

Riverview

PSYCHIATRIC CENTER



PERFORMANCE IMPROVEMENT REPORT

THIRD QUARTER
January-February-March 2009

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Introduction:

Riverview's rate of clients restrained remains above the National statistical mean. The restraint hours (duration) rate remains however, well below the statistical mean. The data would suggest that Riverview's restraint events are short by comparison, and efforts to reduce the frequency of restraint are what the hospital will focus on.

Seclusion hours (duration of events) at Riverview continue to remain below the national weighted mean. The percent of clients secluded has been level or decreasing over the past several months. The number of clients secluded has decreased this past quarter. RPC will continue to increase its efforts to reduce the use of this intervention.

Chart Review results remain mixed, with some areas (interventions and measurable goals) reflect improvements. The presence of GAP notes every 24 hours and MHW notes being co-signed by RN have shown significant improvement while staff completing Weekly Summary notes area remains needing attention.

Community provider participation is another area that continues to remain below expectations and can prolong or complicate discharge planning and placements

The presence of psychological assessments, notes, and development of client short-term goals continue to show remarkable improvements. Dental Services, Dietary, Health Information, Medical Services, Safety, Security and Staff Development are at full compliance.

Client injuries and Elopement rates remain well below the National Mean.



COMMUNITY FORENSIC ACT TEAM

ASPECT: Descriptive Report on various components

CASE MANAGEMENT:

Clients enrolled in the ACT program	
	Number of ACT clients
January 2009	32
February 2009	33
March 2009	34

Two clients admitted from the Forensic Unit of RPC and two clients placed into PTP during this past quarter. The ACT team anticipates discharging two clients within the next month.

CRISIS MANAGEMENT:

	Client incidents	Hospitalized RPC	Hospitalized Medical
January 2009	3	1	1
February 2009	2	1	0
March 2009	2	1	1

Two PTP clients were readmitted to RPC during this quarter, one multiple times.

SUBSTANCE ABUSE:

	Client with Substance Abuse as a Clinical Focus	Percent of ACT Clients In SA treatment
January 2009	10	31%
February 2009	11	33%
March 2009	13	31%

A co-occurring disorder specialist works with persons served by the ACT team and also provides a weekly group. All team members are working to become more proficient in co-occurring disorders.

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
January 2009	23	9	70%	30%
February 2009	24	9	70%	30%
March 2009	24	10	70%	30%

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
January 2009	11	2	754
February 2009	11	2	672
March 2009	11	2	754

Summary: One client unable to meet the requirements of holding a job. Another lost a job due to medical problems. A third client's mother died resulting in his move to another town and adjusting to living with his brother prior to working. The hours for the courier were cut in half. A motel

where two clients work cut staff hours due to the economy. A client who works at McDonald's had hours cut temporarily until business picks up later this Spring.

DENTAL SERVICES-PORTLAND CLINIC

ASPECT: Monitoring of Patient IV Sedation Experience on Day Following

Indicators	Findings	Compliance	Threshold Percentile
Clinical Services will make follow-up calls to all IV sedation patients within one day of sedation in order to rate sedation experience. They will be asked if they experienced continued lethargy, dizziness, nausea, vomiting or other symptoms on the day following sedation.	74 patients sedated; none reporting symptoms.	100%	100%

Summary: Post-anesthesia instructions are given to patients and/or caregivers both verbally and in writing. All 74 patients sedated in the 3rd quarter had satisfactory outcomes.

Action: Continue to call all sedation patients on the day following sedation. Continue to discuss outcomes at staff meetings and forward reports quarterly to Riverview. Continue to have patients and/or caregivers sign post-anesthesia form indicating that they have received and understand discharge instructions and have no further questions.

ASPECT: Monitoring of Client/Caregiver Satisfaction at Clinical Services

Indicators	Findings	Compliance	Threshold Percentile
Clinical Services will provide every client and/or caregiver with a satisfaction survey sheet after their appointment in order to rate performance of medical/dental staff as well as treatment received.	75 out of 75 surveys were collected	100%	100%

Summary: Twenty-five survey sheets were distributed and collected for each month of the 3rd quarter. All survey sheets were positive for services received, as well as for staff performance. There were no complaints.

Action: Continue to collect 25 survey sheets per month. Review at monthly staff meetings and forward reports to Riverview quarterly.

ASPECT: Complication Management after Dental Extractions

Indicators	Findings	Compliance	Threshold Percentile
Clinical Services will assess each patient for pain after surgical extractions. Patients will be assessed for pain, infection or other complications after surgical extractions..	14 extractions	100%	100%

Summary: Aftercare instructions are given both orally and in writing to every extraction patient and/or caregiver prior to leaving recovery. There were 14 extractions in the 3rd quarter with no complications or symptoms of infection.

Action: Continue to call extraction patients 72 hours post-extraction. Review at month staff meetings and forward reports quarterly to Riverview.

DIETARY

ASPECT: Timeliness and accuracy of data entry

Indicators	Findings	Compliance	Threshold Percentile
1. Admission data was placed into the Geri menu meal service program within 24 hours.	54 of 55	98%	95%
2. Discharge information was updated in the Geri menu meal service program within 48 hours.	51 of 51	100%	95%
3. Transfers were updated in the Geri menu meal service program with 24 hours.	186 of 187	99%	95%

Summary: All indicators are within threshold percentiles. One client was admitted on January 5, 2009. This client was entered into the Geri menu system on January 6, 2009. One client was transferred to a different unit on January 28, 2009. This information was updated in Geri menu on January 29, 2009. One problem that was found was that the “Geri Menu” software program logs the date of the data entry, not the time. Thus, findings may not be accurate.

Action: The Dietary Department now refers to the “Meditech” computer program for exact time stamp of admission to solve the above problem. Current method of inputting data into the “Geri Menu” system is now accurate and timely. This indicator will end due to the consistency of high compliance levels. In beginning in the month of April, the Dietary department will track the cleanliness of the Main Kitchen area to ensure compliance with federal & state regulations.

HEALTH INFORMATION

ASPECT: Confidentiality

Indicators	Findings	Compliance	Threshold Percentile
All client information released from the Health Information department will meet all Joint Commission, State, Federal & HIPAA standards.	3078 requests for information (203 requests for client information and 2875 police checks) were released for quarter 3 2009.	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	5 new employees/contract staff in quarter 3 2009.	100%	100%
Confidentiality/Privacy issues tracked through incident reports.	0 privacy-related incident reports during quarter 3 2009.	100%	100%

Summary: The indicators are based on the review of all requests for information, orientation for all new employees/contract staff and confidentiality/privacy-related incident reports. No problems were found in quarter 3, however compliance with current law and HIPAA regulations need to be strictly adhered to requiring training, education and policy development at all levels.

Action: The above indicators will continue to be monitored.

ASPECT: Documentation & Timeliness

Indicators	Findings	Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	There were 51 discharges in quarter 3 2009. Of those, 51 were completed by 30 days.	100%	80%
Discharge summaries will be completed within 15 days of discharge.	51 out of 51 discharge summaries were completed within 15 days of discharge during quarter 3 2009.	100%	100%
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	2 forms were revised in quarter 3 2009 (see minutes).	100%	100%
Medical transcription will be timely and accurate.	Out of 500 dictated reports, 500 were completed within 24 hours.	100%	90%

Summary: The indicators are based on the review of all discharged records. There was 100% compliance with record completion. Weekly “charts needing attention” lists are distributed to medical staff, including the Medical Director, along with the Superintendent, Deputy Superintendent, and the Risk Manager. There was 100% compliance with timely & accurate medical transcription services. No issues this quarter.

Action: Continue to monitor.

HUMAN RESOURCES

ASPECT: Management of Human Resources

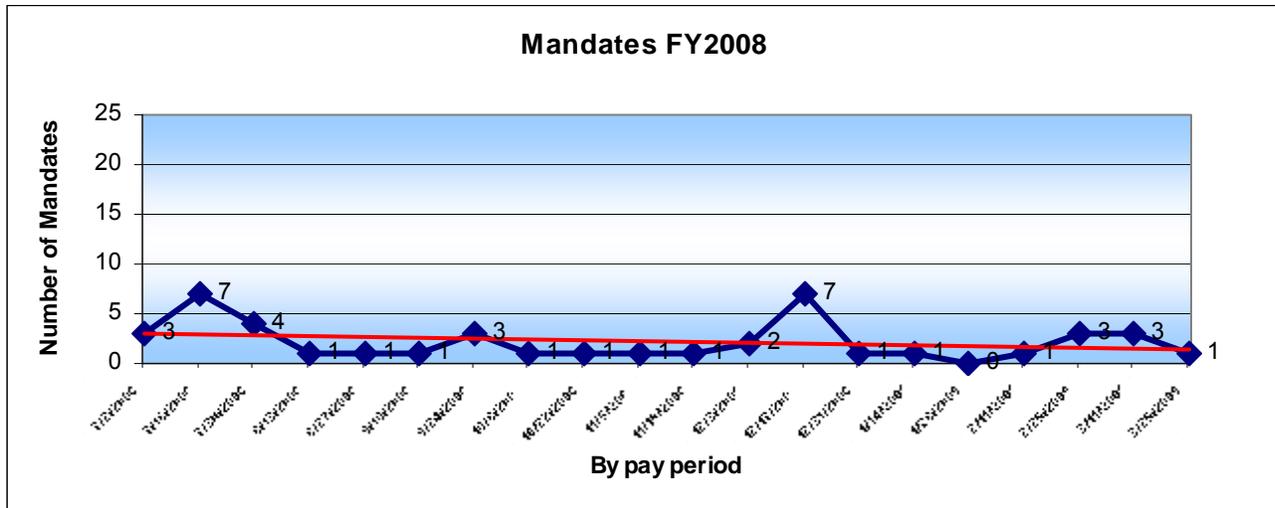
Indicator	Findings	Compliance	Threshold Percentile
Employee Performance Evaluations expected to be completed within 30 days of the due date.			
Jan 2009 (Nov evals)	19 of 32	59%	85%
Feb 2009 (Dec evals)	18 of 30	60%	85%

Mar 2009 (Jan evals)	15 of 20	75%	85%
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Summary: As compared to last quarter (63%) this quarter increased to 64%. As compared to the same quarter last year, 2008, we were at 80% compliance. During this quarter 82 performance evaluations were sent out; 52 were received in a timely manner.

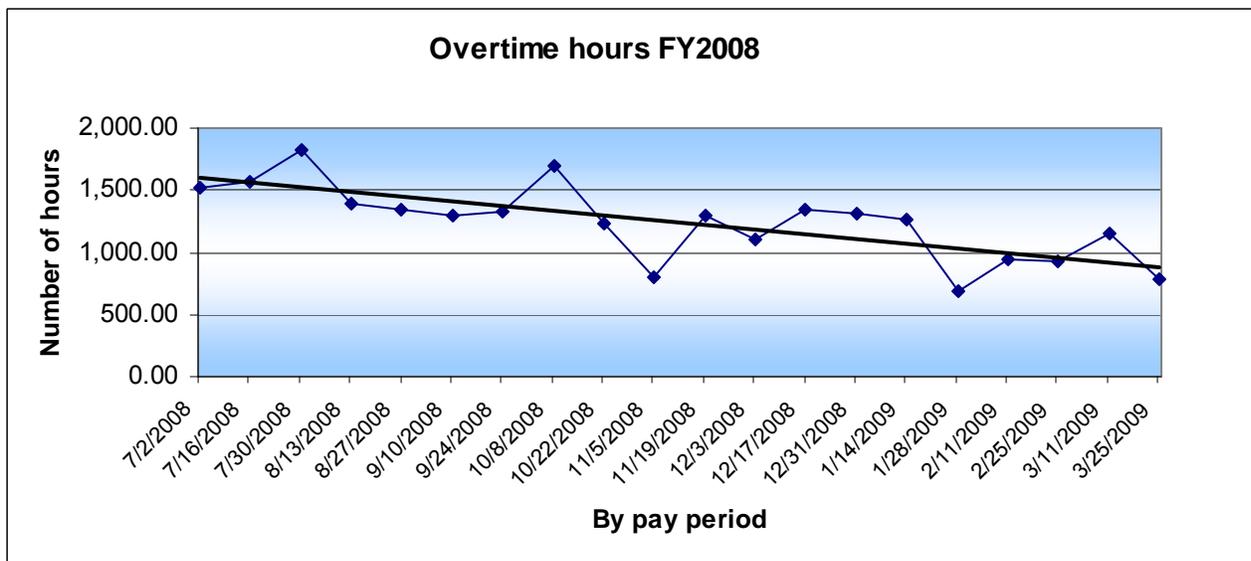
Action: Human Resources continue to follow-up with supervisors on overdue evaluations. Human Resources also began adding an expectation to all supervisors' performance evaluations that they complete performance evaluations in a timely manner to increase the supervisor's accountability in this process.

ASPECT: Mandates



Summary: Mandated shifts have **decreased** this past quarter as compared to last quarter. Mandates decreased from 14 last quarter to 9 during this quarter. Last year we had a total of 46 mandated shifts during this same rating period; this represents an 80% decrease from last year.

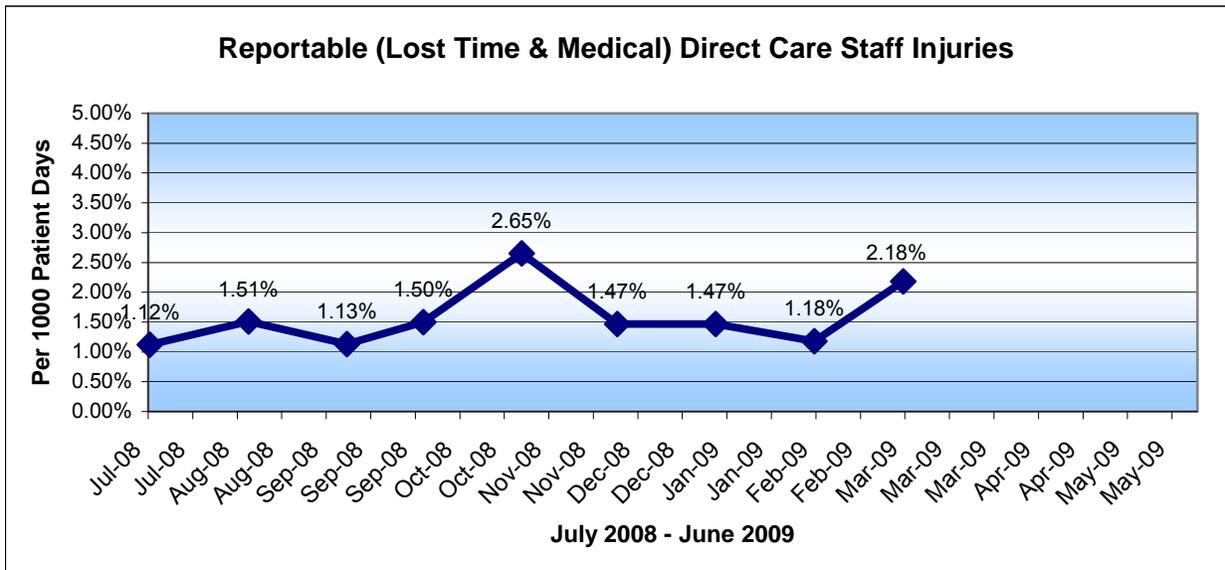
ASPECT: Overtime Hours



Summary: Overtime has **decreased** this quarter as compared to last quarter. Overtime decreased from 8,799.75 hours to 5,753.00 hours. As compared to the same quarter last year

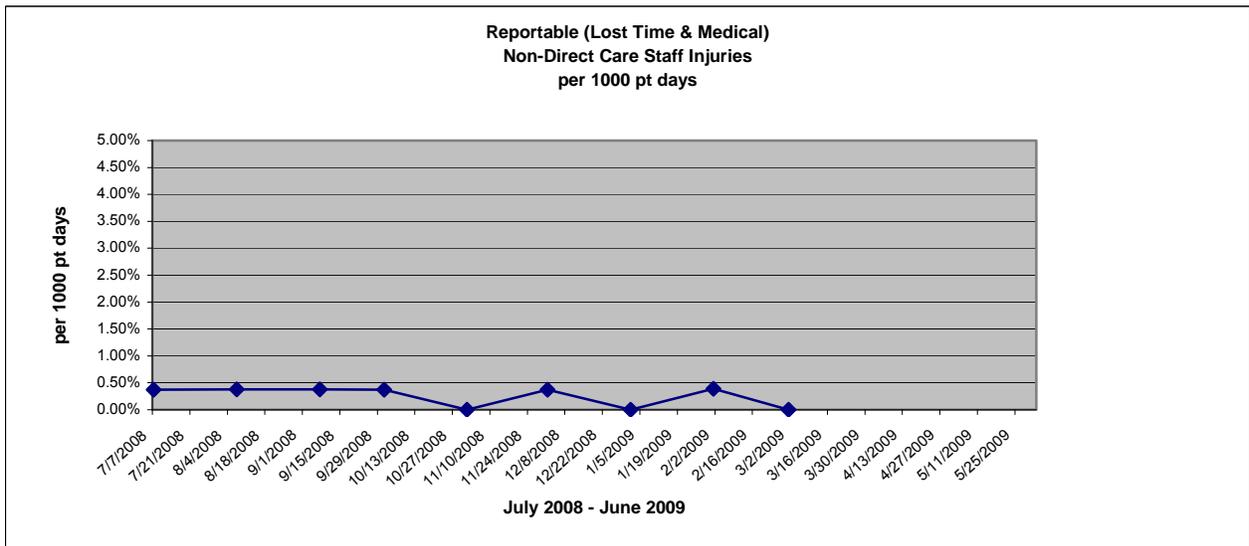
we had 10,764.00 hrs of overtime, this represents a 47% decrease from last year. Trend line is shown and extrapolated for future projection.

ASPECT: Direct Care Staff Injuries



Summary: This quarter review reveals that there was a **decrease** in direct care staff injuries from 1.87% per 1000 patient days last quarter to 1.61% per 1000 patient days this quarter. This number represents (13) direct care staff who sought medical treatment or lost time from work, as compared to (15) last quarter.

ASPECT: Non-Direct Care Staff Injuries



Summary: There was (1) non-direct care injury for this quarter as compared to (2) last quarter, representing those who lost time or sought medical treatment.

INFECTION CONTROL

ASPECT: Hospital Acquired Infection

Indicators	Findings	Compliance	Threshold Percentile
Total number of infections for the third quarter of the fiscal year, per 1000 patient days	27/2.8	100 % within standard	5.8 or less
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	3/2.0	100% within standard	5.8 or less

Summary: The hospital maintains total house surveillance. Data is collected via antibiotic reports, lab and/or radiology reports, chart review and clinical findings. The rate of hospital infections is within the threshold percentile and within the accepted two (2) standard deviations. The rate of hospital acquired (healthcare associated) infections is within the threshold percentile and well within the accepted two (2) standard deviations.

Action: Hand hygiene continues to be stressed to employees and clients. Purell hand sanitizer is readily available. Posters reflecting hand hygiene are throughout the facility. House Keeping works diligently to maintain overall cleanliness. Members of the Infection Control Committee are encouraging employees to clean medical equipment, counters and exam tables after each individual use.

MEDICAL SERVICES

ASPECT: Monitor Clients on Orally Disintegrating Tablets (ODTs) for More than 30 Days

Indicators	Findings	Compliance	Threshold Percentile
All clients receiving an orally disintegrating tablet for greater than 30 days will be reviewed at a medical staff meeting to be certain it is needed to maintain compliance or other clinical justification. This is seen as cost-effectiveness indicator.	13 clients discussed; 3 discontinued; 2 consider discontinuing; 8 remain on	100%	100%

Summary: This is the first quarterly review of clients on ODTs for more than 30 days. All such clients in the hospital were reviewed. Of the 13 clients reviewed, 3 had their ODT discontinued, 2 will be considered for discontinuation, and 8 will remain on their ODT for sufficient clinical reasons.

Action: We will continue to monitor clients on orally disintegrating tablets on a quarterly basis, and review the medical necessity for same.

ASPECT: Assessment and Reduction of Client BMIs

Indicators	Findings	Compliance	Threshold Percentile
All clients with elevated BMIs will have a comprehensive peer review of current treatment plans with a goal of encouraging weight loss.	10 of 10 clients reviewed	100%	100%

Summary: Perceived problems causing clients to be overweight are: lack of exercise; excessive availability of snacks and soda machines; treatment mall cooking groups with high calorie foods; process for asking for double/increased portions at mealtime; overall poor eating habits; and medications that promote weight gain. 27% of hospital clients are overweight (BMI 25-29); 40% are obese (BMI 30-39); and 9% are extremely obese (BMI 40+); and 24% have ideal body weight.

Action: Physicians will continue to track BMIs, on a quarterly basis, for all hospital clients and correlating lipid profile and blood sugar data. Physicians may write specific orders for a client to have his meal tray on the unit and only receive snacks from dietary. They will encourage outings that do not involve eating out or buying extra food; work towards developing a more limited policy for ordering take-out; and limit foods brought in by family and friends. They will attempt to reduce use of medications that promote weight gain. They will encourage more exercise and other sponsored activities to reduce weight.

ASPECT: Completion of AIMS

Indicators	Findings	Compliance	Threshold Percentile
Charts of clients at Riverview for six or more months are reviewed. Each client should have an AIMS exam done upon admission and every six months thereafter.	11 of 38 were in compliance	29%	90%

Summary: AIMS testing is being done upon admission, but follow-up tests every six months are not, by and large, therefore, making the hospital non-compliant with its policy. Clients' charts were reviewed for completion of AIMS in February and March. By the end of the 3rd quarter 11 of 38 charts were in compliance. The compliance rate increased from 10% in February to 29% in March.

Action: We will continue to monitor AIMS testing on clients at the hospital for six months or more. Psychiatrists will be provided with a monthly list indicating which clients are due for AIMS testing each month. Feedback to individual psychiatrists is given at the Peer Review Committee.

NURSING

ASPECT: Seclusion and Restraint Related to Staffing Effectiveness

Indicators Seclusion/Restraint related to staffing effectiveness:	Findings	Compliance
1. Staff mix appropriate	97 of 97	100%
2. Staffing numbers within appropriate acuity level for unit	97 of 97	100%

3. Debriefing completed	97 of 97	100%
4. Dr. Orders	97 of 97	100%

Summary: All findings were 100%. This is an improvement from the last quarter on debriefing.

Action: This will continue to be followed up by the Nurse IV on the unit and the Assistant Director of Nursing for the unit. The expectation is that the debriefing will be completed even if it is not done immediately.

ASPECT: Injuries related to Staffing Effectiveness

Indicators Injuries related to staffing effectiveness:	Findings	Compliance
1. Staff mix appropriate	16 of 16	100%
2. Staffing numbers within appropriate acuity level for unit	16 of 16	100%

Summary: Overall staff injuries are monitored by Risk Management and Human Resources for Direct care and by Human Resources' and Environment of Care for staff injuries due to the environment. Injuries are decreasing . The staffing numbers are within the appropriate level for the current staffing plan and the acuity level.

Actions: Nursing will continue to monitor this indicator and will add another Staffing Effectiveness indicator next quarter related to several issues surrounding staff such as longevity, number of hours worked, comfort with unit.

ASPECT: Redlining

Indicators-Redlining	Findings	Compliance
Lower Kennebec	269 of 270	100%
Upper Kennebec	269 of 270	100%
Lower Saco	266 of 270	99%
Upper Saco	269 of 269	100 %

Summary: The two ADONs have monitored the Redlining checks daily to assure compliance. The evening and night NOD has continued 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. This continues to be high compliance and will be dropped as an official indicator.

Action: This will be dropped as an indicator but will be checked on a random basis and if any change in compliance will be monitored again.

ASPECT: Pain Management

Indicator		Findings	Compliance
Pre-administration	Assessed using pain scale	841 of 850	99 %
Post-administration	Assessed using pain scale	719 of 850	85%

Summary: This indicator has decreased from last quarter with preassessment at 100% and post assessment at 85. The post assessment is as follows: Upper Kennebec 100%; Lower Kennebec 69%; Upper Saco 93%; Lower Saco 77%.

Action: Nursing will continue to place a great deal of attention and effort on post administration assessment. Nursing will continue to track this indicator and strive for increase in post assessment in the next quarter. Special work will be focused on Lower Kennebec and Lower Saco. The two ADONs will continue to work with unit nursing staff to assure that this is done more consistently.

ASPECT: Chart Review

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	94 of 128	73%
2. MHW notes cosigned by RN	72 of 128	56%
3. STGs/Interventions are written, dated and numbered.	121 of 128	95%
4. STGs are measureable and observable	121 of 128	95%
5. STGs/Interventions are modified / met as appropriate.	108 of 128	84%
6. STGs/Interventions tie directly to documentation.	117 of 128	91%
7. Weekly Summary note completed.	57 of 1160	49%
8. Progress notes/flow sheets document a level of functional skill support provided, consistent with the identified area of need, delivered within last 24 hours.	125 of 128	98%

Summary: The overall compliance in this documentation area has increased considerably. Overall compliance last quarter was 62% with overall compliance this quarter at 80%. There was a large increase in MHW notes cosigned from 20% last quarter to 56% this quarter. GAP notes written in appropriate manner at least every 24 hours increased from 56% to 73%. Short-term goals/interventions are written, dated, and numbered increased from 86% to 95%. Short-term goals tie directly to documentation increased from 78% to 91%. Progress notes document a level of functional skill support provided has increased from 53% to 98%. Most areas have improved or remained the same but need continued monitoring and education.

Action: The unit RNs will audit 1 chart per RN and discuss during supervision. This PSD/ Nurse IV will continue to discuss and review chart audit results at staff meetings. The RN IVs assisted by the Assistant Directors of Nursing will ascertain if Unit Nurses are aware of documentation requirements and review with each using the CSP manual and nursing documentation policy. Documentation education and expectations will continue in areas needing

attention. The Nurses doing the chart audits will meet with individual staff to educate individuals on their documentation problems. This documentation area will be a high focus for the next quarter.

PEER SUPPORT

ASPECT: Integration of Peer Specialists into client care

Indicators	Findings	Compliance	Threshold Percentile
1. Attendance at Comprehensive Treatment Team meetings.	403 of 490	82%	80%
2. Grievances responded to by RPC on time.	30 of 42	71%	100%
3. Attendance at Service Integration meetings.	44 of 45	98%	100%
4. Contact during admission.	55 of 55	100%	100%
5. Grievances responded to by peer support on time.	42 of 42	100%	100%
6. Client satisfaction survey completed.	21 of 42	50%	75%

Summary: Overall compliance is 84%, down 7% from last quarter. The most significant drop in compliance was in Peer Specialist attendance at treatment team meetings, dropping 13% from last quarter. This was due to shortages in staff during the month of March. There was an increase in the number of satisfaction surveys completed, up by 4%. There was a 17% increase in grievances responded to by RPC on time this quarter. Compliance for indicator #3 was down 2% from last quarter due to peer support not being notified of 1 service integration meeting.

Action: New peer support staffs are being hired and oriented to address shortage in staffing. Risk manager will continue to send reminders to PSDs about late grievances. Peer Services Director will work with Social Work Director as needed to address lack of notice of service integration meetings.

ASPECT: Client satisfaction with care

Indicators	Findings	Compliance	Threshold Percentile
1. Did anyone tell you about your rights?	14 of 22	64%	85%
2. Has anyone talked to you about the kinds of services that are available to you?	17 of 23	74%	85%
3. Are you told ahead of time of changes in your privileges, appointments, or daily routines?	15 of 22	68%	85%

4. Do you know someone who can help you get what you want or stand up for your rights?	21 of 22	95%	85%
5. Do you have a worker in the community?	9 of 18	50%	85%
6. Has your worker from the community visited or contacted you since you have been in the hospital?	7 of 10	70%	85%
7. Do you know how to get in touch with your worker from the community if you need to?	7 of 10	70%	85%
8. Do you have a community treatment plan?	14 of 18	78%	85%
9. I feel more able to deal with crisis.	19 of 20	95%	85%
10. I am not as bothered by my symptoms.	15 of 21	71%	85%
11. I am better able to care for myself.	19 of 21	90%	85%
12. I get along better with people.	18 of 19	95%	85%
13. I am treated with dignity and respect.	18 of 21	86%	85%
14. I feel comfortable asking questions about my treatment and medications.	21 of 23	91%	85%
15. I understand how my medication works and the side effects.	20 of 24	83%	85%
16. I've been told about self-help/peer support and support groups to use after discharge.	15 of 22	68%	85%
17. I've been told about the benefits and risks of my medication.	17 of 23	74%	85%
18. I have been given information to help me understand and deal with my illness.	18 of 21	86%	85%
19. I feel my other medical conditions are being treated.	18 of 23	78%	85%
20. My pain was managed.	17 of 20	85%	85%
21. I feel free to make complaints and suggestions.	20 of 22	91%	85%
22. I feel my right to refuse medication or treatment is respected.	17 of 22	77%	85%
23. I help in planning my discharge.	15 of 22	68%	85%
24. I feel I have had enough privacy in the hospital.	17 of 24	71%	85%
25. I feel safe while at Riverview?	18 of 22	82%	85%
26. If I had a choice of hospitals, I would choose this one.	13 of 18	72%	85%

Summary: Overall compliance was 79%, up 14% from last quarter. Of the 26 indicators, 9 were at or above compliance, up from 2 last quarter. All but three indicators (5, 7, and 14) increased and one (23) stayed the same.

Some of the identified concerns of clients were:

- Not being informed of all rights
- Not being treated respectfully by some staff
- Confidentiality of health information

Action:

- 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.

PROGRAM SERVICE

ASPECT: Active Treatment

Indicator	Findings	Compliance	Threshold Percentile
1. CSP has, & documentation in progress notes and / or flow sheets demonstrate identified functional need/s including present Level of Support and what Level of Support the goal is.	120/120	100%	80%
2. Progress notes / flow sheets document a level of functional skill support provided, consistent with the identified area of need, delivered within the last 24 hours.	99/120	83%	70%
3. Documentation reveals that the client attended 50% of assigned psycho-social-educational interventions within the last 24 hours.	70/120	60%	70%
4. A minimum of three psychosocial educational interventions are assigned daily.	119/120	99%	70%
5. A minimum of four groups is prescribed for the weekend.	94/120	77%	70%
6. The client is able to state what his assigned psycho-social-educational interventions are and why they have been assigned.	91/120	73%	60%
7. The client can correctly identify assigned RN and MHW. (Or where the information is available to him / her)	108/120	89%	75%
8. The medical record documents the client's active participation in Morning Meeting within the last 24 hours.	44/60	70%	70% LK/LS
	37/60	63%	85% UK/US
9. The client can identify personally effective distress tolerance mechanisms available within the milieu.	111/120	92%	65%
10. Level and quality of client's use of leisure within the milieu are documented in the medical record over the last 7 days.	120/120	100%	75%
11. Level and quality of social interactions within the milieu are documented in the medical record over the last 7 days.	116/120	97%	75%
12. Potential for violence assessed upon admission	115/120	98%	100%
13.a Suicide potential assessed upon admission. (TASR)	112/120	95%	100%
b. Suicide potential moderate or above incorporated into CSP		85%	90%
14a. Fall risk assessed upon admission. (Universal assessment)	113/120	95%	100%

b. Score of 5 or above incorporated into CSP as fall potential		100%	90%
15. Medication reconciliation completed upon admission / transfer / discharge.	69/120	58%	100%
16. Allergies displayed on order sheets and on spine of medical record.	115/120	96%	100%

Summary: Documentation of assigned interventions #3 evidenced an 11% improvement over last quarter, however it remains below threshold. #8 remains below threshold for two of the four treatment units. All other previous indicators are above threshold and many show continuous improvement over previous quarters.

Five new indicators were added this quarter (12-16). As predicted, all initially have fallen below the 100% threshold goal.

Action: PSD's will review all interventions that fall below thresholds with professional staff and unit staff at staff meetings. PSD group will identify hospital-wide variability and build upon individual unit success.

ASPECT: Milieu Treatment

Indicator	Findings	Compliance	Threshold Percentile
1. Percentage of clients participating in Morning Meeting	68%LK 42%UK 54%LS 80%US	61% Ave.	70% LK /LS 80%UK /US
2. Percentage of clients who establish a daily goal.	80% LK 76%UK 70%LS 83%US	77%	80%
3. Percentage of clients who attend Wrap Up group in the evening or address with primary staff, the status of their daily goal.	73%LK 35%UK 55%LS 86%US	62%	70%LK / LS 80%UK /US
4. Percentage of clients attending Community Meeting	65%LK 57%UK 63%LS 86%US	68%	70%
5. Number of clients who have an affirmation read at community Meeting (per meeting)	2.5 LK 1.1 UK 2.6 LS 1.1 US	1.8 Ave. per meeting	7 LK & LS 12 UK& US
6. Number of clients who have a confrontation read at Community Meeting (per meeting)	1 LK 1 UK 1 LS 1 US	.5 Ave. per meeting	7 LK/LS 12 UK/US

Summary: All indicators show some evidence of modest improvement. The US unit remains the only unit that reaches threshold for all #1-4. All other units remain below expectations. Total numbers of affirmations and confrontation #5-6 increased this quarter slightly. All units remain below expectations.

Action: PSD's will address unit specific issues regarding #1-4 and share success strategies with each other. Professional staff will be provided with additional training on how to model affirmations and confrontations. This did not happen as expected last quarter.

PSYCHOLOGY

ASPECT: Co-Occurring Treatment

Co-Occurring Disorders TX Integration	Findings	Compliance	Threshold Percentile
1. There is evidence of an integrated co-occurring comprehensive service plan for identified clients.	22/34	66%	100%
2. There is evidence of "stage of Change" documented in client comprehensive service plan	14/34	41%	85%
3. There is documentation of identified client's participation in co-occurring treatment.	12/34	35%	65%
4. 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"	11/19	58%	65%
5. Consumer Satisfaction Survey indicates that since beginning treatment with us, their condition is better.	14/24	58%	65%
6. Consumer Satisfaction Survey reports client satisfaction with current treatment experience is better than with any other previous treatment experiences.	17/24	71%	65%
7. Percent of clients with co-occurring disorders as reported by NASMHPD		<i>Data unavailable</i>	

Summary: Service plans showed improvement in integrating co-occurring treatment and in participation in treatment. Stage of change identification remained approx. the same. Indicators are below threshold. Consumer satisfaction dropped slightly overall. Due to small numbers this drop is not statistically significant, however, two indicators remain below threshold.

Action: Change in duties made to co-occurring staff has been somewhat effective in identifying clients with co-occurring disorders, these efforts will continue. Clinical staff in social work and psychology will receive education in staff meeting regarding the importance of discussing client satisfaction and assessment of recovery.

ASPECT: Psychological Services

Psychologist Service Delivery & Documentation	Findings	Compliance	Threshold Percentile
1. Psychologist short-term goals on CSP are measurable and time limited.	30/30	100%	100%
2. Psychologist progress notes indicate treatment offered as prescribed on CSP.	30/30	100%	100%
3. Psychologist progress notes indicate client's understanding of goals and client self-assessment of progress.	30/30	100%	100%

Summary: 100% compliance achieved with all indicators.

Action: Peer review chart audits will continue for next quarter. Psychologist supervisors will provide feedback to supervisees. Sustained compliance is expected.

REHABILITATION SERVICES

ASPECT- Readiness Assessments, Comprehensive Service Plans and Progress Notes

Indicators	Findings	Compliance	Threshold Percentile
1. Readiness assessment and treatment plan completed within 7 days of admission.	29 / 30	97%	100%
2. Rehabilitation short term goals on Comprehensive Service Plan are measurable and time limited.	28 / 30	93%	100%
3. Rehabilitation progress notes indicate treatment being offered as prescribed on Comprehensive Service Plan.	27 / 30	90%	100%
4. Rehabilitation progress notes indicate progress towards addressing identified goals on the Comprehensive Service Plan.	23 / 30	77%	100%

Summary: This is the second quarter review of the above indicators and will continue to be focused on and monitored to ensure continuity of care from assessment to progress notes.

Indicator #1- Only one assessment was not completed within 7 days of admission. Client transferred units within the first 7 days of admission and RT on receiving unit not aware that assessment hadn't been completed.

Indicator #2 & 3- Two of the charts did not have updated STG's identified and those two charts also did not reflect prescribed treatment in the documentation. Indicator # 3 also had one other chart that did not reflect the prescribed treatment in the progress note. Notes were present in this chart but did not identify groups client was attending and progress in these groups.

Indicator #4- In review of the other 4 treatment plans and documentation, progress towards the identified goals is not reflected in the rehabilitation progress note in a consistent manner.

Action: The Director will meet with the Recreation Therapist on the two units to review individualized treatment planning and progress note writing so that they can meet with the HA's to assist them with progress note writing. This was discussed at the April 8th department meeting for all rehabilitation staff. The Director will continue to audit charts and provide individual supervision for all RT's to ensure expectations of indicators are achieved as outlined above.

SAFETY

ASPECT: Life Safety

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%	95%
2. Total number of staff assigned to Lower Saco and Lower Kennebec who have received training with the evacuation chair.	80/80	100%	95%
3. Total number of staff assigned to the Float Pool who have received training with the evacuation chair.	26/26	100%	95%
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.	3/3	100%	100%
5. Total number of staff who knows what R.A.C.E. stands for.	114/114	100%	95%
6. Total number of staff who knows how to acknowledge the fire alarm or trouble alarm on the enunciator panel.	114/114	100%	95%
7. Total number of staff who knows the emergency number.	110/114	96%	95%
8. During unannounced safety audits conducted by the Safety Officer, this represents the total number of staff who display identification tags.	113/114	99%	95%
9. During unannounced safety audits conducted by the Safety Officer, this represents the total number of direct care staff who carry a personal duress transmitter.	112/114	98%	95%

Summary: All staff have received training in the use of the evacuation chair. Riverview is at 100% compliance. Riverview continues to train newly hired staff during their initial orientation. The (3) alarms reported for the hospital meet the required number of drills per Joint Commission and Life Safety Code. Indicators 5 through 7 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. #'s 5-9 also reflect the response during a recent training fair held on March 18, 2009.

Action: Riverview continues to train newly hired staff during their initial orientation on the use of the evacuation chair. Riverview continues the initiative by conducting a hospital-wide census during such events utilizing two-way radios. The NOD's have also been assisting in that initiative by immediately securing a two-way radio and initiating the census. Drills continue to show an improvement in that area. Riverview continues with environmental tours and safety audits to assure that staff is in possession of required safety equipment and facility ID's.

Riverview will continue to monitor these indicators during future safety fairs, along with those during the tours and audits.

ASPECT: Fire Drills Remote Sites

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 based on the fact that it is business occupancy.	1 drill	100%	100%

Summary: 1 drill conducted with 100% compliance

Action: The Portland Clinic is scheduled to have a fire drill during the month of May. Staff continues to perform Environmental tours and still monitor the knowledge base of staff as it relates to what they need to do in the event of an alarm or event by asking them questions and having informal 5 minute “tailgate talks”.

ASPECT: Securitas/RPC Security Team

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).	55/55	100%	95%
2. Security Officer “foot patrols” during Open Hospital times. (Total # of “foot patrols” done vs. total # of “foot patrols” to be done.)	1973/1980	99%	95%
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.)	540/540	100%	95%

Summary: Security continues to reach its goal with regard to the indicators above.

Action: Securitas and the Safety Officer are in the process of formulating new indicators. The target was to roll them out for the 3rd quarter, but continued meetings and conversing with other like facilities has delayed this change. It is now set for the 4th quarter as a target for reporting.

SOCIAL WORK

ASPECT: Preliminary Continuity of Care Meeting and Comprehensive Psychosocial Assessments

Indicators	Findings	Compliance	Threshold Percentile
1. Preliminary Continuity of Care meeting completed by end of 3 rd day	30/30	100%	100%

2. Service Integration form completed by the end of the 3rd day	30/30	100%	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.	5/5	100%	100%
3a. Client Participation in Preliminary Continuity of Care meeting.	30/30	100%	90%
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.	28/30	93%	90%
3d. Community Provider Participation in Preliminary Continuity of Care meeting.	5/15	33%	90%
3e. Correctional Personnel Participation in Preliminary Continuity of Care Meeting.	0/15	0%	90%
4a. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	25/30	83%	100%
4b. Annual Psychosocial Assessment completed and current in chart	30/30	100%	100%

Summary: Indicator 3d: This area is down slightly from 36% last quarter to a measure of 33%. Indicator 3e: This area has been low or indicated no participation for numerous quarters. Indicator 4a: This area was down 3% from a last quarter showing of 86% to 83%.

Action: 3d Will continue to monitor and foster support from the regional supervisors and the CDC offices and we are continuing with on-going quarterly meetings with the region CDC coordinators and mental health team leaders to continue to monitor this important continuity of care area. A CDC coordinator attends the weekly Wednesday discharge planning meeting to address community issues.

3e: Director will continue to monitor and work with the mental health liaison with the Department of Corrections and the jail assigned ICM staff to continue to problem solve this area.

4a: This area will continue to be monitored through individual and group supervision and on-going chart audits. Progressive discipline is used through supervision to correct this area as needed.

ASPECT: Institutional and Annual Reports

Indicators	Findings	Compliance	Threshold Percentile
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	5/8	62%	95%
2. The assigned CCM will review the new court order with the client and document the meeting in a progress note or treatment team note.	8/8	100%	100%
3. Annual Reports (due Dec) to the commissioner for all inpatient NCR clients are submitted annually	N/A	N/A	100%

Summary: Indicator 1 increased 42% from a last quarter showing of 20% compliance. This is a significant increase from the last quarter report. The Forensic teams will continue to monitor this critical area and our on-going efforts to streamline the institutional report process. Members of the Forensic Units have begun meeting with members from Clinical Leadership to discuss the long range vision of the forensic units and population. In addition a Forensic shared drive was created to hold all reports and streamline the input and editing process to improve the outcomes of indicator 1.

Action: Continue to monitor

ASPECT: Client Discharge Plan Report/Referrals

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

Summary: All areas met compliance for this quarter

Action: Continue to monitor

ASPECT: Treatment Plans and Progress Notes

Indicators	Findings	Compliance	Threshold Percentile
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all clients on assigned CCM caseload.	43/45	95%	95%
2. On Upper Saco progress notes in GAP/Incidental format will indicate at minimum bi- weekly 1:1 meeting with all clients on assigned CCM caseload	15/15	100%	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.	54/60	90%	95%

Summary: Indicator 3: This area is up slightly 4% from last quarter. The quality of treatment plans has improved over the last several quarters and the team continues to focus on this area.

Action: Continue to monitor

STAFF DEVELOPMENT

ASPECT: New Employee Education and Mandatory Training

Indicators	Findings	Compliance	Threshold Percentile
1. New employees will complete new employee orientation within 60 days of hire.	6 of 6	100%	100%
2. New employees will complete CPR training within 30 days of hire.	5 of 5	100%	100%
3. New employees will complete NAPPI training within 60 days of hire.	5 of 5	100%	100%
4. Riverview staff will attend CPR training bi-annually.	315 of 315	100%	100%
5. Riverview staff will attend NAPPI training annually. Goal to be at 100% by end of fiscal training year 09 on June 30 th . Fiscal year 08 at 100%	321 of 370	87%	100%
6. River staff will attend Annual training. Goal is to be at 100% by end of fiscal training year 09 on June 30 th . Fiscal year 08 at 100%	372 of 381	98%	100%

Summary: The indicators are based on the requirements for all new/current staff to complete mandatory training and maintain current certifications. **5 out of 5 of** (100%) new employees completed these trainings. **315 of 315** (100%) employees are current with CPR certification. **321 of 370** (87%) employees are current in Nappi training. **372 of 381** (98%) employees are current in Annual training. All indicators remained at 100 % compliance for quarter 3-FY 2009.

Action: Three more Nappi classes and one more annual training date have been scheduled before June 30th to be in compliance with training requirements.

SUPPORT SERVICES

ASPECT: Injuries Due To the Environment

Indicators	Findings	Compliance	Threshold Percentile
Total of staff injuries reported due to the environment and corrected within 24 hours.	2 of 4	50%	100%

Summary: 4 of 44 total staff injuries were reported due to the environment this quarter. 2 of the 4 occurrences were immediately addressed within 24 hrs. In January, one staff person slipped on an icy walkway to the facility. In February a staff person slipped on an icy walkway not in the same location where previous slip injury occurred. In March, on two separate occasions, staff was lifting filled soiled linen bags causing an injury to their shoulder and an injury to their wrist for the other. Housekeeping could not completely resolve problem within 24 hrs. due to the amount of laundry hampers throughout the facility, thus a 50% compliance for this quarter.

Action: (*Falls in January & February*):

- The maintenance department was immediately dispatched to salt/sand areas where incident occurred.

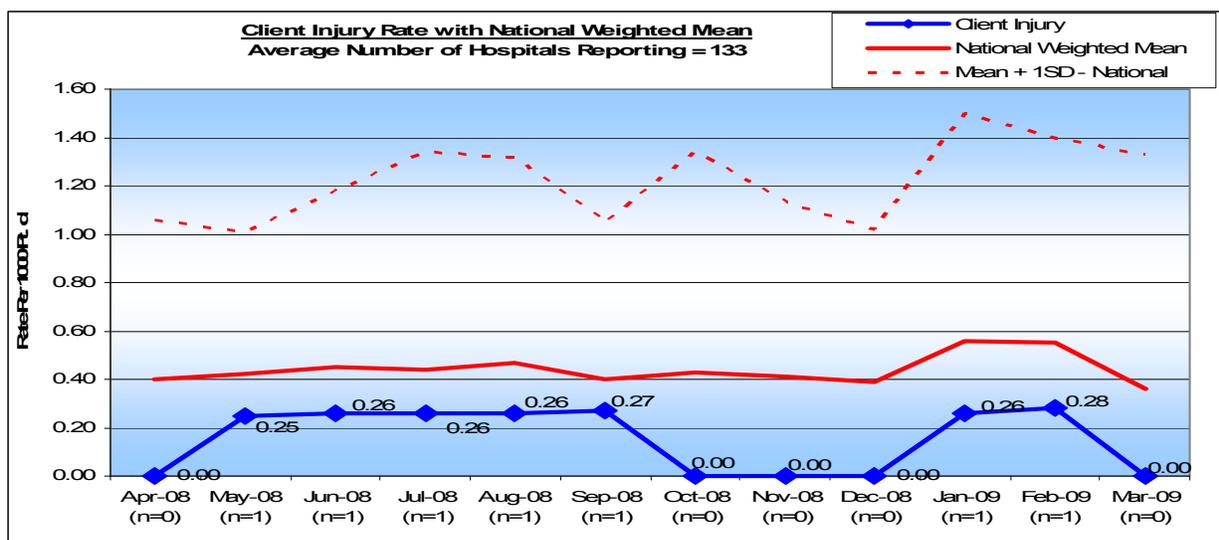
(*Lifting laundry bag injuries in March*)

- Fill line indicators are to be installed on each laundry hamper so to not overfill causing a potential heavy lifting scenario for staff.
- Email to be sent out to staff to be cognizant of not lifting bags that are too heavy.
- Research will be done by Executive Housekeeper to find other options to use to help address this issue
- Repairs and necessary changes are to be made in a timely manner (within 24 hours)

PERFORMANCE TRENDS COMPARED TO NATIONAL BENCHMARKS

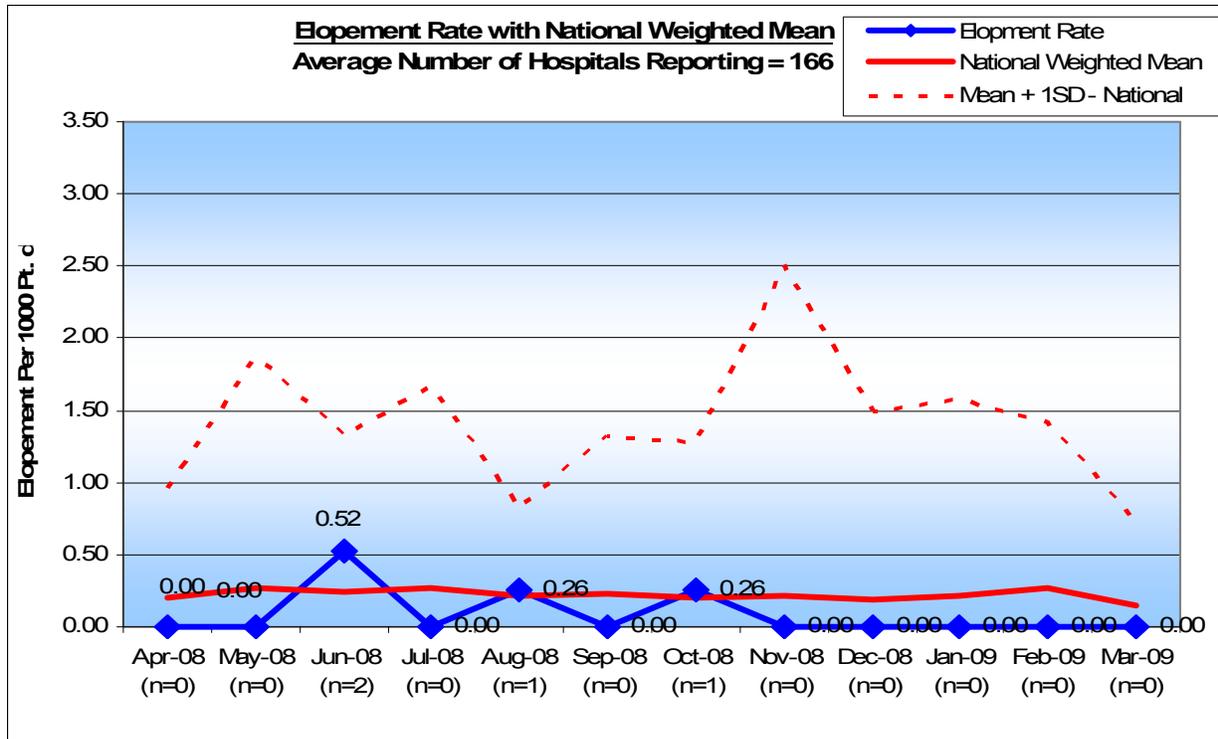
This section contains a number of graphs that compare Riverview Psychiatric Center to a national sample (the range is approximately 75-205 hospital across all aspects) of participating like facilities. Each line graph presents the national weighted mean (solid red line) and the limit of the first standard 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 1st Standard Deviation) of other hospitals in the sample.

CLIENT INJURY RATE GRAPH



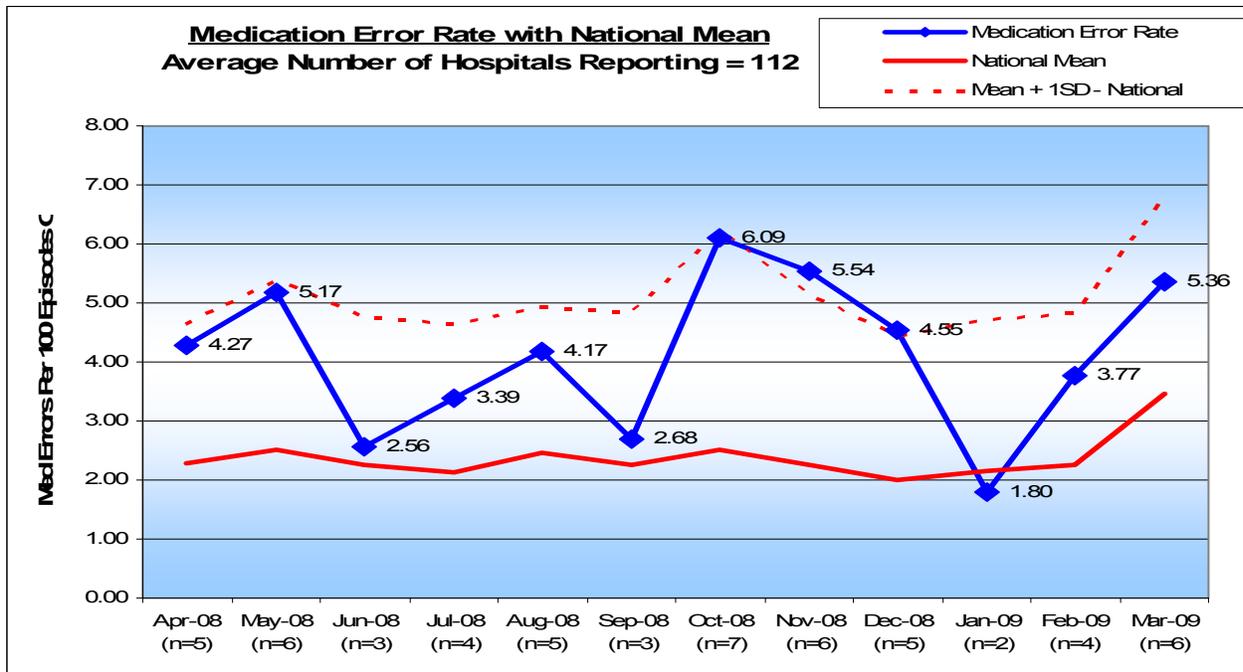
Client Injury Rate considers slips, trips and falls; self-injurious behavior; and client-to-client injury that requires more than first aid. The numbers of such incidents are low, as shown by the little "n" under each month. Riverview is well within the 1st standard deviation of the national sample. Please note the sheer number of events at Riverview is very low, between zero and 1 each month. Over the last 3 months reported in this graph, there were 2 injuries requiring more than first aid level of care.

ELOPEMENT RATE GRAPH



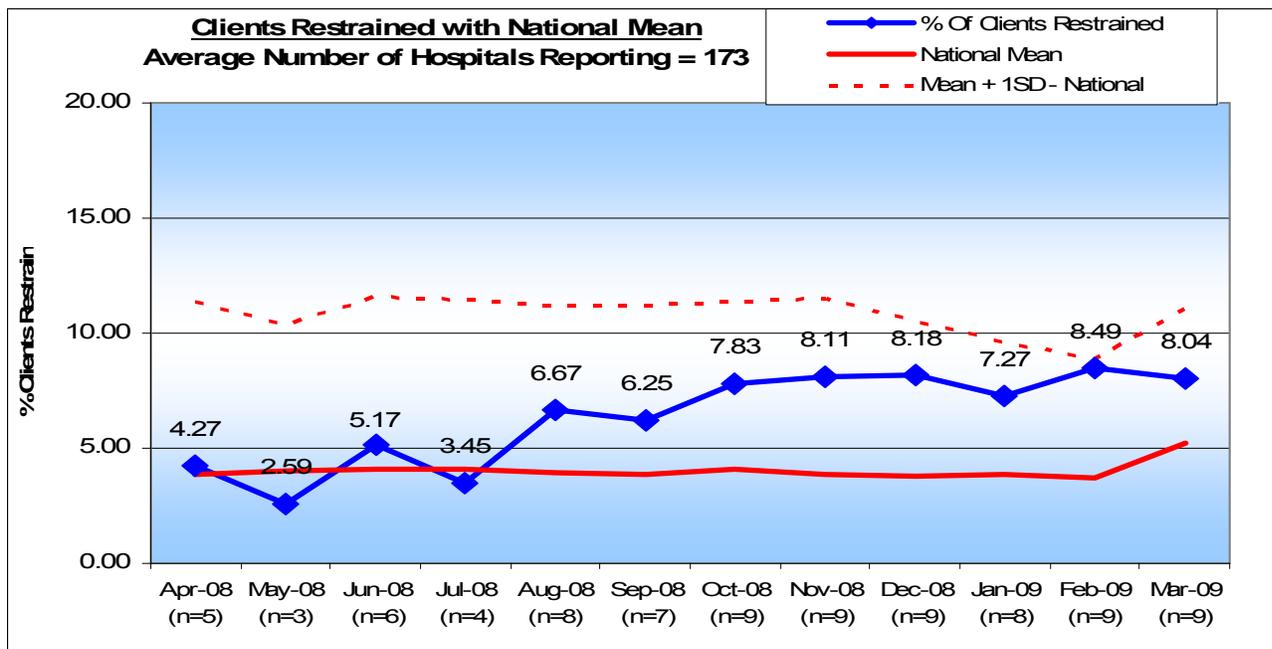
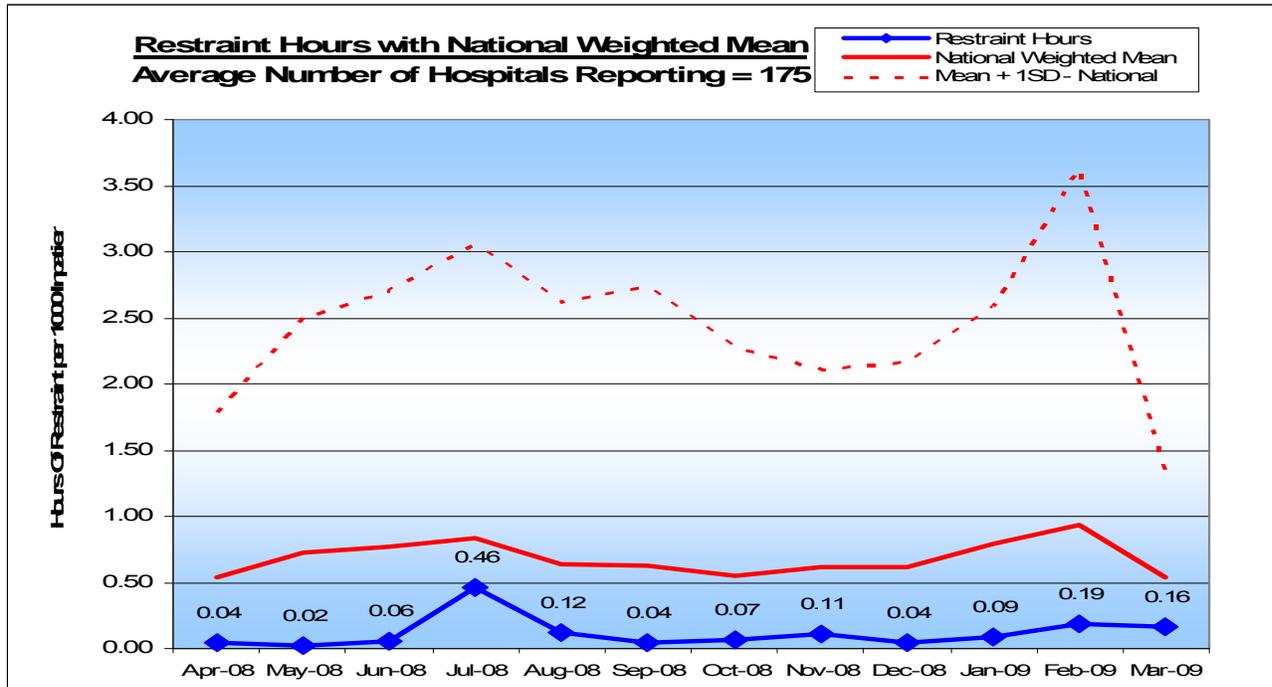
Elopement Rate is calculated per 1000 patient days. Elopement is defined as the client not being where expected at any given time, for instance if the client is supposed to return at 8 pm but is late and does not call to report the circumstance the client is considered to have eloped. The treatment team evaluates elopement risk and is treatment planned if necessary to keep the client and the community safe. RPC's elopement rate remains at zero for the last five months.

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. Higher error rate indicates Riverview is capturing the vast majority of medication errors providing the opportunity to correct process or performance issues.

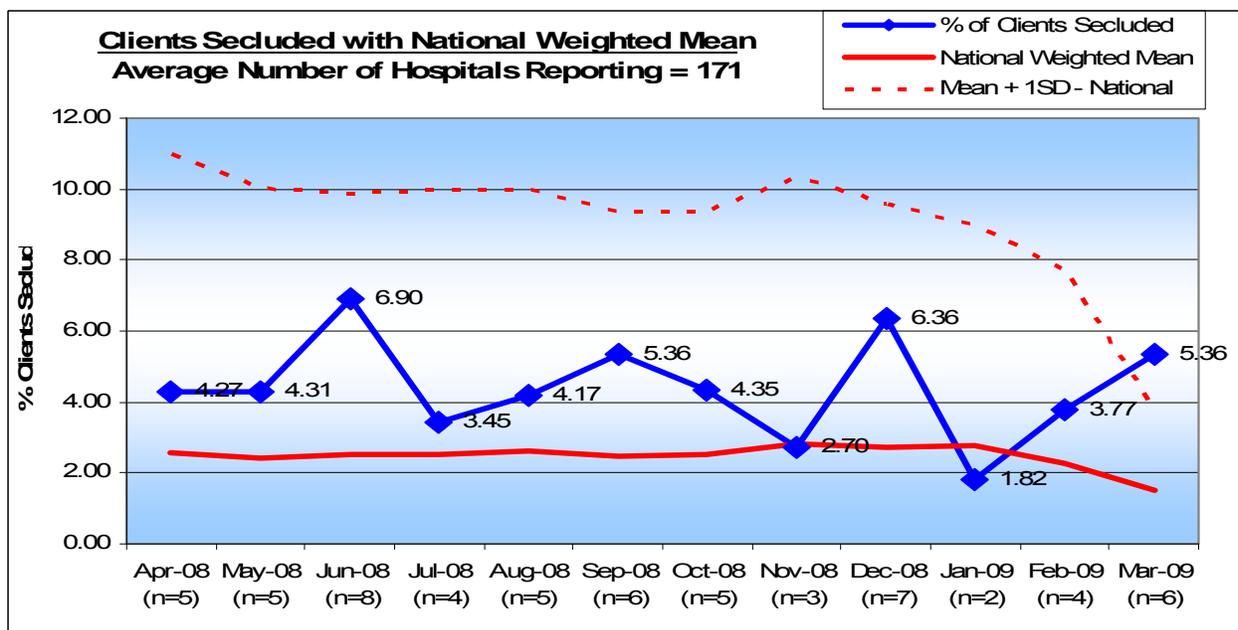
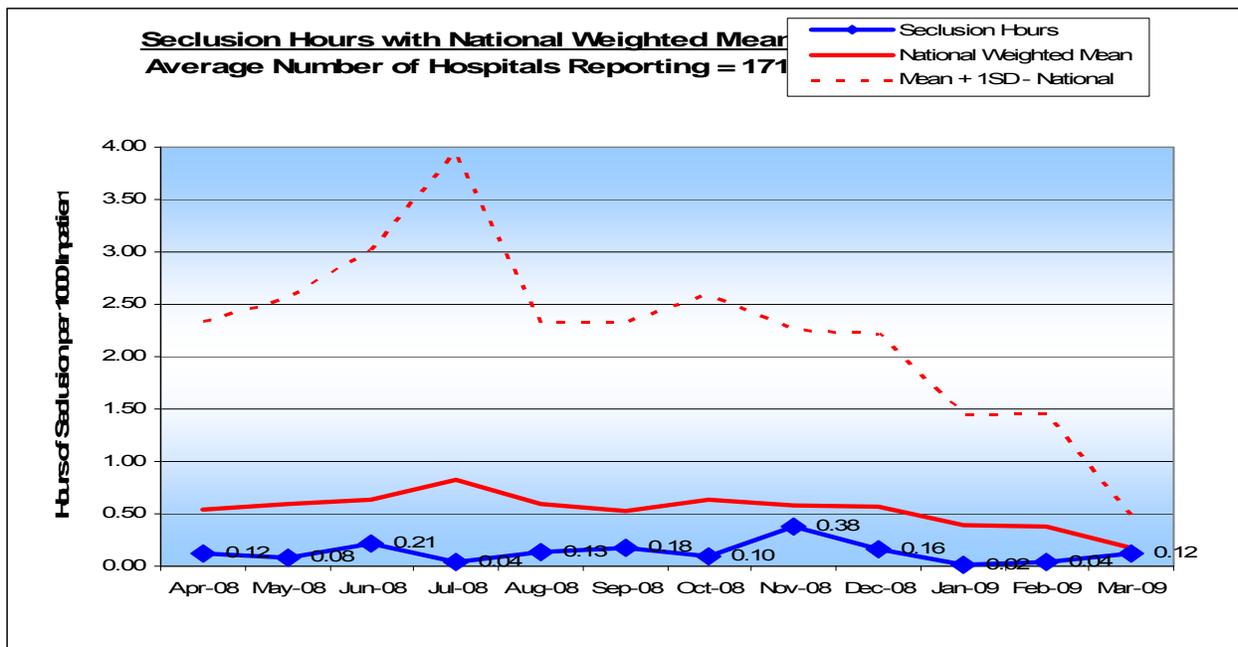
RESTRAINT GRAPHS



Riverview's rate of clients restrained remains above the statistical mean. The restraint hours (duration) rate remains well below the statistical mean. 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 were applied last quarter and RPC has seen a decline in both time and frequency. These strategies included, reducing the time for restraint order renewal from 1 hour to ½ hour; education concerning need to debrief client within 72 hours following event and teaching staff early intervention Nappi verbal skills.

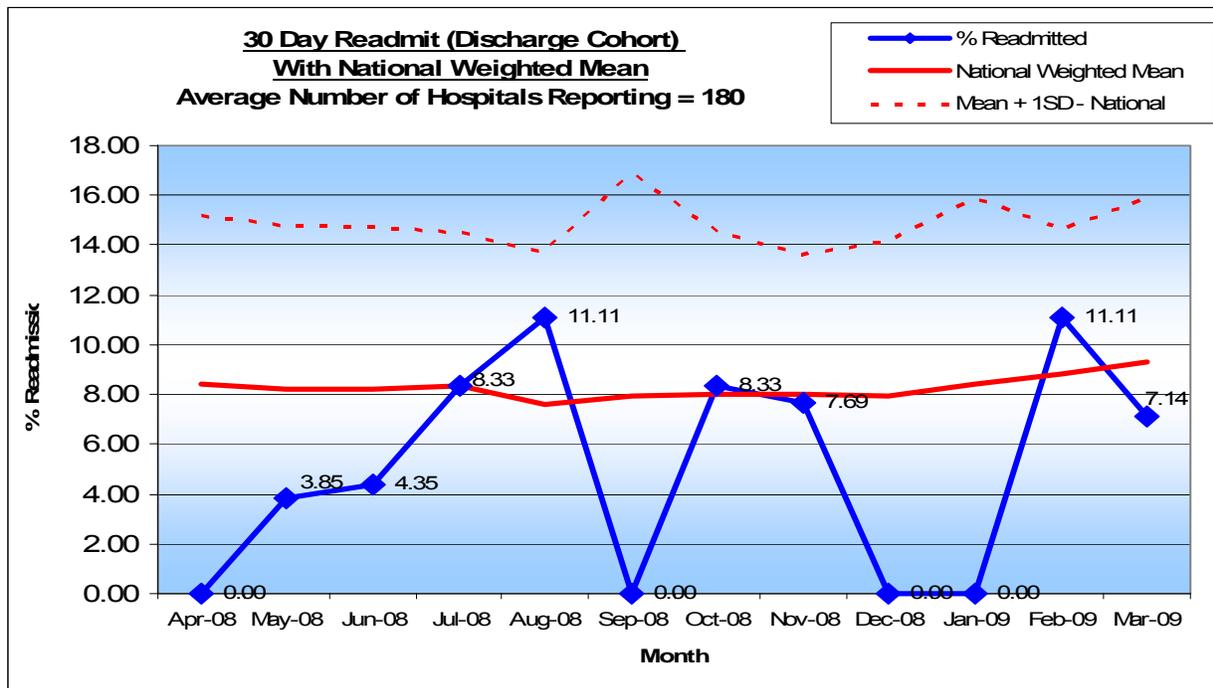
SECLUSION GRAPHS



Seclusion hours (duration of events) at Riverview continue to remain below the national weighted mean. The percent of clients secluded has been level or decreasing over the past several months. The number of clients secluded has decreased this past quarter. RPC will continue its efforts to reduce use of these interventions. Corrective actions were applied last quarter and RPC has seen a decline in both time and frequency. These strategies included, reducing the time for restraint order renewal from 1 hour to ½ hour;

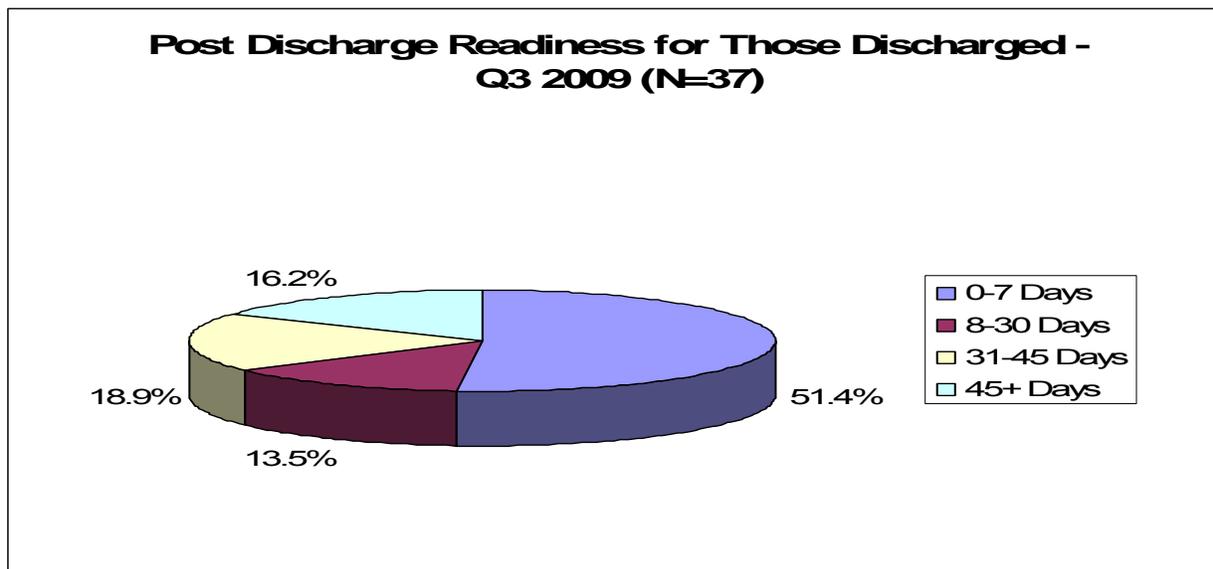
education concerning need to debrief client within 72 hours following event and teaching staff early intervention Nappi verbal skills. Expansion of the multi-sensory rooms to all other units is expected to decrease the use of seclusions.

THIRTY-DAY READMIT GRAPH



30 Day Readmission Rate is slightly above or below the mean of the 205 other facilities reporting on this indicator this quarter with this indicator slightly above in September 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. The Director of Social Work Services reviews all RPC readmissions that occur in less than 30 days of discharge.

POST DISCHARGE PRIOR READINESS CIVIL CLIENTS



This chart shows the percent of civil clients who were discharged within 7 days of their discharge readiness to be at 51.4% for this quarter compared to 47.4% last quarter. Cumulative percentages and targets are as follows:

- Within 7 days = 51.4% (target 75%)
- Within 30 days = 13.5% (target 90%)
- Within 45 days = 18.9% (target 100%)

The previous 6 quarters are displayed in the table below:

Quarter	Within 7 days	Within 30days	Within 45 days	45 +days
Target	75%	90%	100%	0%
Q3 2009	51.4%	13.5%	18.9%	16.2%
Q2 2009	47.4%	76.3%	84.2%	15.8%
Q1 2009	57.5%	62.5%	72.5%	27.5%
Q4 2008	47.6%	76.2%	83.3%	16.7%
Q3 2008	42%	73%	78%	22%
Q2 2008	65.6%	79.3 %	82.7 %	17.3%

HEALTH INFORMATION

ASPECT: Documentation & Timeliness

Indicators	Findings	Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	There were 51 discharges in quarter 3 2009. Of those, 46 were completed by 30 days. Note: There were 14 incomplete records from the previous reporting period.	90%	80%
Discharge summaries will be completed within 15 days of discharge.	50 out of 51 discharge summaries were completed within 15 days	98%	100%

	<p>of discharge during quarter 3 2009.</p> <p>Note; There were 3 incomplete discharge summaries from the previous reporting period.</p>		
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	2 forms were revised in quarter 3 2009 (see minutes).	100%	100%
Medical transcription will be timely and accurate.	Out of 500 dictated reports, 500 were completed within 24 hours.	100%	90%

Summary: The indicators are based on the review of all discharged records. There was 90% compliance with record completion, although there were 14 incomplete records from a previous reporting period. There was 98% compliance with discharge summary completion, although there were 3 incomplete discharge summaries from previous reporting periods. Weekly “charts needing attention” lists are distributed to medical staff, including the Medical Director, along with the Superintendent, Deputy Superintendent, and the Risk Manager. There was 100% compliance with timely & accurate medical transcription services. No issues this quarter.

Actions: Continue to monitor.