

# Riverview

PSYCHIATRIC CENTER



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PERFORMANCE IMPROVEMENT REPORT

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THIRD QUARTER  
SFY 08  
JANUARY, FEBUARY AND MARCH 2008

DAVID PROFFITT, SUPERINTENDENT

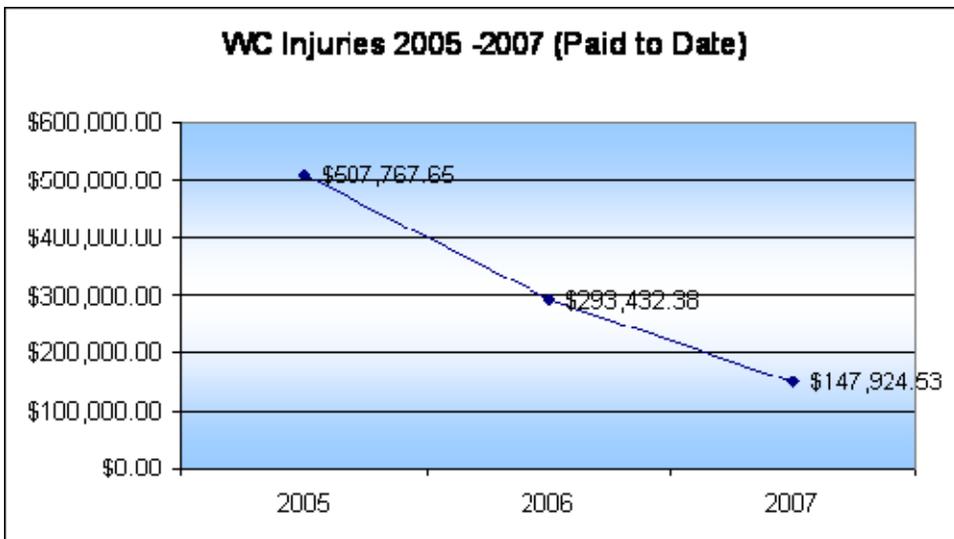
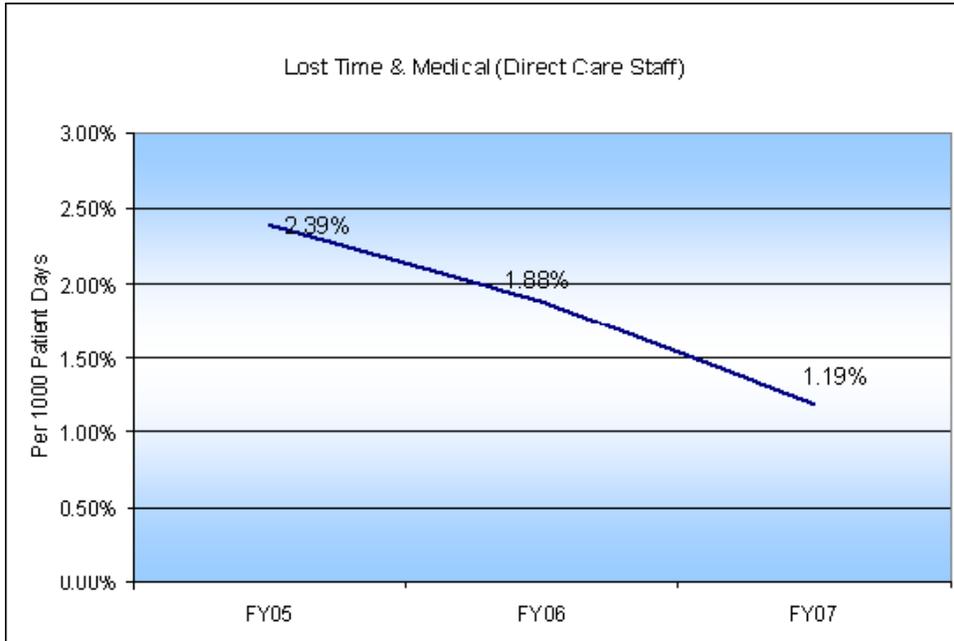
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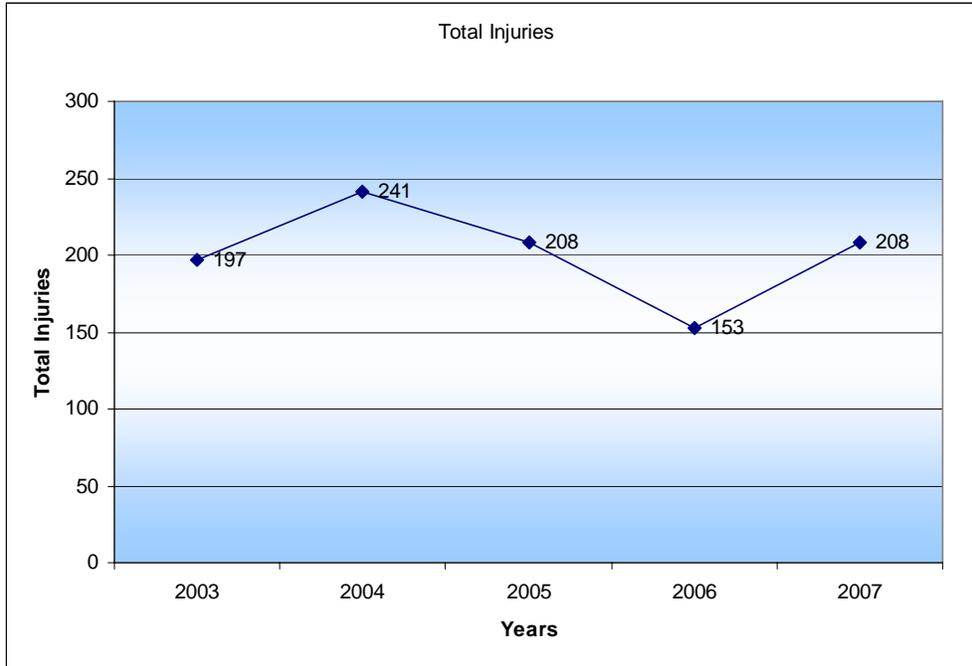
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**Introduction:**

In this quarter the significant issue reviewed was staff injuries related to the severity of injuries, work time loss, and cost of injuries. The data indicates both severity and cost of injuries has decreased over the last two years, but the number of reported injuries is staying fairly constant.





Overtime and Mandates continue to be a concern for this hospital. As presented later in this report, overtime hours have increased 25% over the past year resulting in a corresponding increase in expenditures in costs for personal services of \$5,000 a week. The overtime issue is proportionately most acute for Nurses as the hospital is finding the recruitment and retention of nurses a continued challenge. As a result of staff shortages (particularly in the Nursing department) the subsequent use of Mandates is also significantly increasing (77% over last year's levels). The reliance of overtime to staff units, and the subsequent use of mandates to make up for staff shortages, exacerbates the nursing recruitment and retention problem. From a budgetary point of view, this increased use of overtime is simply not a cost effective use of resources nor is it a sustainable fiscal policy.

Discharges soon after clinically ready are somewhat disappointing this quarter as displayed on the last two pages of this report. This is the first quarter of utilizing the APS managed care system so perhaps this is just a one time anomaly. It does warrant keeping a close eye to assure clients are able to be in the least restrictive environment timely.

On a positive note is the continued decrease in hours of restraint and seclusion.

## Section I: Departmental Quality Assessment & Performance Improvement

### Infection Control

**Aspect: Hospital acquired infection**

**Overall Compliance: 3rd quarter SFY08 rate 0.64**

Indicators	Number	Rate	Threshold Rate
Hospital Acquired (healthcare associated) Infection rate, infections per 1000 patient-days.	8	0.64	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:** None noted.

**Status:** This quarter's numbers are 8 infections for a rate of 0.64. This is well within the threshold percentile. Infection rate for this period is well below the accepted 2 standard deviation for threshold of action.

**Actions:** Hand hygiene continues to be stressed to staff and clients. Posters displayed to remind staff and clients to cover coughs and sneezes to stop the spread of infections. All reported infections are reviewed by Risk Management to assure a treatment plan addressing the infection is current and progress documented in the clients record.

**Information Management**

Aspect: Confidentiality

Overall compliance: 100%

INDICATORS	COMPLIANCE	THRESHOLD PERCENTILE
1. All client information released from the Health Information department will meet all Joint Commission, State, Federal & HIPAA standards.	100 %	100%
2. All new employees/contract staff will attend confidentiality/HIPAA training.	100 % -13 new employees/contract staff in 3 <sup>rd</sup> quarter, who attended training.	100%
3. The Director of Health Information will track the number of confidentiality/privacy issues through incident reports.	There were 0 confidentiality/Privacy-related 3 <sup>rd</sup> quarter.	Incident reports will be monitored for privacy issues. The incident rate will remain at 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. **2126 out of 2126** (100%) requests for information (1896 police checks and 230 requests for client information) were released from the Health Information department during this quarter. 13 out of 13 (100%) new employees/contract staff attended Confidentiality/HIPAA training. All indicators remained at 100 % compliance for quarter 3-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 3. Continue to monitor.

**Actions:** The above indicators will continue to be monitored.

**Information Management**

Aspect: Documentation & Timeliness

Overall compliance: 93%

INDICATORS	COMPLIANCE	THRESHOLD PERCENTILE
1. Records will be completed within Joint Commission standards, state requirements	100 % -There were 63 discharges in Q3 Of those, 63 were completed by 30 days.	All records will be completed within 30 days of discharge. The completion rate will

and Medical Staff bylaws timeframes.		remain at or above 80%.
2. Discharge summaries will be completed within 15 days of discharge.	100 % -63 out of 63 were completed within 15 days in the 3 <sup>rd</sup> quarter.	The completion rate will remain at 100%.
3. Forms used in the medical record will be reviewed by the Medical Record Committee.	100%- 1 was revised in the 3 <sup>rd</sup> quarter in Feb. (see minutes)	100%
4. Medical transcription will be timely & accurate.	85 %-Out of 171 dictated reports, 146 were completed within 24 hours in January.  91 %-Out of 152 reports, 138 were received within 24 hours in February.  38 %-Out of 206 reports, 78 were received within 24 hours in March.	90%

**Findings:** The indicators are based on the review of all discharged records. There was 100% compliance rate with record completion within 30 days. There was 100% compliance rate with discharge summaries. 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. There was 71% compliance rate with timely medical transcription services.

**Problem:** Timely medical transcription dropped (71%) below the threshold. This does not allow for documentation to be in the clients' records in a timely fashion or to the discharged facilities in a timely fashion.

**Status:** 71% timely medical transcription reports.

**Actions:** An e-mail was sent to the transcription company (MD-IT) with these results and requested that they send us all reports within 24 hours, as per our contract. Will continue to monitor daily and bring to the attention of the deputy superintendent if no improvement by 4/30/08.

## MEDICAL STAFF

**Aspect:** Review of Suicide Risk Assessment on clients 3rd Quarter FY08

**Overall compliance:** 76.6%

January, February, March 2008								
Indicator	Findings/Score			Compliance			Avg	Target
	Jan	Feb	Mar	Jan	Feb	Mar		
1. Presence or absence of current suicidal ideation/intent is documented.	15 of 20 passed	19 of 20 passed	20 of 20 passed	75%	95%	100%	90%	90%
2. Presence or absence of current suicidal plan is documented.	15 of 20 passed	18 of 20 passed	19 of 20 passed	75%	90%	95%	87%	90%

3. Presence or absence of current suicidal command hallucinations is documented.	13 of 20 passed	17 of 20 passed	17 of 20 passed	65%	85%	85%	78%	90%
4. Presence or absence of current feelings of hopelessness/ helplessness is documented	10 of 20 passed	12 of 20 passed	16 of 20 passed	50%	60%	80%	63%	90%
5. Presence or absence of prior suicide attempts is documented.	11 of 20 passed	12 of 20 passed	16 of 20 passed	55%	60%	80%	65%	90%

**Findings:** The medical staff reviewed the adequacy of suicide risk assessment documentation in admission notes and discharge summaries over the quarter. The overall adequacy of the documentation improved over the course of the quarter. By March we were over threshold on two indicators and very near threshold in the other three.

**Problems:** The only problem noted was that in general the admission notes were deemed to be more fully documented than the discharge summaries.

**Status:** We elected to terminate monitoring admission notes for future quarters and will concentrate on evaluating the discharge summaries. In addition we had added the "Tool for the Assessment of Suicide Risk-TASR" as a routine part of the hospital admission, and this tool will have the required information on suicide risk for admission notes. A retrospective review (not reported here) showed that a completed "TASR" was present in 100% of admissions.

**Actions:** Medical staff were given feedback on their individual and group performance. We added the "TASR" midway through the quarter. Performance on admission notes improved dramatically during the quarter because of use of the "TASR". We will continue to monitor only discharge summaries into the new quarter. If this performance fails to reach threshold consistently we will look at requiring a reuse of the "TASR" as part of the discharge summary.

### Medical Staff Satisfaction Survey.

	1	2	3	4	5
Please rate the quality of the following hospital services:	Very poor	Poor	Fair	Good	Very good
Average Scores					
1. Pharmacy					5
2. Laboratory				4.6	
3. Nursing Department				4.8	
4. Psychology Department				4.7	
5. Social Work Department				4.2	
6. Dietary Department				4.2	
7. Housekeeping Department				4.8	
8. MIS / Technical Support				4.8	
9. Medical Records				4.8	
10. Please rate the overall quality of care provided in the hospital.				4.7	

1 2 3 4 5

Please rate your degree of agreement or disagreement with the following statements:	Very much disagree	Disagree	No Opinion	Agree	Very much agree
1. I have adequate equipment and human resources to make my practice efficient.				4.6	
2. The hospital is organized to ease medical practice and efficiency.			3.5		
3. The Medical Director provides effective leadership to the medical staff				4.7	
4. I am confident in Hospital Administration to carry out its duties and responsibilities.				4.2	
5. Hospital Administration is responsive to the ideas and needs of the Medical Staff.				4	
6. I feel like there is good communication between me and the Medical Director and the Superintendent.				4.2	
7. I have enough time to meet with my clients and to fully understand their problems.				4.3	
8. Riverview is a hospital I would recommend to my colleagues or friends for employment.				4.5	

### 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	54 of 54	100%	100%
2. Staffing numbers within appropriate acuity level for unit	54 of 54	100%	100%
3. Debriefing completed	54 of 54	100%	100%
4. Dr. Orders	54 of 54	100%	100%

**Findings:** 100% Compliance

**Problem:** None identified.

**Status:** The indicator continues to be at 100% but is important to continue monitoring.

**Actions:** None at this time. The staffing effectiveness indication to be added to monitor staff levels when there is an injury has been postponed. Overall staff injuries are monitored by Human Resources for direct care and by Environment of Care for staff injuries due to the environment. Injuries are decreasing and the staffing office indicates staffing numbers are within the appropriate acuity level for the units. The DON will work with the Nurse IVs as a part of the Injury Review Process (4/2/08) to develop an additional indicator.

**Nursing**

**Aspect: Redlining**

**Compliance: Redlining 99%**

Indicators-Redlining	Findings	Compliance	Threshold Percentile
Lower Kennebec	273 of 273	100%	100%
Upper Kennebec	273 of 273	100%	100%
Lower Saco	262 of 273	96%	100%
Upper Saco	267 of 273	98%	100%

**Findings:** Redlining is a safety check of each client's medical record, performed by nurses at the beginning of each shift to assure all medical orders have been noted, faxed and carried out in the previous 8 hours. The actual redlining occurs on the 11-7 shift when the MAR is also assessed for accurate transcription of any medication changes that have occurred in the previous 24 hours as well.

**Problem:** Redlining is not always completed; Redlining hospital wide is at 99% - an increase from last quarter.

**Status:** Lower Kennebec 100%; Upper Kennebec 100%; Lower Saco 96%; Upper Saco 98%. All units demonstrated an increase in compliance except on Upper Saco which remained the same.

**Actions:** The two ADONs will monitor the Redlining checks daily to assure compliance.

The redlining protocol will be reviewed on each unit at the Professional Staff meeting by the end of May. The night NOD will continue to check with the charge nurse on each unit and report on the progress of the redlining procedure on each unit on the daily nursing report.

**Nursing**

**Aspect: Code cart checks**

**Compliance: Code cart checks 99.75 %**

Indicators-Code Cart Sign Off	Findings	Compliance	Threshold Percentile
1) Lower Kennebec	269 of 273	99%	100%
2) Upper Kennebec	273 of 273	100%	100%
3) Lower Saco	273 of 273	100%	100%
4) Upper Saco	273 of 273	100%	100%
5) NOD Building Control	273 of 273	100%	100%
6) NOD Staff Room I 580	273 of 273	100%	100%

**Findings:** 100% Compliance

**Problem:** None identified.

**Status:** All code cart checks have been completed 100% of the time on all units. This is the first quarter that all have been at 100%.

**Actions:** Continue to monitor the code carts on the shift report as an extra reminder for nursing to complete this task. The on coming Nursing Supervisor and NOD's have been checking Room I-580 to make it a part of their shift report, this too needs to continue. Code carts are used in emergency situations and must be complete and ready to use. Code cart checking will continue to be reviewed with the nurse who is responsible for narcotic count and key change during each shift change. Nurses will be thanked for their diligence in completing this important task.

**Nursing**

**Aspect: Pain Management**

**Overall compliance:**

**PRE: 100% POST: 90% OVERALL: 95%**

Aspect		Findings	Compliance	Threshold Percentile
Preadministration	Assessed using pain scale	566 of 566	100%	100%
Post-administration	Assessed using pain scale	510 of 566	90%	97%

**Findings:** The indicator for assessing pain using pain scale pre medication administration is at 100% an increase from last quarter. The indicator for assessing pain post administration is at 90% which is the same from last quarter.

**Problems:** Nurses have not been consistently documenting their assessment post administration of pain meds . Pre and post assessments are done by the Registered Nurse and the changes with nursing have made an improvement but more consistency is needed.

**Status:** The preadministration has improved. The post administration remains the same. With the initiation of Primary Nursing the Upper units, 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:** The ADON's will meet with LPN's to review multiple location of post-administration of pain medication documentations with an eye to increasing the likelihood of documentation in one place and decreasing places for the nurse to forget to document on the post administration by 5/30/08.

**NURSING 3rd Quarter SFY 2008**

**Aspect: Chart Review**

**Overall compliance: 62%**

Indicators	Findings	Compliance	Threshold Percentile
1. GAP note written in appropriate manner at least every 24 hours	37 of 46	80%	100%
2. MHW notes cosigned by RN	15 of 28	53%	85%
3. STGs/Interventions are written, dated and numbered.	32 of 48	67%	100%
4. STGs are measurable and observable	41 of 48	85%	100%
5. STGs/Interventions are modified / met as appropriate.	28 of 36	77%	100%

6. STGs/Interventions tie directly to documentation.	32 of 40	66%	90%
7. Weekly Summary note completed encompassing everything from that week.	2 of 49	4%	85%

**Findings:** The indicators for the chart review of nursing documentation were decreased from 18 to 7. The seven indicators for this quarter represents areas needing improvement from the last quarter report. The overall compliance rate is lower than the past quarter, however, individual indicators show increased compliance. Compliance rates from this quarter compared to the second quarter are as follows:

**Problems:** Indicator #1, GAP notes every 24 hours is 80%, up from 64%.

Indicator #2, MHW notes signed is 53%. There was no comparison to last quarter. It is interesting to note that a limited number of notes by MHWs were present. Over 50% of those present were signed by the RN.

Indicator #3, STGs written, dated and numbered. While this did not meet the 85% threshold there is an increase from 38% last quarter to 67% this quarter.

Indicator #4, STGs measurable increased from 38% to 85% this quarter and met the required threshold.

Indicator #5, Interventions modified. There was no comparison to last quarter and the compliance rate is 77%.

Indicator #6, Interventions tie to documentation. The compliance rate is 66%. The notes were largely incidental or observational and did not relate to the specific goal or intervention.

Indicator #7, Weekly Summaries. This is by far the area needing the most improvement. The compliance rate was only 4%.

**Status:** Charts were reviewed on four units. Overall compliance indicated on 1 out of 7 indicators met the thresholds. Specific unit compliance is as follows:

Unit #1 – 5 Of 7 indicators were above the threshold; 2 were significantly below (MHW cosigned and weekly summaries).

Unit #2 – 3 of 7 met or were above the threshold. The remaining 4 indicators were below (1 only 1% point and 3 significantly below).

Unit #3 – 2 of 7 indicators were above the threshold. 5 were below the threshold (3 of which were significantly below).

Unit #4 – Only 1 of 7 indicators were above the threshold (6 were below).

**Actions:**

- The nurses who audit the charts will continue to educate individual unit nurses.
- The RN IVs will ascertain if Unit Nurses are aware of documentation requirements and review with each using the CSP manual and nursing documentation policy by May 15th.
- The unit RNs will audit 1 chart per week and discuss the audit during supervision each month beginning June 1, 2008.
- The two ADONs and nurse educator will continue to be assigned to nursing units. They will continue to address areas needing improvement.

**PSD**

**Aspect: Comprehensive Treatment Plan**

Aspect – **Treatment Plan**

Observed Compliance

1. Evidence of <b>initial treatment plan</b> (minimum of one Safety STG & one Treatment STG each having minimum of two interventions) is in place within 24 hours of admission.	100%
2. The Presenting Problem of the CSP identifies <b>specific client symptoms, stated in behavioral terms</b> , causing admission (identifies any functional behavioral collapse)	100%
3 The CSP incorporates for treatment, all <b>“active” client needs/problems</b>	100%

obtained through the assessment process. ("active" as designated by the priority status "1" on the Integrated Needs / Problem List)	
4. Client strengths and preferences which <b>can be utilized</b> to achieve / enhance treatment outcomes are identified. (should be evident within the interventions)	97%
5. A <b>Suicide Assessment</b> is done upon admission by the physician / designee	87%
6. A <b>Suicide Assessment of "moderate or high risk"</b> is incorporated into the Safety Plan within 8 hours of admission.	100%
7. The CSP has a " <b>Safety Goal</b> ", based on identified individual risks, stated in observable and behavioral terms.	90%
8. The CSP has at a minimum one " <b>Treatment Goal</b> " based on individual assessed needs to reduce or eliminate symptom or illness stated in observable and measurable terms.	97%
9. The CSP has at a minimum one " <b>Rehabilitation Goal</b> " based on assessed needs to improve self selected value roles, stated in observable and measurable terms.	97%
10. The CSP has at a minimum one " <b>Transition Goal</b> " based on assessed needs and reflecting client preferences stated in observable and measurable terms.	85%
11. Each CSP goal has a minimum of <b>two stepped STGs</b> , which should reasonably lead to goal attainment, stated in clear client based behavioral terms, which are observable and measurable.	93%
12. Interventions are designated for each STG, that reasonably lead to attainment of the STG.	97%
13. Each Intervention states <b>what the intervention is, how often it occurs, what the purpose is and who provides it.</b>	97%
14. An individual is identified ( <i>responsible</i> ) by name to monitor/ document the effectiveness of each intervention (progress toward or away from STG).	97%
15. The CSP is <b>properly authenticated</b> by signature AND date, of treatment team members, no later then 7 days from the date of admission. Identify participants below:	90%
(a) MD**	100%
(b) RN**	100%
(c) SW**	100%
(d) Client / Guardian**	85%
(e) Psychology	
16. CSP has any assessed <b>functional skill deficits</b> including <b>present Level of Support</b> and <b>Level of Support to be attained</b>	73%

**Findings:**

30 charts were reviewed for March. None of the clients utilized a restraint or seclusion.

**Improvement Opportunities:**

- 1) Director of Social Services will be informed of 85% compliance to standard of having appropriate transition goals in plan. The TTC to monitor Transition plans for completeness by day #7 and send a memo to PSD for any not completed by this time.
- 2) Functioning skill deficits.
  - a. Nursing department shall train RN's on assessing level of functional skill deficit and prescribing supports to be placed on cardex.
  - b. Milieu Managers shall define a written procedure for capturing functional skill support level.

- 3) Discuss the above findings with staff responsible for documentation.
- 4) Reviewed the results of this report at Professional staff meetings during March.

**Aspect - Integrated Summary**

1. <b>Integrated Summary Note</b> is documented in the medical record the day of CSP meeting.	100%
2. Summary briefly identifies <b>findings of assessments / needs</b> (MD/RN/Rehab/SW/Psychology).	100%
3. Summary identifies <b>NEEDS not to be addressed at this time</b> and why (deferred as denoted by "2" priority status on the Integrated Needs / Problem List.)	100%
4. Summary describes <b>client preferences</b> utilized in service planning.	97%
5. Summary identifies <b>predicted community placement</b> .	95%
6. Summary identifies <b>additional assessment/ evaluations or services</b> to be sought.	100%
7. Summary describes <b>level of client participation</b> in planning service.	100%

Findings: 30 Charts reviewed.

**Improvement Opportunities:**

Documentation reviews reveal a stable practice at this time.

**Aspect – Service Plan Reviews**

1. At a minimum <b>review is completed within 14 days</b> of last review for first 6 months or within the last 30 days for hospitalizations of over 6 months.	100%
2. <b>Within 72 hours</b> of the use of (a) seclusion, (b) restraint, (c) episode of violence, or (d) transfer a service plan review is completed.	N/A
3. The <b>review participants</b> are documented	
(a) MD**	100%
(b) RN**	100%
(c) SW**	100%
(d) Client/ Guardian**	90%
(e) Rehab	90%
(f) Psychology	30%
** <b>MANDATORY</b>	
4. A <b>behavioral description of client behavior related to each goal</b> 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)	83%
5. <b>Client's self-assessment of effectiveness</b> of current plan is documented.	97%
6. Evidence of <b>positive client progress</b> related to each goal is documented.	97%

7. The <b>CSP is modified</b> 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.	70%
8. <b>Client level of participation</b> in the service plan review is documented	100%
9. <b>Client's current BMI</b> in the service plan review has improved or maintained at optimal.	83%

**Findings:**

30 records reviewed.

Clients not signing the service plans are related to clients leaving the meeting prior to completion of the meeting or expressing a desire to continue to review document prior to signing.

**Improvement Opportunities:**

1. Begin to incorporate client BMI into the review process.

Aspect - **Active Treatment**

1. CSP has, and documentation in progress notes and or flow sheets demonstrate <b>identified functional need/s</b> (Space maintenance / hygiene / clothes care / time management / self expression) [nursing assessment and care plan] <b>including present Level of Support and what Level of support is the goal.</b>	85%
2. Progress notes / flow sheets document <b>a level of functional skill support provided, consistent with the identified</b> area of need, delivered within last 24 hours.	70% <i>10% UK</i>
3. Documentation demonstrates that the client <b>attended all assigned psycho-social-educational interventions within last 24 hours.</b>	<i>15%</i>
4. <b>A minimum of three psychosocial educational interventions are assigned daily.</b>	100%
5. <b>A minimum of four groups is prescribed for the weekend.</b>	<i>33%</i>
6. The client is <b>able to state what his assigned psycho-social-educational interventions are and why they have been assigned?</b>	<i>48%</i>
7. The client can <b>correctly identify assigned RN and MHW.</b>	73%
8. The medical record <b>documents the clients active participation in Morning Meeting within the last 24 hours</b>	<i>53%</i>
9. The client can <b>identify personally effective distress tolerance mechanisms available within the milieu.</b>	90%
10. <b>Level and quality of client's use of leisure within the milieu</b> are documented in the medical record within the last 7 days.	97%
11. <b>Level and quality of social interactions</b> within the milieu are documented in the medical record over the last 7 days.	100%

**FINDINGS:**

30 per month during this report period.

**Improvement Opportunities:**

1. The flow sheets have been updated to ensure capturing the required elements.
2. Nursing leadership will provide education/training to nurses and MHWs regarding the new flow sheets and levels of support that are reflected on the treatment plan prior to their implementation.
3. On Upper Kennebec PSD met with each nurse individually to stress the importance of making sure the treatment plan reflects were the clients current level is for consistency in documentation.
4. Assigned MHW to meet with clients weekly to review what psycho-social activities they are assigned and why.

**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.	498 of 531	94%	80%
2. Grievances responded to by RPC on time.	124 of 194	64%	100%
3. Attendance at Service Integration meetings.	60 of 61	98%	100%
4. Contact during admission.	64 of 64	100%	100%
5. Grievances responded to by peer support on time.	194 of 194	100%	100%
6. Client satisfaction survey completed.	23 of 34	68%	80%

**Findings:** Overall compliance is up 3% from last quarter.

(1) Peer Specialists attended 498 of 531 treatment team meetings. Peer support was unavailable to attend meetings due to attending admissions (3), mandatory training (2), out sick/on vacation (20), and client not wanting peer support (8).

(2) RPC responded late to 36 grievances and 34 have not been responded to at the time of this report for a total of 70 late responses. Of the 70 late grievances, 9 were on Lower Kennebec (7, 3-4 days late, 2 no response), 2 were on Upper Kennebec (1, 1 day late, 1 no response), 53 on Lower Saco (23, 1-34 days late, 30 no response), and 6 on Upper Saco (5, 1-4 days late, 1 no response). The grievances on LS have frequently been attempted to be resolved by the client is either unable or unwilling to work on a resolution.

(3) Peer Specialists missed 1 of 61 Service Integration meetings.

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

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

(6) Of the 34 Client Satisfaction Surveys that were offered to clients, 23 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 completed by RPC within the time allowed.

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

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

**Status:**

(1) Peer Specialists attended 94% of treatment team meetings this quarter, which is up 10% from last quarter. More meetings were missed in February (15) than January (8) and March (10). There were more meetings missed on the lower units (LS-10, LK-10) than the upper units (US-7, UK-6), primarily due to the increased obligations on the lower units.

(2) Compliance with grievance response time was down 5% from last quarter. Of the 194 grievances filed, 13 were withdrawn and resubmitted as concerns or suggestions. The majority of grievances filed were on Lower Saco (94) at 48% of total grievances. Total number of grievances increased 3% from last quarter. The number of grievances decreased 43% on Upper Saco and 16% on Upper Kennebec. Grievances increased 16% on Lower Saco and 76% on Lower Kennebec.

Overall, there has been a steady decrease in grievances filed on each unit over the quarter, except for Lower Saco. The number of grievances filed on Lower Kennebec dropped 79%, 71% on Upper Kennebec, and 70% on Upper Saco. The decrease appears to be a result of decreased acuity of clients and the additional effort of peer specialists to encourage clients to resolve complaints in other ways (i.e. community meeting).

(3) One Service Integration meetings was missed this quarter, increasing compliance 2%. Meeting was missed due to mandatory training for all peer specialists.

(4) All clients admitted during this quarter to RPC had documented contact with a peer specialist, up from 99% last quarter.

(6) Completion of Client Satisfaction Surveys was down 4% this quarter from last quarter. Reasons cited for not completing surveys were noted as: client didn't want to, client left after court before it could be offered, and one client stated, "I don't want everyone to know my business."

**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.
- A part-time peer specialist will be assigned to the lower units to assist in coverage of team meetings.
- Mandatory training for peer specialists will be arranged to allow for availability of a peer specialist to attend meetings.
- An additional peer specialist has been hired to allow for more coverage of meetings.
- Peer Specialists will work closely with social workers to manage the schedule of Service Integration Meetings to ensure their attendance.
- Peer Specialists will learn ways to elicit reasons for clients refusing to complete satisfaction surveys.
- Changes to the "Client Grievance/Concern/Suggestion" policy are being considered to assist clients in learning how to resolve their concerns or grievances in a more life skills improving way.

**Client Satisfaction Survey** 3rd Quarter 2008 Jan- March

**Aspect:** Client satisfaction with care

Overall compliance: 69%

Indicators	Findings		Threshold Percentile	+/-
1. Did anyone tell you about your rights?	17 of 24	71%	85 %	+4%
2. Has anyone talked to you about the kinds of services that are available to you?	17 of 23	74%	85 %	+1%
3. Are you told ahead of time of changes in your privileges, appointments, or daily routines?	11 of 24	46%	85 %	-8%
4. Do you know someone who can help you get what you want or stand up for your rights?	20 of 23	87%	85 %	+4%
5. Do you have a worker in the community?	13 of 22	59%	85 %	N/A
6. Has your worker from the community visited or contacted you since you have been in the hospital?	10 of 16	63%	85 %	-4%
7. Do you know how to get in touch with your worker from the community if you need to?	8 of 15	53%	85 %	-20%
8. Do you have a community treatment plan?	9 of 21	43%	85 %	-20%
9. I feel more able to deal with crisis.	15 of 22	68%	85 %	-18%
10. I am not as bothered by my symptoms.	11 of 23	48%	85 %	-34%
11. I am better able to care for myself.	18 of 21	82%	85 %	-1%
12. I get along better with people.	15 of 23	65%	85 %	+1%
13. I am treated with dignity and respect.	21 of 24	88%	85 %	+4%
14. I feel comfortable asking questions about my treatment and medications.	18 of 22	82%	85 %	+2%
15. I understand how my medication works and the side effects.	13 of 16	81%	85 %	N/A
16. I've been told about self-help/peer support and support groups to use after discharge.	18 of 23	78%	85 %	+21%
17. I've been told about the benefits and risks of my medication.	13 of 18	72%	85 %	+7%
18. I have been given information to help me understand and deal with my illness.	16 of 23	70%	85 %	+11%
19. I feel my other medical conditions are being treated.	10 of 22	45%	85 %	-25%
20. My pain was managed.	10 of 17	59%	85 %	N/A
21. I feel free to make complaints and suggestions.	21 of 23	91%	85 %	+8%
22. I feel my right to refuse medication or treatment is respected.	13 of 28	46%	85 %	-20%
23. I help in planning my discharge.	16 of 21	76%	85 %	-5%
24. I feel I have had enough privacy in the hospital.	17 of 24	71%	85 %	-7%
25. I feel safe while at Riverview?	18 of 24	75%	85 %	-8%
26. If I had a choice of hospitals, I would choose this one.	15 of 22	68%	85 %	-6%

Since the last quarterly report, the survey has been revised. Questions 5, 15, and 20 are new; questions 2, 4, 13, 14, 22, 24, and 26 remained the same; all others were reworded to clarify or use simplified language.

Overall compliance was down 4% from last quarter.

**Findings:**

Of the 26 indicators, 3 met or exceeded threshold and 23 were below threshold. The number of items that met or exceeded threshold was up by 2 from last quarter. The one item that was above threshold last quarter (#9), is now below threshold.

**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.

Thirteen indicators dropped this quarter from 1-34% and 10 increased 1-21%. The three remaining indicators are new questions, so the above compliance is baseline. Five of the indicators that dropped last quarter continued to drop this quarter (indicators 3, 22, 24, 25, 26). Two of the 11 indicators that increased last quarter continue to increase (indicators 13 and 17).

Overall satisfaction with care on Lower Saco and Upper Kennebec dropped 12% and 16% respectively this quarter compared to last quarter. Satisfaction on Lower Kennebec increased by 4%. There is no data for Upper Saco this quarter.

**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 encourage clients to use community meetings as a forum for addressing concerns.
- Peer support will provide feedback to PSD's about client concerns/suggestions.
- Peer support will review annual dates for US clients so there can be input from US clients.
- Satisfaction Information will be shared with Executive Leadership Committee, Advisory Board, and Riverview Institute Committee.

**REHABILITATION**

**ASPECT: UPPER SACO CLIENT'S ATTENDANCE to prescribed treatment**

**COMPLIANCE: 55%**

Indicators	Findings	Compliance	Threshold
Number of Scheduled Program Hours Offered	60 of 60	100.0%	100%
Number of Program Hours Attended	33 of 60	55.0%	75%
Number of Program Hours Refused	22 of 60	37.0%	25%
Number of Program Hours Excused	9 of 60	15%	5%
Level of Engagement	56 out of 166	3.0average	4.0 average

**Findings:** Data for this indicator was taken from the week of March 16<sup>th</sup> to March 22<sup>nd</sup>. Each of the charts that were reviewed showed that clients were offered a different number of program hours ranging from as little as 6 hours to the high mark of 17 hours. Of the 24 clients on the unit, 6 charts were reviewed. The total number of programs offered to all 6 clients was 60 hours. Of the total 60 hours of programming offered to clients, the clients participated in 33 hours for a 55% total. The number of hours that client's refused or were excused from programming represented 31 of the 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.

**Problem:** The referral system continues to be a problem, even after the modifications were made to simplify the form. Zero percent of the client charts reviewed had referrals to the treatment mall. Also after reviewing these clients prescribed treatment schedule, only one of the clients had a complete schedule-20 groups, which means that the other clients were not maximizing their involvement in treatment by signing up for or being prescribed groups.

**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. Treatment Mall PIT was developed to look at increasing client involvement in prescribed treatment and the recommendations from this PIT are to be presented to all Department Heads. The number of program hours refused increased by 22%, which is significant and will need to be reviewed more closely.

**Actions:**

- The Harbor Mall Ward Clerk will review each note to ensure level of engagement is completed on each client and that this information is logged into the data collection sheet for that unit.
- The Director of Rehabilitation Services will meet with the Department Heads (Clinical Leaders) and discuss the findings of the PIT and develop a plan to increase the number of hours of prescribed treatment for all clients by 5/1. They will also work on looking at how to assist the staff in getting clients to attend their prescribed treatment more regularly to decrease the number of refusals.
- The Director of Rehabilitation Services will develop a QI plan that addresses the client's refusal to engage in prescribed treatment for the next quarter.

**Continuity of Care/Social Services Department-**

**Aspect:** Preliminary Continuity of Care Meeting and Comprehensive Psychosocial Assessments

**Overall Compliance:** 82%

Indicators	Findings	Compliance	Threshold Percentile
1. Preliminary Continuity of Care meeting completed by end of 3rd day	28/30	93%	100%
2. Service Integration form completed by the end of the 3rd 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. <b>Client Participation</b> in Preliminary Continuity of Care meeting.	29/30	96%	80%
3b. <b>CCM Participation</b> in Preliminary Continuity of Care meeting.	30/30	100%	100%
3c. Client's <b>Family Member and/or Natural Support (e.g., peer support, advocacy, attorney) Participation</b> in Preliminary Continuity of Care meeting.	30/30	100%	80%

3d. <b>Community Provider Participation</b> in Preliminary Continuity of Care meeting.	13/30	43%	80%
3e. <b>Correctional Personnel Participation</b> in Preliminary Continuity of Care Meeting.	0/15	0%	60%
4. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission	27/30	90%	95%
5. Annual Psychosocial Assessment completed and current in chart	30/30	100%	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 and 4. 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. Both clients initially refused to participate in the Service Integration Meeting and were approached daily for several days following admission. The forms were completed with minimal client input and historical information though not within the threshold of 3 days. Indicators 1 and 2 increased 3% respectively from last quarter but did not reach the threshold percent.

Indicator 3d fell below the threshold percentile this quarter and registered at 43% this area remains low and is down 13% from the second quarter. In some instances clients declined to sign releases for assigned community providers to attend and participate in the initial Service Integration Meeting. 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. In this aspect are we also see many clients who are requesting to change providers and sometimes communities upon discharge which can contribute to agencies not attending meetings. It was anticipated that the new APS system could have a positive impact on this area but at this time we have not been able to report evidence of that. The recent budget issues have had a profound impact on community agencies. We continue to work with the department on this issue.

Indicator 3e fell below the threshold percentile and for this quarter and registered at 0%. This remained the same from the 2nd quarter. As stated in previous reports clients routinely refuse to have corrections personnel as part of their treatment team. For many clients we often have input from probation officers, Maine Pre-Trial Services and jail case workers during the clients stay at subsequent treatment and discharge meetings.

Indicator 4 fell below the threshold percentile at 93% this quarter. This is up 4% from last quarter. Two initial assessments were not completed within the 7 day timeframe. The individual staff has been counseled about the importance of meeting required timelines to ensure quality service care and delivery for clients served. The outstanding reports have been completed.

**Status:** Monitor all aspect areas and utilize individual supervision and team meetings to brainstorm continued ways to engage clients at admission. Coordinate a meeting with the MH Team Leader to discuss ways to foster early and on-going involvement with care providers through the use of

Consent Decree Coordinators as liaisons between RPC and providers to gather information at or prior to admission. The Director will meet with the RPC admissions office to brainstorm and liaison with Spring Harbor Hospital regarding admissions and identified providers for individuals on the admission list to RPC.

**Corrective Actions:**

Indicators 1 and 2: These areas will continue to be focused on and monitored. Clients with high acuity at admission will continue to pose a challenge to this aspect area and will require increased attention and engagement.

Indicator 3d: This indicator area remains a challenge for the department in part because the rapid timeframe in which the Service Integration Meeting occurs causes challenges in the notification process with providers. We have a greater level of participation with providers during the initial and on-going treatment planning process. We will continue to work with the Consent Decree Office as a community liaison to foster this process and brainstorm with the admissions department and Spring Harbor Hospital on ways to alert providers within the, guidelines of confidentiality, when these meetings are scheduled. In addition the department will continue to support clients in remaining engaged with current providers and partnering with them throughout the clients hospital stay.

Indicator 3e: This is an area that has had traditionally low indicator numbers most quarters. The Director will seek support from the MH Team Leaders and the new ICM staff who have been recently assigned to the various jails to address this ongoing issue and need area. We do see continued engagement with the corrections providers in other aspects of the treatment and discharge processes which is critical as discharges from the Forensic Units to community placements is on the rise.

Indicator 4: This area will continue to be monitored through individual and group supervision and on-going chart audits

**CONTINUITY OF CARE/ Social Services**  
**ASPECT: Forensic Unit: Institutional Reports**  
**Overall Compliance: 98%**

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.	76/79	96%	95%
2. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	4/4	100%	100%
3. The assigned <b>CCM</b> will review the new court order with the client and document the meeting in a progress note or treatment team note.	3/3	100%	95%
4. Reports to the commissioner for all NCR clients are submitted annually.	67/67	100%	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:** No Issues in this area for this quarter.

**Status:** On-going

**Corrective Actions:** None needed

**Continuity of Care/Social Services SFY2Q 2008**

**Aspect: Client Discharge Plan Report/Referrals**

**Overall Compliance:** 87%

Indicators	Findings	Compliance	Threshold Percentile
1. The Client Discharge Plan Report will be updated/reviewed by each <b>Social Worker minimally one time per week.</b>	10/12	83%	80%
2. The Client Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	12/12	100%	95%
2a. The Client Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	9/12	75%	95%
3. Each week the Social Work team and Director will meet and discuss current housing options provided by the respective regions and prioritize referrals.	11/12	91%	95%

**Findings:** The timeframe for this aspect area was 12 weeks. During that time the report was sent out on 9 occasions via email. The report was distributed to stakeholders in hardcopy on three occasions at the Wednesday regional Meeting. The three occasions that the report was not sent out was due to a computer data base issue that took several weeks to rectify.

**Problems:**

Indicator 2a and 3 Document was not distributed via email 3 times due to computer data issues and one occasion the Social Work team meeting was cancelled.

**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 weekly. 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: Treatment Plans and Progress Notes**

**Overall Compliance:** 88%

Indicators	Findings	Compliance	Threshold Percentile
1. Progress notes in GAP/Incidental format will indicate at minimum weekly 1:1 meeting with all clients on assigned <b>CCM</b> caseload.	41/45	91%	90%
2. On Upper Saco progress notes in GAP/Incidental format will indicate at minimum bi- weekly 1:1 meeting with all clients on assigned <b>CCM</b> 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.	52/60	86%	90%

**Findings:** This aspect area includes chart samples from all units except as noted in Indicator 2 which represents information from Upper Saco only.

**Problems:** Indicators 2 and 3 were both fell below the threshold this quarter. Indicator 2 was up 13% from the 2<sup>nd</sup> quarter while indicator 3 was down 2% from the last quarter.

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

**Corrective Actions:**

Indicator 2and 3: Continued monitoring of the process with unit teams and focus on engagement/strengths based treatment planning.

Indicator 2: Staff will be supported in individual supervision to utilize improved time management skills and establish a plan of improvement. In addition this will be an ongoing focus of Social Work team meeting.

**PSYCHOLOGY**

**ASPECT: CO-OCCURRING DISORDERS INTEGRATION**

3 <sup>rd</sup> Quarter 2008 January, February, March 2008 Co-Occurring Disorders Integration			
Indicators	Findings	Compliance	Threshold
1. There is evidence of an integrated co-occurring comprehensive service plan for identified clients.	14/34	41%	85%
2. There is evidence of "stage of change" documented in client comprehensive service plan	2/34	6%	85%
3. There is documentation of identified client's participation in co-occurring treatment.	12/34	35%	85%
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 and ACT team and Capital Clinic	All treatment units ACT Team and Capital Clinic	No report this quarter	10% Increase  To be Reported Annually

**Findings:**

For indicators #1-3 47 charts were audited indicating 34 clients positive for co-occurring disorders.

- 1. Indicator remains below threshold.
- 2. New indicator. Baseline established. Compliance is below threshold.
- 3. New indicator. Baseline established. Compliance is below threshold.
- 4. NA

**Problems:**

- 1. The CSP does not accurately reflect co-occurring assessment.
- 2. The assessment information is not adequately reflected in the CSP.
- 3. Admission diagnosis for co-occurring illness is not reflected in treatment interventions.
- 4. NA

**Status:**

- 1. Integrated service plans for identified clients remains below threshold with little change in past 6 months.
- 2. (Steps 1)-Stage of change identified in assessments (100% compliance for 6 months-goal met last quarter) however (step 2) this assessment information not being used to develop the CSP.
- 3. Admission diagnosis for co-occurring exceeds expectations (goal met last quarter), however treatment for the identified diagnosis is not reflected in the treatment delivery.
- 4. Each unit asked to identify areas to target for continued improvement based unit specific analysis of data. (ACT team and Capital Clinic COMPASS surveys due 1<sup>st</sup> quarter next year. All others will be due 2<sup>nd</sup> quarter next year.)

**Actions:**

- 1 -3 Report baseline data and consult with coaches group and clinical leaders to identify educational gaps and identification of a possible rapid cycle change process.
- 4. Co-occurring coordinator working with unit professional staff to clarify unit specific goals and actions.

Co-Occurring Disorders	Findings	Compliance	Threshold
Consumer Satisfaction			
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"	14/17	82%	85%
6. Consumer satisfaction survey indicates that since beginning treatment with us, their condition is better.	13/17	76%	90%
7. Consumer satisfaction survey reports client satisfaction with current treatment experience is better than with any other previous treatment experiences.	14/17	82%	85%
8. Percent of clients with co-occurring disorders as reported by NASMHPD	56% Nat. Mean 36% (Oct,Nov,Dec,Jan)	56%	50%

**Findings:**

For indicators #5-7 A total of 17 surveys were administered. Of those, 8 identified themselves as co-occurring clients.

5-7 Thresholds not met.

8. Threshold exceeded. NASMHPD comparative statistic report indicates that for the months of Oct., Nov., Dec., and Jan., Riverview reported 56.37% of clients with co-occurring diagnoses. This is above the national mean of 35%.

**Problem:**

5. Integrated treatment not perceived by clients. (Small N of co-occurring clients is an issue for data analysis).
- 6-7 Consumers report of self-improvement and satisfaction with treatment while improved, continues to be below desired outcome.
8. Threshold met. No problem.

**Status:**

5. Threshold met in pervious two quarters. Slight drop past quarter and improved again this quarter-up 19%.
6. 7% improvement over previous quarter
7. 26% improvement over previous quarter
8. Threshold exceeded. Higher diagnosis rate is most likely due to better screening by admissions personnel. Continue to monitor. Rapid cycle change project to improve completion of diagnostic specifiers to further clarify diagnosis has been completed and resulted in clearer admissions assessment information.

**Action:**

- 5-7 Increase the number of surveys next quarter. Co-occurring coaches have discussed this indicator and will continue to identified ways to improve client satisfaction with recovery. Continue to focus on discussing client perceptions and feedback to clients in co-occurring groups.
8. Monitor for continued compliance.

Psychologist Service delivery & documentation Indicators	Findings	Compliance	Threshold
1. Psychologist short-term goals on CSP are measurable and time limited.	24/35	69%	95%
2. Psychologist progress notes indicate treatment offered as prescribed on CSP.	29/35	83%	95%
3. Psychologist progress notes indicate client's understanding of goals and client self-assessment of progress.	29/35	83%	90%

**Findings:**

1. Data indicates CSP short-term goals do not meet standard. Threshold not met.
2. Data indicates progress notes do not adequately reflect CSP goals. Threshold not met.
3. Data indicates lack of client participation in goal setting and self-evaluation. Threshold not met.

**Problems:**

1. Psychologists are not adequately 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. More coaching needed.
3. Failure to engage and report client participation in goals for treatment and self-assessment of progress.

**Status:** Performance for all three indicators has improved significantly from 1<sup>st</sup> quarters findings, however thresholds have not been reached.

1. Chart review indicates a 54% increase in performance over 1<sup>st</sup> quarter findings.
2. Chart review indicates a 23% increase in performance over 1<sup>st</sup> quarter findings.
3. Chart review indicates a 73% increase in performance over 1<sup>st</sup> quarter findings.

**Actions:** For all three indicators:

- Psychologists will use peer review process to review progress notes and provide feedback to assigned peers monthly.

- Individual psychologists who are not meeting expectations will be identified. Supervisor will review performance expectations in weekly supervision for psychologists who fall below standards.

**Safety**

**Aspect:** Life Safety 3rd quarter SFY2008

**Overall Compliance:**

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.	58/62	93%	100%
2. Total number of staff assigned to Lower Saco and Lower Kennebec who have received training with the evacuation chair.	78/80	97%	100%
3. Total number if staff assigned to the Float Pool who have received training with the evacuation chair.	13/18	72%	100%
4. Total number of fire drills and actual alarms conducted during the quarter compared to the total number of alarm activations required per Life Safety Code, that being (1) drill per shift, per quarter.	5/3	100%	100%
5. Total number of staff who knows what R.A.C.E. stands for.	308/308	100%	100%
6. Total number of staff who 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.	308/308	100%	100%
7. Total number of staff who knows how to activate the nearest fire alarm pull station.	308/308	100%	100%
8. Total number of staff who knows how to acknowledge the fire alarm or trouble alarm on the enunciator panel.	287/308	93%	100%
9. Total number of staff who knows the emergency number.	308/308	100%	100%
10. Total number of staff who knows what the verbal code is used to announce a fire.	308/308	100%	100%
11. Total number of staff who knows it is necessary to close all doors after checking rooms or areas.	308/308	100%	100%

12. The total number of staff who knows what the acronym, P.A.S.S. stands for.	308/308	100%	100%
13. The total number of staff who knows the locations of the two nearest exits to evacuate away from a fire area	308/308	100%	100%
14. The total number of staff who knows two ways that may be used to move a person who is non-ambulatory to safety.	308/308	100%	100%

**Findings:**

1. During the 1<sup>st</sup> quarter, Upper Saco and Upper Kennebec entire staff had received training in the use of the evacuation chair training. This equated to 100%. Since that time, we have had a number of newly-hired staff and staff who have transferred from other jobs into direct care assignments. Currently (58) out of (62) have received the training. This equates to 93%.
2. Lower Saco has (39) out of (41) who have received the training. This equates to 95% of staff trained with the evacuation chair. Lower Kennebec has (39) out of (39) who have received the training.
3. Not reported in the past, is a separate new category titled "Float Pool". The total number of staff assigned to the Float Pool who have received training with the evacuation chair is (13) out of (18) or 72 %.
4. The (5) alarms reported for the hospital meets the required number of drills per Joint Commission and Life Safety Code. Of the (5) alarms, (1) alarm was caused by A detector that was pulled from its' base by a client while in their bedroom, (1) alarm was caused by inattention while cooking, and the other (3) alarms were unannounced drills conducted by the Safety Officer.
- 4-13. Indicators 4 through 13 are indicators used for 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).

**Problems:**

- 2, 3. A decision had been made to train all permanent staff assigned to the units. This has not been completed. A new email has been drawn and has been sent to both the Supervisors and the HR Director, along with one going to the affected staff.
7. During a review of all reports filed, 21 staff members either reported to their supervisor that they were not sure how to acquire the location information from the annunciator panel located on that unit or the supervisor felt that the staff were not sure how to acknowledge the information on the panel.

Following an actual Fire alarm event the Safety Officer found the following:

- a. Food in a pan burned and set off the smoke detector in the hallway outside the kitchen.
- b. There were no immediate tools such as a cover, readily available to place over the pan in the event of a fire.

After review of all reports, the Safety Officer noted the following:

- c. One unit did not immediately employ the two-way radios.
- d. One unit had telephones which did not display the facility's designated emergency number.
- e. Two units had staff without an emergency sticker for their key card.
- f. Three units reported not all staff evacuated when the fire alarm was sounding.
- g. A door with a magnetic holder did not positively latch when the magnet released.
- h. Two units reported a total of (3) staff members did not have a red key identifier on their fire key.

**Action:**

7. Twenty-one staff members had an overview of the annunciator panel and the necessary steps

to acknowledge and obtain the event location.

Following alarm events, both actual and drills, the following corrective measures were taken by the Safety Officer:

- Telephone stickers were placed on phones which were reported not to have them.
- Staff who were identified to not have the most current emergency sticker were given direct to the reported supervisor.
- Staff were reminded that the two-way radios are a necessary form of communication during these type of events.
- Maintenance installed an additional spring-activated door hinge which would cause the door to positively latch in the event that the magnetic door holder does release.
- A presentation was given by the Safety Officer to staff on the Treatment Mall as it relates to safeguards to be taken while cooking and the proper steps to take in the event of a cooking emergency.

**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 (3) drills per year as business occupancy.	2 drills	100%	100%

**Findings:**

Has had 2 drills thus far this year.

**Problems:**

None

**Status/Action:**

The Safety Officer will conduct a fire drill during the last quarter of this fiscal year.

**Securitas/RPC Security manager**

Aspect: Safety/security

Overall Compliance: 98%

Indicators	Findings	Compliance	Threshold Percentile
1. Security search/screening of all clients (Forensic & Civil) being admitted to Riverview for treatment. (total # of admissions screened vs. total # of admissions).	64/64	100%	100%
2. Security Officer "foot patrols" during Open Hospital times. (Total # of "foot patrols" done vs. total # of "foot patrols" to be done.)	1957/2002	98%	98%
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.)	539/546	99%	95%

**Findings:** The Securitas / RPC Security Team is pleased to report that we met our overall target

percentage number for this reporting period of the 3<sup>rd</sup> Qtr of the FY 2008! Through some hard work and steadily increased attempts at “multi-tasking” various security duties, we were able to get our numbers up for this period.

**Problems:** We had no major problems or issues during this reporting period that hindered us from completing our required duties & “foot patrols”.

**Status:** There are no status changes for this quarter.

**Actions:** The Securitas / RPC Security Management Team will continue to work very diligently at keeping the team on track to continue meeting and / or exceeding the threshold percentile goals for the three indicators “tracked” by our team

## STAFF DEVELOPMENT

### ASPECT: New Employee and Mandatory Training

3 <sup>rd</sup> Quarter SFY08 January, February, March 2008 Staff Development			
Indicators	Findings	Compliance	Threshold Percentile
1. New employees will complete new employee orientation within 60 days of hire.	13 of 13 completed orientation	100%	100 %
2. New employees will complete CPR training within 30 days of hire.	8 of 8 completed CPR training	100%	100 %
3. New employees will complete NAPPI training within 60 days of hire.	12 of 12 completed Nappi training	100%	100 %
4. Riverview staff will attend CPR training bi-annually.	292 of 295 are current in CPR certifications	99%	100 %
5. Riverview staff will attend NAPPI training annually. Goal to be at 100% by end of fiscal training year 08 on June 30 <sup>th</sup> . <b>Fiscal year 07 at 100%</b>	259 of 362 have completed annual training	72% to date	100 %
6. River staff will attend Annual training. Goal is to be at 100% by end of fiscal training year 08 on June 30 <sup>th</sup> . <b>Fiscal year 07 at 99%</b>	362 of 382 have completed annual training	95% to date	100 %

**Findings:** The indicators are based on the requirements for all new/current staff to complete mandatory training and maintain current certifications. **13 out of 13** (100%) new employees completed these trainings. **292 of 295** (99%) employees are current with CPR certification. **259 of 362** (72%) employees are current in Nappi training. **362 of 382** (95%) employees are current in Annual training. All indicators remained at 100 % compliance for quarter 3-FY 2008.

**Problem:** Indicator 4 is identified as a problem as it is below established threshold. 3 employees did not attend their annual recertification in CPR due to illness.

**Status:** This is the third quarter of report for these indicators. The 3 employees that missed their CPR recertification have been mandated to go to the April 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 April. 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 April.

## STAFF DEVELOPMENT

**ASPECT: COMMUNITY PROVIDER TRAINING**  
**Public Education- Standard 34 January-March 2008**

Topic	Type	Date(s)	Level of Participation	Information Packets/Publications
Multimodal treatment of ADHS	Psychiatric Grand Rounds	1/8/08 RPC	8 participants	Hard copy available
Experience –dependant plasticity in the mature brain: Insights from amputation and allogenic transplantation of the human hand	Psychiatric Grand Rounds	1/15/08 RPC	5 participants	Hard copy available
Cognitive Remediation and Work in Severe Mental Illness	Psychiatric Grand Rounds	1/22/08 RPC	5 participants	Hard copy available
Behavior Therapy for Depression in the 21 <sup>st</sup> Century: New Advances and Applications	Psychiatric Grand Rounds	1/29/08 RPC	7 participants	Hard copy available
DHMC's Roles as a STEMI receiving Center in a Regional Care Network; Past, Present & Future	Medical Grand Rounds	1/4/08 RPC	4 participants	Hard copy available
Healthcare Experience for the Older Old in America	Medical Grand Rounds	1/11/08 RPC	4 participants	Hard copy available
Addressing Low Health Literacy in Patient Care: Strategies for Effective Care	Medical Grand Rounds	1/18/08 RPC	2 participants	Hard copy available
New Drugs for Prevention and Treatment of Breast Cancer and Lung Cancer	Medical Grand Rounds	1/25/08 RPC	6 participants	Hard copy available
CPR	Recertification	1/24/08	16 participants	Hard copy available
CPR	Recertification	1/27/08	2 participants	Hard copy available
CPR	Initial Class	1/28/08	21 participants	Hard copy available
CPR	Recertification	1/29/08	1 participants	Hard copy available
From genes to therapeutics; nicotine receptors and schizophrenia	Psychiatric Grand Rounds	2/5/07 RPC	4 participants	Hard copy available
Patient Safety in Psychiatry: Aristotle or Arête	Psychiatric Grand Rounds	2/12/08 RPC	9 participants	Hard copy available
In return for their sacrifice: Primary care approaches to post-war syndromes	Psychiatric Grand Rounds	2/26/08 RPC	6 participants	Hard copy available
Treatment of postmenopausal osteoporosis and the role of anabolic therapy	Medical Grand Rounds	2/1/08 RPC	5 participants	Hard copy available

Anklosing Spondylitis	Medical Grand Rounds	2/8/08 RPC	3 participants	Hard copy available
The World Trade Center; Worker health in the Wake of an Unprecedented Man-Made Environmental Disaster	Medical Grand Rounds	2/15/08 RPC	4 participants	Hard copy available
The Common Thread of Public Health Emergencies	Medical Grand Rounds	2/22/08 RPC	4 participants	Hard copy available
How does previous Hypoglycemia Cause Impaired Counter regulatory responses?	Medical Grand Rounds	2/29/08 RPC	4 participants	Hard copy available
CPR	Initial Class	2/12/08 RPC	5 participants	Hard copy available
Mental Health Specialist Training	In-service	2/5, 2/11, 2/22/08	83 participants	Hard copy available
An Update on the treatment of Major Depression and Bipolar disorder and New research Direction	Psychiatric Grand Rounds	3/4/08 RPC	5 participants	Hard copy available
Cingulate Cortex: Roles in Attention, Emotion & Decision- Making	Psychiatric Grand Rounds	3/11/08 RPC	5 participants	Hard copy available
Apathy in Neuropsychiatric Disorders	Psychiatric Grand Rounds	3/18 RPC	5 participants	Hard copy available
Integrating Mental Health into Primary Care	Psychiatric Grand Rounds	3/25/08 RPC	5 participants	Hard copy available
Special Medicine/Pediatric GR; Topic SHS Exposure and Acute MI	Medical Grand Rounds	3/7/08 RPC	4 participants	Hard copy available
Special MGR for World Nephrology Day: Aquaporin Water Channels-from Atomic Structure to Clinical Medicine	Medical Grand Rounds	3/14/08 RPC	4 participants	Hard copy available
Altruism in Medicine	Medical Grand Rounds	3/21/08 RPC	4 participants	Hard copy available
Special MGR: Arrest and reverse: The Preferred Treatment of Coronary	Medical Grand Rounds	3/28/08 RPC	4 participants	Hard copy available
CPR	Initial Class	3/11/08 RPC	3 participants	Hard copy available
CPR	Re-certification	3/27/08 RPC	10 participants	Hard copy available
A Developmental Path to Mental Illness and Suicide	In-service	3/6/08 RPC	24 participants	Hard copy available
Mental Health Specialist Training	In-service	3/3, 3/17/08 RPC	52 participants	Hard copy available
Bipolar Treatment	In-service	3/26/08 RPC	12 participants	Hard copy available
Dialectical Behavioral Therapy	In-service	3/24/08 RPC	11 Participants	Hard copy available

**COMMUNITY FORENSIC ACT TEAM**

Aspect: Descriptive Report on various components

3<sup>rd</sup> quarter Jan Feb and March 2008

CASE MANAGEMENT:

<b>Clients enrolled in the ACT program</b>	
	Number of ACT clients
January, 2008	33
February, 2008	33
March, 2008	33

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.

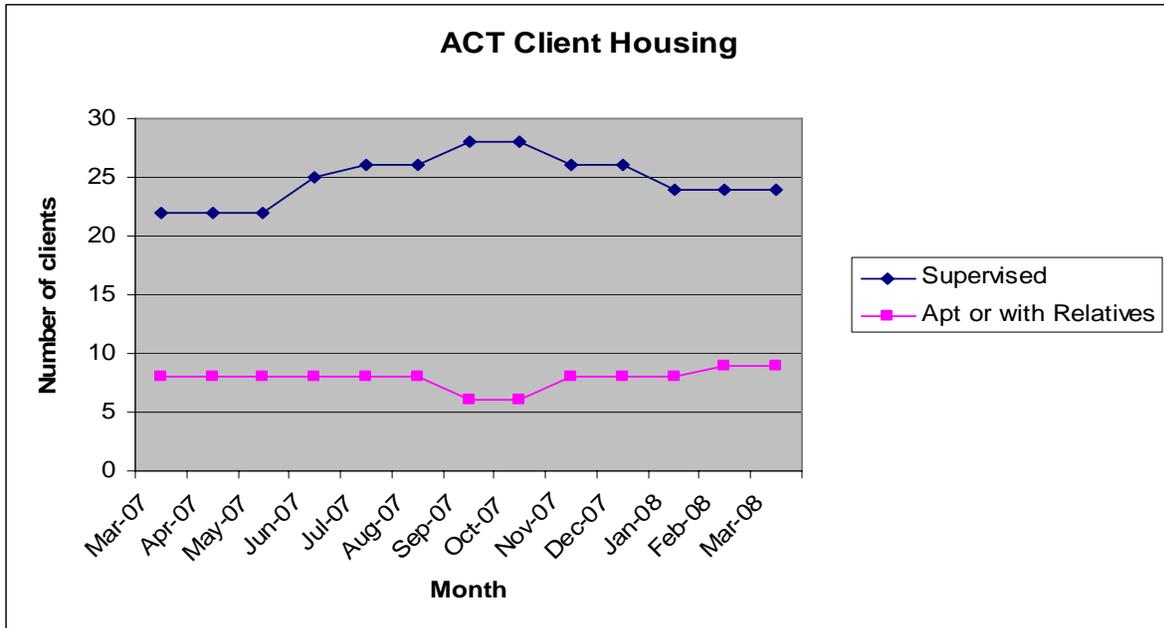
CRISIS MANAGEMENT:

1st Quarter 2008	Client incidents	Hospitalized RPC	Hospitalized Medical
January, 2008	4	3	0
February, 2008	4	3	0
March, 2008	4	3	0

SUBSTANCE ABUSE:

<b>2nd Quarter 2008</b>	<b>Client with Substance Abuse as a Clinical Focus</b>	<b>Percent of ACT Clients In SA treatment</b>
January, 2008	9	26%
February, 2008	9	26%
March, 2008	9	26%

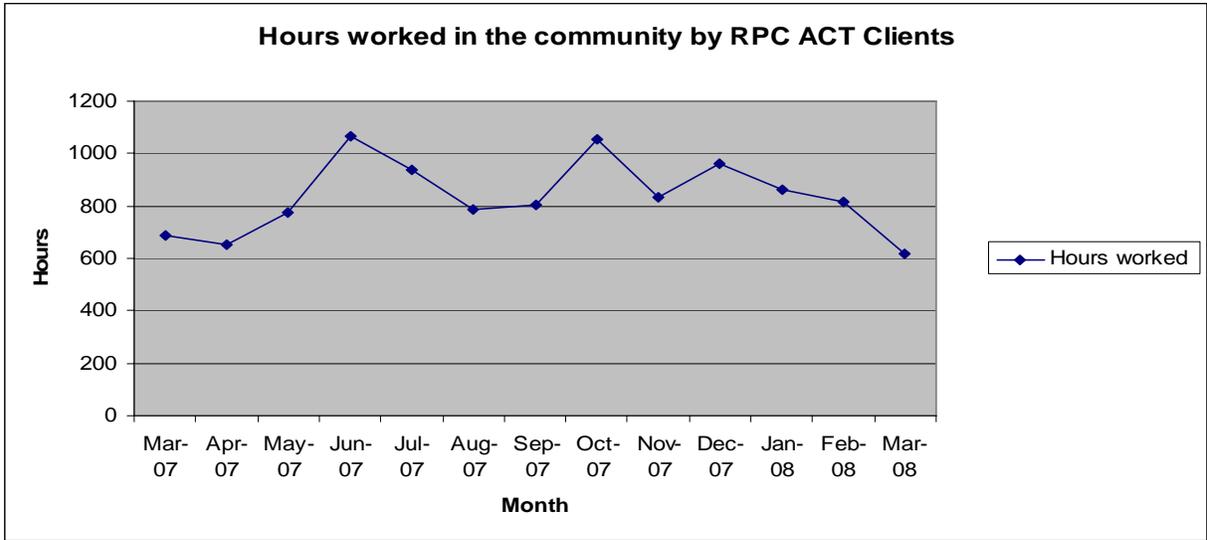
<b>ACT Clients Living Situation</b>				
<b>3rd Quarter 2008</b>	Clients in Supervised Settings	Clients in own apt. or with family	% of clients Supervised Settings	% of Clients in own home or with family
January, 2008	24	8	72.7%	24%
February, 2008	24	8	72.7%	24%
March, 2008	24	9	72.7%	27.2%



The number of clients in supervised housing has decreased because two individuals returned to Riverview and two other individuals moved to apartments. This pattern has been fairly constant for the past three months. Clients obtain court permission to move to a less restrictive living situation. One NCR client moved out of Arsenal Heights into his own apartment and a PTP client moved out of Independence House into his own apartment. We also picked up two PTP clients who have taken residence at Arsenal Heights as they do not have the capability to live on their own at this time.

**VOCATIONAL / EDUCATIONAL:**

<b>Regarding Clients working or volunteering in the community</b>			
	# Client Community Site Work involved with VOC/ED	# of Client who offer Community Volunteer Services	# Hours worked in Community
January, 2008	13	2	864
February, 2008	13	2	816
March, 2008	12	2	620

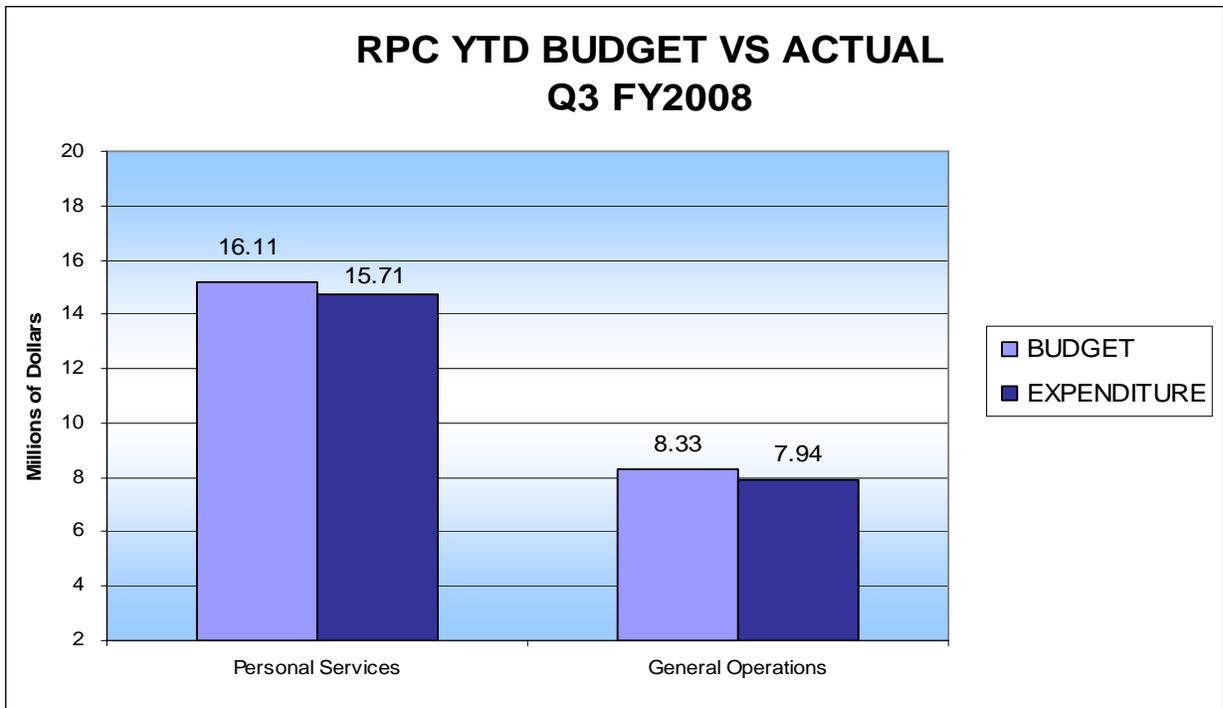


Community work hours have decreased slowly since November of 2007. Two ACT clients were dismissed from their jobs because of conflicts with co-workers. Another client who averaged 35 hours per week has been re-hospitalized at RPC, and three other clients who work in the food service industry have had their work hours reduced as a result of slow sales.

**Section II: Riverview Unique Information**

**BUDGET**

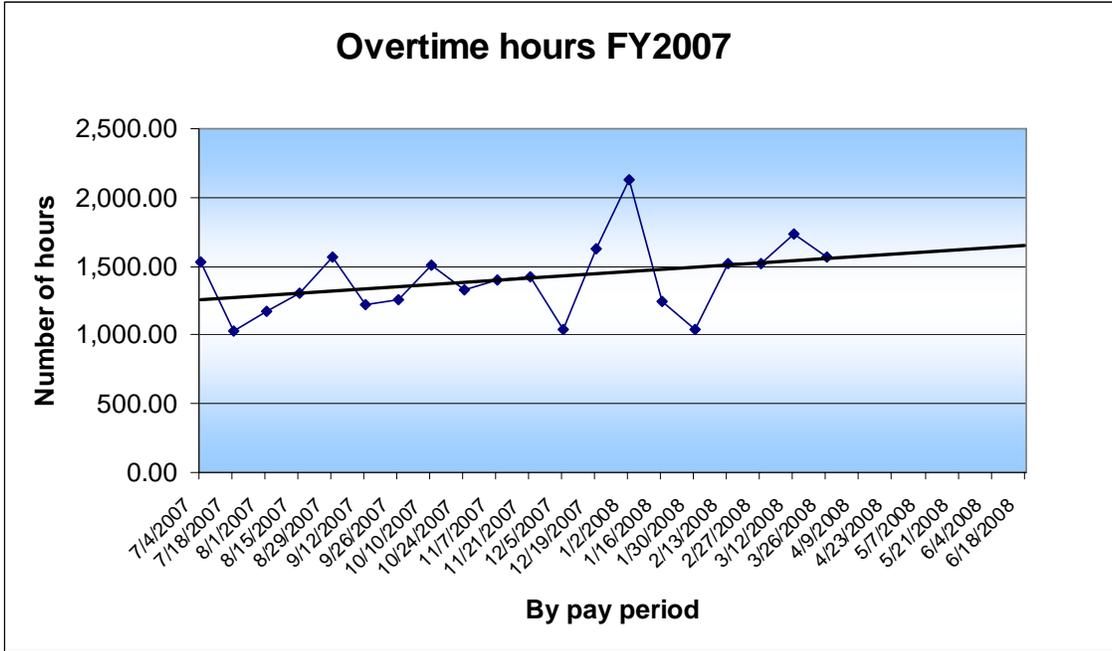
ASPECT: BUDGET INFORMATION



The hospital currently continues to stay within budget. Action plan includes continuing to carefully

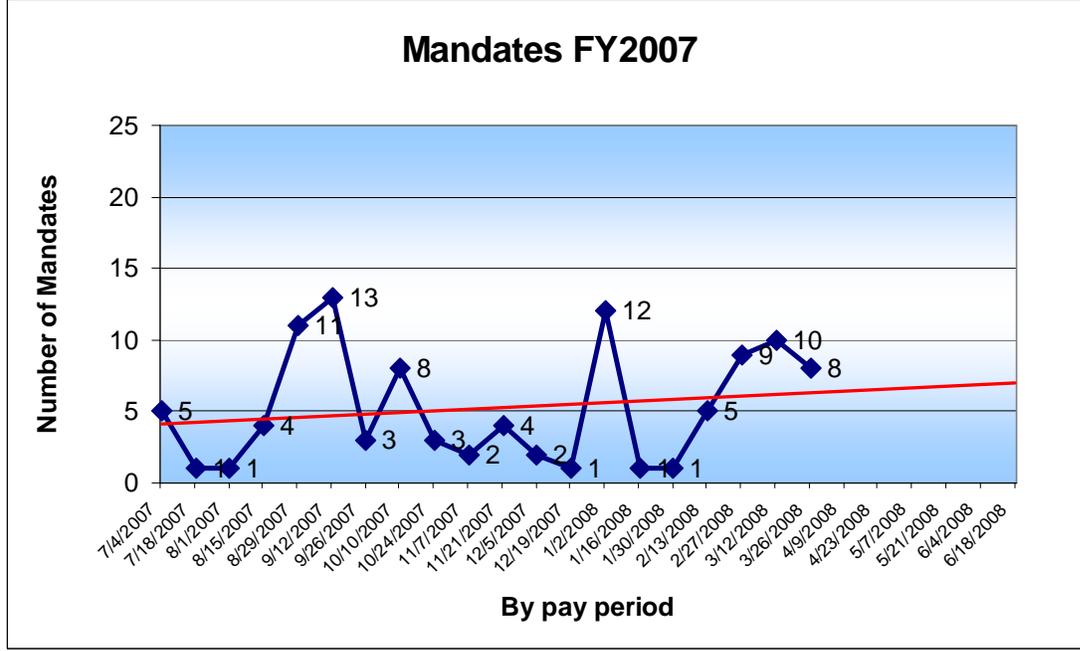
monitor and manage overtime and mandates. Continue aggressive management of all contractual services via fiscal and programmatic accountability.

**HUMAN RESOURCES**  
OVERTIME



Overtime has **increased** this quarter as compared to last quarter. Overtime rose from 8,338.75 hours to 10,764.00 hours. As compared to the same quarter last year (Jan 07 - March 07) we had 9,328.5 hrs of overtime. This quarter we have 10,764.00 hrs of overtime, this represents an 15% increase from last year.

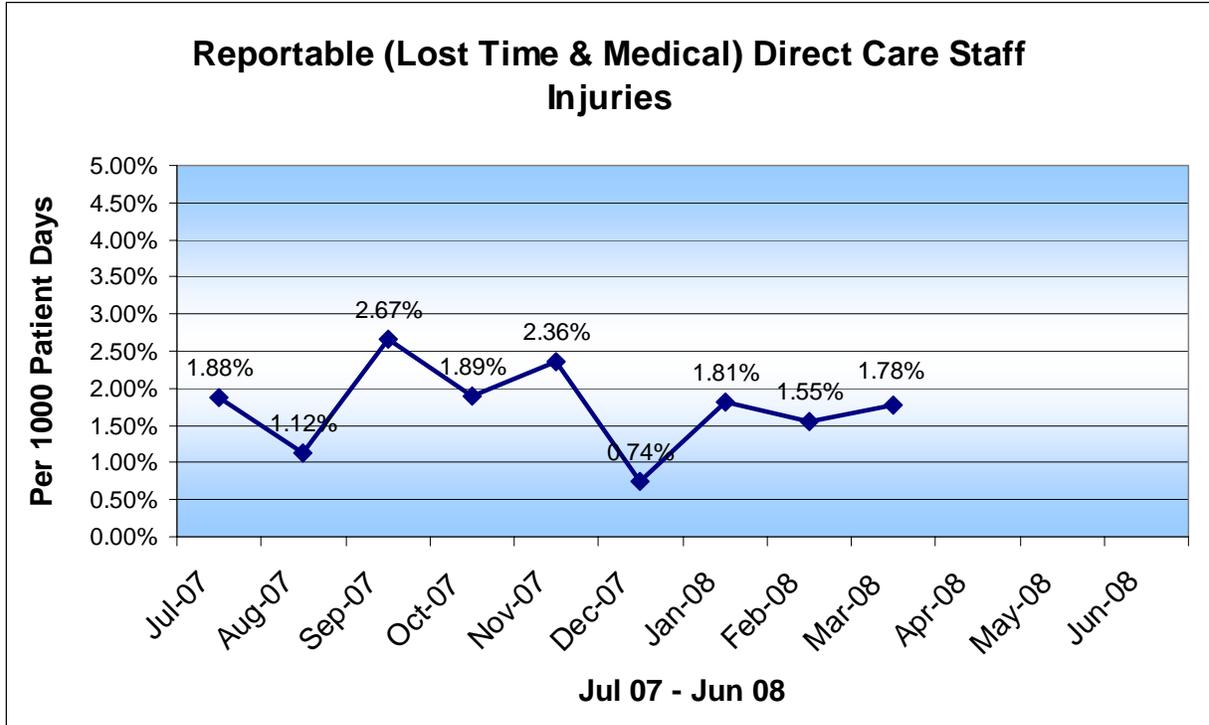
**HUMAN RESOURCES** ASPECT: MANDATES



Mandated shifts have **increased** this past quarter as compared to last quarter. Mandates rose from 20 to 46. Last year we had a total of 26 mandated shifts during this same rating period (Jan 07 - March 07), this year we had 46. This represents a 77% 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 an **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. The two year average is 1.43%.

**Management of Human Resources**

ASPECT: Timely Performance Evaluations

OVERALL COMPLIANCE: 80.65%

INDICATOR	FINDINGS		TARGET PERCENTILE
Employee Performance Evaluations expected to be completed within 30 days of the due date.			
Jan 2008 (Nov evals)	25 of 31	80.65%	85%
Feb 2008 (Dec evals)	27 of 32	84.38%	85%

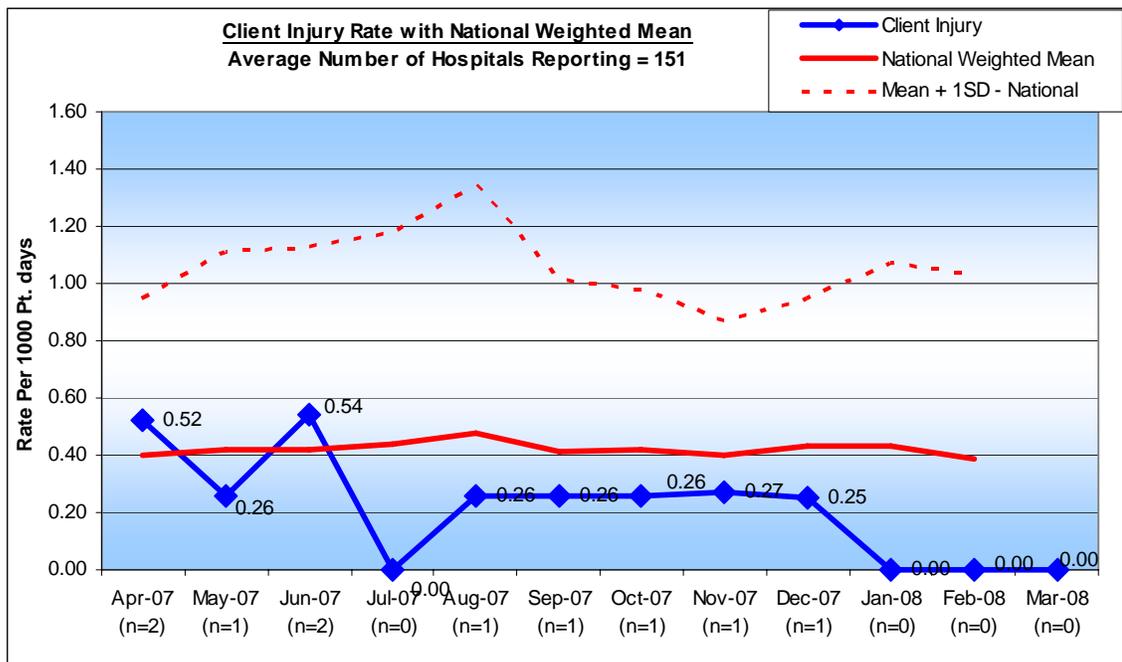
Mar 2008 (Jan evals)	20 of 26	76.92%	85%
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As compared to last quarter (87.20%) this quarter's decrease to 80.65%. As compared to the same quarter last year, 2007, we were at 72% compliance. During this quarter 89 performance evaluations were sent out; 72 were received in a timely manner.

### 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 75-205 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 1<sup>st</sup> Standard Deviation) of other hospitals in the sample.

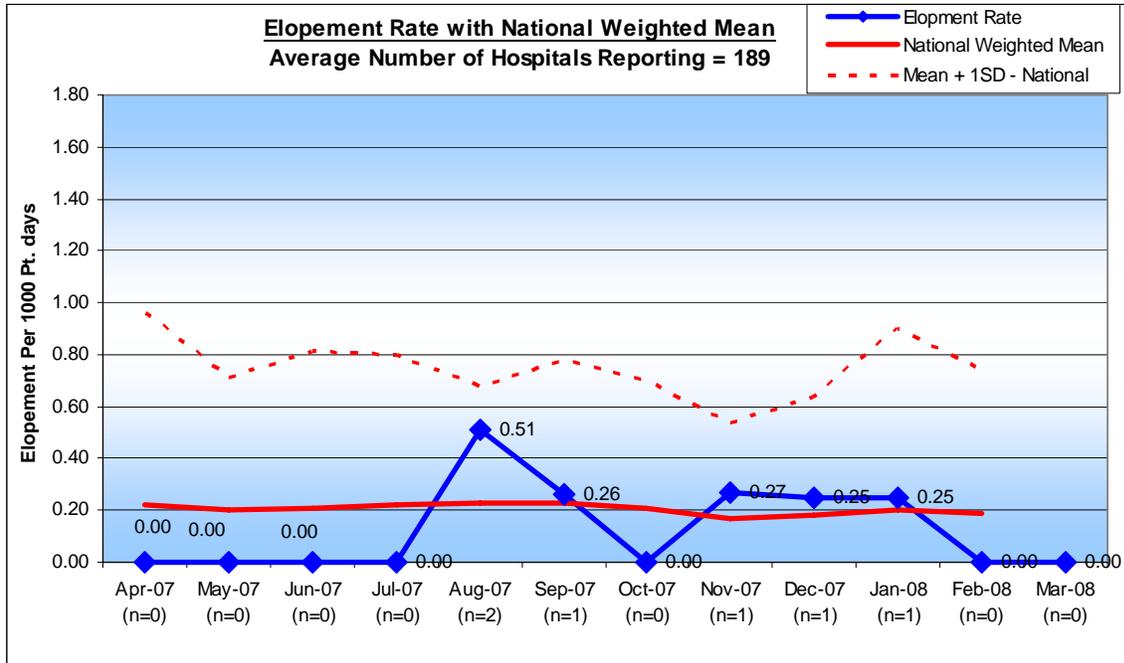
#### CLIENT INJURY RATE GRAPH



**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 1<sup>st</sup> standard deviation of the national sample.

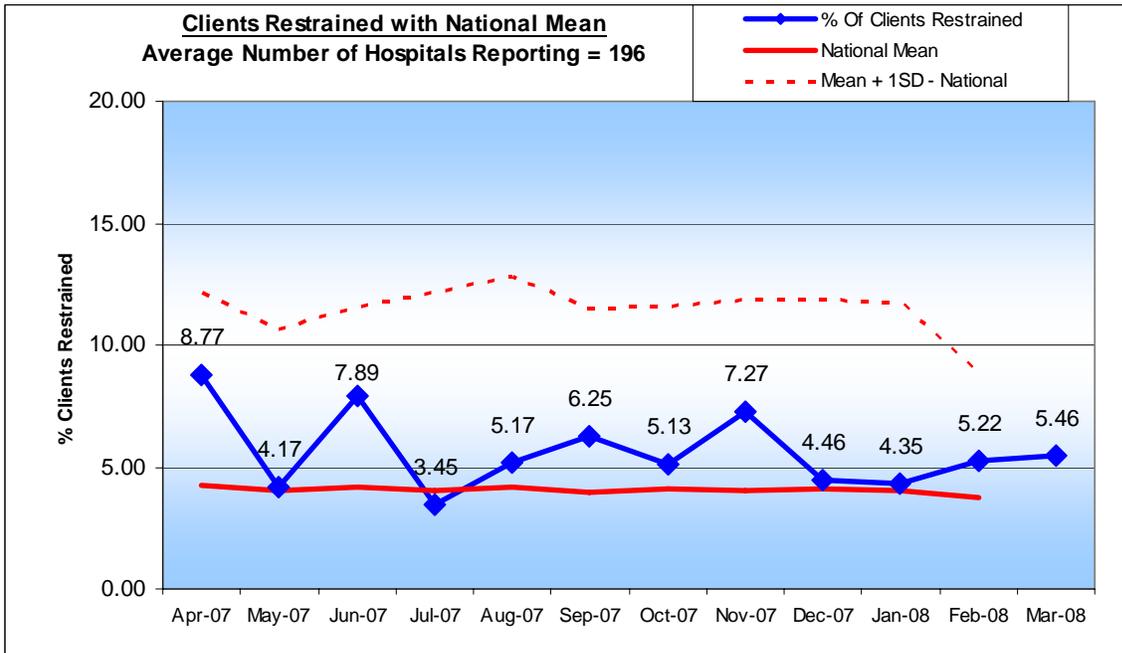
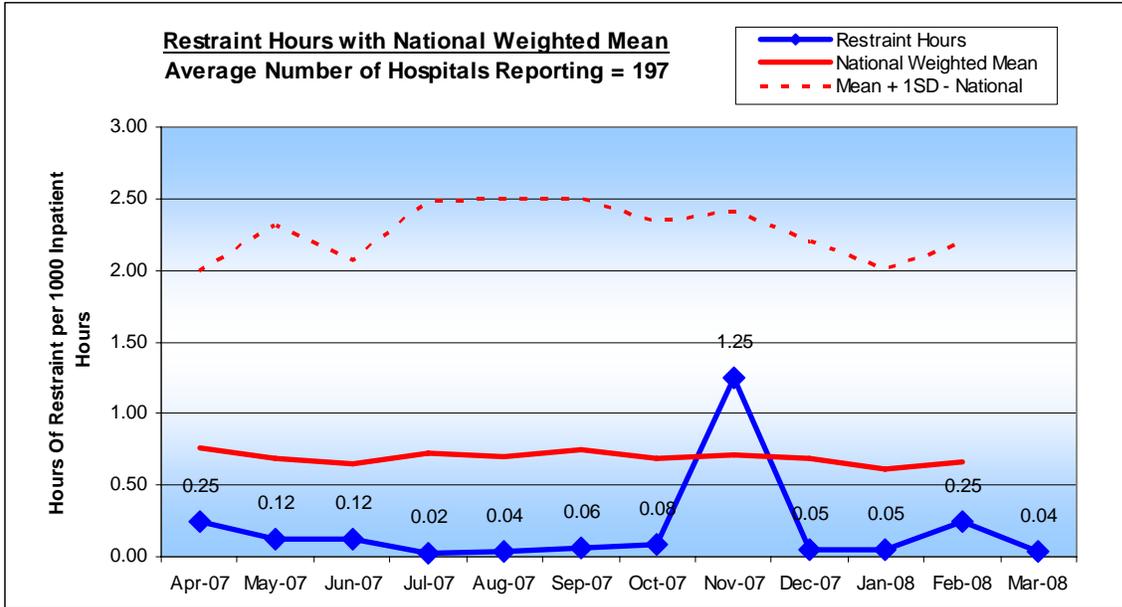
Please note the sheer number of events at Riverview is very low, between zero and 3 each month. Over the last 3 months reported in this graph, there were 0 injuries requiring more than first aid level of care.

**ELOPEMENT RATE GRAPH**



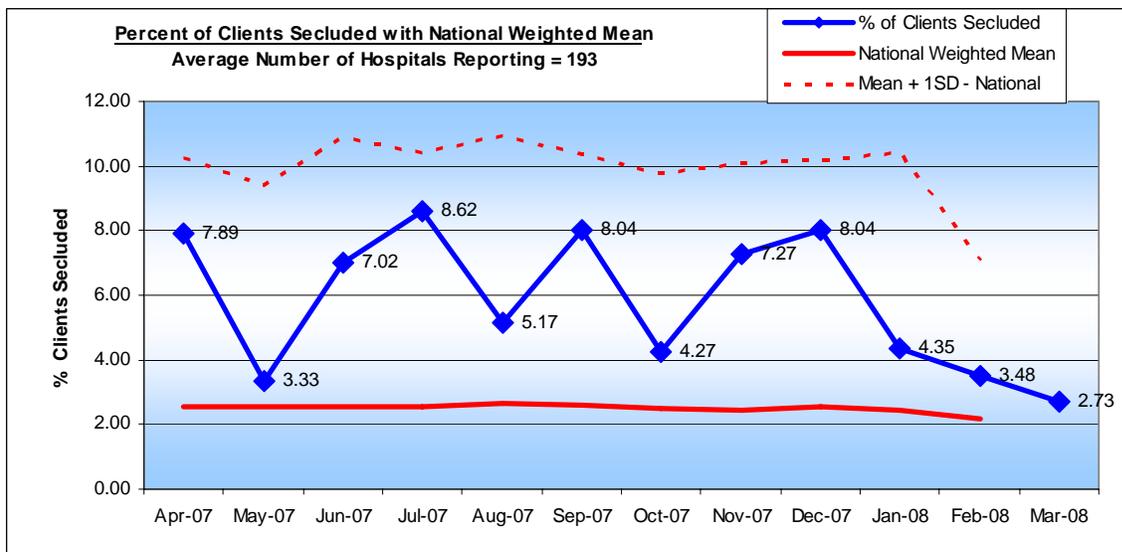
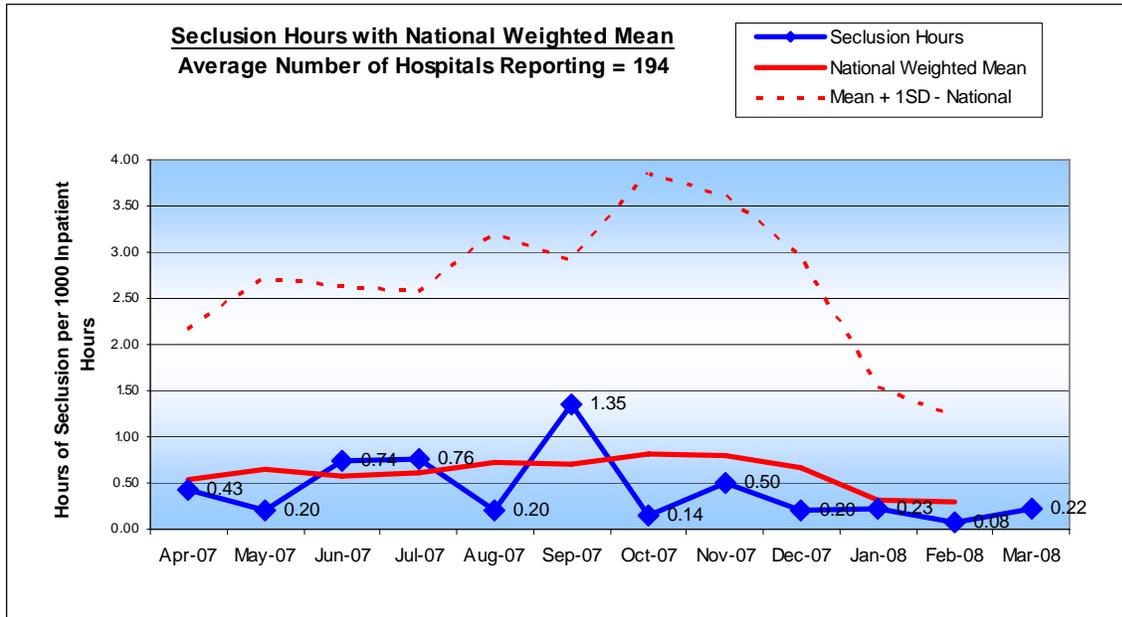
Elopement Rate is calculated per 1000 patient days. Elopement is defined as the client not being where expected at any given time, for instance if the client is supposed to return at 8 pm but is late and does not call to report the circumstance the client is considered to have eloped. Elopement risk is evaluated by the treatment team and is treatment planned if necessary to keep the client and the community safe.

**RESTRAINT GRAPHS**



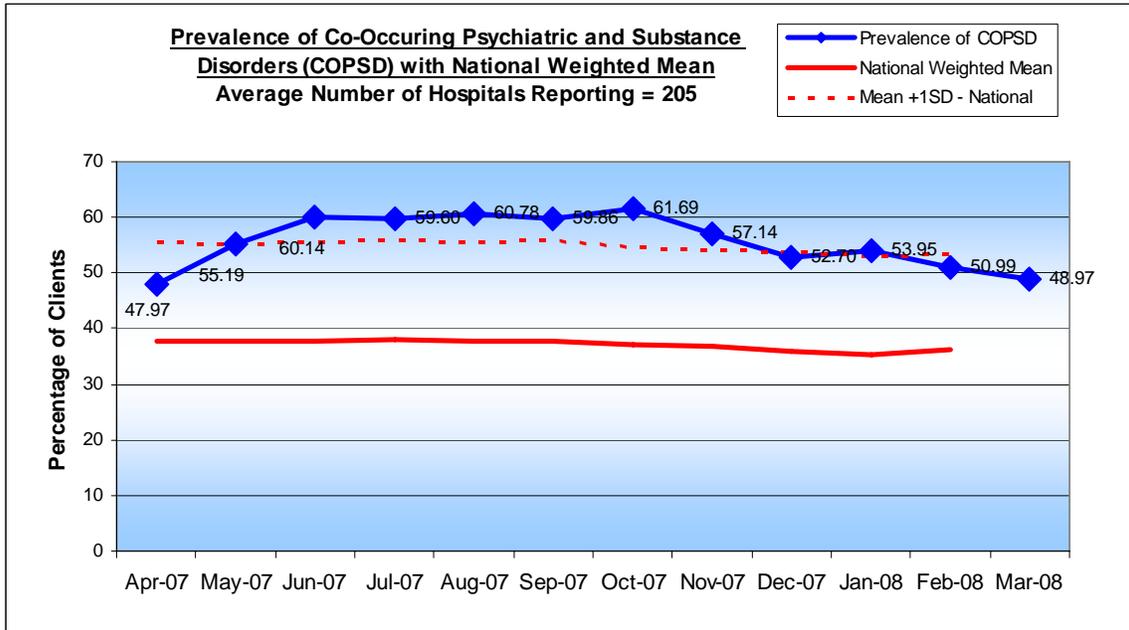
Riverview's rate of clients restrained, although above the statistical mean, is comparable to at least 68% of hospitals in the national sample. The restraint hours (duration) rate is well below the statistical mean, but also comparable to the bulk of hospitals in the national sample. The data would suggest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

## SECLUSION GRAPHS



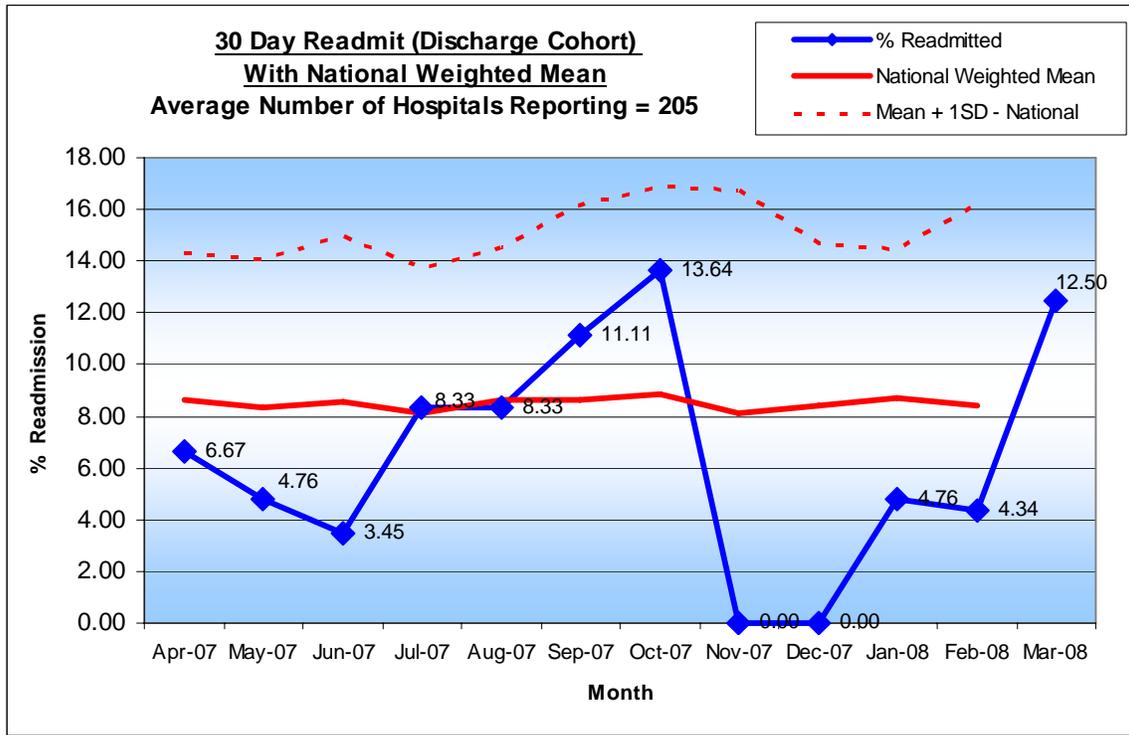
Seclusion hours (duration of events) at Riverview are tending to be below the national weighted mean n of other hospitals in the national sample. The percent of clients secluded has been decreasing over the last quarter. Riverview's efforts to reduce use of these interventions should focus on both the 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;

**CO-OCCURRING PSYCHIATRIC AND SUBSTANCE ABUSE DISORDERS GRAPH**



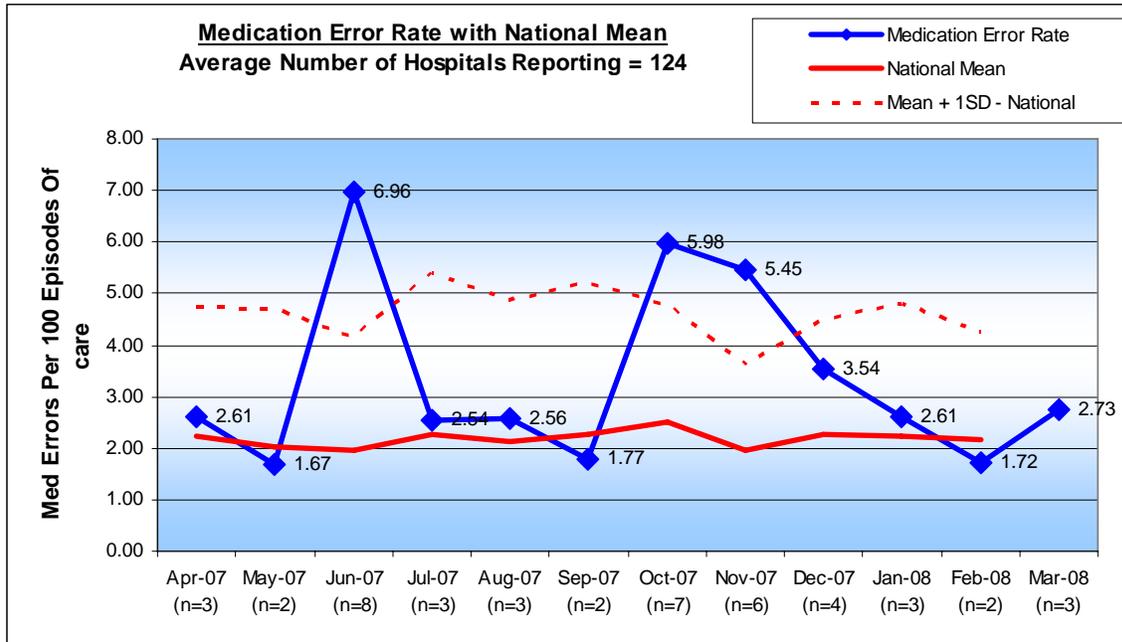
RPC has collaborative effort with Spring Harbor Hospital Co-Occurring Disorders providers to contract with RPC to develop a Co-Occurring program. Though RPC is currently a bit above the trend line, this is an indicator current initiatives are working as anticipated; with the advent of this program to 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 205 other facilities reporting on this indicator, except in September 07 and March 08. 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.

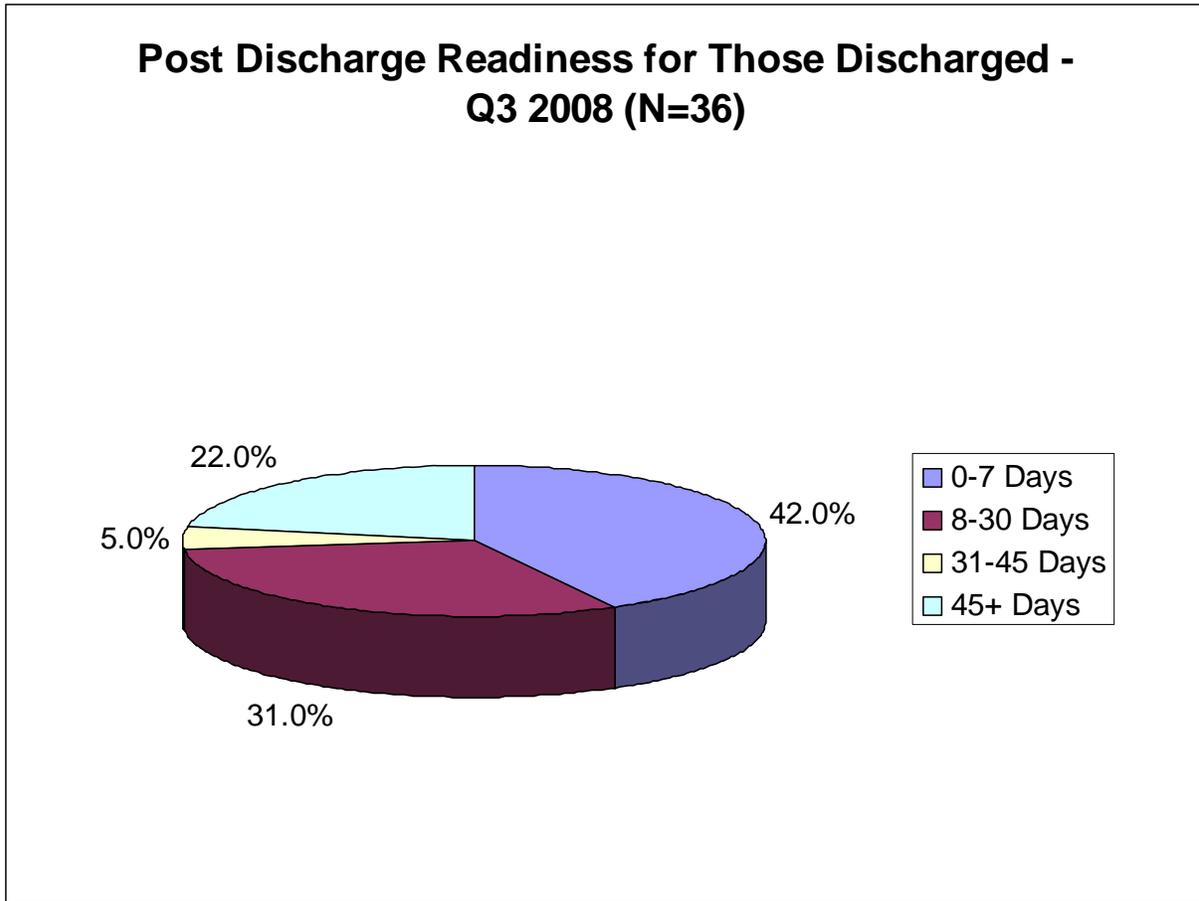
## MEDICATION ERROR RATE WITH NATIONAL MEAN GRAPH



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

The medication errors graph this quarter depicts RPC is reporting Medication errors at about the same rate as like facilities.

**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 42%; 8- 30 days post readiness 31%.; 31-45days at 5% and Greater than 45 days post discharge ready 22% of clients discharged this quarter. Cumulative percentages and targets are as follows:

- Within 7 days = 42% (target 75%)
- Within 30 days = 75% (31) (target 90%)
- Within 45 days = 81% (5) (target 100%)

There was a decrease in clients' discharges within 7 days from 65.6 % to 42% this quarter, a decrease 79.3% to 75 % within 30 days of being discharge ready, and a decrease within 45 days from 92.1% last quarter to 81% in the 3rd quarter.

The previous 4 quarters with the FY08 3<sup>rd</sup>/2<sup>nd</sup> quarters in comparison are displayed in the table portrayed below:

Quarter	Within 7 days	Within 30days	Within 45 days	45 +days
Target	75%	90%	100%	0%

Q3 2008	42% (-23.6%)	75%(- 4.3%)	81%(-1.7%)	22%(-4.7%)
Q2 2008	65.6%	79.3 %	82.7 %	17.3%
Q1 2008	61.1%	89.9 %	94.1%	5.9%
Q4 2007	78.8 %	94%	94%	6.1%
Q3 2007	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%