

Equity | Equitable | **Optional Indicator**

Indicator #7	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 (Trillium Court)	100.00	100	NA	--	NA

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

Continue to ensure all leadership completed diversity education

**Process measure**

- # of leadership staff that have completed education

**Target for process measure**

- # of leaders who have completed education

**Lessons Learned**

leadership completed diversity education

**Comment**

the organization will continue to provide diversity education to staff leadership and frontline

Experience | Patient-centred | **Custom Indicator**

	Last Year		This Year		
<b>Indicator #8</b>	<b>0.00</b>	<b>68.10</b>	<b>100.00</b>	<b>--</b>	<b>NA</b>
Quality care from a Social Worker (Trillium Court)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

Explore external resources within the community and communicate this information to residents and families

**Process measure**

- # of local providers # of residents seeking social work services # of residents who had social work services provided # of brochures available # of Grey Bruce County LTC meetings attended

**Target for process measure**

- Ontario Health at Home will be contacted by May 2025. Brochures will be sources and available by June 2025. List of local resources will be created by May 2025 and shared with residents and families by June 2025. Our home will have attended at least 2 Grey Bruce County Long Term Care meetings by December 2025 100% of our Residents requiring social work services will have had access by December 2025.

**Lessons Learned**

resources given within the community and communicated resulted in exceeding target

**Comment**

The organization exceed target for 2025

Indicator #2	Last Year		This Year		
I am satisfied with the quality of laundry services for my clothing and linens (Trillium Court)	<b>60.00</b>	<b>78.60</b>	<b>81.30</b>	--	<b>NA</b>
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

Environmental service manager will attend resident council

**Process measure**

- # of Resident council meetings attended and minutes of meetings

**Target for process measure**

- ESM will attend resident council by June 2025

**Lessons Learned**

ESM attending resident council upon invite to discuss laundry concerns

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

ESM to audit laundry process

**Process measure**

- Audit 10% of resident items each month for correct labelling Audit the delivery time of laundry # of newsletters sent out with labelling process in it

**Target for process measure**

- 10% of audits will be completed monthly for 3 months Review of audits on a quarterly basis and action plan Review of concern forms quarterly and action plan Laundry will be delivered, and items will be labeled appropriately by September 2025

**Lessons Learned**

audits of laundry services

**Comment**

the home met the exceed the target goal on this indicator for 2025

Indicator #1	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
Bladder products keep me dry and are comfortable (Trillium Court)	64.30	82.60	60.00	--	NA

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

Continence product review

**Process measure**

- # of audits # of vendor visits # of staff education sessions # of Resident council meetings the vendor attended

**Target for process measure**

- Review audit scores and vendor visit reports action on the deficiencies after each visit All PSW staff education to be completed by June 2025 Improvement in product application will be demonstrated by August 2025

**Lessons Learned**

reviewed continence product

**Comment**

will be implementing for 2026 a survey including input from staff on incontinent product.  
 Incontinent provider to provide inservices meeting with residents to determine issue with incontinence product

Indicator #3	Last Year		This Year		
	If I need help right away I can get it (Trillium Court)	<b>60.00</b> Performance (2025/26)	<b>69.10</b> Target (2025/26)	<b>68.80</b> Performance (2026/27)	<b>--</b> Percentage Improvement (2026/27)

Change Idea #1  Implemented  Not Implemented  In Progress

Increase staff awareness on call bell wait times

**Process measure**

- # of call bell response time audits done # of team meetings discussing call bell times # of staff follow up sessions

**Target for process measure**

- Call bell review process will be in place May 2025 Communication of audit results regularly during morning Take 5 resulting in a 15% decrease of wait times by October 2025

**Lessons Learned**

education to staff on expectation around call bell times  
 audits of call bells and responses  
 new call bell system to be installed in 2026

**Comment**

although the home didn't achieve target indicator their was significant improvement 2025 compared to 2024 results

**Safety | Safe | Optional Indicator**

	Last Year		This Year		
<b>Indicator #5</b>	<b>15.97</b>	<b>15</b>	<b>19.66</b>	<b>-23.11%</b>	<b>17</b>
Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Trillium Court)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

Ensure residents at risk have an individualized plan of care

**Process measure**

- # of resident's at risk for falls # of plan of care reviewed and revised # of fall committee meetings with minutes # of sessions held to communicate with staff

**Target for process measure**

- 100% of Residents at risk for falls will be identified by April 2025. Plan of care for every identify high fall risk resident will be updated on an ongoing basis but all initial updates will be completed by August 2025 and communicated to staff after completion

**Lessons Learned**

care plan updated on high risk residents

**Comment**

although the home improved in this indicator we failed to meet target. This indicator will be included on our workplan for 2026/2027

Indicator #6	Last Year		This Year		
	Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Trillium Court)	<b>30.65</b> Performance (2025/26)	<b>25</b> Target (2025/26)	<b>20.00</b> Performance (2026/27)	<b>34.75%</b> Percentage Improvement (2026/27)

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

Provide GPA education for responsive behaviors related to dementia

**Process measure**

- # of staff that have attended GPA # of training sessions offered Feedback from participants # of feedback areas actioned on

**Target for process measure**

- GPA will be provided for 10% of staff in the home by June 2025 Session feedback will be reviewed and actioned on by July 2025.

**Lessons Learned**

continually educating staff on GPA

**Comment**

the home achieved target we will continue to include this indicator in our workplan for 2026/2027

Safety | Safe | **Custom Indicator**

Indicator #4	Last Year		This Year		
Percentage of long-term care home residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 (Trillium Court)	<b>3.48</b>	<b>2</b>	<b>1.75</b>	<b>--</b>	<b>NA</b>
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

Education of Registered staff on skin and wound care including designated wound care lead

**Process measure**

- # of staff who have completed the education on a monthly basis DOC to audit # of staff who have completed the education

**Target for process measure**

- 100% of registered staff have completed the education by September 2025.

**Lessons Learned**

continually educating staff front line and registered on skin and wound care.

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

Interdisciplinary review of skin and wound issues

**Process measure**

- # of meetings with agenda followed # of members recruited

**Target for process measure**

- Agenda will be standardized by September 2025 Recruitment of interdisciplinary members will be completed by Sept 2025 At least 3 meetings will be held by December 2025

**Lessons Learned**

change of management doc, admin impacted ability to implement this change idea

**Comment**

purchase of pressure reduction mattresses, in addition offering wound care lead SWAN program to enhance knowledge base Will be including this indicator for 2026/2027 workplan

