

**Equity | Equitable | Optional Indicator**

Indicator #5	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Township Of Osgoode Care Centre)	90.91	100	87.33	-3.94%	100

**Change Idea #1**  Implemented  Not Implemented  In Progress

Staff will complete equity, diversity and inclusion training

**Process measure**

- Number of staff who have completed EDI training by the end of December 2025

**Target for process measure**

- 80% of all staff will have completed EDI training by the end of December 2025

**Lessons Learned**

Training was provided in various ways. Equity, Diversity and inclusion training was provided to staff during annual mandatory training. This included using the CLRI resources "What would you do " posters and the " Cultural Humility in Action: Nurturing Inclusion in LTC" video with facilitated discussion by our educator. Three members of the Leadership team attended a two session training on the Indigenous Perspectives on Truth and Reconciliation in Healthcare offered through the Great River Ontario Health Team. Seven members of our interdisciplinary team took a one-day equity, diversity, inclusion anti-racism training. 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 reinforce our commitment to proving equality and fairness to all members of our team.

**Comment**

We will continue to develop our EDI committee and recruit new members from our diverse staff to ensure that we are respecting our commitment to encouraging a supportive and inclusive culture amongst all members of our team.

**Experience | Patient-centred | Optional Indicator**

	Last Year		This Year		
<b>Indicator #3</b>	<b>CB</b>	<b>80</b>	<b>NA</b>	<b>--</b>	<b>NA</b>
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Township Of Osgoode Care Centre)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

**Change Idea #1**  Implemented  Not Implemented  In Progress

Increase the rate of resident's agreement to the statement " People know what I am interested in" from 61.5% to 80%.

**Process measure**

- % of BSO personhood tools completed for those admitted to the home between June 1 2025 and March 15 2026.

**Target for process measure**

- 80% of BSO personhood tools will be completed for those admitted to the home between June 1 2025 and March 15 2026.

**Lessons Learned**

When a person moves into the home, they (or family) are asked to complete a "Who I am and This is Me" form to gather information about the person. This information is used as part of their leisure assessment to ensure their interests, skills and abilities are reflected in their plan of care. This information is also shared with the BSO team to help discover non-pharmacological approaches when person is in distress. The summary of this form, is put into a "20 Things about Me" sheet which is posted in a resident's room for all staff and volunteers to get to know that person i.e. I like to watch hockey and I'm a Sens fan - there a PSW can ensure that the person's TV is on the proper TV channel when a game is being broadcast. Similarly, Recreation will post a schedule of games in the person's room. It is a challenge when a resident is unable to tell us what is important to them and family have not completed the form. It does take longer for staff to get to know the person and the transition to living in long term care is not always as smooth as it can be.

**Comment**

In January 2026, the Osgoode Care implemented the Welbi Resident Engagement AI platform. Within this platform is a Resident Profile that assists in the capturing of information about the resident's personhood - likes, dislikes, interests, abilities, challenges and past life experiences, etc. This one page summary will be shared with staff and volunteers to promote increased knowledge of who the resident is and will support increased meaningful engagement with the resident.

	Last Year		This Year		
<b>Indicator #4</b>	<b>CB</b>	<b>80</b>	<b>100.00</b>	<b>--</b>	<b>NA</b>
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Township Of Osgoode Care Centre)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

**Change Idea #1**  Implemented  Not Implemented  In Progress

Increase staff awareness of the importance for residents to have the opportunity to express their opinions and feel these opinions count.

**Process measure**

- The percentage of residents who agree with the statement "My opinion counts"

**Target for process measure**

- 80% of residents surveyed in 2026, following the OARC education, will agree with the statement "My opinion counts"

**Lessons Learned**

Review and discussion regarding Residents' Rights is part of our staff orientation training and mandatory annual education. We celebrated the OARC Resident Council Awareness Week in September 2025 with display boards depicting how residents' opinions and suggestions have directed change in the home. Some examples include using smaller hamburger and hot dog buns, having a quieter dining room at meal times with no radio playing and lowered voices of staff, needing more physiotherapy resulting in hiring a part time PTA and including changing the paint in the hallways to a more calming colour. One resident was part of our palliative and end-of-life project with the CLRI and was an integral part in the development of our end-of-life survey to send to families and in the development of the cover letter to accompany the survey.

Indicator #1 Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Township Of Osgoode Care Centre)	Last Year		This Year		
	<p><b>18.16</b></p> <p>Performance (2025/26)</p>	<p><b>15</b></p> <p>Target (2025/26)</p>	<p><b>22.51</b></p> <p>Performance (2026/27)</p>	<p><b>-23.95%</b></p> <p>Percentage Improvement (2026/27)</p>	<p><b>18</b></p> <p>Target (2026/27)</p>

**Change Idea #1**  Implemented  Not Implemented  In Progress

To hold a post-fall huddle with staff working on the home area following each resident fall in the home.

**Process measure**

- Number of post-fall huddles completed after each fall

**Target for process measure**

- 100% of residents who had experienced a fall will have a post-fall huddle form completed on their electronic chart - PCC.

**Lessons Learned**

A post fall huddle was identified as a gap in the completion of the gap analysis in the pre-implementation work for the RNAO Falls Clinical Pathway. We currently do not have a post-fall huddle form and did explore resources in other long term care homes. With the implementation of the RNAO Falls clinical pathway, a post huddle is part of the post-fall assessment and management clinical pathway to be completed.

**Change Idea #2**  Implemented  Not Implemented  In Progress

The Osgoode Care Centre is part of Cohort 8 of the RNAO Clinical Pathways Implementation project. Beginning in the fall of 2025, the second phase of the project for this Cohort is a focus on pain and falls.

**Process measure**

- The number of RNAO best practices related to falls that are implemented

**Target for process measure**

- 100% of best practices will be implemented

**Lessons Learned**

In July 2025, we implemented the RNAO Clinical Pathway Admission assessment in which residents are screened for risk of falls and MORSE falls scale is completed. A plan of care item is developed if a resident is at a moderate to high risk of falls to help address the risk of falls. IF the resident is a low risk, S.A.F.E. precautions are put into place, as per best practice. As part of the implementation of the RNAO Clinical Pathways for falls, a gap analysis was conducted in the fall of 2025. Areas for improvement in our Falls Prevention and Management program were identified. The Falls Clinical Pathway will implemented in our home in April 2026.

**Comment**

In May of 2026, the Osgoode Care Centre will be implementing the RAO Falls Clinical Pathway and this will support the implementation of best practices into our Falls Prevention and Management Program.

Indicator #2	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Township Of Osgoode Care Centre)	<b>30.99</b>	<b>28</b>	<b>26.81</b>	<b>13.49%</b>	<b>22</b>

**Change Idea #1**  Implemented  Not Implemented  In Progress

To become part of the Healthcare Excellence Canada Sparking Change in the Appropriate Use of Antipsychotics Award Program.

**Process measure**

- Number of residents, without a diagnosis of psychosis, for whom we have been able to successfully deprescribe antipsychotic medications

**Target for process measure**

- Our goal is reduce the use of antipsychotic medication administered to those with a diagnosis of psychosis by 10%

**Lessons Learned**

The Osgoode Care Centre became part of the Healthcare Excellence Canada (HEC) Sparking Change in the Appropriate Use of Antipsychotics Award program in March 2025. The education and coaching sessions offered through this program helped us to develop a quality improvement project to focus on reducing the inappropriate use of antipsychotics. Based on projects developed by other long term care homes, we focused on one home area and the residents of one physician who was pleased to be part of the project. Of the 5 residents in our focused project group, one resident became more agitated when the antipsychotic was deprescribed and family requested it be resumed but a lower dose was used, two residents had their antipsychotic medication deprescribed, one resident had their doses reduced by half and for one resident it was decided to not touch her antipsychotic medication from feedback from the team. We also submitted a project for an award, focusing on the ways we use non-pharmacologic approaches to help support residents, rather than using anti-psychotic medications. We review these medications upon admission to determine if they are still beneficial now that they are in a more supportive setting with trained staff. If we determine a person may have difficulty adjusting to life in long term care, our BSO team will spend extra time with the resident to help them to adjust with decreased agitation.

**Change Idea #2**  Implemented  Not Implemented  In Progress

Completion of the Point Click Care Nursing Advantage delirium assessment upon admission, in accordance with the RNAO best practice guidelines.

**Process measure**

- number of delirium assessments completed upon admission of residents from August 1, 2025 to March 15, 2026.

**Target for process measure**

- 80% of new residents to the home will have a completed delirium assessment completed within 24 hours of admission.

**Lessons Learned**

As part of Cohort 8 in the implementation of the RNAO Clinical Pathways, the completion of a delirium assessment became a requirement, as of its launch in July 2025. With the increased awareness and knowledge of the signs of delirium, residents are receiving treatment in a more effective and timely manner. The treatment is to use antipsychotic medication but to treat the cause of the delirium.

