



# **CONTINUOUS QUALITY IMPROVEMENT REPORT**

**Apr. 1, 2025 to  
Mar. 31, 2026**

**May 15, 2026**

## **1. Designated Lead for Quality Improvement at Strathmere Lodge**

The Lead for Quality Improvement (QI) at Strathmere Lodge is Brent Kerwin, Lodge Administrator. Contact information:

- a) Phone: (519) 245-2520, ext. 6222; and
- b) Email: [bkerwin@middlesex.ca](mailto:bkerwin@middlesex.ca)

## **2. Priority Areas for Quality Improvement for 2026/27**

As determined by The Lodge's QI Committee, The Lodge's Priority Areas for Quality Improvement for 2026/27 (i.e., Apr. 1, 2026 to Mar. 31, 2027) are:

- Minimizing the need to transfer residents to the hospital emergency department; and
- Minimizing resident pressure injuries (commonly known as "bed sores").

See Appendix 1 for The Lodge's Annual (2026-27) Quality Improvement Plan, which was approved by The Lodge's QI Committee and Middlesex County Council (Lodge owner/operator), before submission to Health Quality Ontario (HQO) on March 25, 2026, as required by the province.

## **3. Process to Identify Priority Areas for Annual Quality Improvement Plan**

The Lodge's Quality Improvement Committee decides on annual Priority Areas for Quality Improvement by considering a variety of metrics/data/information, both anecdotal and empirical. Such includes:

- a) Comparative provincial long term care home metrics from the Canadian Institute for Health Information (CIHI);

- b) Annual resident/family satisfaction survey results;
- c) Audits;
- d) Residents' Council and Family Council feedback;
- e) Provincial government funding announcements;
- f) Asset Inventory Review;
- g) Feedback from Admission Care Conferences and Annual Care Conferences held with residents/family members;
- h) Brainstorming by Quality Improvement Committee members;
- i) Incident Reports (both resident and employee);
- j) Post-discharge questionnaires;
- k) Staff Exit questionnaires;
- l) Informal feedback from residents, family members and staff members;
- m) Concerns/complaints from residents/families;
- n) Results of Ministry of Long Term Care inspection reports; and
- o) Staff Suggestion Box submissions.

#### **4. Measuring/Monitoring Quality Improvement Plans/Initiatives**

Quality Improvement Plans developed by The Lodge's Quality Improvement Committee are reviewed/revisited at quarterly QI Committee meetings. Progress made on implementing our Annual Quality Improvement Plan is a standing agenda item at meetings.

Progress reports are made to residents, families and staff via Residents' Council meetings, Family Council meetings and newsletters (both staff newsletter and resident/family newsletter).

#### **5. Annual Resident/Family Survey**

During late 2025/2026, The Lodge surveyed residents, families and staff as part of launching a Strategic Planning initiative. Our external planning consultant held in-person meetings with residents, families

and staff, and conducted an on-line survey for those who could not attend an in-person meeting. Feedback was sought as to what can be improved at The Lodge.

The planning consultant will use the aforementioned feedback to produce a strategic plan outline in later May 2026, outlining to residents, families and staff as to what improvement initiatives will be implemented by The Lodge over the next 3-5 years.

## **6. Improvements to Resident Care, Accommodations, Services, Programs and Goods**

Improvements to resident care, accommodations, services, programs and goods were made throughout 2025/2026.

Communication on improvements is done throughout the year through vehicles such as Residents' Council meetings, Family Council meetings and regular newsletters (both resident/family newsletter and staff newsletter).

A summary of improvements for 2025/26 (i.e., Apr. 1, 2025 to Mar. 31, 2026) is as follows:

- a) New Lodge video, "In The Jungle", made in collaboration with the students at Strathroy District Collegiate Institute
- b) PSW staffing increases (an additional full-time Personal Support Worker position for the day shift, 7 days a week, on each of The Lodge's five (5) resident home areas)
- c) New television for rejuvenated Calming Room on our Bear Creek resident home area (Lodge's Ladies' Auxiliary donation)
- d) New commercial fridge for upstairs resident home area serveries (Arbour Glen and Parkview Place)

- e) Four (4) new resident lifts (lift equipment required to transfer/lift residents when staff need to aid residents)
- f) 14 therapeutic mattresses (used in the healing of pressure (skin) injuries or to prevent pressure injuries for residents susceptible to pressure injuries)
- g) Replacement of the two (2) hot water holding tanks that service the domestic hot water needs of Lodge residents (resident rooms and bathing facilities)
- h) Implementation of revised provincial resident health assessment tools/process effective July, 1, 2025 (quarterly resident health assessments are streamlined, leading to more staff time for direct resident care and more personalized care plans)
- i) Bird exclusion project – erecting discreet building structures that act as physical barriers to prevent birds from accessing or inhabiting specific building areas where birds nest/roost (and possibly gain building entry)
- j) New floor scrubber – for better cleaning and hygiene versus traditional mopping methods
- k) New “DAKboards” (electronic resident directories posted via TV monitors in each resident home area)
- l) Elevators (2) Rejuvenation (hydraulic oil change crucial for ensuring proper functioning and longevity of elevator hydraulic system)
- m) New full-time Nurse Practitioner (an advanced clinical provider who helps residents receive faster, more consistent medical care on-site)
- n) New electronic piano (resident programming)
- o) Student Placement - Hosted 21 nursing students from the *Western University-Fanshawe College Collaborative Bachelor of Nursing (BScN) Program*
  - *Assisted 21 students to complete their Nursing education requirements*

- *Students on-site at The Lodge Monday-Wednesday from October to December 2025*
  - *Mutually beneficial in that the students provided The Lodge with “extra hands” to care for Lodge residents*
  - *Assists The Lodge to recruit future Nursing staff*
- p) Aluminum cladding of Lodge window sills to enhance weather resistance (e.g., prevent rain leaks)
- q) Automatic sliding door track replaced (front entrance)
- r) Resident washroom plumbing upgrades (Hickory Woods)
- s) Staff fire extinguisher training with Strathroy-Caradoc Fire Prevention Officer
- t) New Robot Coupe (commercial food processor for kitchen)
- u) Modified Bowling Game (resident programming)
- v) New plants to adorn all dining room fireplace mantles
- w) Staff education to enhance care/service:
  - Four (4) Lodge staff attended “**LEAP**” training (Pallium Canada’s Learning Essential Approaches to Palliative Care)
  - One RPN is attending the “**SWAN**” Program (Skin Wellness Associate Nurse Program)
- x) Rimmed plates replaced on all resident home areas (rimmed plates are specialized, adaptive dining aids designed to help residents with limited dexterity, dementia, and/or visual impairment eat independently)

# **APPENDIX 1**

**2026/27 Quality Improvement Plan**

**Lodge Quality Improvement Plan (QIP) – Two (2) “Indicator” (Improvement) Foci, Each With Four (4) “Change Ideas”**

**Indicator (Improvement) Focus #1 – Minimizing Hospital Emergency Department Transfers**

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)	21.78	16.00	Our Home is performing better than the provincial average (latest available NACRS data).  Minimizing hospital transfers of long term care home residents is widely considered beneficial for both clinical and quality-of-life reasons. Minimizing resident transfers to hospital is also beneficial for the health care system as whole (e.g., aids in minimizing hospital emergency department pressures).	

**Change Ideas (4) for Indicator #1 – Minimizing Hospital Emergency Department Transfers**

Change Idea #1 Implement an “Early Warning Signs” screening tool for residents with a diagnosis of Congestive Heart Failure (CHF) to ensure timely recognition of, and treatment for, worsening CHF symptoms, and in an effort to minimize the need for emergency department transfer (CHF diagnosis is among diagnoses considered “potentially avoidable” as to hospital visit need).

Methods	Process measures	Target for process measure	Comments
PSWs to receive education on CHF. An “Early Warning Signs” screening tool will be a readily available to PSWs caring for residents with a CHF diagnosis. As applicable, PSWs will alert registered nursing staff of worsening CHF symptoms observed.	# of PSWs receiving education on CHF and the early warning signs screening tool.	100% of residents with CHF diagnosis (approx. 17 residents) will be monitored referencing the “Early Warning Signs” CHF screening tool.	

**Change Idea #2** Strengthen Advance Care Planning by implementing an “End of Life Wishes” initiative that supports residents/families in formally identifying/documenting end of life care preferences. Incorporating these wishes into the health record will ensure that the Home’s care team has clear direction when making end of life care decisions regarding treatment and hospital transfers.

Methods	Process measures	Target for process measure	Comments
Residents/families will be approached via annual/initial care conference meetings, and by assigned registered nursing staff, starting with residents who are assessed as having higher health instability (such that a hospital transfer may be more likely).	Number of individual residents/families with end of life wishes identified/documentated.	100% of residents/families will have provided their End of Life Wishes information by June 30, 2026.	

**Change Idea #3** Early identification of Delirium (an acute, fluctuating syndrome of sudden-onset confusion, altered consciousness), so as to better detect/treat possible underlying infections (e.g., pneumonia, urinary tract infections) before need for hospital transfer arises.

Methods	Process measures	Target for process measure	Comments
Introduce/Implement a “Change in Behaviour Protocol”, including a “Confusion Assessment Method (CAM)” screening tool for Delirium identification.	Educate registered nursing staff on new protocol and screening tool.	100% of registered nursing staff will be trained on new protocol and screening tool.	

**Change Idea #4** Continue to call upon the Middlesex-London Community Paramedicine for Long Term Care Plus (CPLTC+) Program to conduct Point-of-Care (PoC) testing (e.g., urinalysis, bloodwork, ultrasounds) to aid in clinical decision-making as to need for hospital transfer.

Methods	Process measures	Target for process measure	Comments
Registered nursing staff and attending physicians to receive periodic updates on utilization of CPLTC+ Program, along with other related communication to promote CPLTC+ Program utilization.	Number of visits made to The Home by CPLTC+ Program paramedics on a quarterly basis (as reviewed by Home's Quality Improvement Team).	Volume of CPLTC+ Program use to increase 10% annually.	

**Indicator (Improvement) Focus #2 – Minimizing Pressure Injuries**

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of resident with a Stage 2 to 4 pressure injury	C	% / LTC home residents	CIHI CCRS / Q3 2025 - 2026 (to Sept. 30, 2025)	10.20	5.00	The Lodge compares favourably to the provincial long term care home average (latest available risk-adjusted CIHI data).  Preventing pressure injuries (and treating them efficaciously if developed) helps protect residents from possible pain and health complications.	

**Change Ideas (4) for Indicator #2 – Minimizing Pressure Injuries**

Change Idea #1 One (1) of our Treatment Nurses will attend the "SWAN" (Skin Wellness Associate Nurse) Program, which is a five (5)-month Canadian Nurses Association (CNA)-accredited wound care course designed to equip nurses with advanced knowledge in wound, ostomy, and continence management, enabling them to act as clinical champions and leaders in their respective long term care home. Other Treatment Nurses will attend the program as future course opportunity presents.

**Methods**

Methods	Process measures	Target for process measure	Comments
One Treatment Nurse will attend the SWAN Program.	Successful course completion and certification.	Treatment Nurse to complete SWAN Program by end of August 2026.	

Change Idea #2 Invest in additional therapeutic mattresses and positioning aids to promote pressure injury healing.

Methods	Process measures	Target for process measure	Comments
Allocate additional therapeutic mattresses and positioning aids to applicable residents (those with Stage 2 to 4 pressure injuries, or the potential to acquire pressure injury). Mattresses/aids to be reallocated as pressure injury conditions improve. Applicable pressure indicator data will be reviewed at quarterly meetings of The Home's Quality Improvement Committee.	Number of residents with Stage 2 to 4 pressure injuries.	100% of residents with current Stage 2 to 4 pressure injury will be allocated a pressure injury mattress and applicable positioning aid(s) by June 30, 2026.	

Change Idea #3 Re-educate PSW staff on the importance of Repositioning, and ensure repositioning schedules are documented and followed, for residents with applicable pressure injuries.

Methods	Process measures	Target for process measure	Comments
Conduct PSW education sessions on Repositioning. Have RAI Coordinators add "Tasks" to the electronic health record of applicable residents to prompt regular repositioning.	Number of PSWs trained on Repositioning. Number of residents with individualized repositioning "Task" in electronic health record.	100% of PSWs will receive Repositioning education. 100% of residents with Stage 2 to 4 pressure injuries will have individualized repositioning "Task" in health record.	

Change Idea #4 Identify residents at risk of developing pressure injuries, and proactively implement interventions to prevent pressure injuries.

Methods	Process measures	Target for process measure	Comments
Review the PURS score of residents after each quarterly health assessment, and implement appropriate interventions (e.g., Dietitian review, protein/supplement introduction, "ROHO" wheelchair cushion, "lay down" program for pressure relief) for residents with a PURS score of 4 or greater (the interRAI Pressure Ulcer Risk Scale (PURS) is a validated tool designed to assess the risk of developing pressure injuries - a PURS score of 4 or greater is an indication of pressure injury risk).	# of residents with a PURS score of 4 or greater.	% of residents with a PURS score of 4 or greater with one or more pressure injury prevention interventions in place.	