Riverview
PSYCHIATRIC CENTER

PERFORMANCE IMPROVEMENT REPORT

FOURTH STATE FISCAL QUARTER 2011
April, May, June 2011

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July 22, 2011

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INTRODUCTION

The various departments at Riverview Psychiatric Center continue to strive to meet or exceed the substantial compliance standards as outlined in the consent decree. In addition, each department conducts other performance improvement activities that are designed to enhance the process and environment of safety and care for residential and ACT clients in the Maine Adult Mental Health System. The overall goal of this endeavor is provide these services with an eye toward client recovery and organizational excellence while continuing to recognize the need to maintain a high degree of efficiency and fiscal responsibility.

There are some significant changes to this report in an attempt to clarify some of the information contained herein. The section on Comparative Statistics has been completely redesigned to make many of the charts more easily readable, especially for those with difficulty in color differentiation. In addition, the main graph that depicts the results of the facility in the various aspects being evaluated has been changed to exclude the data from the Dorothea Dix Psychiatric Center. This was done primarily to allow a more accurate comparison between the two facilities. Whereas the Riverview Psychiatric Center cares for a mix of forensic and civil clients, the Dorothea Dix Psychiatric Center client population is, for all intents and purposes, a civil population. To provide an accurate comparison of the results from the two facilities, the Dorothea Dix Psychiatric Center data is now depicted on a civil stratification chart for each of the aspects evaluated that also includes data on the civil population at Riverview Psychiatric Center.

The use of seclusion and restraint as a safety mechanism for clients and staff in the clinical setting remains a focus of risk and process improvement activities. Both the number and duration of client incidents managed with restraint and seclusion techniques is variable and often dependent upon client acuity and concerns for maintaining client safety. The duration of both seclusion and restraint remain the national mean as determined by the National Association of State Mental Health Program Directors Research Institute (NRI). For the same period, the average number of restraint and seclusion incidents over the past several quarters has been within one standard deviation of the national mean as determined by NRI. Efforts continue to further reduce the incidence of both restraint and seclusion while maintaining the safety of the client, the milieu and our staffs.

Ongoing efforts to modify analysis and treatment methods to respond to client agitation and escalation have produced some examples of success with individual clients. Efforts to widely adopt these proactive methods throughout the milieu are implemented on a case by case basis as trends are identified through an ongoing system of data collection and analysis.

Introduced last quarter, the section on Consent Decree Compliance continues to be developed. The elements of substantial compliance abstracted from this document are listed with an explanation of how current operations fulfill the standards described. Several of the compliance standards require specific evidence or documentation of compliance that in various stages of development. One of these evaluation methods includes an ongoing process for evaluating the appropriate application and management of seclusion and mechanical restraints. This tool has been implemented and ongoing reports regarding this measure have been included in this report. As this reporting mechanism is developed, it is expected that subsequent reports will address all of the standards of substantial compliance in a manner that demonstrates a good faith effort to maintain continual compliance with all of the elements of the Consent Decree and to maintain an environment and treatment methods that are both safe and therapeutic and focused on the recovery of the client.

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ADMISSIONS

Figure CD-06
Client Admission Diagnoses

	2011				Total
	Qtr1	Qtr2	Qtr3	Qtr4	
ADJUSTMENT DIS W MIXED DISTURBANCE OF EMOTIONS & CONDUCT	1			1	2
ADJUSTMENT DISORDER WITH DEPRESSED MOOD	1	2	1		4
ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED MOOD			1		1
ADJUSTMENT REACTION NOS		1	1		2
ALCOH DEP NEC/NOS-REMISS	2				2
BIPOL I DIS, MOST RECENT EPIS (OR CURRENT) MANIC, UNSPEC		1			1
BIPOL I, MOST RECENT EPISODE (OR CURRENT) MIXED, UNSPECIFIED	1				1
BIPOL I, REC EPIS OR CURRENT MANIC, SEVERE, SPEC W PSYCH BEH	1	1			2
BIPOLAR DISORDER, UNSPECIFIED	10	11	11	11	43
CANNABIS ABUSE-IN REMISS		1			1
CONDUCT DISTURBANCE NOS		1			1
DELUSIONAL DISORDER	2	2	2	2	8
DEPRESS DISORDER-UNSPEC		1			1
DEPRESSIVE DISORDER NEC	5	7	4	5	21
DRUG ABUSE NEC-UNSPEC		1			1
DYSTHYMIC DISORDER	1	2			3
HEBEPHRENIA-CHRONIC		1		1	2
INTERMITT EXPLOSIVE DIS	1				1
NONPSYCHOT BRAIN SYN NOS	1				1
OPPOSITIONAL DEFIANT DISORDER	1				1
PARANOID SCHIZO-CHRONIC	4	5	7	6	22
PARANOID SCHIZO-UNSPEC	5	2	2	4	13
POSTTRAUMATIC STRESS DISORDER	2	3	4	4	13
PSYCHOSIS NOS	13	14	4	7	38
REC DEPR DISOR-PSYCHOTIC			2	2	4
RECURR DEPR DISORD-UNSP	1			1	2
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED	14	13	13	21	61
SCHIZOPHRENIA NOS-CHR	4	2	1	6	13
SCHIZOPHRENIA NOS-UNSPEC	1		2	1	4
SCHIZOPHRENIFORM DISORDER, UNSPECIFIED	1				1
UNSPECIFIED EPISODIC MOOD DISORDER	3	5	3	3	14
Total Admissions	75	76	58	75	284
% Admitted with primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	2.67%	2.67%	0	0	1.41%

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ADMISSIONS

Figure CD-04
Client Legal Status on Admission

	2011				Total
	Qtr1	Qtr2	Qtr3	Qtr4	
ICDCC	3	17	26	23	69
ICDCC-PTP				1	1
IC-PTP+M			1		1
ICRDCC		1		2	3
INVOL CRIM	19	20	29	30	98
INVOL-CIV	1	2	7	2	12
PCHDCC		1		2	3
PCHDCC+M			1	1	2
VOL	35	34	11	10	90
VOL-OTHER	1	1	1	2	5
ICDCC-M				3	3

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COMMUNITY FORENSIC ACT TEAM

ASPECT: REDUCTION OF RE-HOSPITALIZATION FOR ACT TEAM CLIENTS

Indicators	Findings	Compliance	Threshold Percentile
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: 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	One PTP client was admitted this quarter, he was in the community less than 1 week in a group home.	100%	100%
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.	100%	100%	100%

Summary

1. The PTP client was re-admitted to RPC after de-stabilizing while living in a group home in Augusta. He had his medications administered by staff and there is reason to believe may have not swallowed them (mouth checks were not done). Upon his next discharge to the community, it would be beneficial to have mouth checks done to enhance this client's ability to fully stabilize in residential treatment in the community.

2. The ACT Team has become more collaborative in treatment team meeting participation while clients are in the hospital, particularly regarding recommendations for goals of re-hospitalization.

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COMMUNITY FORENSIC ACT TEAM

ASPECT: INSTITUTIONAL AND ANNUAL REPORTS

Indicators	Findings	Compliance	Threshold Percentile
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of notification of submitted petition.	4 of 7 on time	60%	95%
2. The assigned case manager will review the new court order with the client and document the meeting in a progress note or treatment team note.	4 new court orders, all reviewed.	100%	100%
3. Annual Reports (due Nov) to the commissioner for all out-patient Riverview ACT NCR clients are submitted annually	N/A	N/A	100%

Summary

1. Eight clients petitioned to have their cases heard on the 5/13/11 court date; one withdrew his petition so seven went to court. Four of seven had Institutional reports completed on time. The major factor influencing this poor outcome was the continued revision of the internal process for writing/filing reports. The process has been further improved to include essential reviewers and continued emphasis on deadlines triggered with the receipt of petitions.

2. ACT Team Leader delivers all new Court Orders to Case Managers upon receipt, who then reviews with both client and supported housing staff involved in compliance with order. This is documented in progress notes and/or reviewed in ISP treatment team.

3. Annual Reports were not due within this quarter.

ASPECT: SUBSTANCE ABUSE AND ADDICTIVE BEHAVIOR HISTORY

Indicators	Findings	Compliance	Threshold Percentile
1. age of onset documented in Comprehensive Assessment	40/40	100%	95%
2. duration of behavior documented in C.A. and progress notes	39/40	90%	95%
3. pattern of behavior documented in C.A. and progress notes	39/40	90%	95%

Summary

The Co-Occurring Specialist has begun to review all urinalyses for illicit drug/alcohol use. We believe this will streamline the process of responding to the client with the information and will identify one point-person for the Maine General Lab for drug screens and one for all other lab work (Nurse).Our randomization of urinalyses for drug/alcohol detection implemented by the Co-Occurring Specialist has been adapted to meet the MaineCare standards in order for lab work to be funded (no more than one time in 7 days).

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COMMUNITY FORENSIC ACT TEAM

ASPECT: INDIVIDUAL SERVICE PLANS AND PROGRESS NOTES

Indicators	Findings	Compliance	Threshold Percentile
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly contact with all clients assigned on an active status caseload.	36/40	80%	95%
2. Individual Service Plans will have measurable goals and interventions listing client strengths and areas of need related to community integration and increased court ordered privileges based on risk reduction activities.	38/40	90%	95%
3. Case notes will indicate at minimum monthly contact with all NCR clients who remain under the care of the Commissioner. These clients receive treatment services by community providers and RPC ACT monitors for court order and annual report compliance only.	10/10	100%	95%

Summary

1. Team now offers four groups, creating increased capacity for face-to-face contacts and supporting documentation. Clients in transition from ACT to other community resources have had less than weekly direct contact but are discussed weekly in clinical meeting and are seen face to face at least 4 times per month (averaging weekly contacts).
2. ISPs also contain group attendance goals, especially with clients who are petitioning for increased court ordered privileges. Case managers are focused on including group attendance in ISP goals.
3. One client in an outlying status petitioned for increased privileges for the July 12, 2011 docket.

ASPECT: PEER SUPPORT

Indicators	Findings	Compliance	Threshold Percentile
1. Engagement attempt with client within 7 days of admission.	1/2	50%	95%
2. Documented offer of peer support services.	2/2	100%	95%
3. Attendance at treatment team meetings as appropriate.	15/30	50%	95%

Summary

As in prior report, Peer Support Specialist makes every effort to attend treatment team meetings at ACT offices and in hospital; this quarter the Peer Support Specialist returned to work mid-May so 50% of the reporting period saw excellent results. The number and quality of contacts with clients by Peer Support continues to contribute to the ACT Teams goal of seeing clients face to face three times per week, and when needed, Peer Support Specialists from the hospital have met with clients of the ACT Team in the absence of the ACT PSP.

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CAPITOL COMMUNITY CLINIC

ASPECT: DENTAL CLINIC SURVEY

Indicators	Findings	Compliance	Threshold Percentile
Clients from RPC as well as clients in the community will receive a survey to fill out at the time of appt. The survey has several questions and in those questions we are asking the client how we can better serve there needs.	**April** Twenty-four surveys done by in-house clients as well as outpatient, all were positive.	100%	90%
	May Nine surveys done by in-house clients as well as outpatient, all were positive.	100%	90%
	June Fifteen surveys done by in-house clients as well as outpatient, all were positive.	100 %	90%

Summary

Forty-eight surveys were returned and all showed positive results for the third quarter.

Actions

Will continue the client surveys to monitor and evaluate weekly as well as monthly with staff.

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CAPITOL COMMUNITY CLINIC

ASPECT: DENTAL CLINIC 24 HOUR POST EXTRACTION FOLLOW-UP

Indicators	Findings	Compliance	Threshold Percentile
a. 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 • Bleeding • Swelling • Pain • Muscle soreness • Mouth care • Diet • Signs/symptoms of infection b. The client, post procedure tooth extraction, will verbalize understanding of the above by repeating instructions given by Dental Assistant/Hygienist.	**April** Eight extractions were performed. Post extraction instructions verbalized to each client. Client repeated back to Dental Assistant that they understood the instructions without difficulty.	100%	100%
	May Nine extractions were performed. Post extraction instructions verbalized to each client. Client repeated back to Dental Assistant that they understood the instructions without difficulty.	100%	100%
	June Three extractions were performed. Post extraction instructions verbalized to each client. Client repeated back to Dental Assistant that they understood the instructions without difficulty.	100%	100%

Summary

There were twenty extractions in the fourth quarter. All clients had been educated on each topic listed above with post extraction, after care instructions were given both orally and in writing. Clients had no issues repeating and understanding the oral instructions.

A follow up post procedure phone call is done to check on the client's progress. Of the twenty-seven calls made, there were no issues or complications post procedure. Reports were reviewed at monthly staff meetings and forwarded quarterly to RPC.

Action

Results will be reviewed monthly by staff and will continue to report monthly to RPC.

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CAPITOL COMMUNITY CLINIC

ASPECT: DENTAL CLINIC TIMEOUT/IDENTIFICATION OF CLIENT

Indicators	Findings	Compliance	Threshold Percentile
National Patent Safety Goals Goal 1: Improve the accuracy of Client Identification. Capital Community Dental Clinic assures accurate client identification by asking the client to state his/her name and date of birth. Goal 2: Verify the correct procedure and site for each procedure. A time out will be taken before the procedure to verify location and number of the tooth to be extracted. 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.	**April** There were eight extractions for the month, The client was given a time out to identify extraction site, and asked to state their name and dob.	100 %	100%
	May There were nine extractions done for the month. The each client was given a time out to identify extraction site, and asked to state their name and dob.	100%	100%
	June There were three extractions done for the month. The each client was given a time out to identify extraction site, and asked to state their name and dob.	100%	100%

Summary:

In the 4th quarter 2011, twenty clients had extractions. In all twenty cases there is appropriate documentation of a time-out procedure prior to the extraction. The client was asked to identify the extraction site and was also asked to identify themselves by providing their full name and date of birth.

Actions

The dental clinic staff will continue to report and monitor performance of key safety strategies.

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CAPITOL COMMUNITY CLINIC

ASPECT: MED MANAGEMENT CLINIC APPOINTMENT ASSESSMENT

Indicators	Findings	Compliance	Threshold Percentile
All Outpatient clients will have Vital Signs and Weight recorded upon arrival for appointment.	**April** Twenty-eight clients that had scheduled appointments had their vitals signs taken before their clinic appointment.	100%	100%
	May There were thirty-one clients scheduled for appointments during the month of February. All clients had vital signs taken before their appointment.	100%	100%
	June There were thirty clients scheduled for appointments. All clients had their vital signs taken before their clinic appointment.	100%	100%

Summary

For the third quarter there were 81 clients. All clients had their vitals taken before their scheduled appointment. This information was reviewed at monthly staff meetings and reports forwarded quarterly to RPC Quality Council.

Actions

Staff will continue to strive for 100% of the goal. Staff will monitor and report monthly, as well as quarterly to RPC.

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CLIENT SATISFACTION

ASPECT: CLIENT SATISFACTION WITH CARE

#	Indicators	Findings	
		Results	% Change
1	I am better able to deal with crisis.	39%	+5%
2	My symptoms are not bothering me as much.	29%	-34%
3	The medications I am taking help me control symptoms that used to bother me.	34%	-29%
4	I do better in social situations.	37%	-4%
5	I deal more effectively with daily problems.	21%	-23%
6	I was treated with dignity and respect.	26%	-18%
7	Staff here believed that I could grow, change and recover.	26%	-40%
8	I felt comfortable asking questions about my treatment and medications.	18%	-45%
9	I was encouraged to use self-help/support groups.	45%	-11%
10	I was given information about how to manage my medication side effects.	26%	+1%
11	My other medical conditions were treated.	16%	-25%
12	I felt this hospital stay was necessary.	8%	-23%
13	I felt free to complain without fear of retaliation.	8%	-20%
14	I felt safe to refuse medication or treatment during my hospital stay.	-11%	-30%
15	My complaints and grievances were addressed.	24%	-7%
16	I participated in planning my discharge.	37%	-29%
17	Both I and my doctor or therapist from the community were actively involved in my hospital treatment plan.	16%	-22%
18	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	34%	+15%
19	The surroundings and atmosphere at the hospital helped me get better.	26%	-8%
20	I felt I had enough privacy in the hospital.	34%	-7%

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CLIENT SATISFACTION

#	Indicators	Findings	
		Results	% Change
21	I felt safe while I was in the hospital.	34%	0%
22	The hospital environment was clean and comfortable.	45%	+20%
23	Staff were sensitive to my cultural background.	18%	-1%
24	My family and/or friends were able to visit me.	45%	-8%
25	I had a choice of treatment options.	24%	-20%
26	My contact with my doctor was helpful.	32%	-27%
27	My contact with nurses and therapists was helpful.	37%	-22%
28	If I had a choice of hospitals, I would still choose this one.	21%	-20%
29	Did anyone tell you about your rights?	32%	-18%
30	Are you told ahead of time of changes in your privileges, appointments, or daily routine?	16%	-22%
31	Do you know someone who can help you get what you want or stand up for your rights?	29%	-18%
32	My pain was managed.	5%	-39%

ND = no data

Summary

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 19. The first column indicates the score for 4th quarter and the second column shows increases/decreases from 3rd quarter. Overall satisfaction for 4th quarter decreased significantly, down 17% from last quarter.

Only four indicators increased, while the remainder decreased. The most significant drops in satisfaction were with the following items: staff here believed that I could grow, change and recover; I felt comfortable asking questions about my treatment and medications; my pain was managed.

There were only two significant increases in satisfaction which were in the following items: I had an opportunity to talk with my doctor or therapist from the community prior to discharge; the hospital environment was clean and comfortable.

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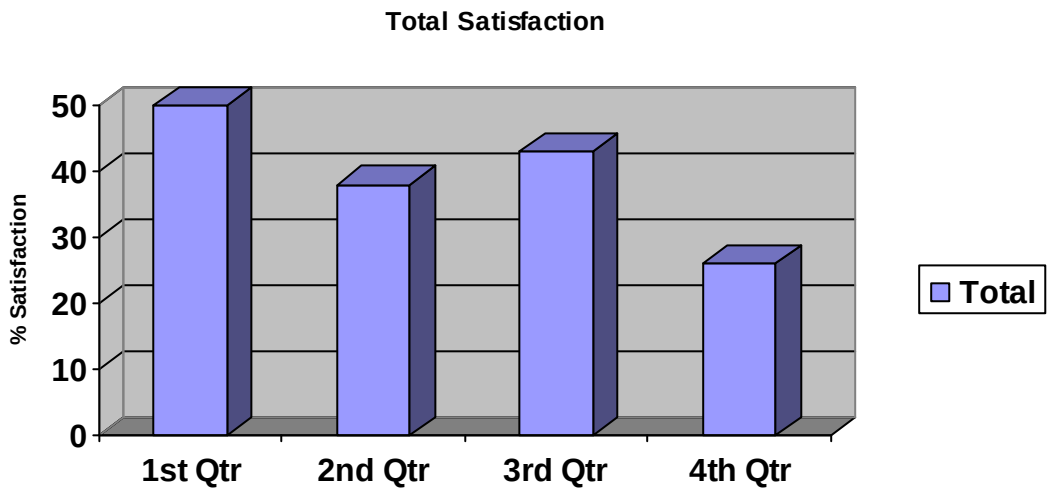
CLIENT SATISFACTION



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COMPARATIVE STATISTICS

The comparative statistics reports include the following elements:

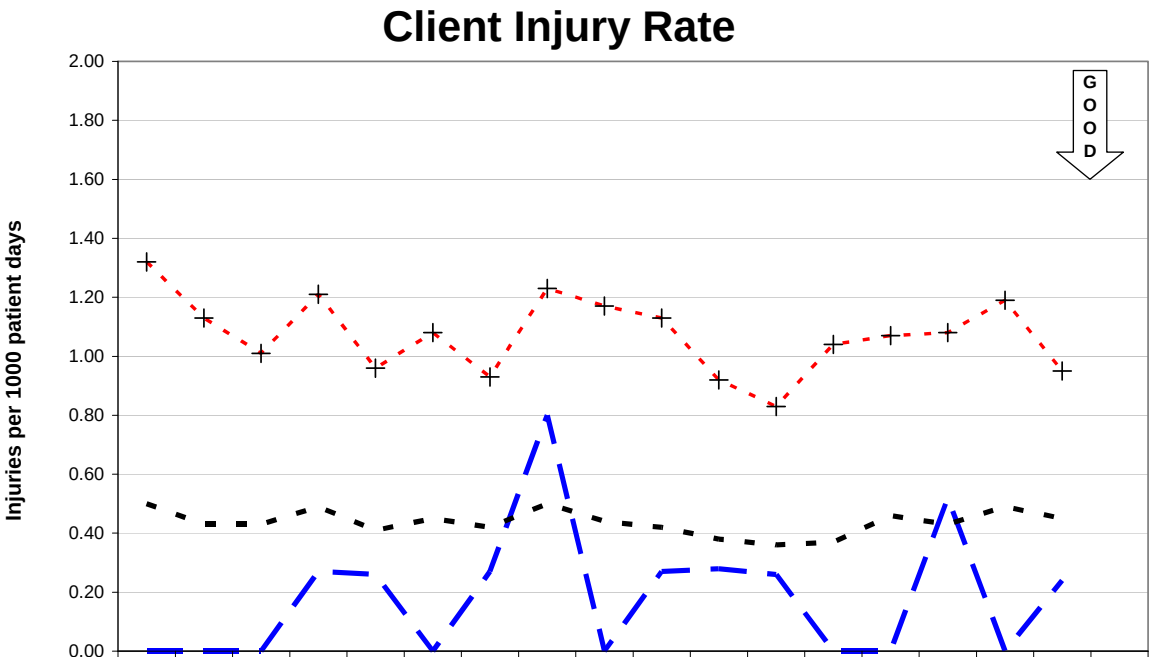
- Client Injury Rate
- Elopement Rate
- Medication Error Rate
- 30 Day Readmit Rate
- Percent of Clients Restrained
- Hours of Restraint
- Percent of Clients Secluded
- Hours of Seclusion
- Confinement Events Analysis
- Confinement Events Management
- Medication Administration during Behavioral Events

In addition to the areas of performance listed above, each of the comparative statistics areas includes a graph that depicts the stratification of forensic and non-forensic (civil) services provided to clients. This is new information that is being provided by the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI). NRI is charged with collecting data from state mental health facilities, aggregating the data and providing feedback to the facilities as well as report findings of performance to the Joint Commission.

According to NRI, “forensic clients are those clients having a value for Admission Legal Status of "4" (Involuntary-Criminal) and having any value for justice system involvement (excluding no involvement). Clients with any other combination of codes for these two fields are considered non-forensic.”

COMPARATIVE STATISTICS

Figure CD-29



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011		
Riverview	0.00	0.00	0.00	0.27	0.26	0.00	0.27	0.80	0.00	0.27	0.28	0.26	0.00	0.00	0.52	0.00	0.24	
Ntl Mean	0.50	0.43	0.43	0.49	0.41	0.45	0.42	0.50	0.44	0.42	0.38	0.36	0.37	0.46	0.43	0.49	0.45	
+1 StDev	1.32	1.13	1.01	1.21	0.96	1.08	0.93	1.23	1.17	1.13	0.92	0.83	1.04	1.07	1.08	1.19	0.95	

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 NRI 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.

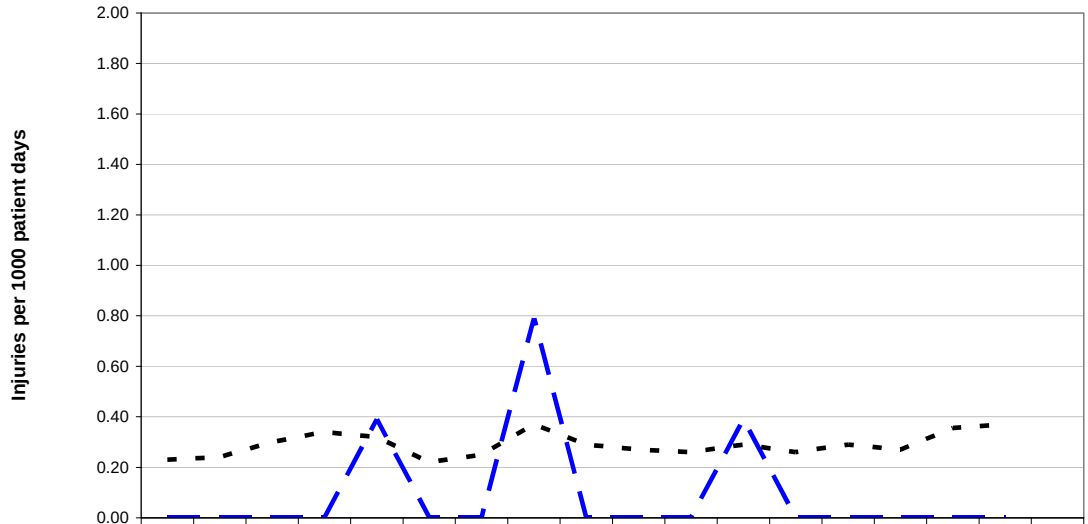
- No Treatment – The injury received by a client may be examined by a clinician but no treatment is applied to the injury.
- Minor First Aid – The injury received is of minor severity and requires the administration of minor first aid.
- Medical Intervention Needed – The injury received is severe enough 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 NRI.

COMPARATIVE STATISTICS

Client Injury Rate

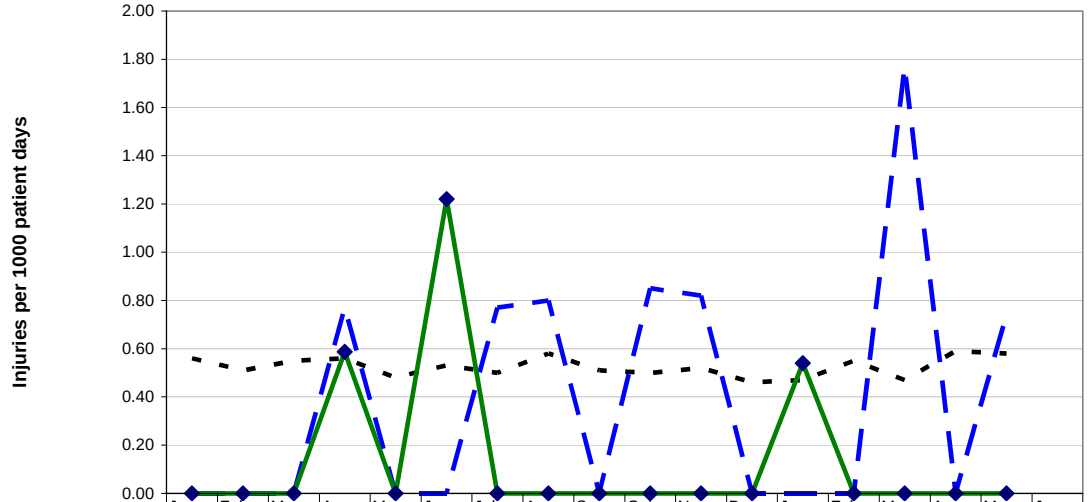
Forensic Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011		
Riverview	0.00	0.00	0.00	0.00	0.39	0.00	0.00	0.79	0.00	0.00	0.00	0.39	0.00	0.00	0.00	0.00	0.00	
Ntl Mean	0.23	0.24	0.30	0.34	0.32	0.22	0.25	0.37	0.29	0.27	0.26	0.29	0.26	0.29	0.27	0.36	0.37	

Client Injury Rate

Civil Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011		
Riverview	0.00	0.00	0.00	0.77	0.00	0.00	0.77	0.80	0.00	0.85	0.82	0.00	0.00	0.00	1.77	0.00	0.74	
Ntl Mean	0.56	0.51	0.55	0.56	0.48	0.53	0.50	0.58	0.51	0.50	0.52	0.46	0.47	0.55	0.47	0.59	0.58	
Dorothea Dix	0.00	0.00	0.00	0.59	0.00	1.22	0.00	0.00	0.00	0.00	0.00	0.00	0.54	0.00	0.00	0.00	0.00	

These 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.

COMPARATIVE STATISTICS

Client Injuries	Apr	May	Jun	4TH FQ 2011
Total	4	2	4	10

ASPECT: SEVERITY OF INJURY BY MONTH

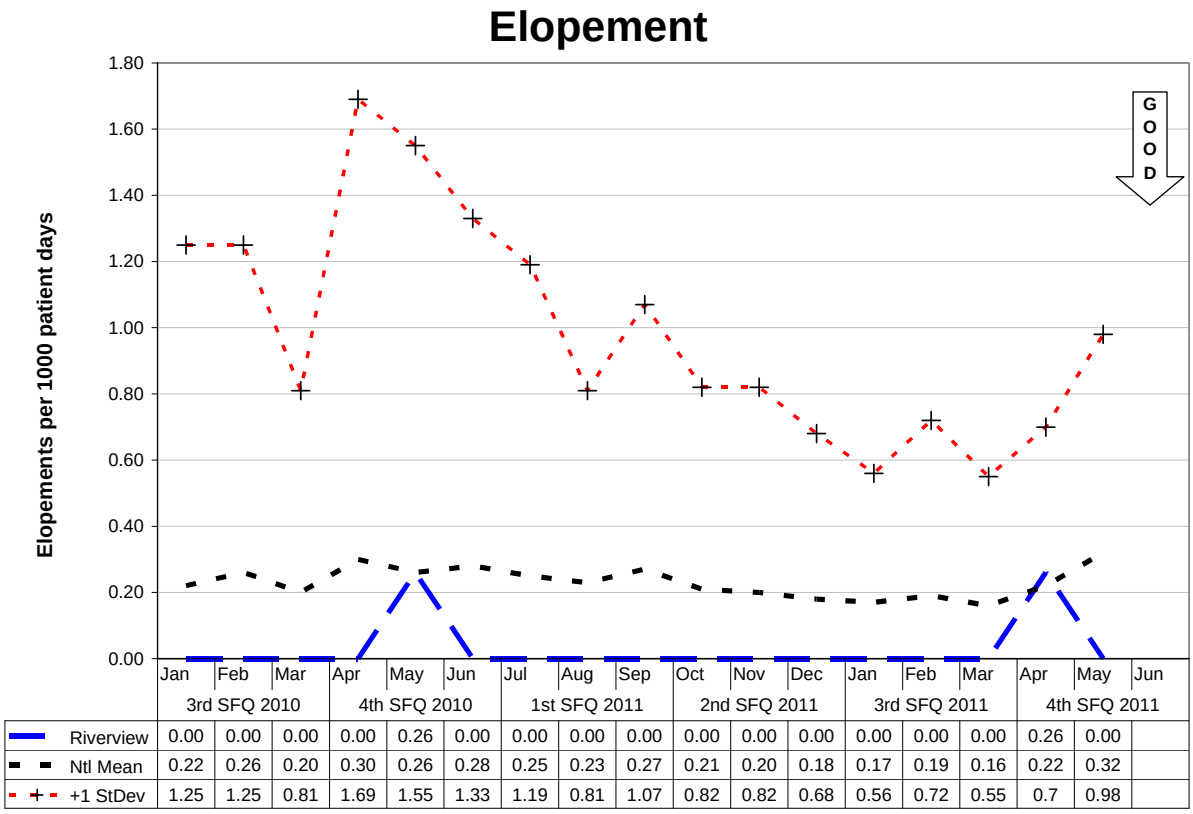
Severity	Apr	May	Jun	4TH FQ 2011
No Treatment	3	1	2	6
Minor First Aid	1	1	2	4
Medical Intervention Required	0	0	0	0
Hospitalization Required	0	0	0	0
Death Occurred	0	0	0	0

ASPECT: TYPE AND CAUSE OF INJURY BY MONTH

Type - Cause	Apr	May	Jun	4TH FQ 2011
Accident-Equipment Use			1	3
Accident-Fall Witnessed	3			3
Assault-Client to Client	1	1	2	4

COMPARATIVE STATISTICS

Figure CD-28



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011		
Riverview	0.00	0.00	0.00	0.00	0.26	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.26	0.00	
Ntl Mean	0.22	0.26	0.20	0.30	0.26	0.28	0.25	0.23	0.27	0.21	0.20	0.18	0.17	0.19	0.16	0.22	0.32	
+1 StDev	1.25	1.25	0.81	1.69	1.55	1.33	1.19	0.81	1.07	0.82	0.82	0.68	0.56	0.72	0.55	0.7	0.98	

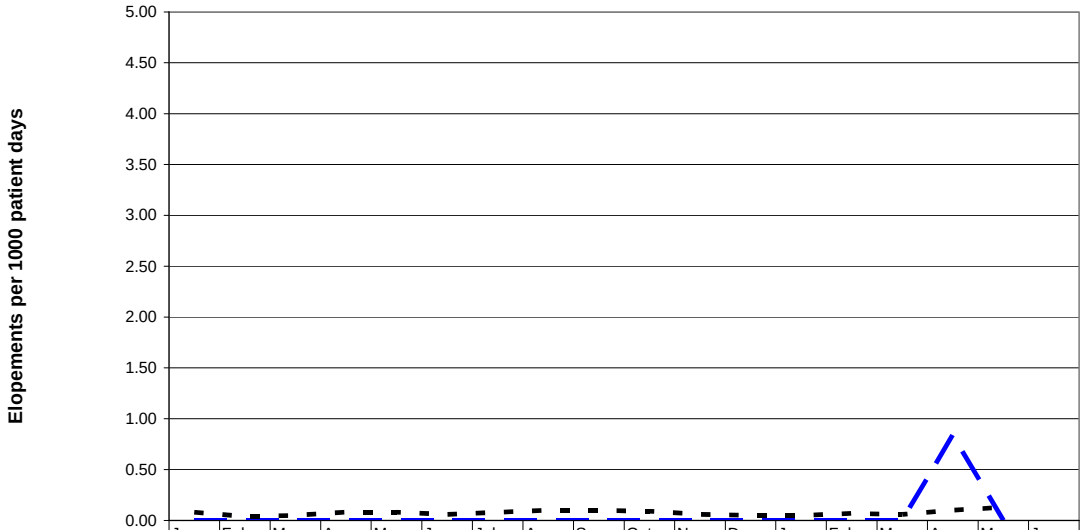
This graph depicts the number of elopements that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days.

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.”

COMPARATIVE STATISTICS

Elopement

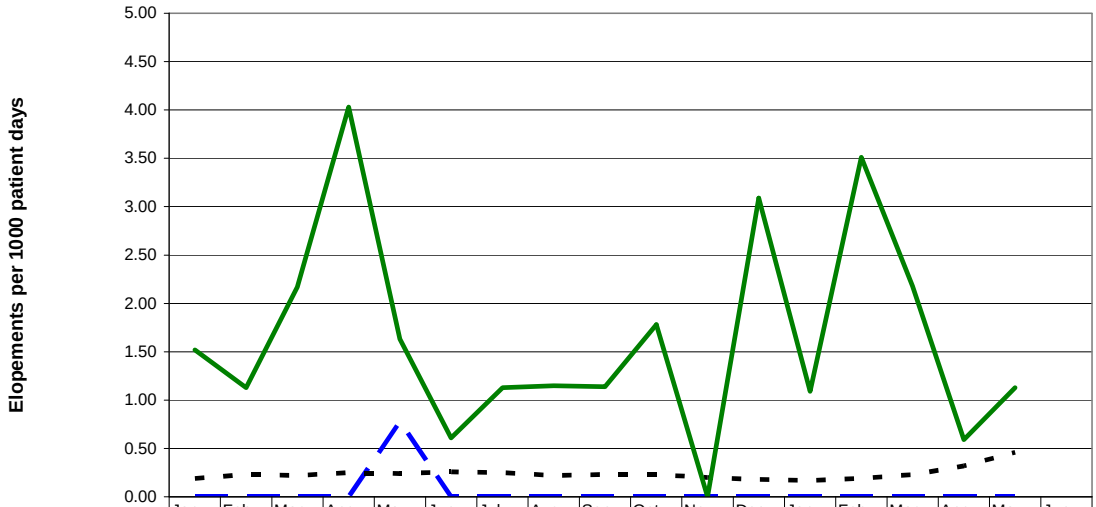
Forensic Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011		
Riverview	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.84	0.00	
Ntl Mean	0.08	0.04	0.05	0.08	0.08	0.06	0.08	0.10	0.10	0.09	0.06	0.05	0.05	0.07	0.06	0.10	0.13	

Elopement

Civil Stratification

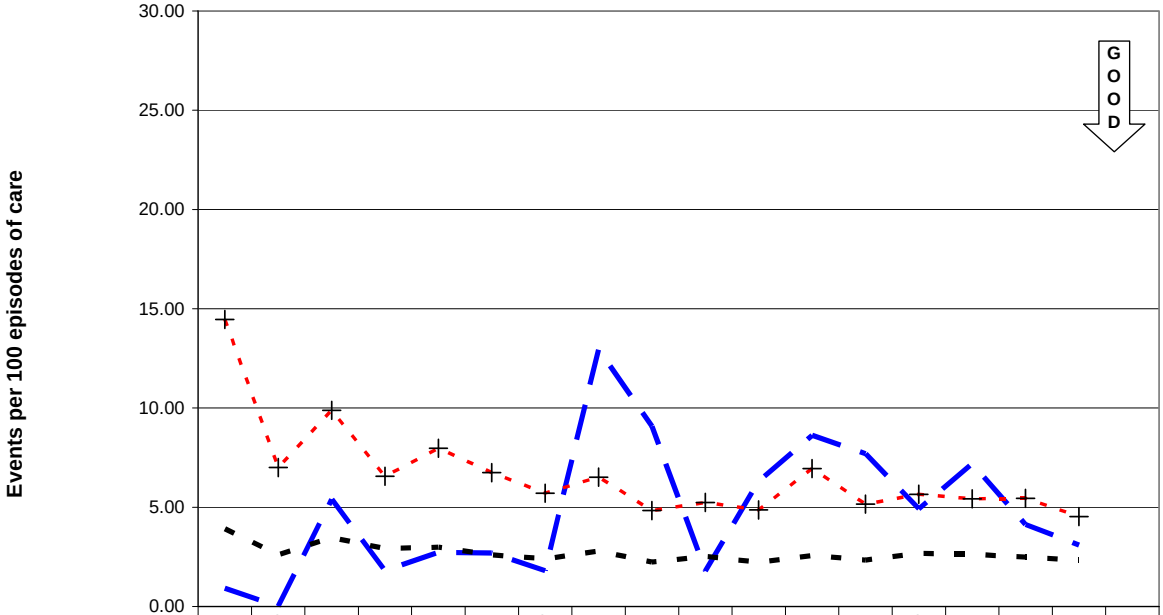


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011		
Riverview	0.00	0.00	0.00	0.00	0.78	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Ntl Mean	0.19	0.23	0.22	0.25	0.24	0.26	0.25	0.22	0.23	0.23	0.20	0.18	0.17	0.19	0.23	0.32	0.46	
Dorothea Dix	1.52	1.13	2.17	4.03	1.63	0.61	1.13	1.15	1.14	1.78	0.00	3.09	1.09	3.51	2.18	0.59	1.13	

This graph depicts 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.

COMPARATIVE STATISTICS

Medication Errors



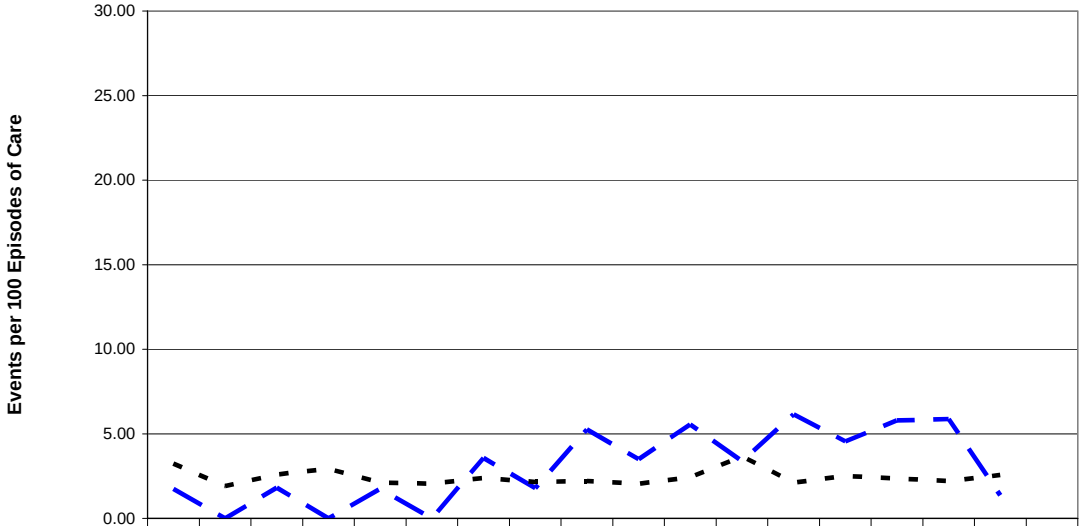
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011		
Riverview	0.92	0.00	5.41	1.80	2.73	2.70	1.80	12.96	9.09	1.79	6.31	8.62	7.69	4.92	7.20	4.13	3.10	
Ntl Mean	3.92	2.60	3.48	2.92	2.99	2.60	2.41	2.79	2.24	2.52	2.23	2.57	2.34	2.68	2.63	2.49	2.33	
Nat Mean +1 StDev	14.46	7.00	9.89	6.56	7.97	6.74	5.71	6.52	4.83	5.25	4.87	6.95	5.16	5.65	5.43	5.45	4.53	

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.

COMPARATIVE STATISTICS

Medication Errors

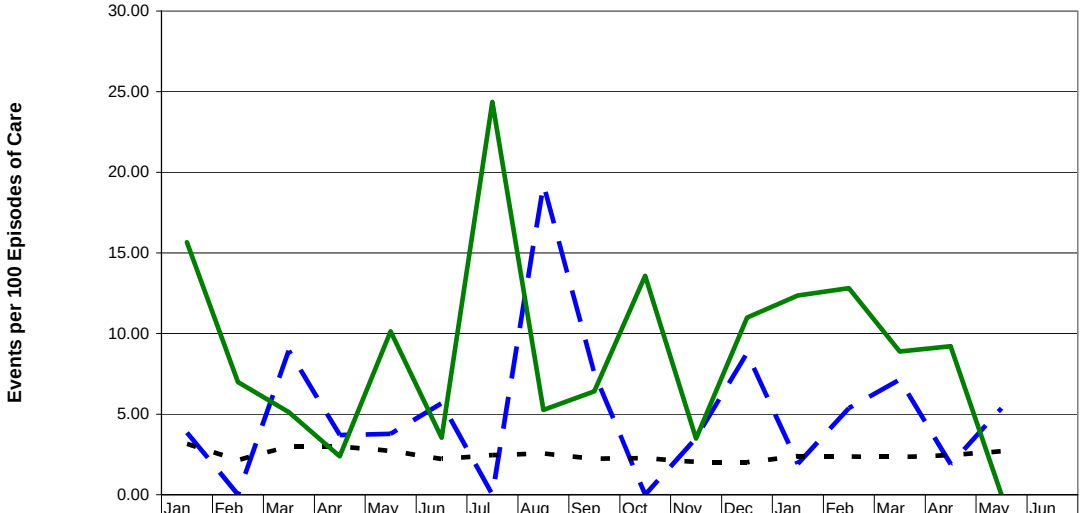
Forensic Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011		
Riverview	1.75	0.00	1.82	0.00	1.75	0.00	3.57	1.79	5.26	3.51	5.56	3.39	6.15	4.55	5.80	5.88	1.37	
Ntl Mean	3.24	1.91	2.60	2.93	2.12	2.06	2.40	2.16	2.22	2.05	2.44	3.66	2.12	2.51	2.36	2.22	2.57	

Medication Errors

Civil Stratification

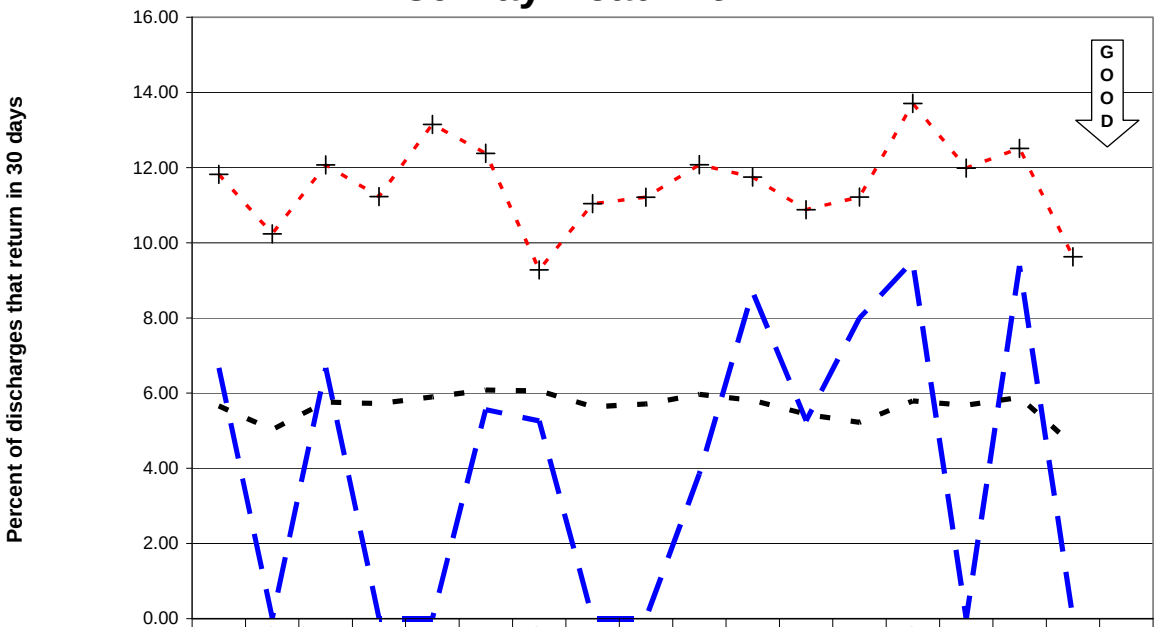


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011		
Riverview	3.85	0.00	8.93	3.70	3.77	5.66	0.00	19.23	7.55	0.00	3.51	8.77	1.92	5.36	7.14	1.89	5.36	
Ntl Mean	3.15	2.14	3.00	2.99	2.72	2.22	2.46	2.56	2.24	2.26	2.03	2.01	2.39	2.37	2.34	2.46	2.69	
Dorothea Dix	15.66	6.98	5.13	2.38	10.13	3.53	24.36	5.26	6.41	13.58	3.49	10.98	12.36	12.82	8.89	9.21	0.00	

This graph depicts the number of medication error events stratified by forensic or civil classifications 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. 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.

COMPARATIVE STATISTICS

30 Day Readmit



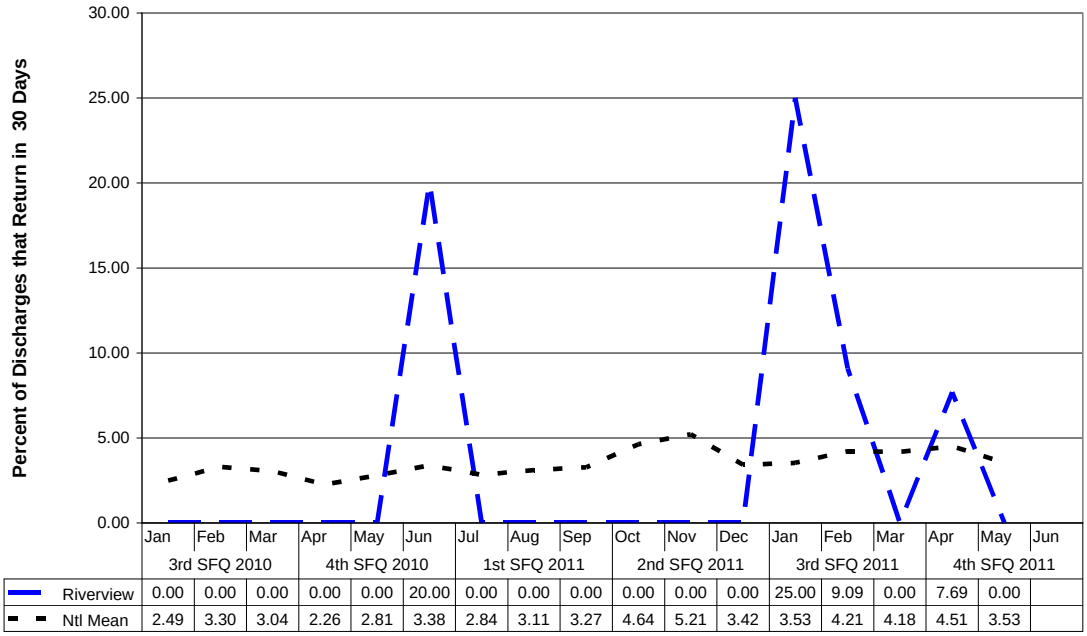
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011		
Riverview	6.67	0.00	6.67	0.00	0.00	5.56	5.26	0.00	0.00	3.85	8.70	5.26	8.00	9.52	0.00	9.38	0.00	
Ntl Mean	5.66	5.03	5.76	5.72	5.90	6.08	6.06	5.64	5.71	5.97	5.81	5.44	5.22	5.79	5.68	5.89	4.62	
Nat Mean +1 StDec	11.82	10.24	12.07	11.23	13.15	12.38	9.28	11.04	11.21	12.08	11.75	10.88	11.22	13.71	11.99	12.51	9.63	

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.

COMPARATIVE STATISTICS

30 Day Readmit

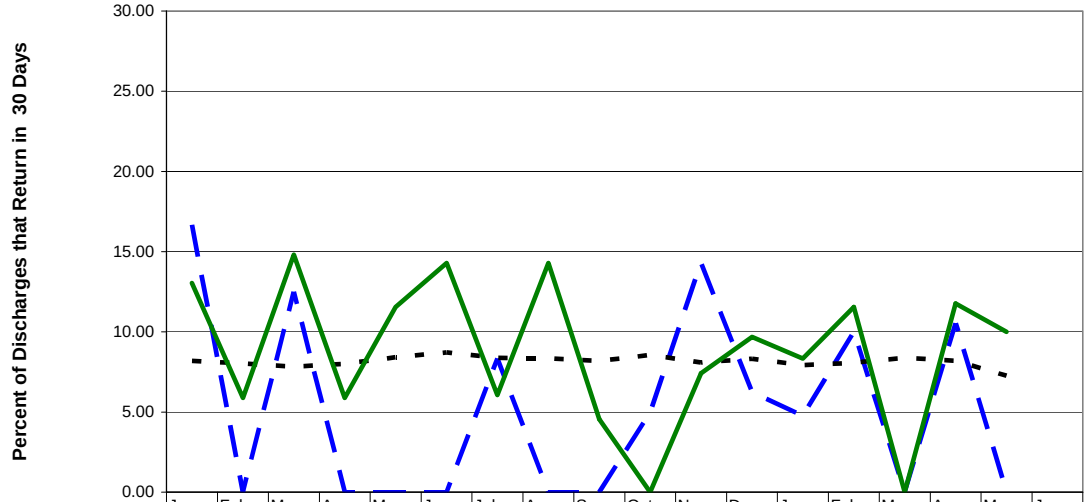
Forensic Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011		
Riverview	0.00	0.00	0.00	0.00	0.00	20.00	0.00	0.00	0.00	0.00	0.00	0.00	25.00	9.09	0.00	7.69	0.00	
Ntl Mean	2.49	3.30	3.04	2.26	2.81	3.38	2.84	3.11	3.27	4.64	5.21	3.42	3.53	4.21	4.18	4.51	3.53	

30 Day Readmit

Civil Stratification

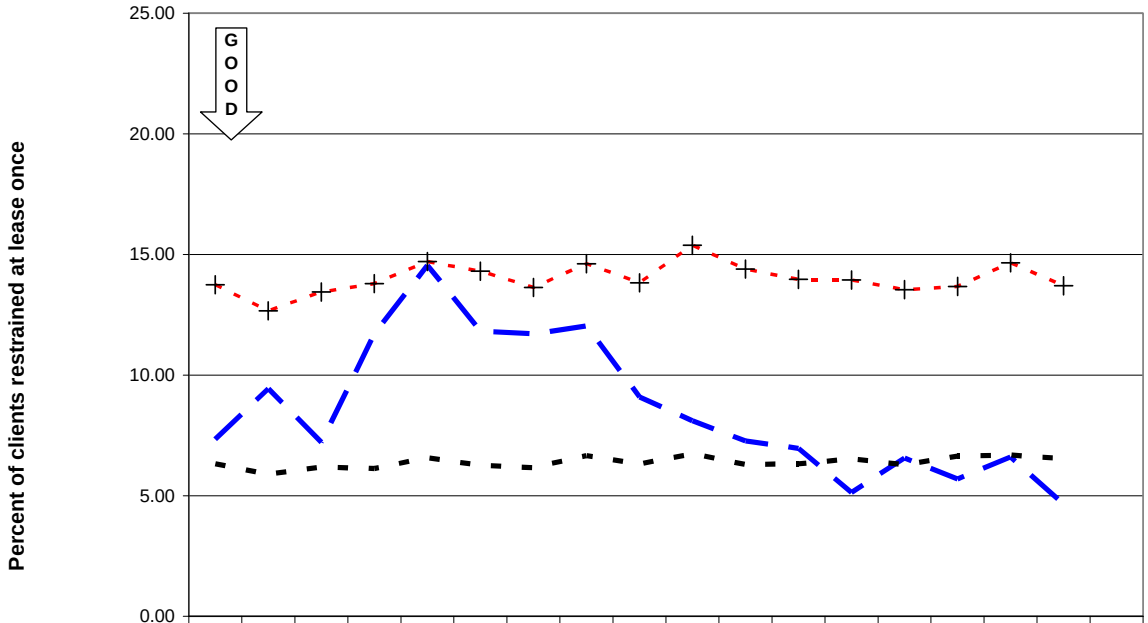


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011		
Riverview	16.67	0.00	12.50	0.00	0.00	0.00	8.33	0.00	0.00	5.00	14.29	6.25	4.76	10.00	0.00	10.53	0.00	
Ntl Mean	8.19	8.03	7.82	8.01	8.41	8.72	8.38	8.34	8.19	8.56	8.09	8.32	7.93	8.07	8.39	8.19	7.26	
Dorothea Dix	13.04	5.88	14.81	5.88	11.54	14.29	6.06	14.29	4.55	0.00	7.41	9.68	8.33	11.54	0.00	11.76	10.00	

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 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.

COMPARATIVE STATISTICS

Percent of Clients Restrained



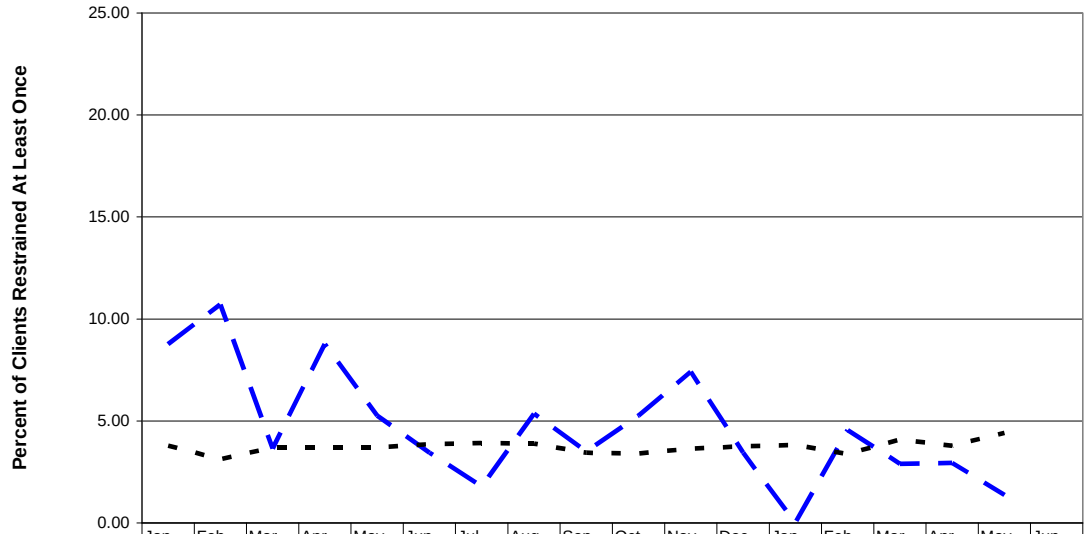
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011		
Riverview	7.34	9.43	7.21	11.71	14.55	11.82	11.71	12.04	9.09	8.11	7.27	6.96	5.13	6.56	5.69	6.61	4.65	
Ntl Mean	6.32	5.90	6.19	6.13	6.57	6.26	6.16	6.66	6.31	6.74	6.30	6.32	6.53	6.29	6.64	6.69	6.54	
Nat Mean +1 St Dev	13.75	12.66	13.45	13.79	14.71	14.31	13.63	14.62	13.83	15.38	14.4	13.97	13.94	13.54	13.68	14.65	13.7	

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.

COMPARATIVE STATISTICS

Percent of Clients Restrained

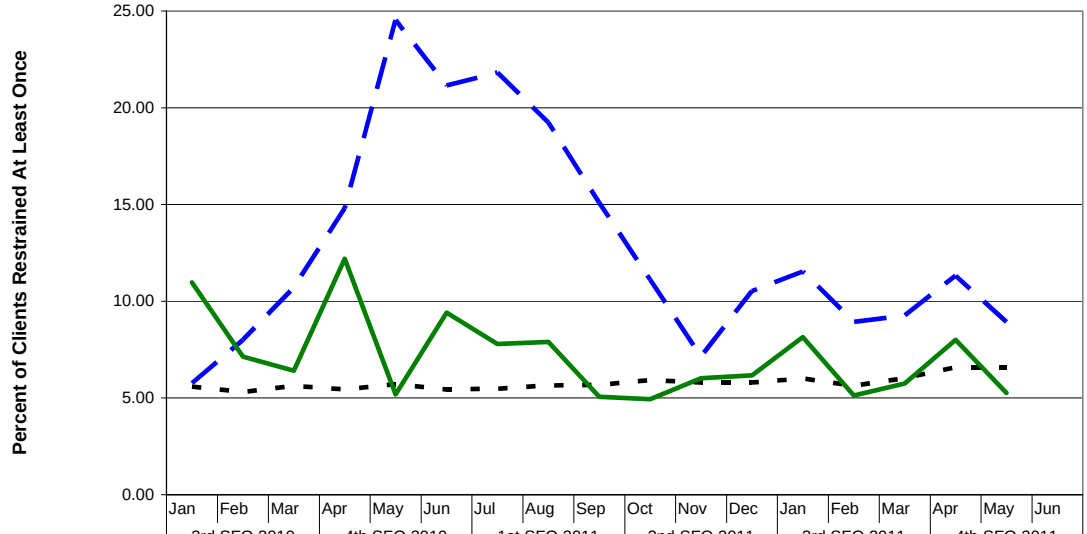
Forensic Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011		
Riverview	8.77	10.71	3.64	8.77	5.26	3.45	1.79	5.36	3.51	5.26	7.41	3.45	0	4.55	2.9	2.94	1.37	
Ntl Mean	3.79	3.12	3.69	3.69	3.7	3.86	3.92	3.89	3.45	3.41	3.64	3.76	3.82	3.38	4.09	3.79	4.41	

Percent of Clients Restrained

Civil Stratification

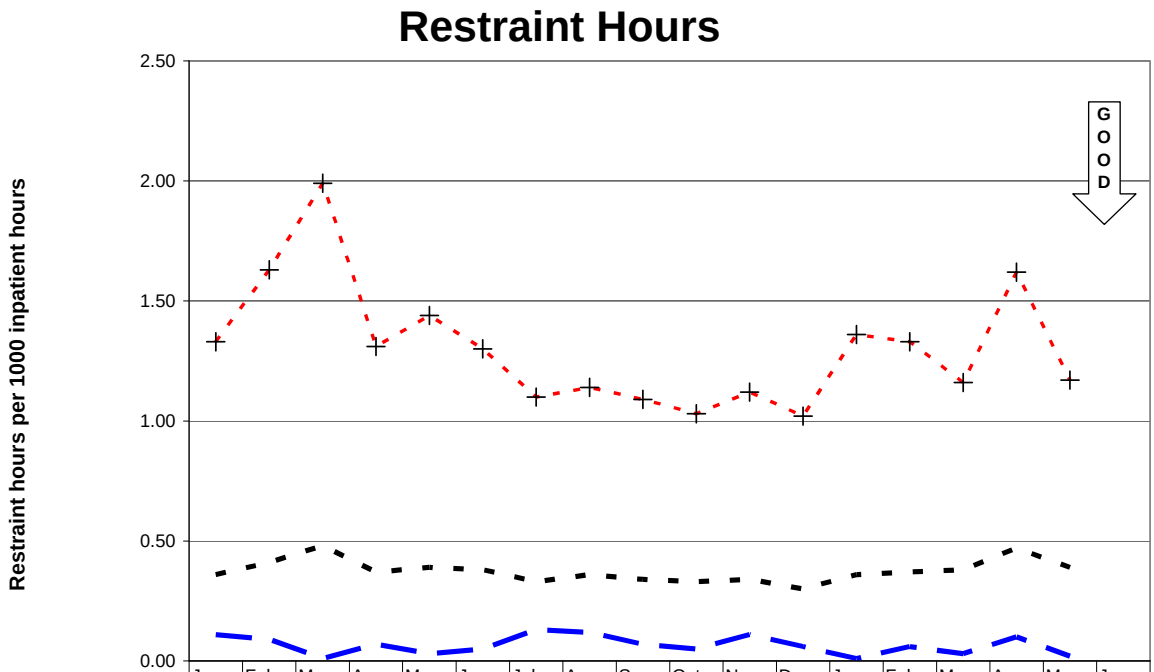


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011		
Riverview	5.77	8.00	10.71	14.81	24.53	21.15	21.82	19.23	15.09	11.11	7.14	10.53	11.54	8.93	9.26	11.32	8.93	
Ntl Mean	5.59	5.31	5.63	5.44	5.72	5.44	5.48	5.65	5.68	5.93	5.8	5.8	6.01	5.64	6.02	6.59	6.6	
Dorothea Dix	10.98	7.14	6.41	12.20	5.19	9.41	7.79	7.89	5.06	4.94	6.02	6.17	8.14	5.13	5.75	8.00	5.26	

This graph depicts 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.

COMPARATIVE STATISTICS

Figure CD-24



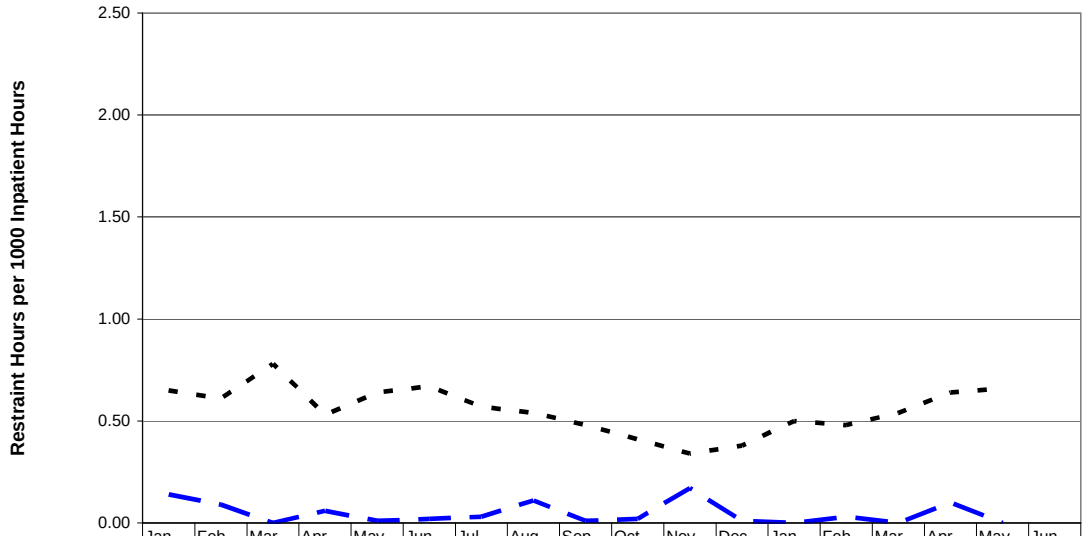
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011		
Riverview	0.11	0.09	0.01	0.07	0.03	0.05	0.13	0.12	0.07	0.05	0.11	0.06	0.01	0.06	0.03	0.10	0.02	
Ntl Mean	0.36	0.41	0.48	0.37	0.39	0.38	0.33	0.36	0.34	0.33	0.34	0.30	0.36	0.37	0.38	0.47	0.39	
Nat Mean +1 StDev	1.33	1.63	1.99	1.31	1.44	1.3	1.1	1.14	1.09	1.03	1.12	1.02	1.36	1.33	1.16	1.62	1.17	

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.

COMPARATIVE STATISTICS

Restraint Hours

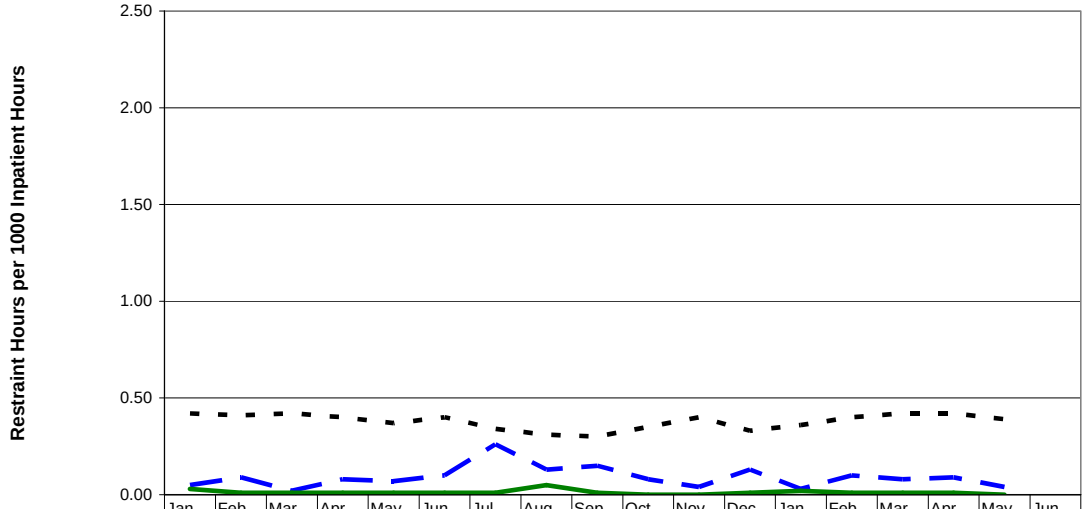
Forensic Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011		
Riverview	0.14	0.09	0.00	0.06	0.01	0.02	0.03	0.11	0.01	0.02	0.17	0.01	0.00	0.03	0.00	0.10	0.00	
Ntl Mean	0.65	0.61	0.78	0.53	0.64	0.67	0.57	0.54	0.48	0.41	0.34	0.38	0.50	0.48	0.54	0.64	0.66	

Restraint Hours

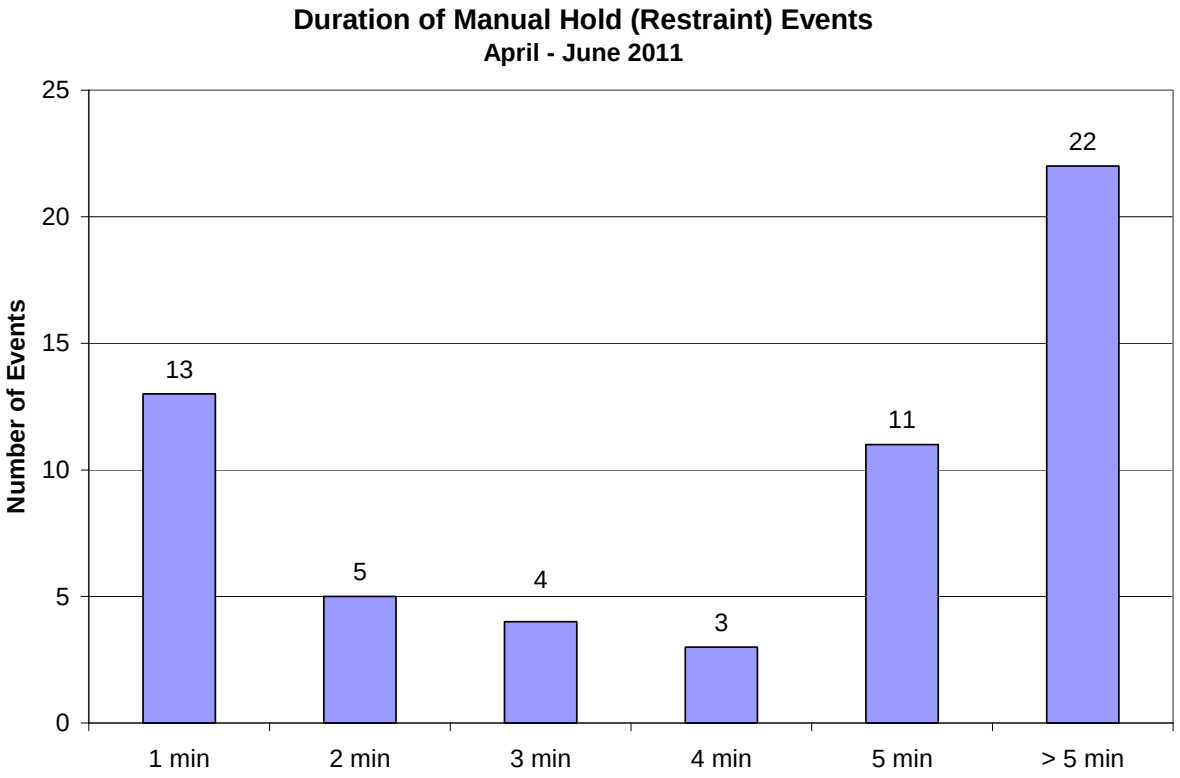
Civil Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011		
Riverview	0.05	0.09	0.02	0.08	0.07	0.10	0.26	0.13	0.15	0.08	0.04	0.13	0.03	0.10	0.08	0.09	0.04	
Ntl Mean	0.42	0.41	0.42	0.40	0.37	0.40	0.34	0.31	0.30	0.35	0.40	0.33	0.36	0.40	0.42	0.42	0.39	
Dorothea Dix	0.03	0.01	0.01	0.01	0.01	0.01	0.01	0.05	0.01	0.00	0.00	0.01	0.02	0.01	0.01	0.01	0.00	

This graph depicts 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.

COMPARATIVE STATISTICS

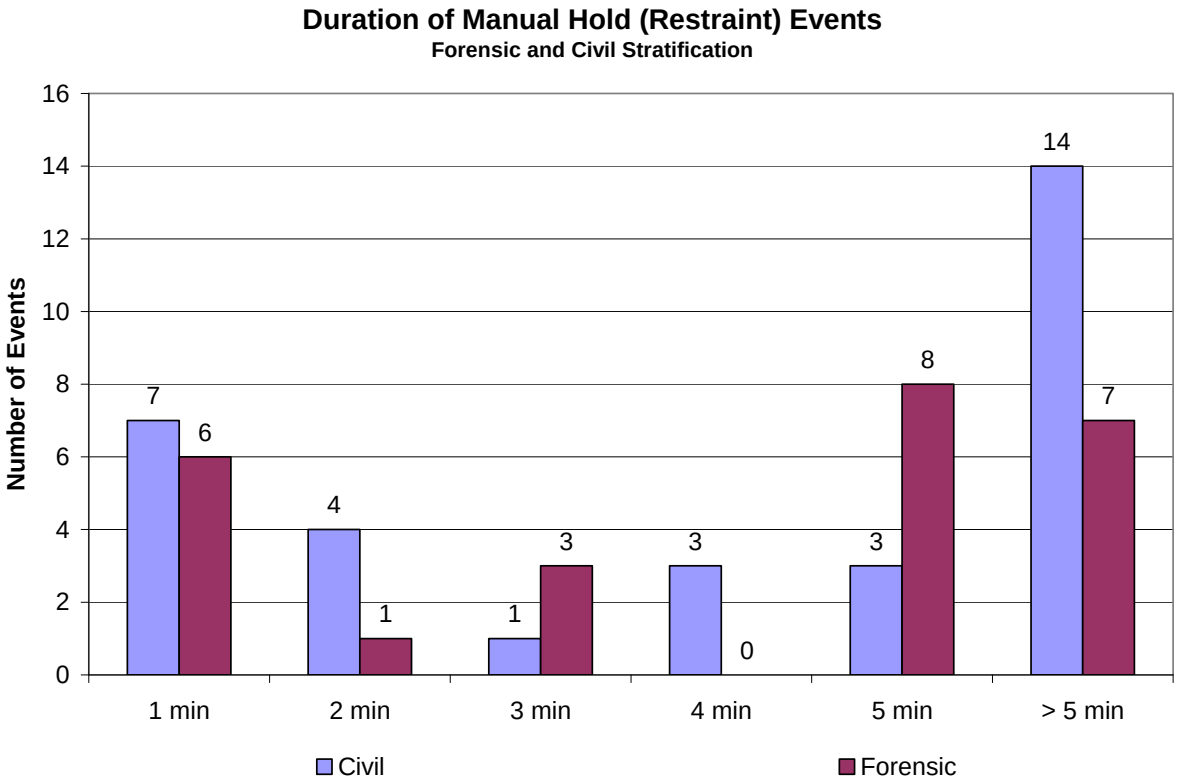


The overall number of manual hold events as well as the number of clients restrained for greater than 5 minutes increased insignificantly during the 4th quarter 2011. The overall increase in the number of manual holds was 9% during the period (from 53 to 58) and the increase in manual holds greater than 5 minutes was 10% (from 20 to 22).

Manual holds greater than 5 minutes most often result from a clinical assessment of the clients acuity and the potential for injury should the patient be left alone and without the control afforded by the manual hold. Those clients with the greatest number of manual holds over five minutes are usually suicidal, exhibit self injurious behaviors, or are highly psychotic and require one on one control that other methods of containment (e.g. seclusion) do not offer.

The decision on how each incident is managed is made on an individualized basis depending on the presentation and needs of the client. Each event is reviewed during the debriefing process and changes in methods of managing the events related to each client are evaluated to determine opportunities for improvement.

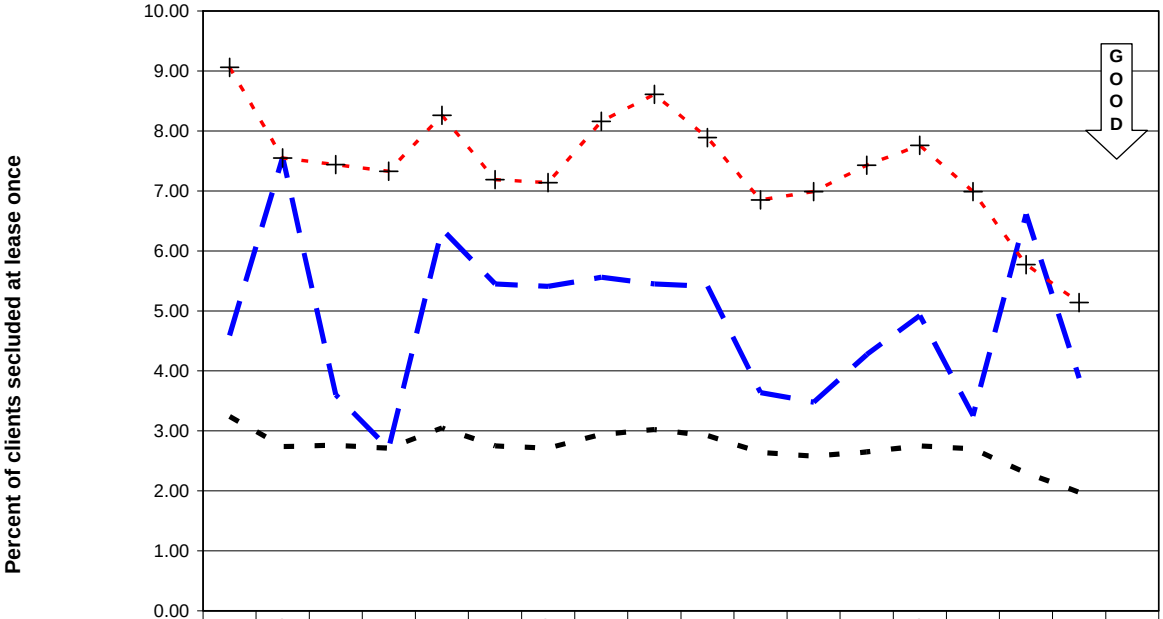
COMPARATIVE STATISTICS



The mix of manual hold incidents in this chart depicts the differentiation between the civil and forensic units.

COMPARATIVE STATISTICS

Percent of Clients Secluded



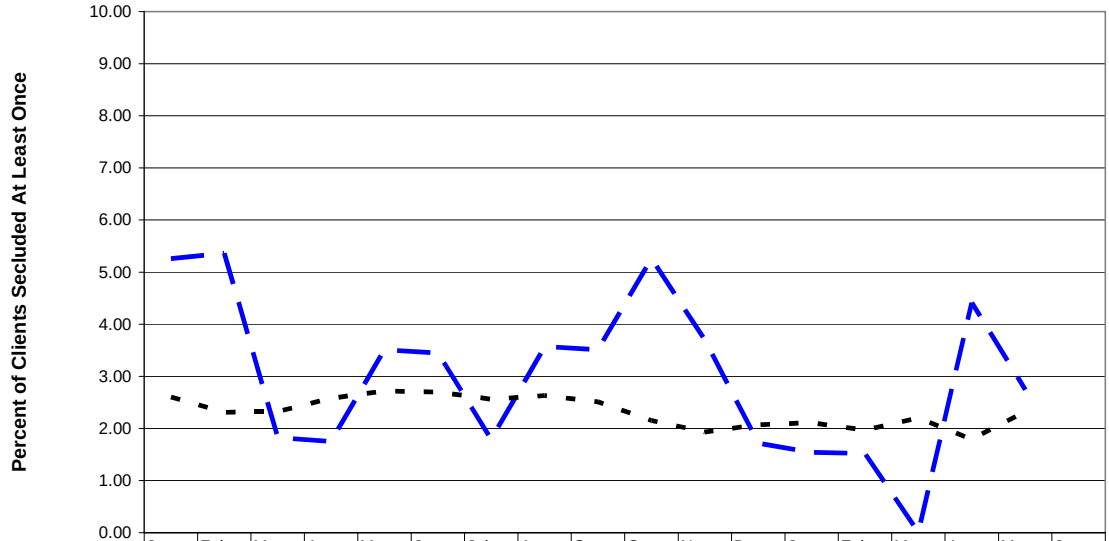
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011		
Riverview	4.59	7.55	3.60	2.70	6.36	5.45	5.41	5.56	5.45	5.41	3.64	3.48	4.27	4.92	3.25	6.61	3.88	
Ntl Mean	3.24	2.74	2.76	2.71	3.05	2.75	2.71	2.94	3.02	2.92	2.64	2.58	2.65	2.75	2.70	2.30	1.98	
Nat Mean +1 St Dev	9.06	7.55	7.44	7.33	8.26	7.19	7.14	8.16	8.61	7.89	6.85	6.99	7.43	7.76	6.99	5.77	5.14	

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.

COMPARATIVE STATISTICS

Percent of Clients Secluded

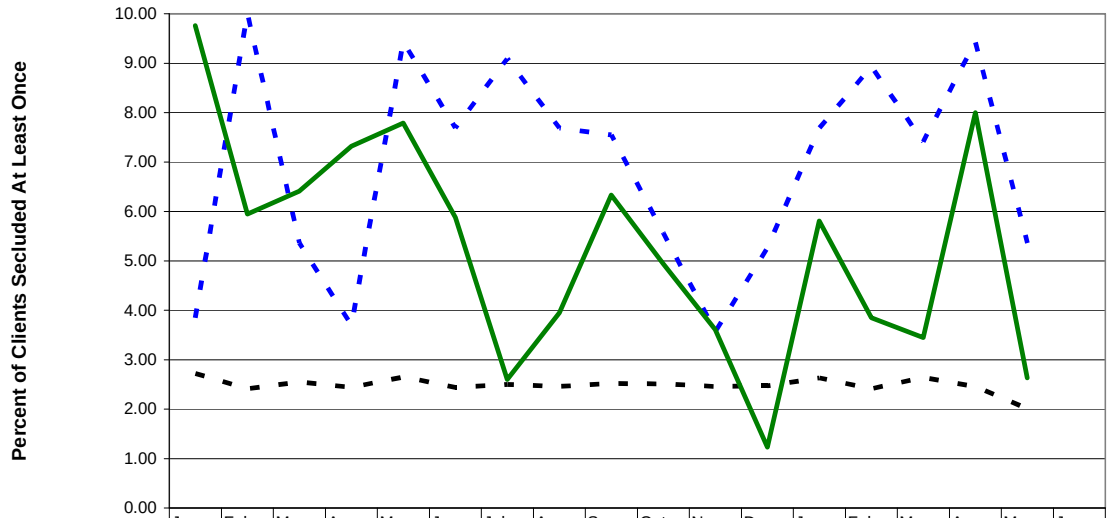
Forensic Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011		
Riverview	5.26	5.36	1.82	1.75	3.51	3.45	1.79	3.57	3.51	5.26	3.70	1.72	1.54	1.52	0.00	4.41	2.74	
Ntl Mean	2.60	2.31	2.32	2.58	2.72	2.70	2.56	2.63	2.51	2.15	1.93	2.07	2.11	1.97	2.20	1.79	2.32	

Percent of Clients Secluded

Civil Stratification

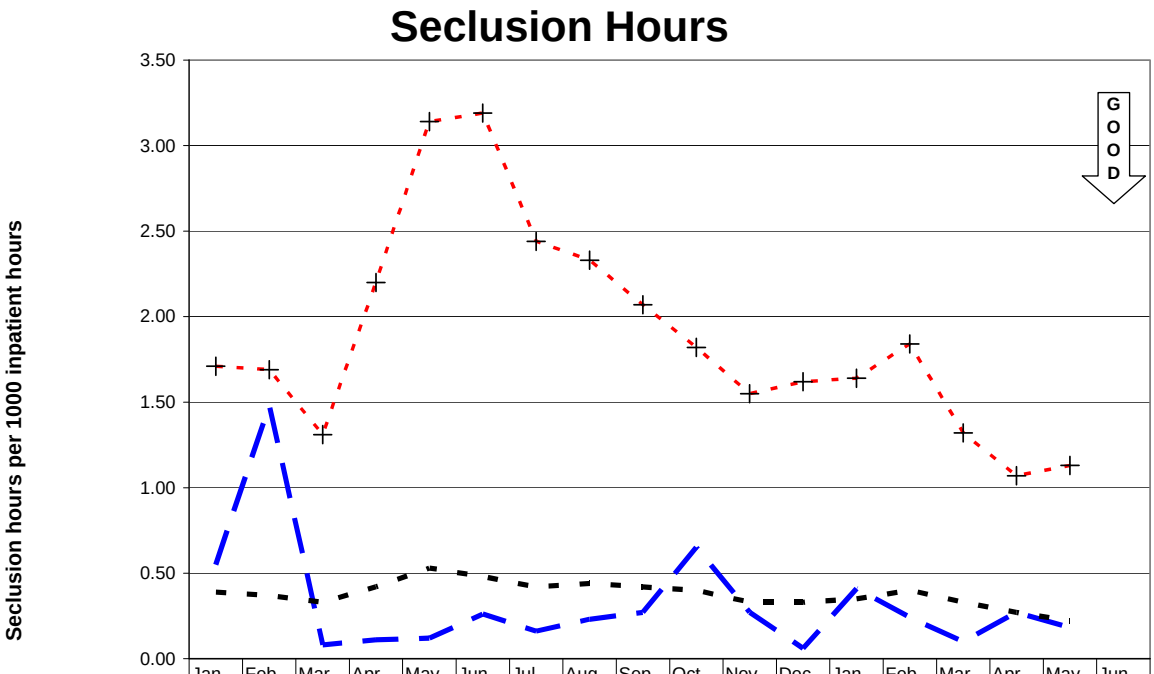


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011		
Riverview	3.85	10.00	5.36	3.70	9.43	7.69	9.09	7.69	7.55	5.56	3.57	5.26	7.69	8.93	7.41	9.43	5.36	
Ntl Mean	2.72	2.41	2.55	2.44	2.65	2.44	2.50	2.46	2.52	2.51	2.46	2.47	2.63	2.41	2.64	2.46	2.01	
Dorothea Dix	9.76	5.95	6.41	7.32	7.79	5.88	2.60	3.95	6.33	4.94	3.61	1.23	5.81	3.85	3.45	8.00	2.63	

This graph depicts 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.

COMPARATIVE STATISTICS

Figure CD-23



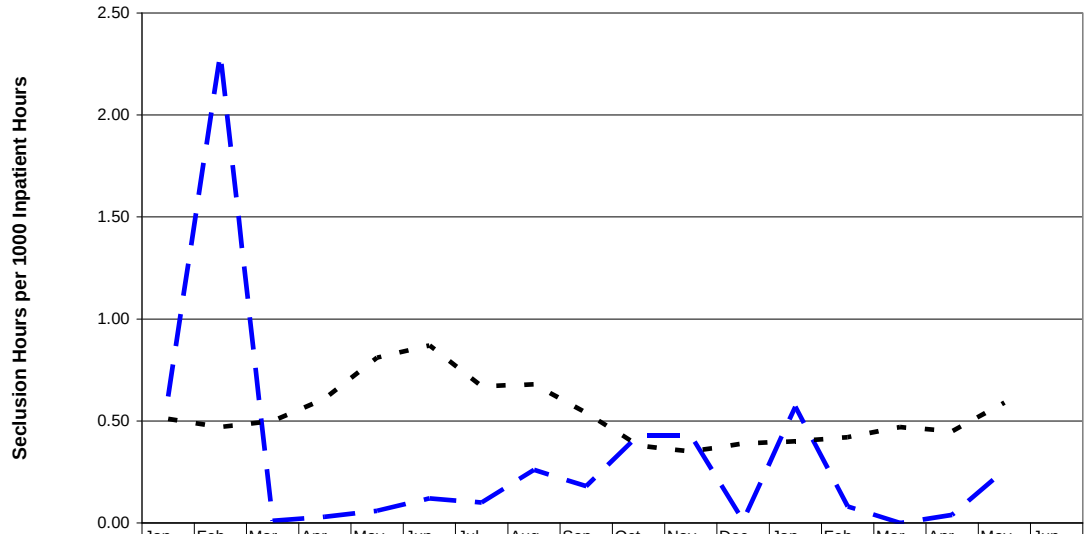
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011		
Riverview	0.55	1.48	0.08	0.11	0.12	0.26	0.16	0.23	0.27	0.65	0.27	0.06	0.41	0.24	0.10	0.27	0.18	
Ntl Mean	0.39	0.37	0.33	0.42	0.53	0.48	0.42	0.44	0.42	0.40	0.33	0.33	0.35	0.40	0.33	0.27	0.22	
Nat Mean +1 StDev	1.71	1.69	1.31	2.2	3.14	3.19	2.44	2.33	2.07	1.82	1.55	1.62	1.64	1.84	1.32	1.07	1.13	

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.

COMPARATIVE STATISTICS

Seclusion Hours

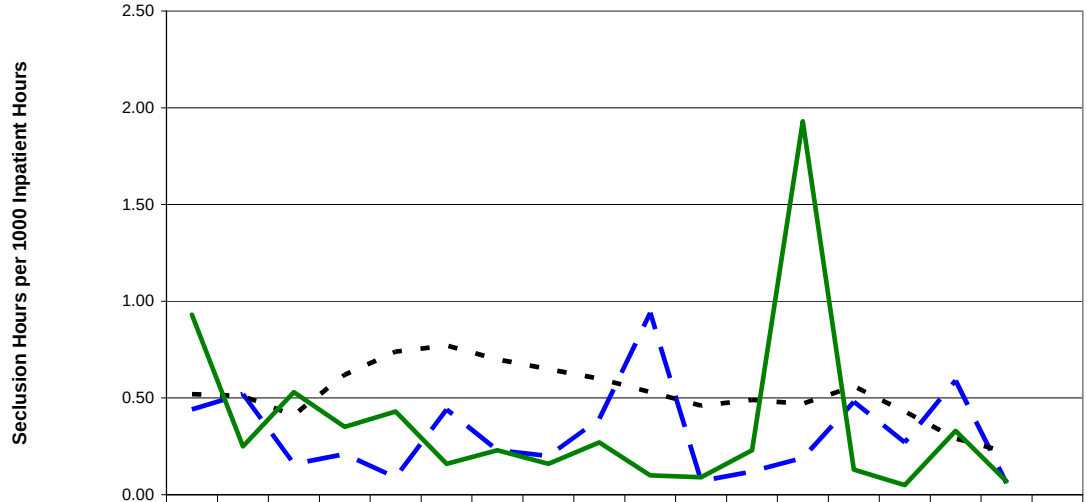
Forensic Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011		
Riverview	0.62	2.30	0.01	0.03	0.06	0.12	0.1	0.26	0.18	0.43	0.43	0.01	0.57	0.08	0	0.04	0.26	
Ntl Mean	0.51	0.47	0.5	0.61	0.81	0.87	0.67	0.68	0.54	0.38	0.35	0.39	0.4	0.42	0.47	0.45	0.59	

Seclusion Hours

Forensic Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011		
Riverview	0.44	0.52	0.16	0.21	0.09	0.44	0.23	0.2	0.39	0.94	0.07	0.12	0.19	0.48	0.27	0.59	0.06	
Ntl Mean	0.52	0.51	0.41	0.62	0.74	0.77	0.7	0.65	0.6	0.53	0.46	0.49	0.47	0.56	0.43	0.29	0.22	
Dorothea Dix	0.93	0.25	0.53	0.35	0.43	0.16	0.23	0.16	0.27	0.10	0.09	0.23	1.93	0.13	0.05	0.33	0.07	

This graph depicts 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.

COMPARATIVE STATISTICS

Confinement Event Breakdown

	Manual Hold	Mechanical Restraint	Locked Seclusion	Open Seclusion	Grand Total	% of Total	Cumulative %
FR0000284430	19		33		52	45%	45%
FR0000250266	13		3		16	14%	59%
FR0000291906	3		4		7	6%	65%
FR0000278119	3		2		5	4%	70%
FR0000269597	1		2		3	3%	72%
FR0000261594	1		3		4	3%	76%
FR0000266668	2				2	2%	77%
FR0000265736	1		1		2	2%	79%
FR0000274597	1	1	1		3	3%	82%
FR0000276436			2		2	2%	83%
FR0000285262	2				2	2%	85%
FR0000287797	1		1		2	2%	87%
FR0000084616	1				1	1%	88%
FR0000253377	2				2	2%	90%
FR0000273532	1		1		2	2%	91%
FR0000275370			1		1	1%	92%
FR0000277319	1		1		2	2%	94%
FR0000284901	1				1	1%	95%
FR0000289603	1		1		2	2%	97%
FR0000279315	1				1	1%	97%
FR0000281485	1				1	1%	98%
FR0000285866	1				1	1%	99%
FR0000273516	1				1	1%	100%

27% (23/84) of average hospital population experienced some form of confinement event during the 4th fiscal quarter 2011. Eleven of these clients (13% of the average hospital population) accounted for 85% of the containment events.

Confinement Events by Time of Day

	0000-0359	0400-0759	0800-1159	1200-1559	1600-1959	2000-2359
FR0000284430	4	4	22	8	14	
FR0000250266	3	4	3	2		4
FR0000291906	1			3	2	1
FR0000278119			2	1	2	
FR0000261594			2		2	
FR0000269597			2			1
FR0000274597				2	1	
FR0000253377	1					1
FR0000265736					2	
FR0000266668				1	1	
FR0000273532					2	
FR0000276436				1		1
FR0000277319				2		
FR0000285262			1			1
FR0000287797						2
FR0000289603			2			
FR0000084616				1		
FR0000273516						1
FR0000275370						1
FR0000279315			1			
FR0000281485				1		
FR0000284901				1		
FR0000285866			1			

COMPARATIVE STATISTICS

Figure CD-25, CD-26

Factors of Causation Related to All Confinement Events

(Manual Hold, Mechanical Restraint, Seclusion)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Danger to Others/Self	6	18	6	5	2	1	15	33	27	27	17	57
Danger to Others	8	11	7	3	5	6	4	1		5	1	7
Danger to Self	3	1	3	4	1	2		1		1		
% Dangerous Precipitation	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total Events	17	30	16	12	8	9	19	35	27	33	18	64

COMPARATIVE STATISTICS

Figure CD-42

Confinement Events Management

Seclusion Events (56) Events

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 record reflects that lesser restrictive alternatives were inappropriate or ineffective. This can be reflected anywhere in record.	90%	100%
The record reflects that the decision to place the patient in seclusion was made by a physician or physician extender.	90%	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, 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%
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 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%
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%
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 the 2 hour re-evaluation was conducted while the patient was out of seclusion room unless clinically contraindicated.	70%	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 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%
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 medical order for seclusion 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

COMPARATIVE STATISTICS

Figure CD-43

Confinement Events Management

Mechanical Restraint Events (1) 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%
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%

COMPARATIVE STATISTICS

Medication Administration during Behavioral Events

	Jan	Feb	Mar	Apr	May	Jun	Total
COURTN		3		1		2	6
COURTY					1		1
GUARDN	2	6	9	12	2	1	32
GUARDY		7	11	7	4	1	30
PEMEDSN	1	4	1	3	1	8	18
PEMEDSY	1	2	5	6	5	13	32
PRNY	10	14	11	11	12	31	89
Total Meds Admin	14	36	37	40	25	56	208
Percent Unwilling	21.43%	35.22%	27.03%	40.00%	12.00%	19.64%	26.92%

4th SFQ 2011	Abuse	Elopement	Manual Hold	Patient Incident	Patient Injury	Mechanical Restraint	Locked Seclusion
COURTN			2	1			
COURTY				1			
GUARDN			9	4		2	
GUARDY			5	6		1	
PEMEDSN			4	3		5	
PEMEDSY			1	14		9	
PRNY	1	1	6	28	2	16	1
Total	1	1	27	57	2	33	1

The high incidence of co-occurring manual holds and medication administrations, especially those that were given unwillingly, may have resulted from the need to temporarily secure the client and protect their safety during the administration of an intramuscular injection of ordered medication.

4th SFQ 2011	COURTN	GUARDN	PEMEDSN	TOTAL
FR0000250266		11		11
FR0000291906			4	4
FR0000253377		2		2
FR0000265736			1	1
FR0000266668		1		1
FR0000269597			1	1
FR0000273516	1			1
FR0000274597			1	1
FR0000277319		1		1
FR0000279315			1	1
FR0000281485			1	1
FR0000284430			1	1
FR0000285262	1			1
FR0000285866	1			1
FR0000287797			1	1
FR0000289603			1	1
Total	3	15	12	30

Average daily census for the period was 84 clients per day. The number of clients that received medication unwillingly was 19% of the average client census. All unwilling administrations of medications were supported by a court order, a guardian order, or the declaration of a psychiatric emergency.

COURTN = Court ordered medication administration, client unwilling
COURTY = Court ordered medication administration, client willing
GUARDN = Guardian permission for medication administration, client unwilling
GUARDY = Guarding permission for medication administration, client willing
PEMEDSN = Psychiatric Emergency declared, client unwilling
PEMEDSY = Psychiatric Emergency declared, client willing
PRNY = PRN medications offered, client willing

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DIETARY

ASPECT: CLEANLINESS OF MAIN KITCHEN

Indicators	Quarterly % Compliance						Threshold Percentile
	April 2011-June 2011	Jan. '11-Mar. '11	Oct. '10-Dec. '10	Jul. '10-Sep. '10	Apr. '10-Jun. '10	Jan. '10-Mar. '10	
1. All convection ovens (4) were thoroughly cleaned monthly.	100% (12 of 12)	100% (12 of 12)	75% (9 of 12)	92% (11 of 12)	83% (10 of 12)	92% (11 of 12)	100%
2. Dish machine was de-limed monthly	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100%
3. Shelves (6) used for storage of clean pots and pans were cleaned monthly	100% (9 of 9)	100% (18 of 18)	100% (18 of 18)	100% (18 of 18)	100% (18 of 18)	89% (16 of 18)	100%
4. Knife cabinet was thoroughly cleaned monthly	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100%
5. Walk in coolers were cleaned thoroughly monthly.	100% (6 of 6)	100% (6 of 6)	100% (6 of 6)	100% (6 of 6)	100% (6 of 6)	100% (6 of 6)	100%
6. Steam kettles (2) were cleaned thoroughly on a weekly basis	100% (26 of 26)	100% (26 of 26)	69% (18 of 26)	93% (26 of 28)	93% (26 of 28)	79% (19 of 24)	95%
7. All trash cans (4) and bins (1) were cleaned daily	97% (530 of 546)	89% (401 of 450)	98.9% (455 of 460)	97% (445 of 460)	85% (462 of 546)	63% (341 of 540)	95%
8. All carts(9) used for food transport (tiered) were cleaned daily	99.4% (814 of 819)	97.7% (792 of 810)	98% (812 of 828)	98% (811 of 828)	97% (794 of 819)	85% (686 of 810)	100%
9. All hand sinks (4) were cleaned daily	100% (364 of364)	100% (360 of 360)	95.6% (352 of 368)	98% (360 of 368)	92% (794 of 819)	84% (304 of 360)	95%
10. Racks(3) used for drying dishes were cleaned daily	98.9% (270 of 273)	98.8% (267 of 270)	99% (273 of 276)	99% (273 of 276)	81% 222 of 273	77% (207 of 270)	100%

Summary

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

- The improvement seen in the cleaning of the trash cans and bins is due to employee compliance

DIETARY

- and comprehension of the task..
- Cleaning the food transport carts and cleaning the racks used for drying dishes improved slightly to 98.9%

Overall Compliance: 98.8%

Actions

- FSM reviews all cleaning schedules on a daily basis to assure staff completion.
- Cleaning schedules are modified to reflect changes in staff availability.
- Weekly staff meetings include review of the past weeks completion rates.
- Results of this CPI indicator will be discussed with staff.
- The department will be fully staffed as of August 2011.

ASPECT: TIMELINESS OF NUTRITIONAL ASSESSMENT

Indicator	Quarterly % Compliance						Threshold Percentile
	April 2011-June 2011	Jan. '11-Mar. '11	Oct. '10-Dec. '10	Jul. '10-Sep. '10			
A nutrition assessment is completed within 5 days of admission when risk is identified via the nutrition	100% (76 of 76)	100% (75 of 75)	97.4% (74 of 76)	100% (59 of 59) (New Indicator)			100%

Summary

All assessments completed within 5 days of admission.

Overall Compliance: 100%

Actions

- The nutrition screen, which is part of the Initial Nursing Assessment and Admission Data, will be completed by nursing within 24 hours of admission.
- The Dietitian reviews the nutrition screening to determine whether the client is at nutrition risk.
- Nursing will contact the Dietary Department at 287-7248 if an Urgent consult is required. Dietary staff will then contact the Registered Dietitian/Dietetic Technician Registered. This includes weekends and holidays. The RD/DTR will respond by telephone or with an on-site follow-up as deemed appropriate within 24 hours. Nursing must document in the progress notes any recommendations made by the RD/DTR.

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HARBOR TREATMENT MALL

Aspect: Harbor Mall Hand-off Communication

Indicators	Findings	Compliance	Threshold Percentile
1. Hand-off communication sheet was received at the Harbor Mall within the designated time frame.	26 of 42	62%	100%
2. RN signature/Harbor Mall staff signatures present.	42 of 42	100%	100%
3. SBAR information completed from the units to the Harbor Mall.	23 of 42	55%	100%
4. SBAR information completed from the Harbor Mall to the receiving unit.	30 of 42	71%	100%

Summary

This is the second quarterly report for this year. All units were made aware of the criteria that would be monitored in order to ensure that the hand-off communication process for the Harbor Mall is being done properly. Indicators number one and two remain the same as the first quarter, indicator number three increased from 52% to 55% and indicator number four increased from 55% to 71% from the first quarter.

Indicator #1-Sixteen of the hand-off communication sheets did not arrive to the Harbor Mall within the allotted time frame. The sheet is to be brought to the mall no later than 5 minutes before the start of groups and this did not happen on sixteen of the sheets that were reviewed for this quarter. The PSD for the mall will remind each of the units what the protocol is for the hand-off sheet to ensure that the information reaches the mall in time to be relayed to group leaders.

Indicator #2- All hand-off communication sheets were received with RN signatures and signed off as received by the Harbor Mall. No issues at this time.

Indicator #3- Nineteen out of the 42 sheets reviewed did not have any client concerns or comments from the unit(s) written for the Harbor Mall and/or did not state no issues to report on the HOC. PSD for the Harbor Mall will review the need for accuracy in completing the HOC sheet with each of the units.

Indicator #4 – Twelve out of the 42 sheets reviewed did not have any client concerns or comments from the Harbor Mall back to the units and/or did not state know issues to report on the HOC sheet. PSD will remind Harbor Mall staff to complete issues/concerns section.

Actions

The PSD will continue to randomly audit all the hand-off communication sheets received from the units. Any patterns from one particular unit will be reported to that unit's PSD in order to ensure accurate and timely communication between the two areas.

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HEALTH INFORMATION MANAGEMENT

ASPECT: DOCUMENTATION & TIMELINESS

Indicators	Findings	4th Qtr 2011	3rd Qtr 2011	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	There were 67 discharges in the 4th quarter 2011. Of those, 53 were completed by 30 days.	79 %	49 %	80%
Discharge summaries will be completed within 15 days of discharge.	67 out of 67 discharge summaries were completed within 15 days of discharge during the 4th quarter 2011.	100 %	100 %	100%
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	1 forms was approved/ revised in the 4th quarter 2011 (see minutes).	100%	100%	100%
Medical transcription will be timely and accurate.	Out of 1310 dictated reports, 1121 were completed within 24 hours.	86%	84%	90%

Summary

The indicators are based on the review of all discharged records. There was 79% compliance with record completion. There was 100% compliance with discharge summary completion. Weekly “charts needing attention” lists are distributed to medical staff, including the Medical Director, along with the Superintendent, Risk Manager and the Quality Improvement Manager. There was 86% compliance with timely & accurate medical transcription services.

Actions

Continue to monitor the compliance rate of each measure and work closely with the Medical Director to identify barriers to on-time completion of medical records according to the prescribed timeline.

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HEALTH INFORMATION MANAGEMENT

ASPECT: CONFIDENTIALITY

Indicators	Findings	Compliance	Threshold Percentile
All client information released from the Health Information department will meet all Joint Commission, State, Federal & HIPAA standards.	3501 requests for information (128 requests for client information and 3373 police checks) were released for the 4th quarter 2011.	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	16 new employees/contract staff in the 4th quarter 2011.	100%	100%
Confidentiality/Privacy issues tracked through incident reports.	1 privacy-related incident reports during the 4th quarter 2011.	100%	100%

Summary

The indicators are based on the review of all requests for information, orientation for all new employees/contract staff and confidentiality/privacy-related incident reports. There was 1 confidentiality/privacy-related incident report in 4th quarter 2011. This was an external breach of confidentiality. To date, we have been unable to determine the source of the breach, however, the fact-finding is ongoing.

No problems were found in 4th quarter 2011 related to release of information from the Health Information department and training of new employees/contract staff, however compliance with current law and HIPAA regulations need to be strictly adhered to requiring training, education and policy development at all levels.

Actions

The above indicators will continue to be monitored.

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HOUSEKEEPING

ASPECT: LINEN CLEANLINESS AND QUALITY

Indicators	Quarterly % Compliance						Threshold Percentile
	Apr. '11-Jun. '11	Jan. '11-Mar. '11	Oct. '10-Dec. '10	Jul. '10-Sep. '10	Apr. '10-Jun. '10	Jan. '10-Mar. '10	
1. Was linen clean coming back from vendor?	98% (45 of 46)	100% (34 of 34)	100% (53 of 53)	96% (23 of 24)	100% (37 of 37)	100% (32 of 32)	100%
2. Was linen free of any holes or rips coming back from vendor?	98% (45 of 46)	92% (31 of 34)	100% (53 of 53)	92% (22 of 24)	81% (30 of 37)	97% (31 of 32)	95%
3. Did we have enough linen on units via complaints from unit staff?	98% (45 of 46)	88% (30 of 34)	96% (51of 53)	92% (22 of 24)	97% (36 of 37)	94% (30 of 32)	90%
4. Was linen covered on units?	100% (46 of 46)	97% (33 of 34)	100% (53 of 53)	100% (24 of 24)	100% (37 of 37)	88% (28 of 32)	95%
5. Did vendor provide a 24 hr. turn around service as specified in the contract?	96% (44 of 46)	97% (33 of 34)	96% (51 of 53)	79% (19 of 24)	95% (35 of 37)	94% (30 of 32)	100%
6. Did we receive an adequate supply of mops and rags from vendor?	98% (45 of 46)	97% (33 of 34)	100% (53 of 53)	100% (24 of 24)	100% (37 of 37)	97% (31 of 32)	95%
7. Was linen bins clean returning from vendor?	87% (40 of 46)	100% (34 of 34)	100% (53 of 53)	100% (24 of 24)	97% (36 of 37)	100% (32 of 32)	100%
8. Was the linen manifest accurate from the vendor	89% (41 of 46)	88% (30 of 34)	96% (51 of 53)	31% (5 of 16) (New)			85%

Summary

Eight different criteria are to be met for acceptability. The indicators are based on the inspections of linen closets throughout the facility including the returned linen from the vendor. All linen types were reviewed randomly this quarter. All indicators are within threshold percentiles except for indicators #1, #5, & #7.
The overall compliance for this quarter was 95.5%. This is shows a .5% increase from last quarters' report.

1. (Indicator #1) inadequate supply of linen (blankets) were not coming back from vendor
2. Linen coming back from the vendor was not delivered to Riverview in a timely fashion (2 occurrences) (indicator # 5).

HOUSEKEEPING

3. Linen bins that were returned from vendor with clean linens were found to be dirty (Indicator #

Overall Compliance: 95.5%

Actions

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

- ✓ Housekeeping Supervisor will monitor how many blankets are being sent out to be cleaned and how many return from vendor.
- ✓ Housekeeping Supervisor contacted the linen vendor and advised them of the problems with dirty linen bins returning from their facility.
- ✓ Communicate to all Housekeeping staff to be aware of the status of this indicator.
- ✓ Housekeeping staff member will continue to document all information regarding to inventory and manifest statistics from the vendor.
- ✓ Housekeeping Supervisor will monitor the timeliness of linen deliveries.
- ✓ Housekeeping Supervisor will schedule a visit to the linen cleaning facility to see how the linen processing is done.

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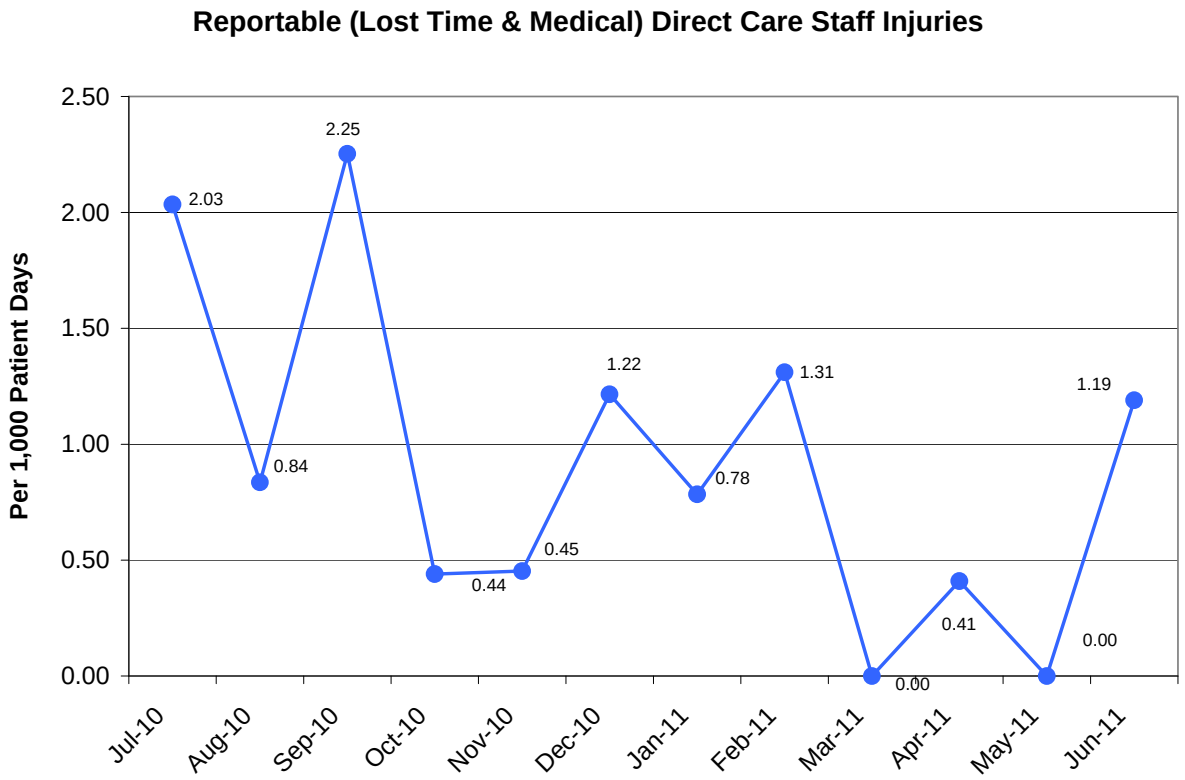
HUMAN RESOURCES

ASPECT: DIRECT CARE STAFF INJURIES



Summary

The trend for reportable injuries sustained by direct care staff increased during the month of June.

The greatest percentage of injuries with direct care staff tend to be related to client to staff interactions. Current work on developing tools to reduce the incidence of physical interaction between clients and staff through heightened awareness of client's triggers and coping mechanisms appear to be having an impact on the frequency of client to staff physical interactions. Any reduction in the number of these interactions may also impact the number of both client and staff injuries that may result from these interactions.

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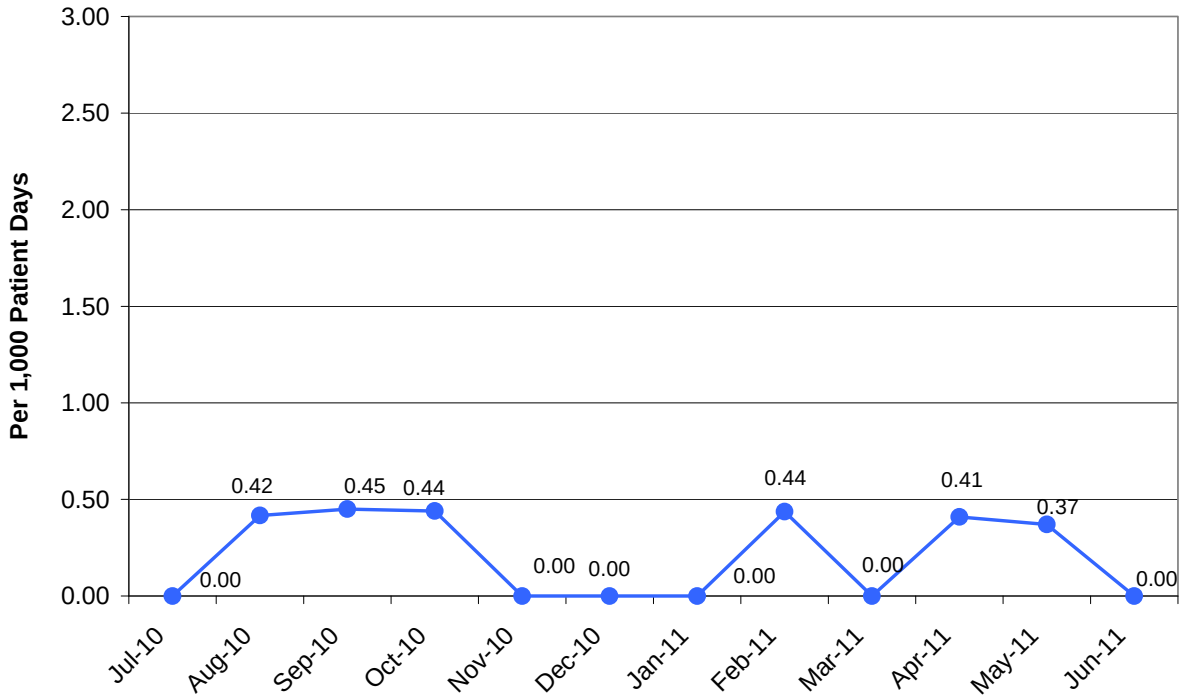
HUMAN RESOURCES

ASPECT: NON-DIRECT CARE STAFF INJURIES

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



Summary

The average percent of non-direct care staff who sought medical attention or lost time from work remains low. The annual trend shows a steady yet low rate of injury. As with the incidence of direct care staff injuries, close monitoring of surrounding events and activities is being conducted to determine correlations between injury rates and work activities.

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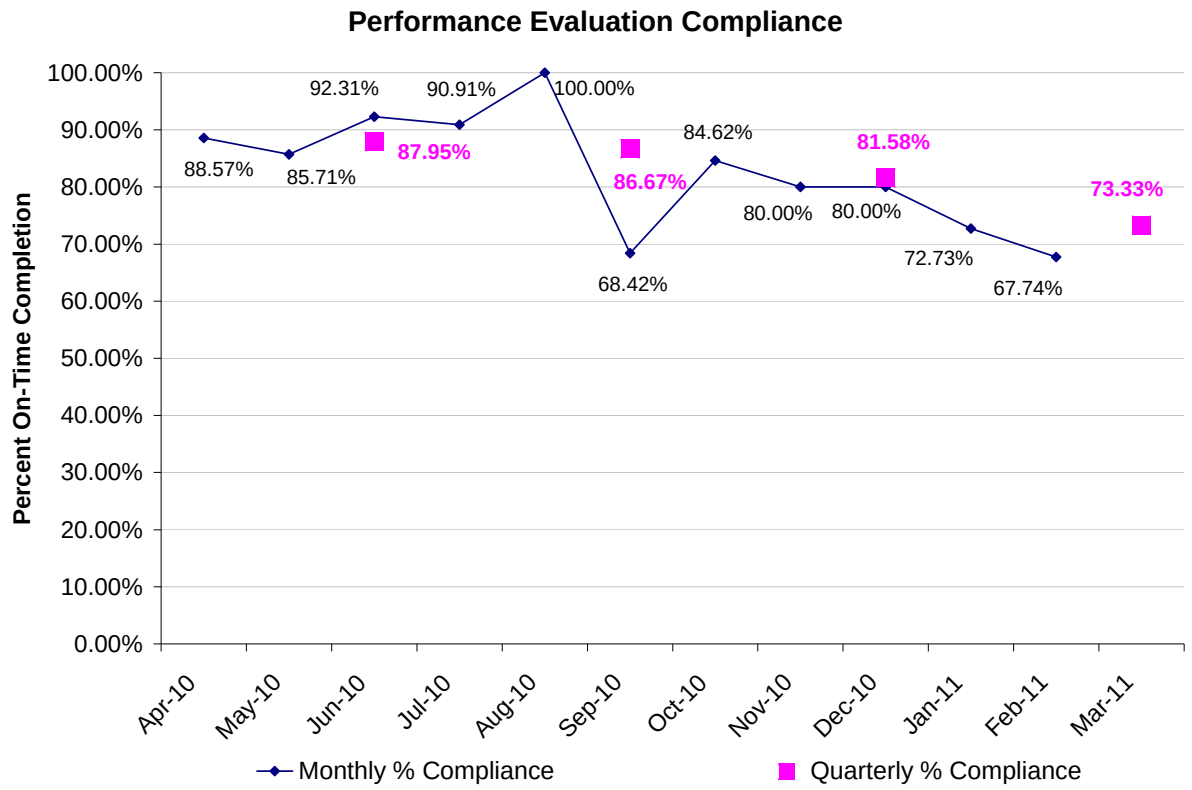
HUMAN RESOURCES

ASPECT: PERFORMANCE EVALUATIONS COMPLETION

Completion of performance evaluations within 30 days of the due date.



Summary

This quarter has shown some difficulties in maintaining a high degree of completion of performance evaluations.

Cumulative results from this quarter (73.33%) are below the planned performance threshold of 85%. The monthly results for compliance are also all below the planned performance threshold. These results are beginning to show a trend lower than planned performance as six data points are below the threshold level. Ongoing measurement of performance is indicated for the remainder of the calendar year. Ongoing efforts to insure on time completion of performance evaluations by unit managers will continue in order to achieve the highest possible rate of on-time performance and to maintain a sustainable level of performance above the 85% level.

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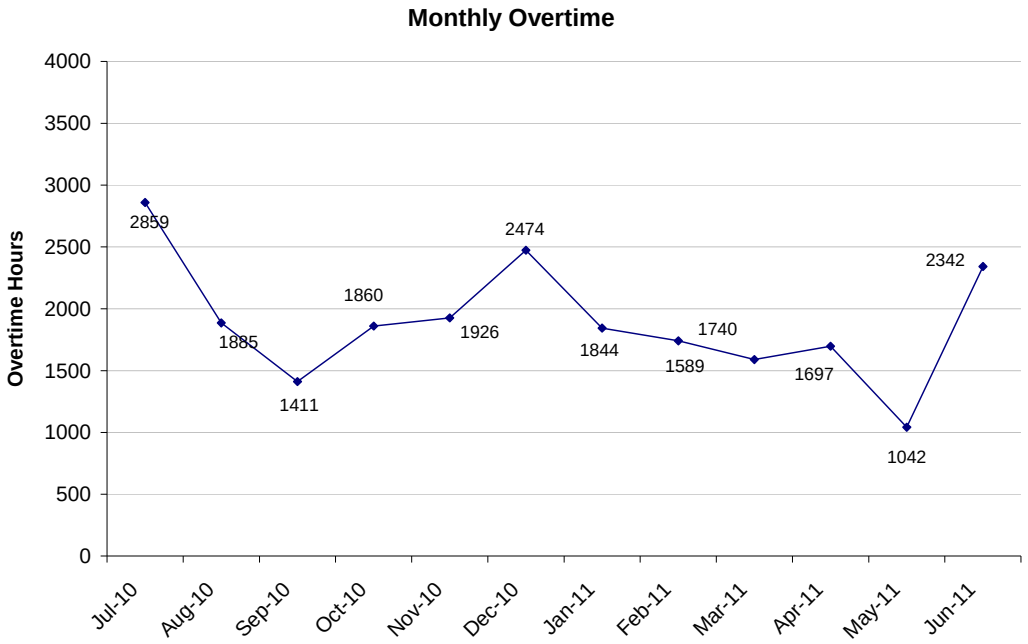
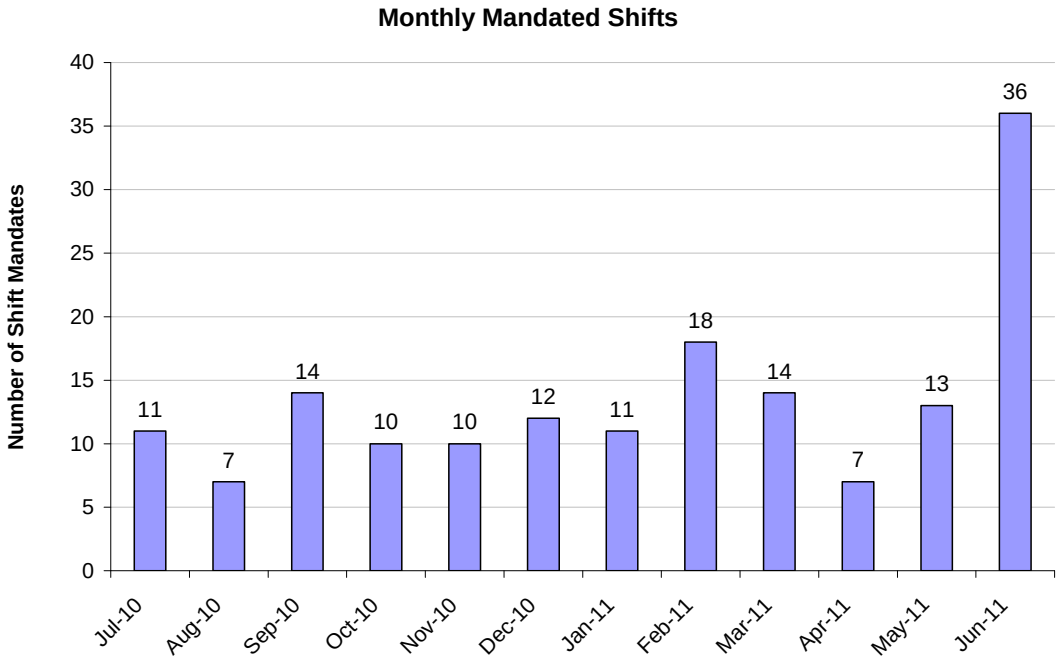
HUMAN RESOURCES

ASPECT: PERSONNEL MANAGEMENT

Overtime hours and mandated shift coverage





The level of overtime hours and number of mandates for the month of June showed significant spikes while the preceding months remained stable and low. There also appears to be a correlation between overtime hours, mandates, and the level of direct care staff injuries. It is unclear if a true cause and effect relationship exists between these variables.

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INFECTION CONTROL

ASPECT: HOSPITAL ACQUIRED INFECTION

Indicators	Findings	Compliance	Threshold Percentile
Total number of infections for the fourth quarter of the fiscal year, per 1000 patient days	35/4.5	100 % within standard	1 SD within the mean
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	10/1.3	100% within standard	1 SD within the mean

Data

35 total infections and 10 hospital acquired infections

- 2 hospital acquired URI –long term clients and 1 community acquired URI
- 3 dental infections
- 24 skin infections – 6 were hospital acquired – Athlete's Foot outbreak in May 2011 on Kennebec units
- 2 hospital acquired UTI
- 3 eye infections – 1 was hospital acquired – conjunctivitis
- 1 newly diagnosed HIV

Summary

Infection rates remained consistent with third quarterly rates. A spike in hospital acquired infections in May 2011 was due to an Athlete's Foot outbreak on the Kennebec units.

Action Plan

- Put a protocol in place to ensure disinfection of the showers after each client use.
- Client and Staff education.
- Maintain a Total House Surveillance Program.

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LIFE SAFETY

ASPECT: LIFE SAFETY

Indicators	Quarterly % Compliance						Threshold Percentile
	Apr. '11-Jun. '11	Jan. '11-Mar. '11	Oct. '10-Dec. '10	Jul. '10-Sep. '10	Apr. '10-Jun. '10	Jan. '10-Mar. '10	
1. Total number of fire drills and actual alarms conducted during the quarter compared to the total number of alarm activations required per Life Safety Code, that being (1) drill per shift, per quarter.	100% (3/3)	100% (3/3)	100% (3/3)	100% (3/3)	100% (3/3)	100% (3/3)	**100%**
2. Total number of staff who knows what R.A.C.E. stands for.	100% (159/159)	100% (202/202)	100% (221/221)	100% (285/285)	100% (160/160)	100% (107/107)	**95%**
3. Total number of staff who knows how to acknowledge the fire alarm or trouble alarm on the enunciator panel.	96% (153/159)	100% (202/202)	100% (221/221)	100% (285/285)	100% (160/160)	93% (100/107)	**95%**
4. Total number of staff who knows the emergency number.	100% (159/159)	100% (202/202)	100% (221/221)	100% (285/285)	100% (160/160)	100% (107/107)	**95%**
5. During unannounced safety audits conducted by the Safety Officer, this represents the total number of staff who displays identification tags.	98% (163/165)	98% (204/208)	97% (224/230)	100% (285/285)	96% (164/170)	92% (99/107)	**95%**
6. During unannounced safety audits conducted by the Safety Officer, this represents the total number of direct care staff who carries a personal duress transmitter.	98% 162/165	97% 206/208	97% 225/230	100% (92/92)	98% (167/170)	91% (98/107)	**95%**

Summary

The (3) alarms reported for the hospital meets the required number of drills per JCAHO and Life Safety Code. Indicators 2 through 4 are indicators used for the purpose of evaluating the knowledge and skills of staff as it relates to critical skills and knowledge necessary to carry out functions in the event of a fire and/or smoke emergency.

LIFE SAFETY

During drills, the following was discovered and noted:

1. Six staff people were unsure how to acknowledge the annunciator panel and get the required information
2. One 2-way radio did not operate.
3. One staff person did not have the proper fire key.
4. There continues to be a significant improvement in the completeness of and timely submission of fire reports.
5. One unit did not utilize the 2-way radios.

Drills and environmental tours addressed areas such as R.A.C.E., evacuation routes, use of fire extinguishers, use of annunciator panels, census taking, and emergency communications.

Actions

Actions taken after drills were the following:

1. Two separate mini training sessions were conducted with those staff with regard to the use of the annunciator panel.
2. The unit staff immediately utilized one of the 2-way radios on an adjacent unit. The radio was immediately brought to the Safety Office who changed the battery, tested the radio, and returned the radio to the unit. The Safety Officer will be conducting regular tests on the 2-way radios.
3. A new fire key was issued.
4. No action required.
5. During the after-drill critique, the unit was reminded of the importance of immediately utilizing the 2-way radios.

We continue to conduct environmental tours and safety audits to assure that staff is in possession of required safety equipment and facility ID's. This area of monitoring has shown improvement.

ASPECT: FIRE DRILLS REMOTE SITES

Indicators	Quarterly % Compliance						Threshold Percentile
	Apr. '11-Jun. '11	Jan. '11-Mar. '11	Oct. '10-Dec. '10	Jul. '10-Sep. '10	Apr. '10-Jun. '10	Jan. '10-Mar. '10	
Total number of fire drills and actual alarms conducted at Portland Clinic compared to the total number of alarm activations required per Life Safety Code (3) drills per year based on the fact that it is business occupancy.	100% (1 drill)	100% (1 drill)	100% (1 drill)	100% (1 drill)	100% (1 drill)	100% (1 drill)	100%

Summary

On 3/30/11, the Safety Officer conducted an unannounced drill. There were dental and psychiatric services being performed at that time. The Safety Officer allowed the (3) staff members conducting those to continue since rescheduling those would have had a negative

impact on those clients. During the drill with the remaining staff and for a time thereafter, time was spent with staff, especially with the recently hired receptionist, covering their role as it relates to the securing of the Receptionist area and the records cabinets within that area. Education was given with regard to closing the cabinets if time permits, but not if that act could in any way jeopardize their safety. This drill satisfies the NFPA requirement.
We continue to perform environmental tours during which time we ask them questions as it relates to what actions they must take in the event of a fire and/or smoke emergency. Questions are later posed to staff that are not caring for clients when the decision is made to not conduct a drill.

Actions

No actions are required at this time. The required drills have been performed.

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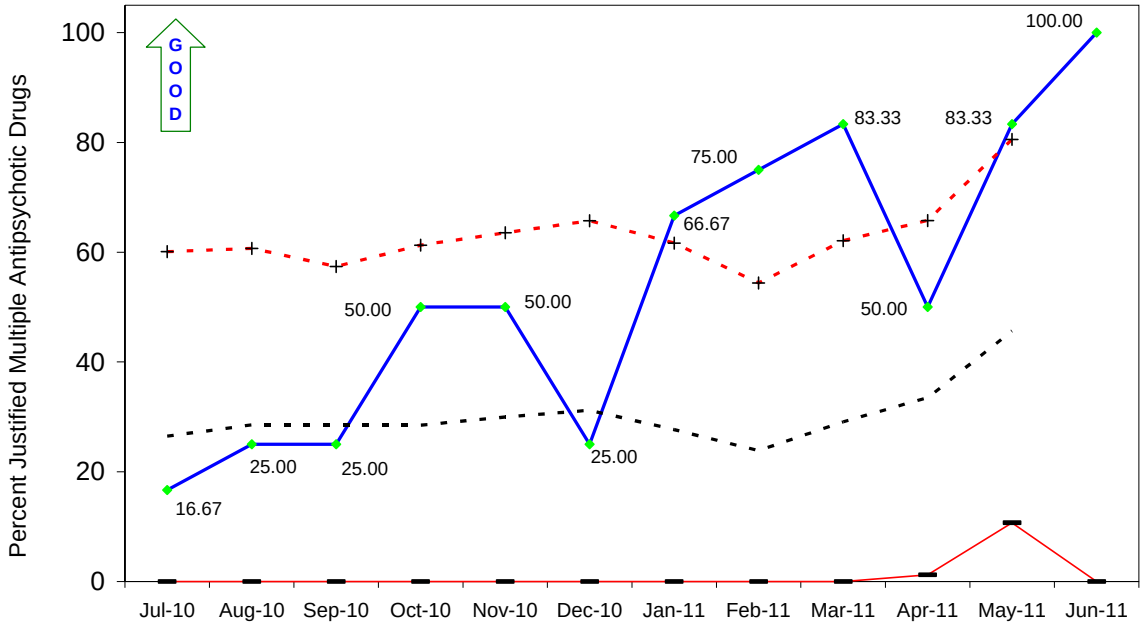
MEDICAL STAFF

ASPECT: JUSTIFICATION FOR DISCHARGE ON MULTIPLE ANTIPSYCHOTICS

Indicators	Findings	Compliance	Threshold Percentile
Patients discharged on multi-antipsychotic medications will have clinical justification documented in the discharge summary.	Over a 3-mo period (Feb-May) 72 discharges had 12 patients on 2 or more antipsychotics; 9 were justified.	75%	80%

Multiple Antipsychotics Justified

Percent of Clients Discharged on Multiple Antipsychotic Drugs
With Appropriate Justification



	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11
RPC%	16.67	25.00	25.00	50.00	50.00	25.00	66.67	75.00	83.33	50.00	83.33	100.00
Ntl Mean	26.48	28.53	28.51	28.48	29.96	31.20	27.67	23.82	29.09	33.51	45.64	
+1 St Dev	60.1	60.67	57.39	61.28	63.53	65.71	61.66	54.4	62.11	65.78	80.56	
-1 StDev	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.24	10.72	0.00

Summary

The number of clients discharged on multiple antipsychotics is slowly improving. For the past three months, one case a month was not justified.

Actions

We will continue to monitor justification documentation on patients discharged. Psychiatrists will be provided with a monthly list. Feedback to individual psychiatrists is given at the Peer Review Committee.

NURSING

ASPECT: SECLUSION/RESTRAINT RELATED TO STAFFING EFFECTIVENESS

Figure CD-27

Indicators	Findings	Compliance
1. Staff mix appropriate	93 of 93	100%
2. Staffing numbers within appropriate acuity level for unit	93 of 93	100%
3. Debriefing completed	91 of 93	97%
4. Dr. Orders	93 of 93	100%

SUMMARY

The indicators of “Seclusion/Restraint Related to Staffing Effectiveness” has increased to 99.5%.

ACTION

Good Progress. We will continue to monitor.

ASPECT: INJURIES RELATED TO STAFFING EFFECTIVENESS

Indicators	Findings	Compliance
1. Staff mix appropriate	34 of 34	100%
2. Staffing numbers within appropriate acuity level for unit	34 of 34	100%

SUMMARY

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

ACTIONS

This is an important issue that is of concern to all. The Director of Nursing is working in concert with the Superintendent and Risk management to monitor and measure trends and variables that contribute to staff injury. We will continue the focus is on appropriate use of stat calls for support to heighten awareness of safety and the obvious support in numbers for lifting and other manual activities.

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NURSING

ASPECT: MEDICATION ERRORS RELATED TO STAFFING EFFECTIVENESS

NURSING: Staffing levels during medication errors – April - June 2011 NASMHPD reportable variances

Date	Omit	Co-mission	Float	New	O/T	Unit Acuity	Staff Mix
3/22/11	N	Transcription error - order for PO cover note clarified	Yes	Yes	No	LS	3 RN, 1 LPN, 6 MHW
3/23/11	Y	Med not signed off or given	No	No	No	LS	3 RN, 1 LPN, 7 MHW
3/24/11	Y	Order for 2 meds noted and fixed, not given – 1 dose each	No	No	No	LS	3 RN, 1 LPN, 7 MHW
4/8/11	N	Recent order change noon dose halved, full dose given	No	No	No	LK-S	5 RN, 0 LPN, 7 MHW
4/20/11	Y	Transcription error, incorrect stop date – 3 missed doses	No	No	No	LS	4.5 RN, 1 LPN, 6.5 MHW
4/25/11	N	1 extra dose given due to handwriting issue – Transcription	No	No	1	MS	2 RN, 0 LPN, 4 MHW
4/29/11	Y	1 dose Clozaril not given due to line on MAR - Transcription	Yes	No	No	LS	3 RN, 0 LPN, 7 MHW
4/31/11	N	Expired med (Insulin) given 11 doses Novolog Insulin by multiple RNs, LPNs,	N/A	N/A	N/A	UK	Varied
5/4/11	N	Cogentin 1 mg. given after changing MAR	No	No	No	UK	3 RN, 0 LPN, 4 MHW
5/10/11	Y	Metoprolol 25 mg. 1 dose order not noted, ordered or faxed	No	No	No	LSSCU	2 RN, 1 LPN, 6 MHW
5/19/11	Y	Ambien found in med cup unopened	No	No	No	UK	3 RN, 0 LPN, 3 MHW
5/22/11	N	Zyprexa Zydis 5 doses given after med was discontinued. Not removed from profile or MAR multiple nurses involved RNs and others	No	No	No	UK	2 RN, 1 LPN, 4 MHW
6/13/11	Y	Bacitracin cream – Transcription error caused omission of 11 doses	No	No	Yes	LK	3 RN, 1 LPN, 7 MHW
6/22/11	Y	Clonazepam – Transcription error – med was not put on MAR	No	No	No	LS	3 RN, 1 LPN, 8 MHW
6/25/11	Y	Naproxen – signed off that med was given but did not do it	No	No	No	US	2 Rn, 1 LPN, 5 MHW
6/27/11	Y	Icy Hot Patch – worker overlooked – chart not flagged	N/A	N/A	N/A	US	3 RN, 0 LPN, 3 MHW

SUMMARY

There were a total of 16 reportable errors; ten (10) involved omissions and six (6) involved omissions. Of the 16 variances, 9 involved the admissions units, and 7 involved the long term units (3 Forensic/ 4 Civil). One med error involved administering an expired medication (Insulin) for 11 doses. Multiple incidents involved not checking the MAR vs. Accudose orders. Transcription errors involved 6 incidents. Incorrect follow-through with procedures was also noted (i.e. med signed off and not given, order not noted or faxed.) Staffing was noted to be at appropriate levels on all occasions. Two instances involved float nurses, one of which was also a new employee. One med variance occurred

on a unit where a split shift occurred, which may have contributed to the med error.

Actions

- Check orders more carefully, particularly comparing the MAR to Accudose prior to med administration.
- Remind nurses not to document that a med has been given until it has been administered.
- Frequently check meds for expiration dates.
- Process orders in a timely fashion and check for completion. Nurse recommended placing a check mark next to completed transcribed orders if interrupted during the process.
- Remind providers to flag charts with newly written orders for timely processing.

ASPECT: PAIN MANAGEMENT

Indicator		Findings	Compliance
Pre-administration	Assessed using pain scale	802 of 806	99.5%
Post-administration	Assessed using pain scale	740 of 806	92%

SUMMARY

The “Pre-administration assessment” indicator met the maximum compliance of 99.51% this quarter and there is a continued improvement from 88% to 92% in “Post-administration” assessment using the pain scale. The modest improvement in “Post-administration” assessment is expected to increase with the advent of implementation of the pharmacy module of our Electronic Medical Record.

ACTION

Assure complete and thorough education of new Nurse by reviewing the process and revising as necessary. Allow more time for them to function in medication delivery under supervision.

Nursing will continue to place a great deal of attention and effort on post administration assessment and management of the related documentation. Nursing will continue to track this indicator and strive for increase in post assessment in the next quarter. The two ADONs will continue to work with unit nursing staff to assure that this is done consistently.

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NURSING

ASPECT: CHART REVIEW EFFECTIVENESS

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	51 of 60	85%
2. STGs/ Interventions relate directly to content of GAP note.	59 of 60	98%
3. Weekly Summary note completed.	56 of 60	93%
4. BMI on every Treatment Plan.	50 of 60 1 N/A	83%
5. Diabetes education Teaching checklist shows documentation of client teaching (diabetic clients)	11 of 60 38 N/A	18%
6. Multidisciplinary Teaching checklist active being completed.	43 of 60	72%
7. Dental education Teaching checklist	42 of 60	70%

SUMMARY

Four indicators, numbers, 2, 3, 4, and 6 are up from last quarter. Two indicators are down from last quarter, number 5 and 7.

ACTION

Continue to monitor**.**

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NURSING

ASPECT: INITIAL CHART COMPLIANCE

Indicator	Findings	Compliance
1. Universal Assessment completed by RN within 24 hours	75 of 76	99%
2. All sections completed or deferred within document	74 of 76	97%
3. Initial Safety Treatment Plan initiated	44 of 76	58%
4. All sheets required signature authenticated by assessing RN	72 of 76 2 N/A	95%
5. Medical Care Plan initiated if Medical problems identified	7 of 76 33 N/A	9%
6. Informed Consent sheet signed	69 of 76 1 N/A 2 ref.	91%
7. Potential for violence assessment upon admission	72 of 76	95%
8. Suicide potential assessed upon admission	75 of 76	99%
9. Fall Risk assessment completed upon admission	70 of 76	92%
10. Score of 5 or above incorporated into problem need list	1 of 76 62 N/A 1 unknown	1%

SUMMARY

All aspects of initial chart review have decreased in compliance.

ACTION

Assure complete and thorough education of new Nurse by reviewing the process and revising as necessary. Allow more time for them to function in medication delivery under supervision. Continue to monitor.

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PEER SUPPORT

ASPECT: INTEGRATION OF PEER SPECIALISTS INTO CLIENT CARE

Indicators	Findings	Compliance	Threshold Percentile
1. Attendance at Comprehensive Treatment Team meetings.	399 of 481	83%	80%
2. Level II grievances responded to by RPC on time.	19 of 20	95%	100%
3. Attendance at Service Integration meetings.	57 of 59	97%	100%
4. Contact during admission.	76 of 76	100%	100%
5. Level I grievances responded to by RPC on time.	48 of 59	81%	100%
6. Client satisfaction surveys completed.	19 of 32	59%	50%

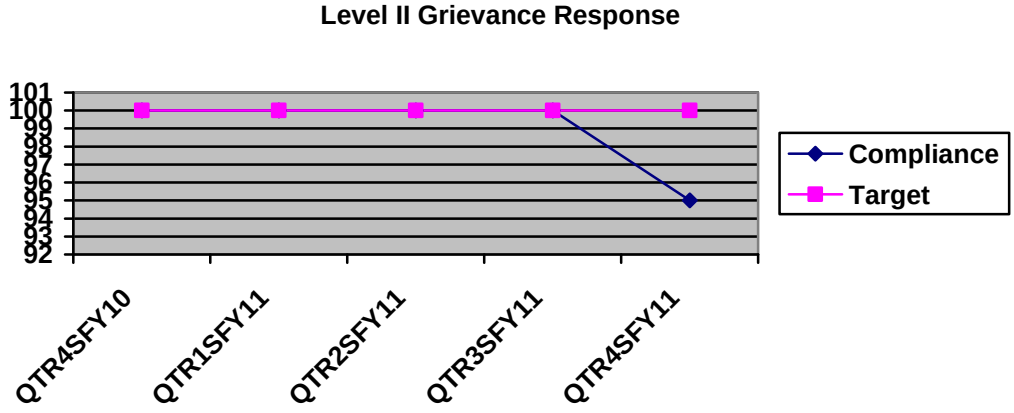
Summary

Overall compliance is 85%, down 8% from last quarter. Peer support attendance at treatment team meetings dropped 9%, but is still meeting the compliance threshold. Return rate of client satisfaction surveys remained the same as last quarter. Hospital response time to Level I and II grievances dropped, 5% for Level II and 17% for Level I. There was only one late Level II grievance and it was only one day late. The majority of late grievances were on the forensic side and ranged from 1 to 18 days late. Documented contact between clients and peer support remains at 100%. Peer support attendance at Service Integration Meetings dropped 3%. Both meetings missed were due to peer support not being notified of the meetings.

Actions

Work with the social work department to improve communication regarding service integration meeting notifications.

Figure CD-03



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PEER SUPPORT

Figure CD-07

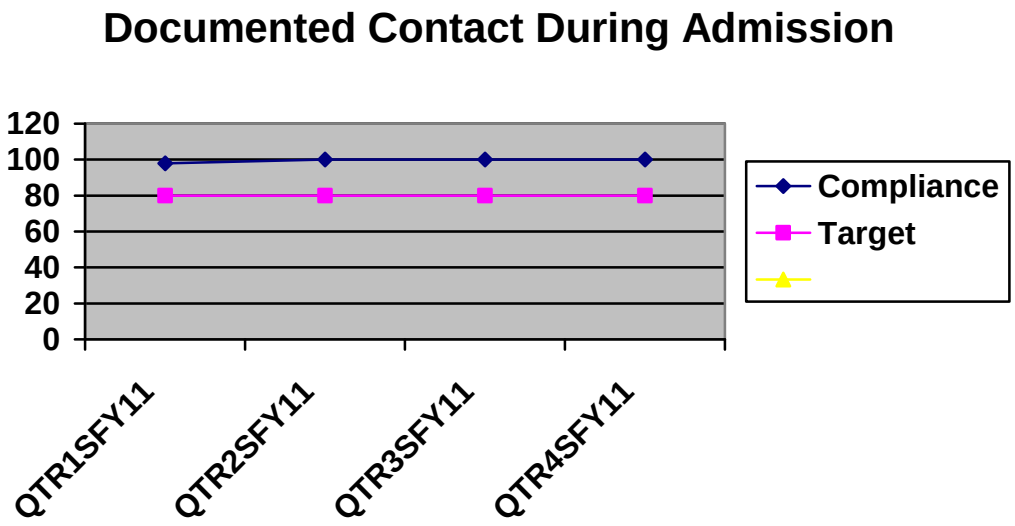
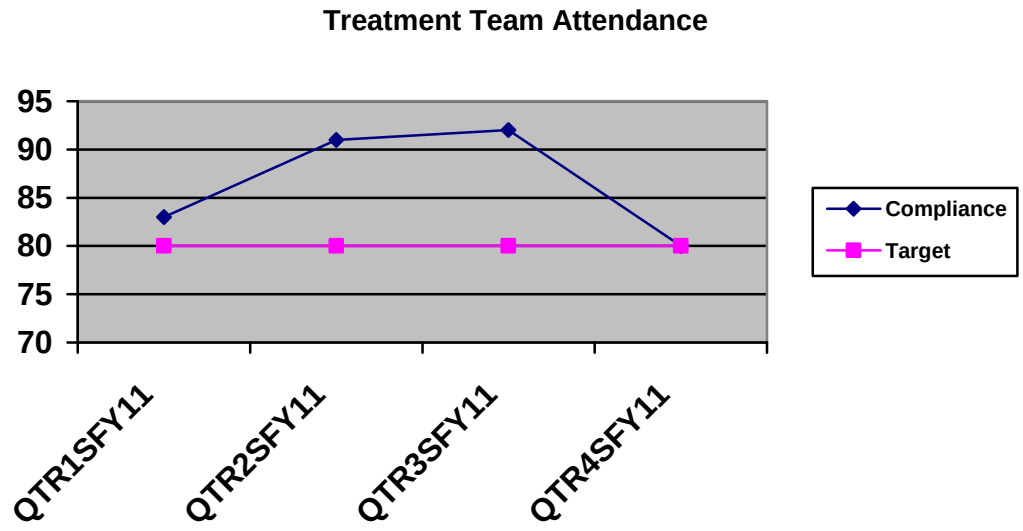


Figure CD-08



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PHARMACY & THERAPEUTICS

Verifying that a patient is not allergic to a medication that is being prescribed is essential to the safety of any medication safety system. One of the many methods Riverview uses to prevent the administration of a medication known to be an allergen to that patient is to list that patient's allergies at the top of the order sheets. Occasionally the pharmacy received orders without allergies

ASPECT: ORDER WRITING POLICY

Indicators	Findings	Compliance	Threshold Percentile
All order sheets are required to have that patient's allergies listed at the top of the sheet	**April** Thirteen orders were received by the pharmacy without allergies listed and an estimated 1200 total orders were received by pharmacy.	99.0%	98.0%
	May Twenty orders were received by the pharmacy without allergies listed and an estimated 1325 total orders were received by pharmacy.	98.4%	98.0%
	June 22 orders were received by the pharmacy without allergies listed and an estimated 1200 total orders were received by pharmacy	98.2%	98.0%

Summary

There were a total of 55 orders sent to the pharmacy during Q4 without allergy information written at the top of the page. An estimated 3725 total orders were received during that time period. Total compliance during this time period is 98.5%. All orders received without allergies listed were faxed back to their respective units for clarification.

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PHARMACY & THERAPEUTICS

ASPECT: DIVERSION OF CONTROLLED SUBSTANCES

Controlled substances are potentially habit forming medications that are useful in the treatment of specific disease states. Under proper supervision these medications are used to treat a wide variety of disease states effectively, easing the suffering of millions of Americans. If used improperly they can become addictive and destroy lives.

Due to their addictive side effects controlled substances have a high potential for being diverted for a number of different uses. For this reason Riverview has many safeguards to prevent the diversion of controlled substances.

Riverview utilizes Automatic Dispensing Cabinets (produced by McKesson called AcuDose machines) as the primary medication delivery system. This technology provides excellent documentation for all medications which are stored in the ADCs, including controlled substances. All medication transactions are tracked. All controlled substance transactions require 2 users and a count of the medication in the pocket to be entered into the machine. If the quantity enters differs from the quantity in the computer's database that ADC will register the error and will notify the user. Until the discrepancy is resolved by a Riverview employee credentialed to do so the word discrepancy will appear on that ADC alerting all users of the problem.

Pharmacists, NODs, and members of nursing leadership privileged by the Director of Nursing are allowed to correct discrepancies. Another user of the ADC must also sign off with the above described staff to resolve the discrepancy electronically. If the pharmacy is open, the discrepancies will be corrected by the pharmacy. If the pharmacy is closed the discrepancies will be corrected by the NOD.

The ADC software creates a report daily at 0730 alerting the pharmacy of any open discrepancies called the "AcuDose-Rx Discrepancy By Station Report." A pharmacist reviews these reports daily (or the next day the pharmacy is open for weekends and holidays).

The goal of this report is to review all ADC discrepancies from January 1, 2011 through March 31, 2011 and ensure that controlled substances are not being diverted from unit stock and discrepancies are being addressed in a timely manner.

Discrepancies Recorded	Incidences	Pharmacy Corrected	NOD Correction	Suspected Diversion	Actual Diversion
10	8	2	6	0	0

A review of the AcuDose-Rx Discrepancy By Station Report showed no active discrepancies reported.

All of the 10 discrepancies recorded were all accounted for by user error and correction of previously created error. (A discrepancy will sometimes be purposely created to correct a previous mistake. For example, if there was 1 tablet in the ADC and the nurses finger slips and presses both the "1" and "2" key at the same time thus accidently entering a quantity of 12. The computer will them believe that 12 is the correct quantity. A second discrepancy will have to be created to correct the computer quantity to 1.)

The above data shows strong evidence that controlled substances are not being diverted from the ADCs and that any discrepancies created are being addressed in a timely manner.

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PROGRAM SERVICES

ASPECT: ACTIVE TREATMENT IN ALL FOUR UNITS

Figure CD-11

Indicator	Findings	Compliance
1. Documentation reveals that the client attended 50% of assigned psycho-social-educational interventions within the last 24 hours.	62 of 80	77.5 %
2. A minimum of three psychosocial educational interventions are assigned daily.	67 of 80	84%
3 A minimum of four groups is prescribed for the weekend.	49 of 80	61%
4. The client is able to state what his assigned psycho-social-educational interventions are and why they have been assigned.	61 of 80	76%
5 The client can correctly identify assigned RN and MHW. (Or where the information is available to him / her)	76 of 80	95%
6. The medical record documents the client's active participation in Morning Meeting within the last 24 hours.	56 of 80	70%
7. The client can identify personally effective distress tolerance mechanisms available within the milieu.	74 of 80	92 %
8. Level and quality of client's use of leisure within the milieu are documented in the medical record over the last 7 days.	72 of 80	90%
9. Level and quality of social interactions within the milieu are documented in the medical record over the last 7 days.	74 of 80	92,5%
10. Suicide potential moderate or above incorporated into CSP	13 of 13	100%
11. Allergies displayed on order sheets and on spine of medical record.	71 of 80	88.75%
12. By the 7th day if Fall Risk prioritized as active-was it incorporated into CSP	13 of 13	100%

SUMMARY

Seven of the indicators have increased since last quarter; number 1,2,3,5,6,8,9 have shown improvement. Three have decreased slightly; numbers 4, 7, and 11. Two have remained the same.

ACTION

Continue to monitor focusing on the indicators that have decreased slightly.

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PROGRAM SERVICES

Aspect-Milieu Treatment

Indicator	Findings-%
1. Percentage of clients participating in Morning Meeting	61%
2. Percentage of clients who establish a daily goal.	75%
3. Percentage of clients who attend Wrap Up group in the evening or address with primary staff, the status of their daily goal.	63%
4. Percentage of clients attending Community Meeting	64%

Summary

All areas have improved since last quarter. We have had average attendance at the treatment mall through the quarter The. Percentage of clients attending morning meeting has been up from last quarter at 61%All other areas for the top monitors met or exceeded threshold.

Actions

Our effort toward improving our attendance with weekend groups is long standing and will continue to encourage all clients to attend all meetings

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REHABILITATION SERVICES

ASPECT: READINESS ASSESSMENTS, COMPREHENSIVE SERVICE PLANS & PROGRESS NOTES

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

Summary

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

Indicator #1- All assessments and annual updates reviewed were completed in the allotted time frame. No issues at this time with the completion of the assessment and treatment plan.

Indicator #2-The short term Rehabilitation goals on all treatment plans reviewed were measurable and time limited. No issues at this time but it should be noted that there will be changes in the treatment plans in the near future that will make this indicator easier to maintain at 100% with the new structure.

Indicator #3 & 4-Rehabilitation progress notes were reflective of the treatment being offered and the progress towards the identified goals in all charts reviewed. No issues at this time.

In regards to all indicators, the Director will continue to audit charts and provide individual supervision for all RT's to ensure expectations of indicators are achieved. The treatment planning process still continues to need review as it applies to client's participation in groups at the Harbor Mall and development of measurable short term goals for all disciplines.

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SECURITY & SAFETY

ASPECT: SECURITAS/RPC SECURITY TEAM

Indicators	Quarterly % Compliance						Threshold Percentile
	Apr. '11-Jun. '11	Jan. '11-Mar. '11	Oct. '10-Dec. '10	Jul. '10-Sep. '10	Apr. '10-Jun. '10	Jan. '10-Mar. '10	
Security Officer "foot patrols" during Open Hospital times. (Total # of "foot patrols" done vs. total # of "foot patrols" to be done.)	98% (1975/2002)	99% (1980/2002)	98% (1964/2002)	89% (1797/2002)	98% (1973/2002)	97% (1944/2002)	95%

Summary

Foot patrols continue to be done despite those rare times that the officers are on other details which take priority over the "foot patrol".

Actions

We continue our attempt to accomplish all foot patrols. Other tasks which are placed at a greater priority get assigned first. We contribute the significant increase in our ability to conduct foot patrols to a periodic scheduling of the newly reassigned "Float Officer". We continue our work on the tour system.

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SOCIAL WORK

ASPECT: PRELIMINARY CONTINUITY OF CARE MEETING AND COMPREHENSIVE PSYCHOSOCIAL ASSESSMENTS

Figure CD-05 Indicators	Findings	Compliance	Threshold Percentile
1. Preliminary Continuity of Care meeting completed by end of 3rd day	30/30	96%	100%
2. Service Integration form completed by the end of the 3rd day	30/30	96%	100%
2a. Director of Social Services reviews all readmissions occurring within 60 days of the last discharge and for each client who spent fewer than 30 days in the community, evaluated the circumstances of the readmission to determine an indicated need for resources or a change in treatment and discharge planning or the need for alternative resources. In cases where such a need or change was indicated that corrective action was taken.	1/1	100%	100%
3a. Client Participation in Preliminary Continuity of Care meeting.	30/30	96%	90%
3b. CCM Participation in Preliminary Continuity of Care meeting.	30/30	100%	100%
3c. Client's Family Member and/or Natural Support (e.g., peer support, advocacy, attorney) Participation in Preliminary Continuity of Care meeting.	29/30	96%	100%
3d. Community Provider Participation in Preliminary Continuity of Care meeting.	5/15	20%	90%
3e. Correctional Personnel Participation in Preliminary Continuity of Care Meeting.	0/15	0%	90%
4a. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	28/30	93%	100%
4b. Annual Psychosocial Assessment completed and current in chart	30/30	100%	100%

SUMMARY

Areas 3d and 3c are consistently low each quarter. It continues to be discussed in various venues but continues to be an issue for many varying reasons.

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SOCIAL WORK

ASPECT: INSTITUTIONAL AND ANNUAL REPORTS

Figure CD-18 Indicators	Findings	Compliance	Threshold Percentile
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	6 /6	100%	95%
2. The assigned **CCM** will review the new court order with the client and document the meeting in a progress note or treatment team note.	4/4	100%	100%
3. Annual Reports (due Dec) to the commissioner for all inpatient NCR clients are submitted annually	N/A	N/A	100%

SUMMARY

Indicator 1 has been at 100% compliance for the last five reporting quarters.

ASPECT: CLIENT DISCHARGE PLAN REPORT/REFERRALS

Indicators	Findings	Compliance	Threshold Percentile
1. The Client Discharge Plan Report will be updated/reviewed by each **Social Worker minimally one time per week.**	13/13	100%	95%
2. The Client Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	13/13	100%	100%
2a. The Client Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	13/13	100%	100%
3. Each week the Social Work team and Director will meet and discuss current housing options provided by the respective regions and prioritize referrals.	13/13	100%	100%

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SOCIAL WORK

ASPECT: TREATMENT PLANS AND PROGRESS NOTES

Figure CD-15, CD-16, CD-17 **Indicators**	**Findings**	**Compliance**	**Threshold Percentile**
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all clients on assigned **CCM** caseload.	42/45	93%	95%
2. On Upper Saco progress notes in GAP/Incidental format will indicate at minimum bi- weekly 1:1 meeting with all clients on assigned **CCM** caseload	15/15	100%	95%
3. Treatment plans will have measurable goals and interventions listing client strengths and areas of need related to transition to the community or transition back to a correctional facility.	58/60	96%	95%

SUMMARY

Area 1 is being monitored in the Social Work Team Meeting and individually through supervision. Indicator 2 will change in the next report to reflect the addition of a second social worker on the Upper Saco unit.

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SOCIAL WORK

ASPECT: BARRIERS TO COMMUNITY PLACEMENT OF CIVIL CLIENTS

FY11 Q3 22 % of civil clients discharged faced a barrier

40 civil clients discharged in the quarter.
7 faced identified barrier

Figures CD-12, CD-13, CD-14

Clinical Readiness

31 discharged 7days
3 discharged 8-30 days
1 discharged 31-45days
5 discharged post 45 days

Residential Supports (0) 0%

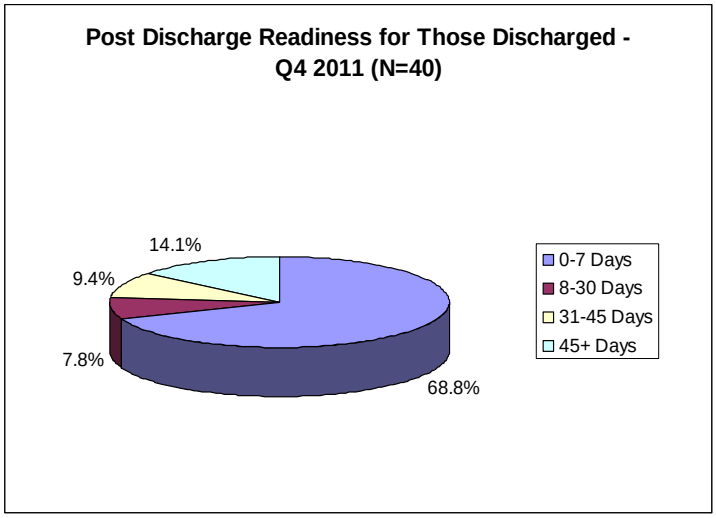
No Barriers in this area this quarter

Treatment Services (1) 2%

1 client discharged 121 days post clinical readiness/treatment barrier

Housing (6) 15 %

1 client discharged 20 days post clinical readiness
1 client discharged 23 days post clinical readiness
1 client discharged 50 days post clinical readiness
1 client discharged 51 days post clinical readiness
1 client discharged 78 days post clinical readiness
1 client discharged 114 days post clinical readiness



This chart shows the percent of civil clients who were discharged within 7 days of their discharge readiness to be at 54.4% for this quarter. Cumulative percentages and targets are as follows:

Within 7 days = 68.8% (target 75%)
Within 30 days = 76.6% (target 90%)
Within 45 days = 86.0% (target 100%)
14.1% faced a barrier and were discharged post 45 days.

The previous five quarters are displayed in the table below

Quarter	Within 7 days	Within 30days	Within 45 days	45 +days
Target	75%	90%	100%	0%
Q3 2011	54.4%	77.9%	88.2%	11.0%
Q2 2011	67.6%	83.8%	89.2%	10.8%
Q1 2011	51.4%	64.9%	83.8%	16.2%
Q4 2010	47.4%	76.3%	84.2%	15.8%
Q3 2010	57.5%	62.5%	72.5%	27.5%

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STAFF DEVELOPMENT

ASPECT: NEW EMPLOYEE AND MANDATORY TRAINING

Figure CD-19 and CD-20

Indicators	Findings	Compliance	Threshold Percentile
1. New employees will complete new employee orientation within 60 days of hire.	14 of 14 completed orientation	100%	100 %
2. New employees will complete CPR training within 30 days of hire.	14 of 14 completed CPR training	100%	100 %
3. New employees will complete NAPPI training within 60 days of hire.	14 of 14 completed Nappi training	100%	100 %
4. Riverview and Contract staff will attend CPR training bi-annually.	325 of 325 are current in CPR certifications	100 %	100 %
5. Riverview and Contract staff will attend NAPPI training annually. Goal to be at 100% by end of fiscal training year 2011 on June 30th. **Last Fiscal Year (2010) at 99.7%**	381 of 382 have completed annual NAPPI training	99.7%	100 %
6. Riverview and Contract staff will attend Annual training. Goal is to be at 100% by end of fiscal training year 2011 on June 30th. **Last Fiscal Year (2010) at 100%**	392 of 392 have completed annual mandatory training	100%	100 %
7. Riverview nursing and medical staff will complete 10 hours of training each year in the psychiatric aspects of their treatment responsibilities. Goal is to be at 100% by end of fiscal training year 2011 on June 30th.	221 of 221 have received a minimum of 10 hours annually	100%	100 %

Findings

The indicators are based on the requirements for all new/current staff to complete mandatory training and maintain current certifications. **14 out 14 of** (100%) new Riverview/Contracted employees completed these trainings. **325 of 325** (100%) Riverview/Contracted employees are current with CPR certification. **381 of 382** (99.7%) Riverview/Contracted employees are current in Nappi training (the one employee who has not completed training is on light duty due to a worker's compensation injury and unable to participate effectively in the training). **392 of 392** (100%) employees are current in Annual training. **221 of 221** (100%) Riverview nursing and medical staff will complete 10 hours of training each year in the psychiatric aspects of their treatment responsibilities. All thresholds remain at 100% compliance for quarter 4-FY 2011.

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CONSENT DECREE COMPLIANCE

Subject Area	Standard of Substantial Compliance	Efforts to Comply & Evidence of Compliance
Client Rights	Riverview produces documentation that clients are routinely informed of their rights upon admission in accordance with ¶ 150 of the Settlement Agreement	CD-02: *An abstraction process is being developed that will illustrate the degree to which clients are informed of their rights on admission.*
	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.	CD-03: Report compiled by Peer Support. Information extracted from Grievance tracking database.
Admissions	Quarterly performance data shows that in 4 consecutive quarters, 95% of admissions to Riverview meet legal criteria.	CD-04: Report compiled for Admissions. Information extracted from the Meditech report entitled, "Admission Legal Report."
	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.	CD-05: This items in reported in the Social Work section under the report entitled, "Preliminary Continuity of Care Meeting and Comprehensive Psychosocial Assessments" under section 2a of that report.
	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.	CD-06: Report compiled for Admissions. Information extracted from the Meditech report entitled, "Admission Diagnosis Report by Date."
Peer Support	In 3 out of 4 consecutive quarters: • 80% of all clients have documented contact with a peer specialist during hospitalization	CD-07: Report compiled by Peer Support.
	• 80% of all treatment meetings involve a peer specialist.	CD-08: Report compiled by Peer Support.
Treatment Planning	In 3 out of 4 consecutive quarters • 95% of clients have a preliminary treatment and transition plan developed within 3 working days of admission	CD-09: *A method for the reporting of this compliance standard is currently under development.*
	• 95% of clients also have individualized treatment plans in their records within 7 days thereafter	CD-10: *A method for the reporting of this compliance standard is currently under development.*
	• Riverview certifies that all treatment modalities required by ¶155 are available.	CD-11: Records of client participation in active treatment are maintained by the unit PSD. All required, unit and Harbor Mall treatment schedules are available for review. *A method for the reporting trends of compliance is currently under development.*

CONSENT DECREE COMPLIANCE

Subject Area	Standard of Substantial Compliance	Efforts to Comply & Evidence of Compliance
Treatment Planning (cont'd)	An evaluation of treatment planning and implementation, performed in accordance with **Attachment D**, demonstrates that, for 90% of the cases reviewed quarterly performance data shows that in 4 consecutive quarters:	CD-12: Information on this standard is illustrated in the Social Work performance measures related to the aspect of care entitled, "Barriers to Community Placement of Civil Clients"
	• 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	
	• 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	CD-13: Information on this standard is illustrated in the Social Work performance measured related to the aspect of care entitled, "Barriers to Community Placement of Civil Clients"
	• 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).	CD-14: Information on this standard is illustrated in the Social Work performance measured related to the aspect of care entitled, "Barriers to Community Placement of Civil Clients"
	• treatment and discharge plans reflect interventions appropriate to address discharge and transition goals	CD-15: This compliance standard is addressed in the Social Work report on "Treatment Plans and Progress Notes."
	• 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	CD-16: This compliance standard is addressed in the Social Work report on "Treatment Plans and Progress Notes."
	• interventions to address discharge and transition planning goals are in fact being implemented	CD-17: This compliance standard is addressed in the Social Work report on "Treatment Plans and Progress Notes."
	• 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.	CD-18: This compliance standard is addressed in the Social Work report on "Institutional and Annual Reports."

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CONSENT DECREE COMPLIANCE

Subject Area	Standard of Substantial Compliance	Efforts to Comply & Evidence of Compliance
Staffing and Staff Training	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.	CD-19: Compliance with this standard is documented under the section of Staff Development.
	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	CD-20: Compliance with this standard is documented under the section of Staff Development.
	Riverview certifies that staffing ratios required by ¶202 are met, and makes available documentation that shows actual staffing for up to one recent month.	CD-21: All required staffing ratios are regularly met. Evidence of compliance can be reviewed through staffing office and other human resource records.
	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.	CD-22: *A process for the review of the requisite 28 client records is being developed and will be conducted on a quarterly basis. To determine substantial compliance in the areas of: 1) treatment and discharge planning and implementation, and 2) staffing.*
Seclusion and Restraint	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	Report compiled by the Integrated Quality Team and reported in Comparative Statistics section on… CD-23: Seclusion Hours and CD-24: Restraint Hours.
	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.	CD-25: Report compiled by the Integrated Quality Team and reported in Comparative Statistics
	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.	CD-26: Report compiled by the Integrated Quality Team and reported in Comparative Statistics
	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.**	CD-42: Seclusion and CD-43 restraint events are reviewed as part of a regular analysis of performance by the Nursing Department.

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CONSENT DECREE COMPLIANCE

Subject Area	Standard of Substantial Compliance	Efforts to Comply & Evidence of Compliance
Elopement	Quarterly performance data shows that, in 5 out of 6 quarters, the number of client elopements does not exceed one standard deviation from the national mean as reported by NASMHPD.	CD-27: Report compiled by the Integrated Quality Team and reported in Comparative Statistics section on Elopement.
Client Injuries	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.	CD-28: Report compiled by the Integrated Quality Team and reported in Comparative Statistics section on Client Injuries.
Patient Abuse, Neglect, Exploitation, Injury or Death	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.	CD-29: Regular reports of any events related to allegations of abuse, neglect, exploitation, injury or death are submitted to the Disability Rights Center, the Human Rights Committee and the Consent Decree Court Master per the requirements of the Settlement Agreement. Minutes of the Human Rights Committee are available for review by regulators and accreditation agencies upon request. The Superintendent also certifies annually according to 22 MRSA, Chapter 1684, and 10-44 CMR Chapter 114, Rules Governing the Reporting of Sentinel Events that all sentinel and serious reportable events are reported to the DHHS DLRS Sentinel Events Team as required by this law.
Performance Improvement	Riverview maintains JCAHO accreditation	CD-30: A joint commission survey conducted on November 15-19, 2010 resulted in a full accreditation determination for both the hospital and the Community Forensic ACT team. Documentation of this action can be viewed in the office of the Superintendent.
	Riverview maintains its hospital license	CD-40: Documentation of the hospital's licensure status can be viewed in the office of the Superintendent and verified with the Maine DHHS Department of Licensure and Regulatory Services.
	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	CD-41: Documentation of the hospital's CMS certification status can be viewed in the office of the Superintendent.

The items listed in this table were abstracted from the Standards for Defining Substantial Compliance dated October 29, 2007.