

Riverview

PSYCHIATRIC CENTER



PERFORMANCE IMPROVEMENT REPORT

FIRST QUARTER
SFY 08
JULY AUGUST AND SEPTEMBER 2007

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10/29/07

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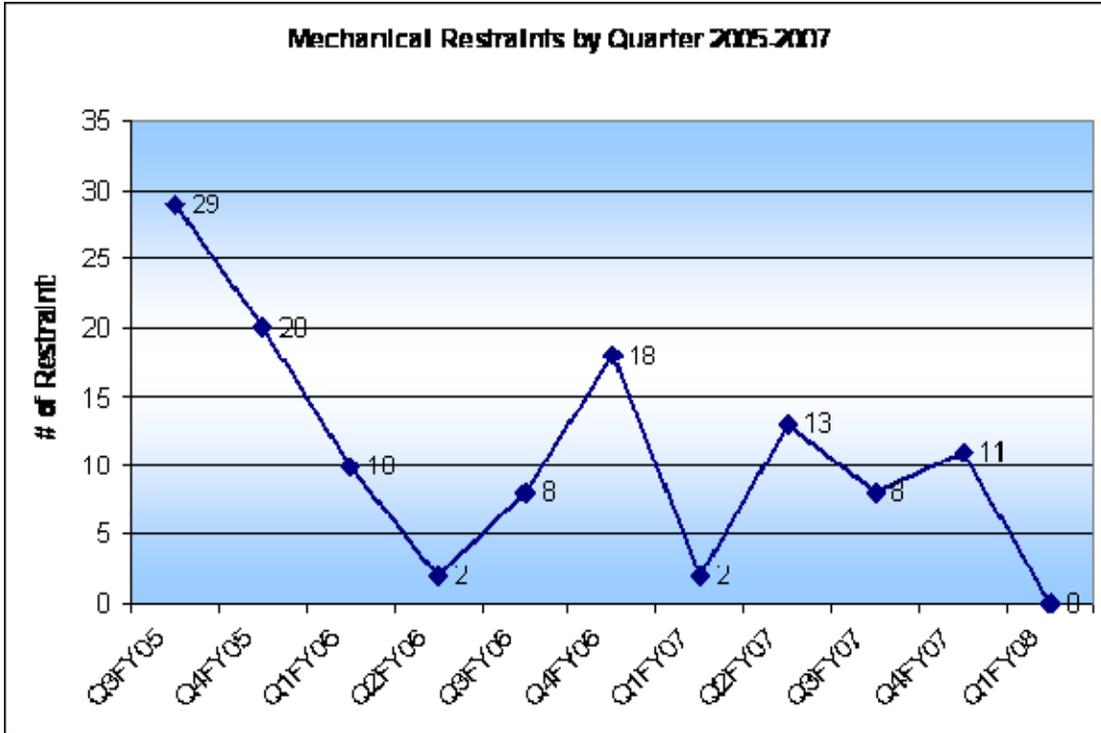
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Introduction:

This quarter represents a milestone for Riverview Psychiatric Center in its restraint reduction efforts. This is the first quarter in which no mechanical restraints have been used since 1840.



Increased efforts are being implemented to reduce seclusion utilization. A large group of staff including Executive Leadership, nurses, Program Directors, Quality Champions, Mental Health Workers and others have been engaged in identifying steps to reducing seclusion.

This quarter also involved significant work by the hospital to prepare for anticipated third party reviews by CMS, JCAHO, and State Licensing. Next quarter the results of these assessments of the quality of services at Riverview Psychiatric Center will be reported.

The quarterly report is presented in 3 different sections. Section I focuses on various departmental quality assessment and process improvement indicators. Each department has identified indicators, established thresholds, and concurrently collects data and assesses the data to help assure improvement actions are data driven and measurable. Implementation and evaluation of all departmental improvement actions is ongoing, and is intended to help each department to continuously improve the services offered to clients at Riverview Psychiatric Center. Section II includes budget and Human Resources data with trends unique to Riverview. Section III focuses on Performance Measurement trend information comparing Riverview Psychiatric Center to the National Norms for similar psychiatric facilities.

Section I: Departmental Quality Assessment & Performance Improvement

INFECTION CONTROL

ASPECT: HOSPITAL INFECTION CONTROL

OVERALL COMPLIANCE: Hospital average for 1st quarter 07-08 = 2.17

Indicators	Number	Rate	Threshold Rate
Hospital Acquired (healthcare associated) Infection rate, infections per 1000 patient-days	26	2.17	5.8 or less

Findings:

Infection rate is obtained by total house surveillance. This remains the best method for behavioral healthcare facilities to identify trends and problems. Surveillance accomplished by chart reviews, review of antibiotic prescribing (used for infections or prophylaxis), and clinical staff reporting.

Problem:

This quarters numbers are 26 infections for a rate of 2.17.This is well within the threshold percentile.

Status:

Infection rate for this period is within the accepted 2 standard deviation for threshold of action.

Actions:

Hand hygiene continues to be stressed to staff and clients. Informational e-mails have been routinely sent out to staff regarding the flu, availability of vaccines and clinics. Posters displayed to remind staff and clients to cover coughs and sneezes to stop the spread of infections.

Information Management

Aspect: CONFIDENTIALITY

Overall compliance: 100%

INDICATORS	Findings	Compliance	THRESHOLD PERCENTILE
1. All client information released from the Health Information Department will meet all JCAHO, State, Federal & HIPAA standards.	2206 out of 2206 Requests for information were properly filled.	100%	100%
2. All new employees/contract staff will attend confidentiality/HIPAA training.	15/15 new employees attended confidentiality/HIPAA orientation.	100%	100%
3. The Director of Health Information will track the number of confidentiality/privacy issues through incident reports.	There were 0 confidentiality/privacy-related incident reports this quarter.	0%	0%

Findings: The indicators are based on the review of all requests for information, orientation for all new employees/contracted staff and confidentiality/privacy-related incident reports. **2206 out of 2206** (100%) requests for information (2015 police checks and 191 requests for client information) were released from the Health Information Department during this quarter. 15 out of 15 (100%) new employees/contract staff attended Confidentiality/HIPAA training. All indicators remained at 100 % compliance for quarter 1-FY 2008.

Problem: None found. Still, the introduction and compliance with current law and HIPAA regulations needs to be strictly adhered to, requiring training, education, and policy development at all levels.

Status: No issues during quarter 1. Continue to monitor.

Actions: The above indicators will continue to be monitored.

Information Management

Aspect: Documentation & Timeliness

Overall compliance: 97 %

Indicators	Findings	Compliance	Threshold Percent
1. Records will be completed within JCAHO standards, state requirements and Medical Staff bylaws timeframes.	71/74	96%	100 %
2. Discharge summaries will be completed within 15 days of discharge.	67/74	90.5%	100%.
3. Forms used in the medical record will be reviewed by the Medical Record Committee.	0 forms were approved/revised this quarter.	100%	100%
4. Medical transcription will be timely & accurate.	No errors or issues reported this quarter.	100%	90%

Findings: The indicators are based on the review of all discharged records. There was 96% compliance rate with record completion within 30 days. There was 90% compliance rate with discharge summaries.

Problem: Discharge Summary completion has decreased (90%) below the threshold.

Status: 96% compliance rate with record completion within 30 days and 90% compliance rate with discharge summary completion.

Actions: All medical staff (including the Medical Director) receives weekly notification regarding "charts needing attention". Weekly "charts needing attention" lists are distributed to all medical staff, including the Medical Director, along with the Superintendent, Deputy Superintendent of Administrative Services, and the Risk Manager. Medical Staff are notified via telephone call and or e-mail regarding any discharge summaries that need to be completed prior to deficiency. The above indicators will continue to be monitored.

MEDICAL STAFF

Aspect: Review of Atypical Antipsychotics for June, July, August, September 2007

Overall compliance: 100%

June, July, August, September, 2007			
Indicator	Findings	Compliance	Target %
All clients receiving greater than one standing atypical antipsychotic will be reviewed by pharmacy and by peers to determine medical appropriateness and to recommend possible alternative therapies	36 clients received more than one atypical: 36 clients were peer reviewed	100%	100%

Findings: This was a new indicator for medical staff. Pharmacy database was consulted to ascertain unique clients receiving multiple antipsychotic medications. All clients were then peer reviewed during a medical staff meeting with pharmacists in attendance. In all cases the individual prescribers provided medical justification and/or alternative treatment approaches were suggested by the peer group to simplify the drug regimen.

Problems: A larger number of clients than was expected were receiving multiple atypicals, but that there was medical justification (e.g. failure to respond to only one agent, simultaneous titrations between agents, continuing the same regiment the client was admitted on). This was also likely due to this monitor never having been undertaken before and the lack of practice guidelines nationally to guide prescribers. It was noted that over the quarter the total number of clients reviewed did decrease from 24 in June to 12 in September.

Status: This monitor will continue for at least one additional quarter. It was also noted that medical staff greatly appreciated the feedback from peers and pharmacists.

Actions: No actions against individual prescribers were deemed necessary. This monitor will continue into next quarter.

MEDICAL STAFF PEER REVIEW

Aspect: Pharmacist and Peer Review of all medication-resistant clients for (First quarter FY08 June 07)

Overall compliance: 100%

June, July, August, September, 2007			
Indicator	Findings	Compliance	Target %
All clients identified to be medication-resistant or non-responsive by the attending physician or by nursing or administrative staff, will have a formal pharmacist consultation and peer review.	3 clients were identified/ 3 clients were reviewed	100%	100%

Findings: This was a new medical staff quality indicator commencing in this quarter. During the quarter the case identification for this indicator was enlarged to include nursing and administrative staff, which may also request a formal medication consultation and peer review. This indicator was well received by the medical and pharmacy staff. Pharmacy staff did a thorough review of past medications and made suggestions for possible changes in drug regimens in the 3 clients. Additional feedback was

given by peers in a formal meeting where the clients were thoroughly discussed. All identified clients were reviewed within one month of identification.

Problems: There were no problems encountered other than noting the pharmacy consultations were rather labor intensive when accomplished as thoroughly as they were. This might limit the total number of cases that could be reviewed in a given month. Individual clinicians received suggested regimen changes and implemented them in all cases and with good cheer.

Status: The methodology appears sound, was well accepted by medical staff, and appeared to result in improved outcomes for the three clients.

Actions: No specific actions were deemed necessary. This indicator will continue into the next quarter.

Pharmacy

Aspect: Height Weight Available to Pharmacist

Compliance: 99%

July 07	Missing Heights and Weights	Total Clients	Percent Compliance	Threshold Compliance
Missing heights and weights before pharmacist intervention	9	90	90	95 %
Missing heights and weights after initial pharmacist intervention	1	90	98.8	95%
Missing heights and weights after second pharmacist intervention	1 (1 CLIENT REFUSED)	90	98.8	100%
August 07	Missing Heights and Weights	Total Clients	Percent Compliance	Threshold Compliance
Missing heights and weights before pharmacist intervention	8	89	91	95 %
Missing heights and weights after initial pharmacist intervention	4	89	95.5	95%
Missing heights and weights after second pharmacist intervention	0	89	100	100%
September 07	Missing Heights &	Total Clients	Percent Compliance	Threshold

	Weights			Compliance
Missing heights and weights before pharmacist intervention	9	87	89.7	95 %
Missing heights and weights after initial pharmacist intervention	8	87	90.8	95%
Missing heights and weights after second pharmacist intervention	3	87	96.5	100%

Methods: In order to provide the best pharmaceutical care for our clients, it is essential that the height and weight for each client be sent to the pharmacy. With this information, we are able to provide the most accurate dose for our clients. All four units of the hospital were evaluated on a monthly basis over the months of July, August and Sept, for client's missing height and weight values. Upon noting the discrepancies, an initial attempt by the pharmacist was made to obtain these values by sending each unit a form that included the client name as well as a place to indicate the missing height and/or weight or to document if the client refused having these done. If the unit did not comply with this request, a second attempt was made to get the information. This involved the pharmacists' going to the floor and looking through the client's chart, and documenting the information.

Findings: The sample size ranged from 87-90 clients per month. It is important to note that due to the diagnoses of this client population, there may be an increase in the number of refusals of heights and weights as compared to the general population. These refusals may not have been appropriately documented, thus contributing to decreased compliance.

Status: The pharmacist intervention for obtaining heights and weight on each client was instituted in November 2006. Before any intervention, the overall compliance for all units during the month of November 2006 was only 70%. Looking at the results from this current reporting quarter, the overall compliance is now 95% before any monthly pharmacist intervention. While we are still not at 100%, this 35% increase is encouraging and represents the effectiveness of this particular intervention. For this reporting quarter, after both pharmacist interventions, there was only 1 missing height, which was subsequently later retrieved. Overall, with the institution of the two different means of intervention, an increase in compliance of sending height and weight information to the pharmacy has been seen over the last year.

Actions: On-going nursing education regarding required forms that need to be sent to the pharmacy will continue to facilitate increasing compliance. Reinforcing the importance of documentation, particularly refusals may have an effect on compliance. In order to reach our goal of 100%, we will continue to monitor compliance on a monthly basis and report the progress every quarter.

NURSING

ASPECT: Seclusion and Restraint Related to Staffing Effectiveness

COMPLIANCE: 100%

Indicators	Findings	Compliance	Threshold Percentile
Seclusion/Restraint related to staffing effectiveness:			
1. Staff mix appropriate	79 of 79	100%	100%
2. Staffing numbers within appropriate acuity level for unit	79 of 79	100%	100%
3. Debriefing completed	79 of 79	100%	100%
4. Dr. Orders	79 of 79	100%	100%

Findings: 100% Compliance

Problem: None

Status: The indicator continues to be at 100%

Actions: Change the staffing effectiveness monitor for next quarter

NURSING

ASPECT: Code Cart / Redlining

COMPLIANCE: REDLINING 98% CODE CART 99.5%

Indicators-Redlining	Findings	Compliance	Threshold Percentile
Lower Kennebec	274 of 278	99%	100%
Upper Kennebec	278 of 278	100%	100%
Lower Saco	263 of 278	95%	100%
Upper Saco	273 of 278	98%	100%

Indicators-Code Cart Sign Off	Findings	Compliance	Threshold Percentile
1) Lower Kennebec	276 of 278	99%	100%
2) Upper Kennebec	278 of 278	100%	100%
3) Lower Saco	278 of 278	100%	100%

4) Upper Saco	273 of 278	98%	100%
5) NOD Building Control	278 of 278	100%	100%
6) NOD Staff Room I 580	278 of 278	100%	100%

Findings: Redlining is at 98% and has remained at the same level as last quarter. Lower Saco has completed redlining 95% of the time which is an increase from 947%. Lower Kennebec has completed redlining 99% of the time which is the same as last quarter. Upper Saco was at 98% which is a decrease from 100% last quarter. Upper Kennebec is at 100% which is an increase from 99% last quarter.

Code cart checking is at 99.5% this quarter which is an overall increase from 99%. Four areas are at 100% NOD, Building control, Lower Saco and Upper Kennebec.

Problem: Code carts are not being checked 100% of the time. Redlining is not being done 100% of the time on all units.

Status: Code cart checking and redlining has improved this quarter. The staffs have gotten the message that code cart checking is an important issue on all code carts. This is being done more consistently. Redlining is being done more consistently. This has been added to the shift report and has been an extra reminder to nursing. The on coming Nursing Supervisor and NOD's have been checking Room I-580 to make it a part of their shift report.

Action:

- This will continue to be included on the day, evening and night shift nursing report.
- The night NOD will continue to check with the charge nurse on each unit.
- Code cart checking will continue to be reviewed with the nurse who is responsible for narcotic count and key change during each shift change.

NURSING

ASPECT: PAIN MANAGEMENT

COMPLIANCE: PRE: 99% POST: 91% OVERALL: 95%

Aspect		Findings	Compliance	Threshold Percentile
Pre administration	Assessed using pain scale	821 of 829	99%	100%
Post administration	Assessed using pain scale	754 of 829	91%	97%

Findings: The indicator for assessing pain using pain scale pre medication administration is at 99%. The indicator for assessing pain post administration is up to 91%. The post administration has improved 1% since the last quarter and the pre administration has remained the same.

Problems: Nurses have not been consistently assessing post administration of pain meds . Pre and post assessments are done by the Registered Nurse and the changes with nursing have made a 1% improvement but more consistency is needed.

Status: The preadministration has remained the same. The post administration has increased by 1% to 91%. With the initiation of Primary Nursing on Upper Saco, the post administration assessment is

done more consistently. As other units go to Primary Nursing during the next quarter there should be improvement in this indicator.

Actions:

- Continue education on doing pre and post assessment.
- Continue to move toward primary nursing.

NURSING Quarterly Report July, August, September 2007

ASPECT: CHART REVIEW

OVERALL COMPLIANCE: 76%

Indicators	Findings	Compliance	Threshold Percentile
1. Universal Assessment completed by RN within 24 hours	75 of 97	77%	100%
2. Care Plan Initiated	93 of 97	96%	85%
3. Client Preference Identified	85 of 97	88%	100%
4. Signature Finalizing Assessment	84 of 94	89%	100%
5. Re-assessment if pain present	38 of 51	75%	100%
6. GAP notes at a minimum 1. Identifies STG goal/objective 2. Once per shift either MHW/RN(observational note as appropriate 3. Minimally Q 24 hours RN after first 72 hours	27 of 54 24 of 40 43 of 52	50% 60% 83%	90% 95% 100%
7. Initial care plan documented within 24 hours	44 of 48	92%	85%
8. Presenting Problem in behavioral terms	33 of 52	63%	85%
9. Strengths Identified	46 of 53	87%	85%
10. Client LTG is observable and measurable	22 of 51	43%	100%
11. Comprehensive Plan completed by the 7 th day	35 of 40	88%	85%
12. STG/Objectives are written, dated, numbered, observable and measurable	21 of 50	42%	85%
13. Interventions are identified	45 of 52	87%	85%

14. a. Integrated Needs/Assessment prioritized by scale at bottom of sheet b. Integrated Needs/Assessment contains all needs/issues/problems found within the assessments/evaluations since admission	46 of 53 35 of 53	87% 66%	85%
15. Active medical issues addressed via medical/nursing care plans	35 of 52	67%	85%
16. Documented in the chart on the day of Comprehensive Service Plan meeting	35 of 39	90%	85%
17. Identifies client preferences at Service Integration meeting	27 of 36	75%	85%
18. States whether further assessments will be needed or not per MD, PA or psychiatrist	29 of 39	74%	85%
19. Identifies the unmet current goals of services	24 of 37	65%	85%
20. Documents the client or guardian participation in the treatment planning process	38 of 41	93%	85%

Findings: There were charts audited from all 4 Nursing units for nursing documentation this quarter. Overall this group of indicators has decreased in compliance from 81% last quarter to 76% this quarter. All of chart review aspects are considered together and were in part of documentation report with. Eight indicators are above the threshold. Care Plan initiated is at 96%. Initial care plan within 24 hours is at 92%. Strengths identified are at 87%. Comprehensive plan completed by the 7th day at 88%. Interventions identified at 87%. Integrated needs assessment prioritized by scale is at 87%. Documentation on the day of service plan meeting is at 90%. Documentation of client and/or guardian participation in treatment planning is at 93%. Minimal every 24 hours of nursing documentation is at 83% compliance from 89% last quarter.

Problems: There remains a problem in the consistency of documentation although there has been some improvement in some areas of these aspects of documentation. The problems are across units and shifts. The documentation is not organized as we would like it to be nor does it connect to the treatment plan as it should.

Status: Although documentation looks better this quarter, in some areas efforts will continue to improve the understanding of why documentation is done the way it is and the process for accomplishing it. The education for comprehensive service plans and notes has been provided to all nurses in group sessions. Education has also been provided to many nurses on an individual basis. Education manuals with guidelines for staff have been placed on each unit. A new Mental Health Worker flow sheet was developed to assist in the documentation. Mental Health workers are using the sheets but need to fill them out more completely. The Comprehensive Service Plans do not always connect to the written notes.

Actions:

- The nurses who audit charts are educating nurses to “fill in the blanks” on the Universal Assessment If the client is unable to complete because of their acuity, nurses will be expected to check on each shift to see if completed.
- Reassess pain is addressed under the pain indicator.
- The nursing staff will be directed to include upon admission any Medical issues that have been identified. Templates will be given to all units.
- The two ADONs, Nurse Consultant and Nurse Educator have all been assigned nursing units. This will address the low percentages in the GAP note area included in several indicators. There has been a great deal of education but behavior must now change. They will review

- charts, teach and make changes 1:1 with nursing to improve documentation.
- Treatment Plan templates will be added to the education manual on each unit.
- Additions of new tracking indicators will be added

PSD Comprehensive Treatment Plan

Comprehensive Treatment Plan

Indicators	Findings	Compliance	Threshold Percentile
1. Evidence of initial treatment plan (minimum of one Safety STG & one Treatment STG each having minimum of two interventions) is in place within 24 hours of admission.	LK 12 of 12 UK N/A LS 9 of 11 US 12 of 12	94%	100%
2. The Presenting Problem of the CSP identifies specific client symptoms, stated in behavioral terms , causing admission (identifies any functional behavioral collapse)	LK 12 of 12 UK N/A LS 8 of 12 US 12 of 12	88%	90%
3. The CSP incorporates for treatment, all “active” client needs/problems obtained through the assessment process. (“active” as designated by the priority status “1” on the Integrated Needs / Problem List)	LK 12 of 12 UK 12 of 12 LS 6 of 12 US 6 of 12	75%	100%
4. Client strengths and preferences which can be utilized to achieve / enhance treatment outcomes are identified. (should be evident within the interventions).	LK 12 of 12 UK 12 of 12 LS 7 of 12 US 12 of 12	90%	90%
5. The CSP has a “Safety Goal” , based on identified individual risks, stated in observable and behavioral terms.	LK 12 of 12 UK 12 of 12 LS 11 of 12 US 11 of 12	94%	90%
6. The CSP has at a minimum one “Treatment Goal” based on individual assessed needs to reduce or eliminate symptom or illness stated in observable and measurable terms.	LK 12 of 12 UK 10 of 12 LS 11 of 12 US 12 of 12	94%	90%
7. The CSP has at a minimum one “Rehabilitation Goal” based on assessed needs to improve self selected value roles, stated in observable and measurable terms.	LK 12 of 12 UK 11 of 12 LS 1 of 12 US 3 of 12	56%	90%
8. The CSP has at a minimum one “Transition Goal” based on assessed needs and reflecting client preferences stated in observable and measurable terms.	LK 11 of 12 UK 12 of 12 LS 7 of 12 US 9 of 12	81%	90%

9. Each CSP goal has a minimum of two stepped STGs , which should reasonably lead to goal attainment, stated in clear client based behavioral terms, which are observable and measurable.	LK 12 of 12 UK 11 of 12 LS 4 of 12 US 6 of 12	69%	80%
10. Interventions are designated for each STG, that reasonably lead to attainment of the STG.	LK 12 of 12 UK 11 of 12 LS 8 of 12 US 6 of 12	77%	100%
11. Each Intervention states what the intervention is, how often it occurs, what the purpose is and who provides it.	LK 12 of 12 UK 11 of 12 LS 5 of 12 US 9 of 12	79%	80%
12. An individual is identified (responsible) by name to monitor/ document the effectiveness of each intervention (progress toward or away from STG).	LK 12 of 12 UK 12 of 12 LS 3 of 12 US 11 of 12	79%	90%
13. The CSP is properly authenticated by signature AND date, of treatment team members, no later than 7 days from the date of admission. Identify participants below: <ul style="list-style-type: none"> • MD • RN • SW • Client / Guardian 	LK 11 of 12 UK N/A LS 11 of 12 US 12 of 12	94%	95%
14. CSP has any assessed functional skill deficits including present Level of Support and Level of Support to be attained	LK 12 of 12 UK 10 of 12 LS 3 of 12 US 0 of 12	52%	90%

Aspect - **Integrated Summary**

1. Integrated Summary Note is documented in the medical record the day of CSP meeting.	LK 12 of 12 UK N/A LS 3 of 12 US N/A	63%	80%
2. Summary briefly identifies findings of assessments / needs (MD/RN/Rehab/SW/Psychology).	LK 11 of 12 UK N/A LS 2 of 12 US N/A	54%	90%
3. Summary identifies NEEDS not to be addressed at this time and why (deferred as denoted by "2" priority status on the Integrated Needs / Problem List.)	LK 12 of 12 UK N/A LS 2 of 12 US N/A	58%	70%
4. Summary describes client preferences	LK 11 of 12	58%	85%

utilized in service planning.	UK N/A LS 3 of 12 US N/A		
5. Summary identifies predicted community placement .	LK 12 of 12 UK N/A LS 3 of 12 US N/A	62%	90%
6. Summary identifies additional assessment/ evaluations or services to be sought.	LK 11 of 12 UK N/A LS 4 of 12 US N/A	62%	70%
7. Summary describes level of client participation in planning service.	LK 11 of 12 UK N/A LS 3 of 12 US N/A	62%	95%

Aspect – **Service Plan Reviews**

1. At a minimum review is completed within 14 days of last review for first 6 months or within the last 30 days for hospitalizations of over 6 months.	LK 8 of 8 UK 11 of 12 LS 9 of 10 US 12 of 12	95%	90%
2. Within 72 hours of the use of (a) seclusion, (b) restraint, (c) episode of violence, or (d) transfer a service plan review is completed.	LK 4 of 4 UK 1 of 1 LS 0 of 2 US 1 of 1	75%	85%
3. The review participants are documented (a) MD** (b) RN** (c) SW** (d) Client/ Guardian**	LK 8 of 8 UK 11 of 12 LS 10 of 12 US 11 of 12	95%	100%
4. A behavioral description of client behavior related to each goal area is documented, supporting whether the goal was met or not "AEB"= as evidenced by (can be on the review form itself or the progress note as long as it is in narrative form)	LK 8 of 8 UK 11 of 12 LS 9 of 10 US 6 of 12	86%	90%
5. Client's self-assessment of effectiveness of current plan is documented.	LK 6 of 8 UK 11 of 12 LS 6 of 10 US 10 of 12	79%	85%
6. Evidence of positive client progress related to each goal is documented.	LK 8 of 8 UK 11 of 12	76%	70%

	LS 7 of 10 US 6 of 12		
7. The CSP is modified as a result of the review, as evidenced by target dates addressed as met or extended and dates changed. May also be evidenced by the addition or modification of STGs.	LK 4 of 8 UK 11 of 12 LS 4 of 10 US 4 of 12	55%	70%
8. Client level of participation in the service plan review is documented.	LK 8 of 8 UK 11 of 12 LS 10 of 10 US 12 of 12	98%	90%

Aspect - **Active Treatment**

1. CSP has, and documentation in progress notes and or flow sheets demonstrate identified functional need/s (Space maintenance / hygiene / clothes care / time management / self expression) [nursing assessment and care plan] including present Level of Support and what Level of support is the goal.	LK 9 of 10 UK 10 of 12 LS 9 of 11 US 0 of 12	62%	80%
2. Progress notes / flow sheets document a level of functional skill support provided, consistent with the identified area of need, delivered within last 24 hours.	LK 9 of 10 UK 7 of 12 LS 8 of 12 US 12 of 12	78%	70%
3. Documentation demonstrates that the client attended all assigned psycho-social-educational interventions within last 24 hours.	LK 2 of 10 UK 4 of 12 LS 1 of 11 US 10 of 12	38%	70%
4. A minimum of three psychosocial educational interventions are assigned daily.	LK 2 of 10 UK 12 of 12 LS 2 of 10 US 3 of 12	43%	70%
5. The client is able to state what his assigned psycho-social-educational interventions are and why they have been assigned?	LK 10 of 10 UK 5 of 11 LS 3 of 11 US 10 of 10	67%	60%
6. The client can correctly identify assigned RN and MHW.	LK 2 of 9 UK 1 of 11 LS 9 of 11 US 11 of 12	51%	75%

7. The medical record <i>documents the clients active participation in Morning Meeting within the last 24 hours</i>	LK 6 of 9 UK 11 of 12 LS 5 of 11 US 6 of 12	55% 71%	70% for adm units 85% for extended care units
8. The client can <i>identify personally effective distress tolerance mechanisms available within the milieu.</i>	LK 7 of 9 UK 8 of 11 LS 11 of 12 US 9 of 12	80%	65%
9. <i>Level and quality of client's use of leisure within the milieu</i> are documented in the medical record within the last 7 days.	LK 9 of 9 UK 12 of 12 LS 11 of 12 US 10 of 12	93%	75%
10. <i>Level and quality of social interactions</i> within the milieu are documented in the medical record over the last 7 days.	LK 12 of 12 UK 12 of 12 LS 11 of 12 US 12 of 12	98%	75%

Findings:

A new structure for assessing program measures of quality focusing on the above aspects and indicators were established during this quarter. Program Service Directors review records from these programs for evidence of quality indicators, review with staff responsible for the documentation, and establish plans of correction with the unit nurse four and department heads specific to each unit. As process flaws are identified which transcend programs, process enhancement activity is implemented across all programs. Monthly monitoring is maintained to ensure implementation of action is occurring and are effective in manifestation of quality indicators.

Problems: Problem areas are identified in red above. Quality indicators highlighted in red represent quality issues across all units. Individual units accounting for variance in threshold are highlighted as appropriate.

Status: Indicators under study beyond this report period have demonstrated improvement. Active treatment indicators, newly implemented to focus increased efforts on engagement of clients and delivery of psycho-educational and rehabilitation services have demonstrated organizational process improvements be implemented.

Principle Actions Implemented:

- Results of quality assessment activity is discussed at staff meetings on each unit and clinical leaders meetings.
- Individual staff has their performance reviewed by PSD and RN4 and department head concerning quality trends.
- Nursing services is providing teaching sessions through the nursing educator to all units on documentation requirements. A reference manual has been developed by nursing and they utilize this tool for teaching. An example of a GAP note has been distributed by nursing to the unit nurses and is posted in the nurses' station.
- Acting Director of Rehabilitation shall conduct reviews of adequacy of rehabilitation goals on the forensic units and report to the Deputy Director of Clinical Services.
- Director of Nursing shall implement a review of the process of identification of, and service delivery to, primary functional supports of clients on forensic units and report to Clinical Leaders Group.

- A template on writing service review notes has been provided to nursing staff to assist in displaying quality indicators.
- Competency assessment on treatment plan writing and progress note writing shall be implemented within the next month in the nursing department to ensure capacity to meet documentation expectations. Director of nursing shall report to ELC process implementation.
- Implementation of Primary Nursing Plan to clarify responsibilities of care providers and enhance accountability for actions is being implemented. The Director of Nursing shall report to ELC monthly progress.
- PSD are implementing various strategies to address (1) morning meeting attendance [including changing format of meeting], and (2) engaging clients in psycho-educational involvements.
- Information technology shall distribute to each unit an automated CSP support program that will assist staff in choosing measurable goals, objectives, and specific interventions by end of next quarter. This action shall be monitored and reported to ELC via the Deputy Superintendent of Administrative Services.
- Individual treatment schedules will be placed in client rooms minimum of weekly to assist clients' awareness of psycho-social-educational activates. PSDs shall monitor and report to Superintendent.
- Milieu managers shall be assigned to develop a process to ensure that assigned MHW review client schedules with each client, minimum weekly, and document same in the medical record. Director of Staff Development shall monitor and report to Superintendent.
- Director of Peer Support Services shall lead a process for clients to complete weekly self assessments to be added to the medical record. This will be monitored by the Deputy Superintendent of Clinical Services and reported to the ELC.

PEER SUPPORT

ASPECT: Integration of Peer Specialists into client care

OVERALL COMPLIANCE: 89%

Indicators	Compliance	Findings	Threshold Percentile
1. Attendance at Comprehensive Treatment Team meetings.	439 of 511	86%	80%
2. Grievances responded to by RPC on time.	131 of 154	85%	100%
3. Attendance at Service Integration meetings.	64 of 67	96%	100%
4. Contact during admission.	74 of 74	100%	100%
5. Grievances responded to by peer support on time.	154 of 154	100%	100%
6. Client satisfaction survey completed.	28 of 41	68%	80%

Findings:

Overall compliance is down 2% from last quarter.

(1) Peer Specialists attended 439 of 511 treatment team meetings. Of the 72 missed meetings, 53 were due to peer support not being available to attend meetings and 19 were due to clients not wanting peer support present. Peer support was unavailable to attend meetings due to attending admissions (4), mandatory training (7), being out sick/on vacation (4), no peer support available (36), and attending other meetings (2).

(2) RPC responded late to 23 grievances. Of the 23 late grievances, 10 were on Lower Kennebec (1-11 days late), 1 was on Upper Kennebec (1 day late), 11 on Lower Saco (1-17 days late), and 1 on Upper Saco (1 day late).

(3) Peer Specialists missed 3 of 67 Service Integration meetings. Two meetings were missed on Lower Saco and one on Lower Kennebec.

(4) All clients admitted had documented contact with a peer specialist this quarter.

(5) All grievances were responded to by peer specialists within one business day.

(6) Of the 41 Client Satisfaction Surveys that were offered to clients, 28 completed the survey.

Problem:

(1) A Peer Specialist is not always available to attend all client Comprehensive Treatment Team Meetings.

(2) All level I grievances are not being responded to by RPC within the time allowed.

(3) Peer Specialists are not attending all client Service Integration Meetings.

(4) All clients admitted to RPC did not have documented contact with a peer specialist.

(6) Clients are not always willing to complete a client satisfaction survey.

Status:

(1) Peer Specialists attended 86% of treatment team meetings this quarter, which is down 1% from last quarter. The majority of meetings missed were in the month of July. The peer support team leader was out on medical leave for half of July and one full-time position was vacant.

(2) Compliance with grievance response time was down 9% from last quarter. The majority of grievances filed were on Lower Saco (66) and Lower Kennebec (47) at 73% of total grievances. Total number of grievances increased 17% from last quarter. The majority of the grievances filed on Lower Saco and Lower Kennebec were filed by 2 people.

(3) Three Service Integration meetings were missed this quarter. Two meetings were missed due to peer specialist not being notified of changes in meeting schedule and one was due to mandatory training for all peer specialists.

(6) Completion of Client Satisfaction Surveys was down 7% this quarter from last quarter.

Actions:

- Peer Specialists will continue to track Comprehensive Treatment Team Meeting attendance and reasons for not attending in order to problem solve ways to address the reasons for missed meetings.
- Peer Specialists will be counseled at least twice per month on issues related to missed meetings and work attendance.
- Peer Specialists will make additional efforts to adjust their schedules to be available for meetings and problem-solve with the peer support team leader on how to manage their schedule and overcome barriers to attending team meetings.
- Peer Services Director will meet with the Social Services Director and Continuity of Care Managers as needed to coordinate meeting schedule in order to ensure Peer Support attendance.
- Peer Specialists will begin tracking reasons for clients refusing to complete surveys.
- PI director will remind PSDs when need to obtain an extension on grievances.

Client Satisfaction Survey: 1st Quarter Jul-Aug-Sep 2008

Aspect: Client satisfaction with care

Overall compliance: 74%

Indicators	Findings		Threshold Percentile	+/-
1. Has anyone informed you about your rights?	20 of 23	87%	85 %	+22%
2. Has anyone talked to you about the kinds of services that are available to you?	19 of 23	83%	85 %	+14%
3. Are you informed ahead of time of changes in your privileges, appointments or daily routines?	18 of 27	67%	85 %	+2%
4. Do you know someone who can help you get what you want or stand up for your rights?	17 of 19	89%	85 %	-15%
5. Has your community worker visited or contacted you since you have been in the hospital?	14 of 23	61%	85 %	-4%
6. Do you know how to get in touch with your community worker if you need to?	11 of 23	48%	85 %	-21%
7. Do you have an individualized support plan (ISP)?	14 of 25	56%	85 %	-11%
8. I feel more confident in my ability to deal with crisis situations?	19 of 25	76%	85 %	-20%
9. I am less bothered by my symptoms now?	18 of 25	72%	85 %	-24%
10. I am better able to function?	18 of 24	75%	85 %	-21%
11. I do better in social situations?	19 of 25	76%	85 %	-12%
12. I experience less difficulty in my life?	15 of 28	54%	85 %	-27%
13. I am treated with dignity and respect?	20 of 25	80%	85 %	-1%
14. I feel comfortable asking questions about my treatment and medications?	21 of 25	84%	85 %	-2%
15. I am encouraged to use self-help/peer support and support groups after discharge?	20 of 24	83%	85 %	+1%
16. My medication benefits and risks were discussed with me?	15 of 26	58%	85 %	-17%
17. I am given information about how to understand and manage my illness?	17 of 24	71%	85 %	-17%
18. My other medical conditions are being treated?	14 of 24	58%	85 %	-2%
19. I feel free to voice complaints and suggestions?	20 of 24	83%	85 %	+2%
20. I feel my right to refuse medication or treatment is respected?	19 of 23	83%	85 %	+19%
21. I participate in planning my discharge?	16 of 22	73%	85 %	-16%
22. I feel I had enough privacy in the hospital?	21 of 25	84%	85 %	-1%
23. I feel safe while I am in the hospital?	21 of 24	88%	85 %	-8%
24. If I had a choice of hospitals, I would choose this one.	20 of 23	87%	85 %	+20%

Overall compliance was down 5% from last quarter.

Findings: Of the 24 indicators, 4 met or exceeded threshold and 20 were below threshold. The number of items that met or exceeded threshold was down by 5 from last quarter. Items that did not meet threshold were up by 5.

Problem: Clients are not satisfied with all aspects of care provided by RPC.

Status: Increases and decreases from last quarter are indicated in the table above.

Only 1 of the indicators from last quarter remained at or above threshold this quarter, but fell 8%.

Three indicators that were below threshold last quarter met or exceeded the threshold this quarter. Of the 9 indicators that reached threshold last quarter 8 dropped below threshold this quarter (1-24%). Of those that remained below threshold, 5 increased 1-19% while 7 decreased 2-27%.

Some of the identified concerns by clients were around safety and communication.

Actions:

- Peer support will encourage and support clients to voice their concerns and needs with their treatment teams regarding these aspects of care.
- Peer support will provide feedback to RPC about client concerns/suggestions.
- Executive Leadership will review and initiate action plans as appropriate.
- Medical Executives will review and initiate action plans as appropriate.

CONTINUITY OF CARE/Social Services Department
ASPECT: Preliminary Continuity of Care Meeting and
Comprehensive Psychosocial Assessments
Overall Compliance: 81%

Indicators	Findings	Compliance	Threshold Percentile
1. Preliminary Continuity of Care meeting completed by end of 3 rd day	27/30	90%	100%
2. Service Integration form completed by the end of the 3 rd day	28/30	93%	100%
2a. Director of Social Services reviews all readmissions occurring within 60 days of the last discharge and for each client who spent fewer than 30 days in the community, evaluated the circumstances of the readmission to determine an indicated need for resources or a change in treatment and discharge planning or the need for alternative resources. In cases where such a need or change was indicated that corrective action was taken.	4/4	100%	100%
3a. Client Participation in Preliminary Continuity of Care meeting.	28/30	93%	80%
3b. CCM Participation in Preliminary Continuity of Care meeting.	30/30	100%	100%
3c. Client's Family Member and/or Natural Support (e.g., peer support, advocacy, attorney) Participation in Preliminary Continuity of Care meeting.	29/30	96%	80%
3d. Community Provider Participation in Preliminary Continuity of Care meeting.	14/30	46%	80%
3e. Correctional Personnel Participation in Preliminary Continuity of Care Meeting.	2/15	13%	60%

4. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission	24/30	83%	95%
5. Annual Psychosocial Assessment completed and current in chart	29/30	96%	95%

Findings:

The sample size for this aspect was 15 charts for the quarter from each of the two admission units, Lower Saco and Lower Kennebec for the indicators 1-3d. For indicator 3e the sample was for Lower Saco only. For indicator 5 the sample was 15 charts for the quarter from both Upper Saco and Upper Kennebec.

Problems: Indicators 1 and 2 fell below compliance as indicated with two clients from Lower Saco SCU and one client from Lower Kennebec. The clients refused to participate in the Service Integration Meeting and were approached daily for several days following admission. Two of the forms were completed with client input and historical information though not within the threshold of 3days. The other form was partially completed but also not within the threshold timetable.

Indicator 3d fell below the threshold percentile this quarter and registered at 46%. In several instances clients declined to sign releases for assigned community providers to attend and participate in the initial Service Integration Meeting. Additionally impacting this area is the short timeframe in which this meeting occurs after admission to the facility. On several occasions providers could not attend but had given input to the assigned CCM or had made arrangements to attend the 7 day meeting. This is an area that we continue to problem solve and have received assistance from the regional consent decree coordinators to facilitate as a go between for the hospital and providers to best support clients that are struggling to engage or reconnect with their pre-admission community providers.

Indicator 3e fell below the threshold percentile and for this quarter is at 13%. As stated in previous reports clients routinely refuse to have corrections personnel as part of their treatment team. There were two occurrences that corrections personnel, two probation officers gave input in the Service Integration process.

Indicator 4 fell below the threshold percentile at 83% for two reasons this quarter. The first is that two clients had acuity levels that though the report to be initiated within designated time frames it was completed after the seven day threshold. The other assessments were initiated within the seven day process on LS but were not completed by the seventh day as required. The individual staff has been counseled about the importance of meeting required timelines to ensure quality service care and delivery for clients served.

Status: Monitor all aspect areas and utilize individual supervision and team meetings to brainstorm continued ways to engage clients and continued dialogs with service providers.

Corrective Actions:

Indicators 1 and 2: These areas will continue to be focused on and monitored. For clients who may struggle with the process due to their level of acuity or challenges the process can begin immediately upon admission which would provide an increased opportunity for the process to be complete by the 3rd day.

Indicator 3d: The department will continue to focus on fostering the value of community providers in the overall treatment process and continue to encourage clients to allow them to be part of their course of treatment at RPC. We will continue to attend the Ken-Som Provider meeting at Maine General to facilitate stronger relationships between RPC and community providers. We also will continue to work with consent decree coordinators to act as a go between for the hospital and providers.

Indicator 3e: The department will continue to monitor this area and strategies ways to increase participation and support clients to see the potential value in their communication with the corrections system. A CCM from LS has begun participating at the Community Corrections Provider meeting held at the sheriff's department the last Wednesday of each month.

Indicator 4: This area will continue to be monitored through individual supervision and on-going engagement strategies with clients.

CONTINUITY OF CARE/ Social Services

ASPECT: Forensic Unit: Institutional Reports

Overall Compliance: 100%

Indicators	Findings	Compliance	Threshold Percentile
1. As part of the Individualized Treatment Meeting all Forensic clients will be prompted to indicate the initiation of a court petition.	66/66	100%	95%
2. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	5/5	100%	95%
3. The assigned CCM will review the new court order with the client and document the meeting in a progress note or treatment team note.	1/1	100%	95%
4. Reports to the commissioner for all NCR clients are submitted annually.	0/0	N/A	100%

Findings: The sample size for this area is based on the number of treatment meetings held during the designated quarter. Clients with NCR status, who have not petitioned in the last six months, are asked if they are considering petitioning the court. Clients who are considering are supported to initiate the process with their lawyer or independently with support from assigned CCM. Once a petition is recorded at the court the team constructs an institutional report within 10 days. The aspect area of annual reports will be reported on in the second quarter. All annual reports to the Commissioner for NCR clients are due in December. Psychiatrists on the Forensic units were prompted in October to be mindful of timelines for completion of these required reports by December.

Problems: All areas in this aspect fell within designated thresholds.

Status: On-going

Corrective Actions: None needed but on-going vigilance of the 10 day deadline and continued communication with team members will maintain this required level of compliance.

Continuity of Care/Social Services

Aspect: Client Discharge Plan Report/Referrals

Overall Compliance: 86%

Indicators	Findings	Compliance	Threshold Percentile
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1. The Client Discharge Plan Report will be updated/reviewed by each CCM minimally one time per week.	12/13	92%	80%
2. The Client Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	13/13	100%	95%
2a. The Client Discharge Plan Report will be sent out weekly.	11/13	84%	95%
3. Each week the CCM team and Director will meet and discuss current housing options provided by the respective regions and prioritize referrals.	11/11	100%	95%

Findings: The timeframe for this aspect area was 13 weeks. During that time the report was sent out on 11 occasions via email. The report was distributed to stakeholders in hardcopy on two occasions at the Wednesday regional meeting. The two occasions that the report was distributed hardcopy was due to restructuring of the document for increased ease of use and to add two new indicator areas.

Problems: Indicator 2a Document was not emailed but was distributed in hardcopy form at the regional meeting due to restructuring of the document on two occasions.

Status: Continued vigilance in monitoring the document and fine tuning the information to meet evolving needs of the department and RPC in the area of reporting unmet needs and discharge planning.

Corrective Actions: Continue monitoring as indicated and ensure that an updated and streamlined report is distributed week. Utilize individual supervision to support staff to ensure that the information contained in the report is concise, accurate, and encompasses all information needed in regards to discharge planning for each individual client.

Continuity of Care/Social Services

ASPECT: PROGRESS NOTES

Overall Compliance: 75%

Indicators	Findings	Compliance	Threshold Percentile
1. Progress notes in GAP format will indicate at minimum weekly 1:1 meeting with all clients on assigned CCM caseload.	33/45	73%	90%
2. On Upper Saco progress notes in GAP format will indicate at minimum bi- weekly 1:1 meeting with all clients on assigned CCM caseload	13/15	86%	95%
3. Treatment plans will have measurable goals and interventions listing client strengths and areas of need related to transition to the community or transition back to a correctional facility.	40/60	66%	90%

Findings: This aspect area includes chart samples from all units except as noted in Indicator 3 which represents information from Upper Saco only.

Problems: All indicators in this aspect area fell below thresholds and in most instances can be contributed to the change over in format for documentation and treatment planning. In indicator 1 and

2 most notes were in the charts though they were in a format other than GAP which is incorrect. For indicator 3 again treatment plans were in the charts but some were in the wrong format and did not list client strengths as indicated for this report.

Status: On-going improvement is indicated for this aspect area and report should see increased compliance next quarter.

Corrective Actions: Department team has been retrained on the area of treatment planning and GAP note format. This aspect area is a standing agenda item for department team meeting and individual supervision. Director will also with the assistance of CCM department support staff audit the charts bi-weekly rather than monthly for the next quarter. This more frequent monitoring will ensure that areas needing attention will be discovered and corrected more rapidly.

REHABILITATION

ASPECT: LOWER SACO CLIENT’S ATTENDANCE to prescribed treatment

COMPLIANCE: 84.0%

Indicators	Findings	Compliance	Threshold
Number of Scheduled Program Hours Offered	50 of 50	100.0%	100%
Number of Program Hours Attended	38 of 50	76.0%	75%
Number of Program Hours Refused	9 of 50	18.0%	25%
Number of Program Hours Excused	3 of 50	6%	5%
Level of Engagement	56 out of 166	3.0 average	4.0 average

Findings: Data for this indicator was taken from the week of August 19th to August 26th. Each of the charts reviewed showed that clients were offered a different number of program hours ranging from as little as 9.25 hours to the high mark of 25.0 hours. Of the 20 clients on the unit, 6 charts were reviewed. The total number of programs offered to all 6 clients was 85.0 hours. Of the total 85.0 hours of programming offered to clients, the clients participated in 67.0 hours for a 78% total. The number of hours that client’s refused or were excused from programming represented 21.05% of the 85.0 hours offered. Clients were rated on a scale from 1-4, with 1 being distracted/disengaged and 4 being actively engaged in discussion or activity. For this report period, clients averaged a 3.0. This is the first period that Lower Saco has been reviewed and this is that units starting point.

Problem: The referral system continues to be a problem, even after the modifications were made to simplify the form. The meetings that occurred with all Department Directors did not result in an increase in completing the simplified form. The tracking system to be implemented for the referrals does not appear to be implemented at the time of review. Zero percent of the client charts reviewed had referrals at the treatment mall. Also in review of the client’s charts, not all prescribed treatment is specifically reflected in their care plans by all disciplines.

Status: All notes reviewed for this quarter had the level of engagement section completed by the group leader. The revised referral forms have been given to all Discipline Directors and a system still needs to be set up to monitor compliance with this expectation. Finding documentation of all programs offered this quarter continues to be difficult as there is no centralized location to look for this information and perhaps it is not all being recorded.

Actions:

- The Director of Rehabilitation Services will develop a monitoring system for the clients that are prescribed treatment and do not have referrals.

- All care plans will be reviewed and reflect a minimum of 3 prescribed treatment hours per client per day.
- The Director of Rehabilitation Services will establish a procedure for collecting all hours of client attendance to programs in one central location for this unit as developed for Upper Saco.

PSYCHOLOGY

ASPECT: CO-OCCURRING DISORDERS INTEGRATION

1 st Quarter 2008 (June) July, August, September 2007 Co-Occurring Disorders Integration			
Indicators	Findings	Compliance	Threshold
1. There is evidence of an integrated co-occurring assessment.	42/42	100%	100%
2. There is evidence of an assessment of "stage of change".	42/42	100%	100%
3. There is evidence of an integrated co-occurring comprehensive service plan for identified clients.	20/42	49%	85% To be Reported Quarterly
4. Positive change in staff practices as measured by the COMPASS (Co-Morbidity Program Audit and Self-Survey for Behavioral Health Services) on each clinical unit.	COMPASS completed on four treatment units ACT team and Capital Clinic	No report this quarter	Four units participating 10% Increase To be Reported Annually 2 st quarter
5. Consumer Satisfaction Survey indicates clients were "encouraged to talk about and work on any mental health and alcohol and drug issues at the same time"	12/14	85%	85%
6. Consumer satisfaction survey indicates that since beginning treatment with us, their condition is better.	16/24	67%	95%
7. Consumer satisfaction survey reports client satisfaction with current treatment experience is better than with any other previous treatment experiences.	17/22	77%	85%
8. Percent of clients with co-occurring disorders as reported by NASMHPD	June data only	60%	50%

Findings:

For indicators #1-3 42 charts were audited indicating 42 clients positive for co-occurring disorders.

1. Threshold met. Goal met. Evidence of an integrated assessment met goal of 100% for the second consecutive quarter.
2. Threshold met. Stage of change assessment threshold of 100% for the quarter was met for the first time. New psychosocial assessments fully implemented.
3. Indicator below threshold. Integrated service plans for identified clients dropped from 80% to 49%.
4. No data to report this quarter.
For indicators #5-7 A total of 24 surveys were administered. Of those 12 identified themselves as co-occurring clients.
5. Threshold met.
6. Threshold not met. 16 clients reported their condition as "Better" 8 clients report "same".
No clients report "worse".
7. Threshold not met. There was a significant positive increase of 37% from last quarter.
8. Threshold exceeded. NASMHPD comparative statistics report indicates that for the month of June Riverview reported 60% of clients with co-occurring diagnoses. This is above the national mean of 35%.

Problems:

1. No problem threshold attained
2. No problem threshold attained
3. The CSP does not accurately reflect co-occurring issues assessed. Previous data had evidenced a positive trend. Reason for drop in performance unknown. Responsibility for CSP integration of co-occurring treatment not clearly defined.
4. COMPASS was not completed as scheduled
5. Threshold met. Slight decrease from last quarter.
6. Consumer report of improvement continues to be below expectations.
7. The trend is positive but indicator remains significantly below threshold.
8. No problem. This increase is likely due to better screening initiated upon admissions.

Status:

1. Threshold attained for two consecutive quarters. Goal met. Discontinue monitoring
2. Threshold met. New psychosocial assessment is now being used consistently. Continue to monitor for sustained results.
3. Responsibility of integrated treatment plan on CSP not clearly defined.
4. ACT team and Capital Clinic COMPASS surveys completed last quarter to set baseline data.
5. Goal expected to be reached next quarter.
6. Continue to identify methods to improve service delivery and client satisfaction with recovery.
7. Positive trend.
8. Threshold exceeded. Rapid cycle change project initiated to improve completion of diagnostic specifiers to further clarify diagnosis.

Actions:

1. Discontinue monitoring of this indicator
2. Continue to monitor for sustained results
3. Responsibility of integrated co-occurring treatment plan on CSP to be discussed at clinical leaders and with co-occurring coaches to develop action steps. Consider developing rapid cycle change process to address inclusion of Co-occurring treatment in CSP.
4. COMPASS assessment for inpatient units to be completed next quarter.
- 5-7 Continue education with Riverview "co-occurring coaches" and with unit staff regarding addressing needs of co-occurring clients. Expand consumer involvement in coaches group. Implement rapid cycle change process for "welcoming" attitudes by staff as evidenced in the treatment plan review meetings.
8. Education with psychiatry staff regarding completion of diagnostic specifiers for dual diagnosis. Monitor for continued positive trend and goal attainment.

1st Quarter 2007 August, September 2007 Psychologist Service delivery & documentation

Indicators	Findings	Compliance	Threshold
1. Psychologist short-term goals on CSP are measurable and time limited.	3/20	15%	95%
2. Psychologist progress notes indicate treatment offered as prescribed on CSP.	12/20	60%	95%
3. Psychologist progress notes indicate client's understanding of goals and client self-assessment of progress.	2/20	10%	90%

Findings:

1. New Indicator: Baseline data indicates CSP short-term goals are not measurable and/or time limited. Threshold set at 95%.
2. New Indicator: Baseline data indicates progress notes do not adequately reflect CSP goals. Threshold set at 95%.
3. New Indicator: Baseline data indicates lack of client participation in goal setting and self-evaluation. Threshold set at 90%.

Problems:

1. Psychologists are not developing measurable time limited short-term goals that are reflected on client's service plans.
2. Psychologist progress notes do not adequately address goals on CSP.
3. Failure to engage and report client participation in goals for treatment and self-assessment of progress.

Status:

1. Chart review indicates 15% compliance, far below acceptable threshold.
2. Chart review indicates 60% compliance. Below threshold
3. Chart review indicates 10% compliance, far below acceptable threshold.

Action: Goal is to improve psychologist service delivery and documentation on CSP's.

A minimum of 20 charts will be reviewed quarterly.

1. Psychologist will review standards for formulating a short-term goal at weekly staff meetings for 4 weeks.
2. Psychologist will use peer review process to review progress notes and provide feedback to assigned peer monthly.
3. Engaging clients in collaborative process of developing goals and self-assessment will be discussed bi-monthly in-group supervision.

SAFETY

ASPECT: LIFE SAFETY

OVERALL COMPLIANCE: 99%

Indicators	Findings	Compliance	Threshold Percentile
1. Total number of staff assigned to Upper Saco and Upper Kennebec who have received training with the evacuation chair.	61/61	100%	100%

2. Total number of staff assigned to Lower Saco and Lower Kennebec who have received training with the evacuation chair.	78/79	98%	100%
3. Total number of fire drills and actual alarms conducted at RPC during the quarter compared to the total number of alarm activations required per Life Safety Code, that being (1) drill per shift, per quarter.	3/3	100%	100%
4. Total number of staff that knows what R.A.C.E. stands for.	18/18	100%	100%
5. Total number of staff that knows that if there was a one-on-one or situation requiring one-on-one, i.e. client would not leave room, that they should stay with them.	18/18	100%	100%
6. Total number of staff that knows how to activate the nearest fire alarm pull station.	18/18	100%	100%
7. Total number of staff that knows how to acknowledge the fire alarm or trouble alarm on the enunciator panel.	17/18	97%	100%
8. Total number of staff that knows the emergency number.	18/18	100%	100%
9. Total number of staff that knows what the verbal code is used to announce a fire.	18/18	100%	100%
10. Total number of staff that knows it is necessary to close all doors after checking rooms or areas.	18/18	100%	100%
11. The total number of staff that knows what the acronym, P.A.S.S. stands for.	18/18	100%	100%
12. The total number of staff that knows the locations of the two nearest exits to evacuate away from a fire area	18/18	100%	100%
13. The total number of staff that knows two ways that may be used to move a person who is non-ambulatory to safety.	18/18	100%	100%

Findings:

1. Upper Saco and Upper Kennebec entire staff has received training in the use of the evacuation chair training. This equates to 100%.
2. Lower Saco has (42) out of (43) who have received the training. This equates to 98% of staff trained for the evacuation chair. Lower Kennebec has (36) out of (36) who have received the training. This equates to 100%.
3. The (3) alarms reported for the hospital meets the required number of drills per JCAHO and Life Safety Code. Of the (3) alarms, (1) drills were activated by the Safety Officer.

4-13. Indicators 4 through 13 are new indicators with the purpose of evaluating the knowledge and skills of staff as it relates to critical skills and knowledge necessary to carry out functions in the event of a fire and/or smoke emergency. The hospital conducts 1 drill per shift per quarter, (3 drills total) plus 1 drill at the Portland clinic for a hospital total of 4 drills per quarter. At the conclusion of each drill, a number of available staff are asked to answer indicators 4-13. Previously, this office would select one person to answer the questions. I also felt that staff seemed to be very cognizant of what was expected of them during a fire event since it had been only a short time since Riverview's Safety Fair which covers these specific areas.

Problems:

- 2. A decision had been made to train all staff, including the lower units, permanently assigned to the lower units in order to cover times that they may float. One staff person from Lower Saco has been out due to family medical issues
- 7. With regard to acquiring the location information from the annunciator panel, one staff member reported that they expected to receive the alarm location from the duress pagers. Unless the fire incident is obvious, most often than not, the information will only be immediately available from the remote annunciator panels. I did place this within this category since I felt that staff should know that the immediate information necessary to formulate their decisions, again, come from that panel.

Status:

- 1. RPC is now at 100% compliance for this training by current staff that is permanently assigned to both upper units...and all staff receives this training at orientation.

SAFETY

Aspect: Fire Drills Remote Sites

Compliance: 100 %

Indicators	Findings	Compliance	Threshold Percentile
1. Total number of fire drills and actual alarms conducted at Portland Clinic compared to the total number of alarm activations required per Life Safety Code (1) drill.	2 drills	100%	100%

Findings:

Portland Clinic had the required amount of fire drills. NOTE: This clinic only operates during the day.

Problems:

During the last reporting period, it was reported that the Safety Officer felt that staff was not quite aggressive enough during the sweep of clearing the area. Although the end result was satisfactory, it was felt that the actual sweep could be more efficient. This was discussed during the critique and placed as a review point during these two reported drills.

Status:

During these two reported drills, the Safety Officer felt that the evacuation sweeps were much more efficient and orderly. One drill even included clients in the waiting area. There has been a marked improvement over the course of the past (6) months in all areas.

Securitas/RPC Security manager

Aspect: Safety/security

Overall Compliance:

Unit: Security Desk/Lobby

Indicators	Findings	Compliance	Threshold Percentile
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1. Security search/screening of all clients (Forensic & Civil) being admitted to Riverview for treatment. (total # of admissions screened vs. total # of admissions).	74/74	100%	100%
2. Security Officer "foot patrols" during Open Hospital times. (Total # of "foot patrols" done vs. total # of "foot patrols" to be done.)	1833/1838	99%	100%
3. Security/safety checks done of the "lower" client units during the hours of 8:00 am thru 8:00 pm. (To be done 6 times in this 12 hour period.)	594/558	106%	95%

Findings: The Securitas/RPC Security Team exceeded the threshold percentile "goal" for this 1st quarter of FY 08. Due to a strong effort of increased "multi-tasking" & "time management" by the team, we were able to surpass the goal for two of the three indicators during this reporting period. We consistently meet the 100% goal for the "client admissions" indicator, as admissions are a top priority for the security staff.

Problems: The "target" numbers of Lower Unit checks were met during the first quarter reporting period. The "open hospital time checks" sometimes have difficulty accomplishing due to lack of help during a certain time period of the work day. Many client admissions (Forensic & Civil) happen in the early afternoon, when security officers begin their rotation for lunch breaks. During this time, we also need to perform three (3) open hospital time checks.

Status: We are finding that for our three (3) indicators, the status is fairly "steady" and even. During this 1st quarter of FY 08, we did have an increase in the number of times open hospital checks were to be performed in a day. It went from 16 to 22 times per day / per 13 hour period.

Actions: With the "open hospital time checks", The Security Team is going to manage time a bit differently during the next quarter. When admissions are planned during the time period of 1230-1300 hours, Securitas will adjust the "lunch break rotation" so the hospital needs can be met successfully.

STAFF DEVELOPMENT

ASPECT: New Employee and Mandatory Training

Indicators	Findings	Compliance	Threshold Percentile
1. New employees will complete new employee orientation within 60 days of hire.	14 of 15 completed orientation	93 %	100 %
2. New employees will complete CPR training within 30 days of hire.	14 of 14 completed CPR training	100 %	100 %
3. New employees will complete NAPPI training within 60 days of hire.	17 of 17 completed Nappi training	100 %	100 %
4. Riverview staff will attend CPR training bi-annually.	287 of 289 are current in CPR certifications	99 %	100 %
5. Riverview staff will attend NAPPI training annually. Goal to be at 100% by end of fiscal	165 of 345 have completed annual	48 %	100 %

training year 08 on June 30 th . Fiscal year 07 at 100%	training	to date	
6. River staff will attend Annual training. Goal is to be at 100% by end of fiscal training year 08 on June 30 th . Fiscal year 07 at 99%	27 of 355 have completed annual training	8 % to date	100 %

Findings: The indicators are based on the requirements for all new/current staff to complete mandatory training and maintain current certifications. **14 out of 15** (93%) new employees completed these trainings. **287 of 289** (99%) employees are current with CPR certification. **165 of 345** (48%) employees are current in Nappi training. **27 of 355** (8%) employees are current in Annual training. All indicators remained at 100 % compliance for quarter 1-FY 2008.

Problem: Indicators 1 and 4 are identified as problems as they are below established threshold. 1 employee did not attend the required mandatory training during orientation as they had prior commitments. 2 employees did not attend their annual recertification in CPR.

Status: This is the first quarter of report for these indicators. 1 employee will attend the 2 trainings that she missed during Orientation to complete within the 60-day requirement. The 2 employees that missed their CPR recertification have been mandated to go to the October 26th training. Continue to monitor.

Actions: Supervisors of those employees that are not current with their training have been notified and recommendations of counseling were made as well as scheduling them for the next class in those classes for October. Staff Development has discussed the importance of completion of mandatory training with employees and supervisors and all employees that are currently not up to date in mandatory training are scheduled for the next available class in October.

STAFF DEVELOPMENT

ASPECT: COMMUNITY PROVIDER TRAINING

Topic	Type	Date(s)	Level of Participation	Information Packets/Publications
BEST PRACTICES				
Just one bug: H. pylori and the complexity of chronic infection	Medicine Grand Rounds	7/6/07 RPC	3 Participants	Hard copy available
Cardiac CT	Medicine Grand Rounds	7/13/07 RPC	3 Participants	Hard copy available
Clinical dialogues in liver disease: Common things are common, rare things are rare	Medicine Grand Rounds	7/27/07 RPC	3 Participants	Hard copy available
Understanding Self Harm	In-service	7/24/07 RPC	23 Participants	Hard copy available
Molecular Causes of Cardiac Arrhythmias and Sudden Cardiac	Medicine Grand Rounds	8/3/07 RPC	2 Participants	Hard copy available

Topic	Type	Date(s)	Level of Participation	Information Packets/Publications
Death				
NSF and CKD: find out what they mean to me? or MRI contrast and nephrogenic fibrosis	Medicine Grand Rounds	8/10/07 RPC	4 Participants	Hard copy available
Influenza Pneumonia: Playing Chicken with the Next Pandemic	Medicine Grand Rounds	8/17/07 RPC	4 Participants	Hard copy available
Emergency department Crowding: a patient safety issue	Medicine Grand Rounds	8/24/07 RPC	4 Participants	Hard copy available
Emerging role of novel therapy in management of Multiple Myeloma	Medicine Grand Rounds	8/31/07 RPC	2 Participants	Hard copy available
Mechanisms of Working Memory Impairment after Mild and Moderate TBI	Psychiatric Grand Rounds	9/11/07 RPC	4 Participants	Hard copy available
Co-Occurring Mental Illness and Addiction: Schizophrenia and Nicotine Dependence	Psychiatric Grand Rounds	9/18/07 RPC	6 Participants	Hard copy available
Substance Abuse in Older Adults: The Coming Wave Age	Psychiatric Grand Rounds	9/25/07 RPC	4 Participants	Hard copy available
Osteoarthritis: More of an Orthopedic Disease that we thought	Medicine Grand Rounds	9/7/07 RPC	5 Participants	Hard copy available
A sticky problem: Staphylococcal Catheter Infections in	Medicine Grand Rounds	9/14/07 RPC	3 Participants	Hard copy available

Topic	Type	Date(s)	Level of Participation	Information Packets/Publications
Dialysis patients				
Outpatient IV Antibiotics: Successes and Challenges	Medicine Grand Rounds	9/21/07 RPC	5 Participants	Hard copy available
Not Your Grandma's CME: the case for getting the CME out of the Holiday Inn and into the clinical practice	Medicine Grand Rounds	9/28/07 RPC	5 Participants	Hard copy available
Mental Health Specialist Training	In-service	9/4,11,18,21/07 RPC	47 Participants	Hard copy available

COMMUNITY FORENSIC ACT TEAM

Aspect: Descriptive Report on various components
July August and September 2007

CASE MANAGEMENT:

Clients enrolled in the ACT program	
1 st Quarter 2008	Number of ACT clients
July 2007	34
August 2007	34
September 2007	34

Riverview ACT Team is now serving all but one of the clients previously case managed by their ICM. One client intends to grieve this change of case managers. ACT case management is presently at capacity.

CRISIS MANAGEMENT:

Resolution of Crisis Calls				
1 st Quarter 2008	Client incidents	Medication Changes/ +Monitoring	Hospitalized RPC	Hospitalized Medical
July 2007	5	2	2	1
August 2007	1			
September 2007	1		1	

SUBSTANCE ABUSE:

1 st Quarter 2008	Client with Substance Abuse as a Clinical Focus	Percent of ACT Clients In SA treatment
July 2007	8	24%
August 2007	8	24%
September 2007	9	26%

ACT Clients Living Situation				
	Clients in Supervised Settings	Clients in own apt. or with family	% of clients Supervised Settings	% of Clients in own home or with family
July	26	8	76.4%	24%
August	26	8	76.4%	24%
Sept	28	6	82.4%	17.6%

VOCATIONAL / EDUCATIONAL:

Regarding Clients working or volunteering in the community			
	# Client Community Site Work involved with VOC/ED	# of Client who offer Community Volunteer Services	# Hours worked in Community
July	13	2	940
Aug	14	2	784
Sept	15	2	804

ACT Program

Month: SEPTEMBER, 2007

Accountability Area: ACT PSD

Aspect: COMPREHENSIVE SERVICE PLANS

Indicators	Findings	Compliance	Threshold Percentile
1. Initial treatment documented within 24 hours	6/12	50%	100%
2. The presenting problem of the CSP identifies specific client symptoms, stated in behavioral terms.	12/12	100%	90%
3. The CSP incorporates for treatment, all "active" client needs/problems obtained through assessment process.	12/12	100%	100 %
4. Client strengths and preferences which can be utilized to active/ enhance treatment outcomes are identified.	12/12	100%	90%
5. The CSP has a "safety goal" based on identified individual risks, stated in observable & behavioral terms.	12/12	100%	90%
6. The CSP has at a minimum one " treatment goal " based on individual assessed needs to reduce or eliminate symptom or illness stated in measurable terms	12/12	100 %	90%

7. The CSP has at a minimum one "rehabilitation goal" based on assessed need.	0/12	0%	90%\
8. The CSP has a minimum of one transitional goal based on assessed need..	0/12	0%	90%
9. Each CSP goal has a minimum of two stepped STGs which should reasonably lead to goal attainment.	12/12	100%	80%
10. Interventions are designated for each STG, that reasonably lead to attainment of the STG.	12/12	100%	100%
11. Each intervention states what the intervention is, how often it occurs, what the purpose is and who provides it.	12/12	100%	80%
12. An individual is identified (responsible) by name to monitor/document the effectiveness of each intervention	11/12	91.6%	90%
13. The CSP is properly authenticated by signature and date, of treatment team meeting, no later then 7 days	11/12	91.6%%	95%
14. CSP has any assessed functional skill deficits including present level of support and level of support attained.	11/12	91.6%	90%

Findings: During the month of September 12 ACT Program charts were reviewed for compliance with the comprehensive service plan model. All 12 charts reviewed had a face sheet, emergency contact, psycho-social history, psychiatric assessment, nursing assessment, advance directive, crisis plan, court order was present and court order was current. All indicators except number 1, 7 and 8 within threshold.

Problems: During the month of September 12 charts were audited for compliance. Indicator # 1 evidence of initial treatment plan within 24 hours showed only 50% compliance. Indicators # 7 and #8 measured 0 compliance. Act was receiving training on the CSP in September and we were not aware that indicators #7 and #8 needed a rehabilitation and transitional goal.

Status: This is ACT's initial Chart Review and we do not have previous chart reviews to compare or discuss. Indicators # 7 and # 8 were not addressed on the current plans reviewed for this time period because staff was unsure what needed to be addressed. Indicator # 1. only 50% of the 12 charts I reviewed had an initial treatment plan within 24 hours . ACT needs to address this deficiency and assure 100% compliance next month.

Actions: Problems were noted on Indicator # 7 Rehabilitation goal and Indicator # 8 Transition goal. The rehabilitation goal and the transition goal were an oversight by ACT. Our recent review by DHHS community licensing suggested ACT should be using the ISP instead of the CSP. We will make the necessary corrections in the plan format and track the indicators for compliance over the next month. Indicator # 1 only measured 50 % compliance. ACT will assure that all clients have a minimum of one short term goal and one treatment short term goal each having a minimum of two interventions with in 24 hours of admission to the program.

Aspect: Integrated Summary

Indicators	Findings	Compliance	Threshold Percentile
1. Integrated Summary Note is documented in the medical record prior to client leaving RPC.	0/12	0%	80%
2. Summary briefly identifies findings of assessments/ needs (MD/CM/SW).	0/12	0%	90%
3 Summary identifies Needs not be too addressed at this time and why (deferred as denoted by "2" priority status on the integrated needs/problem list.)	0/12	0%	70%
4. Summary describes client preferences utilized in service planning.	0/12	0%	85%
5. Summary identifies additional assessment/ evaluations or services to be sought.	0/12	0%	70%
6. Summary describes level of client participation in planning service.	0/12	0%	95%

Findings: Twelve (12) charts were reviewed during the month of September for compliance with the integrated summary. Indicators #1 - #6 were not addressed on the ACT plan. Staff was learning to use the CSP and the integrated summary was overlooked. All 12 charts neglected to address these issues.

Problems: All six aspects were not addressed. Indicator # 1. Integrated summary, #2. Findings of assessments/ needs, #3 Needs not to be addressed at this time, #4. Client preferences, #5. Additional assessments/ evaluations or services to be sought, #6. level of client participation.

Status: This is ACT's initial report on Chart reviews so there is no data to review or compare the current data to for review or comparison. Indicators # 1 Integrated

Actions: All aspects in the integrated summary were not addressed by Act staff because we were not aware of this required documentation. That being said, our plan is to correct the deficiency immediately. The DHHS Licensing review of October 11th and October 15th suggested ACT return to the ISP format as this is the community service plan and the document identified in our licensing application of 2006- 2007. ACT will change all treatment plans back to the ISP and with assistance from the Risk Manager we will identify other aspects to be tracked on a monthly basis for our report.

ACT

Aspect: Treatment Plan Review

Indicators	Findings	Compliance	Threshold Percentile
1. At a minimum review is completed within 90 days.	12/12	100%	90%
2. Within 72 hours of a significant event (a) substance use, (b) not following court order (c) episode of violence or (d) return to hospital a service	12/12	100%	85%

plan review is completed			
3. The review participants are documented (a) MD ; (b)CM, (c) SW , (d) Client/Guardian	11/12	91.6%	100%
4. A behavioral description of client behavior related to each goal area is documented	12/12	100%	90%
5. Client's self-assessment of effectiveness of current plan is documented	0/12	0%	85%
6. Evidence of positive client progress related to each goal is documented.	12/12	100%	70%

Findings: Indicators # 1 and #2 exceeded the threshold for the month of September while Indicator # 3 was slightly below the desired threshold of 100 % coming in at 91.6%. Indicator # 4 met full compliance with 100% while Indicator #5 was 0%. Indicators # 6, # 7, and #8 all met 100 % compliance.

Problems: Indicator # 3 Review lacked the required signatures on the 12 plans that were reviewed scoring only 91.6% out of 100 %. Indicator # 5 scored 0% when the threshold was 85%.

Status: Act will assure that all participants at treatment planning sessions sign the documents prior to departing from the meeting; Indicator # 3. Indicator #5 will require Act to have clients complete a self-assessment of their current treatment plan.

Actions: Two aspects under the service plan review require immediate attention. #3 will require ACT to assure that all treatment team members and participants document their participation in the meeting by signing the plan. # 5. will require ACT to provide clients with a self-assessment document to measure the effectiveness of their current plan.

ACT

ASPECT – ACTIVE TREATMENT

Indicators	Finding	Compliance	Threshold
1. CSP includes documentation in progress notes, that identify functional needs.	12/12	100%	80%
2. Progress notes document a level of functional skill support provided	12/12	100%	70%
3. Documentation client attended psycho social education interventions	11/12	91.6%	70%
4. A minimum of 3 psycho social interventions are assigned daily	12/12	100%	70%
5. The client is able to state what his assigned psycho social ed interventions or ACT is notified when client not participating	12/12	100%	60%
6.The client correctly Id's assigned case manager	12/12	100%	75%
7. The record documents clients active participation in treatment	12/12	100%	85%
8. The client can identify effective distress tolerance mechanisms for self.	12/12	100%	65%
9. Level and quality of client's use of leisure within the community	5/12	41%	75%
10. Level and quality of social interactions with in the community are documented weekly	11/12	91.6%	75%

Findings: Indicators # 1, #2, #3, #4, #5, #6,#7 and #8 all exceeded compliance with 100% findings. Indicator # 10 **also exceeded the threshold of 75% with 91.**

Problem: Indicator # 9 was only 41% in compliance. ACT will develop a community integration goal with clients and we will document their level of community use of leisure time on a weekly basis.

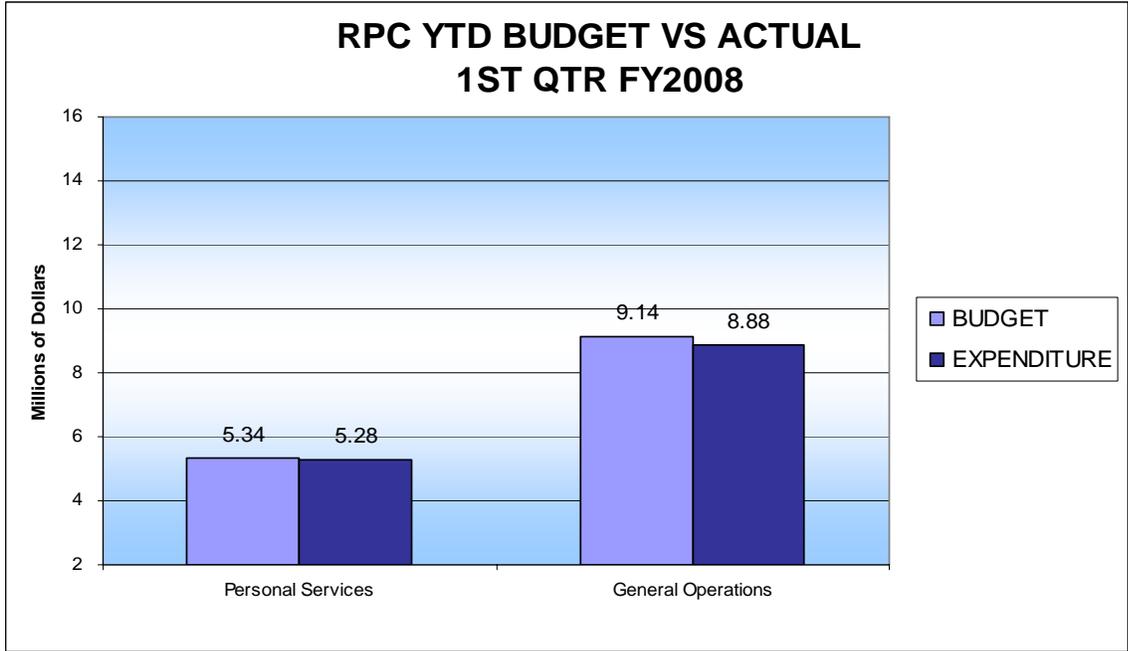
Status: Just one indicator was below the threshold for the month of September. Indicator # 9. This is the initial month of tracking and ACT does not have other months of documentation to compare this aspect with at this time.

Actions: ACT will work with clients to identify a community integration goal for leisure time and it will be noted weekly in the client's progress notes.

Section II: Riverview Unique Information

BUDGET

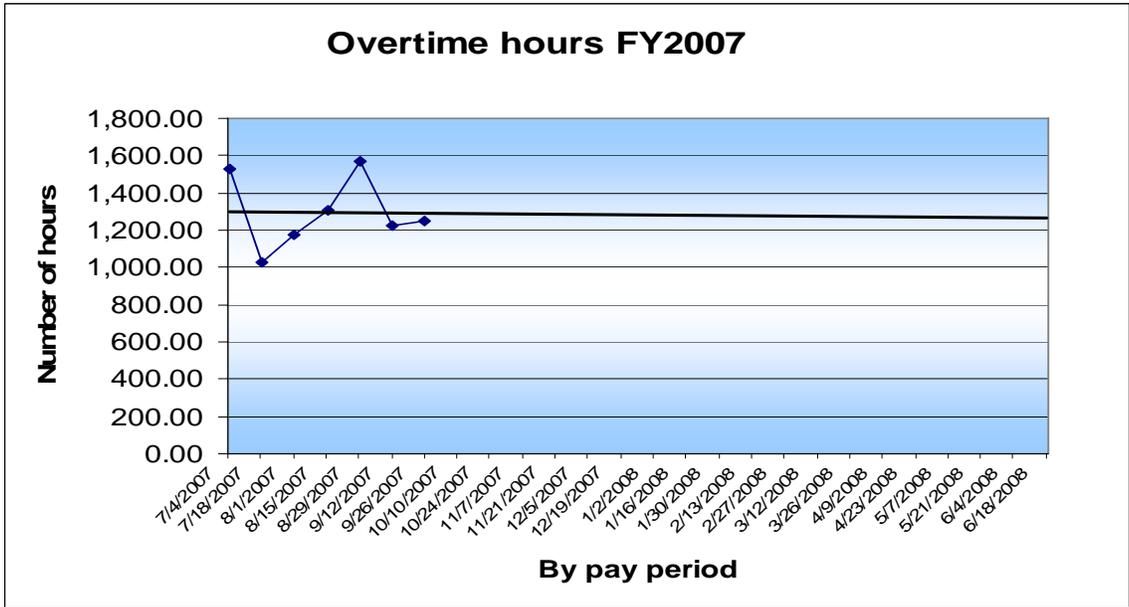
ASPECT: BUDGET INFORMATION



The hospital currently continues to stay within budget. Action plan includes continuing to carefully monitor and manage overtime and mandates. Continue aggressive management of all contractual services via fiscal and programmatic accountability.

HUMAN RESOURCES

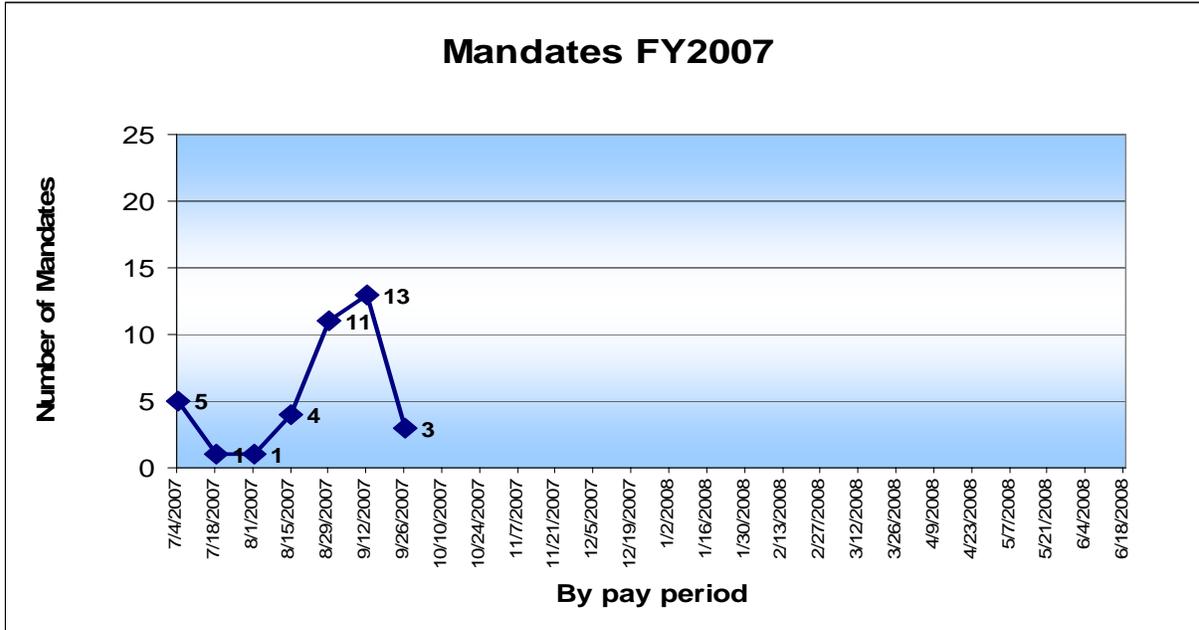
OVERTIME



Overtime has increased this quarter as compared to last quarter, 7,996.75 hrs to 9,076.50 hrs. As compared to the same quarter last year (July 06 - Sept 06) we had 9,874.25 hrs of overtime. This year we have 9,076.50 hrs of overtime; this represents an 8% decrease from last year.

HUMAN RESOURCES

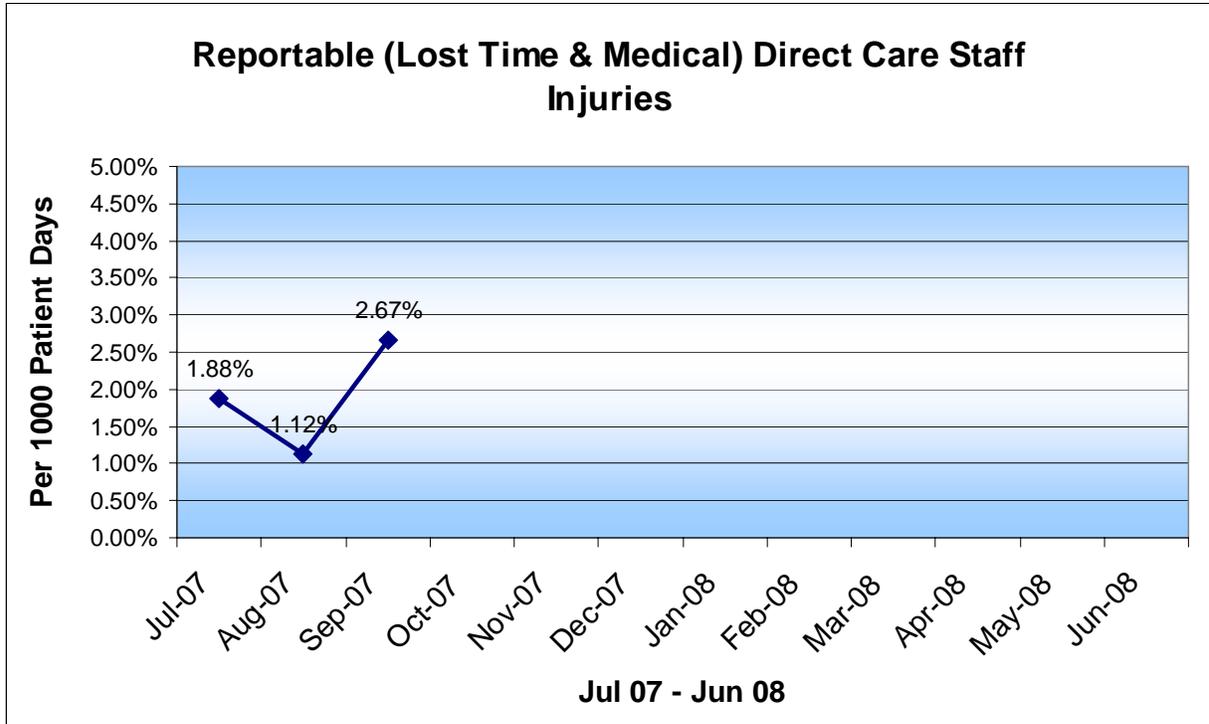
ASPECT: MANDATES



Mandated shifts have increased this past quarter as compared to the previous quarter, 25 to 38. Last year we had a total of 32 mandated shifts during this same rating period (July 06 - Sept 06), this year we had 38. This represents a 16% increase from last year.

HUMAN RESOURCES/RISK MANAGEMENT

ASPECT: Direct Care Staff Injury resulting in lost time & medical care



This quarter review reveals that there was a decrease in direct care staff injuries from 2.37% per 1000 patient days to 1.89% per 1000 patient days. This number represents (15) direct care staff who sought medical treatment or lost time from work, as compared to (20) last quarter.

Management of Human Resources

ASPECT: Timely Performance Evaluations

OVERALL COMPLIANCE: 95.89%

<u>INDICATOR</u>	<u>FINDINGS</u>		<u>TARGET PERCENTILE</u>
Employee Performance Evaluations expected to be completed within 30 days of the due date.			
July 2007 (May evals)	28 of 29	96.55%	85%
Aug 2007 (Jun evals)	41 of 45	91.11%	85%
Sept 2007 (Jul evals)	40 of 40	100%	85%

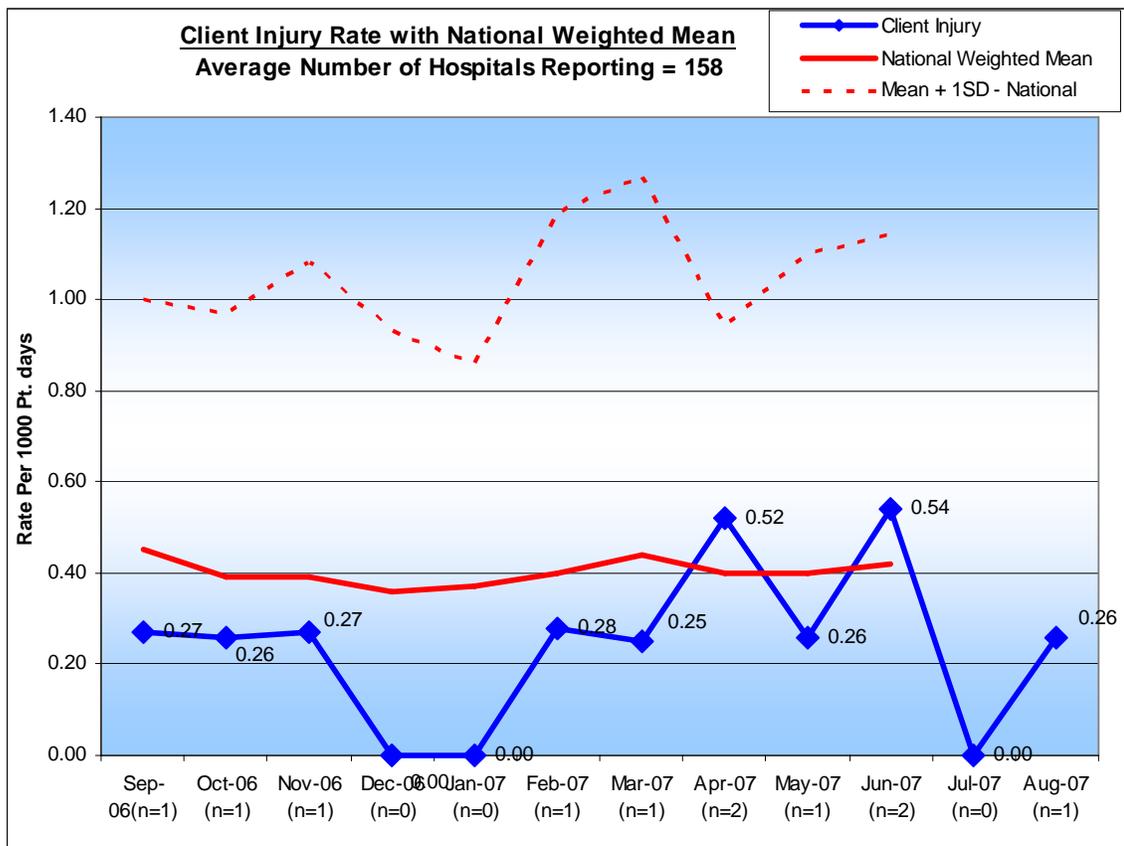
As compared to last quarter (63.73%) this quarter's performance evaluation completion rate increased to 95.89%. As compared to the same quarter last year, 2006, we were at 83.8% compliance. This is a significant improvement. During this quarter 114 performance evaluations were sent out; 109 were received in a timely manner. Human Resources continues to stress the importance of timely completion

of performance evaluations. Human Resources requests all Department Heads to submit their evaluations for processing so timely merit increases for staff can occur.

Section III: Performance Measurement Trends Compared to National Benchmarks.

This section contains a number of graphs that compare Riverview Psychiatric Center to a national sample (the range is approximately 75-215 hospital across all aspects) of participating like facilities. Each line graph presents the national weighted mean (solid red line) and the limit of the first standard deviation (dashed red line) as reference points. Practically speaking, about 68% of participating hospitals' rates would be within the limit denoted by the dashed red line. The solid blue line represents Riverview's rate by comparison. As the majority of these graphs will show, Riverview's rates do vary above and below the weighted national mean, but are typically within the "normal" range (within the 1st Standard Deviation) of other hospitals in the sample.

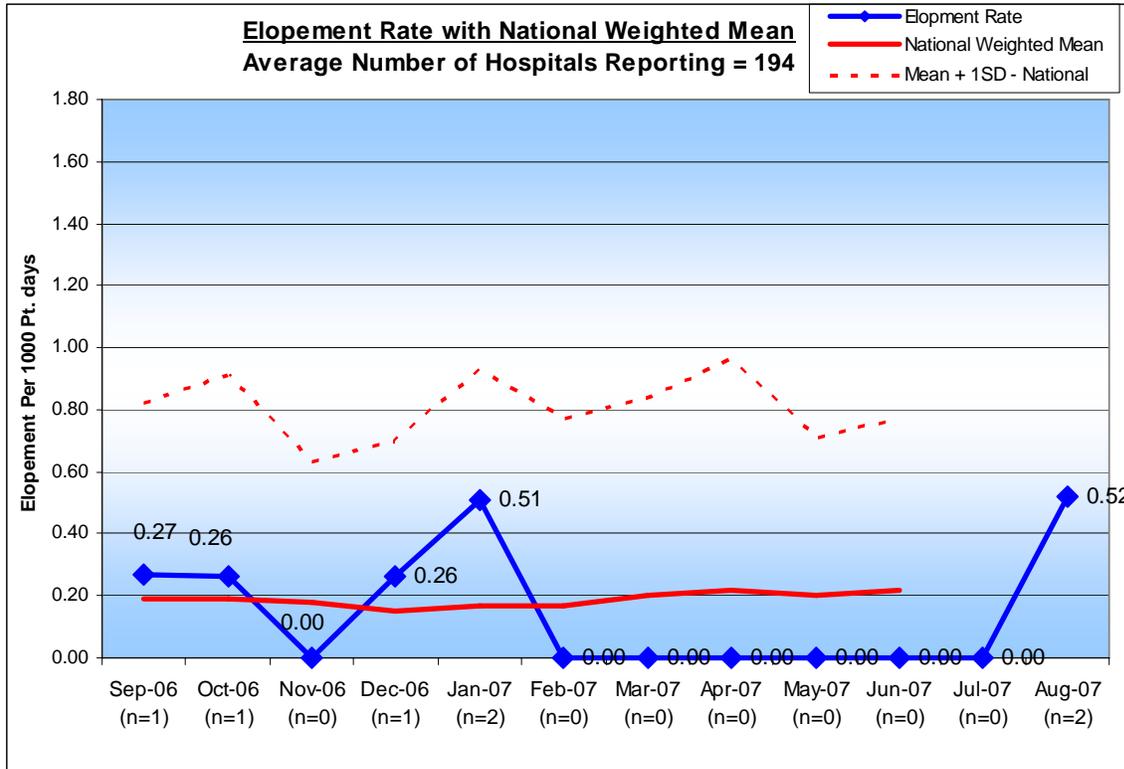
CLIENT INJURY RATE GRAPH



Client Injury Rate considers slips, trips and falls; self-injurious behavior; and client-to-client injury that requires more than first-aid. The numbers of such incidents are low, as shown by the little n under each month. Riverview's line, although appearing to have dramatic fluctuation, is in part the result of the scale used on the Y-axis. Riverview is well within the 1st standard deviation of the national sample. Please note the sheer number of events at Riverview is very low, between zero and 3 each month. Over the last 3 months reported in this graph, there were 3 injuries requiring more than first aid level of

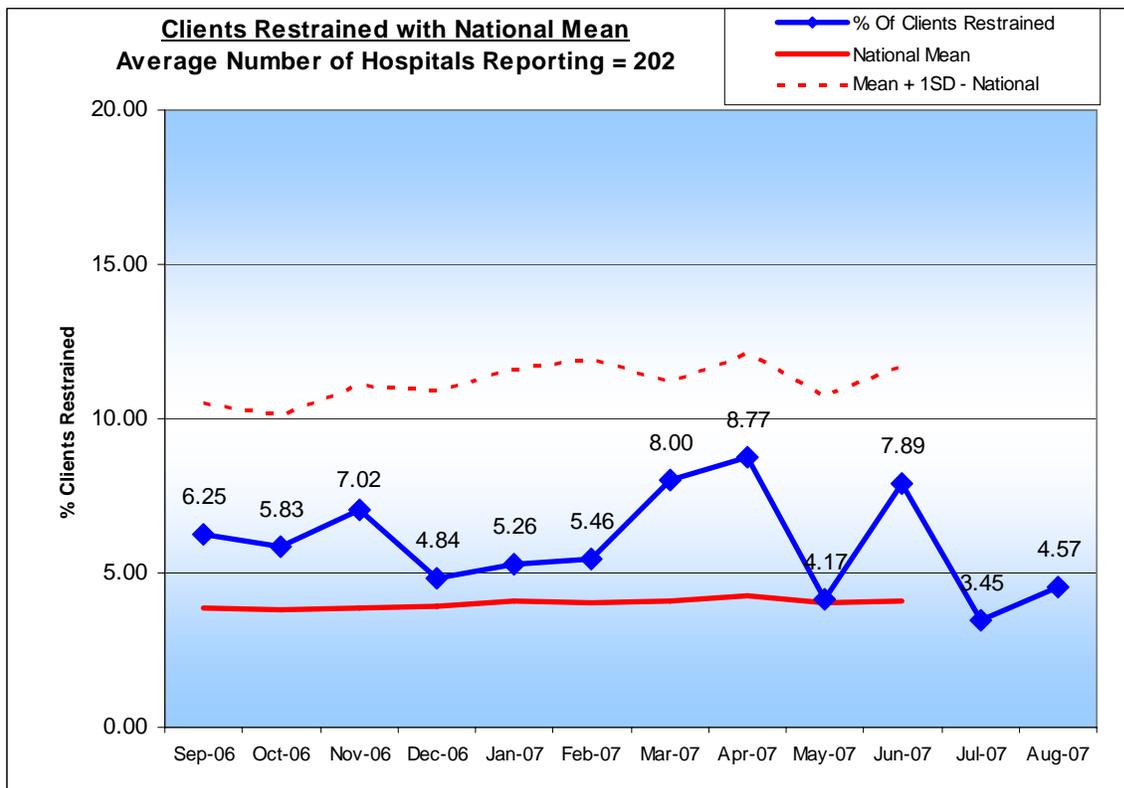
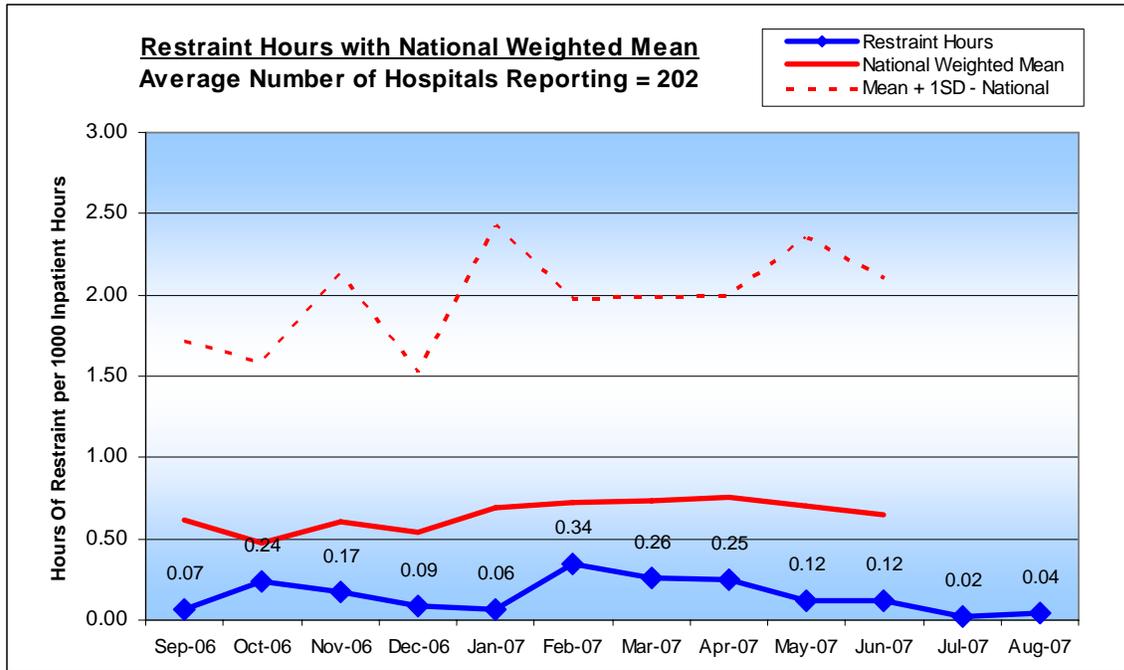
care. Taking the mean of Riverview's rate over the quarter (given client injuries are very infrequent) would put Riverview's rate below the national mean at 0.18.

ELOPEMENT RATE GRAPH



Elopement Rate is calculated per 1000 patient days. Elopement risk is evaluated by the treatment team and is treatment planned if necessary to keep the client and the community safe. There were two incidents of client elopement in the month of August, one client eloped while in the community with a guardian; and the other client eloped while in the community, and failed to return at the expected time.

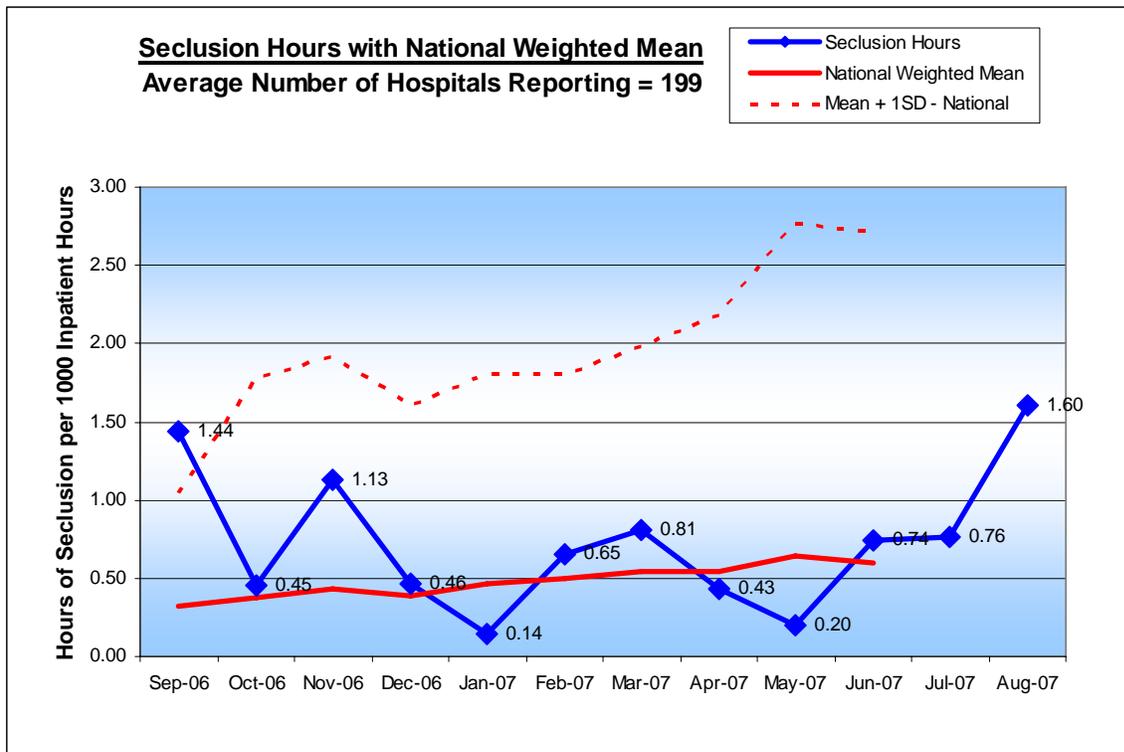
RESTRAINT GRAPHS

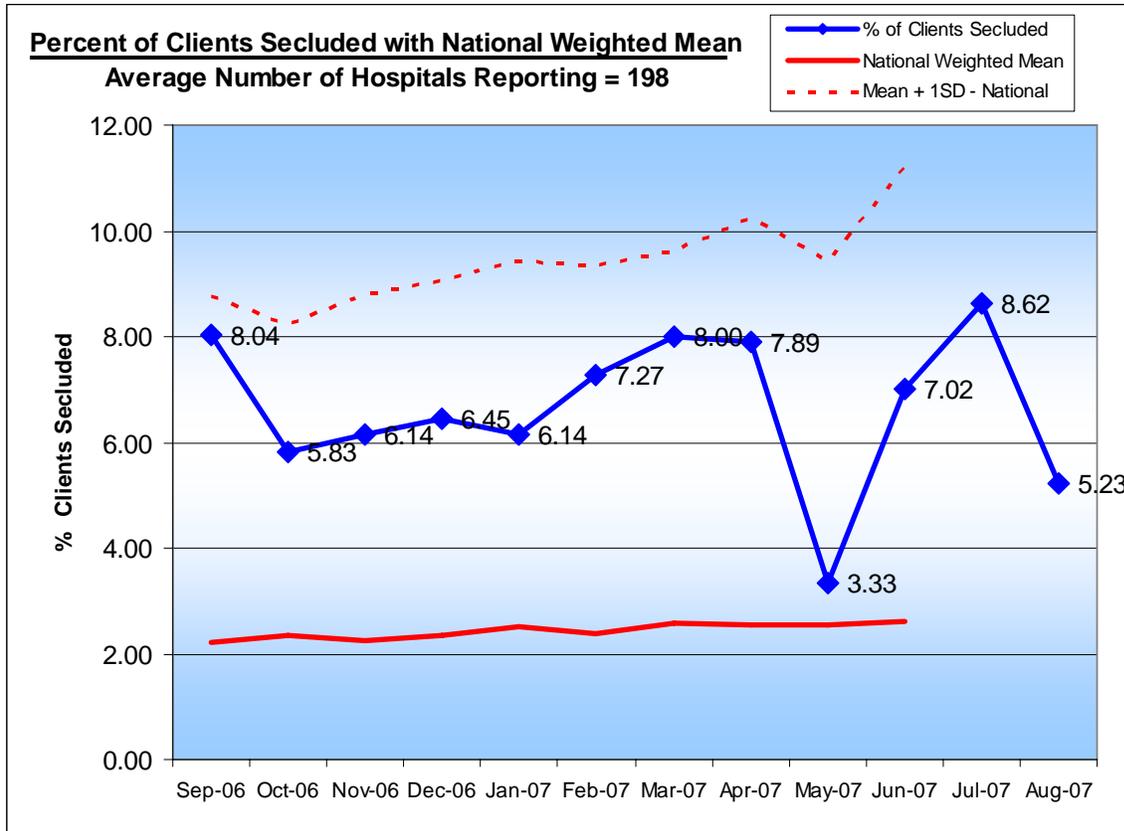


Riverview's rate of clients restrained, although above the statistical mean, is comparable to at least 68% of hospitals in the national sample. The restraint hours (duration) rate is well below the statistical

mean, but also comparable to the bulk of hospitals in the national sample. The data would suggest that Riverview's restraint events are short by comparison, and efforts to reduce the frequency of restraint use would have the most impact. Corrective actions applied are: reducing the time for restraint order renewal from 4 hours to 1 hour; revision of debriefing process; new protocol and form to guide treatment plan revisions within 72 hours following the event is in place; education initiatives; increased clinical, supervisory and administrative oversight; expanding opportunities for client choice is a priority to be monitored and tracked in monthly administrative reports; the hospital has put forward a proposed tobacco-free campus policy, that is being phased in and will be fully implemented by 4/2/07, as national data show that tobacco-related issues are often precipitants to restraint/seclusion events in a national sample (smoking/tobacco as significant precursor to restraint/seclusion events was **5%** in non-smoking facilities vs. **34%** in smoking facilities--7 times more).

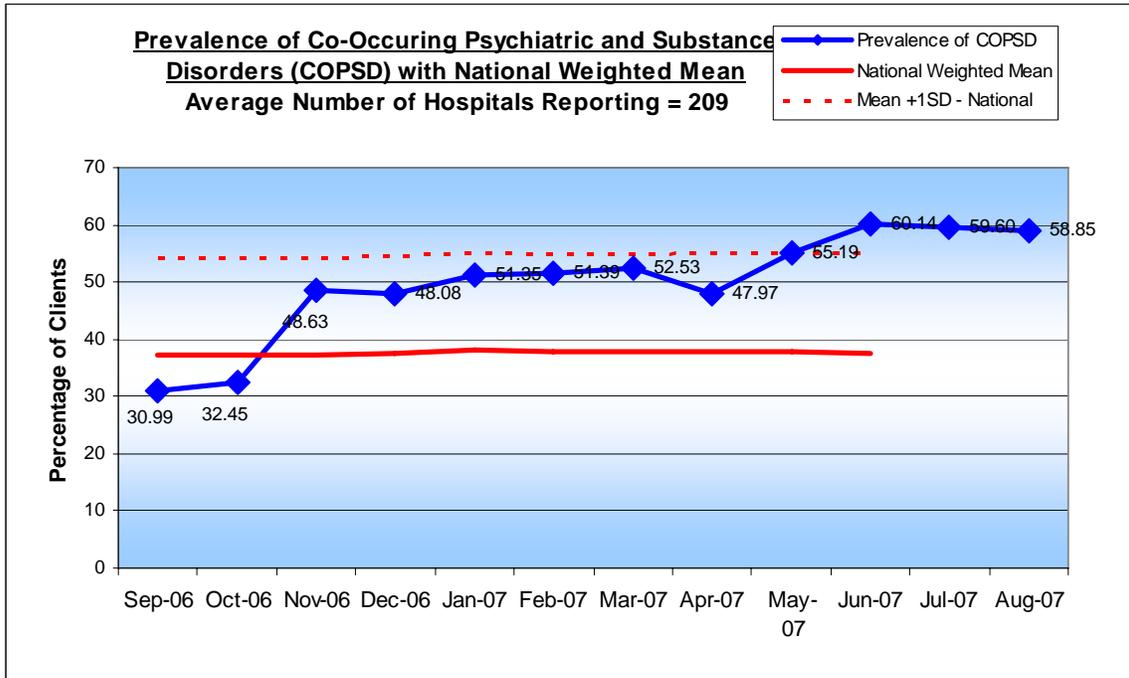
SECLUSION GRAPHS





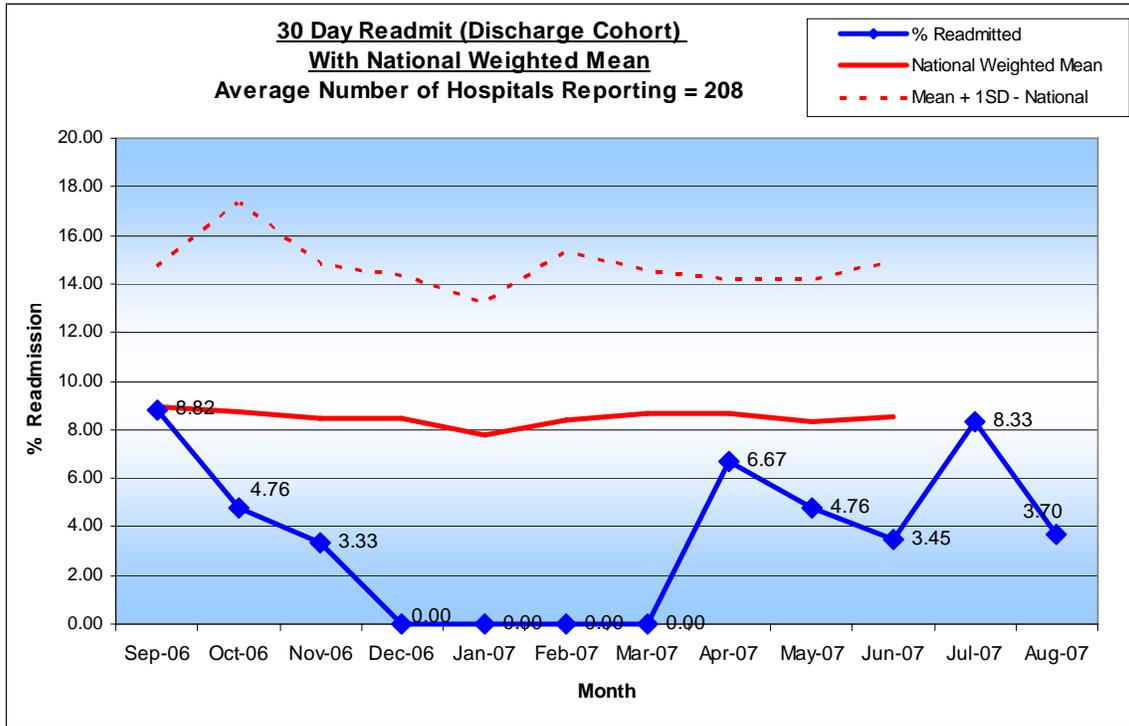
Riverview used seclusion more frequently than 68% of hospitals in the national sample in the months of March and July, but the rate is generally comparable to the national sample in other months. Seclusion hours (duration of events) at Riverview, although tending to be above the national weighted mean, are within the 1st Standard Deviation of other hospitals in the national sample. Riverview's efforts to reduce use of these interventions should focus on both the frequency and duration of seclusion events. Corrective actions applied are: reducing the time for seclusion order renewal from 2 hours to one hour; revision of debriefing process; new protocol and form to guide treatment plan revisions within 72 hours following the event is in place; expanding opportunities for client choice is a priority to be monitored and tracked in monthly administrative reports; education initiatives; increased clinical, supervisory and administrative oversight; the hospital became tobacco-free campus 4/2/07. National data show that tobacco-related issues are often precipitants to restraint/seclusion events in a national sample (smoking/tobacco as significant precursor to restraint/seclusion events was **5%** in non-smoking facilities vs. **34%** in smoking facilities--7 times more)

CO-OCCURRING PSYCHIATRIC AND SUBSTANCE ABUSE DISORDERS GRAPH



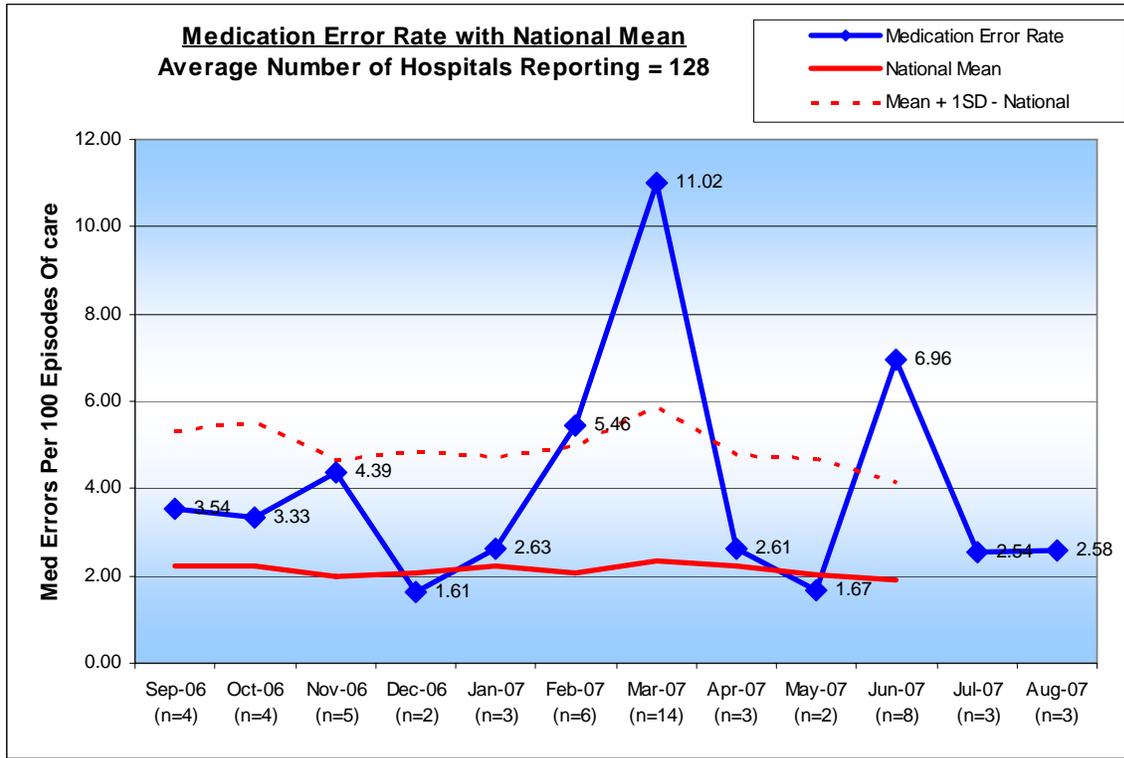
RPC has collaborative effort with Spring Harbor Hospital Co-Occurring Disorders providers to contract with RPC to develop a Co-Occurring program. Though RPC is currently a bit above the trend line, this is an indicator current initiatives are working as anticipated; with the advent of this program to help identify and treat clients with co-occurring disorders it should rise above the trend line. This information is gathered from admission diagnosis.

THIRTY DAY READMIT GRAPH



30 Day Readmission Rate is at or below the mean of the 209 other facilities reporting on this indicator. Thirty day readmission rate is calculated considering the percent of discharges for the facility that returned within 30 days of a discharge of the same client from the same facility. All RPC readmissions that occur in less than 30 days of discharge are reviewed by the Director of Social Work Services.

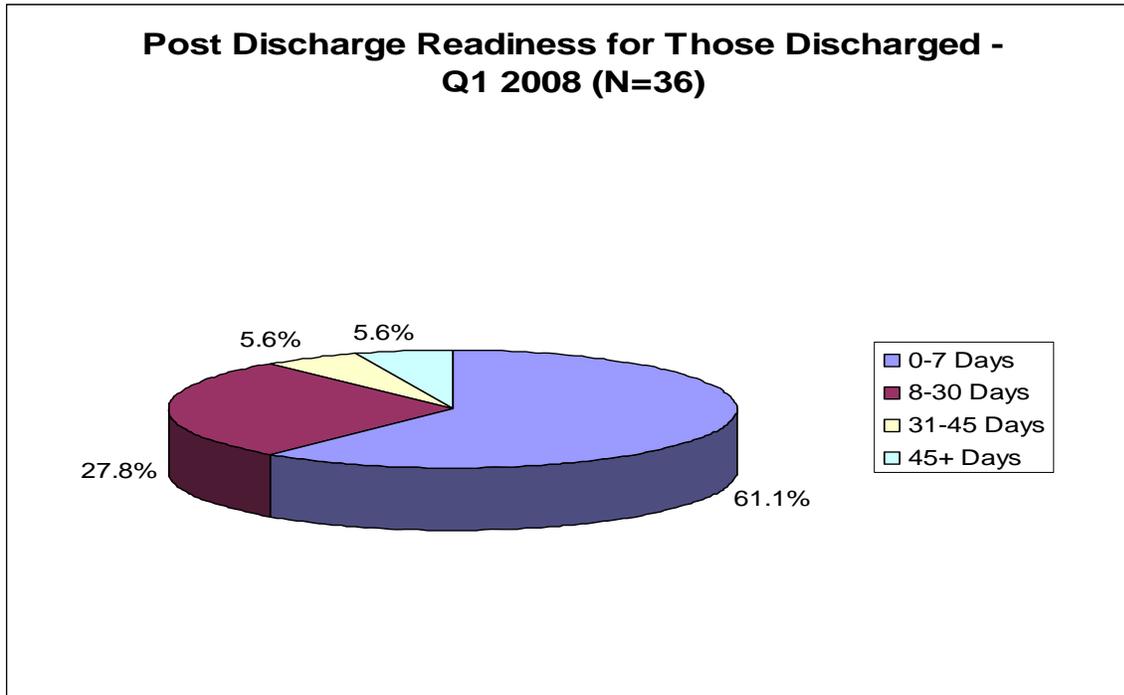
MEDICATION ERROR RATE WITH NATIONAL MEAN GRAPH



The medication error rate considers the number of medication errors for every 100 episodes of care. For example a medication error rater of 1.6 means that 2 medication errors occurred each 125 episodes of care.

The medication errors report was up in February as the hospital did a pilot of daily MAR (medication administration records) which causes a more frequent assessment of the medication process on a daily basis.

POST DISCHARGE PRIOR READINESS



READINESS PRIOR TO DISCHARGE

This chart shows the percent of clients who were discharged within 7 days of their discharge readiness to be at 61.1%; 8- 30 days post readiness 27.8.; 31-45days at 5.6% and Greater than 45 days post discharge ready 5.6% of clients discharged this quarter. Cumulative percentages and targets are as follows:

- Within 7 days = 61.1% (target 75%)
- Within 30 days = 88.9% (target 90%)
- Within 45 days = 94.1% (target 100%)

There was a decline in the discharges within 7 days from 78.8 % to 61.1 % this quarter. The previous 3 quarters are displayed in the table portrayed below:

Quarter	Within 7 days	Within 30days	Within 45 days	45 +days
Target	75%	90%	100%	0%
Q42007	78.8	94%	94	6.1%
Q32007	74.1%	88.9% (14.8%)	96.3% (5.6%)	3.7%
Q2 2007	64.1%	82% (17.9%)	85.6% (2.6%)	15.4%