objective assessment of the fit between the skills and qualifications of the prospective worker and the needs of HDH)	Number of workers hired each year Number of referrals Number of jobs posted Percentage of new graduates hired (out of all new workers) Number of job application received every year

Goal # 4	Critical Actions to Take/ Strategies	Next Five Years	Outcomes/ Results	Measurements
Improve the volunteer program	Engage with high schools and youth groups to create a more inclusive and learning opportunity. Enhance Volunteer Recognition	Build partnerships with local schools and youth groups. Embrace technology to streamline scheduling. Attract Volunteers from various sources, social media, website, job boards. Create a volunteer recognition program.	A more robust volunteer program which is diverse and engages with different age demographics	A program that includes students and youth from the community. A program that continuous attracts new volunteers.

Goal # 5	Critical Actions to Take/ Strategies	Next Five Years	Outcomes/ Results	Measurements
To support a diverse workforce	Develop diverse partnerships to enhance our learning. Offer training to build awareness and understanding of diverse cultures, traditions and perspectives. Create EDI Strategy Create Indigenous Cultural Safety Plan	All policies and procedures reflecting cultural diversity Ongoing cooperation with key community-based groups, and professional associations as stakeholders to promote a diverse and inclusive workplaces – Ongoing increase of workers' awareness and value of diversity and knowledge of diversity influencing patient care Empower employees to form groups that celebrate and support their identities. Provide funding and executive	Educational sessions on impact of diversity on communication between patients and health care providers Meeting the requirements of OH Meeting the action items within the EDI Strategy Indigenous Cultural Safety Plan No complaints by workers and patients on discrimination	Global Workforce Survey Number of new stakeholders promoting diversity Number of educational initiatives promoting diversity

		sponsorship/recognition for Employee Resource Groups (e.g 2SLGBTQ+, Indigenous, BIPOC) Recognize and celebrate cultural, religious and identity based events to make all employees feel valued. Collect and analyze demographic data to help create safe spaces. Equip leaders and employees with tools to recognize and mitigate biases in decision-making. Robust training plan for EDI courses. Conduct regular pay equity audits to eliminate disparities.	based on the prohibited grounds No complaints on violation of the Employment Standards Act and the Human Rights Code by HDH	

Conclusion

For this plan to succeed it needs the support of all the staff and the commitment of Senior Leadership, this is a shared commitment to the overall achievement of the plan and essential to the organizational success.

HANOVER & DISTRICT HOSPITAL

Engagement & Communications Plan for Internal and External Stakeholders

2026/27

Revised February 2026

About Hanover & District Hospital

Hanover and District Hospital (HDH) was originally established in 1923 and a new acute care hospital was built in 1973. A state-of-the-art facility with a 24-hour Emergency Department, the hospital operates as a 28-bed acute care organization with services and programs that include day surgery, two operating suites, obstetrics unit, multi-purpose intensive care, palliative care services, rehabilitation services, dialysis unit, specialist clinics, laboratory and diagnostic imaging.

HDH's vision is to partner for excellence in rural health care. Our vision depicts our commitment to partnering with other health service providers in the Grey Bruce area and beyond to ensure that patients receive the care they need and deserve.

Executive Summary

The Engagement and Communication Plan outlines how HDH will communicate with internal and external stakeholders, including patients, staff, physicians, community partners, and the public. Key objectives are to:

1. Develop a process for clear, consistent, and culturally responsive communication through an annual Action Plan.
2. Improve information sharing between healthcare organizations while ensuring equitable access.
3. Raise awareness of HDH's role and successes as a leader in rural acute care.
4. Better inform stakeholders about hospital services and resources.
5. Ensure equitable and inclusive communication that reflects, respects, and serves our diverse community, including Indigenous Peoples, newcomers, and persons with disabilities.

Recognizing the importance of patient and community engagement, HDH has adapted Health Quality Ontario's Patient Engagement Framework (2016). This guide's purpose is to help HDH plan, implement, and evaluate patient engagement activities across personal care, program/service design, and organizational policy and strategy. The goal is to foster a strong culture of patient, caregiver, and public engagement to support high-quality, equitable healthcare.

Specific communication methods include the corporate website, social media, media relations, internal forums, electronic newsletters, and community engagement events. The plan emphasizes the importance of accessibility to ensure messaging reaches all stakeholders.

Evaluation metrics include media coverage, event attendance, website traffic, and stakeholder feedback. It will be reviewed annually.

Patient Engagement and the Patient Engagement Framework

Involving patients and their loved ones in the conversation about how to improve health care quality generates important results for people receiving care, for health care professionals, and for the health system at-large.

To promote and support the drive for active patient engagement, HDH has adapted Health Quality Ontario's Patient Engagement Framework. This framework was approved and modified in partnership with the Patient & Family Advisory Committee at HDH.

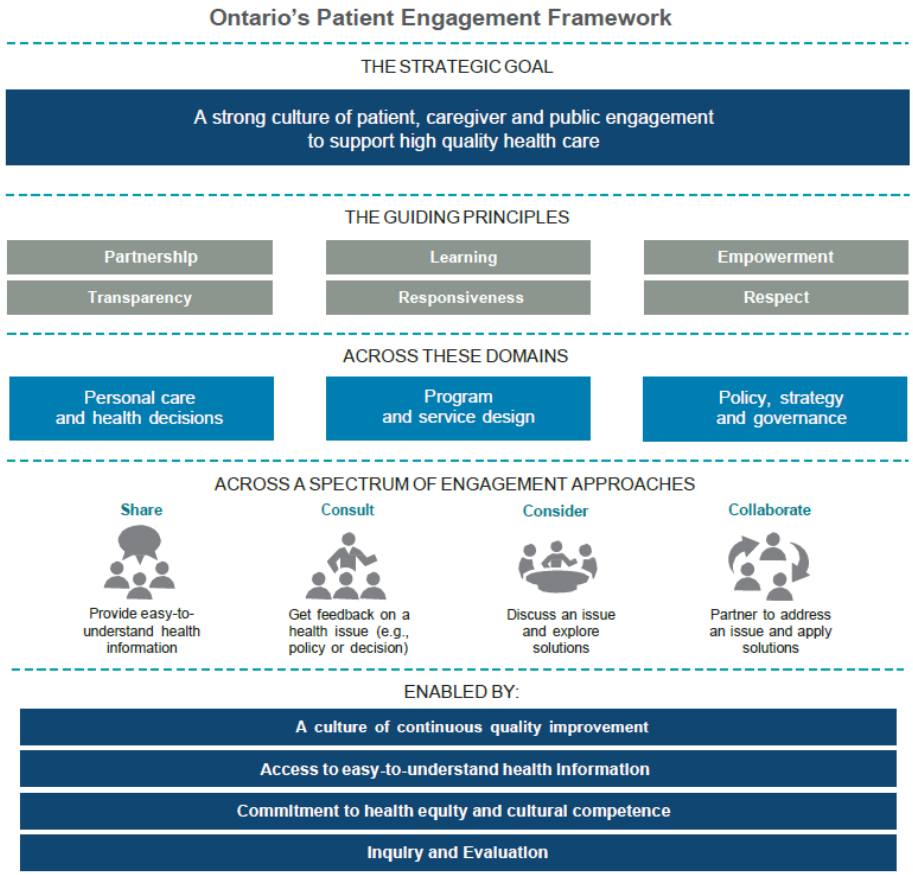
Its purpose is to guide HDH in planning for, implementing and evaluating patient engagement activities across each of the health system's domains: in personal care and health decisions, program and service design, and in health care policy, strategy and governance.

The goal of patient engagement is to create a strong culture of patient, caregiver and public engagement to support high quality health care. Core principles for success include partnership, transparency, learning, responsiveness, empowerment and respect.

HDH engages with patients in a variety of ways including but not limited to:

- Patient and Family Advisory Committee (PFAC)
- PFAC representatives are embedded into the following committees: Patient Safety, Health Equity, Infection Prevention and Control, Product Evaluation and Professional Practice, Ethics and the Board Quality Governance and Risk Management.
- Patient & Family Advisory are included in quality improvement initiatives and hospital project planning committees
- Patient Satisfaction Surveys

- Through social media mediums and website



Resource: Ontario's Patient Engagement Framework, 2016

Stakeholders

Any person that is affected by healthcare is considered a stakeholder. The stakeholders for communication and/or engagement are:

External Stakeholders

- Patients, Families and Caregivers
- Donors
- Health Service Providers
- Health Care Community Partners
- Community
- Media
- Government (political leaders, mayors, town councilors)
- Ministry of Health (MOH)
- Ontario Health West (OHW)

Internal Stakeholders

- HDH Staff
- HDH Physicians
- HDH Auxiliary/Clinical Volunteers
- HDH Board Directors
- HDH Foundation
- HDH Patient & Family Advisors

The President & CEO will work with the Board Chair to communicate effectively. It is the goal of this plan to create a process of communication to ensure the success of HDH by engaging internal and external stakeholders in the process. Providing ongoing messaging through a variety of mediums develops trust and understanding with stakeholders. The communication plan can help raise awareness of the hospital's needs and challenges and also champion successes.

Planning Communication

With each communication the following questions will need to be answered:

1. Why is this important to communicate? (**What's the purpose?)**
2. With whom do we want to communicate? **(Who are the stakeholders?)**
3. What do we want to communicate? **(What's the message?)**
4. How do we want to communicate it and through which medium? **(What communication tools are to be used?)**
5. What is the timeline of communications/presentations? **(Define when and who plans, prepares and presents)**
6. What needs to be developed? **(Develop material, ads, news articles etc.)**
7. How can we ensure this communication is accessible, inclusive, and culturally appropriate for all intended audiences?
8. What barriers might prevent certain community members from receiving or understanding this message?

The answers to these questions will establish the **action plan** to communicate successfully with the intended audience. This action plan will focus the messaging making it possible to target the stakeholders accurately, providing structure to define who HDH 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.

Communication Tools

When the target audience is identified strategies can be defined as to which communication tool would be used to achieve maximum outreach and efficient information sharing. HDH is committed to provide accessible communication for our patients and visitors. Persons with disabilities, those with language barriers, and individuals from diverse cultural backgrounds will be given equal opportunity to access information and will be considered in all communication planning.

HDH uses several methods to communicate including:

- Patient Interactions (Staff and patient contact)
- Word of Mouth
- Website – www.hdhospital.ca
- Social Media (Facebook https://www.facebook.com/HDHospital/, X (Formerly Twitter) @HDHospital, Instagram, Linked In & YouTube)

- Advertising (Media Releases, News Stories, Other Publications)
- Community Engagements/Events
- Internal communications, including weekly e-blasts, staff forums and HDH Documents

EDI Communication Principles

HDH is committed to communication that:

- Reflects our community's diversity in imagery, language, and content
- Removes barriers to accessing health information and services
- Respects cultural traditions and practices in health communication
- Uses inclusive language that welcomes all community members
- Celebrates diversity through recognition of cultural events and awareness days per the EDI and Recognition Calendar (Appendix B)

Corporate Publications

Annual Report

Following the Annual General Meeting, the Hospital's annual report is released electronically on the website and social media.

Patient Information Guide

The Patient Information Guide is published annually at no cost to HDH as sponsors advertise in the publication. Hard copies are available in print for pick-up in high traffic locations (front lobbies & elevator), and electronically on the hospital's website.

Program/Service Brochures and Posters

These are developed as needed by program leaders and the Executive Assistant to the CEO using HDH's Graphic Standards. Templates are designed for patient information and presentation materials.

Media Relations

HDH recognizes that timely and accurate media attention can support recruitment and retention, employee and community engagement, reward and recognition, and fundraising and funding. Every effort is made to communicate with media in a proactive rather than a reactive manner via designated spokespersons. The hospital also provides press releases to the media when the need arises.

Digital Media

Corporate Website

The website is maintained by the Executive Assistant to the CEO and HR Administrative Assistant. The site will continue to evolve with new and improved content needed.

HDH Documents (Shared Drive) & Board Portal

The HDH Documents folder on the shared drive is used as a file storage and sharing system for memos, reports, hospital committee information etc. Memos and other items are regularly communicated via

the “HDH E-blast”. A portal for the Board of Directors is located on the hospital website. It houses policies, by-laws, agendas and other committee information.

Social Media

Guided by a Social Media Policy and Social Media Annual Plan, the Executive Assistant to the CEO creates and maintains social media presence on Facebook, X (Formerly Twitter), Instagram, LinkedIn and You Tube. Pages are regularly updated with timely content and photographs related to hospital activities, services, disruptions and wellness content. Posts highlight HDH’s commitment to serving all community members.

Objectives

The Board of Directors is responsible for reviewing a communications action plan developed by the President & CEO which includes strategies for communication throughout the year to HDH’s stakeholders. The goal is ***to promote clear messaging and communication throughout the Hanover and District Hospital organization and to internal and external stakeholders***

Objectives include the following;

1. To develop processes for communication via the HDH Communications: Action Plan (Appendix A), which will be updated annually and reviewed by the Board of Directors through the Operational Plan;
2. To develop clear and consistent messaging and branding;
3. To improve the sharing of information between healthcare agencies/organizations;
4. To improve awareness of the role and successes of HDH as a leader in acute care; and
5. To improve information about services and resources.
6. To ensure all communication reflects HDH’s commitment to equity, diversity, and inclusion.

The Hospital Brand

The Hospital is constantly growing and evolving. Communicating with a unified appearance for all formats will help our patients, staff, physicians and community better understand who we are, the services we offer and the values we share. (Refer to the Graphics Standards Manual) The *Accessibility for All Ontarians with Disabilities Act, 2005* and the HDH Accessibility Plan will be referenced when making communication decisions around branding.

Evaluation

For *internal* audiences, feedback to leaders, questions in forums and meetings, attendance at meetings and special events help provide an indication of the effectiveness and receptiveness of corporate messaging.

Measure of *external* communication, effectiveness can be gauged by media coverage (positive, negative, neutral), participation in Hospital events, letters to the editor, survey responses, social media followers, complaints related to communications, website traffic, donation influence and volunteer recruitment.

Related Policies

1. Board Policy # 301 – Board Linkage with Community

2. Board Policy # 302 – Board Linkage with Other Organizations
3. Board Policy # 503 – Communication and Supports to the Board
4. Board Policy # 504 – Development of Collaborative Partnerships
5. Administrative Policy # ADM 1-60 – Media Release
6. Administrative Policy # ADM 1-105 – Social Media

Appendix

Appendix A – HDH Communications: Action Plan

Appendix B – Equity, Diversity and Inclusion (EDI) and Recognition Calendar

HDH Communications: Action Plan 2026/27				
	Description	**Frequency**	**Format/Channel**	**Audience**
1	**Website Updates (Content & News)**	Ongoing, as needed	• Blue Lemon Media Web Portal	All External & Internal Stakeholders
2	**Social Media**	Weekly	• Facebook • X (Formerly Twitter) • Instagram • LinkedIn • YouTube	All External & Internal Stakeholders
3	**Earned Media**	Monthly	• Local Radio and News Stations • The Post	All External & Internal Stakeholders
4	**Community Engagement/Events**	Two per year	• Virtual Platforms • In person	External Stakeholders
5	**Patient Information Guide**	Reviewed once/year	• Willow Publishing – no cost to HDH with advertising sponsors	Patients & Families
6	**Annual Report**	Annually	• Digital publication	All External & Internal Stakeholders
7	**EBlast**	Weekly	• Email newsletter	HDH Staff & HDH Physicians
8	**CEO/Staff Forums**	Monthly	• Virtual Forum • Email Distribution of Recording	HDH Staff & HDH Physicians
9	**HDH Documents**	Ongoing, as needed	• Shared Drive	HDH Staff & HDH Physicians
10	**Review Communication Plan & Graphic Standards Manual**	Annually	• Document	Internal Stakeholders

HANOVER & DISTRICT HOSPITAL

Equity, Diversity and Inclusion (EDI) and Recognition Calendar (2026)

January

- Tamil Heritage Month
- Alzheimer's Awareness Month

- New Year's Day - January 1
- Shogatsu/Gantan-sai – January 1 (Japanese New Year)
- National Braille Day – January 4
- Orthodox Christmas Day – January 7
- National Maintenance Worker Day – January 18
- World Religion Day – January 18
- Martin Luther King Jr. Day – January 19
- Blue Monday – January 19
- Bell Let's Talk Day - January 21
- International Day to Commemorate Memory of Victims of Holocaust – January 27
- Nation Day of Remembrance of the Quebec City Mosque Attack & Action Against Islamophobia – January 29

February

- Black History Month
- Recreation Therapy Month
- Heart Month

- Phlebotomist Week – February 9 – 13
- Cardiac Rehab Week - February 8-14
- Ramadan – February 17 – March 18-19

- World Cancer Day - February 4
- Lunar (Chinese) New Year - February 17
- World Day of the Sick - February 11
- Valentine's Day - February 14
- Lunar New Year Starts – February 17
- Random Act of Kindness Day – February 17
- Pink Shirt Day (anti-bullying) - February 25

March

- Pharmacy Appreciation Month
- National Social Work Month
- Colorectal Awareness Month
- Liver Health Month
- Nutrition Month

- Patient Safety Awareness Week - March 8-14
- Healthcare HR Week - March 16-20
- Poison Prevention Week – March 15-21

- International Women's Day - March 8
- Rangwali Holi - March 4
- Hola Mohalla – March 4-6
- Dietitian's Day - March 11
- St. Patrick's Day - March 17
- International Francophonie Day – March 20
- International Day for Elimination of Racial Discrimination – March 21
- Purple Day for Epilepsy Awareness – March 26
- Eid Al-Fitr – March 20-21

- Hindu New Year – March 19
- International Transgender Day of Visibility – March 31

April

- World Autism Month
- Sikh Heritage Month
- Be A Donor Month

- National Medical Laboratory Week - April 19-25
- NSWOCC Week – April 24-28
- National Organ and Tissue Awareness Week - April 19-25
- Health Information Professionals' Week - April 18-24
- National Volunteer Week - April 19-25

- World Autism Awareness Day – April 2
- World Health Day - April 7
- Trillium Gift of Life (TGLN) Green Shirt Day - April 7
- Advanced Care Planning Day – April 16
- Good Friday – April 3
- Earth Day – April 22
- Administrative Professionals' Day - April 22
- National Day of Mourning - April 28

May

- National Physiotherapy Month
- Critical Care Awareness and Recognition Month
- National Speech and Hearing Month
- Asian Heritage Month
- Jewish Heritage Month
- Stroke Awareness Month

- Occupational Health and Safety Week - May 3-9
- National Police Week – May 10-16
- National Hospital Week - May 10-16
- National Nursing Week - May 11-17
- Mental Health Week - May 4-10
- EMS Week – May 17-23
- National Accessibility Week – May 31- June 6

- National Physicians' Day - May 1
- Cinco de Mayo - May 5
- Red Dress Day – May 5
- Child and Youth MH Day – May 7
- World Ovarian Cancer Day – May 8
- Mother's Day- May 10
- Canada Health Day - May 12
- Global Accessibility Awareness – May 21
- Victoria Day - May 18
- Eid al-Adha – May 26-27
- World Hunger Day – May 28
- World No Tobacco Day - May 31

June

- National Indigenous History Month
- Pride Month
- Stroke Awareness Month
- Seniors Month

- Men’s Health Week – June 15-21

- Canadian Armed Forces Day - June 7
- Father's Day - June 21
- World Elder Abuse Awareness – June 15
- National Indigenous People’s Day – June 21
- Canadian Multiculturalism Day – June 27

July

- Canada Day - July 1
- International Self-Care Day – July 24

August

- Emancipation Day – August 1
- Civic Holiday - August 3
- International Day of the World's Indigenous People – August 9
- Overdose Awareness Day – August 31

September

- Prostate Cancer Awareness Month
- World Alzheimer's Month

- Mennonite Heritage Week September 7-13
- Environmental Services and Housekeeper Appreciation Week - September 13-19

- Labour Day - September 7
- World Suicide Prevention – September 10
- World First Aid Day – September 12
- National IT Professionals' Day - September 15
- HR Professional Day – September 26
- National Day for Truth and Reconciliation / Orange Shirt Day - September 30

October

- Occupational Therapy Month
- Breast Cancer Awareness Month
- Women's History Month
- Fire Prevention Month

- Healthcare Supply Chain Week - October 4-10
- Healthcare Food Service Workers' Week - October 4-10
- Sterile Processing (MDR) Week - October 11-17
- International Infection Prevention Week - October 18-24
- Spiritual Care Week - October 18-24
- Respiratory Therapy Week - October 18-24
- Invisible Disabilities Week – October 18-24
- Pharmacy Week – October 19-25
- Canadian Patient Safety Week - October 28 – November 1
- Sonography Week

- Senior's Day – October 1
- Yom Kippur - October 1-2
- National Day of Action for MMIWG2S – October 4
- Thanksgiving - October 12
- Pregnancy and Infant Loss Remembrance Day – October 15
- International Pronouns Day – October 21
- Diwali – October 20
- Rosh Hashanah - October 22-24
- Halloween - October 31

November

- Fall Prevention Month
- Domestic Violence Month
- Lung Cancer Awareness Month

- Allied Health Professional Week- November 8-14
- Medical Radiation Technologist (MRT) Week - November 8-14
- Treaties Recognition Week – November 1-7
- Nurse Practitioner Week – November 8-14
- Transgender Awareness Week – November 13-19
- National Indigenous Veteran's Day – November 8
- Remembrance Day - November 11
- World Diabetes Day – November 14
- International Men's Day - November 19
- World Child Day - November 20
- International Day for the Elimination of Violence Against Women – November 25

December

- International Day of Persons with Disabilities – December 3
- National Day of Remembrance and Action on Violence Against Women – December 6
- International Human Rights Day – December 10
- Christmas - December 25
- Hanukkah - December 4 – December 12
- Kwanzaa - December 26 - Jan 1
- Boxing Day - December 26

HANOVER & DISTRICT HOSPITAL

Infection Prevention & Control Plan 2026-27

Reviewed January 2026

Introduction

An effective infection control plan is paramount in ensuring the health and safety of patients, physicians, staff, and volunteers at Hanover & District Hospital (HDH). In a busy and fast-paced environment, the risk of hospital-acquired infections (HAIs) poses a constant challenge. The introduction of a comprehensive infection control plan is instrumental in mitigating these risks and maintaining a standard of care that prioritizes patient safety.

The infection control plan serves as a proactive and systematic approach to identify, prevent, and control the spread of infections within the hospital setting. By integrating evidence-based practices, guidelines, and protocols, the infection control plan aims to create a robust framework that aligns with the Provincial Infectious Diseases Advisory Committee on Infection Prevention and Control (PIDAC-IPC) standards, and other accredited Infection Prevention and Control (IPAC) guidelines. The plan is a dynamic strategy that is responsive to emerging infectious threats, technological advances, and healthcare trends.

Under the direction of the Infection Control Manager, the infection control program fosters a culture of accountability, education, and continuous improvement. It recognizes the collaborative effort required across all disciplines and departments to effectively manage and control the negative outcome potential from improper execution of IPAC practices. HDH promotes the belief that infection control is everyone's responsibility. Regular training, communication and monitoring mechanisms are integral components of this plan, supporting HDH's commitment to preventing the spread of infections and enhancing patient outcomes.

This infection control plan is the cornerstone of patient safety and quality healthcare. It reflects a commitment to excellence, ensuring the hospital remains a place of healing, where patients can receive high-quality care with confidence.

Specific Components

The infection control plan includes the following components:

Infection Prevention and Control Committee

All infection prevention and control activities are overseen by the hospital's Infection Prevention and Control Committee. The committee is comprised of representatives from the hospital (frontline staff and management), local long-term care facilities, primary care, Grey Bruce Public Health (GBPH) and the medical consultant. The committee meets on a bi-monthly basis.

Infection Control Medical Consultant

HDH retains the services of Dr. Michael Gardam as a Medical Consultant to the Infection Prevention and Control Committee and the Infection Control Manager.

Hand Hygiene

Hand hygiene audits are performed on a regular basis by trained auditors. These results are reported on a monthly basis. The monthly results are reviewed by the Infection Control Manager and the relevant departmental managers. The results are posted throughout the hospital for staff and patient viewing.

The Infection Control Manager also collates and reports monthly, quarterly and annual hand hygiene metrics. These reports are provided to the following committees: Infection Control, Patient Safety and Risk Management, Professional Practice, Medical Advisory Committee, Patient and Family Advisory Committee and, the Quality Governance and Risk Management Committee of the Board of Directors. These statistics are also placed on the website and at various locations around the hospital for full transparency to the public. Annually, this information is reported to Ontario Health (OH) through the Self-Reporting Initiative (SRI).

Appropriate Use of Personal Protective Equipment (PPE)

PPE, including masks, gloves, isolation gowns, and face shields, are located throughout the hospital and clinical areas for use by physicians, staff, volunteers, visitors and patients. Signage is used at the entrance to patient rooms to signal when isolation precautions are in place. Healthcare professionals, staff, and visitors are required to comply with any precautions that are in place.
There are also organizational policies that outline the requirements of appropriate PPE use.

PPE audits are performed monthly to assess staff compliance and ability to don and doff PPE appropriately. These audits are compiled by the Infection Control Manager and reported at the Infection Control Committee. Education opportunities are given at time of observation if required and hospital-wide education is provided when multiple areas are assessed to need reminders.

Universal Screening and Surveillance of Antibiotic Resistant Organisms

Universal screening is required on all patients admitted to HDH's inpatient units. Samples are collected to screen for Antibiotic Resistant Organisms as outlined in the IPAC policy. Any positive results are recorded in the patients' chart for ease of identification to initiate additional precautions on any subsequent interactions.

In addition, patients are assessed using the Febrile Respiratory Illness (FRI) screening tool and will have all travel history documented to rule out any contagious endemic diseases.

Based on the results of the above-noted screening, appropriate additional precautions are implemented with signage placed at the entrance to the patient's room.

Surveillance Reporting and Reportable Communicable Diseases

HDH complies with all mandatory infection control reporting. Positive confirmation of infectious diseases are reported to Grey Bruce Public Health in accordance with all applicable regulations.
On a monthly basis, hospital-acquired cases of Clostridium Difficile (C. Difficile), Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia and Vancomycin-resistant Enterococci (VRE) bacteremia are reported to Ontario Health (OH) through the Self-Reporting Initiative (SRI). Quarterly, Surgical Safety Checklist compliance is reported to OH through the SRI.

The pressure rate and nosocomial transmission of MRSA and C. Difficile is monitored and reported to the Infection Control Committee, Patient Safety and Risk Management Committee, Professional Practice Committee, Medical Advisory Committee, Patient and Family Advisory Committee, and the Quality Governance and Risk Management Committee of the Board of Directors. If any increase of transmission is noted, steps are taken to increase cleaning practices, perform point prevalence studies for admitted patients, and increase hand hygiene practices through education and increased audits.

Surgical Site Infection Surveillance

Selected surgeries performed at HDH are monitored by the Infection Control Manager for any surgical site infections that may arise subsequently. Any potential surgical site infections are brought to the attention of the surgeon, and feedback is received on the case. There is appropriate follow-up and remediation, if required. The surgical site infection rates are reported to the following committees: Infection Control, Patient Safety and Risk Management, Professional Practice, Medical Advisory Committee, Patient and Family Advisory Committee and, the Quality Governance and Risk Management Committee of the Board of Directors.

Outbreak Management

When a potential outbreak is recognized, the Infection Control Manager notifies the appropriate parties according to the Outbreak policy. The Outbreak Management Team works collaboratively with GBPH to provide the best possible outcome for all patients, staff, and visitors.

Environmental Audits

In collaboration with the Environmental Services department, the Infection Control manager performs environmental audits on a regular basis to assess the effectiveness of cleaning and infection control practices. These audits are completed throughout the hospital using an ATP meter. The results of these audits are provided to the relevant department managers, the Environmental Services Manager, as well as the Infection Control Committee.

The audits are utilized for educational purposes. The Infection Control Manager, in conjunction with the Environmental Services Charge, will provide education and training on cleaning practices to Environmental Services staff, and staff within the impacted department to ensure those involved are knowledgeable and engaged in all infection control practices.

Use of UV Sanitizers and Cleaning Practices

HDH has invested in three (3) Clean Slate UV sanitizers, 2 UV washroom sanitizers, and 2 UV tower sanitizers for use throughout the hospital.

Clean Slate equipment provides a quick and effective solution for sanitizing handheld devices, includes mobile phones, pens, ID badges and stethoscopes and promotes hand hygiene and infection control. The devices are situated in areas for convenient use by staff.

The washroom sanitizers and tower sanitizers do not replace the need for routine or additional precaution cleaning, but are utilized as an adjunct to ensure that all potentially infectious/contagious microorganisms have been removed from the patient care area.

All cleaning practices and products utilized by HDH comply with PIDAC standards.

Educational Activities

The infection control manager will provide or facilitate education for all employees. These activities include:

- Infection control orientation for all new employees, students and volunteers on hand hygiene and donning/doffing of PPE

- Annual training on patient screening and isolation requirements through Brain Train program
- Informal feedback for staff regarding PPE donning and doffing practices
- Annual review of policies and cleaning practices in conjunction with IPAC guidelines
- IPAC education courses purchased by the hospital and distributed to employees
- Additional training, as required, based on results of environmental audits

Construction or Facilities Projects

Plans for all construction and/or renovation projects undertaken by Facilities or an outside contractor are required to be reviewed by the infection control manager to ensure all IPAC guidelines are followed for the duration of the project. These projects may also be subject to inspection by the infection control manager.

Communication

Major policy changes, outbreak notification, changes in applicable practice and any reminders needed are communicated to all staff, physicians, and occupants of the building using a multi-faceted approach, including memos, departmental huddles, email communication, signage posted throughout the building.

There is also an IPAC communication board located in the service hallway that also displays these changes, the statistics collected by the Infection Control Manager and any other relevant information from GBPH.

Reports to the Governing Body via Quality Governance and Risk Management Committee

The following reports are provided quarterly to the Quality Governance and Risk Management Committee through the risk manager:

- Hand Hygiene
- Hospital Acquired Infections
- Surgical Site Infections
- Surgical Safety Checklists

Review of the Infection Control Plan

The infection prevention and control plan will be reviewed, updated, and approved annually, or as needed.

Hanover and District Hospital
Accessibility Plan
Five (5) Year Plan - 2022/23 – 2026/27

Submitted to
Dana Howes, President and Chief Executive Officer

Prepared by
Health Equity Committee

This publication is available on the hospital's Website
(www.hdhospital.ca)

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1. CEO MESSAGE:

Hanover & District Hospital (HDH) is committed to meeting the standards outlined in the province's *Accessibility of Ontarians with Disabilities Act*. The hospital incorporates these standards through our values of integrity, compassion and collaboration.

HDH is committed to provide an inclusive environment for all by continually improving access, by removing barriers and investigating new initiatives, to our hospital facilities, policies, programs, practices and services for our patients, family members, staff, healthcare practitioners, volunteers and members of the community with disabilities.

Our mission of providing exceptional care is at the forefront of our services that we provide. HDH is committed to promote inclusion for everyone with the respect and dignity they deserve.

Dana Howes
President and Chief Executive Officer

2. Introduction

Hanover & District Hospital (HDH) works with its partners to provide a full range of primary acute care hospital services and selected secondary services to meet the needs of the population of Hanover and the surrounding rural townships.

The Board of Directors, staff, physicians and community partners work together to accomplish seamless care that provides core rural health services close to home and formulizes a clear pathway for referrals to additional services. HDH partners with peer acute hospitals, community agencies; long term care homes, mental health and addictions and social service providers.

HDH provides the people we service access to the care they need through 24/7 Emergency Department, Acute Care Unit (inclusive of medical/surgical beds and multipurpose ICU), Physiotherapy Program, Surgical Services Department, Family Centred Birthing Unit, Hemodialysis Unit and Palliative Care Services.

3. HDH Commitment:

HDH is committed to fulfilling our requirements under the *Accessibility for Ontarians with Disabilities Act, 2005*. HDH is committed to promoting and providing an environment where respect, independence, and dignity are equally demonstrated at all times, to all patients. We shall provide accessible service for our patients and visitors. Persons with disabilities are given an opportunity equal to that given to others.

HDH is committed to addressing barrier removal strategies in:

- ongoing access improvements to facilities, policies, programs, practices and services for patients, their family members, staff, health care practitioners, volunteers and members of the community
- participation of people with disabilities in the development and review of its annual accessibility plans
- ongoing updates to the building's structure and equipment to ensure it meets accessibility standards
- ensuring hospital policies are compliant with the *Accessibility of Ontarians with Disabilities Act*
- provide training and maintain records on whom the training was provided

Many initiatives are underway across the organization to ensure that our care and services are accessible to people with disabilities.

4. Accessibility Plan Objectives:

The accessibility plan describes the measures that HDH has taken in the past and what the hospital is working at presently and in the future, to identify, remove and prevent barriers to people with disabilities who work in or use our hospital for services. The plan encompasses staff, patients, family members, health care practitioners, volunteers and members of the community.

The accessibility plan is reviewed and updated annually by the Health Equity Committee. The plan is presented annually to the Board of Directors for approval.

The accessibility plan will include strategies and actions applicable to Customer Services, Information and Communication, Employment and Training.
Note: Procurement, Self-service Kiosks, Design of Public Spaces and Transportation are not applicable to us.

5. Accessibility Training:

HDH provides training as soon as practicable after hire and ongoing training of any changes to the policies. Annual accessibility training is provided during Brain Train.

The hospital maintains records of the training provided including the dates on which the training was provided and the number of individuals to whom it was provided.

6. Health Equity Committee:

The Health Equity Committee will create a culture, working in partnership both internally and externally, to make recommendations and initiate strategies to remove barriers of accessing healthcare to enhance the patient and workplace experience. This will involve the Accessibility for Ontarians with Disabilities Act, Senior Friendly Hospital framework, diversity, cultural

sensitivity and Indigenous awareness. The Committee is guided by the vision, mission and values of the Hanover & District Hospital and is accountable to senior management.

The Health Equity Committee's responsibilities and objectives are:

- To develop and/or recommend strategies to implement improvements in systems and processes that align with the goals of the organization, consistent with the provincial Senior Friendly Hospital framework, to enable seniors to maintain optimal health and function while they are hospitalized, so they can successfully transition home or to the next level of appropriate care;
- To ensure that legislative requirements with respect to the *Accessibility for Ontarians with Disabilities Act*, 2005 are met; evaluate and make recommendations on matters related to goods, services, accommodation, employment, buildings, wayfinding, structures and premises that will impact patient, staff or visitor accessibility;
- To build capacity to provide safe, quality care for diverse and vulnerable populations through increasing the cultural competencies of Hanover & District Hospital employees by providing proactive education and organizational training and development aimed at creating an environment that embraces diversity and cultural sensitivity, including Indigenous;
- Establish a monitoring framework to ensure continuous improvement to measure the effectiveness of implementation strategies and monitor indicators related to health equity and accessibility (for example patient satisfaction, employee and physician experience use of translation services and opportunities for improvement arising from complaints); and
- To create a healthier and more inclusive workplace environment for all staff, volunteers and physicians.

7. Communication and Information:

The hospital's accessibility plan is posted on the Hanover & District Hospital website. On request, the accessibility plan is made available in hard copy, electronic format, in larger print or on audiotape.

8. Past Achievements to Remove and Prevent Barriers

HDH is proud of the accomplishments to remove accessibility barriers to allow access to all. Refer to Appendix A for the *Accessibility Barrier-Removal Accomplishments*.

9. Current Five-Year Accessibility Plan

Refer to Appendix B for our *Current Five-Year Accessibility Plan*

APPENDIX:

Appendix A – Accessibility Barrier-Removal Accomplishments (2005 – 2025)
Appendix B – Current Five-Year Accessibility Plan (2022/23 – 2026-27)

ACCESSIBILITY PLAN APPENDIX A:

Accessibility Barrier-Removal Accomplishments (2005 – 2020, 2021-2025)

2005-2020

1. Wheelchair accessible washroom renovated in Dialysis/Family Health Team
2. Wheelchair accessible washroom in renovated in patient Room 117
3. Website Update to meet AODA standards (2020)
4. More wheelchairs purchased for mobility
5. Removal of stone wall at front entrance for wheelchair storage; more accessible
6. Implemented customer service training/education on how to approach and talk to people of all abilities
7. Hearing/visually impaired phones; large number pad
8. Wheelchair accessible washroom renovation on Unit 2
9. Purchased four “Evacu-Trac” units for stair evacuation; used for mobility impaired patients in an emergency; one unit is at each stairwell; ongoing staff training on Evacu-Trac equipment; ongoing staff training provided
10. Waiting room seating replaced with firmer/higher chairs; bariatric seating included
11. Main front entrance to hospital had step removed and a concrete ramp installed to make it wheelchair accessible
12. Main front doors changed from manual to automatic sliding doors
13. Concrete sidewalk at outer edge of front canopy was ramped to allow wheelchair access from the pavement to sidewalk
14. The main front entrance to the hospital had a step removed and a concrete ramp installed to make it wheelchair accessible
15. The main hospital entrance doors were manual swing doors and upgraded to automatic sliding doors to produce hands free entrance
16. The concrete sidewalk at the outer end of the front canopy was ramped to allow wheelchair access from the payment up to the sidewalk
17. The entrance into the emergency department from the previous drive through had an asphalt ramp installed to eliminate one step into the hospital
18. The addition of the day hospital to the hospital included barrier free washrooms, tub room and shower; entrance and exits from their exterior tranquility garden had sloped concrete walks to make them wheelchair accessible
19. Accessible washroom installed in the waiting room area of the emergency/out-patient department when department was renovated
20. Automatic swing door operators, complete with accessible activation buttons, installed on the entrances to the operating rooms, imaging department, laboratory and the west wing first floor corridor door
21. Two close proximity disability parking spaces created in the hospital’s front visitor parking lot; Six additional disability parking spaces added when the parking lot reorganized for the new medical clinic; hospital patrols these reserved spaces to ensure compliance and availability
22. The patient room numbers lowered to wheelchair level in all of the nursing units and the number enlarged from one-inch number to two-inch numbers
23. The shine of the finish used on sheet resilient flooring removed so the floors would have a non-shine surface to assist people with depth perception when walking on these floors
24. Re-development of the obstetrics unit, which included patient room accessible washrooms
25. Accessible washroom constructed in palliative care unit’s family rooms 206 and 209
26. Carpet replaced in Emergency department waiting area with safety flooring

27. Handrails on both sides of corridor from Day Hospital entrance to Diagnostic Imaging Department entrance installed
28. A "No Scent" policy implemented and signage posted
29. Accessible washroom installed on the second floor for patients and the Public
30. CNIB and Hearing Impaired Phones are available
31. Education for staff on CNIB needs
32. The addition of four accessible parking spots adjacent to the buildings and strategically located in high volume areas
33. Installation of new signage for direction and flow pedestrian traffic
34. Stop blocks and speed bumps at cross walks to slow traffic around accessible entrances and access points
35. New Lab renovations – completion fall 2013
    - installation of a phone/video display for patient identification
    - installation of automatic door openers in Laboratory renovations for completion
    - installation of accessible washroom
36. Installed an automatic door leading into the dialysis unit.
37. Retrofitted the fire alarm system so that the alarm signals are both audible and visual throughout the building
38. Purchased some "raised" toilet seats and began a program to evaluate the seats in patient room washrooms; they did not prove to be a satisfactory solution
39. Replace compact fluorescent lamps that were slower to brighten with newer lamps that brighten quicker
40. Retrofitted both elevators to meet current codes and standards and installed new safety system on the doors (meets current accessibility codes); buttons are at wheelchair height and include braille to assist persons with vision impairment
41. Retrofit the lighting in the Pediatric Speech room so that is not as bright as when the main room lighting is currently on; Installation of incandescent fixtures to offer an alternate level of lighting
42. Developed a policy to accommodate a caseworker to be with a mental health patient in the ER department rather than the waiting room whenever possible
43. Doctors' entrance had a ramp installed to facilitate wheelchairs and the transfer of air ambulance stretchers
44. Investigated the feasibility and costs associated with constructing one accessible washroom using the space or portion of the space now occupied by the female staff and male public washrooms at switchboard and the housekeeping janitor closet located across from the hospital's boardroom; construction project awarded & completed
45. The carpet has been replaced in the Emergency department waiting area with non-slip flooring
46. The female staff washroom on the second level renovated to make one large accessible public washroom
47. Installed a second automatic door push plate at the main entrance door to Diagnostic Imaging department to accommodate people who approach from the Emergency department
48. Installed twin level water drinking fountain to accommodate wheelchair height and children
49. Purchased speakerphones
50. Purchased a wheelchair accessible weight scale

2021-2025

1. Temporary Wayfinding Signage posted during COVID-19
2. Wheelchair accessible washroom & Shower on Acute Care
3. Ceiling Lift Installed in Room 121 & 122 for improved transfers for patients with disabilities

4. Staff training on ceiling lift provided by vendor
5. Wheelchair accessible washroom (Diagnostic Imaging)
6. Installed LED lighting on first floor
7. Implemented QR Codes on the Patient Feedback Surveys
8. Added a comment line under the accessibility question to patient feedback survey
9. Ongoing monitoring of accessibility comments on patient feedback survey
10. Implemented “Boogie” board to enhance patient communication
11. Ongoing staff education at Brain Train
12. Wheelchair accessible automatic door installed on the Quiet Room on the second floor
13. Purchased clear masks for staff to wear for hearing impaired patients, as needed
14. Purchased a Pocket Talker for hearing impaired patients
15. Installed LED lighting on second floor
16. Review accessibility comments from Patient Feedback Surveys
17. Wooden railing replacement
18. Investigate Interpreter Resources to remove language barriers
19. Implemented interpreter resource utilizing iPad
20. Staff Education: implemented AODA online training for new hires at orientation
21. Monitor Accessibility comments on Patient Feedback Surveys; present quarterly at Health Equity
22. Creation of an accessible Reflection Room for staff, patients and visitors to utilize
23. Education Centre Renovation/Relocation; ensured entrance and space was accessible for staff and visitors.
24. Relocated the automatic door button leaving surgical services after feedback from patients that there was not enough time to push button and back away from door before it opened.
25. Purchased height-adjustable desk for Emergency Room Triage
26. Purchased height-adjustable desk for Acute Care Charge Office
27. Implementation of appointment reminders (by e-mail/phone call/text)
28. Introduction and Implementation of Pocket Health
29. Online patient surveys now available
30. Renovation of Registration to meet accessibility requirements for visitors (completed)
31. Height adjustable desks purchased for Registration Office to accommodate various employees’ needs
32. Wayfinding Project - Directional Signage completed
33. Ceiling lifts installed in Rm 118 and Rm 119 on Acute Care
34. Updated HDH website accessibility; toggle button in right lower corner allowing visitors to choose from different accessible navigations and profiles (seizure safe, vision impaired, ADHD friendly, keyboard navigation, screen reader, etc.)
35. Updated HDH website accessibility; ability to see content in English, French or Spanish
36. Broadened language translation/interpreter services available at front line
37. Installed additional fire alarm strobe lights to accommodate an employee accessibility request (hearing impairment)
38. Replace ceiling lift in morgue to be more accessible for staff.

ACCESSIBILITY PLAN APPENDIX B:

Five (5) Year Plan

2022-23 & 2023-24

☑ Wheelchair accessible door installed on the Quiet Room on the second floor
☑ Purchased clear masks for staff to wear for hearing impaired patients, as needed
☑ Purchased a Pocket Talker for hearing impaired patients
☑ Ongoing staff education at Brain Train
☑ Installed LED lighting on second floor
☑ Review accessibility comments from Patient Feedback Surveys
☑ Wooden railing replacement
☑ Investigate Interpreter Resources to remove language barriers
☑ Implemented interpreter resource utilizing iPads
☑ Staff Education: implemented AODA online training for new hires at orientation
☑ Monitor Accessibility comments on Patient Feedback Surveys; present quarterly at Health Equity
☑ Health Equity Committee AODA training
❒ Wayfinding Project - Directional Signage (on hold due to COVID-19)
❒ Evaluate entrances into the building and make suggestions to increase accessibility
❒ Automatic Door on ER washroom outside Treatment #1 and in waiting room

2024-25

☑ Ongoing staff education at Brain Train
☑ Updated staff education
☑ Monitor Accessibility comments on Patient Feedback Surveys; present quarterly at Health Equity
☑ Implementation of appointment reminders; by phone, e-mail or text
☑ Continued training initiatives
☑ Renovated Education Centre – wheelchair accessible
☑ Introduction and Implementation of PocketHealth
❒ Wheelchair accessible washroom
❒ Evaluate entrances into the building and make suggestions to increase accessibility
❒ Automatic Door on ER washroom outside Treatment #1 and in waiting room
❒ Wayfinding Project - Directional Signage

2025-26

☑ Online patient surveys now available
☑ Reviewed ADM 1-15 Accessibility Policy
☑ Reviewed ADM 6-70 Pets in the Hospital or Service Animals
☑ Renovation of Registration to meet accessibility requirements for visitors (completed)
☑ Ongoing staff education at Brain Train
☑ Height adjustable desks purchased for Registration Office to accommodate various employees needs

- ☑ Monitor Accessibility comments on Patient Feedback Surveys; present quarterly at Health Equity
- ☑ Wayfinding Project - Directional Signage completed
- ☑ Ceiling lifts installed in Rm 118 and Rm 119 on Acute Care
- ☑ Updated HDH website accessibility; toggle button in right lower corner allowing visitors to choose from different accessible navigations and profiles (seizure safe, vision impaired, ADHD friendly, keyboard navigation, screen reader, etc.)
- ☑ Updated HDH website accessibility; ability to see content in English, French or Spanish
- ☑ Broadening language translation/interpreter services available at front line
- ☑ Installed additional fire alarm strobe lights to accommodate an accessibility request for an employee whom is affected by hearing impairment.
- ☑ Replaced ceiling lift in morgue to be more accessible for staff.
- ❒ Wheelchair accessible washroom (capital request – not approved)
- ❒ Implement Self-Service Kiosks (on hold)

2026-27

- ❒ Wheelchair accessible washroom (capital request)
- ❒ Implement Self-service Kiosks
- ❒ Ongoing staff education at Brain Train
- ❒ Monitor Accessibility comments on Patient Feedback Surveys; present quarterly at Health Equity
- ❒ Sharps containers in Public Washrooms
- ❒ Installation of third elevator – pending HIRF funding approval

Ongoing Projects:

- ❒ Changing faucets in washrooms (being changed to lever handles or motion activated) as repairs and replacement of old ones required.
- ❒ Changing door knobs (being changed to lever handles) as repairs and replacement required.
- ❒ Higher toilet in washrooms (on going). Short term solution purchased seat adjusters.

Future Projects:

- ❒ E.R. Accessible washroom.
- ❒ E.R. treatment rooms (5-9) larger, more accessible.
- ❒ Increase accessibility of Registration Office
- ❒ Elevator sound to identify arrival at floor/ when door is opening or closing (to be completed when elevator has to be replaced)
- ❒ Automatic Door on ER washroom outside Treatment #1 and in waiting room

HANOVER & DISTRICT HOSPITAL

Conservation and Demand Management Plan

2024-2029

Hanover & District Hospital

90 7th Ave.

Hanover, ON

N4N 1N1

July 2024

The Senior Team at Hanover & District Hospital is excited and pleased to present the enclosed five-year Energy Conservation and Demand Management (CDM) plan. This plan renews our 2019 CDM plan while providing an update on our successes and outlining possible opportunities for future conservation.

Our organization realizes that conservation takes many forms and provides benefits which include but are not limited to:

- Improved patient and employee experience
- Reduced utility bills to focus money on direct patient care
- Limiting our Green House Gas Emissions

In line with our initial CDM Plan in 2019, this document will act as a foundation for procurement, operational, and behavioural efforts over the coming years.

We look forward to providing an update on our efforts via our annual reporting and 2029 CDM Plan.

Sincerely,

Kim Mighton, Vice President of Finance & Operations

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HANOVER & DISTRICT HOSPITAL

The Hanover & District Hospital (HDH) provides a full range of primary care hospital services and selected secondary care services to the population of Hanover and the surrounding rural municipalities. The original hospital was established in 1923 and a new acute care hospital was built in 1973. It is a state-of-the-art facility with a 24-hour Emergency Department.

The Hospital's vision is to be a rural acute care center of excellence and its primary goal is to achieve organizational excellence in patient safety and care closer to home.

OUR SERVICES:

- Two state of the art Operating Rooms
- Day Surgery
- Obstetrics
- Emergency Department
- Specialist Clinics
- Medical/Surgical In-patient Unit
- Palliative Care
- Hemodialysis Unit
- Rehabilitation Services
- Restorative Care Unit
- Laboratory Services
- Diagnostic Imaging

OUR MISSION AND VALUES

HDH's mission is "**Providing Exceptional Care**."

PARTNERSHIPS & COMMUNICATION

The Board of ire tors, staff, physicians, and community partners work together to accomplish seamless care that provides core rural health services close to home and formulizes a clear pathway for referrals to additional services. HDH partners with peer acute hospitals, community agencies; long term care homes, mental health and addictions and social service providers.

OVERVIEW OF OUR PLAN

In 2014 HDH developed our initial five-year conservation and demand management (CDM) plan to actively work towards decreasing our overall energy consumption and greenhouse gas (GHG) emissions. The plan was updated and reaffirmed in 2019 to outlined goals that our hospital wished to achieve over the past five years. Once again in 2024 HDH is putting forward a new which reflects our results over the past five years and a renewal of our commitment to reducing our environmental impact.

HDH is proud to report that we have successfully decreased our total electricity consumption by 3% and saw a 13% drop in natural gas usages. This represents a decrease of 133 tCO2e or 12% in GHG emissions. Using 2018 as a baseline and adjusting for weather, HDH sees a net 3% decrease in natural gas usages with a slight uptick in baseload power consumption resulting in less than a 1% increase. It is important to note that these achievements occurred during a period of increased service for the community.

	Electricity [kWh]	Natural Gas [m^3]	Greenhouse Gas [tCO_2e]	Energy Use Intensity [$ekWh/ft^2$]
2018	2,419,155	597,837	1,245	95
2023	2,342,418	530,990	1,112	87
2018 vs. 2023	3%	13%	12%	10%

By 2029, HDH is focused on identifying conservation measures which will continue to reduce overall energy and ultimately emissions intensity.

To further strengthen and obtain full value from energy management activities, a strategic approach will be taken: the organization will fully integrate energy management into its business decision-making, policies, and operating procedures.

Active management of energy related costs and risks in this manner will provide a significant economic return to the organization and will support other key organizational objectives.

REAFFIRM OUR ENERGY MANAGEMENT VISION

In 2014 HDH made a commitment to reducing its energy usage and greenhouse gas emissions by creating an energy efficiency vision. Recognizing the role HDH has in the community, we put a focus on using our natural resources wisely, including conserving energy and reducing our impact on the environment whenever possible. The vision developed for the hospital and the community is:

To improve energy efficiency and reduce waste by improving infrastructure, by developing forward-think policies and processes, and by incorporating new best practices and technologies.

HDH also recognizes the additional benefits that come with effective energy management including a reduction in operating costs, enabling us to place more focus on the health care needs of our community. Additionally, many energy conservation measures positively effect the environment of the hospital, whether it be through lighting conditions, staff, and patient comfort, or by having a more reliable and effective system in place.

Going forward, HDH will renew this energy management vision, in addition to applying the energy management principles discussed later in this report. Over the next five years, HDH will continue to place a focus on reducing our energy consumption (both electricity and natural gas) with the goal of reducing both and overall GHG emissions.

GUIDING PRINCIPLES AND GOING FORWARD

Going forward, HDH will apply the same guiding principles implemented in 2019 to achieve our reduction goals and improve our consumption performance. We recognize that integrating conservation and demand measures into our everyday operation is key to being successful. Detailed below are the guiding principles.

Incorporate Energy Efficiency Considerations in Infrastructure Renewal

When deciding on infrastructure renewal projects, HDH will incorporate energy efficient options into the process. HDH recognizes that improving our infrastructure not only benefits staff, patient, and visitor experience, but also enhances the hospitals efficiency, thereby reducing our energy consumption and greenhouse gas emissions. We will continue to place a focus on choosing options that are the best fit for the hospital and will do the most to improve our patient care while also offering a smaller environmental footprint.

Being Strategic in Our Policies and Processes

Continuing to track electricity and natural gas usages, we strive to significantly improve our energy-related performance. Internalize energy management into HDH's everyday decision-making, policies, and operating procedures to help assure substantial and long-lasting reductions in energy, operating costs, and environmental impact.

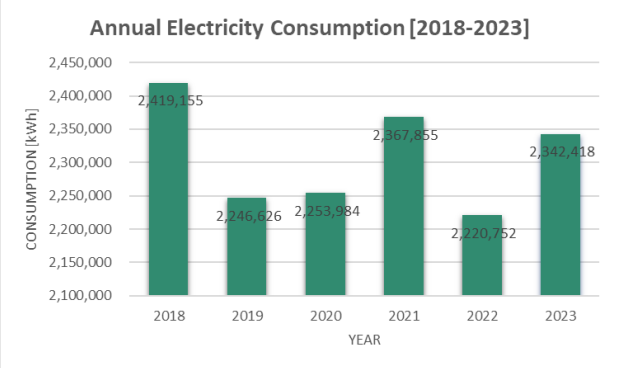
Pursue New Best Practices and Technologies

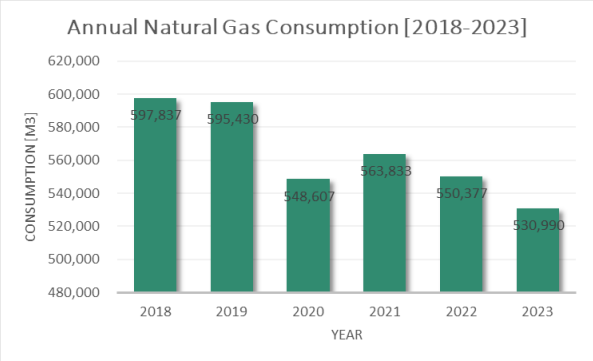
HDH will look to new practices and technology to better improve our hospital. HDH will continue to stay up to date with current best practices and work towards motivating staff and patients to implement such practices such as turning lights off when leaving a room or unplugging equipment when not in use. With new technologies offering better and cleaner options for equipment, HDH will look for medical equipment with shorter run times and higher efficiency to not only reduce consumption but also improve patient comfort and experience while ensuring high quality care.

ANNUAL ENERGY CONSUMPTION AND GREENHOUSE GAS EMISSIONS

As part of Ontario Regulation 25/23 under the Electricity Act, 1998, HDH prepares, publishes, and makes available its annual energy consumption and resulting greenhouse gas (GHG) emissions. The historical consumption data for our hospital has been included below.

Year	Electricity (kWh)	Natural Gas (m^3)	GHG Emissions (tCO_2e)	Energy Use Intensity ($ekWh/ft^2$)
2018	2,419,155	597,837	1,245	95.16
2019	2,246,626	595,430	1,233	92.97
2020	2,253,984	548,607	1,139	87.70
2021	2,367,855	563,833	1,177	90.70
2022	2,220,752	550,377	1,146	87.53
2023	2,342,418	530,990	1,112	86.67





RESULTS OF CONSERVATION INITIATIVES SINCE 2019

HDH developed goals in 2019 and green initiatives to decrease the facilities annual energy consumption and resulting greenhouse gas emissions. Our 2019 CDM Plan also included details on significant projects and initiatives the hospital was targeting to help achieve these goals. Outlined below are some of the projects completed over the past 5 years along their overall benefit energy consumption, lowering annual operating costs, and reducing greenhouse gas emissions summarized in a table.

Roof Replacement

Replacing a roof presents an excellent opportunity to increase the insulation which prevents heat loss in the winter and heat penetration during the summer. The extent to which insulation resists heat flow is measured as an R-value. The higher the R-value, the more the resistance and the better the material is at insulating a home.

As identified in our 2019 plan, the current roofing system exhibited wear and damage with minimal rigid insulation. In the past couple years, HDH was able to replace 13,595 square feet of roofing and replace old ineffective insulation with new 3-inch R-17.1 rigid insulation.

Lighting Upgrade

Replacing old inefficient lights such as compact fluorescent with highly efficient LEDs can drive significant energy savings especially for hospital which requires 24/7 lighting in significant portions of the building. Just as important, LED lights typically provide better lighting levels and quality improving staff/patient safety and experience while reducing maintenance costs because of their prolonged life cycle. HDH has recently undertaken a two-stage lighting upgrade throughout the hospital whereby approximately 1,000 T8 lights were exchanged with LEDs on the first and second floors. In addition, the over bed T12 lights in approximately 100 patient rooms were replaced with LEDs.

As part of these projects, HDH worked with our local electricity utility to capture $11,103 in incentives while recycling old lamps which diverted glass, metals, phosphor, mercury, porcelain, and plastic from landfills.

Variable Speed Drive on Chiller/ Cooling Tower Replacement

HDH implemented Adaptive Frequency Drive (AFD) which combines chiller control systems and frequency drive technology to convert the chiller from a constant speed to variable speed compressor operation.

Variable speed operation improves chiller efficiency by reducing chiller energy consumption and electrical demand charges. Slowing chiller motor speeds also provides operational savings reducing compressor wear and the soft start provided by a drive greatly reduce stress on compressor components. In our experience, typical savings range from 18% to 25%, with paybacks often under 3 years.

Pump & Motor Replacement

In an effort to improve energy efficiency and provide more reliable cooling to the facility, NHH replaced the existing Condenser Water Pump, Stand by Pump, and Chiller Pump and associated motors which were at the end of their useful life. All three new motors installed are VFD which regulate the cycles of motors, reducing the wear and tear on the machine components while driving efficiencies when compared to constant running motors.

New Walk-in Cooler & Freezer

Replacing end of life appliances and equipment with more energy efficient models is often an effective way to reduce overall energy intensity. In most cases, not only is a reduction in energy usage achieved but performance and safety are also improved. Leveraging HIRF funding, HDH was able to replace the dietary walk-in cooler & freezer which was at the end of its useful life. In some cases, new appliances can reduce overall energy usage by up to 25%. In addition to more efficient compressors, some of the other energy saving measures associated with this project include:

- ✓ Increased R-value providing better insulation for the cooled space.
- ✓ LED lighting equipped with automatic shut off.
- ✓ Automatic door closers
- ✓ Meeting energy efficiency standards set out by Natural Resources Canada and the Energy Efficiency act.

Energy Savings Table

Project Description	Electricity (kWh)	Natural Gas (m^3)	GHG Emissions (tCO_2e)	Savings ($)
Roof Replacement	53,784	-	1.16	6,992
1st Floor - Lighting Upgrade	149,853	-	4.50	19,481
2nd Floor – Lighting Upgrade	77,248	-	2.32	10,042
Overbed Lighting Upgrade	1,775	-	0.05	231
Cooling Tower Replacement/VFD on Chiller	76,063	-	2.28	9,888
Pump & Motor Replacement	90,496	-	2.72	11,764
New Walk-in Cooler & Freezer	4,315	-	0.09	561

It is always important to point out that, in addition to the energy savings outlined above and resulting reductions in operating costs, each one of these measures provides additional benefits the hospital and the community we support, including but not limited to: improved patient and staff comfort and safety with enhanced infection control measures.

ENERGY MANAGEMENT GOALS

Established in 2019, the following goals are what HDH uses to work towards achieving our energy vision. These same goals will continue to be an important set of objectives over the next 5 years.

1. Obtaining Executive Approval

For HDH to have the resources available to achieve our energy management goals, we will need executive approval. Ensuring that all departments, specifically key staff including financial management, purchasing/procurement, construction and building operations are aware of and ready to support HDH's CDM plans will be essential to our success. This will include clarifying and communicating staff roles and responsibilities, performance foals, and energy management reporting. In addition, creating mechanisms and processes to make resources available will assist in this process.

2. Implement Financial Practices and Decision-Making Processes

Hospitals primarily rely on available funding from the province community and volunteer organizations, and as such, need to make good decisions about how to utilize funding. HDH already has solid decision-making processes in effect but will continue to fine tune these and recognize money spent to achieve energy efficiency as an investment, not a cost. We will continue to use Life Cycle Cost Analysis (LCCA) on all new construction, major renovations, and equipment replacement. The decisions we make about energy management investments will become a part of HDH's high-level, long-range process of budgeting for capital and operations.

3. Implement Strategic Energy Management Practices

Energy management is a process of monitoring, controlling and conserving energy and involves many steps. This goal is broken down into sub-goals to better explain what HDH will be working towards over the next five years.

Utilize purchasing specifications for energy efficient equipment & services

HDH consistently use purchasing specifications that minimize life-cycle costs for energy efficient equipment and services. We also deploy efficiency specifications for standard equipment routinely replaced (e.g. lights, motors, and unitary HVAC equipment) as well as focus on LCCA for custom equipment purchases (e.g. chillers).

Set and meet clear energy performance targets; measure and improve over time.

To measure our performance goals, HDH will use 2023 as our new baseline year. This will become our target for EUI (normalized for weather and changes to care offerings) to measure our performance and improve over time.

Improve Building Operating Performance

By implementing energy efficiency standards and energy management procedures, hospital equipment will see a tune-up and operations and maintenance will see improvements, all of which will support patient care

and facility comfort and safety. As equipment reaches the end of its service life and infrastructure requires upgrades, the improved and up-to-date standards that replace the old equipment/structure will directly improve the hospitals building operating performance.

Implement Cost-Effective Facility Upgrades

When justified by LCCA, HDH will implement equipment and systems upgrades and expand our use of qualified service providers as needed. Additionally, HDH will utilize standard RFP documents, contract terms, and reporting standards.

Actively Manage Energy Commodity

HDH already actively manages energy commodity but will continue to minimize utility costs and exposure to market risks, with utility costs including natural gas, electricity, water, and sewage. We will also participate in the energy and utility regulatory process.

4. Monitor, Report, and Reward Progress

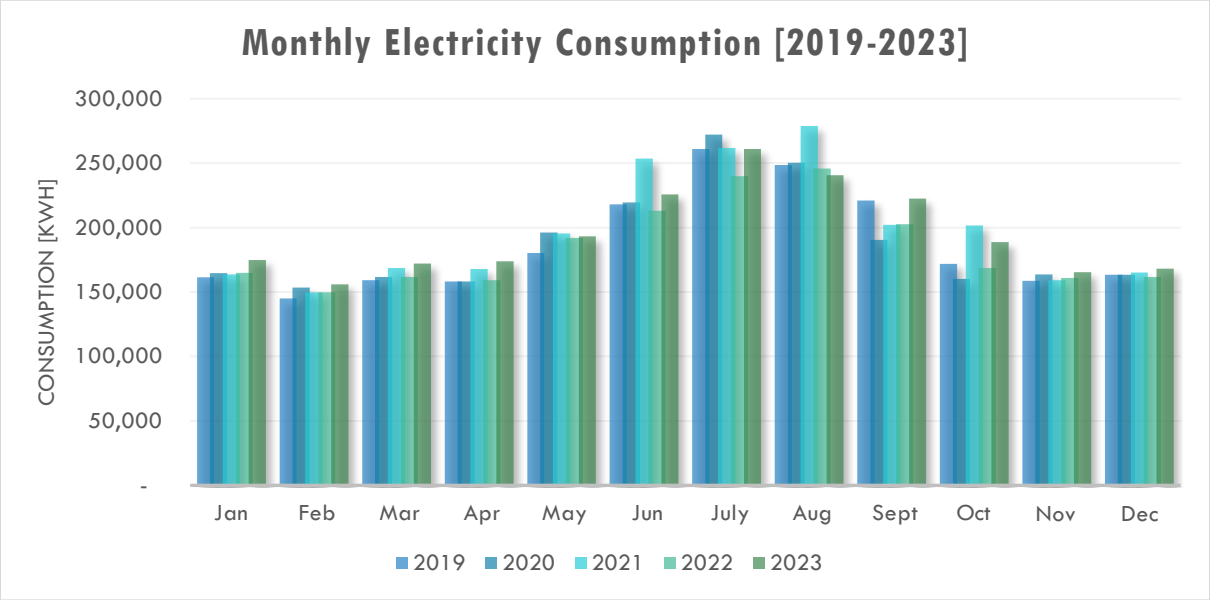
Over the next five years HDH will track our progress on achieving the goals laid out in this plan through active reporting and regular meetings. We will report energy reduction and unexpected increase so senior management and reward staff for their successes. Most importantly, we will learn from set-backs and make changes based on them to reach our energy conservation and demand management goals.

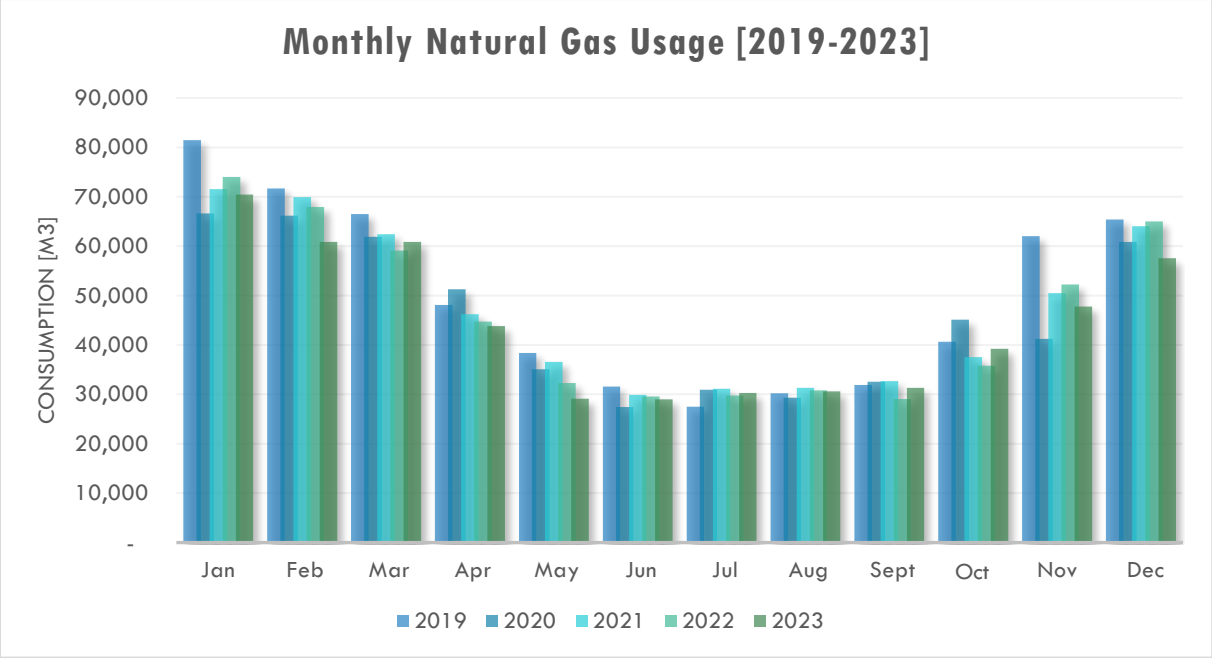
5. Continue with Facility Upgrades

HDH will continue to renew, replace, and upgrade our facility infrastructure, systems, and equipment, much of which will directly affect our annual energy consumption. These changes not only improve the hospital itself, but also its efficiency, environmental impact, and patient/staff/visitor experience. The below table includes projects that, funding permitted, we will be targeted over the next five years.

Project	Present State	Proposed State
Emergency Room (ER) Redevelopment	The HDH ER is in need of redevelopment to bring up to todays standards while improving patient and staff experience.	While undertaking redevelopment of the ER, HDH will look to include the most up to date technology including but not limited to: LED lighting, energy efficient equipment, new AHUs, etc.
Replace Air Handling Unit (AHU)	Several AHUs are approaching the end of their useful life.	As funding becomes available, HDH will replace AHUs in order of necessity while implementing new more energy efficient units.
Update 3rd Elevator	Currently not in service.	Bringing the 3rd elevator back into services will allow HDH to utilize newer, safer, more energy efficient equipment while improving service to staff and patients.
Identify New Conservation Measures	HDH has implement significant conservation measures over the past 5 years, with a need to look for new opportunities to capitalize on going forward.	As part of our efforts over the next 5 years, HDH will look to engage third party experts to help identify opportunities for improvement.

APPENDIX


Monthly Electricity Consumption [2019-2023]
CONSUMPTION [KWH]
300,000
250,000
200,000
150,000
100,000
50,000
-
Jan
Feb
Mar
Apr
May
Jun
July
Aug
Sept
Oct
Nov
Dec
2019
2020
2021
2022
2023


Monthly Natural Gas Usage [2019-2023]
CONSUMPTION [M3]
90,000
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
-
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sept
Oct
Nov
Dec
2019
2020
2021
2022
2023