Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 30, 2026

Westgate Lodge
Long-term Care Home

Ontario Health

OVERVIEW

Westgate Lodge is long term care home located in Belleville Ontario. It is a family owned and operated home that is part of Crown Ridge Health Care Services Inc.

Crown Ridge Health Care Services Inc. and Westgate Lodge Loge Term Care Home are committed to providing the highest possible quality of care to our residents. We are committed to continuous improvement, and on an ongoing basis, we seek new ways to evolve our practices and strengthen our services.

Our 2026-2027 Quality Improvement Plan is developed to support the home's mission and values statements. We are committed to providing care to our residents that support our homes Values:
C-Creative-We Seek creative opportunities to enrich life experiences for everyone in our family.
R-Respect-We engage in activities that are respectful of everyone's rights.
O-Outstanding-We aim to deliver outstanding service in all that we do.
W-Welcoming-We strive to provide a welcoming and safe environment for all.
N-Nurturing-We develop nurturing relationships for living and working.

Our values were redeveloped in 2018 to support a new Mission Statement of "Embracing Life's Journey". The Mission and Values are reviewed annually to ensure that they continue to represent our Vision. Over the past 8 years, we have worked closely with our residents, families and employees to promote a culture of inclusion and diversity while being respectful of individual needs and safety.

We are excited about our creative approaches to quality improvement projects in the areas of activity programming, dietary service, responsive behaviours and onboarding programs. We have developed new tools to promote safety, improve communication and welcome new team members and residents and families to long term care services. New approaches and improvement to existing dementia care and complex medical needs to promote purpose and independence for our residents is the focus of our quality improvement plan.

We are very excited to complete our redevelopment of our current home from a 88 bed home to 128 beds this spring. The home will further redevelop another 32 beds in 2026/27 to our final capacity of 160 residents. Plans for further improvements to our existing onboarding program and education are priorities as the home anticipates double staff numbers. Education on diversity and inclusion has been a focus for our home and will continue to be a focus in 2026/27.

ACCESS AND FLOW

Westgate Lodge is committed to working closely with our community partners to ensure safe, effective and high quality of care for our residents.

The home engages with many clinicians to ensure that access and flow of patients across the health care network to promote a reduction in ED visits, hospitalization and to promote admission to long term care homes of choice. We work together with residents, their families, hospitals and Ontario Health to ensure safe, effective admissions to our home, and understand transitions throughout the system are not easy for those we serve. A designated lead works hard to ensure timely acceptance and matching of residents to beds and units appropriate for care. A Nurse Practitioner through the NLOT program is frequently in the home to assist our team with minimizing hospital admissions and visits to the ED.

Monthly and Quarterly meetings continue to occur within the home that include:
-Physicians
-Nurse Practitioners
-Registered Nurses
-Registered Practical Nurses
-Personal Support Workers
-Dietary, Laundry and Housekeeping Aides
-Life Enrichment Aides
-Physiotherapy and Physiotherapy Aides
-Dietitian
-Wound Specialists
-Pain and Palliative Care Support
-Infection Control Practitioners
-Behavioural Support Staff
-IPAC Leads
-Pharmacists

Crown Ridge Health Care Services Inc. Interfacility Advisory Board meets monthly and is comprised of multi-site Senor Management staff that include:
-CEO/Vice President
-Director of Corporate Operations
-HR and Infection Control Director
-Chief Financial Advisor
-Long Term Care Administrators

-Retirement Home Administrators
-Environmental Services Manager

These meetings provide an opportunity for the engagement of staff in the development, review, evaluation and revision of departmental, facility and corporate planning processes that assist in ensuring access and flow. The regular review of our progress towards our improvement plan targets allows us to make adjustments and identify challenges that may impede on our success. Revision and review during the course of the fiscal year will be conducted through the engagement of these clinicians and leaders.

Our home continues to have an active and very informative Family Support Group that meets on a regular basis and invites our participation in their meetings to provide information and updates, engage in meaningful discussions regarding improvement projects and receive feedback on successes and challenges faced by residents and families to assist in evaluating our quality improvement plan.

EQUITY AND INDIGENOUS HEALTH

Our home continues to develop programs and education to support equality, inclusion and diversity. Education and training has been our primary objective and will continue to develop in 2026/27.

All staff receive annual mandatory education on Diversity, Equity, Inclusion and Belonging and training on Accessibility for Ontarians with Disabilities Act requirements and education on how to provide excellent customer service to those with disabilities.

A committee of staff, residents and families will be established to assist in identifying the needs of all for our improvement initiatives in 2026/27.

The home will continue to develop improvement initiatives in regards to indigenous cultural diversities. The home has several French speaking employees and have several staff who have a second language that can benefit residents who may be admitted into our home.

PATIENT/CLIENT/RESIDENT EXPERIENCE

The home completes multiple surveys annually to monitor resident and family experiences as well as address employee satisfaction, safety and overall well being. We initiated a new program and hired a lead for employee well being in 2024.A software program called Niuz was initiated in early 2024 to improve communication, celebrate our successes and expand our employee EAP program. This program has been very successful in communicating information to staff.

A designated staff member completes our admissions and stays as a support contact throughout the first six weeks of admission to promote a safe and pleasurable transition. The home plans to hire a SSW to assist in this role with our redevelopment in 2026/27.

Resident surveys are completed post admission, annually, and post discharge. A review of survey information is completed annually.

Family and residents have joined our quality improvement and safety meetings to assist us in identification of initiatives.

PROVIDER EXPERIENCE

We have had some success in improving our human resources and have been successful in hiring qualified staff for our nursing department.

We are working on strategies to assist in the hiring of a large number of staff for the additional 40-72 residents scheduled for admission in 2026-27.

Our current communication program which allows us to spotlight our employees successes such as certification, upgrading qualifications, recognition of years of services, plaques for 30+ years of service, fundraising for staff BBQs, a staff thrift exchange program, STAY interviews, Good News reporting.

We offer mentorship opportunities and support for employees facing challenges - divorce, bereavement, financial challenges, health issues, etc.

SAFETY

Resident safety is an essential component of how we deliver high quality care. Keeping residents safe is always forefront in our Quality Improvement plan.

Our Quality Improvement Committee consists of the interdisciplinary team, resident council & family support group. During these meetings, we review and discuss multiple areas of resident safety including falls prevention, medication management, responsive behaviours and various other topics. With this information, we discuss how to prevent future incidents from occurring in the home and develop new strategies to ensure our

residents feel safe.

We review with our multidisciplinary teams post incidents and potential contributing factors that could be avoided in future planning.

Our goal is to achieve a safe and secure environment for our residents. Our redeveloped home will incorporate a number of new initiatives and changes to design that will improve resident safety.

Education is the most vital component with all staff especially within the professional growth of our Registered Staff. Continuous education and skill development is essential in lowering risk to our residents. We achieve this
through education which occurs upon hire and annually.

The home plans to start a Mentorship program in the near future for registered staff that will aim at improving retention, strengthening clinical skills and easing the transition for new employees.

Education is delivered online and in person, some examples of education include: lift and transfer training, Falls prevention, IPAC, medication management, resident bill of rights, abuse and neglect, violence and harassment, fire safety and emergency preparedness, responsive behaviours and restraints.

A review of emergency codes and training is provided to staff annually through online education, drills, table top scenarios to ensure staff are trained to respond to emergencies. The home continues to meet with external partners such as Fire, Police, EMS and the Public Health Unit annually or as required to review policies, discuss any suggestions or areas of improvement that could enhance resident safety.

These experiences are shared with all staff at round table discussions in our education plan.

New technology is being installed in our redeveloped home that will improve safety.

PALLIATIVE CARE

We are very proud of our existing palliative support for our residents and families.

A multidisciplinary team meets regularly to identify residents who have changing care needs and are approaching or
have reached a point that palliative support is required. We work closely with our local hospice team, our Nurse Practitioner and our physicians to provide comfort, support to residents and families and to explain medical conditions and expectations as a resident moves through the palliative process. Another important part of palliative care is pain management.

Our medical director and nurse practitioners are experienced in managing pain for palliative residents and utilize a standardized order set of pain medications to keep residents comfortable at end-of-life.

We have a strong relationship with our local churches and have been working with all denominations to encourage a volunteer support team that can assist our residents and families during this

difficult time. Support is also offered through our Life Enrichment team to any residents who do not have family immediately available or unavailable to ensure that the resident never feels alone. Staff will volunteer or take time through their shift to provide

support to the families and resident.

We hope to implement a position in our new home for a SSW or Support lead, who will assume the lead of our palliative team.

A strong palliative program is crucial to the care we provide at our home and is constantly being improved upon with feedback from each palliative experience.

POPULATION HEALTH MANAGEMENT

Our home works with many of our community partners to ensure a health approach that prevents disease and promotes healthy living. We promote vaccination compliance amongst our residents and provide education as to the benefits of our families and employees supporting vaccine use and following strict compliance with infection control. We support our staff during incidents of outbreaks and high respiratory infections in our community, promoting use of face masks while providing care and promoting self monitoring for early identification of symptoms.

We have strong relationships with the Alzheimer's society and offer support to our resident families and to our staff in developing stronger skills in working with those facing dementia challenges at all stages.

We have a local hospice program which supports educational opportunities for our staff to develop skills in end of life care.

Our home meets monthly with a collaborative care team that assists to provide safe interventions to ensure that residents exhibiting challenges with behaviors can be maintained safely in our homes and assist us in developing strategies to support their health needs.

In 2024 the home continued to implement improve IPAC training and has at least one CIP certified member. Other staff continue to complete IPAC education and complete courses both internally and externally to increase their IPAC knowledge. The home has a strong relationship with the Public Health and the SE IPAC Hub.

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 30, 2026**

Leslie Morrow, Board Chair / Licensee or delegate

Shelly Hills, Administrator /Executive Director

Laura Cranston, Quality Committee Chair or delegate

Rebecca Briscoe, Other leadership as appropriate

Equity | Equitable | Optional Indicator

	Last Year		This Year		
Indicator #5 Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Westgate Lodge Nursing Home)	**96.00** Performance (2025/26)	**100** Target (2025/26)	**100.00** Performance (2026/27)	**4.17%** Percentage Improvement (2026/27)	**100** Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Education to senior managers

Process measure

- Number of senior managers who have attended education this year

Target for process measure

- 100% of managers will attend education on inclusion, anti-racism and diversity by December 2025

Lessons Learned

The target was met, no challenges.
All senior managers completed education on diversity, equity, inclusion and belonging through our Niuz education platform.

Change Idea #2 ☐ Implemented ☑ Not Implemented ☐ In Progress

Employee committee will be initiated to develop and review policies on diversity, inclusion and anti-racism

Process measure

- Number of new policies or reviewed policies in 2025

Target for process measure

- The home will implement or revise all policies on race, language diversity, gender identification and indigenous programs by end of year.

Lessons Learned

The target was not met.
The home faced challenges in developing a committee but will plan to prioritize this for next year.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

All employees will attend education on diversity, inclusion and anti-racism in 2025

Process measure

- Provide as mandatory and orientation mandatory education.

Target for process measure

- 100% of staff will attend one form of education of inclusion, diversity and anti-racism by Dec 31, 2025

Lessons Learned

The target was met, no challenges.
100% of employees completed education by Dec. 31, 2025.

The home is very happy with the results of education.

Comment

All leadership team members trained. Very pleased with training compliance on this. Leadership team continues to support diversity, inclusion, equity and belonging.
The home will focus on establishing a committee this year.

Experience | Patient-centred | Optional Indicator

Indicator #3	Last Year		This Year		
	66.67	80	79.17	18.75%	NA
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Westgate Lodge Nursing 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

Improve the number of residents responding 9 or 10 to how well staff listen to you?

Process measure

- Complete a minimum of 10 surveys per month.

Target for process measure

- 0% of residents will report a rating of 8 or 9 by Dec 31, 2025

Lessons Learned

The target was met.
However, residents continue to find it very challenging to complete the survey on their own. Family members, life enrichment staff and volunteers are required to provide assistance.

Change Idea #2 ☐ Implemented ☑ Not Implemented ☐ In Progress

Repeat survey every 3 months for residents answering less than 9

Process measure

- # surveys that demonstrate improvement from previous survey

Target for process measure

- 100% of surveys will record an 9 or above each month.

Lessons Learned

The home was unable to meet this target.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

All staff will attend customer service training

Process measure

- # staff completed education

Target for process measure

- 100% of staff will complete education by Dec 31, 2025

Lessons Learned

The home was successful in providing customer service education to 100% of staff by Dec.31/25.

Comment

Although the home is very happy with satisfaction survey results this year, we will continue to look for ways to make it easier for residents to complete on their own.

	Last Year		This Year		
Indicator #4	**92.00**	**100**	**100.00**	**8.70%**	**NA**
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Westgate Lodge Nursing 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

All staff receive training on customer service in 2025

Process measure

- # of staff completing customer training each month.

Target for process measure

- 100% of staff will complete customer service training by Dec 31, 2025

Lessons Learned

The home was successful in providing customer service education to all employees this year.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

All residents are given an opportunity to answer this question on our annual survey.

Process measure

- Complete monthly survey of new admissions and at least 10 residents to ensure that a minimum of 100 responses are recorded.

Target for process measure

- 100% of residents respond positively to this question by Dec 31, 2025

Lessons Learned

The target was met.
Surveys were provided to all residents who were capable of completing them on their own. Family members and life enrichment staff assisted residents who required help.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

Resident Plan of Care/Kardex sheet will be available to all staff to improve communication about changes in resident care

Process measure

- Residents will report increased positive response to QIP question

Target for process measure

- 80% of all residents will respond positively to the question by Dec 31, 2025

Lessons Learned

Resident care plans/kardex sheets are available for all staff to review. The home continues to encourage staff to check these resources daily.

Comment

The home is very happy with the annual satisfaction survey results this year. The home will continue to provide admission, discharge and annual satisfaction surveys to residents and families in order to gain feedback that will assist with Quality Improvement. Management staff will continue to attend Resident and Family Council meetings to share new information and provide support to residents and family members as required.

Safety | Safe | Optional Indicator

	Last Year		This Year		
Indicator #1 Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Westgate Lodge Nursing Home)	**16.80** Performance (2025/26)	**15.52** Target (2025/26)	**18.28** Performance (2026/27)	**-8.81%** Percentage Improvement (2026/27)	**NA** Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

All staff to receive falls prevention training

Process measure

- # new staff receiving education # staff attending annual training

Target for process measure

- 100% of staff will receive falls prevention training by Dec 31, 2025

Lessons Learned

Target met, no challenges identified.
All staff received annual falls prevention training and training upon orientation. PT providers do annual training with staff to supplement our education.

Change Idea #2 ☐ Implemented ☑ Not Implemented ☐ In Progress

Number of preventable falls will decrease

Process measure

- # resident falls in month # of falls with injury # of falls with CIS # residents with multiple falls

Target for process measure

- A reduction in falls will decrease by 15% in 2025

Lessons Learned

Target was not met. There was a slight increase in 2025.

There are residents that have frequent falls even though falls prevention measures are in place.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

Develop fall audit tool

Process measure

- Complete falls audit weekly # falls witnessed # residents with falls prevention measures in place

Target for process measure

- A reduction in falls by 15% will be recorded in this year.

Lessons Learned

Target met, no challenges identified.
Audit tool was implemented, audits continue to be completed on a weekly basis.
Results are reviewed with PT and during Quality improvement, multidisciplinary and Falls prevention committee meetings.

Comment

The number of falls in the home has remained consistent with slight monthly increases and decreases dependent on the current resident population. Falls continue to be reviewed with PT and during our monthly multidisciplinary meeting, and with our Falls Prevention committee to ensure falls prevention measures are in place.

Indicator #2

Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Westgate Lodge Nursing Home)

Last Year		This Year		
52.38	**20**	**54.93**	**-4.87%**	**20**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☐ Implemented ☐ Not Implemented ☑ In Progress

Review number of residents that are receiving antipsychotic medications and determine if appropriate or if can be discontinued.

Process measure

- # of residents receiving antipsychotic medication without a diagnosis of psychosis

Target for process measure

- 100% of residents on antipsychotics will have diagnosis of psychosis

Lessons Learned

The home reviews the antipsychotic usage data during CQI/PAC and monthly medication management meetings. The home will continue to work on this change idea in 2026/27.

Change Idea #2 ☐ Implemented ☐ Not Implemented ☑ In Progress

Ensure accuracy of documentation in resident record and RAI

Process measure

- Record # of residents on antipsychotic Record # of residents with delusions or hallucinations Record # residents with diagnosis of psychosis

Target for process measure

- 100% of residents recorded using an antipsychotic will have a diagnosis of psychosis

Lessons Learned

The home will continue to work on this change idea in 2026/27.

A home recently hired a new RAI Coordinator that is still learning the position and the changeover to InterRAI.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

Provide education to staff on responsive behaviors and dementia care

Process measure

- # of staff completing education

Target for process measure

- 100% of staff will complete education by Dec 31, 2025

Lessons Learned

The home was successful in providing responsive behaviour education to 100% of employees by Dec. 31/25.

GPA training was offered throughout the year for employees in all departments.

Comment

A challenge the home has identified is that many new admissions to the home come in with an order for an antipsychotic medication and often they do not have a diagnosis to support this.
The home is planning to increase BSO positions to better support residents, looking for non-pharmalogical interventions for residents who exhibit responsive behaviours. The home will continue to work on this indicator in 2026/27 with hopes for improvement.

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)	34.15	20.00	The home would like to improve performance.	

Change Ideas

Change Idea #1 Hire a full time Nurse Practitioner for the home.

Methods	Process measures	Target for process measure	Comments
Begin recruitment for NP for when the homes second phase of redevelopment is completed in 2027. The number of residents in the home will increase to 160.	Advertise for NP as we approach the end of 2026 and prepare to finish the second phase of redevelopment in 2027.	Hire NP by January 1, 2027.	

Change Idea #2 Complete monthly audits on all resident transfers to hospital.

Methods	Process measures	Target for process measure	Comments
Review all ED visits monthly.	# of residents sent to ED this month. # of residents with diagnosed conditions from modified list of ambulatory care sensitive conditions.	< 20% of residents sent to ED for assessment will return or be admitted with a diagnosis from the modified list.	

Change Idea #3 The home will track number of residents avoiding ED visit due to NP visit.

Methods	Process measures	Target for process measure	Comments
Monitor NP visits monthly and track the reason for visit. Record if NP visit prevented ED visit.	Less than 10% of residents will require ED visit for avoidable diagnosis.	The home will see a decreases of 10% in avoidable ED visits in 2026.	

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	All staff in the home will attend annual education and training.	

Change Ideas

Change Idea #1 Employee committee will be initiated to develop and review policies on diversity, equity, inclusion and anti-racism.

Methods	Process measures	Target for process measure	Comments
The committee will be held quarterly to review progress.	Number of new policies or reviewed policies in 2026.	The home will implement or revise all policies on race, language diversity, gender identification and indigenous programs by the end of 2026.	

Change Idea #2 All employees in the home will attend education on diversity, inclusion and anti-racism in 2026.

Methods	Process measures	Target for process measure	Comments
# of staff attending each month.	Provide education to new staff upon hire and as annual education for staff.	100% of staff will attend d=one form of education on inclusion, diversity and anti-racism by Dec. 31, 2026.	

Change Idea #3 Celebrate and recognize diverse holidays at Westgate.			
Methods	Process measures	Target for process measure	Comments
Westgate will celebrate culture and diversity events in the home.	The # of cultural and diversity events that occurred in 2026.	The home will celebrate and recognize 6 or more holidays in 2026.	

Change Idea #4 To include both residents and staff in events and celebrations within the home that are related to culture, diversity and inclusion.			
Methods	Process measures	Target for process measure	Comments
The home will post upcoming events and celebrations in newsletters and activity boards in the home for residents and on Niuz for staff to see.	% of events/celebrations that had resident and staff participation in 2026.	100% 0f events/celebrations will have staff and resident participation in 2026.	

Safety

Measure - Dimension: Safe

Indicator #3	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	54.93	20.00	The home will strive to meet the provincial average.	

Change Ideas

Change Idea #1 Review number of residents that are receiving antipsychotic medications and determine if appropriate or if it can be discontinued.

Methods	Process measures	Target for process measure	Comments
Review all residents on antipsychotics and record the # without a diagnosis.	# of residents receiving antipsychotic medication without a diagnosis of psychosis.	100% of residents on antipsychotics will have a diagnosis of psychosis.	The Nursing team will work meet with the MD, NP and pharmacy on a regular basis to review residents who are receiving antipsychotic medications.

Change Idea #2 Provide annual education to staff on responsive behaviours and dementia care.			
Methods	Process measures	Target for process measure	Comments
Responsive behaviours and dementia care education will be assigned to staff on orientation and annually.	# of staff members who complete annual education.	100% of staff will complete education by December 31, 2026.	The home will continue to offer additional education sessions throughout the year such as: GPA, BSO Foundations and PIECES courses for employees.

Change Idea #3 Review all new residents moving into the home that are utilizing antipsychotic medication within the first month of admission.			
Methods	Process measures	Target for process measure	Comments
BSO lead will review the list of new residents each month to determine if any new residents are using antipsychotics upon admission to the home. A meeting will be held with the BSO lead, MD or NP and the pharmacist to review medications within the first month of moving in.	% of residents moving into the home between April 2026 and December 2026 who use antipsychotic medications that have a medication review within the first month of admission to the home.	100% of residents moving into the home that use antipsychotic medications will have a medication review completed within the first month of admission to the home.	

Change Idea #4 Reduce inappropriate use of antipsychotic medications.			
Methods	Process measures	Target for process measure	Comments
Identify residents with potential to reduce or discontinue use of antipsychotic medications.	# of residents triggering the inappropriate antipsychotic use.	5% reduction in residents triggering the inappropriate antipsychotic use.	