

Riverview

PSYCHIATRIC CENTER



QUARTERLY REPORT ON
ORGANIZATIONAL PERFORMANCE EXCELLENCE

FOURTH STATE FISCAL QUARTER 2013
April, May, June 2013

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Superintendent

July 15, 2013



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Glossary of Terms, Acronyms & Abbreviations

ACT	Assertive Community Treatment
ADC	Automated Dispensing Cabinets (for medications)
ADON	Assistant Director of Nursing
AOC	Administrator on Call
CCM	Continuation of Care Management (Social Work Services)
CCP	Continuation of Care Plan
CMS	Centers for Medicare & Medicaid Services
CoP	Community of Practice or Conditions of Participation (CMS)
CPI	Continuous Process (or Performance) Improvement
CPR	Cardio-Pulmonary Resuscitation
CSP	Comprehensive Service Plan
GAP	Goal, Assessment, Plan Documentation
HOC	Hand off communications.
IMD	Institute for Mental Disease
ICDCC	Involuntary Civil District Court Commitment
ICDCC-M	Involuntary Civil District Court Commitment, Court Ordered Medications
ICDCC-PTP	Involuntary Civil District Court Commitment, Progressive Treatment Plan
IC-PTP+M	Involuntary Commitment, Progressive Treatment Plan, Court Ordered Medications
ICRDCC	Involuntary Criminal District Court Commitment
INVOL CRIM	Involuntary Criminal Commitment
INVOL-CIV	Involuntary Civil Commitment
ISP	Individualized Service Plan
IST	Incompetent to Stand Trial
LCSW	Licensed Clinical Social Worker
LPN	License Practical Nurse
TJC	The Joint Commission (formerly JCAHO, Joint Commission on Accreditation of Healthcare Organizations)
MAR	Medication Administration Record
MRDO	Medication Resistant Disease Organism (MRSA, VRE, C-Dif)
NAPPI	Non Abusive Psychological and Physical Intervention
NASMHPD	National Association of State Mental Health Program Directors
NCR	Not Criminally Responsible
NOD	Nurse on Duty
NP	Nurse Practitioner
NPSG	National Patient Safety Goals (established by the Joint Commission)
NRI	NASMHPD Research Institute, Inc.
OT	Occupational Therapist
PA or PA-C	Physician's Assistant (Certified)
PCHDCC	Pending Court Hearing
PCHDCC+M	Pending Court Hearing for Court Ordered Medications



Glossary of Terms, Acronyms & Abbreviations

PPR	Periodic Performance Review – a self-assessment based upon TJC standards that are conducted annually by each department head.
PSD	Program Services Director
PTP	Progressive Treatment Plan
R.A.C.E.	Rescue/Alarm/Confine/Extinguish
RN	Registered Nurse
RT	Recreation Therapist
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration (Federal)
SAMHS	Substance Abuse and Mental Health Services, Office of (Maine DHHS)
SBAR	Acronym for a model of concise communications first developed by the US Navy Submarine Command. S = Situation, B = Background, A = Assessment, R = Recommendation
SD	Standard Deviation – a measure of data variability.
Seclusion, Locked	Client is placed in a secured room with the door locked.
Seclusion, Open	Client is placed in a room and instructed not to leave the room.
SRC	Single Room Care (seclusion)
URI	Upper respiratory infection
UTI	Urinary tract infection
VOL	Voluntary – Self
VOL-OTHER	Voluntary – Others (Guardian)
MHW	Mental Health Worker



INTRODUCTION

The Riverview Psychiatric Center Quarterly Report on Organizational Performance Excellence has been created to highlight the efforts of the hospital and its staffs to provide evidence of a commitment to client recovery, safety in culture and practices and fiscal accountability. The report is structure to reflect a philosophy and contemporary practices in addressing overall organizational performance in a systems improvement approach instead of a purely compliance approach. The structure of the report also reflects a focus on meaningful measures of organizational process improvement while maintaining measures of compliance that are mandated though regulatory and legal standards.

The methods of reporting are driven by a national accepted focused approach that seeks out areas for improvement that were clearly identified as performance priorities. The American Society for Quality, National Quality Forum, Baldrige National Quality Program and the National Patient Safety Foundation all recommend a systems-based approach where organizational improvement activities are focused on strategic priorities rather than compliance standards.

There are three major sections that make up this report:

The first section reflects compliance factors related to the Consent Decree and includes those performance measure described in the Order Adopting Compliance Standards dated October 29, 2007.

The second section describes the hospital's performance with regard to Joint Commission performance measures that are derived from the Hospital-Based Inpatient Psychiatric Services (HBIPS) that are reflected in the Joint Commissions quarterly ORYX Report and priority focus areas that are referenced in the Joint Commission standards;

- I. Data Collection (PI.01.01.01)
- II. Data Analysis (PI.02.01.01, PI.02.01.03)
- III. Performance Improvement (PI.03.01.01)

The third section encompasses those departmental process improvement projects that are designed to improve the overall effectiveness and efficiency of the hospital's operations and contribute to the system's overall strategic performance excellence. Several departments and work areas have made significant progress in developing the concepts of this new methodology.

As with any change in how organizations operate, there are early adopters and those whose adoption of system changes is delayed. It is anticipated that over the next year, further contributors to this section of strategic performance excellence will be added as opportunities for improvement and methods of improving operational functions are defined.



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CONSENT DECREE

Consent Decree Plan

V1) The Consent Decree Plan, established pursuant to paragraphs 36, 37, 38, and 39 of the Settlement Agreement in Bates v. DHHS defines the role of Riverview Psychiatric Center in providing consumer-centered inpatient psychiatric care to Maine citizens with serious mental illness that meets constitutional, statutory, and regulatory standards.

The following elements outline the hospital's processes for ensuring substantial compliance with the provisions of the Settlement Agreement as stipulated in an Order Adopting Compliance Standards dated October 29, 2007.

Client Rights

V2) Riverview produces documentation that clients are routinely informed of their rights upon admission in accordance with ¶ 150 of the Settlement Agreement;

Indicators	1Q2013	2Q2013	3Q2013	4Q2013
1. Clients are routinely informed of their rights upon admission	74% 37/50	91% 42/46	91% 42/46	100% 19/20 1 refusal

This measure has recently been established. The practice of informing clients of their rights is often delayed as a result of admission acuity. While this process is usually completed after the initial assessment and stabilization, documentation of the act may not be readily available for abstraction. Further refinement of the process is warranted.

V3) Grievance tracking data shows that the hospital responds to 90% of **Level II** grievances within five working days of the date of receipt or within a five-day extension.

Indicators	1Q2013	2Q2013	3Q2013	4Q2013
1. Level II grievances responded to by RPC on time.	100% 1/1	100% 5/5	100% 1/1	0/0
2. Level I grievances responded to by RPC on time.	73% 27/37	60% 64/106	95% 96/101	98% 58/59

Admissions

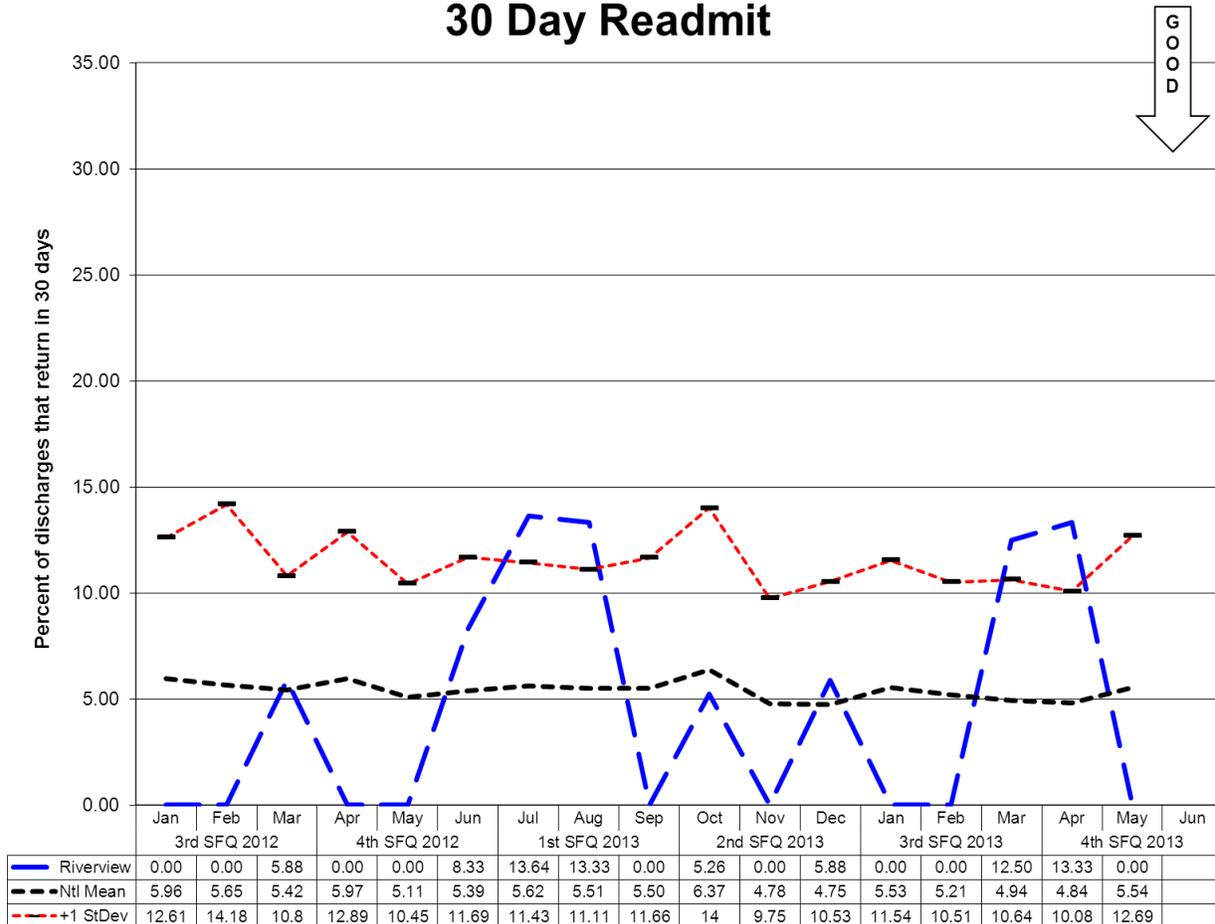
V4) Quarterly performance data shows that in 4 consecutive quarters, 95% of admissions to Riverview meet legal criteria;

Legal Status on Admission	1Q2013	2Q2013	3Q2013	4Q2013
ICDCC	17	9	20	17
ICRDCC	3			
INVOL CRIM	19	34	21	
INVOL CRIM – Forensic Evaluation				16
INVOL CRIM – IST				3
INVOL CRIM – NCR				
INVOL CRIM – Jail Transfer				
INVOL-CIV			1	
PCHDCC	1			3
PCHDCC+M		1	1	
PCHDSS-PTP-R				1
VOL	6		7	3

CONSENT DECREE

V5) Quarterly performance data shows that in 3 out of 4 consecutive quarters, the % of readmissions within 30 days of discharge does not exceed one standard deviation from the national mean as reported by NASMHPD;

30 Day Readmit



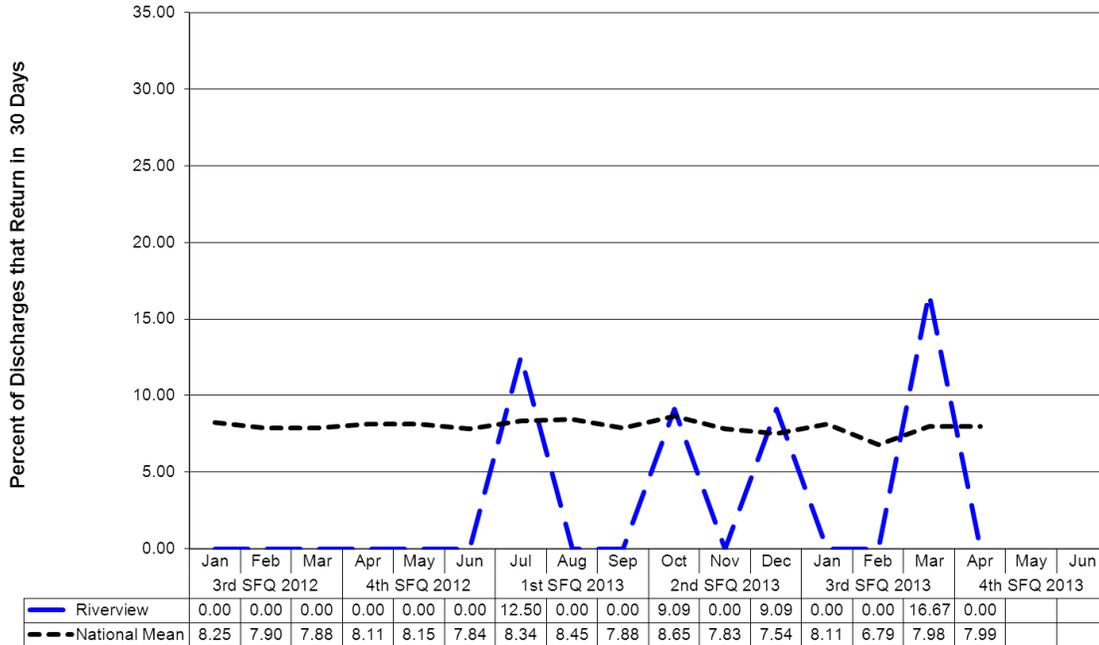
This graph depicts the percent of discharges from the facility that returned within 30 days of a discharge of the same client from the same facility. For example, a rate of 10.0 means that 10% of all discharges were readmitted within 30 days.

The graphs shown on the next page depict the percent of discharges from the facility that returned within 30 days of a discharge of the same client from the same facility stratified by forensic or civil classifications. For example, a rate of 10.0 means that 10% of all discharges were readmitted within 30 days. The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

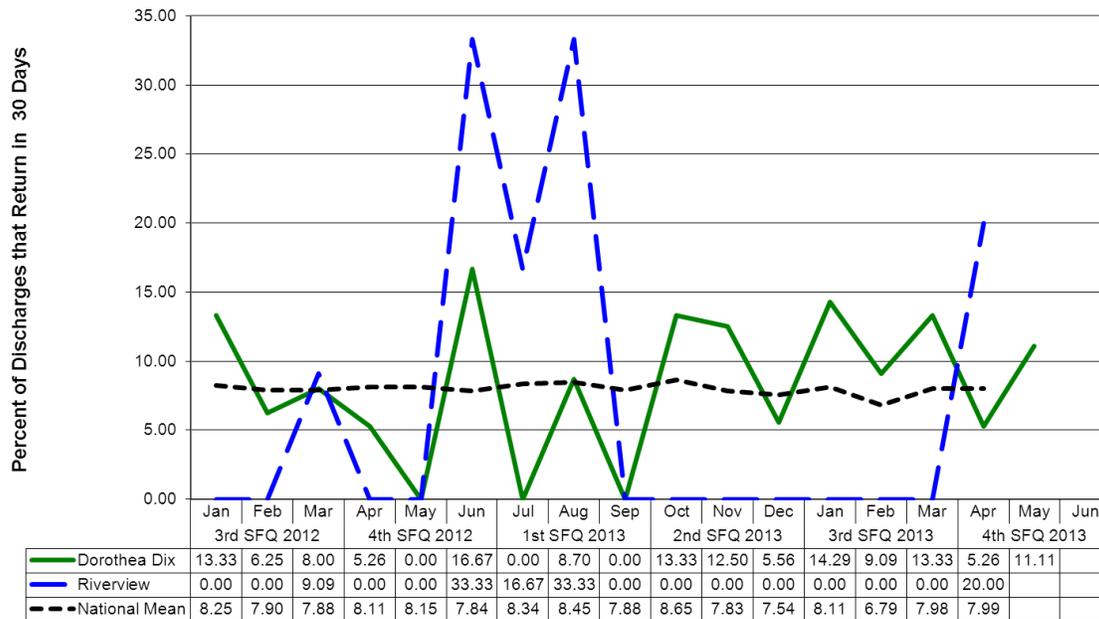
Reasons for client readmission are varied and may include decompensating or lack of compliance with a PTP to name a few. Specific causes for readmission are reviewed with each client upon their return. These graphs are intended to provide an overview of the readmission picture and do not provide sufficient granularity in data elements to determine trends for causes of readmission.

CONSENT DECREE

30 Day Readmit Forensic Stratification



30 Day Readmit Civil Stratification



CONSENT DECREE

V6) Riverview documents, as part of the Performance Improvement & Quality Assurance process, that the Director of Social Work 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 to determine whether the readmission indicated a need for resources or a change in treatment and discharge planning or a need for different resources and, where such a need or change was indicated, that corrective action was taken;

REVIEW OF READMISSION OCCURRING WITHIN 60 DAYS

Indicators	1Q2013	2Q2013	3Q2013	4Q2013
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.	100% 3/3	n/a 0/0	100% 2/2	100% 3/3

In this aspect area one of the clients that returned is on the Progressive Treatment program with the Riverview ACT team and as part of his court ordered treatment plan was returned to the hospital after displaying increased symptoms in his current group home. Client will remain on PTP and return to placement once stable. The second client is under Progressive Treatment with a provider in Portland he eloped from his group home placement and was re-admitted to Riverview as part of his court ordered treatment plan for increased symptomology. Client will also return to his placement under the PTP. The third client was discharged at his request to the Oxford St Shelter after refusing all placement offerings from his team. Client was assigned to a case manager and psychiatric providers. Client left the shelter and was re-admitted to Riverview after he was found wandering in the community exhibiting aggressive behaviors and psychotic symptoms. Team will work with client to identify needs and wants and set up a discharge plan if client will accept that provides him with a more stable living environment that can provide a compliment of mental health services.

CONSENT DECREE

REDUCTION OF RE-HOSPITALIZATION FOR ACT TEAM CLIENTS

Indicators	1Q2013	2Q2013	3Q2013	4Q2013
<p>1. The ACT Team Director will review all client cases of re-hospitalization from the community for patterns and trends of the contributing factors leading to re-hospitalization each quarter. The following elements are considered during the review:</p> <ul style="list-style-type: none"> a. Length of stay in community b. Type of residence (i.e.: group home, apartment, etc) c. Geographic location of residence d. Community support network e. Client demographics (age, gender, financial) f. Behavior pattern/mental status g. Medication adherence h. Level of communication with ACT Team 	<p>100% 8 readmissions to RPC, 2 medical admissions to MMC</p>	<p>100% 3 clients were re-admitted to RPC;all were NCR, two due to increased psychiatric symptoms, one for using illicit substance in the forensic group home.</p>	<p>100% 3 clients were returned to RPC; two for substance use and 1 for psychiatric decompensating</p>	<p>100% 5 clients were returned to RPC; 4 for psychiatric symptoms, one for relapse while in supervised apartment.</p>
<p>2. ACT Team will work closely with inpatient treatment team to create and apply discharge plan incorporating additional supports determined by review noted in #1.</p>	<p>100%</p>		<p>100%</p>	<p>100%</p>

Current Quarter Summary

1. All readmissions were male, between the ages of 40 and 68, median age being 50; four under the care of the DHHS Commissioner (NCR), one PTP. Four of five are socioeconomically disadvantaged, one is not. Three of the NCR clients were living in supervised apartments (one in Waterville and 2 in Augusta); two for over a nine months and the other had been transferred two months prior from RPC following a relapse using the same substance he went in RPC for 3 months before. The other NCR client was living in an assisted living facility on a locked unit in Waterville (Mt. St. Joseph's) where he had been living for over three years. Behaviorally, one client became physically violent by throwing a chair through a window, one made verbal threats to other residents and staff of nursing home, one relapsed on cocaine, one caused staff to barricade themselves in the staff office of his supervised apartment and one presented with very delusional thinking and would not respond to staff knocking on door. It appears all clients re-admitted were medication adherent and had been attending appointments as scheduled with the ACT Team.
2. The ACT Team and the inpatient unit of RPC (Lower Saco, Upper Saco, Lower Kennebec and Upper Kennebec) worked collaboratively to minimize the time spent in Riverview while maximizing the opportunity for success upon their return to their community placements.

CONSENT DECREE

- V7) Riverview certifies that no more than 5% of patients admitted in any year have a primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.

Client Admission Diagnoses	1Q13	2Q13	3Q13	4Q13	TOT
ADJUSTMENT DIS W MIXED DISTURBANCE OF EMOTIONS & CONDUCT	1				1
ADJUSTMENT DISORDER WITH DEPRESSED MOOD	1	1			2
ADJUSTMENT DISORDER WITH ANXIETY			1		1
ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED MOOD		3	1		4
ADJUSTMENT REACTION NOS	2	1	1	1	5
ALCOHOL ABUSE-IN REMISS		1			1
ANXIETY STATE NOS			1		1
ATTN DEFICIT W HYPERACT			1		1
BIPOL I DIS, MOST RECENT EPIS (OR CURRENT) MANIC, UNSPEC	1				1
BIPOL I, REC EPIS OR CURRENT MANIC, SEVERE, SPEC W PSYCH BEH				1	1
BIPOLAR DISORDER, UNSPECIFIED	6	5	5	4	20
DELUSIONAL DISORDER		1	2		3
DEPRESS DISORDER-UNSPEC				1	1
DEPRESSIVE DISORDER NEC		2	2	1	5
DRUG ABUSE NEC-IN REMISS		1			1
IMPULSE CONTROL DIS NOS	1	1	2	1	5
INTERMITT EXPLOSIVE DIS		1	1		2
MOOD DISORDER IN CONDITIONS CLASSIFIED ELSEWHERE	1	1			2
OTHER AND UNSPECIFIED BIPOLAR DISORDERS, OTHER	1				1
OTH PERSISTENT MENTAL DIS DUE TO COND CLASSIFIED ELSEWHERE		1			1
PARANOID SCHIZO-CHRONIC	7	5	8	5	25
PARANOID SCHIZO-UNSPEC			1		1
PERSON FEIGNING ILLNESS		1			1
POSTTRAUMATIC STRESS DISORDER	2	3	3	2	10
PSYCHOSIS NOS	6	4	4	7	21
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED	9	6	9	12	36
SCHIZOPHRENIA NOS-CHR	1		1		2
SCHIZOPHRENIA NOS-UNSPEC			2	2	4
SCHIZOPHRENIFORM DISORDER, UNSPECIFIED			1		1
UNSPECIFIED EPISODIC MOOD DISORDER	7	6	4	5	22
Total Admissions	46	44	50	43	183
Admitted with primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	0.0%	4.5%	0%	0%	1.1%

CONSENT DECREE

Peer Supports

Quarterly performance data shows that in 3 out of 4 consecutive quarters:

V8) 80% of all clients have documented contact with a peer specialist during hospitalization;

V9) 80% of all treatment meetings involve a peer specialist.

Indicators	1Q2013	2Q2013	3Q2013	4Q2013
1. Attendance at Comprehensive Treatment Team meetings. (v9)	90% 410/458	87% 342/395	87% 354/406	87% 362/418
2. Attendance at Service Integration meetings. (v8)	100% 42/42	100% 31/31	98% 48/49	79% 26/33
3. Contact during admission. (v8)	100% 46/46	100% 44/44	100% 50/50	100% 46/46

Treatment Planning

Quarterly performance data shows that in 3 out of 4 consecutive quarters,

V10) 95% of clients have a preliminary treatment and transition plan developed within 3 working days of admission;

Indicators	1Q2013	2Q2013	3Q2013	4Q2013
1. Preliminary Continuity of Care meeting completed by end of 3 rd day	93% 28/30	100% 30/30	100% 30/30	100% 30/30
2. Service Integration form completed by the end of the 3 rd day	93% 28/30	100% 30/30	100% 30/30	100% 30/30
3a. Client Participation in Preliminary Continuity of Care meeting.	93% 28/30	96% 29/30	96% 29/30	100% 30/30
3b. CCM Participation in Preliminary Continuity of Care meeting.	93% 28/30	100% 30/30	100% 30/30	100% 30/30
3c. Client's Family Member and/or Natural Support (e.g., peer support, advocacy, attorney) Participation in Preliminary Continuity of Care meeting.	93% 28/30	100% 30/30	100% 30/30	100% 30/30
4a. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	96% 29/30	93% 28/30	93% 28/30	90% 27/30
4b. Annual Psychosocial Assessment completed and current in chart	100% 30/30	100% 30/30	100% 30/30	100% 30/30

Medical Staff, Nursing, and Rehabilitation Services are all engaged in the initial review process. Evidence of fulfilling the standard can be found through a review of individual charts.

4a) Social Work Director met with team during department meeting and discussed the importance of meeting critical documentation deadlines and reminded all staff of the timeframes for completion. Director will continue chart audits and discussions at weekly meetings for improved compliance.

CONSENT DECREE

V11) 95% of clients also have individualized treatment plans in their records within 7 days thereafter;

Indicators	1Q2013	2Q2013	3Q2013	4Q2013
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all clients on assigned CCM caseload.	95% 43/45	97% 44/45	93% 43/45	96% 44/45
2. On Upper Saco progress notes in GAP/Incidental format will indicate at minimum weekly 1:1 meeting with all clients on assigned CCM caseload	93% 14/15	93% 14/15	95% 14/15	100% 15/15
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.	98% 59/60	96% 58/60	96% 58/60	91% 55/60

Medical Staff, Nursing, and Rehabilitation Services are all engaged in the treatment planning process. Evidence of fulfilling the standard can be found through a review of individual charts.

Area 3. Social Worker met with department members on 3 occasions in staff meeting to discuss treatment plans and writing plans. Discussion regarding strengths based plans that focus transition and discharge planning at the various stage of readiness for each unique client.

V12) Riverview certifies that all treatment modalities required by ¶155 are available.

The treatment modalities listed below as listed in ¶155 are offered to all clients according to the individual client’s ability to participate in a safe and productive manner as determined by the treatment team and established in collaboration with the client during the formulation of the individualized treatment plan.

Treatment Modality	Provision of Services Normally by...			
	Medical Staff Psychology	Nursing	Social Services	Rehabilitation Services/ Treatment Mall
Group and Individual Psychotherapy	X			
Psychopharmacological Therapy	X			
Social Services			X	
Physical Therapy				X
Occupational Therapy				X
ADL Skills Training		X		X
Recreational Therapy				X
Vocational/Educational Programs				X
Family Support Services and Education		X	X	X
Substance Abuse Services	X			
Sexual/Physical Abuse Counseling	X			
Intro to Basic Principles of Health, Hygiene, and Nutrition		X		X

CONSENT DECREE

An evaluation of treatment planning and implementation, performed in accordance with **Attachment D**, demonstrates that, for 90% of the cases reviewed:

V13) The treatment plans reflect

- Screening of the patient's needs in all the domains listed in ¶61;
- Consideration of the patient's need for the services listed in ¶155;
- Treatment goals for each area of need identified, unless the patient chooses not, or is not yet ready, to address that treatment goal;
- Appropriate interventions to address treatment goals;
- Provision of services listed in ¶155 for which the patient has an assessed need;
- Treatment goals necessary to meet discharge criteria; and
- Assessments of whether the patient is clinically safe for discharge;

V14) The treatment provided is consistent with the individual treatment plans;

V15) If the record reflects limitations on a patient's rights listed in ¶159, those limitations were imposed consistent with the Rights of Recipients of Mental Health Services

An abstraction of pertinent elements of a random selection of charts is periodically conducted to determine compliance with the compliance standards of the consent decree outlined in parts V13, V14, and V15.

This review of randomly selected charts revealed substantial compliance with the consent decree elements. Individual charts can be reviewed by authorized to validate this chart review.

CONSENT DECREE

Medications

V16) Riverview certifies that the pharmacy computer database system for monitoring the use of psychoactive medications is in place and in use, and that the system as used meets the objectives of ¶168.

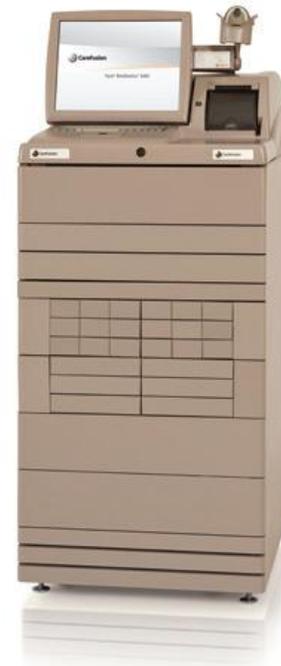
Riverview utilizes a Pyxis Medstation 4000 System for the dispensing of medications on each client care unit. A total of six devices, one on each of the four main units and in each of the two special care units, provide access to all medications used for client care, the pharmacy medication record, and allow review of dispensing and administration of pharmaceuticals.

A database program, HCS Medics, contains records of medication use for each client and allows access by an after-hours remote pharmacy service to these records, to the Pyxis Medstation 4000 System. The purpose of this after-hours service is to maintain 24 hour coverage and pharmacy validation and verification services for prescribers.

Records of transactions are evaluated by the Director of Pharmacy and the Medical Director to validate the appropriate utilization of all medication classes dispensed by the hospital. The Pharmacy and Therapeutics Committee, a multidisciplinary group of physicians, pharmacists, and other clinical staff evaluate issues related to the prescribing, dispensing, and administration of all pharmaceuticals.

The system as described is capable of providing information to process reviewers on the status of medications management in the hospital and to ensure the appropriate use of psychoactive and other medications.

The effectiveness and accuracy of the Pyxis Medstation 4000 System is analyzed regularly through the conduct of process improvement and functional efficiency studies. These studies can be found in the [Medication Management](#) and [Pharmacy Services](#) sections of this report.



CONSENT DECREE

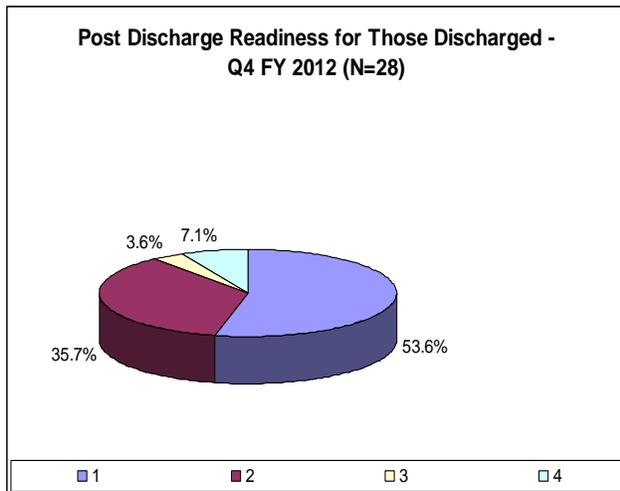
Discharges

Quarterly performance data shows that in 4 consecutive quarters:

V17) 70% of clients who remained ready for discharge were transitioned out of the hospital within 7 days of a determination that they had received maximum benefit from inpatient care;

V18) 80 % of clients who remained ready for discharge were transitioned out of the hospital within 30 days of a determination that they had received maximum benefit from inpatient care;

V19) 90% of clients who remained ready for discharge were transitioned out of the hospital within 45 days of a determination that they had received maximum benefit from inpatient care (with certain clients excepted, by agreement of the parties and court master).



Cumulative percentages & targets are as follows:

Within 7 days = (15) 53.6% (target 70%)
Within 30 days = (25) 89.3% (target 80%)
Within 45 days = (26) 92.9% (target 90%)
Post 45 days = (2) 7.1% (target 0%)

Barriers to Discharge Following Clinical Readiness

Residential Supports (1%)

1 client discharged 49 days post clinical readiness

Housing (10%)

1 client discharged 30 days post clinical readiness
 1 client discharged 32 days post clinical readiness
 1 client discharged 123 days post clinical readiness

Treatment Services (0)

No barriers in this area

The previous four quarters are displayed in the table below

		Within 7 days	Within 30days	Within 45 days	45 +days
Target >>		70%	80%	90%	< 10%
3Q2013	N=22	77.3%	86.4%	90.0%	9.1%
2Q2013	N=24	54.2%	70.9%	87.6%	12.5%
1Q2013	N=27	66.7%	85.2%	96.3%	3.7%
4Q2012	N=28	53.6%	89.2%	92.9%	7.1%
3Q2012	N=42	69.0%	85.7%	92.9%	7.1%

CONSENT DECREE

An evaluation of treatment and discharge planning, performed in accordance with **Attachment D**, demonstrates that, for 90% of the cases reviewed:

V20) Treatment and discharge plans reflect interventions appropriate to address discharge and transition goals;

V21a) For patients who have been found not criminally responsible or not guilty by reason of insanity, appropriate interventions include timely reviews of progress toward the maximum levels allowed by court order; and the record reflects timely reviews of progress toward the maximum levels allowed by court order;

V21) Interventions to address discharge and transition planning goals are in fact being implemented;

V21a) For patients who have been found not criminally responsible or not guilty by reason of insanity, this means that, if the treatment team determines that the patient is ready for an increase in levels beyond those allowed by the current court order, Riverview is taking reasonable steps to support a court petition for an increase in levels.

Indicators	1Q2013	2Q2013	3Q2013	4Q2013
1. The Client Discharge Plan Report will be updated/reviewed by each Social Worker minimally one time per week.	100% 13/13	100% 12/12	100% 12/12	100% 13/13
2. The Client Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	100% 13/13	100% 12/12	100% 12/12	100% 13/13
2a. The Client Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	100% 13/13	100% 12/12	100% 12/12	100% 13/13
3. Each week the Social Work team and Director will meet and discuss current housing options provided by the respective regions and prioritize referrals.	100% 13/13	100% 12/12	100% 12/12	100% 13/13

V22) The Department demonstrates that 95% of the annual reports for forensic patients are submitted to the Commissioner and forwarded to the court on time.

Indicators	1Q2013	2Q2013	3Q2013	4Q2013
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	60% 3/5	100% 3/3	87% 7/8	80% 8/10
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.	100% 9/9	100% 5/5	100% 9/9	100% 4/4
3. Annual Reports (due Dec) to the commissioner for all inpatient NCR clients are submitted annually				

Area 1. Director of Social Work will work with Saco PSD to ensure that the Institutional Reports are completed within the required deadline times. Director will work with social workers and PSD to identify barriers to meeting the threshold compliance level required in this aspect area.

CONSENT DECREE

Staffing and Staff Training

V23) Riverview performance data shows that 95% of all new direct care staff have received 90% of their orientation training before having been assigned to duties requiring unsupervised direct care of patients;

Indicators	1Q2013	2Q2013	3Q2013	4Q2013	2012 Total
1. New employees will complete new employee orientation within 60 days of hire.	100% 25/25	100% 21/21	100% 20/20	100% 22/22	100% 88/88
2. New employees will complete CPR training within 30 days of hire.	100% 25/25	100% 21/21	100% 20/20	100% 22/22	100% 88/88
3. New employees will complete NAPPI training within 60 days of hire.	100% 25/25	100% 21/21	100% 20/20	100% 22/22	100% 88/88
4. Riverview and Contract staff will attend CPR training bi-annually.	100% 50/51*	100% 29/31	98% 47/48*	95% 59/62*	99% 185/192*
5. Riverview and Contract staff will attend NAPPI training annually.	100% 118/118	100% 112/134*	100% 99/125	99% 52/54	99% 399/401
6. Riverview and Contract staff will attend Annual training.	100% 27/27	100% 238/244*	98% 297/311*	100% 383/383	100% 401/401

The indicators are based on the requirements for all new/current staff to complete mandatory training and maintain current certifications.

* Two Riverview employees are out of compliance due to being out of work on a medical leave one employee is out of compliance on light duty.

*Two Riverview employees returned from Leave of Absence Status, and are scheduled to complete the training.

*One Riverview employee is on LOA. One Employee is on light duty. Two Employees will be scheduled for the next available training.

CONSENT DECREE

V24) Riverview certifies that 95% of professional staff have maintained professionally-required continuing education credits and have received the ten hours of annual cross-training required by ¶216;

DATE	HRS	TITLE	PRESENTER
3Q2012	14	Jan- March 2012	Winter Semester (see1Q13 Quarterly Report)
4Q2012	11	Apr – June 2012	Spring Semester (see1Q13 Quarterly Report)
1Q2013	3	Jul – Sep 2012	Summer Hiatus (see1Q13 Quarterly Report)
2Q2013	9	Oct – Dec 2012	Fall Semester (see2Q13 Quarterly Report)
3Q2013	11	Jan – Mar 2013	Winter Semester (see 3Q13 Quarterly Report)
4/4/13	1	Cognitive Decline in Severe and Persistent Mental Illness	Teresa Mayo, PsyD Eliz. H-Faryna PsyD Jennifer Heidler-Gary Brian Charette
4/15/13	1	Advanced Assessment: Current Issues and Controversies in Evaluating Adolescents Referred for Illegal Sexual Behavior	Sue Righthand, PhD
4/18/13	1	Cognitive Decline in Severe and Persistent Mental Illness (continuation)	Teresa Mayo, PsyD Eliz. H-Faryna PsyD Jennifer Heidler-Gary Brian Charette
4/26/13	1	Problem Solving Therapy	Mark Hegel, PhD
5/2/13	1	Recreation Therapy: The What, Why, How, Where and Who (and What-Nots)	Heidi Blodgett Hilary Spear
5/9/13	1	Seclusion and Trauma: the case of CM	Patrick Steele
5/16/13	1	Improving cognition in people with schizophrenia: medication, physical exercise, cognitive remediation and functional skills training	Douglas Noordsy, MD
5/23/13	1	Brain Injury, Substance Use and psychosis	Brendan Kirby, MD
6/6/13	1	1 + 1 doesn't always = 2; and the more information you receive doesn't always help treatment or diagnosis	Randy Beal, PMHNP
6/13/13	1	1+1 doesn't always = 2 - Part II	Randy Beal, PMHNP
6/20/13	1	Pharmacokinetics of Mood Stabilizers and the Impact on Dosing and Monitoring	Miranda Cole, PharmD
6/27/13	1	Sexual Assault Crisis and Support Center Overview	James Weathersby Jenn Howe Jenna McCarthy

CONSENT DECREE

V25) Riverview certifies that staffing ratios required by ¶202 are met, and makes available documentation that shows actual staffing for up to one recent month;

Staff Type	Consent Decree Ratio
General Medicine Physicians	1:75
Psychiatrists	1:25
Psychologists	1:25
Nursing	1:20
Social Workers	1:15
Mental Health Workers	1:6
Recreational/Occupational Therapists/Aides	1:8

With 92 licensed beds, Riverview regularly meets or exceeds the staffing ratio requirements of the consent decree.

Staffing levels are most often determined by an analysis of unity acuity, individual monitoring needs of the clients who residing on specific units, and unit census.

V26) The evaluation of treatment and discharge planning, performed in accordance with **Attachment D**, demonstrates that staffing was sufficient to provide patients access to activities necessary to achieve the patients' treatment goals, and to enable patients to exercise daily and to recreate outdoors consistent with their treatment plans.

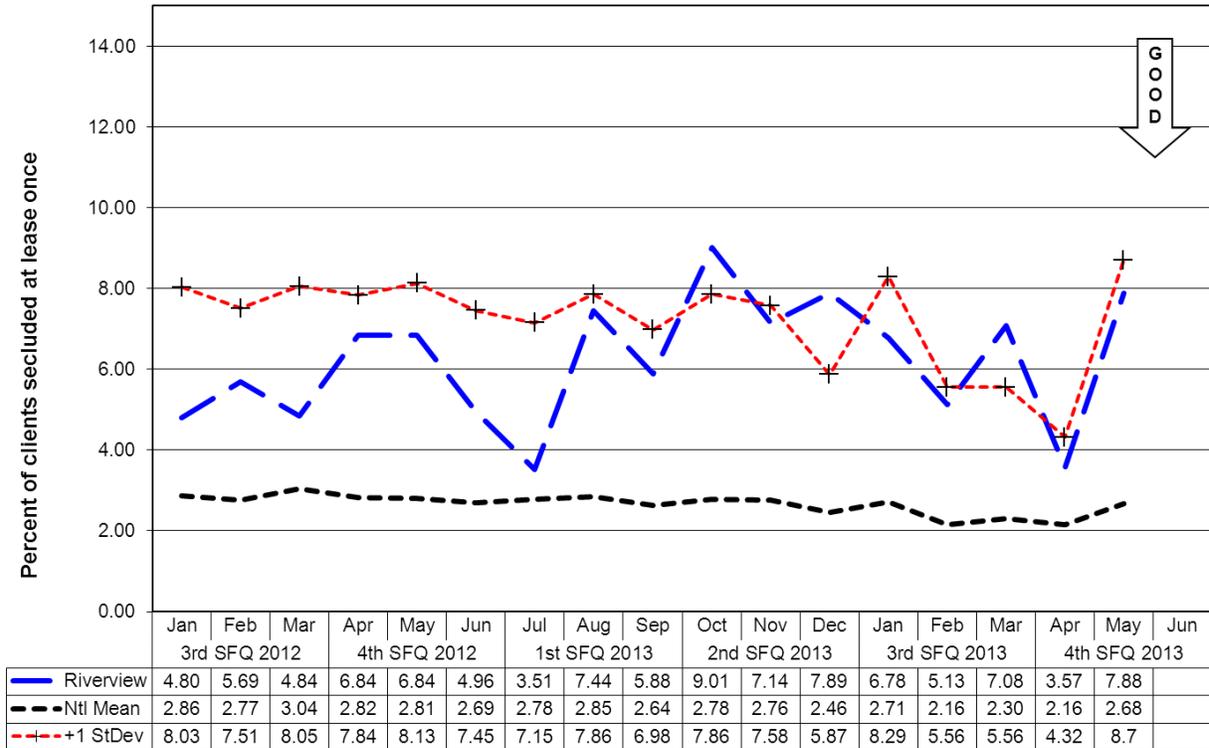
Treatment teams regularly monitor the needs of individual clients and make recommendations for ongoing treatment modalities. Staffing levels are carefully monitored to ensure that all treatment goals, exercise needs, and outdoor activities are achievable. Staffing does not present a barrier to the fulfillment of client needs. Staffing deficiencies that may periodically be present are rectified through utilization of overtime or mandated staff members.

CONSENT DECREE

Use of Seclusion and Restraints

V27) Quarterly performance data shows that, in 5 out of 6 quarters, total seclusion and restraint hours do not exceed one standard deviation from the national mean as reported by NASMHPD;

Percent of Clients Secluded



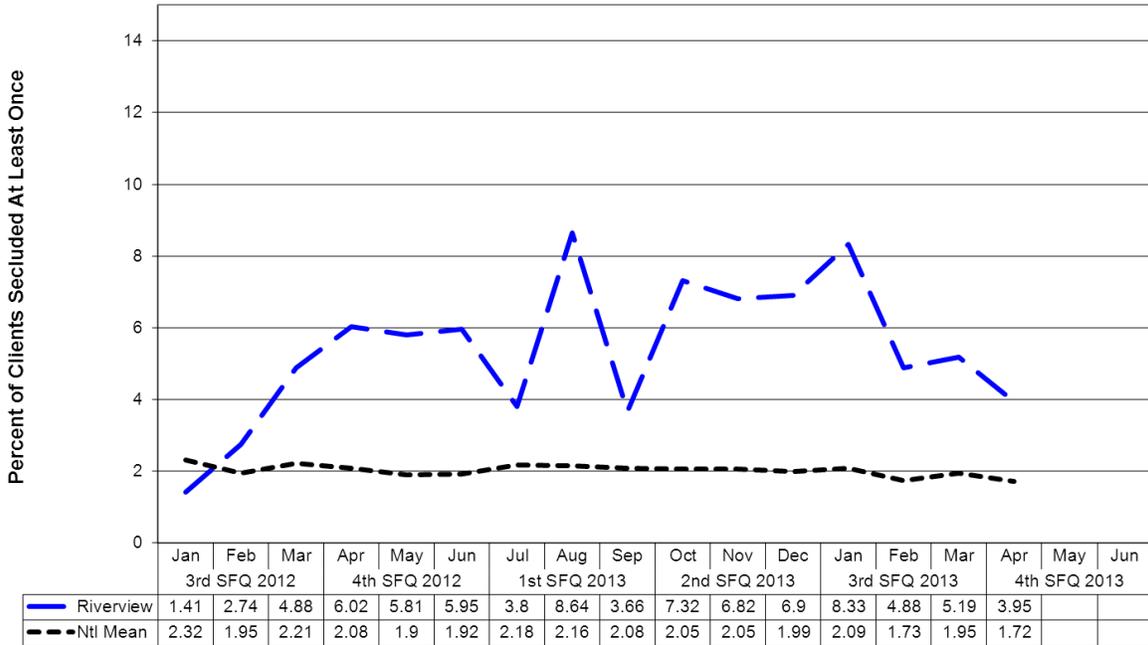
This graph depicts the percent of unique clients who were secluded at least once. For example, a rate of 3.0 means that 3% of the unique clients served were secluded at least once.

The following graphs depict the percent of unique clients who were secluded at least once stratified by forensic or civil classifications. For example, a rate of 3.0 means that 3% of the unique clients served were secluded at least once.

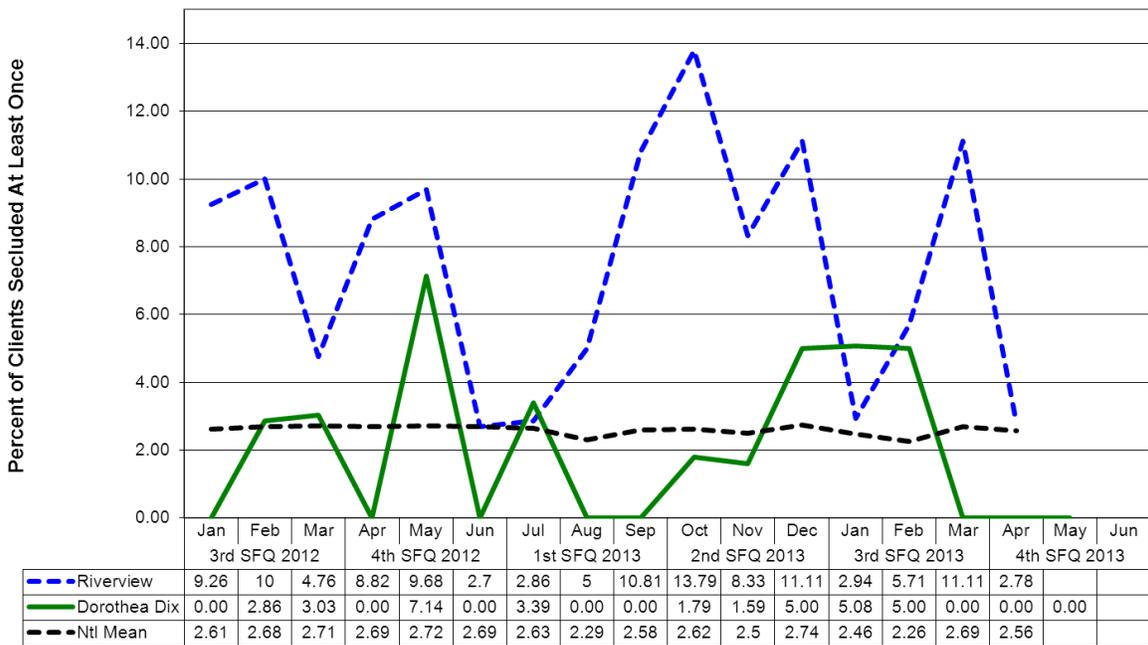
The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Percent of Clients Secluded Forensic Stratification

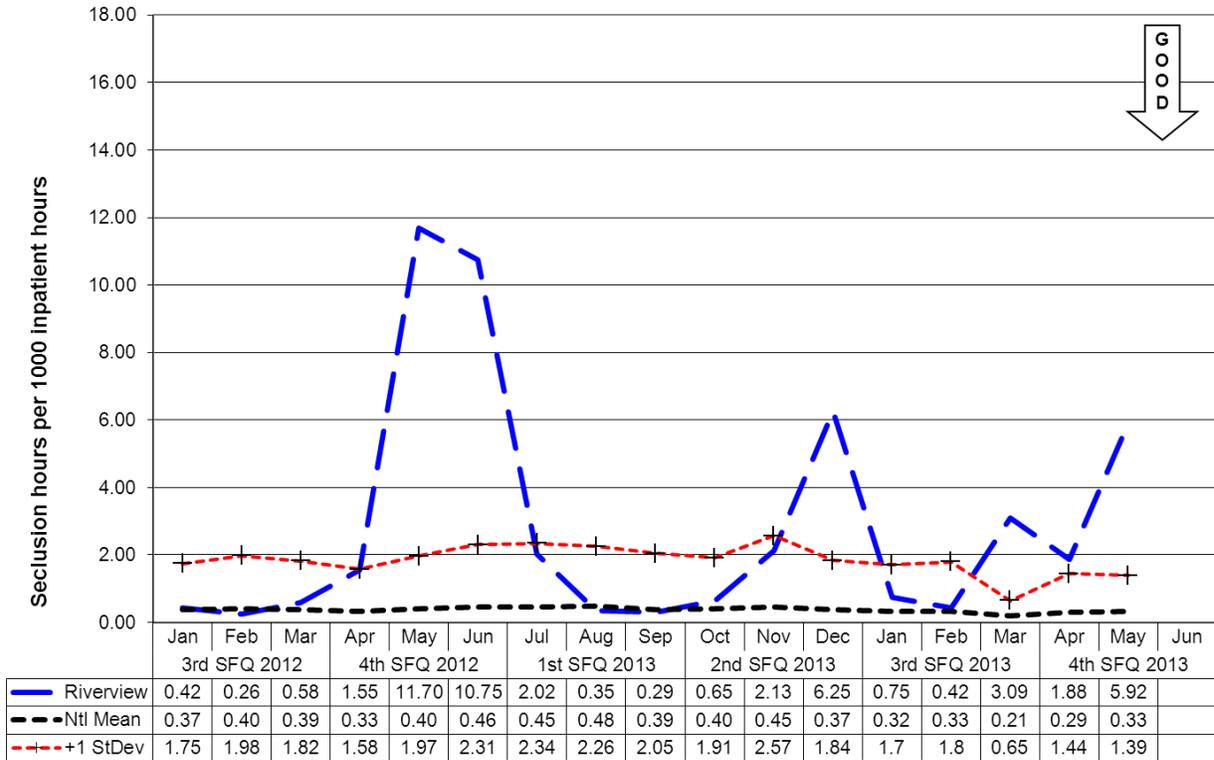


Percent of Clients Secluded Civil Stratification



CONSENT DECREE

Seclusion Hours



This graph depicts the number of hours clients spent in seclusion for every 1000 inpatient hours. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours.

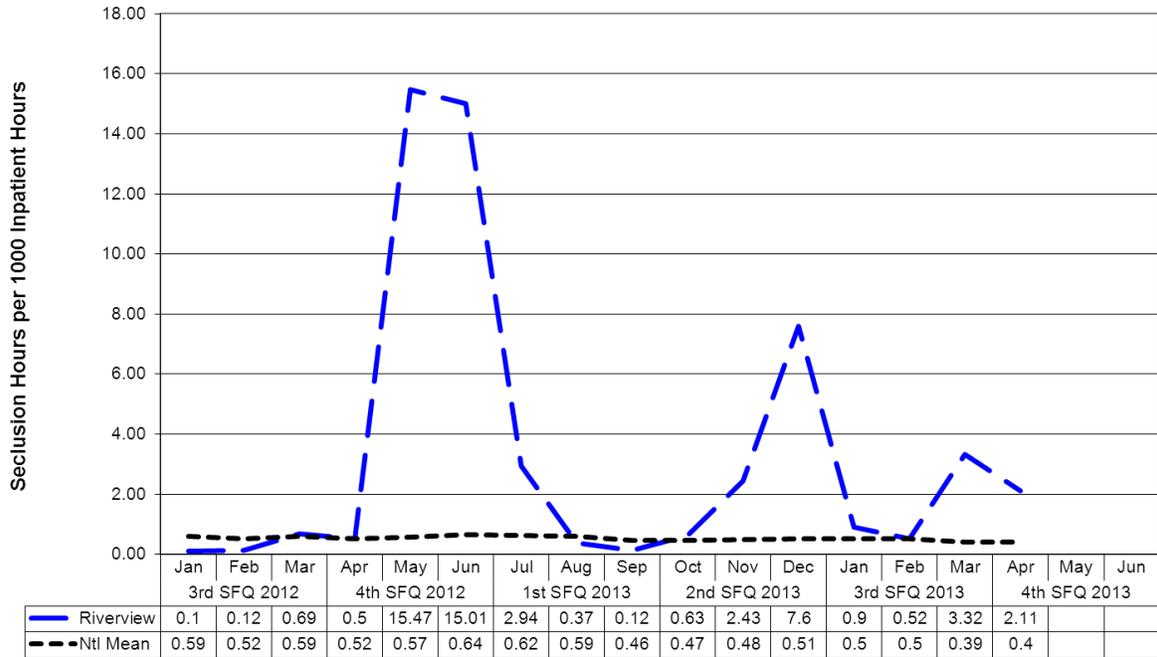
The outlier values shown in May and June reflect the events related to a single individual during this period. This individual was in seclusion for extended periods of time due to extremely aggressive behaviors that are focused on staff. It was determined that the only way to effectively manage this client and create a safe environment for both the staff and other clients was to segregate him in an area away from other clients and to provide frequent support and interaction with staff in a manner that ensured the safety of the staff so engaged.

The following graphs depict the number of hours clients spent in seclusion for every 1000 inpatient hours stratified by forensic or civil classifications. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours.

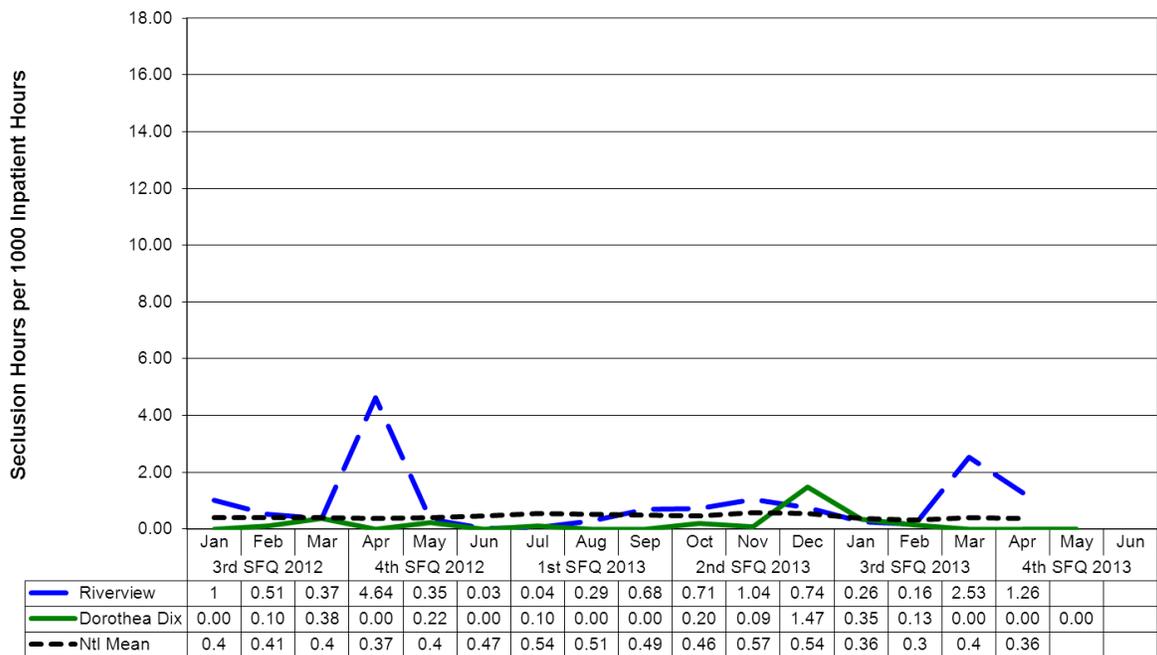
The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Seclusion Hours Forensic Stratification

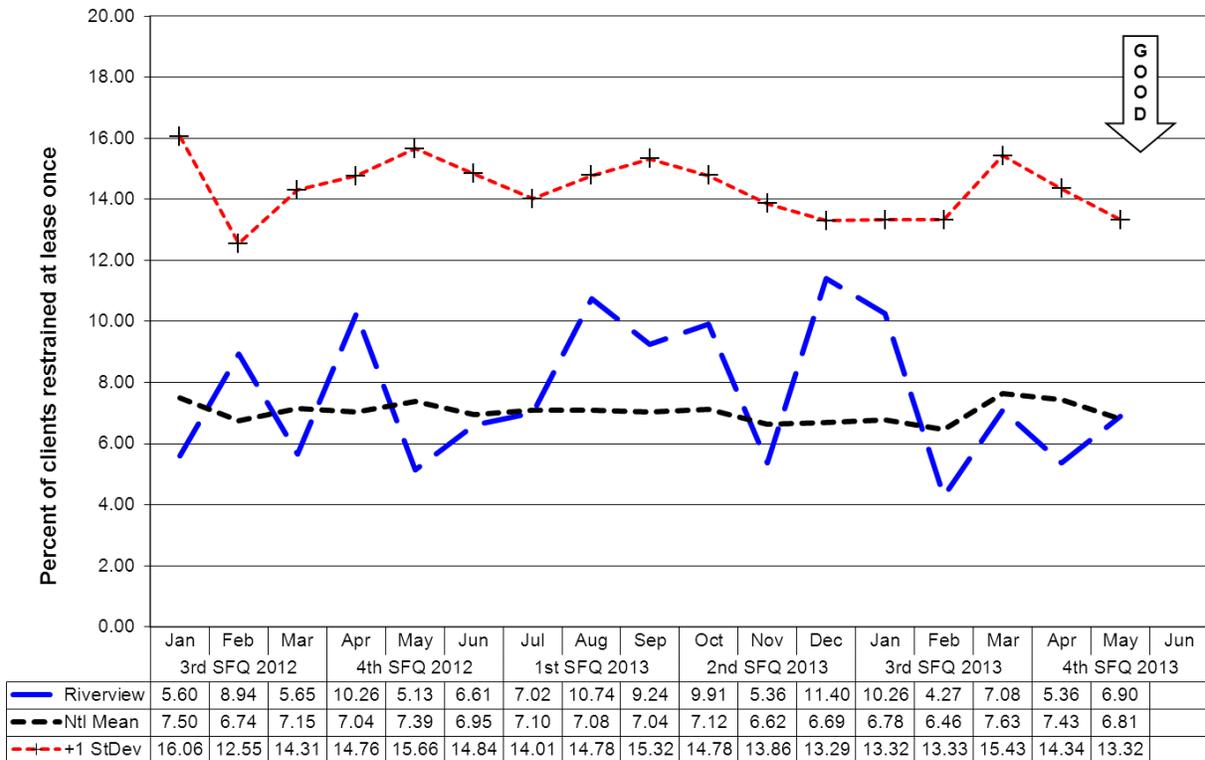


Seclusion Hours Civil Stratification



CONSENT DECREE

Percent of Clients Restrained



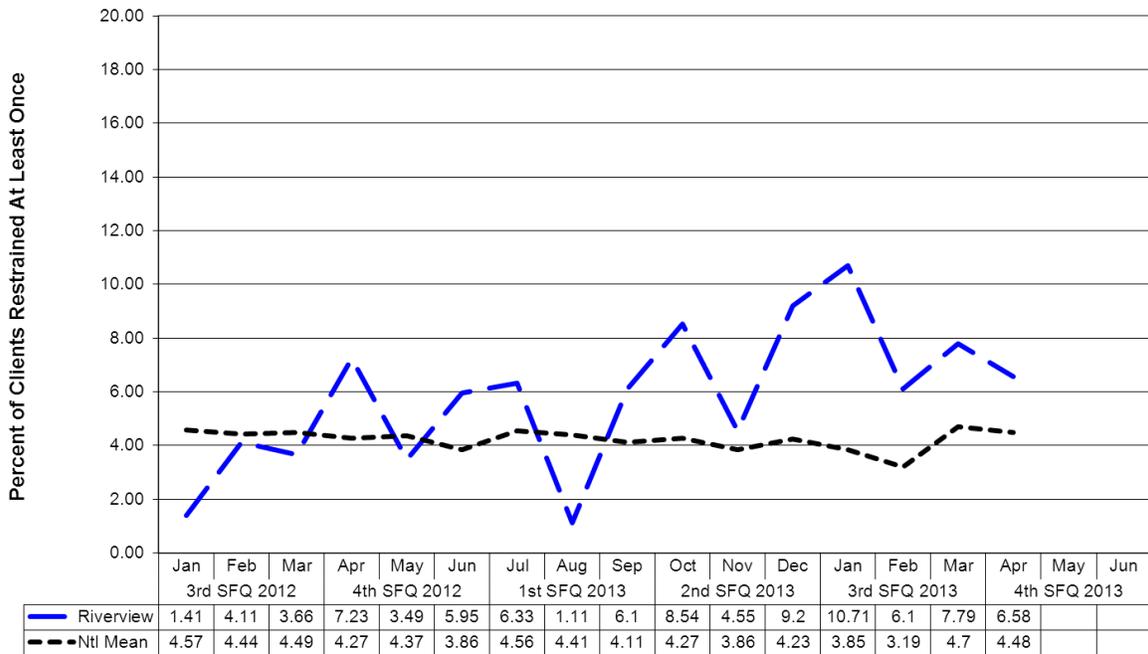
This graph depicts the percent of unique clients who were restrained at least once – includes all forms of restraint of any duration. For example, a rate of 4.0 means that 4% of the unique clients served were restrained at least once.

The following graphs depict the percent of unique clients who were restrained at least once stratified by forensic or civil classifications – includes all forms of restraint of any duration. For example, a rate of 4.0 means that 4% of the unique clients served were restrained at least once.

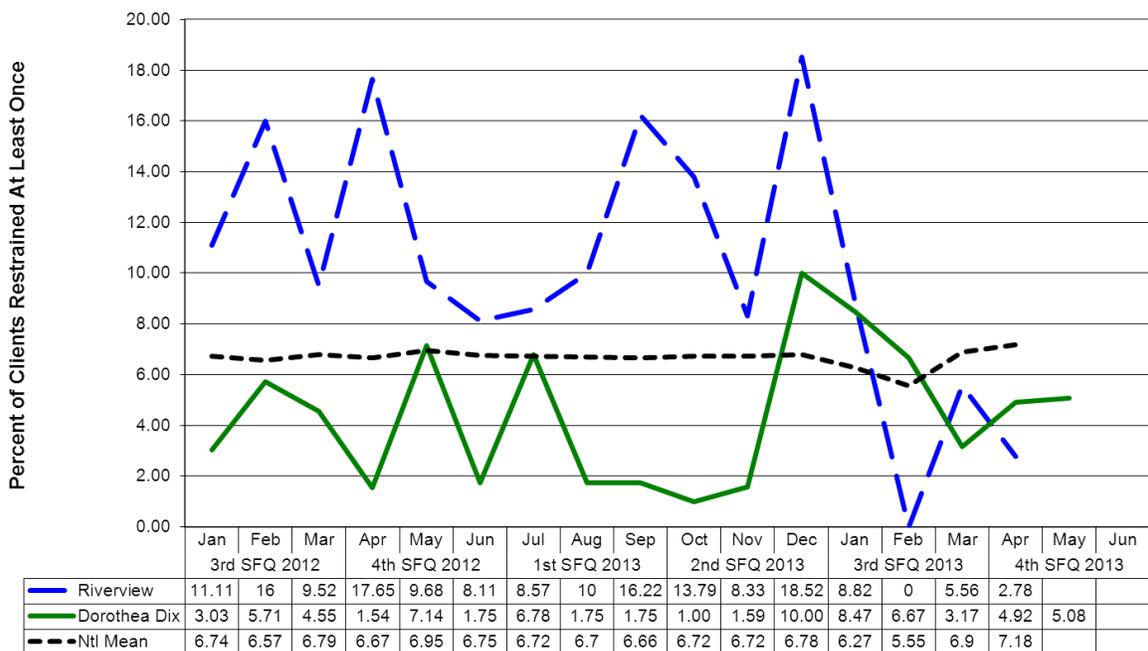
The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Percent of Clients Restrained Forensic Stratification

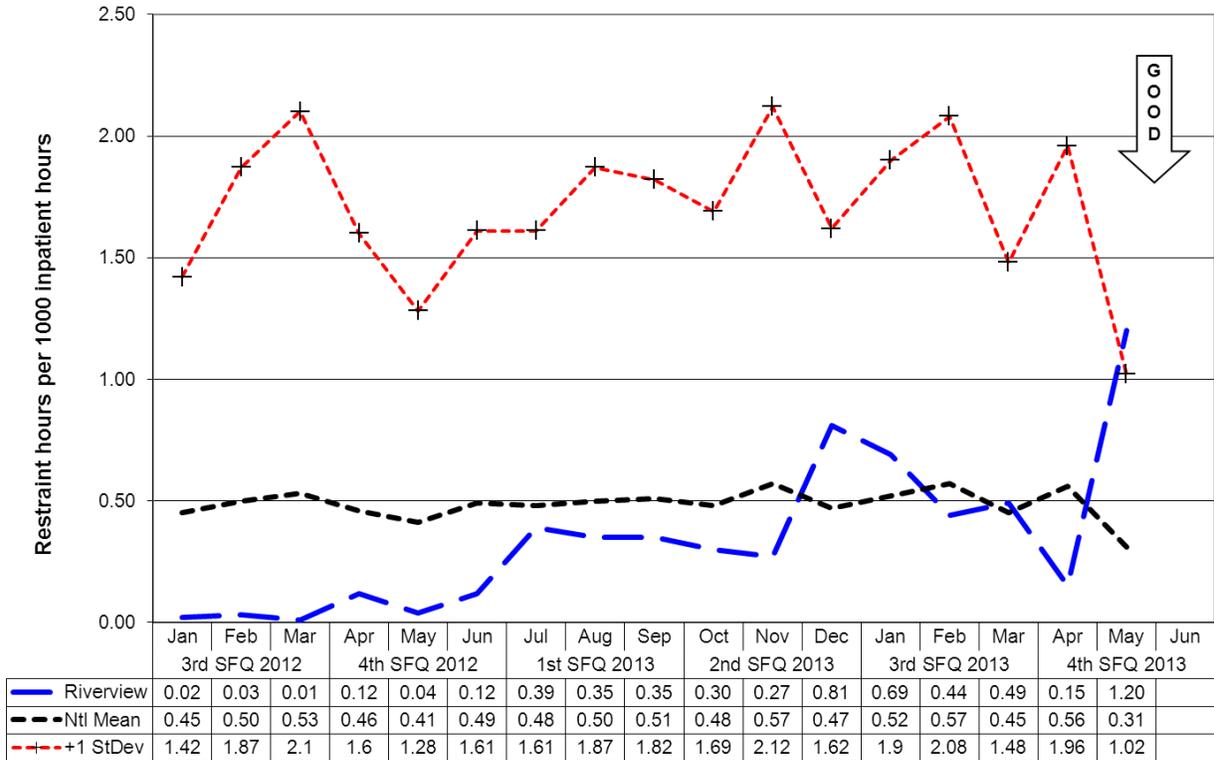


Percent of Clients Restrained Civil Stratification



CONSENT DECREE

Restraint Hours



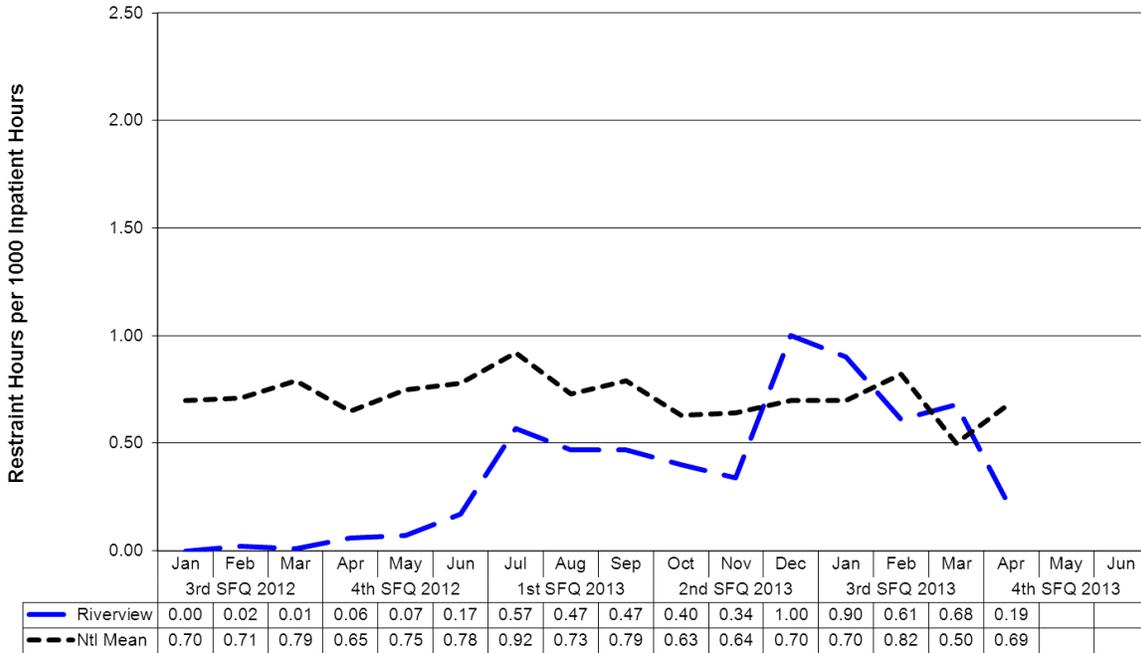
This graph depicts the number of hours clients spent in restraint for every 1000 inpatient hours - includes all forms of restraint of any duration. For example, a rate of 1.6 means that 2 hours were spent in restraint for each 1250 inpatient hours.

The following graphs depict the number of hours clients spent in restraint for every 1000 inpatient hours stratified by forensic or civil classifications - includes all forms of restraint of any duration. For example, a rate of 1.6 means that 2 hours were spent in restraint for each 1250 inpatient hours.

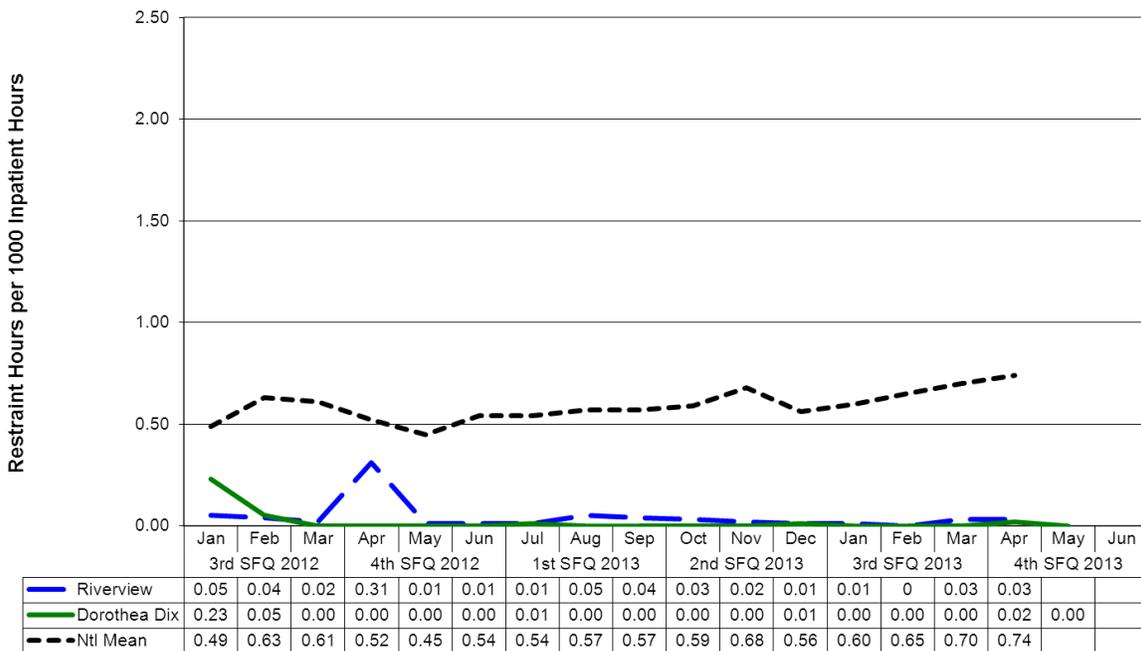
The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Restraint Hours Forensic Stratification



Restraint Hours Civil Stratification



CONSENT DECREE

Confinement Event Detail

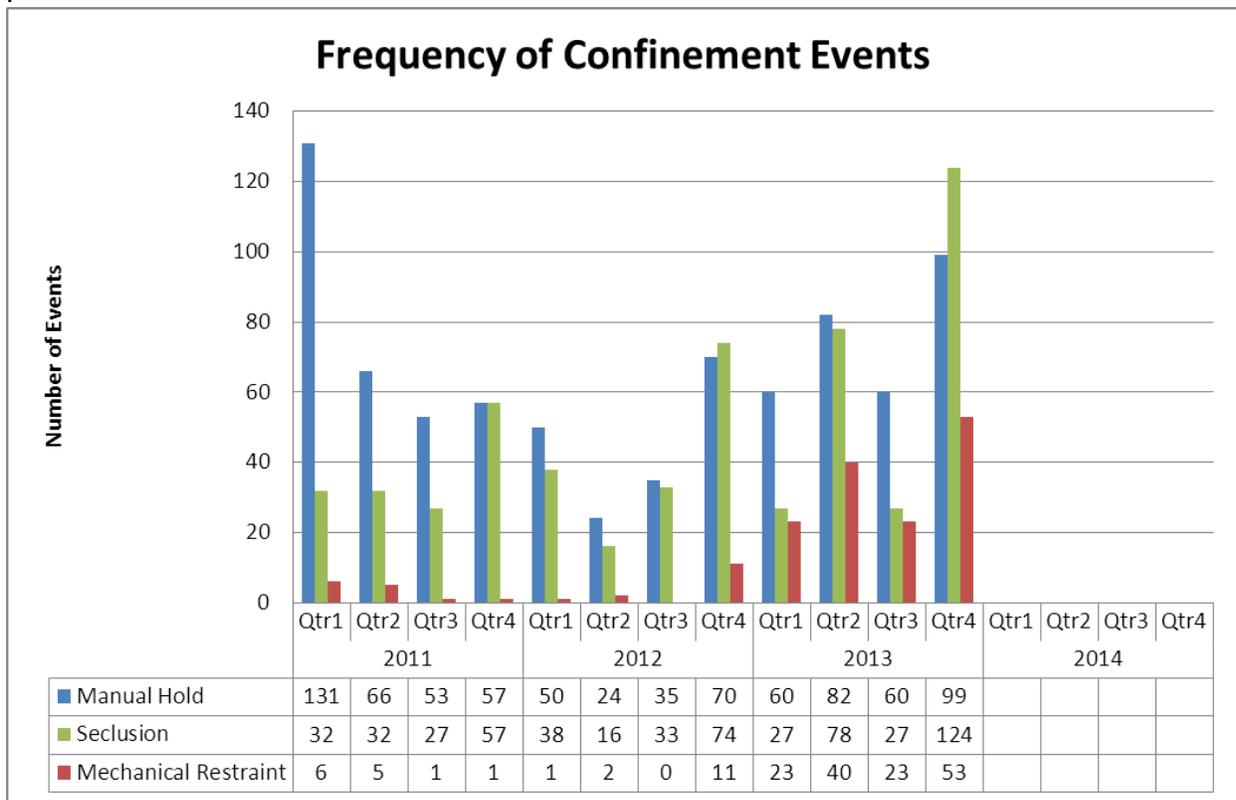
4th Quarter 2013

	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
MR00003374	46	27	48	121	43.8%	43.8%
MR00006963	18		38	56	20.3%	64.1%
MR00000091	10	13	8	31	11.2%	75.4%
MR00006799	4	4	7	15	5.4%	80.8%
MR00000657	4	1	7	12	4.3%	85.1%
MR00007326	4	1	4	9	3.3%	88.4%
MR00000029	3	4	1	8	2.9%	91.3%
MR00007340	1		2	3	1.1%	92.4%
MR00007327	2		1	3	1.1%	93.5%
MR00007189	1	1	1	3	1.1%	94.6%
MR00000477	2		1	3	1.1%	95.7%
MR00007121	1		2	3	1.1%	96.7%
MR00000026	1	1		2	0.7%	97.5%
MR00000202	1		1	2	0.7%	98.2%
MR00007292			2	2	0.7%	98.9%
MR00000814		1		1	0.4%	99.3%
MR00007287			1	1	0.4%	99.6%
MR00007323	1			1	0.4%	100.0%
	99	53	124	276		

23% (18/80) of average hospital population experienced some form of confinement event during the 4th fiscal quarter 2013. Five of these clients (6% of the average hospital population) accounted for 85% of the containment events.

The trend in frequency of confinement event, specifically the increase in the trend related to mechanical restraints is due to a few high acute clients requiring special management to ensure the safety of the milieu.

CONSENT DECREE



Since December 2012, Riverview has been admitting an increasing number of forensic clients that are extremely violent and difficult to manage. This increase in high acuity clients has required the use of specialized management techniques that ensure the safety of these clients, other clients, and staff while attempting to maintain a therapeutic milieu.

Best practices from other forensic facilities and recommendations from experts in forensic client management from other State of Maine departments have been considered in the management of these clients.

CONSENT DECREE

V28) Riverview demonstrates that, based on a review of two quarters of data, for 95% of seclusion events, seclusion was employed only when absolutely necessary to protect the patient from causing physical harm to self or others or for the management of violent behavior;

Factors of Causation Related to Seclusion Events

	4Q12	1Q13	2Q13	3Q13	4Q13
Danger to Others/Self	73	23	78	50	124
Danger to Others		4			
Danger to Self	1			1	
% Dangerous Precipitation	100%	100%	100%	100%	100%
Total Events	74	27	78	51	124

V29) Riverview demonstrates that, based on a review of two quarters of data, for 95% of restraint events involving mechanical restraints, the restraint was used only when absolutely necessary to protect the patient from serious physical injury to self or others;

Factors of Causation Related to Mechanical Restraint Events

	4Q12	1Q13	2Q13	3Q13	4Q13
Danger to Others/Self	11	22	40	40	53
Danger to Others		1			
Danger to Self					
% Dangerous Precipitation	100%	100%	100%	100%	100%
Total Events	11	23	40	40	53

V30) Riverview demonstrates that, based on a review of two quarters of data, for 95% of seclusion and restraint events, the hospital achieved an acceptable rating for meeting the requirements of paragraphs 182 and 184 of the Settlement Agreement, in accordance with a methodology defined in **Attachments E-1 and E-2.**

See Pages 26 & 27

CONSENT DECREE

Confinement Events Management

Seclusion Events (124) Events

Standard	Threshold	Compliance	Standard	Threshold	Compliance
The record reflects that seclusion was absolutely necessary to protect the patient from causing physical harm to self or others, or if the patient was examined by a physician or physician extender prior to implementation of seclusion, to prevent further serious disruption that significantly interferes with other patients' treatment.	95%	100%	The medical order states time of entry of order and that number of hours in seclusion shall not exceed 4.	85%	100%
			The medical order states the conditions under which the patient may be sooner released.	85%	100%
			The record reflects that the need for seclusion is re-evaluated at least every 2 hours by a nurse.	90%	100%
The record reflects that lesser restrictive alternatives were inappropriate or ineffective. This can be reflected anywhere in record.	90%	100%	The record reflects that the 2 hour re-evaluation was conducted while the patient was out of seclusion room unless clinically contraindicated.	70%	100%
The record reflects that the decision to place the patient in seclusion was made by a physician or physician extender.	90%	100%	The record includes a special check sheet that has been filled out to document reason for seclusion, description of behavior and the lesser restrictive alternatives considered.	85%	100%
The decision to place the patient in seclusion was entered in the patient's records as a medical order.	90%	100%	The record reflects that the patient was released, unless clinically contraindicated, at least every 2 hours or as necessary for eating, drinking, bathing, toileting or special medical orders.	85%	100%
The record reflects that, if the physician or physician extender was not immediately available to examine the patient, the patient was placed in seclusion following an examination by a nurse.	90%	100%	Reports of seclusion events were forwarded to medical director and advocate.	90%	100%
			The record reflects that, for persons with mental retardation, the regulations governing seclusion of clients with mental retardation were met.	85%	100%
The record reflects that the physician or physician extender personally evaluated the patient within 30 minutes after the patient has been placed in seclusion, and if there is a delay, the reasons for the delay.	90%	100%	The medical order for seclusion was not entered as a PRN order.	90%	100%
The record reflects that the patient was monitored every 15 minutes. (Compliance will be deemed if the patient was monitored at least 3 times per hour.)	90%	100%	Where there was a PRN order, there is evidence that physician was counseled.	95%	N/A
			Individuals implementing seclusion have been trained in techniques and alternatives.	90%	100%
The record reflects that reasonable efforts were taken to notify guardian or designated representative as soon as possible that patient was placed in seclusion.	75%	100%			

CONSENT DECREE

Confinement Events Management

Mechanical Restraint Events (53) Events

Standard	Threshold	Compliance
The record reflects that restraint was absolutely necessary to protect the patient from causing serious physical injury to self or others.	95%	100%
The record reflects that lesser restrictive alternatives were inappropriate or ineffective.	90%	100%
The record reflects that the decision to place the patient in restraint was made by a physician or physician extender	90%	100%
The decision to place the patient in restraint was entered in the patient's records as a medical order.	90%	100%
The record reflects that, if a physician or physician extended was not immediately available to examine the patient, the patient was placed in restraint following an examination by a nurse.	90%	100%
The record reflects that the physician or physician extender personally evaluated the patient within 30 minutes after the patient has been placed in restraint, or, if there was a delay, the reasons for the delay.	90%	100%
The record reflects that the patient was kept under constant observation during restraint.	95%	100%
Individuals implementing restraint have been trained in techniques and alternatives.	90%	100%
The record reflects that reasonable efforts taken to notify guardian or designated representative as soon as possible that patient was placed in restraint.	75%	100%
The medical order states time of entry of order and that number of hours shall not exceed four.	90%	100%
The medical order shall state the conditions under which the patient may be sooner released.	85%	100%

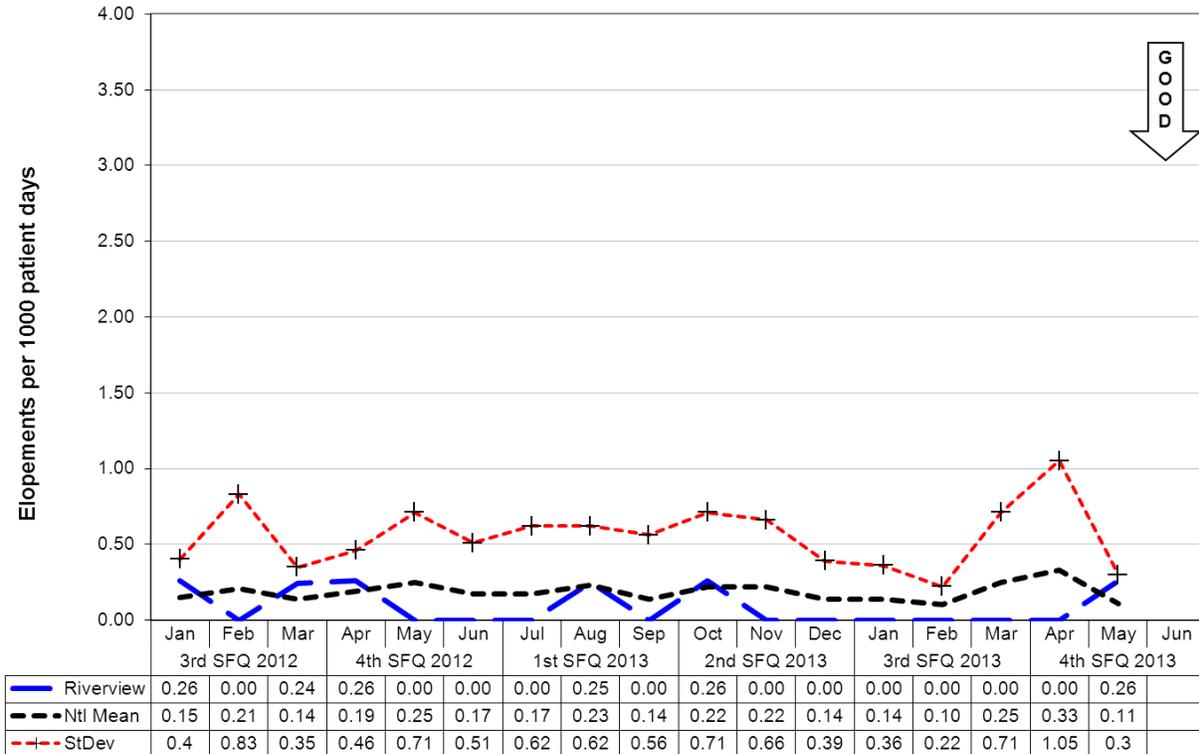
Standard	Threshold	Compliance
The record reflects that the need for restraint was re-evaluated every 2 hours by a nurse.	90%	100%
The record reflects that re-evaluation was conducted while the patient was free of restraints unless clinically contraindicated.	70%	100%
The record includes a special check sheet that has been filled out to document the reason for the restraint, description of behavior and the lesser restrictive alternatives considered.	85%	100%
The record reflects that the patient was released as necessary for eating, drinking, bathing, toileting or special medical orders.	90%	100%
The record reflects that the patient's extremities were released sequentially, with one released at least every fifteen minutes.	90%	100%
Copies of events were forwarded to medical director and advocate.	90%	100%
For persons with mental retardation, the applicable regulations were met.	85%	100%
The record reflects that the order was not entered as a PRN order.	90%	100%
Where there was a PRN order, there is evidence that physician was counseled.	95%	N/A
A restraint event that exceeds 24 hours will be reviewed against the following requirement: If total consecutive hours in restraint, with renewals, exceeded 24 hours, the record reflects that the patient was medically assessed and treated for any injuries; that the order extending restraint beyond 24 hours was entered by Medical Director (or if the Medical Director is out of the hospital, by the individual acting in the Medical Director's stead) following examination of the patient; and that the patient's guardian or representative has been notified.	90%	100%

CONSENT DECREE

Client Elopements

V31) Quarterly performance data shows that, in 5 out of 6 quarters, the number of client elopements do not exceed one standard deviation from the national mean as reported by NASMHPD

Elopement



This graph depicts the number of elopements that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days.

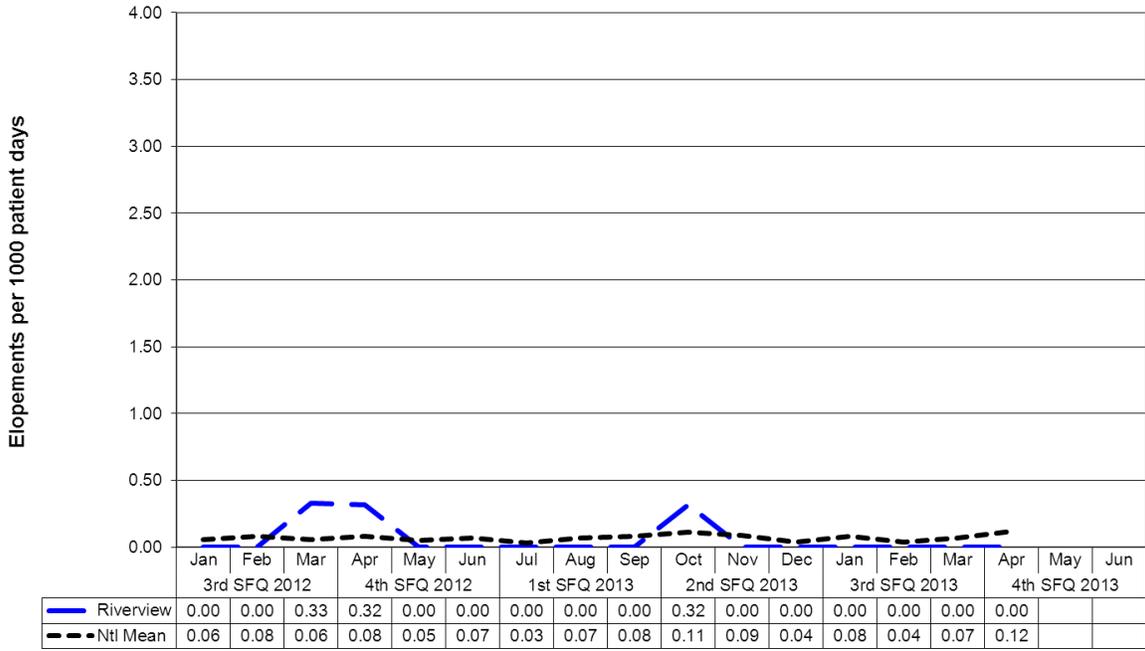
An elopement is defined as any time a client is “absent from a location defined by the client’s privilege status regardless of the client’s leave or legal status.”

The following graphs depict the number of elopements stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days.

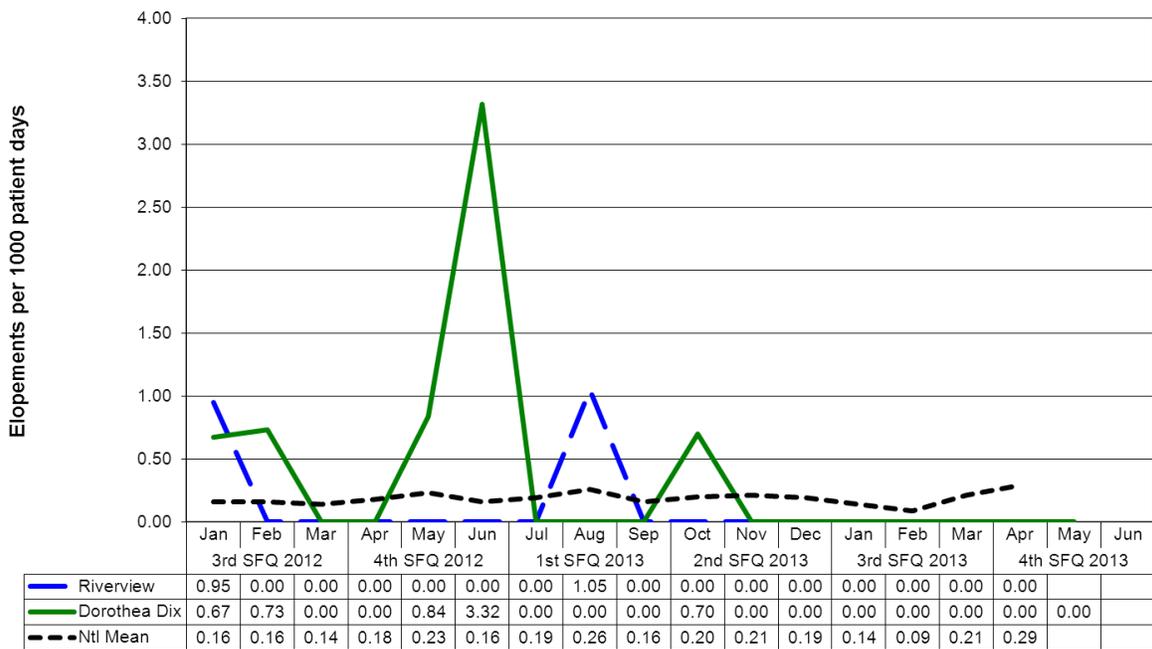
The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Elopement Forensic Stratification



Elopement Civil Stratification



CONSENT DECREE

Client Injuries

V32) Quarterly performance data shows that, in 5 out of 6 quarters, the number of client injuries does not exceed one standard deviation from the national mean as reported by NASMHPD.

The NASMHPD standards for measuring client injuries differentiate between injuries that are considered reportable to the Joint Commission as a performance measure and those injuries that are of a less severe nature. While all injuries are currently reported internally, only certain types of injuries are documented and reported to NRI for inclusion in the performance measure analysis process.

“Non-reportable” injuries include those that require: 1) No Treatment, or 2) Minor First Aid

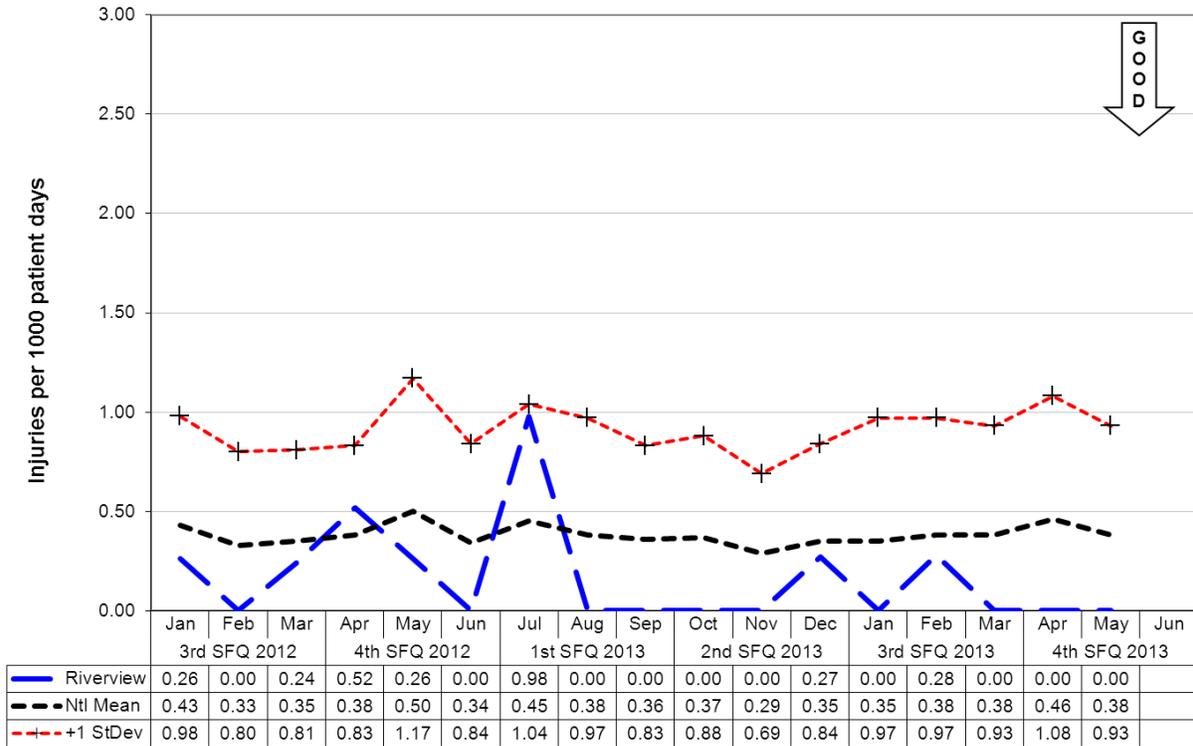
Reportable injuries include those that require: 3) Medical Intervention, 4) Hospitalization or where, 5) Death Occurred.

- No Treatment – The injury received by a client may be examined by a clinician but no treatment is applied to the injury.
- Minor First Aid – The injury received is of minor severity and requires the administration of minor first aid.
- Medical Intervention Needed – The injury received is severe enough to require the treatment of the client by a licensed practitioner, but does not require hospitalization.
- Hospitalization Required – The injury is so severe that it requires medical intervention and treatment as well as care of the injured client at a general acute care medical ward within the facility or at a general acute care hospital outside the facility.
- Death Occurred – The injury received was so severe that if resulted in, or complications of the injury lead to, the termination of the life of the injured client.

The comparative statistics graph only includes those events that are considered “Reportable” by NASMHPD.

CONSENT DECREE

Client Injury Rate



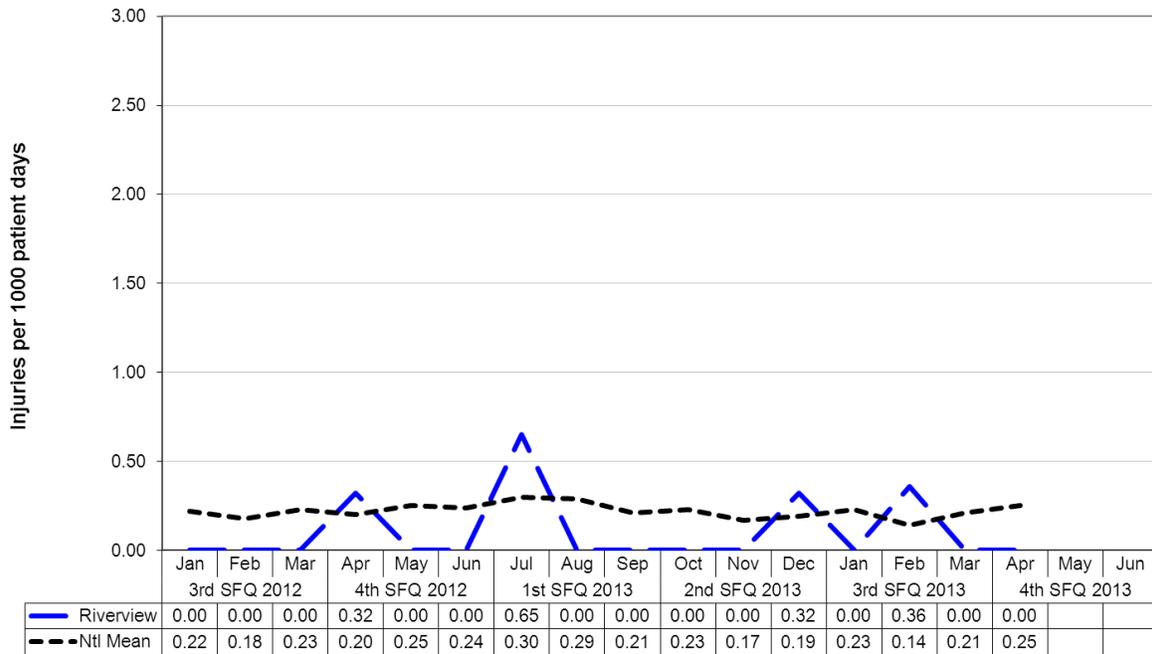
This graph depicts the number of client injury events that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days.

The following graphs depict the number of client injury events stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days.

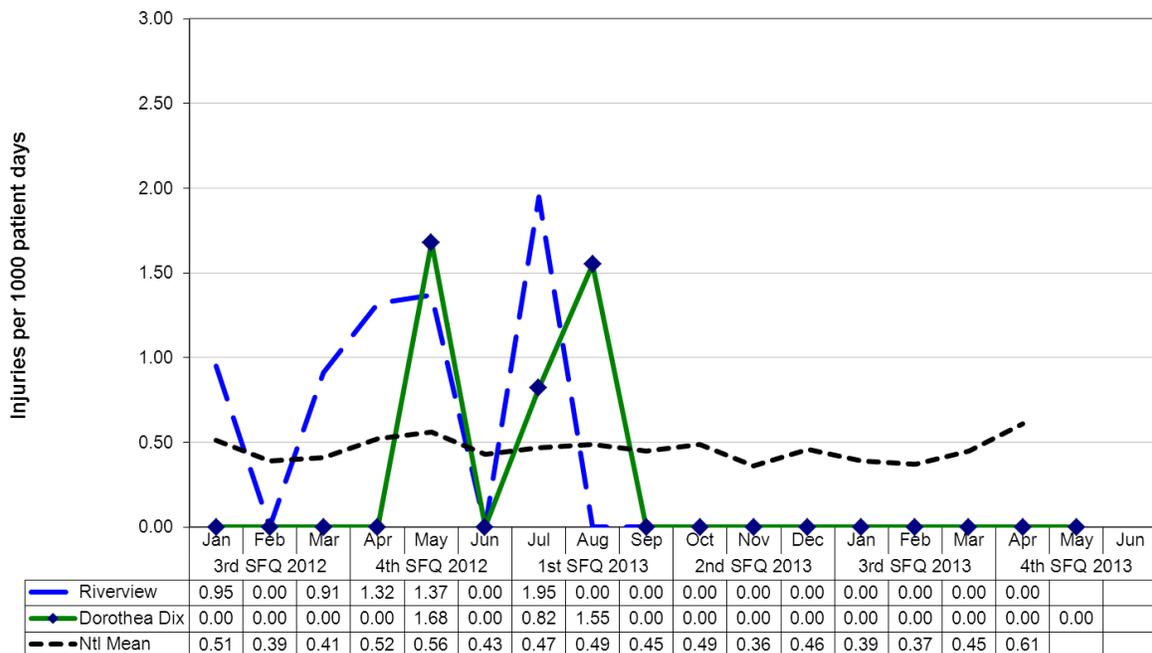
The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Client Injury Rate Forensic Stratification



Client Injury Rate Civil Stratification



CONSENT DECREE

Severity of injury by Month

Severity	APR	MAY	JUN	4Q2013
No Treatment	26	38	29	93
Minor First Aid				
Medical Intervention Required				
Hospitalization Required				
Death Occurred				
Total	26	38	29	93

The event that required medical intervention involved a client to client assault. The four events that required minor first aid also involved client to client assaults.

Type and Cause of Injury by Month

Type - Cause	APR	MAY	JUN	4Q2013
Accident – Fall Unwitnessed	2	4	2	8
Accident – Fall Witnessed	8	15		23
Accident – Other	2		1	3
Assault – Client to Client	14	19	24	57
Self-Injurious Behavior			2	2

Changes in reporting standards related to “criminal” events as defined by the “State of Maine Rules for Reporting Sentinel Events”, effective February 1, 2013 as defined the by “National Quality Forum 2011 List of Serious Reportable Events” the number of reportable “assaults” that occur as the result of client interactions increased significantly. This change is due primarily as a result of the methods and rules related to data collection and abstraction.

Falls continues to be the predominant cause of potentially injurious events not related to the assaults discussed previously. Fall incidents remain a focus of the hospital. None of the fall incidents required treatment of any kind but are address as to causation during the Falls Process Review Team Meeting held each month.

Further information on Fall Reduction Strategies can be found under the [Joint Commission Priority Focus Areas](#) section of this report.

CONSENT DECREE

Patient Abuse, Neglect, Exploitation, Injury or Death

V33) Riverview certifies that it is reporting and responding to instances of patient abuse, neglect, exploitation, injury or death consistent with the requirements of ¶¶ 192-201 of the Settlement Agreement.

Type of Allegation	1Q2013	2Q2013	3Q2013	4Q2013
Abuse Physical	3	5	2	3
Abuse Sexual	6	2	2	5
Abuse Verbal		1		
Coercion/Exploitation				1
Neglect				

Riverview utilizes several vehicles to communicate concerns or allegations related to abuse, neglect or exploitation.

1. Staff members complete an incident report upon becoming aware of an incident or an allegation of any form of abuse, neglect, or exploitation.
2. Clients have the option to complete a grievance or communicate allegations of abuse, neglect, or exploitation during any interaction with staff at all levels, peer support personnel, or the client advocates.
3. Any allegation of abuse, neglect, or exploitation is reported both internally and externally to appropriate stakeholders, include:
 - Superintendent and/or AOC
 - Adult Protective Services
 - Guardian
 - Client Advocate
4. Allegations are reported to the Risk Manager through the incident reporting system and fact-finding or investigations occur at multiple levels. The purpose of this investigation is to evaluate the event to determine if the allegations can be substantiated or not and to refer the incident to the client’s treatment team, hospital administration, or outside entities.
5. When appropriate to the allegation and circumstances, investigations involving law enforcement, family members, or human resources may be conducted.
6. The Human Rights Committee, a group consisting of consumers, family members, providers, and interested community members, and the Medical Executive Committee receive a report on the incidence of alleged abuse, neglect, and exploitation monthly.

CONSENT DECREE

Performance Improvement and Quality Assurance

V34) Riverview maintains Joint Commission accreditation;

Riverview successfully completed an accreditation survey with the Joint Commission on November 15-19, 2010. A triennial accreditation survey is expected to occur in November 2013 or earlier.

The surveyors identified four areas of direct impact that required a review and revision of hospital processes within 45 days.

The surveyors identified nine areas of indirect impact that required a review and revision of hospital processes within 60 days.

Riverview received notification of full accreditation status on October 3, 2011 with an effective date of November 20, 2010.

V35) Riverview maintains its hospital license;

Riverview maintains licensing status as required through the Department of Health and Human Services Division of Licensing and Regulatory Services Centers for Medicare and Medicaid Services.

V36) The hospital does not lose its CMS certification (for the entire hospital excluding Lower Saco SCU so long as Lower Saco SCU is a distinct part of the hospital for purposes of CMS certification) as a result of patient care issues;

Centers for Medicare and Medicaid Services certification is ongoing and applicable for all units, including the Lower Saco SCU. Lower Saco SCU received CMS Certification in January 2011. This certification is required to ensure reimbursement under Medicare, Medicaid, and through the Disproportionate Share Process.

V37) Riverview conducts quarterly monitoring of performance indicators in key areas of hospital administration, in accordance with the Consent Decree Plan, the accreditation standards of the Joint Commission, and according to a QAPI plan reviewed and approved by the Advisory Board each biennium, and demonstrates through quarterly reports that management uses that data to improve institutional performance, prioritize resources and evaluate strategic operations.

Riverview complies with this element of substantial compliance as evidenced by the current Integrated Plan for Performance Excellence, the data and reports presented in this document, the work of the Integrated Performance Excellence Committee and sub-groups of this committee that are engaged in a transition to an improvement orientated methodology that is support by the Joint Commission and is consistent with modern principles of process management and strategic methods of promoting organizational performance excellence.

JOINT COMMISSION

Hospital-Based Inpatient Psychiatric Services (ORYX Data Elements)

The Joint Commission Quality Initiatives

In 1987, The Joint Commission announced its *Agenda for Change*, which outlined a series of major steps designed to modernize the accreditation process. A key component of the *Agenda for Change* was the eventual introduction of standardized core performance measures into the accreditation process. As the vision to integrate performance measurement into accreditation became more focused, the name ORYX® was chosen for the entire initiative. The ORYX initiative became operational in March of 1999, when performance measurement systems began transmitting data to The Joint Commission on behalf of accredited hospitals and long term care organizations. Since that time, home care and behavioral healthcare organizations have been included in the ORYX initiative.

The initial phase of the ORYX initiative provided healthcare organizations a great degree of flexibility, offering greater than 100 measurement systems capable of meeting an accredited organization's internal measurement goals and the Joint Commission's ORYX requirements. This flexibility, however, also presented certain challenges. The most significant challenge was the lack of standardization of measure specifications across systems. Although many ORYX measures appeared to be similar, valid comparisons could only be made between healthcare organizations using the same measures that were designed and collected based on standard specifications. The availability of over 8,000 disparate ORYX measures also limited the size of some comparison groups and hindered statistically valid data analyses. To address these challenges, standardized sets of valid, reliable, and evidence-based quality measures have been implemented by The Joint Commission for use within the ORYX initiative.

Hospital-Based Inpatient Psychiatric Services (HBIPS) Core Measure Set

Driven by an overwhelming request from the field, The Joint Commission was approached in late 2003 by the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD) and the NASMHPD Research Institute, Inc. (NRI) to work together to identify and implement a set of core performance measures for hospital-based inpatient psychiatric services. Project activities were launched in March 2004. At this time, a diverse panel of stakeholders convened to discuss and recommend an overarching initial framework for the identification of HBIPS core performance measures. The Technical Advisory Panel (TAP) was established in March 2005 consisting of many prominent experts in the field.

The first meeting of the TAP was held May 2005 and a framework and priorities for performance measures was established for an initial set of core measures. The framework consisted of seven domains:

Assessment

Treatment Planning and Implementation

Hope and Empowerment

Patient Driven Care

Patient Safety

Continuity and Transition of Care

Outcomes

The current HBIPS standards reflected in this report a designed to reflect these core domains in the delivery of psychiatric care.

JOINT COMMISSION

Admissions Screening (HBIPS 1)

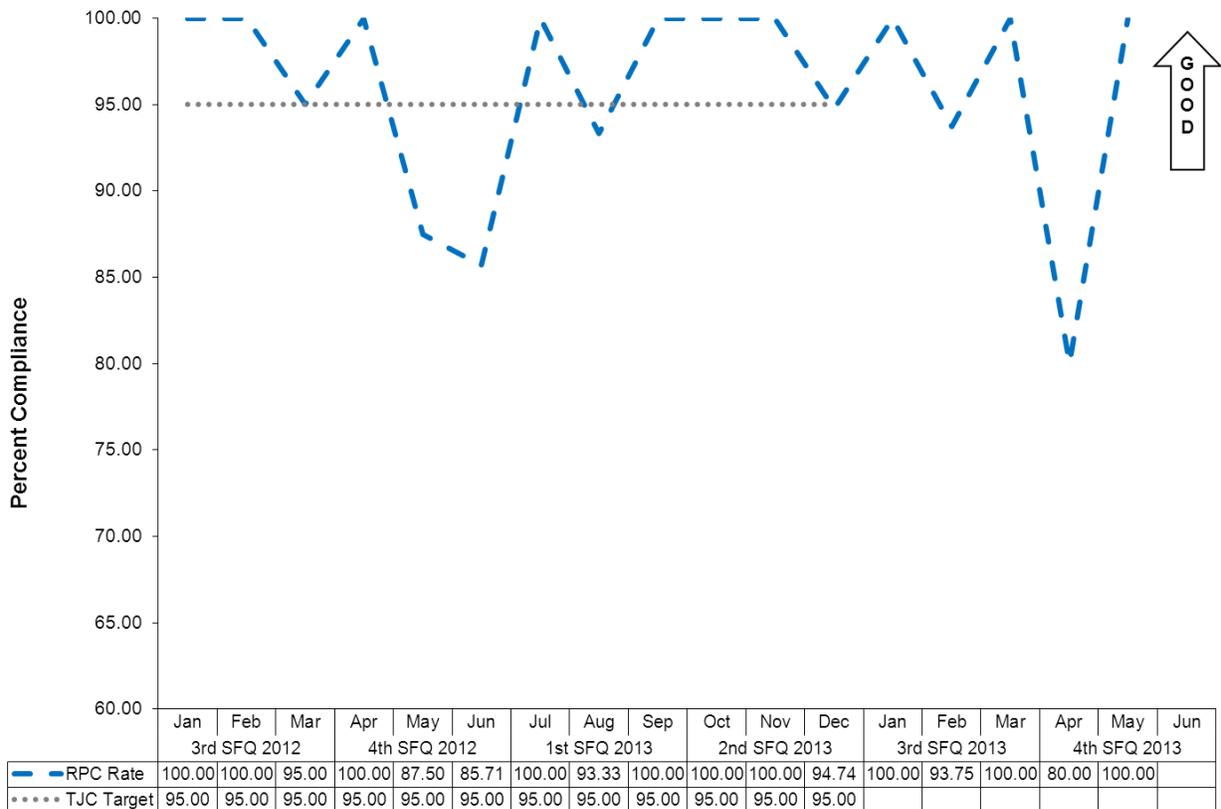
For Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths

Description

Patients admitted to a hospital-based inpatient psychiatric setting who are screened within the first three days of admission for all of the following: risk of violence to self or others, substance use, psychological trauma history and patient strengths

Rationale

Substantial evidence exists that there is a high prevalence of co-occurring substance use disorders as well as history of trauma among persons admitted to acute psychiatric settings. Professional literature suggests that these factors are under-identified yet integral to current psychiatric status and should be assessed in order to develop appropriate treatment (Ziedonis, 2004; NASMHPD, 2005). Similarly, persons admitted to inpatient settings require a careful assessment of risk for violence and the use of seclusion and restraint. Careful assessment of risk is critical to safety and treatment. Effective, individualized treatment relies on assessments that explicitly recognize patients' strengths. These strengths may be characteristics of the individuals themselves, supports provided by families and others, or contributions made by the individuals' community or cultural environment (Rapp, 1998). In the same way, inpatient environments require assessment for factors that lead to conflict or less than optimal outcomes.



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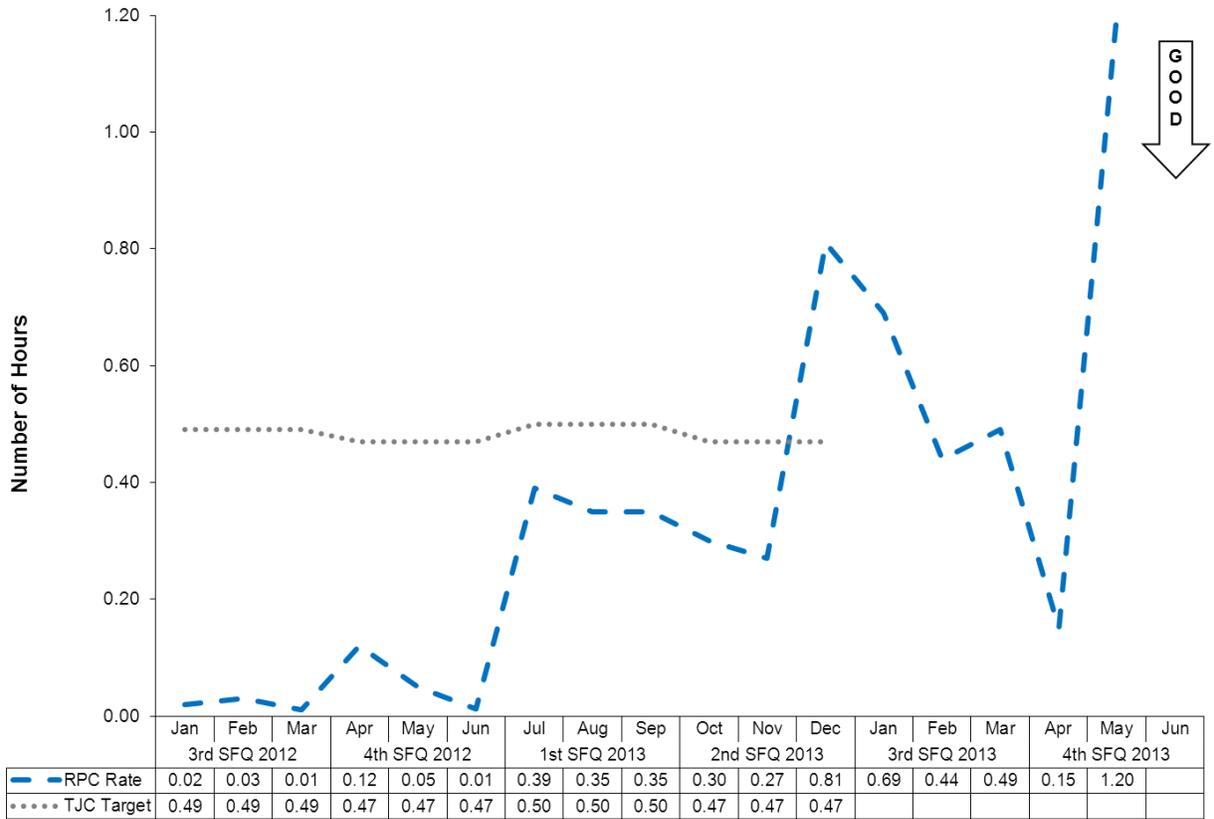
Physical Restraint (HBIPS 2) Hours of Use

Description

The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint

Rationale

Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint and seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).



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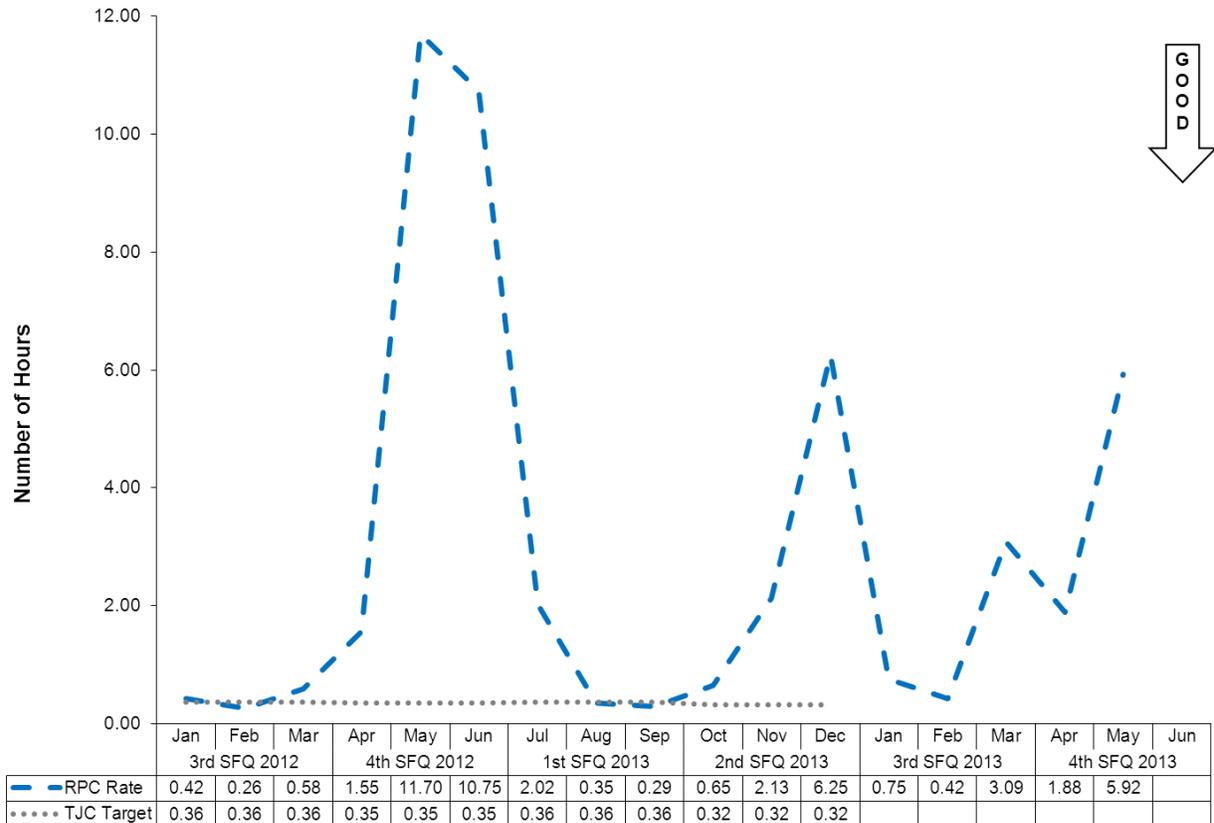
Seclusion (HBIPS 3) Hours of Use

Description

The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion

Rationale

Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).



JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)

Description

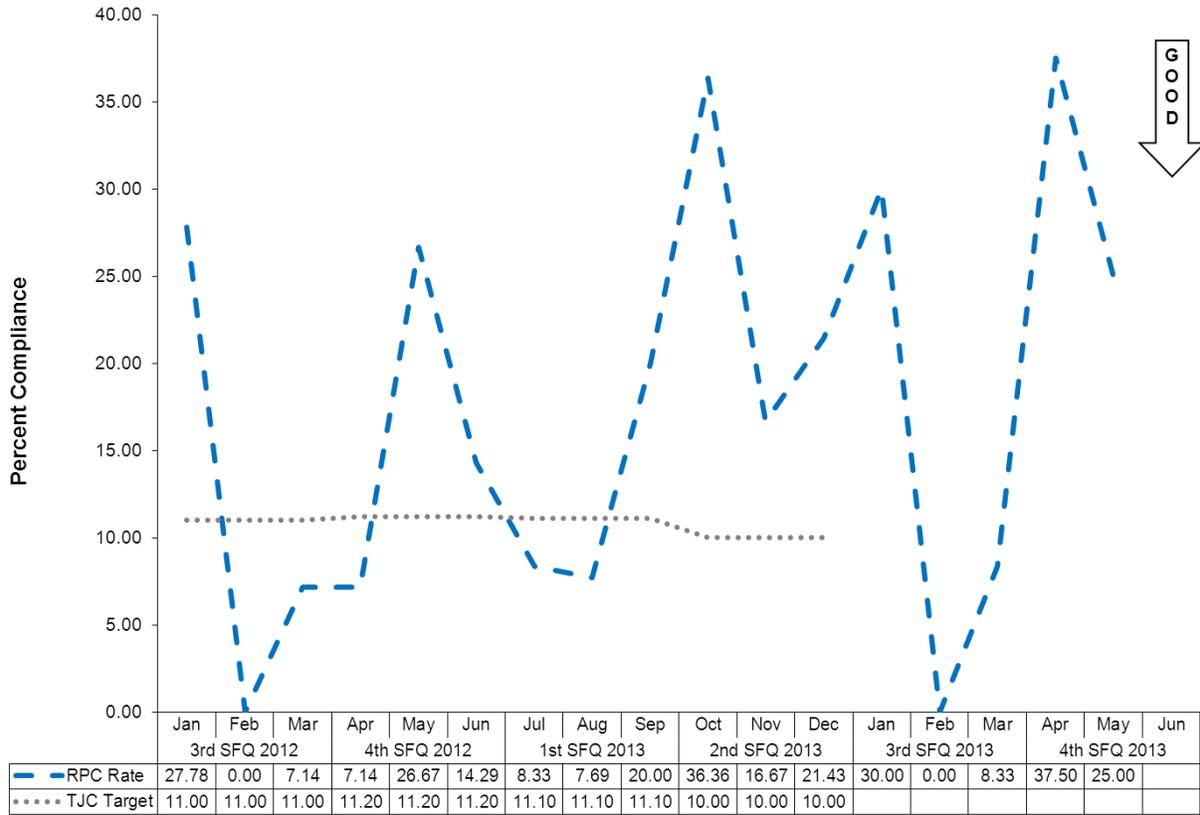
Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications

Rationale

Research studies have found that 4-35% of outpatients and 30-50% of inpatients treated with an antipsychotic medication concurrently received 2 or more antipsychotics (Covell, Jackson, Evans, & Essock, 2002; Ganguly, Kotzan, Miller, Kennedy, & Martin, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; Kreyenbuhl, Valenstein, McCarthy, Ganocy, & Blow, 2006; Stahl & Grady, 2004). One study reported 4.6% of patients concurrently received 3 or more antipsychotics (Jaffe & Levine, 2003). These findings are seen across diverse sectors: state mental health authorities, the Veterans Health System and Medicaid-financed care. Antipsychotic polypharmacy can lead to greater side effects, often without improving clinical outcomes (Ananth, Parameswaran, & Gunatilake, 2004; Stahl & Grady, 2004). As a result, a range of stakeholders have called for efforts to reduce unnecessary use of multiple antipsychotics (Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; National Association of State Mental Health Program Directors, 2001; University HealthSystem Consortium, 2006). Practice guidelines recommend the use of a second antipsychotic only after multiple trials of a single antipsychotic have proven inadequate (American Psychiatric Association [APA] Practice Guidelines, 2004). Randomized controlled trials (RCTs) provide some evidence to support augmentation with a second antipsychotic in *treatment resistant* patients. Most of these studies were limited to augmentation of clozapine with another second-generation antipsychotic (Tranulis, Skalli, Lalonde, & Nicole, 2008). Among patients *without* a documented history of previous treatment failures of antipsychotic monotherapy, multiple RCTs and other controlled trials failed to show a benefit of antipsychotic polypharmacy over monotherapy (Ananth, Parameswaran, & Gunatilake, 2004; Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Potkin, Thyrum, Alva, Bera, Yeh, & Arvanitis, 2002; Shim et al., 2007; Stahl, & Grady, 2004). Clinical circumstances, such as shorter inpatient stays, may require hospitals to discharge a patient on multiple antipsychotics with an aftercare plan to transition to monotherapy. In such cases, effective communication between the inpatient and aftercare clinician is an essential element of care.

JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)



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Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)

Description

Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification

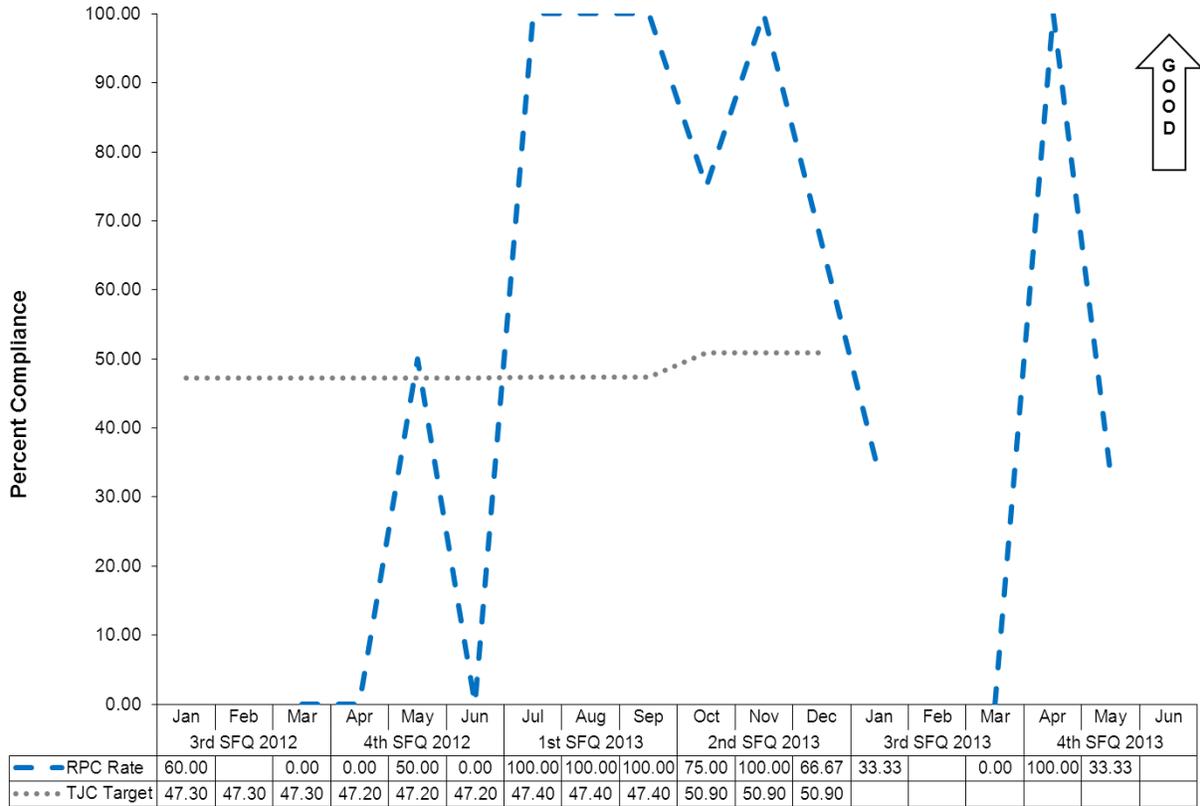
Rationale

Research studies have found that 4-35% of outpatients and 30-50% of inpatients treated with an antipsychotic medication concurrently received 2 or more antipsychotics (Covell, Jackson, Evans, & Essock, 2002; Ganguly, Kotzan, Miller, Kennedy, & Martin, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; Kreyenbuhl, Valenstein, McCarthy, Ganocy, & Blow, 2006; Stahl & Grady, 2004). One study reported 4.6% of patients concurrently received 3 or more antipsychotics (Jaffe & Levine, 2003). These findings are seen across diverse sectors: state mental health authorities, the Veterans Health System and Medicaid-financed care. Antipsychotic polypharmacy can lead to greater side effects, often without improving clinical outcomes (Ananth, Parameswaran, & Gunatilake, 2004; Stahl & Grady, 2004). As a result, a range of stakeholders have called for efforts to reduce unnecessary use of multiple antipsychotics (Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; National Association of State Mental Health Program Directors, 2001; University HealthSystem Consortium, 2006).

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JOINT COMMISSION

Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)



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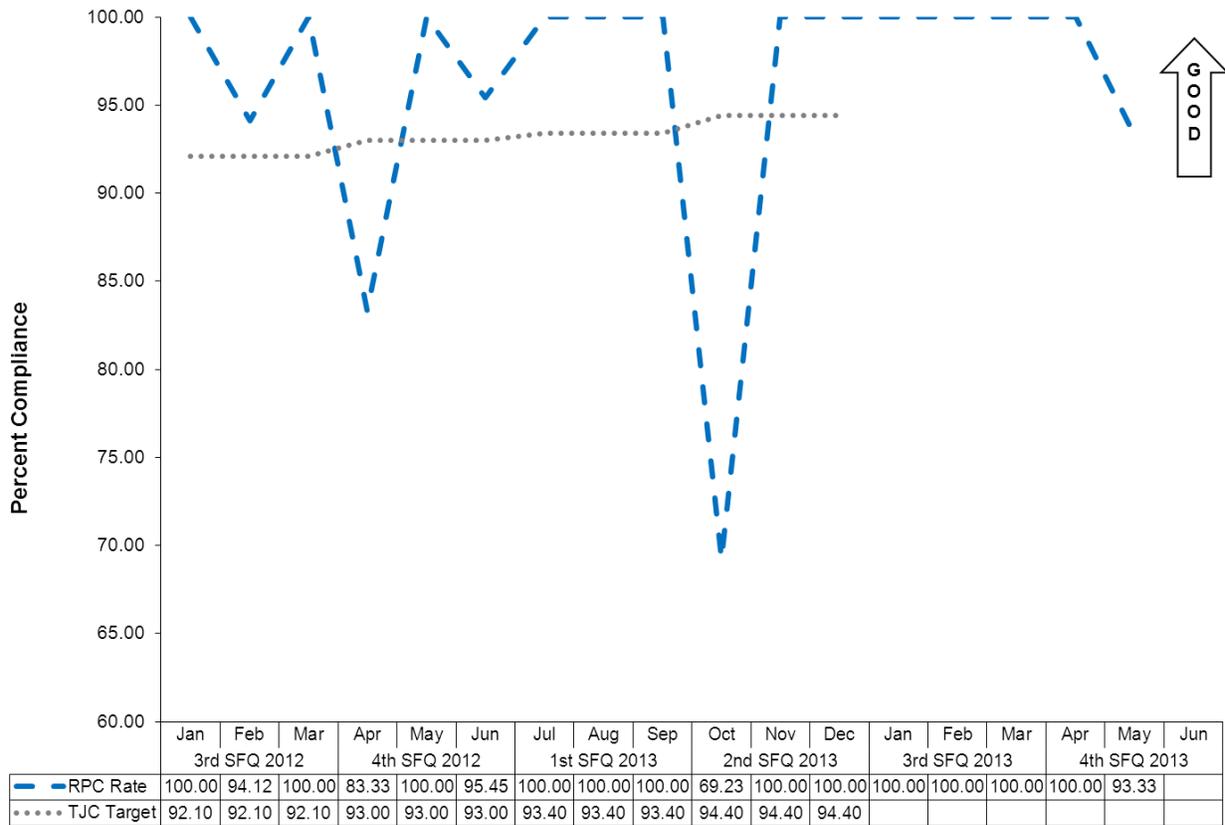
Post Discharge Continuing Care Plan (HBIPS 6)

Description

Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan created

Rationale

Patients may not be able to fully report to their next level of care health-care provider their course of hospitalization or discharge treatment recommendations. The aftercare instructions given the patient may not be available to the next level of care provider at the patient's initial intake or follow-up appointment. In order to provide optimum care, next level of care providers need to know details of precipitating events immediately preceding hospital admission, the patient's treatment course during hospitalization, discharge medications and next level of care recommendations (American Association of Community Psychiatrists [AAP], 2001).



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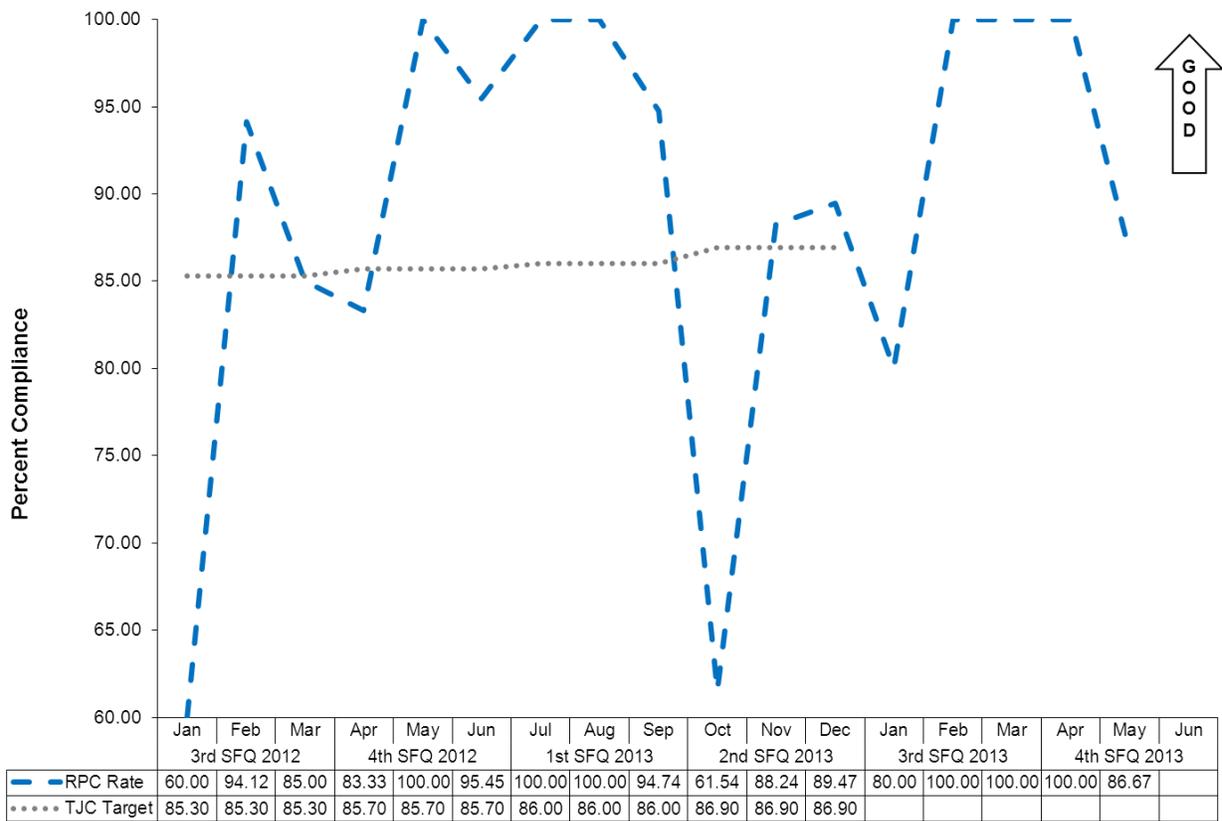
Post Discharge Continuing Care Plan Transmitted (HBIPS 7) To Next Level of Care Provider on Discharge

Description

Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity

Rationale

Patients may not be able to fully report to their next level of care health-care provider their course of hospitalization or discharge treatment recommendations. The aftercare instructions given the patient may not be available to the next level of care provider at the patient’s initial intake or follow-up appointment. In order to provide optimum care, next level of care providers need to know details of precipitating events immediately preceding hospital admission, the patient’s treatment course during hospitalization, discharge medications and next level of care recommendations (American Association of Community Psychiatrists [AACPP], 2001).



JOINT COMMISSION

Joint Commission Priority Focus Areas

Capital Community Clinic

Adverse Reactions to Sedation or Anesthesia

TJC PI.01.01.01 EP6: The hospital collects data on the following: adverse events related to using moderate or deep sedation or anesthesia. (See also LD.04.04.01, EP 2)

Dental Clinic Timeout/Identification of Client

Indicators	1Q2013	2Q2013	3Q2013	4Q2013
National Patient Safety Goals	July 100%	October 100%	January 100%	April 100%
Goal 1: Improve the accuracy of Client Identification.	14/14	5/5	7/7	2/2
Capital Community Dental Clinic assures accurate client identification by: asking the client to state his/her name and date of birth.	August 100%	November 100%	February 100%	May 100%
	4/4	3/3	3/3	7/7
A time out will be taken before the procedure to verify location and numbered tooth. The time out section is in the progress notes of the patient chart. This page will be signed by the Dentist as well as the dental assistant.	September 100%	December 100%	March 100%	June 100%
	5/5	4/4	9/9	7/7
	Total 100%	Total 100%	Total 100%	Total 100%
	23/23	12/12	19/19	7/7

Dental Clinic Post Extraction Prevention of Complications and Follow-up

Indicators	1Q2013	2Q2013	3Q2013	4Q2013
1. All clients with tooth extractions, will be assessed and have teaching post procedure, on the following topics, as provided by the Dentist or Dental Assistant	July 100%	October 100%	January 100%	April 100%
	14/14	5/5	7/7	2/2
• Bleeding	August 100%	November 100%	February 100%	May 100%
• Swelling	4/4	3/3	3/3	7/7
• Pain	September 100%	December 100%	March 100%	June 100%
• Muscle soreness	5/5	4/4	9/9	7/7
• Mouth care	Total 100%	Total 100%	Total 100%	Total 100%
• Diet	23/23	12/12	19/19	7/7
• Signs/symptoms of infection				
2. The client, post procedure tooth extraction, will verbalize understanding of the above by repeating instructions given by Dental Assistant/Hygienist.				
3. Post dental extractions, the clients will receive a follow-up phone call from the clinic within 24hrs of procedure to assess for post procedure complications				

JOINT COMMISSION

Healthcare Acquired Infections Monitoring and Management

NPSG.07.03.01 Implement evidence-based practices to prevent health care–associated infections due to multidrug-resistant organisms in acute care hospitals.

Indicators	Findings	Compliance	Threshold Percentile
Total number of infections for the third quarter of the fiscal year, per 1000 patient days	3.7	100 % within standard	1 SD within the mean
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	02.6	100% within standard	1 SD within the mean

Total Number of Infections: 27 /4.0
Hospital Associated Infections: 8/2.6
Community Acquired Infections: 19/2.7
Self Injury: 0

Hospital Associated Infections
 Ear Infections 4
 RLL Pneumonia 1
 Hordeolum 1
 Acute Viral Bronchitis 1
 Conjunctivitis 1

Community Acquired Infections:

- Dental Abscess 3
- Peridontal Disease 1
- Prostate Hypertrophy around the Urethra 1
- Acne 2
- Chronic Pansinusitis 1
- Acute Bacterial Rhinosinustitiis 1
- Chronic Mastoid Sinusitis 1
- Mild Prostatitis 1
- Erythrasm 1
- Diabetic Foot Infection, plantar area left foot 1
- Athlete’s Foot 1
- Chronic Hepatitis C
- Bartholinitis 1
- Paronychia Rt. Great Toe 1
- Ingrown toenail with slight paronychial Infection 1
- Chronic Hepatitis B

Infestation:

- Scabies/CAI

Lower Saco - 12
 URI/1/HAI and 1/CAI
 Reproductive 1
 Dental 1
 Skin 4/CAI
 Ear 3/HAI
 Eye 1/HAI
Upper Saco - 5
 RLL Pneumonia/HAI
 Reproductive 2
 Ear 1
 Eye 1

Lower Kennebec - 6
 URI 2/CAI
 GI 2/CAI
 Dental 2
Upper Kennebec - 4
 Dental 1
 Skin 3

Summary

Hospital associated infection rates remain low. No unusual infections. Six (6) of the hospital associated infections were respiratory and consistent with Spring in Maine. One client was treated for scabies (CAI).

Plan

Continue total house surveillance

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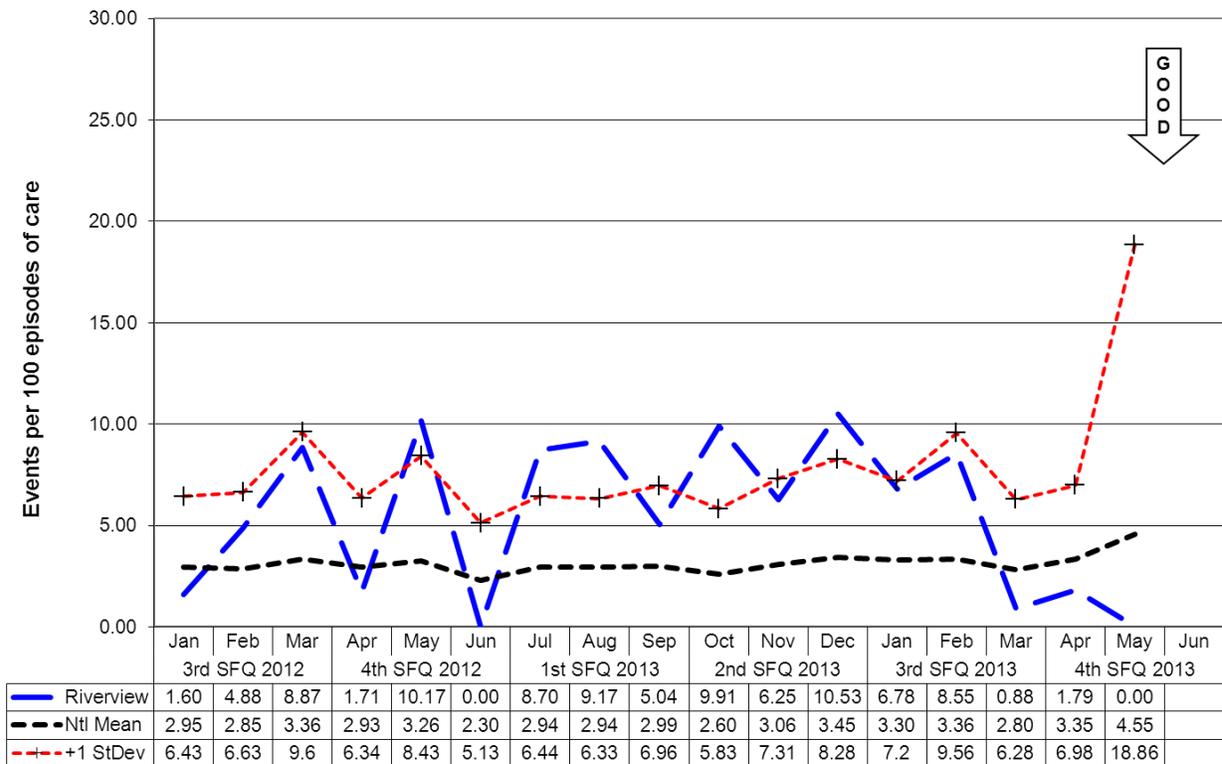
Medication Management

Medication Errors and Adverse Reactions

TJC PI.01.01.01 EP14: The hospital collects data on the following: Significant medication errors. (See also LD.04.04.01, EP 2; MM.08.01.01, EP 1)

TJC PI.01.01.01 EP15: The hospital collects data on the following: Significant adverse drug reactions. (See also LD.04.04.01, EP 2; MM.08.01.01, EP 1)

Medication Errors



This graph depicts the number of medication error events that occurred for every 100 episodes of care (duplicated client count). For example, a rate of 1.6 means that 2 medication error events occurred for each 125 episodes of care.

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Medication variances are classified according to four major areas related to the area of service delivery. The error must have resulted in some form of variance in the desired treatment or outcome of care. A variance in treatment may involve one incident but multiple medications; each medication variance is counted separately irrespective of whether it involves one error event or many. Medication error classifications include:

Prescribing

An error of prescribing occurs when there is an incorrect selection of drug, drug dose, dosage form, quantity, route, concentration, rate of administration, or instructions for use of a drug product ordered or authorized by physician or other legitimate prescriber. Errors may occur due to improper evaluation of indications, contraindications, known allergies, existing drug therapy and other factors. Illegible prescriptions or medication orders that lead to client level errors are also defined as errors of prescribing. In identifying and ordering the appropriate medication to be used in the care of the client.

Dispensing

An error of dispensing occurs when the incorrect drug, drug dose or concentration, dosage form, or quantity is formulated and delivered for use to the point of intended use.

Administration

An error of administration occurs when there is an incorrect selection and administration of drug, drug dose, dosage form, quantity, route, concentration, rate of administration, or instructions for use of a drug product ordered or authorized by physician or other legitimate prescriber.

Complex

An error which resulted from two or more distinct errors of different types is classified as a complex error.

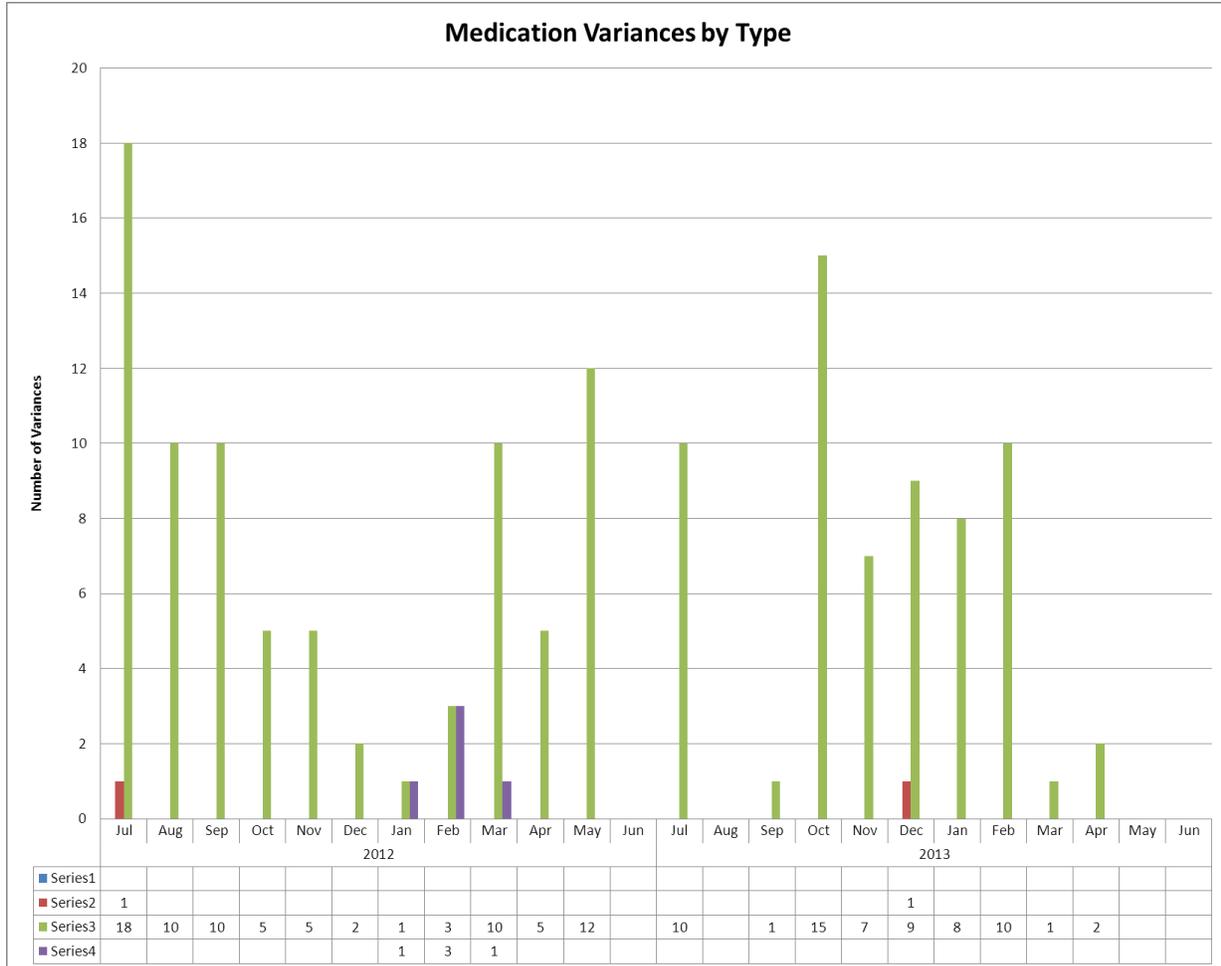
Review, Reporting and Follow-up Process

The Medication Variances Process Review Team (PRT) meets weekly to evaluate the causation factors related to the medication variances reported on the units and in the pharmacy and makes recommendations, through its multi-disciplinary membership, for changes to workflow, environmental factor, and client care practices. The team consists of the Medical Director (or designee), the Director of Nursing (or designee), the Director of Pharmacy (or designee), and the Clinical Risk Manager or the Performance Improvement Manager.

The activities and recommendations of the Medication Variances PRT are reported monthly to the Integrated Performance Excellence Committee.

JOINT COMMISSION

Medication Management



JOINT COMMISSION

Medication Management - Administration Process Medication Errors Related to Staffing Effectiveness

Date	OMIT	Co-mission	Float	New	O/T	Unit Acuity		Staff Mix	
3-4-13	N	Wrong time – Amoxicillin	N	N	N	UK		3RN 3 MHW	
3-25-13	Y	Miralax	N	N	N	LS		4 RN 1 LPN & MHW	
3-27-13	Y	Trazadone 150mg	N	N	N	LS		4 RN 1 LPN 7 MHW	
4-1-13	Y	Med with IM back up omitted	N	N	N	LS		3RN – 1 LPN 7 MHW	
4-2-13	N	Wrong dose	N	N	N	LK		3 RN 1 LPN 7 MHW	
4-3-13 4-4-13	N	2 doses Keflex given after order ended	N	N	N	LS		3RN – 1 LPN – 7 MHW	
4-25-13	Y	Safetussin – multiple doses	N	Y	N	LS		3 RN 8MHW	
4-27-13	Y	Glucosamine – 5 doses	N	N	N	LS		3 RN 1 LPN 7 MHW	
4-30-13	Y	Zyprexa- 4 doses	N	Y	N	LS		3 RN 7 MHW	
5-1-13	N	Ketaprofen 50-mg ordered PRN – given as scheduled med (5 doses)	Y	N	N	LS		4 RN 1 LPN 7 MHW	
5-14-13	Y	Zydis –IM back up not given	N	Y	N	LS		3 RN 1 LPN 8 MHW	
5-19-13	N	Wrong dose x 3	N	N	N	LS		2 RN 1 LPN 8 MHW	
5-16-12	Y	Risperdal with IM backup not given	N	Y	N	UK		2RN 4 MHW	
5-22-13	Y	Lisinopril	N	Y	Y	LS		4 RN 8 MHW	
5-26-13	N	Wrong dose Synthroid	Y	Y	N	US		1RN 3 MHW	
5-29-13	N	Wrong dose Haldol	N	Y	N	LS		3 RN 9 MHW	
6-3-13	N	Wrong form Zydis given Zyprexa ordered	N	Y	N	LS		3 RN 8 MHW	
6-4-13	Y	Adalimunab 40mg IM	N	N	N	LS		3RN 8 MHW	
6-4-13	N	Wrong dose – Novolog	N	N	N	UK		3 RN 3 MHW	
6-9-13	Y	Geodon 120 mg	N	Y	N	LS		3 RN 1 LPN 8 MHW	
Totals	10	9	2	9	0	LS 15	US 1	LK 1	UK 3
Percent	53%	47%	11%	47%	--	79%	5%	5%	16%

*Each dose of medication is documented as an individual variance (error)

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Summary

Total of 20 errors for the quarter – This is 14 less than last quarter. Eleven (55%) were errors of omission. Five (21%) were wrong dose. There was 1 error involving meds being given without a valid order, 1 error of wrong time, 1 error of wrong form (Zydis instead of Zyprexa) and one instance where a medication was given on a scheduled basis but the order was for PRN.

Most of the omissions occurred on LS with staff that has been here between 3-9 months. The RN IV assigned to the unit will be reviewing the importance of following medication administration protocol and the checking process.

Actions

Counseling was provided to one individual nurse who twice did not give the ordered IM back up for a refused medication even after the first error was explained. We monitored to see a reduction in errors for fourth quarter and there was a significant decline in medication errors with the new staff more settled in their positions. Additionally, we added a second license to the night shift on both lower units which should address acuity and allow for the nurses assigned there to be less rushed when giving medications and managing the milieu.

JOINT COMMISSION

Medication Management - Dispensing Process

Medication Management	Unit	Baseline (July- Sept)	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Controlled Substances Loss Data	All	0%	0%	0%	0%		0%	Goal of "0" discrepancies between Pyxis and CII Safe transactions
Daily Pyxis-CII Safe Compare Report								
Quarterly Results								
Monthly CII Safe Vendor Receipt Report	Rx	0	0	0			0	*No discrepancies between CII Safe and vendor transactions for December.
Quarterly Results				0*	0			
Monthly Pyxis Controlled Drug discrepancies	All	9	0	0	0		0	Goal of "0" discrepancies involving controlled drugs dispensed from Pxyis
Quarterly Results			9	13	9			
Med Mgmt Monitoring								
Measures of drug reactions, adverse drug events and other management data	Rx	17/ year	0	0	0			4 ADR's reported in Q1 and Q2
Quarterly Results			3	1	3			
Resource Documentation Reports of Clinical Interventions	Rx	134 reports in 2012						100% of all clinical interventions are documented
Quarterly Results			16	36	69			

The key indicators in Medication Management are focused on preventing Controlled Substances loss and monitoring/trending of adverse drug reactions and clinical interventions. *Controlled Substances Loss* reviews two key reports generated by the Pyxis CII Safe which compare controlled drug transactions between the pharmacy's CII Safe and the various Pyxis Medstations; and, the purchasing data from our drug wholesaler and the corresponding CII Safe transactions. In both instances, we are looking for zero variation. *Medication Management Monitoring* is comprised of the reporting, review and monitoring of adverse drug reactions (ADR's) and Clinical Interventions as documented in the Resource Documentation tool to generate historical and graphical analysis which is reported to the P&T Committee regularly. TJC requires ongoing reporting and surveillance of adverse drug reactions, medication errors and medication related issues to the hospital wide performance improvement program with the goal of strategies to minimize their occurrence.

JOINT COMMISSION

Inpatient Consumer Survey

TJC PI.01.01.01 EP16: The hospital collects data on the following: Patient perception of the safety and quality of care, treatment, and services.

The **Inpatient Consumer Survey (ICS)** is a standardized national survey of customer satisfaction. The National Association of State Mental Health Program Directors Research Institute (NRI) collects data from state psychiatric hospitals throughout the country in an effort to compare the results of client satisfaction in five areas or domains of focus. These domains include Outcomes, Dignity, Rights, Participation, and Environment.

Inpatient Consumer Survey (ICS) has been recently endorsed by NQF, under the Patient Outcomes Phase 3: Child Health and Mental Health Project, as an outcome measure to assess the results, and thereby improve care provided to people with mental illness. The endorsement supports the ICS as a scientifically sound and meaningful measure to help standardize performance measures and assures quality of care.

Rate of Response for the Inpatient Consumer Survey

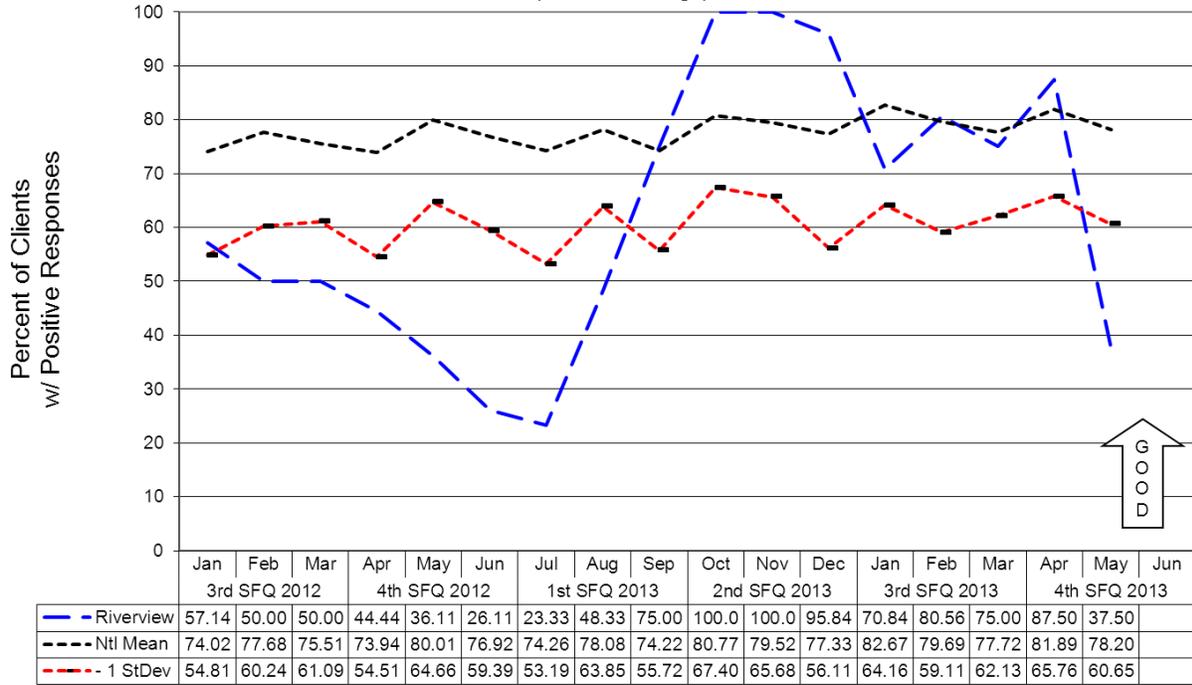
Due to the operational and safety need to refrain from complete openness regarding plans for discharge and dates of discharge for forensic clients, the process of administering the inpatient survey is difficult to administer. Whenever possible the peer support staff work to gather information from clients on their perception of the care provided to them while at Riverview Psychiatric Center.

The Peer Support group has identified a need to improve the overall response rate for the survey. This process improvement project is defined and described in the section on [Client Satisfaction Survey Return Rate](#) of this report.

There is currently no aggregated data on a forensic stratification of responses to the survey.

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Inpatient Consumer Survey Outcome Domain (3 month average)

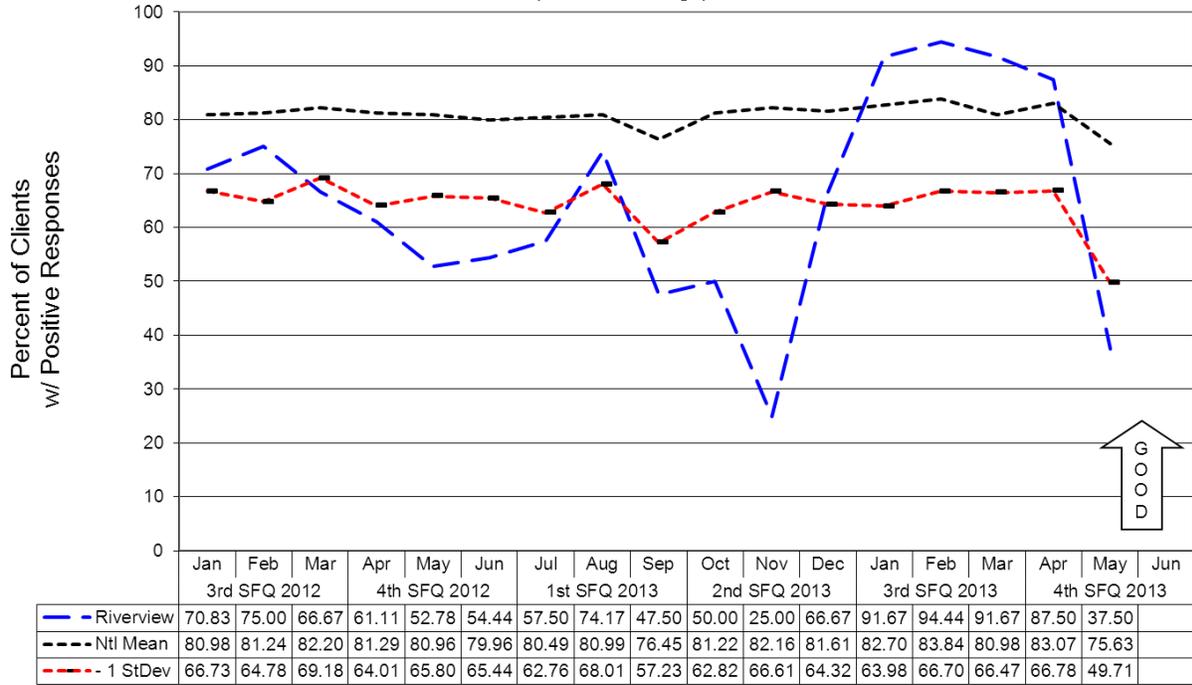


Outcome Domain Questions

1. I am better able to deal with crisis.
2. My symptoms are not bothering me as much.
3. I do better in social situations.
4. I deal more effectively with daily problems.

JOINT COMMISSION

Inpatient Consumer Survey Dignity Domain (3 month average)

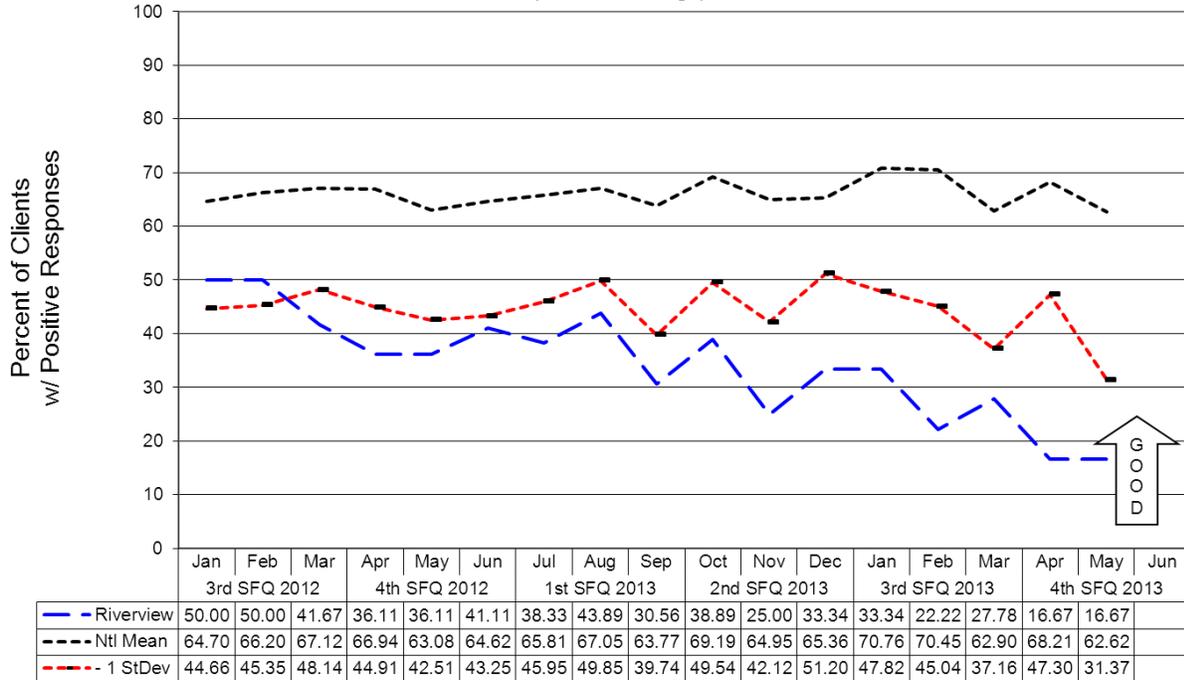


Dignity Domain Questions

1. I was treated with dignity and respect.
2. Staff here believed that I could grow, change and recover.
3. I felt comfortable asking questions about my treatment and medications.
4. I was encouraged to use self-help/support groups.

JOINT COMMISSION

Inpatient Consumer Survey Rights Domain (3 month average)

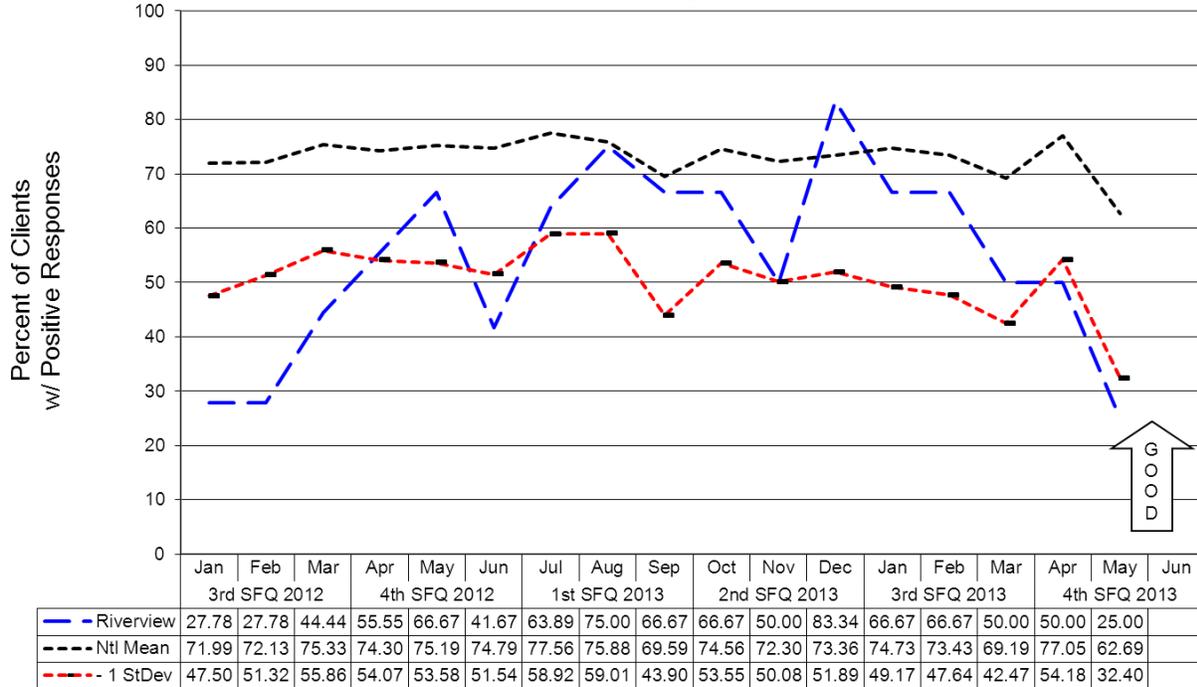


Rights Domain Questions

1. I felt free to complain without fear of retaliation.
2. I felt safe to refuse medication or treatment during my hospital stay.
3. My complaints and grievances were addressed.

JOINT COMMISSION

Inpatient Consumer Survey Participation Domain (3 month average)

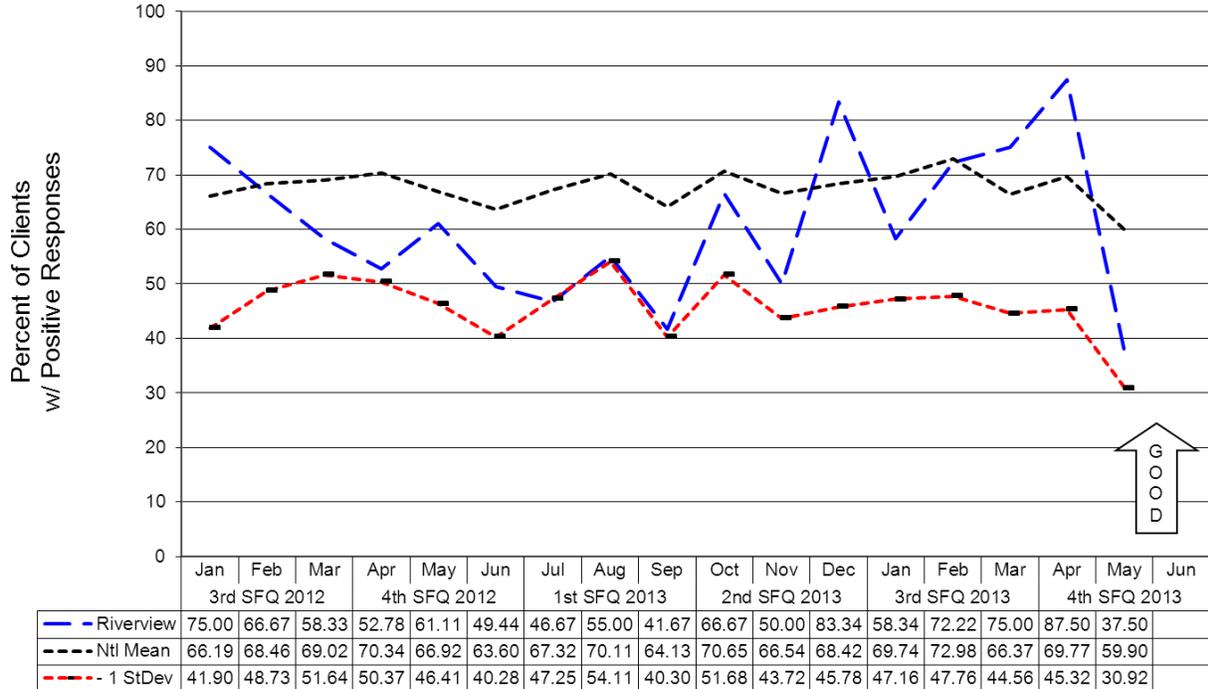


Participation Domain Questions

1. I participated in planning my discharge.
2. Both I and my doctor or therapist from the community were actively involved in my hospital treatment plan.
3. I had an opportunity to talk with my doctor or therapist from the community prior to discharge.

JOINT COMMISSION

Inpatient Consumer Survey Environment Domain (3 month average)



Environment Domain

1. The surroundings and atmosphere at the hospital helped me get better
2. I felt I had enough privacy in the hospital.
3. I felt safe while I was in the hospital.
4. The hospital environment was clean and comfortable.

Data aggregation on this domain began in October 2011. A trend analysis pattern related to this data is only now becoming apparent.

JOINT COMMISSION

Pain Management

TJC **PC.01.02.07**: The hospital assesses and manages the patient's pain.

Indicator	3Q2013	4Q2013	1Q2014	2Q2014
Pre-administration	91%	68%		
Post-administration	81%	59%		

SUMMARY

Both "Pre" and "Post" assessments were down again this quarter. (91% and 81% last quarter)
 The number of pain medications given this quarter was up again this quarter, 2350 medications for pain given this quarter as opposed to 1011 pain meds given in second quarter. There have also been significant changes in staffing personnel and assignments these past two quarters as well as a new staff person doing the audits of pain management. Neither of these factors should affect the percentages; however it is a change that needs to be looked at.

ACTIONS

Will meet with the nurse IVs to set up a system for more frequent monitoring of the assessing process.
 We will meet with all the nurses and reiterate the importance of assessing pain pre and post analgesics.
 Will review the audit process with the newly assigned staff to determine whether or not there has been a change in the way that we audit the information. Will follow up with pharmacy to inquire as to whether they are aware of any reason for the doubling of pain medications given.

JOINT COMMISSION

Fall Reduction Strategies

TJC PI.01.01.01 EP38: The hospital evaluates the effectiveness of all fall reduction activities including assessment, interventions, and education.

TJC PC.01.02.08 The hospital assesses and manages the patient's risks for falls.

EP01: The hospital assesses the patient’s risk for falls based on the patient population and setting.

EP02: The hospital implements interventions to reduce falls based on the patient’s assessed risk.

Falls Risk Management Team has been created to be facilitated by a member of the team with data supplied by the Risk Manager. The role of this team is to conduct root cause analyses on each of the falls incidents and to identify trends and common contributing factors and to make recommendations for changes in the environment and process of care for those clients identified as having a high potential for falls.

Type of Fall by Client and Month

Fall Type	Client	APR	MAY	JUN	4Q2013
Un-witnessed	MR00006963 *		3		3
	MR00007277		1		1
	MR00006799			1	1
	MR00000091*			1	1
	MR00000016	1			1
	MR00005327	1			1
Witnessed	MR00006963 *	3	8		11
	MR00000016	1	2		3
	MR00006868		2		2
	MR00004661	1			1
	MR00006145		1		1
	MR00000091*		1		1
	MR00004974		1		1
	MR00004898	1			1

* Clients have experienced both witnessed and un-witnessed falls during the reporting quarter.

Review, Reporting and Follow-up Process

The Falls Assessment and Prevention Process Review Team (PRT) meets monthly to evaluate the causation factors related to the falls reported on the units and makes recommendations, through its multi-disciplinary membership, for changes to workflow, environmental factor, and client care practices.

The activities and recommendations of the Falls PRT are reported monthly to the Integrated Performance Excellence Committee.

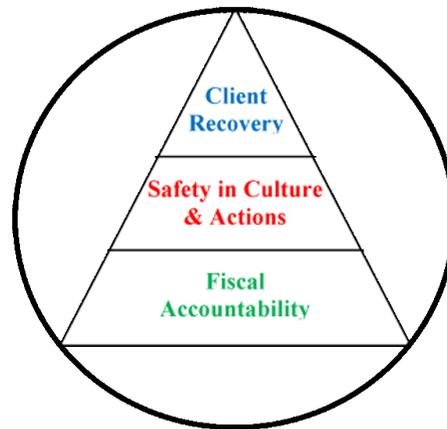
Falls Process Review Team – Analysis of MD 00006963

An in depth analysis of the events surrounding the fall incidents experience by MR00006963, 14 events in total beginning in late April and continuing to mid-May was conducted. The events are a mix of voluntary “falls,” trips, and slips related to the clients gate. While the client does have a seizure history, medical assessments were conducted on several occasions as a result of the fall events and no clear correlation between this medical history and the incidents of falls was made.

STRATEGIC PERFORMANCE EXCELLENCE

Priority Focus Areas for Strategic Performance Excellence

In an effort to ensure that quality management methods used within the Maine Psychiatric Hospitals System are consistent with modern approaches of systems engineering, culture transformation, and process focused improvement strategies and in response to the evolution of Joint Commission methods to a more modern systems-based approach instead of compliance-based approach

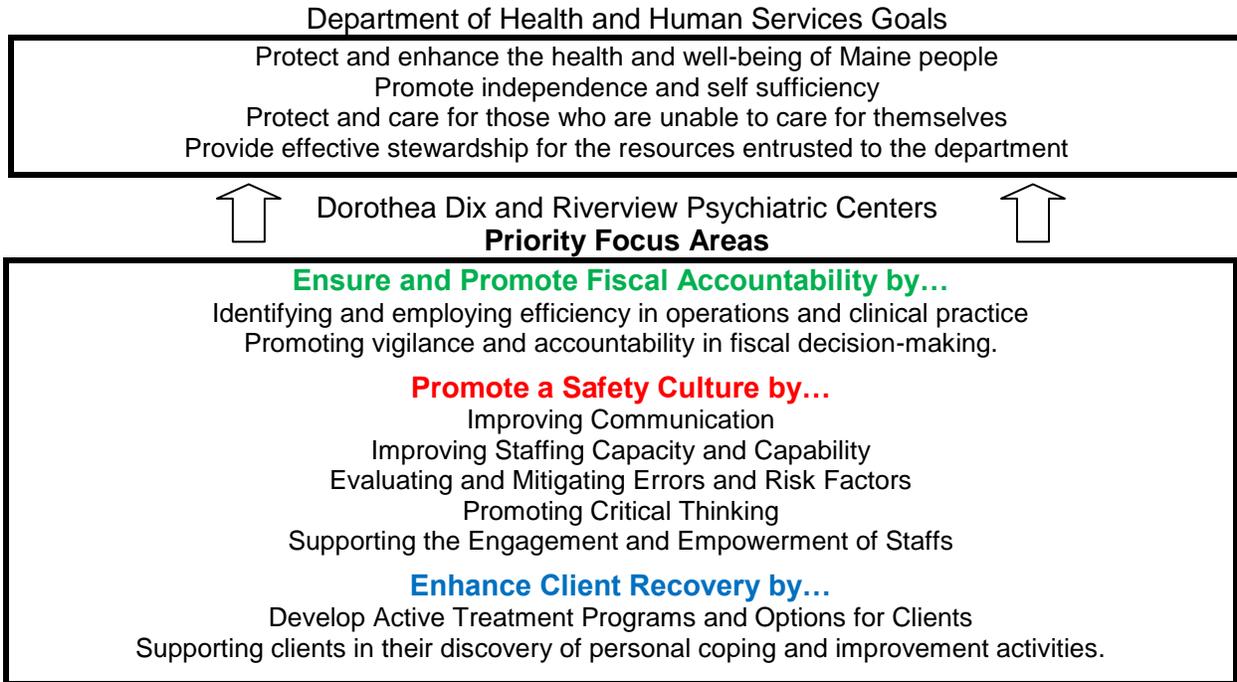


Building a framework for client recovery by ensuring fiscal accountability and a culture of organizational safety through the promotion of...

- The conviction that staffs are concerned with doing the right thing in support of client rights and recovery;
- A philosophy that promotes an understanding that errors most often occur as a result of deficiencies in system design or deployment;
- Systems and processes that strive to evaluate and mitigate risks and identify the root cause of operational deficits or deficiencies without erroneously assigning blame to system stakeholders;
- The practice of engaging staffs and clients in the planning and implementing of organizational policy and protocol as a critical step in the development of a system that fulfills ethical and regulatory requirements while maintaining a practicable workflow;
- A cycle of improvement that aligns organizational performance objectives with key success factors determined by stakeholder defined strategic imperatives.
- Enhanced communications and collaborative relationships within and between cross-functional work teams to support organizational change and effective process improvement;
- Transitions of care practices where knowledge is freely shared to improve the safety of clients before, during, and after care;
- A just culture that supports the emotional and physical needs of staffs, clients, and family members that are impacted by serious, acute, and cumulative events.

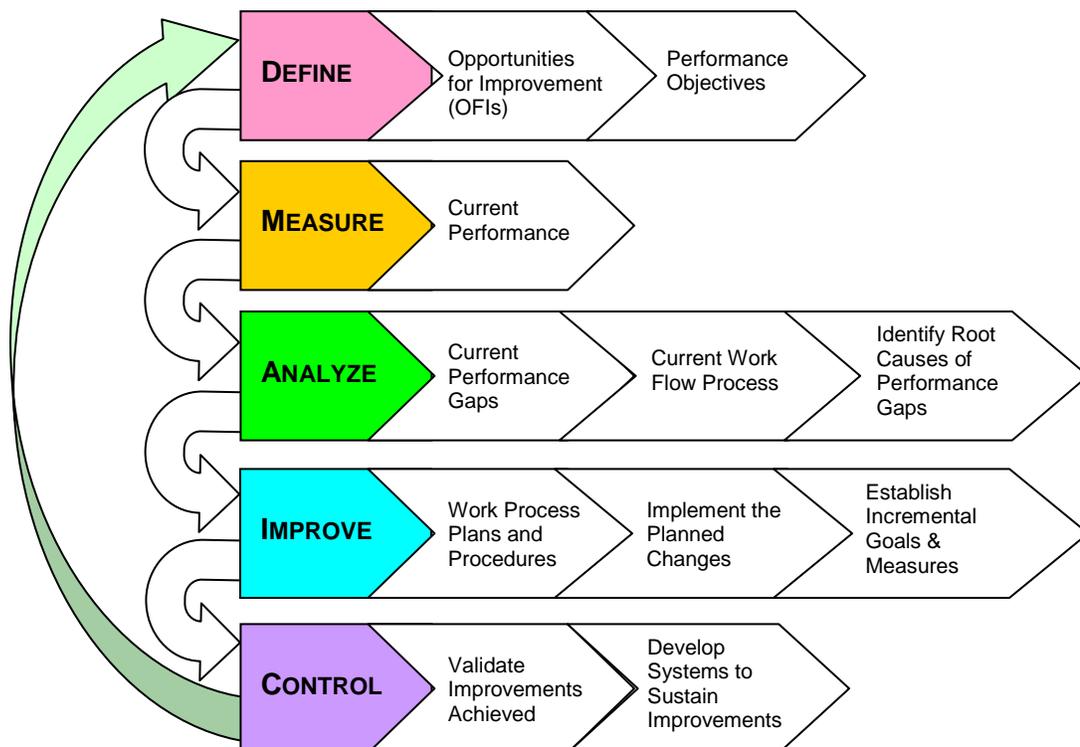
STRATEGIC PERFORMANCE EXCELLENCE

Strategic Performance Excellence Model Reporting Process



Each Department Determines Unique Opportunities and Methods to Address the Hospital Goals

The Quarterly Report Consists of the Following



STRATEGIC PERFORMANCE EXCELLENCE

Admissions

DEFINE

OPPORTUNITIES FOR IMPROVEMENT (OFI'S)

- Streamline Pre-Admission Face Sheet (PAFS) and remove obsolete items.

PERFORMANCE OBJECTIVES

- Decrease paperwork redundancy due to repetitive information on current worksheet.
- Increase provider satisfaction with information gathered and accessibility of information.

MEASURE

Based on a survey:

- How happy are the employees with the new PASF forms?
- Does it contain the proper/needed information?
- Is it easy to find the information needed?
- Is it well organized?
- Is it legible?
- Is it easier/faster to complete than the previous forms?
- Overall improvement of the forms?

ANALYZE

CURRENT PERFORMANCE GAPS:

- Duplication of the same information required.
- Wasted space on the PSAF.
- Time consuming to complete multiple forms.
- Disorganized, hard to read and find information.
- Lacking important information needed.

CURRENT WORK FLOW PROCESS:

- Based on the amount of history faxed from the referral source, at times, 50-100 pages or more of information is sent per client. This may come in several packets over a period of time, which needs to be reviewed to determine if the client is appropriate for admission.
- The average wait period is 24 days for an admission (based on figures of Sept, 2012 Forensic Referral List) and many clients decompensate further and have to be medically cleared an additional time.

IDENTIFY ROOT CAUSES OF PERFORMANCE GAPS:

- Time and duplication of client information.
- Lacking important information needed.

STRATEGIC PERFORMANCE EXCELLENCE

IMPROVE:

WORK PROCESS PLANS AND PROCEDURES:

- Talk to the Nurse IV and other direct care staff to gather opinions on Admission form revision.
- Hand out survey's to be completed and get feedback regarding the new forms.

IMPLEMENT THE PLANNED PROCEDURES:

- Rearrange the needed information.
- Remove non-applicable items from the PAFS.
- Attend the scheduled meeting with Medical Records staff and obtain approval for 1st draft of changes.
- Add additional information needed by the units upon admission.

CONTROL:

VALIDATE IMPROVEMENTS ACHIEVED

- Based on interviews and surveys completed by staff: Is it working?

DEVELOP SYSTEMS TO SUSTAIN IMPROVEMENTS:

- A new form will be used to support the previous Admission forms.
- It will be reviewed each year to determine if it continues to support the admission process adequately.
- Any feedback from direct staff will be discussed and implemented as necessary for improvements.

Admissions Pilot PSFA Form

Please rate the new forms .					
1.	The new admission pilot forms contain the information needed upon admission.	Strongly Disagree	Disagree	Agree	Strongly Agree
2.	It is easy to find the information needed on the new admission pilot forms.	Strongly Disagree	Disagree	Agree	Strongly Agree
3.	The new admission pilot forms are well organized.	Strongly Disagree	Disagree	Agree	Strongly Agree
4.	The information is legible on the new admission pilot forms.	Strongly Disagree	Disagree	Agree	Strongly Agree
5.	For those of you who have to complete the new form: It now takes less time to complete the new PASF form than it did to complete the old PASF form.	Strongly Disagree	Disagree	Agree	Strongly Agree
6.	I would not make any changes to the new admission pilot forms.	Strongly Disagree	Disagree	Agree	Strongly Agree

STRATEGIC PERFORMANCE EXCELLENCE

Admissions Process Improvement Activities

4Q2013

- Changes to the PASF form are now completed. Staff surveyed were happy with the changes and these forms are working out well.
- Psychotropic flow sheets were added to the admission packets to ensure that they are updated added to the patients' record.
- Lower Saco's new unit guidelines were added to the patient packets to ensure that they receive this information in a timely manner.
- Our Forensic wait list has grown exponentially over the last few months. Forensic referrals are waiting an average of 35-45 days for admittance.
- Some forensic clients are being screened prior to admission to see if they would be appropriate for the civil side in order to decrease the wait time. There have been a few forensic admissions to the civil side this quarter.
- We are continuing to build relationships with the jails, keeping open communication so information is passed on in a timely manner. There have not been any issues regarding communication this quarter.
- Our civil referral list has been manageable and we have been able to get these referrals into the hospital in a timely manner.
- We are currently seeing an increase in re-referrals of clients that have been discharged from RPC recently (within 2-3 months, some within days of discharge).
- Admissions has been working with the education and training departments to help orient new employees and students.
- We have been successfully collaborating with SFS regarding evaluations, admissions and discharges. Some violent forensic clients have been seen within the jail to avoid the need for hospitalization here at RPC.
- Admissions has received positive feedback from the medical providers and psychiatrists regarding preparedness for admissions along with appropriateness.

STRATEGIC PERFORMANCE EXCELLENCE

Dietary Services

Responsible Party: Kristen Piela DSM

Strategic Objective: Safety in Culture and Actions												
Hand Hygiene Compliance: In an effort to monitor, sustain and improve hand hygiene compliance, the Dietary department measures its results through observations of Dietary staff when returning from a scheduled break.												
1 st Quarter			2 nd Quarter			3 rd Quarter			4 th Quarter			Goal
Baseline Established	Findings	Compliance	Target – Q1 + 12%	Findings	Compliance	Target – Q2 + 10%	Findings	Compliance	Target – Q3 + 10%	Findings	Compliance	
58%	22/43	N/A	70%	18/34	53%	63%	41/49	84%	94%	22/26	85%	80-90%

Data

22 compliant observations / 26 hand hygiene observations = 85% hand hygiene compliance rate

Summary

- Hand hygiene observations may have been too low to attain accurate levels of compliance.
- Hand hygiene compliance increased by 1%; this compliance level has reached the annual goal.

Action Plan

- To validate the high level of hand hygiene compliance; DSM will investigate alternative means of data gathering to increase incidents of observation.
- Involve input from staff regarding solutions to creating alternatives for data collection processes.
- Reformat the Hand Hygiene Monitoring Tool to make it easier and less cumbersome to complete.
- Encourage employees to adhere hand hygiene via verbal interaction.
- Present quarterly report at departmental staff meeting and IPEC meeting.

STRATEGIC PERFORMANCE EXCELLENCE

Environment of Care

INDICATOR

GROUNDS SAFETY/SECURITY INCIDENTS

DEFINITION

Safety/Security incidents occurring on the grounds at Riverview. Grounds being defined as *“outside the building footprint of the facility, being the secured yards, parking lots, pathways surrounding the footprint, unsecured exterior doors, and lawns.* Incidents being defined as, *“Acts of thefts, vandalism, injuries, mischief, contraband found, and safety / security breaches.* These incidents shall also include *“near misses, being of which if they had gone unnoticed, could have resulted in injury, an accident, or unwanted event”.*

OBJECTIVE

Through inspection, observation, and aggressive incident management, an effective management process would limit or eliminate the likelihood that a safety/security incident would occur. This process would ultimately create and foster a safe environment for all staff, clients, and visitors.

THOSE RESPONSIBLE FOR MONITORING

Monitoring would be performed by Safety Officer, Security Site-Manager, Security Officers, Operations Supervisor, Operations staff, Director of Support Services, Director of Environmental Services, Environmental Services staff, Supervisors, and frontline staff.

METHODS OF MONITORING

Monitoring would be performed by;

- Direct observation
- Cameras
- Patrol media such as “Vision System”
- Assigned foot patrol

METHODS OF REPORTING: Reporting would occur by one or all of the following methods;

- Daily Activity Reports (DAR’s)
- Incident Reporting System (IR’s)
- Web-based media such as the Vision System

UNIT

Hospital grounds as defined above

BASELINE

To be determined after compilation of data during the months on August/12 to September/12.

Q2-Q4 TARGETS

Baseline – 5% each Q

STRATEGIC PERFORMANCE EXCELLENCE

Environment of Care

Department: Safety & Security Responsible Party: Bob Patnaude
Safety Officer

Strategic Objectives								
Safety in Culture and Actions	Unit	Baseline	Q1 Target	Q2 Target Actual	Q3 Target Actual	Q4 Target Actual	Goal	Comments
Grounds Safety & Security Incidents								
Safety/Security incidents occurring on the grounds at Riverview, which include <i>“Acts of thefts, vandalism, injuries, mischief, contraband found, and safety / security breaches</i>	# of Incidents	* Baseline of 10 was determined in the months of Aug. & Sept. of 2012	*	(10) -5%	(13) -5%	(6) -5%	(16) -5%	**** See below
				(13)	(6)	(16)		

SUMMARY OF EVENTS

The Q3 Target was (6)-5%. Our actual number was (16); a significant increase. ****Although we would like to report that our incident rate has decreased, we are pleased that in all the cases, our Security staff or clinical staff have discovered items before those items get into the hands of anyone who would have an ill intent with the items. In fact, one incident was reported by a responsible client. We feel that the reporting, which follows below, continues to provide a very clear picture of Safety and Security events, how they are handled, and that the use of surveillance equipment plays an integral part in combating safety and security threats to people and property. Our aggressive rounds by Security continues to prove its' worth with regard to Security's presence and patrol techniques.

EVENT	DATE	TIME	LOCATION	DISPOSITION	COMMENTS
2. Safety Threat (items in back of truck) (Sofa, metal box, 8x4x1/2 molding)	04/23/13	0212	Staff Lot	KSO officer/owner notified and secured	1. Security found during rounds 2. Owner secured. Advised of concerns 3. NOD notified 4. IR # 485 completed/Safety notified
3. Property damage(minor) (State vehicle backed into sign)	04/25/13	2111	State vehicle Lot	NOD notified and requested IR	1. Staff member reported minor damage to Security 2. Security notified NOD 3. IR #486 completed/Safety notified
4. Safety Threat (items in back of truck) (8' length of chain, tin cans, 2 fuel cans, ceiling fan)	04/28/13	2346	Staff Lot	Owner responded and secured	1. Security notified Operations 2. Operations notified staff/owner 3. Secured items 4. IR #487 completed/Safety notified 5. Supervisor notified

STRATEGIC PERFORMANCE EXCELLENCE

Environment of Care

EVENT	DATE	TIME	LOCATION	DISPOSTION	COMMENTS
5. Safety Threat (keys left in motorcycle)	05/06/13	1433	Staff Lot	Security removed and secured	<ol style="list-style-type: none"> 1. Staff reported keys left in motorcycle 2. Security responded, removed, and secured 3. Note left on motorcycle to retrieve keys at Security 4. IR # 4077 completed/Safety notified
6. Security Concern (Main lobby door being held open by pebble)	05/13/13	0208	Main entrance	<p>Rock removed by staff</p> <p>Door secured</p> <p>Area cleaned</p>	<ol style="list-style-type: none"> 1. Staff reported pebble holding door open 2. Safety Officer investigated and found other small rocks which may pose the same problem 3. Area cleaned and will be monitored by Housekeeping 4. IR # 1497 completed/Safety notified
7. Safety Concern (Safety pin found in lot)	05/15/13	0137	Staff Lot	Secured by Security	<ol style="list-style-type: none"> 1. Safety pin found on ground by Security 2. Secured 3. IR # 493 completed/Safety notified
8. Safety Concern (Outsider using softball in lot)	05/19/13	1905	Staff Lot	Security asked to take ball playing somewhere else	<ol style="list-style-type: none"> 1. Security discovered during rounds 2. Did not comply at 1st request 3. NOD notified. Security supervisor responded. Person complied 4. IR #494 completed/Safety notified
9. Safety Concern (State vehicle unlocked)	05/22/13	0129	State Vehicle Slots	Security secured door	<ol style="list-style-type: none"> 1. Security discovered during rounds 2. Security secured door 3. NOD notified 4. IR # 496 completed/Safety notified
10. Safety Threat (items in back of 2 trucks) (rope, gas can)	05/21/13	0855	Staff Lot	Security secured	<ol style="list-style-type: none"> 1. Security discovered during rounds 2. Emails sent for owners to respond 3. Security secured 4. IR # 495 completed/Safety notified
11. Safety Concern (1/2 can of beer by cargo container)	05/28/13	0600	Maintenance Area	Security emptied and disposed of can	<ol style="list-style-type: none"> 1. Security discovered during rounds 2. Emptied contents/Disposed of can 3. IR# 497 completed/Safety notified 4. Pass-on to Security officers

STRATEGIC PERFORMANCE EXCELLENCE

Environment of Care

EVENT	DATE	TIME	LOCATION	DISPOSTION	COMMENTS
12. Safety Concern (open vehicle with ignition key on console)	06/03/13	2109	Visitor's Lot	1.Capitol PD responded 2.Registered owner notified and secured the vehicle	1. Security responded to report of car window down 2. Upon further investigation, found ignition key laying on console 3. Capitol PD called to ID vehicle 4. Registered owner responded and secured 5. IR # 498 completed/Safety notified
13. Safety Threat (Items in back of truck) (tin cans)	06/03/13	2250	Staff Lot	Security investigated	1.Security discovered during rounds 2.Email sent out to hospital 3. IR # 503 completed/Safety notified
14. Safety Threat (items in back of State vehicle in adjacent lot) (broken bottle)	06/09/13	1710	Adjacent bordering State vehicle Lot	Security secured	1.Security discovered during rounds 2.Capitol Police notified 3. Secured items 4. IR # 503 completed/Safety notified
15. Safety Concern (pill outside main door)	06/10/13	1245	Outside Main Entrance	Security secured	1.Client found nicotine pill outside on ground and gave to Security 2. Security took to Pharmacy to identify 3. Pill disposed of by Safety 4. IR #504 completed
16. Safety Concern (key found by Main Entrance)	06/17/13	0800	Outside Main Entrance	Security turned over to Operations Lost and Found	1.Staff found key by bikes at Main Entrance and turned over to Security 2.Security turned over to Operations 3.Email sent out 4.IR 3 507 completed/Safety notified
17. Safety Concern (board game piece in Center Courtyard)	06/24/13	0700	Center Courtyard on ground near café doors	Security discarded	1.Security discovered during rounds 2.Removed and discarded 3.IR # 510 completed/Safety notified

STRATEGIC PERFORMANCE EXCELLENCE

Harbor Treatment Mall

Objectives	2Q2013	3Q2013	4Q2013	1Q2014
1. Hand-off communication sheet was received at the Harbor Mall within the designated time frame.	45% 19 of 42	67% 28 of 42	60% 25/42	
2. SBAR information completed from the units to the Harbor Mall.	67% 28 of 42	76% 32 of 42	88% 37/42	

DEFINE

To provide the exchange of client-specific information between the client care units and the Harbor Mall for the purpose of ensuring continuity of care and safety within designated time frames.

MEASURE

Indicator number one has decreased from 67% last quarter to 60% for this quarter. Indicator number two has increased from 76% last quarter to 88% this quarter.

ANALYZE

Overall compliance has increased from 72 % last quarter to 74% this quarter. For indicator number one the designated time for the sheets to be received is not in compliance. The amount of time the sheets are late has increased. Continue to concentrate on both indicators to improve current performance gaps.

IMPROVE

On January 23rd I attended a meeting with the Kennebec PSD, all four Nurse IV's, three Treatment Team Coordinators, one floor nurse and one milieu manager. This meeting was scheduled to educate the Treatment Team Coordinators on the Hand-off Communication sheets since this is one of their responsibilities. We reviewed policy, protocol, forms, performance improvement data collected and current results and the reasons why we have this policy.

CONTROL

The plan is to continue to monitor the data and follow up with any unit(s) who may be having difficulties in developing a system that works for them to meet the objectives. I will meet with the Nurse IV from one unit that has shown improvement but continues to have difficulties meeting the objectives.

Department: Harbor Mall Responsible Party: Lisa Manwaring, PSD

Strategic Objectives							
Hand of Communication	<u>Baseline</u>	<u>Q1 Target</u>	<u>Q2 Target</u>	<u>Q3 Target</u>	<u>Q4 Target</u>	<u>Goal</u>	<u>Comments</u>
95% of HOC sheets were received at the Harbor Mall within the designated time frame.	55	60	70	80	90	95%	
95% of SBAR information completed from the units to the Harbor Mall	64	60	70	80	90	95%	

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Documentation of Client Encounters in Support of Superbills Submitted

Define

The opportunity for improvement in the Health Information Department is auditing the charges submitted, along with documentation of those charges.

Measure

24 providers submitted superbills to the Health Information department for quarter 4.

Analyze

Three providers delivered April superbills in May (CC, ZS, PM). One superbill was missing date of service and diagnosis. One provider (GD) had 4 bills with the dates of service missing. Provider BD had 1 duplicate superbill. Provider H-F had delivered an unsigned superbill. Provider JK submitted a superbill for a progress note, but it was for a history & physical and also delivered 3 bills with no service dates. Provider AR submitted 2 duplicate superbills. JS submitted 8 bills with incorrect dates. MW submitted a bill with incorrect date of service.

Improve

Spoke with the Medical Director regarding the various issues. In regards to the incorrect dating issue, superbills are all being returned to the providers for correction. Continue to work with providers on appropriate/consistent documentation.

Control

Continue auditing 10 (at minimum) superbills & documentation per provider. For quarter 4, 100% of superbills were audited.

Process Deficiencies Identified	2Q2013	3Q2013	4Q2013	1Q2014
Superbill Submission without supporting documentation	72% 18/25	35% 9/26	4% 1/24	
Superbills with incorrect information		69% 18/26	75% 18/24	
Duplicate Superbills	76% 19/25	8% 2/26	13% 3/24	

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records) Release of Information for Concealed Carry Permits

Define

The process of conducting background checks on applicants for concealed carry permits is the responsibility of the two State psychiatric hospitals. Clients admitted to private psychiatric hospitals, voluntarily or by court order, are not subject to this review. Delays in the processing of background checks has become problematic due to an increasing volume of applications and complaints received regarding delays in the processing of these requests

Measure

To evaluate the validity of the perceived delays a process was established to measure the date the application was signed by the applicant and the date the application was received for processing by the hospital. This measure produces data on the number of days the application is in the hands of the issuing agency before being referred to the hospitals for review. In addition, the date that application was returned to the issuing agency is also recorded to measure the delay in processing by the hospital.

Analyze

Data collected for the 4th quarter 2013 showed the following results:

- Maine State Police forwarded the greatest number of applications, a total of 2138 applications for the quarter with an average processing delay prior to receipt by the hospital of 82 days. The maximum delay for any application was 1694 days as measured from the date the application was signed by the applicant to the date received by the hospital.
- The average number of days for hospital processing of applications was 12 days. The maximum number of days was 20.

Improve

Several improvements have been implemented to facilitate the workflow within the department including the immediate sorting of the applications as they arrive so the alphabetic records can be reviewed more efficiently.

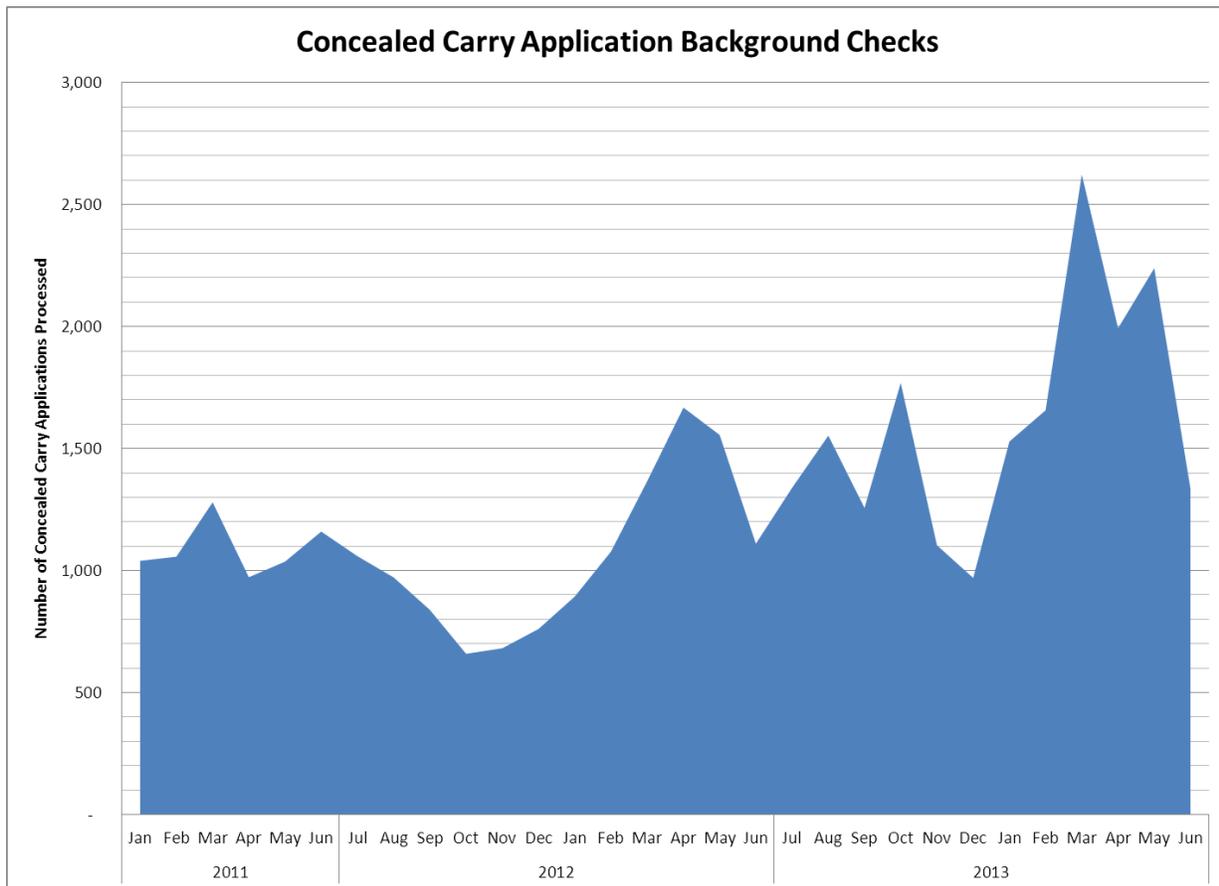
Other improvements being considered include transforming the existing archival records to a digital format. Barriers to be considered in this change include the significant time and fiscal impact required.

Control

While not always the case, many of the significant delays in processing the concealed carry applications originate with the workflow of the issuing agency. Ongoing monitoring of the process will be conducted and staff input on improvements will be solicited for the purpose of enhancing the timeliness of applications processes by hospital staff.

FY 2013	Jul	Aug	Sep	Oct	Nov	Dec	Jan`	Feb	Mar	Apr	May	Jun
# Applications Received	1339	1553	1257	1757	1104	970	1529	1657	2623	1993	2239	1336
Avg Receipt Delay	--	--	--	--	--	--	--	--	35	26	42	66
Max Receipt Delay	--	--	--	--	--	--	--	--	381	451	504	1694
Avg Processing Time	--	--	--	--	--	--	--	--	11	8	13	15
Max Processing Time	--	--	--	--	--	--	--	--	13	11	20	19

STRATEGIC PERFORMANCE EXCELLENCE



Over the past two years the number of applications for concealed carry permits has increased significantly. While there is a seasonal drop in applications during the winter months the overall trend has been upward with March 2013 showing the highest volume of applications to date.

STRATEGIC PERFORMANCE EXCELLENCE

Human Resources

Define

Completion of performance evaluations according to scheduled due dates continues to be problematic.

Measure

Current results are consistently below the 85% average quarterly performance goal.

Analyze

A thorough analysis of the root causes for lack of compliance with this performance standard is indicated. This analysis

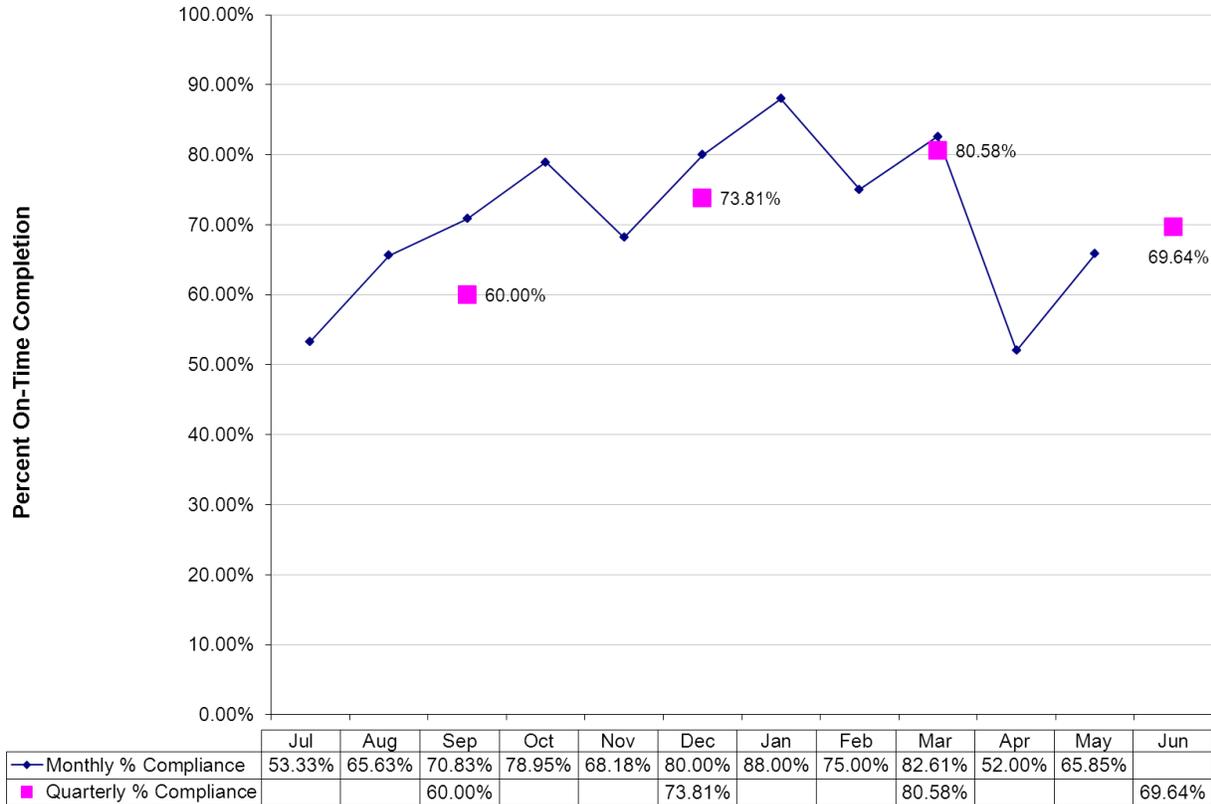
Improve

In the interim, the Personnel Director has begun the process of reporting to hospital leadership the status of performance evaluation completion at least monthly so follow-up with responsible parties can be accomplished..

Control

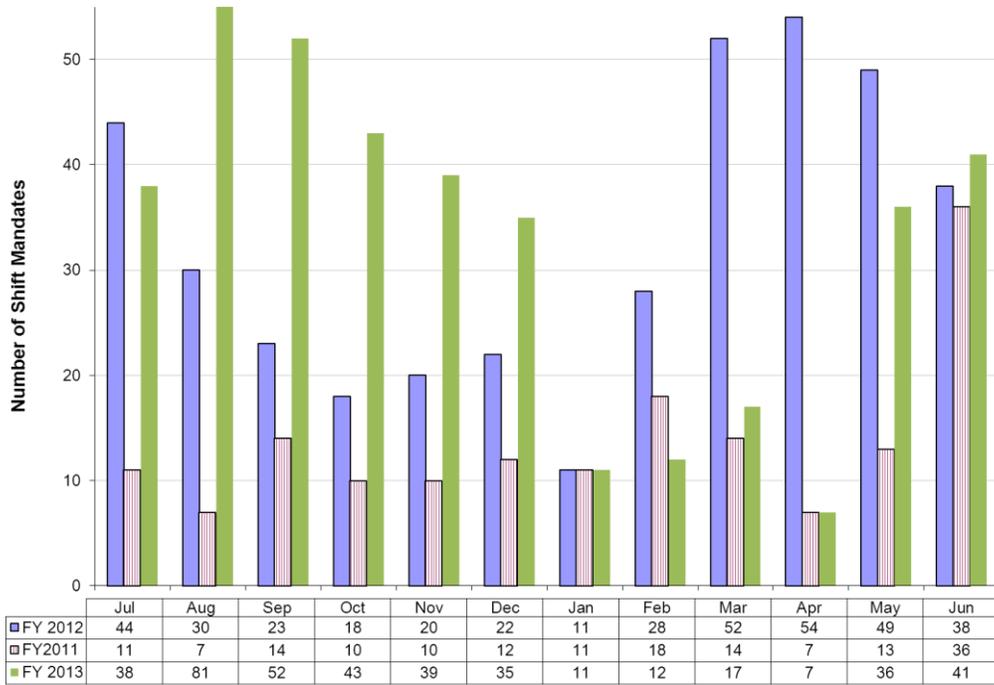
Plans to modify hospital performance evaluation goals for supervisory personnel will include the completion of subordinate performance evaluations in a timely manner as a critical supervisory function.

Performance Evaluation Compliance

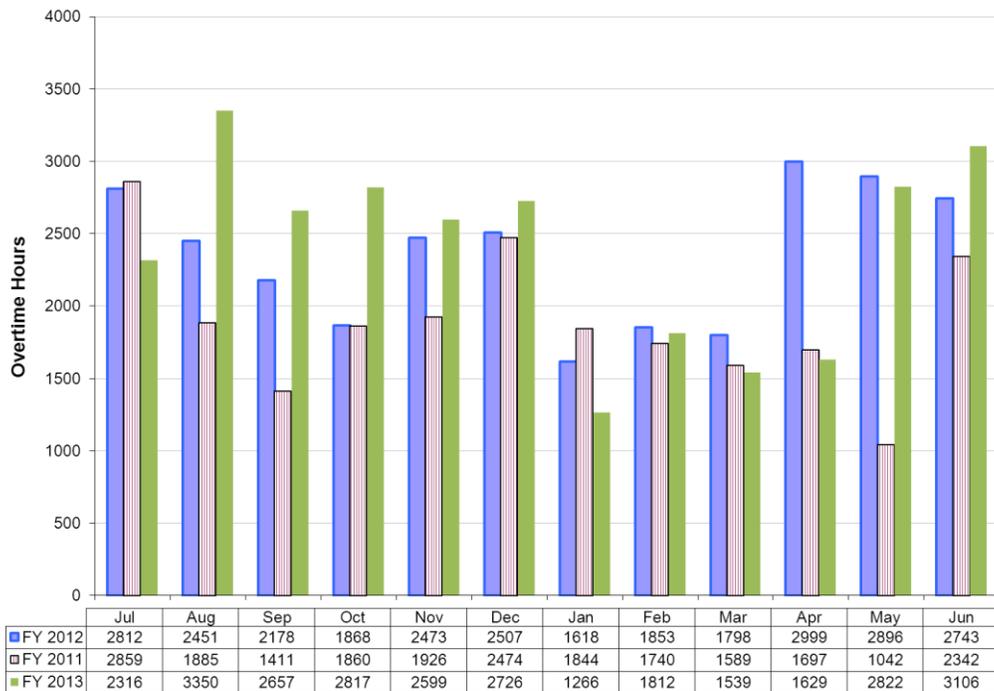


STRATEGIC PERFORMANCE EXCELLENCE

Monthly Mandated Shifts



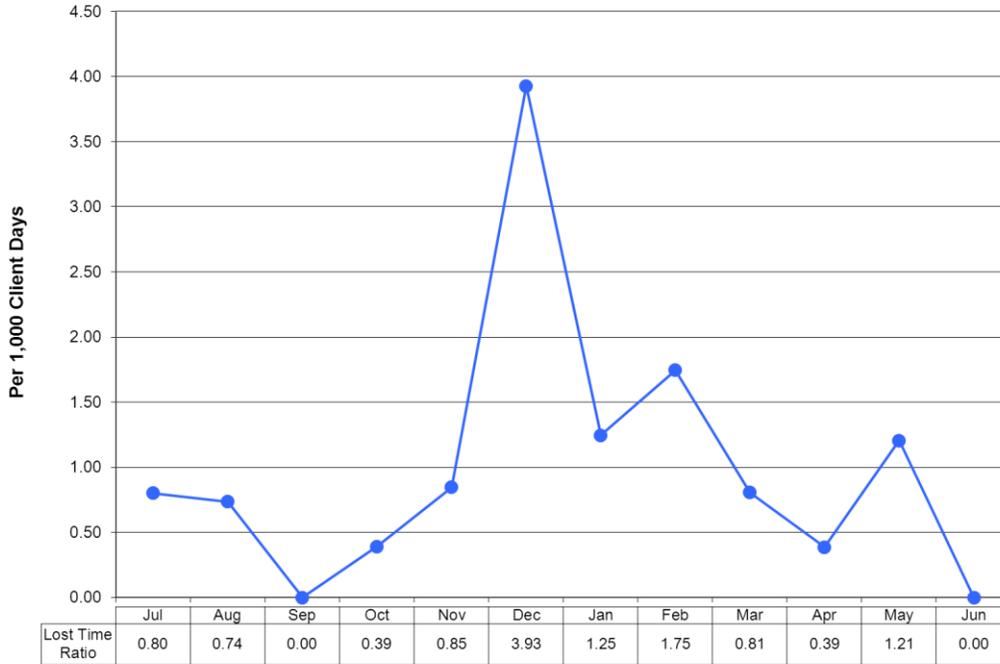
Monthly Overtime



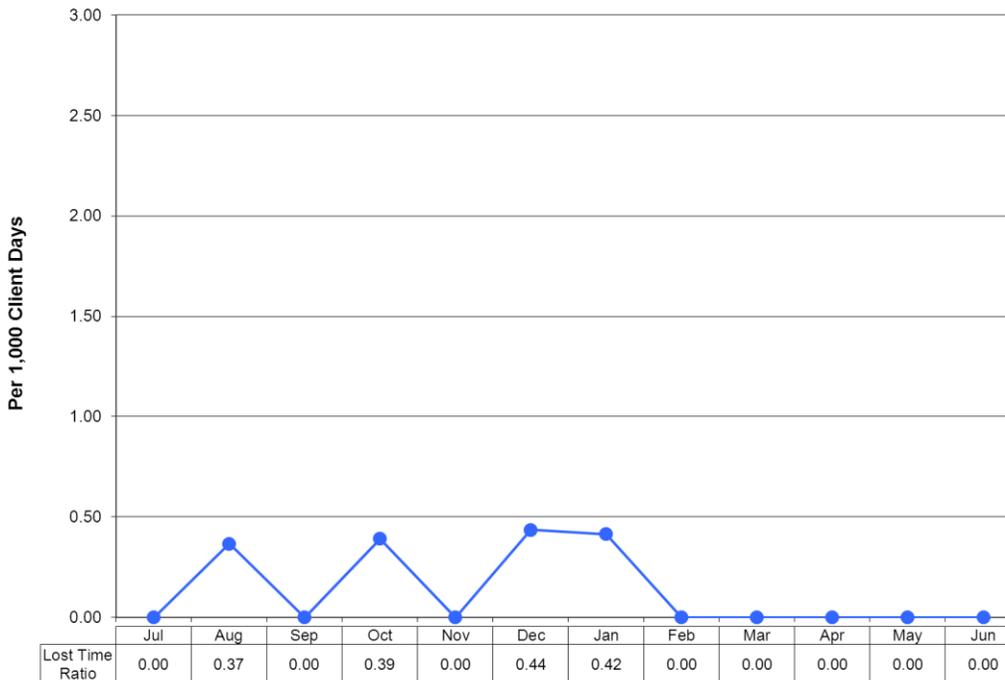
The nursing department has implemented a staffing patterns study in an attempt to minimize the incidence of mandates. Further information on this study can be viewed on [page 75](#) of this report.

STRATEGIC PERFORMANCE EXCELLENCE

Reportable (Lost Time & Medical) Direct Care Staff Injuries



Reportable (Lost Time & Medical) Non-Direct Care Staff Injuries



STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff Psychological Testing Services

1. Identification of Opportunities for Improvement:

Some members of the medical staff have long complained about lack of timeliness and difficulty in obtaining certain psychological services. For example there is an unclear process for requesting or ordering such services as individual psychotherapy, psychological testing, and related activities for individual clients. Furthermore there continued to be anecdotal complaints of the quality and responsiveness of some services. A review of the process did determine that there was a "Request Form for Psychological Services" in existence but it was not widely disseminated amongst all units and providers. There was also a "Psychological Services Satisfaction Survey" in existence, but again, it was neither widely known nor utilized. Initial work by the Medical Executive Committee was done to improve both forms and to mandate their use by all medical and nursing staff when requesting any psychological service.

2. The Measurement Process:

The Medical Executive Committee is in the process of revising both the Referral Form and the Satisfaction Survey to better articulate the ordering clinician's specific need for a service, the clinical question to be addressed, and the time acuity of the need. It was agreed that the ordering clinicians would always utilize this form and no procedure would be conducted without one. It was further agreed that there would be a central point of contact in the Psychology Section Office for the review of the requests for service, a triage function, and the assignment of requested tasks (therapy or testing or consultation) to individual psychologists for completion. The Chief of Section, will oversee the process and track the time from assignment to completion (or in the case of psychotherapy until the first session has been completed). He will also make certain ordering medical staff complete a Satisfaction Questionnaire upon completion of the requested task, and he will track the outcome of this rating scale. We will therefore be tracking two data sets: one of timeliness of completion of requested service and one on the quality and usefulness of the completed work product.

3. Baseline Measures:

Baseline data on the averages and range of time to completion of a given service, and on the averages and range of ratings on the Satisfaction Survey is being collected. An initial accounting found that over the period of mid-June to mid-August the average time to completion of requested psychological testing was 9.6 working days, with a range of 2 to 31 working days. Additional baseline data, incorporating all requested services (not just testing), is necessary. Once these are obtained we will determine our goals of improvement for the next 4 quarters.

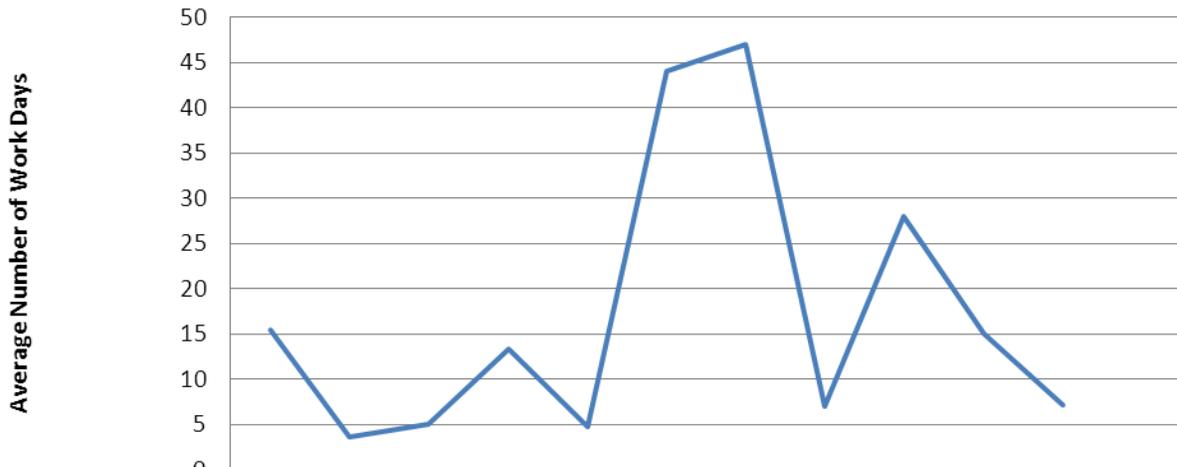
4. Goal of Improvement and Measures of Success:

We will monitor on a monthly basis the average waiting time for completion of the requested service, and the ratings of satisfaction with the service. Our goal obviously is to improve both timeliness and quality of the reports and interventions. We will make further process improvements as needed based on the data obtained over the next 4 quarters.

STRATEGIC PERFORMANCE EXCELLENCE

Psychological Testing

Average Work Days Request to Completion



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	2013Q1			2013Q2			2013Q3			2013Q4		
N Tests	6	7	8	3	4	1	1	1	1	1	6	
— Average Days	16	4	5	13	5	44	47	7	28	15	7	
Max Days	31	12	18	20	9	44	47	7	28	15	13	
Min Days	5	1	1	6	3	44	47	7	28	15	2	

Ongoing collection of Psychological Testing time to completion will be conducted to determine if trends are occurring in the provision of testing services. The performance of individual providers is being evaluated as part of a peer review process and recommendations for improved efficiency and responsiveness are being made by peers.

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff PolyAntipsychotic Medication Monitoring

Define

This is a new monitor for the medical staff this quarter and is consistent with the Joint Commission Core Measures related to the prescribing and appropriate justification of polyantipsychotic medications. We wished to establish a baseline of the frequency of clients in the hospital receiving greater than one antipsychotic medication, and to ascertain which of those clients had a clinical justification for such polypharmacy.

Measure

On June 13, 2013 the hospital pharmacy generated a profile of ordered medications on all clients in the building that day. Of the 80 clients on the hospital census 64 (80%) were receiving at least one antipsychotic medication. Of the 64 receiving antipsychotics 40 were receiving one agent, 24 (or 37.5 %) were receiving more than 1 agent, 10 clients were receiving more than 2 agents, and 3 clients were receiving more than 3 agents. We more closely reviewed the 24 clients receiving polypharmacy and attempted to justify clinically the prescribing patterns based on pre-agreed upon criteria. Following this analysis we determined that 17 of the 24 clients were justifiably receiving polypharmacy. This left a baseline rate of 71% justified with a goal of 90%.

Analyze

Going forward we will review the above data on a monthly basis, with emphasis on new clients added to the census as well as a re-review of clients previously not justified who may have had their drug regimens changed or who now meet justification criteria.

Improve

Individual clinicians participated in this exercise and they were given feedback on their own clients who did or did not meet clinical justifications.

Control

It is the twin goal of this monitor to reduce the percentage of clients receiving more than one antipsychotic medication, and for those that do to be certain there is a good clinical justification.

STRATEGIC PERFORMANCE EXCELLENCE

Nursing

INDICATOR

Mandate Occurrences

DEFINITION

When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy. This creates difficulty for the employee who is required to unexpectedly stay at work up to 16 hours. It also creates a safety risk.

OBJECTIVE

Through collaboration among direct care staff and management, solutions will be identified to improve the staffing process in order to reduce and eventually eliminate mandate occurrences. This process will foster safety in culture and actions by improving communication, improving staffing capacity, mitigating risk factors, supporting the engagement and empowerment of staff. It will also enhance fiscal accountability by promoting accountability and employing efficiency in operations.

THOSE RESPONSIBLE FOR MONITORING

Monitoring will be performed by members of the Staffing Improvement Task Force which includes representation of Nurses and Mental Health Workers on all units, Staffing Office and Nursing Leadership.

METHODS OF MONITORING

Monitoring would be performed by;

- Staffing Office Database Tracking System

METHODS OF REPORTING

Reporting would occur by one or all of the following methods;

- Staffing Improvement Task Force
- Nursing Leadership
- Riverview Nursing Staff Communication

UNIT

Mandate shift occurrences

BASELINE

August 2012: Nurse Mandates 24 shifts, Mental Health Worker Mandates 53 shifts

MONTHLY TARGETS

Baseline –10% each month

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Mandates Staffing Improvement Task Force

Department:	Nursing	Responsible Party:				Coleen Cutler, Acting DON; Staffing Improvement Task Force		
Safety in Culture and Actions	Baseline Aug 2012	Mth 1: Sep 2012	Mth 2: Oct 2012	Mth 3: Nov 2012	Mth 4: Dec 2012	Goal	Comments	
Mandate Occurrences - Nurses	24	10	5	0	6	16 (10% reduction monthly x4 from baseline)	Goal exceeded.	
When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy.								
Mandate Occurrences – Mental Health Workers	53	38	36	34	28	35 (10% reduction monthly x4 from baseline)	Goal exceeded	
When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy.								
Safety in Culture and Actions	Mth 5 Jan 2013	Mth 6 Feb 2013	Mth 7 Mar 2013	Mth 8 April 2013	Mth 9 May 2013	Mth 10 June 2013		
Mandate Occurrences - Nurses	1	2	1	0	1	4	Goal Exceeded	
Mandate Occurrences – Mental Health Workers	8	8	15	7	35	41	Increase in MHW mandates – increased acuity and 1-1 coverage ordered	

STRATEGIC PERFORMANCE EXCELLENCE

Peer Support

INDICATOR

Client Satisfaction Survey Return Rate

DEFINITION

There is a low number of satisfaction surveys completed and returned once offered to clients due to a number of factors.

OBJECTIVE

To increase the number of surveys offered to clients, as well as increase the return rate.

THOSE RESPONSIBLE FOR MONITORING

Peer Services Director and Peer Support Team Leader will be responsible for developing tracking tools to monitor survey due dates and surveys that are offered, refused, and completed. Full-time peer support staff will be responsible for offering surveys to clients and tracking them until the responsibility can be assigned to one person.

METHODS OF MONITORING

- Biweekly supervision check-ins
- Monthly tracking sheets/reports submitted for review

METHODS OF REPORTING

- Client Satisfaction Survey Tracking Sheet
- Completed surveys entered into spreadsheet/database

UNIT

All client care/residential units

BASELINE

Determined from previous year's data.

QUARTERLY TARGETS

Quarterly targets vary based on unit baseline with the end target being 50%.

STRATEGIC PERFORMANCE EXCELLENCE

Peer Support

Inpatient Client Survey – Improving the Rate of Return

Department: Peer Support Responsible Party: Susan Vangeli, Interim

Strategic Objectives								
Client Recovery	Unit	Baseline	Q1	Q2	Q3	Q4 Target	Goal	Comments
CSS Return Rate	LK	15%	ND	9%	8%	5%	50%	<i>Percentages are calculated based on number of people eligible to receive a survey vs. the number of people who completed the surveys.</i>
<i>The client satisfaction survey is the primary tool for collecting data on how clients feel about the services they are provided at the hospital. Data collection has been low on all units and the way in which the surveys are administered has challenges based on the unit operations and performance of the peer support worker.</i>	LS	5%	ND	0%	0%	0%	50%	
	UK	45%	ND	44%	27%	25%	50%	
	US	30%	ND	78%	60%	0%	50%	

Summary

Compliance on LK remained relatively the same this quarter. Although a number of surveys were offered to clients, the number of refusals brought the potential compliance from 22% to 5%, which would have been closer to the 3rd quarter target of 25%. LS continues to have a 0% return rate. This is primarily due to the nature of the unit population and the lack of staff administration of the surveys, despite reminders. Protocols are being put into place for the 1st quarter 2014 to ensure that surveys are offered on a regular basis. The return rate on UK increased slightly. The reported discharge numbers was zero.

STRATEGIC PERFORMANCE EXCELLENCE

Summary of Inpatient Client Survey Results

#	Indicators	Findings Total	
1	I am better able to deal with crisis.	33%	+4%
2	My symptoms are not bothering me as much.	21%	-36%
3	The medications I am taking help me control symptoms that used to bother me.	33%	-3%
4	I do better in social situations.	8%	-6%
5	I deal more effectively with daily problems.	21%	-15%
6	I was treated with dignity and respect.	21%	-58%
7	Staff here believed that I could grow, change and recover.	27%	-37%
8	I felt comfortable asking questions about my treatment and medications.	50%	0%
9	I was encouraged to use self-help/support groups.	66%	+9%
10	I was given information about how to manage my medication side effects.	16%	-13%
11	My other medical conditions were treated.	16%	-34%
12	I felt this hospital stay was necessary.	50%	+43%
13	I felt free to complain without fear of retaliation.	41%	+34%
14	I felt safe to refuse medication or treatment during my hospital stay.	17%	+24%
15	My complaints and grievances were addressed.	33%	+19%
16	I participated in planning my discharge.	16%	-13%
17	Both I and my doctor or therapist from the community were actively involved in my hospital treatment plan.	8%	+8%
18	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	8%	+15%
19	The surroundings and atmosphere at the hospital helped me get better.	17%	-19%
20	I felt I had enough privacy in the hospital.	50%	-7%
21	I felt safe while I was in the hospital.	33%	-3%
22	The hospital environment was clean and comfortable.	59%	+9%
23	Staff were sensitive to my cultural background.	34%	+20%
24	My family and/or friends were able to visit me.	33%	-17%
25	I had a choice of treatment options.	50%	+29%
26	My contact with my doctor was helpful.	42%	-8%
27	My contact with nurses and therapists was helpful.	42%	-22%
28	If I had a choice of hospitals, I would still choose this one.	17%	-44%
29	Did anyone tell you about your rights?	38%	+13%
30	Are you told ahead of time of changes in your privileges, appointments, or daily routine?	21%	+2%
31	Do you know someone who can help you get what you want or stand up for your rights?	5%	-39%
32	My pain was managed.	13%	-12%

Summary

Overall satisfaction dropped by 45%. Positive scores indicate satisfaction, while negative scores indicate dissatisfaction. Percentages are calculated using actual weighted scores and highest possible score for each indicator. The total number of respondents was 4. The first column indicates the score for 4th quarter and the second column shows increases/decreases from 3rd quarter. The most significant decreases in satisfaction were with indicators 2, 6, 7, 17, 11, and 28. The most significant increases were in indicators 12, 13, 14, 15, and 23. Indicators 13 and 14 increased significantly in satisfaction. Two indicators indicated dissatisfaction this quarter, indicators number 2, 11, and 31.

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

The IPEC reporting reflects three major areas of focus for performance improvement that have pharmacy specific indicators: **Safety in Culture and Actions, Fiscal Accountability and Medication Management** (see [Medication Management – Dispensing Process](#)). The pharmacy specific indicators for each of the priority focus areas utilizes measurable and objective data that is trended and analyzed to support performance improvement efforts and medication safety, as well as, ensure regulatory compliance and best practice in key areas.

Safety in Culture and Actions

RPC's primary medication distribution system uses the Pyxis Medstations to provide an electronic "closed loop" system to dispense medications for patients. Within the Pyxis system, key data elements are reported, trended and analyzed to ensure medication safety and regulatory compliance are maintained. *Pyxis Discrepancies* created by nursing staff are monitored daily and analyzed by Pharmacy with follow up to Nursing as needed for resolution. A monthly summary is provided to the Nursing-Pharmacy Committee for further review and discussion of trends and ideas to minimize the occurrence of discrepancies by Nursing. *Pyxis Overrides of Controlled Drugs* by nursing staff is another indicator that is closely monitored and trended with follow up for resolution as needed. A monthly summary is also reviewed by the Nursing-Pharmacy Committee for action steps. The goal with each of these indicators is to minimize the occurrence of either discrepancies or overrides by action steps to address performance issues via education or system changes which help satisfy TJC requirements for monitoring the effectiveness of the Medication Management system. *Veriform Medication Room Audits* are performed on each medication room to determine compliance with established medication storage procedures and requirements. The results of the audits are shared with the nursing managers for their respective corrective actions or staff education.

Fiscal Accountability

The *Discharge Prescriptions* indicator tracks the cost and number of prescription drugs dispensed to patients at discharge. This baseline data will be used to determine the best approach to implement steps to decrease this expense. The lack of a resource to perform insurance verification and research prior authorizations needed so clinicians' can make timely and informed prescribing decisions is believed to be inherent in the discharge process. Without this resource, RPC is obliged to provide discharge medications to prevent a gap in medication coverage as the patient is being transitioned to another facility. The plan of correction is to explore options and propose a resolution to RPC's Medical Director.

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

Department: Pharmacy Responsible Party: Garry Miller, R.Ph.

Safety in Culture & Actions	Unit	Baseline (Sept-Oct)	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Pyxis CII Safe Comparison	Rx							Goal of no discrepancies between Pyxis and CII Safe transactions.
<i>Daily and monthly comparison of Pyxis vs CII Safe transactions</i>								
Quarterly Results								
Veriform Medication Room Audits	All	Apr-June 100%	100%	100%	100%		90%	Overall compliance is 99% for Q2
<i>Monthly comprehensive audits of 14 criteria</i>								
Quarterly Results			92%	99%	98%			
Pyxis Discrepancies	All	Aug-Nov 107/mo	107	107	50	50	50/mo	Target goal is 50/month discrepancies after 6 months of Pyxis use
<i>Monthly monitoring and trending of Pyxis discrepancies.</i>								
Quarterly Results			128	96	156*			*March 2013
Pyxis Overrides – Controlled Drugs	All	Aug-Nov 25/month	25	25	10	10	10	Target goal is 10/month after 6 months of Pyxis use
<i>Monthly monitoring and trending of Pyxis overrides for Controlled Drugs</i>								
Quarterly Results			32	17	79			
Fiscal Accountability	Unit	July-Dec Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Discharge Prescriptions	Rx	\$12412	\$5809	\$19015	\$4977			Significant costs are incurred in providing discharge drugs.
<i>Monitoring and Tracking of dispensed Discharge Prescriptions</i>		361 drugs	345 drugs	377 drugs	297 drugs			

STRATEGIC PERFORMANCE EXCELLENCE

Program Services

Define

Client participation in on-unit groups and utilization of resources to relieve distress is variable but should be promoted to encourage activities that support recovery and the development of skills necessary for successful community integration.

Measure

The program services team will measure the current status of program participation and resource utilization to identify a baseline for each of the four units.

Analyze

Analysis of the barriers to utilization will be conducted in an attempt to determine causation factors for limited participation.

Improve

Strategies for encouraging increased participation in on-unit groups and the utilization of resources to relieve distress will be identified in a collaborative manner with client and staff participation.

Control

Ongoing review of utilization of programs and resources will be conducted to determine whether unit practice has changed and improvements are sustainable.

INDICATOR	Baseline	Quarterly Improvement Target	Improvement Objective
1. How many on unit groups were offered each week Day shift → Evenings →			14
2. Number of clients attending day groups on unit or facilitated by day staff (# of clients in all of day groups divided by # of day groups provided)			
3. Number of clients attending evening groups on unit or facilitated by evening staff (# of clients in all of evenings groups divided by # of evening groups provided)			
4. Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended.			100%
5. The client can identify distress tolerance tools on the unit			100%
7. The client is able to can identify his or her primary staff.			100%

STRATEGIC PERFORMANCE EXCELLENCE

Program Services Lower Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. How many on unit groups were offered each week Day shift → Evenings →	12/14	84%	14 weekly
2. Number of clients attending day groups on unit or facilitated by day staff (# of clients in all of day groups divided by # of day groups provided)	4/7	57%	5/group
3. Number of clients attending evening groups on unit or facilitated by evening staff (# of clients in all of evenings groups divided by # of evening groups provided)	4/7	57%	5/group
4. Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended	5/10	50%	100%
5. The client can identify distress tolerance tools on the unit	5/10	50%	100%
7. The client is able to state who his primary staff is	10/10	100%	100%

EVALUATION OF EFFECTIVENESS

There are now on unit groups seven days a week on Lower Kennebec. There is one on the day shift and one on the evening shift daily. The group listing is posted to the left of the nursing station in the ward area. These groups are open to all Clients on the unit. Clients who do not have a level to attend the Treatment Mall are strongly encouraged to attend the on unit groups. The treatment plans are being updated to reflect on unit groups. Participation in on unit groups is a consideration in advancing to a higher level. The charge nurse has been identified as the person responsible to ensure that these groups are conducted as scheduled and charted in a consistent way.

ISSUES

Changes in the RN4 leadership position have impacted consistency in the approach and delivery of the on unit groups.

ACTIONS

The former RN4 has been reassigned to LK and a consistent approach has been resumed. Unit leadership will continue to promote the on unit groups. Documentation will be monitored for compliance. On unit groups will be addressed at each treatment team meeting. The benefits of engaging in active treatment will be promoted as a milieu enhancement.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services Upper Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. How many on unit groups were offered each week Day shift → Evenings →	7/7	100%	14weekly
2. Number of clients attending day groups on unit or facilitated by day staff (# of clients in all of day groups divided by # of day groups provided)	3/7	42%	5/group
3. Number of clients attending evening groups on unit or facilitated by evening staff (# of clients in all of evenings groups divided by # of evening groups provided)	4/7	57%	5/group
4. Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended	9/10	90%	100%
5. The client can identify distress tolerance tools on the unit	8/10	80%	100%
7. The client is able to state who his primary staff is	10/10	100%	100%

EVALUATION OF EFFECTIVENESS

Upper Kennebec maintains organization to the on unit groups. The RN Treatment Team Coordinator maintains a formalized group listing which is posted on the unit for reference. UK typically has more clients attending the treatment mall. Evenings groups remain more of leisure in nature. Day group attendance decreased due to increased number of clients attending the treatment mall.

Many of the Clients on UK have a preference for the computer lab and the gym.

ISSUES

Consistency in on unit groups continues to improve.

ACTIONS

Continue to promote on unit groups. Continue to monitor documentation for compliance. Explore client interests in on unit groups. Request Consistence in the charting of on unit groups will be implemented on both of the Kennebec units.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services Lower Saco

INDICATOR	FINDINGS	%	THRESHOLD
1. How many on unit groups were offered each week Day shift → Evenings →	Main/SCU 33 / 12 24 / 10	100% 100%	7 / 7 = 14 7 / 7 = 14
2. Number of clients attending day groups on unit or facilitated by day staff (# of clients in all of day groups divided by # of day groups provided)	3 / 1.5		N/A
3. Number of clients attending evening groups on unit or facilitated by evening staff (# of clients in all of evenings groups divided by # of evening groups provided)	3.5/ 1		N/A
4. Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended	4	40%	100%
5. The client can identify distress tolerance tools on the unit	30/30	100%	100%
7. The client is able to state who his primary staff is	27/30	100%	100%

EVALUATION OF EFFECTIVENESS

ISSUES

The Lower Saco unit improved significantly with on-unit groups by MHWS and professional staff. Although the documentation in the medi-tech has improved, more work is needed. There is evidence that this treatment effort is being reflected in the treatment plans but the RT staff is much more consistent in documenting participation than nursing staff.

ACTIONS

The on-unit groups have been increased dramatically since mid-May 2013 and this will be maintained. The team coordinator continues to work on incorporating these on-unit groups in to the Rx plans.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services Upper Saco

INDICATOR	FINDINGS	%	THRESHOLD
1. How many on unit groups were offered each week Day shift → Evenings →	12 10	100% 100%	Days/ Even. 7 / 7 = 14
2. Number of clients attending day groups on unit or facilitated by day staff (# of clients in all of day groups divided by # of day groups provided)	2/12	17%	N/A
3. Number of clients attending evening groups on unit or facilitated by evening staff (# of clients in all of evenings groups divided by # of evening groups provided)	4/10	40%	N/A
4. Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended	4	40%	100%
5. The client can identify distress tolerance tools on the unit	30/30	100%	100%
7. The client is able to state who his primary staff is	30/30	100%	100%

EVALUATION OF EFFECTIVENESS

ISSUES

The Upper Saco unit has increased offering on-unit groups. The documentation in the medi-tech is improving. There continues to be little evidence that this treatment effort was reflected in the treatment plans up until the last month. Nearly all of the clients on Upper Saco attend the hospital treatment mall and there is a high level of participation and attendance with this off-unit treatment.

ACTIONS

The team coordinator is now incorporating on unit groups in client plans. Continued efforts are being made to offer groups to those clients that have less activity at the hospital treatment mall.

STRATEGIC PERFORMANCE EXCELLENCE

Rehabilitation Services

Department: Rehabilitation ServicesResponsible Party: Janet Barrett

Strategic Objectives							
Client Recovery	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
<p><u>Vocational Incentive Program Treatment Plans</u></p> <p><i>The objective of this improvement project is to ensure vocational treatment plans are initiated on all clients within 5 days of beginning work and will be reviewed and updated if necessary every 30 days. Documentation on interventions in the treatment plans will reflect progress towards interventions and will be documented on weekly.</i></p>	55%	Baseline Data Gathered	70%	85%	100%	The treatment plans will be reviewed more regularly and updated at each client 30 day treatment team meeting.	Treatment plans were completed in a timely fashion but the review and updates were not consistent. Documentation is not always done on a weekly basis. Goal for next quarter is to increase by 19%.
<u>Quarterly Results</u>			77%	81%	92%		

Safety in Culture and Actions	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
<p><u>Client/Staff Injuries in the Gym (to start in the second quarter)</u></p> <p><i>The objective of this improvement project is to reduce/eliminate staff/client injury in the gym by increasing education on the proper techniques for equipment use as well as proper techniques for other activities in done in the gym. This will also include education on performing environmental checks of the area to ensure there are no safety issues.</i></p>	No data available to establish baseline						The data continues to show that there has been no reported injuries staff/client for the past 3 quarters. This is will be the last quarter for review for this objective as the reviews show that it is less of an issue than originally identified last year
<u>Quarterly Results</u>			No injuries during the quarter	No injuries during the quarter	No injuries during the quarter		