Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 26, 2025

Ontario Health

OVERVIEW

Huron Lodge is a municipally owned long-term care (LTC) home located in Windsor, Ontario – a city full of history and potential, with a diverse culture, a durable economy, and a healthy environment where citizens share a strong sense of belonging and a collective pride of place. Our home consists of 224 permanent residents. There are 7 home units of 32 beds with a secure home area with enclosed courtyard to meet the needs of our residents who wish to explore and enjoy the outdoors in a safe manner. Huron lodge is home to adults needing continuous care, ranging from 43 to 100 years of age. Home occupancy rate remains steadily over 97% ongoing.

Our Quality Improvement Plan (QIP) is built on evidence-based best practices and is aligned with the City of Windsor strategic action plan, our CARF accreditation and with L-SAA quality indicator requirements. These, together with the vision of Huron Lodge – Make each day better than the one before – demonstrate our team's dedication to continuous quality improvement in our home.

Huron Lodge provides an opportunity to maintain self-esteem and self-worth for those who require long-term care home placement in an environment that promotes the quality of life for residents, family, and staff. Residents lead productive, active lives, in a friendly and caring environment. Huron Lodge has one medical director, one attending physician and one nurse practitioner that oversee the medical care for our residents. The remainder of the care team includes over 200 nursing staff in the registered nurse, registered practical nurse and personal support worker categories, along with additional staff allied health, dietary services, therapeutic recreation, and support staff.

We focus on actualizing our vision through quality of care and reaching resident safety goals in our quality improvement program, scored by key indicators as set out by the Ministry of Long-Term Care. We are responding to changes in the complexity of residents' health issues, restructuring in service delivery, and emerging best practices by developing creative new program initiatives, demonstrating our continued commitment to resident-driven quality improvement. Enthusiastic feedback and involvement from Residents' Council is shared monthly during the council meetings during which the quality improvement manager provides regular updates, seeks input, and reports back as requested by council.

ACCESS AND FLOW

Huron Lodge continues to strive toward efficient and effective collaboration with community partners to provide quality care in the right place at the right time. The home continues to work with the Nurse Practitioner-Led Outreach Team program to reduce avoidable emergency department visits, supporting our local hospitals. Engagement with stakeholders in our community, such as our local Ontario Health Team (OHT) and local long-term care home Administrators, serves to raise a harmonized voice to address communication and effectiveness within processes between Ontario Health and the long-term care sector. Engaging key stakeholders - Ontario Health at Home, hospitals, patients, families, LTC - is pivotal to identifying gaps - and committing to solutions - to support appropriate long-term care placement.

The home continues to work alongside partners with shared vision, such as the Behaviour Supports Ontario and Geriatric Mental Health Outreach Teams, our respiratory therapy provider, enterostomal therapy (ET) nurse, in-house dental hygienist, registered dieticians, among many others, to provide resident-centred care in their home, where comfort, autonomy, and independence are upheld. Empowering and supporting our residents' self-identified goals of care throughout their journey into and through long-term care, is just one of the ways the Huron Lodge team can remain committed to affecting access and flow and positively contributing to the right care in the right place at the right time.

EQUITY AND INDIGENOUS HEALTH

The City of Windsor consistently strives to reduce social and health inequities within the community. Several initiatives remain underway to respect, incorporate, and observe Indigenous health

and cultural safety across the organization.

To foster ongoing growth and progress, numerous members of City Administration actively participate in a variety of conferences, workshops, and training sessions aimed at deepening their understanding of Indigenous affairs and strengthening connections with local First Nations communities. In alignment with the Corporation's Action Plan, Huron Lodge has again identified Equity as a quality indicator of choice for the 2025/2026 QIP year with endeavouring to provide equity, diversity, inclusion, and anti-racism education to build cultural competency in the home and foster an atmosphere where advancing health equity is the standard.

Huron Lodge is committed to operating from a position of not-knowing; that is, we view the resident and family as experts and the knowledge and lived experience they bring as invaluable expertise that only serves to positively inform and support the work we do in our LTC home. We seek to honour every resident's story as a function of their unique intersectionality. Our programming in the home reflects the needs, wants, desires, and wishes of our residents individually, and of their collective culture. Our culturally diverse staff support our equally diverse residents through advocacy for culturally sensitive language, tradition observances, and communication in first-language.

We acknowledge that it is not enough to simply recognize health outcome disparities, we must also actively work to reduce these, and as such, strategic efforts to positively impact and advance equitable access and outcomes have been captured in our Service Accountability Agreement priorities. Aligning our work plans with provincial priorities provides a married approach between sustained efforts toward - and with the goal of - reducing health inequities in our area and across the province at large.

PATIENT/CLIENT/RESIDENT EXPERIENCE

Residents and families continue to utilize several avenues for expressing their feedback regarding the care experiences received, which - in conjunction with passion and collaboration - drives our quality improvement initiatives in the home, year after year. Satisfaction surveys, provided to families, and administered to residents, are a source of invaluable feedback. The resident satisfaction surveys, administered by our compassionate social work team, further serves to deepen trust and engagement with, and accountability to, our residents. We utilize our survey results to guide the development of our quality improvement initiatives as we continue our commitment to resident-centred action through resident-led decision-making.

Our robust residents' council is the hub around which leadership pivots to sustain transparency and continue to build, every day and with every initiative, the solid and extensive partnership that has grown over the past several years. Transparency is not limited to our interactions with Residents' Council, but extends to families when care concerns are brought forward. Further refinement of our Care Conference process over the past QIP year has supported increased targeted engagement - and often results in feedback - from each individual resident/family attending, where concerns (if present) are addressed in depth by the interdisciplinary team and follow up provided by a social worker.

Through the Chrysalis project, all team members look forward to the next phase of enhancing the resident experience in the home.

All phases of the project are steeped in resident decision-making with choice and voice regarding what residents need, want, and wish for their home. In our 2024/2025 year, landscape improvements were completed including additional covered seating areas for residents to enjoy the outdoors with visitors; an initiative directly extracted from Residents' Council. Additionally, a sensory tub was installed in our secure unit, featuring visual, tactile, and audio stimuli through lights, bubbles, and Bluetooth capability. This provides residents experiencing challenges with bathing a sensory experience tailored to their unique needs to allow for a more peaceful, enjoyable, and meaningful bathing experience that has positive effects long after they leave the spa room.

PROVIDER EXPERIENCE

Our team is responsible for ensuring that residents' needs are met through programs and services in nursing, dietary, environmental, recreation programming, and administrative services. To this end, a wide range of services are provided for all residents. This supports and facilitates residents' rights, independence, dignity, personal choice, and self-determination. The interdisciplinary team works together to provide various programs in the home with active involvement with and between staff, family, friends, volunteers, and the community.

We persist with actioning our chosen strategic plan pillars: recruitment, retention, accountability, and communication. Transitioning into the 2025/2026 QIP year, we are engaging in further enhancement of our recruitment and retention processes; this includes remedying found gaps as well as finding efficiencies to interject into the onboarding procedure and placing the resident securely in the centre of our Orientation program objectives. Not only supporting retention efforts, but also largely reinforcing accountability, we have deployed a consultant on the ground to work directly with staff over the year to aid in culture change, reframing everything we do in the home through the lens: "how does this affect the resident?" With purposeful positive changes to, and shifts in, workplace culture, we aim to meet our staff retention objectives - staff who are more satisfied with their onboarding experience, staff who incorporate home's mission, vision, values from onset, and staff who embody the residents-first approach throughout a lengthy and fulfilling career at Huron Lodge.

SAFETY

The safety and well-being of our residents was, and always will be,

our priority. Huron lodge further promotes quality improvement through examining the efficacy of incident analysis. Following a patient safety incident, we ask: what are the opportunities to do better, how do we involve staff in the improvement process, and further, how do we communicate our plans not only to staff, but to residents, families, and other stakeholders?

In our 2024/2025 QIP year we focused on antipsychotic reduction with respect to speaking to patient safety. Through several vigorous Plan-Do-Study-Act (PDSA) cycles, the team successfully, and significantly, reduced the rate of antipsychotic medication usage in our current residents and effectually put a sustainable program in place for all newly admitted residents. This two-pronged strategy not only effectively reduced possible patient safety incidents for residents presently in the home, but established a template to mitigate patient safety risk upon admission with all new residents who qualify entering the program upon admission.

In our upcoming 2025/2026 QIP year we look to focus on patient safety through a falls reduction lens. Planned changes include enhanced auditing for at-risk residents, re-education for staff, implementation of new fall monitoring devices in the home, and promotion of purposeful rounding - aiming for patient safety at the centre with mitigating identifiable risks, learning from unavoidable fall incidents, and decreasing preventable falls in the home.

Our residents and families continue to shift and adapt alongside us as we navigate, communicate, and actualize legislative requirements that arise from amendments that govern our 'what we do' and 'how we do it' with the end goal of keeping our vulnerable population safe.

PALLIATIVE CARE

Over the past year, the team at Huron Lodge has worked tirelessly to improve the delivery of palliative care in our home, with improvements having been made in the following realms: policy and procedure revision, increased resident/care partner engagement, further program development with respect to staff education via collaborative partnerships. Through regular Palliative Committee meetings in the home, feedback from frontline staff has informed our updated policies and procedures in the home to meet resident need with respect to pain management and resident-centred care through end of life. In the past year, the home resumed its annual memorial service to honour and hold space for those residents who left us in 2024 and support family/care giver connectedness with the home, regardless of length of stay at Huron Lodge.

In further support of resident engagement in the palliative care program, the social work team has collaborated with residents to complete My End of Life wishes care plans, outlining residents' comfort desires throughout their palliation and end of life journey. Initiated in 2024, residents and families are receiving palliative care information upon admission to the home through a comprehensive resident/family-centred package that allows for review shortly after admission to create a foundation for sensitive conversations throughout the palliative care trajectory. Through the Collaborative Project to Sustain a Palliative Approach to Care, the home's palliative committee has been able to partner with Ontario Centres for Learning, Research & Innovation in Long-Term Care [CLRI] (at Bruyere Health) to facilitate education for frontline staff on a multitude of palliative care topics, presented by our local consultant through the Palliative Pain & Symptom Management Program of

Southwestern Ontario.

POPULATION HEALTH MANAGEMENT

Our population, consisting of vulnerable persons (older adults, medically complex and compromised, those living with mental health diagnoses and/or cognitive impairment), face a multitude of challenges both outside of and inside of long-term care. To ensure the individualized approach to care required to meet the needs of those we serve, we enshrine the resident at the centre of all care goals. Our staff recognize autonomy as an integral part of improving residents' health; we approach residents to make their own decisions, within their capabilities, encourage them to ask questions about their care ongoing, and capitalize on health advocacy and teaching opportunities.

We have partnered with Medical Laboratories of Windsor to pilot a point-of-care urinalysis testing program within Huron Lodge to support the right care, at the right time, in the right place. Our community partnerships thrive with onboarding a dental hygienist to support oral and dental health for our residents in their home. Grant funding received through the Windsor Accessibility Committee will see initiatives in place in the 2025/2026 QIP year including a wheelchair accessible bike for residents and a solar projector. Further, funding from an environmental grant was awarded to the home, which will allow for the installation of a sunshade over our wheelchair accessible outdoor exercise equipment, supporting our residents to safely engage in physical activity outdoors. Finally, Huron Lodge continues to value space at the Ontario Health Team table to represent the long-term care sector at the provincial level while at the local level, our team works industriously alongside Ontario Health at Home to ensure our population's transition to long-term care is efficient, compassionate, and timely.

CONTACT INFORMATION/DESIGNATED LEAD

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SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on

MARCH 26, 2025

Board Chair / Licensee or delegate

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Administrator /Executive Director

Quality Committee Chair or delegate

Other leadership as appropriate

Access and Flow

Measure - Dimension: Efficient

Indicator #2	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.	O	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / Oct 1, 2023, to Sep 30, 2024 (Q3 to the end of the following Q2)	17.99	17.99	Maintain current performance and remain under LHIN average of 18.2.	MedLabs of Windsor, WRH - NLOT program, FCS International

Change Ideas

Change Idea #1 Implement in home urinalysis pilot program as a screening tool.

Methods	Process measures	Target for process measure	Comments
Collaborate with lab services to implement program to conduct on-site urinalysis testing.	Number of tests run in pilot program within review period to collect baseline data.	Collect raw number of tests over period of pilot program (Q4) to establish baseline data for future tracking and analysis.	

Change Idea #2 Strengthen the falls prevention program to reduce injury-related ED visits by using environmental modifications, regular assessments, and other tools.

Methods	Process measures	Target for process measure	Comments
Falls program lead and Falls Committee to determine modifications and purchase supplies and ensure program compliance.	Number of falls resulting in transfer to hospital through review period.	Reduce percentage of falls that result in transfer to hospital from 3.2% to less than 1%.	

Change Idea #3 Work collaboratively with NP from NLOT program to deliver education, training, and clinical guidance to home staff.

Methods	Process measures	Target for process measure	Comments
Nursing program leads and staff education coordinator will work with NP to develop and deliver education/training to staff based on clinical practice need.	Number of education/training sessions offered by end of review period (Q4).	Increase number of education/training session from 8 to 12 by end of Q4 (March 31).	

Change Idea #4 Educate staff on effective communication techniques between members of the health care team and external clinical supports.

Methods	Process measures	Target for process measure	Comments
Administrator/DOC to continue partnership with external consultant educator retained to provide said education.	Number of education/training sessions offered by end of review period (Q4).	.Complete 100% of scheduled (10)education/training sessions by end of Q4 (March 31).	

Change Idea #5 Educate staff on effective communication techniques between members of the health care team and external clinical supports.

Methods	Process measures	Target for process measure	Comments
Administrator/DOC to continue partnership with external consultant educator retained to provide said education.	Number of education/training sessions offered by end of review period (Q4).	.Complete 100% of scheduled (10)education/training sessions by end of Q4 (March 31).	

Equity

Measure - Dimension: Equitable

Indicator #3	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	100.00	Theoretical best possible performance.	

Change Ideas

Change Idea #1 Determine fit of EID-R education to selected departments and apply EID-R selected courses to same.

Methods	Process measures	Target for process measure	Comments
QI/education program lead to determine fit across departments with respect to education re: EID-R through review of current education and apply selected suite of courses to same.	Number of departments selected, number of courses applied.	To have 100% of departments (2)selected have 100% of courses (5) applied by end of Q1	Total LTCH Beds: 224

Change Idea #2 All selected departments will have EID-R courses completed.

Methods	Process measures	Target for process measure	Comments
QI/education program lead to apply selected suite of courses identified departments.	Percentage of education completed across all identified departments.	To have 100% of education completed by end of Q3.	

Change Idea #3	Review socio/demographic data options for our population that will translate for value-added collection, reporting, and usage within the home.		
Methods	Process measures	Target for process measure	Comments
QI lead/admissions SW review gaps in information gathered upon admission, data availability re: incoming population.	Percentage of potential indicators reviewed.	To have 100% of all potential indicators reviewed by end of Q1.	

Change Idea #4	Choose socio/demographic data indicator data to collect from residents to quantify chosen diversity indicator within the home's population to determine baseline data to inform additional programs and services in the home.		
Methods	Process measures	Target for process measure	Comments
QI lead/admissions SW choose data indicator to collect data over coming QIP year to determine baseline data for further review and analysis.	Percentage of new admissions with this sociodemographic indicator recorded .	To have 75% of new admissions disclose chosen indicator by end of Q4.	

Experience

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Resident experience: Overall satisfaction	C	% / Residents	In-house survey / January 1, 2024 to December 31, 2024	100.00	100.00	Theoretical best possible performance.	

Change Ideas

Change Idea #1 Implement next stage of Chrysalis Project.

Methods	Process measures	Target for process measure	Comments
Murals as chosen/designed by residents for each of the 7 RHAs to complement new menu board area in dining room.	Number of murals chosen and installed by review period (26/27 QIP submission).	To have 100% of murals (7/7) will be installed by March 31, 2026.	

Change Idea #2 Improve results of resident satisfaction with home/staff responsiveness to their questions/concerns.

Methods	Process measures	Target for process measure	Comments
QI Lead/SW to review and analyze results of 2025 Resident Satisfaction Survey question #8.	Percentage of residents answering positively to question #8: "I am satisfied that my questions and concerns are answered and/or followed up on" in the 2025 survey (compared to 2024).	To increase positive responses on this question by 3%; from 97% to 100%.	

Change Idea #3 Increase resident engagement in the home with respect to human resources processes.			
Methods	Process measures	Target for process measure	Comments
Have RC Liaison collaborate with Residents' Council to have a representative involved in onboarding process for new staff to speak to residents' bill of rights, resident-centred care, and communication.	Percentage of Orientation sessions/new staff reached through initiative over the calendar year.	To have 100% of Orientation sessions include a Residents' Council rep presentation.	

Change Idea #4 Increase resident response rate for 2025 Satisfaction Survey to gain more accurate measure of overall satisfaction.			
Methods	Process measures	Target for process measure	Comments
QI Lead/SW to review and analyze results of 2025 RSS response rate.	Percentage response rate of 2025 RSS increase from previous survey (2024).	To increase resident response rate by 7%, from 73% to 80%.	

Safety

Measure - Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who have a urinary tract infection.	C	% / Residents	CIHI CCRS / July 1 to Sep 30, 2024 (Q2)	4.20	3.70	Targeting to meet provincial average (3.7).	Pharmacy provider

Change Ideas

Change Idea #1 To reduce catheter use.

Methods	Process measures	Target for process measure	Comments
IPAC Lead/practitioner to develop and lead education for staff, collaborate with physicians to reduce usage.	Percentage of residents with catheter in place by end of review period (Q4).	Catheter use will decrease from 3.9% to 3.5% by end of Q4.	

Change Idea #2 Audit RAI-MDS to ensure accurate data captured through coding.

Methods	Process measures	Target for process measure	Comments
IPAC Lead/practitioner to audit RAI-MDS submissions (applicable sections) to mitigate coding errors and ensure accuracy.	Percentage of RAI-MDS submissions audited by end of review period (Q4).	To audit 100% of RAI-MDS submissions by end of Q4 (March 31).	

Change Idea #3 Development of pharmacist review of anti-biotic prescriptions program.

Methods	Process measures	Target for process measure	Comments
IPAC practitioner to work with Pharmacist to facilitate and complete review program.	Number of reviews completed as result of the program by end of review period (Q4).	Collect raw number of reviews over defined period (to end of Q4 - March 31) to determine baseline data.	

Change Idea #4 Provide pericare education to direct care staff.

Methods	Process measures	Target for process measure	Comments
IPAC lead/practitioner and education coordinator to develop and facilitate education delivery.	Percentage of staff trained by end of review period (Q4).	To have 90% of eligible staff receive the defined education by end of Q4 (March 31).	

Measure - Dimension: Safe

Indicator #5	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 Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	10.10	9.50	Remain under provincial target of 15.4%; percentage improvement within the home.	

Change Ideas

Change Idea #1 Enhance auditing process for residents at risk for falls through new post-fall review form.

Methods	Process measures	Target for process measure	Comments
QI RN/RPN with Falls Lead and collaboration with interdisciplinary team to implement form and process.	Form will be implemented and live by end of Q2 in at least 3 home areas.	To have new form/process implemented in 3/7 home areas by end of Q2 and implemented in remaining 4/7 home areas by end of Q3 (December 31).	

Change Idea #2 Re-education for staff on falls prevention policies and procedures.			
Methods	Process measures	Target for process measure	Comments
Staff development coordinator/Falls lead to provide re-education to staff on post-fall documentation and assessment.	Number of staff (re)trained in post-fall documentation and assessment by end of defined review period (Q3).	To have 100% of registered staff (re)trained in post-fall documentation and assessment by end of Q3 (December 31).	

Change Idea #3 Implement new fall monitoring devices in the home.			
Methods	Process measures	Target for process measure	Comments
Falls lead/QI RN/RPN to roll out trial of chosen device and monitor for effectiveness through feedback from staff.	Number of new intervention devices trialed in the home for a determined sample size of residents by end of review period.	Trial 1 new type of device in the home for a sample size of residents of 5 by end of Q3 (December 31).	

Change Idea #4 Promote purposeful rounding in the home to assist with monitoring residents at high risk for falls.			
Methods	Process measures	Target for process measure	Comments
Falls lead/Falls committee to collaborate to examine BPG related to purposeful rounding and falls, determine recommendations.	Percentage of direct care staff who have received education on purposeful rounding recommendations by end of review period (Q4).	To provide the education to 90% of direct care staff by end of Q4 (March 31).	