Access and Flow | Efficient | Optional Indicator

Indicator #4

Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (AgeCare Trilogy)

Last Year		This Year		
20.25	15	22.89	-13.04%	15
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Avoidable ER Visits = 49 or 20.2%. In 2025, we would like to see Trilogy attain a decreased transfer rate of 15%. This would include on improving on the utilization of the NLOT; increase our education on fall prevention strategies to assist in decreasing incidents with injury resulting in transfer to hospital; and provide education to our Registered Staff on physical assessments and early recognition of resident significant changes. Also bring awareness to new employees and agency staff by ensuring that they are fully oriented on the needs of the residents, especially high risk residents with complex medical concerns. High Risk resident lists to be placed on each neighbourhood to assist Trilogy staff and Agency staff to identify those residents who fall into this group.

Process measure

- 1) All ED visits will be identified and analyzed to determine if they could have been avoidable. 2) Each resident will have their CIHI Outcome Scores reviewed (i.e. FRS; PSI; CHESS) to identify those at high risk 3) Effective resident assessment and critical thinking regarding resident health status prior to transfer

Target for process measure

- 1) All ED visits will be reported and discussed during morning Leadership meeting. The nursing team will identify avoidable visits and ensure that education is provided. 2) A decrease in number of Avoidable ER visits within the quarter identified by LTCH avoidable ER Transfer Quarterly Report 3) Increased awareness of avoidable ER transfers, evidenced by a decrease in number of avoidable ER transfers

Lessons Learned

Successes
1. NLOT provided education to Registered Staff on completing nursing assessments.
2. Assessed SCOTT fall risk scores and ensured Falling S.T.A.R. logos were updated to identify high-risk residents. Successfully implemented fall risk device logos at the head of residents' beds to prompt safety checks and ensure devices are in place.
Challenges
1. Incomplete resident assessment information provided to physicians resulting in avoidable transfers to hospital (i.e. UTI)
2. Registered staff not identifying significant changes in resident's condition resulting in delayed treatment with progression to sepsis
3.Families providing Registered Staff and Physicians directives to transfer resident to hospital for interventions that could have been provided in N.H. - Uninformed decisions
4. Registered staff not utilizing NLOT to their full capabilities

Change Idea #2 ☐ Implemented ☐ Not Implemented ☑ In Progress

Enhance staff training on early recognition and management of common conditions that may result in ED visits, such as infections, sepsis and dehydration

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Initiative that we are focusing on for 2026 but just initiating.

Change Idea #3 ☐ Implemented ☐ Not Implemented ☑ In Progress

Educate staff on effective communication techniques between members of the health care team and external clinical supports about a resident’s condition

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Initiative that we are focusing on for 2026 but just initiating.

Change Idea #4 ☐ Implemented ☐ Not Implemented ☑ In Progress

Implement an ER Tracker to track ER Transfers out and NLOT usage

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Initiative that we are focusing on for 2026 but just initiating.

Change Idea #5 ☐ Implemented ☐ Not Implemented ☑ In Progress

Provide each unit with a resource binder which includes materials on assessing a resident's change in condition, algorithms on how to complete assessments on common changes in condition i.e. CHF, UTI, Dehydration, Acute Mental Status Changes

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Initiative that we are focusing on for 2026 but just initiating.

Comment

In home daily discussion during the leadership morning meeting, and daily tracking of all residents ER and NLOT visits.
Re-educate all clinical registered staff on effective communication with physicians, residents families and external partners (NP/NLOT) in regards to residents transfer to hospital.

Equity | Equitable | Custom Indicator

Indicator #1

Agecare Trilogy will build workforce capacity and promote person-centered care through relevant equity, diversity, inclusion and anti-racism education (AgeCare Trilogy)

Last Year		This Year		
CB	**CB**	**93.28**	**--**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Agecare Trilogy will accomplish relevant equity, diversity, inclusion and anti-racism through the identification, development and spread of information and resources that support diversity and inclusion in senior living. This recognizes that care experiences can be influenced by individual circumstances, including language, ability, race, ethnicity, religion, spirituality, gender identity, gender expression, sexual orientation, and socio-economic status.

Process measure

- 1. Our home develops meaningful partnerships with community-based organizations and community groups to advance equity, diversity and inclusion within the home and enhance life for residents from various communities (e.g., local faith-based organizations, community organizations, etc.). 2. Our home evaluates the effectiveness of its engagement processes (e.g., measures resident and family involvement, assesses resident and family satisfaction with engagement process through annual surveys). 3. Our home maintains a list of team members/residents who speak different languages and are willing to act as interpreters to support linguistic needs of residents and their family, as a backup if translation services are not available 4. Our home offers education for residents and their families (e.g., through resident neighbourhood meetings, Resident Council, Family Council, newsletters, etc.) 5. Meal planning and service is inclusive of cultural dietary regulations and preferences.

Target for process measure

- Agecare Trilogy will ensure that they are meeting the MOH directives as set out by the Resident's Bill Of Rights. 1. Resident Right #1: “Every resident will be treated with courtesy and respect and in a way that fully recognizes [their] individuality and respects [their] dignity.” 2. Resident Right #19: “Every resident will have the right to have [their] lifestyle and choices respected. 3. Resident Right #23: “Every resident will have the right to pursue social, cultural, religious, spiritual and other interests, to develop [their] potential and to be given reasonable assistance by the licensee to pursue these interests and to develop [their] potential.”

Lessons Learned

We learned that requiring participation from all levels of the organization, including senior leadership, clinical teams, support staff, and frontline employees, creates a shared understanding and consistent approach to equity, diversity, and inclusion.Our workforce includes a wide range of ages, backgrounds, and lived experiences. We learned that this diversity significantly enriches delivery of education and conversations. Team members bring different viewpoints that deepen organizational awareness and foster more culturally responsive care. Challenges: -Staff enter training with different levels of prior exposure to education concepts. This creates challenges in ensuring that content remains meaningful for both experienced learners and those new to the material. -Competing operational demands, varying shifts, and workload pressures make consistent attendance difficult, even when multiple formats and times are offered.

Change Idea #2 ☐ Implemented ☐ Not Implemented ☑ In Progress

All current and newly onboarded front-line team members will receive education about Cultural Competence and Indigenous Cultural Safety, Equity, Inclusion, Diversity and Anti-Racism and Ontario Human Rights Commission - Human Rights 101.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

All staff are assigned relevant education through our Surge Learning Platform. Our teams monitor for completeness.

Comment

The home did not meet the 95% target, we will continue working on ensuring that all employee and are properly tracked to ensure compliance, especially onboarding employees.

Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #3 Percentage of residents responding positively to: “Dining room servers are attentive to my needs" (AgeCare Trilogy)	**69.00** Performance (2025/26)	**73** Target (2025/26)	**48.00** Performance (2026/27)	**--** Percentage Improvement (2026/27)	**NA** Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Provide regular training for staff on; -pleasurable dining -food temperature -meal delivery timelines.

Process measure

- a)Staff will be knowledgeable about pleasurable dining and provide quality meal service for each meal.

Target for process measure

- Increase in overall resident satisfaction for survey question: “Dining room servers are attentive to my needs”

Lessons Learned

Over the past year, the home hosted a variety of staff education sessions focused on enhancing the resident experience. Training included customer service, Residents' Bill of Rights, "All About Me," "How Well Do You Know Your Residents," and pleasurable dining practices. In addition, the home offered a range of food□related activities to enrich residents' daily living. The Resident Food Committee facilitated live cooking demonstrations featuring different meals, while culturally diverse dishes were introduced during special celebrations such as Black History Month, Chinese New Year, and through themed menus highlighting Greek, Caribbean, and Indian cuisines.
Challenges: Despite these initiatives, the home identified several areas for improvement. - Staff required re□orientation on the importance of a "residents□first" approach in the dining room. Additional coaching was needed to strengthen attentiveness to resident needs, preferences, and overall dining experience. - The home did not effectively communicate or promote the new dining and cultural initiatives to residents and families. As a result, many residents did not recall these experiences during the annual experience survey.

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

Gather feedback from residents around meal service and food quality.

Process measure

- a) interviews with resident, feedback in resident council, food committee and family council about meal service b) The concerns and issues will be identified immediately from frequent meal service audits and rounds.

Target for process measure

- Audits will be completed as per audit schedule. Increased positive response to dining room servers are attentive to my needs.

Lessons Learned

Home is conducting regular audits focused on meal service and resident satisfaction to the meals served. The food committee also meets regularly and provides feedback and recommendations.

Comment

The 2025 survey did not fully reflect the improvements and initiatives we implemented to enhance pleasurable dining and dining room etiquette.
1. Need for Reinforcement of Resident□Centred Dining Practices.
2. Communication and Marketing of New pleasurable dining Initiatives

Safety | Safe | Optional Indicator

Indicator #2

Percentage of LTC home residents who fell in the 30 days leading up to their assessment (AgeCare Trilogy)

Last Year		This Year		
11.97	**10.75**	**8.44**	**29.49%**	**8**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

a) Staff are accountable for reviewing the plan of care and ensuring fall prevention devices are in place by using the 'Point of Care (POC)' documentation system. Personal Support Workers (PSWs) are required to sign off at the end of each shift, confirming that fall prevention measures are properly in place and functioning. If any issues are identified, they must report them to the direct supervisor for immediate replacement or troubleshooting. In alignment with the POC documentation, a new tool, the 'Falls Device Logo,' has been introduced to highlight each resident's fall prevention plan, providing clear visibility of the devices in place. This logo is positioned alongside the transfer logo for easy and immediate access, ensuring enhanced awareness of fall prevention measures. Resources, including lists of high-risk fall residents and the fall prevention devices in place, are made readily available in linen rooms, registered staff binders, and PSW binders for easy reference. An audit is conducted for residents who experience two or more falls in a month, prompting special care meetings with the multidisciplinary team and family to collaboratively review and update the plan of care. These meetings focus on implementing injury prevention strategies and reducing the occurrence of falls.

Process measure

- a) The number of resident fall incidents and fall-related injury rates are monitored to assess the effectiveness of staff vigilance and the implementation of preventative measures outlined in each resident's plan of care; b) Completion of Point of care documentation every shift indicating staff are checking fall prevention measures are in place every shift; c) The number of critical incidences reported to the Ministry of Long-Term Care related to falls resulting in injury and significant change.

Target for process measure

- Audit of workbooks to review number of fall and injury occurrences monthly.

Lessons Learned

Most of our staff demonstrate strong awareness of the Falls Prevention Program, and our trends show meaningful improvement in both falls and fall-related injuries compared to 2024. This reflects continued commitment to resident safety and consistent application of preventive strategies.
Challenges: -Increase in High-Risk Admissions: We have experienced more discharges alongside a higher number of new admissions who present with significant fall risk. -Newly admitted residents are arriving from the community with higher levels of complexity, often having remained at home longer and requiring more intensive monitoring upon move□in. -We are seeing a rise in retirements among experienced staff and an influx of younger workers who are new to long□term care. These newer team members require additional orientation, coaching, and support to develop the observational skills needed to identify early signs of fall risk and changes in resident condition.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Residents with a SCOTT Fall Risk Assessment score of 12 or higher will have a 'Falling S.T.A.R.' warning indicator displayed on their bedroom nameplates and assistive mobility devices to enhance staff awareness and ensure increased monitoring. The resident's SCOTT Fall Risk Assessment score is reviewed on admission, annually, and/or upon significant change to ensure the 'Falling S.T.A.R.' logo indicator is updated and prominently placed on their bedroom nameplate, walkers, and wheelchairs for ongoing staff awareness and vigilance.

Process measure

- The number of resident fall incidents and fall-related injury rates are monitored to assess the effectiveness of staff vigilance and the implementation of preventative measures outlined in each resident’s plan of care

Target for process measure

- All resident "Scott risk assessment" scores are reflective to current status by June, 1 2025

Lessons Learned

SCOTT Fall risk assessments are completed on move-in, after a resident falls, annually and with significant changes in health status. All residents deemed at High Risk For Falls and Ambulation have a Falling Star Logo in place. Our Falls Program audits are used to verify that the process is being implemented as outlined in our policy.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

Quarterly reviews of Fracture Risk Scores are conducted with the pharmacist consultant and fall prevention program lead to ensure that residents with a score of 4 or higher are prescribed bone-strengthening medications, following recommendations made to the physicians.

Process measure

- a) number of fractures following a fall incidence; b) Number of critical incidences report to Ministry of Long-Term Care related to falls with injury; c) number of residents with bone strengthening medication ordered by physician for persons scoring 4 and above

Target for process measure

- Following schedule of review of resident 3 month medication review. Completion for all residents reviewed by December 16, 2025.

Lessons Learned

FRS scores are reviewed at the completion of the RAI-MDS/LTCF assessment and appropriate referrals are made if the resident is not already taking bone-prescribing medications. The Pharmacy consultant also reviews this as a focus when completed quarterly medication reviews and making recommendations to the physician. Over 80% of residents are on bone-strengthening medications.

Change Idea #4 ☐ Implemented ☐ Not Implemented ☑ In Progress

Staff education, in collaboration with the physiotherapist, emphasizes the importance of recognizing and reporting any decline in mobility in individuals ambulating with or without assistive devices. This enables the implementation of targeted measures, such as referrals to physiotherapy, restorative care programs, and/or occupational therapy, to assess and provide appropriate interventions for residents' activities of daily living.

Process measure

- a) Number of physiotherapist, restorative care, and occupational therapist referrals initiated; b) Number of resident fall incidences related to persons who independently ambulate with or without assistive aide; c) Number of injuries following a fall occurrence

Target for process measure

- Education to front line care staff to be completed before April 31, 2025 and reassess if additional education required. Referrals and review of fall incidences monthly.

Lessons Learned

Staff identify resident change of condition and communicate changes through report and referral systems. Our physiotherapist also sits on the Falls Committee and assists in the review and analysis of Resident Falls and provides input into strategies for individuals or for the home to reduce falls.

Change Idea #5 ☐ Implemented ☐ Not Implemented ☑ In Progress

Increase PSW awareness and accountability as it relates to Fall Prevention Strategies and the use of Fall Prevention Equipment.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Home provides education through various means such as Surge Learning, inservices, and 1:1 instruction on our Falls Prevention Program. We further complete audits on the program, ensuring that fall and injury prevention devices and strategies are being followed as per the resident's plan of care.

Comment

- Identifying residents at risk for falls during move and ensuring that they are monitored closely during adjustment period.
- Additional education for new hires related to Falls Prevention Program.
- Increase falls huddles and specially care meetings with family post admission/move-in.