

# Riverview

PSYCHIATRIC CENTER



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QUARTERLY REPORT ON  
ORGANIZATIONAL PERFORMANCE EXCELLENCE

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FOURTH STATE FISCAL QUARTER 2014  
April, May, June 2014

Robert J. Harper  
Acting Superintendent

July 23, 2014



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## Glossary of Terms, Acronyms & Abbreviations

ACT	Assertive Community Treatment
ADC	Automated Dispensing Cabinets (for medications)
ADON	Assistant Director of Nursing
AOC	Administrator on Call
CCM	Continuation of Care Management (Social Work Services)
CCP	Continuation of Care Plan
CH/CON	Charges/Convicted
CMS	Centers for Medicare & Medicaid Services
CIVIL	Voluntary, No Criminal Justice Involvement
CIVIL-INVOL	Involuntary Civil Court Commitment (No Criminal Justice Involvement)
CoP	Community of Practice or Conditions of Participation (CMS)
CPI	Continuous Process (or Performance) Improvement
CPR	Cardio-Pulmonary Resuscitation
CSP	Comprehensive Service Plan
DCC	Involuntary District Court Committed
DCC-PTP	Involuntary District Court Committed, Progressive Treatment Plan
GAP	Goal, Assessment, Plan Documentation
HOC	Hand off communications.
IMD	Institute for Mental Disease
ICDCC	Involuntary Civil District Court Commitment
ICDCC-M	Involuntary Civil District Court Commitment, Court Ordered Medications
ICDCC-PTP	Involuntary Civil District Court Commitment, Progressive Treatment Plan
IC-PTP+M	Involuntary Commitment, Progressive Treatment Plan, Court Ordered Medications
ICRDCC	Involuntary Criminal District Court Commitment
INVOL CRIM	Involuntary Criminal Commitment
INVOL-CIV	Involuntary Civil Commitment
ISP	Individualized Service Plan
IST	Incompetent to Stand Trial
LCSW	Licensed Clinical Social Worker
LEGHOLD	Legal Hold
LPN	License Practical Nurse
TJC	The Joint Commission (formerly JCAHO, Joint Commission on Accreditation of Healthcare Organizations)
MAR	Medication Administration Record
MHW	Mental Health Worker
MRDO	Medication Resistant Disease Organism (MRSA, VRE, C-Dif)
NAPPI	Non Abusive Psychological and Physical Intervention
NASMHPD	National Association of State Mental Health Program Directors
NCR	Not Criminally Responsible
NOD	Nurse on Duty
NP	Nurse Practitioner



## Glossary of Terms, Acronyms & Abbreviations

NPSG	National Patient Safety Goals (established by the Joint Commission)
NRI	NASMHPD Research Institute, Inc.
OT	Occupational Therapist
PA or PA-C	Physician's Assistant (Certified)
PCHDCC	Pending Court Hearing
PCHDCC+M	Pending Court Hearing for Court Ordered Medications
PPR	Periodic Performance Review – a self-assessment based upon TJC standards that are conducted annually by each department head.
PSD	Program Services Director
PTP	Progressive Treatment Plan
PRET	Pretrial Evaluation
R.A.C.E.	Rescue/Alarm/Confine/Extinguish
RN	Registered Nurse
RT	Recreation Therapist
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration (Federal)
SAMHS	Substance Abuse and Mental Health Services, Office of (Maine DHHS)
SBAR	Acronym for a model of concise communications first developed by the US Navy Submarine Command. S = Situation, B = Background, A = Assessment, R = Recommendation
SD	Standard Deviation – a measure of data variability.
Seclusion, Locked	Client is placed in a secured room with the door locked.
Seclusion, Open	Client is placed in a room and instructed not to leave the room.
SRC	Single Room Care (seclusion)
STAGE III	60 Day Forensic Evaluation
URI	Upper respiratory infection
UTI	Urinary tract infection
VOL	Voluntary – Self
VOL-OTHER	Voluntary – Others (Guardian)



## INTRODUCTION

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

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

There are three major sections that make up this report:

The first section reflects compliance factors related to the Consent Decree and includes those performance measure described in the Order Adopting Compliance Standards dated October 29, 2007. Comparison data is not always available for the last month in the quarter and is included in the next report.

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

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

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

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





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# CONSENT DECREE

## Consent Decree Plan

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

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

## Client Rights

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

Indicators	1Q2014	2Q2014	3Q2014	4Q2014
1. Clients are routinely informed of their rights upon admission	98% 52/55 2 refused	100% 45/45 (100%, 15/15 for Lower Saco)	100% 44/45 1 refused (100%, 15/15 for Lower Saco)	100% 26/32* (97%, 27/29 for Lower Saco**)

\*3 refused, 3 lacked capacity

\*\*1 refused, 1 not accounted for

Clients are informed of their rights and asked to sign that information has been provided to them. If they refuse, the staff documents the refusal and sign, date & time the refusal.

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

Indicators	1Q2014	2Q2014	3Q2014	4Q2014
1. Level II grievances responded to by RPC on time.	50% 3/6	100% 1/1	N/A	100% 2/2
2. Level I grievances responded to by RPC on time.	98% 59/60	100% 61/61	97% 67/69	100% 51/51

# CONSENT DECREE

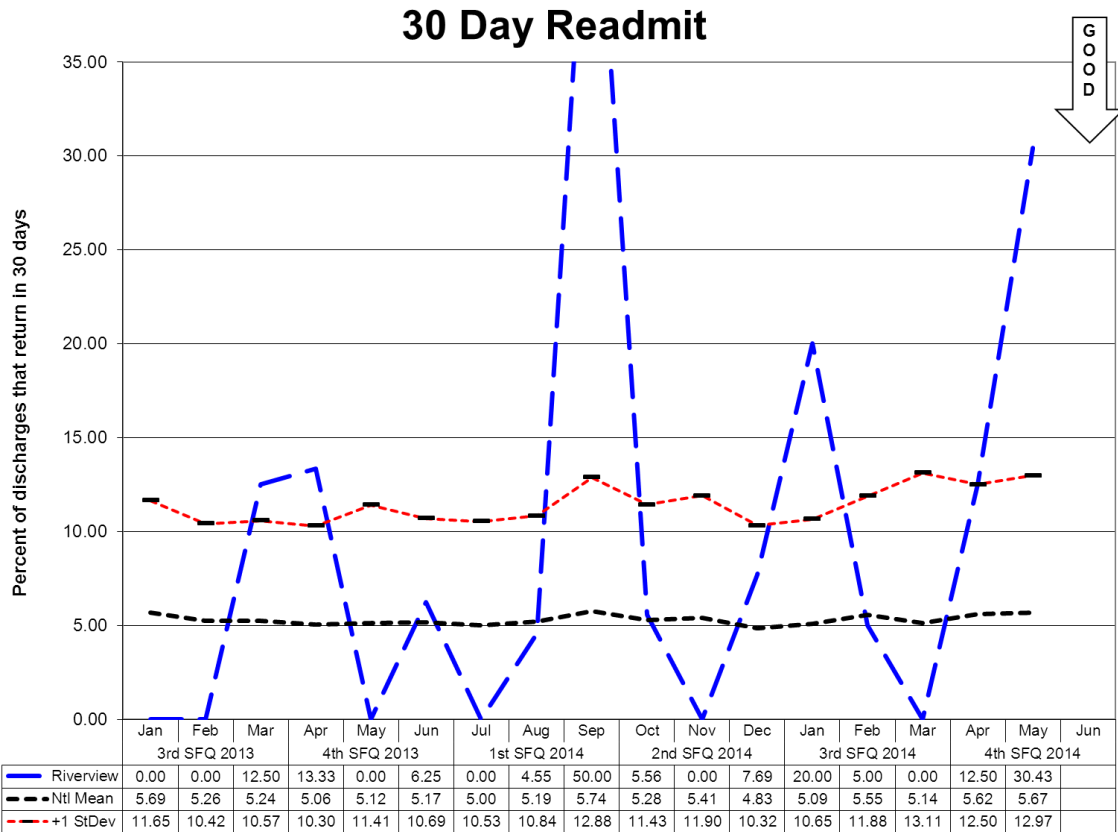
## Admissions

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

<b>Legal Status on Admission</b>	<b>1Q2014</b>	<b>2Q2014</b>	<b>3Q2014</b>	<b>4Q2014</b>	<b>Total</b>
CIVIL				1	1
CIVIL-INVOL	1	3	2	1	7
DCC	29	14	29	24	96
DCC-PTP	1	1			2
<b>Civil Total</b>	<b>31</b>	<b>18</b>	<b>31</b>	<b>26</b>	<b>106</b>
CH/CON			1		1
IST	5	9	7	5	26
LEGHOLD			1	2	3
NCR		2	2		4
PRET		1			1
STAGE III	24	17	19	18	78
<b>Forensic Total</b>	<b>29</b>	<b>29</b>	<b>30</b>	<b>25</b>	<b>113</b>
<b>GRAND TOTAL</b>	<b>60</b>	<b>47</b>	<b>61</b>	<b>51</b>	<b>219</b>

# CONSENT DECREE

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



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

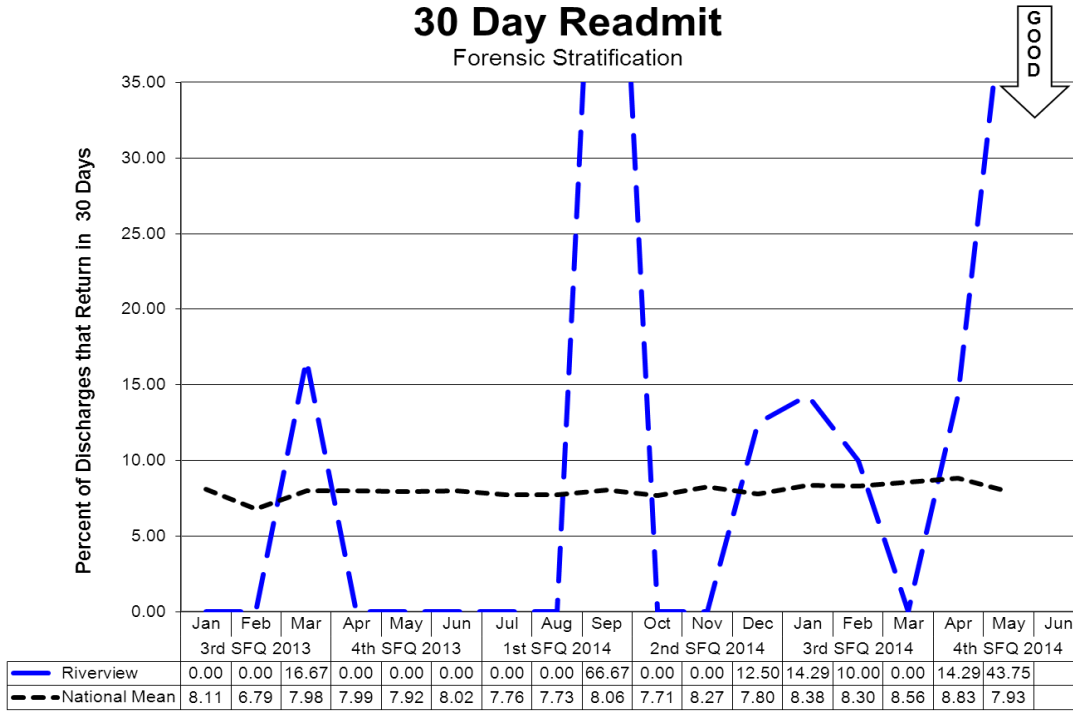
The graphs shown on the next page depict the percent of discharges from the facility that returned within 30 days of a discharge of the same client from the same facility stratified by forensic or civil classifications. For example; a rate of 10.0 means that 10% of all discharges were readmitted within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

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

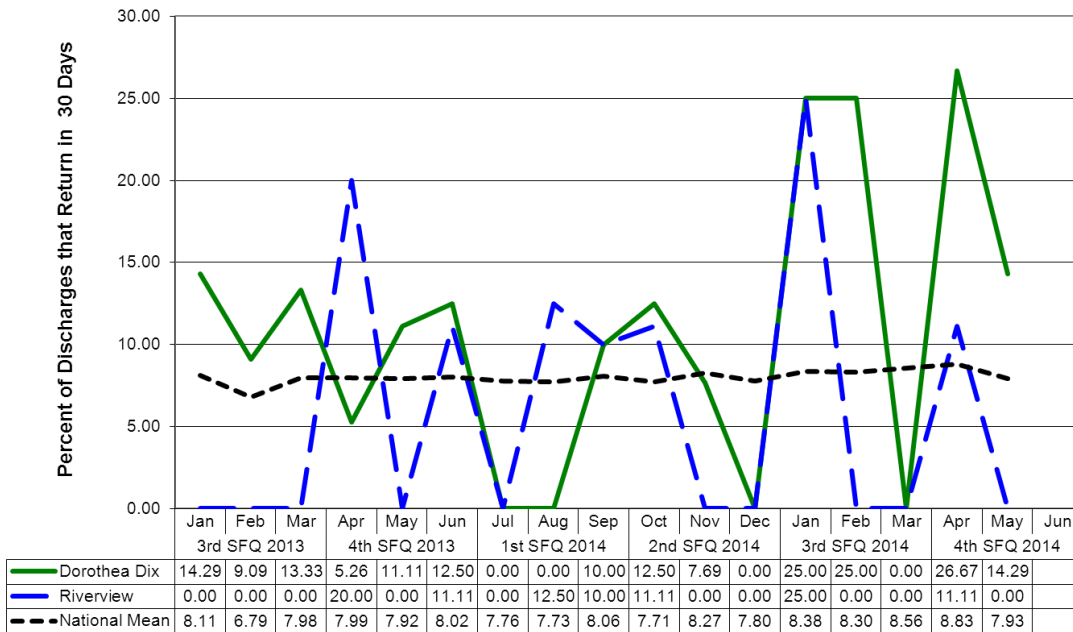
Please Note: In August 2013 the Lower Saco unit was decertified; patients had to be discharged and readmitted in our Meditech Electronic Medical Record System, even though they were not actually discharged from the hospital. This caused the numbers in August 2013 to increase. Starting in August 2013 and going forward anytime that a patient transfers units in the hospital (either from or to Lower Saco) we must now discharge them and readmit them in Meditech, which causes them to show up in this graph as a 30 Day Readmission, even though technically they never left the hospital.

# CONSENT DECREE

## 30 Day Readmit Forensic Stratification



## 30 Day Readmit Civil Stratification



# CONSENT DECREE

V6) Riverview documents, as part of the Performance Improvement & Quality Assurance process, that the Director of Social Work reviews all readmissions occurring within 60 days of the last discharge; and for each client who spent fewer than 30 days in the community, evaluated the circumstances to determine whether the readmission indicated a need for resources or a change in treatment and discharge planning or a need for different resources and, where such a need or change was indicated, that corrective action was taken;

## REVIEW OF READMISSION OCCURRING WITHIN 60 DAYS

Indicators	1Q2014	2Q2014	3Q2014	4Q2014
Director of Social Services reviews all readmissions occurring within 60 days of the last discharge and for each client who spent fewer than 30 days in the community, evaluated the circumstances of the readmission to determine an indicated need for resources or a change in treatment and discharge planning or the need for alternative resources. In cases where such a need or change was indicated that corrective action was taken.	100% 2/2	100% 1/1	N/A	100% 1/1

# CONSENT DECREE

## REDUCTION OF RE-HOSPITALIZATION FOR ACT TEAM CLIENTS

Indicators	1Q2014	2Q2014	3Q2014	4Q2014
<p>1. The ACT Team Director will review all client cases of re-hospitalization from the community for patterns and trends of the contributing factors leading to re-hospitalization each quarter. The following elements are considered during the review:</p> <ul style="list-style-type: none"> <li>a. Length of stay in community</li> <li>b. Type of residence (i.e.: group home, apartment, etc)</li> <li>c. Geographic location of residence</li> <li>d. Community support network</li> <li>e. Client demographics (age, gender, financial)</li> <li>f. Behavior pattern/mental status</li> <li>g. Medication adherence</li> <li>h. Level of communication with ACT Team</li> </ul>	<p>100%</p> <p>2 clients were returned to RPC for psychiatric instability,</p>	<p>100%</p> <p>1 client was returned to RPC for psychiatric instability due to substance abuse relapse</p>	<p>100%</p> <p>1 client was returned to DDPC for psychiatric instability, client remains in DDPC</p>	<p>100%</p> <p>1 client returned to RPC for psychiatric instability from group home, remains in RPC on Upper Saco</p>
<p>2. ACT Team will work closely with inpatient treatment team to create and apply discharge plan incorporating additional supports determined by review noted in #1.</p>	<p>100%</p>	<p>100%</p>	<p>100%</p> <p>Regular contact with DDPC treatment team</p>	<p>100%</p> <p>Attendance at all treatment team meetings and one morning rounds.</p>

### Current Quarter Summary:

1. Readmitted patient is male, age 43, socioeconomically disadvantaged, was living in the community in a group home for 8 months with one other psychiatric hospitalization, has little to no family support and is not able to adequately use resources that are available such as transportation, education. Patient was apparently medication adherent but smoking almost constantly. This patient had been attending appointments such as case management, medication management and peer support as scheduled with the RPC ACT Team and with the RPC Harbor Mall for group therapy.
2. The ACT Team and the Upper Saco Unit are working closely together to formulate a more lasting successful community placement that will likely include a neurological rehabilitation component to assist with this patient’s access to structured, productive time spent in his residence. The Certified Therapeutic Recreation Specialist working with this patient was instrumental in developing this plan.

# CONSENT DECREE

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

Client Admission Diagnoses	1Q14	2Q14	3Q14	4Q14	TOT
ADJUSTMENT DISORDER WITH DEPRESSED MOOD					0
ADJUSTMENT DISORDER WITH ANXIETY					0
ADJUST DISORDER WITH MIXED ANXIETY & DEPRESSED MOOD	2	1			3
ADJUSTMENT REACTION NOS	1				1
ALCOHOL ABUSE-IN REMISS					0
ANXIETY STATE NOS				3	3
ATTN DEFICIT W HYPERACT	1	1			2
BIPOLAR I DISORDER, SINGLE MANIC EPISODE, UNSPECIFIED			1		1
BIPOL I, REC EPIS OR CURRENT MANIC, SEVERE, SPEC W PSYCH BEH			2		2
BIPOL I, MOST RECENT EPISODE (OR CURRENT) MIXED, UNSPEC		3			3
BIPOLAR DISORDER, UNSPECIFIED	8	2	5	3	18
CATATONIA-UNSPECIFIED					0
DELUSIONAL DISORDER			1	2	3
DEPRESSIVE DISORDER NEC	6	3	4		13
DRUG ABUSE NEC-IN REMISS			1		1
FACTITIOUS DIS W PREDOMINANTLY PSYCHOLOGICAL SIGNS & SYMPTOM		1			1
FACTITIOUS ILL NEC/NOS		1			1
HEBEPHRENIA-UNSPEC		1			1
IMPULSE CONTROL DIS NOS		1			1
INTERMITT EXPLOSIVE DIS			1	1	2
MILD INTELLECTUAL DISABILITIES			1		1
OTHER AND UNSPECIFIED BIPOLAR DISORDERS, OTHER				1	1
OTH PERSISTENT MENTAL DIS DUE TO COND CLASS ELSEWHERE					0
PARANOID SCHIZO-CHRONIC	10	3	2	6	21
PARANOID SCHIZO-UNSPEC	1	1	4	1	7
PERSON FEIGNING ILLNESS	1	1			2
POSTTRAUMATIC STRESS DISORDER	4		5	1	10
PSYCHOSIS NOS	5	10	11	8	34
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED	13	11	12	12	48
SCHIZOPHRENIA NOS-CHR			1	2	3
SCHIZOPHRENIA NEC-UNSPEC			1	1	2
SCHIZOPHRENIFORM DISORDER, UNSPECIFIED		1		2	3
UNSPECIFIED EPISODIC MOOD DISORDER	8	5	9	8	30
UNSPECIFIED NONPSYCHOTIC MENTAL DISORDER					0
UNSPEC TRANSIENT MENTAL DIS IN COND CLASSIFIED ELSEWHERE		1			1
<b>Total Admissions</b>	<b>60</b>	<b>47</b>	<b>61</b>	<b>51</b>	<b>219</b>
Admitted with primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	<b>0.00%</b>	<b>0.00%</b>	<b>1.64%</b>	<b>0.00%</b>	<b>0.46%</b>



# CONSENT DECREE

## Peer Supports

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

V8) 100% of all clients have documented contact with a peer specialist during hospitalization;

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

Indicators	1Q2014	2Q2014	3Q2014	4Q2014
1. Attendance at Comprehensive Treatment Team meetings. (v9)	84% 408/488	86% 352/411	86% 395/458	89% 417/466
2. Attendance at Service Integration meetings. (v8)	95% 53/56	100% 41/41	86% 55/64	100% 46/46
3. Contact during admission. (v8)	100% 56/56	100% 57/57	100% 64/64	100% 62/62

## Treatment Planning

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

Indicators	1Q2014	2Q2014	3Q2014	4Q2014
1. Preliminary Continuity of Care meeting completed by end of 3 <sup>rd</sup> day	100% 30/30	100% 30/30	100% 30/30	100% 30/30
2. Service Integration form completed by the end of the 3rd day	100% 30/30	100% 30/30	100% 30/30	100% 30/30
3a. Client Participation in Preliminary Continuity of Care meeting.	100% 30/30	100% 30/30	100% 30/30	100% 30/30
3b. CCM Participation in Preliminary Continuity of Care meeting.	100% 30/30	100% 30/30	100% 30/30	100% 30/30
3c. Client's Family Member and/or Natural Support (e.g., peer support, advocacy, attorney) Participation in Preliminary Continuity of Care meeting.	93% 28/30	90% 27/30	100% 30/30	80% 24/30
4a. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	96% 29/30	93% 28/30	93% 28/30	86% 26/30
4b. Initial Comprehensive Assessment contains summary narrative with conclusion and recommendations for discharge and social worker role	96% 29/30	100% 30/30	100% 30/30	100% 30/30
4c. Annual Psychosocial Assessment completed and current in chart	100% 15/15	100% 15/15	100% 15/15	100% 15/15

### Summary:

3c) The Peer Support department did not provide coverage to the units during a timeframe of training and staff absence. The Social Work Director addressed the issue with the Peer Support Director and the alerted the Superintendent to the coverage issue.

4a) We had four psych-social assessments that were not completed within the 7 day timeframe. The social work department temporarily had four vacancies concurrently and while all psych socials were completed they were not finished in the 7 day timeframe. Director continues to address the issue of unit coverage and staffing for the department.

# CONSENT DECREE

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

Indicators	1Q2014	2Q2014	3Q2014	4Q2014
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all clients on assigned <b>CCM</b> caseload.	96% 29/30	93% 28/30	86% 26/30	83% 25/30
2. 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.	100% 30/30	100% 30/30	96% 29/30	86% 26/30

### Summary

- 1) Director addressed this issue with individual staff in supervision and with the entire team at group staff meeting.
- 2) Director addressed the issue with individual team members and as a group in staff meetings. The social work department continues to focus on this critical area of treatment planning.

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

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

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

# CONSENT DECREE

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

V13) The treatment plans reflect

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

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

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

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

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

# CONSENT DECREE

## Medications

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

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

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

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

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

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



# CONSENT DECREE

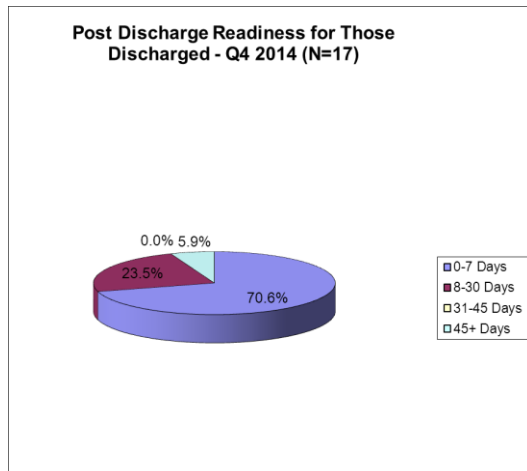
## Discharges

Quarterly performance data shows that in 3 consecutive quarters:

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

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

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



Cumulative percentages & targets are as follows:

- Within 7 days = (12) 70.6% (target 70%)**
- Within 30 days = (16) 94.1% (target 80%)**
- Within 45 days = (16) 94.1% (target 90%)**
- Post 45 days = (1) 5.9% (target 0%)**

### Barriers to Discharge Following Clinical Readiness

#### Residential Supports (0)

No barriers in this area

#### Housing (3) 17%

- 1 client discharged 15 days post clinical readiness/housing barrier
- 1 client discharged 27 days post clinical readiness/housing barrier
- 1 client discharged 49 days post clinical readiness/housing barrier

#### Treatment Services (0) 0%

No barriers in this area

The previous four quarters are displayed in the table below

		Within 7 days	Within 30days	Within 45 days	45 +days
Target >>		70%	80%	90%	< 10%
3Q2014	N=24	73.1%	84.6%	92.3%	7.7%
2Q2014	N=20	73.1%	84.6%	92.3%	7.7%
1Q2014	N=26	73.1%	84.6%	92.3%	7.7%
4Q2013	N=30	70%	86.7%	93.3%	6.7%

# CONSENT DECREE

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

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

V20a) For patients who have been found not criminally responsible or not guilty by reason of insanity, appropriate interventions include timely reviews of progress toward the maximum levels allowed by court order; and the record reflects timely reviews of progress toward the maximum levels allowed by court order;

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

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

Indicators	1Q2014	2Q2014	3Q2014	4Q2014
1. The Client Discharge Plan Report will be updated/reviewed by each <b>Social Worker minimally one time per week.</b>	100% 12/12	100% 11/11	100% 9/9	91% 11/12
2. The Client Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	100% 12/12	100% 11/11	100% 9/9	91% 11/12
2a. The Client Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	91% 11/12	100% 11/11	100% 9/9	91% 11/12
3. Each week the Social Work team and Director will meet and discuss current housing options provided by the respective regions and prioritize referrals.	91% 11/12	100% 11/11	100% 9/9	91% 11/12

Summary:

The last week in June the Director was absent on medical leave and the report was not generated. The housing meeting was held and discharge planning was discussed with the social workers and the gatekeepers.

# CONSENT DECREE

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

Indicators	1Q2014	2Q2014	3Q2014	4Q2014
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	12% 1/8	0% 0/4	0% 0/2	50% 3/6
2. The assigned <b>CCM</b> will review the new court order with the client and document the meeting in a progress note or treatment team note.	100% 2/2	100% 4/4	100% 3/3	100% 4/4
3. Annual Reports (due Dec) to the commissioner for all inpatient NCR clients are submitted annually		100% 92/92	N/A	N/A

Summary:

1) Six reports were filed at 1, 8, 9, 15, 17 and 23 days respectively three of which were outside of the 10 day standard.

# CONSENT DECREE

## Staffing and Staff Training

V23) Riverview performance data shows that 95% of direct care staff have received 90% of their annual training.

Indicators	1Q2014	2Q2014	3Q2014	4Q2014	2014 Total
1. Riverview and Contract staff will attend CPR training bi-annually.	*40/46 87%	*64/67 95.5%	55/58 94.8%	40/40 100%	94.3%
2. Riverview and Contract staff will attend NAPPI training annually.	*101/120	*137/157	*See #4. Below	*See # 4 Below	85%
3. Riverview and Contract staff will attend Annual training.	*11/25	*78/81	34/36 88%	*13/15 86%	78.5%
3. Riverview and Contract staff will attend MOAB training annually.	Changed to MOAB on 1/16/14	Changed to MOAB on 1/16/14	172/408 42%	234/416 56%	49%

### 1Q2014

1. Of the six employees who are not in compliance, two staff are on Workers Compensation status, two staff are on Family Medical Leave, one transferred and missed training due to family emergency, one is out of country. All are scheduled for next available training.
2. Of the nineteen employees who are not in compliance two are on Workers compensation leave, one is on LOA. Those remaining are scheduled for the next available training.
3. Of the eleven staff who are not in compliance; two staff are on Workers compensation, one is out of the country, and one has transferred to another department. Supervisors of remaining staff have been informed they are in non-compliance and corrective actions have been taken.

### 2Q2014

1. Three employees who are out of compliance are on leave status.
2. Eight of the employees are on leave status. The remaining twelve will be attending the next offered behavior management /physical intervention training.
3. The three the individuals who are not in compliance are on leave status.

### 3Q2014

1. The three employees who are out of compliance are on leave status.
2. RPC began using MOAB as their Behavior Management Program January 16<sup>th</sup> 2014. Since that time 197/197 (active) nurses and mental health workers have received.
3. One staff is on leave status, the other staff has been informed they are out of compliance and corrective action has been taken.

### 4Q2014

1. 100% of employees are compliant with CPR certification requirements.
2. Two out of 15 staff are non-compliant with Annual Mandatory Training Requirements. Corrective Action has been taken.
3. There are 234 employees who have received MOAB training, out of the total employees MOAB trained, 190 are unit staff. MOAB continues to be offered monthly.



# CONSENT DECREE

**Goal #1:** SD will provide opportunities for employees to gain, develop and renew skills knowledge and aptitudes.

**Objective:** 100% of employees will be provided with an opportunity both formal and informal training and/or learning experiences that contribute to individual growth and improved performance in current position.

SD will survey staff annually and develop trainings to address training needs as identified by staff.

## **Current Status:**

### **1Q2014:**

Employee Education needs survey distributed to employees in March of 2013.

As a result of identified needs, the training entitled ***Personality Disorder Characteristics and Effective Interventions*** was developed and presented in August 2013.

August 19 & 26 2013, Susan C. Righthand, Ph.D, a nationally recognized speaker and consultant in the field of psychological assessment and treatment of sex offenders, conducted a *two part* training entitled: ***Working Effectively with Adult Sexual Offenders: Characteristics, Assessment, and Interventions*** available to all Riverview Psychiatric Center Employees.

August 20, 2013 Dr. Kenneth Beattie provided an in-service entitled: ***The Psychology of Working with Emotionally Challenging and Emotionally Challenged Clients***. This training was developed in response to the Employee Education needs survey distributed to employees in March of 2013 and made available to all Riverview Psychiatric Center employees.

August 5, 2013, ***Single Wrist Restraint Application*** training was held to provide an opportunity to practice skills taught in the Initial NAPPI course provided to New Employees and NAPPI Recertification Class provided on a monthly basis through-out the year to Riverview Psychiatric Center employees. Over sixty unit staff attended.

### **2Q2014:**

Patricia Deegan Ph D. provided ***Recovery Oriented Care*** training which included lessons from her own recovery from schizophrenia while teaching practical strategies for:

- Balancing the Dignity of Risk with the Duty to Care when supporting individual involvement in decision making.
- Navigating the Neglect/Overprotect Continuum, especially when folks appear to be making self-defeating choices.
- Practicing leadership-for-recovery in the workplace.

On January 18<sup>th</sup>, James Claiborn, Ph. D, provided training entitled ***Understanding Behavior and Treatment Planning*** in which participants learned:

How to identify, define, and describe behavior.

How to develop interventions that reinforce behavior we want to increase and extinguish behavior we want to decrease.

**STAT Drills were** offered throughout the month of November and December to provide staff with the opportunity to develop and enhance behavior intervention techniques and improve overall skill level when dealing with clients having difficulty maintaining positive behavior.

# CONSENT DECREE

## **3Q2014:**

Staff was provided training in Policy revisions and Regulatory standards in January 2014. Additionally Recovery Oriented Care and Personal Medicine training was rolled out at the end of March 2014.

## **4Q2014:**

A variety of additional trainings were offered to staff during this quarter including; Recovery Principles/Personal Medicine, Power Statements, Documentation, ECG Testing and Application, Incident Reporting, Medication Administration, Conducting Mental Status Assessments, Patient Rights, Seclusion and Restraint policy and procedure, HIPAA,/Confidentiality.

**Goal #2:** SD will develop and implement a comprehensive mentoring program to assist new employees in gaining the skills necessary to do their job.

**Objective:** 100% of new Mental Health Workers will be paired with a mentor and will satisfactorily complete 12 competency areas on the unit orientation prior to being assigned regular duties requiring direct care of patients.

## **Current Status:**

### **1Q2014:**

100% of new Mental Health Workers were paired with a mentor and satisfactorily completed competency areas in the Unit Orientation.

### **2Q2014:**

100% of new Mental Health Workers were paired with a mentor and satisfactorily completed competency areas in the Unit Orientation.

- In addition, mentor meetings were re-initiated to assist mentors in gaining, developing and renewing skills in which to increase new employees with the opportunity to learn specific job duties associated with their position and/or care of individuals receiving services.

### **3Q2014:**

100% of new Mental Health Workers were paired with a mentor and satisfactorily completed competency areas in the Unit Orientation.

### **4Q2014:**

All New employees were successfully paired with a mentor and completed all competencies as required.

# CONSENT DECREE

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

DATE	HRS	TITLE	PRESENTER
DATE	HRS	TITLE	PRESENTER
3Q2012	14	January - March 2012	Winter Semester (see 1Q13 Quarterly Report)
4Q2012	11	April – June 2012	Spring Semester (see 1Q13 Quarterly Report)
1Q2013	3	July – September 2012	Summer Hiatus (see 1Q13 Quarterly Report)
2Q2013	9	October – December 2012	Fall Semester (see 2Q13 Quarterly Report)
3Q2013	11	January – March 2013	Winter Semester (see 3Q13 Quarterly Report)
4Q2013	12	April – June 2013	Spring Semester (see 4Q13 Quarterly Report)
1Q2014	5.5	July - September 2013	Summer Semester (see 1Q14 Quarterly Report)
2Q2014	7	October – December 2013	Fall Semester (see 2Q14 Quarterly Report)
3Q2014	15	January – March 2014	Winter Semester (see 3Q14 Quarterly Report)
4/3/2014	1	Black Swans in Psychiatry: Anticoagulation implications in the Psychiatric Setting	Miranda Cole, PharmD Elizabeth Dragatsi, RPh
4/10/2014	1	Neuropsychology in the Assessment of Adult ADHD: Why Bother?	Robert Roth, PhD
4/15/2014	1	Peer Review Committee	Brendan Kirby MD Miriam Davidson, PMHNP
4/17/2014	1	The Functionality of Behaviors	Randy Beal, PMHNP
4/24/2014	1	Addicted to Pain? The case of KR: Self-Injury, Naltrexone and Endogenous Opioids	Dan Filene, MD
5/1/2014	1	Riverview in Recovery	Jay Harper, Superintendent
5/8/2014	1	Holistic Perspective in Assessment: The Case of CS	Jennifer Heidler-Gary, PsyD
5/15/2014	1	Neuroinflammation in Schizophrenia	Doug Noordsy, MD
5/22/2014	1	When in Doubt About the Importance of Cultural Differences, Err on the Side of Discussion	Candice Claiborne, Psychology Intern
5/29/2014	1	Hypothyroidism at Riverview: Considering Variations in the Disease and Etiologies with 3 Recent Patients	George David, MD
6/4/2014	1	MOC	Jonathan Morris, MD
6/5/2014	1	Adult ADHD: Treatment can be life changing	Russell Kimball, PA-C
6/12/2014	1	Life Through a Persecutory Lens: Challenges and Inroads	Tatiana Gregor, EdD
6/19/2014	1	Why Not Clozapine?	Miranda Cole, PharmD
6/26/2014	1	Why a drum? Rhythm Therapy: An evaluation of current research, practices, and myths, and a proposal for research	John Kootz, MD
6/27/2014	6	Violence Risk Assessment	Ira Packer, PhD

# CONSENT DECREE

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

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

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

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

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

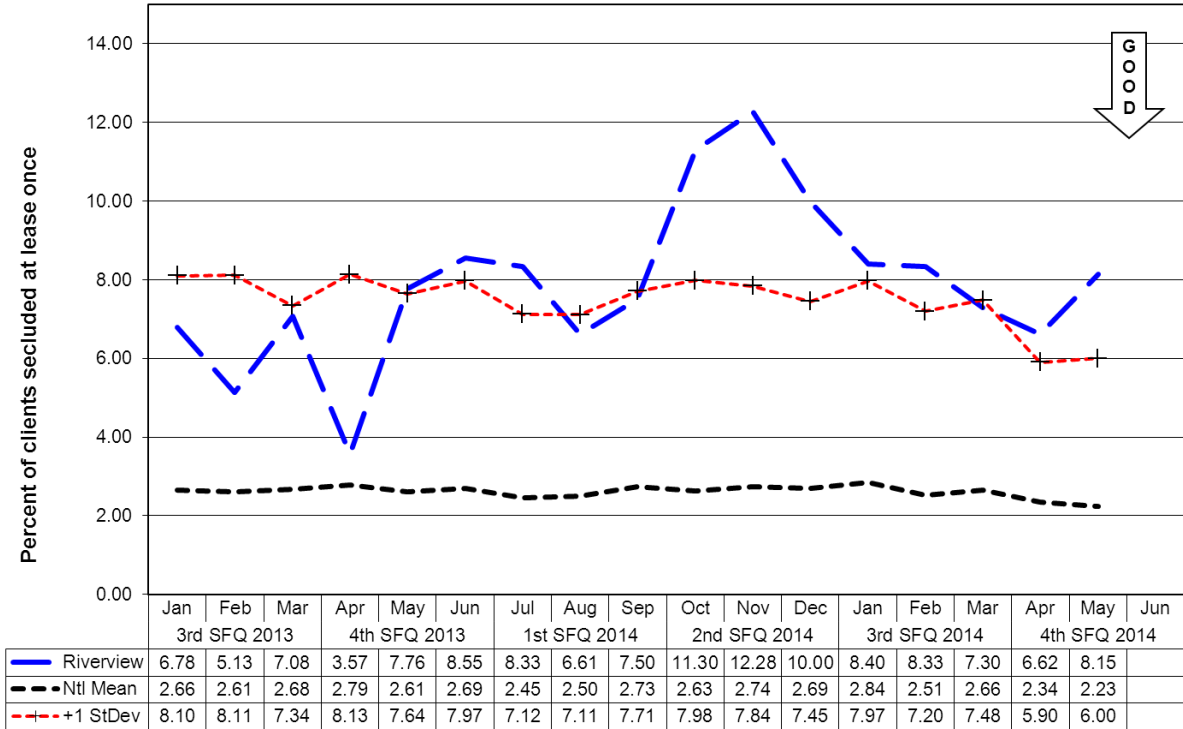
Treatment teams regularly monitor the needs of individual clients and make recommendations for ongoing treatment modalities. Staffing levels are carefully monitored to ensure that all treatment goals, exercise needs, and outdoor activities are achievable. Staffing does not present a barrier to the fulfillment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

# CONSENT DECREE

## Use of Seclusion and Restraints

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

### Percent of Clients Secluded



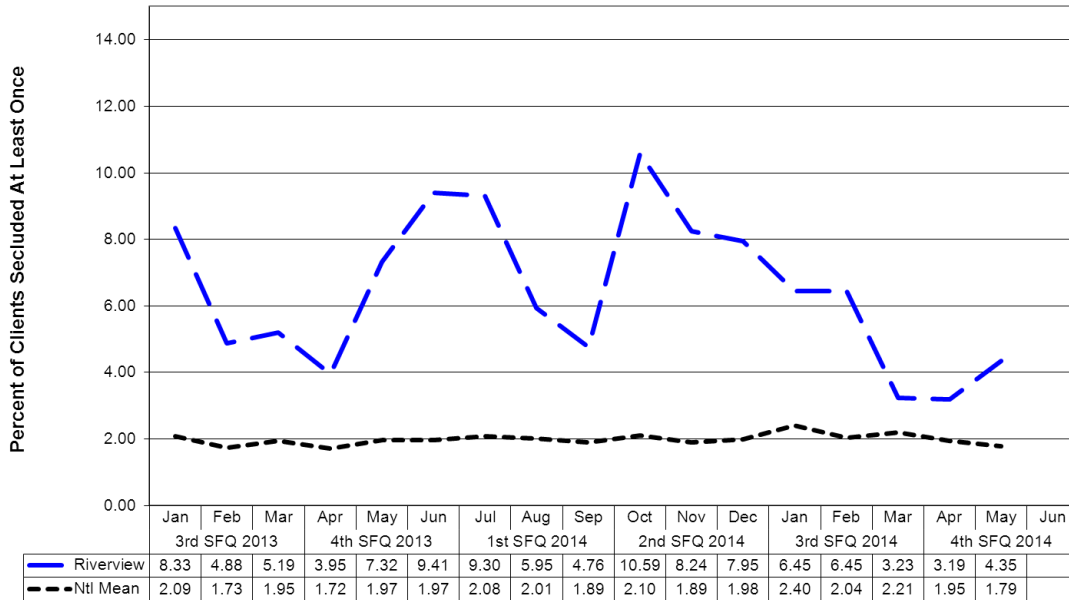
This graph depicts the percent of unique clients who were secluded at least once. For example, rates of 3.0 means that 3% of the unique clients served were secluded at least once.

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

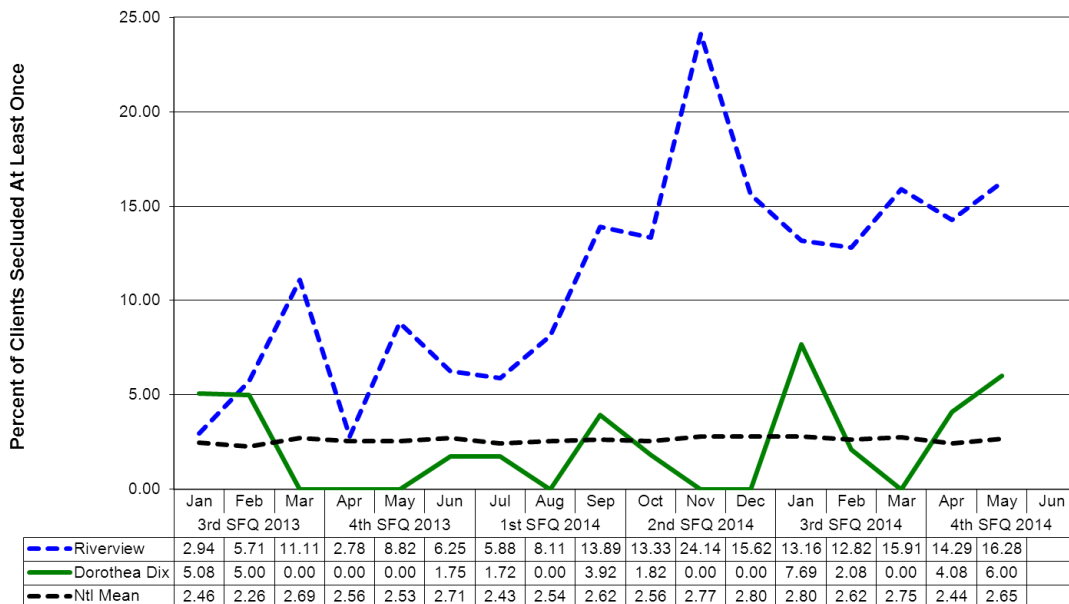
The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

# CONSENT DECREE

## Percent of Clients Secluded Forensic Stratification

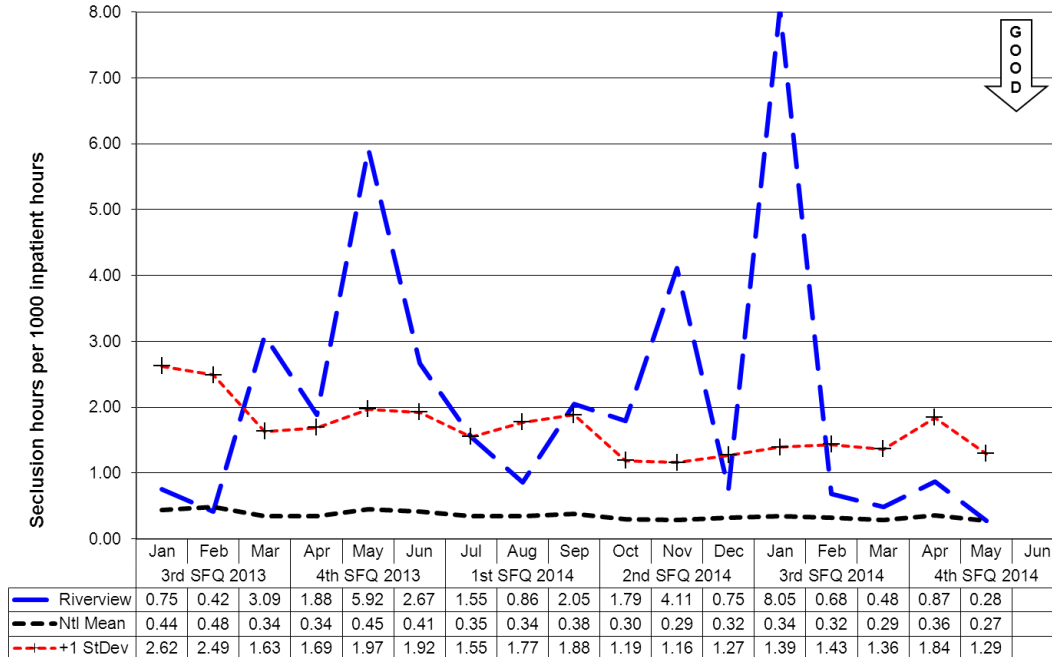


## Percent of Clients Secluded Civil Stratification



# CONSENT DECREE

## Seclusion Hours



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

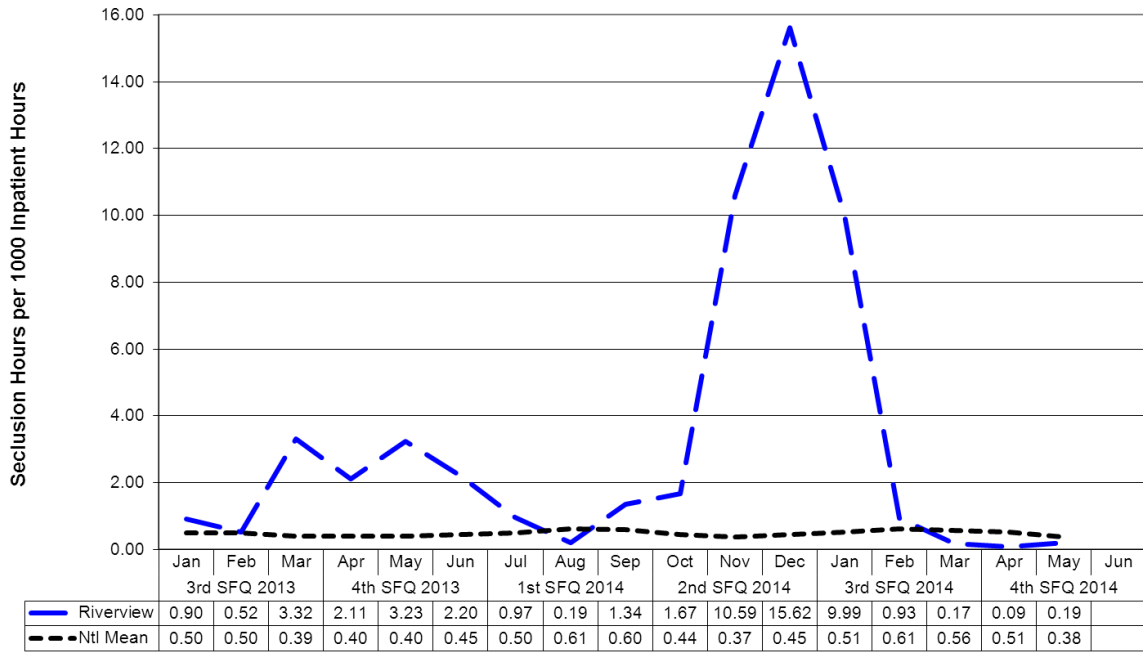
The outlier values shown in May and June reflect the events related to a single individual during this period. This individual was in seclusion for extended periods of time due to extremely aggressive behaviors that are focused on staff. It was determined that the only way to effectively manage this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

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

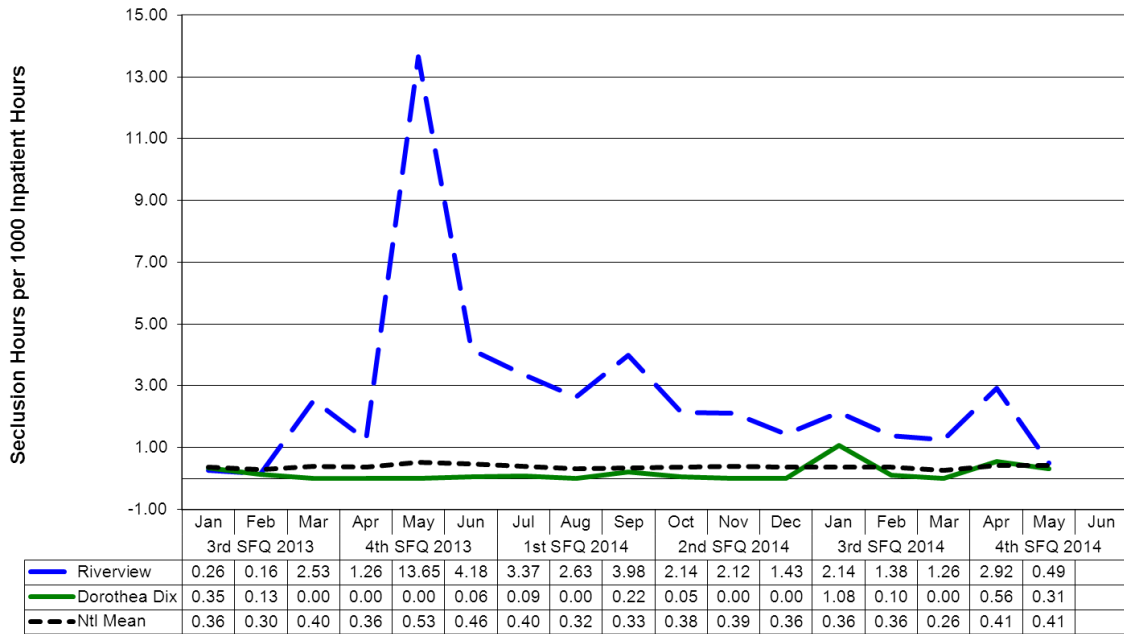
The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

# CONSENT DECREE

## Seclusion Hours Forensic Stratification



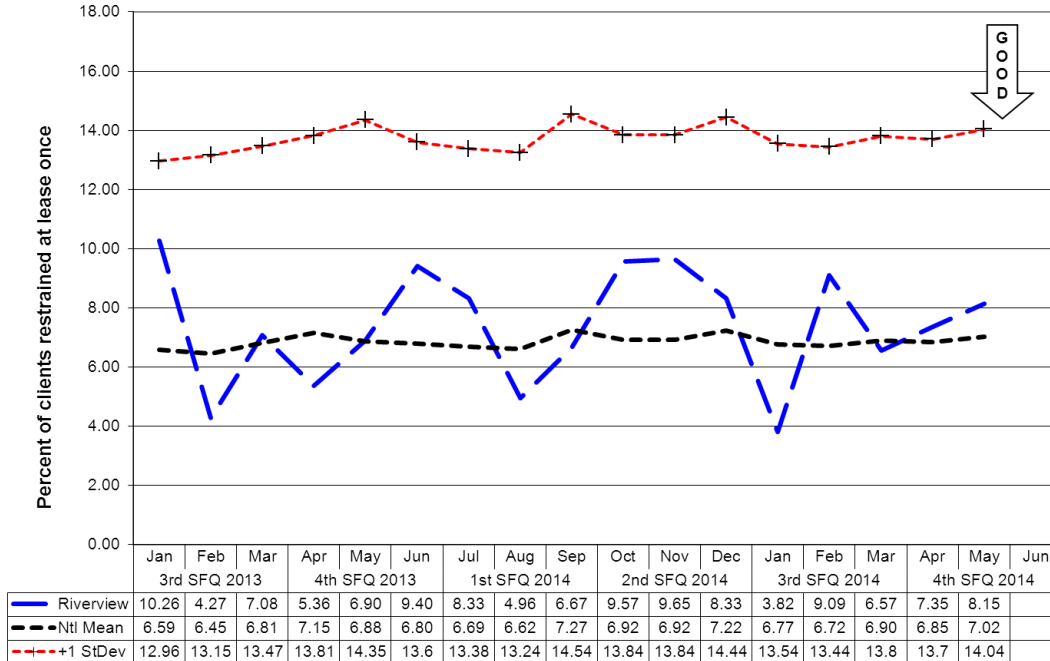
## Seclusion Hours Civil Stratification





# CONSENT DECREE

## Percent of Clients Restrained



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

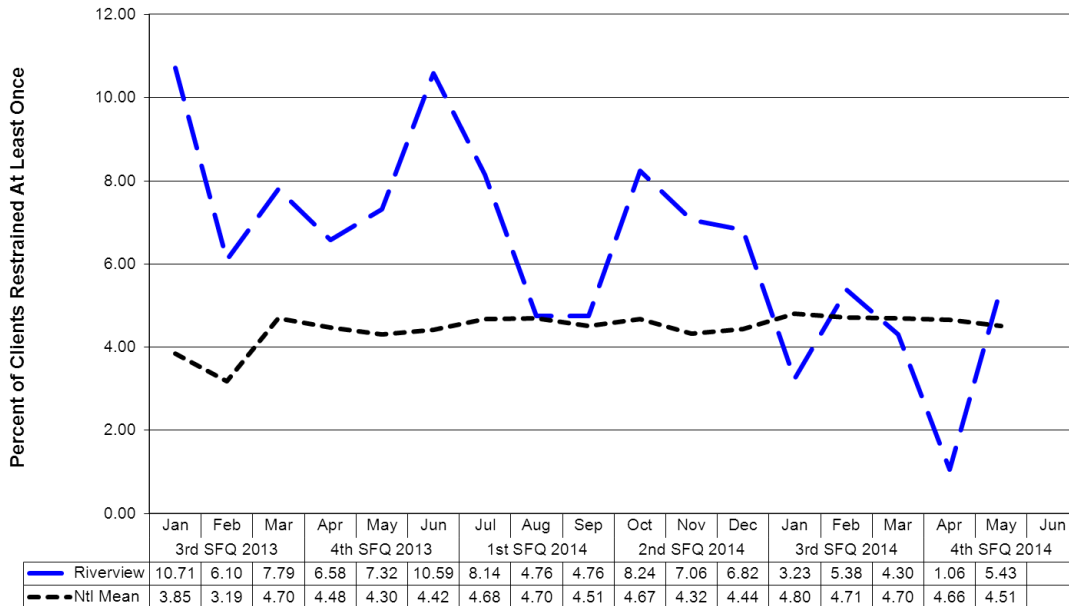
The following graphs depict the percent of unique clients who were restrained at least once stratified by forensic or civil classifications – includes all forms of restraint of any duration. For example; a rate of 4.0 means that 4% of the unique clients served were restrained at least once.

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

# CONSENT DECREE

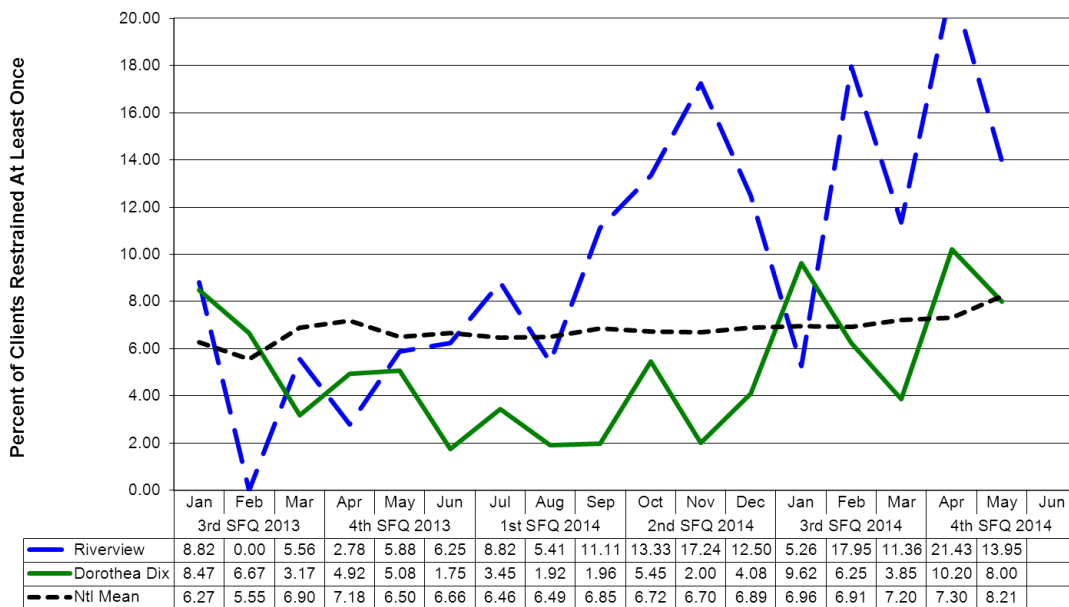
## Percent of Clients Restrained

Forensic Stratification



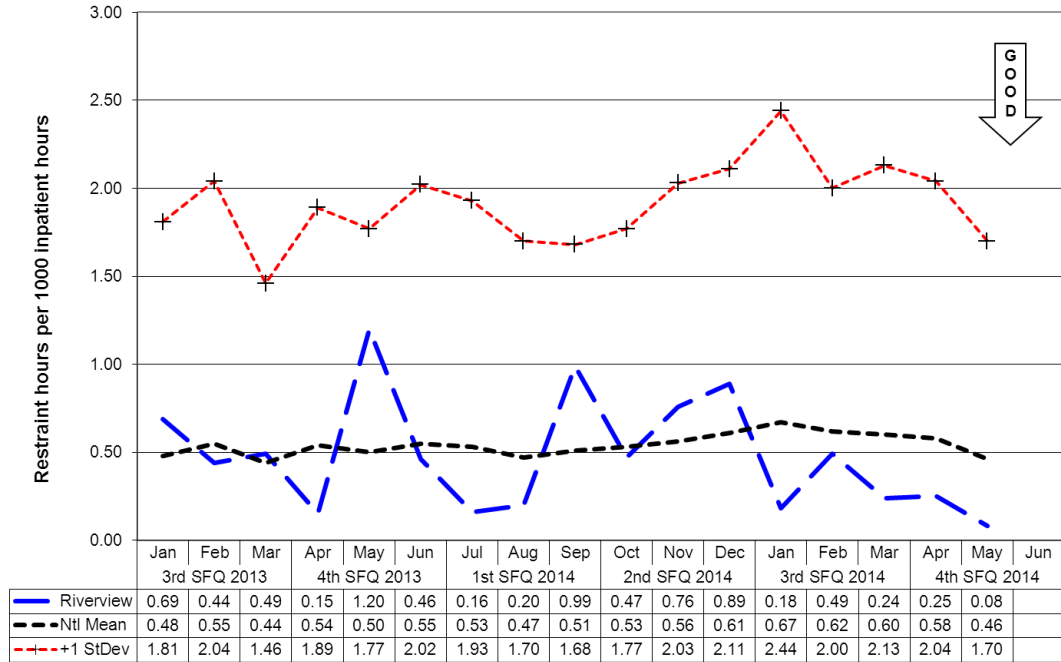
## Percent of Clients Restrained

Civil Stratification



# CONSENT DECREE

## Restraint Hours



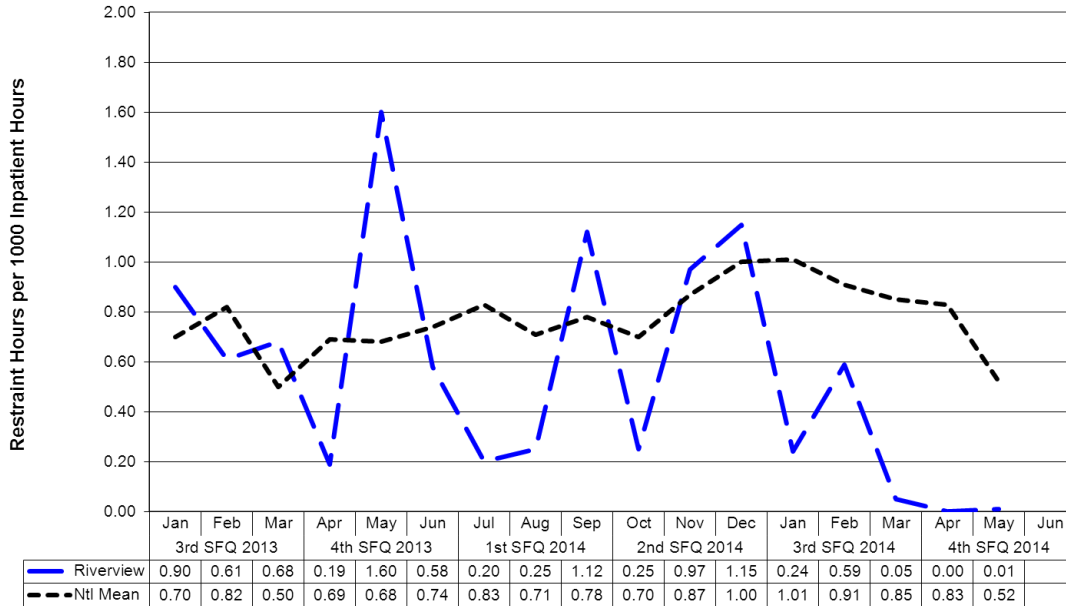
This graph depicts the number of hours clients spent in restraint for every 1000 inpatient hours - includes all forms of restraint of any duration. For example; a rate of 1.6 means those 2 hours were spent in restraint for each 1250 inpatient hours.

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

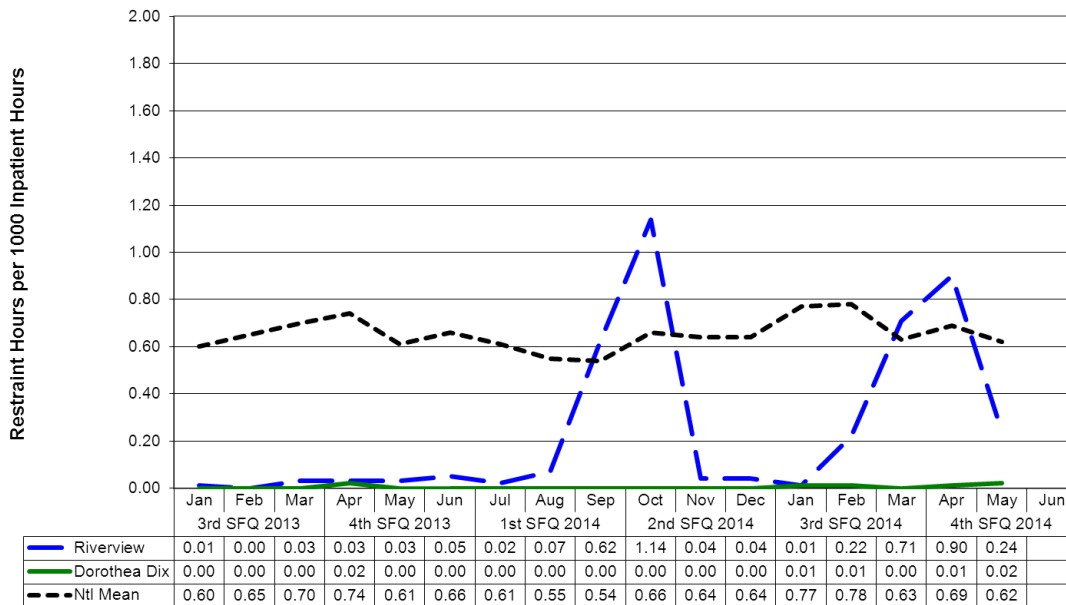
The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

# CONSENT DECREE

## Restraint Hours Forensic Stratification



## Restraint Hours Civil Stratification



# CONSENT DECREE

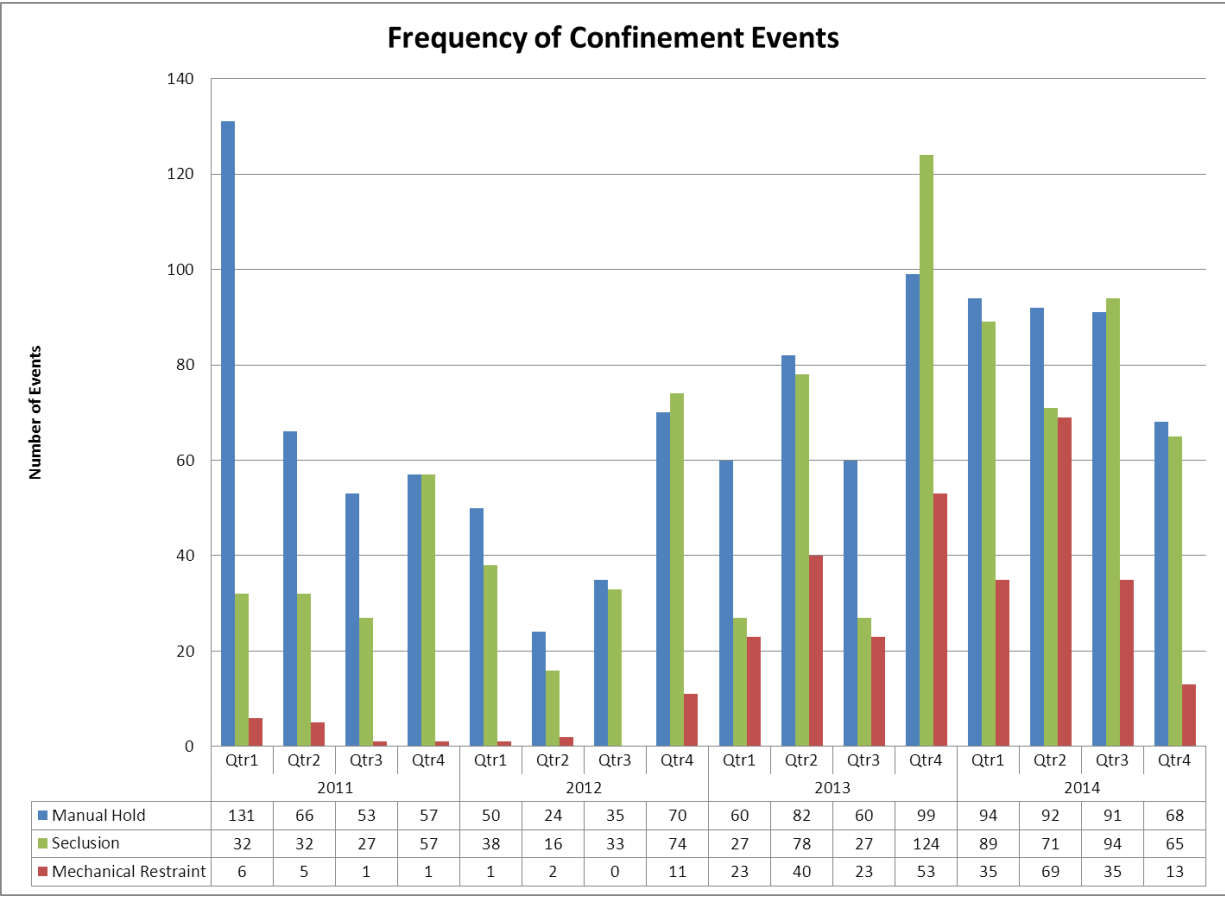
## Confinement Event Detail

4th Quarter 2014

	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
MR00007495	22	10	13	45	30.82%	30.82%
MR00002187	11		15	26	17.81%	48.63%
MR00007489	4	2	6	12	8.22%	56.85%
MR00005267	3		5	8	5.48%	62.33%
MR00000763	4		2	6	4.11%	66.44%
MR00007394	3		2	5	3.42%	69.86%
MR00007204	3		2	5	3.42%	73.29%
MR00007452	2		2	4	2.74%	76.03%
MR00007541	2		1	3	2.05%	78.08%
MR00003191	1		2	3	2.05%	80.14%
MR00007473	2		1	3	2.05%	82.19%
MR00006266	1		2	3	2.05%	84.25%
MR00000029	2		1	3	2.05%	86.30%
MR00006309	1	1		2	1.37%	87.67%
MR00007480	1		1	2	1.37%	89.04%
MR00007515	1		1	2	1.37%	90.41%
MR00007527	1		1	2	1.37%	91.78%
MR00005213			2	2	1.37%	93.15%
MR00007363			2	2	1.37%	94.52%
MR00007409	1			1	0.68%	95.21%
MR00007513	1			1	0.68%	95.89%
MR00007522	1			1	0.68%	96.58%
MR00007032	1			1	0.68%	97.26%
MR00000104			1	1	0.68%	97.95%
MR00005625			1	1	0.68%	98.63%
MR00001416			1	1	0.68%	99.32%
MR00006563			1	1	0.68%	100.00%
	<b>68</b>	<b>13</b>	<b>65</b>	<b>146</b>		

35% (27/78) of average hospital population experienced some form of confinement event during the 4<sup>th</sup> fiscal quarter 2014. Five of these clients (6% of the average hospital population) accounted for 66% of the containment events.

# CONSENT DECREE



# CONSENT DECREE

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

### Factors of Causation Related to Seclusion Events

	4Q13	1Q14	2Q14	3Q14	4Q14
Danger to Others/Self	124	71	88	92	62
Danger to Others					3
Danger to Self					
% Dangerous Precipitation	100%	100%	100%	100%	100%
Total Events	124	71	88	92	65

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

### Factors of Causation Related to Mechanical Restraint Events

	4Q13	1Q14	2Q14	3Q14	4Q14
Danger to Others/Self	53	29	51	35	12
Danger to Others					
Danger to Self			1		1
% Dangerous Precipitation	100%	100%	100%	100%	100%
Total Events	53	29	52	35	13

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

**See Pages 29 & 30**

# CONSENT DECREE

## Confinement Events Management

### Seclusion Events (65) Events

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



# CONSENT DECREE

## Confinement Events Management

### Mechanical Restraint Events (13) Events

<u>Standard</u>	<u>Threshold</u>	<u>Compliance</u>
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%

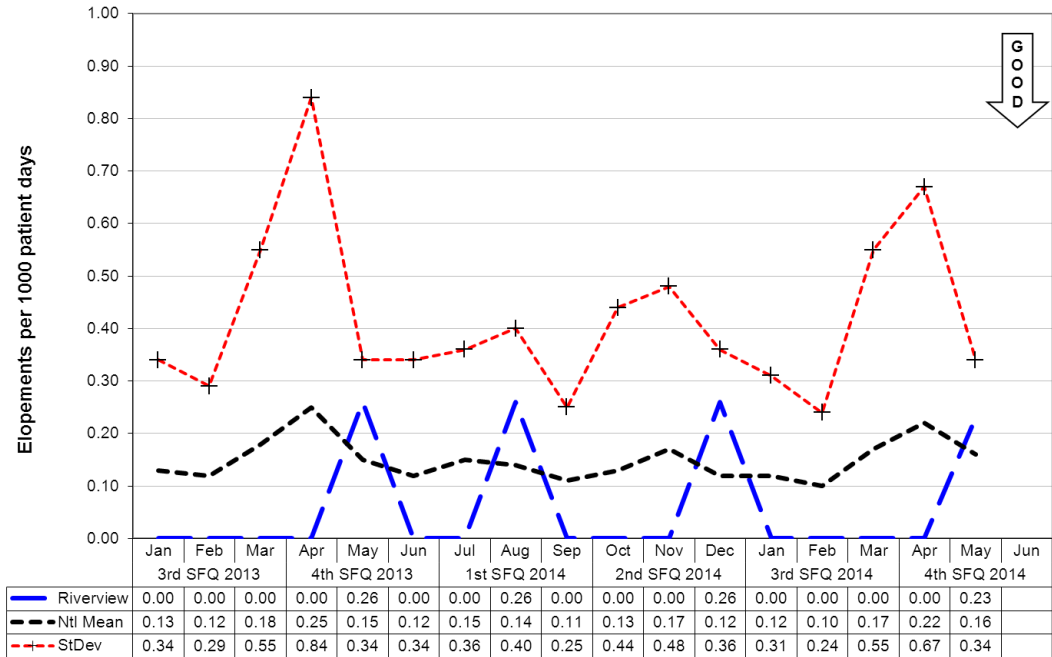
<u>Standard</u>	<u>Threshold</u>	<u>Compliance</u>
The record reflects that the need for restraint was re-evaluated every 2 hours by a nurse.	90%	100%
The record reflects that re-evaluation was conducted while the patient was free of restraints unless clinically contraindicated.	70%	100%
The record includes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

# CONSENT DECREE

## Client Elopements

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

### Elopement



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

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

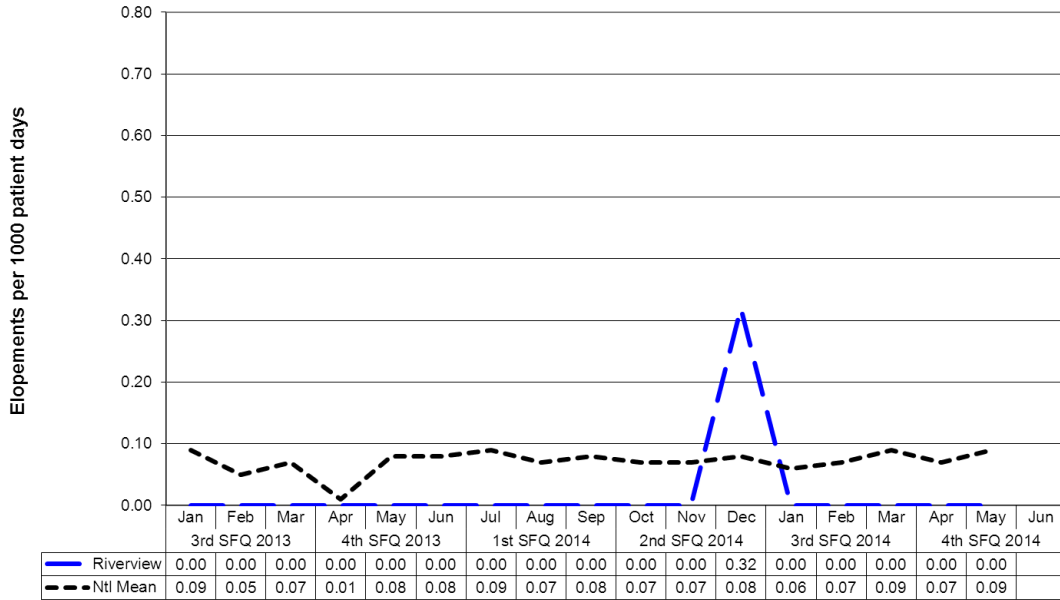
The following graphs depict the number of elopements stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days.

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

# CONSENT DECREE

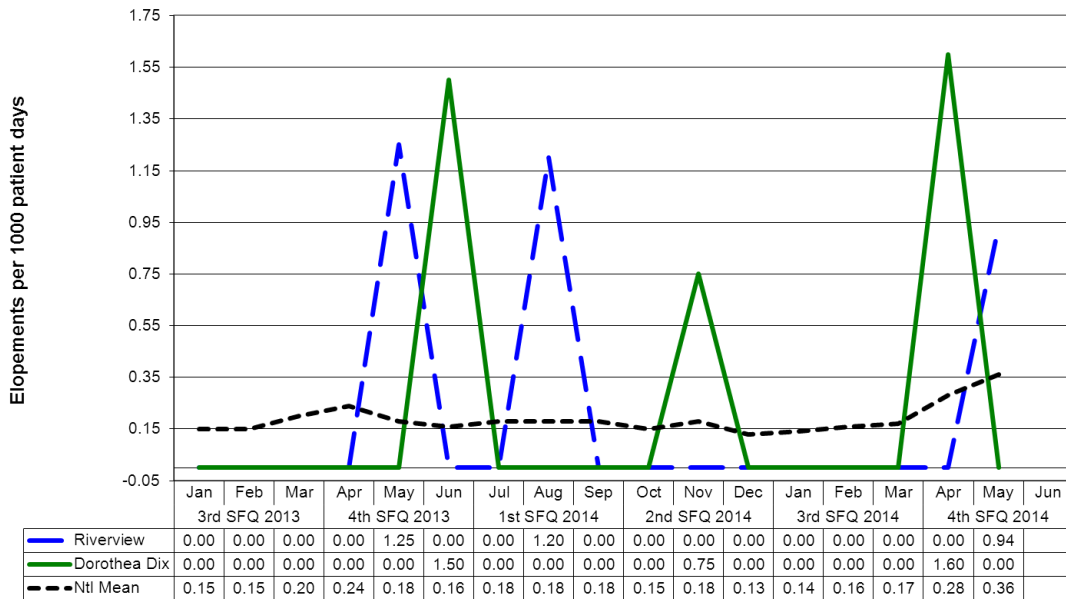
## Elopement

Forensic Stratification



## Elopement

Civil Stratification



# CONSENT DECREE

## Client Injuries

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

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

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

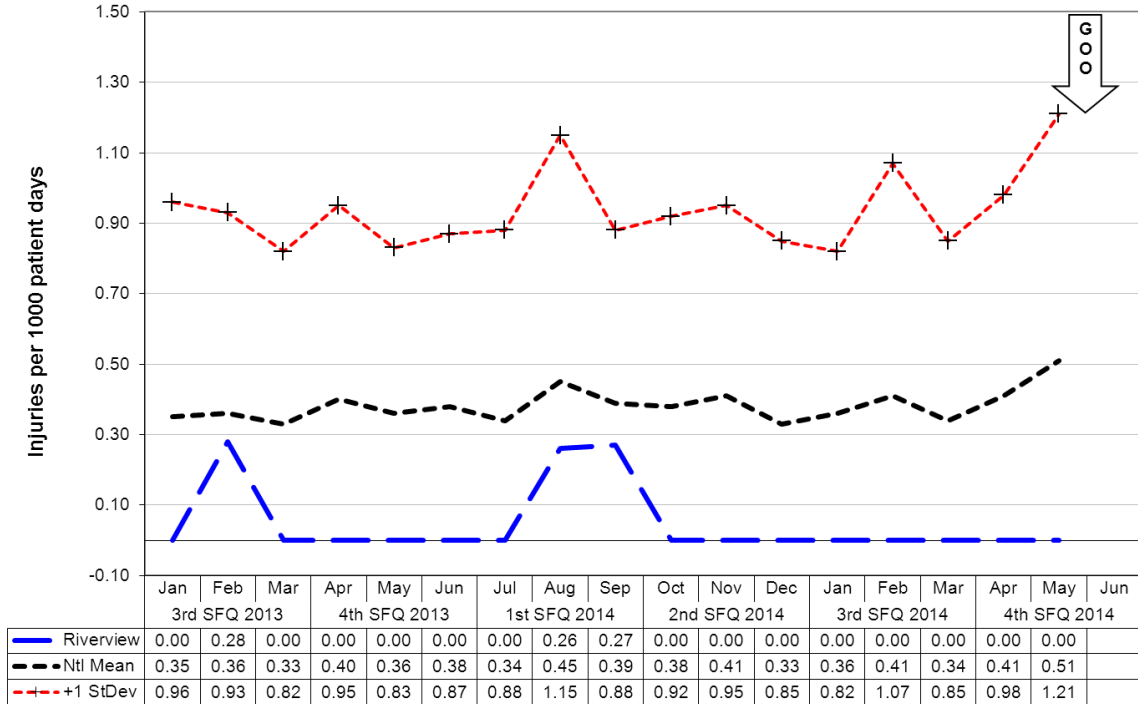
Reportable injuries include those that require: 3) Medical Intervention, 4) Hospitalization or where, 5) Death Occurred.

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

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

# CONSENT DECREE

## Client Injury Rate



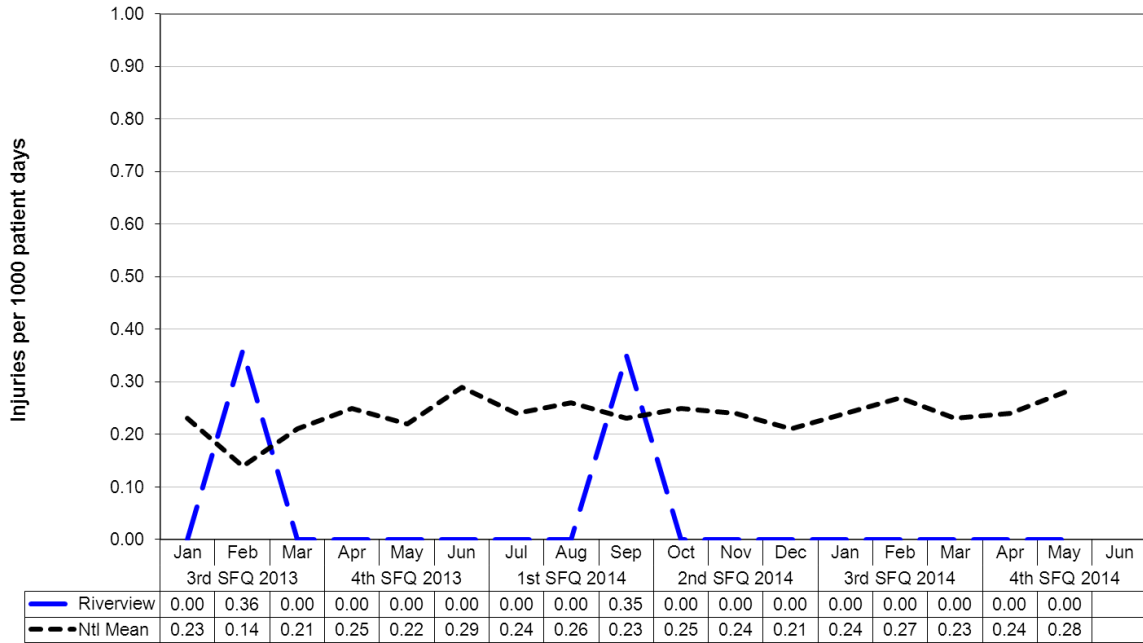
This graph depicts the number of client injury events that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days.

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

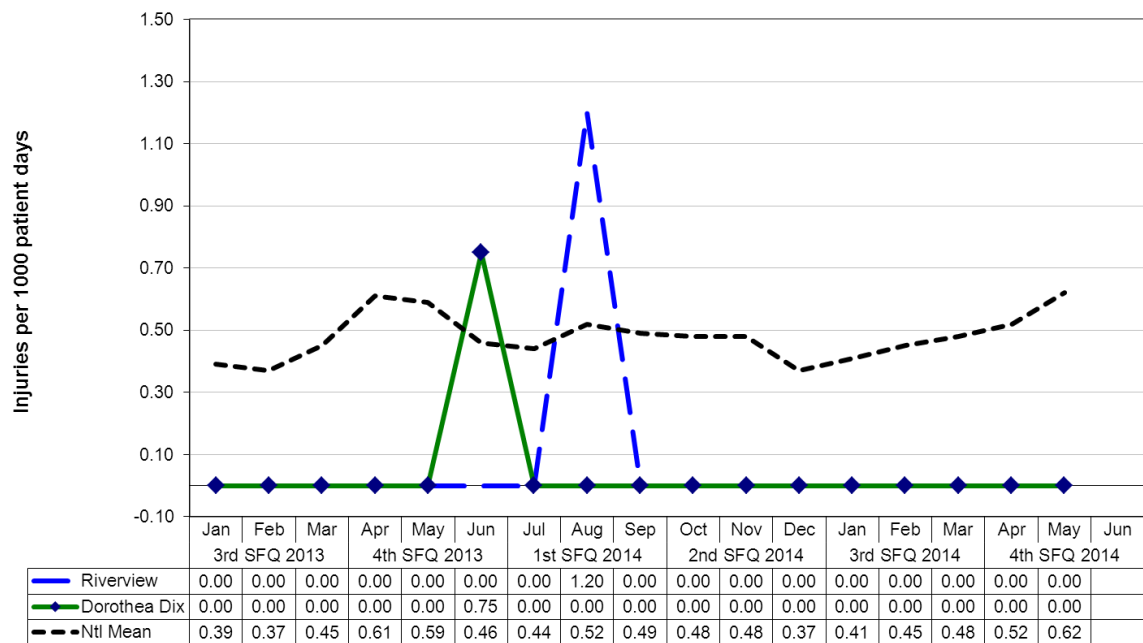
The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

# CONSENT DECREE

## Client Injury Rate Forensic Stratification



## Client Injury Rate Civil Stratification



# CONSENT DECREE

## Severity of Injury by Month

Severity	APRIL	MAY	JUNE	4Q2014
No Treatment	34	40	30	104
Minor First Aid	1	2	2	5
Medical Intervention Required	2	0	1	3
Hospitalization Required	1	2	0	3
Death Occurred	0	0	0	0
<b>Total</b>	<b>38</b>	<b>44</b>	<b>33</b>	<b>115</b>

## Type and Cause of Injury by Month

Type - Cause	APRIL	MAY	JUNE	4Q2014
Accident – Fall Unwitnessed	2	8	4	14
Accident – Fall Witnessed	1	5	7	13
Accident – Other	2	3	1	6
Assault – Client to Client	18	14	10	42
Self-Injurious Behavior	15	14	11	40
<b>Total</b>	<b>38</b>	<b>44</b>	<b>33</b>	<b>115</b>

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

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

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

# CONSENT DECREE

## Patient Abuse, Neglect, Exploitation, Injury or Death

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

Type of Allegation	1Q2014	2Q2014	3Q2014	4Q2014
Abuse Physical	3	4	10	10
Abuse Sexual	4	2	5	15
Abuse Verbal	1	1	4	2
Coercion/Exploitation				
Neglect			1	

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

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



# CONSENT DECREE

## Performance Improvement and Quality Assurance

V34) Riverview maintains Joint Commission accreditation;

Riverview successfully completed an accreditation survey with The Joint Commission on November 11-13, 2013. A triennial accreditation survey is expected to occur in November 2016 or earlier.

The hospital had 10 Measures of Success to complete to maintain certification. Six have been successfully completed and the four others will be completed by annual recertification on November 2014.

V35) Riverview maintains its hospital license;

Riverview maintains licensing status as required through the Maine Department of Health and Human Services Division of Licensing and Regulatory Services.

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

The hospital was terminated from the Medicare Provider Agreement on September 2, 2013 for failing to show evidence of substantial compliance by August 27, 2013. A revisit by CMS occurred on September 16<sup>th</sup> and 17<sup>th</sup>, 2013. The Medicare Provider Agreement will not be accepted unless CMS finds that the reason for termination of the previous agreement has been removed and there is reasonable assurance that it will not recur; and that the hospital has fulfilled, or has made satisfactory arrangements to fulfill, all of its statutory and regulatory responsibilities of its previous agreement. See Section 1866(c) of the Social Security Act and 42 C.F.R. §489.57. Riverview had a CMS visit in May 2014 and the hospital's request for certification was denied. The hospital met seven of eight areas of deficiencies since the prior visit. Staff have undertaken additional efforts to address the one area of deficiency. A new application is being prepared for submission to CMS for certification of the hospital.

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

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

# JOINT COMMISSION

## Hospital-Based Inpatient Psychiatric Services (ORYX Data Elements)

### The Joint Commission Quality Initiatives

In 1987, The Joint Commission announced its *Agenda for Change*, which outlined a series of major steps designed to modernize the accreditation process. A key component of the *Agenda for Change* was the eventual introduction of standardized core performance measures into the accreditation process. As the vision to integrate performance measurement into accreditation became more focused, the name ORYX® was chosen for the entire initiative. The ORYX initiative

data to The Joint Commission on behalf of accredited hospitals and long term care organizations. Since that time, home care and behavioral healthcare organizations have been included in the ORYX initiative.

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

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

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

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

Assessment

Treatment Planning and Implementation

Hope and Empowerment

Patient Driven Care

Patient Safety

Continuity and Transition of Care

Outcomes

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

# JOINT COMMISSION

## Admissions Screening (HBIPS 1)

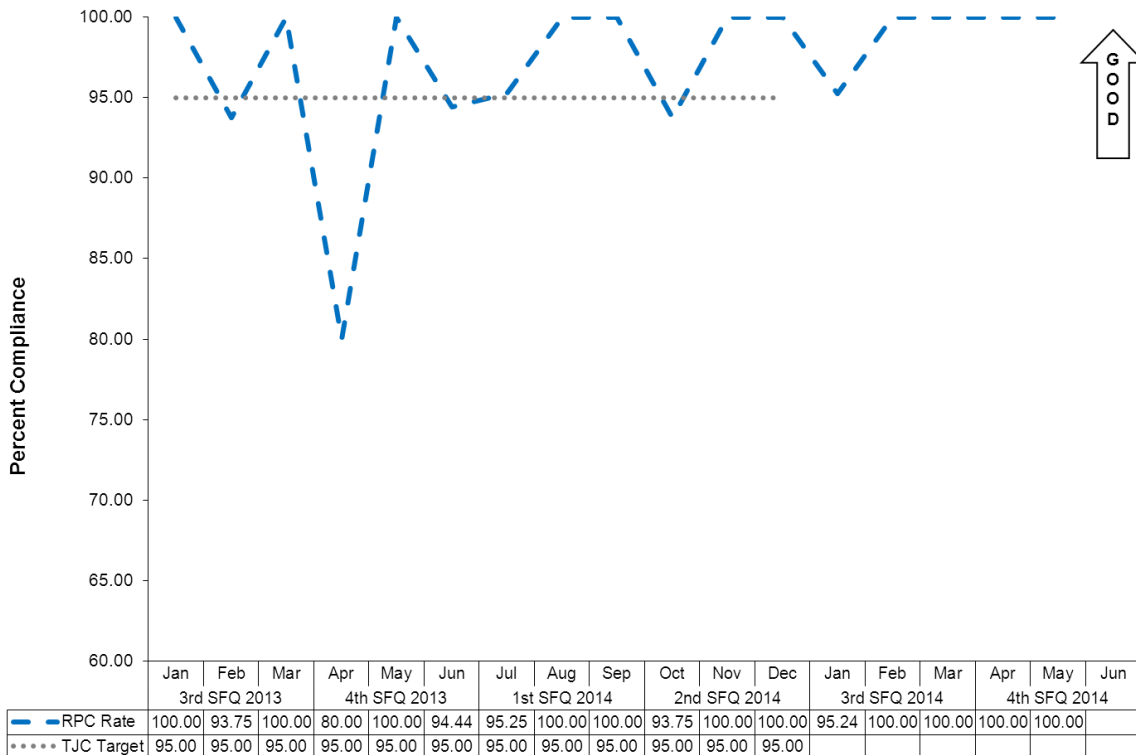
For Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths

### Description

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

### Rationale

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



# JOINT COMMISSION

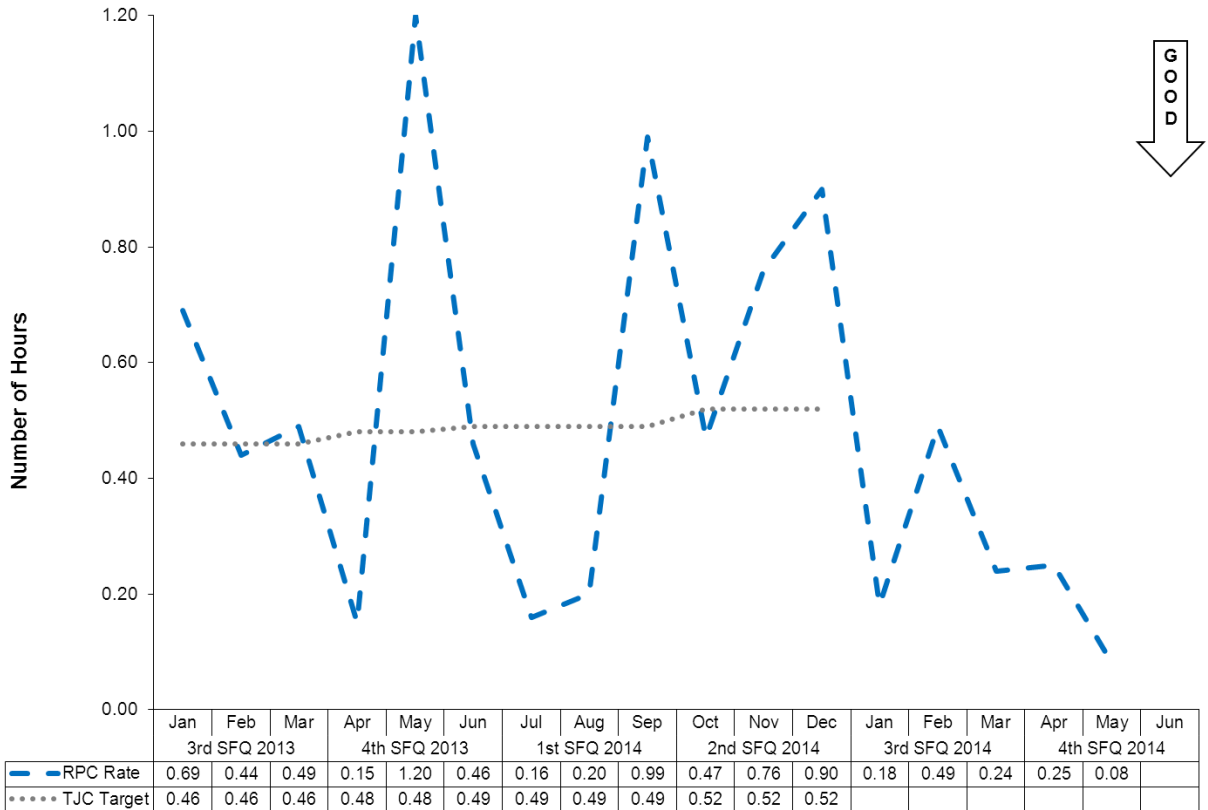
## Physical Restraint (HBIPS 2) Hours of Use

### Description

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

### Rationale

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



# JOINT COMMISSION

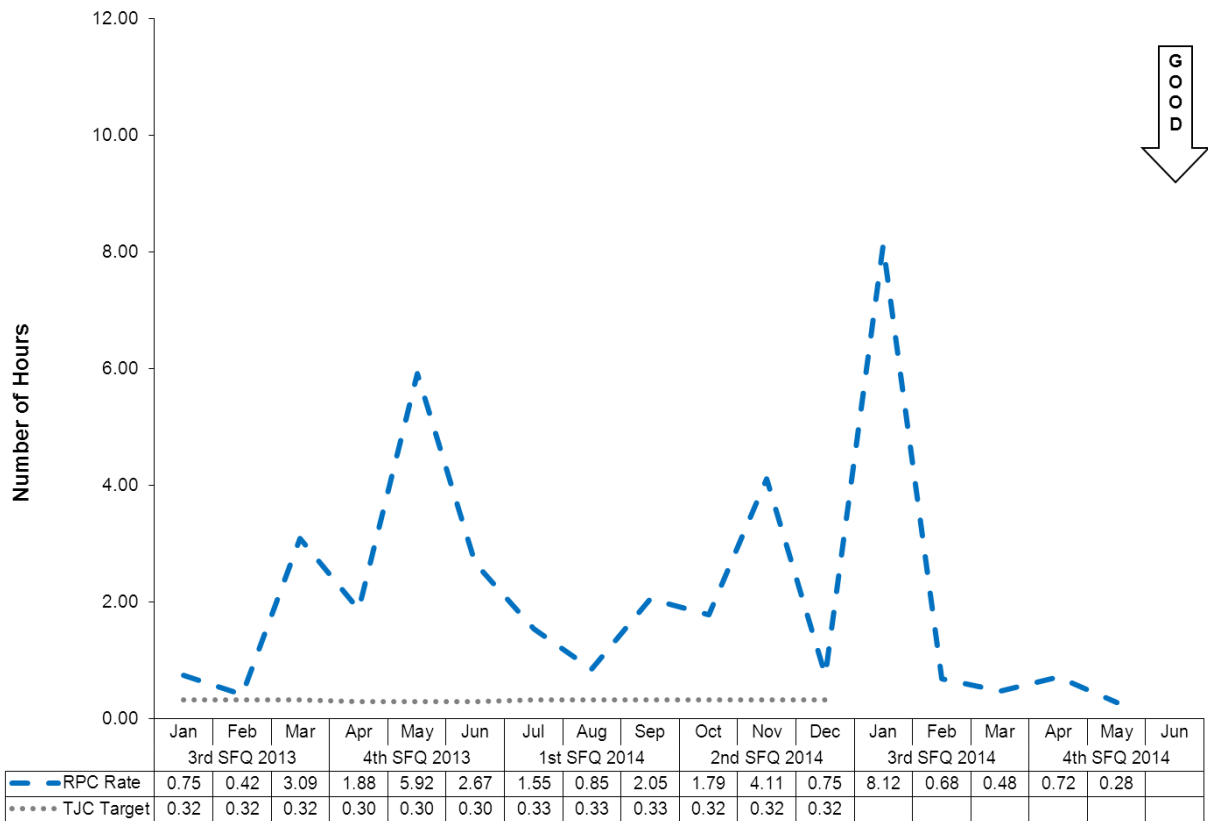
## Seclusion (HBIPS 3) Hours of Use

### Description

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

### Rationale

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



# JOINT COMMISSION

## Multiple Antipsychotic Medications on Discharge (HBIPS 4)

### Description

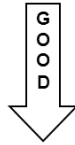
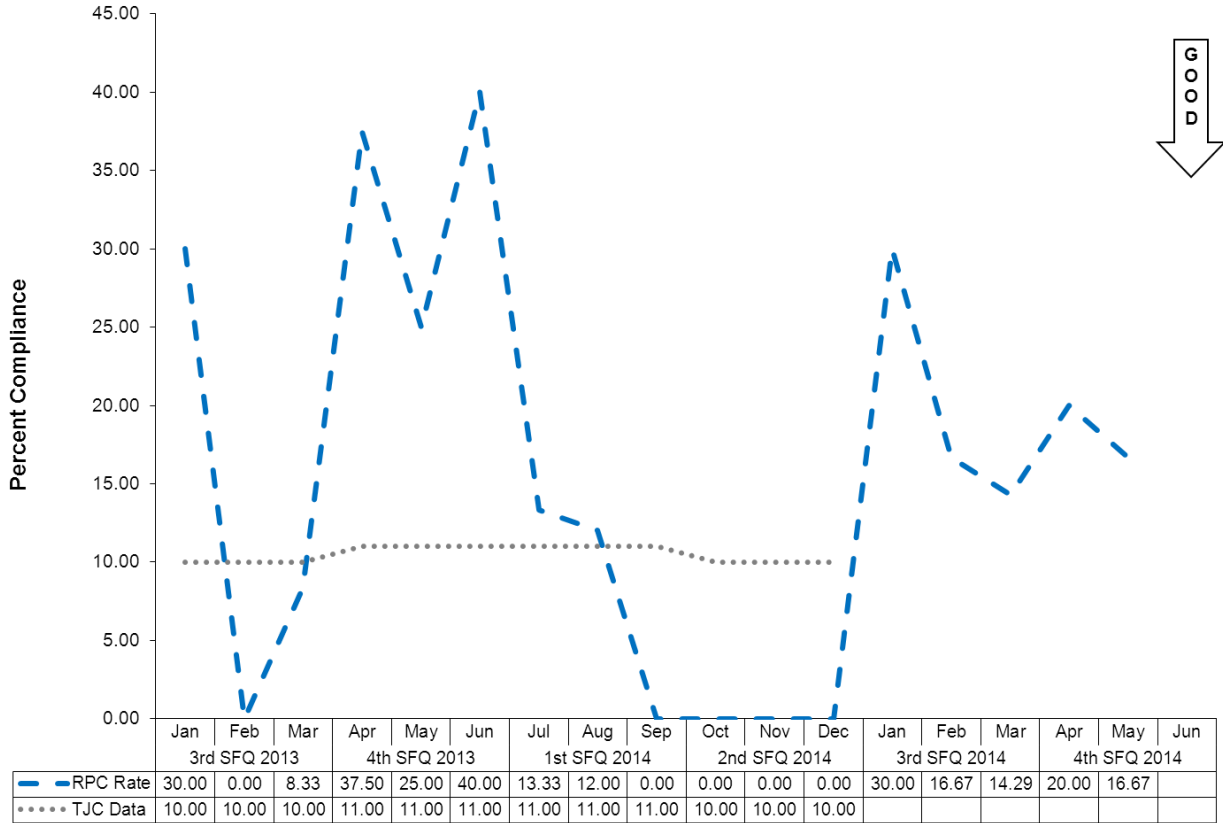
Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications

### Rationale

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

# JOINT COMMISSION

## Multiple Antipsychotic Medications on Discharge (HBIPS 4)



# JOINT COMMISSION

## Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)

### Description

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

### Rationale

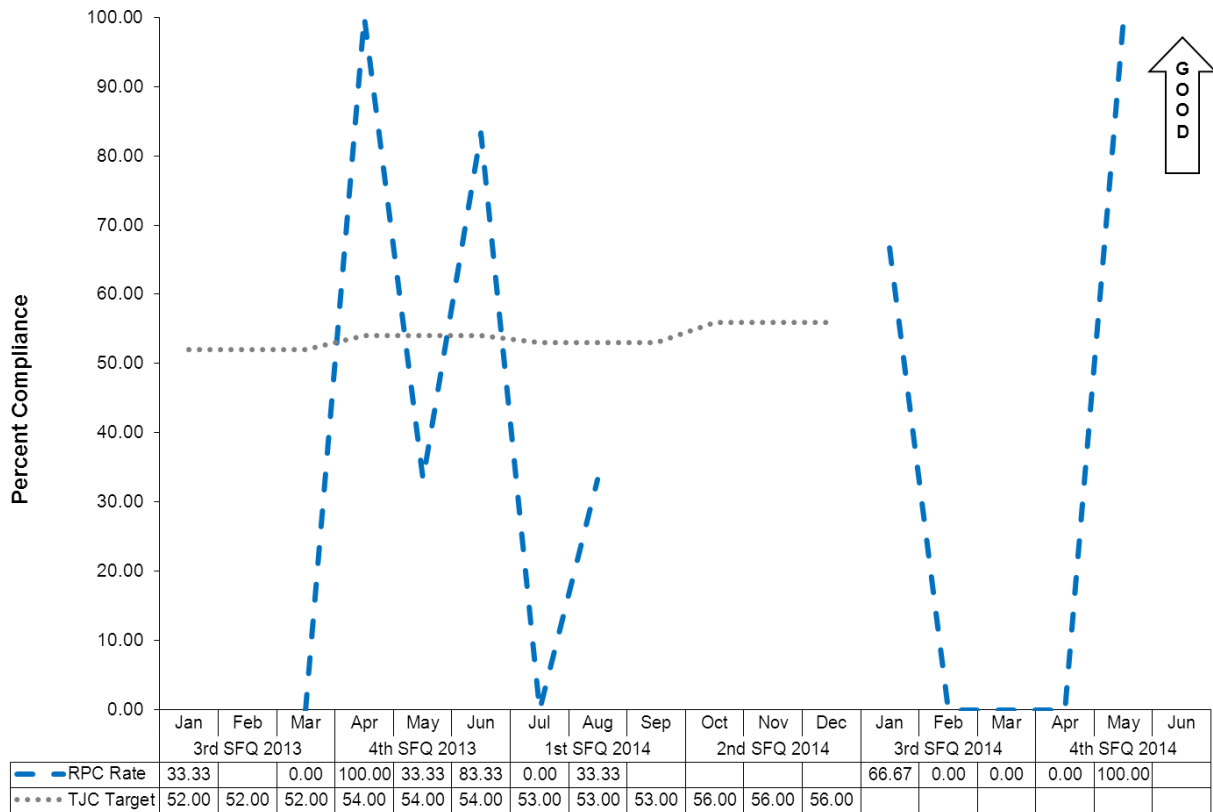
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# JOINT COMMISSION

## Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)



# JOINT COMMISSION

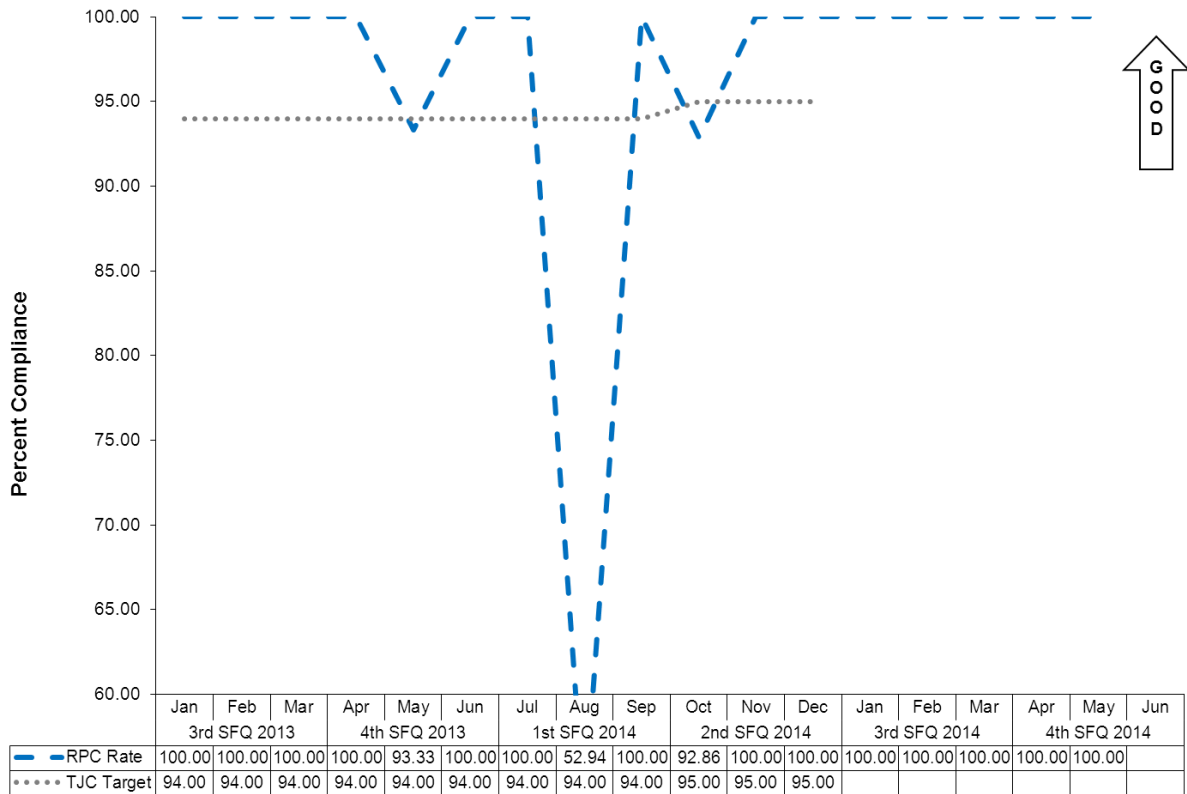
## Post Discharge Continuing Care Plan (HBIPS 6)

**Description**

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

**Rationale**

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



# JOINT COMMISSION

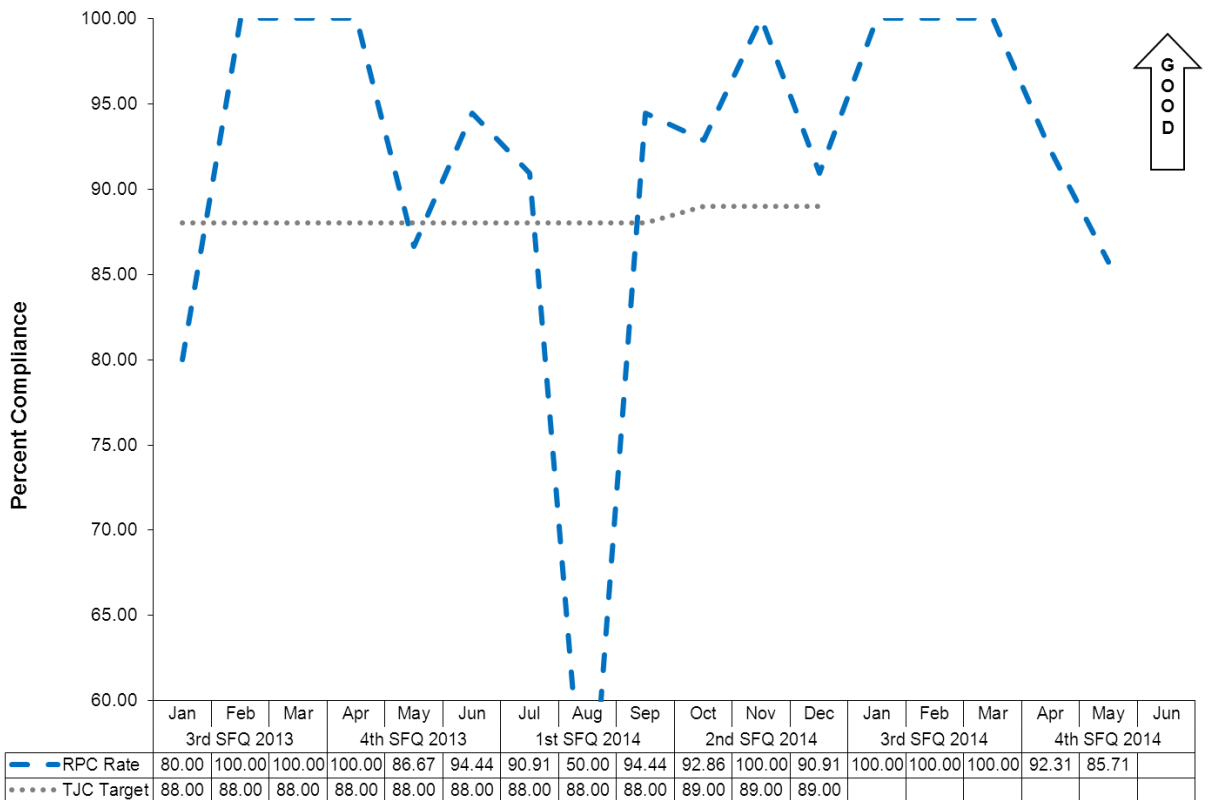
## Post Discharge Continuing Care Plan Transmitted (HBIPS 7) To Next Level of Care Provider on Discharge

### Description

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

### Rationale

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



# JOINT COMMISSION

TJC LD.04.03.09 The same level of care should be delivered to patients regardless of whether services are provided directly by the hospital or through contractual agreement. Leaders provide oversight to make sure that care, treatment, and services provided directly are safe and effective. Likewise, leaders must also oversee contracted services to make sure that they are provided safely and effectively.

<b>Final Report of FY 2014 Clinical Contracts</b>		
<b>Contractor</b>	<b>Program Administrator</b>	<b>Summary of Performance</b>
Amistad Peer Support Services	Stephanie George-Roy Director of Social Services	All indicators met or exceeded standards.
Community Dental, Region II	Dr. Brendan Kirby Medical Director	All indicators met standards.
Comprehensive Pharmacy Services	Dr. Brendan Kirby Medical Director	All indicators met standards.
Dartmouth Medical School	Robert J. Harper Superintendent	All indicators met or exceeded standards.
Disability Rights Center	Robert J. Harper Superintendent	All indicators met standards.
Healthreach	Dr. Brendan Kirby Medical Director	All indicators met standards.
Liberty Healthcare – Physician Staffing	Dr. Brendan Kirby Medical Director	All indicators met standards.
MaineGeneral Medical Center – Laboratory Services	Dr. Brendan Kirby Medical Director	All indicators met standards.
MD-IT	Amy Tasker Health Information Management Director	All indicators met standards.
Medical Staffing and Services of Maine, Inc.	Dr. Brendan Kirby Medical Director	All indicators met standards.
Motivational Services	Dr. Brendan Kirby Medical Director	All indicators met standards.
NEMED	Rick Levesque Director of Support Services	All indicators met standards.
Occupational Therapy Consultation and Rehab Services	Janet Barrett Director of Rehabilitation	All indicators exceeded standards
Securitas Security Services	Robert Patnaude Director of Security	All indicators met or exceeded standards.

# JOINT COMMISSION

## Capital Community Clinic Adverse Reactions to Sedation or Anesthesia

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

### Dental Clinic Timeout/Identification of Client

Indicators	1Q2014	2Q2014	3Q2014	4Q2014	FY14 Total
National Patient Safety Goals	<b>July</b> 100%	<b>October</b> 100%	<b>January</b> 100%	<b>April</b> 100%	<b>Fiscal Year Total</b>
Goal 1: Improve the accuracy of Client Identification.	6/6	3/3	2/2	11/11	100%
Capital Community Dental Clinic assures accurate client identification by: asking the client to state his/her name and date of birth.	<b>August</b> 100%	<b>November</b> 100%	<b>February</b> 100%	<b>May</b> N/A	42/42
	2/2	1/1	2/2	0/0	
A time out will be taken before the procedure to verify location and numbered tooth. The time out section is in the progress notes of the patient chart. This page will be signed by the Dentist as well as the dental assistant.	<b>September</b> 100%	<b>December</b> 100%	<b>March</b> 100%	<b>June</b> 100%	
	4/4	2/2	7/7	2/2	
	<b>Total</b> 100%	<b>Total</b> 100%	<b>Total</b> 100%	<b>Total</b> 100%	
	12/12	6/6	11/11	13/13	

### Dental Clinic Post Extraction Prevention of Complications and Follow-up

Indicators	1Q2014	2Q2014	3Q2014	4Q2014	FY14 Total
1. All clients with tooth extractions, will be assessed and have teaching post procedure, on the following topics, as provided by the Dentist or Dental Assistant	<b>July</b> 100%	<b>October</b> 100%	<b>January</b> 100%	<b>April</b> 100%	<b>Fiscal Year Total</b>
	6/6	3/3	2/2	11/11	100%
• Bleeding	<b>August</b> 100%	<b>November</b> 100%	<b>February</b> 100%	<b>May</b> N/A	42/42
• Swelling	2/2	1/1	2/2	0/0	
• Pain	<b>September</b> 100%	<b>December</b> 100%	<b>March</b> 100%	<b>June</b> 100%	
• Muscle soreness	4/4	2/2	7/7	2/2	
• Mouth care	<b>Total</b> 100%	<b>Total</b> 100%	<b>Total</b> 100%	<b>Total</b> 100%	
• Diet	12/12	6/6	11/11	13/13	
• Signs/symptoms of infection					
2. The client, post procedure tooth extraction, will verbalize understanding of the above by repeating instructions given by Dental Assistant/Hygienist.					
3. Post dental extractions, the clients will receive a follow-up phone call from the clinic within 24hrs of procedure to assess for post procedure complications					

# JOINT COMMISSION

## Healthcare Acquired Infections Monitoring and Management

### Upper Kennebec, Lower Kennebec, Upper Saco

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

Indicators	4Q14 Findings	4Q14 Compliance	Threshold Percentile
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	12/2.1	1 STDV within mean	1 STDV within the mean

Hospital Acquired Infection is any infection present, incubating or exposed to more than 72 hours **after admission** (unless the patient is off hospital grounds during that time) or declared by a physician, a physician’s assistant or advanced practice nurse to be HAI.

A Community Acquired Infection is any infection present, incubating or exposed to prior to admission, while on pass; during off-site medical, dental, or surgical care; by a visitor, any prophylaxis treatment of a condition or treatment of a condition for which the patient has a history of chronic infection no matter how long the patient has been hospitalized; or declared by the physician, physician’s assistant, or advanced practice nurse to be a community acquired infection.

Idiosyncratic Infection is any infection that occurs after admission and is the result of the patient’s action.

Lower Kennebec Unit	Lower Kennebec Scu	Upper Kennebec Unit
LLL Pneumonia (HAI)	Stage III Ulceration (HAI)	Carbuncle (CAI)
Dental Infection/2 (CAI)	Monilial Intertrigo, possibly Vaginal Candida (CAI)	Gastroenteritis (CAI)
Pustula & Cystic Acne (CAI)		
Prophylactic Treatment of Acute Sensitivity Rash/Chemical (HAI)		
Tinea pedis/1 (HAI)		
Tinea pedis/1 (CAI)		
Tinea Versicolor (CAI)		
Superficial Pressure Sore (CAI)		
External Otitis Media (CAI)		
<b>Upper Saco Unit</b>		<b>Total Infection: 30</b>
Inflammatory Nodule/possibly drained abscess (HAI)		<b>HAI: 12/2.1</b>
UTI (CAI)		<b>CAI: 17</b>
Dental Infection/3 (CAI)		<b>Idiosyncratic Infection: 1</b>
Recurrent Aspiration Pneumonia – not counted		
Otitis Media (HAI)		
Viral Pneumonitis (HAI)		
Recurrent C. difficile – not counted		
Recurrent LLL Pneumonai – not counted		
Cellulitis (HAI)		
Tinea Pedis (HAI)		
Intertrigo (self induced)		
Superficial Abraison/Prophylactic Treatment (CAI)		
Vaginal Yeast (CAI)		
Superficial Bacterial Skin Infection (CAI)		
S & S viral URI/3 (HAI)		

# JOINT COMMISSION

The fourth quarter hospital associated infection (HAI) rate is 2.1; and is within 1 standard deviation of the mean. Other than a small cluster of viral URI/LRI on Upper Saco in June, Infections were scattered throughout the hospital.

**Plan:** Continue total house surveillance

## Lower Saco

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

Indicators	4Q14 Findings	4Q14 Compliance	Threshold Percentile
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	1.5	100%	1 SD within the mean

Hospital Acquired Infection is any infection present, incubating or exposed to more than 72 hours **after admission** (unless the patient is off hospital grounds during that time) or declared by a physician, a physician’s assistant or advanced practice nurse to be HAI.

A Community Acquired Infection is any infection present, incubating or exposed to prior to admission, while on pass; during off-site medical, dental, or surgical care; by a visitor, any prophylaxis treatment of a condition or treatment of a condition for which the patient has a history of chronic infection no matter how long the patient has been hospitalized; or declared by the physician, physician’s assistant, or advanced practice nurse to be a community acquired infection.

Idiosyncratic Infection is any infection that occurs after admission and is the result of the patient’s action toward himself or herself.

**Infections:**

- Acne Rosasea (CAI)
- URI (HAI)
- Candida/Thrush (HAI)
- Severe Dental Decay (CAI)
- Bilateral Conjunctivitis (HAI)
- Tinea Corporis, Intertrigo & Tinea Pedis (HAI)
- Recurrent Cellulitis – not counted
- Blister Right Great Toe (CAI)

**Total Infections:** 7

**CAI:** 3

**HAI:** 4 – 1.5

**Findings:** The fourth quarter hospital associated infection rate is 1.5; and is within one standard deviation of the mean.

**Plan:** Continue surveillance

# JOINT COMMISSION

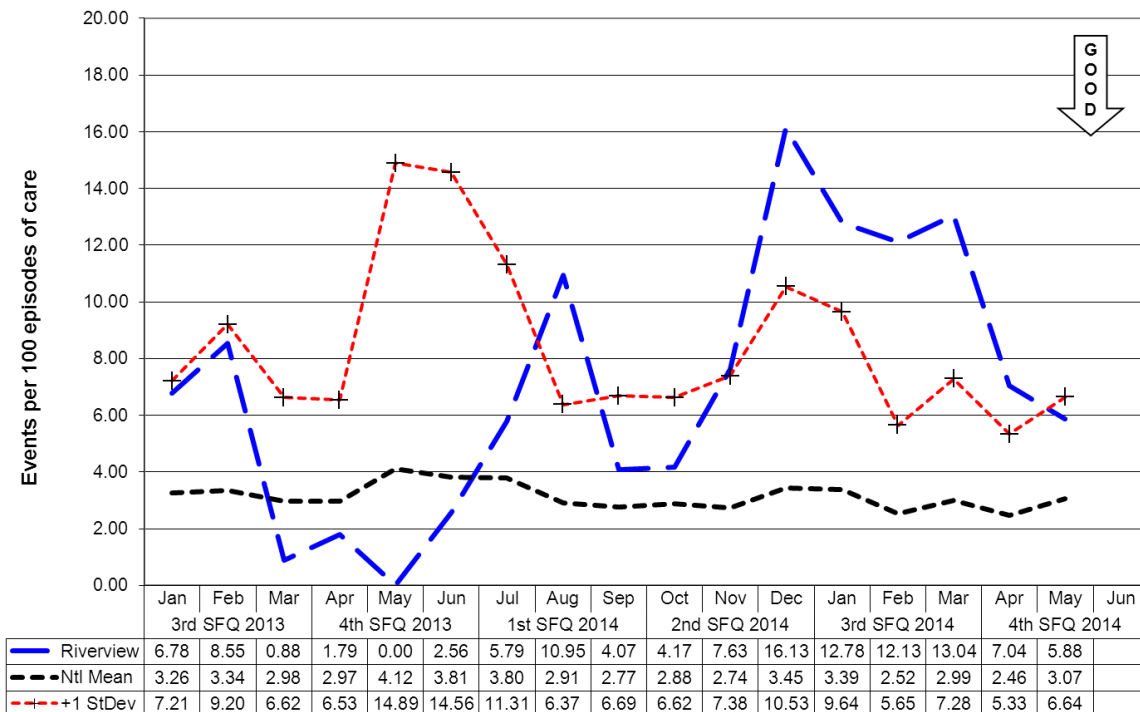
## Medication Management

### Medication Errors and Adverse Reactions

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

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

### Medication Errors



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



# JOINT COMMISSION

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

## Prescribing

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

## Dispensing

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

## Administration

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

## Complex

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

## Review, Reporting and Follow-up Process

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

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

# JOINT COMMISSION

## Medication Management - Administration Process Medication Errors Related to Staffing Effectiveness

Date	OMIT	Co-mission	Float	New	O/T	Unit Acuity	Staff Mix
4-3-14	Y	Omission x1	N	N	N	LK	3 RN, 1 LPN, 7 MHW
4-4-14	Y	Omission x1	N	N	N	UK	2 RN, 0 LPN, 4 MHW
4-8-14	N	Wrong dose	Y	Y	N	LS	4 RN, 0 LPN, 6 MHW
4-12-14	N	Wrong dose	N	Y	N	US	3 RN, 0 LPN, 5 MHW
4-12-14	N	Wrong dose	N	N	N	LK	3 RN, 1 LPN, 7 MHW
4-17-14	N	Wrong med	N	N	N	LK	3 RN, 1 LPN, 7 MHW
4-20-14	N	Wrong med	N	N	N	LS	2 RN, 1 LPN, 8 MHW
4-26-14	N	Wrong time	Y	Y	N	LK	4 RN, 0 LPN, 7 MHW
4-26-14	N	Wrong time	N	N	N	UK	1 RN, 0 LPN, 3 MHW
4-27-14	N	Wrong dose x 4	N	N	N	LK	3 RN, 1 LPN, 7 MHW
4-25-14	N	Expired med	Y	Y	N	LS	2 RN, 0 LPN, 5 MHW
5-27-14	N	Wrong time	N	N	N	US	2.5 RN, 1 LPN, 3 MHW
5-30-14	N	Wrong med	N	N	N	LK	2 RN, 0 LPN, 5 MHW
5-27-14	N	Wrong dose	N	N	N	LK	3 RN, 1 LPN, 6 MHW
5-27-14	Y	Omission x1	Y	Y	N	UK	1 RN, 0 LPN, 3 MHW
5-28-14	Y	Omission x1	N	Y	N	LK	2 RN, 0 LPN, 5 MHW
6-17-14	N	Wrong time x 2 meds	Y	Y	N	US	3 RN, 0 LPN, 4 MHW
6-13-14	N	Wrong time	N	N	N	LS	3 RN, 0 LPN, 7 MHW
6-17-14	Y	Omission x 6	N	N	N	LK	3 RN, 0 LPN, 7 MHW
6-18-14	Y	Omission x 2	N	N	N	US	2 RN, 1 LPN, 4 MHW
6-25-14	N	Wrong time x 2	N	N	N	US	2 RNs, 1 LPN, 4 MHW
6-28-14	N	Wrong time	N	N	N	UK	3 RN, 0 LPN, 4 MHW
6-27-14	Y	Omission x 1	Y	Y	N	LK	4 RN, 0 LPN, 7 MHW

# JOINT COMMISSION

Date	OMIT	Co-mission	Float	New	O/T	Unit Acuity		Staff Mix	
6-27-14	Y	Omission x 1	Y	Y	N	LK		4 RN, 0 LPN, 7 MHW	
6-27-14	N	Wrong time	N	N	N	UK		3 RN, 5 MHW	
<b>Totals</b>	<b>14</b>		<b>8</b>	<b>10</b>	<b>0</b>	<b>LS:</b> <b>4</b>	<b>US:</b> <b>8</b>	<b>LK:</b> <b>19</b>	<b>UK:</b> <b>5</b>
<b>Percent</b>	<b>39%</b>		<b>22%</b>	<b>28%</b>	<b>0</b>	<b>11%</b>	<b>22%</b>	<b>53%</b>	<b>14%</b>

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

## Summary

There were a total of 36 medication errors this quarter. 14 of the med errors were omissions, 8 errors were dose related, 10 errors involved wrong time, 3 were wrong medications given, and 1 was a medication given after the order had expired. 18 of the medication errors were committed by staff floating to another unit or by newly hired staff.

## Actions

All nursing related medication errors were noted to have appropriate staffing levels. Medication errors are reviewed weekly with pharmacy, nursing administration and the Medical Director. New systems are being looked at to track as well as alert nurses to minimize medication errors by having pop up screens for when a medication is too soon to be given, etc. The RN IV or clinical manger on the unit reviews medication errors with staff assigned to their unit if an error is committed.

# JOINT COMMISSION

## Medication Management - Dispensing Process

Medication Management	Unit	Baseline 2013	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
<a href="#">Controlled Substance Loss Data</a>	All		0%	0%	0%	0%	0%	10 discrepancies between Pyxis and CII transactions in Q4
<a href="#">Daily Pyxis-CII Safe Compare Report</a>								
<b>Quarterly Results</b>			0.3%	0%	2.5%	0.7%		
Monthly CII Safe Vendor Receipt	Rx	0	0	0	0	0	0	No discrepancies between CII Safe and vendor transactions for Q1, Q2, Q3, Q4
<b>Quarterly Results</b>			0	0	0	0		
Monthly Pyxis Controlled Drug discrepancies	All	11	0	0	0	0	0	Goal of "0" discrepancies involving controlled drugs dispensed from Pyxis
<b>Quarterly Results</b>			23	39	57	18		
<a href="#">Medication Management Monitoring</a>	Rx	8/year						2 ADR's reported in Q4
Measures of drug reactions, adverse drug events and other management data			0	0	0	0		
<b>Quarterly Results</b>			1	2	4	2		
Resource Documentation Reports of Clinical Interventions	Rx	185 reports						100% of all clinical interventions documented
<b>Quarterly Results</b>			79	86	120	110		

# JOINT COMMISSION

Medication Management	Unit	Baseline 2013	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
<a href="#">Psychiatric Emergency Process</a>	All		N/A	N/A	100%	100%	100%	Goal of 100% compliance as measured by monthly audit tool *2/1/14 to 2/25/14,* *2/26/14 to 3/24/14, 3/24/14 to 5/19/14 and 5/20/14 to 6/30/14
Monthly audit of all psych emergencies measured against 9 criteria								
<b>Quarterly Results</b>					77%, 97%, and 85%	94%		Decrease in % scoring resulted from 2 PE's not being communicated to Pharmacy.
<b>Contract KPI's</b>								
<a href="#">Operational Audit</a>	Rx		N/A	N/A	N/A	100%	100%	Goal of 100% compliance as measured by weekly audit tool for June 2014. *June 2, June 4, June 12 and June 20
Weekly audit of 3 operational indicators from CPS contract								
<b>Quarterly Results</b>						100%		

# STRATEGIC PERFORMANCE EXCELLENCE

## Pharmacy Services

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

Lower Saco								
Medication Management	Unit	Baseline Oct 2013	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
<a href="#">Controlled Substance Loss Data</a>	Lower Saco	100%	100%	100%	100%	100%	100%	Goal of 100% compliance in tracking CII safe transactions
<a href="#">Monthly CII Safe Transactions Report Generated and Reviewed</a>								
<b>Quarterly Results</b>			100% (Oct)	100% (Nov & Dec)	100%	100%		
<a href="#">Monthly CII Safe Transactions Report Separately Maintained</a>	Rx	100%	100%	100%	100%	100%	100%	Transaction Reports separately maintained for Lower Saco
<b>Quarterly Results</b>			100% (Oct)	100% (Nov & Dec)	100%	100%		
<a href="#">After-Hours Drug Access Monitoring</a>	Rx	100%	100%	100%	100%	100%	100%	Monitor daily after hours drug distribution reports to ensure compliance with policy
<a href="#">Monitor daily after-hours drug distribution reports</a>								
<b>Quarterly Results</b>			100% (Oct)	100% (Nov & Dec)	1	100%		

3/16/14: Called in my certified hospital NOD (Paul Courtemanche) at 0937 for issues on decertified unit, not directed to by AOC. Asked that Decertified unit's NOD (Mary Owen) contact me, did not attempt to do so until 1153 (2.5 hours later), rph already on site checking orders and unit dosing lactobacillus. Paul notified me that they took 2 cups of VPA from certified night closet for decertified unit via the inventory function (see Night Cabinet all station events report in pharmacy – Med removed by Patti Kantor at 0912 on 3/16/14) as the valproic acid stocked out on SLSCU, and needed lactobacillus again (client on SL).

# JOINT COMMISSION

## Inpatient Consumer Survey

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

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

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

### Rate of Response for the Inpatient Consumer Survey

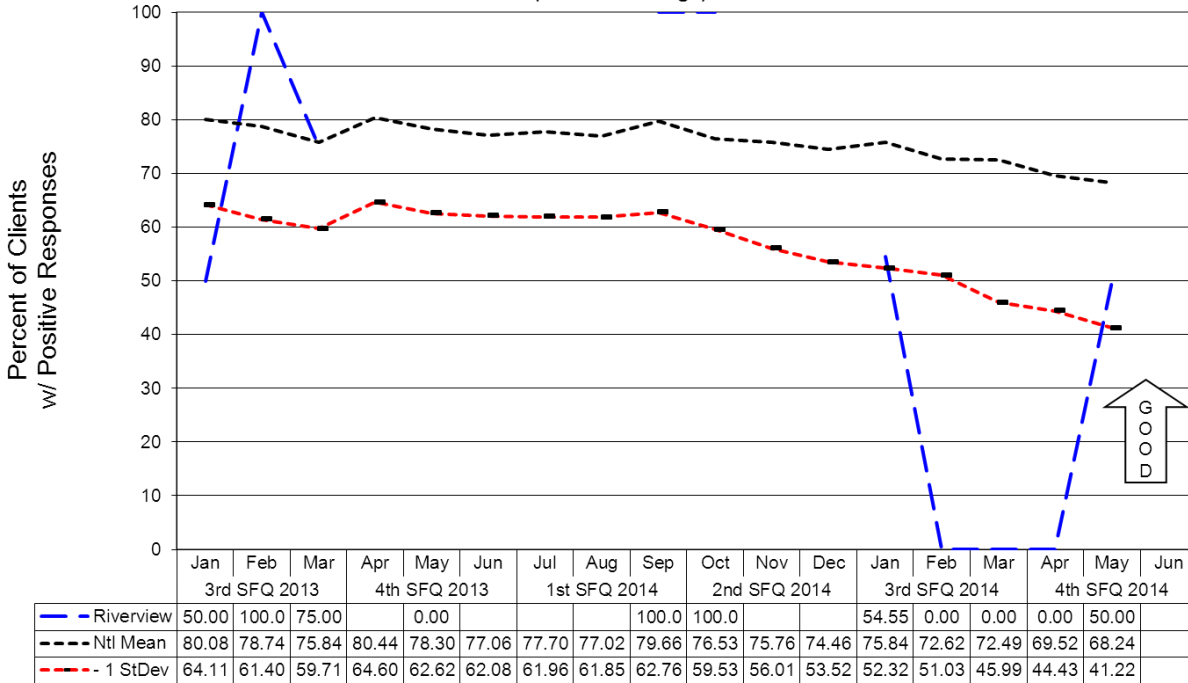
Due to the operational and safety need to refrain from complete openness regarding plans for discharge and dates of discharge for forensic clients, the process of administering the inpatient survey is difficult to administer. Whenever possible the peer support staff work to gather information from clients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

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

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

# JOINT COMMISSION

## Inpatient Consumer Survey Outcome Domain (3 month average)



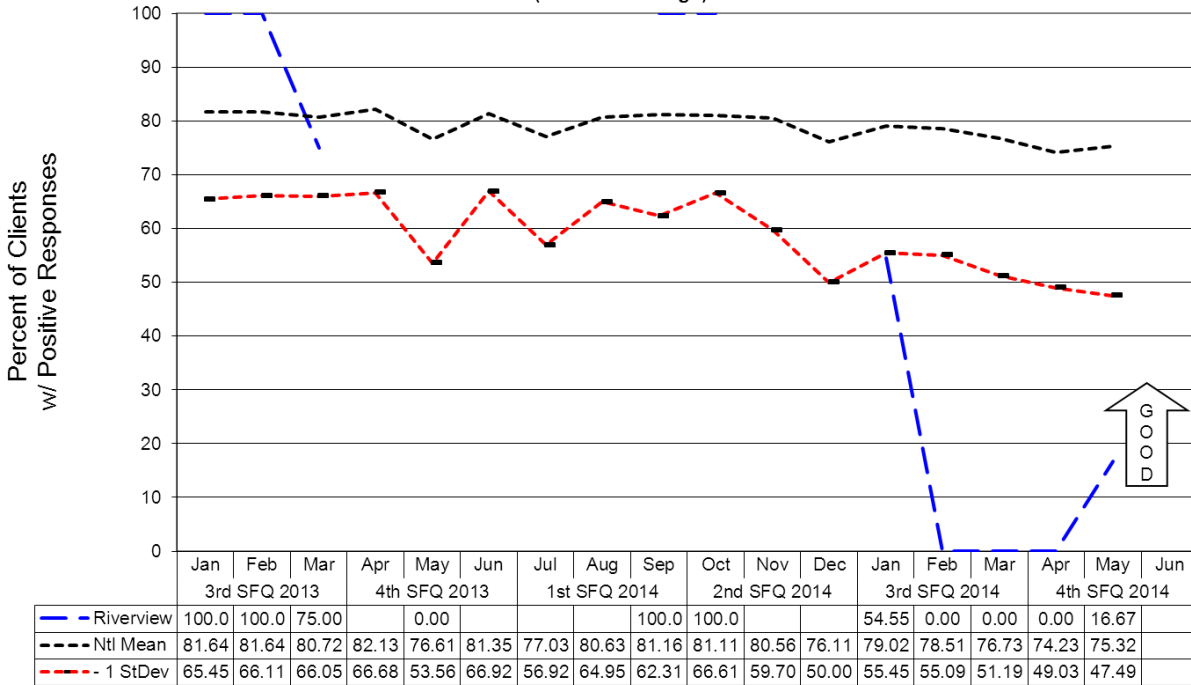
### Outcome Domain Questions

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



# JOINT COMMISSION

## Inpatient Consumer Survey Dignity Domain (3 month average)

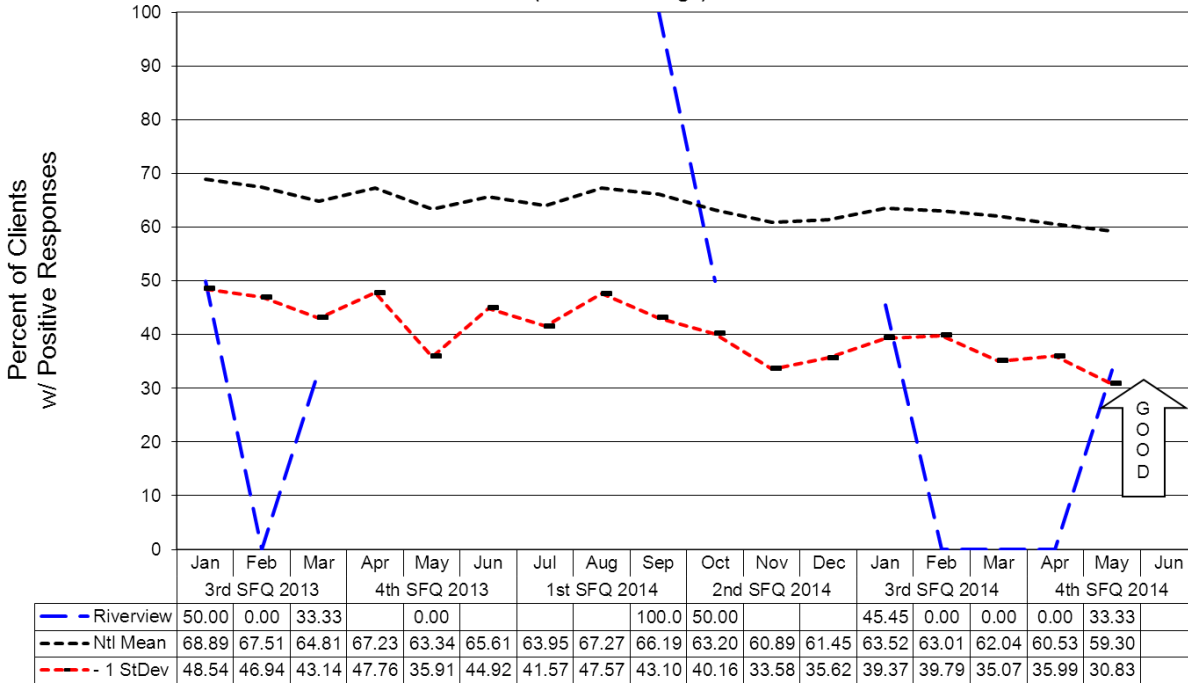


### Dignity Domain Questions

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

# JOINT COMMISSION

## Inpatient Consumer Survey Rights Domain (3 month average)

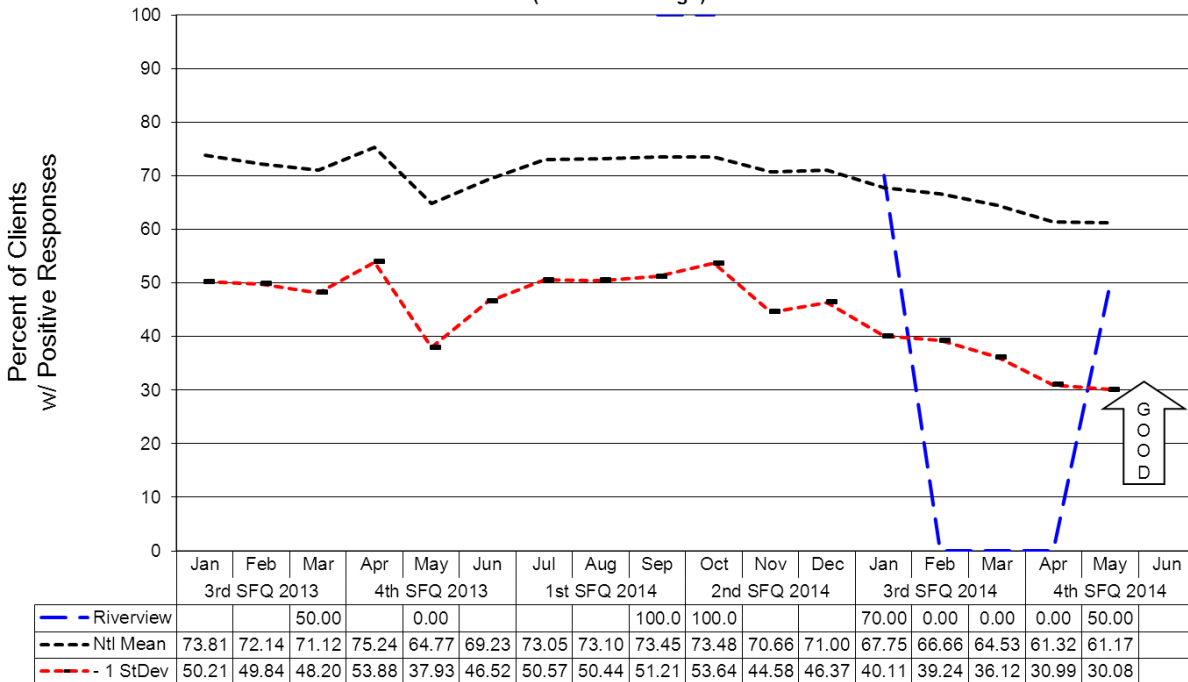


### Rights Domain Questions

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

# JOINT COMMISSION

## Inpatient Consumer Survey Participation Domain (3 month average)

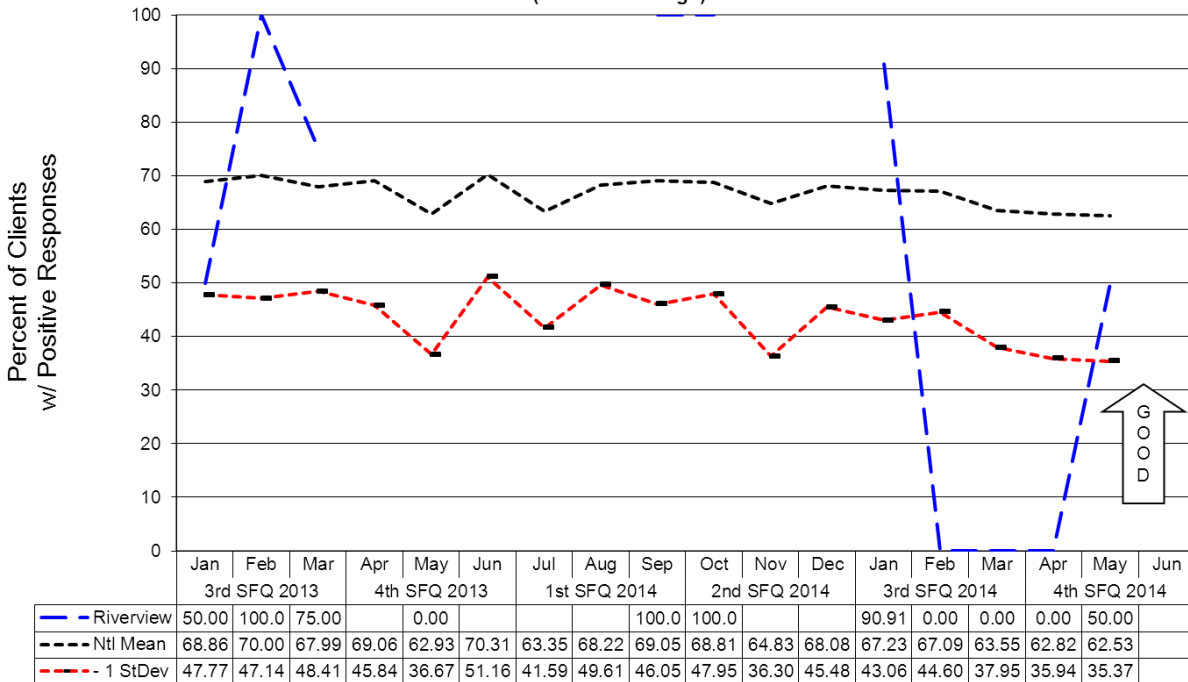


### Participation Domain Questions

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

# JOINT COMMISSION

## Inpatient Consumer Survey Environment Domain (3 month average)



### Environment Domain

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

# JOINT COMMISSION

## Pain Management

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

Indicator	1Q2014	2Q2014	3Q2014	4Q2014
Pre-administration	70%	74% 2774 of 3749	88% 3217 out of 3652	90% 2811 out of 3114
Post-administration	60%	63% 2362 of 3749	78% 2866 out of 3652	80% 2477 out of 3114

### SUMMARY

Total number of PRN pain medications administered has decreased since last quarter (3114 compared to 3652). Both pre-assessment and post-assessment percentages have increased slightly; post-assessment being the area still needing improvement.

### ACTIONS

Will meet with clinical managers to let them know that nursing needs to be more vigilant about assessing client pre and post administration of PRN pain medications. Will recommend having the oncoming shift check with the off going shift for any pain meds given that may need an assessment. Pharmacy is looking at future possibilities with Pyxis to see if a program can be installed that will alert nurses that an assessment is due/ needed.

# JOINT COMMISSION

## Fall Reduction Strategies

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

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

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

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

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

### Type of Fall by Client and Month

Fall Type	Client	APRIL	MAY	JUNE	4Q2014
Un-witnessed	MR00003191*		1	2	3
	MR00003120		2		2
	MR00000091	1			1
	MR00007509	1			1
	MR00007363*		1		1
	MR00007547		1		1
	MR00007291		1		1
	MR00007127		1		1
	MR00007502		1		1
	MR00007032				1
MR00007480*				1	1

Witnessed	MR00003191*		1	3	4
	MR00007340	1			1
	MR00002313		1		1
	MR00007363*		1		1
	MR00007204		1		1
	MR00002127		1		1
	MR00007416			1	1
	MR00003374			1	1
	MR00000065			1	1
	MR00007480*			1	1

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

### Review, Reporting and Follow-up Process

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

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

# JOINT COMMISSION

## Measures of Success

### CTS.01.04.01

**For organizations that serve adults with serious mental illness. The organization documents whether the adult has a psychiatric advance directive.**

**Responsible for Reporting: Director of Social Work/ACT Director**

Corrective Action Taken:

WHO: The ACT Program Director is ultimately responsible for the corrective action and overall and ongoing compliance.

WHAT: Staff training was conducted in bi-weekly administrative meeting directing all case managers to use standard Disability Rights Psychiatric (Mental Health) Advanced Directive form and to date completion or declination to complete directive.

WHEN: Care, Treatment and Services issue was discussed with case managers in all-staff meeting 12-27-13, document to be used was copied and placed in admission and annual documentation folder.

HOW: The Program Director and Team Leader will perform bi-weekly reviews of charts to assess ongoing compliance, reporting findings to staff in bi-weekly administrative meetings.

Evaluation Method: Plan for assessing effectiveness of the corrective action taken:

- Sample size: Based on an ADC of 50, 30 records will be selected using random selection.
- Random sampling method used will be to identify six charts from 5 total shelves by selecting every other chart from right to left until 30 are identified.
- Frequency of the audit will be bi-weekly, reviewing six to eight charts per session, totaling up to 48 charts reviewed by the end of four months.
- Monitor for four consecutive months (expectation a minimum of 90% compliance)
- 30 = total number of charts reviewed for psychiatric advanced directives
- 28= total number of psychiatric advanced directives present in the chart or documented as having been offered but declined by client.
- The audit results will be reported by the program Director and Team Leader to the staff at each administrative meeting, the IPEC Committee, as well as to the Social Work Program Director.

**RESULTS:**

February	March	April	May	June
58%	82%	78%	79%	100%

# JOINT COMMISSION

## Measures of Success

### CTS.02.02.07

The organization reassesses each individual served, as needed

**Responsible for Reporting: Director of Social Work/ACT Director**

Corrective Action Taken:

WHO: The ACT Program Director is ultimately responsible for the corrective action and overall ongoing compliance.

WHAT: Staff training was conducted in bi-weekly administrative meeting identifying the discovery of Annual Comprehensive Assessments being worded exactly the same as the previous year, and the necessity of writing new annual assessments for each client including any changes in progress or functioning. It was also identified that there was a missing Annual Comprehensive Assessment in one reviewed record, the standard of keeping at least the current and past year’s Annual Comprehensive Evaluation was reiterated.

WHEN: This corrective action was also conducted in a bi-weekly administrative meeting on 12-27-13. No further procedures or policies were needed.

HOW: The Program Director and Team Leader will perform bi-weekly reviews of records to assess ongoing compliance, reporting findings to staff in bi-weekly administrative meetings for immediate correction, if indicated.

Evaluation Method: Plan for assessing effectiveness of the corrective action taken:

- Sample size: Based on an ADC of 50, 30 records will be selected using random selection.
- Random sampling method used will be to identify six charts from 5 total shelves by selecting every other chart from left to right until 30 are identified.
- Frequency of the audit will be bi-weekly, reviewing six to eight charts per session, totaling up to 48 charts reviewed by the end of four months.
- Monitor for four consecutive months (expectation a minimum of 90% compliance)
- 30 = total number of charts reviewed for presence and accuracy of Comprehensive Annual Assessment
- 28= minimum total number of Comprehensive Annual Assessments present in the chart and distinct from previous year.
- The audit results will be reported by the program Director and Team Leader to the staff at each administrative meeting, the IPEC Committee, as well as to the Social Work Program Director.

### RESULTS:

February	March	April	May	June
83%	100%	78%	100%	90%



# JOINT COMMISSION

## Measures of Success

### HR.01.06.01

Staff competence is assessed and documented once every three years, or more frequently as required by organization policy or in accordance with law and regulation.

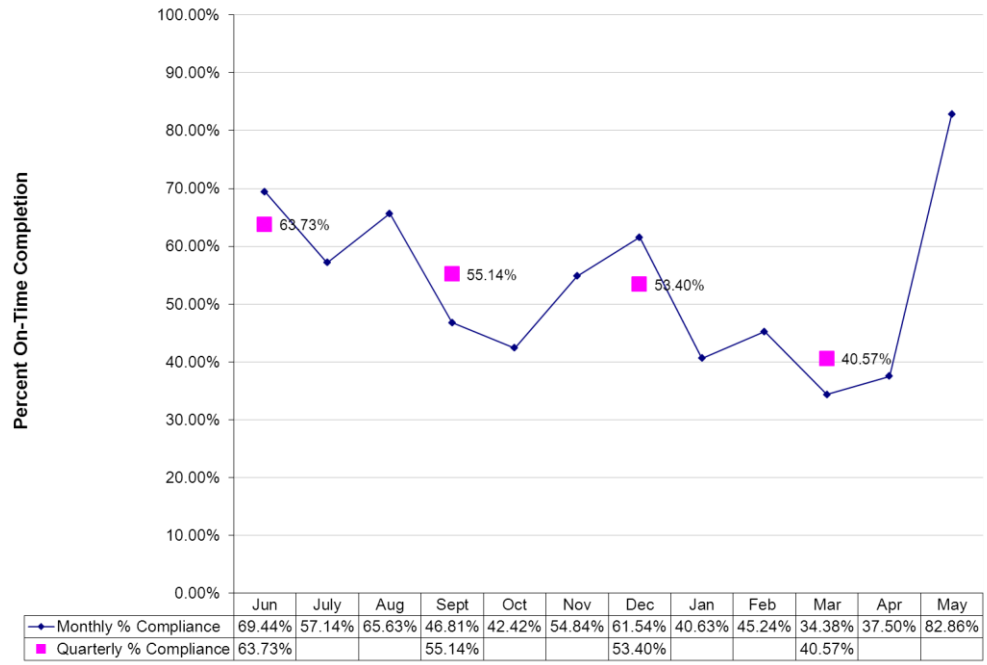
Responsible for Reporting: HR Director

### RESULTS:

	12/2014	1/2014	2/2014	3/2014	4/2014	5/2014	Total
Performance evaluations completed on time (with competency assessment)	24	13	19	11	12	29	<b>108</b>
Total # of performance evaluations due (with competency assessment)	39	32	42	32	32	35	<b>212</b>
Evaluation Compliance	61.54%	41%	45.24%	34.38%	38%	82.86%	<b>50.94%</b>

\*Data not yet available for June 2014

Performance Evaluation Compliance



# JOINT COMMISSION

## Measures of Success

### EC.02.01.01

The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment.

**Responsible for Reporting:** Director of Support Services

**INDICATOR:** Faucet Checks

**FINDING:** *EC.02.01.01 The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment.*

**OBJECTIVE:** Have all bathrooms checked every 7 ½ minutes for patient safety (ligature) until faucets have been replaced with an approved anti-ligature model.

**THOSE RESPONSIBLE FOR MONITORING:** Clinical staff and Director of Support Services

**METHODS OF MONITORING:** Monitoring would be performed by:

- Direct observation for each bathroom by Clinical Staff

**METHODS OF REPORTING:** Reporting would occur by the following method:

- Daily activity bathroom faucet check sheets

**THOSE RESPONSIBLE FOR REPORTING:** Director of Support Services

**UNIT:** Number of actual checks / number of potential checks on all identified ligature problematic faucets on each patient unit.

**Stated Goal:** 90%

Bathroom Faucet Checks	<u>Unit</u>	<u>February</u>	<u>March</u>	<u>April</u>	<u>May</u>
The denominator is the total of potential checks for the month on all unit faucets in this patient area. The numerator is all faucets checked daily every 7 1/2 minutes. Any blanks on the faucet check sheet will count as a missed check. Monitoring of the checks will start January 2014 and continue for four months or until the faucets have been replaced.	# of actual checks	100%	100%	100%	100%
	# of potential checks				

# JOINT COMMISSION

## Measures of Success

### ED.02.06.01

Interior spaces meet the need of the patient population and are safe and suitable to the care, treatment, and services provided.

Responsible for Reporting: Director of Support Services

INDICATOR: Bedroom Ligature / Oxygen Storage Assessments

FINDING: *EC.02.06.01 Interior spaces meet the need of the patient population and are safe and suitable to the care, treatment, and services provided.*

OBJECTIVE: (1) Have all bedrooms checked throughout the hospital for any ligature risks every month

(2) Check each unit for proper oxygen storage, ensuring that empty tanks are segregated from full tanks and labelled accordingly.

THOSE RESPONSIBLE FOR MONITORING: Director of Support Services

METHODS OF MONITORING: Monitoring would be performed by:

- Direct observation of each bedroom for any ligature risks
- Direct observation of proper storage of oxygen canisters

METHODS OF REPORTING: Reporting would occur by the following method:

- Monthly activity using the Bedroom Ligature / Oxygen Storage Assessment check sheets

Bedroom Ligature / Oxygen Storage Checks	Unit	Stated Goal	February	March	April	May
The Director of Support Services (or his designee) will perform monthly environment of care rounds (January 2014 thru April 2014) and assess ongoing compliance for both findings. The rounds consist of inspecting every patient room for oxygen tubing or other potential ligature evident in the room and ensuring the oxygen tanks are properly stored. The Director of Support Services will report findings to the monthly meeting of the Environment of Care Committee and the monthly meeting of IPEC (quality committee) under the "safety" agenda item.	Perform bedroom ligature / Oxygen Storage Assessments	100% of checks completed	100%	100%	100%	100%

# JOINT COMMISSION

## Measures of Success

### MM.03.01.01

The hospital stores medications according to manufacturers' recommendations, or in the absence of such recommendations, according to a pharmacist's instructions.

**Responsible for Reporting: Director of Nursing**

The hospital stores medications according to the manufacturer's recommendations or, in the absence of such recommendations, according to a pharmacist's instructions.

Refrigerator temperatures are monitored on each unit for four consecutive months until 90% compliance is achieved.

### Results:

<b>February</b>	<b>March</b>	<b>April</b>	<b>May</b>
99%	99%	100%	99%

# JOINT COMMISSION

## Measures of Success

**PC.02.01.15**

**Care, treatment and services are provided to the patient in an interdisciplinary, collaborative manner.**

**Responsible for Reporting: Clinical Director**

**Results:**

<b>February</b>	<b>March</b>	<b>April</b>	<b>May</b>
90%	90%	95%	90%

# JOINT COMMISSION

## Measures of Success

### PC.02.03.03

The hospital helps the patient with his or her personal hygiene and grooming activities.

Responsible for Reporting: Director of Nursing

**Hand Hygiene Measure:** Staff will offer hand gel to clients prior to breakfast, lunch and dinner on 30 days per month.

### Results:

	January 2014	February 2014	March 2014	April 2014	May 2014	June 2014	Mean Rate
Lower Kennebec	68%	82%	61%	65%	96%	100%	79%
Lower Kennebec SCU	10%	18%	25%	95%	96%	94%	56%
Upper Kennebec	46%	46%	46%	100%	100%	100%	73%
Upper Saco	97%	94%	97%	100%	90%	96%	96%
Lower Saco	99%	38%	82%	97%	99%	97%	85%
Lower Saco SCU	14%	43%	1%	38%	96%	96%	48%
Mean Rate	56%	54%	52%	83%	96%	97%	73%

# JOINT COMMISSION

## Measures of Success

**PC.03.03.29**

**Patients are debriefed after the use of restraint or seclusion for behavioral health purposes.**

**Responsible for Reporting: Superintendent**

**Results:**

<b>February</b>	<b>March</b>	<b>April</b>	<b>May</b>
100%	100%	100%	100%

# JOINT COMMISSION

## Measures of Success

### RC.01.02.01

**Entries in the medical records are authenticated.**

Responsible for Reporting: Clinical Director/Director of Nursing

**Results:**

February	March	April	May
96%	100%	100%	99%

### PC.04.01.05

**The hospital provides written discharge instructions in a manner that the patient and/or the patient’s family or caregiver can understand.**

**Results:**

February	March	April	May
96%	100%	99%	99%

**Summary:** Indicators are based on 100% of progress notes created per month. Physicians’ progress notes are audited to ensure authentication is occurring within 7 days of availability in the EMR per RPC’s Medical Record Completion Policy (MS.3.20).

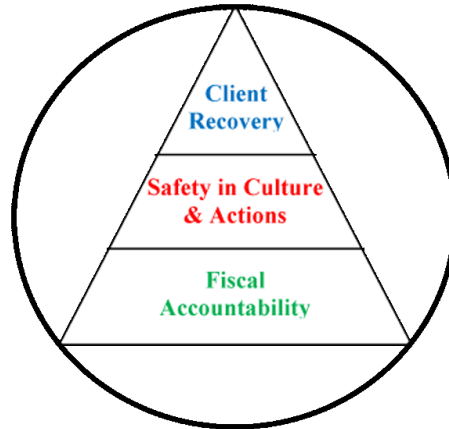
The indicators for the Discharge Instructions (consolidated aftercare form) are based on 100% of discharges occurring each month over 4 consecutive months.



# STRATEGIC PERFORMANCE EXCELLENCE

## Priority Focus Areas for Strategic Performance Excellence

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



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

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

# STRATEGIC PERFORMANCE EXCELLENCE

## Strategic Performance Excellence Model Reporting Process

Department of Health and Human Services Goals

- Protect and enhance the health and well-being of Maine people
- Promote independence and self sufficiency
- Protect and care for those who are unable to care for themselves
- Provide effective stewardship for the resources entrusted to the department



Dorothea Dix and Riverview Psychiatric Centers



### Priority Focus Areas

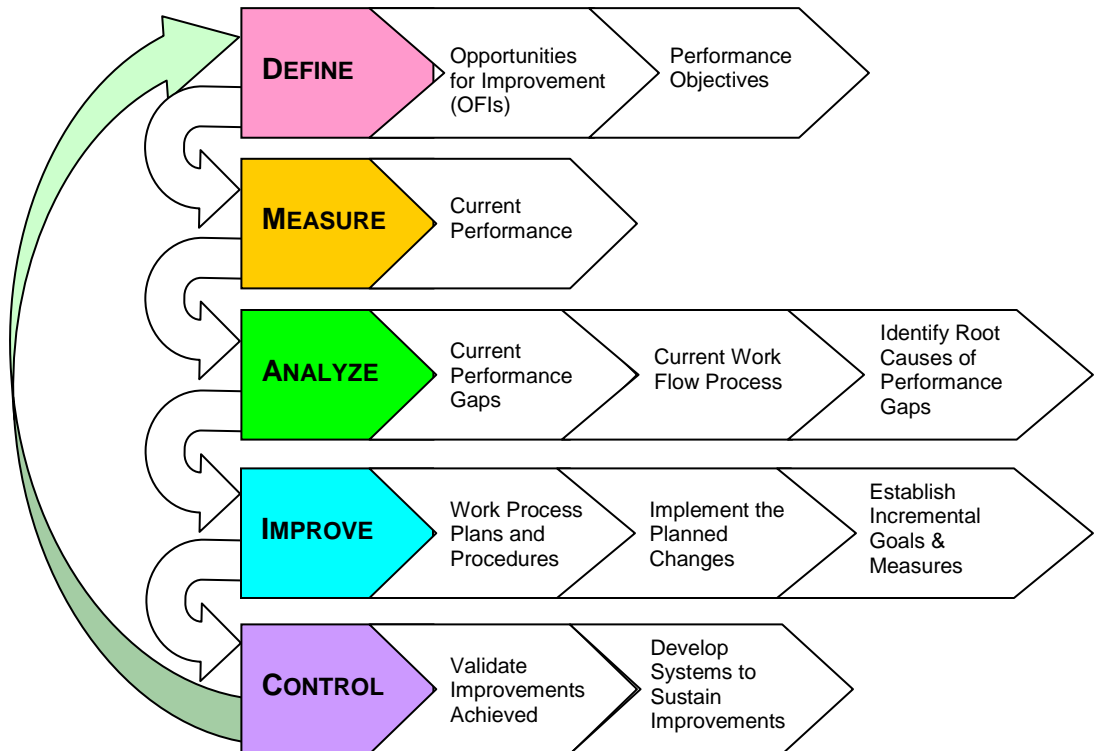
**Ensure and Promote Fiscal Accountability by...**  
 Identifying and employing efficiency in operations and clinical practice  
 Promoting vigilance and accountability in fiscal decision-making.

**Promote a Safety Culture by...**  
 Improving Communication  
 Improving Staffing Capacity and Capability  
 Evaluating and Mitigating Errors and Risk Factors  
 Promoting Critical Thinking  
 Supporting the Engagement and Empowerment of Staffs

**Enhance Client Recovery by...**  
 Develop Active Treatment Programs and Options for Clients  
 Supporting clients in their discovery of personal coping and improvement activities.

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

The Quarterly Report Consists of the Following

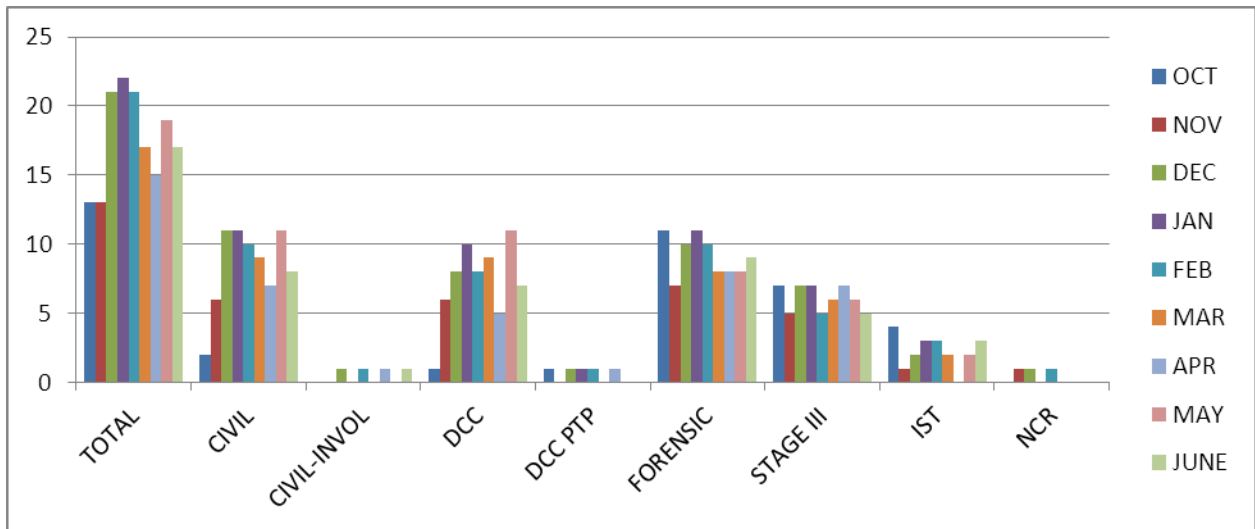


# STRATEGIC PERFORMANCE EXCELLENCE

## Admissions Office Quarterly Report 4Q2014

Here is the Admissions data from the month of October 2013 through the month of June 2014. This data includes statistics on admissions, discharges, length of stay, and wait time. The data is broken down into different categories related to forensic, civil, district court commitment, in patient evaluations, incompetent to stand trial, not criminal responsible, involuntary civil and progressive treatment plan commitment. The Admissions Office continues to work with the IMHU program at the prison and has successfully referred and admitted 3 patients to this unit. The Admission Office is also working on a project related to the Convalescent Status of the NCR population.

Admission Data Graph



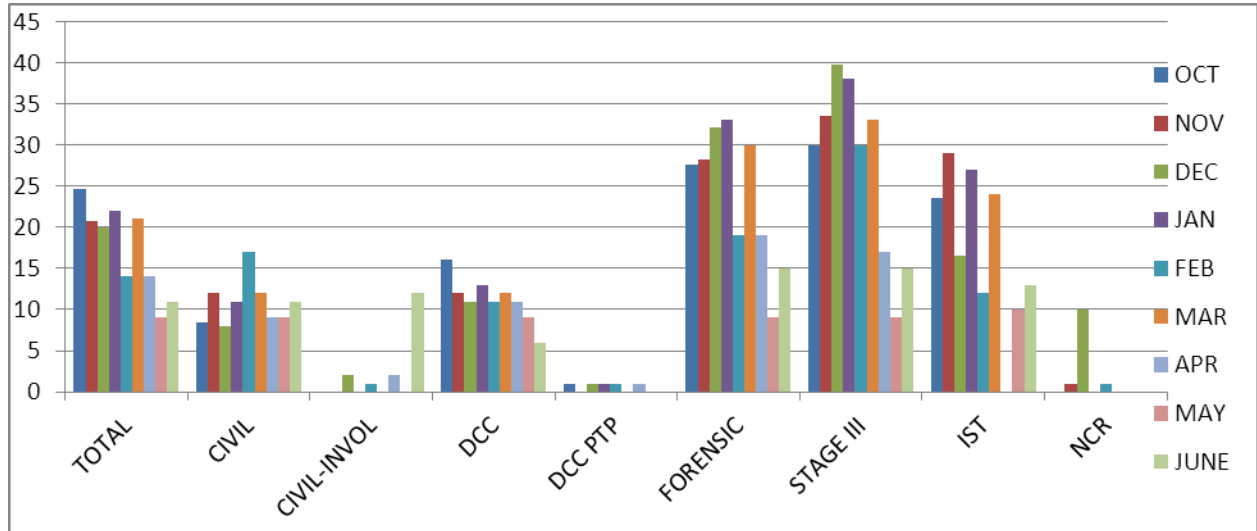
Admission Data

ADMISSIONS	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE
<b>TOTAL</b>	13	13	21	22	21	17	15	19	17
<b>CIVIL</b>	2	6	11	11	10	9	7	11	8
<b>CIVIL-INVOL</b>	0	0	1	0	1	0	1	0	1
<b>DCC</b>	1	6	8	10	8	9	5	11	7
<b>DCC PTP</b>	1	0	1	1	1	0	1	0	0
<b>FORENSIC</b>	11	7	10	11	10	8	8	8	9
<b>STAGE III</b>	7	5	7	7	5	6	7	6	5
<b>IST</b>	4	1	2	3	3	2	0	2	3
<b>NCR</b>	0	1	1	0	1	0	0	0	0

# STRATEGIC PERFORMANCE EXCELLENCE

## Admissions Office Quarterly Report, continued.

Wait List Graph



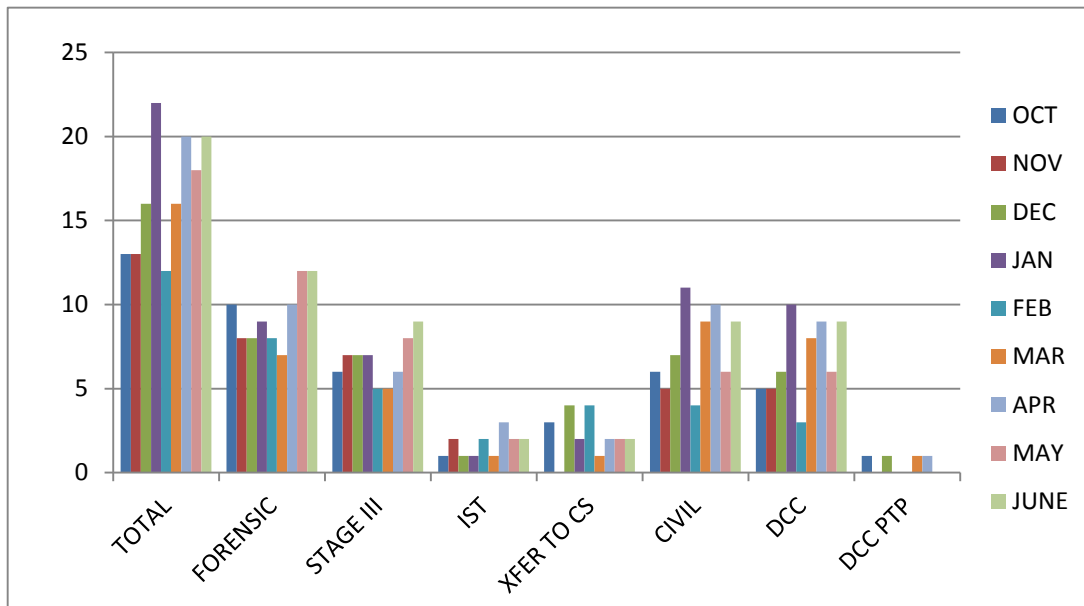
Wait List Data

WAIT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE
<b>TOTAL</b>	25	21	20	22	14	21	14	9	11
<b>CIVIL</b>	9	12	8	11	17	12	9	9	11
<b>CIVIL-INVOL</b>	0	0	2	0	1	0	2	0	12
<b>DCC</b>	16	12	11	13	11	12	11	9	6
<b>DCC PTP</b>	1	0	1	1	1	0	1	0	0
<b>FORENSIC</b>	28	28	32	33	19	30	19	9	15
<b>STAGE III</b>	30	34	40	38	30	33	17	9	15
<b>IST</b>	24	29	17	27	12	24	0	10	13
<b>NCR</b>	0	1	10	0	1	0	0	0	0

# STRATEGIC PERFORMANCE EXCELLENCE

## Admissions Office Quarterly Report, continued.

Discharge Graph



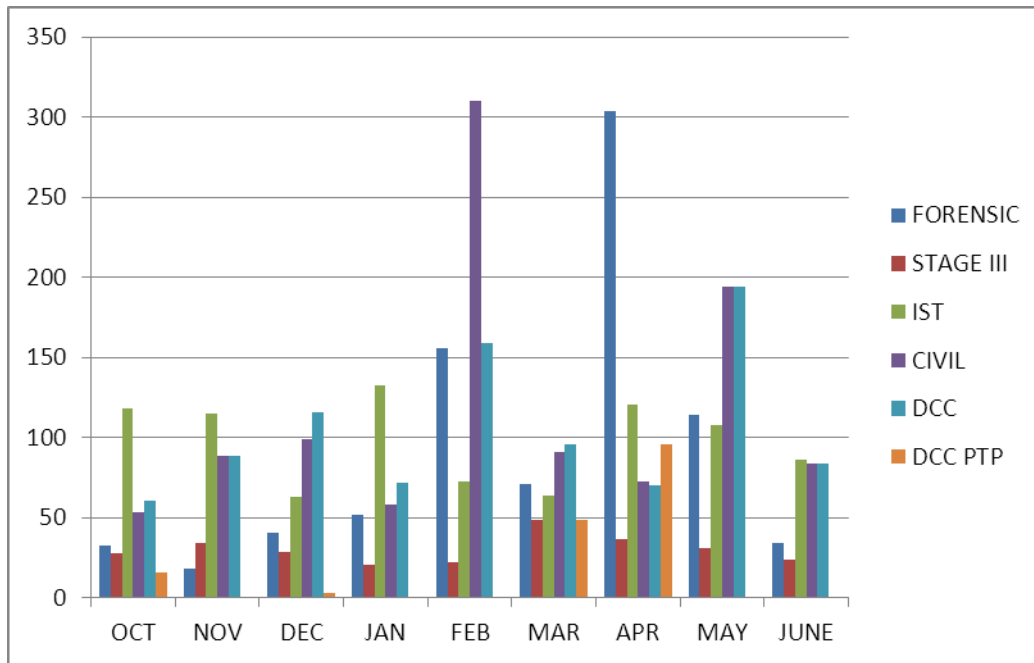
Discharge Data

DISCHARGES	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE
<b>TOTAL</b>	13	13	16	22	12	16	20	18	20
<b>FORENSIC</b>	10	8	8	9	8	7	10	12	12
<b>STAGE III</b>	6	7	7	7	5	5	6	8	9
<b>IST</b>	1	2	1	1	2	1	3	2	2
<b>XFER TO CS</b>	3	0	4	2	4	1	2	2	2
<b>CIVIL</b>	6	5	7	11	4	9	10	6	9
<b>DCC</b>	5	5	6	10	3	8	9	6	9
<b>DCC PTP</b>	1	0	1	0	0	1	1	0	0

# STRATEGIC PERFORMANCE EXCELLENCE

## Admissions Office Quarterly Report, continued.

Length of Stay Graph



Length of Stay Data

LOS	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE
FORENSIC	33	18	41	52	156	71	304	114	34
STAGE III	28	34	29	21	22	49	37	31	24
IST	118	115	63	133	73	64	121	108	86
CIVIL	53	89	99	58	310	91	73	194	84
DCC	61	89	116	72	159	96	70	194	84
DCC PTP	16	0	3	0	0	49	96	0	0

# STRATEGIC PERFORMANCE EXCELLENCE

## Capital Community Clinic

### 2014/2015 Plan

#### I. Performance Indicators:

- Patient Satisfaction Survey
  - o Ask pt. to fill out after each appointment to evaluate procedure and dental staff
- Staff / Case Manager Survey
  - o Ask to fill out yearly per patient to evaluate the dental clinic as a whole
- Plaque Score evaluate patients oral hygiene at each appointment
  - o Aid with oral hygiene education
  - o Aid to discuss with staff and caretakers
  - o Monitor at home hygiene
- Periodontal charting
  - o Complete periodontal charting yearly to evaluate periodontal status

#### II. Quality Assurance Measures:

- Formulate a yearly treatment
  - o Cross out/date treatment as completed
  - o Write NV at the end of each progress note
- Take blood pressure and pulse at the start of each dental appointment
- Signed consent for all RCTs and EXTs
  - o Completed by patient, dentist and assistant
- Time out taken prior to ALL extractions
  - o Dentist initials time out and writes the initials of the assistant
- Patient re-identified by date of birth at the start of each appointment
- Goal of eliminating wait list for patients in pain
  - o Blocking out daily slots for emergency appointment
  - o Goal of 30 appointments per month (if not needed fill with routine care)

# STRATEGIC PERFORMANCE EXCELLENCE

## Dietary Services

**Responsible Party:** Kristen Piela DSM

<b>Strategic Objective: Safety in Culture and Actions</b>													
<b>Hand Hygiene Compliance:</b> In an effort to monitor, sustain and improve hand hygiene compliance, the Dietary department measures its results through observations of Dietary staff when returning from a scheduled break.													
Baseline	1 <sup>st</sup> Quarter 2014			2 <sup>nd</sup> Quarter 2014			3 <sup>rd</sup> Quarter 2014			4 <sup>th</sup> Quarter 2014			Goal
	Target – Baseline	Findings	Compliance	Target – Q1 + 12%	Findings	Compliance	Target – Q2 + 12%	Findings	Compliance	Target – Q3 + 12%	Findings	Compliance	
85%	85%	16/30	53%	65%	33/57	58%	70%	55/66	83%	82%	99/187	53%	80-90%

**Data:**

99 compliant observations /187 hand hygiene observations =53% hand hygiene compliance rate

**Summary:**

- Hand hygiene compliance has decreased by 30%.
- Hand hygiene observations have increased; 66 observations last quarter to 187 observations this first quarter.
- Assigned additional staff to observe Hand Hygiene practices which increased the total number of observations thus increased validity of the compliance rate.
- Updated hand hygiene signage and placed them in different locations.

**Action Plan:**

- Continue use of the current Hand Hygiene Tool.
- Encourage employees to adhere to hand hygiene via verbal interaction/reminders.
- The Food Service Manager will present this quarterly report at the departmental staff meeting.



# STRATEGIC PERFORMANCE EXCELLENCE

## Dietary Services

**Responsible Party:** Kristen Piela DSM

Strategic Objective: Safety in Culture and Actions							
<b>Nutrition Screen Completion:</b> In an effort to monitor, improve and sustain timely completion of the nutrition screen for all admissions to RPC; decertified unit. The Registered Dietitian will review each Nutrition Screen within the Initial Nursing Admission Data. This screen will be completed by Nursing within 24 hours of admission.							
2 <sup>nd</sup> Quarter 2014	3 <sup>rd</sup> Quarter 2014			4 <sup>th</sup> Quarter 2014			Goal
Established Baseline	Jan-March 2014 Target – Q2 + 1%	Findings	Compliance	April-June 2014 Target – Q3 + 0%	Findings	Compliance	
100% 26/26		60/63	95%	95%	57/59	96.6%	95-100%

**Data:**

57 Nutrition screens completed w/in 24 hours of admission

59 Total Admissions = 96.6% of nutrition screens completed within 24 hours of admission

**Summary:**

- The Registered Dietitian reviewed the nutrition screens of the 63 client admissions for this quarter.
- Upon review, the RD discovered 2 nutrition screens incomplete.
- One incomplete nutrition screens was documented on the Lower Kennebec unit; one was documented on the Lower Saco unit.
- RD spoke with a nurse on each unit prior to the 24 hour deadline to facilitate possible completion of the screen.

**Action Plan:**

- RD will continue correspondence with nursing staff regarding the discovery of incomplete nutrition screens and request completion, as appropriate.
- Present quarterly report at departmental staff meeting and IPEC meeting.

# STRATEGIC PERFORMANCE EXCELLENCE

## Environment of Care

### INDICATOR

GROUPS SAFETY/SECURITY INCIDENTS

### DEFINITION

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

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

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

**METHODS OF MONITORING:** Monitoring would be performed by;

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

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

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

**UNIT:** Hospital grounds as defined above

**BASELINE:** 5% each Q

**2014 Q1-Q4 TARGETS:** Baseline – 5% each Q

# STRATEGIC PERFORMANCE EXCELLENCE

## Environment of Care

Department: Safety & Security

Responsible Party: Bob Patnaude  
Safety Officer

Strategic Objectives								
Safety in Culture and Actions	Unit	Baseline	Q4/14 Target Actual	Q1/15 Target Actual	Q2/15 Target Actual	Q3/15 Target Actual	Q4/15 Target Actual	Goal
<b>Grounds Safety &amp; Security Incidents</b>								
Safety/Security incidents occurring on the grounds at Riverview, which include "Acts of thefts, vandalism, injuries, mischief, contraband found, and safety / security breaches"	# of Incidents	* Baseline of 10	(10) -5% (6)	(6) -5%	Q1 Actual -5%	Q2 Actual -5%	Q3 Actual -5%	Baseline -5%

### SUMMARY OF EVENTS

The Q4 Target was (10). Our actual number was (6); although we were just shy of the goal, it was a decrease this quarter. Overall, for the entire year, our actual number of events was 20% less than the hoped for Target amount. We are pleased that in all of the events, our Security staff or clinical staff had discovered/processed the event before there was a negative impact to the Organization. We feel that the reporting, which follows below, continues to provide a very clear picture of Safety and Security events, how they are handled, and that the use of surveillance equipment plays an integral part in combating safety and security threats to people and property. Our aggressive rounds by Security continues to prove its' worth with regard to Security's presence and patrol techniques. The stability and longevity of our Security staff along with its' cohesiveness with the Clinical component of the hospital has proven to be most effective in our management of practices.

EVENT	DATE	TIME	LOCATION	DISPOSTION	COMMENTS
1. Safety Concern (State vehicle unlocked)	04/18/14	0156hrs.	State vehicle parking lot	Vehicle secured	1. Security discovered during outside patrol. 2. Lock mechanism malfunctioned. 3. Safety and NOD notified. 4. SEC IR # 647 completed
2. Security Concern (Exterior door ajar)	05/09/14	1825hrs.	Exterior Door	Door secured by Security	1. Security discovered during security tour. 2. Security checked entire area. 3. Safety and NOD notified. 4. SEC IR # 650 completed.

# STRATEGIC PERFORMANCE EXCELLENCE

EVENT	DATE	TIME	LOCATION	DISPOSTION	COMMENTS
3. Safety Concern (Building material on ground)	06/14/14	2000hrs	Saco Yard	Material to Operations to alert Maintenance	1. MHW alerted Security. 2. Security secured material and took to Ops. 3. Safety, Maintenance, and NOD notified. 4. SEC IR # 657 completed.
4. Safety Concern (Vehicle key in staff lot)	06/19/14	1050hrs	Staff Parking Lot	1. Turned in to Operations. 2. Email sent	1. Employee discovered and turned into Security. 2. Safety, Operations, notified 3. Email sent to staff to claim. 4. SEC IR # 661 completed.
5. Security Concern (Suspicious individual presented in Main Lobby)	06/20/14	1500hrs	Main Lobby	Capitol Police called to respond and investigate	1. Suspicious person came to lobby. When approached, became upset and fled. 2. Operations notified Capitol Police. Individual gone on arrival. 3. Safety and NOD notified. 4. SEC IR # 633 completed.
6. Safety Concern (Metal can discovered in State Vehicle)	06/27/14	1753hrs	State Vehicle	1. Security investigated 2. Removed item. 3. Last known operator's supervisor notified by Safety.	1. Security discovered during vehicle checks. 2. Removed items. 3. Safety and NOD notified. 4. Safety sent email to last known operator's supervisor for follow-up. 3. SEC IR # 669 completed.

# STRATEGIC PERFORMANCE EXCELLENCE

## Harbor Treatment Mall

Objectives	1Q2014	2Q2014	3Q2014	4Q2014
1. Hand-off communication sheet was received at the Harbor Mall within the designated time frame.	71% 30/41	69% 29/42	79% 33/42	71% 30/42
2. SBAR information completed from the units to the Harbor Mall.	86% 36/42	88% 37/42	81% 34/42	79% 33/42

**Unit: All three units January, February, and March 2014**  
**Accountability Area: Harbor Mall**  
**Aspect: Harbor Mall Hand-off Communication**  
**Overall Compliance: 80%**

### **DEFINE**

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

### **MEASURE**

Indicator number one has decreased from 79% last quarter to 71% for this quarter. Indicator number two has decreased from 81% last quarter to 79% this quarter.

### **ANALYZE**

Overall compliance has maintained at 79% for last quarter and this quarter. For indicator number one the designated time for the sheets to be received is not in compliance. The amount of time the sheets are late has decreased. Continue to concentrate on both indicators to improve current performance gaps.

### **IMPROVE**

I met with the Nurse IV on US to review November's data since they had the most HOC sheets that were not received on time or not received at all.

### **CONTROL**

The plan is to continue to monitor the data and follow up with any unit(s) who may be having difficulties in developing a consistent system that works for them to meet the objectives. I will review the results of this quarterly report at Nursing Leadership.

# STRATEGIC PERFORMANCE EXCELLENCE

## Health Information Technology (Medical Records) Documentation and Timeliness

### Upper Saco, Lower Kennebec, Upper Kennebec

Indicators	4Q14 Findings	4Q14 Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	There were 35 discharges in quarter 4 2014. Of those, 35 were completed by 30 days.	100%	80%
Discharge summaries will be completed within 15 days of discharge.	35 out of 35 discharge summaries were completed within 15 days of discharge during quarter 4 2014.	100 %	100%
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	6 forms were approved/ revised in quarter 4 2014 (see minutes).	100%	100%
Medical transcription will be timely and accurate.	Out of 809 dictated reports, 809 were completed within 24 hours.	100%	90%

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

**Actions:** Continue to monitor.

# STRATEGIC PERFORMANCE EXCELLENCE

## Health Information Technology (Medical Records) Documentation and Timeliness

### Lower Saco

Indicators	4Q14 Findings	4Q14 Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	There were 32 discharges in quarter 4 2014. Of those, 32 were completed by 30 days.	100%	80%
Discharge summaries will be completed within 15 days of discharge.	32 out of 32 discharge summaries were completed within 15 days of discharge during quarter 4 2014.	100 %	100%
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	6 forms were approved/ revised in quarter 4 2014 (see minutes).	100%	100%
Medical transcription will be timely and accurate.	Out of 809 dictated reports, 809 were completed within 24 hours.	100%	90%

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

**Actions:** Continue to monitor.

# STRATEGIC PERFORMANCE EXCELLENCE

## Health Information Technology (Medical Records) Confidentiality

Indicators	4Q14 Findings	4Q14 Compliance	Threshold Percentile
All client information released from the Health Information department will meet all Joint Commission, State, Federal & HIPAA standards.	4674 requests for information (108 requests for client information and 4494 police checks) were released for quarter 4 2014.	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	New employees/contract staff in quarter 4 2014.	100%	100%
Confidentiality/Privacy issues tracked through incident reports.	0 privacy-related incident report during quarter 4 2014.	100%	100%

**Summary:** The indicators are based on the review of all requests for information, orientation for all new employees/contract staff and confidentiality/privacy-related incident reports.

No problems were found in quarter 4 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.



# STRATEGIC PERFORMANCE EXCELLENCE

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

### Define

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

### Analyze

Data collected for the 4<sup>th</sup> quarter 2014 showed that we received 2325 applications. This is a decrease from last quarter (3<sup>rd</sup> quarter 2014) when we received 5168 applications.

### Improve

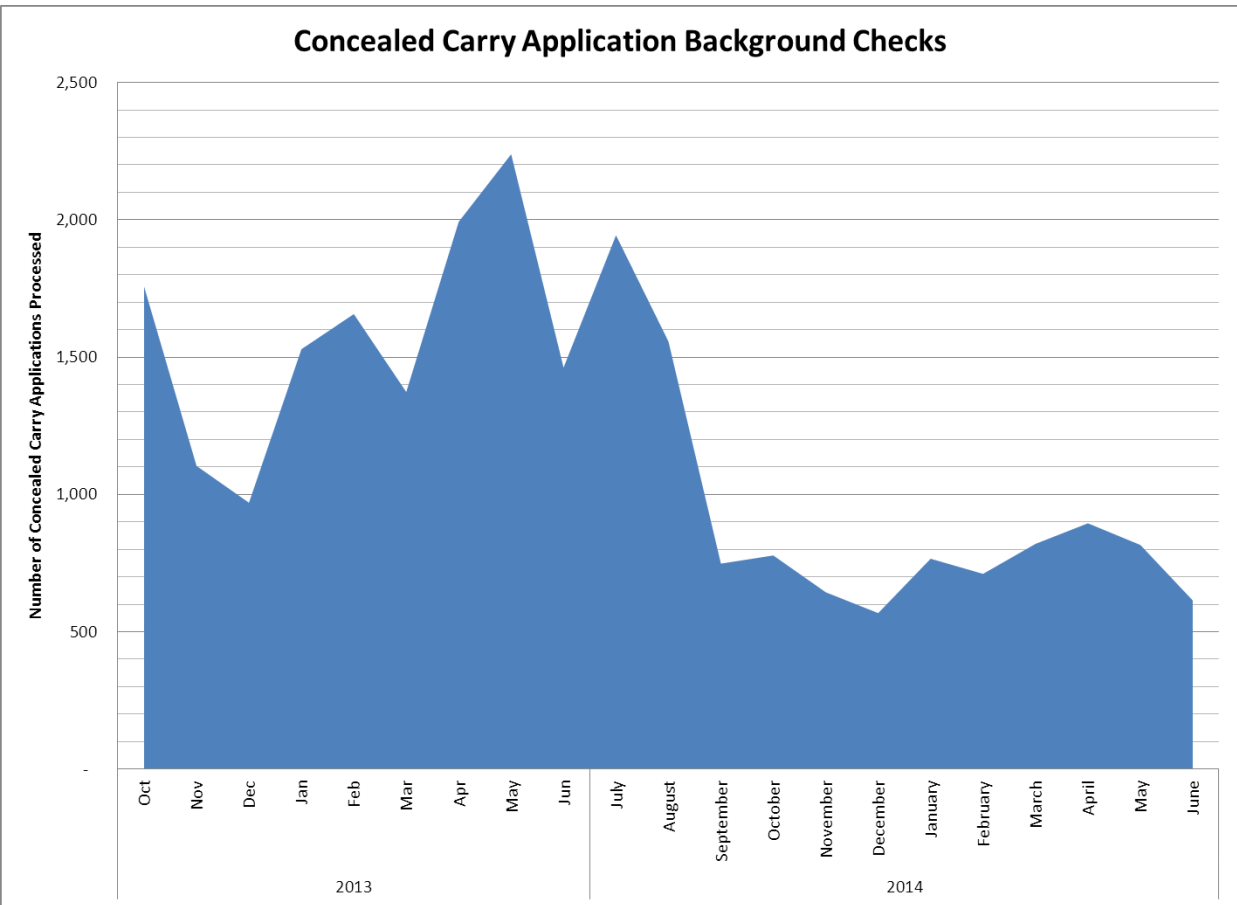
The process has been streamlined as we have been working with the state police by eliminating the mailing of the applications from them to RPC and DDPC. RPC has reactivated the medical records email to receive lists of the applicants from the state police that include the DOB and any alias they may have had. This has cut down on paper as well as time taken sorting all the applications. Due to the change in how we process the applications, we no longer have data on the Max and Avg Receipt Delay and Processing Time.

**NOTE:** At the end of the reporting period, there were 0 police checks outstanding for Riverview Psychiatric Center. We are now processing requests for concealed weapons checks via an emailed listing from the State Police.

OIT has also created a new patient index in which we are in the process of consolidating sources we search into this one system. Over time this will decrease time spent searching as we will no longer have to search several sources.

FY 2014	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
# Applications Received	1944	1557	748	778	644	568	766	711	820	895	816	614

# STRATEGIC PERFORMANCE EXCELLENCE



# STRATEGIC PERFORMANCE EXCELLENCE

## Human Resources

### Define

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

### Measure

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

### Analyze

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

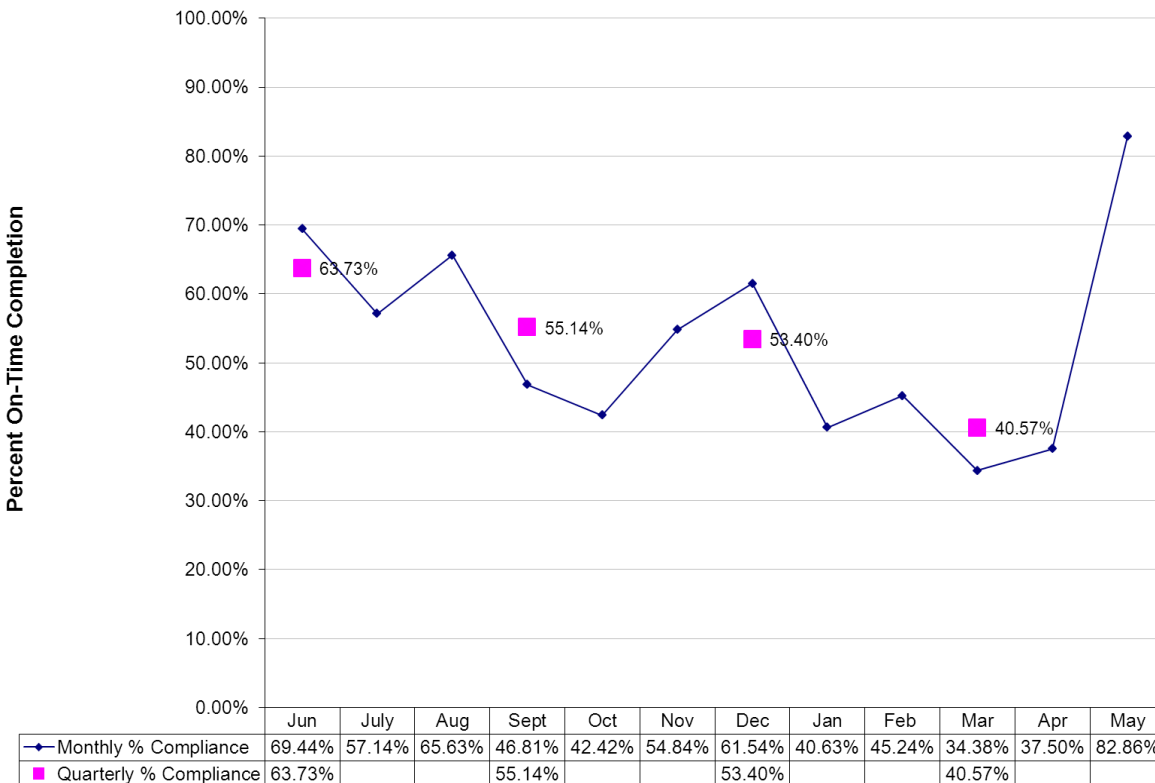
### Improve

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

### Control

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

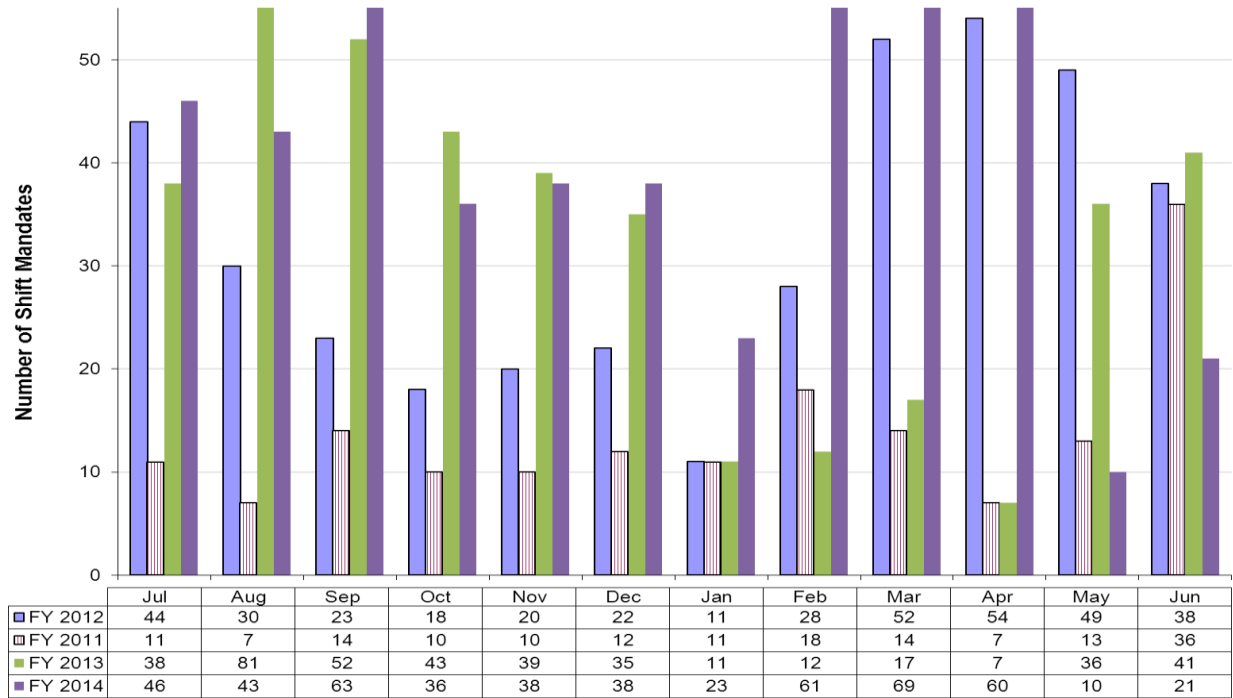
**Performance Evaluation Compliance**



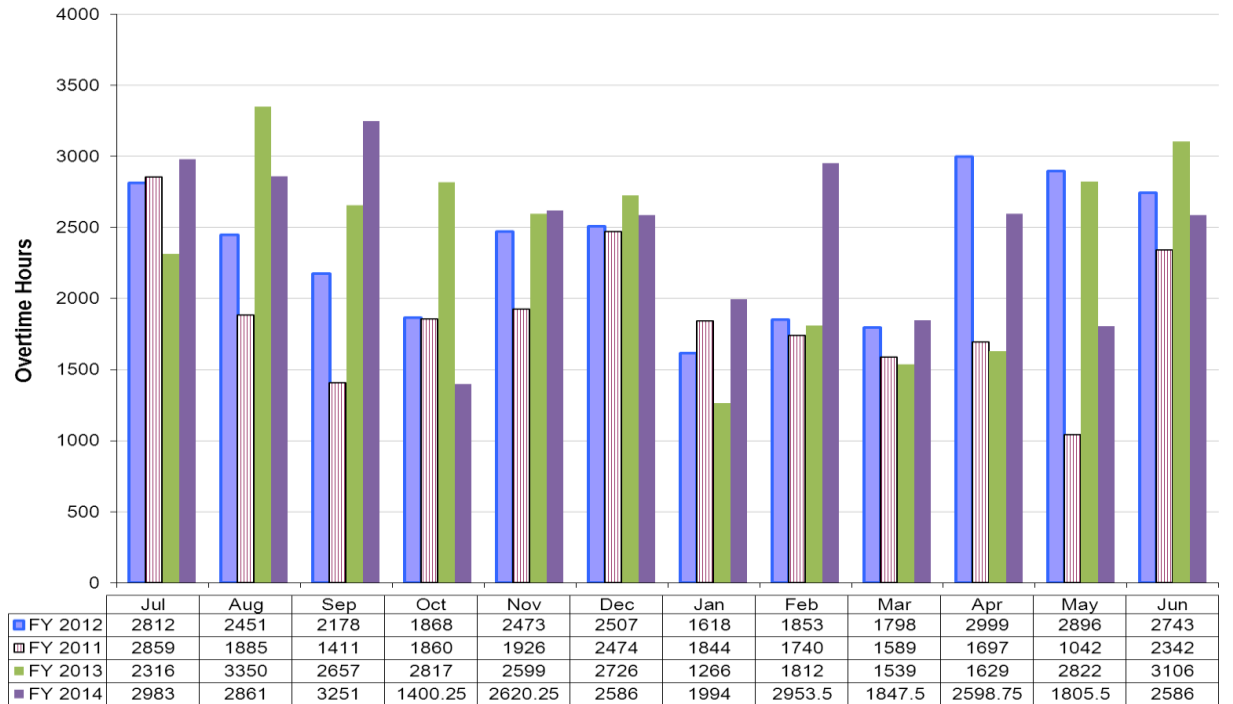
\*Data not yet available for June 2014

# STRATEGIC PERFORMANCE EXCELLENCE

**Monthly Mandated Shifts**

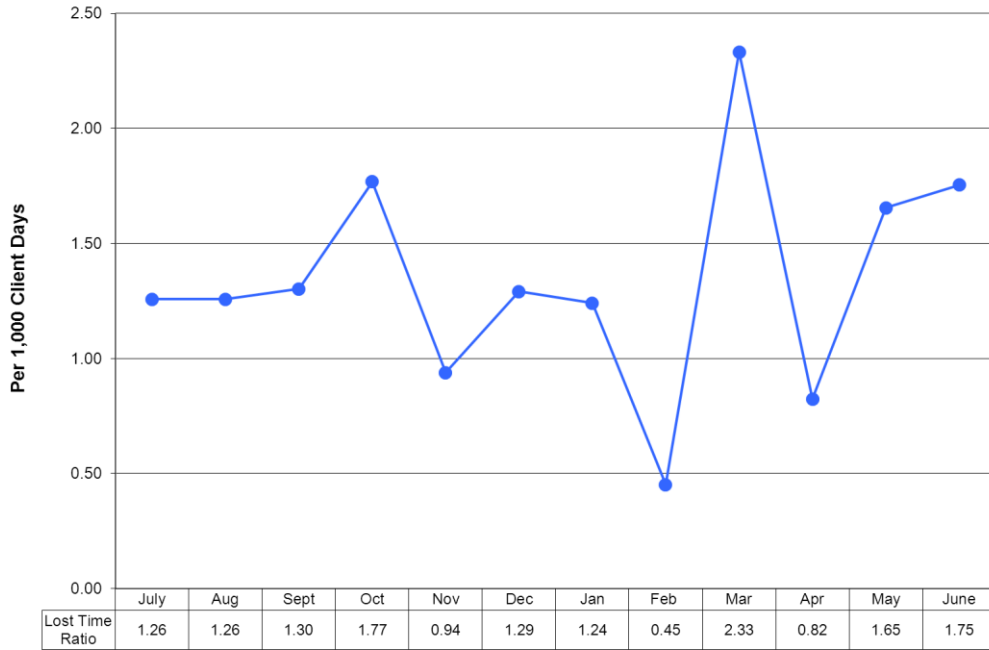


**Monthly Overtime**

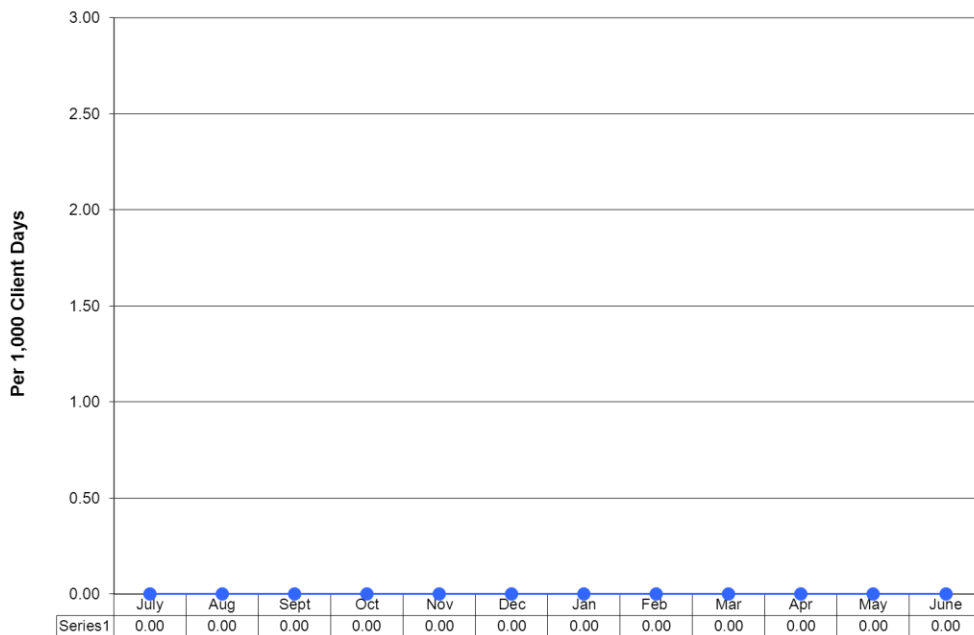


# STRATEGIC PERFORMANCE EXCELLENCE

**Reportable (Lost Time & Medical) Direct Care Staff Injuries**



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



# STRATEGIC PERFORMANCE EXCELLENCE

## Medical Staff Poly Antipsychotic Medication Monitoring

	April	May	June
<b>Census</b>	100	97	94
<b>Antipsychotic Orders for Clients</b>			
<b>No Antipsychotics</b>	23	18 (19%)	14 (15%)
<b>Mono-antipsychotic therapy</b>	55	56 (58%)	57 (61%)
<b>Two Antipsychotics</b>	18	20 (21%)	18 (19%)
<b>Three Antipsychotics</b>	3	0	3 (3%)
<b>Four Antipsychotics</b>	1	3 (3%)	2 (2%)
<b>At least 1 antipsychotic</b>	77	79 (81%)	80 (85%)
<b>Total on Poly-antipsychotic therapy</b>	22	23 (24%)	23 (24%)
<b>Percentage of poly-antipsychotic therapy amongst those with orders for antipsychotics</b>	29% (22/77)	29% (23/79)	29% (23/80)
<b>More than 2 antipsychotics</b>	4	3 (3%)	5 (5%)
<b>Poly-Antipsychotic therapy breakdown</b>			
<b>SGA + FGA</b>	8 (36%)	15 (65%)	11 (48%)
<b>2 SGAs ("Pine" + "Done")</b>	6 (27%)	3 (13%)	4 (17%)
<b>Other (2 antipsychotic regimens)</b>	4 (18%)	2 (9%)	3 (13%)
<b>Other 2 Antipsychotic Regimen Details</b>	1) Aripiprazole + ziprasidone 2) Olanzapine + quetiapine 3) Loxapine + chlorpromazine 4) Clozapine + olanzapine	1) Lurasidone + aripiprazole 2) Paliperidone + ziprasidone	1) Olanzapine + quetiapine 2) Loxapine + haloperidol 3) Paliperidone + ziprasidone
<b>3+ Antipsychotic Regimens</b>	1) Fluphenazine + loxapine + quetiapine 2) Haloperidol + paliperidone + risperidone 3) Asenapine + chlorpromazine + ziprasidone 4) Haloperidol + risperidone + olanzapine + quetiapine	1) Clozapine + haloperidol + paliperidone + risperidone 2) Quetiapine + haloperidol + paliperidone + risperidone 3) Haloperidol + risperidone + olanzapine + quetiapine	1) Olanzapine + perphenazine + chlorpromazine 2) Paliperidone + haloperidol + olanzapine (x2) 3) Quetiapine + haloperidol + paliperidone + risperidone 4) Haloperidol + risperidone + olanzapine + quetiapine

# STRATEGIC PERFORMANCE EXCELLENCE

<b>*Justifiable Poly-Antipsychotic Therapy</b>	82%	87%	87%
<b>Decreases in number of concurrent antipsychotic orders</b>	2AP → 1AP: 5 3AP → 2AP: 1 3AP → 1AP: 1	2AP → 1AP: 6 4AP → 1AP: 1	4AP → 3AP: 2 3A → 2AP: 1

SGA = Second Generation Antipsychotic; FGA = First Generation Antipsychotic; “Pines” = clozapine, olanzapine, quetiapine, asenapine; “Dones” = risperidone, paliperidone, ziprasidone, lurasidone, iloperidone; prn = as needed; AP = Antipsychotic

### Data Collection

All medication profiles in the hospital were reviewed for the months of April, May and June. We were particularly interested in the proportion of patients who were receiving more than one antipsychotic medication, since practice guidelines by the American Psychiatric Association clearly discourage this practice. When a case of polypharmacy was encountered we further required the prescriber to justify the practice based on pre-agreed upon clinical elements required to make the justification.

### Findings

Over the quarter we found that about 79% of patients were receiving at least one antipsychotic medication. Of these patients, about 29%, a two percent decrease from last quarter (31%), were receiving more than one such agent, and by definition was a case of polypharmacy. Within this overall percentage we noted that the individual percentages for all months were 29. We did see an increase in the number of patients on 3 and 4 antipsychotics. However, this quarter also evaluated the number of patients that had a decrease in the number of concurrent antipsychotic orders. In April, 7 patients had a decrease in the number of antipsychotics concurrently ordered, May also had 7 patients and June had 3, for a total of 17 patients.

### Analysis

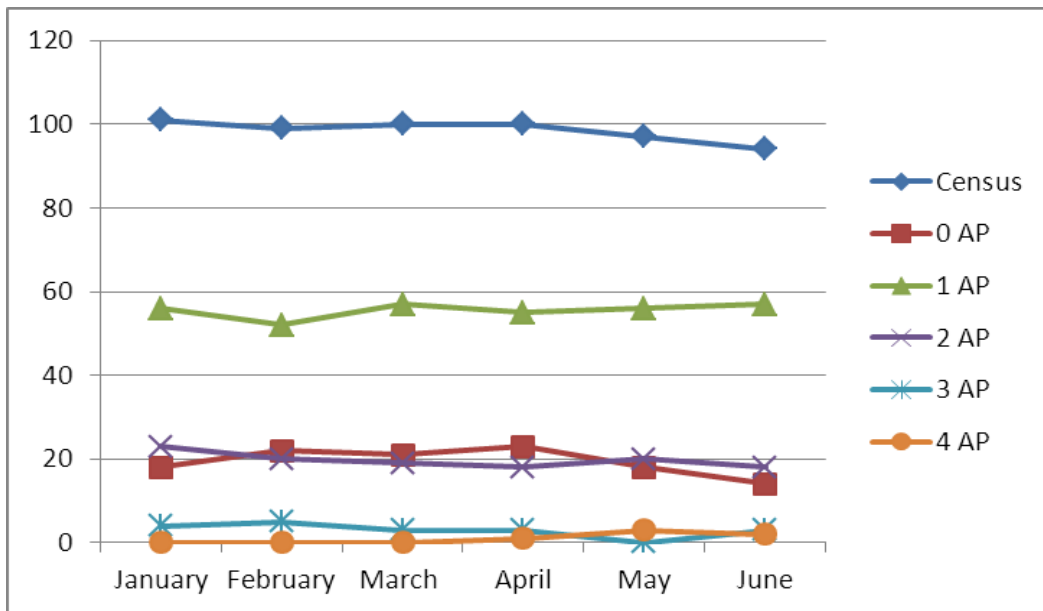
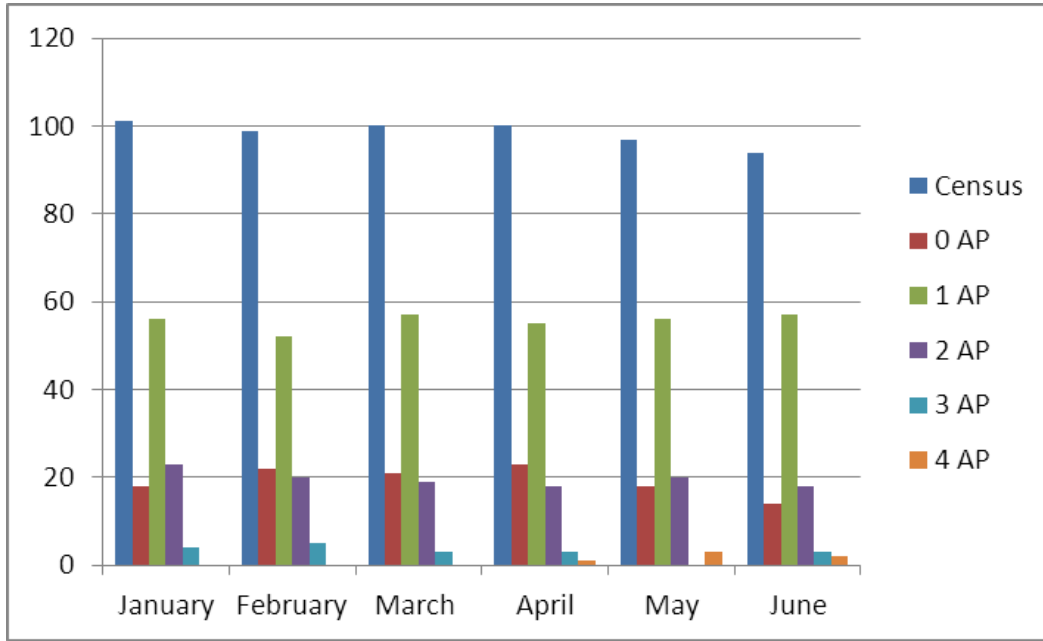
We are just below our target of 90% justified for the quarter at 85%. This is a decrease from last quarter but is likely due to changes in collecting the data prospectively. We have also implemented an electronic justification form that is emailed to prescribers who have a new admission on more than one antipsychotic or write a new order resulting in poly-antipsychotic therapy for a patient. The patients with active orders for 4 antipsychotics have all had at least one antipsychotic discontinued. At the time of this report, there are no patients on 4 antipsychotics.

### Plan

We will continue this monitor for another quarter since appropriate antipsychotic prescribing is both a common task in the hospital as well as one fraught with many potential negative sequellae. We will continue to prospectively gather data on polyantipsychotic therapy and follow-up with prescribers regarding the documented plan of action. We will continue to give feedback to medical staff and to look closely at all cases where it has been difficult to wean the client off high doses of multiple drugs.

# STRATEGIC PERFORMANCE EXCELLENCE

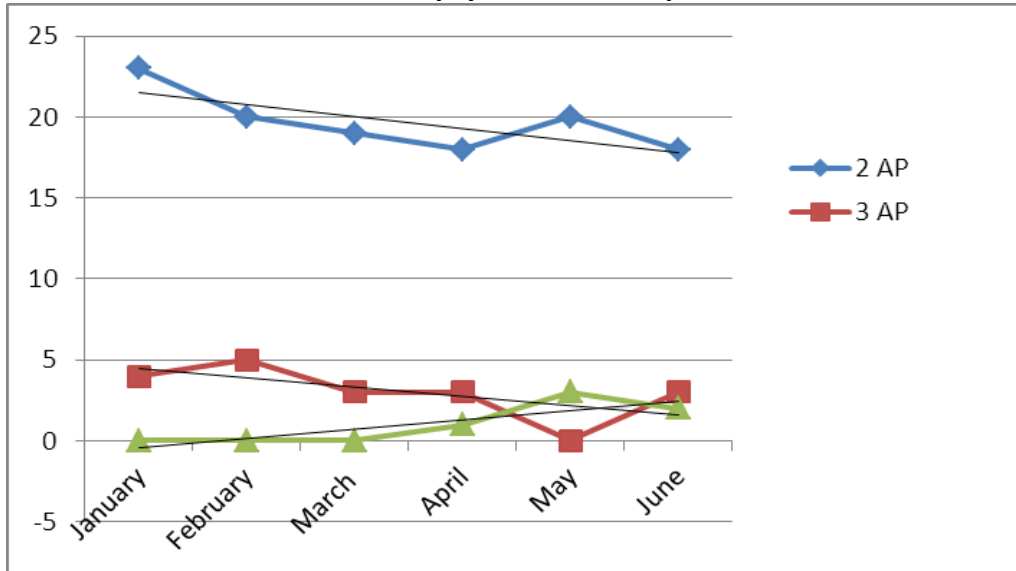
## Census & Number of Patients with 0, 1, 2, 3, & 4 Orders for Antipsychotics





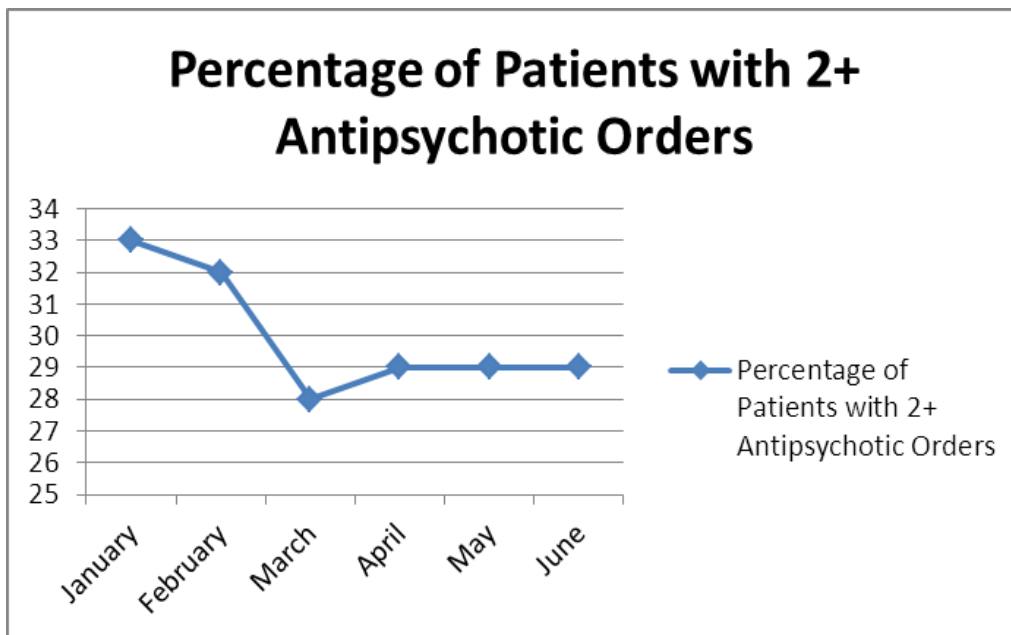
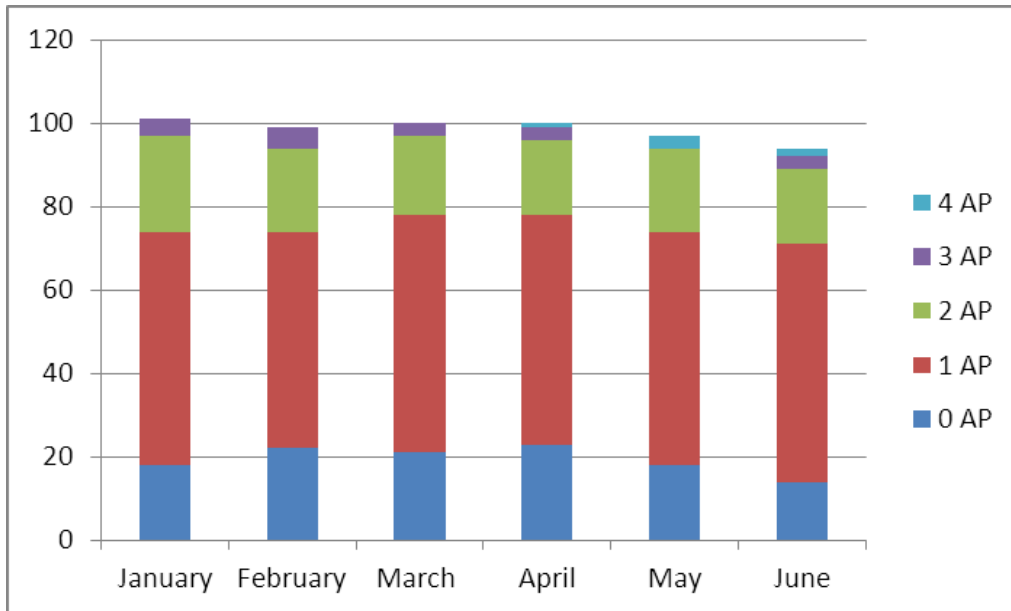
# STRATEGIC PERFORMANCE EXCELLENCE

**Number of Patients with 2+ Antipsychotic Orders per Month**



# STRATEGIC PERFORMANCE EXCELLENCE

## Number of Concurrent Antipsychotic Orders Per Patient Per Month



# STRATEGIC PERFORMANCE EXCELLENCE

## Medical Staff Antibiotic Use Monitoring

### Data Collection

During the quarter the antibiotic monitoring form consisting of a special doctor's order sheet with details of the antibiotic indication, drug, and strength, and giving agreed upon prescribing guidelines was fully implemented. Adherence to utilization of the form and the clinical appropriateness of indications for the antibiotic orders are gathered at the end of each month and the summary is provided at the following months' Pharmacy and Therapeutics (P&T) Committee. The Peer Review Team has been identified.

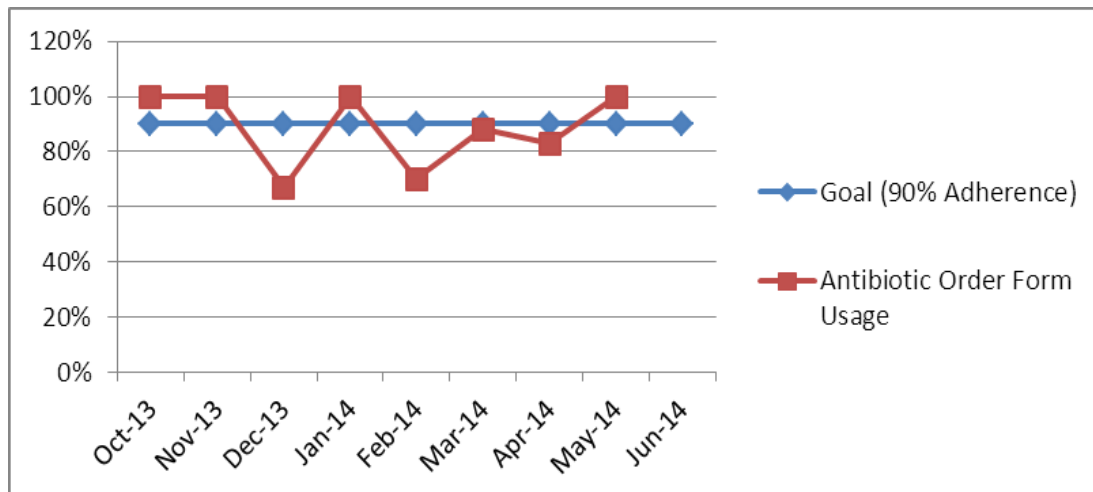
### Findings

During the monitoring period there was an adherence rate of 90%. However, not all of the individual months had an adherence rate of 90% or greater. The adherence rate for April was 88%, May 83% and June 100%. The adherence rate for the quarter is an improvement from the previous quarter, adherence rate of 86%. The orders for April have been presented at the Pharmacy and Therapeutic (P&T) Committee. The May and June results will be presented at the July P&T Committee Meeting. Once again the non-adherence to the form is by after hour/on-call prescribers. There have been many new additions to the on-call roster and the non-adherence may be due to unfamiliarity with the process. Education will be provided to those prescribers that do not utilize the form.

### Medical Staff Performance Improvement Indicator: Antibiotic Stewardship

Goal: 90% Adherence to Antibiotic Order Form for 4 Consecutive Months

	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Goal (90% Adherence)	90%	90%	90%	90%	90%	90%	90%	90%	90%
Antibiotic Order Form Usage	100%	100%	67%	100%	70%	88%	83%	100%	



# STRATEGIC PERFORMANCE EXCELLENCE

## **Plan**

The Peer Review team will evaluate the appropriateness of each antibiotic order. The team will also, on an ongoing basis, review the clinical guidelines and make recommendations for changes. Other trends identified by the team will be reported as necessary. A summary will be presented at each P&T Committee Meeting. Our threshold for this monitor is that 90% of all antibiotic orders will meet clinical guidelines as developed by the Medical Executive Committee.

# STRATEGIC PERFORMANCE EXCELLENCE

## Medical Staff Metabolic Monitoring of Atypical Antipsychotics

### Data Collection

The pharmacy completed data collection of metabolic monitoring parameters for all patients in the hospital who were receiving atypical antipsychotics during the quarter. Data elements collected on all patients included BMI (Body Mass Index) and BP (blood pressure) plus lab results including HDL cholesterol, triglycerides, fasting blood sugar, and hemoglobin A1c. Also collected were the dates of the last tests and the names of the atypical drugs each patient was receiving. This information is posted on the physician’s shared drive and presented monthly at the Pharmacy and Therapeutics (P&T) Committee Meeting

### Findings

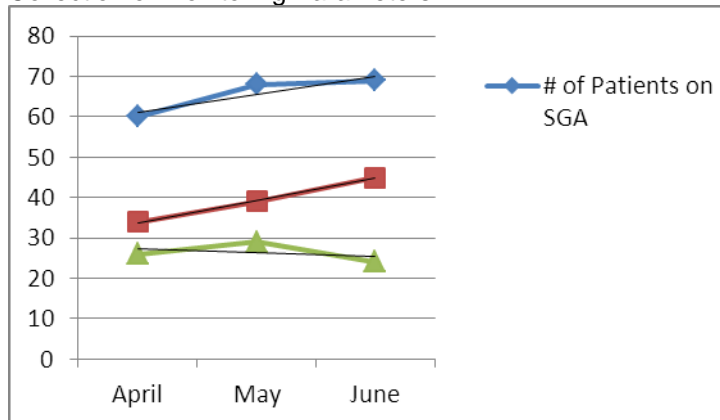
During the monitoring period there were 60, 68 and 69 clients receiving at least one atypical antipsychotic agent, respectively. Data was completely recorded for all desired data elements for about 60% of patients prescribed second generation antipsychotics for the quarter. Fourteen percent Twenty-three percent of patients were missing enough data elements that their metabolic status was unable to be determined. This is a decrease from last quarter’s 23%. Missing data elements were primarily related to lab studies, mostly due to refusal of clients to obtain blood work.

### Medical Staff Performance Improvement Indicator:

#### Metabolic Monitoring 2014

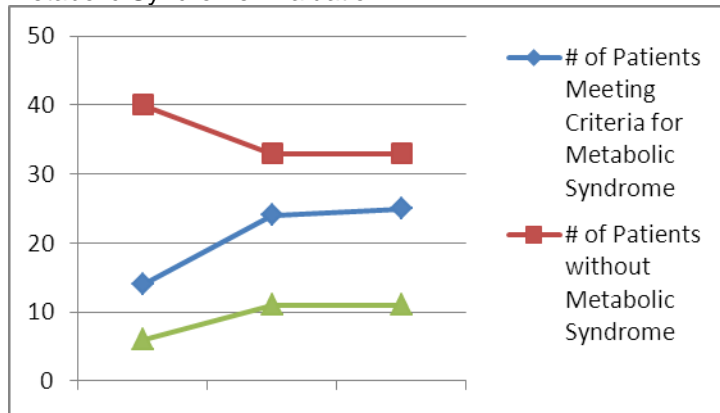
	April	May	June
# of Patients on SGA	60	68	69
# of Patients with Complete/Up-to-date Parameters	34 (57%)	39 (57%)	45 (65%)
# of Patients Missing/ Not Up-to-date Parameters	26 (43%)	29 (43%)	24 (35%)
# of Patients Meeting Criteria for Metabolic Syndrome	14 (23%)	24 (35%)	25 (36%)
# of Patients without Metabolic Syndrome	40 (67%)	33 (49%)	33 (48%)
# Unable to Determine	6 (10%)	11 (16%)	11(16%)

Collection of Monitoring Parameters



# STRATEGIC PERFORMANCE EXCELLENCE

## Metabolic Syndrome Evaluation



### **Analysis**

At 60% we are still below our target of 95% of clients on atypical antipsychotics having a complete metabolic profile available to the pharmacist and to the medical staff. This was primarily due to missing laboratory values in the data base due to refusals.

### **Plan**

Going forward, our plan will be to review the recommended metabolic monitoring frequency for each client to optimize the monitoring and prevent unnecessary lab work. We will continue to monitor the data elements of metabolic monitoring for each client prescribed a second generation antipsychotic. We will also continue to refine and improve our data entry. We will explore the concept of a metabolic clinic to better assess, identify, monitor, educate and treat clients at risk for metabolic syndrome. We will work to develop a schedule for blood draws for monitoring. We will utilize the APA and ADA guidelines to determine each client's recommended frequency of monitoring. We will explore the literature to determine action steps once a client is identified as having metabolic syndrome. We are also planning to provide education on Metabolic Syndrome to the Medical Staff in an attempt to increase awareness.

# STRATEGIC PERFORMANCE EXCELLENCE

## Nursing

### INDICATOR

#### Mandate Occurrences

### DEFINITION

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

### OBJECTIVE

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

### THOSE RESPONSIBLE FOR MONITORING

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

### METHODS OF MONITORING

Monitoring would be performed by;

- Staffing Office Database Tracking System

### METHODS OF REPORTING

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

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

### UNIT

Mandate shift occurrences

### BASELINE

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

### MONTHLY TARGETS

Baseline –10% each month

# STRATEGIC PERFORMANCE EXCELLENCE

## Nursing Department Mandates Staffing Improvement Task Force

		<a href="#">Mandate Occurrences – Nurses</a>	<a href="#">Mandate Occurrences – Mental Health Workers</a>
		When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy.	When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy.
	Unit	# of shifts	# of shifts
	<b>Baseline– August 2012</b>	24	53
1Q2014	July 2013	5	51
	August 2013	3	30
	September 2013	20	98
2Q2014	October 2013	4	32
	November 2013	8	30
	December 2013	9	29
3Q2014	January 2014	3	20
	February 2014	12	49
	March 2014	15	54
4Q2014	April 2014	20	36
	May 2014	1	13
	June 2014	8	14
<b>Total FY2014</b>		<b>108</b>	<b>456</b>
	Goal	16 (10% reduction monthly x4 from baseline)	35 (10% reduction monthly x4 from baseline)
	Comments	Due to posting openings out 30 days we have a significant drop in mandates	This also is R/T staff picking up OT and therefore choosing when to do OT

Nursing mandates were down this quarter from 30 last quarter to 29 this quarter. MHW mandates were also down from 123 last quarter to 63 this quarter.



# STRATEGIC PERFORMANCE EXCELLENCE

## Peer Support

### INDICATOR

Client Satisfaction Survey Return Rate

### DEFINITION

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

### OBJECTIVE

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

### THOSE RESPONSIBLE FOR MONITORING

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

### METHODS OF MONITORING

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

### METHODS OF REPORTING

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

### UNIT

All client care/residential units

### BASELINE

Determined from previous year's data.

### QUARTERLY TARGETS

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

# STRATEGIC PERFORMANCE EXCELLENCE

## Peer Support

### Inpatient Client Survey – Improving the Rate of Return

Department: Peer Support

Responsible Party: Chris Monahan

Strategic Objectives								
Client Recovery	Unit	Baseline	FY14 Q1	FY14 Q2	FY14 Q3	FY14 Q4	Goal	Comments
<b>CSS Return Rate</b>	LK	15%	5%	18%	10%	12%	50%	<i>Percentages are calculated based on number of people eligible to receive a survey vs. the number of people who completed the surveys.</i>
<i>The client satisfaction survey is the primary tool for collecting data on how clients feel about the services they are provided at the hospital. Data collection has been low on all units and the way in which the surveys are administered has challenges based on the unit operations and performance of the peer support worker.</i>	LS	5%	4%	8%	10%	0%	50%	
	UK	45%	39%	47%	50%	12%	50%	
	US	30%	100%	33%	30%	100%	50%	

# STRATEGIC PERFORMANCE EXCELLENCE

## Summary of Inpatient Client Survey Results

#	Indicators	1Q2014 Findings	2Q2014 Findings	3Q2014 Findings	4Q2014 Findings	Average Score
1	I am better able to deal with crisis.	70%	69%	73%	59%	68%
2	My symptoms are not bothering me as much.	78%	71%	63%	59%	68%
3	The medications I am taking help me control symptoms that used to bother me.	65%	75%	83%	59%	71%
4	I do better in social situations.	69%	73%	65%	53%	65%
5	I deal more effectively with daily problems.	70%	69%	68%	53%	65%
6	I was treated with dignity and respect.	70%	75%	73%	63%	70%
7	Staff here believed that I could grow, change and recover.	73%	69%	80%	63%	71%
8	I felt comfortable asking questions about my treatment and medications.	63%	69%	70%	56%	65%
9	I was encouraged to use self-help/support groups.	65%	77%	70%	66%	70%
10	I was given information about how to manage my medication side effects.	65%	63%	65%	47%	60%
11	My other medical conditions were treated.	63%	71%	75%	57%	67%
12	I felt this hospital stay was necessary.	63%	63%	65%	44%	59%
13	I felt free to complain without fear of retaliation.	60%	53%	50%	47%	53%
14	I felt safe to refuse medication or treatment during my hospital stay.	39%	63%	55%	56%	53%
15	My complaints and grievances were addressed.	58%	65%	68%	56%	62%
16	I participated in planning my discharge.	67%	73%	65%	72%	69%
17	Both I and my doctor or therapists from the community were actively involved in my hospital treatment plan.	58%	73%	65%	63%	65%
18	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	72%	71%	63%	59%	66%
19	The surroundings and atmosphere at the hospital helped me get better.	68%	69%	65%	66%	67%
20	I felt I had enough privacy in the hospital.	68%	71%	63%	63%	66%
21	I felt safe while I was in the hospital.	65%	75%	75%	59%	69%
22	The hospital environment was clean and comfortable.	73%	75%	78%	59%	71%
23	Staff were sensitive to my cultural background.	63%	83%	55%	59%	65%
24	My family and/or friends were able to visit me.	78%	77%	78%	59%	73%
25	I had a choice of treatment options.	58%	73%	60%	50%	60%
26	My contact with my doctor was helpful.	70%	77%	68%	47%	66%
27	My contact with nurses and therapists was helpful.	60%	79%	78%	66%	71%
28	If I had a choice of hospitals, I would still choose this one.	58%	69%	48%	56%	58%
29	Did anyone tell you about your rights?	58%	71%	63%	59%	63%
30	Are you told ahead of time of changes in your privileges, appointments, or daily routine?	60%	67%	45%	47%	55%
31	Do you know someone who can help you get what you want or stand up for your rights?	58%	71%	70%	69%	67%
32	My pain was managed.	64%	65%	65%	59%	63%
	<b>Overall Score</b>	<b>64%</b>	<b>71%</b>	<b>66%</b>	<b>58%</b>	<b>65%</b>

# STRATEGIC PERFORMANCE EXCELLENCE

## Pharmacy Services

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

### **Safety in Culture and Actions**

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

### **Fiscal Accountability**

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

# STRATEGIC PERFORMANCE EXCELLENCE

## Pharmacy Services

Pharmacy \_\_\_\_\_

Responsible

Party: Garry Miller, R.Ph.

Strategic Objectives								
Safety in Culture and Actions	Unit	Baseline 2013	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
<a href="#">Pyxis CII Safe Comparison</a>	Rx		0%	0%	0%	0%		2 discrepancies between Pyxis and CII Safe transactions during Q4
<i>Daily and monthly comparison of Pyxis vs CII Safe transactions</i>								
<b>Quarterly Results</b>			0.3%	0%	2.5%	0.7%		
<a href="#">Veriform Medication Room Audits</a>	All	97%	100%	100%	100%	100%	90%	Overall compliance is 98% for Q1,Q2,Q3 and Q4
<i>Monthly comprehensive audits of criteria</i>								
<b>Quarterly Results</b>			98%	98%	98%	97%		
<a href="#">Pyxis Discrepancies</a>	All	63/mo	50	50	50	50	50/mo	Trending of monthly data was significantly increased for Q2 and Q3 vs Q1
<i>Monthly monitoring and trending of Pxyis discrepancies.</i>								
<b>Quarterly Results</b>			226 (75/mo)	403 (134/mo)	389 (130/mo)	452 (150/mo)		
<a href="#">Pyxis Overrides – Controlled Drugs</a>	All	15/month	10	10	10	10	10	Target goal is 10/month
<i>Monthly monitoring and trending of Pyxis overrides for Controlled Drugs</i>								
<b>Quarterly Results</b>			65	53	114	116		
Fiscal Accountability	Unit	2013 Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
<a href="#">Discharge Prescriptions</a>	Rx	\$8440	\$5262	\$4184	\$2679	\$3867		Significant costs are incurred in providing discharge drugs.
<i>Monitoring and Tracking of dispensed Discharge Prescriptions</i>		334 drugs	418 drugs	252 drugs	359 drugs	341 drugs		

# STRATEGIC PERFORMANCE EXCELLENCE

## Program Services

### Define

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

### Measure

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

### Analyze

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

### Improve

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

### Control

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

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

# STRATEGIC PERFORMANCE EXCELLENCE

## Program Services Lower Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. How many on unit groups were offered each week Day shift → Evenings →	Main/SCU 5 7	85% 100%	Days/Even. 7 / 7 = 14
2. Number of clients attending day groups on unit or facilitated by day staff (# of clients in all of day groups divided by # of day groups provided)	6 Avg.		N/A
3. Number of clients attending evening groups on unit or facilitated by evening staff (# of clients in all of evenings groups divided by # of evening groups provided)	6 Avg		N/A
4. Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended	17/30	56%	100%
5. The client can identify distress tolerance tools on the unit	24/30	80%	100%
6. The client is able to state who his primary staff is	24/30	80%	100%

### EVALUATION OF EFFECTIVENESS

#### ISSUES

LK has improved in consistency of unit groups and attendance. Acuity has been a factor in the sporadic attendance. We continue to look at ways to decrease the acuity as well as increase client interest/participation in unit groups. Recovery RNs added to the staffing pattern is one way that we hope to be able to offer more on unit groups for clients as well as some further training for staff. Acuity Specialists on the unit will also free up some staff for group participation.

#### ACTIONS

We will continue to try to increase not only client participation in groups but also in relating the client's Recovery Goals to the groups offered and documenting on the group participation and progress towards goals as well.

# STRATEGIC PERFORMANCE EXCELLENCE

## Program Services Upper Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. How many on unit groups were offered each week Day shift → Evenings →	7 7	100%	7 / 7 = 14 7 / 7 = 14
2. Number of clients attending day groups on unit or facilitated by day staff (# of clients in all of day groups divided by # of day groups provided)	4/6	70%	N/A
3. Number of clients attending evening groups on unit or facilitated by evening staff (# of clients in all of evenings groups divided by # of evening groups provided)	5/6	85%	N/A
4. Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended	8/10	80%	100%
5. The client can identify distress tolerance tools on the unit (re named coping tools)	9/10	90%	100%
6. The client is able to state who his primary staff is	8/10	80%	100%

### EVALUATION OF EFFECTIVENESS

On unit groups are offered once on day shift and once on evenings daily by RN. The percentage of treatment plans increased this quarter from 40% to 80%. The unit acuity has decreased over the last quarter. Regular assigned nurses for the day shift have had a decrease over the last quarter.

### ISSUES

Consistent group leaders on the day shift have become an issue leading to participation in the on unit groups. Treatment plans also need work reflecting the on unit groups.

### ACTIONS

Upper Kennebec is working on getting regularly assigned day nurses to help with consistent day on unit groups. Treatment plans are also being addressed to reflect the on unit groups.



# STRATEGIC PERFORMANCE EXCELLENCE

## Program Services Lower Saco

INDICATOR	FINDINGS	%	THRESHOLD
1. How many on unit groups were offered each week Day shift → Evenings →	Main/SCU 36 / 12 27 / 10	100% 100%	7 / 7 = 14 7 / 7 = 14
2. Number of clients attending day groups on unit or facilitated by day staff (# of clients in all of day groups divided by # of day groups provided)	4.0 / 1.5		N/A
3. Number of clients attending evening groups on unit or facilitated by evening staff (# of clients in all of evenings groups divided by # of evening groups provided)	3.5 / 1		N/A
4. Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended	10	100%	100%
5. The client can identify distress tolerance tools on the unit	30/30	100%	100%
6. The client is able to state who his primary staff is	30/30	100%	100%

### EVALUATION OF EFFECTIVENESS

#### ISSUES

The Lower Saco unit on-unit groups by MHWS and professional staff is on-going and well established. Documentation in the Meditech has improved. This treatment effort continues to be reflected in the treatment plans. The on-unit groups have been a regular part of each client’s daily activity and are incorporated in their Rx plans. A high level of acuity on any given day can negatively impact levels of attendance and interest. Recreational Therapy staff members are more consistent in documenting participation and nursing staff have improved documentation over the past quarter. Only an occasional new client may need to be reminded about available tools/activities to help relieve distress.

#### ACTIONS

RT staff members are very important in providing diversion and therapy groups to Lower Saco clients, which needs to be maintained. The unit is offering many more groups weekly than the threshold; The acuity specialist positions have helped address acuity situations and further improved overall quality of groups.

# STRATEGIC PERFORMANCE EXCELLENCE

## Program Services Upper Saco

INDICATOR	FINDINGS	%	THRESHOLD
1. How many on unit groups were offered each week Day shift → Evenings →	14 9	100% 100%	Days/ Even. 7 / 7 = 14
2. Number of clients attending day groups on unit or facilitated by day staff (# of clients in all of day groups divided by # of day groups provided)	1.5avg./15grps		N/A
3. Number of clients attending evening groups on unit or facilitated by evening staff (# of clients in all of evenings groups divided by # of evening groups provided)	4avg./10grps		N/A
4. Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended	4	40%	100%
5. The client can identify distress tolerance tools on the unit	30/30	100%	100%
6. The client is able to state who his primary staff is	30/30	100%	100%

### EVALUATION OF EFFECTIVENESS

#### ISSUES

There continues to be a need to better reflect this on-unit treatment effort in the treatment plans. Nearly all of the clients on Upper Saco attend the hospital treatment mall with a high level of participation and attendance with off-unit treatment. Off unit groups are reflected in the treatment plans and are a regular part of physician orders. As in previous reports, there needs to be increased effort at reflecting on-unit groups in the treatment plans, especially for weekends and for clients not regularly attending the hospital treatment mall.

#### ACTIONS

Newly admitted clients quickly become familiar with distress tolerance tools (MP3 players, cards, exercise machines, etc.) and how to access them. They also know their assigned primary staff. Additional efforts need to be made to get all on-unit offered groups in individual treatment plans. Continued efforts are being made to offer groups to those clients that have less activity at the hospital treatment mall. Treatment planning for on-unit groups and follow-up documentation issues are being identified with the new nursing leader.

# STRATEGIC PERFORMANCE EXCELLENCE

## Psychology Department

Department: Psychology Services

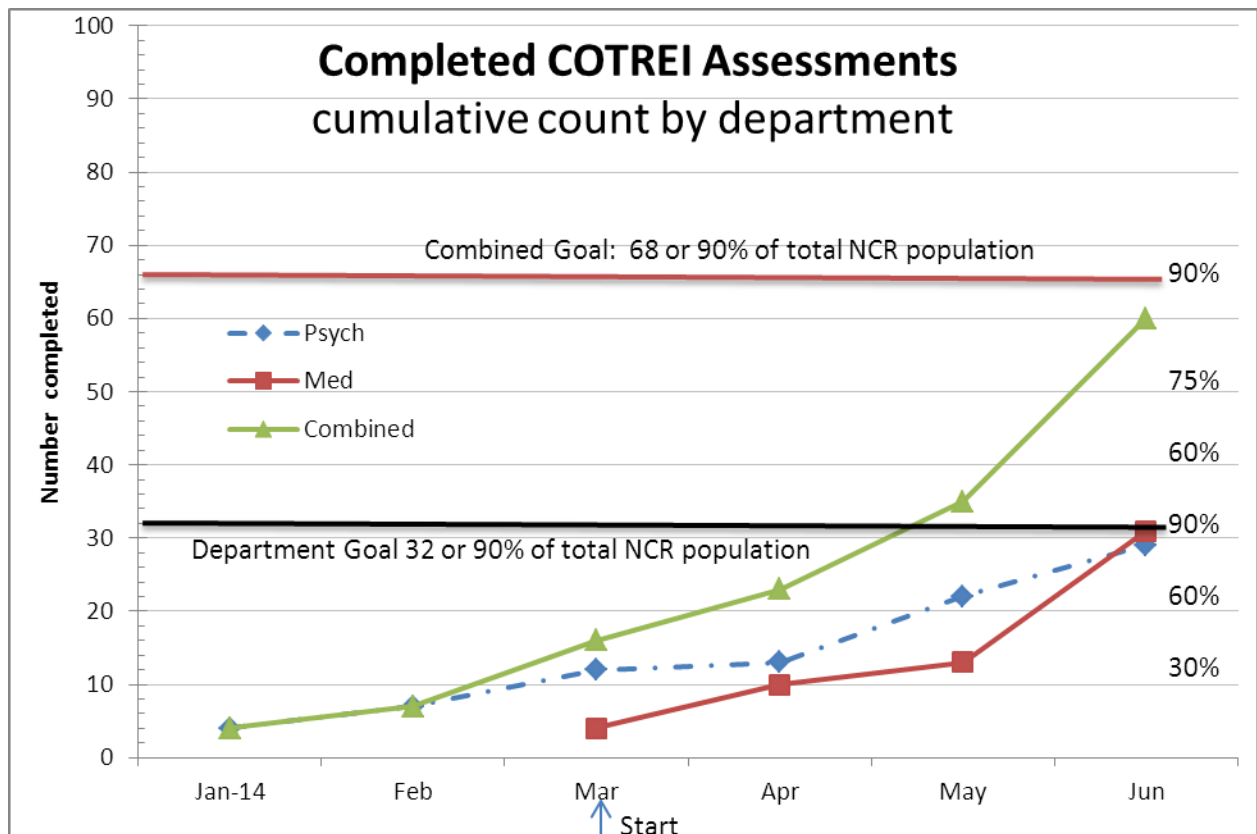
Responsible Party: Arthur DiRocco, PhD

### Current Psychology Performance Improvement Goal

The psychology department engaged in performance improvement activity involving the assessment of at least 90% of all patients residing at RPC who have been adjudicated as not criminally responsible (NCR) by the Court. Beginning in April 1<sup>st</sup>, 2014 to July 1<sup>st</sup>, 2014 members of the psychology and medical department completed a total of 60 assessments of the 68 individuals identified as NCR. This represents an 88% completion rate for the combined departments. Psychology completed 29 out of 32 for a completion rate of 91% of the targeted goal. Medical completed 31 out of 32 for a completion rate of 97% of the targeted goal. The data collected from these assessments will be used to assist the treatment team to identify treatment needs and to measure outcomes for this population of patients.

### Medical Staff Performance Improvement Activity

Target Goal: 90% completion of COTREI assessments of NCR patients in 4 months



COTREI: Community Outpatient Treatment Readiness Evaluation Instrument

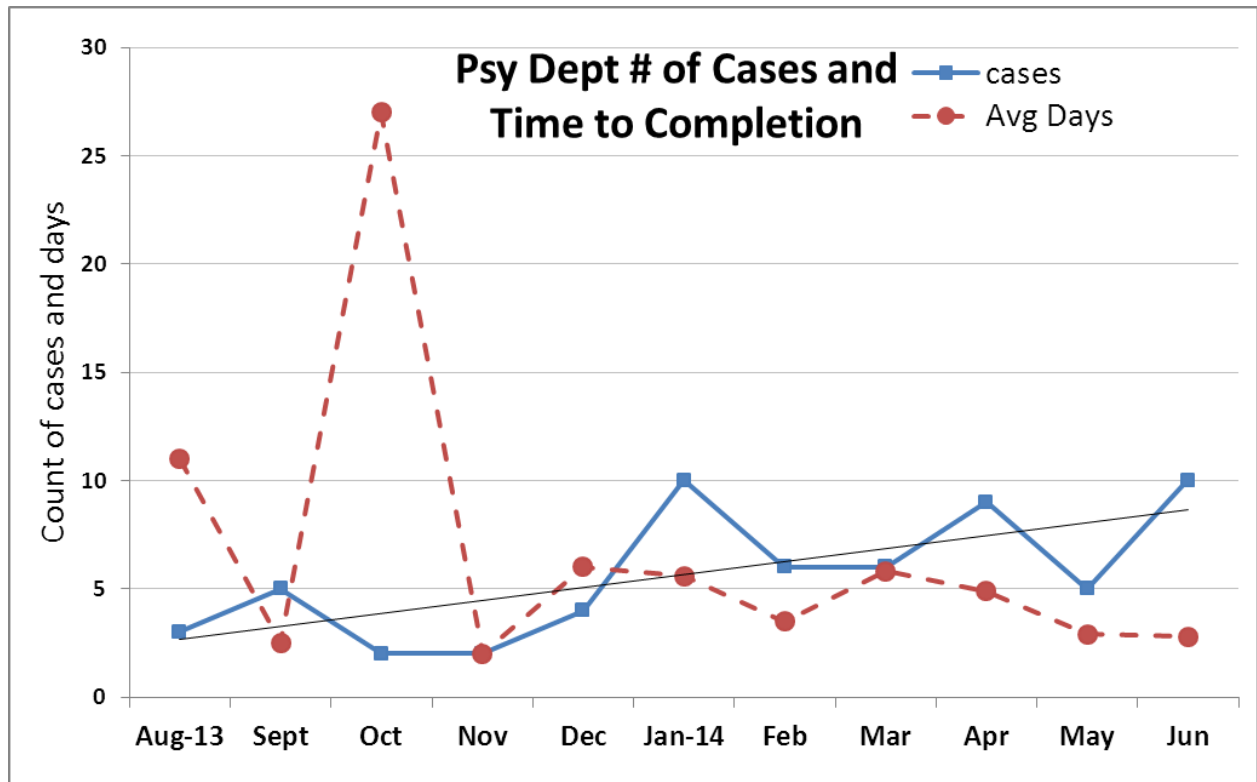
# STRATEGIC PERFORMANCE EXCELLENCE

## Psychology Department

### Successful Performance Improvement Plan

A previous department effort to improve delivery of psychological services was conducted over the first two quarters of 2014; i.e., January to July 2014. The aim of that program was to increase the number of cases which were completed by the department and to decrease the waiting time between referral and completion of the case. The first goal was to increase the number of cases (August 2013 to December 2013) from an average of 3 per month to a target of 6 cases per month or by a factor of 2. The base rate for waiting time for completion of services the previous 5 months (August to December) was 10.6 days. Since January 2014 the number of waiting days has dropped to an average of 4.5 days while the number of cases completed has grown to an average of 7 per month. Goals of 1<sup>st</sup> two quarters have been met.

#### Psychology Staff Performance Improvement Activity Target Goal: Improve efficiency and speed of services



# STRATEGIC PERFORMANCE EXCELLENCE

## Rehabilitation Services

Department: Rehabilitation Services

Responsible Party: Janet Barrett

Strategic Objectives							
Client Recovery	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
<p><b><u>Vocational Incentive Program Treatment Plans</u></b></p> <p><i>The objective of this improvement project is to ensure vocational treatment plans are initiated on all clients within 5 days of beginning work and will be reviewed and updated if necessary every 30 days. Documentation on interventions in the treatment plans will reflect progress towards interventions and will be documented on weekly.</i></p>	55%	92%	95%	98%	100%	The treatment plans will be reviewed more regularly and updated at each client 30 day treatment team meeting.	All charts reviewed had a current plan and documentation was present.
<b><u>Quarterly Results</u></b>		95%	88%	93%	100%		

Client Recovery	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
<p><b><u>Recreational Therapy Assessments &amp; Treatment Plans</u></b></p> <p><i>The objective of this improvement project is to ensure that Recreational Therapy assessments are completed within 7 days of admission and that a treatment plan is initiated after the assessment and will be reviewed and updated if necessary every 30 days. Documentation on interventions in the treatment plans will reflect progress towards interventions and will be documented on weekly.</i></p>	75%	85%	90%	95%	100%	The treatment plans will be reviewed more regularly and updated at each client treatment team meeting or if there is any change in client status	All plans updated and documentation in the chart for this quarter.
<b><u>Quarterly Results</u></b>		85%	91%	100%	100%		

# STRATEGIC PERFORMANCE EXCELLENCE

## Rehabilitation Services

Department: Rehabilitation Services

Responsible Party: Janet Barrett

Strategic Objectives							
Client Recovery & Safety in Culture and Actions	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
<p><a href="#"><u>Occupational Therapy referrals and doctors orders.</u></a></p> <p><i>The objective of this improvement project is to ensure each client receiving Occupational Therapy Services from RPC OT staff has a doctor's order as well as a referral form completed prior to the initiation of services.</i></p>	33%	50% 39 of 43	75% 13 of 16	100% 22 of 23	100% 14 of 14	To increase the percentage of referrals and doctor's orders by 25 % each quarter until we attain 100% compliance .	1 patient had services initiated prior to the order physically being received by Rehab. Dept but OT reviewed the order in the patient chart prior to starting services as they had been made aware of the order by MD.
<a href="#"><u>Quarterly Results</u></a>		91%	81%	96%	100%		