

Riverview

PSYCHIATRIC CENTER



PERFORMANCE IMPROVEMENT REPORT

FOURTH QUARTER
April, May, June 2009

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July 15, 2009



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Introduction

For this report, the section on “Coercive Events Trend Graphs” presents comparison graphs on Seclusion, Mechanical Restraints and Manual Holds for each unit. Upper Saco remains consistent with zero frequency, while the Lower Kennebec and Upper Kennebec units show peaks at intervals. The overall Seclusion hours have decreased during the year. All units except Lower Saco, remain at minimal use of Mechanical Restraints. Efforts to continue to reduce the frequency of Mechanical restraints on all units are having a positive outcome. The Manual Holds graph shows consistent use, the trend continues from holds of 0 to 20 minutes.

Most department reports show positive compliance with all indicators, meeting desired thresholds of 100%. Nursing chart reviews indicate documentation compliance has increased since last quarter. The hospital acquired infection rate, in spite of the H1N1 virus prevalence in the community, continues to remain within the threshold percentile. Medical staff indicators, clinic, psychology, health information, safety, security and staff development are doing well. Human Resources shows improvement with an increase in the completion of employee performance evaluations over last quarter reporting. Select departments will be changing their indicators to reflect more imminent needs of the department, as the present indicators are doing so well.

COMMUNITY FORENSIC ACT TEAM

COMMUNITY FORENSIC ACT TEAM

Aspect: Descriptive Report on various components

4th Qtr. FY '09

CASE MANAGEMENT:

Clients enrolled in the ACT program	
	Number of ACT clients
April 2009	33
May 2009	32
June 2009	35

CRISIS MANAGEMENT:

4th Quarter	Client incidents	Hospitalized RPC	Hospitalized Medical
April 2009	3	1	1
May 2009	3	3	1
June 2009	2	6	1

SUBSTANCE ABUSE:

4th Quarter	Client with Substance Abuse as a Clinical Focus	Percent of ACT Clients In SA treatment
April 2009	12	36%
May 2009	11	30%
June 2009	14	40%

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

ACT Clients Living Situation				
4th Quarter	Clients in Supervised Settings	Clients in own apt. or with family	% of clients Supervised Settings	% of Clients in own home or with family
April 2009	24	8	72%	28%
May 2009	22	8	60%	30%
June 2009	25	8	71%	29%

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
April 2009	11	2	754
May 2009	11	2	794
June 2009	11	2	794

DENTAL SERVICES-PORTLAND CLINIC

ASPECT: Monitoring of Patient IV Sedation Experience on Day Following 4th Quarter FY09

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.	70 patients sedated; none reporting symptoms.	100%	100%

Summary: Post-anesthesia instructions are given to patients and/or caregivers both verbally and in writing. All 70 patients sedated in the 4th quarter had satisfactory outcomes.

Actions: Continue to call all sedation patients on the day following sedation. Continue to discuss outcomes at staff meetings. 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. June 2009 is the last month this indicator will be tracked.

ASPECT: Monitoring of Client/Caregiver Satisfaction at Clinical Services 4th Quarter FY09

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 4th quarter. All survey sheets were positive for services received, as well as for staff performance. There were no complaints.

Actions: June 2009 is the last month this indicator will be tracked.

**ASPECT: Complication Management after Dental Extractions
4th Quarter FY09**

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..	12 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 12 extractions in the 4th quarter with no complications or symptoms of infection.

Actions: Continue to call extraction patients 72 hours post-extraction. June 2009 is the last month this indicator will be tracked.

CAPITOL COMMUNITY CLINIC

ASPECT: Complication Management after Dental Extractions, Overall Compliance

Indicators	Findings	Compliance	Threshold Percentile
Clinical Services will assess patient for pain after surgical extractions. Patients will be assessed for pain, infection or other complications after surgical extractions	There were 20 extractions in the 4 th qtr. No infections or complications.	100%	90%

Summary: After care instructions were provided to clients orally and in writing. Clients are requested to call with any complications post extractions. Review at monthly staff meetings and forward reports to RPC

Actions: No further action necessary. This indicator will be discontinued with new indicators initiated for July 2009.

DIETARY

ASPECT: Cleanliness of Main Kitchen

Indicators	Findings	Compliance	Threshold Percentile
1. All convection ovens (4) were thoroughly cleaned monthly.	11 of 12	92%	100%
2. Walk in coolers were cleaned thoroughly monthly.	6 of 6	100%	100%
3. Steam kettles (2) were cleaned thoroughly on a weekly basis	20 of 24	83%	95%
4. All trash cans (5) and bins (1) were cleaned daily	186 of 546	34%	95%
5. All carts(9) used for food transport (tiered) were cleaned daily	603 of 819	74%	100%
6. Dish machine was de-limed monthly	3 of 3	100%	100%
7. Shelves (6) used for storage of clean pots and pans were cleaned monthly	16 of 18	89%	100%
8. Racks(3) used for drying dishes were cleaned daily	158 of 273	58%	100%
9. Knife cabinet was thoroughly cleaned monthly	3 of 3	100%	100%
10. All hand sinks (4) were cleaned daily	284 of 364	78%	95%

Summary: These indicators are based on state and federal compliance standards. Sanitary conditions shall be maintained in the storage, preparation and distribution of food throughout the facility. Written cleaning and sanitizing assignments shall be posted and implemented for all equipment, food contact surfaces, work areas and storage areas.

Most kitchen equipment and storage areas were cleaned on a regular basis. There were however exceptions of areas not meeting the cleaning schedule due to staff schedule, i.e., vacations, days off etc.

Actions: The cleaning schedule will be revised and posted using a color coded format that will remind staff of these high priority areas. The general staff meeting will include discussion and staff suggestions for successful completion of these tasks. Continue to monitor.

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.	4076 requests for information (151 requests for client information and 3925 police checks) were released for quarter 4 2009.	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	15 new employees/contract staff in quarter 4 2009.	100%	100%
Confidentiality/Privacy issues tracked through incident reports.	0 privacy-related incident reports during quarter 4 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 4, however compliance with current law and HIPAA regulations need to be strictly adhered to requiring training, education and policy development at all levels.

Actions: The above indicators will continue to be monitored. Education for all staff provided as necessary.

ASPECT: Documentation & Timeliness

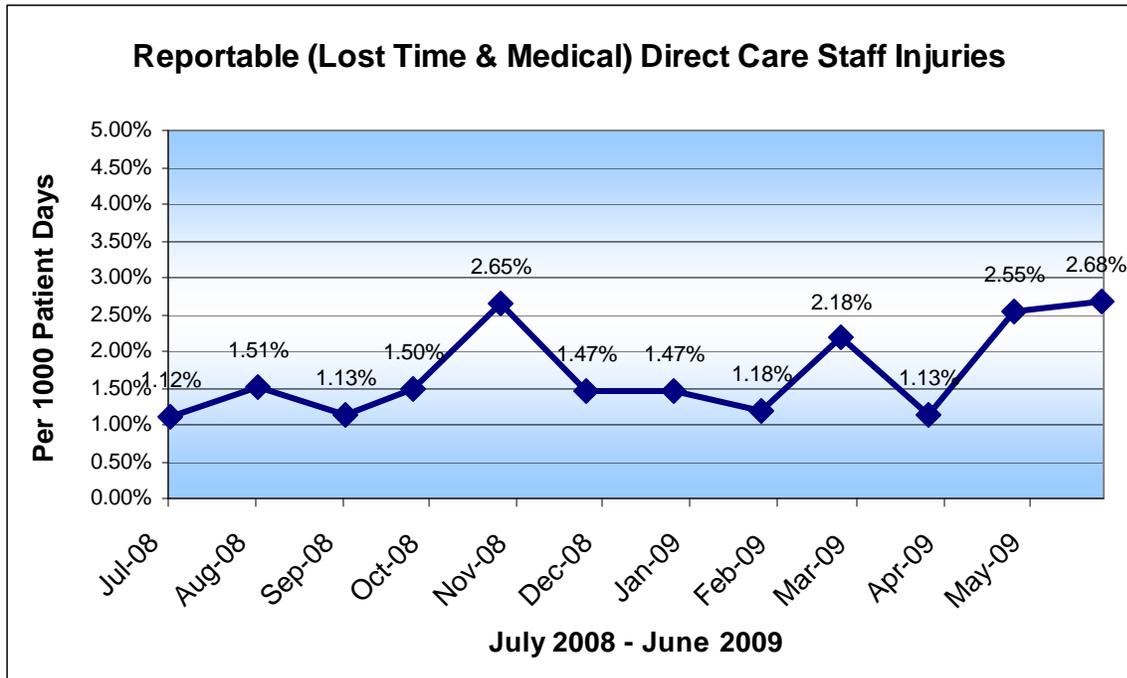
Indicators	Findings	Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	<p>There were 56 discharges in quarter 4 2009. Of those, 34 were completed by 30 days.</p> <p>Note: There were 8 incomplete records from the previous reporting period.</p>	60%	80%
Discharge summaries will be completed within 15 days of discharge.	<p>56 out of 56 discharge summaries were completed within 15 days of discharge during quarter 4 2009.</p> <p>Note; There was 1 incomplete discharge summaries from the previous reporting period.</p>	100%	100%
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	7 forms were revised in quarter 4 2009 (see minutes).	100%	100%
Medical transcription will be timely and accurate.	<p>Out of 406 dictated reports, 386 were completed within 24 hours.</p> <p>Note: 11 of the 20 not received within 24 hours were due to the platform changes over the week of June 15-19.</p>	95%	90%

Summary: The indicators are based on the review of all discharged records. There was 60% compliance with record completion, with 8 incomplete records from a previous reporting period. There was 98% compliance with discharge summary completion, although there was 1 incomplete discharge summary from the previous reporting period. Weekly “charts needing attention” lists are distributed to medical staff, including the Medical Director, along with the Superintendent, Financial Director, and the Quality Improvement Manager. There was 95% compliance with timely & accurate medical transcription services.

Actions: Continue to monitor.

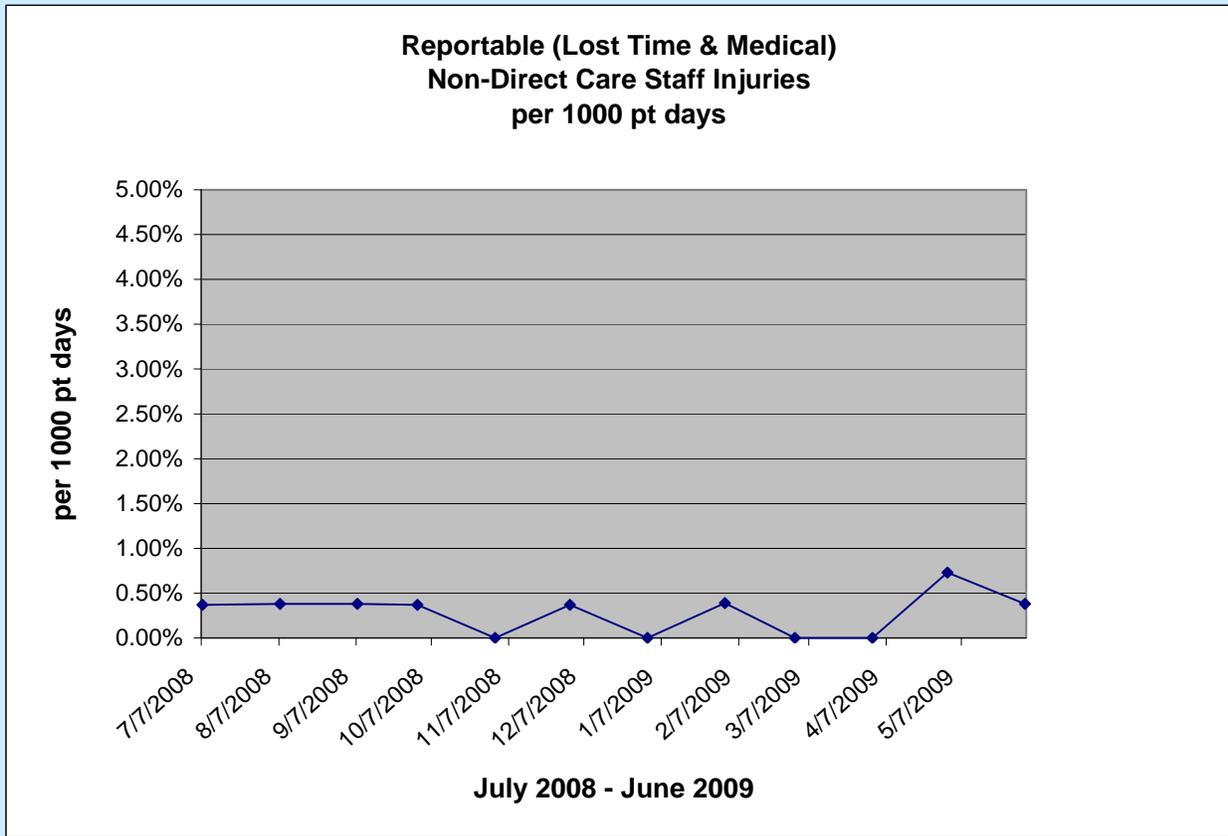
HUMAN RESOURCES

ASPECT: Direct Care Staff Injuries

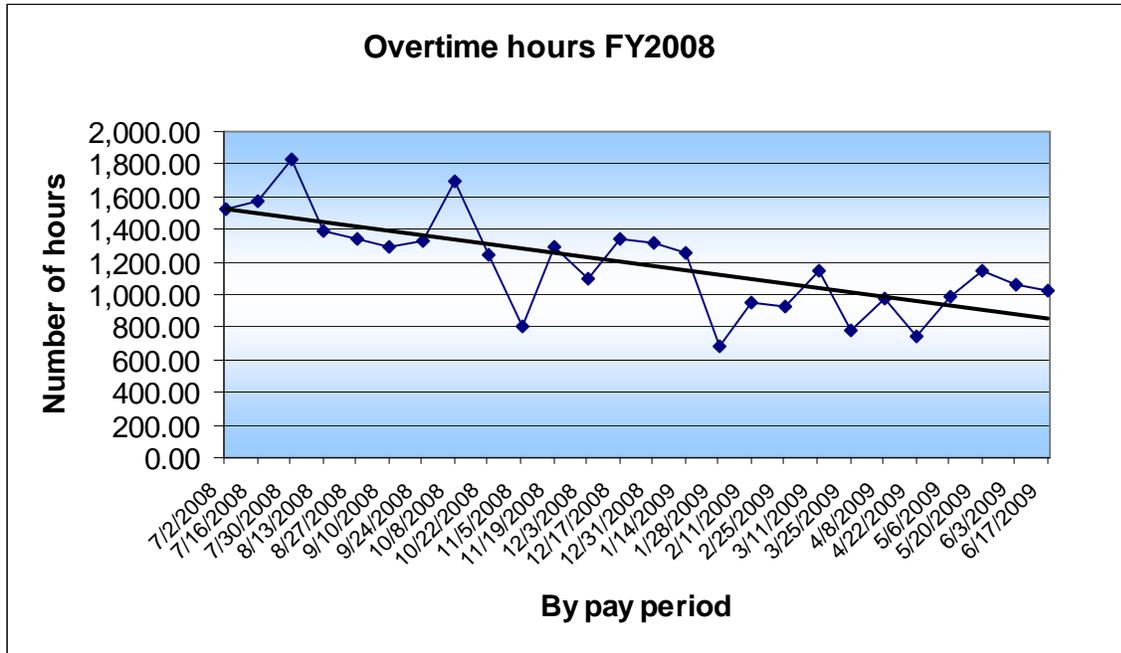


Summary: This quarter review reveals that there was an increase in direct care staff injuries from 1.61% per 1000 patient days last quarter to 2.12% per 1000 patient days this quarter. This number represents (17) direct care staff that sought medical treatment or lost time from work, as compared to (13) last quarter.

ASPECT: Non-Direct Care Staff Injuries

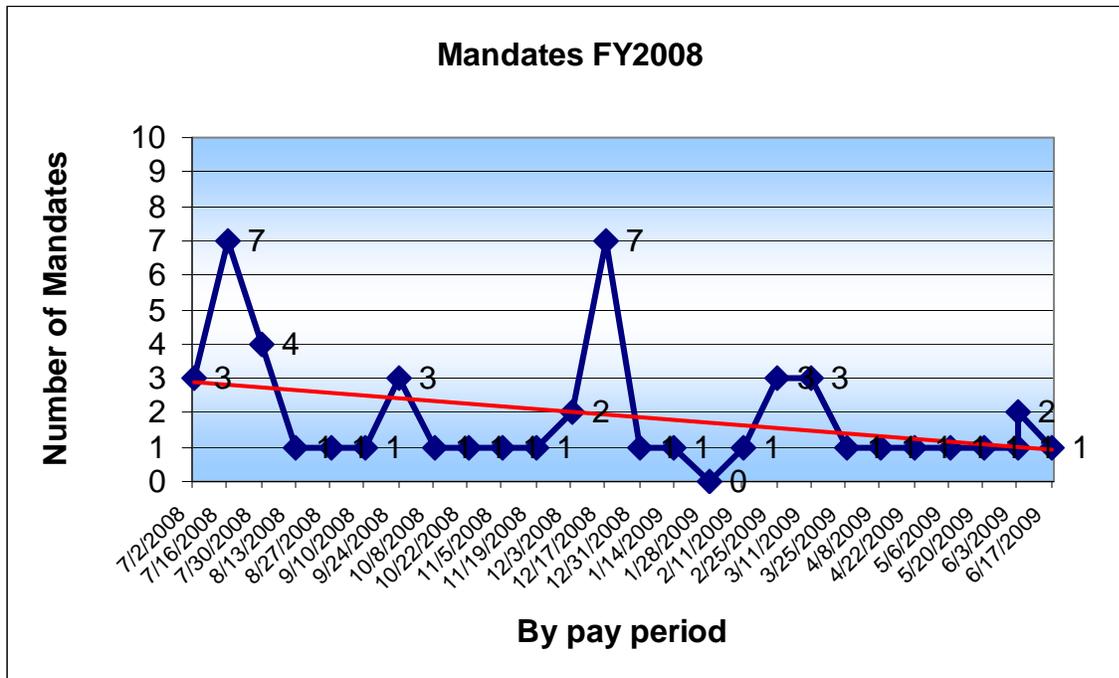


ASPECT: Management of Human Resources



Summary: Overtime has increased slightly this quarter as compared to last quarter. Overtime increased from 5,753.00 hours to 5,943.00 hours. As compared to the same quarter last year we had 9,137.50 hrs of overtime, this represents a 65% decrease from last year. Trend line is shown and extrapolated for future projection

ASPECT: Management of Human Resources



Summary: Mandated shifts have decreased this past quarter as compared to last quarter. Mandates decreased from 9 last quarter to 8 during this quarter. Last year we had a total of 14 mandated shifts during this same rating period; this represents a 57% decrease from last year.

ASPECT: Management of Human Resources

Indicator	Findings	Compliance	Threshold Percentile
Employee Performance Evaluations expected to be completed within 30 days of the due date.			
April 2009 (February evals)	26 of 31	83.87%	85%
May 2009 (March evals)	12 of 31	38.71%	85%
June 2009 (April evals)	28 of 42	66.67%	85%

Summary: As compared to last quarter (64.79%) this quarter decreased to 63.08%. As compared to the same quarter last year, 2008, we were at 66.42% compliance. During this quarter 104 performance evaluations were sent out; 66 were received in a timely manner.

Actions: Human Resources continues 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

INFECTION CONTROL

ASPECT: Hospital Acquired Infection

Indicators	Findings	Compliance	Threshold Percentile
Total number of infections for the fourth quarter of the fiscal year, per 1000 patient days	47/5.9	0.1% above standard	5.8 or less
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	24/3.3	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 slightly above threshold percentile and the accepted two (2) standard deviations. This is most likely due to an increase in total infections in April. There was an out break of Norwalk Virus. 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: Assessment and Reduction of Client BMIs 4th Quarter FY09

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.	All 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. 33% of hospital clients are overweight (BMI 25-29); 41% are obese (BMI 30-39); and 7% are extremely obese (BMI 40+); and 18% have ideal body weight. Overweight and obese are slightly higher than last quarter; extremely obese and normal have gone down.

Actions: Physicians will continue to track BMIs, on a quarterly basis, for all hospital clients and correlating lipid profile and blood sugar data. The diet order form was recently changed to make single serving a standard portion. Also Clinical Leaders are discussing the frequency and type of foods ordered out by clients.

**ASPECT: Completion of AIMS
4th Quarter FY09**

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.	36 of 51 were in compliance	70%	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 April, May and June. By the end of the 4th quarter 36 of 51 charts were in compliance. The compliance rate increased from 29% in the 3rd quarter to 70% this quarter.

Actions: 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.

**ASPECT: Monitor Clients on Orally Disintegrating Tablets (ODTs) for More than 30 Days
4th Quarter FY09**

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.	15 clients discussed; 1 discontinued; 3 consider discontinuing; 10 remain on; 1 was discharged	100%	100%

Summary: This is the second quarterly review of clients on ODTs for more than 30 days. All such clients in the hospital were reviewed. Of the 15 clients reviewed, 1 had his ODT discontinued, 3 will be considered for discontinuation, and 10 will remain on their ODT for sufficient clinical reasons.

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

NURSING

ASPECT: Seclusion and Restraint Related to Staffing Effectiveness

Indicators Seclusion/Restraint related to staffing effectiveness:	Findings	Compliance
1. Staff mix appropriate	114 of 114	100%
2. Staffing numbers within appropriate acuity level for unit	114 of 114	100%
3. Debriefing completed	104 of 114	91%
4. Dr. Orders	114 of 114	100%

Summary: All findings were 100%.except debriefing. The debriefing process continues to be an area that needs improvement.

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	23 of 23	100%
2. Staffing numbers within appropriate acuity level for unit	23 of 23	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 have increased from last quarter. 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. Another staffing effectiveness indicator has been added for Medication errors.

ASPECT: Pain Management

Indicators		Findings	Compliance
Pre-administration	Assessed using pain scale	1158 of 1170	99 %
Post-administration	Assessed using pain scale	970 of 1170	83%

Summary: This indicator is about the same as last quarter with pre-assessment at 99% and post assessment at 83%

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. 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	128 of 152	84%
2. MHW notes cosigned by RN	87 of 152	59%
3. STGs/Interventions are written, dated and numbered.	140 of 152	95%
4. STGs are measureable and observable	148 of 152	96%
5. STGs/Interventions are modified / met as appropriate.	130 of 152	86%
6. STGs/Interventions tie directly to documentation.	136 of 142	96%
7. Weekly Summary note completed.	53 of 150	35%
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.	152 of 152	100%

Summary: The overall compliance in this documentation area has increased approximately 1% which is very favorable since the increase last quarter was great. Overall compliance last quarter was 80% with overall compliance this quarter at 82%. There was a slight increase in MHW notes cosigned from 56% last quarter to 58% this quarter. GAP notes written in appropriate manner at least every 24 hours increased from 73% to 84%. Short-term goals/interventions are written, dated, and numbered in creased from 95% to 98%. Short-term goals tie directly to documentation increased from 91% to 96%. Progress notes document a level of functional skill support provided has remained at 100% 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. The 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.	357 of 476	75%	80%
2. Grievances responded to by RPC on time.	32 of 52	62%	100%
3. Attendance at Service Integration meetings.	42 of 48	88%	100%
4. Contact during admission.	56 of 56	100%	100%
5. Grievances responded to by peer support on time.	52 of 52	100%	100%
6. Client satisfaction survey completed.	18 of 30	60%	75%

Summary: Overall compliance is 81%. The most significant drop in compliance was in Peer Specialist attendance at service integration meetings, dropping 10% from last quarter. There was an increase in the number of satisfaction surveys completed, up by 10%. Compliance for indicator #1 was down 6% from last quarter due to changes in peer support staffing pattern and shortages of staff.

Actions: New peer support staff are being hired and oriented to address shortage in staffing and staffing pattern is being stabilized. Risk manager/designee will continue to send reminders to PSDs about late grievances. Peer Services Director will work with Social Work Director as needed.

Client Satisfaction Survey

ASPECT: Client satisfaction with care

Indicators	Findings	Compliance	Threshold Percentile
1. Did anyone tell you about your rights?	18 of 22	82%	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?	14 of 22	64%	85%
4. Do you know someone who can help you get what you want or stand up for your rights?	20 of 22	91%	85%
5. Do you have a worker in the community?	9 of 16	56%	85%
6. Has your worker from the community visited or contacted you since you have been in the hospital?	7 of 12	58%	85%
7. Do you know how to get in touch with your worker from the community if you need to?	9 of 13	69%	85%
8. Do you have a community treatment plan?	14 of 19	74%	85%
9. I feel more able to deal with crisis.	17 of 19	89%	85%
10. I am not as bothered by my symptoms.	16 of 23	70%	85%
11. I am better able to care for myself.	17 of 18	94%	85%
12. I get along better with people.	16 of 20	80%	85%
13. I am treated with dignity and respect.	17 of 18	94%	85%
14. I feel comfortable asking questions about my treatment and medications.	17 of 23	74%	85%
15. I understand how my medication works and the side effects.	17 of 23	74%	85%
16. I've been told about self-help/peer support and support groups to use after discharge.	17 of 23	74%	85%
17. I've been told about the benefits and risks of my medication.	15 of 22	68%	85%
18. I have been given information to help me understand and deal with my illness.	13 of 22	59%	85%
19. I feel my other medical conditions are being treated.	15 of 22	68%	85%
20. My pain was managed.	17 of 22	77%	85%

21. I feel free to make complaints and suggestions.	18 of 22	82%	85%
22. I feel my right to refuse medication or treatment is respected.	19 of 22	86%	85%
23. I help in planning my discharge.	15 of 19	79%	85%
24. I feel I have had enough privacy in the hospital.	17 of 22	77%	85%
25. I feel safe while at Riverview?	17 of 20	85%	85%
26. If I had a choice of hospitals, I would choose this one.	15 of 19	79%	85%

Summary: Overall compliance was 76%. Of the 26 indicators, 6 were at or above compliance. The majority of the indicators dropped this quarter (15) and one (#2) stayed the same. Indicators that decreased in compliance dropped 1-27%. There was little to no data collected on two of the units, Lower Kennebec and Upper Saco.

Some of the identified concerns of clients were:

- Rights only given in written format and not explained
- Medical needs not being addressed
- Pain not being managed

Actions:

- Peer support will encourage and support clients to voice their concerns and needs with their treatment teams regarding these aspects of care.
- Peer support will provide feedback to RPC about client concerns/ suggestions.
- Peer Specialists will be counseled about administration of the surveys.
- NRI survey will be used starting July 1, 2009.

PROGRAM SERVICE

Aspect -Active Treatment

Indicator	Findings	Compliance	Threshold
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.	117/120	97%	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.	96//120	80%	70%
3. Documentation reveals that the client attended 50%of assigned psycho-social-educational interventions within the last 24 hours.	75/120	62%	70%
4. A minimum of three psychosocial educational interventions are assigned daily.	114/120	95%	70%
5. A minimum of four groups is prescribed for the weekend.	102/120	85%	70%
6. The client knows what his assigned psycho-social-educational interventions are and why they have been assigned.	87/120	73%	60%
7. The client can correctly identify assigned RN and MHW. (Or where the information is available to him / her)	105/120	87%	75%
8. The medical record documents the client's active participation in Morning Meeting within the last 24 hours.	45/60 42/60	75% 70%	70% LK/LS 85% UK/US
9. The client can identify personally effective distress tolerance mechanisms available within the milieu.	110/120	91%	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.	120/120	100%	75%
12. Potential for violence assessed upon admission	120/120	100%	100%
13.a Suicide potential assessed upon admission. (TASR)	116/120	96%	100%
b. Suicide potential moderate or above incorporated into CSP	7/7	100%	90%
14a. Fall risk assessed upon admission. (Universal assessment)	119/120	99%	100%
b. Score of 5 or above incorporated into CSP as fall potential	3/4	75%	90%
15. Medication reconciliation completed upon admission / transfer / discharge.	34/120	28%	100%
16. Allergies displayed on order sheets and on spine of medical record.	119/120	99%	100%

Summary: #3 Documentation of assigned interventions continues to improve slightly this quarter, however it remains below threshold. #8 Client participation in morning meeting continues to improve slightly, if remains below expectations for two of the four units. #13 & #14 continue to fall slightly below expectation. #15 Medication reconciliation falls far below expectation on three of the four units. All other indicators are above threshold.

Action: PSD's will review variations in unit success for identified indicators and make recommendations to specific department leaders. PSD will inform supervisors of staff regarding errors in assessment of suicide and fall risk. A performance improvement team under nursing leadership has been formed to make recommendations for changing procedures to improve #15 medication reconciliation.

Aspect-Milieu Treatment -Overall compliance

Indicator	Findings	Compliance	Threshold
1. Percentage of clients participating in Morning Meeting	LK 60 UK 52 LS 50 US 93	55% 73%	70% LK /LS 80%UK /US
2. Percentage of clients who establish a daily goal.	LK 84 UK 84 LS 60 US 100	82%	80%
3. Percentage of clients who attend Wrap Up group in the evening or address with primary staff, the status of their daily goal.	LK 77 UK 46 LS 50 US 90	62% 68%	70%LK / LS 80%UK /US
4. Percentage of clients attending Community Meeting	LK 64 UK 50 LS 50 US 83	62%	70%
5. Number of individual clients who present (or author) an affirmation or confrontation statement at Community Meeting (quarterly totals)	LK 24 UK 5 LS 95 US 24	37 4.6 per mtg.	24 per mo. 3 per mtg.
6. Number of individual staff who present an affirmation or confrontation statement at Community Meeting (quarterly totals)	LK 15 UK 6 LS 74 US 21	29 3.6 per mtg.	24 per mo. 3 per mtg.

Summary: Three indicators met or exceeded threshold for the first time this quarter. Affirmations/confrontation statements #5 increased significantly on several units going from an average of 2.3 per meeting last quarter to an average of 4.6 per meeting this quarter. The Lower Saco unit made significant improvement in use of affirmation and confrontation statements for both clients and staff, exceeding expectations. The remaining three indicators continue to fall below thresholds with modest improvement. Participation in morning meetings and community meetings continues to be a challenge on three of the four units #1 & #4.

Action: PSD's will provide feedback and reinforce staff efforts regarding specific improvements. Indicators #5 & 6 were reconfigured to add staff use of affirmations and confrontation statements and change in threshold. LS 's successful interventions with #5 & #6 will be reviewed by PSD's for use on other units. Increasing threshold for #5 & 6 will be

considered. Clinical Council will review the expectations for professional staff to model affirmations and confrontation statements at community meetings.

PSYCHOLOGY

Aspect -Co-Occurring Treatment

Co-Occurring Disorders TX Integration	Findings	Compliance	Threshold
1. There is evidence of an integrated co-occurring comprehensive service plan for identified clients.	29/44	66%	100%
2. There is evidence of “stage of Change” documented in client comprehensive service plan	26/44	60%	85%
3. There is documentation of identified client’s participation in co-occurring treatment.	13/44	29%	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”	11/17	65%	65%
5. Consumer Satisfaction Survey indicates that since beginning treatment with us, their condition is better.	12/17	70%	65%
6. Consumer Satisfaction Survey reports client satisfaction with current treatment experience is better than with any other previous treatment experiences.	12/17	70%	65%
7. Percent of clients with co-occurring disorders as reported by NASMHPD		Data unavailable	

Summary: Service plans showed 20% improvement in Stage of Change identification (#2). Integrating co-occurring treatment and in participation in treatment (#1,2) remained approx. the same. Indicators are all below threshold. Consumer satisfaction (#4-6) increase on all indicators. All measures were above threshold for the first time. Please note: Due to the small N however slight changes may not be statistically significant.

Action: Co-occurring specialist job duties will be changed to increase attention to identifying clients in #1 and consulting with staff re: creating treatment plans. Increased clarification and focus on treatment plan should impact participation (#3).

Aspect- Psychological Services

Psychologist Service Delivery & Documentation	Findings	Compliance	Threshold
1. Psychologist short-term goals on CSP are measurable and time limited.	27/30	90%	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 for second quarter on 2 of the 3 indicators. Three (3) charts were found not to have measurable short-term goals. All three were attributed to one staff member and charts were corrected in supervision.

Action: Peer review chart audits will continue for next quarter. Two newly hired psychologists and two new interns will be added to the peer review process. 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
1 Readiness assessment and treatment plan completed within 7 days of admission.	29 of 30	97%	100%
2 Rehabilitation short term goals on Comprehensive Service Plan are measurable and time limited.	29 of 30	97%	100%
3. Rehabilitation progress notes indicate treatment being offered as prescribed on Comprehensive Service Plan.	27 of 30	90%	100%
4. Rehabilitation progress notes indicate progress towards addressing identified goals on the Comprehensive Service Plan.	25 of 30	90%	100%

Summary:

This is the fourth 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 was not cooperative with the attempts made during the 6 & 7 days of admission. Assessment was not completed to reflect this until the 8th day.

Indicator #2 & 3- The one chart that did not have STG's was the same as the chart that did not have the assessment in by the 7th day. The chart was reviewed on the client's 10th day of admission and there were not any Rehab. goals identified. Progress note documentation has improved since the training.

Indicator #4- Documentation of progress towards the identified goals is being better reflected in the rehabilitation progress note. In regards to all indicators, the Director will continue to audit charts and provide individual supervision for all RT's to ensure expectations of indicators are achieved.

Action: . Director of Rehab will meet with RT to remind them that even if a client refuses to cooperate with the assessment process, the assessment needs to go in the chart within 7 days of admission. The Director will meet with the Chief Recreation Therapist to review offering documentation training to Harbor Mall group leaders to ensure client progress is being captured in the notes.

The Director will meet with the Recreation Therapist on the units to review individualized treatment planning and progress note writing so that they can meet with the Hab Aides to assist them with progress note writing. 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 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%
2. Total number of staff who knows what R.A.C.E. stands for.	88/88	100%	95%
3. Total number of staff who knows how to acknowledge the fire alarm or trouble alarm on the enunciator panel.	85/88	96%	95%
4. Total number of staff who knows the emergency number.	88/88	100%	95%
5. During unannounced safety audits conducted by the Safety Officer, this represents the total number of staff who display identification tags.	93/98	94%	95%
6. During unannounced safety audits conducted by the Safety Officer, this represents the total number of direct care staff who carry a personal duress transmitter.	84/88	95%	95%

Summary: All staff have received training in the use of the evacuation chair. 100% compliance. We continue to train newly hired staff during their initial orientation. We are discontinuing the reporting of those indicators as they relate to the number of staff who have been trained in the use of the evacuation chair. We will continue to monitor this to assure that all staff have been trained. The (3) alarms reported for the hospital meets the required number of drills per JCAHO and Life Safety Code. Indicators 2 through 4 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 May 14, 2009.

Actions: Continue to train newly hired staff during initial orientation on the use of the evacuation chair. Continue initiative by conducting a hospital-wide census during such events utilizing two-way radios. Drills continue to show an improvement in that area. Continue with environmental tours and safety audits. Ask Supervisors to be vigilant in regard to their staff not carrying the required equipment. 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: During a recent environmental tour at the Portland Clinic, the clinic was crowded with clients and had a client under conscious sedation. Based on previous experiences and competent performance evaluations of staff, the Safety Officer elected to go over the drill objectives without doing the physical drill in order not to interfere with conscious sedation. The Safety Officer will conduct another drill during the 1st quarter of FY2009-2010. We continue to perform Environmental tours and 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”.

Actions: There are no required actions at this time. Continue to monitor.

ASPECT: Securitas/RPC Security Team

Indicators	Findings	Compliance	Threshold Percentile
1. Security Officer “foot patrols” during Open Hospital times. (Total # of “foot patrols” done vs. total # of “foot patrols” to be done.)	648/660*	98%	95%
2. 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.)	272/272*	100%	95%

Summary: Indicators with regard to Security search/screening of all clients (Forensic & Civil) being admitted to Riverview for treatment. (Total # of admissions screened vs. total # of admissions) has been at or near 100% compliance for many reporting periods. We have discontinued that reporting and will replace that indicator with a different indicator in the next quarter. Indicators # 1 & 2 are reported for the month of June. The compilation of April and May stats were not completed at the time of report and will be announced on the next quarter.

Actions: Securitas and the Safety Officer continue to formulate new indicators. We had hoped to roll those out for the 4th quarter, but continued meetings and conversing with other like facilities has delayed this change. We have set the 1st quarter of FY 2009-2010 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.	4/4	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.	24/30	80%	90%
3d. Community Provider Participation in Preliminary Continuity of Care meeting.	7/15	46%	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.	26/30	86%	100%
4b. Annual Psychosocial Assessment completed and current in chart	30/30	100%	100%

Summary: Indicator 3c: This indicator is decreased 13% from last quarter and Director of Social Work and Director of Peer Support are examining the cause of decline it appears that it could be from a communication and scheduling issue.

Indicator 3d: This area increased from a last quarter of 33% to this quarter a measure of 46%. While this is an increase we will continue to monitor and foster support from the regional supervisors and the CDC offices. We continue to discuss this issue at the weekly discharge planning meeting on Wednesdays as needed. Indicator 3e: This area has been low or indicated no participation for numerous quarters. Director will continue to monitor and work with the mental health liaison with the Department of Corrections. Over the last quarter we had two meetings with mental health providers in Corrections regarding systems issues and on-going communications between the systems. Indicator 4a: This area will continue to be monitored. Progressive discipline is used through supervision to correct this area as needed.

Action: Continue to monitor

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.	2/10	20%	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.	6/6	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: This area decreased 42% from a last quarter showing of 62% compliance. This is a significant decrease 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 continue meeting with members from Clinical Leadership to discuss the long range vision of the forensic units and population. The Forensic shared drive was created to hold all reports and streamline the input and editing process to improve the outcomes. We are anticipating these changes and improvements will have a positive impact on our process over the next quarters and improve our outcome numbers.

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.	13/13	100%	95%
2. The Client Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	13/13	100%	100%
2a. The Client Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	13/13	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.	13/13	100%	100%

Summary: All areas met compliance for this quarter

Action: Continue to monitor

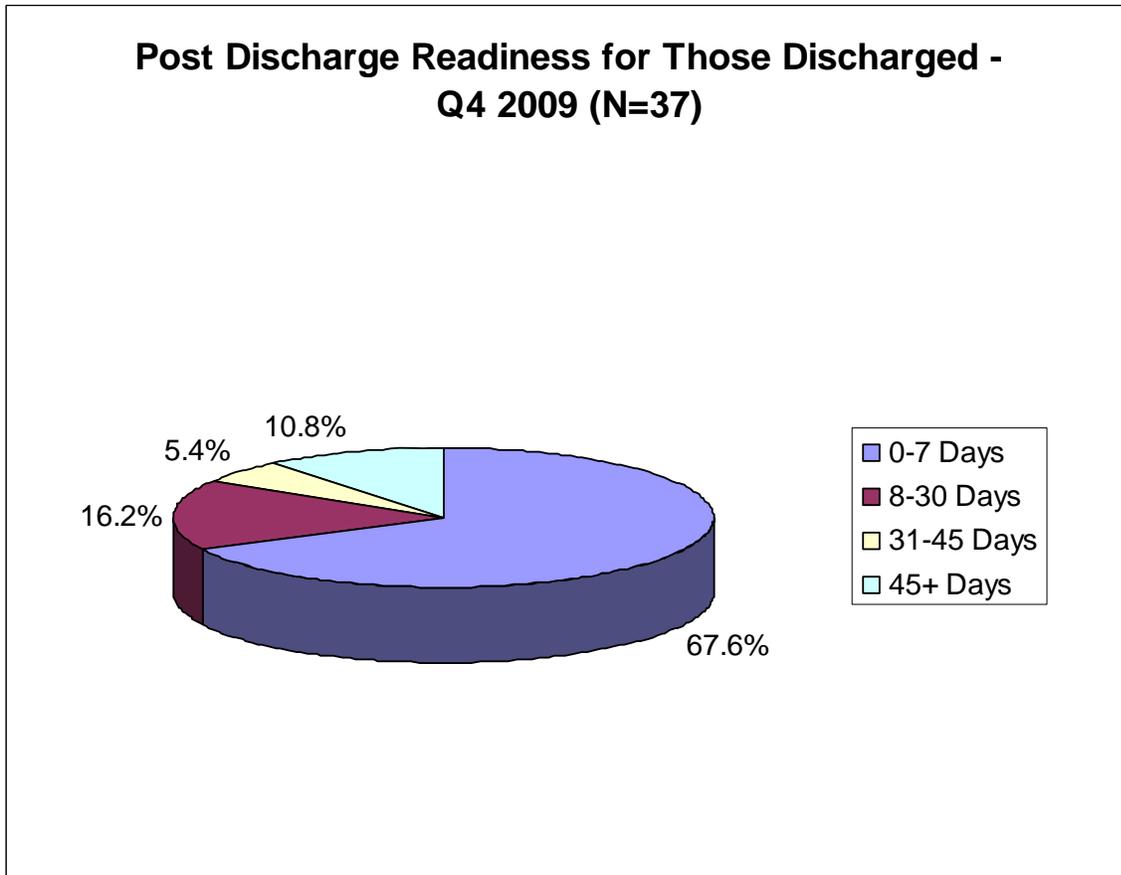
Aspect: Treatment Plans and Progress Notes

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.	40/45	88%	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.	56/60	93%	95%

Summary: Indicator 3: This area is up slightly 3% from last quarter and will continue to be monitored as it is under the threshold percent. The quality of treatment plans continues to improve and the team continues to focus on this area. A central focus for next year will be stage of change language in plans and engagement focused plans for clients that struggle with those issues.

Action: Continue to monitor

Aspect: Post Discharge Readiness Graph



This chart shows the percent of civil clients who were discharged within 7 days of their discharge readiness to be at 67.6% for this quarter compared to 51.4% last quarter. Cumulative percentages and targets are as follows:

- Within 7 days = 67.6% (target 75%)
- Within 30 days = 83.8% (target 90%)
- Within 45 days = 89.2% (target 100%)

The previous 3 quarters are displayed in the table below:

Quarter	Within 7 days	Within 30days	Within 45 days	45 +days
Target	75%	90%	100%	0%
Q4 2009	67.6%	83.8%	89.2%	10.8%
Q3 2009	51.4%	64.9%	83.8%	16.2%
Q2 2009	47.4%	76.3%	84.2%	15.8%
Q1 2009	57.5%	62.5%	72.5%	27.5%

STAFF DEVELOPMENT

ASPECT: New Employee and Mandatory Training

4 th Quarter STFDIQ1SFY09 April, May and June 2009 Staff Development			
Indicators	Findings	Compliance	Threshold Percentile
1. New employees will complete new employee orientation within 60 days of hire.	16 of 16 completed orientation	100%	100 %
2. New employees will complete CPR training within 30 days of hire.	16 of 16 completed CPR training	100%	100 %
3. New employees will complete NAPPI training within 60 days of hire.	16 of 16 completed Nappi training	100%	100 %
4. Riverview and Contract staff will attend CPR training bi-annually.	312 of 314 are current in CPR certifications	99%	100 %
5. Riverview and Contract 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 98%	365 of 367 have completed annual training	99%	100 %
6. Riverview and Contract 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%	382 of 382 have completed annual training	100%	100 %

Summary: The indicators are based on the requirements for all new/current staff to complete mandatory training and maintain current certifications. **16 out of 16** of (100%) new Riverview/Contracted employees completed these trainings. **312 of 314** (99%) Riverview/Contracted employees are current with CPR certification. **365 of 367** (99%) Riverview/Contracted employees are current in Nappi training. **382 of 382** (100%) employees are current in Annual training. All indicators remained at 100 % compliance for quarter 4-FY 2009.

Actions: Continue to monitor

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.	0 of 0	50%	100%

Summary: 0 of 60 total staff injuries were reported due to the environment this quarter.

Actions: Repairs and necessary changes are to be made in a timely manner (within 24 hours). This will end this indicator.

ASPECT: Linen Cleanliness and Quality

Indicators	Findings	Compliance	Threshold Percentile
1. Was linen clean coming back from vendor?	35 of 38	92%	100%
2. Was linen free of any holes or rips coming back from vendor?	38 of 38	100%	95%
3. Did we have enough linen on units via complaints from unit staff?	32 of 38	84%	90%
4. Was linen covered on units?	38 of 38	100%	95%
5. Did vendor provide a 24 hr. turn around service as specified in the contract?	38 of 38	100%	100%
6. Did we receive an adequate supply of mops and rags from vendor?	38 of 38	100%	95%
7. Was linen bins clean returning from vendor?	38 of 38	100%	100%

Summary: 7 different criteria are to be met for acceptability. The indicators are based on the inspections of linen closets throughout the facility including the returned linen from the vendor. All linen types were reviewed randomly this quarter. All indicators are within threshold percentiles except for #1 and #3 (overall compliance 97%).

1. U. Kennebec, U. Saco, L. Saco, and L. Kennebec were short on the supply of linen bags.
2. U. Kennebec, U. Saco, L. Saco, and L. Kennebec were short on the supply of wash cloths.
3. L. Saco and main supply room @ the facilities area had worn blankets delivered.

Actions: The Housekeeping Department has done the following actions to remedy the above problem indicators:

- ✓ The housekeeping staff on each unit will monitor the supply of linen bags delivered to their respective units.
- ✓ The housekeeping staff on each unit will monitor the supply of wash cloths delivered to their respective units.
- ✓ Housekeeping supervisor contacted linen vendor and advised them of the problem of the shortage of the linen bags.
- ✓ Housekeeping supervisor contacted linen vendor and advised them of the problem of the shortage of the wash cloths.
- ✓ Housekeeping supervisor purchased 25 dozen wash cloths to supplement current inventory to assure adequate amount on each client unit.
- ✓ Housekeeping supervisor advised linen vendor that worn blankets were being shipped back. The vendor is supposed to remove worn blankets and notify us.
- ✓ Housekeeping supervisor ordered 12 more blankets to supplement current inventory to assure adequate amount on each unit.

COERCIVE EVENTS TREND GRAPHS

