Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 1, 2024, to September 30, 2025 (Q3 to the end of the following Q2)	22.89	15.00	The home would like to be lower than the provincial average with a relative improvement of 25%	

Change Ideas

Change Idea #1	Identify ER visit trends and improve interdisciplinary strategies to reduce ER visits by: 1. Increasing the utilization of the NLOT 2. Bringing 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. 3. Educating family members during Family Council on preventing unnecessary transfers to hospital. 4. Involving the Medical Director to assist with decreasing unnecessary ED transfers by providing education to his colleagues in his physician pool		
Methods	**Process measures**	**Target for process measure**	**Comments**
Develop a Tracker to track all Hospital Transfers monthly to identify ER Transfers vs Hospital Admissions, NLOT usage, Resident Dx. All ED visits will be analyzed to identify trends in transfers. All ED visits will be reported and discussed during morning Leadership meetings to identify avoidable visits. ED transfer trends will be discussed in monthly Quality Committee meetings and quarterly PAC meetings.	Decrease in the number of Avoidable ER visits within the quarter identified by LTCH avoidable ER Transfer Quarterly Report. Increased awareness of avoidable ER transfers, evidenced by a decrease in number of avoidable ER transfer.	Avoidable ER Visits = 22.89%. In 2026, we would like to see Trilogy attain a decreased transfer rate of 15%.	

Change Idea #2	Reduced ER transfer related to falls by early risk identification and action.		
Methods	**Process measures**	**Target for process measure**	**Comments**
Identify high risk resident on each unit and ensure that effective interventions are put in place. Increased monitoring of these residents will assist in reducing the number of ER transfers due to falls with injury.	# of falls requiring ER transfer will be reduced.	Falls requiring transfer to hospitals will reduce to less than 1 resident each quarter.	

Change Idea #3	Early identification of resident decline. Effective assessments and critical thinking by Registered Staff regarding resident health status prior to transfer out.		
Methods	Process measures	Target for process measure	Comments
Provide Registered Staff with education on how to identify the early signs of deterioration in a resident's condition. For example: Early signs of UTI with in home treatment versus having to transfer resident due to urosepsis. Each resident will have their InterRAI Outcome Scores reviewed (i.e. FRS; CHESS) to identify high risk residents at a minimum quarterly. 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. Clinical Pathway Algorisms to identify need to transfer to be available on each unit.	# of education sessions offered to registered staff to increase competency in early identification.	There will be at least one education session offered each quarter. 100 % of residents will have their InterRAI Outcomes scores analyzed each quarter to identify residents at high risk.	

Equity

Measure - Dimension: Equitable

Indicator #2	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	C	Rate per 100 / Staff	Local data collection / Mandatory Education Report	93.28	100.00	Trilogy would like to have all staff receive the training as part of the provincial initiative to create awareness and promote inclusiveness.	

Change Ideas

Change Idea #1 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.

Methods	Process measures	Target for process measure	Comments
Track all staff Surge completion rates and update the education board on the Main floor on a weekly basis so staff are aware of completion rates - The mandatory should be part of the Standing agenda items in all department meetings as well as Team Up for 10 meetings. Monthly reports to follow up on Surge courses which are due. Ensuring staff are up to date with completion.	Percentage of staff who complete assigned education in 2026.	Agecare Trilogy staff will achieve 100% completion of the Diversity and Inclusion related mandatory training requirements by December 31, 2026	Our home requires team members from all levels of the organization to participate in training and education related to equity, diversity and inclusion. (e.g., Senior leadership, interdisciplinary teams) -Trilogy offers ongoing training on equity, diversity and inclusion topics (e.g., in-services, and e-modules (SURGE)) to all team members in a way that accommodates different learning styles. - The orientation of all new employee includes equity, diversity and inclusion training.

Change Idea #2 Increase awareness of home's diverse population of our residents, and community to increase measures to promote inclusion in all areas.

Methods	Process measures	Target for process measure	Comments
Review the diversity of our local community and consider potential demographic changes to be proactive in education and training. Home's performance evaluation includes equity, diversity and inclusion indicators for team members at all levels of the organization (e.g., professional development on diversity topics, adherence to policies). Maintain 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. Offer education for residents and their families (e.g., through resident neighbourhood meetings, Resident Council, Family Council, newsletters, etc.) - Meal planning and service is inclusive of cultural dietary regulations and preferences. Quarterly evaluations will be completed for residents, staff and families to determine awareness. Annual residents, families and staff satisfaction results outcome	Evaluate the effectiveness of its engagement processes (e.g., measures resident and family involvement, assesses resident and family satisfaction with engagement process through annual surveys). Home aims to achieve high percentage of residents who respond positively around their cultural preferences being met.	Resident Engagement Survey results will be over 80% of satisfaction with cultural needs being met.	

Experience

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Improve resident engagement satisfaction scores in overall dining experience.	C	Rate per 100 residents / LTC home residents	In-house survey / Residents Annual Experience Survey	48.00	50.50	Aim for a relative increase of approximately 5%.	

Change Ideas

Change Idea #1 Obtain feedback from residents in timely manner through interviews with resident, feedback in resident council, food committee and family council about meal service. Address concerns and issues identified during frequent meal service audits and rounds.

Methods	Process measures	Target for process measure	Comments
a) Increase the frequency of meal service and food quality audits to address issues promptly. b) Ensure the audits are analyzed and action plans generated.	# of audits completed as per audit schedule. # of complaints related to dining experience.	Audits will be completed as per audit schedule. Increased positive response to dining room servers are attentive to my needs and few concerns related to dining.	

Change Idea #2 Ensure all staff are knowledgeable about strategies to enhance Pleasurable Dining Experiences for our residents.

Methods	Process measures	Target for process measure	Comments
a) Higher mandatory Surge Learning completion for dining services by staff. b) On the spot education to staff on meal service and pleasurable dining with routine leadership presence in dining rooms.	# of staff who are trained in Pleasurable Dining and can demonstrate strategies during dining room observations. Overall resident satisfaction for survey question: "Dining room servers are attentive to my needs"	5% increase in overall resident satisfaction for survey question: "Dining room servers are attentive to my needs". 100% of staff who assist in the dining room will be trained and demonstrate strategies to enhance the resident dining experience.	

Change Idea #3 Improve menu variety and resident choice by enhancing person centered dining by offering more cultural choices and flexibility.

Methods	Process measures	Target for process measure	Comments
Add a new cultural or ethnic food choice on the menu monthly that aligns with the diverse resident population in the home.	# of new culturally diverse menu items offered on the menu each month.	At least 1 new culturally diverse menu items will be added into the menu monthly.	

Safety

Measure - Dimension: Safe

Indicator #4	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	8.44	8.00	Aim to reduce by 5% as already performing well in this area but it aligns with strategy to reduce ER transfers related to falls.	

Change Ideas

Change Idea #1	Conduct an audit 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 to focus on implementing injury prevention strategies and reducing the occurrence of falls.		
Methods	Process measures	Target for process measure	Comments
a) Quarterly quality indicator report - review "has fallen" percentages through the quarters to assess fall rate trends; b) Critical incidences submitted to the Ministry of Long-Term Care related to falls with injury - Review and analyze trends to formulate preventative measures to decrease fall related injuries; c) Falls & injury tracker workbook - Monthly input to review and analyze numbers of falls that sustained an injury resulting in adverse, serious, and sentinel effect; d) Monthly quality meeting to review fall incidences and trends from previous month to assess measures/interventions to reduce fall incidences to decrease risk of repeated fall occurrences that could lead to an injury; e) Quarterly Professional Advisory Meeting to review fall incidences and fall related injuries from previous 3 months	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.	# of falls per month will decrease. # of residents who have more than one fall will decrease. Overall fall rate will reduce to meet target of 8%.	

Change Idea #2	Increase PSW awareness and accountability as it relates to Fall Prevention Strategies and the use of Fall Prevention Equipment.		
Methods	Process measures	Target for process measure	Comments
Utilize the 'Point of Care (POC)' documentation system to identify fall prevention devices that must be in place for each resident. 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.	Audit compliance rate of fall prevention documentation and the appropriate use of falls prevention devices.	Audits of fall prevention documentation and the appropriate use of falls prevention devices will be 100% compliant.	

Change Idea #3	Ensure 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.		
Methods	Process measures	Target for process measure	Comments
A '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.	% of residents who have a falls device logo present in their room.	100% or residents will have the falls device logo present in their room if require a device for fall prevention.	