Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

April 15, 2026

OVERVIEW

The Osgoode Care Centre is home to 100 people, located in rural Ottawa. It is a not-for-profit stand-alone home, governed by a volunteer Board of Directors. The mission of the Osgoode Care Centre is to provide a long term care home of choice where residents can enjoy life fully. Our vision is to be a leader in rural eldercare, growing with the ever changing needs of our community to ensure our neighbours have choices close to home. Our core values (C.A.R.I.N.G.) support our commitment to continually improving the quality care to our residents:

Commitment - expecting the best of ourselves and others
Accountability- accepting responsibility for everything we do
Resident-Driven - honouring the rights of residents to live their lives their way
Inspiring- leading by example and aspiring to be exceptional
Nurturing - being compassionate, patient, kind in our words and actions
Growing Together - working and learning together to succeed together.

Over this past year, the Osgoode Care Centre has embarked on several quality improvement journeys with the commitment to our core values. In January 2025, the Osgoode Care Centre became part of Cohort 8 of the implementation of the Registered Nurses Association of Ontario (RNAO) Clinical Pathways. The first three pathways that launched in July of 2025 included the Admission Assessment, Delirium Assessment and Resident and Family-Centred Care assessment. These assessments are based on best practice guidelines, support a more comprehensive person-centred assessment of the residents physical, emotional and cognitive

needs, ensures alignment with legislative and regulatory requirements for the mandatory clinical programs, inspection protocols and LTCF and is embedded with many efficiencies that streamline clinical documentation and care planning. The next two clinical pathways to be implemented in May of 2026 are falls and pain. The application of the falls clinical pathway into practice will assist the home to identify current gaps in processes related to best practices, support a comprehensive fall prevention program with the goal of reducing the number of falls in the home. The Osgoode Care Centre is also part of the PREVENT Trial, through the Geras Centre for Aging Research at McMaster University- a study aimed to reduce hip fractures in residents living in long term care.

In December 2025, the Osgoode Care Centre received a 1-year PoET certification, following its 4-week work during the Initiation Stream of the Provincial PoET Program. This program helps homes to meet their obligations related to consent, capacity and substitute decision making. This individualized approach to decision making has resulted in the reduction of avoidable ED visits. This also reinforces the obligation to respect and adhere to the resident's wishes, values and beliefs at end-of-life.

In 2017, the Osgoode Care Centre embarked on it's culture change journey, adopting the Eden Alterative Approach - "an approach to care that supports the whole person, that upholds their right to a life full of purpose, connection, empowerment and possibility, regardless of age or changing abilities". The Eden Alternative is based on education and best practices that have been proven effective for over 30 years. Its 10 Principles help to guide us in our journey moving from an institutional model of care to a more home-like social model of care - with the goal of addressing the three plagues of long term care: hopeless, helplessness and boredom. In 2024, the Osgoode Care Centre became a Growth Member and is required to implement, at minimum, two best practice changes each year. The home now has two Certified Eden educators so we are now able to train more staff in-house to become Certified Eden Associates to help to foster change. Education is the antidote to fear and resistance often brought about with change. We currently have 24 Certified Eden Associates in our home. Our goal for 2027 is to become a Certified Eden home. The Eden Alternative Approach to Care will be the foundation in the redevelopment of our home in hopefully the near future.

ACCESS AND FLOW

The Osgoode Care Centre is committed to ensure our residents receive the right care in the right place at the right time.
In the Ontario Health "The Alternative Level of Care (ALC) Leading Practices Guide: Preventing Hospitalization and Extended Stays for Older Adults - September 2021" document it primarily addresses leading practices to help reduce length of stay (LOS) and alternate levels of care (ALC) for hospitals. However, several of the leading practices are applicable in a long term care setting.
Reducing avoidable ED visits has been an ongoing quality improvement project in this home. ED visits are viewed quarterly at the Quality Risk and Safety Committee and goals to reduce ED visits are discussed. Falls with head injuries and infections which were difficult to detect are the two main reasons for an admission to hospital. In July of 2025, the RNAO Clinical Pathways went live for Admission assessment, Delirium assessment and Resident and Family Centered assessment as part of Cohort 8. Through the Admission Assessment, residents are screened for their risk of

delirium and if at risk, interventions are documented in their plan of care to help reduce the risk. The Delirium assessment is also used when a change in behaviour is noted in a resident so interventions can be proactively put into place. The Admission assessment also screens for risk of falls and if at risk, intervention can be put into place at time of admission e.g. fall mats, hip protectors, physio referral, mobility aids. Head injuries requiring ED visits, due to falls, often involve lacerations. Our Skin and Wound Care lead will be training Registered staff on how to glue a laceration, no longer than 5 cm, thereby avoiding an ED visit.
In December 2025, the Osgoode Care Centre received a 1-year PoET certification. The Provincial Prevention of Error-based Transfers (PoET) Program is an ethics quality improvement project that supports Ontario long term care homes to align their habits, practices and policies with Ontario's Health Care Consent Act. In October 2025, the home had the opportunity to become a part of the PoET)- Initiation Stream. The work of the Initiation Stream takes place over four consecutive weeks; during this time, the PoET Team works with the home to collaboratively identify opportunities for alignment with the Health Care Consent Act; design and test change ideas; track and monitor the success of these changes; and make refinements wherever necessary. The results of this program, in other parts of the province, have shown that this individualized approach has helped to reduce unnecessary and unwanted transfers to hospital. Increased care was provided in the home, in line with the resident's wishes. Since the implementation of this project, the number of transfers to hospital for those at end of life have dramatically decreased and number of resident who died in hospital has decreased to zero. Families are receiving education on their role as the SDM, if a resident has been determined to be incapable to make the decision at that time, and that the wishes of the resident are to respected.

EQUITY AND INDIGENOUS HEALTH

The Osgoode Care Centre is part of Great River Ontario Health Team which is a collective of health and social service providers who plan and work together, to provide integrated services and supports to meet the health needs of people who seek care in the City of Cornwall, Stormont, Dundas & Glengarry, Akwesasne and parts of rural Southeast Ottawa and Russell Township. The Great River health Team offers indigenous training to its partners annually. In November 2025, the Osgoode Care sent 4 Leadership Team members to its two half-day training sessions. The goal is to send all Leadership Team members to these sessions in 2026.

In review of Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework. In review of the 11 areas of action, the Osgoode Care Centre has incorporated the 4 core areas of action:

1)Embed in strategic plan: Under our Strategic Priority #4 Promote Enhanced Workforce Capacity, Health & Wellness to support people to excel and grow in their roles, an operational objective is to develop our Wellness and EDI Committee to support an inclusive workforce environment and support EDI training to all staff. Our EDI committee has established a terms of reference and will be further developing to support our commitment to advancing equity, inclusion and diversity, in addition to addressing racism.

2)Partner to advance Indigenous Health Equity- Through the education resources of the Great River Ontario Health Team and Centre for Learning Research and Innovation, we are able to advance education to all staff

3) Collect, report and use equity data - Our Wellness and EDI Committee has administered a staff surveys to explore the cultural diversity of our workforce. In preparation for our 2026 Accreditation Canada survey, we also asked staff to complete the Global Workforce survey. Four questions in this survey relate to equity, inclusion, diversity and anti-racism which were all responded to positively: i) At work, I feel comfortable being myself - 88.6% ii)
(Leadership) Takes effective action to prevent racism and discrimination in the workplace - 79.7% iii) The people I work with treat each other with respect, regardless of race, ethnicity, gender, disability or age - 78.6% and iv) People from all backgrounds are treated fairly - 80%.

Upon admission to the home, we gather information from the resident with respect to their cultural background, languages spoken, religious and spiritual beliefs and traditions to incorporate into their plan of care to ensure, as a home, these are respected and supported in their day to day life in the home, thereby engaging these key voices.

4) Invest in Implementation: Education opportunities for staff to learn, whether on-site or in the community, are supported. As we plan for the redevelopment of our home, we have ensured that this will include a spiritual space to support religious, spiritual and ceremonial traditions, such as smudging.

A land acknowledgement statement is posted on our publicly viewed website at www.osgoode.ca. A land acknowledgment is also recognized prior to meetings of the Board of Directors.

All external job posting will include a statement that supports our commitment to being an equitable and inclusive workplace.

PATIENT/CLIENT/RESIDENT EXPERIENCE

As per the Fixing Long Term Care Act 2021, the Osgoode Care annually administers a Resident and Family satisfaction survey. For 2025 and 2026, we administered the Eden Alternative Domains of Well-Being® Assessment tool (EAWBAT)for ElderRs and Family Members as we are a recognized Eden Alternative Growth member. As per the Eden Alternative model of culture change, there are 7 Domains of Well-Being: identity, connectedness, security, autonomy, meaning, growth and joy.
The EAWBAT for ElderRs consists of 26 statements to which the resident can agree or disagree. Having a choice of two responses is much easier for the resident as opposed to a 5 point likert scale. The survey was administered to 22 residents by an Algonquin college student completing required placement hours and this helped to reduce bias in responses to the statements. The student very much enjoyed the opportunity to meet and speak with the residents. It also helped to give them an insight into a life living in long term care. Overall, responses were very positive. Statements that were agreed to 100% included: My room shows who I am, I can come and go as I please, My spiritual beliefs are respected here, My opinion counts, Life here is generally good, I am mostly content and I trust my caregivers. Two statements that had a high disagree (<40%) include: I feel a connection with many people here and Staff visit me every day just to talk. These two statements are reflective of the Connectedness domain of well-being. Principle #3 of the Ten Principles of the Eden Alternative states "We thrive when we have easy access to the companionship we desire. This is the antidote to

loneliness." A quality improvement project for 2006 is to implement ways for our residents to develop better connections connections with others who also live in the home and to support ways for staff to have enhanced engagement with residents, beyond their care responsibilities.
The EAWBAT for Family Members was administered to the primary contact of residents in January 2026. The survey was sent through Cliniconnex, and we had a return rate of approximately 50%. This tool has 32 statements of which family members can choose a response of Strongly Agree, Agree, Neutral, Disagree or Strongly Disagree. The highest percentage of responses of positive responses (agree, strongly agree) where tot he following statements: I have a say in my loved one's care, My opinion about my loved one matters, I can visit my loved one when I want, I am able to express my own opinion without resentment from the staff, I feel my loved one is safe here, this home has a cherry atmosphere, Our family traditions are respected here and I have opportunities to be alone with my loved one. The lowest response received was to the statement " I have made several friends here". This relates to the domain of Joy.
There is an opportunity for the home to support family members to engage more with each other and to support increased engagement with staff. We have been working with the Ontario Caregivers Organization in the development of our Essential Caregivers program and this will be ready to implement in September 2026.

PROVIDER EXPERIENCE

With the increased demand for long term care, due to our aging population, comes an increased demand for the staffing to support and provide the necessary care to those living in long term care. The Osgoode Care Centre is one of the largest employers in our area, with approximately 150 staff. While we have a low turnover rate, the greatest turnover is in nursing. However, various Ontario Health programs have assisted us to attract RNs, RPNs and PSWs. The Osgoode Care Centre is working with Humber College as a placement site for PSWs taking the on-line PSW training program. We have had 14 PSWS complete the course to date with two more enrolled in the current session. We also 5 PSW preceptors trained through the CLRI Preceptor program to support the students during their required clinical placements. The Osgoode Care is also the site for these students to complete their practical training days, with the support of our PSW preceptors. The Osgoode Care Centre has also received funding through the Nursing PLEDGE program to support the funding for nursing mentors. We have also received support through the Jumpstart Opportunities in Nursing in Long Term Care JOIN LTC) to support the recruitment of RNs and RPNs. Very recently, funding was announced to support a pilot project through Humber College to support fast track education of PSWs interested in pursuing a career as an RPN. Thirteen PSWs at the Osgoode Care Centre expressed interest in the 40 possible spots available throughout the province.
Any position openings are posted on HFOJobs, Indeed and the Osgoode Care Centre Facebook page. The Osgoode Care Centre also has a roadside billboard sign listing job vacancies. This sign does bring in people with their resumes and also helps to spread the word of positions available at our home.

In 2025, we administered the Global Workforce Survey to all staff, as required for our 2026 Accreditation Canada Survey. We had a 46.1% response rate. The survey focused on 7 dimensions: people-centred care, job characteristics, patient safety, leadership, work team, well-being and engagement and immediate supervisor. Top 5

strengths identified included staff understanding what is expected of them in their job, using input from residents and families to improve care and services, ensuring residents and families actively participate in making care decisions, residents are treated with dignity and respect and that the training required to their job is received. The one of the top opportunities for improvement is in response to " I feel burned out from my work". It is important to ensure that there is adequate staffing to decrease workload of those at work, to provide support to staff to ensure they have the time off to recharge their batteries, to provide education so they can feel competent and confident in their roles and to ensure their opinions, concerns and ideas are heard and acted upon. The Osgoode Care Centre newly formed Wellness Committee has the mandate to discover ways to help support our valued staff.

In 2025, our home created an EDI committee and surveyed staff to identify what gender they closely align with, country of origin and what languages staff speak. It was very interesting to discover how diverse our staff are. An Equity Diversity and Inclusion policy was created in June 2025, reinforcing our commitment to proving equality and fairness to all members of our team.

It's important to celebrate the accomplishments of the team! We hold an annual employee recognition event to celebrate years of service with the Osgoode Care Centre. We celebrated the launch of the RNAO Clinical Pathways, of which we are part of Cohort 8. We have a "Shout Out" board where families and staff can give a "shout out" to someone who went the extra mile or did something extra special for a resident, a co-worker or a resident. Each month, a draw occurs for those who received a "shout out" that month.

SAFETY

The Osgoode Care Centre endorses a "just culture" - a culture focused on the prevention of harm. We have a culture that focuses on openness, transparency and learning from adverse events rather than assigning blame. Every member of the team, from every department, works to provide our residents with a safe environment to live in. We have also implemented programs and processes that support a more responsive safety culture.

Resident safety is a primary focus in our day to day work and it involves everyone who works in home. The Osgoode Care Centre is the first "Positive Approach to Care" (PAC) certified home in Canada and has two Certified PAC coaches/trainers/consultants. PAC is a method and series of techniques developed by Teepa Snow, a dementia care specialist. Her approach teaches team members about dementia so everyone can understand the changes in the brain and how to support a person in a more positive a respectful way. It supports developing a meaningful relationship between the caregiver and the resident, which helps to decrease resistance and stress when providing care to a resident. Our two PAC coaches are also our BSO leads - an RPN and PSW. When it is identified that a resident is being resistive to care, and exhibiting signs of distress (kicking, biting, swearing, hitting) during care, our PAC team will work with the resident to develop ways to help connect with the resident, gain their confidence and trust, understand how that resident is processing the information due to their dementia and develop ways to deliver the care in a way that is more person-centred and less stressful for all involved. the PAC coaches will then model and mentor their techniques with the staff to help increase their confidence and competence in caring for that resident. It also helps to improve that relationship between the staff and resident. It goes from " I'm afraid to care for him because he is going to hit me"

to " George and I had a great discussion about fishing today while I was giving him his bath. It took a little longer but he's all cleaned up". When a staff has had a difficult encounter with a resident, they are asked to complete an ABC form - what was the antecedent?, what was the behavior?, what was the consequence? This exercise helps the staff to reflect on the situation and also helps to identify any triggers to the behaviour so we can then adjust our approach, the environment, etc. We may also need to review the person's plan of care and their own personal story. For example-maybe baths are trigger as the resident may have had a traumatic near drowning experience so showers are the alternative, in the evening before bed. As a result of incorporating the PAC techniques into the home, with the support of our two PAC coaches, the number of staff injuries has declined.
We have also expanded our BSO program to include 4 PSW BSO champions and 3 Recreation BSO champions. The BSO champions met every week for a 15 min huddle to identify which residents in the home may require some extra support with care or engagement. This supports an "exploring, learning and acting before harm occurs" approach as opposed to responding to an incident that has occurred.
All staff in the home have received PAC training in 2025 and it has helped to change the culture in how we view and engage with those residents who may have distressing behaviours. Our PAC coaches also offer two community education sessions a year and will provide education to resident families so they also can meaningful interactions with their loved ones.

The Osgoode Care Centre is a part of the PREVENT trial Intervention group, through the Geras Centre for Aging Research at McMaster University. This is the first study in the world looking to reduce hip fracture rates in long term care. PREVENT is a knowledge translation program to educate health care providers in long term care on the evidence-based fracture recommendations. Hip fractures account for 50% of fractures in long term care. A hip fracture results in an increased risk of death, increased dependence on support for activities of daily living and results in the inability to walk independently. A person with dementia has an increased risk for fractures due to changes in gait and the inability to multi-task i.e. walking and talking. Through our involvement in this study, with 80 other long term homes, is to reduce falls and fractures in our vulnerable resident population.

In preparation for our 2026 Accreditation Canada survey, we have been self-assessing the various indicators of safety and risk this survey requires and identifying areas for improvement.

The Osgoode Care Centre's Quality, Risk and Safety Committee reviews indicators related to risk on a quarterly basis. Examples of indicators include : # of falls, # of avoidable ED visits, # of medication errors, # of incidents involving residents and staff or resident to resident, # of codes and # of outbreaks. The goal of reporting is to develop QI projects to reduce those indicators, mitigate the risk and explore ways to a create safer home environment.

PALLIATIVE CARE

In 2025, the Osgoode Care Centre had the opportunity to further enhance its palliative and end-of-life program through involvement in the Centre for Learning Research and Innovation (CLRI) Collaborative Project to Sustain a Palliative Approach to Care in LTC project. A self-questionnaire helped us to determine the needs of

our home and where supports and coaching through the CLRI could be best applied. Our Palliative Lead and the VP Clinical Care and Quality lead this project.
Five goals were developed:
1) Provide education on Palliative care to 20 team members. Five palliative champions also received training. We are constantly explore opportunities for continuing education of all members of our team. For 2026, our goal is to help support our Registered staff with Serious Illness conversations to enhance their comfort and competency in what can be very difficult conversations to have. The Osgoode Care Centre was recently was accepted in to the LTC Quick Guide initiative and is now one of 250 homes who are part of this project. Webinars are being offered to residents, families, and staff and this initiative is focused on the book developed by Dr. Hsien Seow and Dr. Sammy Winemaker _ Hope for the Best Plan for the Rest : 7 keys for Navigating a Life-Changing Diagnosis. Serious Illness conversation training for registered staff has also been offered through our palliative coach.

2) Provide education on Palliative Care to 10-20 family members. This occurred through a virtual Family Council meeting. Approximately 15 family members attended and it supported ongoing education for families would be beneficial. It encouraged conversation amongst the family members.

3) Review our Palliative Care Policy to ensure it encompasses the entire palliative care trajectory. In the process of doing so, it raised many other areas that needed to be addressed. For example, at the time when a person moves into long term care, their goals of care are discussed with the team to help inform health care decisions. The plan of care is developed in collaboration with the resident or SDM to ensure it is individualized and person-centred. The RNAO Admission assessment that we implemented in July 2025 has the Palliative Performance Score embedded in it so it encourages a conversation concerning the trajectory of a resident's disease process. It is also the opportunity to discuss their preferred setting of care and place of death, informing the resident or SDM of the opportunity to stay in the home and receive end-of-life care here. Goals of care are again reviewed at the post-admission care conference and annual care conference. When a resident is experiencing a significant change in condition, a care conference is organized with the interdisciplinary team and the resident/SDM to again review goals of care and the wishes of the resident. Our training through the Provincial PoET program has helped us to ensure that a resident's wishes are respected and acted upon by the SDM.

4) Develop an End-of-life survey to provide team members with key principles of improvement (KPIs). An end of life survey was developed with the assistance of a coach with a sub-committee of the Palliative Committee. The committee included the Palliative lead, the VP of Clinical Care and Quality, 2 Palliative champions a family member and a resident. The survey will begin to be sent to family members in April 2025, via mail with a return, stamped envelope and a cover letter explaining how their voice is important in helping us to improve our palliative and end-of-life program. The survey will be sent out 4 months following a resident's passing to give families time in their grief.

5) Provide education on grief and loss to 20 team members. This was a focus we felt was very important to help support the well-being of those who work within the home. While some residents

are with us a short time, others have lived in the home for several years. We promote consistent staffing, supporting staff to develop trusting relationships with the residents they care for every day. When a resident passes, we need to be mindful of the impact on staff. It is a tradition in our home that when a resident passes, a "code angel" is called and all staff are to come to the Atrium to form an "honour guard" process as the resident is taken, through the front door, by the funeral home, covered a beautiful dignity quilt. It is a time to say goodbye. Families are asked if they would like to also be present. For staff who have found the passing of the resident to be difficult, an informal huddle is held in our chapel where staff can share memories, express their grief and have the support of other team members. These huddles are facilitated by team members who have been trained in the INNPUT model.

In the true definition of palliative, all people living in long term care can be considered palliative due to the life-threatening illness that they are living with. It is our goal that all residents are provided with the care they need, that the care reflects their needs and wishes, and is provided with dignity and respect by all staff, no matter what department they work in.

POPULATION HEALTH MANAGEMENT

The Osgoode Care Centre is a partner organization with the Great River Ontario Health team. Our role, as a long term care provider within this Health Team, is to provide quality care and a safe living environment to those who require more care and support than the community can provide. We work closely with Ontario Health At Home, Champlain to determine eligibility, categorize applicants to our home and to oversee our ever-growing waitlist.

The Osgoode Care Centre is located in the southern, rural outskirts of the city of Ottawa. Many of those who live here, or their family members who support them, are from the surrounding areas, within approximate radius of 25 kilometers of the home.

In 2025, the home experienced a 50% turnover of residents. Of those moving in: 17 from hospital, 15 from their home, 14 from retirement home and 2 from another long term care home.

As people are supported to age at home as long as possible, their care and medical needs have become more complex when it is time to move into long term care. It is often quoted that the average length of stay in long term care is 18 months, which also reflects the high turnover rates.

Who are the people who live at the Osgoode Care Centre? Of the 100 people who live at the Osgoode Care Centre:

-61 use a wheelchair, 33 use a walker and 10 are able to walk independently

-47 have a visual impairment and 49 have no visual impairment

-55 have a communication barrier and 45 have no communication barrier

-91 have a cognitive impairment and 9 have no cognitive impairment

Our residents have multiple conditions that need to be managed by trained staff each day such CHF, diabetes and arthritis to name but a few. Residents take an average of 12 medications a day. We are supported by physicians, nurse practitioners and pharmacists and we have access to other specialists as required e.g. palliative consultants to help manage pain when someone is approaching end of life, an NSWOC when a pressure ulcer is not responding to our treatment and OT/PT to support residents with changes in their mobility. We have the support of the Royal Ottawa Mental Health Centre Geriatric Psychiatry Outreach team to support residents who

are experiencing changes in their cognitive abilities and who may require medication or other interventions to help with the management of responsive behaviours, working in collaboration with our BSO team.
Some other interesting demographic information about those who live in our home includes:
-69% of our residents are female and 31% are male. It is important that we provide opportunities for those gentleman living in the home that are specific to their interests
- 45% are widowed and 20% are married. We need to ensure that we are supporting the social and emotional needs of those who no longer have a spouse and supporting the spouse of residents in their continued role as a caregiver
- 96% speak English and 4% speak other languages. We have discovered creative means and use of technology to help us to communicate with those who's primary language is not English. Through our work in supporting equity, diversity and equality in the home, we have discovered that many of our staff speak other languages that is a support to the team.
-71% of our residents were born in Canada with 8% born in the Netherlands and 5% in the UK. Other countries of origin include Denmark, Italy, Australia, Ireland, Portugal, Ukraine, Sri Lanka and St. Lucia. Our home is becoming more diverse in culture and it is important to respect and celebrate the tradition of these various cultures.

As we plan for the redevelopment of the Osgoode Care Centre and the future needs of those who will be moving into long term care in the future, understanding our resident population in respect to their diagnosis, care needs, cultures, religions, socioeconomic status, etc. will be important to ensure we can deliver more effective, equitable and person-centred care to those who live here.

CONTACT INFORMATION/DESIGNATED LEAD

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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 27, 2026**

David Eggett, Board Chair / Licensee or delegate

Lori-Norris-Dudley, Administrator /Executive Director

Lindsay Passfield-Leu, Quality Committee Chair or delegate

Other leadership as appropriate
