

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	95.00	To promote education with all team members with our DEI team	

Change Ideas

Change Idea #1 Workplace Diversity and Inclusion: we would like to support and inclusive workplace culture.

Methods	Process measures	Target for process measure	Comments
Human Resources and leadership will track staff participation in DEI education, staff engagement, and feedback related to workplace culture. Data will be reviewed monthly at leadership and quality meetings, with key updates shared at staff huddles and meetings to support transparency and continuous improvement.	% of staff who complete DEI education annually Number of staff participating in DEI training sessions per quarter % of new hires receiving DEI education during orientation Number of staff feedback surveys completed related to workplace inclusion per quarter	Target: 85% of staff will complete annual Diversity, Equity, and Inclusion (DEI) education, including cultural safety and anti-racism training, by December 31, 2026, increasing to 95% by March 31, 2027.	

Experience

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Residents with worsening mood.	C	Number / All patients	Local data collection / until March 31 2027	28.30	20.00	We feel that working on this quality measure has the potential for a large impact in other areas such as falls, worsening pain etc.	

Change Ideas

Change Idea #1 Delhi LTC will reduce the percentage of residents experiencing worsening mood by 20% by March 31, 2027 through enhanced engagement opportunities, person centered programming and improved staff awareness of resident histories and preferences.

Methods	Process measures	Target for process measure	Comments
Progress on the Resident Mood and Engagement initiative will be monitored through a structured, interdisciplinary approach to data collection, analysis, and reporting. Data will be gathered from multiple sources to ensure a comprehensive understanding of resident outcomes and program effectiveness. Clinical data related to the percentage of residents experiencing worsening mood will be collected quarterly through RAI-MDS assessments and reviewed by the Director of Care. Recreation-related data, including participation in activities and the number of evening and weekend programs offered, will be collected monthly by the Recreation Team using	% of residents with a completed “Know My Story” profile documented by June 2026 Number of evening and weekend recreation programs offered per week % of residents participating in at least one structured activity per week Number of residents participating in social connection initiatives (e.g., buddy programs, peer dining) per month % of staff who have completed mood awareness and engagement education by September 2026 Number of home areas equipped with engagement kits and actively using them per month Number of resident and family satisfaction surveys completed related to engagement per reporting period ?? Recommended Top 3 (if you need to	Know My Story Profiles 100% of residents will have a completed “Know My Story” profile documented and accessible to staff by June 30, 2026, and maintained at 100% thereafter. 2. Evening & Weekend Programming A minimum of 3 additional evening and/or weekend recreation programs will be offered per week by July 1, 2026, and sustained through December 31, 2026. 3. Resident Participation in Activities 75% of residents will participate in at least one structured activity per week by September 30, 2026, increasing to 85% by December 31, 2026. 4. Staff Education (Mood Awareness) 90% of staff will complete education on recognizing and responding to changes	

attendance records and program schedules. Resident satisfaction with activities and engagement opportunities will be measured through bi-annual resident and family surveys, coordinated by the leadership team. Each department is responsible for collecting and submitting relevant data on a defined schedule. The Director of Programs will oversee the implementation and tracking of engagement initiatives, including the “Know My Story” profiles, enhanced programming, and engagement kits. Nursing staff will support daily monitoring of resident mood and participation, while also contributing to documentation and communication of any observed changes. Data will be analyzed monthly by the Director of Care and Director of Programs to identify trends, gaps, and opportunities for improvement. Findings will be reviewed through established governance structures, including monthly quality meetings and quarterly Quality Committee reviews, with oversight from the Executive Director. Progress and key outcomes will be shared with staff through daily huddles, team meetings, and internal communications to support awareness and accountability. Updates will also be provided to residents and families through Resident Council, Family Council, and quarterly QIP reporting. This consistent, data-driven approach ensures that interventions remain responsive, resident-centered, and aligned with the goal of improving

narrow it down) % of residents with completed “Know My Story” profiles
Number of evening/weekend programs offered per week
% of residents participating in at least one activity per week

in resident mood by September 30, 2026. 5. Social Connection Initiatives
Participation in structured social connection programs (e.g., buddy programs, peer dining) will increase by 15% from baseline by March 31, 2027

mood, engagement, and overall quality of life.

Safety

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	21.25	17.20	We are striving to get this down to the provincial target.	

Change Ideas

Change Idea #1 Objective: Address root causes of falls and improve response times

Methods	Process measures	Target for process measure	Comments
Identify high-risk residents using RAI-MDS and internal data Implement tailored interventions (e.g., mobility supports, environmental adjustments) Establish individualized and scheduled toileting routines for residents identified as high risk for falls in the washroom Where operationally feasible, prioritize placement of high-risk residents in more central or observable locations within the unit to support quicker PSW response times Engage families in prevention strategies Lead: Interdisciplinary Team Timeline: Ongoing	% of high-risk residents with individualized fall prevention plans Reduction in bathroom-related falls Reduction in response time to high-risk residents	By March 31, 2027, 90% of residents identified as high risk for falls will have an individualized fall prevention care plan in place, including tailored interventions, scheduled toileting routines (where indicated), and consideration of strategic room placement to support timely staff response. In addition, the home will achieve a 15% reduction in bathroom-related falls and improve response times to high-risk residents, as measured through internal audits and incident reporting data.	