

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 23, 2026

OVERVIEW

Huron Lodge is a municipally owned long term care (LTC) home located in Windsor, Ontario. The home provides care to 224 permanent residents across seven 32 bed home areas, including a secure unit with an enclosed courtyard that supports residents who benefit from safe access to outdoor space. Huron Lodge serves adults requiring continuous care, with residents ranging in age from 43 to 100 years, and consistently maintains an occupancy rate exceeding 97 percent.

The Quality Improvement Plan (QIP) at Huron Lodge is grounded in evidence based best practices and aligned with the City of Windsor Strategic Action Plan, CARF accreditation standards, and LSAA quality indicator requirements. Guided by the home's vision, "Huron Lodge is first and foremost the home of our residents," the QIP reflects a sustained commitment to continuous quality improvement, resident centred care, and accountability.

Huron Lodge fosters an environment that promotes dignity, self esteem, and quality of life while supporting residents, families, and staff. Residents are encouraged to lead meaningful, active lives within a welcoming and compassionate community. Medical care is provided by an interprofessional team including a Medical Director, an attending physician, and a Nurse Practitioner, supported by over 200 nursing staff and a broad range of allied health, dietary, therapeutic recreation, and support services professionals.

Quality of care and resident safety goals are advanced through the Quality Improvement Program and monitored using Ministry of Long Term Care indicators. In response to increasing resident complexity and evolving best practices, the Home continues to implement programs.

quality improvement.

Resident voice remains central to this work. Meaningful feedback

and active participation from Residents' Council are integrated into our quality improvement processes through monthly council meetings, during which the Quality Improvement Manager provides updates, seeks resident input, and reports back on actions taken in response to council recommendations.

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, and 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, NLOT Nurse Practitioner Team, 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 one of the ways the Huron Lodge team remains committed to improving 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 is committed to reducing social and health inequities across the community. Several initiatives are underway to respect, incorporate, and uphold Indigenous health and cultural safety throughout the organization.

To support continuous learning and improvement, members of City Administration actively participate in conferences, workshops, and training opportunities that enhance understanding of Indigenous affairs and strengthen relationships with local First Nations communities. In alignment with the Corporation's Action Plan, Huron Lodge has again selected Equity as a quality indicator of choice for the 2026/2027 Quality Improvement Plan (QIP) year. This includes a continued focus on equity, diversity, inclusion, and anti racism education to build cultural competency and foster an environment where advancing health equity is standard practice. Huron Lodge is committed to operating from a position of not knowing, recognizing residents and families as experts in their own lived experiences. These experiences are viewed as invaluable sources of knowledge that meaningfully inform and strengthen the care and services provided within the home. We strive to honour each resident's story through an understanding of their unique intersectionality. Programming at Huron Lodge reflects the individual and collective needs, preferences, and cultural identities of residents. Our culturally diverse staff support residents through advocacy for culturally responsive communication, respectful language, observance of traditions, and the use of first language whenever possible.

We acknowledge that recognizing disparities in health outcomes alone is insufficient; meaningful action is required to reduce them. Accordingly, strategic initiatives aimed at advancing equitable access and outcomes are embedded within our Service

Accountability Agreement priorities. Aligning local work plans with provincial priorities ensures a coordinated and sustained approach to reducing health inequities within our community and across the province.

PATIENT/CLIENT/RESIDENT EXPERIENCE

Resident engagement remains integral to innovation and continuous improvement initiatives at the Home. Through the Chrysalis Project, team members are preparing for the next phase of work focused on enhancing the resident experience and quality of life. The Home resumed its annual memorial service to honour residents who passed away in 2025, supporting meaningful connection, reflection, and remembrance for families regardless of length of stay.

As part of a Residents' Council–led initiative, a resident led subcommittee is collaborating with the Palliative Care Committee and the David Suzuki Foundation to plan a Memorial Garden. This dedicated space will support residents and families in remembering and celebrating their loved ones and will be designed with cultural considerations, native plantings, and a focus on enhancing biodiversity. Every phase of the project is grounded in resident decision making, ensuring resident choice and voice guide what residents need, want, and value in their home.

During the 2025/2026 QIP year, resident feedback was gathered through a pilot LED lighting project designed to improve visibility and support residents living with visual impairments. Residents actively participated in trialing the lighting and provided feedback on comfort, glare, wayfinding, and overall usability, helping to inform next steps for broader implementation.

The Home has also implemented Mealsuite to enhance the dining experience by supporting individualized menus and consistent

communication of resident preferences at point of service. This initiative enables dietary and care teams to better align meals with residents' needs and choices, while ongoing resident and family feedback continues to inform refinements. Additionally, programs using a wheelchair accessible bicycle further enhance mobility, inclusion, and overall quality of life.

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. As we transition into the 2026/2027 QIP year, the Home is further strengthening its recruitment and retention practices. Efforts include addressing identified gaps, improving efficiencies within the onboarding process, and intentionally centring residents within Orientation program objectives. The Home is pleased to report that a member of the Residents' Council participated in 100% of orientation sessions, providing new hires with valuable first hand perspectives from residents. This initiative was also featured in the OARC Toolkit. Building on this success, Residents' Council members have begun participating in Emergency Preparedness mock codes. These initiatives reinforce a culture of shared accountability and resident centred care, while supporting staff readiness and confidence. Ongoing evaluation and resident feedback will continue to inform improvements, ensuring sustainability and alignment with quality, safety, and regulatory expectations.

SAFETY

The safety and well-being of residents remain a top priority at Huron Lodge. The Home promotes continuous quality improvement

through the systematic review of patient safety incidents, with a strong focus on learning, accountability, and prevention. Following incidents, opportunities to enhance care are identified, staff are engaged in solution-focused improvement, and actions and outcomes are clearly communicated to residents, families, staff, and relevant stakeholders.

During the 2025–2026 QIP year, falls prevention remained a core quality and safety focus. The Falls Prevention Program was strengthened through the implementation and trialing of new fall prevention devices, supporting more individualized interventions based on residents' mobility, needs, and risk profiles. A structured post-fall huddle process was also implemented to support timely interdisciplinary review, identify contributing factors, and ensure immediate updates to care plans. This approach supports the translation of post-incident learning into practice changes, contributing to reduced fall risk and improved resident safety. In the 2026–2027 QIP year, the Home will further strengthen patient safety through a comprehensive focus on skin and wound care. Preventing skin breakdown and promoting timely, effective wound management are essential to reducing harm, preventing infection, and supporting residents' comfort, mobility, and quality of life.

The Home will continue to utilize the PCC Skin and Wound Care application to enhance clinical practice, improve documentation accuracy, and support early identification and monitoring of skin concerns. The Wound Specialist, in collaboration with the Nurse Practitioner, will lead targeted education for nursing staff to reinforce evidence-based practices and consistency across care teams.

Residents and families remain engaged partners throughout this work as the Home adapts to evolving legislative requirements, with

the shared goal of protecting and supporting vulnerable residents.

PALLIATIVE CARE

Over the past year, the team at Huron Lodge has worked diligently to strengthen the delivery of palliative care within the Home. Key improvements have been made across multiple areas, including policy and procedure revision, increased resident and family engagement, and enhanced staff education through collaborative partnerships. Regular Palliative Care Committee meetings have provided a forum for frontline staff feedback, which has directly informed updates to policies and procedures to better support pain and symptom management and promote resident centred care throughout the end of life journey.

The Home resumed its annual memorial service to honour residents who passed away in 2025, supporting meaningful connection and remembrance for families regardless of length of stay. The Palliative Care Committee is excited to collaborate on the development of the Memorial Garden, supporting meaningful remembrance and compassionate end of life care for residents and families.

Ongoing staff education remains a priority. Education sessions were delivered by a local consultant through the Palliative Pain and Symptom Management Program of Southwestern Ontario. Staff from all disciplines participated in training on Serious Illness Conversations and the Fundamentals of Palliative Care, supporting a consistent, informed, and compassionate approach to palliative and end of life care across the Home.

POPULATION HEALTH MANAGEMENT

Our population consists of vulnerable persons, including older adults, individuals with complex and compromised medical conditions, and those living with mental health diagnoses and/or cognitive impairment. These individuals face a range of challenges both within and beyond the long term care environment. To meet their diverse and evolving needs, the Home is committed to an individualized, resident centred approach to care, with residents firmly positioned at the centre of all care goals. Staff actively support resident autonomy by encouraging informed decision making within individual capabilities, promoting ongoing dialogue about care, and leveraging opportunities for health advocacy and education.

The Home is pleased to continue its partnership with the Alzheimer Society of Windsor Essex, whose services have been extended by an additional day per week because of the Home's collaboration and support, enhancing access to specialized programming for residents living with cognitive impairment. In support of continuous quality improvement, the Home actively seeks grant opportunities aligned with identified resident needs, enabling the expansion and sustainability of resident focused initiatives that enhance quality of life, engagement, and care outcomes.

Finally, Huron Lodge values its ongoing participation at the Ontario Health Team table, ensuring the long term care sector is represented at the provincial level. Locally, the Home continues to work collaboratively with Ontario Health at Home to support efficient, compassionate, and timely transitions into long term care, reflecting shared accountability for system integration and patient centred outcomes.

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



Board Chair / Licensee or delegate



Administrator /Executive Director



Quality Committee Chair or delegate



Lauren Meyer, Director of Care

Other leadership as appropriate

Access and Flow | Efficient | Optional Indicator

Indicator #4	Last Year		This Year		
	Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Huron Lodge LTC Home)	17.99 Performance (2025/26)	17.99 Target (2025/26)	21.43 Performance (2026/27)	-19.12% Percentage Improvement (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

Implement in home urinalysis pilot program as a screening tool.

Process measure

- Number of tests run in pilot program within review period to collect baseline data.

Target for process measure

- Collect raw number of tests over period of pilot program (Q4) to establish baseline data for future tracking and analysis.

Lessons Learned

The Home has successfully trained all Registered staff on implementing the in home urinalysis screening tool.

Change Idea #2 Implemented Not Implemented In Progress

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

Process measure

- Number of falls resulting in transfer to hospital through review period.

Target for process measure

- Reduce percentage of falls that result in transfer to hospital from 3.2% to less than 1%.

Lessons Learned

We reduced ED visits related to resident falls through evidence-based interventions, early identification of risk, and consistent post-fall management. Standardize Fall Risk Screening Assessments continue for residents who have fallen as per FLTCA regulations. In May 2025, post-fall huddle forms were introduced to the home to assist with interventions to reduce ED visit rates. This root cause analysis evaluation looks at physical, cognitive and environmental factors that may cause a resident to fall; and reviews medications to see if they are a contributor to falls. Following completion of this form, huddles are held on the unit by QI RPNs to educate staff on ways they can decrease fall risk for high risk residents. This tool has been vital to help further analyze trends in resident falls; inclusive of date, shift, time, location, and injuries. The goal of this documentation is to better individualize a resident’s plan of care and adapt fall prevention initiatives to reduce ED visits. Other fall reduction devices were introduced into the home such as raised edge mattresses, helmets, hip protectors and enhanced lighting to further eliminate environmental concerns and reduce injury related to falls.”

Change Idea #3 Implemented Not Implemented In Progress

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

Process measure

- Number of education/training sessions offered by end of review period (Q4).

Target for process measure

- Increase number of education/training session from 8 to 12 by end of Q4 (March 31).

Lessons Learned

Collaboration with the NLOT Nurse Practitioner program to deliver education, training, and clinical guidance remains in progress. Implementation was deferred due to the concurrent launch of other priority initiatives, including interRAI and MealSuite, and will be revisited as part of future quality improvement planning.

Change Idea #4 Implemented Not Implemented In Progress

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

Process measure

- Number of education/training sessions offered by end of review period (Q4).

Target for process measure

- .Complete 100% of scheduled (10)education/training sessions by end of Q4 (March 31).

Lessons Learned

Staff education on effective communication within the health care team and with external clinical supports was delivered through sessions led by an external consultant and supported by community partner agencies. This collaborative approach strengthened shared understanding, coordination of care, and communication practices across internal and external care providers.

Change Idea #5 Implemented Not Implemented In Progress

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

Process measure

- Number of education/training sessions offered by end of review period (Q4).

Target for process measure

- .Complete 100% of scheduled (10)education/training sessions by end of Q4 (March 31).

Lessons Learned

Staff education on effective communication within the health care team and with external clinical supports was delivered through sessions led by an external consultant and supported by community partner agencies. This collaborative approach strengthened shared understanding, coordination of care, and communication practices across internal and external care providers.

Change Idea #6 Implemented Not Implemented In Progress

Strengthen in-home clinical management and early intervention through collaboration with the Nurse Practitioner–Led Outreach Team (NLOT), Ontario Health at Home, and internal interdisciplinary teams to reduce avoidable emergency department visits.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Through timely NP consultation, enhanced clinical monitoring, and proactive management of changes in resident condition, the Home has supported residents to receive appropriate care within the Home, contributing to reduced reliance on emergency department transfers.

Change Idea #7 Implemented Not Implemented In Progress

Strengthen early identification and in-home management of ambulatory care–sensitive conditions through enhanced interdisciplinary monitoring and timely escalation of changes in resident condition.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Through consistent interdisciplinary communication, proactive monitoring, and timely clinical review of changes in resident condition, the Home has supported residents to receive appropriate care within the Home whenever possible, reducing reliance on emergency department transfers for ambulatory care–sensitive conditions.

Comment

The Home will continue to build on existing initiatives to reduce avoidable emergency department visits by strengthening early identification of changes in resident condition and expanding interdisciplinary collaboration. Ongoing review of ED transfer patterns and resident outcomes will inform future quality improvement activities, with a continued focus on providing the right care, in the right place, at the right time.

Indicator #3	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 (Huron Lodge LTC Home)	100.00	100	100.00	0.00%	100

Change Idea #1 Implemented Not Implemented In Progress

Determine fit of EID-R education to selected departments and apply EID-R selected courses to same.

Process measure

- Number of departments selected, number of courses applied.

Target for process measure

- To have 100% of departments (2)selected have 100% of courses (5) applied by end of Q1

Lessons Learned

The Home assessed the relevance of EID-R education to selected departments and assigned appropriate courses based on staff roles and responsibilities. This targeted approach supported consistent, role-specific learning and strengthened staff capacity to apply equity-informed practices in care delivery.

Change Idea #2 Implemented Not Implemented In Progress

All selected departments will have EID-R courses completed.

Process measure

- Percentage of education completed across all identified departments.

Target for process measure

- To have 100% of education completed by end of Q3.

Lessons Learned

All selected departments have been assigned EID®R courses aligned with their roles and responsibilities. Through the Surge platform, 100% of Administration staff successfully completed EID®R education, while course completion across remaining departments is ongoing.

Change Idea #3 Implemented Not Implemented In Progress

Review socio/demographic data options for our population that will translate for value-added collection, reporting, and usage within the home.

Process measure

- Percentage of potential indicators reviewed.

Target for process measure

- To have 100% of all potential indicators reviewed by end of Q1.

Lessons Learned

Socio®demographic data are collected, where available, at the time of admission to support a more comprehensive understanding of resident needs. This information is meaningfully applied through the Social Work–led development of each resident’s “All About Me” profile, supporting individualized, culturally responsive care planning and improved use of resident®identified information across the Home.

Change Idea #4 Implemented Not Implemented In Progress

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.

Process measure

- Percentage of new admissions with this sociodemographic indicator recorded .

Target for process measure

- To have 75% of new admissions disclose chosen indicator by end of Q4.

Lessons Learned

Socio®demographic data are collected, where available, through the Social Work admission process and used to inform individualized care planning and resident®centred supports.

Comment

The Home will continue to increase EDI and anti-racism education completion across executive, management, and staff groups, with progress monitored through local data collection.

Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #5	100.00	100	100.00	--	NA
Resident experience: Overall satisfaction (Huron Lodge LTC Home)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

Implement next stage of Chrysalis Project.

Process measure

- Number of murals chosen and installed by review period (26/27 QIP submission).

Target for process measure

- To have 100% of murals (7/7) will be installed by March 31, 2026.

Lessons Learned

The Chrysalis Project originally planned to introduce dining room murals to enhance the resident environment. Due to construction and changes in building layout, the initiative was no longer feasible as planned.

As a result, the Home adapted the project while maintaining its focus on resident-centred quality improvement. A resident-led Memorial Garden initiative was introduced, providing residents with meaningful involvement in environmental enhancements and organizational initiatives.

Lesson Learned: Quality improvement initiatives must remain flexible and responsive to operational and construction changes while continuing to prioritize resident engagement. The Home will continue to seek and integrate resident feedback into ongoing quality improvement activities.

Change Idea #2 Implemented Not Implemented In Progress

Improve results of resident satisfaction with home/staff responsiveness to their questions/concerns.

Process measure

- 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).

Target for process measure

- To increase positive responses on this question by 3%; from 97% to 100%.

Lessons Learned

Although the Home did not achieve the targeted 3% increase for this specific survey question, overall resident satisfaction remained strong and consistent. Resident satisfaction survey results were 96.39%, consistent with the previous year, and 100% of residents reported satisfaction with the quality of care and services at Huron Lodge. This demonstrates sustained high performance while reinforcing the importance of targeted improvement efforts to further enhance specific areas of resident experience.

Change Idea #3 Implemented Not Implemented In Progress

Increase resident engagement in the home with respect to human resources processes.

Process measure

- Percentage of Orientation sessions/new staff reached through initiative over the calendar year.

Target for process measure

- To have 100% of Orientation sessions include a Residents' Council rep presentation.

Lessons Learned

The Home is pleased to report that this target was achieved, with 100% of orientation sessions including a Resident Council representative presentation. This initiative was recognized through inclusion in the OARC toolkit as a leading practice. Building on this success, the Home will further strengthen resident engagement by incorporating residents into Emergency Mock Codes in the upcoming year.

Change Idea #4 Implemented Not Implemented In Progress

Increase resident response rate for 2025 Satisfaction Survey to gain more accurate measure of overall satisfaction.

Process measure

- Percentage response rate of 2025 RSS increase from previous survey (2024).

Target for process measure

- To increase resident response rate by 7%, from 73% to 80%.

Lessons Learned

The Home achieved a resident survey response rate exceeding 80% for the 2025 satisfaction survey, demonstrating strong resident engagement. Building on this success, the Home will continue to collaborate with residents in the development of survey tools to ensure feedback remains meaningful, relevant, and reflective of resident priorities.

Change Idea #5 Implemented Not Implemented In Progress

Although not included in the previous QIP, the Home has begun utilizing multiple technology platforms to strengthen the collection of resident experience feedback, including QR codes, Microsoft Forms, and targeted audits.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

This approach has increased accessibility and timeliness of resident input, supporting more responsive service improvements and generating more meaningful, actionable feedback to enhance resident care and services.

Comment

The Home is excited to continue building on resident-led initiatives in the upcoming QIP cycle, including the development of a Resident Memorial Garden. Residents have also expressed enthusiasm for participating in Emergency Mock Codes as a new change idea. In preparation, the Home has begun providing education to residents on emergency codes, supporting informed, meaningful participation. These initiatives reinforce the Home’s commitment to resident engagement, shared learning, and person-centred quality improvement.

Safety | Effective | Custom Indicator

	Last Year		This Year		
Indicator #2	4.20	3.70	5.81	--	NA
Percentage of residents who have a urinary tract infection. (Huron Lodge LTC Home)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

To reduce catheter use.

Process measure

- Percentage of residents with catheter in place by end of review period (Q4).

Target for process measure

- Catheter use will decrease from 3.9% to 3.5% by end of Q4.

Lessons Learned

Review of all new admissions to assess the clinical necessity for indwelling catheter use.
Collaboration with the home physician to determine opportunities for catheter discontinuation.
Use of bladder scanners to monitor urinary retention as an alternative to catheterization.
Utilization of bedside commodes and urinals when clinically appropriate.
Delivery of in-home education regarding catheter-associated risks, including CAUTIs, Catheter care.
5.26% of residents currently have indwelling catheters, all related to admission status.
Ongoing monitoring of catheter utilization and catheter-associated infection rates within the facility. A key challenge identified is the admission/readmission of residents discharged from acute care settings with chronic catheter use. This limits opportunities for immediate catheter removal.

Change Idea #2 Implemented Not Implemented In Progress

Audit RAI-MDS to ensure accurate data captured through coding.

Process measure

- Percentage of RAI-MDS submissions audited by end of review period (Q4).

Target for process measure

- To audit 100% of RAI-MDS submissions by end of Q4 (March 31).

Lessons Learned

We do review MDS on regular basis and follow-up with staff for accuracy.

Change Idea #3 Implemented Not Implemented In Progress

Development of pharmacist review of anti-biotic prescriptions program.

Process measure

- Number of reviews completed as result of the program by end of review period (Q4).

Target for process measure

- Collect raw number of reviews over defined period (to end of Q4 - March 31) to determine baseline data.

Lessons Learned

Overall reduction in systemic antibiotic use within the home.

Decrease in total systemic antibiotic orders observed.

Increase in antibiotic orders that clearly document the indication for use.

Ongoing monitoring of UTI diagnostic criteria met vs. unmet to minimize unnecessary antibiotic prescribing.

Routine use of the facility antibiogram to guide therapy.

Empiric antibiotic therapy aligned with local treatment guidelines.

Shortened antibiotic durations for uncomplicated UTIs, consistent with Public Health Ontario (PHO) guidelines.

The Medical Director, consultant pharmacist, and IPAC team provided education sessions for residents' families on UTIs and Public Health guidelines for treating UTI's.

Change Idea #4 Implemented Not Implemented In Progress

Provide pericare education to direct care staff.

Process measure

- Percentage of staff trained by end of review period (Q4).

Target for process measure

- To have 90% of eligible staff receive the defined education by end of Q4 (March 31).

Lessons Learned

The Staff Development Coordinators provided Peri Care education to direct care staff through the use of standardized Peri Care educational videos. Education was delivered to PSWs to support consistent practices and reinforce best practices related to personal care and infection prevention.

Change Idea #5 Implemented Not Implemented In Progress

Provide education to staff, residents and families through partnerships with external stakeholders.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Session for families was provided through our MD and IPAC team. The Medical Director, consultant pharmacist, and IPAC team provided education sessions for residents’ families on UTIs and Public Health guidelines for treating UTI’s.

Comment

The Home will continue to proactively monitor residents for signs and symptoms of urinary tract infections and implement evidence-based interventions to reduce the incidence of UTIs. Ongoing efforts will focus on preventing infection-related complications, reducing UTI-triggered systemic decline, and minimizing potentially avoidable hospital transfers. Ongoing education will continue

Safety | Safe | Optional Indicator

	Last Year		This Year		
Indicator #1	10.10	9.50	9.72	3.76%	NA
Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Huron Lodge LTC Home)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

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

Process measure

- Form will be implemented and live by end of Q2 in at least 3 home areas.

Target for process measure

- 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).

Lessons Learned

The Home enhanced its falls prevention auditing process through the implementation of a new standardized post-fall review form. All staff received training to support consistent use and timely care plan updates. Residents identified as high risk, including those with five or more falls, were reviewed by the Quality Improvement team to inform targeted prevention strategies.

Change Idea #2 Implemented Not Implemented In Progress

Re-education for staff on falls prevention policies and procedures.

Process measure

- Number of staff (re)trained in post-fall documentation and assessment by end of defined review period (Q3).

Target for process measure

- To have 100% of registered staff (re)trained in post-fall documentation and assessment by end of Q3 (December 31).

Lessons Learned

All Registered staff were re educated. Education is also provided annually and in orientation.

Change Idea #3 Implemented Not Implemented In Progress

Implement new fall monitoring devices in the home.

Process measure

- Number of new intervention devices trialed in the home for a determined sample size of residents by end of review period.

Target for process measure

- Trial 1 new type of device in the home for a sample size of residents of 5 by end of Q3 (December 31).

Lessons Learned

The Home successfully implemented new fall monitoring devices to enhance resident safety and reduce fall risk. Ten raised-edge mattresses were introduced for residents at highest risk, and to date, these devices remain in use with no reported falls, demonstrating a positive impact on fall prevention.

Change Idea #4 Implemented Not Implemented In Progress

Promote purposeful rounding in the home to assist with monitoring residents at high risk for falls.

Process measure

- Percentage of direct care staff who have received education on purposeful rounding recommendations by end of review period (Q4).

Target for process measure

- To provide the education to 90% of direct care staff by end of Q4 (March 31).

Lessons Learned

Purposeful rounding was promoted as a change idea to support monitoring of residents at high risk for falls, with initial staff education delivered following a policy and procedure update. While awareness increased, consistent implementation across the Home remains an ongoing focus area, and further reinforcement and monitoring are planned to strengthen adoption and impact.

Change Idea #5 Implemented Not Implemented In Progress

Increase staff competency in fall prevention through ongoing education with our falls lead ADOC and SDC

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Staff competency in fall prevention was strengthened through ongoing education led by the Falls Lead, ADOC, and Staff Development Coordinator (SDC). All registered staff completed fall prevention training, which has been embedded into orientation and annual education to support sustainability.

Change Idea #6 Implemented Not Implemented In Progress

A change idea not included in the previous QIP involved the QI Nurse initiating audits of Emergency Department (ED) transfers to identify root causes for ED visits. This data will be incorporated into the upcoming QIP to inform targeted improvement strategies.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Early auditing has supported a better understanding of trends, gaps, and contributing factors related to ED transfers. Ongoing collection of raw assessment data will allow the Home to identify patterns, strengthen clinical decision-making, and support proactive interventions aimed at reducing avoidable transfers.

Comment

The Home will continue to track fall incidents and analyze the trends in data to support individualized fall care planning to reduce fall risk for our residents. Our primary goal is to reduce the incidence of falls and fall-related injuries among residents while still maintaining safety, independence, and quality of life.

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)	21.43	17.99	The target reflects a realistic and meaningful improvement from the Home’s current performance, informed by analysis of Emergency Department transfer patterns and lessons learned from the 2025/26 QIP.	

Change Ideas

Change Idea #1 Strengthen the falls prevention program by expanding the use of targeted environmental modifications for residents at highest risk, with the goal of reducing fall related emergency department transfers.

Methods	Process measures	Target for process measure	Comments
Residents who experience five or more falls will undergo a focused interdisciplinary review, including assessment for appropriate environmental modifications (e.g., low beds, mats, lighting, equipment adjustments). Findings and recommendations will be discussed through structured fall huddles and incorporated into individualized care plans.	Number of fall related transfers to hospital during the review period. Percentage of residents with five or more falls who receive a documented environmental modification assessment.	100% of residents with five or more falls will receive a fall review and interdisciplinary huddle. 100% of residents who meet criteria will receive an environmental modification assessment and intervention, where appropriate.	

Change Idea #2 Work collaboratively with NP from NLOT program to deliver education, training, and clinical guidelines to home staff.

Methods	Process measures	Target for process measure	Comments
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)	Provide 4 training sessions by end of Q4.	

Change Idea #3 Improve early recognition and in home management of ambulatory care–sensitive conditions by delivering brief, focused “Take 10” education sessions to frontline staff, supporting timely escalation and reducing avoidable emergency department visits.

Methods	Process measures	Target for process measure	Comments
“Take 10” education sessions will be delivered to frontline staff during shifts, focusing on recognizing early signs of ambulatory care–sensitive conditions (e.g., dehydration, respiratory changes, UTI symptoms, functional decline) and reinforcing appropriate escalation pathways to support in home intervention.	Number of “Take 10” education sessions delivered to staff. Percentage of frontline staff who attend at least one “Take 10” session focused on ambulatory care–sensitive conditions	At least 10 “Take 10” education sessions delivered over the QIP year	

Change Idea #4 To reduce Emergency Department (ED) transfer rates, the QI Nurse and ADOC will audit all ED transfers to identify root causes and contributing factors. This change idea builds on Emergency Department transfer audit findings identified during the 2025/26 QIP Progress Report and formalizes this work as a core quality improvement strategy.

Methods	Process measures	Target for process measure	Comments
ED transfer audits will be completed using standardized review of assessments and documentation to determine the reason for transfer and identify opportunities for improvement.	Percentage of hospital transfers audited to determine cause	100% of hospital transfers audited. Raw assessment data collected through Q4 to identify trends, gaps, and areas for targeted quality improvement.	

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	O	% / Staff	Local data collection / Most recent consecutive 12-month period	100.00	100.00	Theoretical best possible performance.	

Change Ideas

Change Idea #1 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 percent of education completed by end of Q4	

Change Idea #2 Building on the collection of resident social and demographic data to support diversity and inclusion, the Home will begin collecting resident pronouns at admission to promote respectful, person-centred care.

Methods	Process measures	Target for process measure	Comments
Admission processes and documentation will be updated to include an optional, resident-identified pronoun field, with staff applying principles from EDI and Anti-Racism education during intake conversations.	Percentage of new admissions offered the opportunity to self-identify pronouns.	"100% of new admissions offered the opportunity to self-identify pronouns by December 2026.	

Change Idea #3 Integrate DEI (Diversity, Equity, and Inclusion) Training Into New Employee Orientation

Methods	Process measures	Target for process measure	Comments
Embed DEI content into home specific orientation (cultural safety, inclusive communication, bias awareness). Include real world LTC scenarios to reinforce application in practice.	Percentage of new staff completing DEI orientation	100 percent of new staff to receive DEI orientation starting May 2026	

Change Idea #4 Create a centralized EDIA resource hub on Teams/SharePoint

Methods	Process measures	Target for process measure	Comments
Upload curated content: videos, slides, FAQs, reporting support. Promote monthly through email and huddles.	Monthly hub promotion completed (email and/or huddle) (% of months with documented promotion). Resource hub content build (# of EDIA resources posted to the hub)	Launch: Hub launched and accessible to all staff by October 31, 2026. Promotion: Documented monthly promotion completed in =90% of months following launch. Content build: Post 25 EDIA resources to the hub by December 31, 2026 (minimum: =10 by end of Nov 2026).	

Experience

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Do residents feel they have a voice and are listened to by staff?	C	% / Residents	In-house survey / 2026		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
As part of the next stage of the Chrysalis Project, residents will collaborate with the Palliative Care Committee and community partners to co-develop and implement a Memorial Garden. Resident input will be actively sought through Residents' Council discussions, planning meetings, and feedback opportunities to ensure their perspectives directly inform design and implementation.	Planning and consultation stages to be completed by Fall 2026 Resident-informed implementation of Phase One planting of the Memorial Garden by 2027	100% of planning and consultation stages to be completed by Fall 2026 100% completion of Phase One of the Memorial Garden planting	

Change Idea #2 Increase resident engagement in the home's emergency preparedness program by involving Resident Council representatives in planning, communication, and participation in emergency code drills.

Methods	Process measures	Target for process measure	Comments
The Emergency Preparedness team will provide education to Resident Council members on emergency preparedness and the purpose of mock code drills. Resident Council representatives will be invited to participate in emergency code drills and debriefs when appropriate and safe. Feedback will be shared with the emergency preparedness team and reported back through Resident Council.	Drill participation: # and % of scheduled mock code drills with at least one Resident Council representative participating (attending drill and/or debrief).	Resident Council representative participates in 10/10 (100%) scheduled mock code drills during the QIP year.	

Change Idea #3 Engage more resident feedback using accessible technology-based options (e.g., tablet-based surveys, QR codes, and phone/virtual check-ins) to help residents feel they have a voice and are listened to by staff

Methods	Process measures	Target for process measure	Comments
The interdisciplinary team will use simple, consistent feedback tools (short surveys/questionnaires and brief check-ins) delivered through different platforms (paper, tablet, QR code, or phone) to collect resident input on services.	Monthly feedback volume: # of completed resident feedback surveys/questionnaires collected each month.	Monthly feedback volume: Collect 20 completed resident feedback surveys each month (i.e., 20/20 surveys completed monthly).	

Change Idea #4 Strengthen resident voice by integrating resident feedback into new staff orientation and tracking the impact through the annual Resident Satisfaction Survey.

Methods	Process measures	Target for process measure	Comments
The QI Lead and Social Worker (SW) will review and analyze the 2026 Resident Satisfaction Survey results for the question: "Do you feel residents' input during staff orientation helps new team members understand what makes this place feel like home?"	% of residents answering positively to: "Do you feel residents' input during staff orientation helps new team members understand what makes this place feel like home?"	Maintain 100% positive responses to this survey question (from 2025 Survey)	

Safety

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	23.52	22.00	Improve Home's percentage and remain same as provincial average of 20.00	Advantage- Gentle Persuasive Approaches, The Geriatric Mental Health Outreach Team (GMHOT)

Change Ideas

Change Idea #1 Strengthen appropriate antipsychotic use by implementing a standardized post admission medication review process to identify opportunities for dose reduction or discontinuation of antipsychotics for newly admitted residents.

Methods	Process measures	Target for process measure	Comments
Continue to assess all new admissions with antipsychotics at the 6 week post-admit mark for potential reduction or discontinuation of antipsychotic.	Measure % of new admits who have had an antipsychotic review.	Measure 100% of newly admitted residents with an antipsychotic to be reviewed after 6 weeks post-admission.	

Change Idea #2 Improve the accuracy and consistency of behavioural documentation by strengthening frontline staff knowledge in recognizing and documenting delusions and hallucinations, supporting more reliable RAI MDS coding and appropriate antipsychotic use

Methods	Process measures	Target for process measure	Comments
Education for frontline staff on recognizing delusions and hallucinations to improve documentation that impacts the antipsychotic RAI indicator.	% of staff who PSWs who have received training on delusion and hallucination coding.	Measure 100% of PSWs to receive training on delusions and hallucination	

Change Idea #3 Engage external partners (e.g., GHMOT) to deliver four education sessions on mental health diagnoses, dual diagnosis, and schizophrenia to strengthen assessment and non-pharmacological strategies and support reduction of antipsychotic use for residents not living with psychosis.

Methods	Process measures	Target for process measure	Comments
Confirm schedule with external partner (s) (e.g., GHMOT); coordinate dates/times; invite/register direct care staff; track attendance and completion for each session.	Measure Number of education sessions delivered by external partner(s). Percentage of staff who attend at least one session.	Measure Deliver 4 education sessions by external partner(s) (e.g., GHMOT) by December 2026. At least 75% of direct care staff attend one session by December 2026.	

Change Idea #4 Strengthen non pharmacological approaches to responsive behaviours by utilizing trained Gentle Persuasive Approaches (GPA) coaches to champion GPA bathing techniques and provide focused “Take 10” education sessions to frontline staff, supporting reduced reliance on antipsychotic medications for residents without psychosis.

Methods	Process measures	Target for process measure	Comments
Two trained GPA coaches will receive specialized education in GPA bathing techniques. GPA coaches will act as unit based champions, providing a total of 10 brief “Take 10” education sessions to frontline staff focused on practical application of GPA strategies during personal care.	Number of GPA coaches trained in GPA bathing techniques. Number of “Take 10” GPA education sessions delivered to staff.	100% (2/2) GPA coaches trained in GPA bathing techniques. 10 “Take 10” education sessions delivered to staff.	

Measure - Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as reporting quarter for the rolling 4-quarter average	5.80	3.00	The target reflects maintenance of the Home's current strong performance in the prevention and management of stage 2–4 pressure injuries within a complex long-term care population. Given the high acuity, medical complexity, and admission of residents with existing or advanced wounds, the focus for 2026/27 is on sustaining performance while strengthening early identification, standardized monitoring, interdisciplinary wound review, and staff competency.	

Change Ideas

Change Idea #1 Improve pressure injury prevention by enhancing staff competency, access to ROHO maintenance supplies, and standardized monitoring of ROHO cushion use for residents at risk.

Methods	Process measures	Target for process measure	Comments
Improve knowledge of ROHO cushion maintenance through in-service training and access to supplies through installation of ROHO stations in every tub room; tracking and accountability of ROHO assessments to be implemented through PCC charting.	# of in services provided % of units equipped with a ROHO pump and 1-sheet reference guide in each tub room % of residents with a ROHO cushion with a scheduled ROHO assessment task tied to their bath days.	100% of units to receive in service training on both days and afternoon shifts. 100% of unit tub rooms to be set up with an installed ROHO pump and quick reference guide 100% of residents with a ROHO cushion to have a scheduled task for PSWs to sign.	

Change Idea #2 Strengthen evidence based wound prevention and management practices by leveraging Nurse Practitioner and wound specialist expertise to deliver focused, standardized wound education to frontline staff.

Methods	Process measures	Target for process measure	Comments
Nurse Practitioner / wound specialist to put together a series of in-services on key wound education topics.	# of NP designed and led wound education in-services.	At least 3 NP wound in-services throughout 2026.	

Change Idea #3 Establish an in-home interdisciplinary wound review process monthly to identify risks early, standardize treatment plans, and escalate delayed healing to reduce worsening of stage 2–4 pressure injuries.

Methods	Process measures	Target for process measure	Comments
For every resident with a stage 2–4 pressure injury that is worsening or not healing as expected, complete an interdisciplinary wound review (e.g., nursing, wound lead, dietitian, physician/NP) and ensure the dietitian completes a monthly nutrition assessment with an updated nutrition plan.	Percentage of residents with a stage 2–4 (or worsening/delayed healing) pressure injury who receive a documented monthly dietitian assessment.	100% of residents with a stage 2–4 (or worsening/delayed healing) pressure injury will have a documented monthly dietitian assessment by December 2026.	

Change Idea #4 To improve early identification and prevention of wounds, the Home will enhance staff education through regular wound audits and focused interdisciplinary learning, supporting proactive and preventative wound care practices.

Methods	Process measures	Target for process measure	Comments
The Staff Development Coordinator (SDC)/ QI Nurse will complete four wound chart audits monthly to identify early-stage skin integrity issues and gaps in practice. Findings will be shared through interdisciplinary discussions to reinforce prevention strategies and timely interventions.	Number of wound chart audits completed Number of staff education sessions (“Take 10s”) delivered	100% of scheduled wound audits completed 100% of required staff re-education provided based on audit findings	