Riverview
PSYCHIATRIC CENTER

QUARTERLY REPORT ON ORGANIZATIONAL PERFORMANCE EXCELLENCE

FOURTH STATE FISCAL QUARTER 2015

April, May, June 2015

Robert J. Harper
Superintendent
July 24, 2015

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STRATEGIC PERFORMANCE EXCELLENCE

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Glossary of Terms, Acronyms & Abbreviations

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 Communication
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
JAIL TRANS	A patient who has been transferred to RPC from jail.
JTF	A patient who has been transferred to RPC from jail.
LCSW	Licensed Clinical Social Worker
LEGHOLD	Legal Hold
LPN	Licensed Practical Nurse
MAR	Medication Administration Record
MHW	Mental Health Worker
MRDO	Medication Resistant Disease Organism (MRSA, VRE, C-Dif)
NASMHPD	National Association of State Mental Health Program Directors

NCR	Not Criminally Responsible
NOD	Nurse on Duty
NP	Nurse Practitioner
NPSG	National Patient Safety Goals (established by The Joint Commission)
NRI	NASMHPD Research Institute, Inc.
OPS	Outpatient Services Program (formally the ACT Team)
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
RPC	Riverview Psychiatric Center
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. Staff Development.
Seclusion, Locked	Patient is placed in a secured room with the door locked.
Seclusion, Open	Patient is placed in a room and instructed not to leave the room.
SRC	Single Room Care (seclusion)
STAGE III	60 Day Forensic Evaluation
TJC	The Joint Commission (formerly JCAHO, Joint Commission on Accreditation of Healthcare Organizations)
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 staff members to provide evidence of a commitment to patient recovery, safety in culture and practices, and fiscal accountability. The report is structured 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 through regulatory and legal standards.

The methods of reporting are driven by a nationally 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 measures 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.

Patient Rights

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

Indicators	1Q2015	2Q2015	3Q2015	4Q2015
1. Patients are routinely informed of their rights upon admission.	97% 44/45 (100%, 14/15 for Lower Saco)	97% 57/59 (All four units)	95% 57/60 (All four units)	100% 45/45 (All four units)

Patients are informed of their rights and asked to sign that information has been provided to them. If they refuse, staff documents the refusal and signs, dates & times the refusal.

4Q2015:
1. 6 patients refused, 1 lacked capacity.

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	1Q2015	2Q2015	3Q2015	4Q2015
1. Level II grievances responded to by RPC on time.	100% 1/1	100% 3/3	N/A	100% 1/1
2. Level I grievances responded to by RPC on time.	100% 86/86	100% 65/65	98% 96/98	52% 45/86

CONSENT DECREE

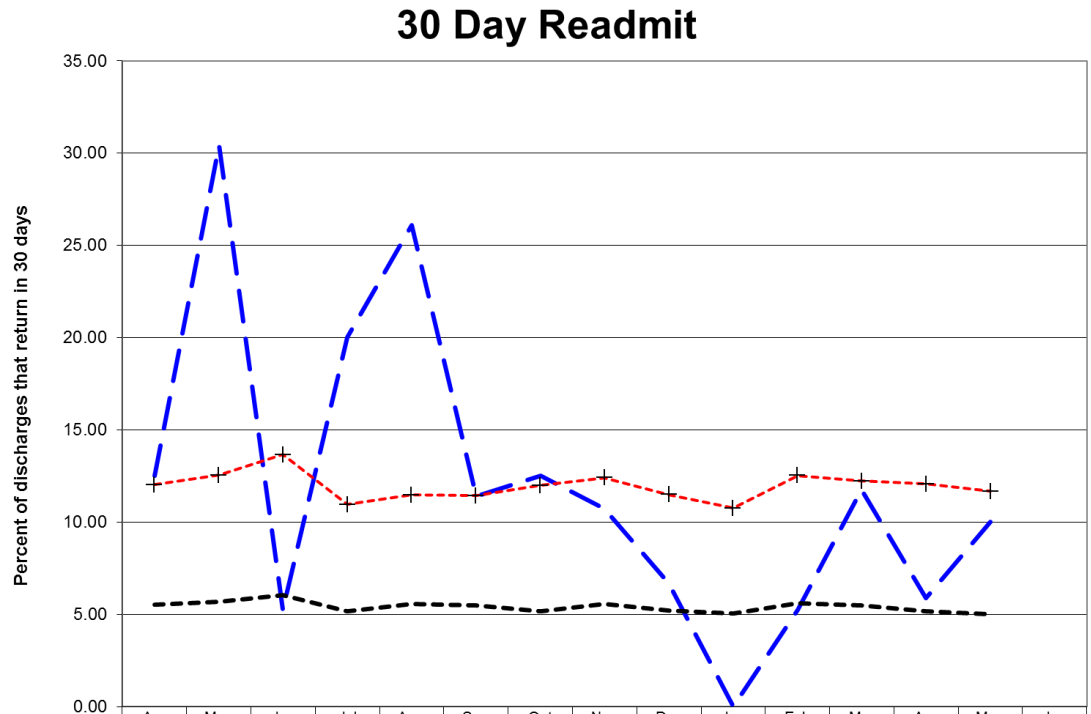
Admissions

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

Legal Status on Admission	1Q2015	2Q2015	3Q2015	4Q2015	Total
CIVIL:	**35**	**41**	**26**	**25**	**127**
VOL	0	2	0	1	**3**
CIVIL-INVOL	8	6	3	2	**19**
DCC	25	33	22	20	**100**
DCC PTP	2	0	1	2	**5**
FORENSIC:	**33**	**28**	**17**	**20**	**98**
STAGE III	20	14	3	6	**43**
JAIL TRANS	1	1	0	0	**2**
IST	7	8	5	13	**33**
NCR	5	5	9	1	**20**
GRAND TOTAL	**68**	**69**	**43**	**45**	**225**

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	12.50	30.43	5.26	20.00	26.09	11.39	12.50	10.71	6.67	0.00	5.26	11.76	5.88	10.00	
Ntl Mean	5.53	5.69	6.05	5.18	5.55	5.48	5.16	5.56	5.20	5.06	5.62	5.48	5.15	5.02	
+1 StDev	12.02	12.53	13.66	10.96	11.47	11.43	11.98	12.40	11.49	10.75	12.51	12.22	12.07	11.66	

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

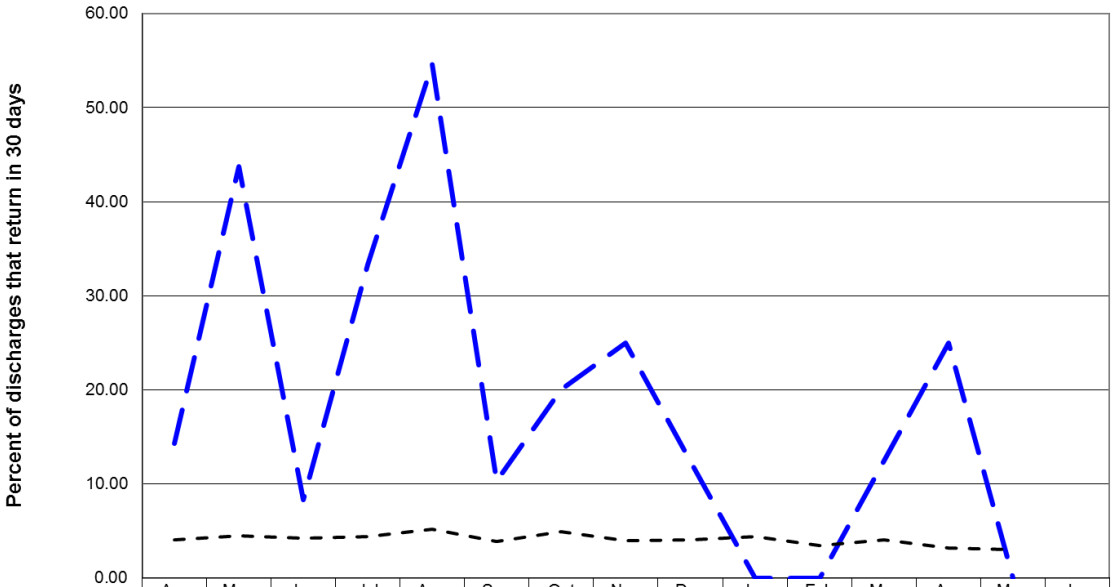
Reasons for patient readmission are varied and may include decompensating or lack of compliance with a PTP. Specific causes for readmission are reviewed with each patient upon their return. These graphs are intended to provide an overview of the readmission picture and do not provide sufficient granularity to determine trends for causes of readmission. Between August 2013 and November 2014, the Lower Saco Unit was decertified; patients had to be discharged and readmitted in our Meditech Electronic Medical Record system whenever they transferred units within the hospital (either from or to Lower Saco), which caused them to show up as a 30 Day Readmission, even though they never left the hospital.

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 patient 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.

CONSENT DECREE

30 Day Readmit

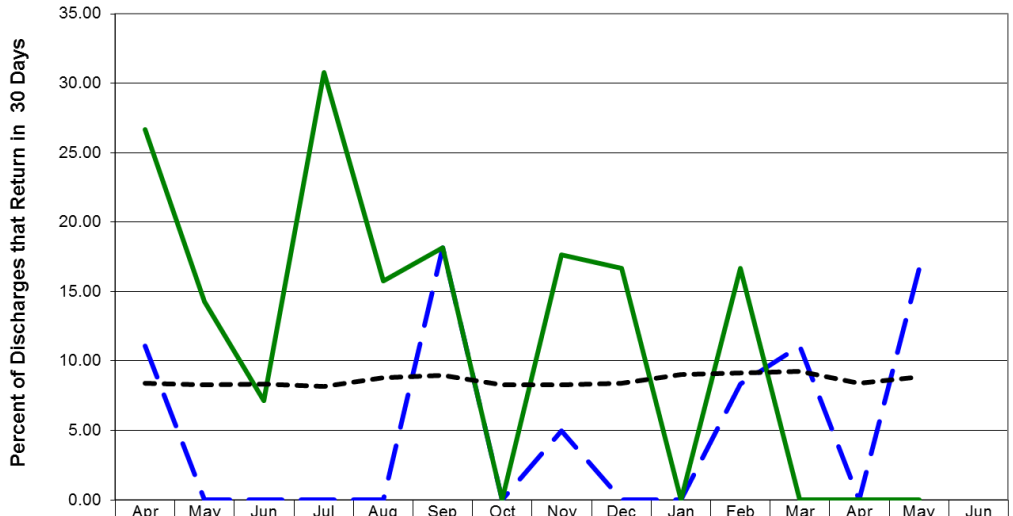
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	14.29	43.75	8.33	33.33	54.55	10.29	20.00	25.00	12.50	0.00	0.00	12.50	25.00	0.00	
Ntl Mean	4.04	4.47	4.22	4.43	5.15	3.86	4.94	3.98	4.08	4.39	3.44	4.03	3.21	2.99	

30 Day Readmit

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	11.11	0.00	0.00	0.00	0.00	18.18	0.00	5.00	0.00	0.00	8.33	11.11	0.00	16.67	
Dorothea Dix	26.67	14.29	7.14	30.77	15.79	18.18	0.00	17.65	16.67	0.00	16.67	0.00	0.00	0.00	
Ntl Mean	8.40	8.30	8.33	8.20	8.78	8.99	8.27	8.30	8.39	9.03	9.15	9.25	8.40	8.85	

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 patient 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	1Q2015	2Q2015	3Q2015	4Q2015
Director of Social Services reviews all readmissions occurring within 60 days of the last discharge, and for each patient 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; and, where such a need or change was indicated, that corrective action was taken.	100% 3/3	100% 4/4	100% 5/5	100% 2/2

4Q2015:

Two patients were readmitted. Of the two readmitted, both spent less than 30 days in the community. Patient 1 spent 10 days in the community post discharge and was readmitted to the hospital for violating his PTP treatment plan. Patient 2 was discharged to a group home under care of the OPS team with PTP and was readmitted 16 days later for instability and eloping. The same patient was discharged to the community again to a group home with PTP and returned 7 days later for instability and verbally threatening residential staff.

CONSENT DECREE

Reduction of re-hospitalization for Outpatient Services Programs (OPS) Patients

Indicators	1Q2015	2Q2015	3Q2015	4Q2015
1. The Program Service Director of the Outpatient Services Program will review all patient cases of re-hospitalization from the community for patterns and trends of the contributing factors leading to re-hospitalization each quarter. The following elements are considered during the review: a. Length of stay in community b. Type of residence (group home, apartment, etc.) c. Geographic location of residence d. Community support network e. Patient demographics (age, gender, financial) f. Behavior pattern/mental status g. Medication adherence h. Level of communication with Outpatient Treatment	100% 2/2	100% 3/3	100% 6/6	100% 1/1
2. Outpatient Services will work closely with inpatient treatment team to create and apply discharge plan incorporating additional supports determined by review noted in #1.	100% 2/2	100% 3/3	100% 6/6	100% 1/1

4Q2015:

1. One PTP patient, a 66 year old male, returned to RPC for disruptive, aggressive, dangerous activity, and inability to follow house rules. He eloped from his group home and went to Noyes Street and walked in on a person in his old apartment. The police returned him to his group home on Winthrop Street; he couldn't sleep, and left again.
2. 100% attendance at RPC treatment team meetings that OPS was scheduled to attend.

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.

Patient Admission Diagnoses	1Q15	2Q15	3Q15	4Q15	Total
ADJUSTMENT DISORDER WITH DEPRESSED MOOD				1	**1**
ADJUSTMENT REACTION NOS			1		**1**
ANXIETY STATE NOS	1	4			**5**
BIPOL I DIS, MOST RECENT EPIS (OR CURRENT) MANIC, UNSPEC	1				**1**
BIPOL I, MOST RECENT EPISODE (OR CURRENT) MIXED, UNSPEC	1				**1**
BIPOL I, REC EPIS OR CURRENT MANIC, SEVERE, SPEC W PSYCH BEH	1	4	1		**6**
BIPOL I DIS, SING MANIC EPIS, SEVERE, SPEC W PSYCHOTIC BEHAV				1	**1**
BIPOLAR I DISORDER, SINGLE MANIC EPISODE, UNSPECIFIED				1	**1**
BIPOLAR DISORDER, UNSPECIFIED	6	7	1		**14**
DELUSIONAL DISORDER	2			1	**3**
DEPRESS DISORDER-SEVERE				3	**3**
DEPRESS DISORDER-UNSPEC	1		1		**2**
DEPRESSIVE DISORDER NEC	5	1			**6**
HEBEPHRENIA-UNSPEC	1				**1**
IMPULSE CONTROL DIS NOS			2		**2**
INTERMITT EXPLOSIVE DIS				1	**1**
OTH AND UNSPECIFIED BIPOLAR DISORDERS, OTHER	2				**2**
OTH SPEC PERVASIVE DEVELOPMENT DIS, CURRENT OR ACT STATE		1			**1**
PARANOID SCHIZO-CHRONIC	8	5	1	2	**16**
PARANOID SCHIZO-UNSPEC		1	3		**4**
POSTTRAUMATIC STRESS DISORDER	4	3	1	1	**9**
PSYCHOSIS NOS	6	11	8	8	**33**
RECURR DEPR DISORD-UNSP		1		1	**2**
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED	16	19	17	17	**69**
SCHIZOPHRENIA NOS-CHR	2	1			**3**

CONSENT DECREE

Patient Admission Diagnoses	1Q15	2Q15	3Q15	4Q15	Total
SCHIZOPHRENIA NOS-UNSPEC	1	4	1	5	**11**
SCHIZOPHRENIFORM DISORDER, UNSPECIFIED	1			1	**2**
UNSPECIFIED ALCOHOL-INDUCED MENTAL DISORDERS	1	1			**2**
UNSPECIFIED EPISODIC MOOD DISORDER	8	6	6	2	**22**
Total Admissions	**68**	**69**	**43**	**45**	**225**
Admitted with primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	0%	0%	0%	0%	0%

Peer Supports

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

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

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

Indicators	1Q2015	2Q2015	3Q2015	4Q2015
1. Attendance at Comprehensive Treatment Team meetings. (v9)	45% 183/404	91% 381/482	96% 383/414	91% 383/414
2. Attendance at Service Integration meetings. (v8)	100% 80/80	Data not available	93% 26/28	61% 19/31
3. Contact during admission. (v8)	100% 80/80	100% 72/72	100% 43/43	100% 45/45
4. Community Integration/Bridging Inpatient & OPS. Inpatient trips OPS		100% 63 130	100% 71 163	100% 25 142
5. Peer Support will make an attempt to assist all patients in recognizing their personal medicine and filling out form.		100% 72/72	100% 43/43	100% 45/45
6. Peer Support will make a documented attempt to have patients fill out a survey before discharge or annually to evaluate the effectiveness of the peer support relationship during hospitalization.		30% 19/64	82% 46/56	62% 28/45
7. Grievances responded to on time by Peer Support, within 1 day of receipt.		100% 65/65	100% 98/98	100% 86/86

4Q2015:

2. The drop in this rate is mainly due to the Peer Worker being at an admission or in training during the time of the meeting. Peer Support is working to ensure that someone attends all meetings and that a part time day float position is filled.

6. The drop in surveys completed was discussed at the 7/10/15 staff meeting. Going forward, monthly monitoring and supervision will take place to ensure that these surveys are completed as they are vital to the hospital and program.

CONSENT DECREE

Treatment Planning

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

Indicators	1Q2015	2Q2015	3Q2015	4Q2015
1. Service Integration Meeting and form completed by the end of the 3rd day.	100% 30/30	100% 45/45	100% 45/45	100% 45/45
2. Patient participation in Service Integration Meeting.	93% 28/30	95% 43/45	93% 42/45	95% 43/45
3. Social Worker participation in Service Integration Meeting.	100% 30/30	100% 45/45	100% 45/45	100% 45/45
4. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	86% 26/30	95% 43/45	95% 43/45	95% 43/45
5. Initial Comprehensive Assessment contains summary narrative with conclusion and recommendations for discharge and Social Worker role.	100% 30/30	100% 45/45	100% 45/45	100% 45/45
6. Annual Psychosocial Assessment completed and current in chart.	100% 30/30	100% 15/15	100% 10/10	100% 10/10

4Q2015:

2. Two patients declined to meet for the Service Integration Meeting and declined follow up.

4. Two Comprehensive Psychosocial Assessments were not completed within the 7 day timeframe, they were completed at 2 and 3 days respectively.

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

Indicators	1Q2015	2Q2015	3Q2015	4Q2015
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all patients on assigned **CCM** caseload.	88% 40/45	91% 41/45	97% 44/45	100% 45/45
2. Treatment plans will have measurable goals and interventions listing patient strengths and areas of need related to transition to the community or transition back to a correctional facility.	100% 45/45	100% 45/45	100% 45/45	100% 45/45

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 patients according to the individual patient's ability to participate in a safe and productive manner as determined by the treatment team and established in collaboration with the patient 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			
Introduction 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 individuals to validate this chart review.

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 patient 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 patient 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 patient 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 Clinical 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

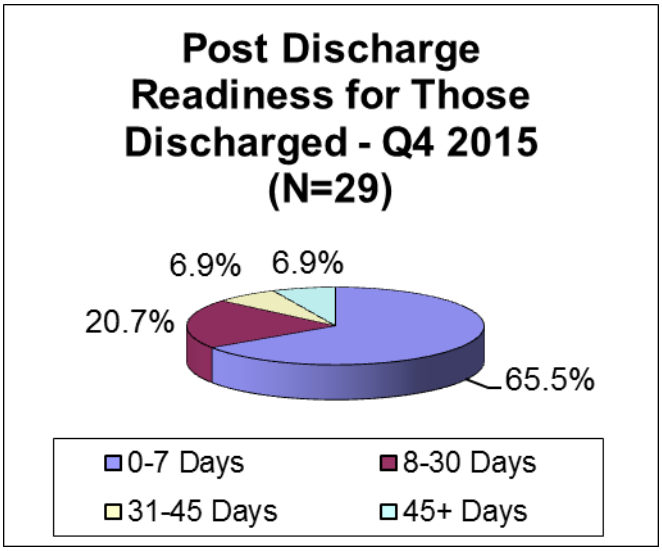
Discharges

Quarterly performance data shows that in 3 consecutive quarters:

V17) 70% of patients 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 patients 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 patients 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 patients excepted, by agreement of the parties and Court Master).



Cumulative percentages & targets are as follows:

Within 7 days = (19) 65.5% (target 70%)

Within 30 days = (6) 86.2% (target 80%)

Within 45 days = (2) 93.1% (target 90%)

Post 45 days = (2) 6.9% (target 0%)

Barriers to Discharge Following Clinical Readiness:

Residential Supports (0) No barriers in this area	Housing (7) • 4 patients discharged 8-30 days post clinical readiness (9, 11, 13, and 14 days) • 2 patients discharged 31-45 days post clinical readiness (40 and 43 days) • 1 patients discharged 45+ days post clinical readiness (77 days)
Treatment Services (0) No barriers in this area	
Other (0) No barriers in this area	

CONSENT DECREE

The previous four quarters are displayed in the table below

		Within 7 days	Within 30 days	Within 45 days	45+ days
Target >>		**70%**	**80%**	**90%**	**< 10%**
3Q2015	N=38	78.9%	86.8%	89.4%	10.5%
2Q2015	N=39	82.1%	87.2%	89.7%	10.3%
1Q2015	N=38	81.6%	92.1%	94.7%	5.3%
4Q2014	N=17	70.6%	94.1%	94.1%	5.9%

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	1Q2015	2Q2015	3Q2015	4Q2015
1. The Patient Discharge Plan Report will be updated/reviewed by each **Social Worker minimally one time per week.**	100% 13/13	100% 11/11	100% 10/10	100% 12/12
2. The Patient Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	76% 10/13	100% 11/11	100% 10/10	100% 12/12
3. The Patient Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	76% 10/13	100% 11/11	90% 9/10	92% 11/12
4. Each week the Social Work team and Director will meet and discuss current housing options provided by the respective regions and prioritize referrals.	100% 13/13	100% 11/11	100% 10/10	100% 12/12

4Q2015:

3. On one occasion the report was not sent out electronically, it was distributed at the housing meeting due to a program computer issue.

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	1Q2015	2Q2015	3Q2015	4Q2015
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	25% 1/4	0% 0/5	0% 0/8	66% 2/3
2. The assigned **CCM** will review the new court order with the patient and document the meeting in a progress note or treatment team note.	100% 6/6	100% 3/3	100% 2/2	100% 3/3
3. Annual Reports (due in December) to the Commissioner for all inpatient NCR patients are submitted annually	N/A	100% 25/25	N/A	N/A

4Q2015:

1. Three Institutional Reports were done. Two of the reports were completed in the 10 business day timeframe. We revamped a process to track the reports in the quarter to get a better result for completion.

Staffing and Staff Training

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

Indicators	1Q2015	2Q2015	3Q2015	4Q2015	YTD Findings
1. Riverview and Contract staff will attend CPR training bi-annually.	100% 62/62	100% 37/37	100% 26/26	98% 55/56	99% 180/ 181
2. Riverview and Contract staff will attend Annual training.	96% 109/113	83% 72/87	74% 34/46	89% 25/28	88% 240/ 274
3. Riverview and contract staff will attend MOAB training bi-annually	92% 389/424	87% 393/451	99% 389/ 391	94% 421/446	93% 1592/ 1712

4Q2015:

1. Employees who are out of compliance have been notified and corrective action is being taken.
2. One employee is out of compliance, and is scheduled to take recertification training. According to AHA guidelines, staff have a grace period of 30 days after the expiration date to be recertified. This employee has no direct care duties and is within compliance with AHA requirements.
3. MOAB was initiated in January 2014. Since the initiation date, 421 current employees have received MOAB training. 25 Current employees are in need training.

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 for both formal and informal training and/or learning experiences that contribute to individual growth and improved performance in their current position.

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

4Q2015:

- Motivational Interviewing was provided in May and June. Approximately 100 employees have received this eight hour training.

- Non-Violent Communication (NVC) was offered in April, May, and June. Approximately 85 employees received the NVC part one, 2 hour training during this quarter. Currently 255 employees have received the 2 hour NVC training to date.
- NVC part 2 (16 hour/two day) training was provided in June. Approximately 23 employees attended.
- HIPAA/HITECH/Confidentiality Training was provided April, May, and June.
- Advanced Intervention Training for Acuity Specialists was provided in June. All newly hired Acuity Specialists received this training.
- In addition four (4) *Advance Intervention Strategy* refresher trainings were offered for all Acuity Specialists in June.
- *The Science of Mindfulness: A Research-Based Path to Well-Being. A Series from The Great Courses*, Video presentations were offered three days per week each month during the quarter.

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.

4Q2015:
100% of new Mental Health Workers satisfactorily completed unit orientation competencies prior to being assigned regular duties requiring direct care of patients**.**

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
1Q2015	18	July - September 2014	
2Q2015	13	October – December 2014	
3Q2015	13	January – March 2015	
4/2/2015	1	The Recovery Model: Benefits and Roadblocks	Brooke Hoffmann, Psychology Intern
4/9/2015	1	The Recovery Model: Practical Applications for Inpatient Care	Brooke Hoffmann, Psychology Intern
4/16/2015	1	Metabolic Syndrome: Does it have to be an uphill battle?	Miranda Cole, PharmD Elizabeth Dragatsi, RPh Lauren Sternad, Pharmacy Student
4/21/2015	1	Med Staff PI & QA Committee	Brendan Kirby, MD
4/23/2015	1	Psychosis and Spirituality: Balancing a Patient's Clinical and Spiritual Needs	Alexander DeNesnera, MD
4/30/2015	1	Patient who refused to engage in treatment, but refused to leave the hospital	Randall Beal, PMH-NP
5/7/2015	1	Risk Need Responsivity (RNR): A Framework for Assessment and Treatment	Dana Swanson, Psychology Intern
5/14/2015	2	Case Review on BP	Will Torrey, MD David Dettmann, DO
5/19/2015	1	Med Staff PI & QA Committee	Brendan Kirby, MD
5/21/2015	1	Hear, Tere -- The positive outcomes of including cultural and spiritual differences in mental health care facilities	James Weathersby, Chaplain
5/28/2015	1	Back When the Barn was New: A Brief History of this Place - Part I	Susan Newkirk-Sanborn, PhD
4/17/2015	6	Thinking Forensically: Conducting Evaluations in Criminal Cases	Ann LeBlanc, PhD
6/4/2015	1	Hepatitis C: Small Virus, Large Problem	John Kootz, MD
5/20/2015	1	Pharmacogenetics	Jeffrey Vernon, DO
6/11/2015	1	DSM Update	Zachary Smith, PA-C
6/18/2015	1	Thinking About Our Thinking: Metacognitive Therapy and Psychosis	Christopher Smith, Psychology Intern
6/26/2015	1	Encountering the Other	Noel Ngai, Psychology Intern

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 patients who reside on specific units, and unit census.

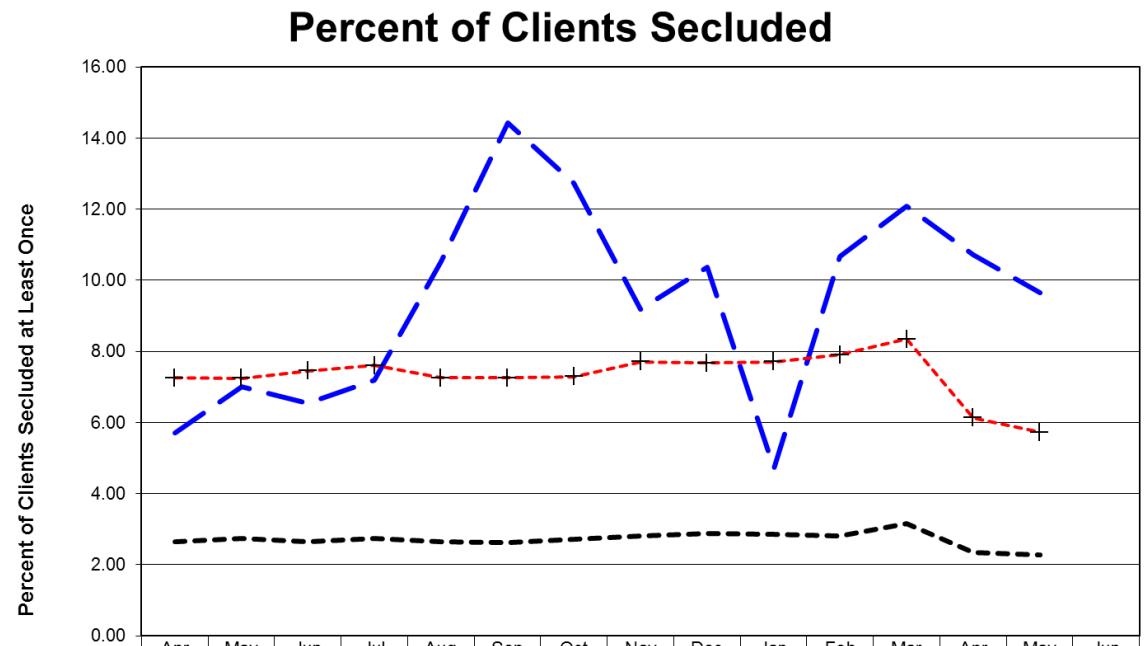
V26) The evaluation of treatment and discharge planning, performed in accordance with **Attachment D**, demonstrates that staffing was sufficient to provide patients access to activities necessary to achieve the patients' treatment goals, and to enable patients to exercise daily and to recreate outdoors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

Treatment teams regularly monitor the needs of individual patients 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 patient 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;



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	5.70	7.01	6.54	7.19	10.53	14.42	12.73	9.18	10.38	4.72	10.68	12.09	10.71	9.64	
Ntl Mean	2.65	2.75	2.64	2.74	2.65	2.62	2.72	2.82	2.87	2.86	2.81	3.15	2.35	2.28	
+1 StDev	7.26	7.24	7.45	7.60	7.26	7.26	7.29	7.71	7.68	7.71	7.91	8.35	6.13	5.73	

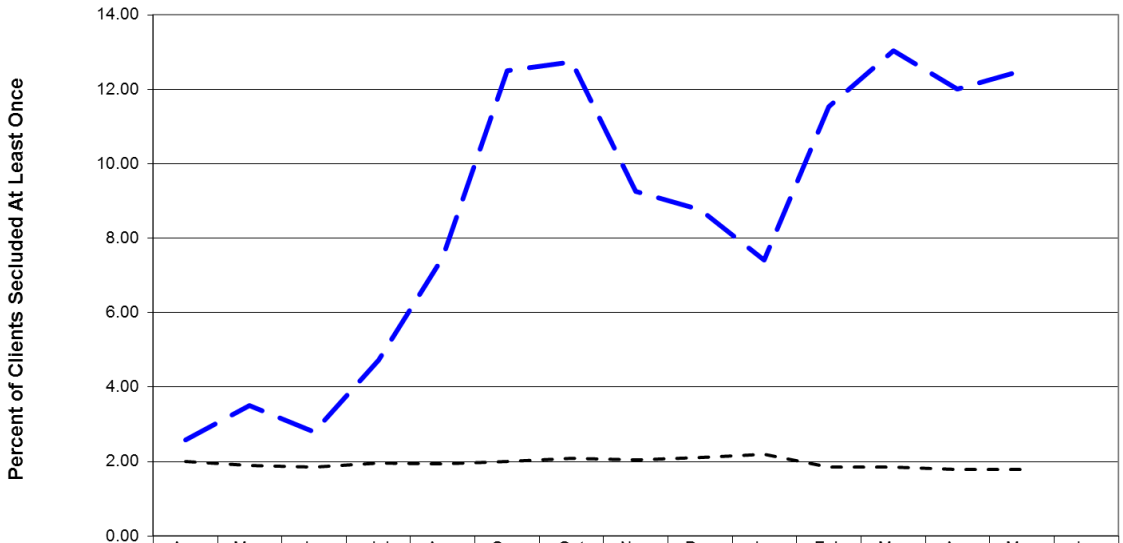
This graph depicts the percent of unique patients who were secluded at least once. For example, rates of 3.0 means that 3% of the unique patients served were secluded at least once.

The following graphs depict the percent of unique patients who were secluded at least once stratified by forensic or civil classifications. For example; rates of 3.0 means that 3% of the unique patients served were secluded at least once. The hospital-wide results from Dorothea Dix are compared to the civil population results at Riverview due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Percent of Clients Secluded

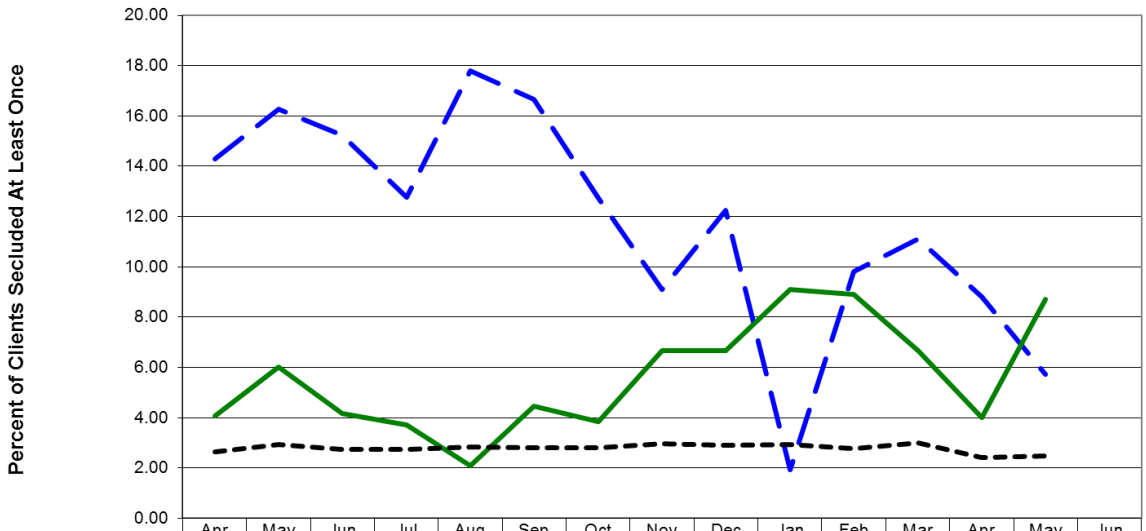
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	2.59	3.51	2.80	4.72	7.48	12.50	12.73	9.26	8.77	7.41	11.54	13.04	12.00	12.50	
Ntl Mean	2.01	1.90	1.84	1.95	1.94	1.99	2.09	2.05	2.10	2.20	1.84	1.84	1.78	1.79	

Percent of Clients Secluded

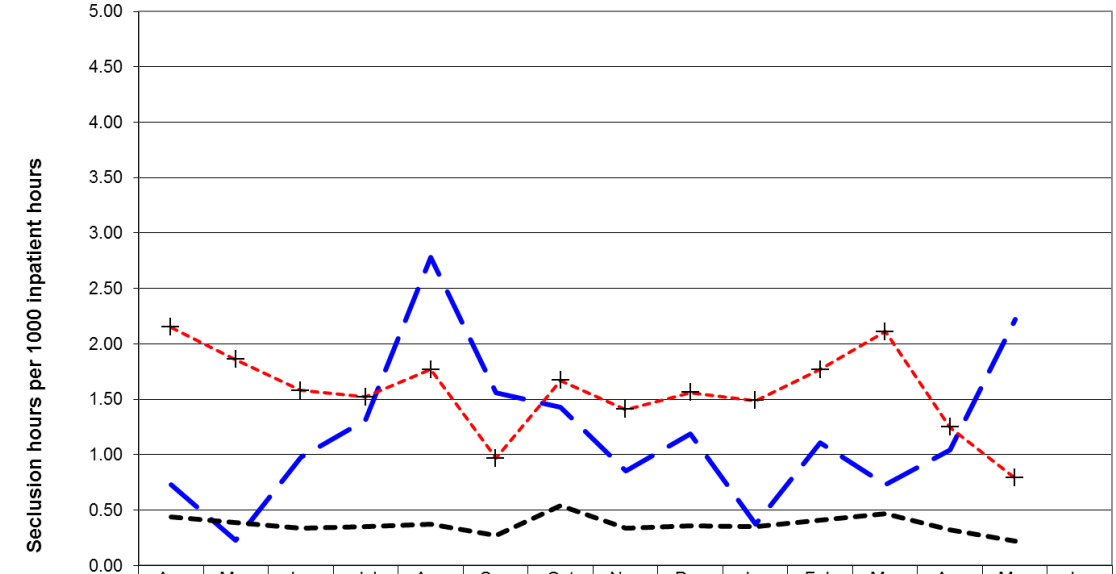
Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	14.29	16.28	15.22	12.77	17.78	16.67	12.73	9.09	12.24	1.92	9.80	11.11	8.82	5.71	
Dorothea Dix	4.08	6.00	4.17	3.70	2.08	4.44	3.85	6.67	6.67	9.09	8.89	6.67	4.00	8.70	
Ntl Mean	2.63	2.94	2.74	2.75	2.83	2.81	2.79	2.95	2.89	2.93	2.76	3.01	2.40	2.46	

CONSENT DECREE

Seclusion Hours



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	0.73	0.23	0.98	1.31	2.78	1.56	1.43	0.85	1.19	0.37	1.11	0.73	1.04	2.22	
Ntl Mean	0.44	0.39	0.34	0.35	0.37	0.27	0.54	0.34	0.36	0.35	0.41	0.47	0.32	0.22	
+1 StDev	2.15	1.86	1.58	1.52	1.77	0.97	1.67	1.41	1.56	1.49	1.77	2.11	1.25	0.79	

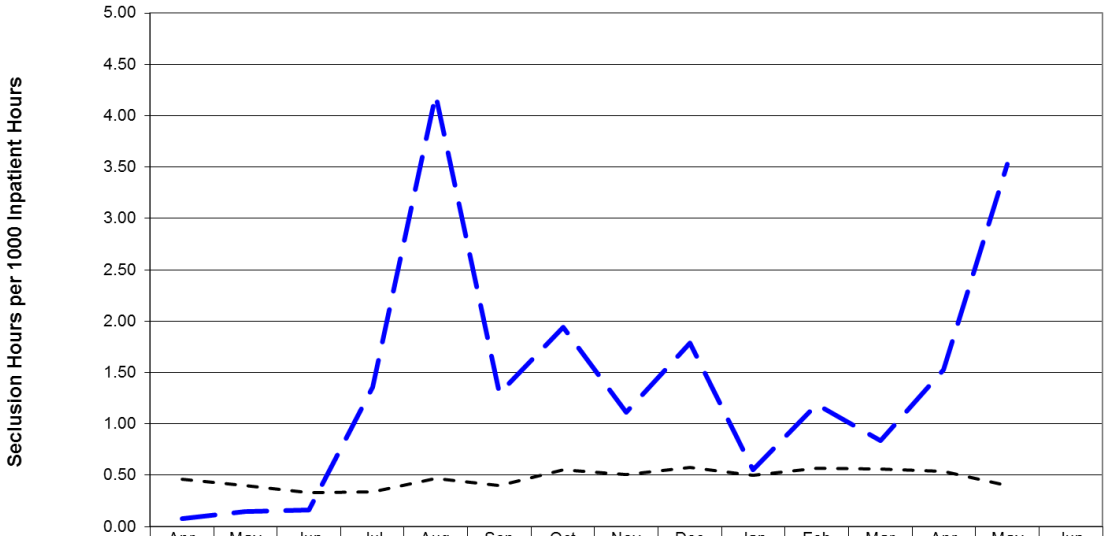
This graph depicts the number of hours patients spent in seclusion for every 1000 inpatient hours. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours.

The following graphs depict the number of hours patients 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 Dorothea Dix are compared to the civil population results at Riverview due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Seclusion Hours

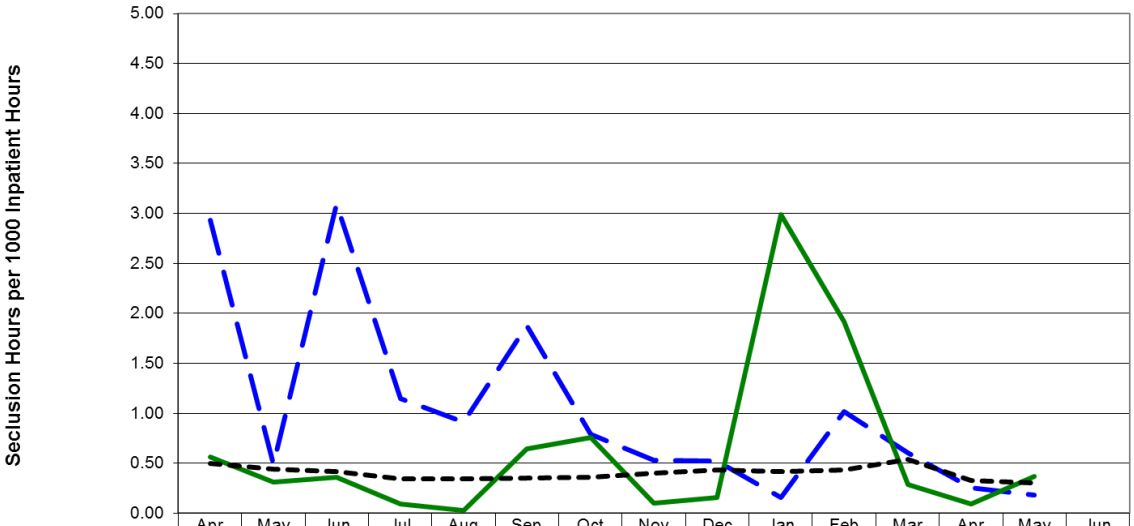
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	0.08	0.15	0.16	1.36	4.20	1.30	1.94	1.11	1.79	0.55	1.19	0.84	1.53	3.53	
Ntl Mean	0.46	0.40	0.33	0.34	0.47	0.40	0.55	0.51	0.58	0.50	0.57	0.56	0.54	0.40	

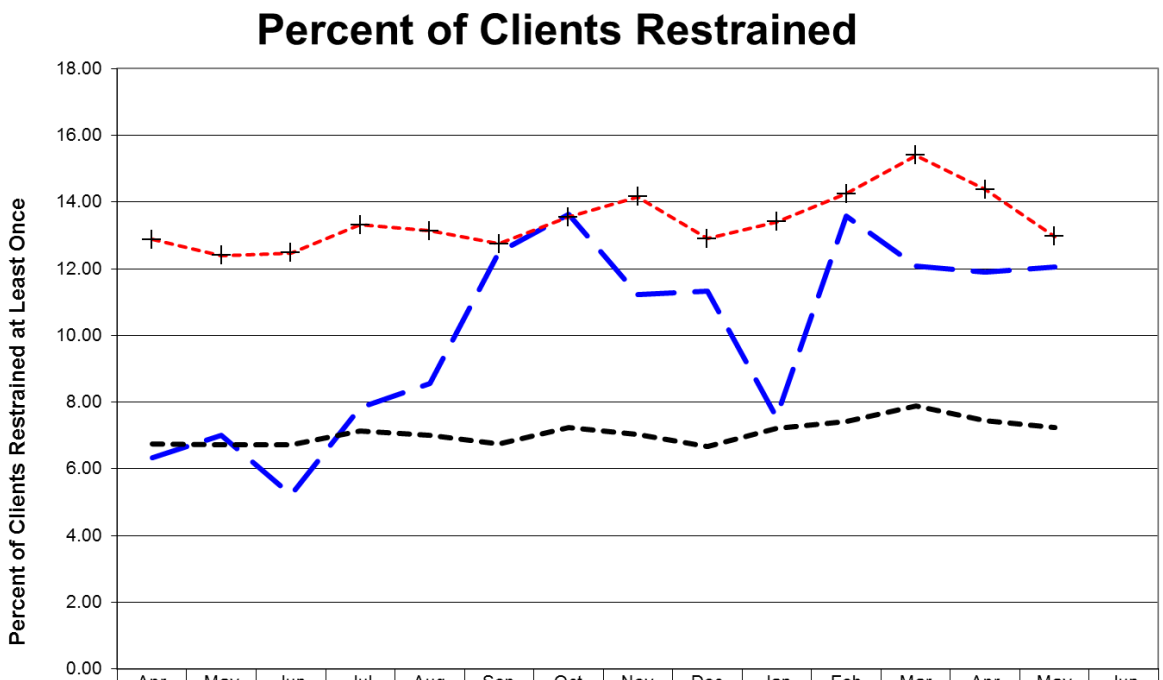
Seclusion Hours

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	2.93	0.49	3.09	1.15	0.91	1.88	0.79	0.53	0.52	0.16	1.02	0.60	0.25	0.18	
Dorothea Dix	0.56	0.31	0.36	0.09	0.03	0.64	0.76	0.10	0.16	2.99	1.92	0.29	0.09	0.37	
Ntl Mean	0.50	0.44	0.42	0.34	0.34	0.35	0.36	0.40	0.43	0.42	0.43	0.54	0.33	0.30	

CONSENT DECREE



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	6.33	7.01	5.23	7.84	8.55	12.50	13.64	11.22	11.32	7.55	13.59	12.09	11.90	12.05	
Ntl Mean	6.76	6.72	6.73	7.15	7.00	6.75	7.25	7.03	6.66	7.22	7.43	7.90	7.45	7.25	
+1 StDev	12.87	12.40	12.48	13.32	13.14	12.74	13.55	14.16	12.90	13.41	14.25	15.40	14.37	12.96	

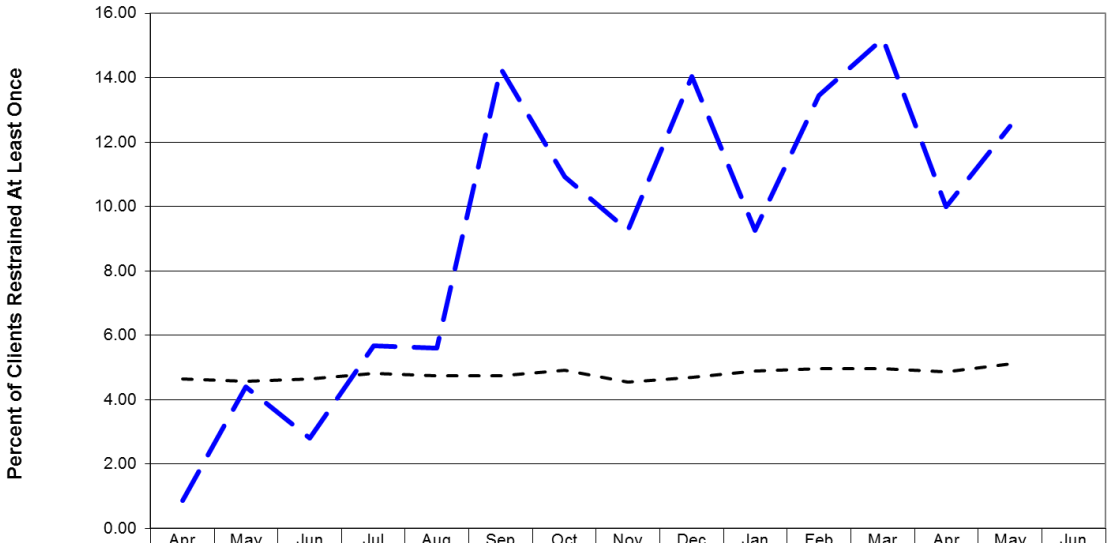
This graph depicts the percent of unique patients who were restrained at least once and includes all forms of restraint of any duration. For example; a rate of 4.0 means that 4% of the unique patients served were restrained at least once.

The following graphs depict the percent of unique patients who were restrained at least once stratified by forensic or civil classifications and includes all forms of restraint of any duration. For example; a rate of 4.0 means that 4% of the unique patients served were restrained at least once. The hospital-wide results from Dorothea Dix are compared to the civil population results at Riverview due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Percent of Clients Restrained

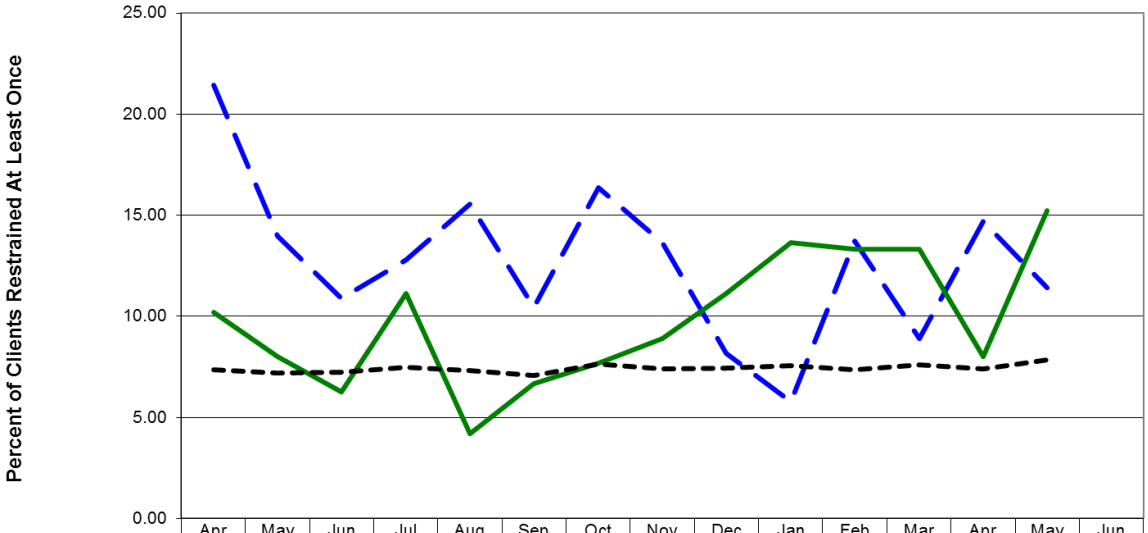
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	0.86	4.39	2.80	5.66	5.61	14.29	10.91	9.26	14.04	9.26	13.46	15.22	10.00	12.50	
Ntl Mean	4.65	4.57	4.64	4.81	4.73	4.73	4.91	4.54	4.69	4.89	4.96	4.96	4.86	5.10	

Percent of Clients Restrained

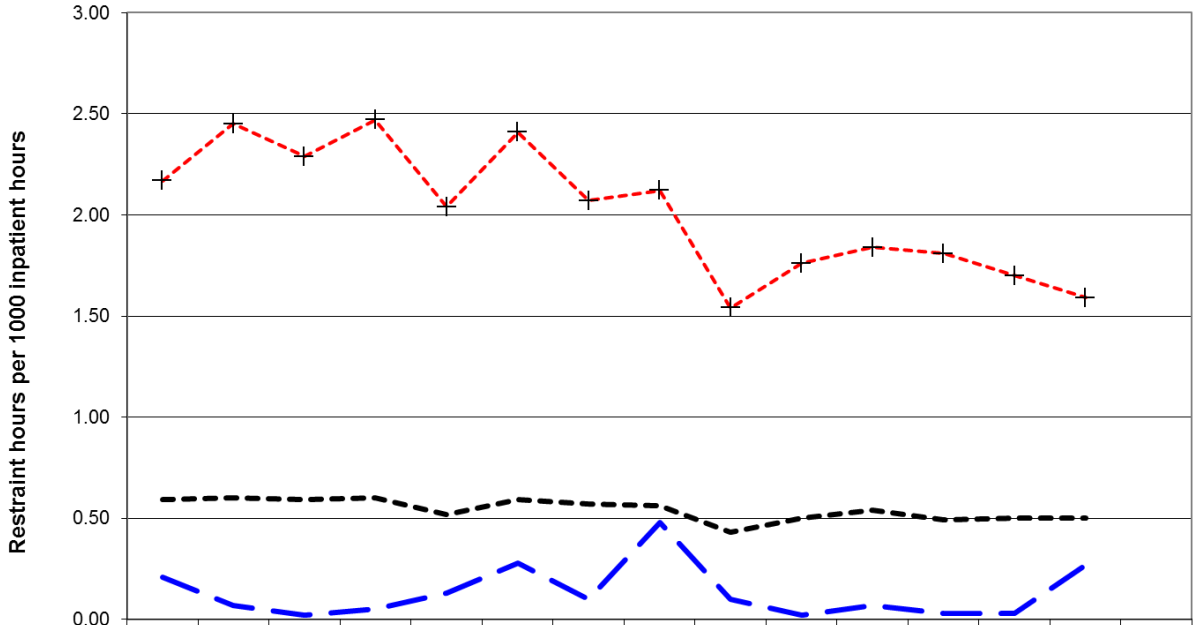
Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	21.43	13.95	10.87	12.77	15.56	10.42	16.36	13.64	8.16	5.77	13.73	8.89	14.71	11.43	
Dorothea Dix	10.20	8.00	6.25	11.11	4.17	6.67	7.69	8.89	11.11	13.64	13.33	13.33	8.00	15.22	
Ntl Mean	7.34	7.21	7.24	7.48	7.30	7.06	7.63	7.39	7.42	7.57	7.37	7.58	7.41	7.84	

CONSENT DECREE

Restraint Hours



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	0.21	0.07	0.02	0.05	0.13	0.28	0.10	0.48	0.10	0.02	0.07	0.03	0.03	0.27	
Ntl Mean	0.59	0.60	0.59	0.60	0.52	0.59	0.57	0.56	0.43	0.50	0.54	0.49	0.50	0.50	
+1 StDev	2.17	2.45	2.29	2.47	2.04	2.41	2.07	2.12	1.54	1.76	1.84	1.81	1.70	1.59	

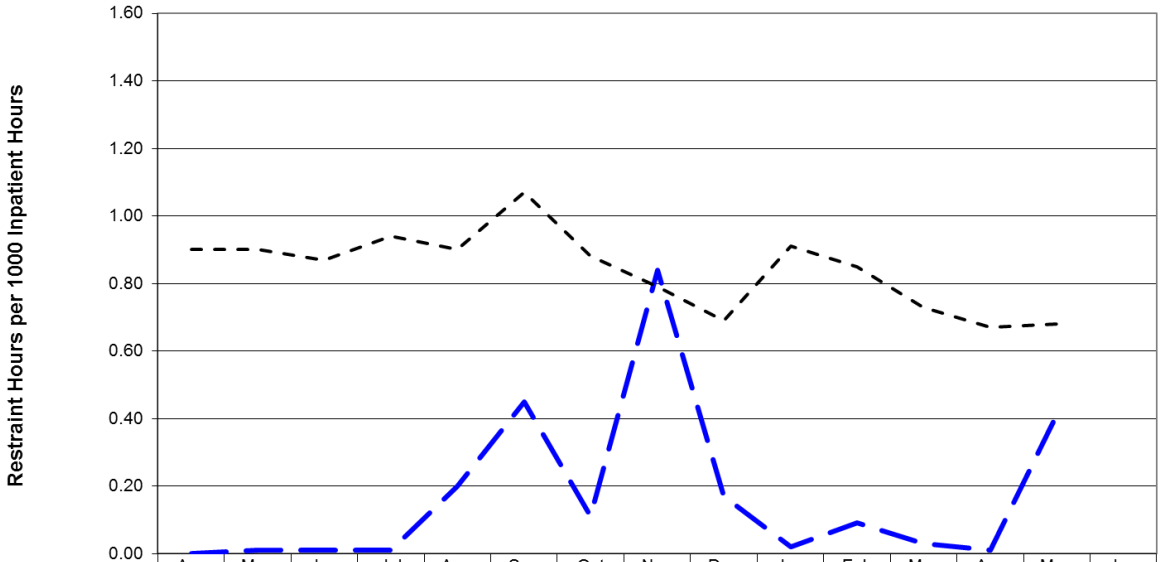
This graph depicts the number of hours patients spent in restraint for every 1000 inpatient hours - includes all forms of restraint of any duration. For example; a rate of 1.6 means those 2 hours were spent in restraint for each 1250 inpatient hours.

The following graphs depict the number of hours patients 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 Dorothea Dix are compared to the civil population results at Riverview due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Restraint Hours

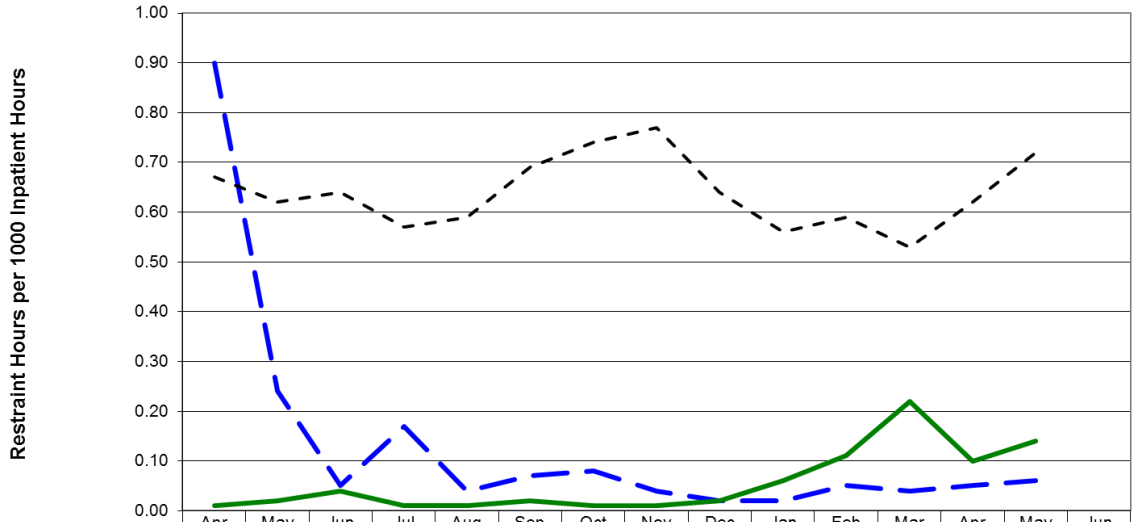
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	0.00	0.01	0.01	0.01	0.20	0.45	0.11	0.84	0.17	0.02	0.09	0.03	0.01	0.41	
Ntl Mean	0.90	0.90	0.87	0.94	0.90	1.07	0.88	0.79	0.69	0.91	0.85	0.73	0.67	0.68	

Restraint Hours

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	0.90	0.24	0.05	0.17	0.04	0.07	0.08	0.04	0.02	0.02	0.05	0.04	0.05	0.06	
Dorothea Dix	0.01	0.02	0.04	0.01	0.01	0.02	0.01	0.01	0.02	0.06	0.11	0.22	0.10	0.14	
Ntl Mean	0.67	0.62	0.64	0.57	0.59	0.69	0.74	0.77	0.64	0.56	0.59	0.53	0.62	0.72	

CONSENT DECREE

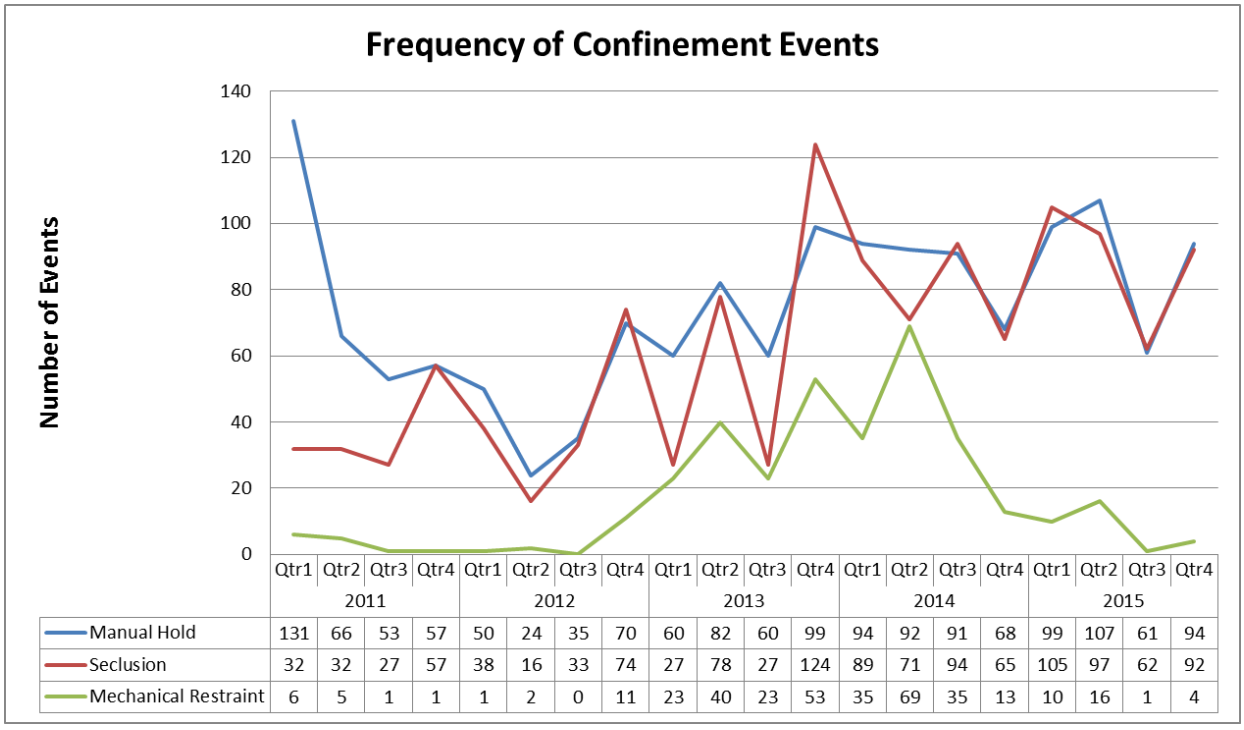
Confinement Event Detail

4th Quarter 2015

	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
MR3374	32		29	**61**	32.11%	32.11%
MR7419	13		23	**36**	18.95%	51.05%
MR7750	8		8	**16**	8.42%	59.47%
MR7739	6	2	4	**12**	6.32%	65.79%
MR997	5		5	**10**	5.26%	71.05%
MR6714	4		5	**9**	4.74%	75.79%
MR7764	4	1	2	**7**	3.68%	79.47%
MR7724	7			**7**	3.68%	83.16%
MR6563	3	1	3	**7**	3.68%	86.84%
MR7735	2		3	**5**	2.63%	89.47%
MR7685	2		2	**4**	2.11%	91.58%
MR6799	1		3	**4**	2.11%	93.68%
MR7665	2		1	**3**	1.58%	95.26%
MR7737	1		1	**2**	1.05%	96.32%
MR6231	1		1	**2**	1.05%	97.37%
MR7032	1		1	**2**	1.05%	98.42%
MR7722			1	**1**	0.53%	98.95%
MR5625	1			**1**	0.53%	99.47%
MR7409	1			**1**	0.53%	100.00%
	94	**4**	**92**	**190**		

28% (19/68) of the average hospital population experienced some form of confinement event during 4Q2015. Five of these patients (7% of the average hospital population) accounted for 71% of the containment events.

CONSENT DECREE



	Qtr1 2011	Qtr2 2011	Qtr3 2011	Qtr4 2011	Qtr1 2012	Qtr2 2012	Qtr3 2012	Qtr4 2012	Qtr1 2013	Qtr2 2013	Qtr3 2013	Qtr4 2013	Qtr1 2014	Qtr2 2014	Qtr3 2014	Qtr4 2014	Qtr1 2015	Qtr2 2015	Qtr3 2015	Qtr4 2015
Manual Hold	131	66	53	57	50	24	35	70	60	82	60	99	94	92	91	68	99	107	61	94
Seclusion	32	32	27	57	38	16	33	74	27	78	27	124	89	71	94	65	105	97	62	92
Mechanical Restraint	6	5	1	1	1	2	0	11	23	40	23	53	35	69	35	13	10	16	1	4

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

	1Q2015	2Q2015	3Q2015	4Q2015	Total
Danger to Others/Self	17	8	7	88	**120**
Danger to Others	88	89	55	1	**233**
Danger to Self				3	**3**
% Dangerous Precipitation	100%	100%	100%	100%	**100%**
Total Events	**105**	**97**	**62**	**92**	**356**

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

	1Q2015	2Q2015	3Q2015	4Q2015	Total
Danger to Others/Self	4	6		4	**14**
Danger to Others	4	9	1		**14**
Danger to Self	2	1			**3**
% Dangerous Precipitation	100%	100%	100%	100%	**100%**
Total Events	**10**	**16**	**1**	**4**	**31**

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 30 & 31

CONSENT DECREE

Confinement Events Management

Seclusion Events (92) Events

Standard	Threshold	Compliance
The record reflects that seclusion was absolutely necessary to protect the patient from causing physical harm to self or others, or if the patient was examined by a physician or physician extender prior to implementation of seclusion, to prevent further serious disruption that significantly interferes with other patients' treatment.	95%	97%
The record reflects that lesser restrictive alternatives were inappropriate or ineffective. This can be reflected anywhere in record.	90%	100%
The record reflects that the decision to place the patient in seclusion was made by a physician or physician extender.	90%	97%
The decision to place the patient in seclusion was entered in the patient's records as a medical order.	90%	100%
The record reflects that, if the physician or physician extender was not immediately available to examine the patient, the patient was placed in seclusion following an examination by a nurse.	90%	100%
The record reflects that the physician or physician extender personally evaluated the patient within 30 minutes after the patient has been placed in seclusion, and if there is a delay, the reasons for the delay.	90%	100%
The record reflects that the patient was monitored every 15 minutes. (Compliance will be deemed if the patient was monitored at least 3 times per hour.)	90%	100%
Individuals implementing seclusion have been trained in techniques and alternatives.	90%	100%
The record reflects that reasonable efforts were taken to notify guardian or designated representative as soon as possible that patient was placed in seclusion.	75%	100%

CONSENT DECREE

Confinement Events Management

Seclusion Events, Continued (92) Events

Standard	Threshold	Compliance
The medical order states time of entry of order and that number of hours in seclusion shall not exceed 4.	85%	98%
The medical order states the conditions under which the patient may be sooner released.	85%	100%
The record reflects that the need for seclusion is re-evaluated at least every 2 hours by a nurse.	90%	100%
The record reflects that the 2 hour re-evaluation was conducted while the patient was out of seclusion room unless clinically contraindicated.	70%	100%
The record includes a special check sheet that has been filled out to document reason for seclusion, description of behavior and the lesser restrictive alternatives considered.	85%	100%
The record reflects that the patient was released, unless clinically contraindicated, at least every 2 hours or as necessary for eating, drinking, bathing, toileting or special medical orders.	85%	100%
Reports of seclusion events were forwarded to Clinical Director and Patient Advocate.	90%	100%
The record reflects that, for persons with mental retardation, the regulations governing seclusion of patients with mental retardation were met.	85%	100%
The medical order for seclusion was not entered as a PRN order.	90%	100%
Where there was a PRN order, there is evidence that physician was counseled.	95%	N/A

CONSENT DECREE

Confinement Events Management

Mechanical Restraint Events (4) Events

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

CONSENT DECREE

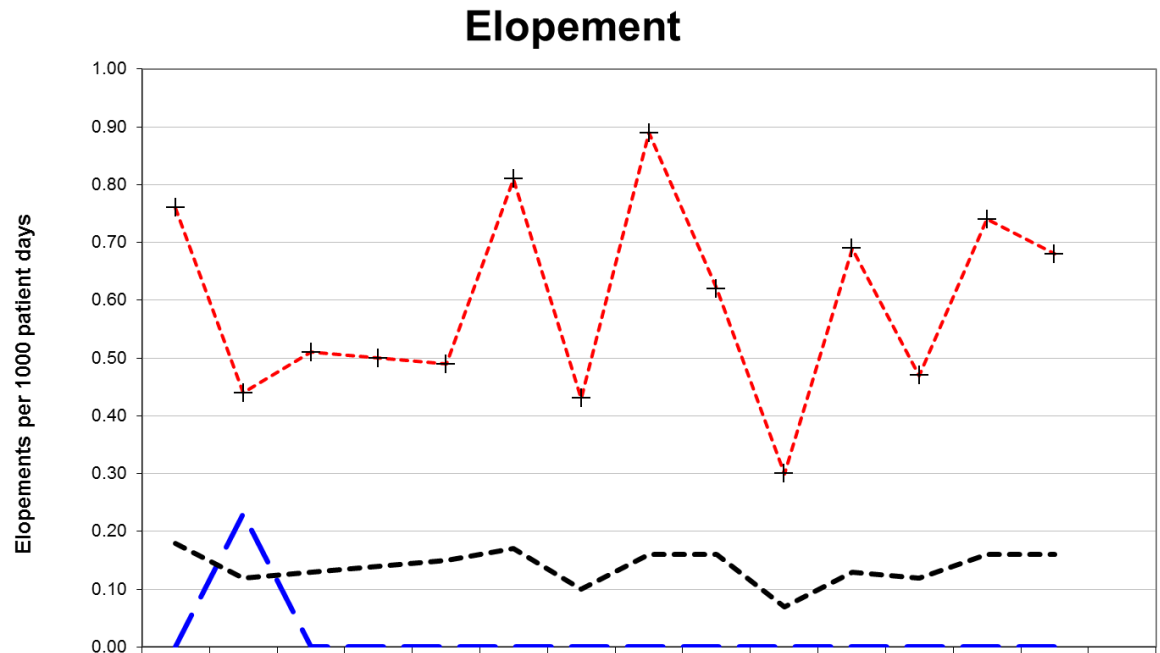
Confinement Events Management

Mechanical Restraint Events, Continued (4) Events

Standard	Threshold	Compliance
The record reflects that the need for restraint was re-evaluated every 2 hours by a nurse.	90%	100%
The record reflects that re-evaluation was conducted while the patient was free of restraints unless clinically contraindicated.	70%	100%
The record includes a special check sheet that has been filled out to document the reason for the restraint, description of behavior and the lesser restrictive alternatives considered.	85%	100%
The record reflects that the patient was released as necessary for eating, drinking, bathing, toileting or special medical orders.	90%	100%
The record reflects that the patient's extremities were released sequentially, with one released at least every fifteen minutes.	90%	100%
Copies of events were forwarded to Clinical Director and Patient 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 Clinical Director (or if the Clinical Director is out of the hospital, by the individual acting in the Clinical Director's stead) following examination of the patient; and that the patient's guardian or representative has been notified.	90%	100%

Patient Elopements

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



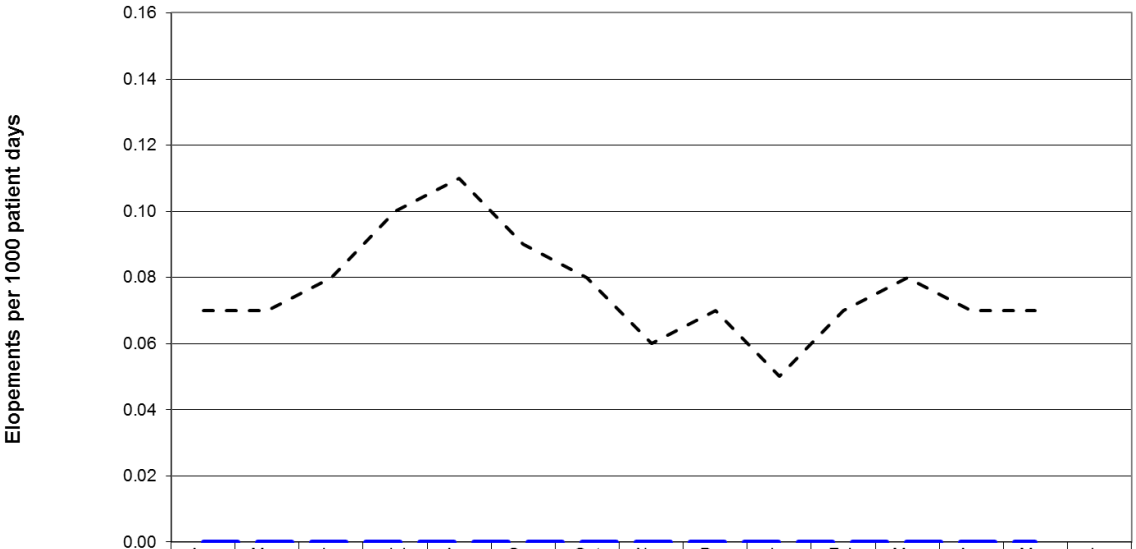
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	0.00	0.23	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Ntl Mean	0.18	0.12	0.13	0.14	0.15	0.17	0.10	0.16	0.16	0.07	0.13	0.12	0.16	0.16	
+1 StDev	0.76	0.44	0.51	0.50	0.49	0.81	0.43	0.89	0.62	0.30	0.69	0.47	0.74	0.68	

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 patient is "absent from a location defined by the patient's privilege status regardless of the patient'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 Dorothea Dix are compared to the civil population results at Riverview due to the homogeneous nature of these two sample groups.

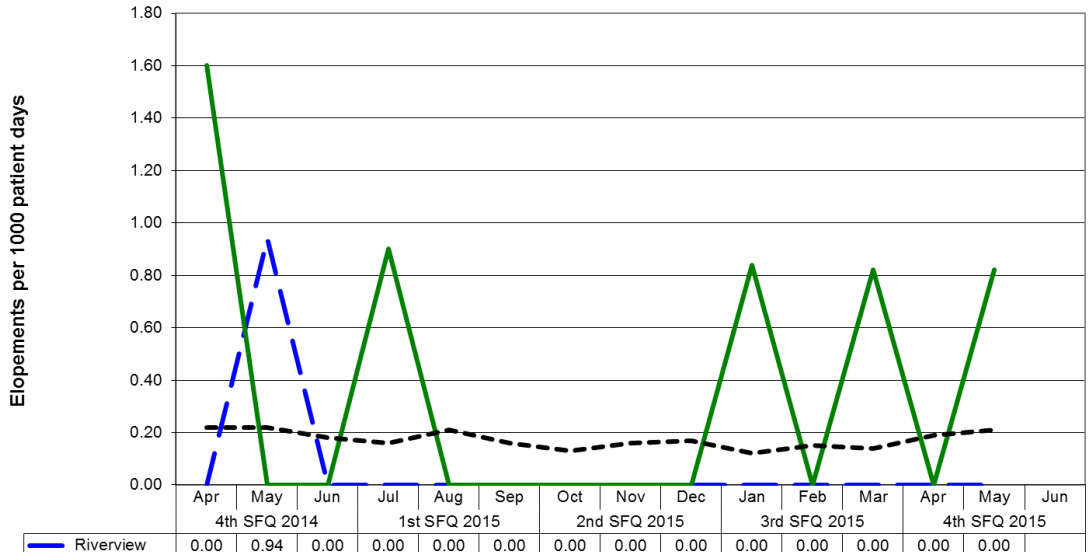
CONSENT DECREE

Elopement
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Ntl Mean	0.07	0.07	0.08	0.10	0.11	0.09	0.08	0.06	0.07	0.05	0.07	0.08	0.07	0.07	

Elopement
Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	0.00	0.94	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Dorothea Dix	1.60	0.00	0.00	0.90	0.00	0.00	0.00	0.00	0.00	0.84	0.00	0.82	0.00	0.82	
Ntl Mean	0.22	0.22	0.18	0.16	0.21	0.16	0.13	0.16	0.17	0.12	0.15	0.14	0.19	0.21	

Patient Injuries

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

The NASMHPD standards for measuring patient 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.

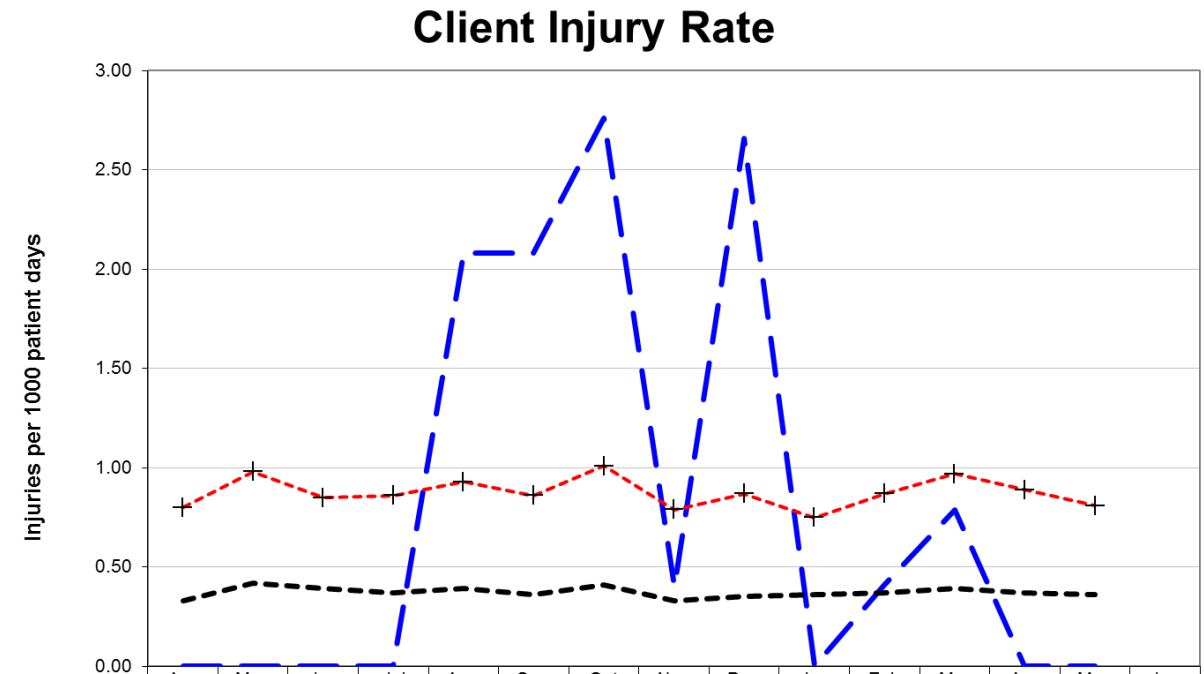
"Non-reportable" injuries include those that require: 1) No Treatment, or 2) Minor First Aid

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

- No Treatment – The injury received by a patient 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 patient 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 patient 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 patient.

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

CONSENT DECREE



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	0.00	0.00	0.00	0.00	2.08	2.08	2.76	0.40	2.66	0.00	0.41	0.79	0.00	0.00	
Ntl Mean	0.33	0.42	0.39	0.37	0.39	0.36	0.41	0.33	0.35	0.36	0.37	0.39	0.37	0.36	
+1 StDev	0.80	0.98	0.85	0.86	0.93	0.86	1.01	0.79	0.87	0.75	0.87	0.97	0.89	0.81	

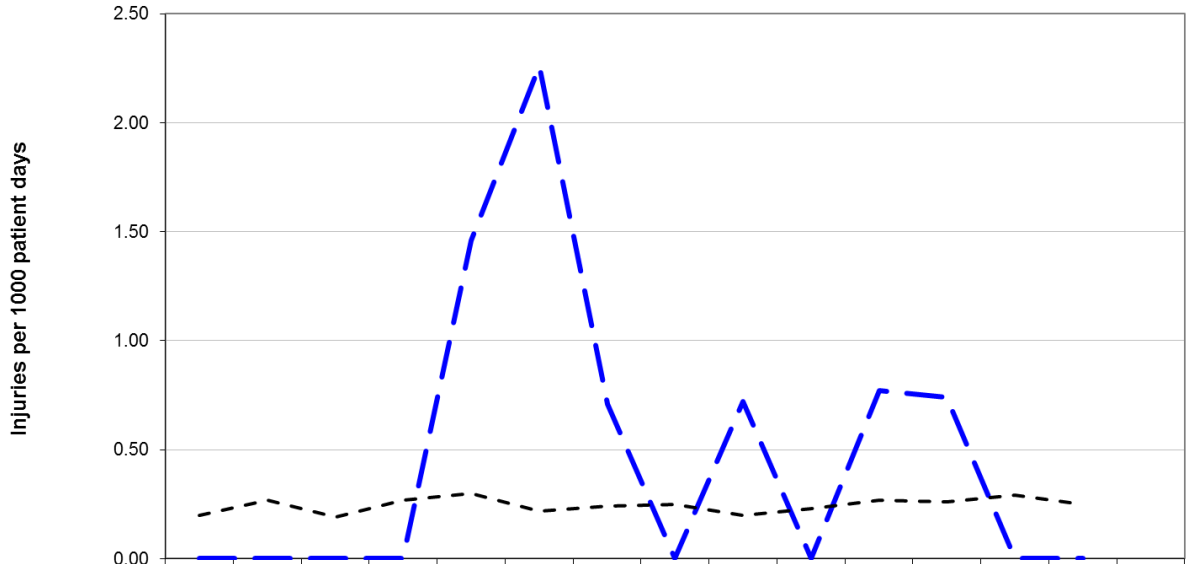
This graph depicts the number of patient injury events that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days.

The following graphs depict the number of patient 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 Dorothea Dix are compared to the civil population results at Riverview due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Client Injury Rate

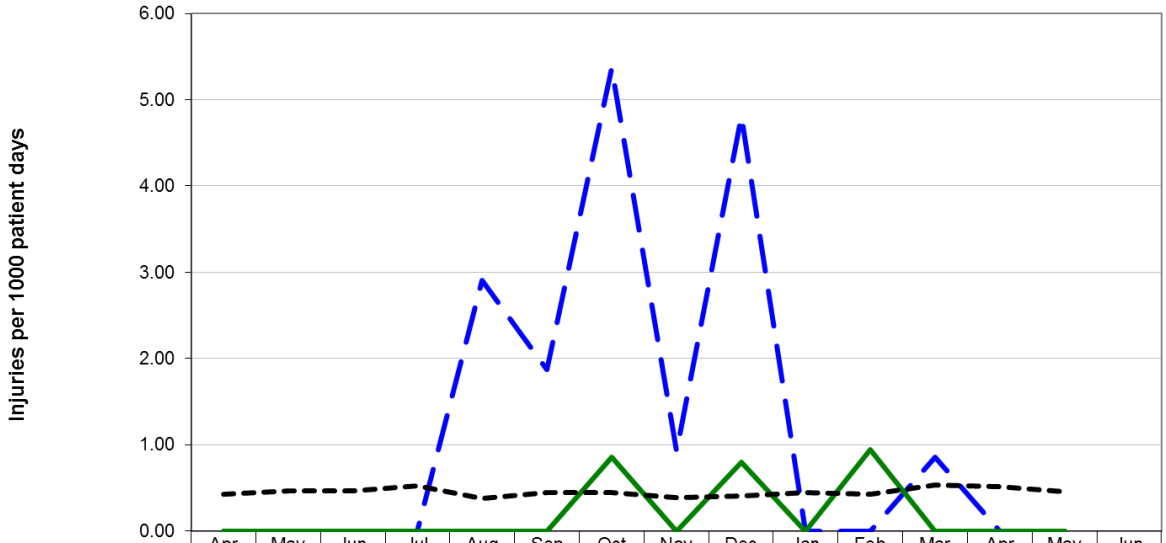
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	0.00	0.00	0.00	0.00	1.46	2.26	0.71	0.00	0.72	0.00	0.77	0.74	0.00	0.00	
Ntl Mean	0.20	0.27	0.19	0.27	0.30	0.22	0.24	0.25	0.20	0.23	0.27	0.26	0.29	0.25	

Client Injury Rate

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	0.00	0.00	0.00	0.00	2.91	1.87	5.37	0.92	4.81	0.00	0.00	0.86	0.00	0.00	
Dorothea Dix	0.00	0.00	0.00	0.00	0.00	0.00	0.86	0.00	0.80	0.00	0.94	0.00	0.00	0.00	
Ntl Mean	0.43	0.47	0.47	0.52	0.38	0.45	0.45	0.39	0.41	0.45	0.43	0.53	0.51	0.46	

CONSENT DECREE

Type and Cause of Injury by Month

Type - Cause	APR	MAY	JUNE	4Q2015
Accident – Fall	1	1	3	**5**
Accident – Other	3		3	**6**
Assault – Patient to Patient	1	1	2	**4**
Injury – Other	1	5		**6**
Self-Injurious Behavior	3	1	1	**5**
Total	**9**	**8**	**9**	**26**

Severity of Injury by Month

Severity	APR	MAY	JUNE	4Q2015
No Treatment	3	5	6	**14**
Minor First Aid	5	1	2	**8**
Medical Intervention Required	1	2	1	**4**
Hospitalization Required				
Death Occurred				
Total	**9**	**8**	**9**	**26**

Note: Previous quarterly report numbers may have been higher as they included data on incidents as well as injuries. This report has been modified to only include injuries. Per NASMHPD, injuries occur when harm or damage is done.

Due to changes in reporting standards related to "criminal" events as defined by the "State of Maine Rules for Reporting Sentinel Events", effective February 1, 2013, as defined the by "National Quality Forum 2011 List of Serious Reportable Events," the number of reportable "assaults" that occur as the result of patient interactions increased significantly. This change is due primarily as a result of the methods and rules related to data collection and abstraction. Further information on Fall Reduction Strategies can be found under The Joint Commission Priority Focus Areas section of this report.

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	1Q2015	2Q2015	3Q2015	4Q2015	Total
Abuse Physical	8	10	14	9	**41**
Abuse Sexual	5	17	11	6	**39**
Abuse Verbal	4	4	3	5	**16**
Coercion/Exploitation	3	7		3	**13**
Neglect	1	1	1		**3**
Total	**21**	**39**	**29**	**23**	**112**

Note: Previous data has been adjusted as we removed allegations of patient abuse, neglect, and exploitation that did not occur within the hospital and/or were not against hospital staff or patients

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. Patients 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 Patient Advocate(s).
3. Any allegation of abuse, neglect, or exploitation is reported both internally and externally to appropriate stakeholders, including:
    - Superintendent and/or AOC
    - Adult Protective Services
    - Guardian
    - Patient 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 patient'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 incident of alleged abuse, neglect, and exploitation monthly.

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. The Joint Commission conducted an unannounced visit on July 28-29, 2014. The hospital maintains its accreditation with The Joint Commission. The hospital will conduct a required annual self-assessment in October 2015. A triennial accreditation survey is expected to occur in November 2016 or earlier.

The hospital recently consulted with The Joint Commission on a Sentinel Event that occurred in the Outpatient Services Program in January 2015. As a result of that consult, two Measures of Success are being monitored for The Joint Commission.

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. In March, the hospital's full license was restored after having a conditional license for 18 months. The hospital is completing its hospital license application which is due on October 1, 2015.

V36) The hospital seeks CMS certification;

The hospital was terminated from the Medicare Provider Agreement on September 2, 2013 for failing to show evidence of substantial compliance in eight areas by August 27, 2013. The hospital reapplied for certification in December 2013 and a 3 day site visit was conducted in May 2014. CMS found the hospital out of substantial compliance in one area and the hospital was denied certification. In meeting with the Division of Licensing and Regulatory Services in 2015, the hospital was informed that CMS would not approve certification with the current level of forensic patients who did not require hospital level of care. Plans are being developed to resolve this issue before an application for certification is resubmitted.

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 supported by The Joint Commission and is consistent with modern principles of process management and strategic methods of promoting organizational performance excellence. The Advisory Board approved the Integrated Plan for Performance Excellence in August 2014 including Maine Division of Licensing and Regulatory Services required language that the hospital will comply with all federal and state hospital Conditions of Participation.

CONSENT DECREE

Quality Improvement Measures from "Response to the Recommendations from the Report by Elizabeth Jones, Consultant"

Approved by the Maine Superior Court on February 27, 2015

Leadership met on Friday, March 6th to review the corrective action steps outlined in the hospital's response.

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
Prior to his/her treatment team meeting, the class members should be provided the opportunity to meet with a peer specialist in order to prepare for the discussion and to clearly outline any preferences for treatment or discharge planning. Recovery-oriented approaches to treatment, including employment, should be consistently explored with and offered to class member, despite disinterest or refusal at the time of admission.	Treatment Team Coordinators will document all patient engagement in preparation for Treatment Team meetings. The daily chart audit form used by Treatment Team Coordinators/Auditors will be updated by Medical Records to reflect which patients received pre-treatment team meeting engagement.	Treatment Team Coordinators developed & use an audit tool on each record as it is reviewed / revised the day of the team meeting. TTCs handout to the patient, the 'Your Input is Essential" form 2-3 days prior to the meeting and offer to assist the patient to complete the form (if needed) prior to the meeting. The form is attached to the treatment plan. If patient refuses to complete the from, this is noted on the form and signed by the staff
Riverview's leadership should take immediate steps to ensure that the principles of the Recovery model are clearly defined, articulated, and supported throughout each of the four units.	100% of patient records will include documentation of the patient's input into their individualized treatment plan and that the input was used during the Treatment Team meeting.	Staff orientation has increased focus on the principles of recovery. As part of this effort staff are encouraged to support patients with making their needs, goals and life expectations made know. Where appropriate and in consistency with the TP, the patients' comments are incorporated into treatment planning activities.

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
Riverview's clinical leadership should work with nursing and Mental Health Worker staff to design and implement case conferences or Grand Rounds so that there is greater knowledge, skills, and support in working with class members with challenging behaviors.	The list of case conferences and Grand Rounds will be maintained. The roster of staff participation will be maintained by the Staff and Organizational Development Office. These data will be reported in the Quarterly Report.	Clinical case conference occurs regularly on Thursdays at 12 noon. In addition, longer audiovisual conferences with faculty at Dartmouth College occur three times per year and will move to a similar Thursday noon slot for the next academic year. Attendance list for the clinical case conference is now kept, in addition to those individuals who wish to fill in the appropriate sheets to obtain continuing medical education (CME) credits. It is noted that attendance at the clinical case conference for academic year 2015 increased to 1142 from 694 in academic year 2014. This represents a 65 percent increase in attendance at the clinical case conferences. Attendance by nursing staff, acuity specialists, and mental health workers continues to lag behind other disciplines. For this reason, academic year 2016 has been identified as the year to ensure marked increase in nursing, acuity specialist, and mental health worker attendance. I have met with the current nursing leadership to set the expectation for nursing attendance at clinical case conference. The response

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
		has been positive. The previous commitment from director of nursing, R. Pushard, to provide relief from senior nursing so that unit nurses and mental health workers could attend the clinical case conference did not produce an increase in attendance. At continuing medical education committee meeting on July 7, 2015, nursing attendance at clinical case conference we the sole item on the agenda and a number of positive suggestions for increasing nursing attendance at clinical case conference were obtained. This supplemented suggestions solicited and obtained from staff and organizational development, which had occurred in April 2015. Figures for attendance at clinical case conference will be forwarded for inclusion in the Quarterly Report.
Efforts should be initiated to intensify the opportunities offered to class members on the Forensic Units in order to increase their social skills and their knowledge and performance competencies about subjects of interest to them.	Patient Individualized Treatment Plans will contain documentation of participation in all treatment activities. Treatment Team Coordinators will conduct daily chart audits to ensure documentation.	All disciplines involved in the patient's care are included in the treatment team meetings. Plans for treatment are individualized to each patient. The Treatment Team Coordinators conduct chart audits to ensure that all documentation is current and accurate.

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
Riverview should be managed as a single Hospital and the exclusion of Lower Saco from the federal Medicaid program should be reconsidered as an urgent priority.	Completed in November 2014.	Completed in November 2014.
In order to ensure that any limitations are not in violation of the Consent Decree, restrictive practices, including access to outdoor areas, should be reviewed with involvement by class members and mental health workers.	Unit activity logs will be reviewed on a monthly basis to determine whether any limitations in a patient's access to treatment or services occurred. Unit community meetings will include a standing agenda item to review whether any restrictive practices were in place.	Administration reviews all grievances from patient, staff and advocate relative to any violations of the Consent Decree. Currently the RPC management is negotiating with the employee unions around the creation of unit based staffing and core staff assignments. Following these negotiations we will be focusing on the systematic review of unit practices that may restrict or inhibit access to outdoor areas and the roles of employees to relieve these restrictions.
The use of seclusion and restraint requires continued independent review to ensure that there are adequate alternatives designed and implemented for any class member potentially subject to such restrictive measures. Specifically, class members with a history of unacceptable behavior, such as aggression towards peers and/or staff, need to be reviewed again by the	The Risk Manager reviews 100% of cases of seclusion and restraint events including the content and timeliness of events. The hospital sends weekly reports of seclusion and restraint events to the Court Master. The Staff and Organizational Development Office will conduct its first annual review of the MOAB program and present results to Executive Leadership in January 2015.	The Risk Manager continues to review 100% of cases of seclusion and restraint events including the content and timeliness of events. A weekly report of seclusion and restraint events is sent to the Court Master weekly. The Staff and Organizational Development Office has identified a consultant to conduct a review of the

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
treatment team, and, if necessary, by an independent clinical consultant, to determine whether sufficiently individualized interventions are being designed and consistently implemented to replace unacceptable behavior with appropriate alternative behaviors.		MOAB program and upon completion will present results to Executive Leadership.
The reporting requirements by Paragraphs 188 and 189 of the Consent Decree should be completed as mandated.	On an annual basis (starting in January 2015), the Staff and Organizational Development Office will present a report to Executive Leadership at the hospital on the Behavioral Management system being used. The report will include (but is not limited to) information on: • Documentation on certification and external reviews of behavioral management system • Number of staff trained • Number of staff retrained • Results of inter-rater reliability tests for trainers • Number of staff injuries • Number of patient injuries • Number of incident reports showing that	Riverview has identified a consultant with expertise in MOAB. The scope of work, deliverables and delivery date are being negotiated. The Staff and Organizational Development Office are working on the metrics to be reported. Training data are reported in the hospital's Quarterly Report. Injury data are reported in the hospital's Quarterly Report. The Risk Manager continues to provide the Court Master a summary report of all seclusion and restraint events. Jonathan Alexis, consultant, provided the external review of the MOAB program in April

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
	staff varied from techniques • Review of fact-findings or investigations where behavioral management system failed to achieve goals • Findings from external reviews of the MOAB program The Risk Manager reviews 100% of all incident reports for seclusion and restraint daily to determine whether further actions are required. A summary report of 100% of all seclusion and restraint events are sent to the Court Master weekly.	2015. The hospital is waiting for the final written report on his findings and will make programmatic decisions based on those recommendations.
In light of the current demographics of admissions to Riverview, the adequacy of staffing requires further independent review. It is highly recommended that staffing ratios be determined by acuity rather than by census on the units.	The hospital will continue to monitor the staffing ratio as defined in the Consent Decree. In addition, the Integrated Quality team will work with Clinical Leadership to establish measurements to test the reliability and validity of data used with acuity based models to ensure that, in addition to meeting the Consent Decree's minimum staffing ratios, staffing is sufficient to carry out Consent Decree requirements.	Nursing works with staffing office daily to ensure that each unit, each shift has adequate numbers of staff based upon Consent Decree and taking into account a minimum of 8 additional acuity factors including: increased level of observation- medical issues – outside appointments – coercive events – admissions – discharges – increased dangerousness level - Nursing has offered flex shifts and is looking at unit based staffing.

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
		Riverview is cooperating with State Psychiatric Hospitals in Maine, Vermont and New Hampshire to test two acuity assessment tools: The "Modified Overt Aggression Scale" and the "Staff Observation Aggression Scale." Meetings among staff at the hospitals are occurring to define measurement. A decision is being made to submit either single or multiple IRB applications for use of the instruments for research purposes.
The use of "float" staff, especially those recently hired at Riverview, requires review in order to reduce the likelihood of risk due to unfamiliarity with and knowledge of the individuals with challenging behaviors or the need for specialized interventions. This review is especially critical for any assignment to the Forensic Units.	100% of new staff on acute units will have received and passed competency based skills training before being assigned.	All new staff must complete skills training as outlined by the hospital prior to being released from orientation. Some of these skills include MOAB training, CPR & power point presentations with competency quizzes on the subjects of Incident Reports, documentation, Patient Rights and seclusion/ restraint.
There should be consideration of supplemental pay for staff assigned to the Lower Saco unit.	The Human Resource office reviews its payroll records to ensure that staff who are eligible for the supplemental pay are receiving it according to Human Resource guidance.	Effective 9/1/15, by contract, all MHW's assigned to the Lower Saco and Lower Kennebec units will receive a stipend of $1.00 per hour for hours worked on those units
Discussions should be held with Mental Health Workers and nursing staff to	Action steps will be developed based on the results of the DHHS Human	The day NOD and Nurse IV's meet every weekday morning and have been meeting more

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
determine what additional measures are required to reduce the pressures experienced by staff and the resulting effects on the class members hospitalized for treatment.	Resources survey. The results of the survey and subsequent action steps will be reported to the Quality Improvement Committee and distributed to staff and included in the Quarterly Report.	regularly to specifically develop a new staffing pattern to reduce staff stress. In addition, a more aggressive effort to quickly review Family Medical Leave requests is being created to assist in reducing these pressures.
Qualification for Mental Health Workers should not be reduced.	100% of Mental Health workers meet and maintain the competencies required for their positions.	Applications for mental health workers are verified by Human Resources against the minimum qualifications established by the state DER (Employee Relations). If a candidate does not meet minimum qualifications they cannot proceed in the application process.
Continuing effort is required to ensure that all staff understand the mandate for reporting any suspected abuse, neglect, or exploitation of class members.	100% of incidents of abuse, neglect or exploitation are reported to Adult Protective Services. This will be monitored by a monthly review of incident reports. On a bi-monthly basis, the hospital's survey team (comprised of quality improvement staff from both Riverview and Dorothea Dix) will conduct an audit of the patient records for seclusion/restraint events to ensure that all events have been reported.	The Risk Manager continues to verify that all allegations of abuse, neglect or exploitation are reported to Adult Protective Services. All incidents are reviewed. A monthly report is sent to hospital's Human Rights Committee for review. On a monthly review of Incident Reports, the hospital's survey team (comprised of quality improvement staff from both RPC and DDPC) conduct an audit of the patient records for seclusion/restraint events to ensure that all events have been reported.
With consultation from class members and staff on the units, there should an	A content analysis will be conducted on all debriefing forms to determine themes	The hospital's Human Rights Committee has reviewed a patient survey instrument.

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
examination of the weaknesses and vulnerabilities that could lead to abuse, neglect and exploitation at Riverview.	and patterns. The results from this analysis will be shared with leadership and included in the Quarterly Report. Results of staff surveys will be included in the Quarterly Report. The results of the patient discharge survey will continue to be included in the Quarterly Report.	Members of the Peer Support Office will conduct the survey across the hospital. After completion of the survey, staff will meet with patients and staff on the units about weaknesses and vulnerabilities about abuse, neglect and exploitation. Patient discharge survey data are included in the Quarterly Report.
The Consent Decree language should be modified to specify that timely reporting of abuse and neglect cases should be made to Adult Protective Services (APS), Licensing, the Court Master and Plaintiffs' Counsel.	100% of alleged cases of abuse, neglect, or exploitation are reviewed and reported as required by statute, rule, and Consent Decree. The Court Master and Patient Advocate will receive copies of the validation form received after submitting reports to Adult Protective Services. A monthly summary report of all allegations of abuse, neglect, and exploration is prepared for the hospital's Human Rights Committee. Substantiated claims of abuse, neglect, or exploitation are noted in the hospital's Quarterly Report.	The Risk Manager continues to verify that all cases of abuse, neglect, or exploitation are reviewed and reported as required by statute, rule, and Consent Decree. The Court Master and Patient Advocates receive copies of the validation form received after submitting reports to APS. A monthly summary is prepared for the hospital's HRC. Substantiated claims of abuse, neglect, or exploitation are noted in the hospital's Quarterly Report.

JOINT COMMISSION

Hospital-Based Inpatient Psychiatric Services (ORYX Data Elements)

The Joint Commission Quality Initiatives

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

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

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

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

JOINT COMMISSION

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)

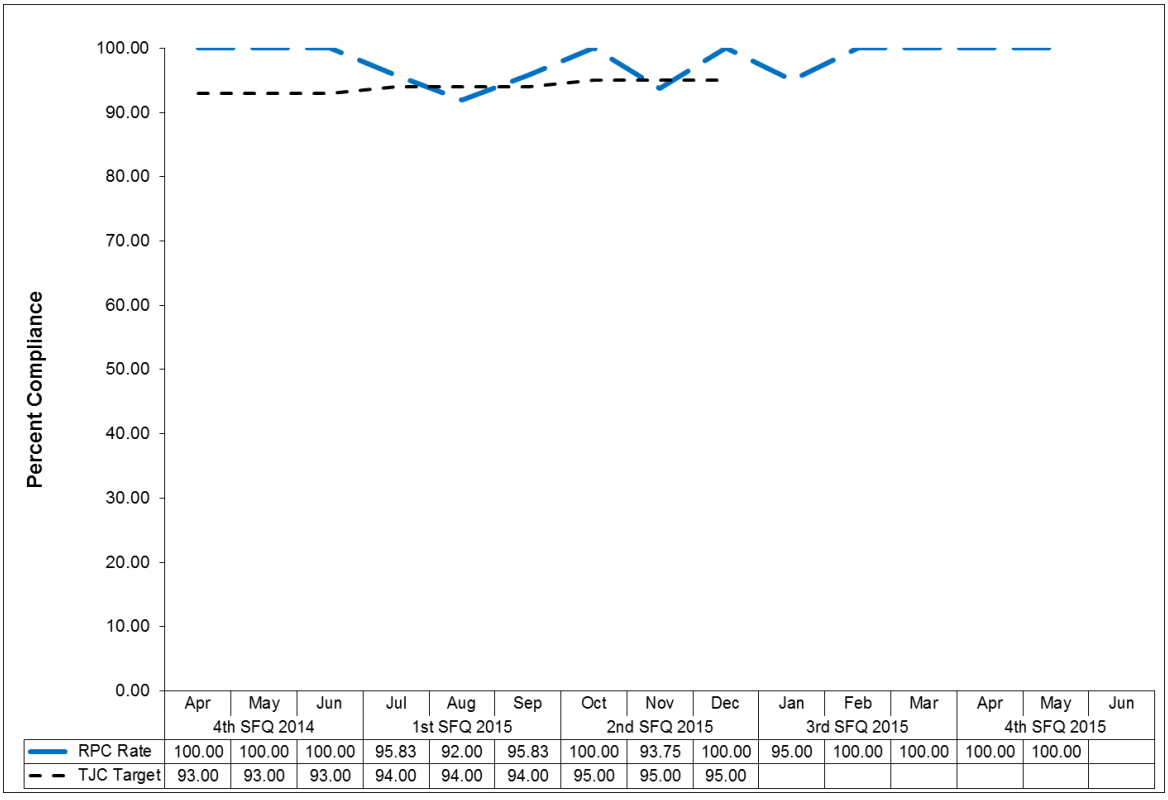
For Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths

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.



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	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
RPC Rate	100.00	100.00	100.00	95.83	92.00	95.83	100.00	93.75	100.00	95.00	100.00	100.00	100.00	100.00	
TJC Target	93.00	93.00	93.00	94.00	94.00	94.00	95.00	95.00	95.00						

JOINT COMMISSION

Physical Restraint (HBIPS 2)

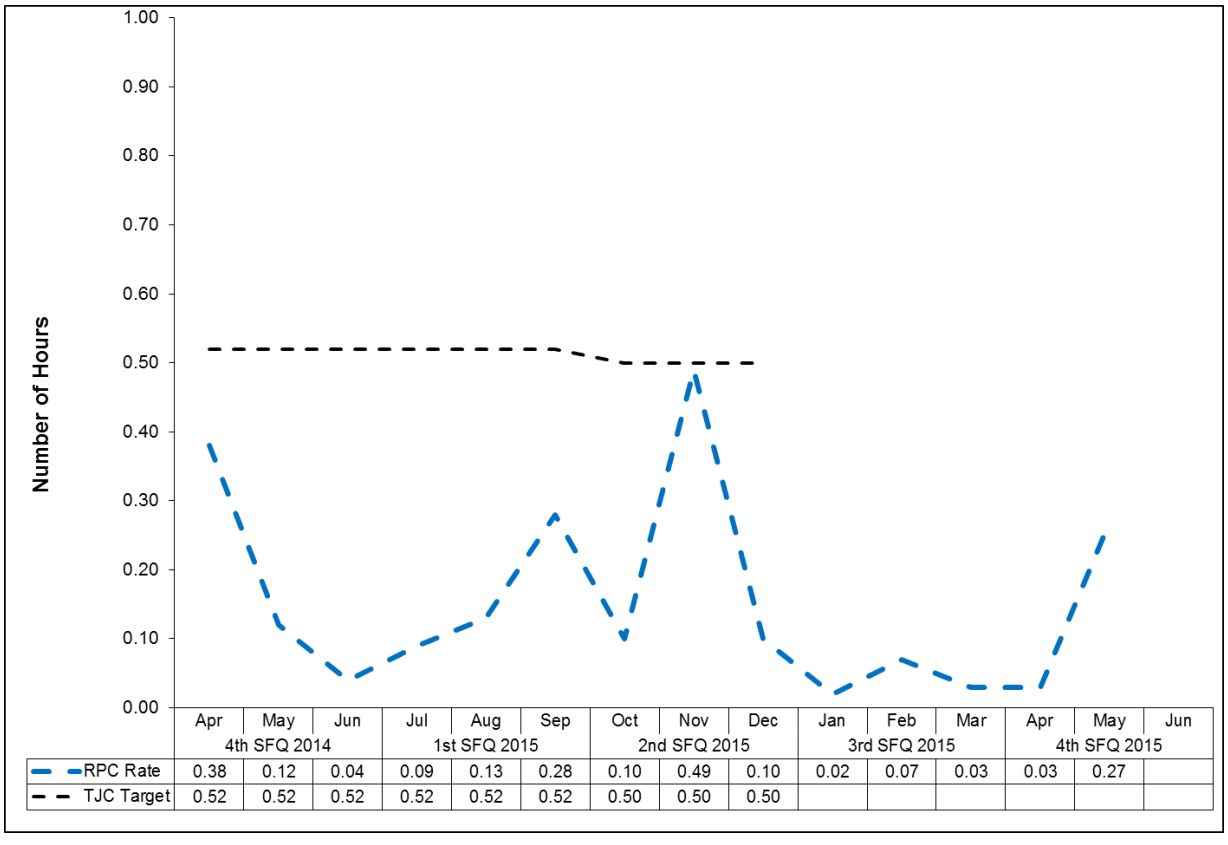
Hours of Use

Description

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

Rationale

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



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	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
RPC Rate	0.38	0.12	0.04	0.09	0.13	0.28	0.10	0.49	0.10	0.02	0.07	0.03	0.03	0.27	
TJC Target	0.52	0.52	0.52	0.52	0.52	0.52	0.50	0.50	0.50						

JOINT COMMISSION

Seclusion (HBIPS 3)

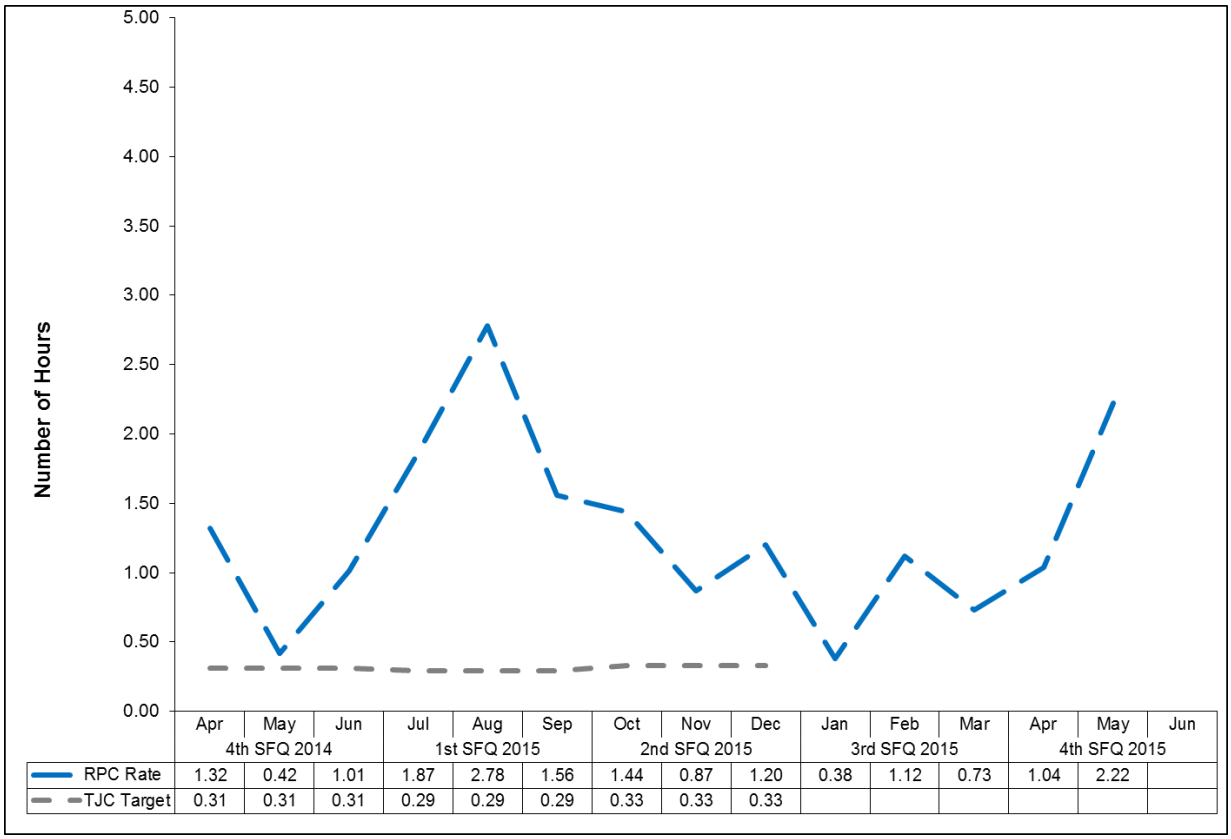
Hours of Use

Description

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

Rationale

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



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	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
RPC Rate	1.32	0.42	1.01	1.87	2.78	1.56	1.44	0.87	1.20	0.38	1.12	0.73	1.04	2.22	
TJC Target	0.31	0.31	0.31	0.29	0.29	0.29	0.33	0.33	0.33						

JOINT COMMISSION

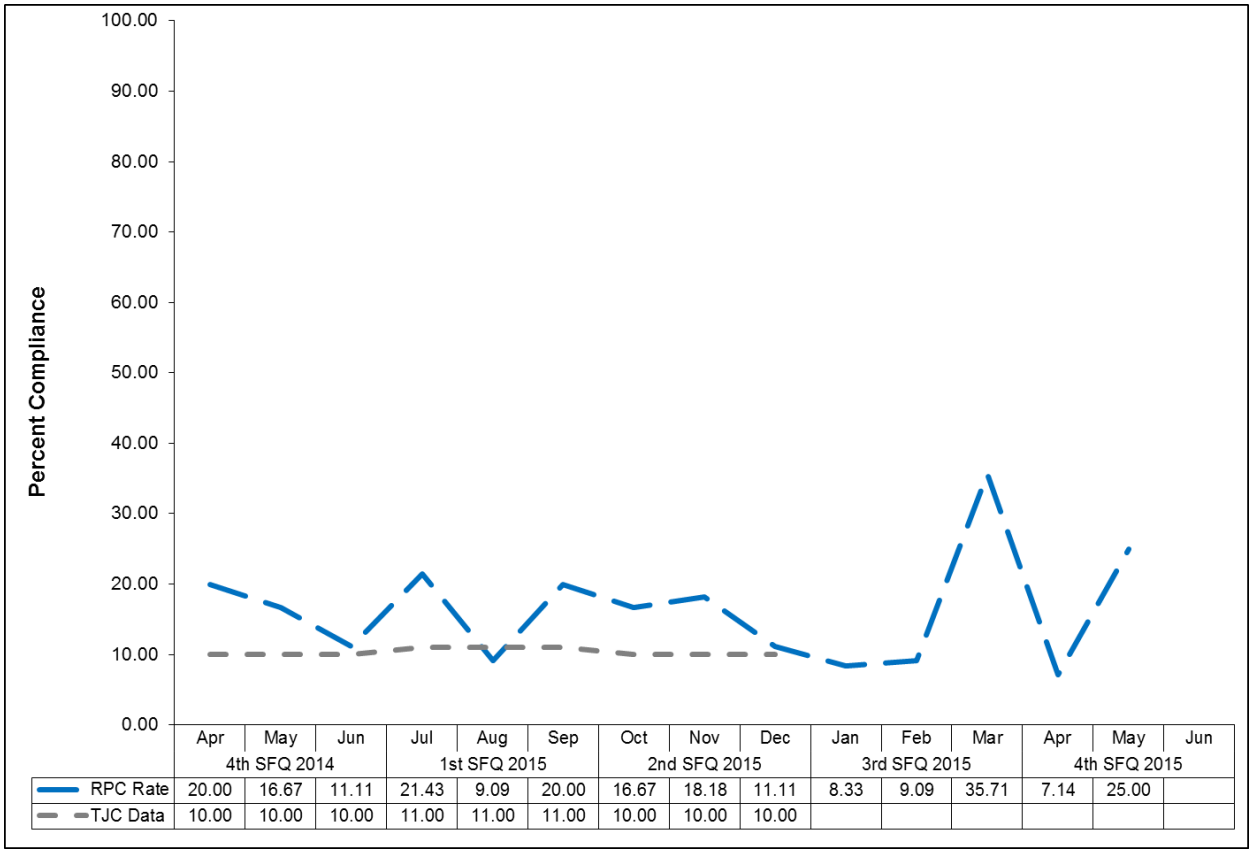
Multiple Antipsychotic Medications on Discharge (HBIPS 4)

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

JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)



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	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
RPC Rate	20.00	16.67	11.11	21.43	9.09	20.00	16.67	18.18	11.11	8.33	9.09	35.71	7.14	25.00	
TJC Data	10.00	10.00	10.00	11.00	11.00	11.00	10.00	10.00	10.00						

JOINT COMMISSION

Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)

Description

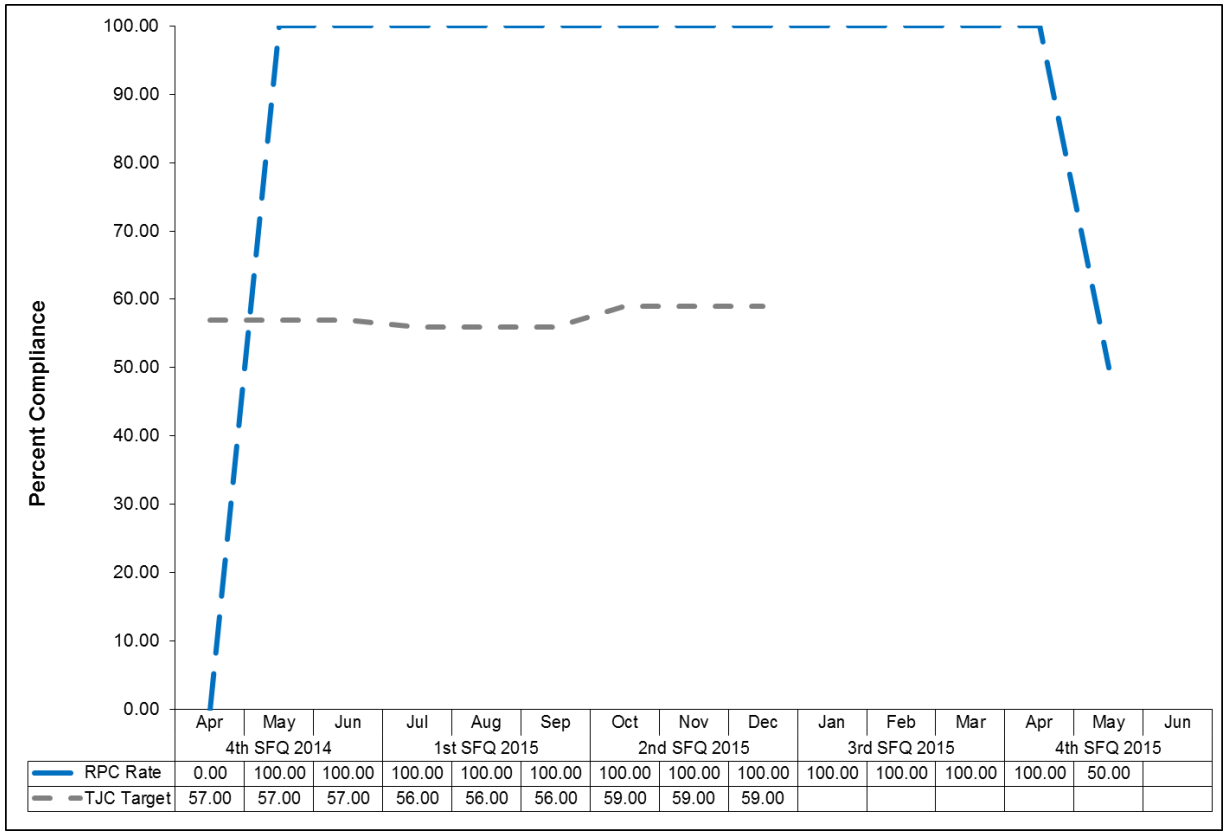
Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification.

Rationale

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, Ganocyz, & 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 at Discharge with Justification (HBIPS 5)



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	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
RPC Rate	0.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	50.00	
TJC Target	57.00	57.00	57.00	56.00	56.00	56.00	59.00	59.00	59.00						

JOINT COMMISSION

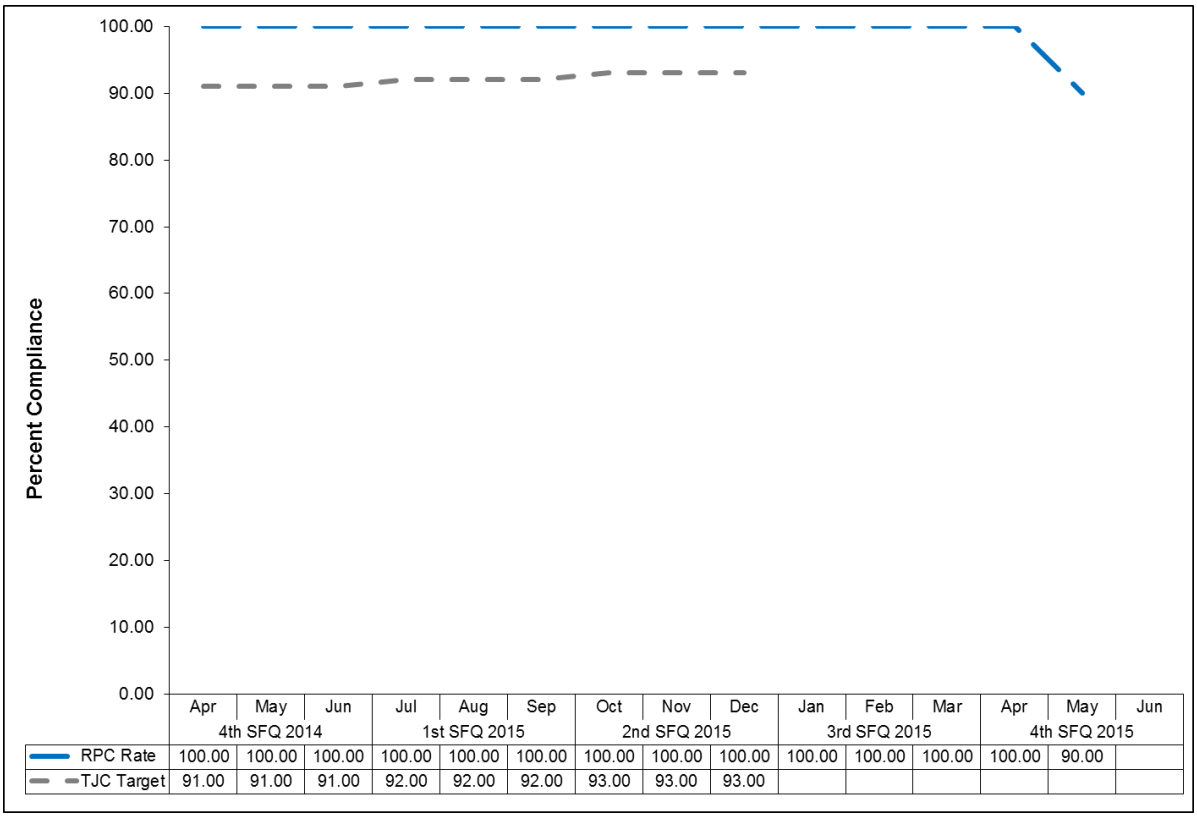
Post Discharge Continuing Care Plan (HBIPS 6)

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 [AACP], 2001).



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	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
RPC Rate	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	90.00	
TJC Target	91.00	91.00	91.00	92.00	92.00	92.00	93.00	93.00	93.00						

Post Discharge Continuing Care Plan Transmitted (HBIPS 7)

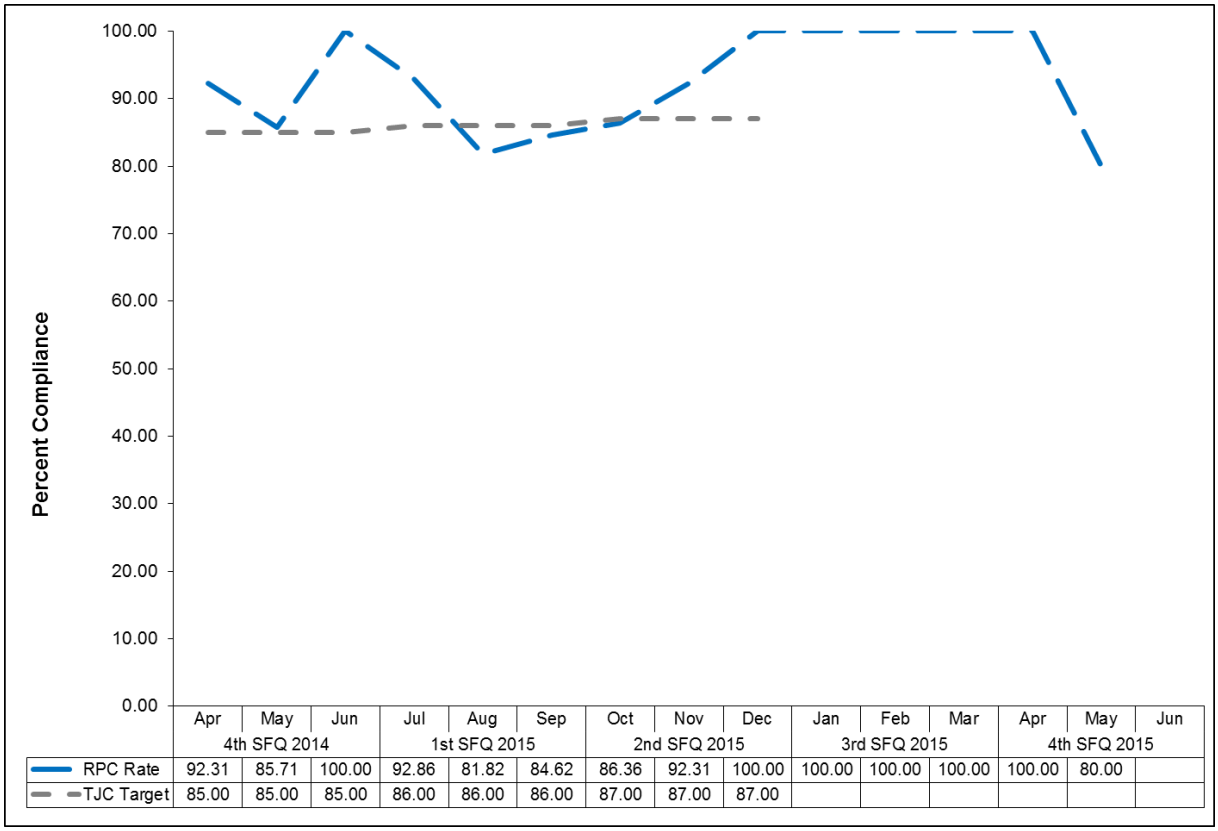
To Next Level of Care Provider on Discharge

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 [AACP], 2001).



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
RPC Rate	92.31	85.71	100.00	92.86	81.82	84.62	86.36	92.31	100.00	100.00	100.00	100.00	100.00	80.00	
TJC Target	85.00	85.00	85.00	86.00	86.00	86.00	87.00	87.00	87.00						

JOINT COMMISSION

Contract Performance Indicators

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.

FY 2015 Quarter 4 Results		
Contractor	**Program Administrator**	**Summary of Performance**
Amistad Peer Support Services	Stephanie George-Roy Director of Social Services	All indicators exceeded standards.
Community Dental, Region II	Dr. Brendan Kirby Clinical Director	All indicators met standards.
Comprehensive Pharmacy Services	Dr. Brendan Kirby Clinical Director	All indicators met standards.
Comtec Security	Debora Proctor Executive Housekeeper	All indicators met or exceeded standards.
Cummins Northeast	Richard Levesque Director of Support Services	No services were provided during this timeframe.
Dartmouth Medical School	Robert J. Harper Acting Superintendent	All indicators exceeded standards.
Disability Rights Center	Robert J. Harper Superintendent	All indicators met standards.
G & E Roofing	Richard Levesque Director of Support Services	No services were provided during this timeframe.
Goodspeed & O'Donnell	Dr. Brendan Kirby Clinical Director	No services were provided during this timeframe.
Liberty Healthcare – After Hours Coverage	Dr. Brendan Kirby Clinical Director	All indicators met or exceeded standards.
Liberty Healthcare – Physician Staffing	Dr. Brendan Kirby Clinical Director	All indicators met standards.
Maine General Community Care/Healthreach	Dr. Brendan Kirby Clinical Director	All indicators met standards
Maine General Medical Center – Laboratory Services	Dr. Brendan Kirby Clinical Director	The 3 indicators did not meet standards: (1) Timeliness or services, (2) Regular test results will be available within 24 hours, and (3) Stat test results will be available within 2 hours.

JOINT COMMISSION

Contractor	Program Administrator	Summary of Performance
		A corrective action plan is being worked on with MGMC.
Main Security Surveillance	Debora Proctor Executive Housekeeper	All indicators met or exceeded standards.
MD-IT Transcription Service	Amy Tasker Director of Health Information	All indicators met standards.
Mechanical Services	Richard Levesque Director of Support Services	All indicators met standards.
Medical Staffing and Services of Maine	Dr. Brendan Kirby Clinical Director	All indicators met standards.
Motivational Services	Dr. Brendan Kirby	All indicators met or exceeded standards.
Occupational Therapy Consultation and Rehabilitation Services	Janet Barrett Director of Rehabilitation	All indicators met or exceeded standards.
Otis Elevator	Richard Levesque Director of Support Services	Indicator met standards.
Pine Tree Legal Assistance	Dr. Brendan Kirby Clinical Director	No services were provided during this timeframe.
Project Staffing – ACT Team Coordinator	Lisa Manwaring, Acting Program Service Director, Outpatient Services	All indicators were not applicable.
Project Staffing – Barber	Janet Barrett Director of Rehabilitation	Indicator met standards.
Project Staffing – Multi Cultural Training Specialist	Janet Barrett Director of Rehabilitation	Indicator exceeded standards.
Project Staffing – Per Diem Nurses	Roland Pushard Director of Nursing	Evaluation not received.
Project Staffing – Post Doctoral Fellowship	Dr. Brendan Kirby Clinical Director	No services were provided during this timeframe.
Project Staffing – Pre-Doctoral Intern	Dr. Brendan Kirby Clinical Director	All indicators met or exceeded standards.
Project Staffing – Recovery Training Specialist	Susan Bundy Staff Development Coordinator	All indicators met standards.
Project Staffing – Teacher	Janet Barrett Director of Rehabilitation	All indicators met standards.

JOINT COMMISSION

Contractor	Program Administrator	Summary of Performance
Protection One	Richard Levesque Director of Support Services	Indicator exceeded standards.
Securitas Security Services	Philip Tricarico Safety Compliance Officer	All indicators met or exceeded standards.
Unifirst Corporation	Richard Levesque Director of Support Services	All indicators met standards.
Waste Management	Debora Proctor Executive Housekeeper	All indicators met standards.

JOINT COMMISSION

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)

Capital Community Clinic - Dental Clinic

Dental Clinic Timeout/Identification of Patient

Indicators	1Q2015	2Q2015	3Q2015	4Q2015	Total
National Patent Safety Goals					
	July	**Oct**	**Jan**	**April**	
Goal 1: Improve the accuracy of Patient Identification.	100% 5/5	100% 9/9	100% 4/4	100% 3/3	
	Aug	**Nov**	**Feb**	**May**	
Capital Community Dental Clinic assures accurate patient identification by: asking the patient to state his/her name and date of birth.	100% 2/2	100% 3/3	100% 6/6	N/A 0/0	100% 42/42
	Sept	**Dec**	**Mar**	**June**	
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.	100% 3/3	100% 2/2	100% 4/4	100% 1/1	
	Total	**Total**	**Total**	**Total**	
	100% 10/10	100% 14/14	100% 14/14	100% 4/4	

JOINT COMMISSION

Dental Clinic Post Extraction Prevention of Complications and Follow-up

Indicators	1Q2015	2Q2015	3Q2015	4Q2015	Total
1. All patients with tooth extractions will be assessed and have teaching post procedure on the following topics, as provided by the Dentist or Dental Assistant: • Bleeding • Swelling • Pain • Muscle soreness • Mouth care • Diet • Signs/symptoms of infection 2. The patient, post procedure tooth extraction, will verbalize understanding of the above by repeating instructions given by Dental Assistant/Hygienist. 3. Post dental extraction patients will receive a follow-up phone call from the clinic within 24 hours of procedure to assess for post procedure complications	**July** 100% 5/5 **Aug** 100% 2/2 **Sept** 100% 3/3 **Total** 100% 10/10	**Oct** 100% 9/9 **Nov** 100% 3/3 **Dec** 100% 2/2 **Total** 100% 14/14	**Jan** 100% 4/4 **Feb** 100% 6/6 **Mar** 100% 4/4 **Total** 100% 14/14	**April** 100% 3/3 **May** N/A 0/0 **June** 100% 1/1 **Total** 100% 4/4	100% 42/42

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Healthcare Acquired Infections Monitoring and Management

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

Infection Control

Responsible Party: George Davis, MD, Chairperson of Infection Control Committee
Kathleen Mitton, RN, Infection Control Nurse

Measure Name: Hospital Associated Infection (HAI) Rate
Measure Description: Fourth Quarter Review of Hospital Associated Infections
Measure Type: Quality Assurance

Results							
Target	**Unit**	**Baseline**	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**
1 STDV within the Mean	Hospital Associated Infection Rate	FY 2014 1 STDV within the mean	9 HAI/IC Rate 1.6	4 HAI/IC Rate 2.2	7 HAI/IC Rate 1.1	4 HAI/IC Rate 0.83	HAI – 1.4
Actual Outcome			1 STDV within the mean	At 1 STDV	1 STDV within the mean	1 STDV within the mean	

A **Hospital Acquired Infection (HAI**) 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 a HAI.

A **Community Acquired Infection (CAI)** 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.

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

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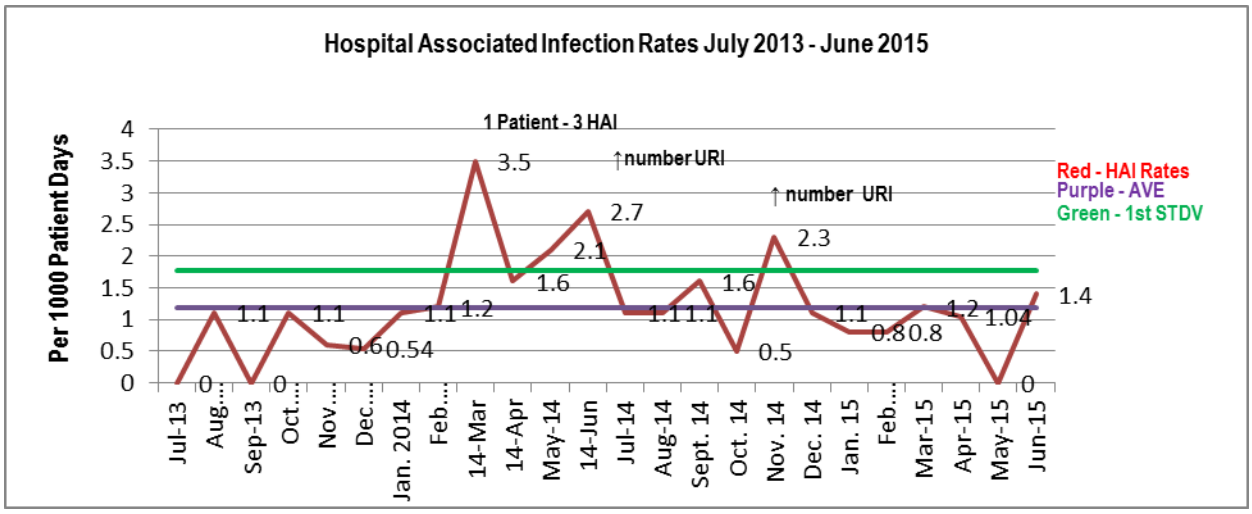
Lower Kennebec Unit:	**Upper Saco Unit:**
Nasal Carbuncle with no soft tissue in Right Maxillary region – CAI	Dental Infection – CAI
Excoriation to scalp, probably early Impetigo – CAI	Pneumonia – HAI
Probable Candida Vaginitis – CAI	Paronychia of left Great Toe – CAI
Dental Abscess – CAI	Conjunctivitis – HAI
Lower Saco Unit:	**Upper Kennebec Unit:**
Folliculitis – CAI	Hepatitis C – CAI
Chronic Prostatitis – CAI	Syphilis – CAI
Dental Abscess – CAI	
Rt. Leg pain, suspect secondary to venous insufficiency, cannot exclude cellulitis – CAI	**Total Infections:** 20
Tinea Pedis – HAI	**HAI:** 4/0.83
Chronic Bilateral Otitis Media – CAI	**CAI:** 16
Chronic prostatitis – CAI	**Idiosyncratic Infections:** 0
Thrush – CAI secondary to antibiotics	
Otitis External – HAI	
Facial fractures – prophylactic treatment – CAI	

Data Analysis: Infection rates remain low and within one standard deviation of the mean.

Plan: Ongoing surveillance



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Measure Name: Hand Hygiene
Measure Description: Fourth Quarter Report

- The Nurse IV will do ten (10) observations per month of the hand hygiene practice of nurses as they pass medications. The standard is hand hygiene before & after each medication pass.
- Staff will do ten (10) hand hygiene observations per month (before & after patient contact) in the milieu on the **7-3pm shift.**
- Staff will do ten (10) hand hygiene observations per month (before & after patient contact) in the milieu on the **3-11pm shift**

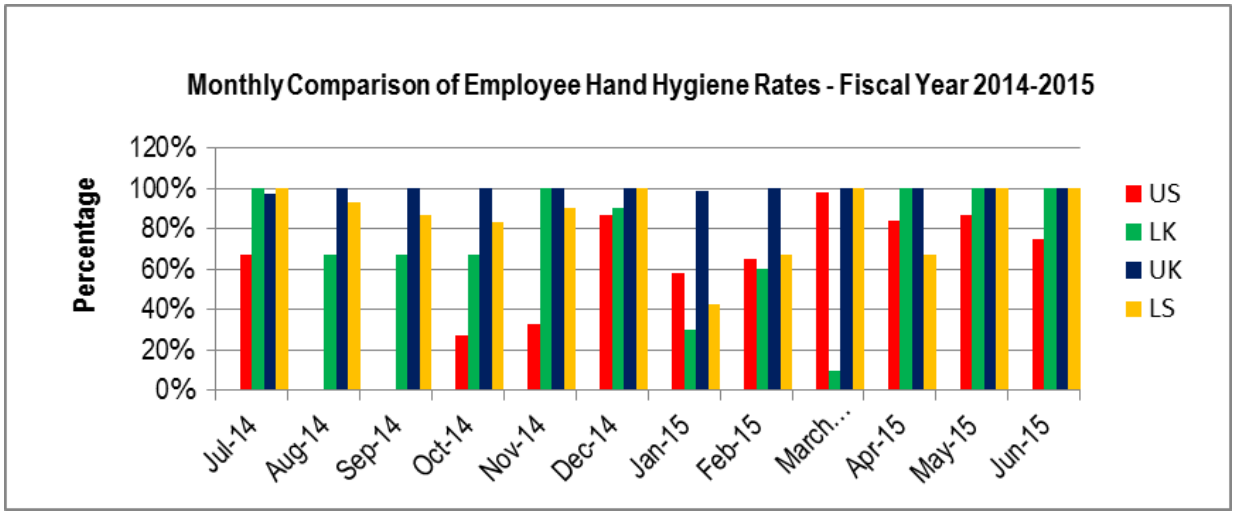
Measure Type: Performance Improvement

Results							
Target	**Unit**	**Baseline**	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**
86%	Hand Hygiene Compliance Rate	FY 2013 – 2014: Hand Hygiene Rate: 81%	526/ 720	580/ 720	515/ 720	661/ 720	
Actual Outcome			73%	81%	72%	92%	**80%**

Data Analysis: The employee hand hygiene rate is 92%. The mean hand hygiene rate for fiscal year 2014-2015 is 80%.

Plan of Action:

- Share this information with staff.
- Continue to hold hand hygiene classes.



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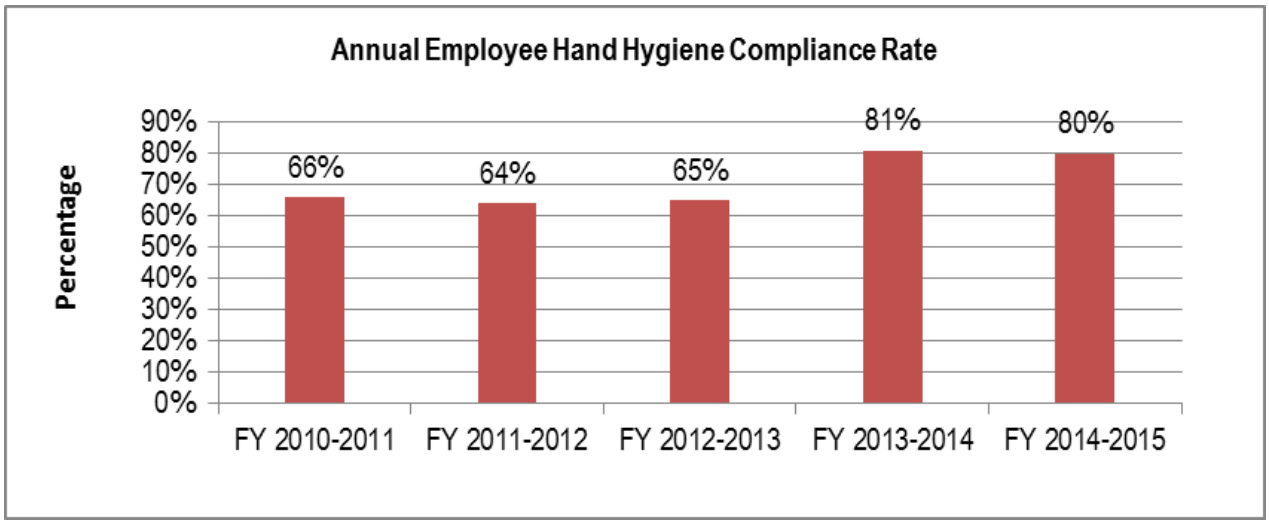
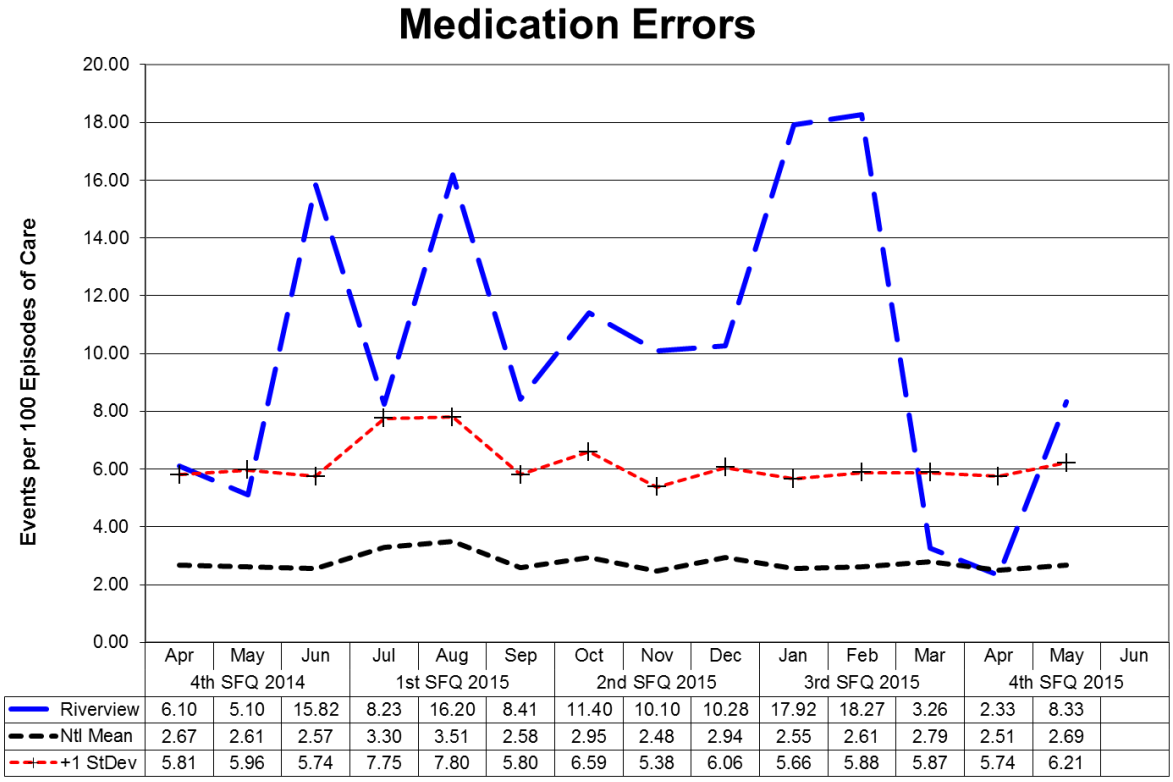


JOINT COMMISSION

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)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	6.10	5.10	15.82	8.23	16.20	8.41	11.40	10.10	10.28	17.92	18.27	3.26	2.33	8.33	
Ntl Mean	2.67	2.61	2.57	3.30	3.51	2.58	2.95	2.48	2.94	2.55	2.61	2.79	2.51	2.69	
+1 StDev	5.81	5.96	5.74	7.75	7.80	5.80	6.59	5.38	6.06	5.66	5.88	5.87	5.74	6.21	

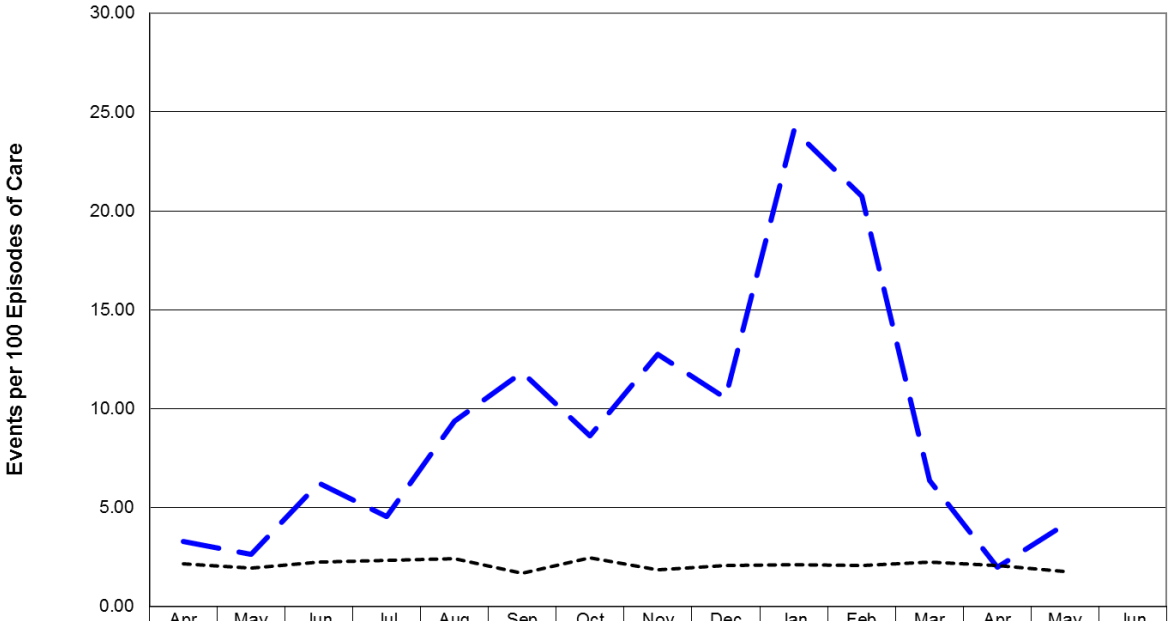
This graph depicts the number of medication error events that occurred for every 100 episodes of care (duplicated patient count). For example, a rate of 1.6 means that 2 medication error events occurred for each 125 episodes of care.

The following graphs depict the number of medication error events that occurred for every 100 episodes of care (duplicated patient count) stratified by forensic or civil classifications. For example, a rate of 1.6 means that 2 medication error events occurred for each 125 episodes of care. The hospital-wide results from Dorothea Dix are compared to the civil population results at Riverview due to the homogeneous nature of these two sample groups.

JOINT COMMISSION

Medication Errors

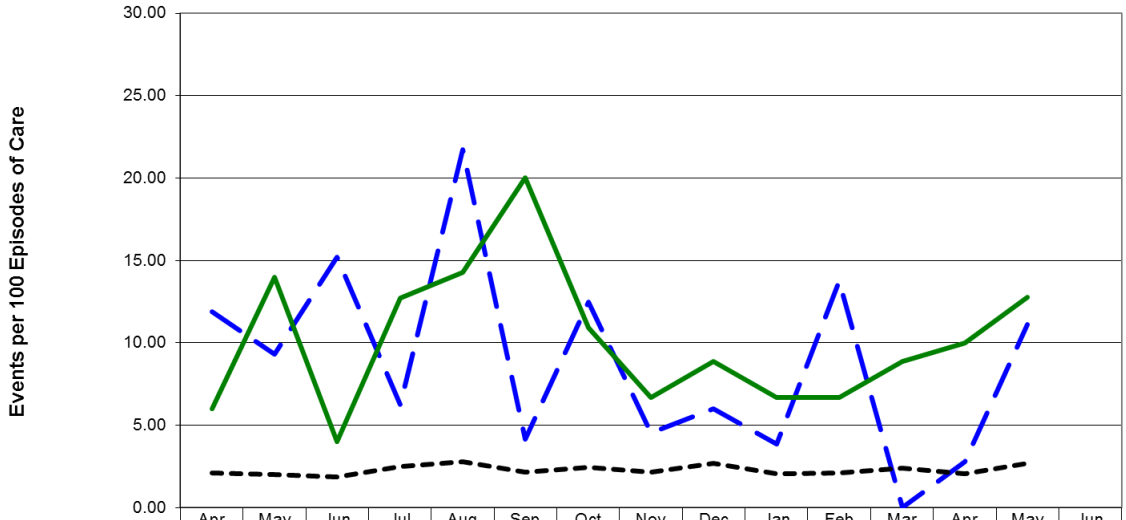
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	3.28	2.63	6.25	4.55	9.38	11.86	8.62	12.73	10.53	24.07	20.75	6.38	2.00	4.17	
Ntl Mean	2.15	1.92	2.25	2.32	2.40	1.69	2.48	1.84	2.05	2.10	2.08	2.26	2.06	1.77	

Medication Errors

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	11.90	9.30	15.22	6.25	21.74	4.17	12.50	4.55	6.00	3.85	13.73	0.00	2.78	11.11	
Dorothea Dix	6.00	14.00	4.00	12.73	14.29	20.00	10.91	6.67	8.89	6.67	6.67	8.89	10.00	12.77	
Ntl Mean	2.09	2.01	1.87	2.49	2.79	2.17	2.47	2.18	2.70	2.04	2.11	2.42	2.08	2.71	

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Medication Variances

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 patient level errors are also defined as errors of prescribing in identifying and ordering the appropriate medication to be used in the care of the patient.

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 patient care practices. The team consists of the Clinical 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

Administration Process

Medication Errors Related to Staffing Effectiveness

Date	Omit	Type of Error	Float	New	O/T	Unit	Staff Mix		
							RN	LPN	MHW
4/7/2015	Y	Omission x1	Y	N	N	LK	4	0	7
4/29/2015	Y	Allergy to med	N	N	N	LS			
5/11/2015	Y	Omission x7	N	N	N	LK	3	1	6
5/11/2015	N	Wrong Drug x7	N	N	N	LK	3	1	6
5/15/2015	Y	Omission x1	N	N	N	LK	2	1	4
5/15/2015	Y	Omission x1	N	N	N	US	2	1	3
5/20/2015	Y	Omission x1	N	N	N	LK	3	1	6
5/21/2015	N	Wrong Drug x1	N	N	N	LK	2	1	6
5/22/2015	Y	Omission x1	N	N	N	LK	2	1	4
5/24/2015	N	Expired Order x1	Y	N	N	US	2	1	
6/1/2015	Y	Omission x1	N	N	N	LK	2	1	6
6/2/2015	Y	Omission x3	N	N	N	LK	3	2	9
6/11/2015	Y	Omission x1	N	N	N	LK	3	1	7
6/15/2015	N	Wrong Dose x1	N	N	N	US	2	1	3
6/16/2015	Y	Omission x1	N	N	N	LK	3		
6/16/2015	Y	Omission x2	N	N	N	LK	4	0	7
6/18/2015	N	Extra dose x4	N	N	N	LK	2	1	
6/18/2015	Y	Omission x1	N	N	N	LS	2	0	4
6/18/2015	Y	Omission x1	N	N	N	LS	3	0	7
6/19/2015	Y	Omission x1	N	N	N	LS	3	0	7
6/19/2015	Y	Omission x1	Y	N	N	LS	2	2	3
Totals	**25**		**3**	**0**	**0**	**LS: 5**	**US: 3**	**LK: 31**	**UK: 0**
Percent	**64%**		**8%**	**0%**	**0%**	**13%**	**8%**	**79%**	**0%**

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

JOINT COMMISSION

Dispensing Process

Measure	Unit	Baseline 2014	Goal	Q1	Q2	Q3	Q4
Controlled Substance Loss Data: Daily Pyxis-CII Safe Compare Report.	All	0.875%	0% Target: Actual:	 0% 0%	 0% 0%	 0% 0%	 0% 0%
Controlled Substance Loss Data: Monthly CII Safe Vendor Receipt Report.	Rx	0	0 Target: Actual:	 0 0	 0 0	 0 0	 0 0
Controlled Substance Loss Data: Monthly Pyxis Controlled Drug discrepancies.	All	22/mo	0 Target: Actual:	 0 58 (19/ mo)	 0 66 (22/ mo)	 0 42 (14/ mo)	 0 37 (12/ mo)
Medication Management Monitoring: Measures of drug reactions, adverse drug events and other management data.	Rx	8/year	0 Target: Actual:	 0 2	 0 1	 0 2	 0 3
Medication Management Monitoring: Resource Documentation Reports of Clinical Interventions.	Rx	395	Actual:	84	79	73	56
Psychiatric Emergency Process: Monthly audit of all psych emergencies measures against 9 criteria.	All	90%	100% Target: Actual:	 100% 93%	 100% 95%	 100% 93%	 100% 94%
Operational Audit: Monthly audit of 3 operational indicators from CPS contract.	Rx		100% Target: Actual:	 100% 100%	 100% 100%	 100% 100%	 100% 100%

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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 patient satisfaction in six areas or domains of focus. These domains include Outcomes, Dignity, Rights, Participation, Environment, and Empowerment.

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 patients, the process of administering the inpatient survey is difficult to administer. Whenever possible, Peer Support staff work to gather information from patients on their perception of the care provided to then 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 Patient Satisfaction Survey Return Rate of this report.

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

Note: When the Riverview field is blank for a month it means that no patients responded to the survey questions on that page in that particular month.

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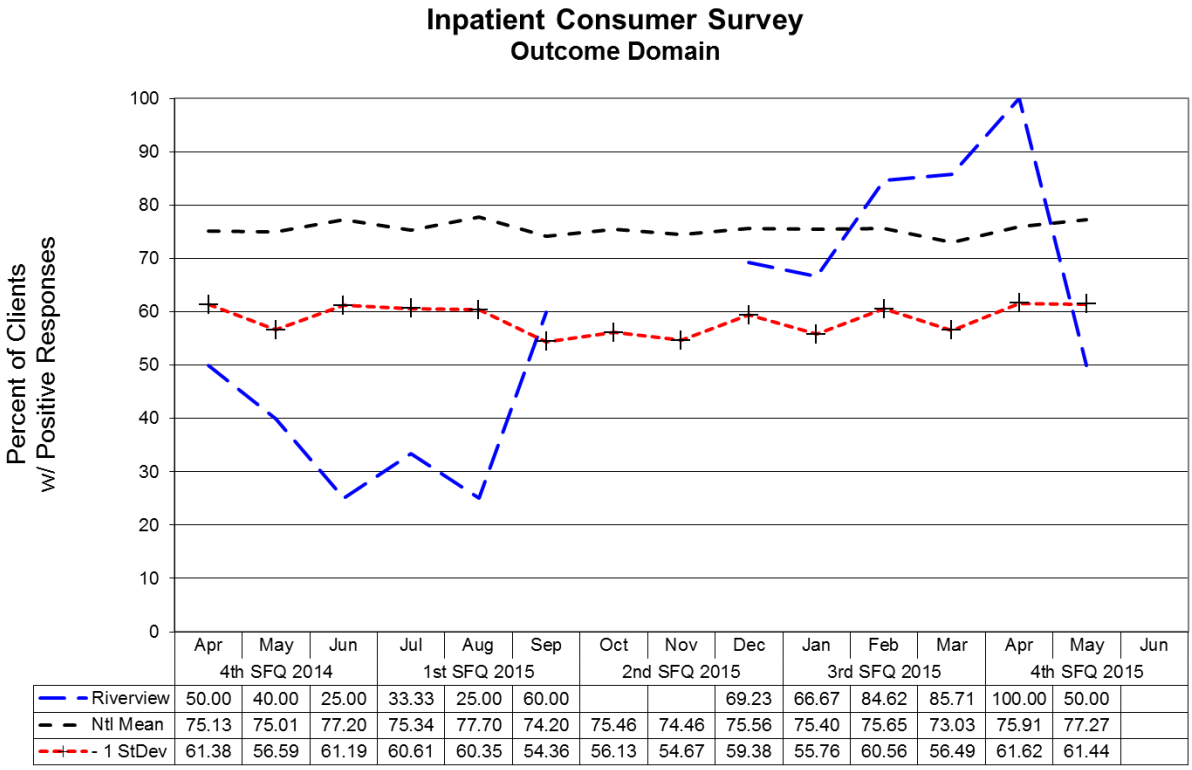

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	50.00	40.00	25.00	33.33	25.00	60.00			69.23	66.67	84.62	85.71	100.00	50.00	
Ntl Mean	75.13	75.01	77.20	75.34	77.70	74.20	75.46	74.46	75.56	75.40	75.65	73.03	75.91	77.27	
- 1 StDev	61.38	56.59	61.19	60.61	60.35	54.36	56.13	54.67	59.38	55.76	60.56	56.49	61.62	61.44	

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.

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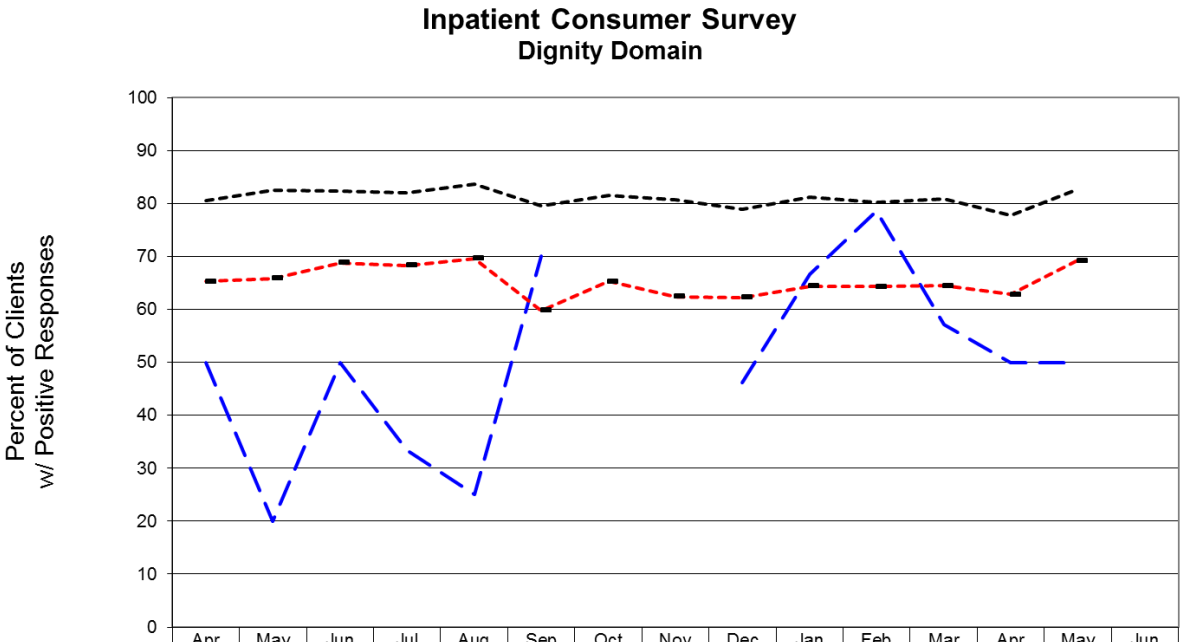

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	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	50.00	20.00	50.00	33.33	25.00	70.00			46.15	66.67	78.57	57.14	50.00	50.00	
Ntl Mean	80.56	82.47	82.40	82.09	83.66	79.61	81.51	80.68	78.95	81.22	80.24	80.93	77.76	82.60	
1 StDev	65.25	65.88	68.78	68.29	69.58	59.76	65.26	62.39	62.24	64.37	64.30	64.43	62.84	69.19	

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.

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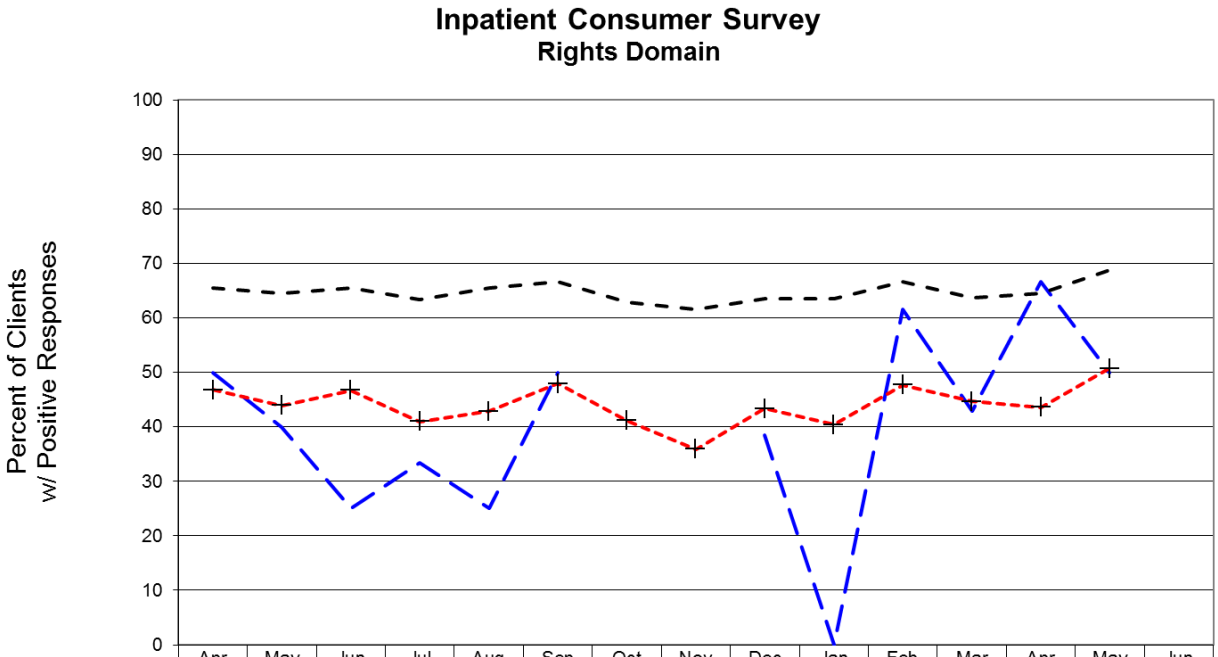

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	4th SFQ 2014			1st SFQ 2015			2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015		
Riverview	50.00	40.00	25.00	33.33	25.00	50.00			38.46	0.00	61.54	42.86	66.67	50.00	
Ntl Mean	65.51	64.44	65.54	63.40	65.49	66.62	62.85	61.61	63.48	63.50	66.69	63.76	64.47	68.79	
1 StDev	46.78	43.93	46.73	40.96	42.83	47.90	41.17	35.93	43.38	40.37	47.65	44.68	43.58	50.71	

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.

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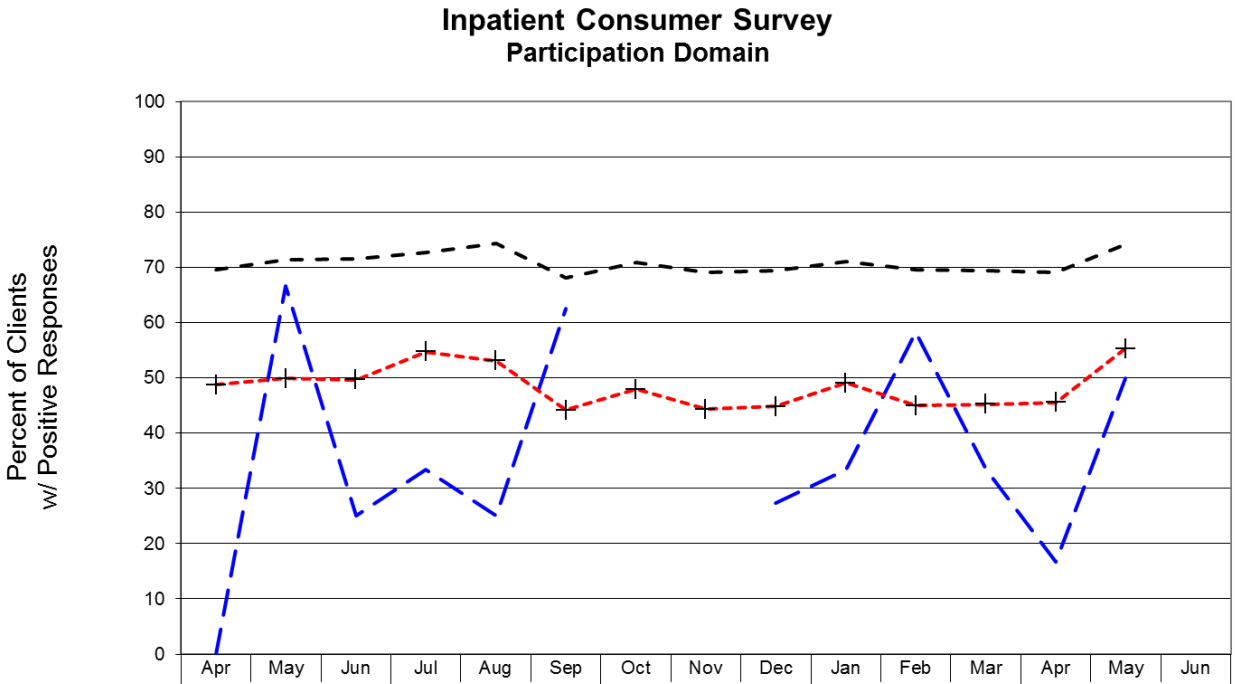

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Riverview	0.00	66.67	25.00	33.33	25.00	62.50			27.27	33.33	58.33	33.33	16.67	50.00	
Ntl Mean	69.64	71.31	71.57	72.71	74.35	68.16	70.82	69.02	69.47	71.01	69.50	69.49	69.01	74.24	
- 1 StDev	48.71	49.87	49.65	54.69	53.07	44.15	47.96	44.36	44.81	49.04	45.01	45.21	45.58	55.32	

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.

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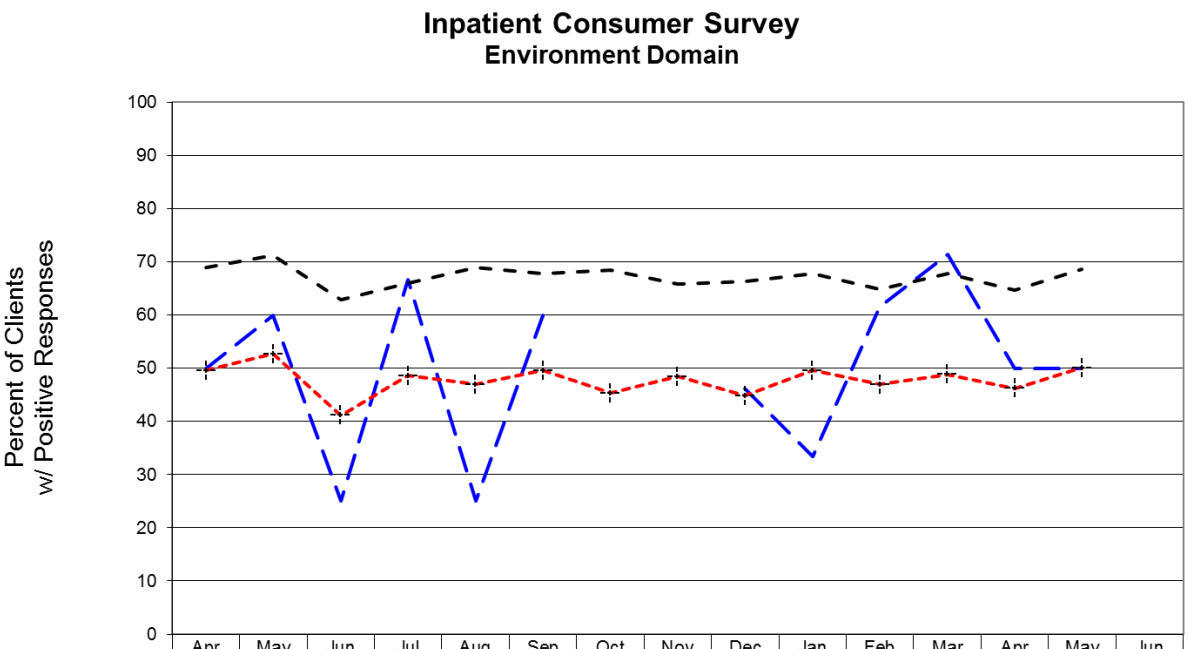

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Riverview	50.00	60.00	25.00	66.67	25.00	60.00			46.15	33.33	61.54	71.43	50.00	50.00	
Ntl Mean	68.97	71.29	62.86	65.97	68.87	67.75	68.37	65.79	66.24	67.84	64.91	67.78	64.65	68.58	
1 StDev	49.56	52.71	41.15	48.58	46.99	49.56	45.28	48.42	44.85	49.57	46.93	48.82	46.25	50.05	

Environment Domain Questions:

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.

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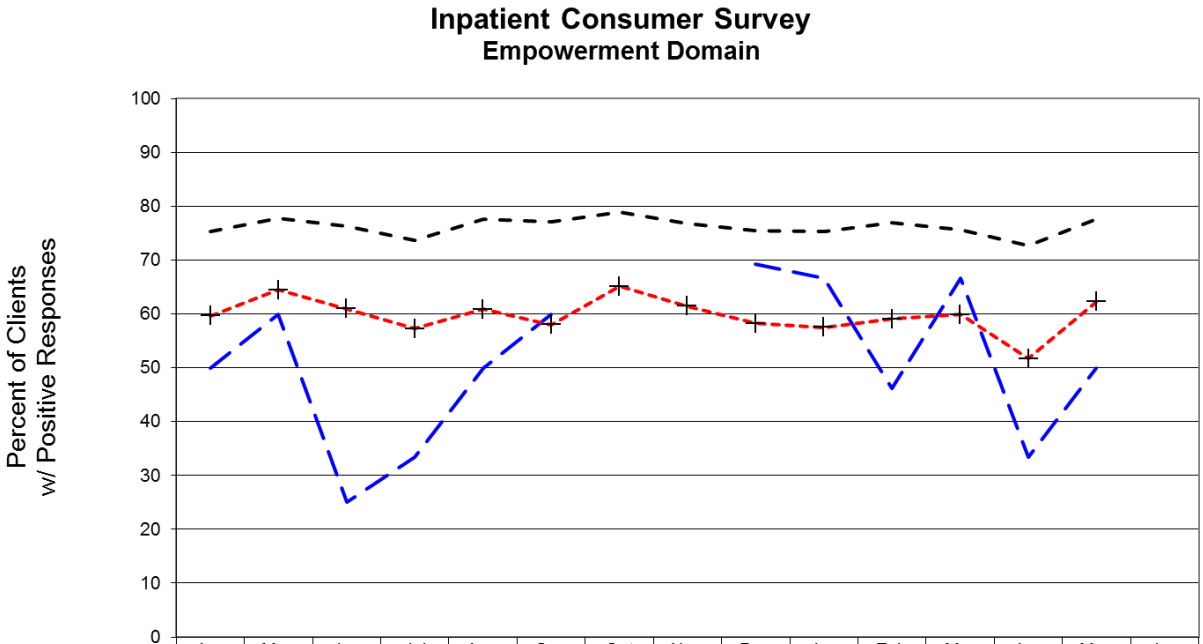

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Riverview	50.00	60.00	25.00	33.33	50.00	60.00			69.23	66.67	46.15	66.67	33.33	50.00	
Ntl Mean	75.35	77.80	76.28	73.72	77.61	77.18	78.87	76.80	75.45	75.28	76.90	75.61	72.70	77.65	
1 StDev	59.64	64.48	60.97	57.28	60.87	58.00	65.14	61.43	58.25	57.54	59.08	59.87	51.71	62.25	

Empowerment Domain Questions:

1. I had a choice of treatment options.
2. My contact with my Doctor was helpful.
3. My contact with nurses and therapists was helpful.

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.

The 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 patients identified as having a high potential for falls.

Type of Fall by Patient and Month:

Fall Type	Patient	APRIL	MAY	JUNE	4Q2015
Un-witnessed	MR6330			1	**1**
	MR1033*			2	**2**
	MR3374			1	**1**
	MR7713*	1			**1**
	MR7502	1			**1**
	MR7665		1		**1**
	MR6963*		1		**1**
	Totals	**2**	**2**	**4**	**8**
Fall Type	**Patient**	**APRIL**	**MAY**	**JUNE**	**4Q2015**
Witnessed	MR4			1	**1**
	MR7722	2			**2**
	MR7756			1	**1**
	MR1033*			9	**9**
	MR5625		1		**1**
	MR7409	1			**1**
	MR7713*	1			**1**
	MR7725		1		**1**
	MR7448			1	**1**
	MR6963*			1	**1**
	Totals	**4**	**2**	**13**	**19**

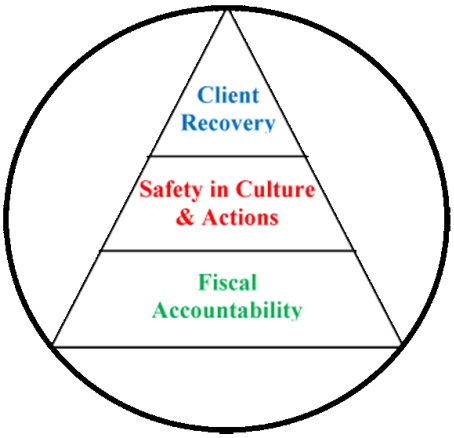
*Patients have experienced witnessed and un-witnessed falls during the reporting quarter.

STRATEGIC PERFORMANCE EXCELLENCE

Process Improvement Plans

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 patient recovery by ensuring fiscal accountability and a culture of organizational safety through the promotion of…

- The conviction that staff members are concerned with doing the right thing in support of patient 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 staff members and patients 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 patients before, during, and after care;
- A just culture that supports the emotional and physical needs of staff members, patients, 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.

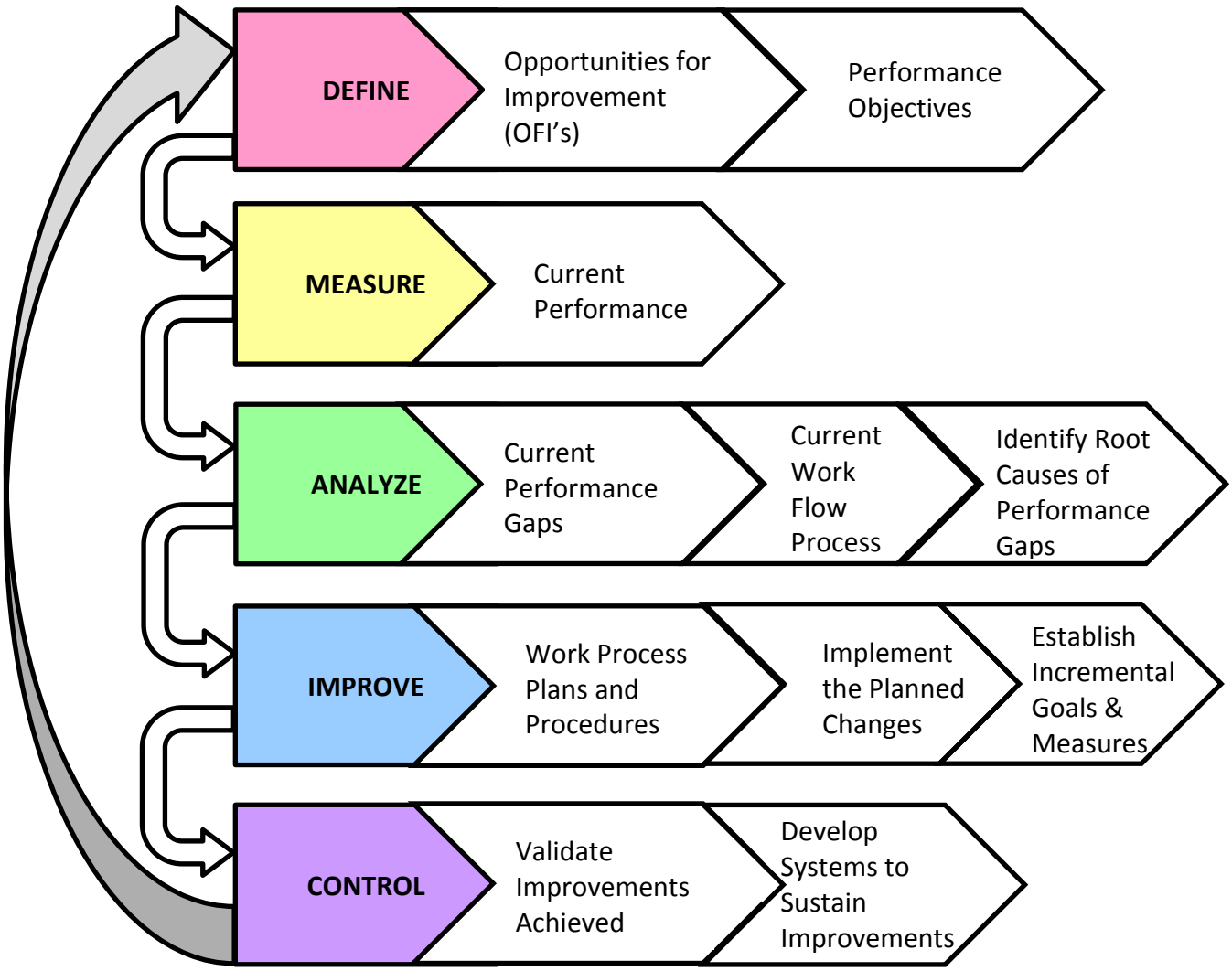
Promote a Safety Culture by…
Improving Communication
Improving Staffing Capacity and Capability
Evaluating and Mitigating Errors and Risk Factors
Promoting Critical Thinking
Supporting the Engagement and Empowerment of Staff Members

Enhance Patient Recovery by…
Develop Active Treatment Programs and Options for Patients
Supporting patients in their discovery of personal coping and improvement activities.

STRATEGIC PERFORMANCE EXCELLENCE

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

The Quarterly Report Consists of the Following:



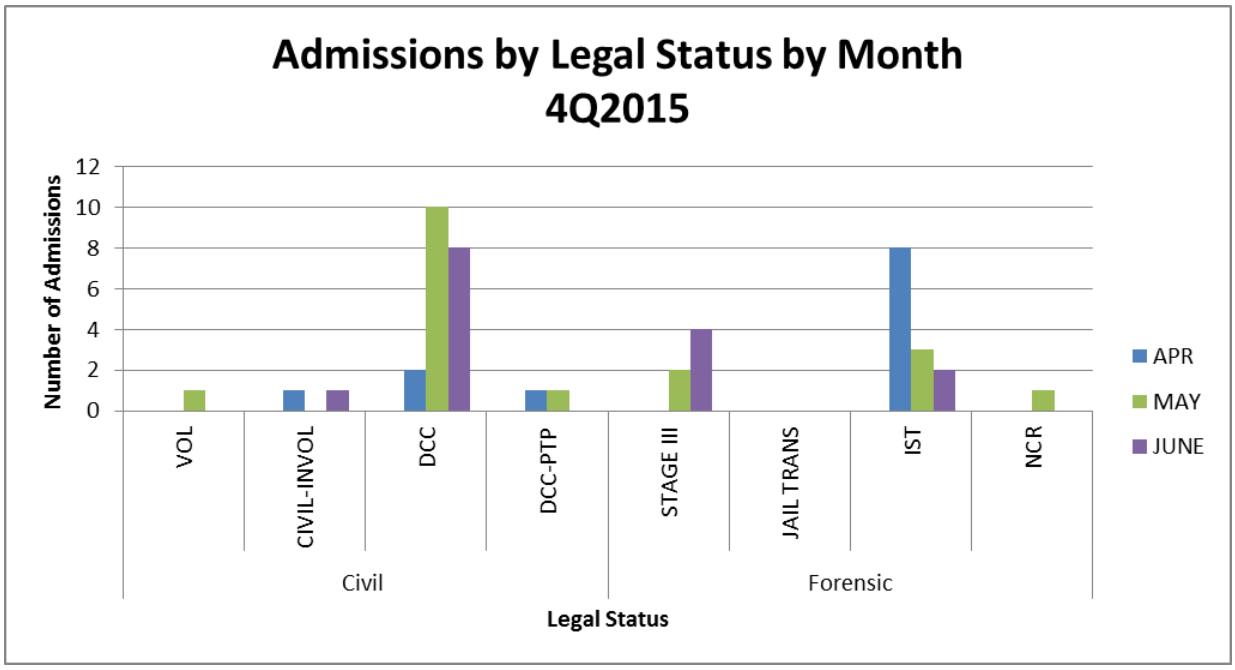
STRATEGIC PERFORMANCE EXCELLENCE

Admissions

Responsible Party: Jamie Meader, RN, Admissions Nurse

Number of Admissions:

ADMISSIONS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTAL
CIVIL:	**11**	**9**	**15**	**17**	**9**	**15**	**11**	**12**	**3**	**4**	**12**	**9**	**127**
VOL	0	0	0	1	0	1	0	0	0	0	1	0	3
CIVIL-INVOL	3	2	3	4	0	2	0	2	1	1	0	1	19
DCC	7	7	11	12	9	12	11	9	2	2	10	8	100
DCC-PTP	1	0	1	0	0	0	0	1	0	1	1	0	5
FORENSIC:	**10**	**12**	**11**	**12**	**6**	**10**	**8**	**6**	**3**	**8**	**6**	**6**	**98**
STAGE III	7	6	7	2	5	7	1	1	1	0	2	4	43
JAIL TRANS	1	0	0	1	0	0	0	0	0	0	0	0	2
IST	1	2	4	7	0	1	3	1	1	8	3	2	33
NCR	1	4	0	2	1	2	4	4	1	0	1	0	20
TOTAL	**21**	**21**	**26**	**29**	**15**	**25**	**19**	**18**	**6**	**12**	**18**	**15**	**225**



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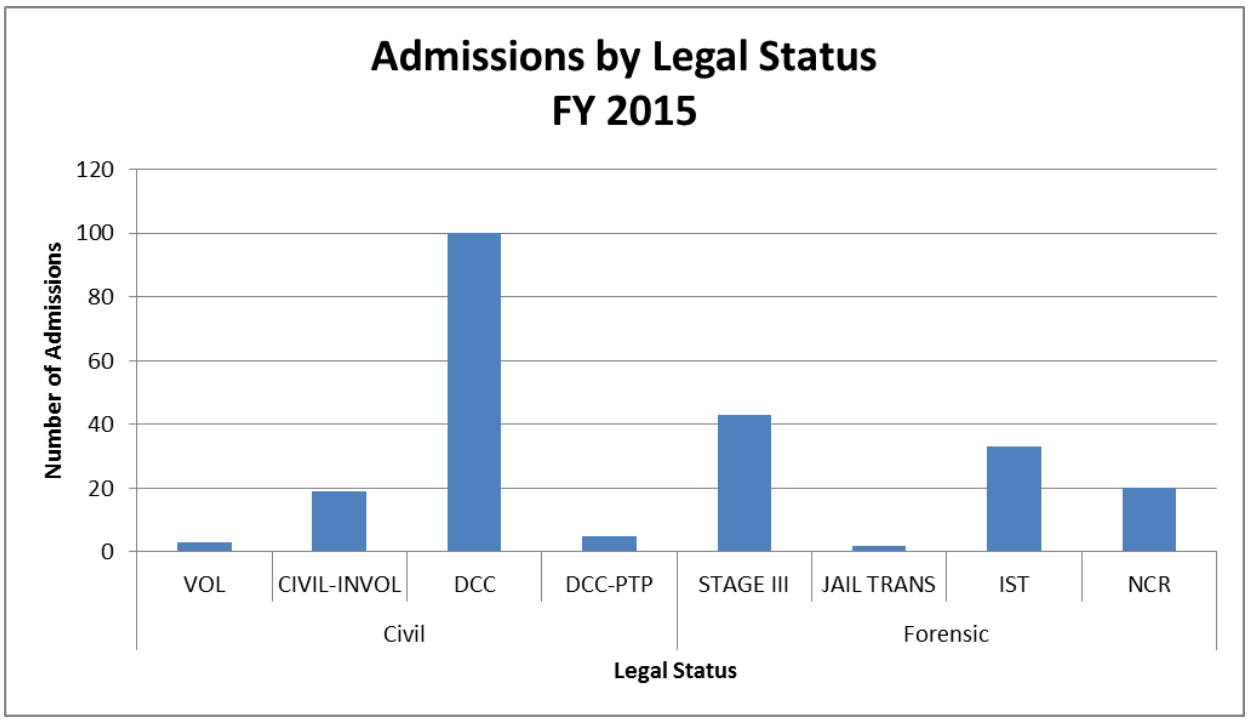
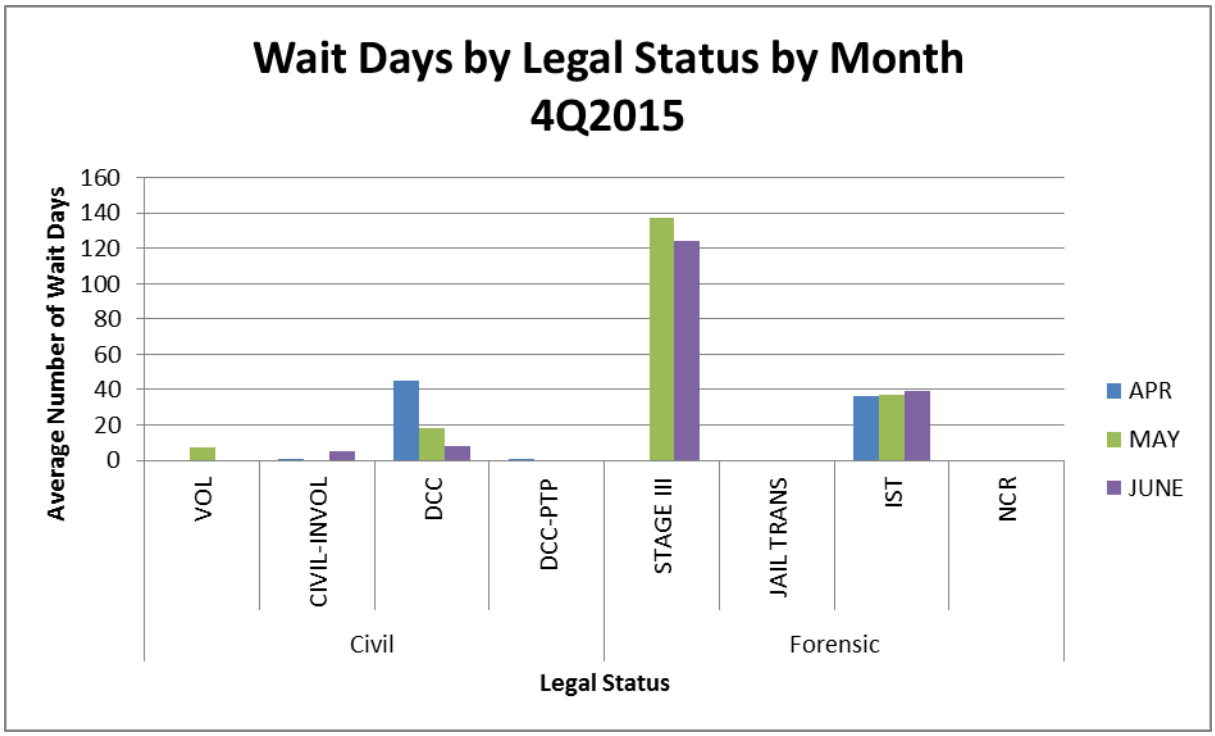
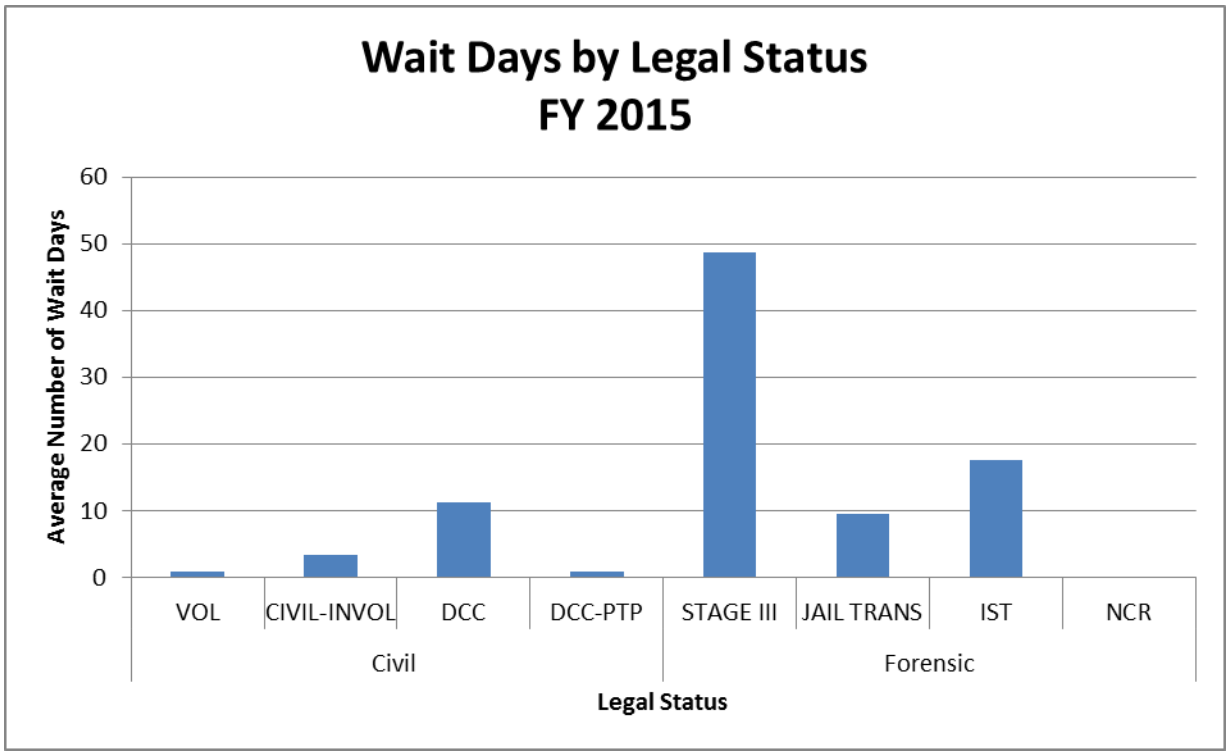


Average Number of Wait Days:

WAIT DAYS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	AVG
CIVIL:	**7**	**5**	**6**	**8**	**7**	**9**	**7**	**5**	**6**	**23**	**16**	**7**	**9**
VOL	0	0	0	2	0	1	0	0	0	0	7	0	**1**
CIVIL-INVOL	1	2	3	6	0	8	0	4	10	1	0	5	**3**
DCC	10	6	7	6	7	11	7	5	5	45	18	8	**11**
DCC-PTP	6	0	1	0	0	0	0	2	0	1	0	0	**1**
FORENSIC:	**9**	**5**	**15**	**19**	**43**	**24**	**10**	**15**	**36**	**36**	**65**	**96**	**31**
STAGE III	11	8	20	26	52	32	25	69	82	0	137	124	**49**
JAIL TRANS	7	0	0	107	0	0	0	0	0	0	0	0	**10**
IST	9	2	8	10	0	13	19	22	16	36	37	39	**18**
NCR	0	1	0	0	0	0	0	0	0	0	0	0	**0**
AVERAGE	**8**	**5**	**10**	**11**	**21**	**15**	**8**	**8**	**21**	**31**	**32**	**43**	**18**

STRATEGIC PERFORMANCE EXCELLENCE

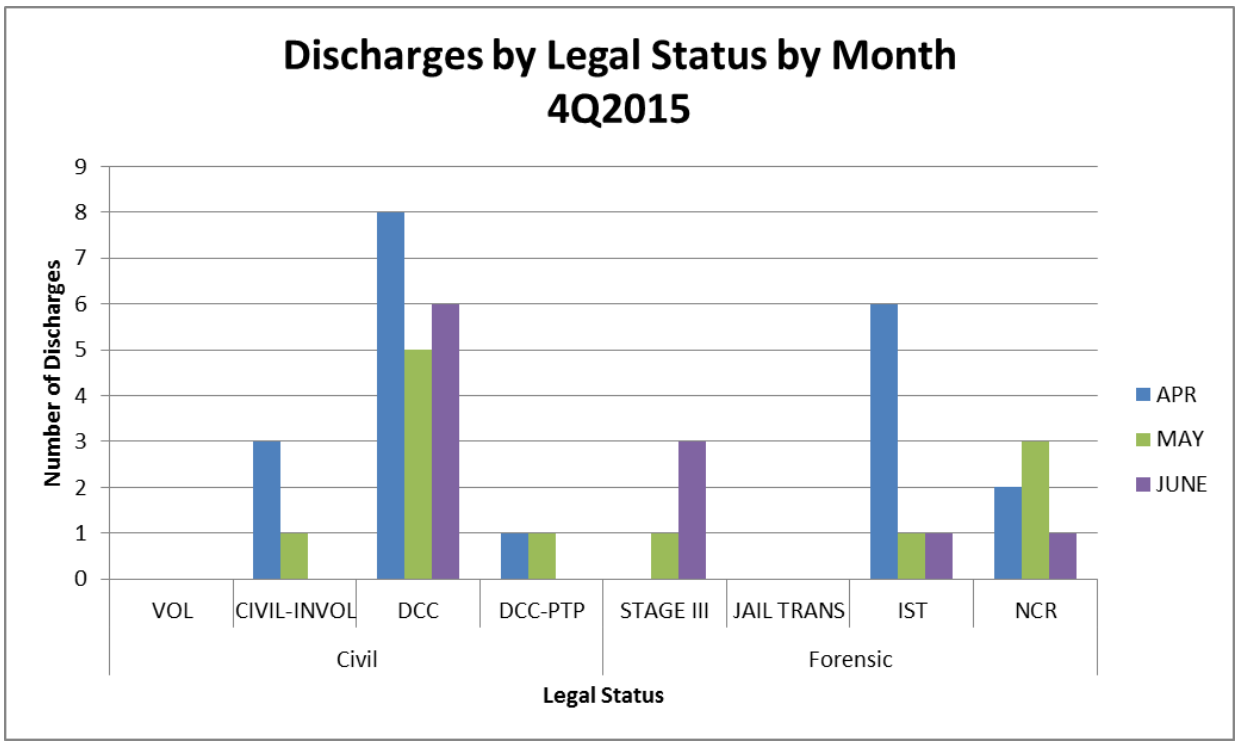




STRATEGIC PERFORMANCE EXCELLENCE

Number of Discharges:

DISCHARGES	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTAL
CIVIL:	**14**	**11**	**8**	**19**	**8**	**9**	**13**	**8**	**14**	**12**	**7**	**6**	**129**
VOL	2	0	0	0	1	0	0	0	0	0	0	0	3
CIVIL-INVOL	1	2	1	3	1	0	2	0	3	3	1	0	17
DCC	9	9	7	16	6	9	10	8	11	8	5	6	104
DCC-PTP	2	0	0	0	0	0	1	0	0	1	1	0	5
FORENSIC:	**7**	**6**	**11**	**7**	**9**	**11**	**7**	**10**	**4**	**8**	**5**	**5**	**90**
STAGE III	5	3	6	3	3	5	5	2	1	0	1	3	37
JAIL TRANS	0	1	0	0	0	0	1	0	0	0	0	0	2
IST	2	1	3	3	4	4	1	2	1	6	1	1	29
NCR	0	1	2	1	2	2	0	6	2	2	3	1	22
TOTAL	**21**	**17**	**19**	**26**	**17**	**20**	**20**	**18**	**18**	**20**	**12**	**11**	**219**



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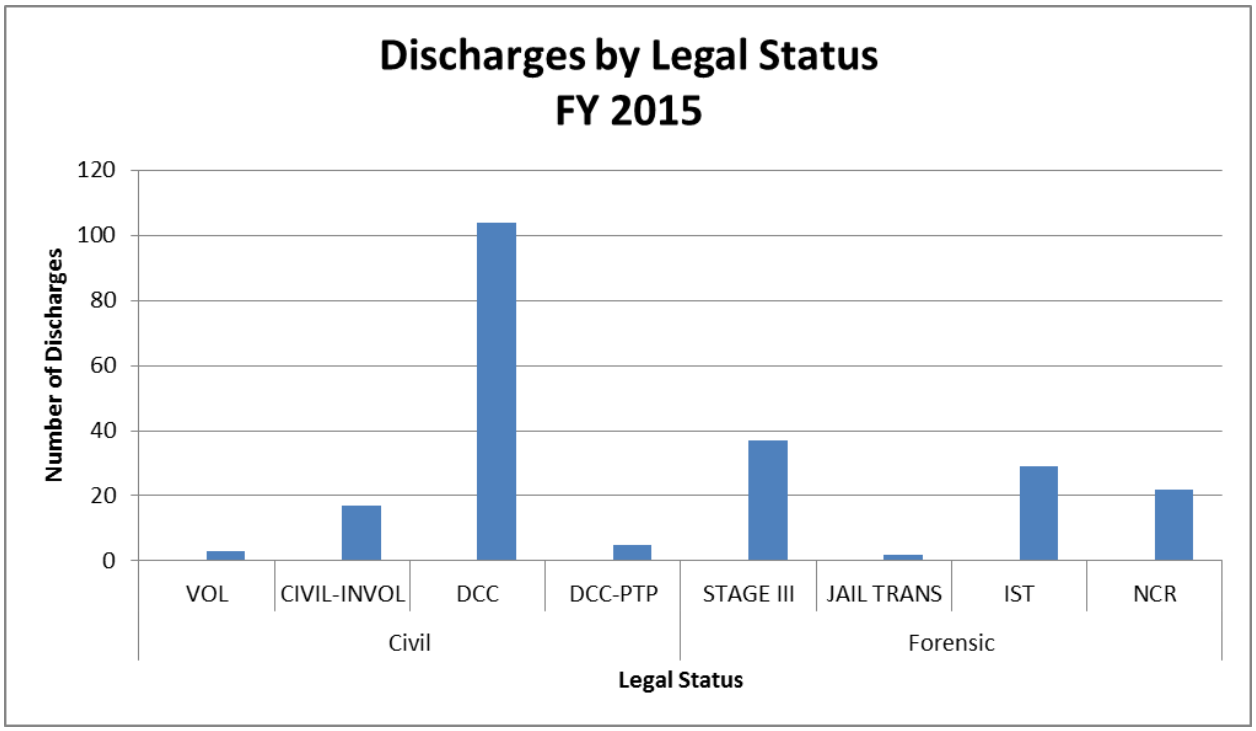
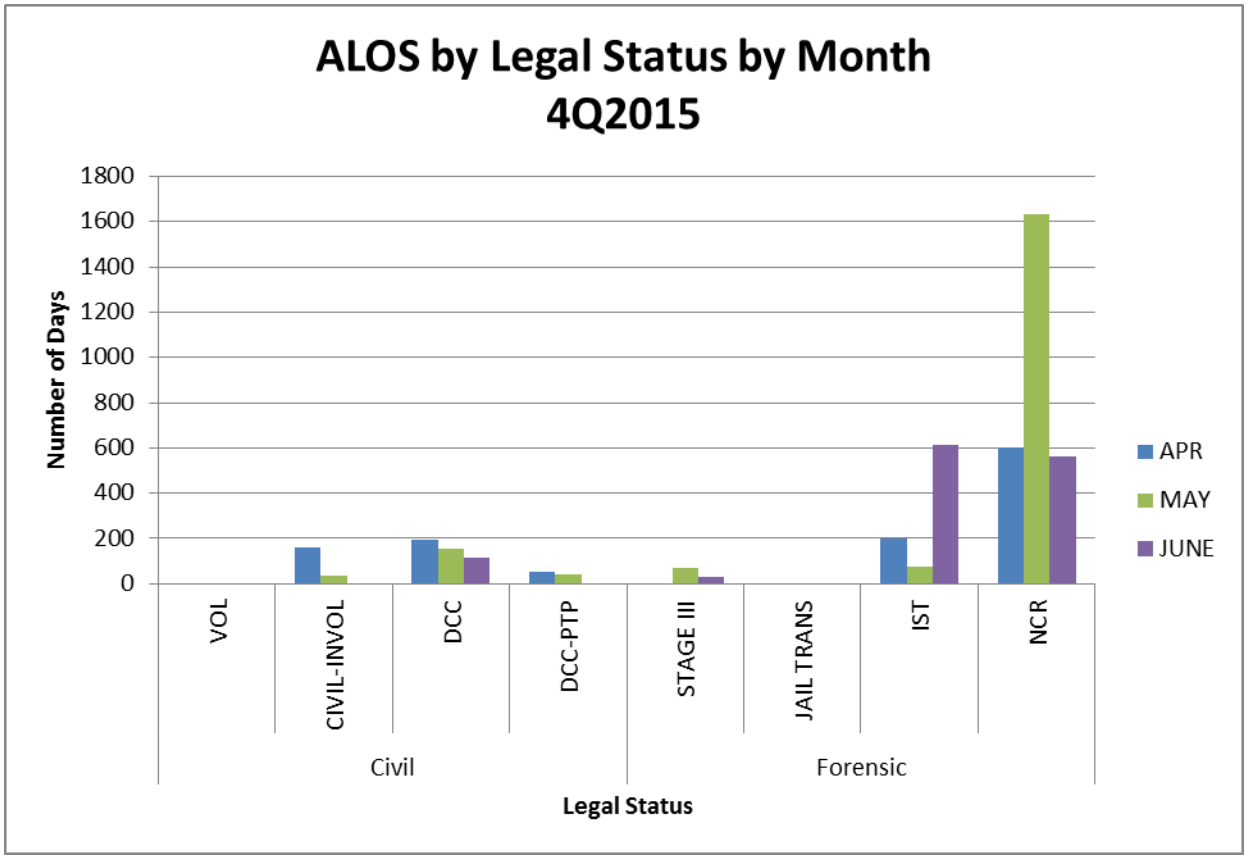
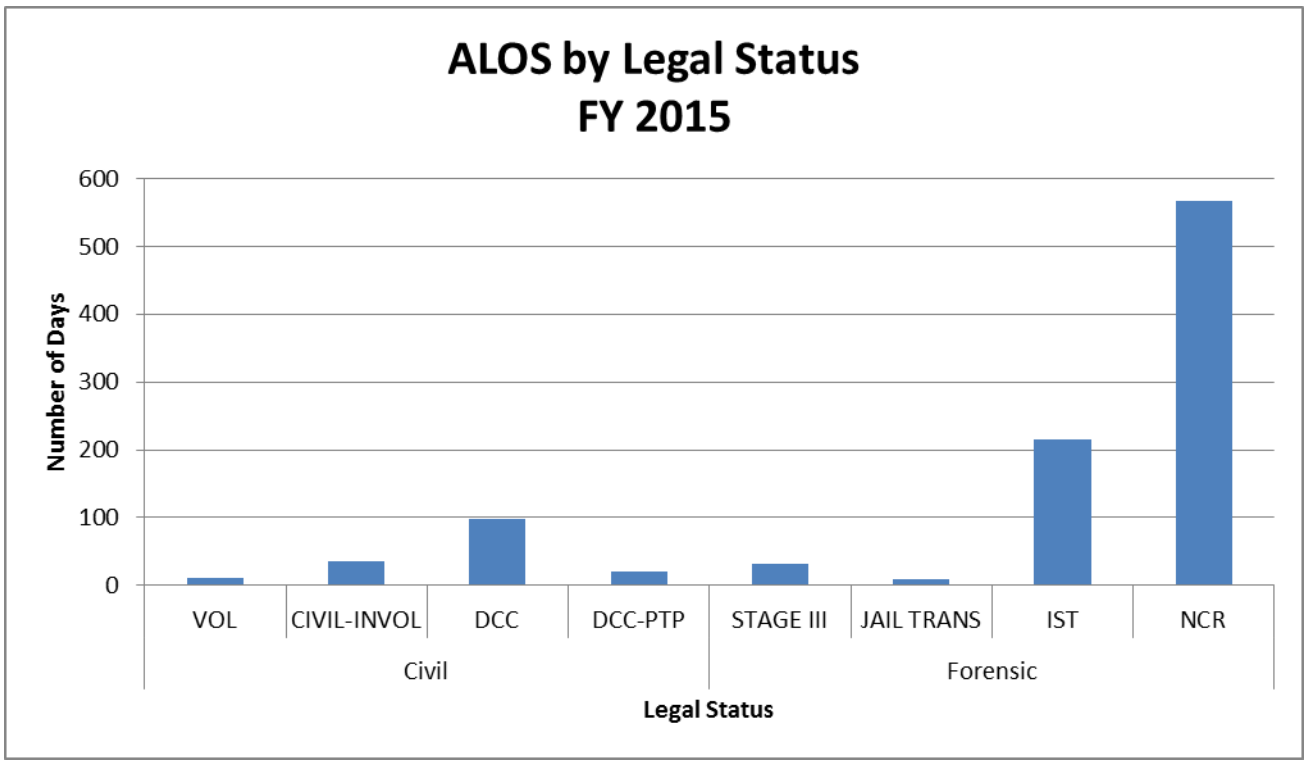


Average Length of Stay (Days):

ALOS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	AVG
CIVIL:	**90**	**69**	**77**	**80**	**68**	**51**	**47**	**54**	**141**	**173**	**117**	**116**	**90**
VOL	87	0	0	0	56	0	0	0	0	0	0	0	12
CIVIL-INVOL	12	32	12	32	30	0	59	0	63	160	33	0	36
DCC	108	78	86	94	77	51	39	54	120	193	157	116	98
DCC-PTP	51	0	0	0	0	0	104	0	0	55	40	0	21
FORENSIC:	**80**	**160**	**111**	**113**	**249**	**193**	**69**	**895**	**61**	**59**	**1007**	**251**	**271**
STAGE III	24	27	21	50	32	19	51	39	28	0	71	28	33
JAIL TRANS	0	14	0	0	0	0	99	0	0	0	0	0	9
IST	222	348	293	148	88	84	133	240	152	199	73	611	216
NCR	0	517	106	198	898	847	0	1412	40	602	1630	561	568
AVERAGE	**85**	**101**	**96**	**98**	**164**	**129**	**55**	**521**	**124**	**224**	**488**	**177**	**180**

STRATEGIC PERFORMANCE EXCELLENCE





STRATEGIC PERFORMANCE EXCELLENCE

Capital Community Clinic
Dental Clinic

Responsible Party: Jodi Bennett, Dental Hygienist, on behalf of Dr. Ingrid Prikryl, Dentist

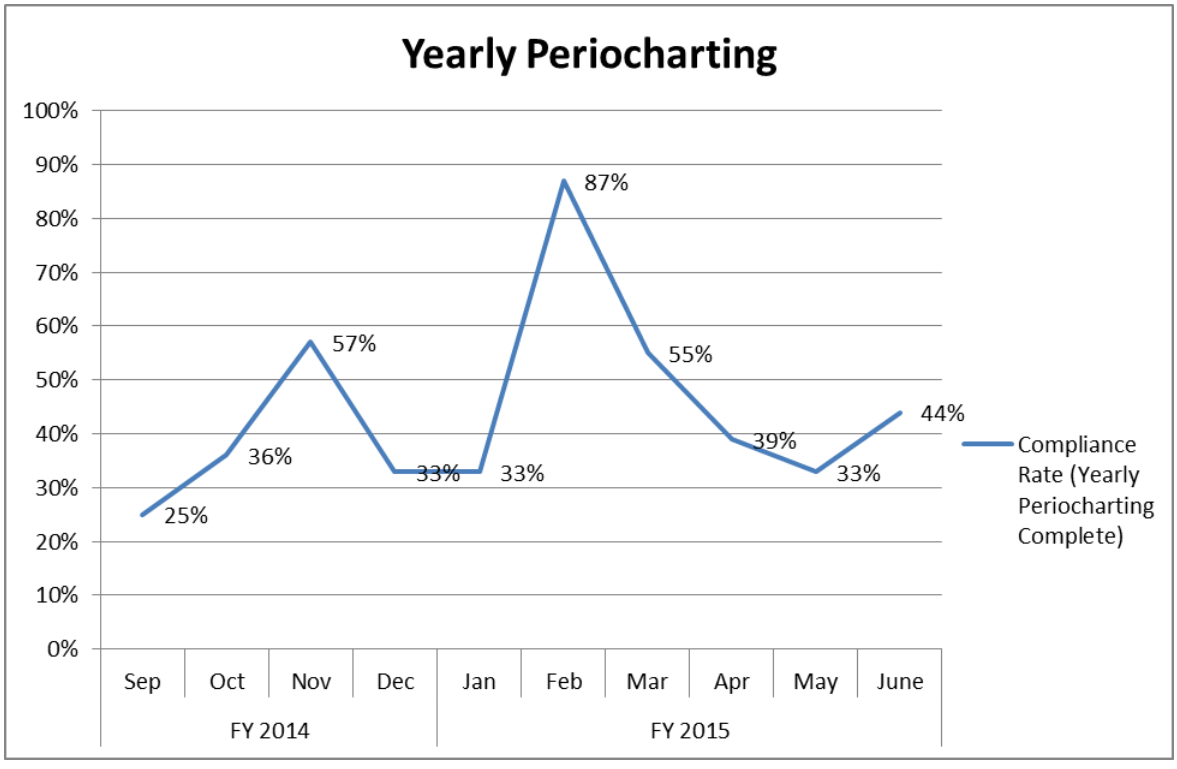
Indicator: Yearly Periocharting
Measure Description: Whether or not periocharting was completed on every patient.

Goal: The goal is to eventually have periocharting completed on every patient. We would like to be at 50% within the next 6 months, and 60% within the next year.

Current Status: Less than 40%.

Results:

Yearly Periocharting	FY 2014				FY 2015					
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Completed	32	54	62	50	33	60	57	42	28	64
Not Completed	129	147	108	149	112	69	103	108	84	145
Compliance Rate	25%	36%	57%	33%	33%	87%	55%	39%	33%	44%



STRATEGIC PERFORMANCE EXCELLENCE

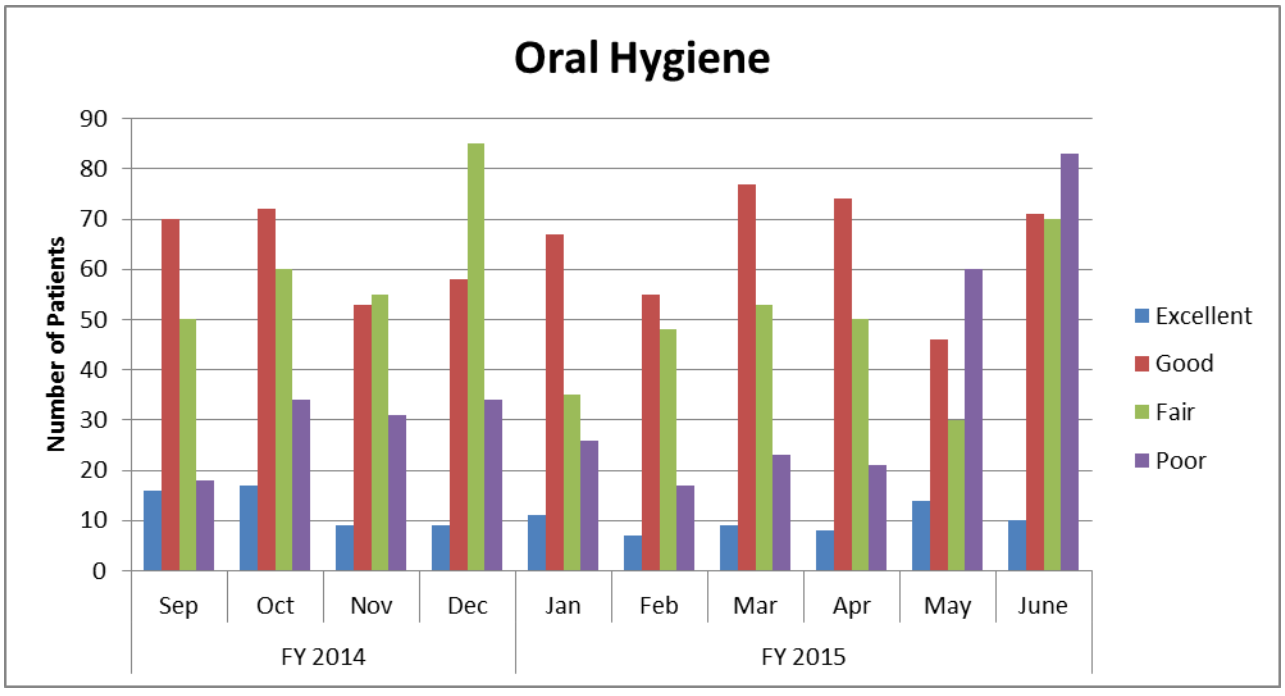
Indicator: Oral Hygiene
Measure Description: Monitor and record each patient's level of oral hygiene.

Goal: See an increase in excellent/good and a decrease in fair/poor within the next 12 months.

Current Status: 753 of 1636 patients have excellent or good oral hygiene (46%). 883 of 1636 patients have fair or poor oral hygiene (54%).

Results:

Level of Oral Hygiene	FY 2014				FY 2015					
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Excellent	16	17	9	9	11	7	9	8	14	10
Good	70	72	53	58	67	55	77	74	46	71
Fair	50	60	55	85	35	48	53	50	30	70
Poor	18	34	31	34	26	17	23	21	60	83



Action Steps: Educating patients on brushing their teeth daily and its importance for proper oral care and retention of teeth.

STRATEGIC PERFORMANCE EXCELLENCE

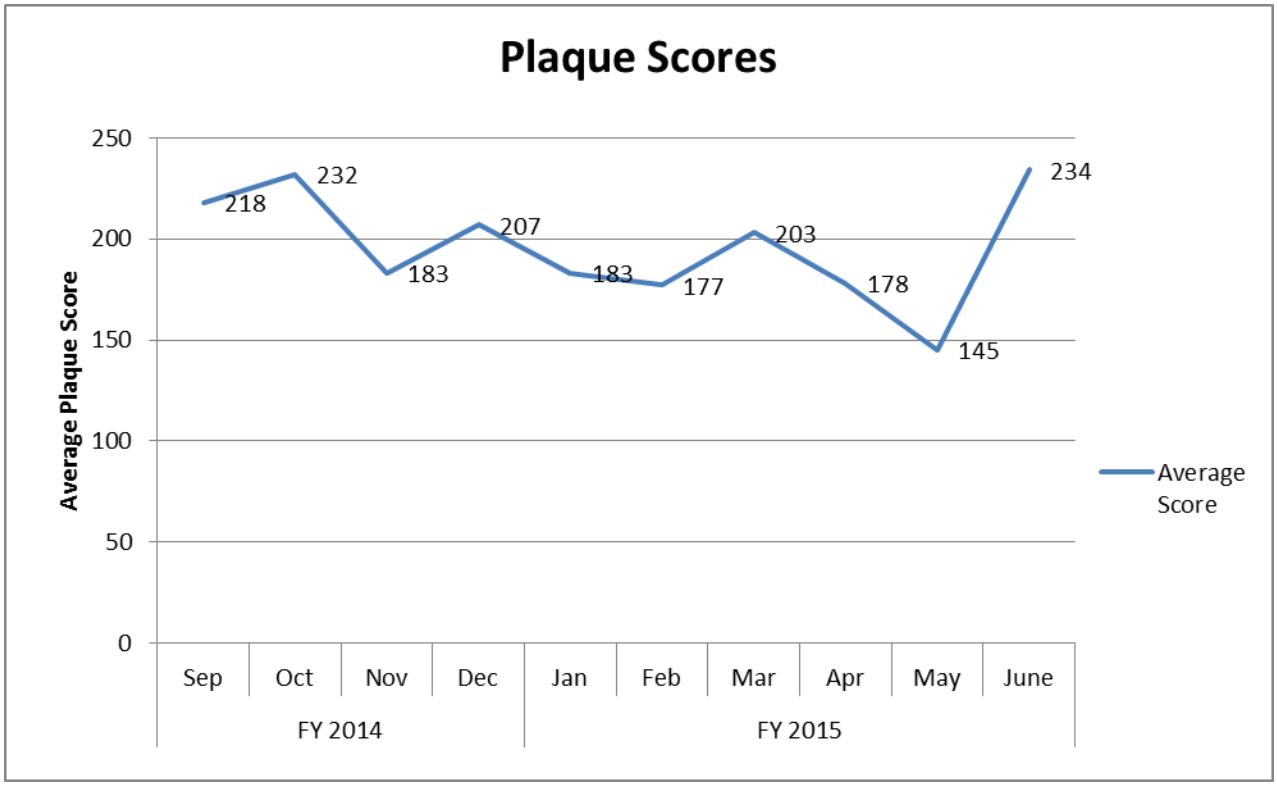
Indicator: Plaque Score
Measure Description: Monitor and record each patient's plaque score. A smaller score demonstrates less plaque on the patient's teeth and improved oral hygiene.

Goal: See a decrease in plaque store within next 6 months with proper oral hygiene instructions.

Current Status: Plaque scores ranged from 145-234. The average score was 196.

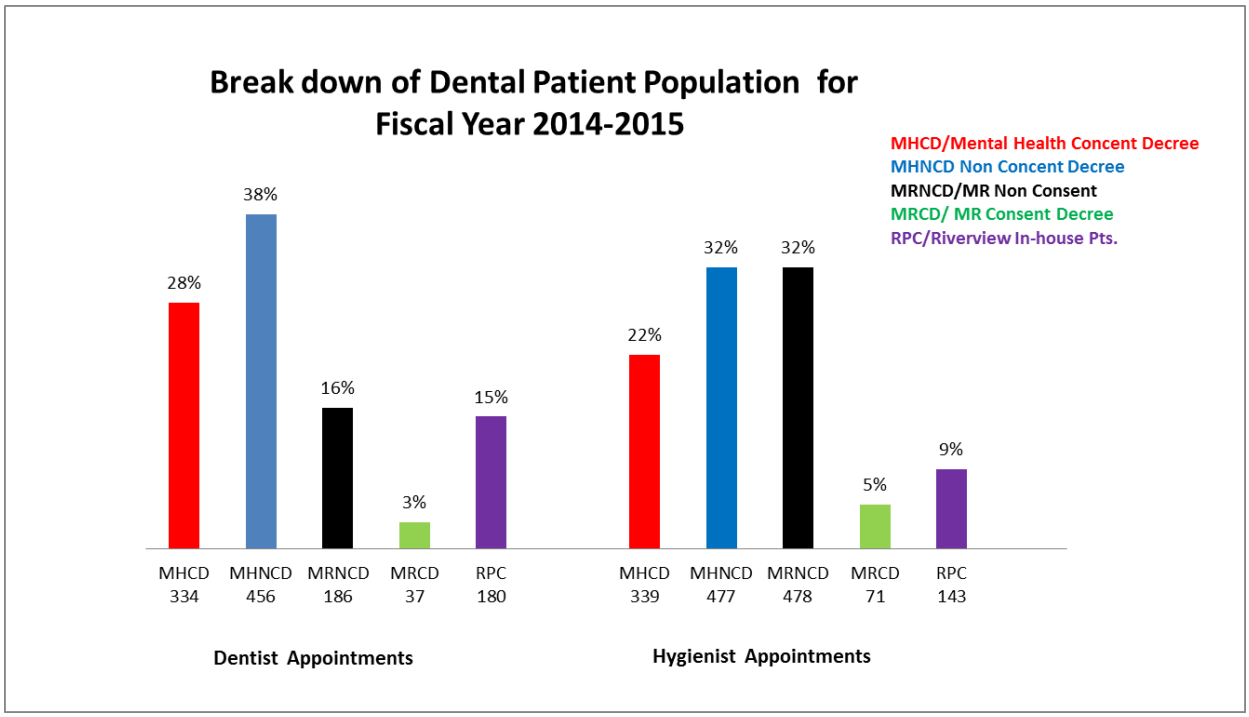
Results:

Plaque Score	FY 2014				FY 2015					
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Average Score	218	232	183	207	183	177	203	178	145	234



STRATEGIC PERFORMANCE EXCELLENCE

Responsible Party: Robin Weeks, Medical Assistant



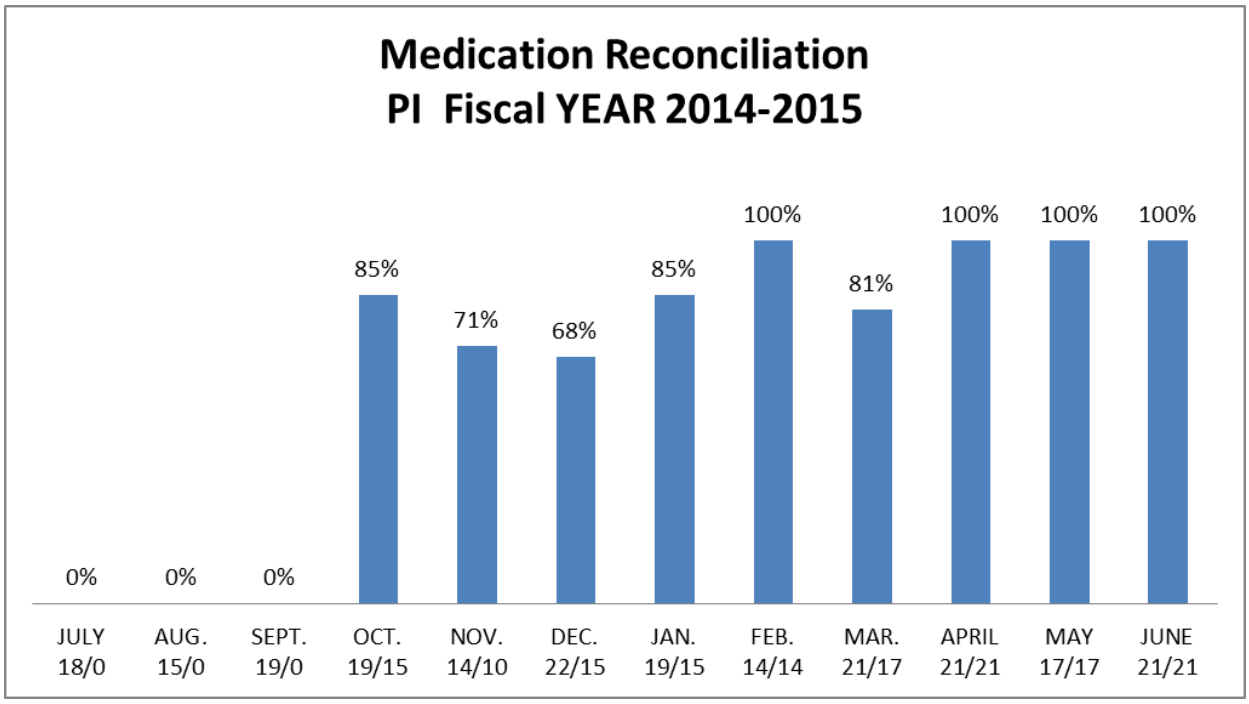
STRATEGIC PERFORMANCE EXCELLENCE

Capital Community Clinic
Medication Management Clinic

Responsible Party: Robin Weeks, Medical Assistant

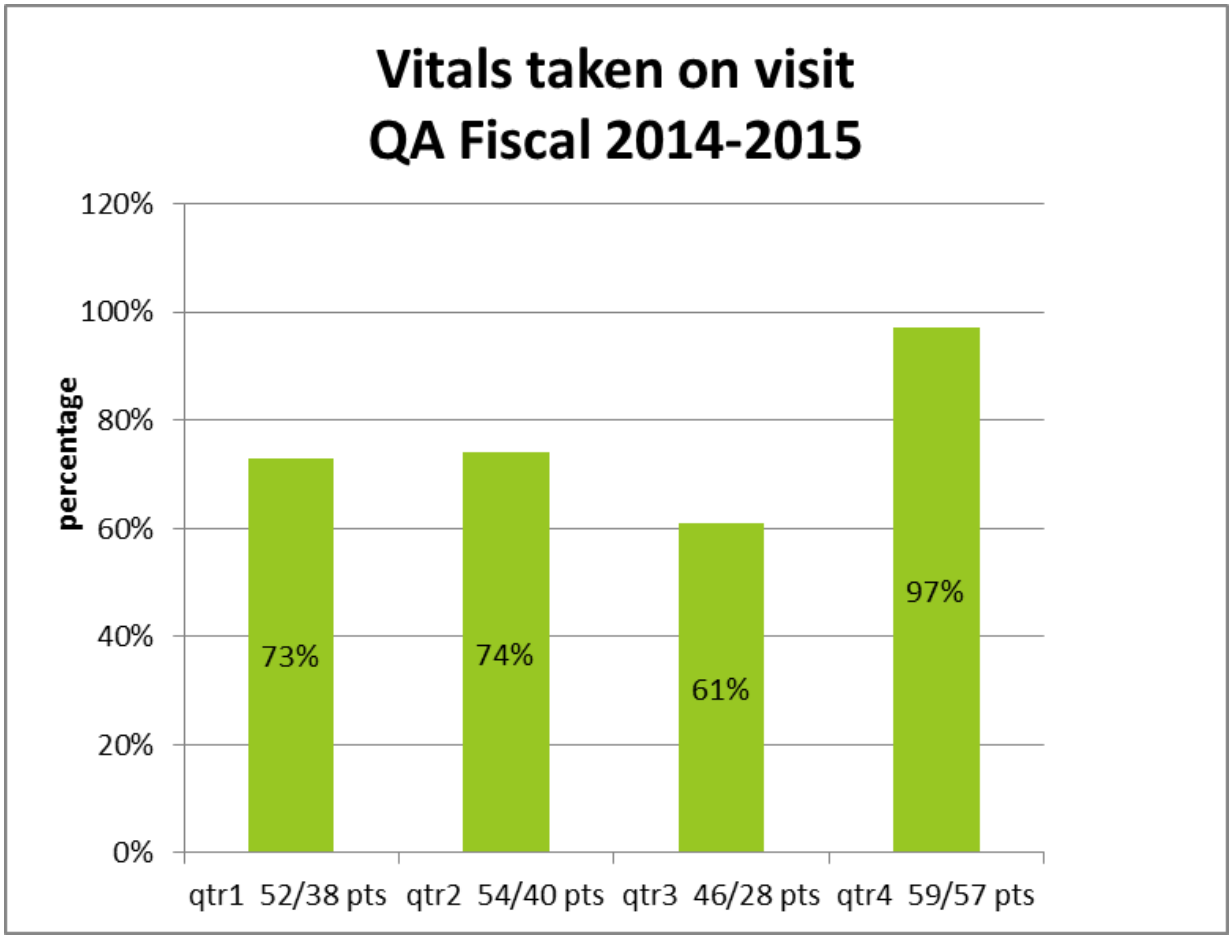
Measure Name: Reconciliation of Medication List
Measure Description: Each visit will cover reconciliation of medical & psychotropic medications with patients.
Measure Type: Performance Improvement

Goal: Medication reconciliation performed at 100% of visits.



STRATEGIC PERFORMANCE EXCELLENCE

Measure Name: Vital Signs
Measure Description: Taking vital signs each visit will give us an idea of the effects of the prescribed medications and early detection of possible medical problems with the patient.
Measure Type: Quality Improvement



STRATEGIC PERFORMANCE EXCELLENCE

Dietary Services

Responsible Party: Kristen Piela, Dietetic Services Manager

Hand Hygiene Compliance: In an effort to monitor, sustain and improve hand hygiene compliance, the Dietary Department measures its results through observations of Dietary Staff when returning from a scheduled break.

	1st Quarter 2015			2nd Quarter 2015			3rd Quarter 2015			4th Quarter 2015		
Baseline	Target – Baseline	Findings	Compliance	Target – Q1 + 12%	Findings	Compliance	Target – Q2 + 12%	Findings	Compliance	Target – Q3 + 12%	Findings	Compliance
53%	58%	138/ 238	58%	70%	116/ 189	61%	82%	621/ 629	99%	94%	338/ 346	98%

Goal: 80-90%

Data:

- 338 compliant observations of 346 hand hygiene observations = 97.7% hand hygiene compliance rate

Summary:

- Hand hygiene compliance has decreased by 1%.
- Hand hygiene observations have decreased from 629 observations last quarter to 346 observations this quarter.
- Supervisors are consistently reminding employees to adhere to hand hygiene.
- Employees are aware of the daily observances, by the supervisory staff.

Action Plan:

- The Dietetic Services Manager will review these findings with the supervisors to assure observances are being documented correctly.
- The Dietetic Services Manager will request unplanned observations are completed by managerial staff.
- The Food Service Manager will present this quarterly report at the departmental staff meeting.

STRATEGIC PERFORMANCE EXCELLENCE

Nutrition Screen Completion: In an effort to monitor, improve and sustain timely completion of the nutrition screen for all admissions to RPC 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.

	1st Quarter 2015			2nd Quarter 2015			3rd Quarter 2015			4th Quarter 2015		
Baseline	Target – Baseline	Findings	Compliance	Target – Q1 + 3%	Findings	Compliance	Target – Q2 + 2%	Findings	Compliance	Target – Q3 + 3%	Findings	Compliance
96%	96%	75/ 80	94%	97%	71/ 72	99%	100 %	43/ 43	1005	100 %	42/ 42	100 %

Goal: 95-100%

Data:
42 Nutrition screens completed w/in 24 hours of admission
42 Total Admissions

= 100% of nutrition screens completed within 24 hours of admission

Summary:

- The Registered Dietitian (RD) reviewed the nutrition screens of 42 admissions for this quarter.
- Upon review, the RD discovered all nutrition screens complete.
- Continued correspondence with unit nursing staff has proven successful with completion of this monitor.

Action Plan:

- RD will continue to correspond with the Admissions Nurse to assure completion of the nutrition screens.
- Present quarterly report at departmental staff meeting and IPEC meeting.

STRATEGIC PERFORMANCE EXCELLENCE

Emergency Management

Responsible Party: Robert Patnaude, Emergency Management Coordinator

Measure Name: Communications Equipment/Two-way radios

Measure Description:
The Joint Commission states the following in EM.02.02.01: "As part of its Emergency Operations Plan, the hospital prepares for how it will communicate during emergencies. *The hospital maintains reliable communications capabilities for the purpose of communicating response efforts to staff, patients, and external organizations."*

In the event of an unforeseen emergency which could impact the safety and security of patients, staff, and visitors, communications equipment, more specifically, two-way radios are a major solution to getting accurate information to and from staff in a timely manner. The objective of the Emergency Management Communications PI is to ensure compliance with The Joint Commission standard with the overall objective of ensuring that the two-way radio system is fully functional and that staff are proficient in its use.

Type of Measure: Performance Improvement

Methodology: Each month, the Emergency Management Coordinator or designee will perform a combination of partial and hospital-wide radio drills. Such drills will utilize a specific form to track the drills (see attached). In conjunction with the drills, environmental rounds will be conducted for the purpose of inspecting communications equipment. Any deficiencies shall have the appropriate corrective measure immediately instituted until compliance is met.

The numerator is the number of timely and appropriate responses by staff utilizing the two-way radios by assignments. The denominator will be the total number of two-way radios by assignments.

Baseline Data: To assure that critical emergency information is disseminated in a timely and accurate manner, **a minimum of 90%** compliance has been established. This data will be reported monthly to the Emergency Management Committee, IPEC, and the Environment of Care (EOC) Committee. Areas that fail to meet the threshold will be immediately reported to the aforementioned committees.

STRATEGIC PERFORMANCE EXCELLENCE

Results							
	Unit	**Baseline**	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**
Target	Percent of timely and appropriate responses	FY 2016 90/51 90%	**	**	*76/51	141/157 90%	**187/208 90%**
Actual			**	**	*39/51	142/157 90%	**181/208 87%**

****This is a new indicator as of March 1, 2015, therefore there is no data for Q1 and Q2.
***Since this is a new indicator as of March 1st, there is only data for March of Q3.

Data Analysis: With a significant amount of hands-on demonstrations, radio tests, and an increase in the use of radios, data showed that staff have become very familiar with operating the radio on the primary channel and have improved in the use beyond the primary channel such as the TAC channel.

Action Plan: Continued tests and remedial training to staff along with supporting handouts as needed.

Comments: Units have been timely in the initial response.

STRATEGIC PERFORMANCE EXCELLENCE

Areas/Groups Monitored N = Numerator D = Denominator	MAR 2015	APR 2015	MAY 2015	JUN 2015	JUL 2015	AUG 2015	SEPT 2015	OCT 2015	NOV 2015	DEC 2015
Patient Care Areas/ # of radios										
• Job Coach/1	1 1*	1 1	1 1*	1 1						
• OPS/2	2 2*	2 2	2 2*	2 2						
• Tx Mall, Clinic, Dietary, Med Rec/5	5 5*	5 5	5 5*	5 5						
• US, UK, LS, LSSCU, LK, LKSCU/10	0 10	0 10	10 10	10 10						
Support Services/ # of radios										
• Administration/3	3 3*	3 3	3 3*	3 3						
• Housekeeping/8	8 8*	8 8	9 10**	10 10						
• Maintenance/14	14 14*	14 14	14 14	14 14						
• NOD/1	0 1	0 1	1 1	1 1						
• Nursing Services/1	1 1*	1 1	1 1	1 1						
• Operations/1	1 1	1 1	1 1	1 1						
• Security/4	4 4	4 4	4 4	4 4						
• State Forensic Services/1	1 1*	1 1	1 1	1 1						
Patient Care Areas	**7** **18**	**7** **18**	**18** **18**	**18** **18**						
Support Services	**32** **33**	**32** **33**	**31** **35**	**32** **35**						
Total	**39** **51**	**39** **51**	**50** **53**	**53** **53**						

*Radio units not on duty due to shift assignment therefore given same weight in order not to have a negative impact.

**Housekeeper turned off radio prior to end of shift. Remedial training completed with staff. Also note: We added (2) more radios to Housekeeping Staff, resulting in a denominator increase to (10).

STRATEGIC PERFORMANCE EXCELLENCE

Harbor Treatment Mall

Responsible Party: Rebecca Eastman, RN

Measure: Harbor Mall Hand-off Communication
Overall Compliance: 75%

Objectives	1Q2015	2Q2015	3Q2015	4Q2015
1. Hand-off communication sheet was received at the Harbor Mall within the designated time frame.	71% 30/42	76% 32/42	86% 36/42	76% 32/42
2. SBAR information completed from the units to the Harbor Mall.	81% 34/42	86% 36/42	86% 36/42	74% 31/42

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

Measure: Indicator 1 has increased from 86% last quarter to 76% for this quarter. Indicator 2 has decreased from 86% last quarter to 74% this quarter.

Analyze: Overall compliance has decreased from 86% last quarter to 75% for this quarter. Indicator 1 increased, decreased and decreased for the three months. Indicator 2 decreased all three months. Six HOC sheets were late for last quarter and six HOC were late for this quarter. Continue to concentrate on both indicators to improve current performance gaps.

Improve: Results will be reviewed with the Director of Nursing.

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.

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Responsible Party: Amy Tasker, Director of Health Information

Documentation and Timeliness:

Indicators	4Q15 Findings	4Q15 Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	There were 43 discharges. Of those, 43 were completed within 30 days.	100%	80%
Discharge summaries will be completed within 15 days of discharge.	43 out of 43 discharge summaries were completed within 15 days of discharge.	100%	100%
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	2 forms were approved/ revised (see minutes).	100%	100%
Medical transcription will be timely and accurate.	Out of 919 dictated reports, 919 were completed within 24 hours.	100%	90%

Summary: The indicators are based on the review of all discharged records. There was 100% compliance with 30 day record completion. Weekly "charts needing attention" lists are distributed to medical staff, including the Clinical 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

Confidentiality:

Indicators	4Q15 Findings	4Q15 Compliance	Threshold Percentile
All patient information released from the Health Information Department will meet all Joint Commission, State, Federal & HIPAA standards.	4,163 requests for information (186 requests for patient information and 3,977 police checks) were released.	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	23 new employees/contract staff.	100%	100%
Confidentiality/privacy issues tracked through incident reports.	0 privacy-related incident reports.		

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 4Q2015 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

Medical Record Compliance – April 2015:

Indicators	April 2015 Findings	Compliance	Threshold Percentile
All progress notes are authenticated within 7 days	362 progress notes were created for April. Out of those 3 were not authenticated within 7 days.	99%	90%
Discharge instructions are in a manner that the patient and/or family member/caregiver understand.	20 closed records were reviewed, 20 of those included the discharge pharmacy labels, 19 were documented that medication teaching was completed In in patient friendly language at discharge.	100%	90%

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.

Actions: The above indicators will be reviewed for 4 consecutive months (beginning in January 2014) providing review yields 90% threshold or above per TJC corrective action plan

STRATEGIC PERFORMANCE EXCELLENCE

Medical Record Compliance – May 2015:

Indicators	May 2015 Findings	Compliance	Threshold Percentile
All progress notes are authenticated within 7 days	441 progress notes were created for February.	100%	90%
Discharge instructions are in a manner that the patient and/or family member/caregiver understand.	12 closed records were reviewed, 12 of those included the discharge pharmacy labels, 12 were documented that medication teaching was completed in patient friendly language at discharge.	100%	90%

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.

Actions: The above indicators will be reviewed for 4 consecutive months (beginning in January 2014) providing review yields 90% threshold or above per TJC corrective action plan.

STRATEGIC PERFORMANCE EXCELLENCE

Medical Record Compliance – June 2015:

Indicators	June 2015 Findings	Compliance	Threshold Percentile
All progress notes are authenticated within 7 days	410 progress notes were created for June.	100%	90%
Discharge instructions are in a manner that the patient and/or family member/caregiver understand.	11 closed records were reviewed, 11 of those included the discharge pharmacy labels, 11 were documented that medication teaching was completed in patient friendly language at discharge.	100%	90%

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.

Actions: The above indicators will be reviewed for 4 consecutive months (beginning in January 2014) providing review yields 90% threshold or above per TJC corrective action plan.

STRATEGIC PERFORMANCE EXCELLENCE

Discharge Instructions Process Improvement – April 2015:

Define:
The hospital provides written discharge instructions in a manner that the patient and/or patient's family member or caregiver can understand.

Measure:
20 discharges in April 2015 were reviewed. The consolidated aftercare forms are being utilized as a form of discharge instruction and accompanying the aftercare forms are the pharmacy labels which clearly define the medication, its frequency, and its use.

Analyze:
After review of 18 closed charts the following was discovered; 1 chart is missing the pharmacy labels required for discharge. One chart had med education in patient friendly language, however, it was not signed by the patient.

- J.R. – No med education in patient friendly manner selected (discharged to supervised apartment).

Improve:
Improvements could be made by assessing the discharge process to ensure pharmacy labels are being created for all patients leaving the facility with medications. Improvement could be made by utilizing typed formats. Currently a "page four of the aftercare" has been created and implemented as a work type in Meditech by transcription. All providers have access to use that and are encouraged to use it. Also, as we utilize the aftercare format as the discharge instruction it has been made available as a fillable form electronically. **Please note the use of abbreviations is strongly discouraged in the discharge instructions. Handwriting is also discouraged.**

A Performance Improvement Team has been developed and has had its first meeting on May 4 to review the discharge planning process. It is ongoing at this time.

Control: 100% of the closed records are being audited.

STRATEGIC PERFORMANCE EXCELLENCE

Discharge Instructions Process Improvement – May 2015:

Define:
The hospital provides written discharge instructions in a manner that the patient and/or patient's family member or caregiver can understand.

Measure:
12 discharges in May 2015 were reviewed. The consolidated aftercare forms are being utilized as a form of discharge instruction and accompanying the aftercare forms are the pharmacy labels which clearly define the medication, its frequency, and its use.

Analyze:
After review of 12 closed charts the following was discovered: no significant findings for the month of May 2015.

Improve:
Improvements could be made by assessing the discharge process to ensure pharmacy labels are being created for all patients leaving the facility with medications. Improvement could be made by utilizing typed formats. Currently a "page four of the aftercare" has been created and implemented as a work type in Meditech by transcription. All providers have access to use that and are encouraged to do so. Also, as we utilize the aftercare format as the discharge instruction it has been made available as a fillable form electronically. **Please note the use of abbreviations is strongly discouraged in the discharge instructions. Handwriting is also discouraged.**

A Performance Improvement Team has been developed and has had its first meeting on May 4 to review the discharge planning process. It is ongoing at this time.

Control: 100% of the closed records are being audited.

STRATEGIC PERFORMANCE EXCELLENCE

Discharge Instructions Process Improvement – June 2015:

Define:
The hospital provides written discharge instructions in a manner that the patient and/or patient's family member or caregiver can understand.

Measure:
11 discharges in June 2015 were reviewed. The consolidated aftercare forms are being utilized as a form of discharge instruction and accompanying the aftercare forms are the pharmacy labels which clearly define the medication, its frequency, and its use.

Analyze:
After review of 11 closed charts the following was discovered: no significant findings for the month of June 2015.

Improve:
Improvements could be made by assessing the discharge process to ensure pharmacy labels are being created for all patients leaving the facility with medications. Improvement could be made by utilizing typed formats. Currently a "page four of the aftercare" has been created and implemented as a work type in Meditech by transcription. All providers have access to use that and are encouraged to do so. Also, as we utilize the aftercare format as the discharge instruction it has been made available as a fillable form electronically. **Please note the use of abbreviations is strongly discouraged in the discharge instructions. Handwriting is also discouraged.**

A Performance Improvement Team has been developed and has had its first meeting on May 4 to review the discharge planning process. It is ongoing at this time.

Control: 100% of the closed records are being audited.

STRATEGIC PERFORMANCE EXCELLENCE

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. Patients 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 4Q2015 showed that we received 1961 applications. This is a decrease from last quarter 3Q2015 when we received 2055 applications.

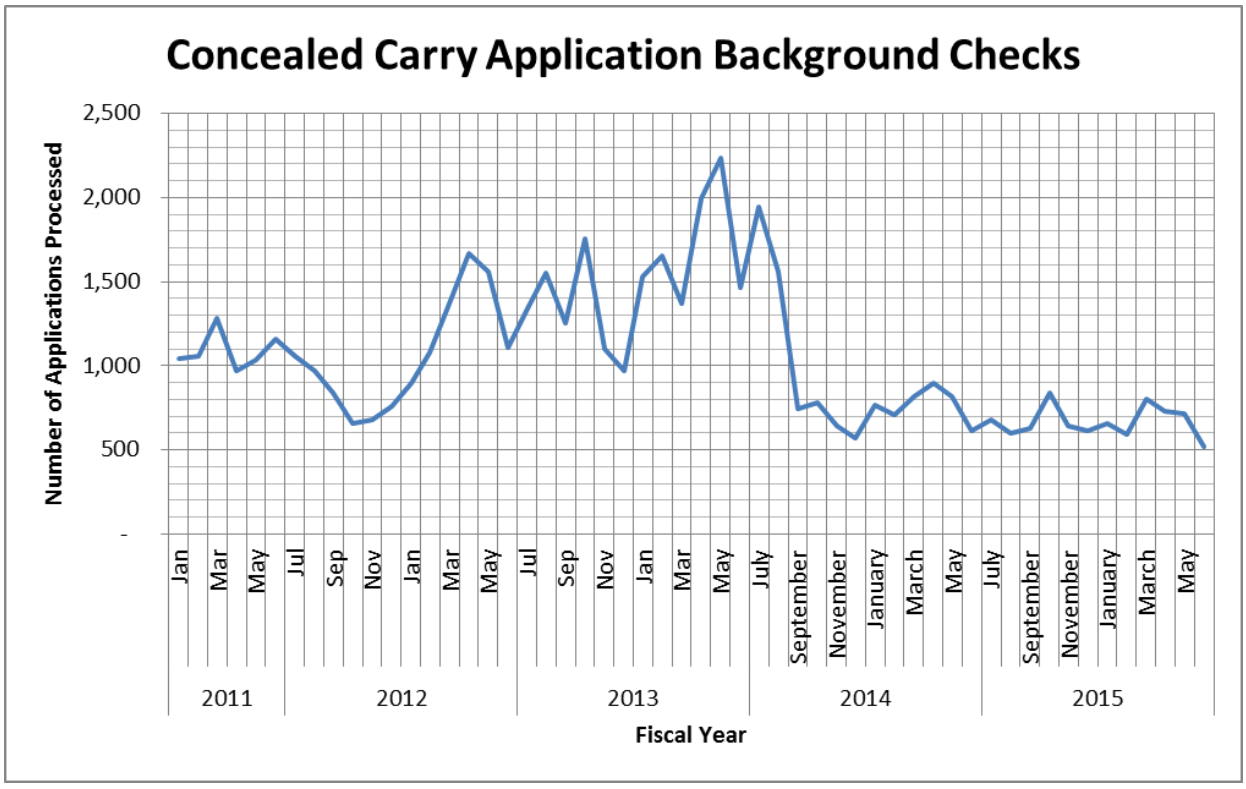
Improve:
The process has been streamlined as we have been working with the state police by eliminating the mailing of the applications from them to RPC and DDPC. RPC has reactivated the medical records email to receive lists of the applicants from the state police that include the DOB and any alias they may have had. This has cut down on paper as well as time taken sorting all the applications.

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. This is ongoing.

Year	FY 2015												Total
Month	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
# Applications Received	681	598	629	842	640	612	655	594	806	732	713	516	8018

STRATEGIC PERFORMANCE EXCELLENCE



STRATEGIC PERFORMANCE EXCELLENCE

Housekeeping

Responsible Party: Debora Proctor, Housekeeping Supervisor

Indicator: Patient Living Area
The Housekeeping Department will maintain an acceptable standard of cleanliness and sanitation in patient living areas.

Measure Description: The Housekeeping Supervisor or designee will perform a monthly inspection of the patient living area and record the findings on the Housekeeping Inspection Form. Any unit not meeting the threshold will be inspected every two weeks until compliance is met.

Method of Monitoring: Inspection scores will be summarized monthly. Patient areas that fail to meet the threshold will be reported to the IPEC group, EOC, and the Director of Support Services. This report will include any actions taken.

Results:

Unit	Threshold	April 2015	May 2015	June 2015	4Q2015
1. Lower Saco	85%	94%	90%	88%	91%
2. Upper Saco	85%	88%	88%	88%	88%
3. Lower Kennebec	85%	84%	84%	86%	85%
4. Upper Kennebec	85%	92%	90%	88%	90%

Overall Average: 88%

Data Analysis: Housekeeping Supervisor inspected units monthly.

Action Plan: Housekeeping Supervisor will continue to do monthly inspections to assure that cleanliness of the environment continues to improve.

STRATEGIC PERFORMANCE EXCELLENCE

Human Resources

Person Responsible: Aimee Rice, Human Resources Manager

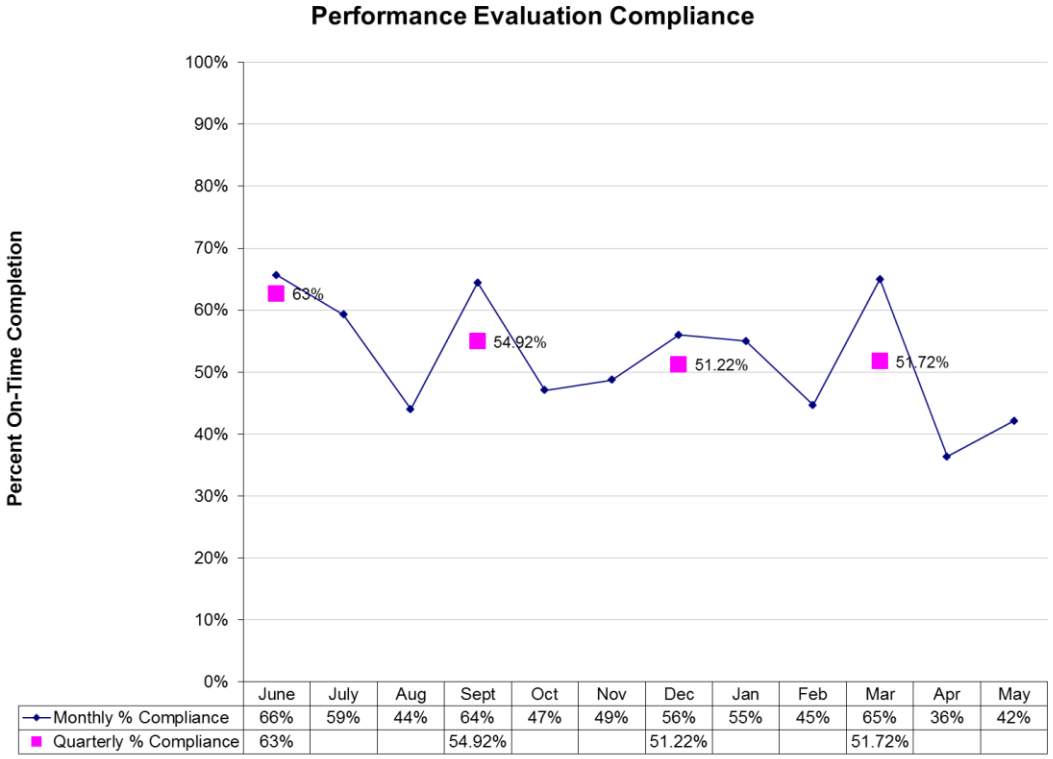
Define:
Completion of performance evaluations according to scheduled due dates continues to be problematic.

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 Human Resources Manager 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.

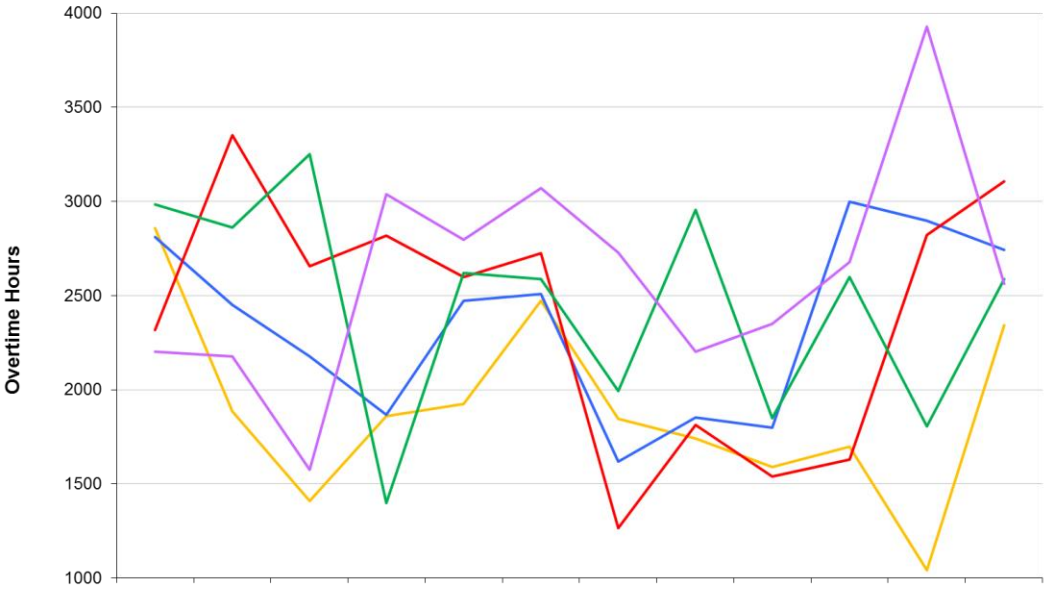


	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Monthly % Compliance	66%	59%	44%	64%	47%	49%	56%	55%	45%	65%	36%	42%
Quarterly % Compliance	63%			54.92%			51.22%			51.72%		

*Data not yet available for June 2015

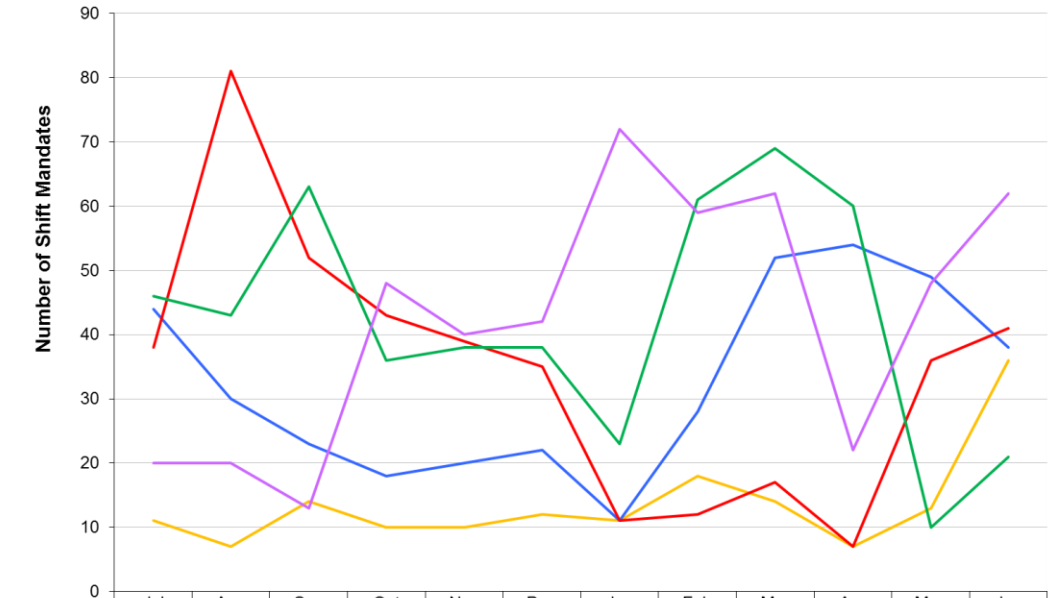
STRATEGIC PERFORMANCE EXCELLENCE

Monthly Overtime



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2011	2859	1885	1411	1860	1926	2474	1844	1740	1589	1697	1042	2342
FY 2012	2812	2451	2178	1868	2473	2507	1618	1853	1798	2999	2896	2743
FY 2013	2316	3350	2657	2817	2599	2726	1266	1812	1539	1629	2822	3106
FY 2014	2983	2861	3251	1400	2620	2586	1994	2954	1848	2599	1806	2586
FY 2015	2204	2177	1575	3040	2797	3070	2729	2203	2351	2677	3927	2562

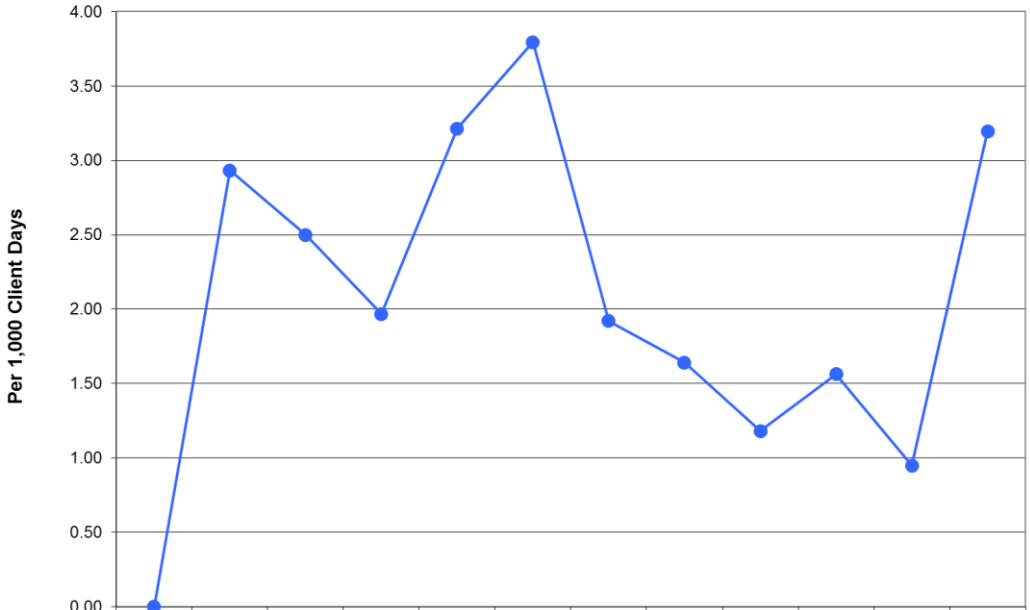
Monthly Mandated Shifts



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2011	11	7	14	10	10	12	11	18	14	7	13	36
FY 2012	44	30	23	18	20	22	11	28	52	54	49	38
FY 2013	38	81	52	43	39	35	11	12	17	7	36	41
FY 2014	46	43	63	36	38	38	23	61	69	60	10	21
FY 2015	20	20	13	48	40	42	72	59	62	22	48	62

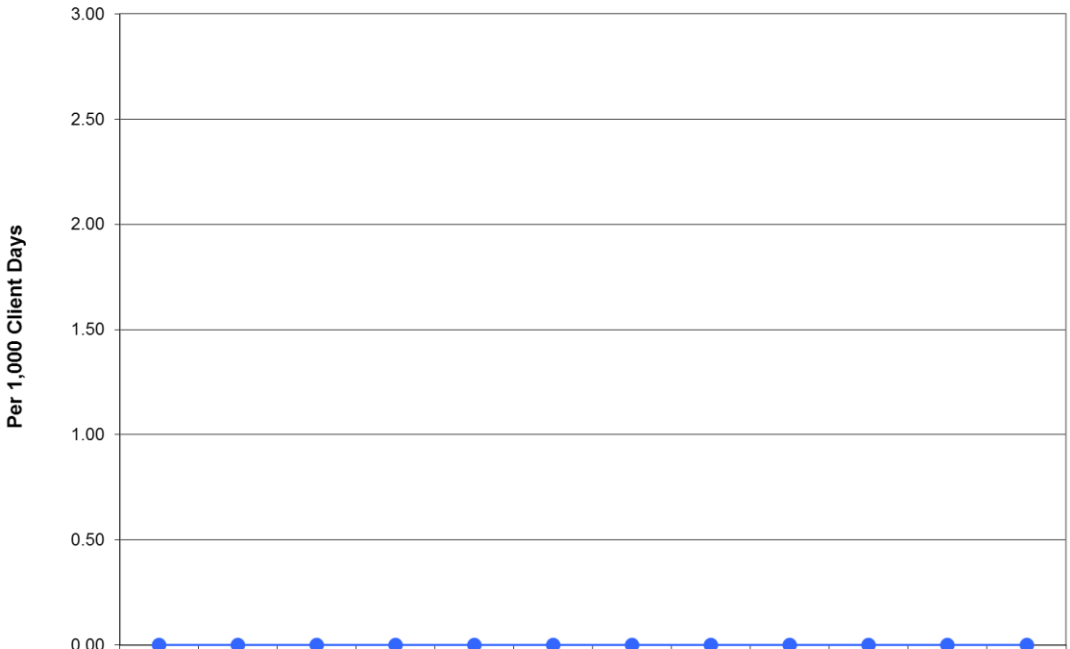
STRATEGIC PERFORMANCE EXCELLENCE

Reportable (Lost Time & Medical) Direct Care Staff Injuries



	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Lost Time Ratio	0.00	2.93	2.50	1.97	3.21	3.80	1.92	1.64	1.18	1.56	0.95	3.20

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



	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Lost Time Ratio	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff

Responsible Party: Dr. Brendan Kirby, Clinical Director

Quality Improvement Plan
FY 2015

As specified in Article Seven of the Medical Staff Bylaws, the improvement and assurance of medical staff quality and performance is of paramount importance to the hospital. This plan insures that the standards of patient care are consistent across all clinical services and all specialties and categories of responsible practitioners. Through a combination of internal and external peer review, indicator monitoring, focused case reviews of adverse outcomes or sentinel events, routine case reviews of patients with less than optimal outcomes, and the establishment of performance improvement teams when clinical process problems arise, the medical staff will insure quality surveillance and intervention activities appropriate to the volume and complexity of Riverview's clinical workload. Medical Staff Quality Improvement efforts will be fully integrated with the hospital-wide Integrated Performance Excellence Committee (IPEC) so that information can be sent to and received from other clinical and administrative units of the hospital. The Clinical Director, assisted by the President of the Medical Staff, will serve as the primary liaison between the MEC and IPEC. Oversight of the Medical Staff Performance Improvement Plan is primarily delegated to the Clinical Director in conjunction with the President of the Medical Staff, the Director of Integrated Quality and Informatics, the Superintendent, and ultimately to the Advisory Board.

The goal of the Medical Staff Quality Improvement Plan is to provide care that is:

Safe
Effective
Patient centered
Timely
Efficient
Equitable
Designed to improve clinical outcomes

To achieve this goal, medical staff members will participate in ongoing and systematic performance improvement efforts. The performance improvement efforts will focus on direct patient care processes and support processes that promote optimal patient outcomes. This is accomplished through peer review, clinical outcomes review, variance analysis, performance appraisals, and other appropriate quality improvement techniques.

STRATEGIC PERFORMANCE EXCELLENCE

1. **Peer Review Activities**:

   a. Regularly scheduled internal peer review by full time medical staff occurs on a monthly basis at the Peer Review and Quality Assurance Committee. The group of assembled clinicians will review case histories and treatment plans, and offer recommendations for possible changes in treatment plans, for any patient judged by the attending physician or psychologist, or others (including nursing, administration, the risk manager, or the Clinical Director), and upon request, to not be exhibiting a satisfactory response to their medical, psychological, or psychiatric regimens. Our goal is to discuss a case monthly. Detailed minutes of these reviews will be maintained, and the effectiveness of the reviews will be determined by recording feedback from the reviewed clinician as to the helpfulness of the recommendations, and by subsequent reports of any clinical improvements or changes noted in the patients discussed over time. Such intensive case reviews can also serve as the generator of new clinical monitors if frequent or systematic problem areas are uncovered. In addition all medical staff members (full and part-time) will have a minimum of one chart every other month peer reviewed and rated for clinical pertinence of diagnosis and treatment as well as for documentation. These may include admission histories and physicals, discharge summaries, and progress notes. The results of these chart audits are available to the reviewed practitioners and trends will be monitored by the Clinical Director as part of performance review and credentialing decisions.

   b. Special internal peer review or focused review. At the direction of the Clinical Director a peer chart review is ordered for any significant adverse clinical event or significant unexpected variance. Examples would be a death, seclusion or restraint of one patient for eight or more continuous hours, patient elopement, the prescribing of three or more atypical antipsychotics for the same patient at the same time, or significant patient injury attributable to a medical intervention or error.

   c. External peer review occurs regularly through contracts with the Maine Medical Association and the Community Dental Clinic program. We plan to continue our recent tradition of a biannual assessment of the psychiatry service and the medical service by peers in those clinical areas based on random record assessment of 25 cases in each service. An outside dentist from Community Dental will also review 20 charts of the hospital dentist for clinical appropriateness at least annually. Our contract with the Maine Medical Association also allows for special focused peer reviews of any unexpected death or when there is a question of a significant departure from the standard of care.

2. **MEC Subcommittee and IPEC Indicator Monitoring Activities**:
The subcommittees of the MEC and the Integrated Performance Excellence Committee are the primary methods by which the medical staff monitor and analyze for trends all hospital-wide quality performance data as well as trends more specific to medical staff performance. The subcommittees, in turn, report their findings on a monthly basis to the Medical Executive Committee and to the Clinical Director for any needed action. The respective committees monitor the following indicators:
    a. Integrated Performance Excellence Committee (this is not a subcommittee of the Medical Staff but the Clinical Director serves as a member and is the primary liaison to the Medical Executive Committee).
        - Psychiatric Emergencies
        - Seclusion and Restraint Events
        - Staff or Patient Injuries
        - Priority I Incident Reports
        - Other clinical/administrative department monitoring activity
    b. Pharmacy and Therapeutics Committee:
        - Medication Errors Including Unapproved abbreviations
        - Adverse Drug Reactions
        - Pharmacy Interventions
        - Antibiotic Monitoring
        - Medication Use Evaluations
        - Psychiatric Emergency process
    c. Medical Records Committee:
        - Chart Completion Rate/Delinquencies
        - Clinical Pertinence of Documentation of Closed Records
    d. Infection Control Committee:
        - Infection Rates (hospital acquired and community acquired)
        - Staff Vaccination Rates/Titers
    e. Utilization Management Committee:
        - Admission Denials
        - Timeliness of Discharges After Denials
    f. Peer Review and Quality Assurance Committee:
        - Hospital-wide Core Measures and NASMHPD Data
        - Patient Satisfaction Surveys
        - Administrative concerns about quality
        - Special quality improvement monitors for the current year (see also the Appendix and number 6 below).
        - Reports from the Human Rights Committee regarding patient rights and safety issues
        - Specific case reviews

3. **Performance or Process Improvement Teams**:
When requested by or initiated by other disciplines or by hospital administration, or when performance issues are identified by the medical staff itself during its monitoring activities, the Clinical Director will appoint a medical staff member to an ad hoc performance improvement team. This is generally a multidisciplinary team looking at ways to improve hospital wide processes. Currently the following performance improvement teams involving medical staff are in existence or have recently completed their reviews:
    a. Review of treatment plans
    b. Lower Saco Unit

4. **Miscellaneous Performance Improvement Activities**:
In addition to the formal monitoring and peer review activities described above, the Clinical Director is vigilant for methods to improve the delivery of clinical care in the hospital from interactions with, and feedback from, other discipline chiefs, from patients or from their complaints and grievances, and from community practitioners who interact with hospital medical staff. These interactions may result in reports to the Medical Executive Committee, in the creation of performance improvement teams, performance of a root-cause analysis, or counseling of individual practitioners.

5. **Reports of Practitioner-specific Data to Individual Practitioners**:
The office of the Clinical Director will provide confidential outcomes of practitioner-specific data to each medical staff member within 30 days of the end of the fiscal year. This information will be available without the necessity of the practitioner requesting it. It will be placed in the confidential section of the practitioner's medical staff file and freely accessible during normal business hours. The office of the Clinical Director will notify all medical staff members when the data is available for review. Each medical staff member may discuss the data with the Clinical Director at any time.

6. **Process to amend the quality improvement plan, including adding or deleting any monitors or processes:**
Upon the recommendation of the Clinical Director, upon recommendation of the MEC as a whole after a request from any member of the medical staff, from a recommendation of the Integrated Performance Excellence Committee, or upon recommendation of the Advisory Board, this plan may be amended with appropriate approvals at any time. Examples of when amendments might be necessary are the detection of new clinical problems requiring monitoring or when it is discovered that current monitors are consistently at or near target thresholds for six consecutive months. Should the number of active clinical monitors fall below four at any time, replacement monitors will be activated within two months of termination of the previous monitor (s). The Clinical Director, the Medical Staff President, and the MEC are jointly responsible for maintaining an active monitoring system at all times and to

insure that all relevant clinical service areas or services are involved in monitoring. The Director of Integrated Quality will also assist in assuring the ongoing presence of appropriate monitors.

Quality Improvement Reporting Schedule to Medical Executive Committee

IPEC:	Med. Director reports monthly
Pharmacy & Therapeutics Committee:	Chair reports monthly
Medical Records Committee:	Chair reports monthly
Infection Control Committee:	Chair reports monthly
Utilization Management Committee:	Chair reports bi-monthly
Medical Executive Committee Direct Indicators:	Clinical Director reports monthly, directly to individual provider and to the MEC
Internal Peer Review outcomes:	Clinical Director reports monthly to the Med Staff QA and Peer Review Committee, to the MEC, and to individual practitioners as necessary

APPENDIX

October, 2014

Medical Staff Pharmacy Indicators:

MULTIPLE ANTI-PSYCHOTICS DURING HOSPITALIZATION: We continue the indicator looking at multiple antipsychotic prescriptions during the hospitalization. This performance improvement indicator has resulted in a 10 percent to 20 percent drop of multiple antipsychotic prescribing. In addition, as of the latest performance improvement meeting, no patients in the hospital are on three or more antipsychotic medications. Further, medical staff have been educated and reminded of the intent to minimize the number of people being discharged on more than one antipsychotic and that, when this occurs, it should be for one of

the approved indications; i.e., three or more monotherapy trials, cross titration, or adjunctive treatment with Clozaril.

METABOLIC MONITOR: With the creation of the database looking at necessary metabolic monitoring for individuals on second- generation antipsychotics, completion of the database resulted in discussion and decision that medical staff education was the next appropriate intervention. On September 17, 2014, Miranda Cole Ph.D., Pharmacist, presented to the medical staff a monogram entitled 'Metabolic Monitoring for Patients on Antipsychotic Medications'. The response from medical staff was very positive and the upshot will be a further meeting between Dr. Cole and Dr. Kirby to operationalize the material discussed into a performance improvement indicator. Baseline indicates that we are 55 percent to 60 percent compliant with ensuring that our patients meet the current recommendations for metabolic monitoring. Decisions to be made include: responsibility for this testing between psychiatry and primary care physicians; whether waist circumference, a more accurate measure of metabolic problems, will be incorporated; and a decision as to when the annual monitoring for longer term patients should occur. It is hoped at October's performance improvement meeting that a suitable indicator will have been formulated at that time, and clearly it is hoped we can readily display marked improvement over our baseline.

ANTIBIOTIC PRESCRIBING: We have achieved 100 percent compliance for over 4 months with the new antibiotic order forms. This part of the performance indicator is appropriately concluded. Discussion as to whether appropriate choice of antibiotic, when necessary, should be a performance improvement indicator was discussed; however, feedback from the non-psychiatric physicians in the hospital indicated that there would be little to be gained from such a monitor as the vast majority of antibiotic choice is appropriate based on the new system. With this monitor ending, creation of a new performance improvement monitor in the pharmacy category will be discussed and implemented, again starting at the next performance improvement meeting.

PROPOSED INDICATOR - PATIENTS ON EXTREME NUMBERS OF MEDICATIONS: The monitor will focus on individuals in the hospital who are on a multitude of medications and a decision as to whether to review all patients who are one or two standard deviations above the norm will be taken when the initial data has been gathered.

ORDERS ENDING PSYCHIATRIC EMERGENCIES: Finally, a performance improvement indicator, which is run by pharmacy of direct relevance to medical staff, is ensuring that an order to end a psychiatric emergency is placed on the chart and that the emergency is not simply allowed lapse after 72 hours. Initial figures indicate that we are at a 50 percent success rate on this issue at baseline and we are monitoring the response to both e-mail and face-to-face medical staff education.

STRATEGIC PERFORMANCE EXCELLENCE

Psychology Focused Medical Staff Performance Improvement:

The COTREI, an evaluative tool for mental health acquities, has been implemented on all inpatient NCR patients and has been carried out both by the psychiatric provider and a psychologist. Our next performance improvement indicator is to show evidence that information from this tool is incorporated into the treatment plans of all inpatients in the NCR recovery program. Dr. Kirby and Dr. DiRocco continue to meet to discuss implementation of the next phase of this indicator.

Dental Clinic Indicators:

Dental clinic has now commenced two indicators. This occurred as a result of Dr. Kirby meeting with Dr. Ingrid Prikryl, the dentist in our clinic. Having reviewed the quality assurance and performance improvement indicators, explanation as to what performance improvement is and how it differs from, but is related to quality assurance was undertaken. Coming out of this discussion, four indicators were considered, two of which were found to be clearly appropriate for performance improvement monitoring. Both indicators are in the baseline data collection stage.

TOTAL PLAQUE SCORES: The first will be an evaluation of total plaque score on patients, followed by research with intervention and re-measurement for improvement in oral hygiene of the patient population attending the dental clinic. Research on improving hygiene in chronic psychiatric populations will be sought to define likely useful information to bring about such improvement.

PERIODONTAL CHARTING: The second issue relates to ensuring that periodontal charting by staff improves to a level ensuring that such charting occurs once a year. Currently, it appears from baseline documentation that the baseline may be starting out well below 50 percent and rapid improvement will be expected on this monitor.

Further Indicator:

A further indicator has been added tracking the behavior of after-hours physician's assistant staff. With the engagement of our new lead physician's assistant for after-hours staff, Reid Kincaid, a monitor has been set up to look at and ensure appropriate signature of telephone orders by after-hours staff prior to leaving the building. This will be associated with the possibility, in extreme cases, that after-hours staff would lose the privilege to be able to give telephone orders, if they were not compliant with ensuring appropriate signatures by the end of their shift.

STRATEGIC PERFORMANCE EXCELLENCE

I. Measure Name: Polyantipsychotic Therapy

Measure Description: The use of two or more antipsychotic medications (polyantipsychotic therapy) is discouraged as current evidence suggests little to no added benefit with an increase in adverse effects when more than one antipsychotic is used. The Joint Commission Core (TJC) Measure HBIPS-5 requires that justification be provided when more than one antipsychotic is used. Three appropriate justifications are recognized: 1) Failure of 3 adequate monotherapy trials, 2) Plan to taper to monotherapy (cross taper) and 3) Augmentation of clozapine therapy. This measure aligns itself with the HBIPS-5 core measure and requires the attending psychiatrist to provide justification for using more than one antipsychotic. In addition to the justification, the clinical/pharmacological appropriateness is also evaluated.

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**
Target	Justified Polyantipsychotic Therapy	90.2% (2014)	90%	90%	90%	90%	**90%**
Actual			96.3%	89.7%	92.7%	63%	**85%**

Data Analysis: All medication profiles in the hospital are reviewed in each month of the quarter for antipsychotic medication orders. Attending psychiatrists are required to complete a Polyantipsychotic Therapy Justification Form when a patient is prescribed more than one antipsychotic. The percentage of justified polyantipsychotic therapy amongst those patients prescribed two or more antipsychotics is reported here. This quarter saw a decrease in the number of patients on justifiable polyantipsychotic therapy. An analysis of the patients on polyantipsychotic therapy yielded the following results: 5 patients were discharged on two antipsychotics. One of the five patients did not have justification for the polyantipsychotic therapy, although the combination was phamacologically rational. 5 inpatients are prescribed two scheduled antipsychotics. Two of the five patients do not have justification for the polyantipsychotic therapy, although both regimens are pharmacologically rational. There are 6 inpatients currently prescribed 2 antipsychotics; one scheduled and one PRN (as needed). These do not have justification but all regimens are pharmacologically rational.

Action Plan: This monitor was moved to Quality Assurance at the end of the second quarter. We will continue to monitor for appropriate justification of polyantipsychotic therapy. The pharmacists have strategized reorganization of the process within the pharmacy, less susceptible to changes within the department. The pharmacy is also investigating how to provide soft stop (or hard stop) reorders with the entire medication profile. Hopefully, these

strategies will provide the necessary prompts to Medical Staff as reminders to address and provide justification for polyantipsychotic therapy.

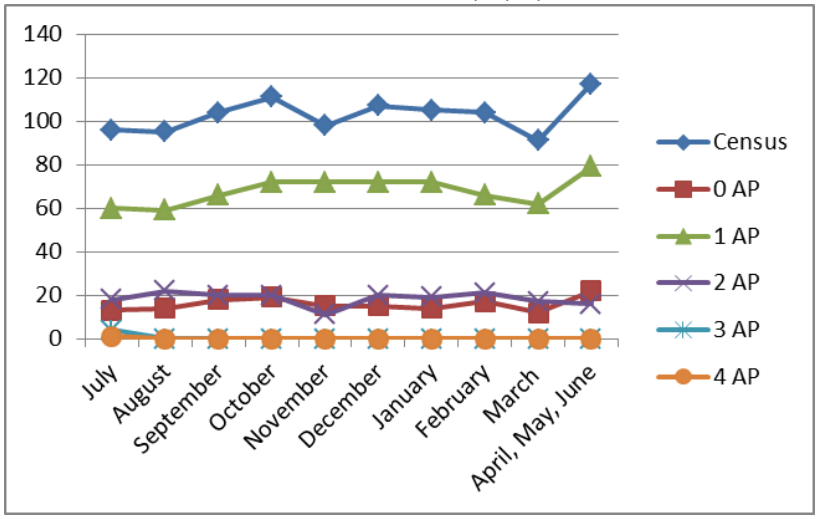
Comments: We this this quarter saw a decline in documentation of justification for a few reasons: 1) Less focus on the parameter as a QA indicator versus a PI indicator; 2) Transitions in the pharmacy led to decreased attention and delayed delivery of the PAPT forms to physicians. The physicians had fewer prompts to provide justification for polyantipsychotic therapy. 3) Pharmacy has identified that some of the polyantipsychotic therapy is initiated by afterhours staff which RxRemote and per diem pharmacists may not pick up on, thus some incidences of polyantipsychotic therapy are missed by the pharmacy again missing the opportunity to prompt the prescriber for justification. 4) Discussion at the P&T meeting identified a potential problem with Soft Stop orders not listing the entirety of a patient's medication profile, a potential additional prompt to the provider to address or justify polyantipsychotic therapy if they are provided a complete medication profile.

Graph/Chart:

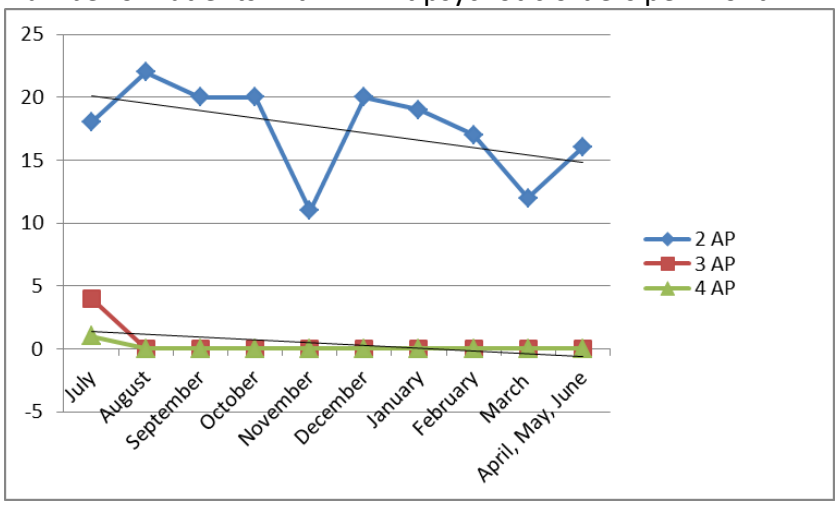
	January	February	March	April, May, June
Census (Beginning + Admissions)	105	104	91	117
Antipsychotic Orders for Clients				
No Antipsychotics	14 (13%)	17 (16%)	12 (13%)	22(18.8%)
Mono-antipsychotic therapy	72 (69%)	66 (63%)	62 (68%)	79 (67.5%)
Two Antipsychotics	19 (18%)	21 (20%)	17 (19%)	16 (13.7%)
Three Antipsychotics	0	0	0	0
Four Antipsychotics	0	0	0	0
At least 1 antipsychotic	90 (86%)	87 (84%)	79 (87%)	95 (81%)
Total on Poly-antipsychotic therapy	19 (18%)	21 (20%)	17 (19%)	16 (14%)
Percentage of poly-antipsychotic therapy amongst those with orders for antipsychotics	21% (19/90)	24% (21/87)	22% (17/79)	17% (16/95)
More than 2 antipsychotics	0	0	0	0
Poly-Antipsychotic therapy breakdown				
SGA + FGA	12 (63%)	12 (57%)	11 (65%)	7 (44%)
2 SGAs ("Pine" + "Done")	1 (5%)	1 (5%)	1 (6%)	1 (6%)
Other (2 antipsychotic regimens)	6 (32%)	8 (38%)	5 (29%)	8 (50%)
Other 2 Antipsychotic Regimen Details	1) Olanzapine + Quetiapine	1) Olanzapine + Quetiapine (x3)	1) Olanzapine + Quetiapine (x2)	1) Olanzapine + Quetiapine
	2) Clozapine + Quetiapine (x2)	2) Fluphenazine + Loxapine	2) Clozapine+ Olanzapine	2) Clozapine + Aripiprazole
	3) Chlorpromazine + Haloperidol	3) Chlorpromazine + Haloperidol	3) Clozapine + Quetiapine	3) Clozapine + Olanzapine X3
	4) Aripiprazole + Paliperidone	4) Aripiprazole + Paliperidone	4) Aripiprazole + Paliperidone	4) Aripiprazole + Paliperidone
	5) Aripiprazole + Olanzapine	5) Clozapine + Quetiapine		5) Asenapine + Olanzapine
		6) Fluphenazine + Haloperidol		6) Aripiprazole + Quetiapine
3+ Antipsychotic Regimens	0		0	0
Justifiable Poly-Antipsychotic Therapy	95% (18/19)	95% (20/21)	88% (15/17)	63% (10/16)

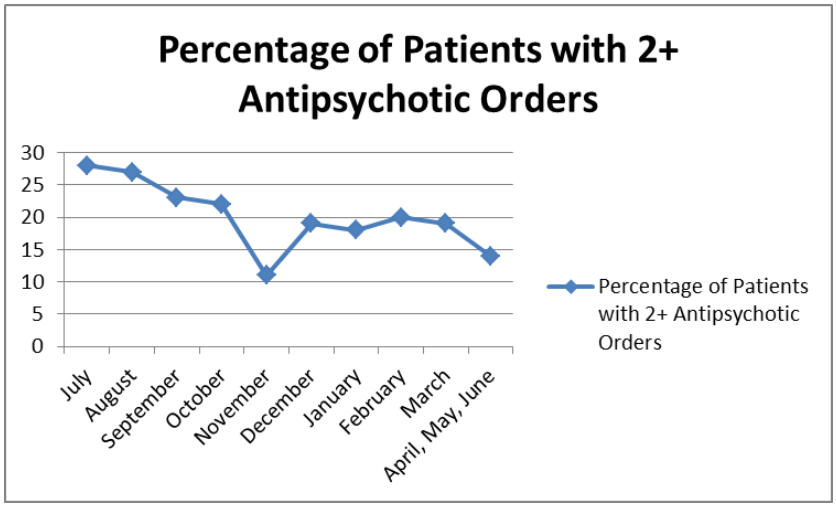
STRATEGIC PERFORMANCE EXCELLENCE

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



Number of Patients with 2+ Antipsychotic orders per Month





STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: Metabolic Monitoring

Measure Description: Metabolic syndrome is a well-known side effect of second generation antipsychotics (SGAs). The majority of patients prescribed antipsychotics are prescribed an entity from the SGA sub-class. The purpose of this monitor is to ensure that we are monitoring, or attempting to monitor, SGA therapy appropriately for those patients prescribed SGAs.

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**
Target	Complete/Up-to-date Metabolic Parameters	56%	75%	75%	75%	75%	**75%**
Actual			56%	86%	71%	79%	**73%**

Data Analysis: 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.

Action Plan: We will continue to monitor SGA therapy by monitoring for Metabolic Syndrome. The patient's right to refuse assessment (weight, blood pressure and lab work) has been identified as a contributing factor to not being able to fully assess their metabolic status. Thus the goal of achieving 95% completed metabolic parameters is unrealistic and has been adjusted to a more reasonable goal of 75%. We have also started incorporating documentation of patient's refusals. This indicates that the provider is making the attempt to monitor the medication. In an attempt to streamline lab work, the Medical Staff has decided to incorporate lab work with the annual physical. This may impact this monitor going forward as data has been collected based on the most recent lab work and addition or changes in SGA therapy.

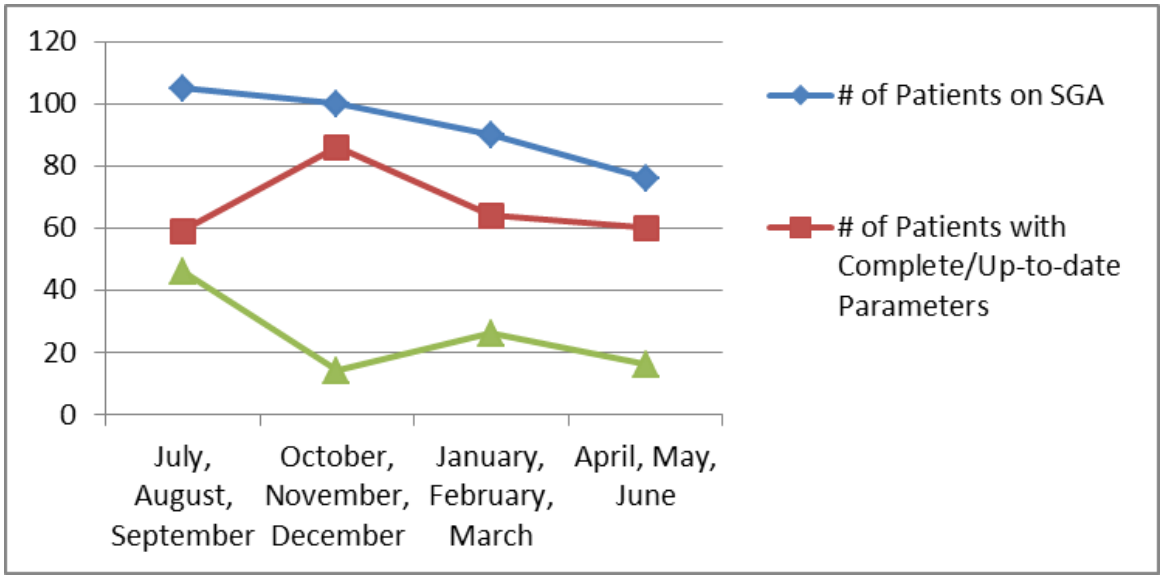
Comments: We saw an increase this last quarter to above our goal of 75%. Of the patients that did not have complete/up-to-date parameters collected, three had documented refusals. For the remainder of the patients, it is likely that their annual physical is not due and thus annual labs have not been ordered.

STRATEGIC PERFORMANCE EXCELLENCE

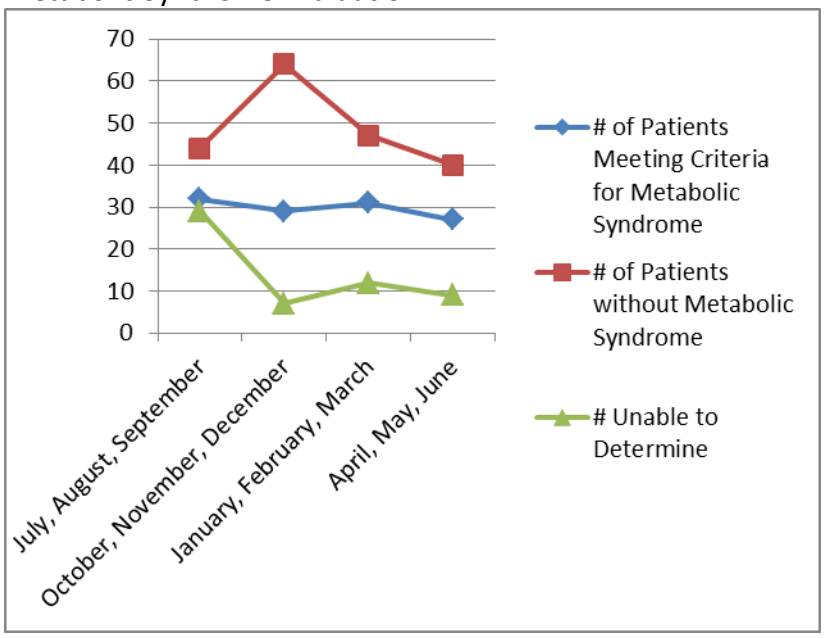
Graph/Chart:

	4Q2015	3Q2015	2Q2015	1Q2015
# of Patients on SGA	76	90	100	105
# of Patients with Complete/Up-to-date Parameters	60 (79%)	64 (71%)	86 (86%)	59 (56%)
# of Patients Missing/Not Up-to-date Parameters	16 (21%)	26 (29%)	14 (14%)	46 (44%)
# of Patients Meeting Criteria for Metabolic Syndrome	27 (36%)	31 (34%)	29 (29%)	32 (30%)
# of Patients without Metabolic Syndrome	40 (53%)	47 (52%)	64 (64%)	44 (42%)
# Unable to Determine	9 (12%)	12 (13%)	7 (7%)	29 (28%)
Documented Refusals	3 (18%)	5 (19%)	6 (43%)	N/A

Collection of Monitoring Parameters



Metabolic Syndrome Evaluation



III. Measure Name: Polytherapy

Measure Description: Polytherapy is defined as "combined treatment of multiple conditions with multiple medications." This differs from polypharmacy, the "treatment of a single condition with multiple medications from the same pharmacologic class or with the same mechanism of action" which our other monitor, Poly-antipsychotic therapy, addresses. Polypharmacy can lead to complex medication regimens and increases the chances of drug-drug interactions potentially negatively impacting or inhibiting another drug from exerting its intended therapeutic effect. When five or more medications are taken together there is almost a 100% chance of a drug-drug interaction. The purpose of this monitor is to evaluate polytherapy and actively discuss cases with the highest number of medications in an attempt to reduce polytherapy.

Type of Measure: Performance Improvement

Data Analysis: We have assessed a baseline group of patients with regards to their total number of medications prescribed and further broken it down to number of scheduled medications and number of PRN or "as needed" medications. Each month the patient medication profiles with the highest total number of medications for each unit will be reviewed at the Peer Review Committee to assess the potential for eliminating unnecessary medications. The number of actual profiles reviewed each month will be dependent on time constraints and presence/availability of the patient's Psychiatric and Medical providers.

Action Plan: Our plan is to continue to review patients with numerous medication orders at the monthly Peer Review Committee Meeting. An effort will be made to obtain more information on medication adherence and PRN usage for the patients reviewed. This monitor

will be reported and discussed with the Medical Staff at the Peer Review and Pharmacy & Therapeutics (P&T) Committees.

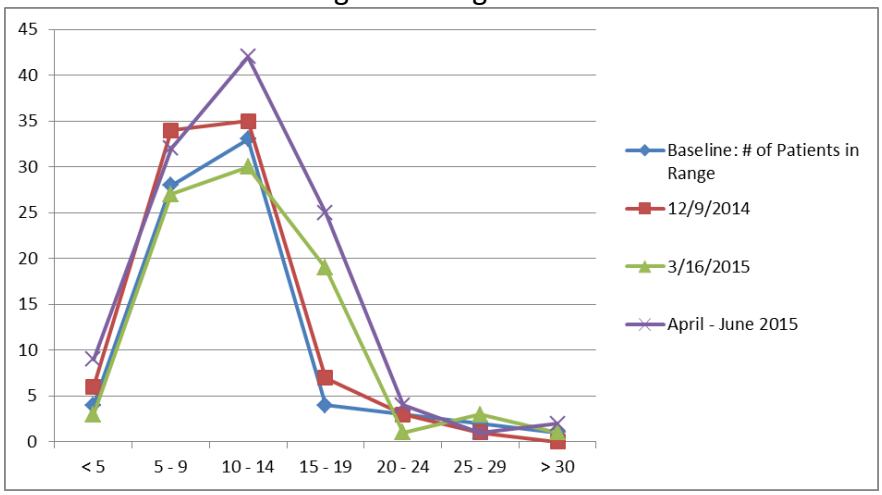
Comments: A shift towards a higher number of medications ordered was seen again this quarter. It is difficult to determine if this is a result of patient specific factors or provider specific habits. The hospital saw more admissions this quarter and there were 2 months where profiles could not be reviewed at the Peer Review Committee. Efforts will be renewed and reenergized in the next quarter to refocus attention on Polytherapy at the Peer Review and P&T Committees.

Graph/Chart:

	Baseline Average	Baseline Range		12/9/14 Average	12/9/14 Range		3/16/15 Average	3/16/15 Range		Q4 2015 Average	Q4 2015 Range
Total Orders	11.4	4 - 37		10.4	0 - 29		12.1	0 – 31		11.9	0 – 41
Scheduled	5.5	0 - 21		4.7	0 - 18		4.9	0 – 17		5.8	0 – 20
PRNs	6	1 - 22		6	0 - 11		5.9	0 – 19		6.5	0 – 21

Medication Number Range	Number of Patients (Baseline)	12/9/2014	3/16/2015	Q4 2015
< 5	4	6	3	9
5 – 9	28	34	27	32
10 – 14	33	35	30	42
15 – 19	4	7	19	25
20 – 24	3	3	1	4
25 – 29	2	1	3	1
> 30	1	0	1	2

Number of Patients Falling in to Range of Medication Orders



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
- Human Resources Department Payroll 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
September 2013: Nurse Mandates 14 shifts, Mental Health Worker Mandates 49 shifts

Monthly Targets
10% reduction monthly x4 from baseline

STRATEGIC PERFORMANCE EXCELLENCE

Mandate Occurrences: When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy.

	New Baseline Sept 2013	FY15 Q1			FY15 Q2			FY15 Q3			FY15 Q4			Goal
		July 2014	Aug2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	April 2015	May 2015	June 2015	
Nursing Mandates	14	4	2	1	3	1	4	6	20	11	2	4	6	10% reduction monthly x4 from baseline)
Mental Health Worker (MHW) Mandates	49	16	18	12	45	39	38	66	39	51	20	44	56	10% reduction monthly x4 from baseline)

Nursing mandates decreased from 37 last quarter to 12 this quarter.
MHW mandates decreased from 156 last quarter to 120 this quarter.

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Initial Chart Compliance

April – June 2015

Lower Saco

Indicator	Findings	Compliance
1. Universal Assessment completed by RN within 24 hours	19 of 19	100%
2. All sections completed or deferred within document	19 of 19	100%
3. Initial Safety Treatment Plan initiated	19 of 19	100%
4. All sheets required signature authenticated by assessing RN	3 of 19 16 n/a	100%
5. Medical Care Plan initiated if Medical problems identified	19 of 19	100%
6. Informed Consent sheet signed	15 of 19 3 ref. 1 loc.	100%
7. Potential for violence assessment upon admission	19 of 19	100%
8. Suicide potential assessed upon admission	19 of 19	100%
9. Fall Risk assessment completed upon admission	3 of 19 16 n/a	100%
10. Score of 5 or above incorporated into problem need list	19 of 19	100%
11. Dangerous Risk Tool done upon admission	11 of 19 8 n/a	100%
12. Score of 11 or above incorporated into Safety Problem	15 of 19 3 ref. 1 loc.	100%
13. Evidence that patients are routinely informed of their rights upon admission in accordance with ¶ 150 of the settlement agreement is found in the document of the charts reviewed	19 of 19	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Initial Chart Compliance

April – June 2015

Upper Saco

Indicator	Findings	Compliance
1. Universal Assessment completed by RN within 24 hours	1 of 1	100%
2. All sections completed or deferred within document	1 of 1	100%
3. Initial Safety Treatment Plan initiated	1 of 1	100%
4. All sheets required signature authenticated by assessing RN	1 of 1	100%
5. Medical Care Plan initiated if Medical problems identified	1 of 1	100%
6. Informed Consent sheet signed	1 of 1	100%
7. Potential for violence assessment upon admission	1 of 1	100%
8. Suicide potential assessed upon admission	1 of 1	100%
9. Fall Risk assessment completed upon admission	1 of 1	100%
10. Score of 5 or above incorporated into problem need list	1 of 1	100%
11. Dangerous Risk Tool done upon admission	1 n/a	100%
12. Score of 11 or above incorporated into Safety Problem	1 of 1	100%
13. Evidence that patients are routinely informed of their rights upon admission in accordance with ¶ 150 of the settlement agreement is found in the document of the charts reviewed.	1 of 1	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Initial Chart Compliance

April – June 2015

Lower Kennebec

Indicator	Findings	Compliance
1. Universal Assessment completed by RN within 24 hours	25 of 25	100%
2. All sections completed or deferred within document	25 of 25	100%
3. Initial Safety Treatment Plan initiated	25 of 25	100%
4. All sheets required signature authenticated by assessing RN	3 of 25 22 n/a	100%
5. Medical Care Plan initiated if Medical problems identified	25 of 25	100%
6. Informed Consent sheet signed	21 of 25 3 loc. 1 ref.	100%
7. Potential for violence assessment upon admission	25 of 25	100%
8. Suicide potential assessed upon admission	25 of 25	100%
9. Fall Risk assessment completed upon admission	3 of 25 22 n/a	100%
10. Score of 5 or above incorporated into problem need list	25 of 25	100%
11. Dangerous Risk Tool done upon admission	13 of 25 12 n/a	100%
12. Score of 11 or above incorporated into Safety Problem	22 of 25 1 ref. 2 loc.	100%
13. Evidence that patients are routinely informed of their rights upon admission in accordance with ¶ 150 of the settlement agreement is found in the document of the charts reviewed.	25 of 25	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Initial Chart Compliance

April – May 2015
Total – All Units

Indicator	Findings	Compliance
1. Universal Assessment completed by RN within 24 hours	45 of 45	100%
2. All sections completed or deferred within document	45 of 45	100%
3. Initial Safety Treatment Plan initiated	45 of 45	100%
4. All sheets required signature authenticated by assessing RN	7 of 45 38 n/a	100%
5. Medical Care Plan initiated if Medical problems identified	45 of 45	100%
6. Informed Consent sheet signed	37 of 45 4 loc. 4 ref.	100%
7. Potential for violence assessment upon admission	45 of 45	100%
8. Suicide potential assessed upon admission	45 of 45	100%
9. Fall Risk assessment completed upon admission	7 of 45 38 n/a	100%
10. Score of 5 or above incorporated into problem need list	45 of 45	100%
11. Dangerous Risk Tool done upon admission	24 of 45 21 n/a	100%
12. Score of 11 or above incorporated into Safety Problem	38 of 45 4 ref. 3 loc.	100%
13. Evidence that patients are routinely informed of their rights upon admission in accordance with ¶ 150 of the settlement agreement is found in the document of the charts reviewed.	45 of 45	100%

Note: There were no admissions to Upper Kennebec in 4Q2015

STRATEGIC PERFORMANCE EXCELLENCE

Peer Support

Responsible Party: Samantha St. Pierre, Peer Support Director

Indicator: Inpatient Consumer Survey Return Rate

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

Objective:
To increase the number of surveys offered to patients, as well as increase the return rate.

Those responsible for Monitoring:
Peer Support 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. Peer Support Staff will be responsible for offering surveys to patients 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:
- Patient Satisfaction Survey Tracking Sheet
- Completed surveys entered into spreadsheet/database

Unit:
All patient 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

Survey Return Rate	Unit	Baseline	Target	1Q2015	2Q2015	3Q2015	4Q2015
The inpatient consumer survey is the primary tool for collecting data on how patients feel about the services they are provided at the hospital.	**LK**	**15%**	**50%**	**23%**	**17%**	**37%**	**20%**
	LS	**5%**	**50%**	**23%**	**25%**	**62%**	**0%**
	UK	**45%**	**50%**	**36%**	**28%**	**26%**	**27%**
	US	**30%**	**50%**	**0%**	**25%**	**100%**	**100%**

Comments:
Percentages are calculated based on the number of people eligible to receive a survey vs. the number of people who completed the surveys.

Inpatient Consumer Survey Results:

#	Indicators	1Q 2015	2Q 2015	3Q 2015	4Q 2015	Average
1	I am better able to deal with crisis.	66%	79%	75%	69%	**72%**
2	My symptoms are not bothering me as much.	63%	71%	73%	69%	**69%**
3	The medications I am taking help me control symptoms that used to bother me.	72%	73%	71%	77%	**73%**
4	I do better in social situations.	67%	69%	73%	63%	**68%**
5	I deal more effectively with daily problems.	67%	69%	75%	71%	**71%**
6	I was treated with dignity and respect.	67%	65%	69%	73%	**69%**
7	Staff here believed that I could grow, change and recover.	72%	75%	74%	63%	**71%**
8	I felt comfortable asking questions about my treatment and medications.	67%	73%	71%	54%	**66%**
9	I was encouraged to use self-help/support groups.	69%	77%	77%	56%	**70%**
10	I was given information about how to manage my medication side effects.	61%	67%	60%	63%	**63%**
11	My other medical conditions were treated.	73%	56%	69%	65%	**66%**
12	I felt this hospital stay was necessary.	64%	67%	50%	67%	**62%**
13	I felt free to complain without fear of retaliation.	69%	67%	54%	56%	**62%**
14	I felt safe to refuse medication or treatment during my hospital stay.	42%	60%	49%	54%	**51%**
15	My complaints and grievances were addressed.	70%	50%	63%	65%	**62%**

STRATEGIC PERFORMANCE EXCELLENCE

#	Indicators	1Q 2015	2Q 2015	3Q 2015	4Q 2015	Average
16	I participated in planning my discharge.	72%	60%	66%	38%	**59%**
17	Both I and my doctor or therapists from the community were actively involved in my hospital treatment plan.	58%	50%	52%	38%	**50%**
18	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	63%	57%	47%	54%	**55%**
19	The surroundings and atmosphere at the hospital helped me get better.	66%	58%	61%	60%	**61%**
20	I felt I had enough privacy in the hospital.	64%	63%	66%	58%	**63%**
21	I felt safe while I was in the hospital.	67%	50%	72%	69%	**65%**
22	The hospital environment was clean and comfortable.	70%	71%	74%	74%	**72%**
23	Staff were sensitive to my cultural background.	52%	60%	65%	65%	**61%**
24	My family and/or friends were able to visit me.	61%	50%	68%	73%	**63%**
25	I had a choice of treatment options.	70%	75%	60%	52%	**64%**
26	My contact with my doctor was helpful.	63%	69%	55%	62%	**62%**
27	My contact with nurses and therapists was helpful.	72%	69%	57%	53%	**63%**
28	If I had a choice of hospitals, I would still choose this one.	55%	67%	54%	60%	**59%**
29	Did anyone tell you about your rights?	58%	62%	74%	77%	**68%**
30	Are you told ahead of time of changes in your privileges, appointments, or daily routine?	66%	60%	60%	69%	**64%**
31	Do you know someone who can help you get what you want or stand up for your rights?	80%	73%	77%	77%	**77%**
32	My pain was managed.	58%	68%	65%	75%	**67%**
	Overall Score	**65%**	**65%**	**65%**	63%	**65%**

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

Responsible Party: Cordelia Saunders, Interim Director of Pharmacy

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 is maintained. *Pyxis Discrepancies* created by Nursing Staff are monitored daily and analyzed by Pharmacy with follow up to Nursing as needed for resolution. A quarterly 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 quarterly 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. Additionally, adverse drug reactions and clinical interventions are monitored, documented and analyzed for review by the P&T Committee. ADR's are reported monthly and Clinical Interventions are reported on a quarterly basis.

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 Clinical Director.

STRATEGIC PERFORMANCE EXCELLENCE

Measure	Unit	Baseline 2014	Goal	Q1	Q2	Q3	Q4
Pyxis CII Safe Comparison: Daily and monthly comparison of Pyxis vs CII Safe Transactions.	Rx	0.875%	0% Target: Actual:	 0% 0%	 0% 0%	 0% 0%	 0% 0%
Veriform Medication Room Audits: Monthly comprehensive audits of criteria.	All	98%	100% Target: Actual:	 100% 97%	 100% 97%	 100% 98%	 100% 98%
Pyxis Discrepancies: Monthly monitoring and trending of Pyxis discrepancies (average # of non-cs discrepancies per station).	All	22/mo	25/mo Target: Actual:	 25 38 (19/ mo)	 25 70 (23/ mo)	 25 68 (23/ mo)	 25 54 (18/ mo)
Discharge Prescriptions: Monitoring and tracking of dispensed discharge prescriptions.	Rx	$3998 343 Drugs		$3293 135 drugs	$2731 170 drugs	$4474 295 drugs	$5266 261 drugs

STRATEGIC PERFORMANCE EXCELLENCE

Psychology

Responsible Party: Arthur DiRocco, Ph.D., Director of Psychology

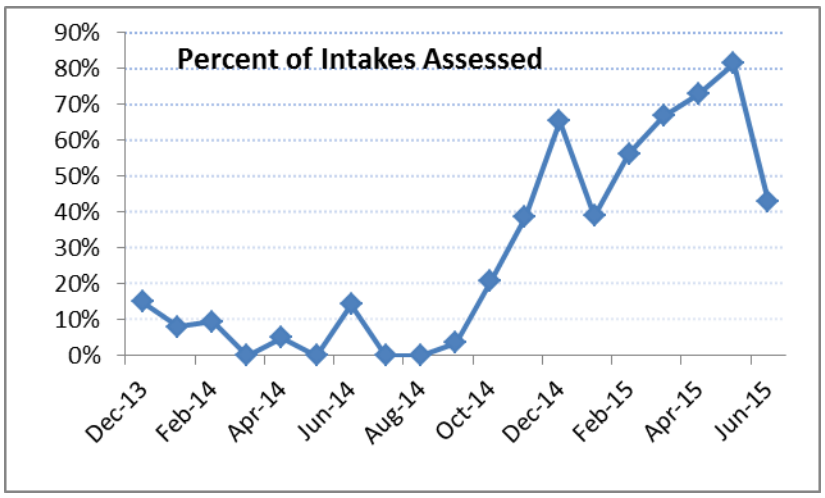
Measure Name: Brief Neuropsychological Assessment within 7 days of admission.

Measure Description: Neuropsychological testing is an important component of the assessment and treatment of such conditions as brain injury, dementia, neurological conditions, and psychological or psychiatric disorders. RPC's brief neuropsychological assessment evaluates various cognitive skills that determines patient strengths and weaknesses and can assist in the patient's treatment planning.

Type of Measure: Performance Improvement

	Results						
	Unit	Baseline	Q1	Q2	Q3	Q4	YTD
Target	Percent of assessments completed on time	3rd & 4th Qtr FY 14 .055	90%	90%	90%	90%	90 / 100
Actual			26 / 65 40%	18 / 37 48.6%	26 / 41 63.4%		70 / 143 .49

Data Analysis: Prior to October 2014 intake assessments were confined to information collected by subjective report of the patient. As of 1Q2015 the baseline of intake assessments was at .055 of patients admitted to RPC. The number of patients assessed each quarter since the beginning of this PI effort has achieved almost 50% of the total intake population. More significantly is the fact that the monthly improvements are in excess of 80% for the months of April and May 2015. The following chart demonstrates the success of the department's efforts over the past 10 months.



STRATEGIC PERFORMANCE EXCELLENCE

Rehabilitation Services

Responsible Party: Janet Barrett, Director of Therapeutic Recreation

Measure	Goal	Baseline	Q1	Q2	Q3	Q4
Recreational Therapy Assessments & Treatment Plans: Must be completed within 7 days of admission. 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 weekly.	100% Review treatment plan intervention every 2 weeks and update at each treatment plan meeting, if necessary, or if there is any other change in patient status.	Target: Actual:	100% 45/45 Charts 100%	100% 40/40 100%	100% 24/25 96%	100% 35/35 100%

Comments: All assessments were completed in the 7 day time frame. All treatment plans were reviewed and updated according to the treatment process implemented at the end of CY 2014. Goal of 100% was achieved for 3 quarters this year.

Measure	Goal	Baseline	Q1	Q2	Q3	Q4
Occupational Therapy Referrals and Doctors Orders: Ensure each patient 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.	100% for 4 consecutive quarters.	33% (original) Target: Actual:	100% 27/27 100%	100% 22/22 100%	100% 27/28 96%	100% 27/29 93%

Comments: Two OT referrals were completed by the doctor but did not have a corresponding doctor order in the chart. One order was written 5 days after referral, the other 12 days later. Same doctor in both cases who was reminded of the protocol.

STRATEGIC PERFORMANCE EXCELLENCE

Safety & Security

Responsible Party: Philip Tricarico, Safety Officer

Measure Name: Grounds Safety & Security Incidents
Measure Description: 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".
Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2015**	**2Q2015**	**3Q2015**	**4Q2015**	**Total**
Target	# of Incidents	*Baseline of 10	6	12	16	4	**38**
Actual			13	17	4	2	**36**

Summary of Events:

The 4Q2015 was 4. Our actual number was 2. We were below our target and that is good. We have had recent quarters that we exceeded our goals, but we are on the right track in meeting our goals. We have not had any issues this quarter with state owned pickup trucks and the contraband they frequently contained. We have been working with Capitol Police, Fleet Management and the Department of Conservation (agency the trucks are assigned to). There has been significant improvement in how often we are finding contraband items in these trucks. We will continue to work with all parties as we seek to resolve this issue. 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 patients. 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 Securitas continue 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.

STRATEGIC PERFORMANCE EXCELLENCE

Safety & Security Incidents:

Event	Date	Time	Location	Disposition	Comments
1. Safety Concern	5/20/15	1240	Front RPC Sign	Properly Disposed	A ¼ full bottle of Absolute Vodka was found at the sign in front of the hospital. It was retrieved by Security.
2. Safety Concern	6/19/15	1630	Exterior of building (LK Day Room)	Security, Unit Staff & NOD Notified	A baby was held up to an exterior window and patient on the inside looked on from the inside. People were gone before Security could get there.