Quality Improvement Plan (QIP)

# Narrative for Health Care Organizations in Ontario

March 21, 2025

Ontario Health

## OVERVIEW

Crown Ridge Health Care Services Inc. and Westgate Lodge are committed to providing the highest possible quality of care to our residents. Our 2025-26 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 Values:
C - Creativity, R - Respect, O - Outstanding, W - Welcoming, N - Nurturing. Our Values 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 7 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 areas of programming, dietary service, responsive behaviors 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 more complex medical needs to promote individualized plans of care to promote purpose and independence for our residents is the focus of our quality improvement plan.

We are very excited to complete a redevelopment of our current home from a 88 bed home to 128 beds in 2025. The home will further redevelop another 32 beds in 2026 to our final capacity of 160 residents. Plans for further improvements to our existing onboarding program and education are priorities as the home anticipates doubling staff numbers by year end. Education on

diversity and inclusion has been a focus for our home and will continue to be a focus in 2025.

## ACCESS AND FLOW

The home engages with many clinicians to ensure that access sand 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. Our home works closely with the hospitals and the HCCSS to promote admission of residents into beds as quickly as possible. A designated lead works to ensure timely acceptance and matching of residents to beds and units appropriate for care. A NP is frequently in the home to assist our team with minimizing hospital admissions and visits to the ED.

Monthly and Quarterly meetings occur within the home that include:

- Physicians
- Nurse Practitioners
- Registered Nurses
- Registered Practical Nurses
- Personal Support Worker
- Dietary, Laundry and Housekeeping Aides
- Life Enrichment Aides
- Physiotherapy
- Dietitian
- Wound Specialists
- Pain and Palliative Care Support
- Infection Control Practitioners
- Behavioural Support Staff
- IPAC Leads

Crown Ridge Health Care Services Inc. Interfacility Advisory Board meets quarterly and is comprised of multi -site Senior 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 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 has developed an active and very informative Family Support Group that meets regularly 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 2025.

A committee of staff, residents and families will be established to assist in identifying the needs of all for our improvement initiatives in 2025.

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 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.

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. Challenges still exist in the hiring of qualified or experienced dietary staff.

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 2025-26.

Despite numerous initiatives for recruitment including sign on bonuses, self scheduling, Ministry initiatives for new graduates, wage review. Local agencies continue to recruit.

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

The home shares our safety statistics with resident and family attended committees. We discuss falls and fall prevention strategies with our team and utilize RNAO BPG to move forward in our quality improvement plan.

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

Our redeveloped home will incorporate a number of new initiatives and changes to design that will improve resident safety.

We review any emergency codes such as Code Yellow and Code White that occur to ensure that our plans meet the safety needs of our residents.

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.

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.

We offer support through our Life Enrichment team to any residents who do not have family support 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.

## 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. Stronger relationships with Public Health and Infection Control Hubs are continuing to

## CONTACT INFORMATION/DESIGNATED LEAD

Leslie Morrow
Director of Corporate Operations
Crown Ridge Health Care Services Inc
lmorrow@crownridgehealth.ca
613-932-1289 ext. 130

Shelly Hills
Administrator
Westgate Lodge
shills@crownridgehealth.ca
613-966-1323 ext 305

## 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

_____
Other leadership as appropriate

_____

## Access and Flow | Efficient | Optional Indicator

### Indicator #6

Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Westgate Lodge Nursing Home)

| Last Year | | This Year | | |
|---|---|---|---|---|
| **22.12** | **20** | **28.00** | **-26.58%** | **NA** |
| Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

**Change Idea #1** ☑ Implemented ☐ Not Implemented

Complete a monthly audit on resident transfers to hospital

**Process measure**

- __ # of residents sent to ED this month. __# of residents with diagnosed conditions from modified list of ambulatory care sensitive conditions

**Target for process measure**

- <20% of residents sent to ED for assessment will return or be admitted with a diagnosis from modified list.

**Lessons Learned**

Results are reviewed at monthly QI meetings and reviewed with NLOT NP

**Change Idea #2** ☐ Implemented ☑ Not Implemented

Hire a Full Time Nurse Practitioner

**Process measure**

- Advertise for a NP as we approach year end and prepare to open newly rebuilt expanded bed home

**Target for process measure**

- Hire NP by June 30, 2025.

### Lessons Learned

Recruitment was difficult in our area and were unable to fulfill this role in the current size of home. The NLOT program has provided more than adequate support to our residents.

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

Track number of residents avoiding ED visit due to NP visit

**Process measure**

- Less than 10% of residents will require ED visit for avoidable diagnoses

**Target for process measure**

- Home will see a decrease of 10% in avoidable ED visits in 2024

### Lessons Learned

This is tracked monthly and reviewed with a multidisciplinary team.

### Comment

The home is very pleased with the ED visits. The home numbers are some of the lowest in the area.

**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) | **100.00** Performance (2024/25) | **79** Target (2024/25) | **96.00** Performance (2025/26) | **-4.00%** Percentage Improvement (2025/26) | **NA** Target (2025/26) |

**Change Idea #1** ☑ **Implemented** ☐ **Not Implemented**

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 2024

**Lessons Learned**

Very high compliance with this change idea.

**Change Idea #2** ☐ **Implemented** ☑ **Not Implemented**

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 2024.

**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**

Home faced some challenges in developing a committee but will continue to promote even a small group of staff to assist with policy review and ensure inclusion.

**Change Idea #3** ☑ **Implemented** ☐ **Not Implemented**

All employees will attend education on diversity, inclusion and anti-racism in 2024

**Process measure**

- Provide weekly on line and 2 small group education sessions each month.

**Target for process measure**

- 100% of staff will attend one form of education of inclusion, diversity and anti-racism by Dec 31, 2024

**Lessons Learned**

Very happy with the results of education.

**Comment**

Home will continue to promote many initiatives to support diversity and inclusion.

## Experience | Patient-centred | Optional Indicator

| | Last Year | | This Year | | |
|---|---|---|---|---|---|
| **Indicator #3** Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Westgate Lodge Nursing Home) | **16.00** Performance (2024/25) | **30** Target (2024/25) | **66.67** Performance (2025/26) | **316.69 %** Percentage Improvement (2025/26) | **NA** Target (2025/26) |

**Change Idea #1** ☐ Implemented ☑ Not Implemented

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**

- 80% of residents will report a rating of 8 or 9 by Dec 31, 2024

**Lessons Learned**

Residents have difficulty assigning a large number scale to this question. Hard to differentiate what a 8, 9 or 10 evaluation would be. Many choose between these numbers.

**Change Idea #2** ☐ Implemented ☑ Not Implemented

Repeat survey every 3 months for residents answering less than 8

**Process measure**

- # surveys that demonstrate improvement from previous survey

**Target for process measure**

- 100% of surveys will record an 8 or above each month.

**Lessons Learned**

Difficult to complete survey. Will assign and audit more in 2025

**Change Idea #3** ☑ Implemented ☐ Not Implemented

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, 2024

**Lessons Learned**

All staff attended training.

**Comment**

The home was unable to complete as many surveys as the plan identified. We will implement this change idea in 2025.

| | Last Year | | This Year | | |
|---|---|---|---|---|---|
| **Indicator #4** | **70.27** | **100** | **92.00** | **30.92%** | **NA** |
| Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Westgate Lodge Nursing Home) | Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

**Change Idea #1** ☑ Implemented ☐ Not Implemented

All staff receive training on customer service in 2024

**Process measure**

- # of staff completing customer training each month.

**Target for process measure**

- 100% of staff will complete customer service training by Dec 31, 2024

**Lessons Learned**

Education included in mandatory annual training as well as orientation and was very successful in ensuring completion.

**Change Idea #2** ☑ Implemented ☐ Not Implemented

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 40 responses are recorded.

**Target for process measure**

- 100% of staff respond positively to this question by Dec 31, 2024

**Lessons Learned**

Many residents are unable to answer this question. Staff do complete the survey with the support of family and volunteers to capture as many responses as possible.

**Change Idea #3** ☐ Implemented ☑ Not Implemented

Resident 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, 2024

**Lessons Learned**

Staff continue to utilize our plans of care to ensure communication strategies are in place.

**Comment**

Overall the home is very satisfied with the response to this question.

**Safety | Safe | Optional Indicator**

| | Last Year | | This Year | | |
|---|---|---|---|---|---|
| **Indicator #1** | **14.72** | **10** | **16.80** | **-14.13%** | **NA** |
| Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Westgate Lodge Nursing Home) | Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

**Change Idea #1** ☑ Implemented ☐ Not Implemented

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, 2024

**Lessons Learned**

All staff received annual training and training in orientation. PT providers do annual training with staff to supplement our education .

**Change Idea #2** ☐ Implemented ☑ Not Implemented

Number of preventable falls will decrease

**Process measure**

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

**Target for process measure**

- A reduction in falls will decrease by 15% in 2024

**Lessons Learned**

The definition of a fall does include falls that are a result of successful interventions including low beds, fall mats, removal of rails and clip alarms
There was a slight increase in 2024

**Change Idea #3** ☑ Implemented ☐ Not Implemented

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**

Falls audit tools were in place and have been reviewed at monthly meetings. Prevention strategies are appropriate

**Comment**

The number of falls in the home has remained consistent with slight monthly increases and decreases dependent on the current resident population.

| | Last Year | | This Year | | |
|---|---|---|---|---|---|
| **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) | **37.00** Performance (2024/25) | **25** Target (2024/25) | **52.38** Performance (2025/26) | **-41.57%** Percentage Improvement (2025/26) | **NA** Target (2025/26) |

**Change Idea #1** ☑ Implemented ☐ Not Implemented

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**

- 80% of residents on antipsychotics will have diagnosis of psychosis

**Lessons Learned**

Our home has a home area that has been home to many of our dementia residents.
Meetings with our physicians continue to occur to support diagnoses.

**Change Idea #2** ☑ Implemented ☐ Not Implemented

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**

- 80% of residents recorded using an antipsychotic will have a diagnosis of psychosis

**Lessons Learned**

Audits are being performed.

**Change Idea #3** ☑ Implemented ☐ Not Implemented

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, 2024

### Lessons Learned

All staff receive education

### Comment

The home will continue to promote improvement in this indicator.

# Equity

## Measure - Dimension: Equitable

| Indicator #1 | 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 | 96.00 | 100.00 | The home will strive for 100% | |

### Change Ideas

**Change Idea #1 Education to senior managers**

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| # of senior managers who have attended training on inclusion, anti-racism and diversity. | Number of senior managers who have attended education this year | 100% of managers will attend education on inclusion, anti-racism and diversity by December 2025 | Total LTCH Beds: 69 |

**Change Idea #2 Employee committee will be initiated to develop and review policies on diversity, inclusion and anti-racism**

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Quarterly meetings to review progress | Number of new policies or reviewed policies in 2025 | The home will implement or revise all policies on race, language diversity, gender identification and indigenous programs by end of year. | |

Change Idea #3 All employees will attend education on diversity, inclusion and anti-racism in 2025

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| # of staff attending education each month. | Provide as mandatory and orientation mandatory education. | 100% of staff will attend one form of education of inclusion, diversity and anti-racism by Dec 31, 2025 | |

# Experience

## Measure - Dimension: Patient-centred

| Indicator #2 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" | O | % / LTC home residents | In house data, NHCAHPS survey / Most recent consecutive 12-month period | 66.67 | 80.00 | Provincial average | |

### Change Ideas

**Change Idea #1** Improve the number of residents responding 9 or 10 to how well staff listen to you?

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Life Enrichment staff will complete a short survey each month with all new admissions and ten residents. | Complete a minimum of 10 surveys per month. | 0% of residents will report a rating of 8 or 9 by Dec 31, 2025 | Total Surveys Initiated: 24<br>Total LTCH Beds: 69 |

**Change Idea #2** Repeat survey every 3 months for residents answering less than 9

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Life Enrichment will record results of 7 and less and re-survey 3 months later | # surveys that demonstrate improvement from previous survey | 100% of surveys will record an 9 or above each month. | |

Change Idea #3 All staff will attend customer service training

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Provide education session for all staff on orientation and annually | # staff completed education | 100% of staff will complete education by Dec 31, 2025 | |

## Measure - Dimension: Patient-centred

| Indicator #3 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". | O | % / LTC home residents | In house data, interRAI survey / Most recent consecutive 12-month period | 92.00 | 100.00 | Improve performance | |

### Change Ideas

Change Idea #1 All staff receive training on customer service in 2025

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Customer service training is a module added to annual training for all staff. | # of staff completing customer training each month. | 100% of staff will complete customer service training by Dec 31, 2025 | Total Surveys Initiated: 25<br>Total LTCH Beds: 69 |

Change Idea #2 All residents are given an opportunity to answer this question on our annual survey.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 80% of residents will return a response to this question om 2025 | Complete monthly survey of new admissions and at least 10 residents to ensure that a minimum of 100 responses are recorded. | 100% of residents respond positively to this question by Dec 31, 2025 | |

Change Idea #3 Resident Plan of Care/Kardex sheet will be available to all staff to improve communication about changes in resident care

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| RAI assistant and unit clerks will implement Kardex sheets are available on each wing | Residents will report increased positive response to QIP question | 80% of all residents will respond positively to the question by Dec 31, 2025 | |

# Safety

## Measure - Dimension: Safe

| Indicator #4 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of LTC home residents who fell in the 30 days leading up to their assessment | O | % / LTC home residents | CIHI CCRS / July 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average | 16.80 | 15.52 | Home is slightly above provincial average. | |

### Change Ideas

**Change Idea #1** All staff to receive falls prevention training

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Falls prevention program lead will ensure all staff have received falls prevention training om orientation and annually. | # new staff receiving education # staff attending annual training | 100% of staff will receive falls prevention training by Dec 31, 2025 | |

**Change Idea #2** Number of preventable falls will decrease

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Falls program lead will track the number of falls monthly and record fall types, time and injury | # resident falls in month # of falls with injury # of falls with CIS # residents with multiple falls | A reduction in falls will decrease by 15% in 2025 | |

Change Idea #3 Develop fall audit tool

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Fall lead will review falls weekly using falls audit tool | Complete falls audit weekly # falls witnessed # residents with falls prevention measures in place | A reduction in falls by 15% will be recorded in this year. | |

## Measure - Dimension: Safe

| Indicator #5 | 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 Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average | 52.38 | 20.00 | Home will strive to meet provincial average. | |

### Change Ideas

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

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| review all residents on antipsychotics and record# not having diagnosis. | # of residents receiving antipsychotic medication without a diagnosis of psychosis | 100% of residents on antipsychotics will have diagnosis of psychosis | |

| Change Idea #2 Ensure accuracy of documentation in resident record and RAI | | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| Review RAI data for documentation of hallucinations or delusions and ensure accuravcy | Record # of residents on antipsychotic Record # of residents with delusions or hallucinations Record # residents with diagnosis of psychosis | 100% of residents recorded using an antipsychotic will have a diagnosis of psychosis | |

| Change Idea #3 Provide education to staff on responsive behaviors and dementia care | | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| Staff to be assigned on orientation and annually education on responsive behaviors and dementia care. | # of staff completing education | 100% of staff will complete education by Dec 31, 2025 | |