Riverview
PSYCHIATRIC CENTER

QUARTERLY REPORT ON ORGANIZATIONAL PERFORMANCE EXCELLENCE

FOURTH STATE FISCAL QUARTER 2016

April, May, June 2016

Rodney Bouffard
Superintendent
July 22, 2016

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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	1Q2016	2Q2016	3Q2016	4Q2016
1. Patients are routinely informed of their rights upon admission.	100% 79/79	80% 16/20	95% 61/64	80% 39/50

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.

4Q2016: 1 patient refused.

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	1Q2016	2Q2016	3Q2016	4Q2016
1. Level II grievances responded to by RPC on time.	100% 1/1	0/0	0/0	0/0
2. Level I grievances responded to by RPC on time.	78% 129/165	51% 49/97	60% 46/77	89% 82/92

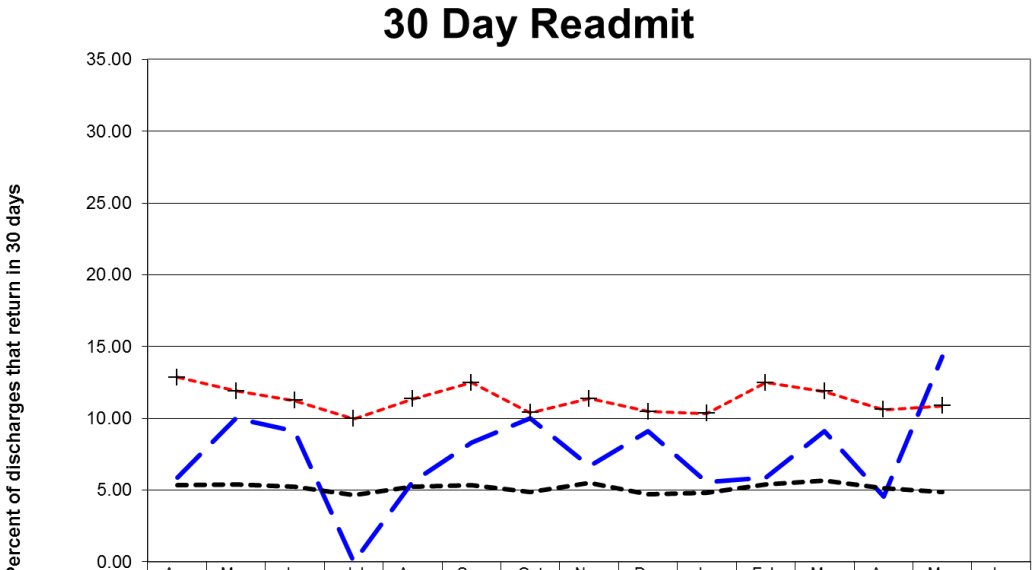
Admissions

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

ADMISSIONS	1Q2016	2Q2016	3Q2016	4Q2016	TOTAL
CIVIL:	**30**	**37**	**37**	**31**	**135**
VOL	2	1	1	1	**5**
INVOL	4	5	7	4	**20**
DCC	23	31	29	25	**108**
DCC-PTP	1	0	0	1	**2**
FORENSIC:	**34**	**21**	**27**	**20**	**102**
60 DAY EVAL	19	11	13	2	**45**
JAIL TRANSFER	2	1	5	1	**9**
IST	6	7	3	8	**24**
NCR	7	2	6	9	**24**
TOTAL	**64**	**58**	**64**	**51**	**237**

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 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	5.88	10.00	9.09	0.00	5.56	8.33	10.00	6.67	9.09	5.56	5.88	9.09	4.55	14.29	
Ntl Mean	5.33	5.38	5.26	4.67	5.23	5.33	4.84	5.48	4.73	4.83	5.42	5.64	5.11	4.86	
+1 StDev	12.85	11.91	11.25	9.96	11.35	12.48	10.40	11.36	10.47	10.33	12.48	11.88	10.61	10.87	

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.

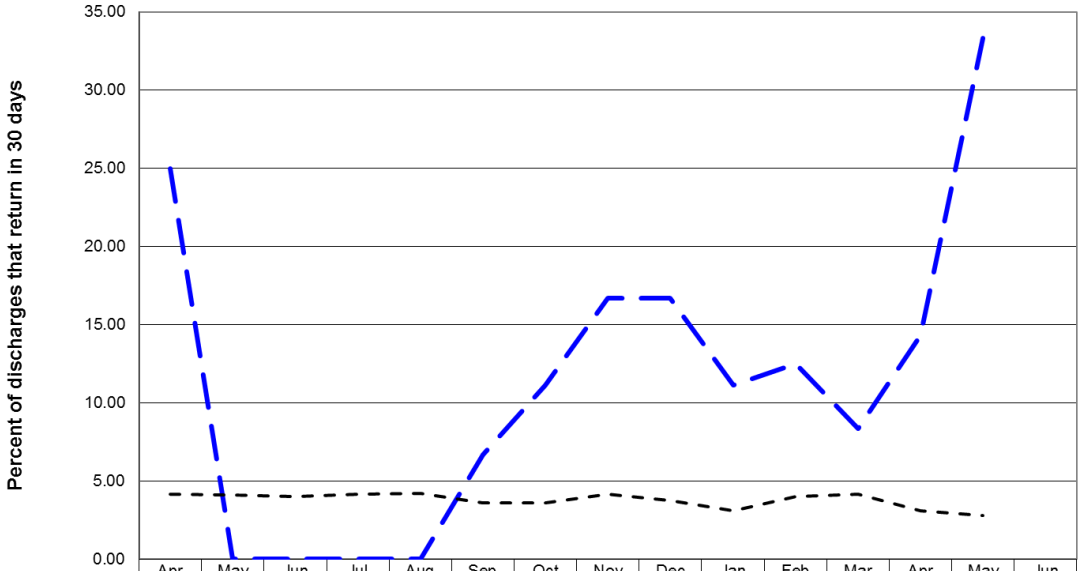
Reasons for patient readmission are varied and may include decompensating or lack of compliance with a PTP. Specific causes for readmission are reviewed with each patient upon their return. These graphs are intended to provide an overview of the readmission picture and do not provide sufficient granularity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

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

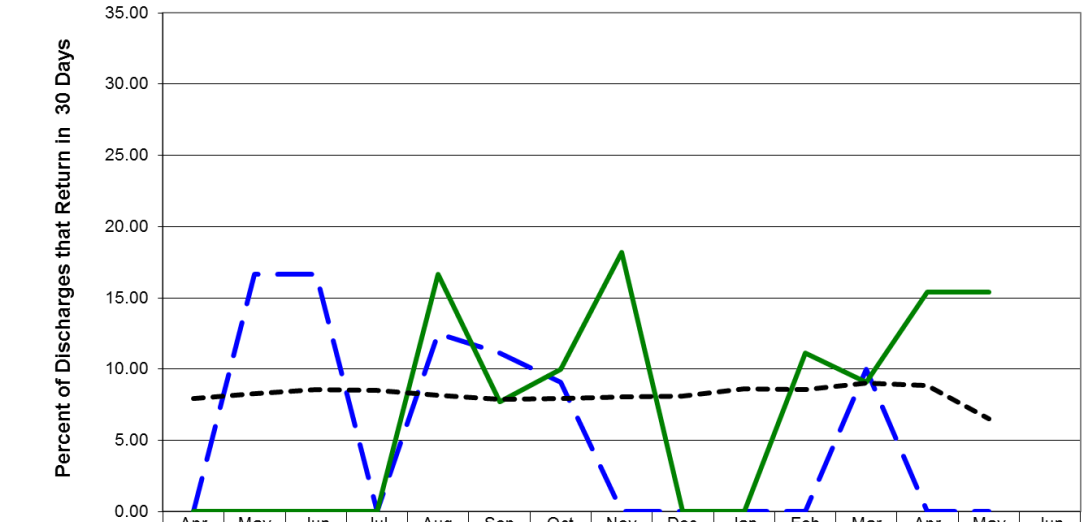
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	25.00	0.00	0.00	0.00	0.00	6.67	11.11	16.67	16.67	11.11	12.50	8.33	14.29	33.33	
Ntl Mean	4.17	4.11	4.01	4.16	4.22	3.58	3.60	4.15	3.76	3.08	4.00	4.15	3.11	2.79	

30 Day Readmit

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	0.00	16.67	16.67	0.00	12.50	11.11	9.09	0.00	0.00	0.00	0.00	10.00	0.00	0.00	
Dorothea Dix	0.00	0.00	0.00	0.00	16.67	7.69	10.00	18.18	0.00	0.00	11.11	9.09	15.38	15.38	
Ntl Mean	7.95	8.26	8.59	8.49	8.16	7.86	7.93	8.06	8.10	8.64	8.57	9.04	8.83	6.51	

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	1Q2016	2Q2016	3Q2016	4Q2016
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% 5/5	100% 4/4	100% 5/5	100% 4/4

4Q2016: Four patients were re-admitted in 4Q2016. Of the 4 re-admitted, all spent less than 30 days in the community. Patient 1 spent 3 days at Maine General Medical Center for medical issues and was readmitted after three days. Patients 2, 3, and 4 were forensic discharges from inpatient evaluations and were each readmitted after 2 days, 22 days, and 25 days, respectively, for IST evaluations.

CONSENT DECREE

Reduction of Re-Hospitalization for Outpatient Services Programs (OPS) Patients

Indicators	1Q16	2Q16	3Q16	4Q16
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% 6/6	100% 2/2	100% 3/3	100% 6/6
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%	100%	100%	100%

4Q2016: 5 NCR patients and 1 PTP patient were returned to RPC; two patients remain at RPC and four have returned to the community. Patient 1 was medically compromised, patient 2 returned for a psychiatric and medical evaluation, patient 3 was returned for allegedly possessing child pornography, patient 4 for threatening to harm others and palming medications, patient 5 for suicidal thoughts, and patient 6 for alcohol use and eviction.

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 DIAGNOSIS	1Q16	2Q16	3Q16	4Q16	TOTAL
ADJUSTMENT DISORDER W/ MIXED DISTURBANCE OF EMOTIONS & CONDUCT	1				**1**
ADJUSTMENT DISORDER WITH DEPRESSED MOOD		1			**1**
ANTISOCIAL PERSONALITY DISORDER	1		1	1	**3**
ANXIETY DISORDER, UNSPECIFIED			1	1	**2**
ATTENTION DEFICIT W/ HYPERACTIVITY	1				**1**
AUTISTIC DISORDER		1			**1**
BIPOLAR DISORD, CRNT EPISODE MANIC SEVER, W PSYCH FEATURES				1	**1**
BIPOLAR DISORD, CRNT EPISODE MANIC W/O PSYCH FEATURES, MILD		1			**1**
BIPOLAR DISORD, CRNT EPSD DEPRESS, SEVERE, W PSYCH FEATURES		1	3		**4**
BIPOLAR DISORDER, UNSPECIFIED	10	6	6	6	**28**
BIPOLAR I DISORDER, SINGLE MANIC EPISODE, SEVERE, SPEC W/ PSYCHOTIC BEHAV	1				**1**
BIPOLAR I DISORDER, SINGLE MANIC EPISODE, SEVERE, W/O PSYCHOTIC FEATURES	1				**1**
BIPOLAR I, REC EPIS OR CURRENT MANIC, IN PARTIAL OR UNSPEC REMISSION	1				**1**
BIPOLAR I, REC EPIS OR CURRENT MANIC, SEVERE, W/ PSYCHOTIC BEHAV	2				**2**
BIPOLAR II DISORDER			1		**1**
BORDERLINE PERSONALITY DISORDER			1	1	**2**
DELUSIONAL DISORDERS	1	1			**2**
DEMENTIA IN OTH DISEASES CLASSD ELSWHR W/ BEHAVIORAL DISTURB		1	1		**2**
DEPRESSIVE DISORDER NEC	3				**3**
DEPRESSIVE DISORDER-UNSPEC	1				**1**
IMPULSE CONTROL DISORDER				1	**1**
MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED			2	1	**3**

CONSENT DECREE

MAJOR DEPRESSV DISORD, RECURRENT, SEVERE W/O PSYCH FEATURES				1	**1**
MAJOR DEPRESSV DISORD, SINGLE EPSD, SEVERE W PSYCH FEATURES			1		**1**
MAJOR DEPRESSV DISORDER, RECURRENT, SEVERE W/PSYCH FEATURES		1	1		**2**
MAJOR DEPRESSV DISORDER, RECURRENT, UNSPECIFIED				1	**1**
MILD COGNITIVE IMPAIRMENT, SO STATED			1		**1**
OTH PSYCH DISORDER NOT DUE TO A SUB OR KNOWN PHYSIOLOGICAL CONDITION		1			**1**
OTHER DEPRESSIVE EPISODES			1		**1**
OTHER SCHIZOPHRENIA		2			**2**
PARANOID SCHIZOPHRENIA		1		4	**5**
PARANOID SCHIZOPHRENIA-UNSPEC	1				**1**
POSTTRAUMATIC STRESS DISORDER-UNSPEC	5	2	3	3	**13**
PSYCHOSIS NOS	4				**4**
RECURRENT DEPRESSIVE DISORDER-PSYCHOTIC	1				**1**
SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE		14	14	12	**40**
SCHIZOAFFECTIVE DISORDER, DEPRESSIVE TYPE			2	1	**3**
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED	14	6	3	2	**25**
SCHIZOPHRENIA, UNSPECIFIED	14	9	14	11	**48**
UNSP PSYCHOSIS NOT DUE TO A SUBSTANCE OR KNOWN PHYSICAL COND		11	8	4	**23**
UNSPECIFIED MODD DISORDER (AFFECTIVE)			1		**1**
UNSPECIFIED MOOD DISORDER (EPISODIC)	2				**2**
Total Admissions	**64**	**59**	**65**	**51**	**239**
Admitted with primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	**0%**	**>1%**	**>1%**	**0%**	**>1%**

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	1Q2016	2Q2016	3Q2016	4Q2016
1. Attendance at Comprehensive Treatment Team meetings. (v9)	*89% 331/401	*86% 446/515	*91% 442/484	78% 430/550
2. Attendance at Service Integration meetings. (v8)	*97% 61/63	96% 47/49	*86% 56/65	43% 20/46
3. Contact during admission. (v8)	100% 64/64	100% 49/49	100% 64/64	100% 51/51
4. Community Integration/Bridging Inpatient & OPS. Inpatient trips OPS	100% 58 127	100% 91 131	100% 26 204	100% 21 221
5. 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.	22% 14/63	41% 20/49	46% 30/65	19% 9/48
6. Grievances responded to on time by Peer Support, within 1 day of receipt.	100% 161/161	100% 97/97	100% 77/77	89% 82/92
7. Peer Specialist will meet with resident's within 48 hours of admission and complete progress note to document meeting.	100% 64/64	100% 49/49	100% 64/64	100% 51/51
8. Each resident has documented contact with a peer supporter during their hospitalization (target is 100%).	100% 64/64	100% 49/49	100% 64/64	100% 51/51

CONSENT DECREE

Treatment Planning

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

Indicators	1Q2016	2Q2016	3Q2016	4Q2016
1. Service Integration Meeting and form completed by the end of the 3rd day.	100% 45/45	100% 45/45	100% 45/45	100% 45/45
2. Patient participation in Service Integration Meeting.	93% 42/45	95% 43/45	97% 44/45	95% 43/45
3. Social Worker participation in Service Integration Meeting.	100% 45/45	100% 45/45	100% 45/45	100% 45/45
4. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	97% 44/45	95% 43/45	95% 43/45	93% 42/45
5. Initial Comprehensive Assessment contains summary narrative with conclusion and recommendations for discharge and Social Worker role.	100% 45/45	100% 45/45	100% 45/45	100% 45/45
6. Annual Psychosocial Assessment completed and current in chart.	100% 10/10	100% 10/10	100% 10/10	100% 10/10

4Q2016:

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

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

Indicators	1Q2016	2Q2016	3Q2016	4Q2016
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all patients on assigned **CCM** caseload.	91% 41/45	96% 43/45	89% 40/45	91% 41/45
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

4Q2016: During chart audits, four charts had a late progress note for the prior week. A meeting was held with the patient, but the note was a late entry. The issue was discussed with individual team members and support was given in supervision. The primary contributing factor is three current social work position vacancies.

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.

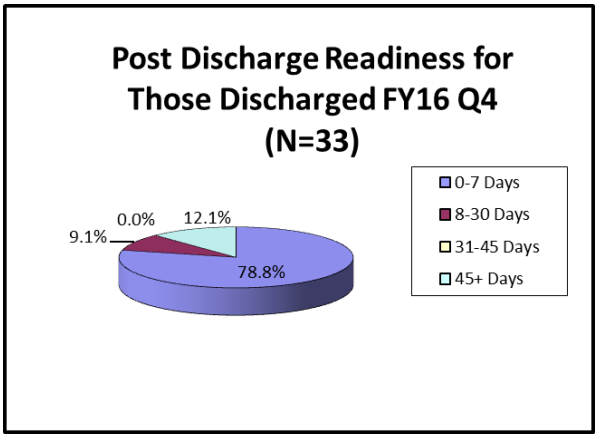
Discharges

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 = (26) 79% (target 79%)

Within 30 days = (3) 88% (target 88%)

Within 45 days = (0) 88% (target 90%)

Post 45 days = (4) 12% (target 0%)

Barriers to Discharge Following Clinical Readiness:

Residential Supports (0) No barriers in this area	Housing (7) • 3 patients discharged (5, 13 and 23 days) post clinical readiness • 4 patients discharged 45+ days post clinical readiness (48, 49, 72, 114 days)
Treatment Services (1) One patient was discharged at 13 days with treatment service barriers (PTP)	
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%**
3Q2016	N=40	57.5%	72.5%	85.0%	10.7%
2Q2016	N=40	67.9%	85.7%	89.3%	10.7%
1Q2016	N=34	64.7%	82.3%	91.1%	8.9%
4Q2015	N=29	65.6%	86.2%	93.1%	6.9%

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	1Q2016	2Q2016	3Q2016	4Q2016
1. The Patient Discharge Plan Report will be updated/reviewed by each **Social Worker minimally one time per week.**	100% 12/12	100% 12/12	100% 13/13	100% 13/13
2. The Patient Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	100% 12/12	100% 12/12	100% 13/13	100% 13/13
3. The Patient Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	83% 10/12	92% 11/12	92% 12/13	85% 11/13
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% 12/12	92% 11/12	100% 13/13	100% 13/13

4Q2016:

3. On two occasions the report was not sent out during the week, it was presented at the Wednesday Housing Meeting; on both occasions it was an issue with the database functioning.

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	1Q2016	2Q2016	3Q2016	4Q2016
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	66% 2/3	0% 0/6	14% 1/7	100% 2/2
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% 3/3	100% 3/3	100% 8/8	100% 3/3
3. Annual Reports (due in December) to the Commissioner for all inpatient NCR patients are submitted annually	N/A	0% 0/25	100% 25/25	N/A

Staffing and Staff Training

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

Indicators	1Q2016	2Q2016	3Q2016	4Q2016	YTD
1. Riverview and Contract staff will attend CPR training bi-annually.	100% 55/55	100% 47/47	100% 41/41	93% 39/42	98% 182/185
2. Riverview and Contract staff will attend Annual training.	86% 89/104	97% 56/58	80% 16/20	62% 58/93	80% 219/275
3. Riverview and contract staff will attend MOAB training bi-annually	100% 28/28	100% 11/11	82% 94/115	76% 152/200	81% 285/354

4Q2016:

1. Three out of 42 employees' CPR has expired. Corrective action has been taken to ensure compliance with this mandatory training component.
2. 35 employees are in need of completing their Annual Mandatory Quiz. Corrective action has been implemented.
3. 48 employees are still in need of MOAB as of January 2016. Due to staff shortages and unit coverage needs, some staff were unable to attend their annual recertification. Several staff in need of recertification have been scheduled to attend training in July 2016.

CONSENT DECREE

Responsible Party: Susan Bundy, Director of Staff Development

I. Measure Name: Ongoing Education and Training

Measure Description: HR.01.05.03 requires that staff will participate in ongoing education and training to increase and maintain their competency.

Type of Measure: Performance Improvement

Goal: 90% of direct support staff will attend Non Violent Communication and Motivational Interviewing training by June 2016. Attendance will be tracked by Staffing and Organizational Development. Progress will be reported quarterly.

Progress: To date, 216 out of 375 current employees, 58%, have attended Non-Violent Communication (NVC) Training. 85 have attended the eight hour NVC Training. 111 employees have attended Motivational Interviewing training.

Comments: Non-Violent Communication and Motivational Interviewing were not offered this quarter.

II. Measure Name: Seclusion and Restraint Reduction

Measure Description: Because restraint and seclusion have the potential to produce serious consequences, such as physical and psychological harm, loss of dignity, violation of the rights of an individual served, and even death, organizations continually explore ways to prevent, reduce, and strive to eliminate restraint and seclusion through effective performance improvement initiatives.

Type of Measure: Performance Improvement

Goal: RPC will decrease the use of seclusion and restraint by 50%.

FY 2015	Manual Holds	Mechanical Restraints	Locked Seclusion	Total Events Per Quarter
Quarter 1	99	10	105	**214**
Quarter 2	107	16	97	**220**
Quarter 3	61	1	62	**124**
Quarter 4	94	4	92	**190**
Total # of events	**361**	**31**	**356**	**748**

***Average # of events per month in FY 2015: 62**

CONSENT DECREE

FY 2016	Manual Holds	Mechanical Restraints	Locked Seclusion	Total Events Per Quarter
Quarter 1	95	6	75	**176**
Quarter 2	61	0	43	**104**
Quarter 3	108	0	72	**180**
Quarter 4	99	3	59	**161**
Total # of events	**363**	**9**	**249**	**621**

***Average # of events per month in FY 2016 to date: 52**

Action Plan:

Staff will receive initial and ongoing education training in MOAB, Non-Violent Communication, and Motivational Interviewing to assist in establishing therapeutic relationships so that when a crisis begins staff will be more influential and effective in preventing the use of seclusions and restraints.

Staff Development will provide ongoing education to reinforce the organization's commitment to ensuring a caring, respectful, therapeutic environment. Data gathered through hospital performance measures will be analyzed to determine progress.

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
4Q2015	17	April – June 2015	
1Q2016	4	July – September 2015	
2Q2016	19	October – December 2015	
3Q2016	14	January – March 2016	
4/7/2016	1	Beyond PTSD: Complex Trauma Caused by Childhood Interpersonal Abuse	Jessica Lloyd, Psychology Intern
4/14/2016	1	Mentalization Based Treatment	Daniel Price, MD
4/20/2016	1	Medical Staff QA & PI Committee	William Nelson, MD
4/21/2016	1.5	Equine Assisted Therapy - The EGALA Model	Hilary Spear, Rec Therapist Heidi Blodgett, Rec Therapist
4/28/2016	1	Treating the Not Guilty by Reason of Insanity Patient: Legal, Ethical and Clinical Issues	Alex de Nesnera, MD
5/12/2016	1	A case history and introduction to Punjabi Culture	Steven Macchione, Psychology Intern
5/17/2016	1	Medical Staff QA/PI Committee	William Nelson, MD
5/19/2016	1	A Complex Case Discussion	Noel Ngai, PsyD; Tatiana Gregor, EdD; Regana Sisson, MD; Maureen Martin, OT
5/26/2016	1	Fire-Setting: Who, Why and How	Brooke Hoffman, PsyD
6/2/2016	1	Hope in the Clinical Context: How Practicing Clinicians Define and Use Hope in Sessions	Brooke Hoffman, PsyD
6/9/2016	1	Precision Medicine: Clinical Applications of Pharmacogenomics	Sarah Perry, PharmD
6/16/2016	1.5	Dartmouth Review: Cultural Aspects of Psychotic Disorder	Regana Sisson, MD
6/17/2016	6	Evaluating the Validity of Miranda Waivers and the Trustworthiness of Confessions	Alen Goldstein, PhD, ABPP
6/23/2016	1	A Multi-Disciplinary Case Presentation	Graham Danzer, Psychology Intern
6/30/2016	1	Psychosis, Seizures or Both?	George Davis, MD

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.

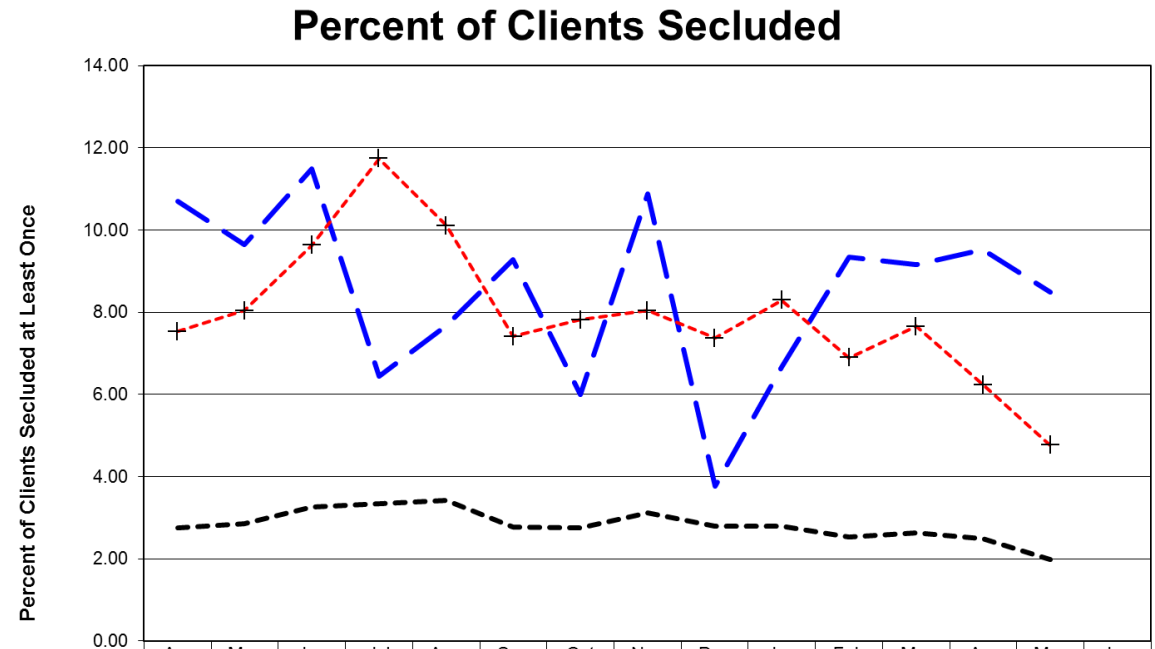
Staffing levels are most often determined by an analysis of unit acuity, individual monitoring needs of the patients who reside on specific units, and unit census.

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.

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 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	10.71	9.64	11.49	6.45	7.69	9.28	6.00	10.89	3.77	6.67	9.35	9.17	9.52	8.49	
Ntl Mean	2.75	2.86	3.26	3.34	3.42	2.78	2.76	3.11	2.80	2.80	2.54	2.63	2.49	1.98	
+1 StDev	7.53	8.04	9.63	11.74	10.11	7.41	7.82	8.04	7.37	8.29	6.89	7.65	6.24	4.77	

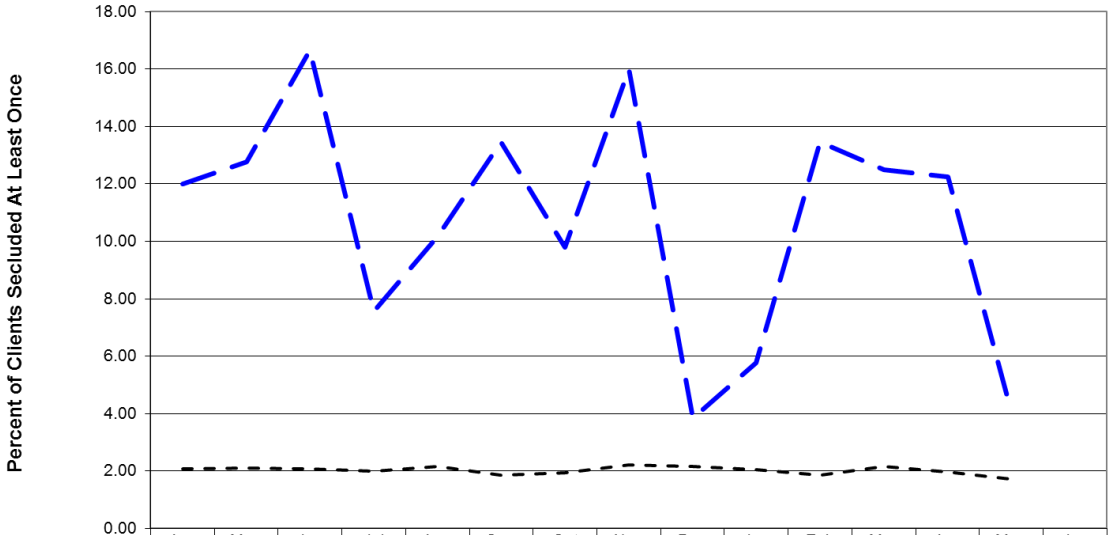
This graph depicts the percent of unique patients who were secluded at least once. For example, rates of 3.0 means that 3% of the unique patients served were secluded at least once.

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

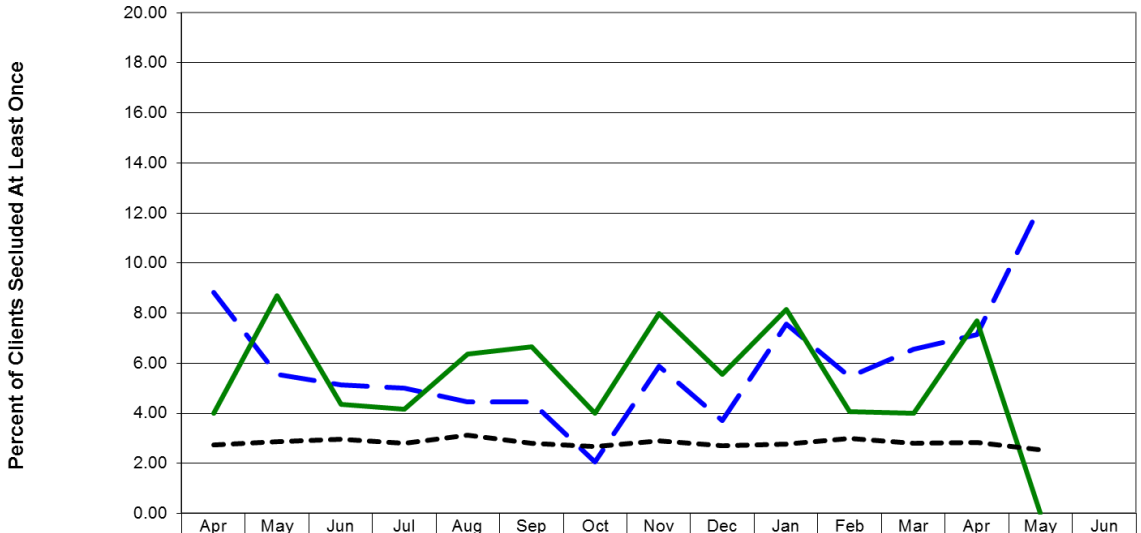
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	12.00	12.77	16.67	7.55	10.17	13.46	9.80	16.00	3.85	5.77	13.46	12.50	12.24	4.08	
Ntl Mean	2.09	2.10	2.07	2.00	2.15	1.86	1.94	2.21	2.15	2.06	1.85	2.16	1.98	1.73	

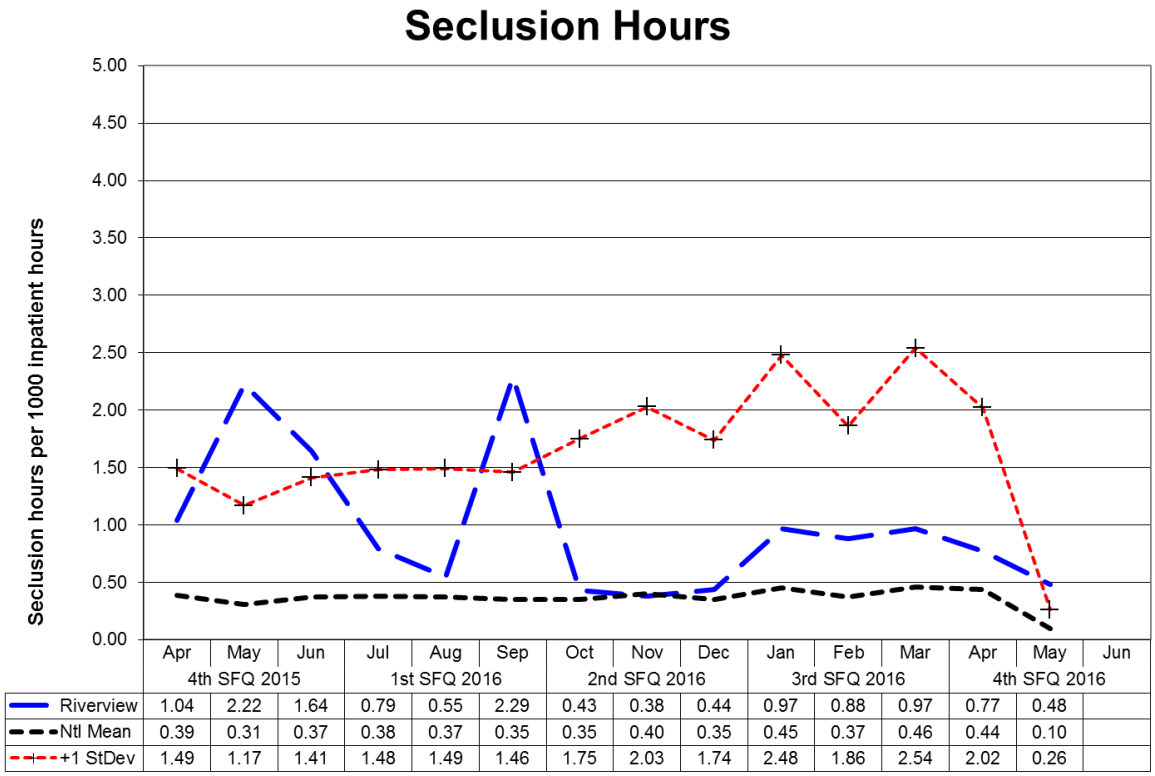
Percent of Clients Secluded

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	8.82	5.56	5.13	5.00	4.44	4.44	2.04	5.88	3.70	7.55	5.45	6.56	7.14	12.28	
Dorothea Dix	4.00	8.70	4.35	4.17	6.38	6.67	4.00	8.00	5.56	8.16	4.08	4.00	7.69	0.00	
Ntl Mean	2.73	2.87	2.97	2.79	3.14	2.81	2.66	2.90	2.72	2.78	2.98	2.79	2.84	2.55	

CONSENT DECREE



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	1.04	2.22	1.64	0.79	0.55	2.29	0.43	0.38	0.44	0.97	0.88	0.97	0.77	0.48	
Ntl Mean	0.39	0.31	0.37	0.38	0.37	0.35	0.35	0.40	0.35	0.45	0.37	0.46	0.44	0.10	
+1 StDev	1.49	1.17	1.41	1.48	1.49	1.46	1.75	2.03	1.74	2.48	1.86	2.54	2.02	0.26	

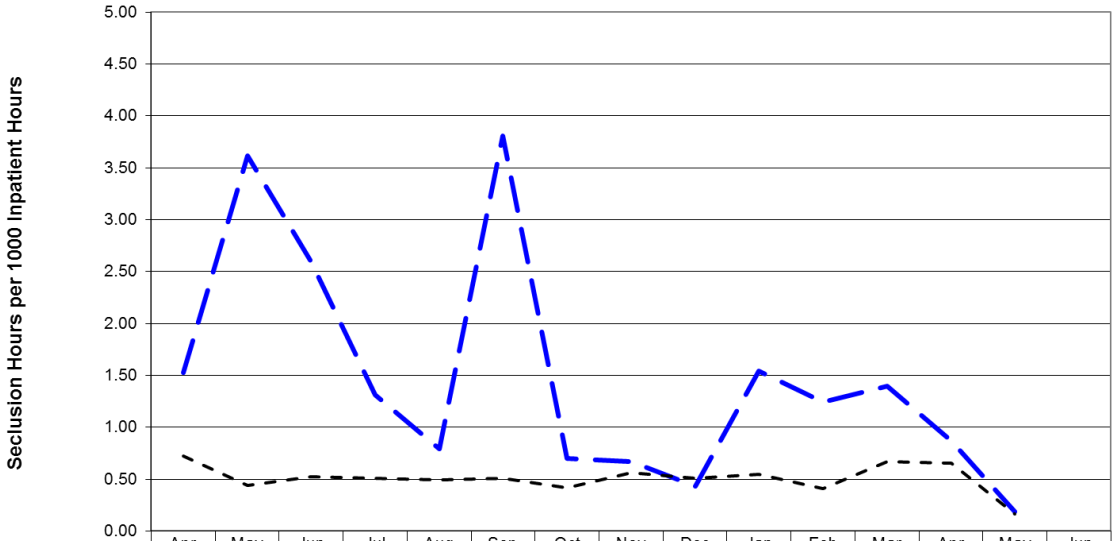
This graph depicts the number of hours patients spent in seclusion for every 1000 inpatient hours. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours.

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

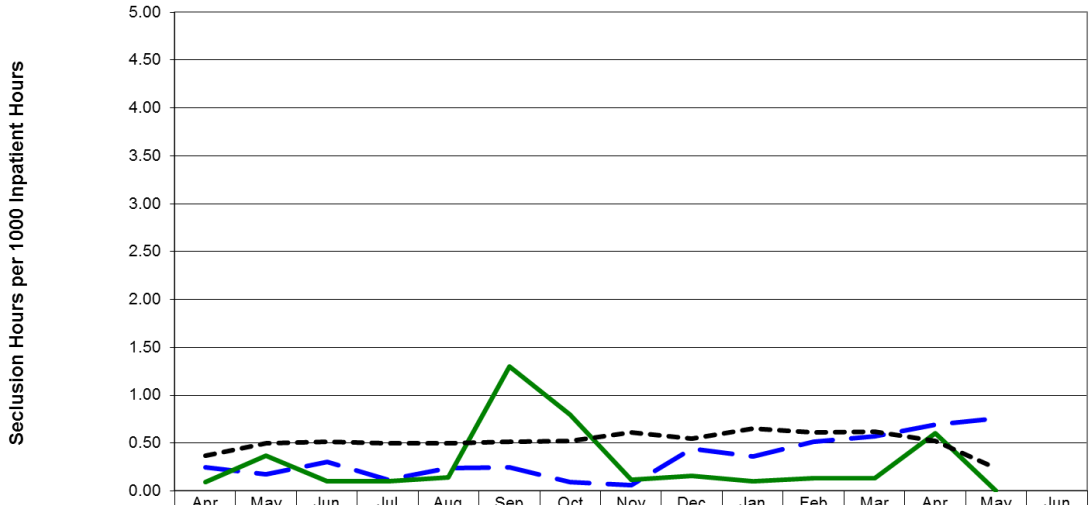
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	1.53	3.62	2.60	1.31	0.79	3.81	0.70	0.67	0.43	1.54	1.24	1.40	0.87	0.19	
Ntl Mean	0.72	0.44	0.52	0.51	0.49	0.51	0.42	0.56	0.51	0.55	0.41	0.67	0.65	0.16	

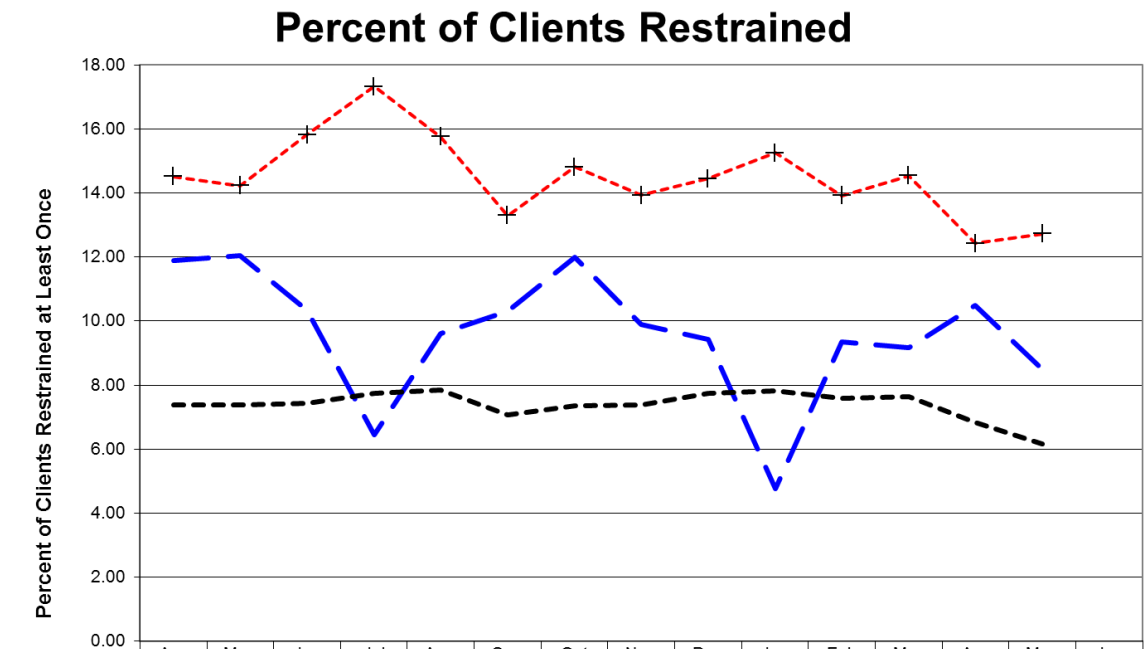
Seclusion Hours

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	0.25	0.17	0.30	0.12	0.24	0.25	0.09	0.06	0.44	0.36	0.51	0.57	0.69	0.76	
Dorothea Dix	0.09	0.37	0.10	0.10	0.14	1.30	0.80	0.12	0.16	0.10	0.13	0.13	0.60	0.00	
Ntl Mean	0.37	0.50	0.51	0.50	0.50	0.51	0.52	0.61	0.55	0.65	0.61	0.62	0.52	0.24	

CONSENT DECREE



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	11.90	12.05	10.34	6.45	9.62	10.31	12.00	9.90	9.43	4.76	9.35	9.17	10.48	8.49	
Ntl Mean	7.38	7.37	7.44	7.74	7.85	7.07	7.36	7.37	7.73	7.83	7.59	7.63	6.83	6.15	
+1 StDev	14.51	14.23	15.82	17.32	15.76	13.29	14.81	13.93	14.45	15.25	13.92	14.54	12.43	12.72	

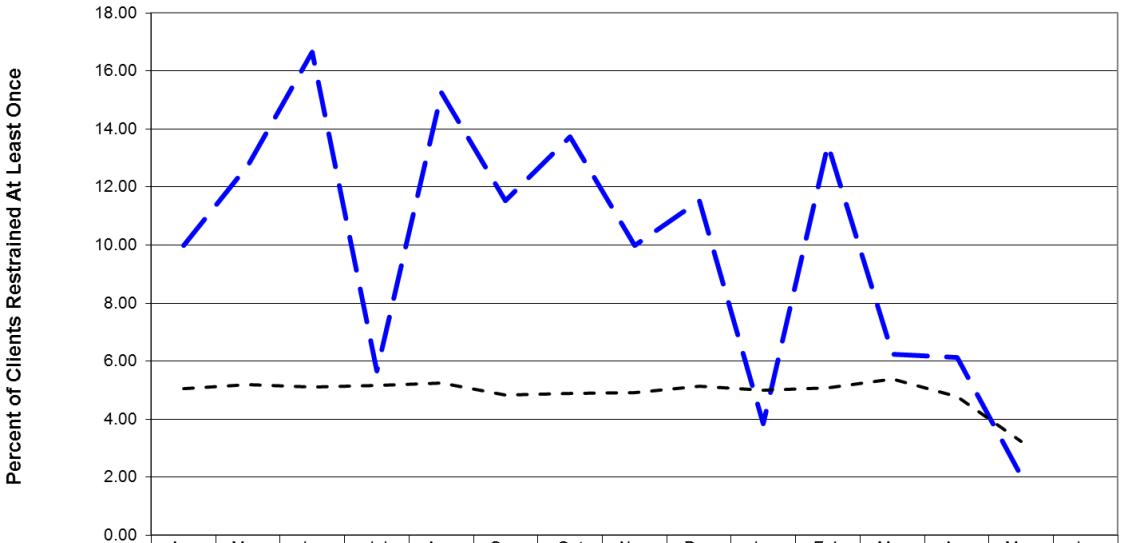
This graph depicts the percent of unique patients who were restrained at least once and includes all forms of restraint of any duration. For example; a rate of 4.0 means that 4% of the unique patients served were restrained at least once.

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

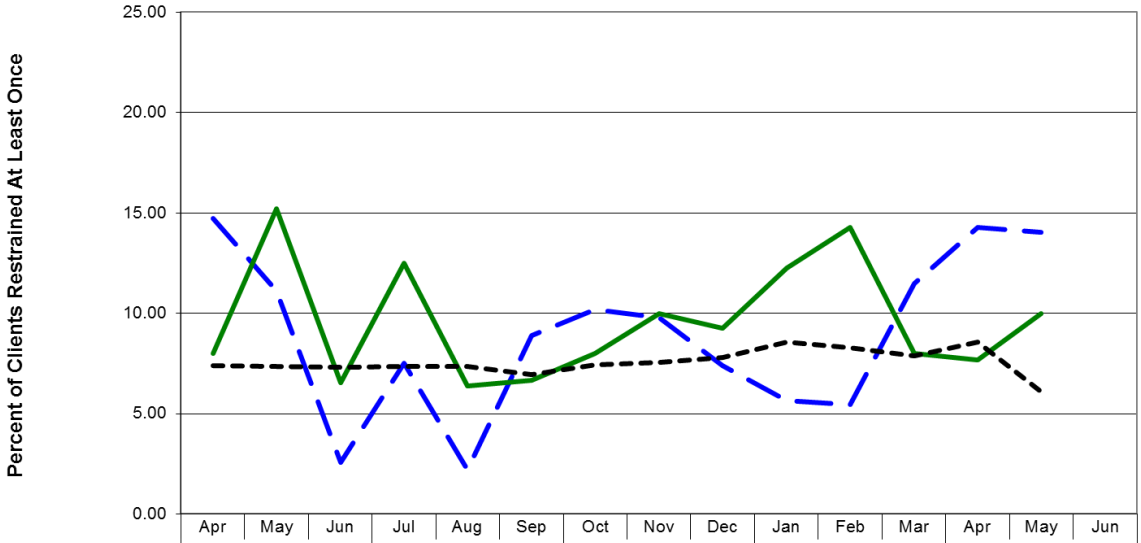
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	10.00	12.77	16.67	5.66	15.25	11.54	13.73	10.00	11.54	3.85	13.46	6.25	6.12	2.04	
Ntl Mean	5.05	5.18	5.10	5.16	5.25	4.84	4.89	4.92	5.14	4.99	5.07	5.39	4.77	3.24	

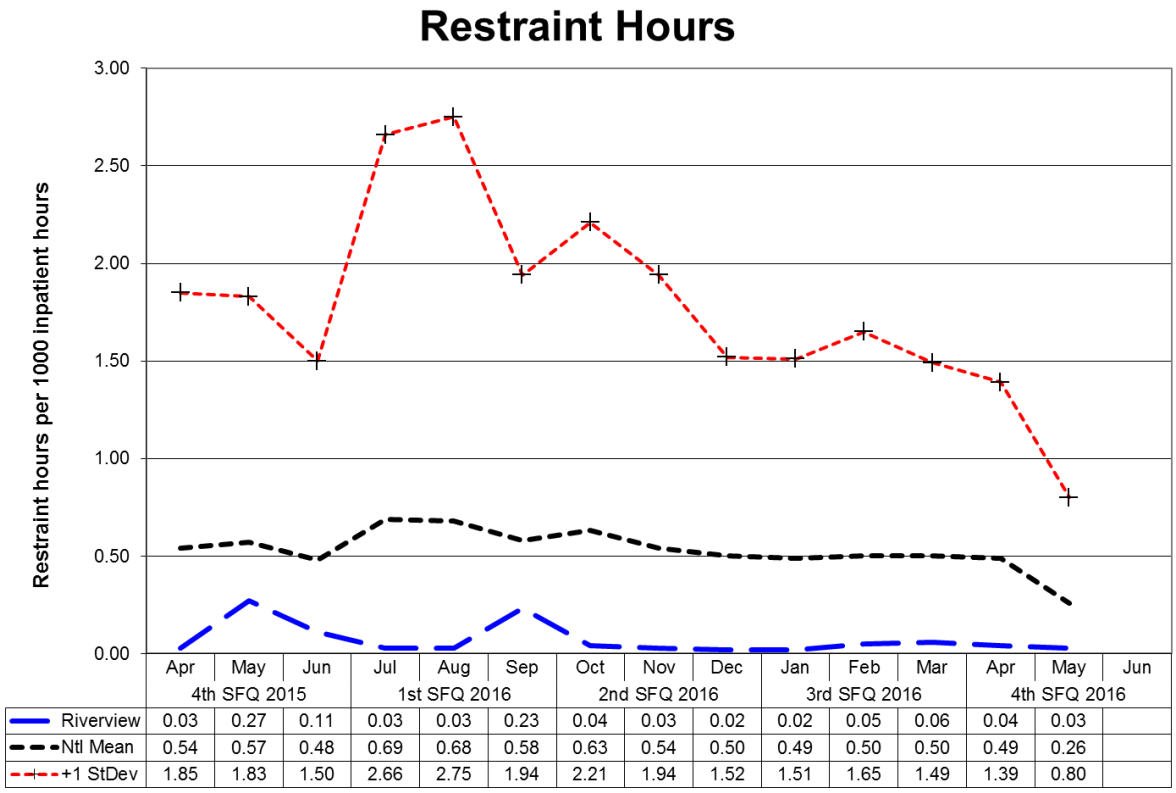
Percent of Clients Restrained

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	14.71	11.11	2.56	7.50	2.22	8.89	10.20	9.80	7.41	5.66	5.45	11.48	14.29	14.04	
Dorothea Dix	8.00	15.22	6.52	12.50	6.38	6.67	8.00	10.00	9.26	12.24	14.29	8.00	7.69	10.00	
Ntl Mean	7.40	7.33	7.32	7.34	7.35	6.96	7.45	7.54	7.81	8.55	8.27	7.86	8.56	6.09	

CONSENT DECREE



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	0.03	0.27	0.11	0.03	0.03	0.23	0.04	0.03	0.02	0.02	0.05	0.06	0.04	0.03	
Ntl Mean	0.54	0.57	0.48	0.69	0.68	0.58	0.63	0.54	0.50	0.49	0.50	0.50	0.49	0.26	
+1 StDev	1.85	1.83	1.50	2.66	2.75	1.94	2.21	1.94	1.52	1.51	1.65	1.49	1.39	0.80	

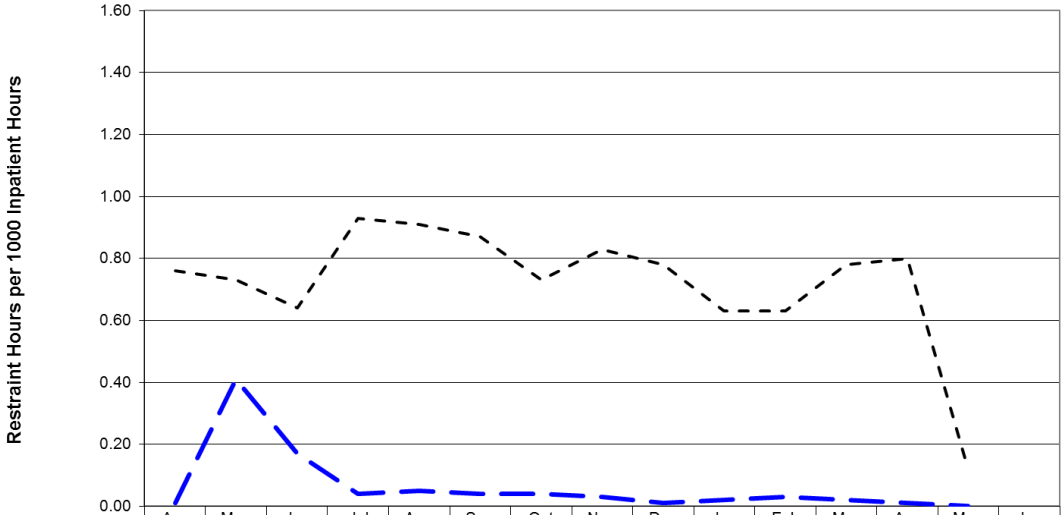
This graph depicts the number of hours patients spent in restraint for every 1000 inpatient hours - includes all forms of restraint of any duration. For example; a rate of 1.6 means those 2 hours were spent in restraint for each 1250 inpatient hours.

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

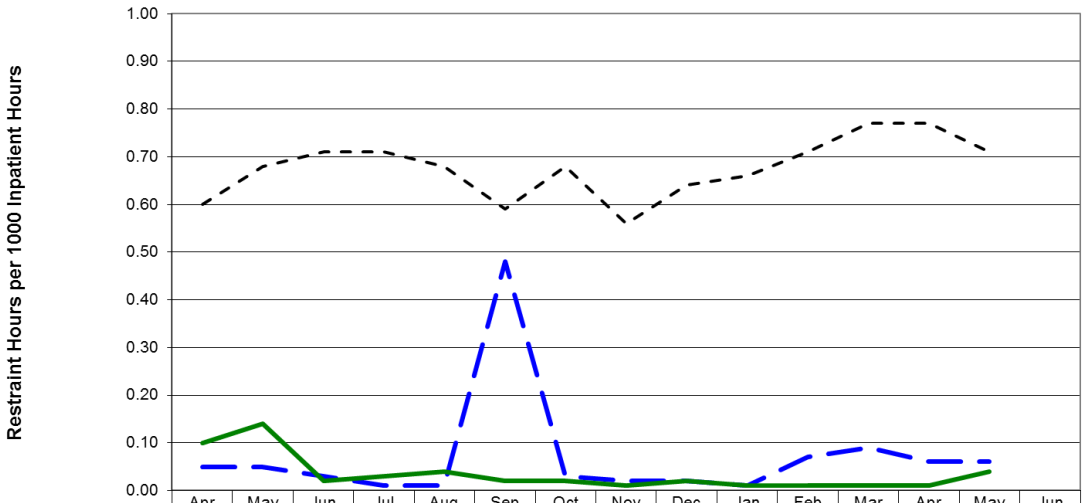
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	0.01	0.41	0.17	0.04	0.05	0.04	0.04	0.03	0.01	0.02	0.03	0.02	0.01	0.00	
Ntl Mean	0.76	0.73	0.64	0.93	0.91	0.87	0.73	0.83	0.78	0.63	0.63	0.78	0.80	0.12	

Restraint Hours

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	0.05	0.05	0.03	0.01	0.01	0.48	0.03	0.02	0.02	0.01	0.07	0.09	0.06	0.06	
Dorothea Dix	0.10	0.14	0.02	0.03	0.04	0.02	0.02	0.01	0.02	0.01	0.01	0.01	0.01	0.04	
Ntl Mean	0.60	0.68	0.71	0.71	0.68	0.59	0.68	0.56	0.64	0.66	0.71	0.77	0.77	0.71	

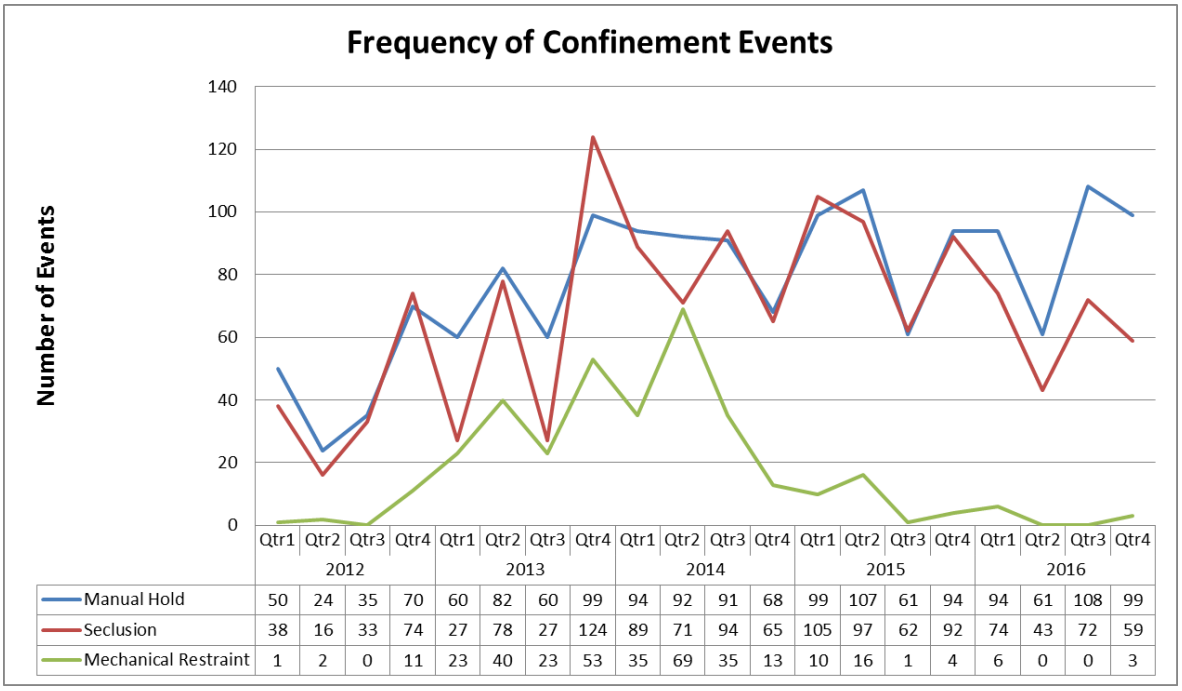
CONSENT DECREE

Confinement Event Detail
4Q2016

	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
MR7880	35		17	52	32.30%	32.30%
MR7127	13		4	17	10.56%	42.86%
MR7878	11		6	17	10.56%	53.42%
MR657	7	3	1	11	6.83%	60.25%
MR7873	5		4	9	5.59%	65.84%
MR7893	3		4	7	4.35%	70.19%
MR4296	2		3	5	3.11%	73.29%
MR7794	2		3	5	3.11%	76.40%
MR7902	3		2	5	3.11%	79.50%
MR7899	2		2	4	2.48%	81.99%
MR7908	4			4	2.48%	84.47%
MR5984			3	3	1.86%	86.34%
MR5297	2		1	3	1.86%	88.20%
MR7315	1		2	3	1.86%	90.06%
MR7924	2		1	3	1.86%	91.93%
MR763	1		1	2	1.24%	93.17%
MR6714	1		1	2	1.24%	94.41%
MR161	1			1	0.62%	95.03%
MR3766			1	1	0.62%	95.65%
MR4647	1			1	0.62%	96.28%
MR5085	1			1	0.62%	96.90%
MR6314			1	1	0.62%	97.52%
MR7363			1	1	0.62%	98.14%
MR7607	1			1	0.62%	98.76%
MR7879			1	1	0.62%	99.38%
MR7915	1			1	0.62%	100.00%
	99	**3**	**59**	**161**		

30% (26/87) of the average hospital population experienced some form of confinement event during 4Q2016. Five of these patients (6% of the average hospital population) accounted for 70% of the confinement events.

CONSENT DECREE



	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	Qtr1 2016	Qtr2 2016	Qtr3 2016	Qtr4 2016
Manual Hold	50	24	35	70	60	82	60	99	94	92	91	68	99	107	61	94	94	61	108	99
Seclusion	38	16	33	74	27	78	27	124	89	71	94	65	105	97	62	92	74	43	72	59
Mechanical Restraint	1	2	0	11	23	40	23	53	35	69	35	13	10	16	1	4	6	0	0	3

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:

	1Q2016	2Q2016	3Q2016	4Q2016	Total
Danger to Others/Self	43	35	42	57	**177**
Danger to Others		23	29	2	**54**
Danger to Self			1		**1**
% Dangerous Participation	100%	100%	100%	100%	**100%**
Total Events	**43**	**58**	**72**	**59**	**232**

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:

	1Q2016	2Q2016	3Q2016	4Q2016	Total
Danger to Others/Self				3	**3**
Danger to Others					**0**
Danger to Self					**0**
% Dangerous Participation				100%	**100%**
Total Events	**0**	**0**	**0**	**3**	**3**

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 35-39

CONSENT DECREE

Confinement Events Management

Seclusion Events

(59) Events

Standard	Threshold	Compliance
1. 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%	98%
2. The record reflects that lesser restrictive alternatives were inappropriate or ineffective. This can be reflected anywhere in record.	90%	98%
3. The record reflects that the decision to place the patient in seclusion was made by a physician or physician extender.	90%	98%
4. The decision to place the patient in seclusion was entered in the patient's records as a medical order.	90%	98%
5. 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%
6. 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%
7. 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%
8. Individuals implementing seclusion have been trained in techniques and alternatives.	90%	100%
9. 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%
10. The medical order states time of entry of order and that number of hours in seclusion shall not exceed 4.	85%	100%
11. The medical order states the conditions under which the patient may be sooner released.	85%	100%

12. The record reflects that the need for seclusion is re-evaluated at least every 2 hours by a nurse.	90%	100%
13. The record reflects that the 2 hour re-evaluation was conducted while the patient was out of seclusion room unless clinically contraindicated.	70%	100%
14. 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%
15. 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%
16. Reports of seclusion events were forwarded to Clinical Director and Patient Advocate.	90%	100%
17. The record reflects that, for persons with mental retardation, the regulations governing seclusion of patients with mental retardation were met.	85%	100%
18. The medical order for seclusion was not entered as a PRN order.	90%	100%
19. Where there was a PRN order, there is evidence that physician was counseled.	95%	N/A

CONSENT DECREE

Confinement Events Management

Mechanical Restraint Events

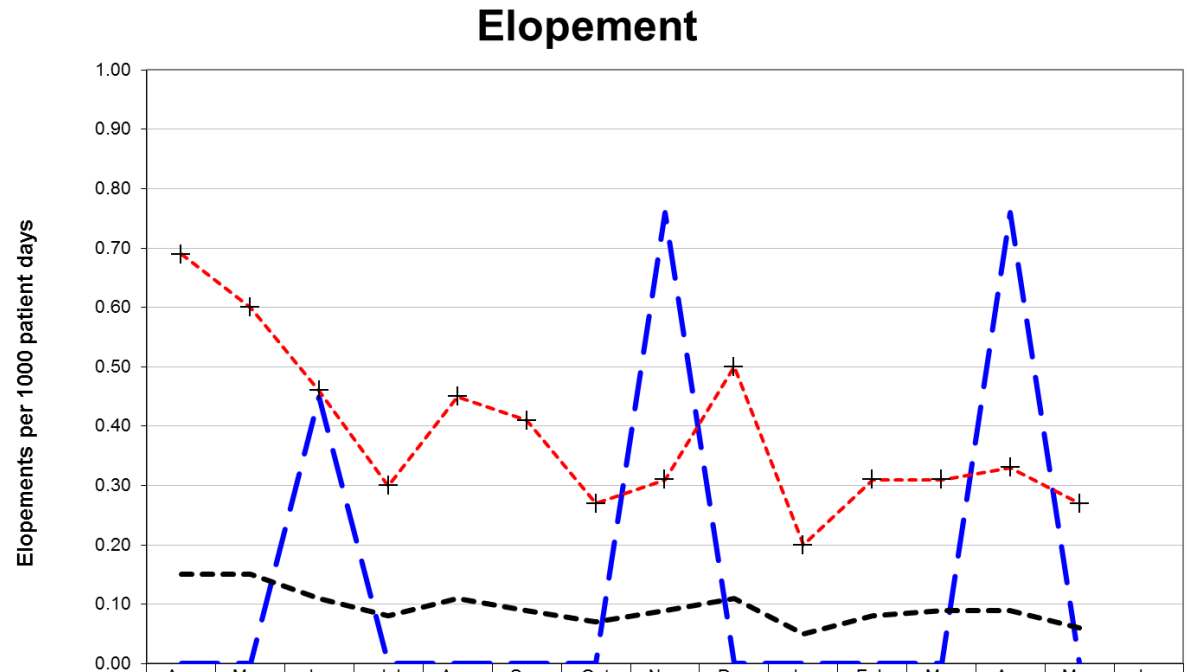
(3) Events

Standard	Threshold	Compliance
1. The record reflects that restraint was absolutely necessary to protect the patient from causing serious physical injury to self or others.	95%	100%
2. The record reflects that lesser restrictive alternatives were inappropriate or ineffective.	90%	100%
3. The record reflects that the decision to place the patient in restraint was made by a physician or physician extender	90%	100%
4. The decision to place the patient in restraint was entered in the patient's records as a medical order.	90%	100%
5. 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%
6. 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%
7. The record reflects that the patient was kept under constant observation during restraint.	95%	100%
8. Individuals implementing restraint have been trained in techniques and alternatives.	90%	100%
9. 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%
10. The medical order states time of entry of order and that number of hours shall not exceed four.	90%	100%
11. The medical order shall state the conditions under which the patient may be sooner released.	85%	100%
12. The record reflects that the need for restraint was re-evaluated every 2 hours by a nurse.	90%	100%
13. The record reflects that re-evaluation was conducted while the patient was free of restraints unless clinically contraindicated.	70%	100%

14. 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%
15. The record reflects that the patient was released as necessary for eating, drinking, bathing, toileting or special medical orders.	90%	100%
16. The record reflects that the patient's extremities were released sequentially, with one released at least every fifteen minutes.	90%	100%
17. Copies of events were forwarded to Clinical Director and Patient Advocate.	90%	100%
18. For persons with mental retardation, the applicable regulations were met.	85%	100%
19. The record reflects that the order was not entered as a PRN order.	90%	100%
20. Where there was a PRN order, there is evidence that physician was counseled.	95%	N/A
21. 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 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	0.00	0.00	0.45	0.00	0.00	0.00	0.00	0.76	0.00	0.00	0.00	0.00	0.76	0.00	
Ntl Mean	0.15	0.15	0.11	0.08	0.11	0.09	0.07	0.09	0.11	0.05	0.08	0.09	0.09	0.06	
+1 StDev	0.69	0.60	0.46	0.30	0.45	0.41	0.27	0.31	0.50	0.20	0.31	0.31	0.33	0.27	

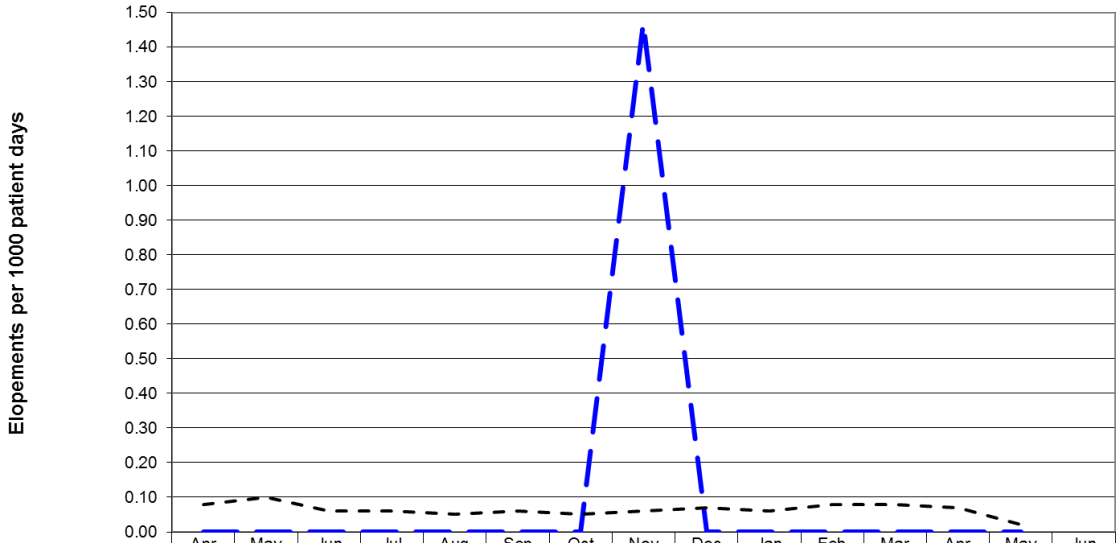
This graph depicts the number of elopements that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days. An elopement is defined as any time a patient is "absent from a location defined by the patient's privilege status regardless 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

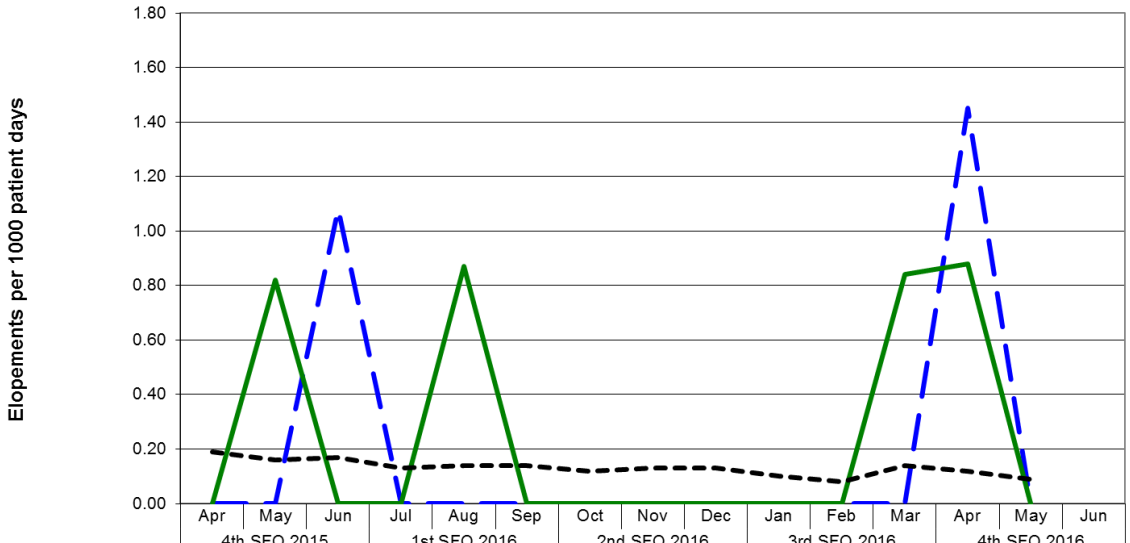
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.47	0.00	0.00	0.00	0.00	0.00	0.00	
Ntl Mean	0.08	0.10	0.06	0.06	0.05	0.06	0.05	0.06	0.07	0.06	0.08	0.08	0.07	0.02	

Elopement

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	0.00	0.00	1.08	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.45	0.00	
Dorothea Dix	0.00	0.82	0.00	0.00	0.87	0.00	0.00	0.00	0.00	0.00	0.00	0.84	0.88	0.00	
Ntl Mean	0.19	0.16	0.17	0.13	0.14	0.14	0.12	0.13	0.13	0.10	0.08	0.14	0.12	0.09	

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.

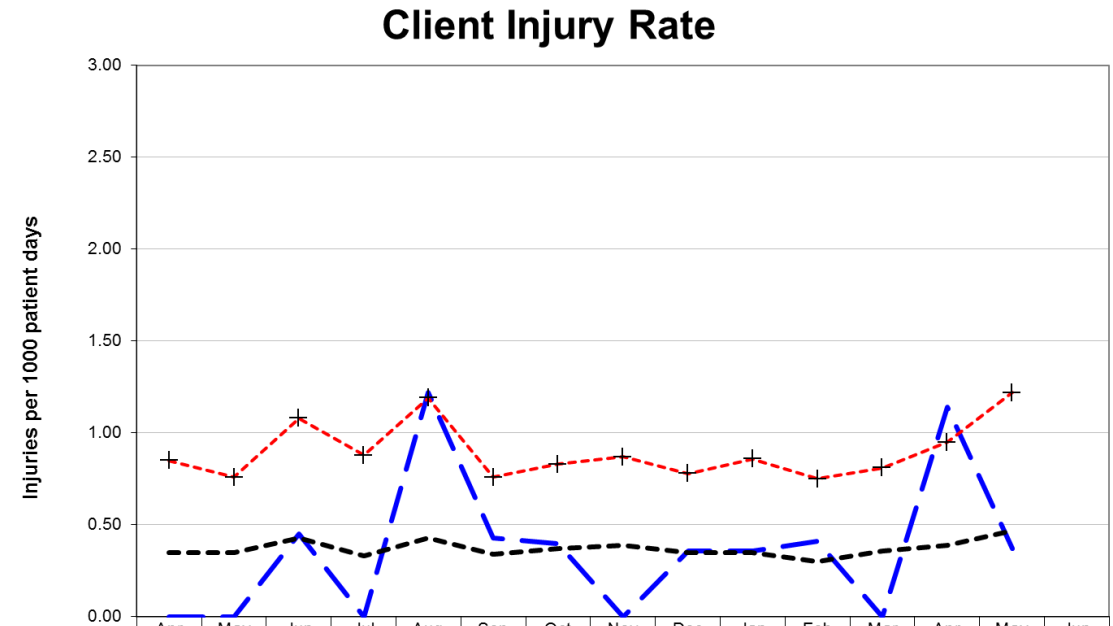
"Non-reportable" injuries include those that require: 1) No Treatment, or 2) Minor First Aid

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 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	0.00	0.00	0.45	0.00	1.22	0.43	0.40	0.00	0.36	0.36	0.41	0.00	1.14	0.37	
Ntl Mean	0.35	0.35	0.43	0.33	0.43	0.34	0.37	0.39	0.35	0.35	0.30	0.36	0.39	0.47	
+1 StDev	0.85	0.76	1.08	0.88	1.19	0.76	0.83	0.87	0.78	0.86	0.75	0.81	0.95	1.22	

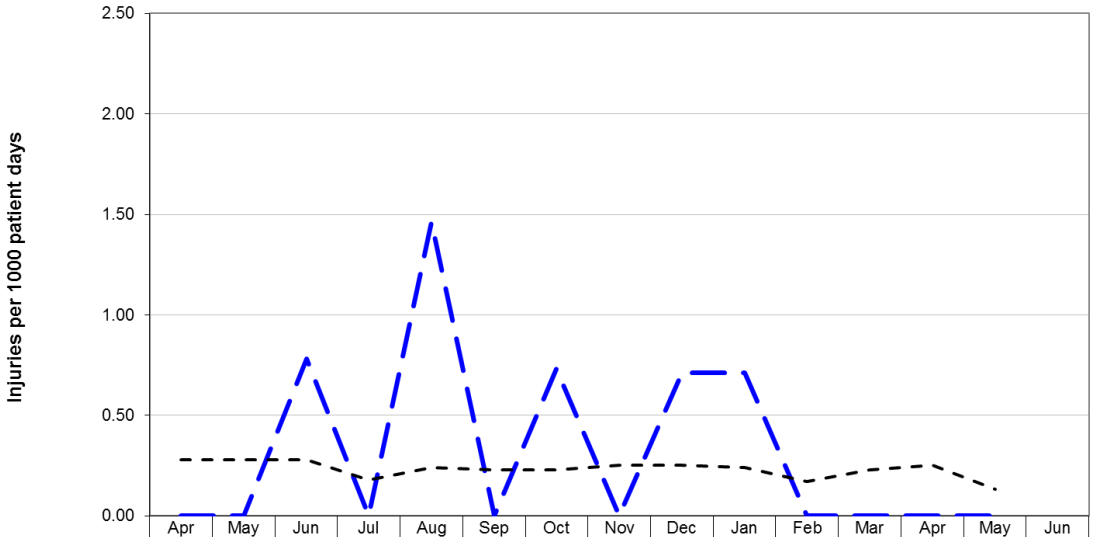
This graph depicts the number of patient injury events that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days.

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

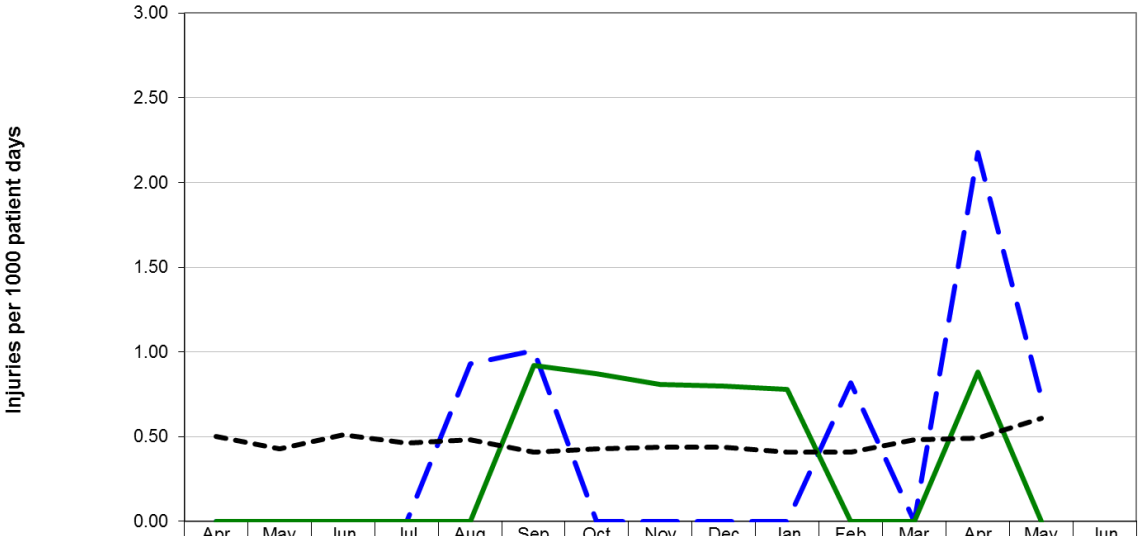
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	0.00	0.00	0.78	0.00	1.46	0.00	0.73	0.00	0.71	0.71	0.00	0.00	0.00	0.00	
Ntl Mean	0.28	0.28	0.28	0.18	0.24	0.23	0.23	0.25	0.25	0.24	0.17	0.23	0.25	0.13	

Client Injury Rate

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	0.00	0.00	0.00	0.00	0.93	1.01	0.00	0.00	0.00	0.00	0.82	0.00	2.18	0.73	
Dorothea Dix	0.00	0.00	0.00	0.00	0.00	0.92	0.87	0.81	0.80	0.78	0.00	0.00	0.88	0.00	
Ntl Mean	0.50	0.43	0.51	0.46	0.48	0.41	0.43	0.44	0.44	0.41	0.41	0.48	0.49	0.61	

CONSENT DECREE

Type and Cause of Injury by Month

Type - Cause	April	May	June	4Q2016
Accident	3	2	3	**8**
Assault (Patient to Patient)	2	2		**4**
Fall	5	1	3	**9**
Injury – Other	2	1	6	**9**
Self-Injurious Behavior	2	1	3	**6**
Total	**14**	**7**	**15**	**36**

Severity of Injury by Month

Severity	April	May	June	4Q2016
No Treatment	5	4	8	**17**
Minor First Aid	7	2	5	**14**
Medical Intervention Required	2	1	2	**5**
Hospitalization Required				
Death Occurred				
Total	**14**	**7**	**15**	**36**

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	1Q2016	2Q2016	3Q2016	4Q2016	Total
Abuse Verbal	8	11	8	6	**33**
Abuse Physical	14	11	13	15	**53**
Abuse Sexual	27	9	11	17	**64**
Neglect	3	2	1	2	**8**
Coercion/Exploitation	2	4	6	8	**20**
Total	**54**	**37**	**39**	**48**	**178**

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 in 2013 and is due for an upcoming reaccreditation visit in 2016. The hospital is currently completing its annual application for an accreditation visit in the fall of 2016.

V35) Riverview maintains its hospital license;

Riverview maintains its licensing status as required through the Maine Department of Health and Human Services Division of Licensing and Regulatory Services. The hospital is licensed through October 31, 2016.

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. Plans are being developed to apply for certification.

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 2015.

CONSENT DECREE

Recommendation from Court Master

February 9, 2016

Court Master Recommendation	Riverview Action
I recommend that Riverview implement unit based staffing on a pilot basis in one of the four units on or before April 4, 2016 with implementation on all other units to be completed on or before August 1, 2016.	The Upper Kennebec Unit moved to unit based staffing on April 4, 2016. The hospital has entered into a contract with Applied Management Services to assist in developing unit based/acuity based staffing models for the entire hospital. The contract has two components: first, an analysis of current staffing models and recommendations based on those findings and second installation of a software program that allows the hospital to monitor patient acuity and assign unit staff based on the acuity. Initial meetings with the vendor have occurred and the vendor's software is being updated to work on State of Maine servers.
I recommend that the newly created positions for acuity specialists not be counted for purposes of determining compliance with the staffing ratios for mental health workers required by the Consent Decree. This change is designed to ensure that acuity specialists are assigned to their designated tasks and not used as substitutes for mental health workers.	The Director of Nursing notified the staffing office of this change. Acuity Specialists are no longer counted for purposes of determining compliance with staffing ratios for mental health workers.
I recommend that an annual review of restrictive practices and the management system being used by the hospital be conducted by a fully independent consultant, with the report of the first review due on or before July 1, 2016. The scope of the review and the selection of the independent consultant to require the approval of the Court Master.	The hospital and Court Master are reviewing the review given the hiring of a new superintendent and anticipated change in practices. The scope of the review and the choice of consultant are under review at this time.

CONSENT DECREE

I recommend that the mental health workers who are most familiar with the patients be invited by the charge nurse on the unit to attend at least the initial portion of the treatment team meetings for those patients in order to provide input and observations, and that acuity specialists be invited to attend whenever it is deemed appropriate by the charge nurse. Current and relevant portions of the treatment plans, such as interventions, shall be maintained on the unit and reviewed with the charge nurse by the mental health workers assigned to those patients.	Changes are in process to determine how to best use the knowledge of the mental health workers in the treatment team meetings. This is being reviewed and implemented on each unit in the hospital. Processes for ensuring that the most current treatment information is being made available to all staff on an ongoing basis.
I recommend that unit activity logs be maintained on each unit and that the logs be reviewed at least on a monthly basis to determine whether any limitation in a patient's access to treatment, services or outdoor areas has occurred.	Unit activity logs are maintained on each unit. Nurse educators are training staff on the required documentation regarding any limitations to treatment, services or outdoor activities.

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 health care 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)

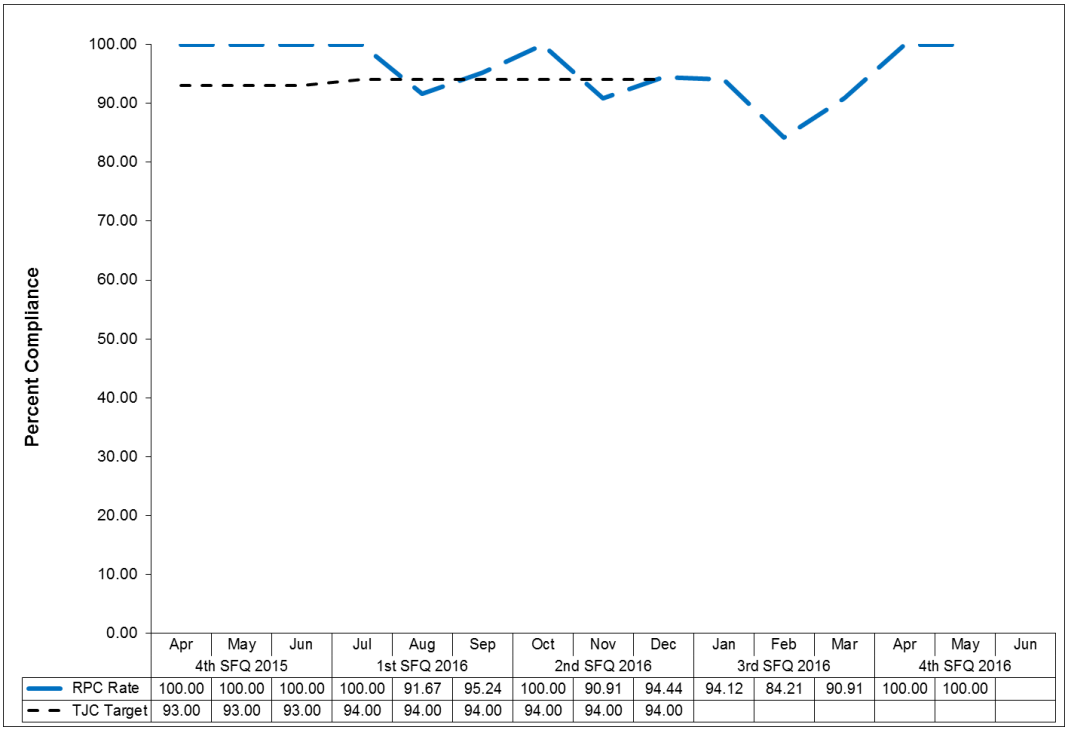
For Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths

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.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
RPC Rate	100.00	100.00	100.00	100.00	91.67	95.24	100.00	90.91	94.44	94.12	84.21	90.91	100.00	100.00	
TJC Target	93.00	93.00	93.00	94.00	94.00	94.00	94.00	94.00	94.00						

JOINT COMMISSION

Physical Restraint (HBIPS 2)

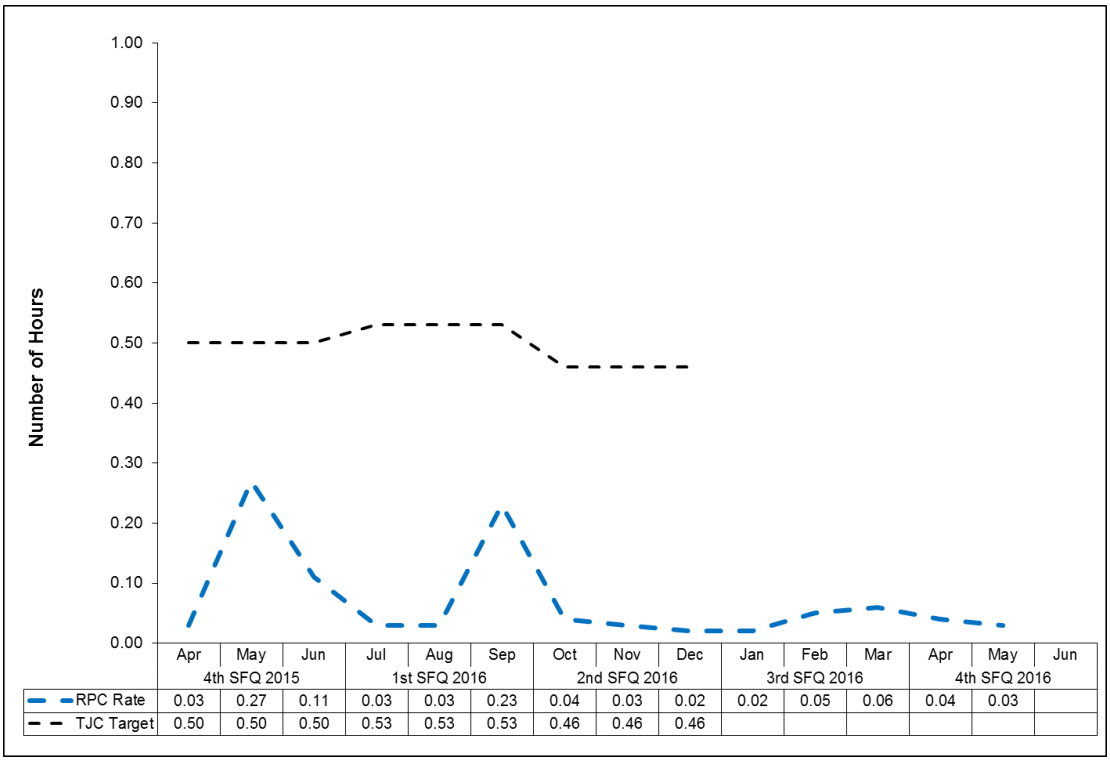
Hours of Use

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).



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
RPC Rate	0.03	0.27	0.11	0.03	0.03	0.23	0.04	0.03	0.02	0.02	0.05	0.06	0.04	0.03	
TJC Target	0.50	0.50	0.50	0.53	0.53	0.53	0.46	0.46	0.46						

JOINT COMMISSION

Seclusion (HBIPS 3)

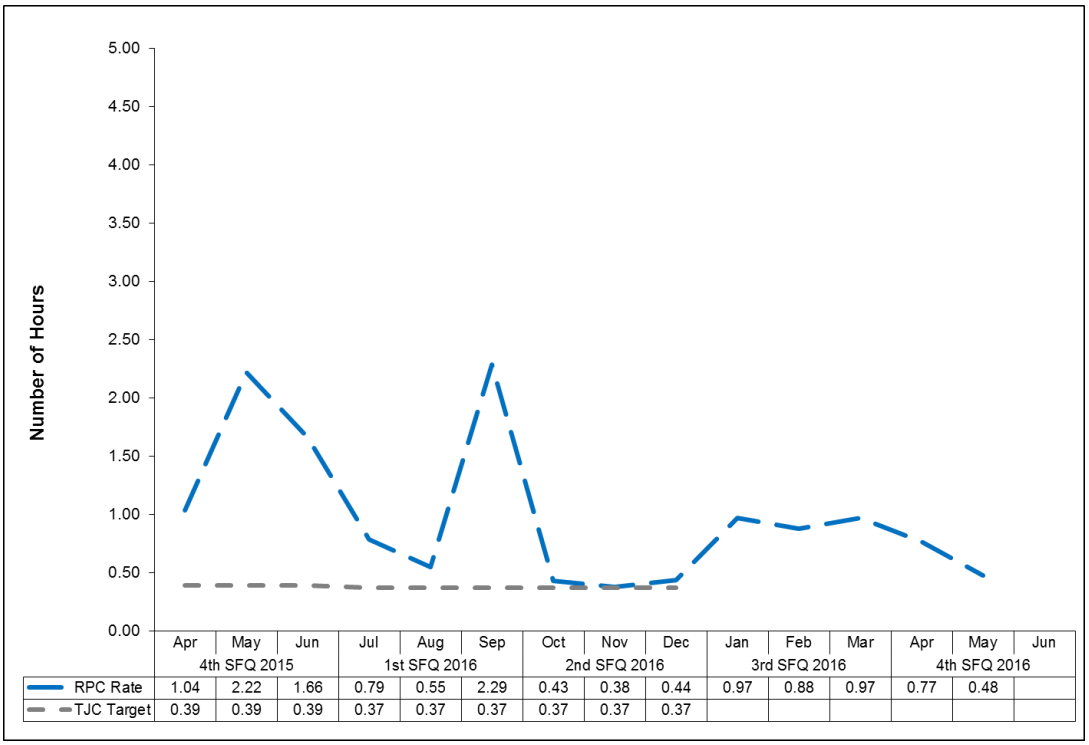
Hours of Use

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).



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
RPC Rate	1.04	2.22	1.66	0.79	0.55	2.29	0.43	0.38	0.44	0.97	0.88	0.97	0.77	0.48	
TJC Target	0.39	0.39	0.39	0.37	0.37	0.37	0.37	0.37	0.37						

JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)

Description

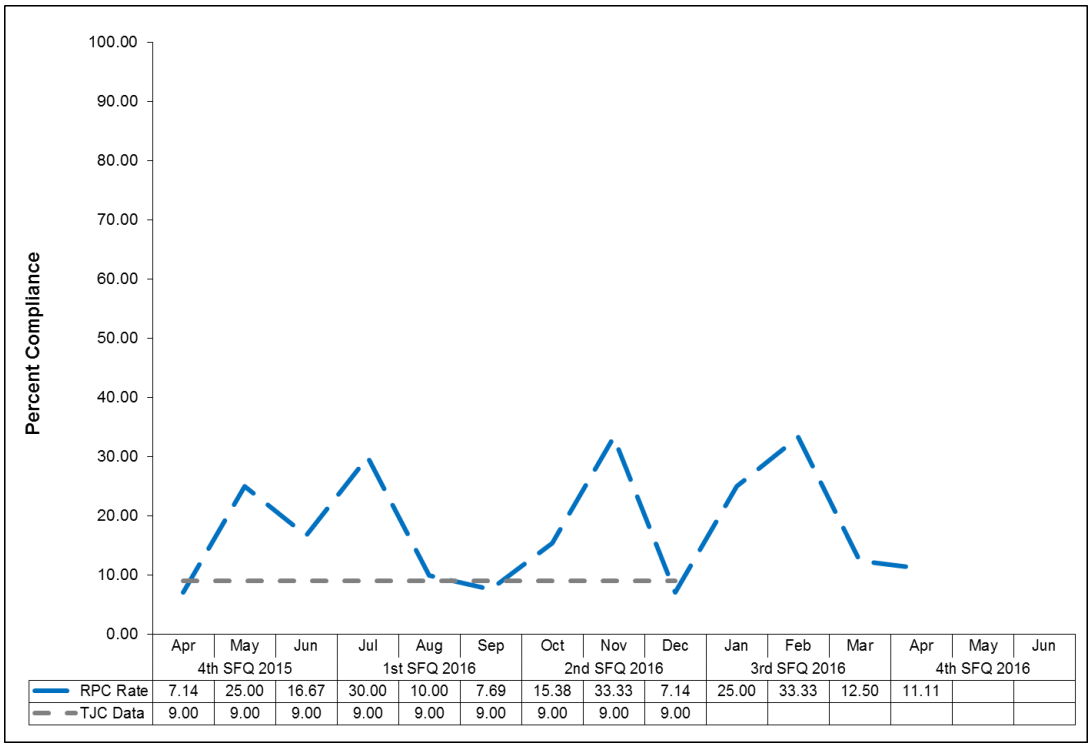
Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications.

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)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
RPC Rate	7.14	25.00	16.67	30.00	10.00	7.69	15.38	33.33	7.14	25.00	33.33	12.50	11.11		
TJC Data	9.00	9.00	9.00	9.00	9.00	9.00	9.00	9.00	9.00						

Note: no patients were prescribed multiple antipsychotics in May 2016.

Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)

Description

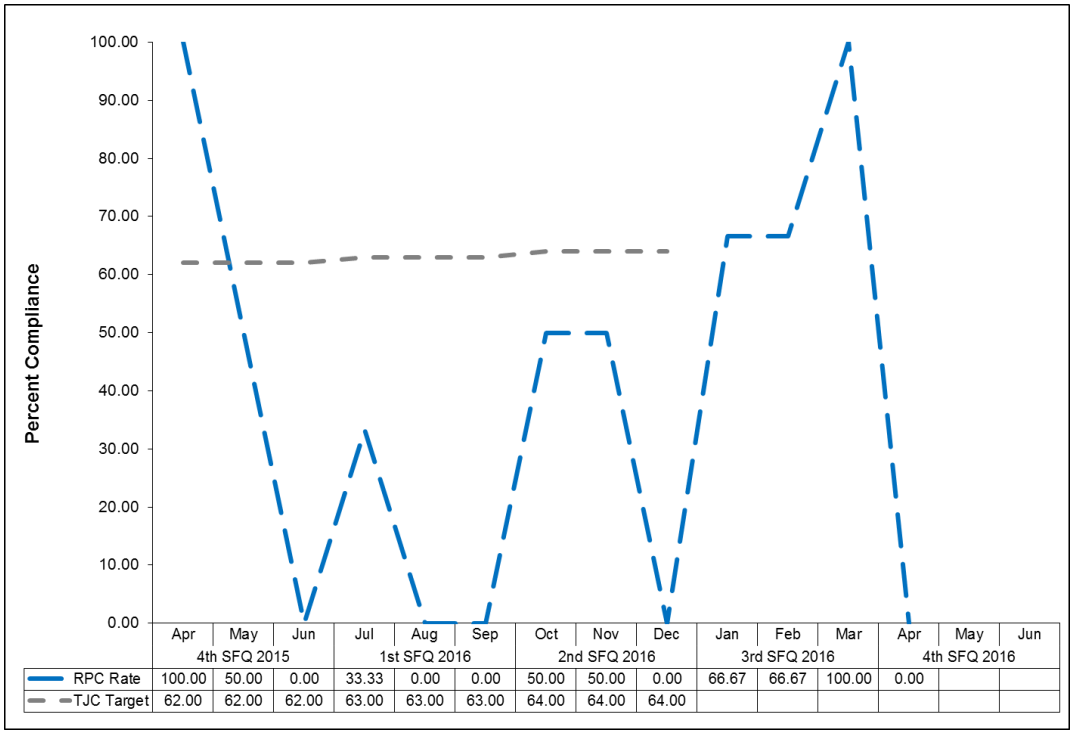
Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification.

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)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
RPC Rate	100.00	50.00	0.00	33.33	0.00	0.00	50.00	50.00	0.00	66.67	66.67	100.00	0.00		
TJC Target	62.00	62.00	62.00	63.00	63.00	63.00	64.00	64.00	64.00						

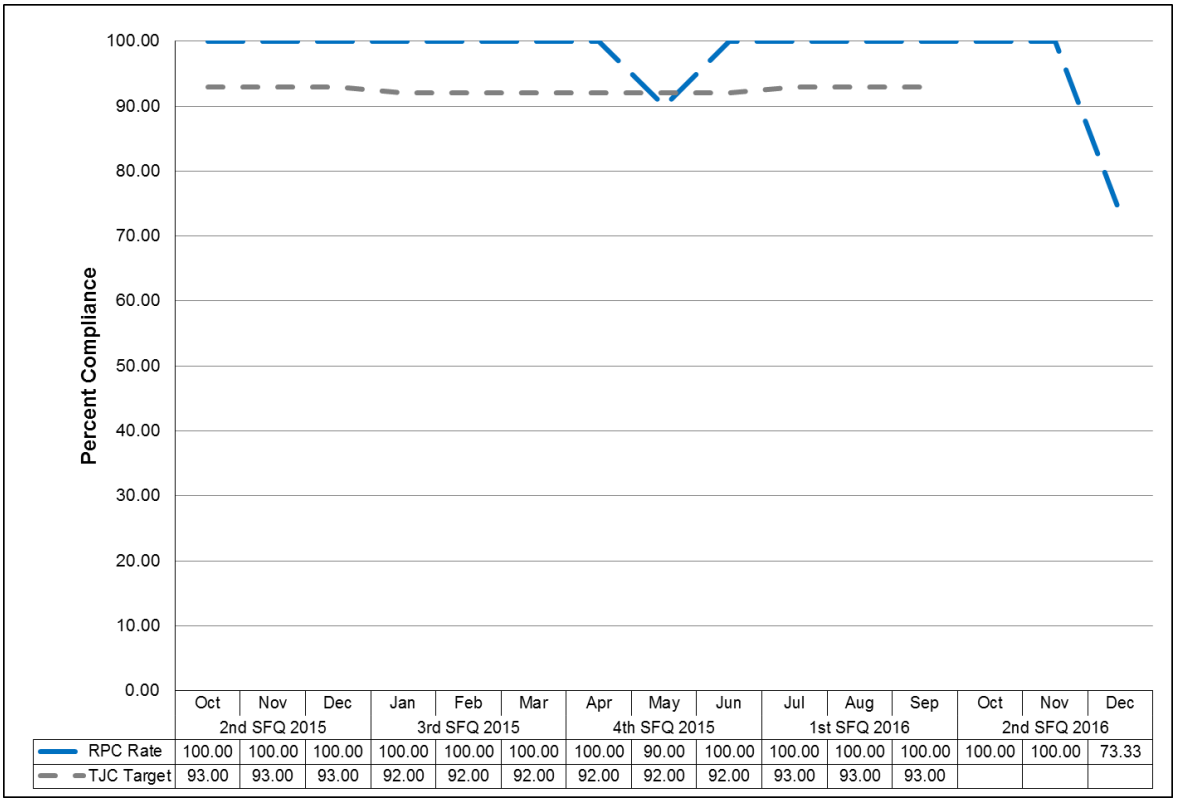
Note: no patients were prescribed multiple antipsychotics in May 2016.

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).



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
RPC Rate	100.00	100.00	100.00	100.00	100.00	100.00	100.00	90.00	100.00	100.00	100.00	100.00	100.00	100.00	73.33
TJC Target	93.00	93.00	93.00	92.00	92.00	92.00	92.00	92.00	92.00	93.00	93.00	93.00			

Note: The Joint Commission discontinued this measure effective 12/31/2015.

JOINT COMMISSION

Post Discharge Continuing Care Plan Transmitted (HBIPS 7)

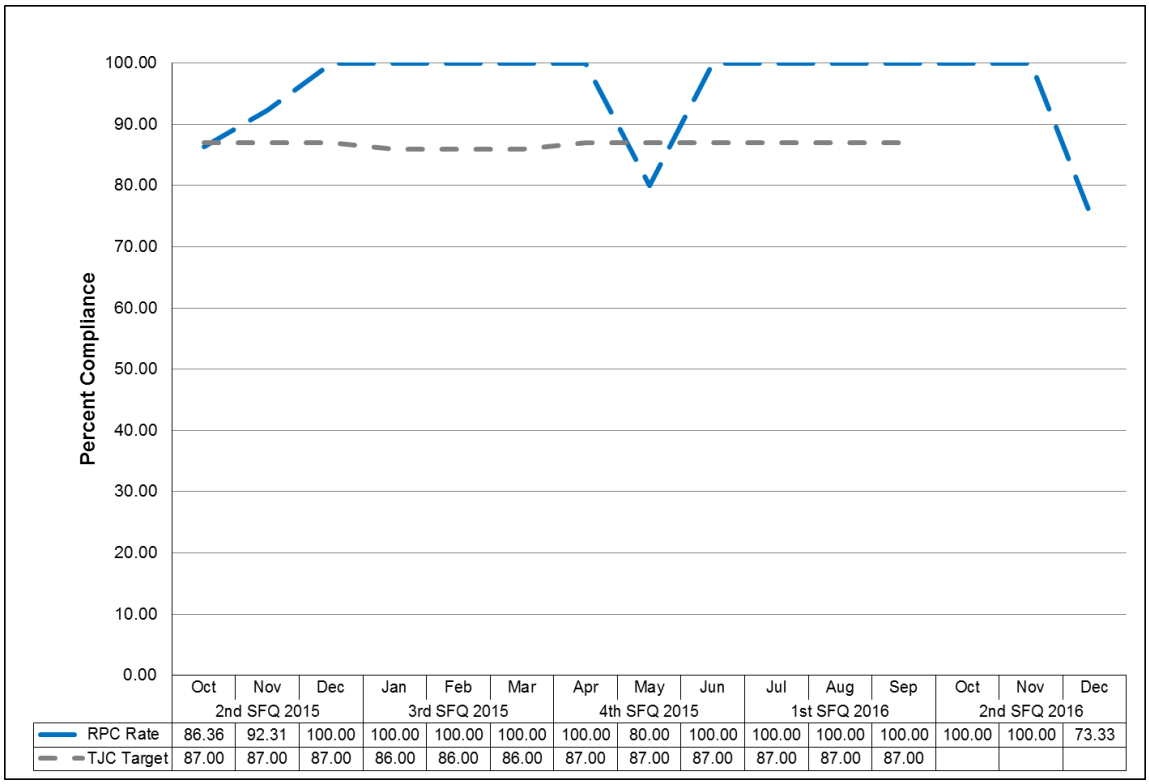
To Next Level of Care Provider on Discharge

Description

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

Rationale

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



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
RPC Rate	86.36	92.31	100.00	100.00	100.00	100.00	100.00	80.00	100.00	100.00	100.00	100.00	100.00	100.00	73.33
TJC Target	87.00	87.00	87.00	86.00	86.00	86.00	87.00	87.00	87.00	87.00	87.00	87.00			

Note: The Joint Commission discontinued this measure effective 12/31/2015.

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.

4Q2016 Results		
Contractor	**Program Administrator**	**Summary of Performance**
Amistad Peer Support Services	Rodney Bouffard Superintendent	One indicator did not meet standard: Attendance by Peer Support Staff at the Service Integration Meetings. All other indicators met standards.
Community Dental, Region II	Dr. William Nelson Acting Clinical Director	All indicators met or exceeded standards.
Comprehensive Pharmacy Services	Dr. William Nelson Acting Clinical Director	All indicators met standards.
Comtec Security	Richard Levesque Director of Support Services	All indicators met standards.
Cummins Northeast	Richard Levesque Director of Support Services	No services were provided during this timeframe.
Disability Rights Center	Rodney Bouffard 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. William Nelson Acting Clinical Director	No services were provided during this timeframe.
Liberty Healthcare – After Hours Coverage	Dr. William Nelson Acting Clinical Director	All indicators exceeded standards.
Liberty Healthcare – Physician Staffing	Dr. William Nelson Acting Clinical Director	All indicators met standards.
Main Security Surveillance	Richard Levesque Director of Support Services	All indicators met standards.
Maine General Community Care/HealthReach	Dr. William Nelson Acting Clinical Director	All indicators met standards.
Maine General Medical Center Laboratory Services	Dr. William Nelson Acting Clinical Director	All indicators met standards.

(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

JOINT COMMISSION

Contractor	Program Administrator	Summary of Performance
MD-IT Transcription Service	Samantha Brockway Medical Records Administrator	All indicators met standards.
Mechanical Services	Richard Levesque Director of Support Services	All indicators met or exceeded standards.
Medical Staffing and Services of Maine	Dr. William Nelson Acting Clinical Director	All indicators met standards.
Motivational Services	Dr. William Nelson Acting Clinical Director	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	All indicators exceeded standards.
Pine Tree Legal Assistance	Dr. William Nelson Acting Clinical Director	No services were provided during this timeframe.
Project Staffing	Cindy Michaud Business Services Manager	All indicators met or exceeded standards.
Protection One	Richard Levesque Director of Support Services	No services were provided during this timeframe.
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	1Q2016	2Q2016	3Q2016	4Q2016	Total
National Patent Safety Goals Goal 1: Improve the accuracy of Patient Identification. Capital Community Dental Clinic assures accurate patient identification by: asking the patient to state his/her name and date of birth. 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.	**July** 100% 3/3 **Aug** N/A 0/0 **Sept** N/A 0/0 **Total** 100% 3/3	**Oct** 100% 2/2 **Nov** 100% 1/1 **Dec** 100% 1/1 **Total** 100% 4/4	**Jan** 100% 5/5 **Feb** 100% 3/3 **Mar** N/A 0/0 **Total** 8/8	**Apr** N/A **May** N/A **June** N/A	**100%** **15/15**

Note: there were no extractions performed in 4Q2016.

JOINT COMMISSION

Dental Clinic Post Extraction Prevention of Complications and Follow-up

Indicators	1Q2016	2Q2016	3Q2016	4Q2016	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% 3/3 **Aug** N/A 0/0 **Sept** N/A 0/0 **Total** 100% 3/3	**Oct** 100% 2/2 **Nov** 100% 1/1 **Dec** 100% 1/1 **Total** 100% 4/4	**Jan** 100% 5/5 **Feb** 100% 3/3 **Mar** N/A 0/0 **Total** 8/8	**Apr** N/A **May** N/A **June** N/A	**100%** **15/15**

Note: there were no extractions performed in 4Q2016.

JOINT COMMISSION

Healthcare Acquired Infections Monitoring and Management

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

Infection Control

Responsible Party: Rebecca Eastman, Infection Control RN

I. Measure Name: Hospital Associated Infection (HAI) Rate

Measure Description: Monitor and Measure of Hospital Associated Infections

Measure Type: Quality Assurance

Results							
Target	**Unit**	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Within 1 STDV of the Mean	Hospital Associated Infection Rate	FY 2014 1 STDV within the mean	12 HAI/IC Rate 1.4	7 HAI/IC Rate 1	11 HAI/IC Rate 1.2	5HAI/IC Rate 1	HAI/IC 1.125
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 Present on Admission (POA) infection is any infection present, incubating or exposed to prior to admission; while on pass; during off-site medical, dental, or surgical care; by a visitor, any prophylaxis treatment of a condition or treatment of a condition for which the patient has a history of chronic infection no matter how long the patient has been hospitalized; or declared by the physician, physician's assistant, or advanced practice nurse to be a community acquired infection.

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

JOINT COMMISSION

Infections:

Lower Kennebec:
Bilateral toe infection (HAI)
URI (HAI)
URI (HAI)
Cellulitis (POA)

Lower Saco:
MRSA open abrasion/wound (HAI)
Dental Abscess (HAI)

Upper Kennebec:
Urinary Tract Bronchitis (HAI)

Data Analysis:
HAI: 6
POA: 1
Idiosyncratic Infections: 0
Total Infections: 7

Plan: Ongoing surveillance.

JOINT COMMISSION

II. Measure Name: Employee Hand Hygiene Rate

Measure Description:

- Staff will observe the hand hygiene practice of nurses as they pass medications. (10 observations per month)
- Staff will do ten (10) hand hygiene observations per month (before & after patient contact) in the milieu on the **7-3 shift.**
- Staff will do ten (10) hand hygiene observations per month (before & after patient contact) in the milieu on the **3-11 shift**

Measure Type: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Employee Hand Hygiene Compliance	80% FY 2015	>90%	>90%	>90%	>90%	**>90%**
Actual			95%	No data available	42%	76%	**71%**

Data:

Upper Saco Meds: 67%
Upper Saco Milieu 7-3: 97%
Upper Saco Milieu 3-11: 100%

Upper Kennebec Meds: 100%
Upper Kennebec Milieu 7-3: 100%
Upper Kennebec Milieu 3-11: 92%

Lower Kennebec Meds: 50%
Lower Kennebec Milieu 7-3: 65%
Lower Kennebec Milieu 3-11: 73%

Lower Saco Meds: 83%
Lower Saco Milieu 7-3: 83%
Lower Saco Milieu 3-11: 67%

Plan: Continue to monitor and measure. On the next report, the second and third measures will reflect the schedule changes and will read 7am-7pm and 7pm-7am respectively. Even though the data does not show an improvement, compliance has improved greatly in the second and third month of the 4Q2016.

JOINT COMMISSION

III. Measure Name: Assisting Patients with Daily Hygiene

Measure Description: Staff offer hand gel to patients prior to breakfast, lunch, and dinner, ten (10) days per month.

Measure Type: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Employee Hand Hygiene Compliance	98% FY 2015	>90%	>90%	>90%	>90%	**>90%**
Actual			95%	No data available	81%	77%	**84%**

Data:
The mean compliance rate for April 2016 is 34%.
The mean compliance rate for May 2016 is 100%.
The mean compliance rate for June 2016 is 96%.

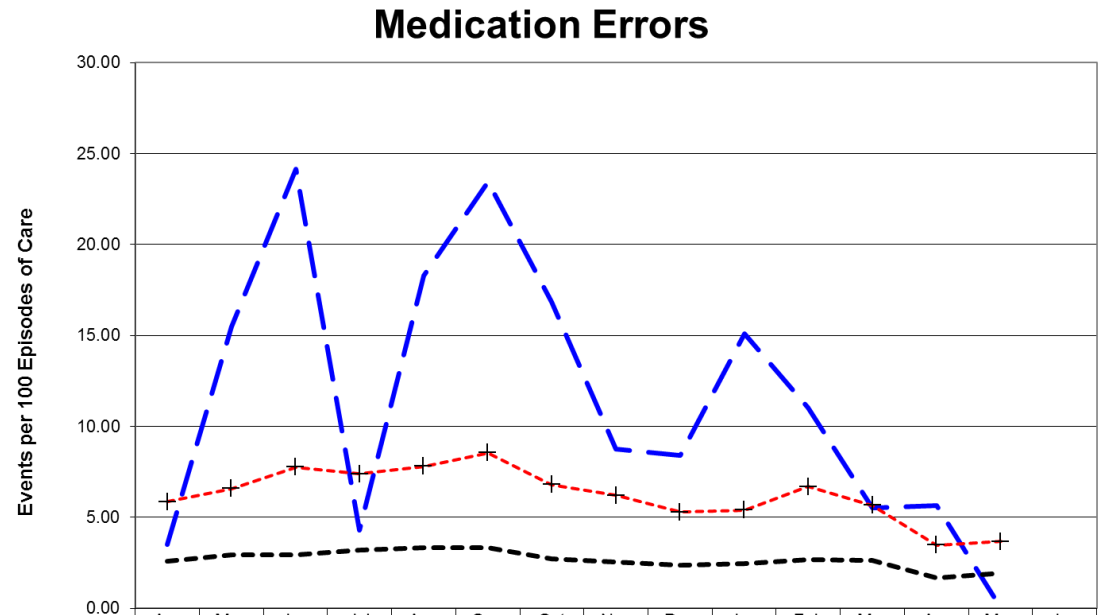
Plan: Continue to monitor and measure.

STRATEGIC PERFORMANCE EXCELLENCE

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 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	3.49	15.48	24.14	4.30	18.27	23.47	16.83	8.74	8.41	15.09	11.01	5.50	5.66	0.00	
Ntl Mean	2.59	2.92	2.94	3.19	3.32	3.34	2.71	2.54	2.36	2.46	2.69	2.62	1.67	1.93	
+1 StDev	5.86	6.59	7.77	7.38	7.80	8.54	6.80	6.20	5.28	5.39	6.69	5.66	3.48	3.68	

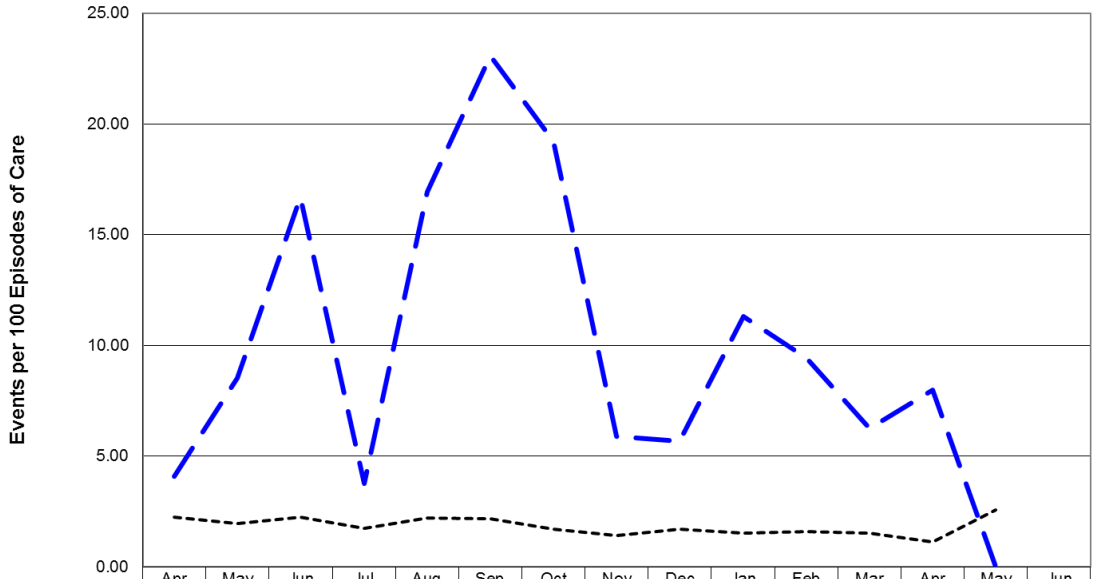
This graph depicts the number of medication error events that occurred for every 100 episodes of care (duplicated patient count). For example, a rate of 1.6 means that 2 medication error events occurred for each 125 episodes of care.

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.

STRATEGIC PERFORMANCE EXCELLENCE

Medication Errors

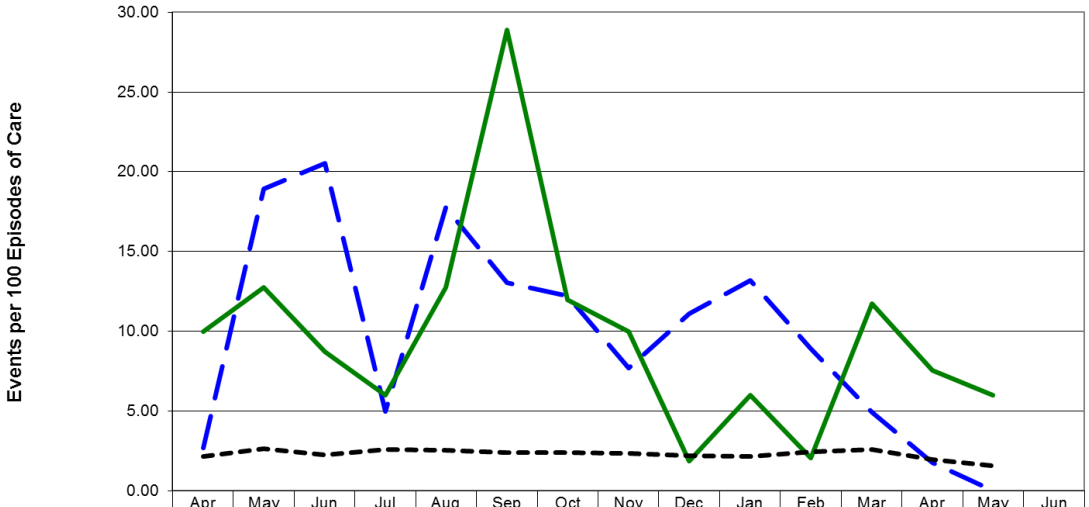
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	4.08	8.51	16.67	3.77	16.95	23.08	19.23	5.88	5.66	11.32	9.43	6.25	8.00	0.00	
Ntl Mean	2.25	1.97	2.25	1.74	2.20	2.18	1.70	1.41	1.70	1.53	1.61	1.53	1.13	2.56	

Medication Errors

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	2.70	18.92	20.51	5.00	17.78	13.04	12.24	7.69	11.11	13.21	8.93	4.92	1.79	0.00	
Dorothea Dix	10.00	12.77	8.70	6.00	12.77	28.89	12.00	10.00	1.85	6.00	2.04	11.76	7.55	6.00	
Ntl Mean	2.18	2.64	2.27	2.58	2.55	2.41	2.39	2.36	2.23	2.16	2.44	2.60	1.95	1.57	

STRATEGIC PERFORMANCE EXCELLENCE

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.

STRATEGIC PERFORMANCE EXCELLENCE

Administration Process

Medication Errors Related to Staffing Effectiveness

Date	Omit	Type of Error	Float	New	O/T	Unit	Staff Mix		
							RN	LPN	MHW
2/16/2016	N	GAVE PATIENT WRONG MEDS X3	N	N	N	UK	2	1	3
4/1/2016	Y	OMISSON X6	N	N	N	LSMAIN	3	1	6
4/3/2016	Y	OMISSION X1	N	N	N	LSMAIN	3	0	7
4/8/2016	Y	OMISSION X2	Y	N	N	LSMAIN	3	1	6
4/10/2016	Y	OMISSON X2	N	N	N	US	3	0	5
4/13/2016	N	GIVEN LATE WITHOUT ORDER	Y	N	N	LKMAIN	2	0	5
4/23/2016	Y	OMIT X3	N	N	N	US	3	0	4
4/26/2016	Y	OMIT X1	Y	N	N	LKMAIN	2	0	5
4/26/2016	N	WRONG FORM OF MEDICATION	N	N	N	LKMAIN	3	1	8
4/27/2016	Y	OMIT X1	Y	N	N	LKMAIN	3	1	7
4/27/2016	Y	OMIT X1	N	N	N	UK	2	0	4
4/28/2016	N	EXTRA DOSE X4	N	N	N	LKMAIN	3	1	7
4/30/2016	N	EXTRA DOSE X3	N	N	N	LKMAIN	2	0	6
5/4/2016	Y	OMIT X1	N	N	N	LKMAIN	3	1	8
5/5/2016	N	WRONG DOSE X1	N	N	N	US	2	1	4
5/7/2016	Y	OMIT X1	N	N	N	UK	3	0	4
5/12/2016	Y	OMIT X1	N	N	N	UK	2	1	4
5/13/2016	N	WRONG DOSE X1	N	N	N	LKMAIN	3	1	5
5/16/2016	Y	OMIT X3	N	N	N	LKSCU	1	0	4
5/17/2016	Y	OMIT X1	Y	N	N	LSSCU	3	1	5
5/17/2016	Y	OMIT X3	Y	N	N	US	3	1	4
5/18/2016	N	WRONG DOSE X2	Y	N	N	LSMAIN	3	0	7
5/21/2016	Y	OMIT X2	N	N	N	UK	3	1	2
5/21/2016	Y	OMIT X3	Y	N	N	LSMAIN	2	0	8
5/23/2016	N	GIVEN LATE WITHOUT ORDER X1	N	N	N	LSMAIN	3	1	7
5/25/2016	N	WRONG DOSE x2	N	N	N	US	2	0	4
5/25/2016	N	WRONG DOSE X2	N	N	N	US	2	1	4
5/28/2016	Y	OMIT X2	N	N	N	LSMAIN	2	1	6
6/8/2016	N	WRONG TIME X6	N	N	N	US	3	2	6
6/8/2016	N	WRONG DOSE X1	Y	N	N	LKSCU	3	1	7
6/15/2016	Y	OMIT X1	Y	N	N	LKSCU	3	0	6
6/18/2016	Y	OMIT X2	Y	N	N	UK	2	0	4
6/21/2016	N	WRONG TIME X3	Y	N	N	LSSCU	3	1	5

STRATEGIC PERFORMANCE EXCELLENCE

6/21/2016	N	EXPIRED DRUG X1	N	N	N	LKSCU	3	2	7
6/22/2016	Y	OMIT X1	N	Y	N	LKSCU	3	2	7
6/23/2016	N	WRONG FORM OF MEDICATION	N	N	N	UK	2	1	3
6/29/2016	N	WRONG DOSE X1	N	Y	N	UK	4	0	5
Totals	**40**		**21**	**2**	**0**	**LS: 23**	**US: 19**	**LK: 20**	**UK: 12**
Percent	**54%**	**74 Total Errors**	**28%**	**3%**	**0%**	**31%**	**26%**	**27%**	**16%**

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

Type of Error	# of Errors
Extra Dose	7
Late/No Order	2
Omission	40
Wrong Dose	10
Wrong Time	9
Wrong Medication	3
Wrong Form	2
Expired Medication	1
Total	**74**

STRATEGIC PERFORMANCE EXCELLENCE

Dispensing Process

Measure	Unit	Baseline 2015	Goal	1Q 2016	2Q 2016	3Q 2016	4Q 2016
1. Controlled Substance Loss Data: Daily Pyxis-CII Safe Compare Report.	All	0.19%	0% Target: Actual:	0% 0%	0% 0%	0% 0%	0% 0%
2. Controlled Substance Loss Data: Monthly CII Safe Vendor Receipt Report.	Rx	0	0 Target: 0 Actual: 0	0 0	0 0	0 0	0 0
3. Controlled Substance Loss Data: Monthly Pyxis Controlled Drug Discrepancies.	All	0/mo	Target: 0 Actual: 0	0 0 (0/mo)	0 0 (0/mo)	0 0 (0/mo)	0 0 (0/mo)
4. Medication Management Monitoring: Measures of drug reactions, adverse drug events, and other management data.	Rx	8/year	Target: 0 Actual: 0	0 0	0 0	0 1	0 9
5. Medication Management Monitoring: Resource Documentation Reports of Clinical Interventions.	Rx	99/ quarter	100% Target: Actual:	100% 31	100% 144	100% 128	100% 241
6. Psychiatric Emergency Process: Monthly audit of all psych emergency measures against 8 criteria.	All	100%	100% Target: Actual:	100% 78%	100% 98.4%	100% 90%	100% 80%*
7. Operational Audit: Monthly audit of 3 operational indicators from CPS contract.	Rx	100%	100% Target: Actual:	100% 100%	100% 100%	100% 100%	100% 100%

*During May/June 2016 part-time relief Pharmacists were unaware of the procedure and therefore the process was not completed. Four Psychiatric Emergencies from the 3Q2016 are included in this 4Q2016 quarter report.

STRATEGIC PERFORMANCE EXCELLENCE

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:

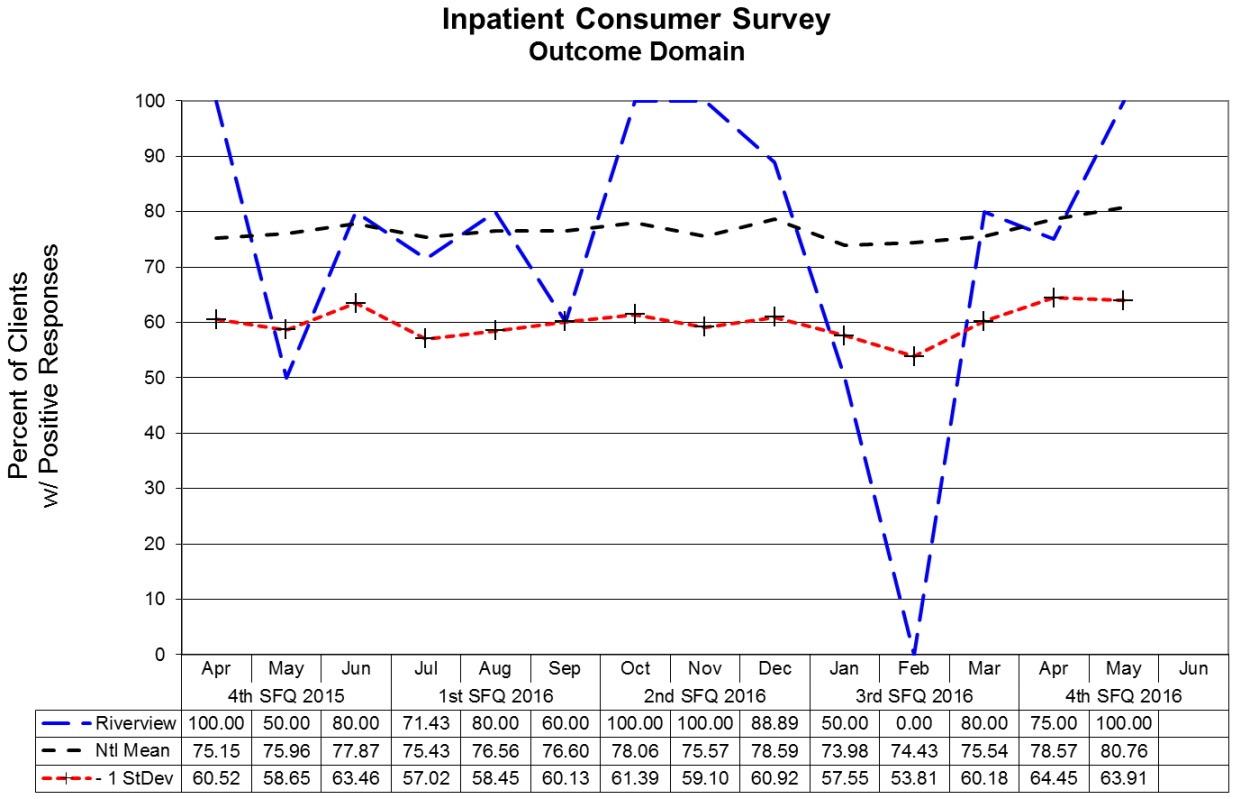
Due to the operational and safety need to refrain from complete openness regarding plans for discharge and dates of discharge for forensic patients, the process of administering the inpatient survey is difficult to administer. Whenever possible, Peer Support staff work to gather information from patients 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.

STRATEGIC PERFORMANCE EXCELLENCE

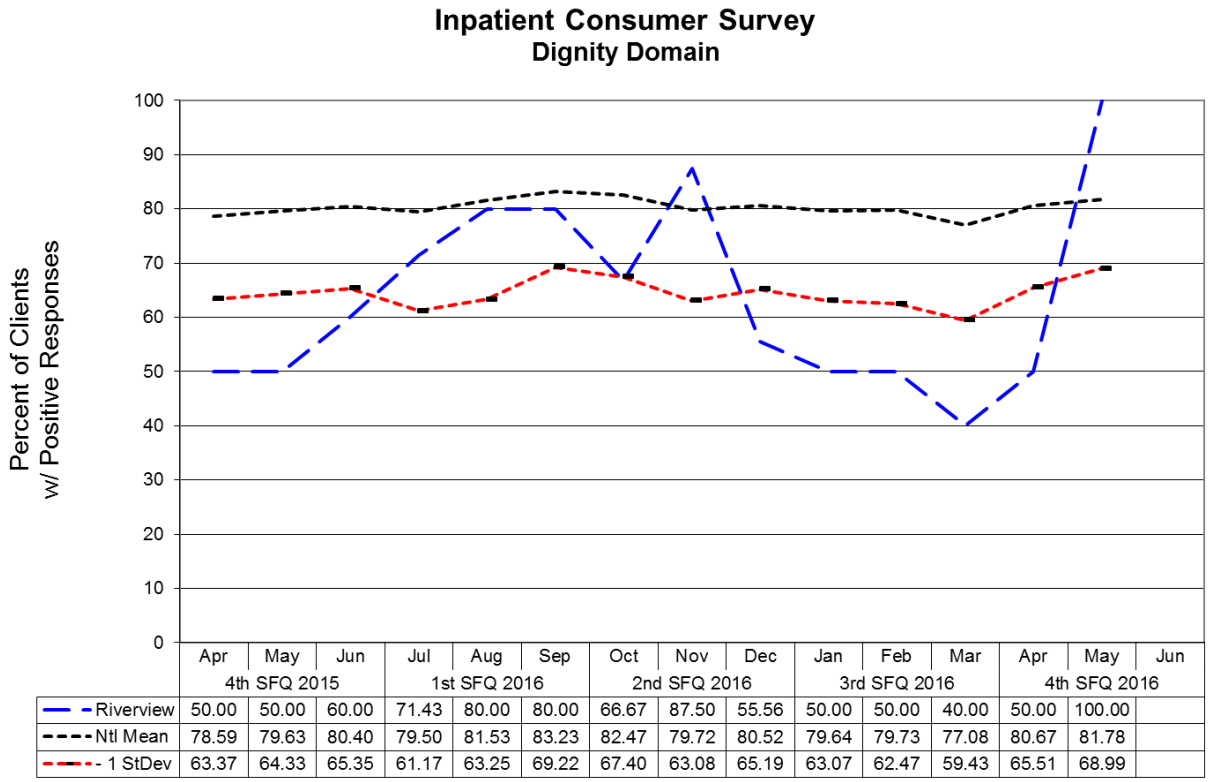


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	100.00	50.00	80.00	71.43	80.00	60.00	100.00	100.00	88.89	50.00	0.00	80.00	75.00	100.00	
Ntl Mean	75.15	75.96	77.87	75.43	76.56	76.60	78.06	75.57	78.59	73.98	74.43	75.54	78.57	80.76	
- 1 StDev	60.52	58.65	63.46	57.02	58.45	60.13	61.39	59.10	60.92	57.55	53.81	60.18	64.45	63.91	

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.

STRATEGIC PERFORMANCE EXCELLENCE

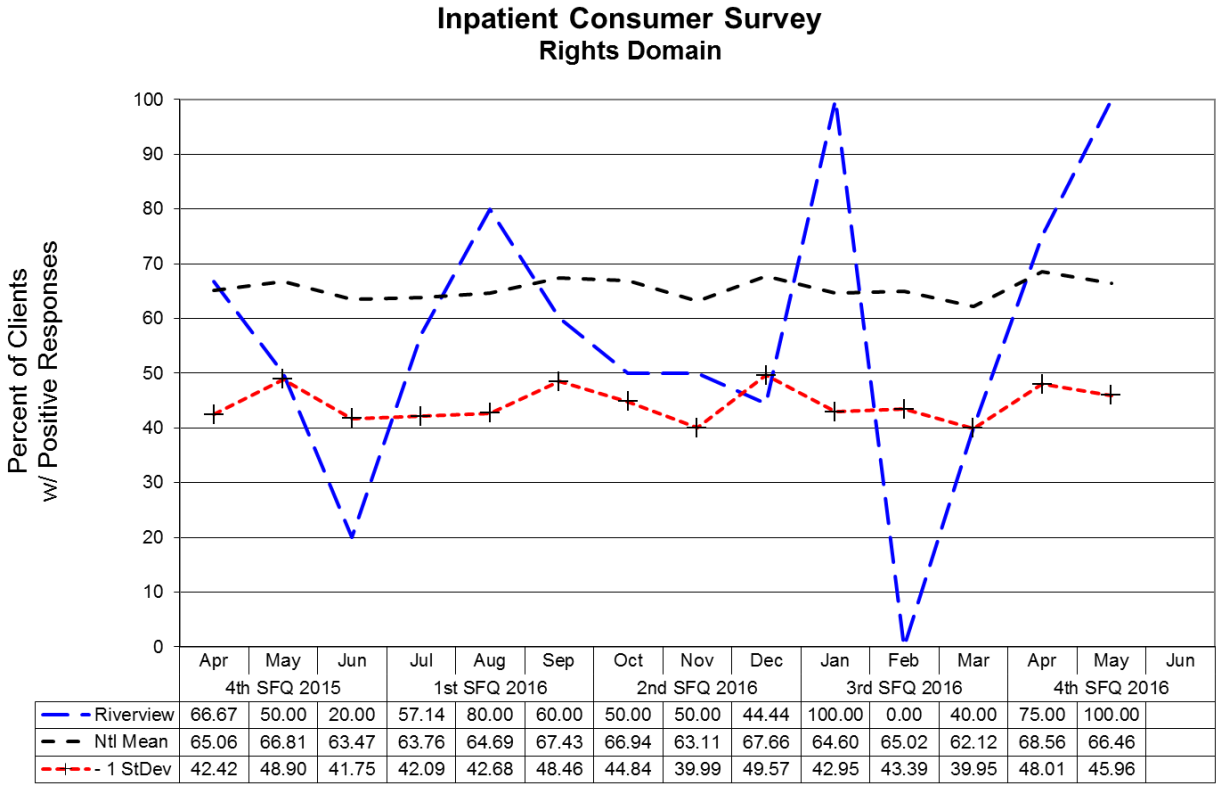


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	50.00	50.00	60.00	71.43	80.00	80.00	66.67	87.50	55.56	50.00	50.00	40.00	50.00	100.00	
Ntl Mean	78.59	79.63	80.40	79.50	81.53	83.23	82.47	79.72	80.52	79.64	79.73	77.08	80.67	81.78	
- 1 StDev	63.37	64.33	65.35	61.17	63.25	69.22	67.40	63.08	65.19	63.07	62.47	59.43	65.51	68.99	

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.

STRATEGIC PERFORMANCE EXCELLENCE

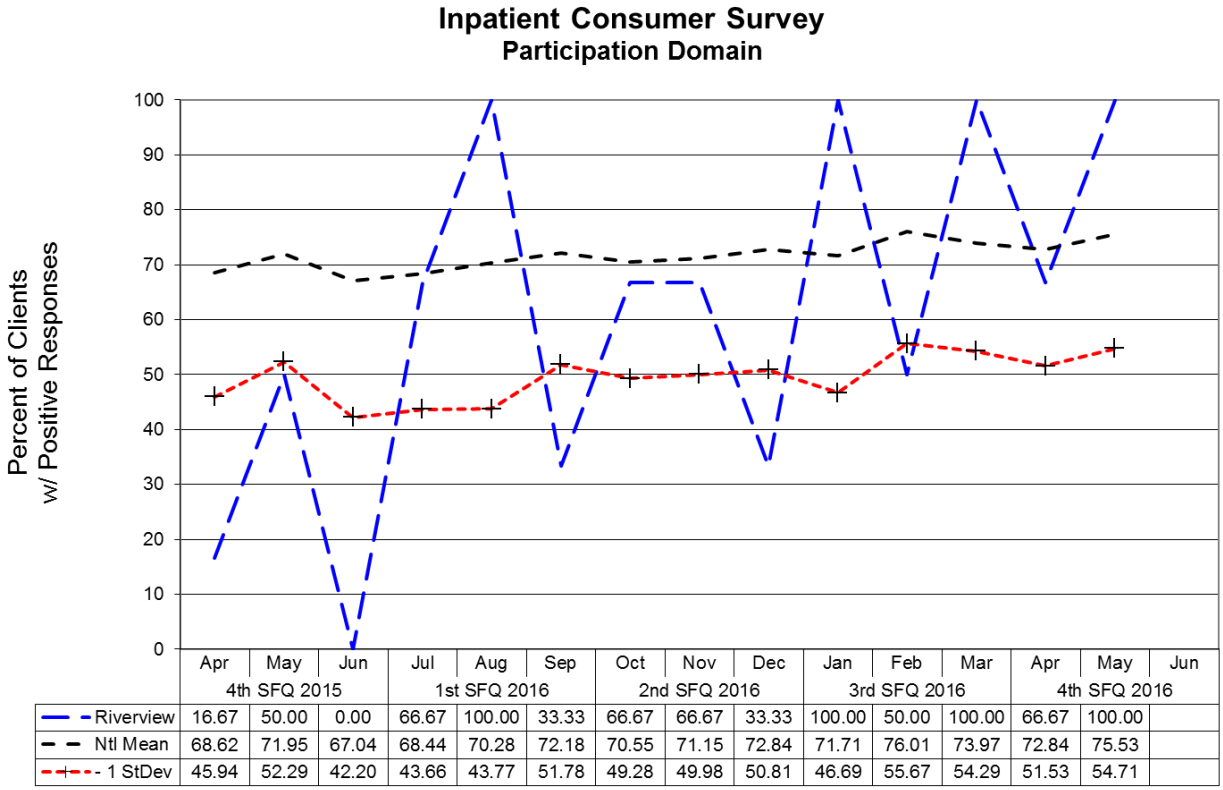


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	66.67	50.00	20.00	57.14	80.00	60.00	50.00	50.00	44.44	100.00	0.00	40.00	75.00	100.00	
Ntl Mean	65.06	66.81	63.47	63.76	64.69	67.43	66.94	63.11	67.66	64.60	65.02	62.12	68.56	66.46	
1 StDev	42.42	48.90	41.75	42.09	42.68	48.46	44.84	39.99	49.57	42.95	43.39	39.95	48.01	45.96	

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.

STRATEGIC PERFORMANCE EXCELLENCE

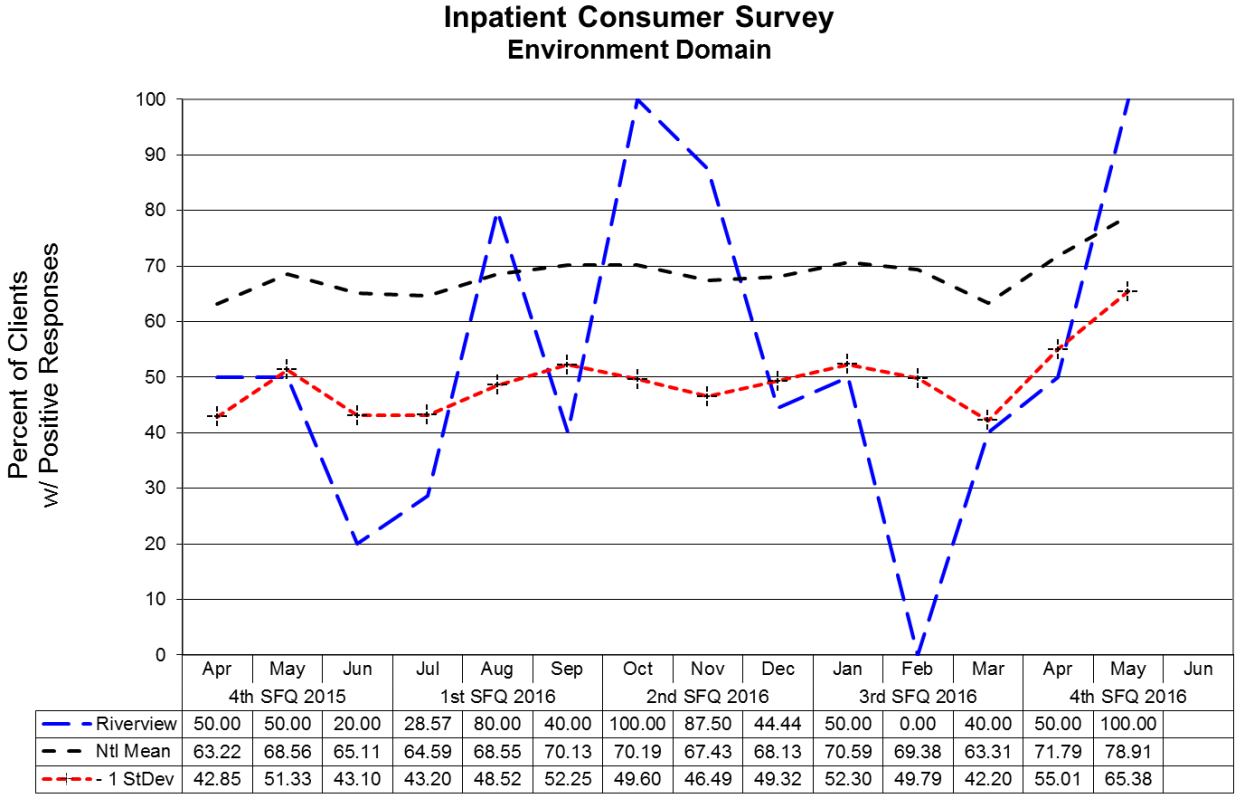


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	16.67	50.00	0.00	66.67	100.00	33.33	66.67	66.67	33.33	100.00	50.00	100.00	66.67	100.00	
Ntl Mean	68.62	71.95	67.04	68.44	70.28	72.18	70.55	71.15	72.84	71.71	76.01	73.97	72.84	75.53	
- 1 StDev	45.94	52.29	42.20	43.66	43.77	51.78	49.28	49.98	50.81	46.69	55.67	54.29	51.53	54.71	

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.

STRATEGIC PERFORMANCE EXCELLENCE

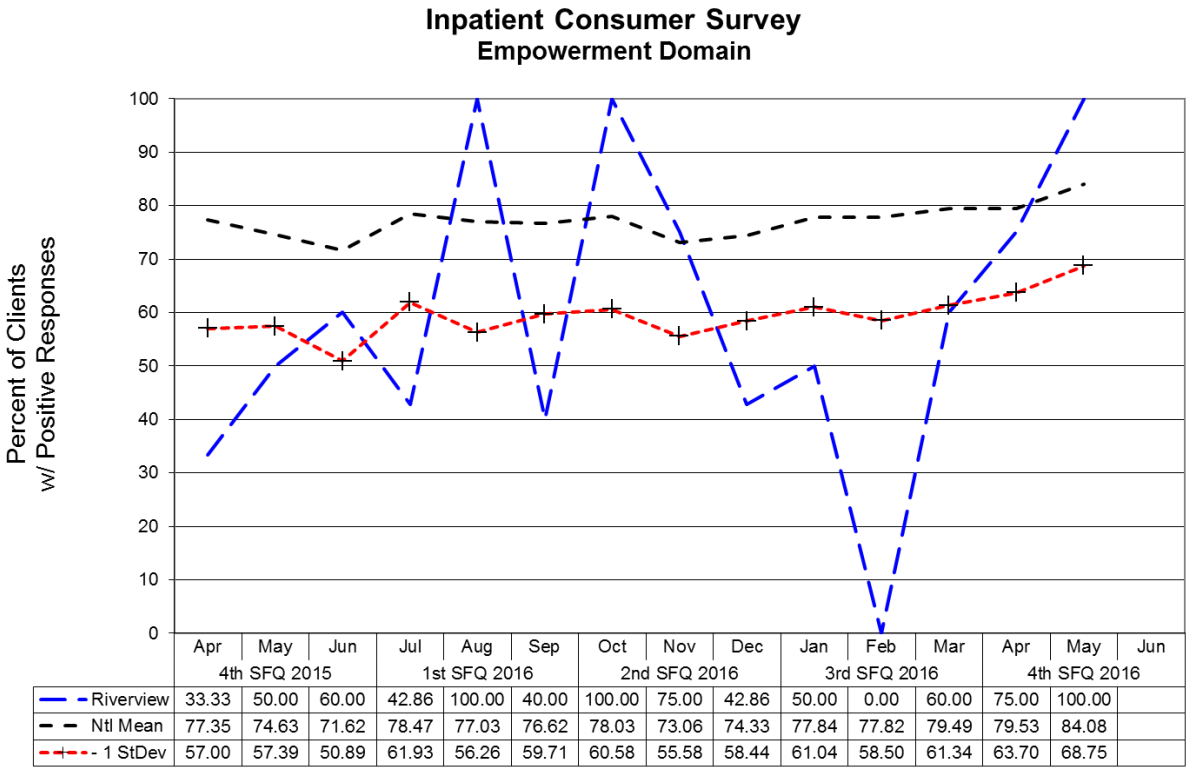


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	50.00	50.00	20.00	28.57	80.00	40.00	100.00	87.50	44.44	50.00	0.00	40.00	50.00	100.00	
Ntl Mean	63.22	68.56	65.11	64.59	68.55	70.13	70.19	67.43	68.13	70.59	69.38	63.31	71.79	78.91	
- 1 StDev	42.85	51.33	43.10	43.20	48.52	52.25	49.60	46.49	49.32	52.30	49.79	42.20	55.01	65.38	

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.

STRATEGIC PERFORMANCE EXCELLENCE



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	33.33	50.00	60.00	42.86	100.00	40.00	100.00	75.00	42.86	50.00	0.00	60.00	75.00	100.00	
Ntl Mean	77.35	74.63	71.62	78.47	77.03	76.62	78.03	73.06	74.33	77.84	77.82	79.49	79.53	84.08	
1 StDev	57.00	57.39	50.89	61.93	56.26	59.71	60.58	55.58	58.44	61.04	58.50	61.34	63.70	68.75	

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.

STRATEGIC PERFORMANCE EXCELLENCE

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. A * below indicates patient had both types of falls.

Type of Fall by Patient and Month

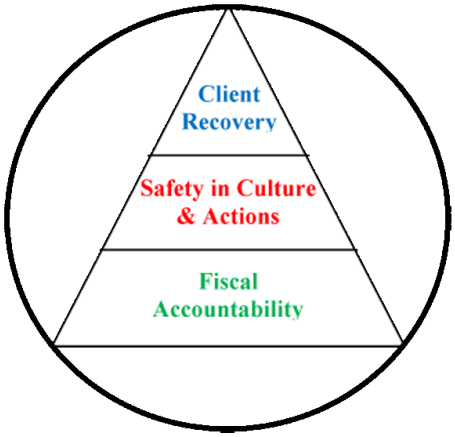
Fall Type	Patient	April	May	June	4Q2016
Un-Witnessed	MR91	2	1		**3**
	MR113*		1		**1**
	MR4296*		1		**1**
	MR5297		1		**1**
	MR7852	1			**1**
	MR7893	1			**1**
	MR7901	1			**1**
	MR7916			1	**1**
	Totals	**5**	**4**	**1**	**10**
Fall Type	**Patient**	**April**	**May**	**June**	**4Q2016**
Witnessed	MR4296*		2		**2**
	MR60			1	**1**
	MR113*	1			**1**
	MR657			1	**1**
	MR4916	1			**1**
	MR4940		1		**1**
	MR7576			1	**1**
	MR7736	1			**1**
	MR7830	1			**1**
	MR7873	1			**1**
	MR7878	1			**1**
	MR7892	1			**1**
	Totals	**7**	**3**	**3**	**13**

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.

(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

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.

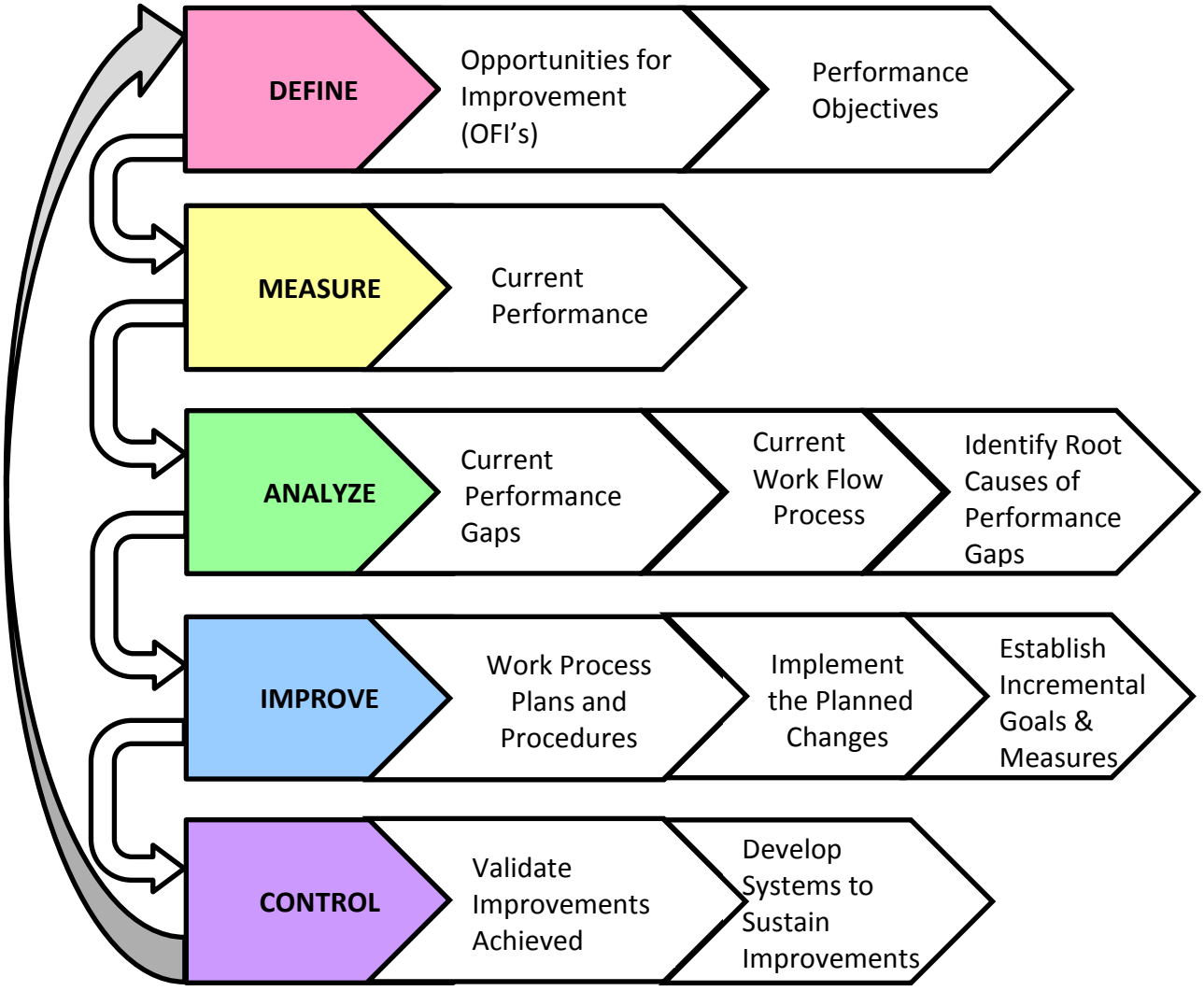
Promote a Safety Culture by…
Improving Communication
Improving Staffing Capacity and Capability
Evaluating and Mitigating Errors and Risk Factors
Promoting Critical Thinking
Supporting the Engagement and Empowerment of Staff Members

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:



(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

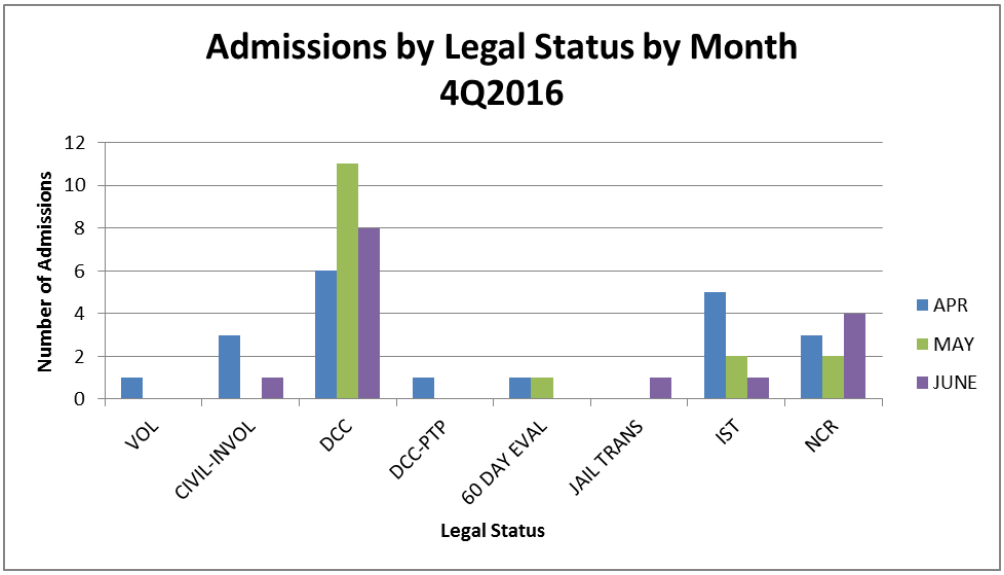
STRATEGIC PERFORMANCE EXCELLENCE

Admissions

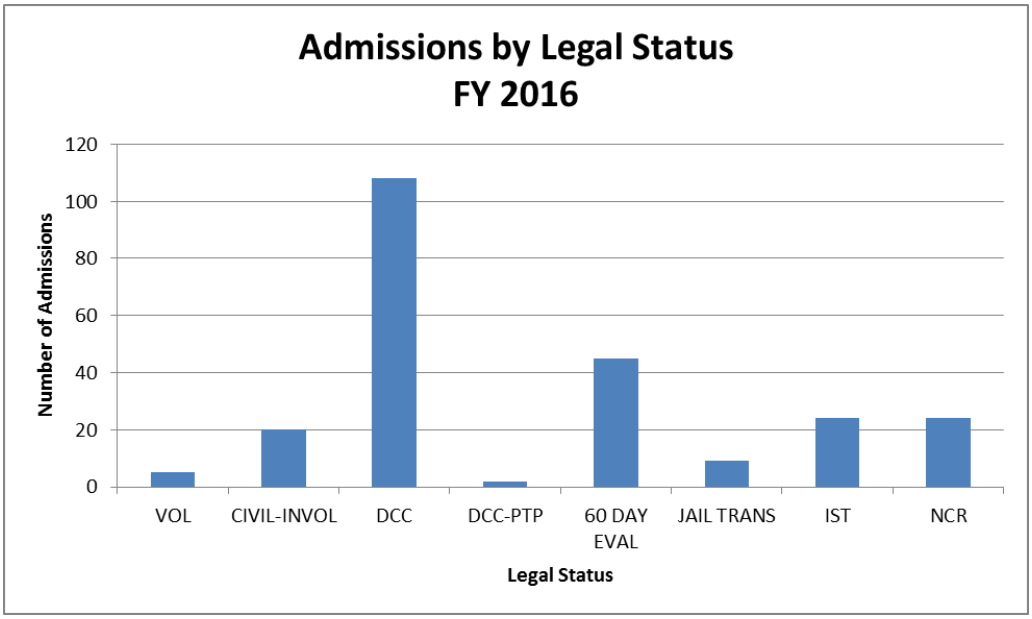
Responsible Party: Samantha Newman, RN, Admissions Nurse

Number of Admissions:

ADMISSIONS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTAL
CIVIL:	**7**	**13**	**10**	**15**	**14**	**8**	**9**	**12**	**16**	**11**	**11**	**9**	**135**
VOL	0	1	1	0	1	0	1	0	0	1	0	0	**5**
CIVIL-INVOL	0	2	2	1	4	0	1	3	3	3	0	1	**20**
DCC	7	9	7	14	9	8	7	9	13	6	11	8	**108**
DCC-PTP	0	1	0	0	0	0	0	0	0	1	0	0	**2**
FORENSIC:	**10**	**16**	**8**	**8**	**5**	**8**	**10**	**10**	**7**	**9**	**5**	**6**	**102**
60 DAY EVAL	8	8	3	2	2	7	5	5	3	1	1	0	**45**
JAIL TRANS	0	0	2	1	0	0	2	2	1	0	0	1	**9**
IST	0	4	2	3	3	1	1	1	1	5	2	1	**24**
NCR	2	4	1	2	0	0	2	2	2	3	2	4	**24**
TOTAL	**17**	**29**	**18**	**23**	**19**	**16**	**19**	**22**	**23**	**20**	**16**	**15**	**237**



STRATEGIC PERFORMANCE EXCELLENCE

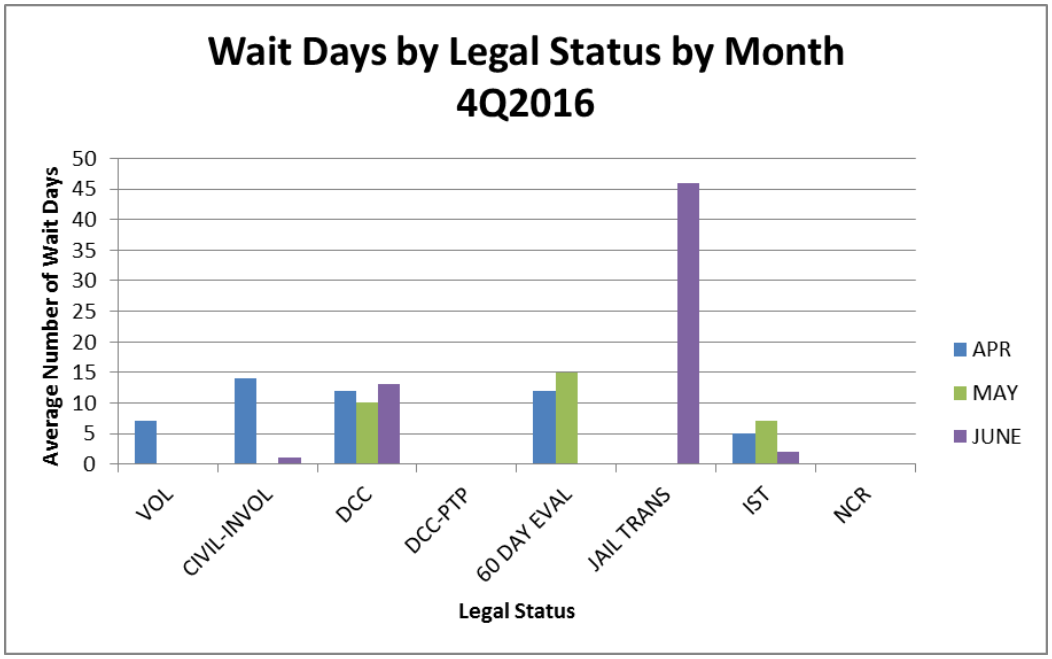


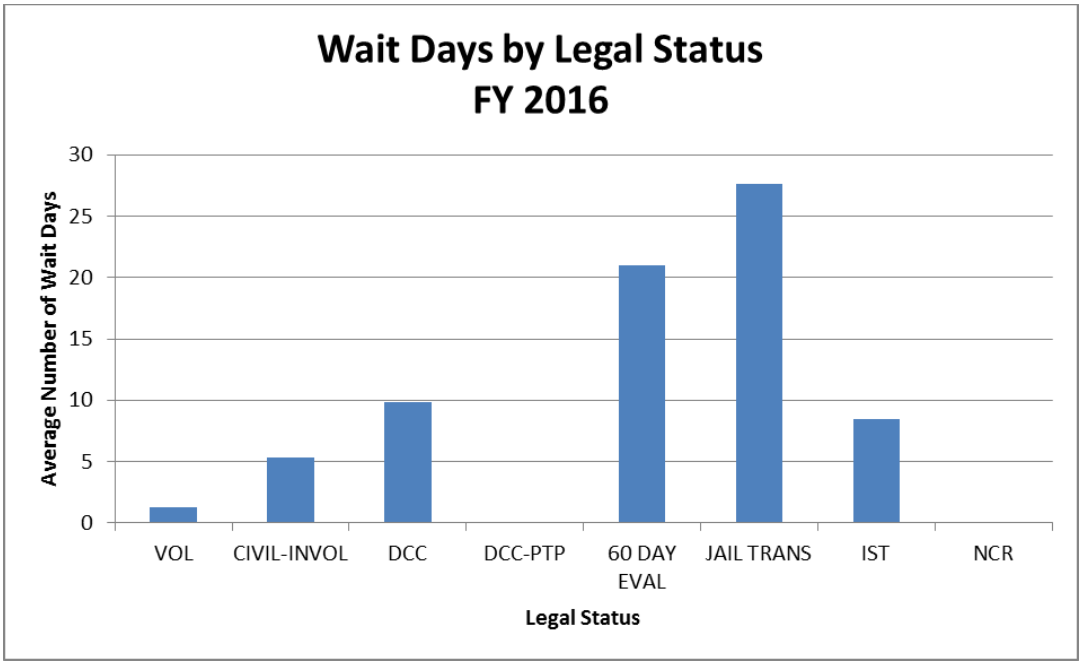
Average Number of Wait Days:

WAIT DAYS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	AVG
CIVIL:	**15**	**13**	**8**	**7**	**4**	**11**	**8**	**5**	**8**	**11**	**10**	**11**	**9**
VOL		1	1		0		3			7			**1**
CIVIL-INVOL		5	3	0	2		2	6	11	14		1	**5**
DCC	15	7	10	7	5	11	9	11	8	12	10	13	**10**
DCC-PTP		0								0			**0**
FORENSIC:	**53**	**18**	**19**	**15**	**14**	**22**	**17**	**10**	**7**	**4**	**6**	**8**	**16**
60 DAY EVAL	66	25	9	24	17	24	18	9	12	12	15		**21**
JAIL TRANS			46	12			38	28	14			46	**28**
IST		20	15	19	12	6	4	2	1	5	7	2	**8**
NCR	0	0	1	0			0	0	0	0	0	0	**0**
AVERAGE	**37**	**12**	**13**	**10**	**6**	**16**	**13**	**10**	**8**	**8**	**8**	**10**	**13**

*If a field is blank it means that there were no admissions for that legal status and timeframe

STRATEGIC PERFORMANCE EXCELLENCE



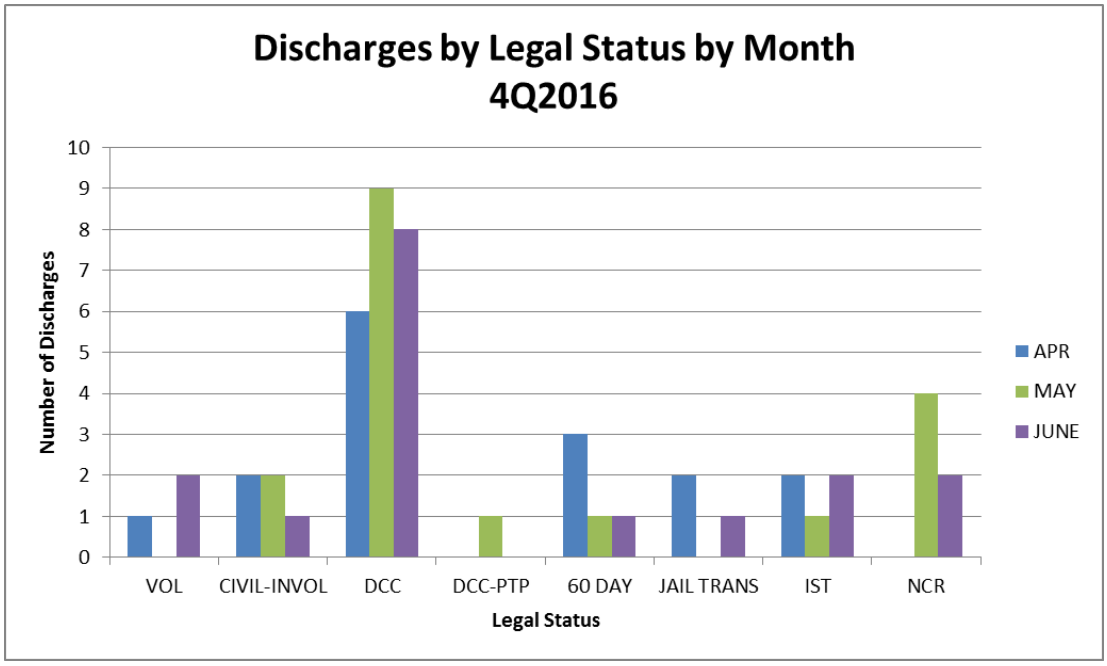


(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

STRATEGIC PERFORMANCE EXCELLENCE

Number of Discharges:

DISCHARGES	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTAL
CIVIL:	**8**	**8**	**11**	**11**	**6**	**12**	**10**	**10**	**16**	**9**	**12**	**11**	**124**
VOL	0	0	0	0	0	1	1	0	0	1	0	2	**5**
CIVIL-INVOL	1	0	0	1	0	0	3	2	3	2	2	1	**15**
DCC	6	8	11	9	6	11	6	8	13	6	9	8	**101**
DCC-PTP	1	0	0	1	0	0	0	0	0	0	1	0	**3**
FORENSIC:	**10**	**16**	**10**	**6**	**6**	**9**	**9**	**13**	**7**	**7**	**6**	**6**	**105**
60 DAY	3	10	5	3	3	4	4	7	4	3	1	1	**48**
JAIL TRANS	0	0	1	0	0	1	1	2	0	2	0	1	**8**
IST	5	5	4	1	2	2	2	2	2	2	1	2	**30**
NCR	2	1	0	2	13	2	2	2	1	0	4	2	**31**
TOTAL	**18**	**24**	**21**	**17**	**12**	**21**	**19**	**23**	**23**	**16**	**18**	**17**	**229**



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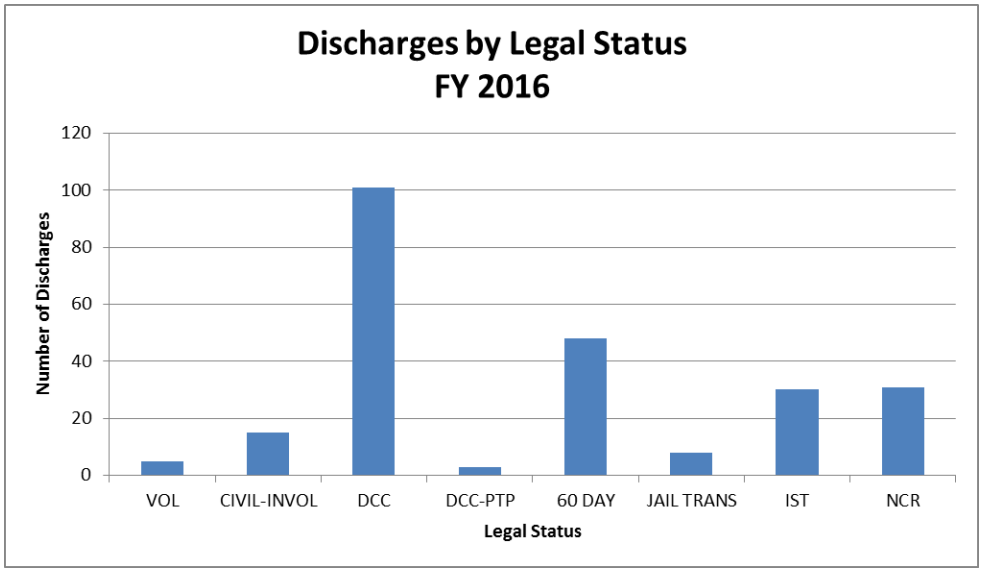
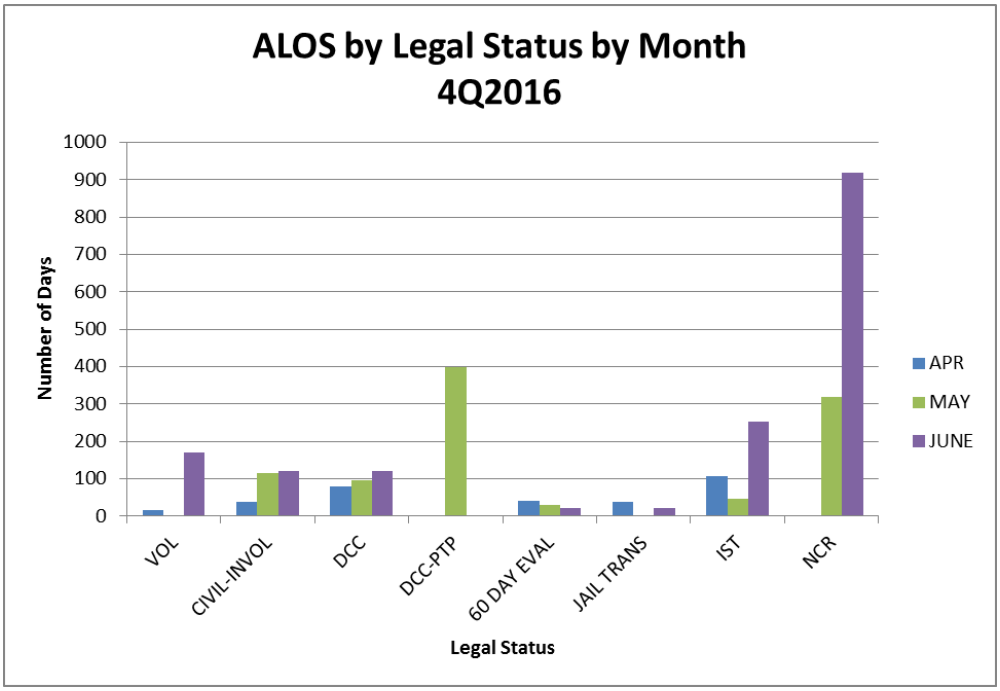
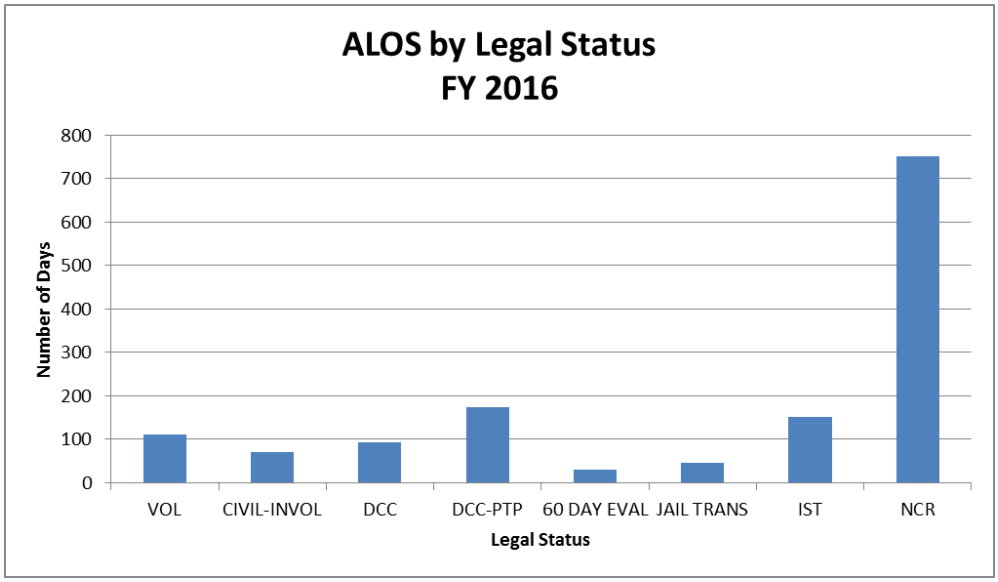


Average Length of Stay (Days):

ALOS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	AVG
CIVIL:	**64**	**70**	**83**	**65**	**74**	**122**	**129**	**98**	**87**	**139**	**124**	**131**	**99**
VOL						135	120			17		171	**111**
CIVIL-INVOL	23			64			88	97	21	38	115	122	**71**
DCC	71	70	83	67	74	121	147	98	102	79	95	122	**94**
DCC-PTP	61			60							400		**174**
FORENSIC:	**118**	**98**	**73**	**41**	**74**	**152**	**716**	**144**	**330**	**73**	**226**	**398**	**204**
60 DAY EVAL	24	27	28	26	50	30	29	28	25	40	31	22	**30**
JAIL TRANS			12			51	125	25		39		23	**46**
IST	74	252	146	50	108	161	90	295	227	107	47	253	**151**
NCR	371	31		59	80	438	3010	524	1757		320	915	**751**
AVERAGE	**94**	**88**	**78**	**57**	**74**	**135**	**407**	**124**	**161**	**75**	**158**	**225**	**140**

STRATEGIC PERFORMANCE EXCELLENCE





STRATEGIC PERFORMANCE EXCELLENCE

I. Measure Name: NCR Admissions

Measure Description: Admittance of all NCR patients within 24 hours of referral

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	NCR referrals admitted within 24 hours	N/A	100%	100%	100%	100%	**100%**
Actual			86% 6/7	100% 2/2	100% 6/6	100% 9/9	**96% 22/23**

Data Analysis: There were 9 NCR admissions this quarter. All were admitted the day of referral.

Action Plan: Continue to gather data on wait days for NCR admissions. Keep one bed available on the Forensic unit for NCR admissions at all times.

	April 2016	**May 2016**	**June 2016**	**4Q2016**
# of NCR Admissions	3	2	4	**9**
Average Wait Days	0	0	0	**0**

II. Measure Name: Jail Transfer Bed

Measure Description: Keep one Jail Transfer bed open and track length of stay and legal outcomes.

Type of Measure: Performance Improvement

	April 2016	**May 2016**	**June 2016**	**4Q2016**
# of Jail Transfer Admissions	0	0	1	**1**
# of Jail Transfer Discharges	2	0	1	**3**

Data Analysis: One Jail Transfer admitted in June waited 46 days for admission. Charges were dropped, patient was moved to the civil side of the hospital, and Length of stay was 23 days.

Action Plan: Continue to track data and keep one bed available for jail transfers.

STRATEGIC PERFORMANCE EXCELLENCE

III. Measure Name: Off Shift PA Admission Paperwork

Measure Description: All required documentation will be complete and accurate for admissions on the off shifts by the PA.

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Documentation complete and accurate for admissions on off shifts	N/A	100%	100%	100%	100%	**100%**
Actual			100% 3/3	50% 1/2	N/A	100% 1/1	**83%** **5/6**

Data Analysis: One off shift admission occurred this quarter and paperwork was completed accurately and timely.

Action Plan: Continue to monitor data so paperwork is completed accurately and timely.

STRATEGIC PERFORMANCE EXCELLENCE

Capital Community Clinic
Dental Clinic

Responsible Party: Dr. Ingrid Prikryl, DMD

I. Measure Name: Yearly Periodontal Charting

Measure Description: Complete a full mouth periodontal charting.

Type of Measure: Performance Improvement

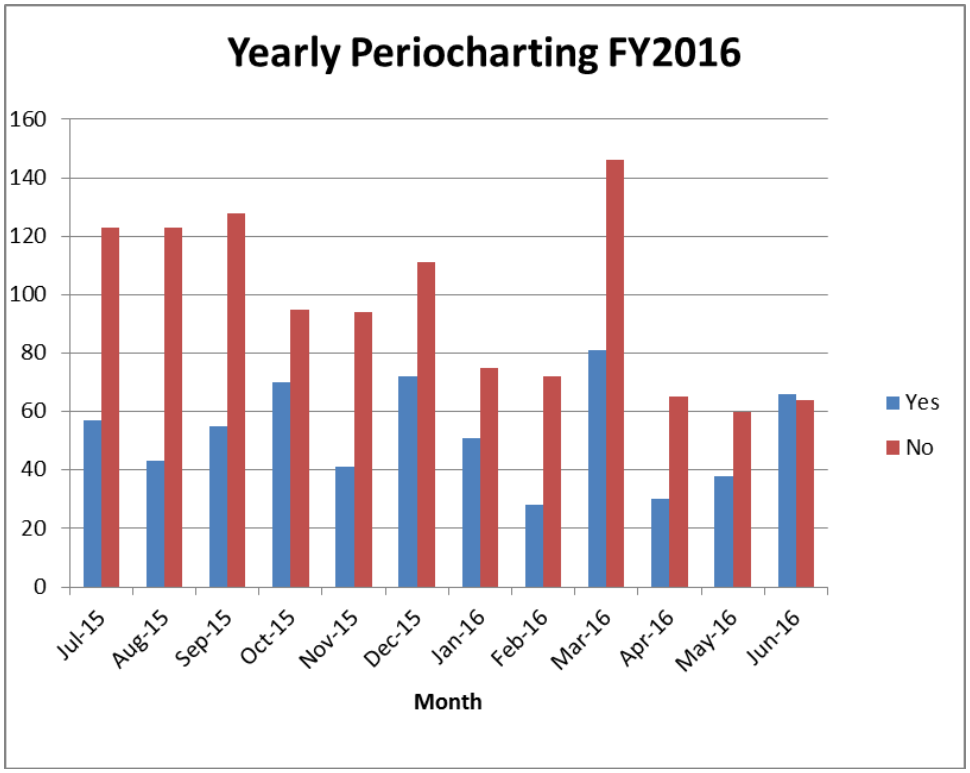
	Results						
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	% of recall appointments where full mouth periodontal charting was completed	FY 2015 42%	50%	55%	60%	65%	**75%**
Actual			30%	37%	35%	40%	**51%**

Data Analysis: To better report this measure, we will only measure periodontal charting on existing patients during their prophylactic recall appointments.

Action Plan: Charting to be completed by the hygienist during prophy appointments only and not during emergency or new patient appointments, in order to get a more accurate percentage.

Comments: Our periodontal charting has improved each month, but we will continue to monitor in FY2017.

STRATEGIC PERFORMANCE EXCELLENCE



II. Measure Name: Improving Oral Hygiene

Measure Description: Monitoring patients' oral hygiene and working to improve it

Type of Measure: Performance Improvement

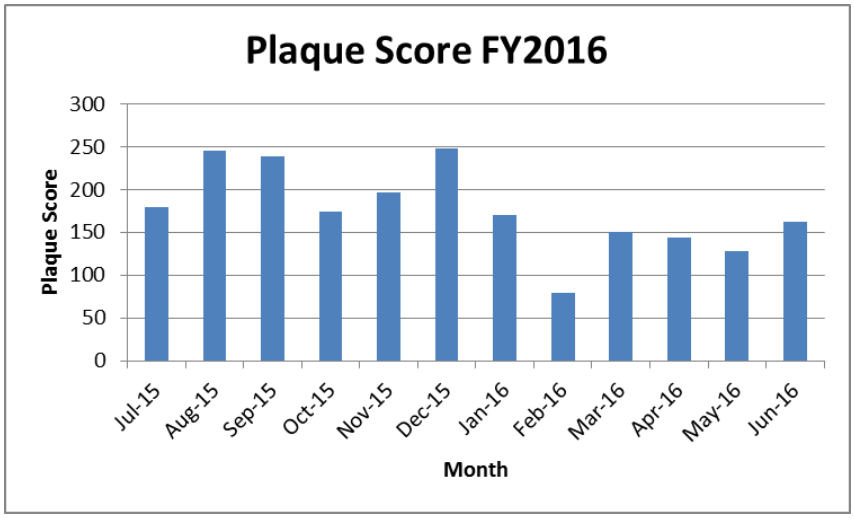
	Results						
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Plaque Score Monthly	Fair (220-160)	Poor	Poor	Fair	Fair	**Fair**
Actual			221	248	150	144	**158**

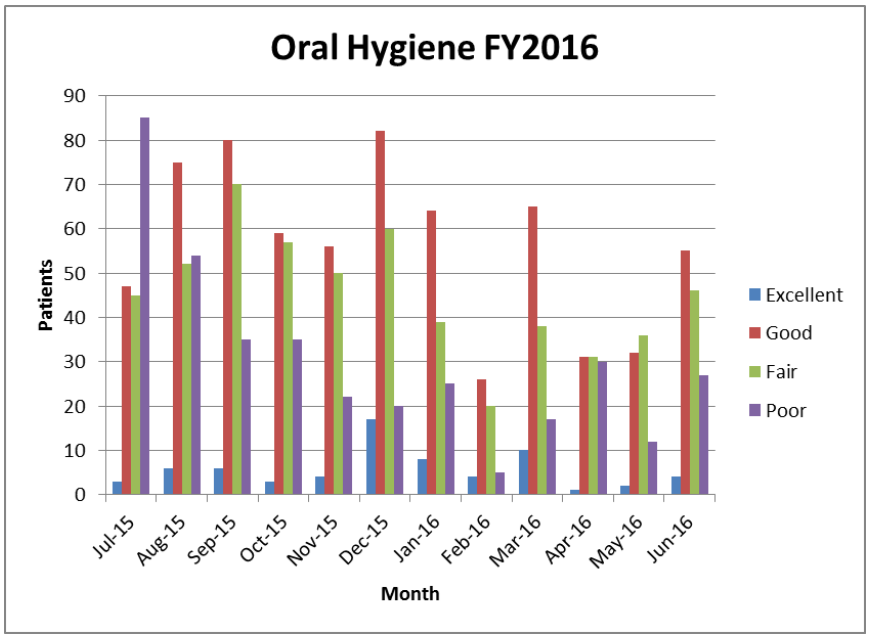
Data Analysis: Smaller numbers demonstrate less plaque on our patients' teeth, therefore improved oral hygiene. Q3 forward has decreased as we are only measuring prophy recall appointments.

STRATEGIC PERFORMANCE EXCELLENCE

Action Plan: Plaque scores should decrease in a 6 month cycle with proper oral hygiene instructions.

Comments: Trying to educate our patients on brushing daily and its importance for proper oral care and retention of teeth. Data collected from daily collected plaque scores as of Q42016 is only on hygiene recall appointments.





STRATEGIC PERFORMANCE EXCELLENCE

III. Measure Name: Next Visit

Measure Description: Writing Next Visit in progress note.

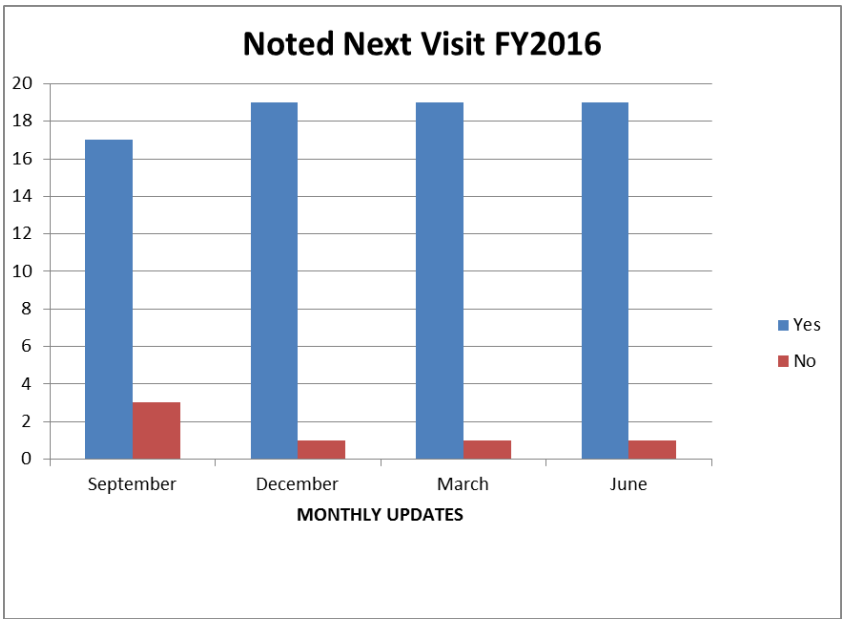
Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	# of progress notes with next visit documented	66% FY 2015	70%	75%	80%	85%	**90%**
Actual			60%	95%	95%	95%	**95%**

Data Analysis: FY2015 YTD was 66%; therefore, it has become a performance improvement measure. We would like this measure to be at 90–100%.

Action Plan: Write at the end of every progress note what the next visit is going to be even if it is a 3 MRC or denture adjustment as needed.

Comments: Data collected from quarterly reviews by Community Dental; evaluate twenty random charts.



STRATEGIC PERFORMANCE EXCELLENCE

IV. Measure Name: RMH and MEDS

Measure Description: Review medical history and medications at the start of each appointment.

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Daily noted	New implemented measure	70%	80%	90%	100%	**100%**
Actual			90%	95%	100%	100%	**100%**

Data Analysis: As of the FY 2015 a new measure was implemented that the medical history and medication list be reviewed at each appointment.

Action Plan: Review patient medical history and medication list at the start of each appointment.

Comments: Data collected from quarterly reviews by Community Dental; evaluate twenty random charts.

STRATEGIC PERFORMANCE EXCELLENCE

V. Measure Name: Blood Pressure

Measure Description: Blood pressure and pulse taken at each dental appointment

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Daily noted; Quarterly reviewed	New implemented measure	90-100%	90-100%	90-100%	90-100%	**90-100%**
Actual			95%	95%	95%	95%	**95%**

Data Analysis: All patients that are seen prior to restorations and prophy appointments; denture patients do not always have their blood pressure taken; especially on denture deliveries.

Action Plan: Take blood pressure and pulse at the start of all dental appointments. To withstand dental care, blood pressure should be less than 160/90.

Comments: Data is collected from quarterly reviews by Community Dental. Twenty random charts were evaluated.

STRATEGIC PERFORMANCE EXCELLENCE

Capital Community Clinic
Medication Management Clinic

Responsible Party: Margaret Todd-Brown, RN

I. Measure Name: Reconciliation of Outpatient Medication List

Measure Description: Each visit will cover reconciliation of medical & psychotropic medications with patients.

Measure Type: Performance Improvement

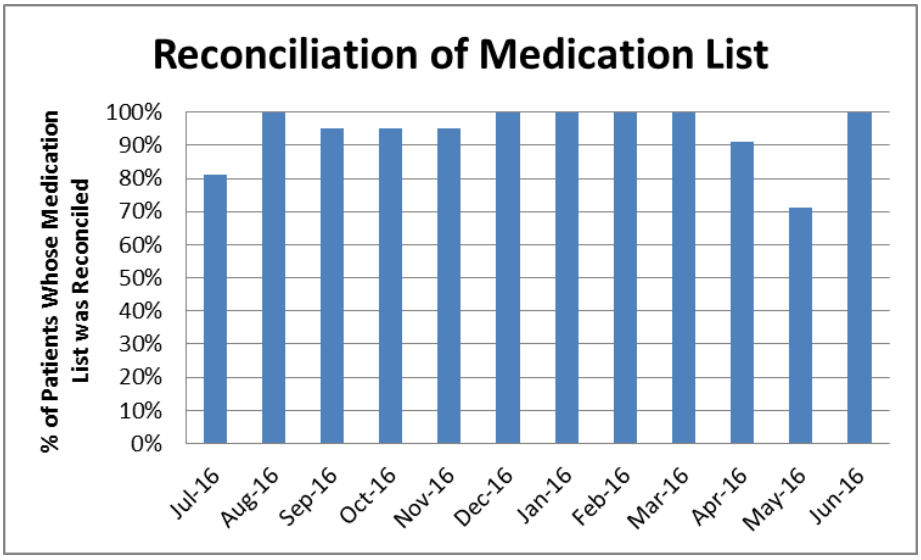
Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**FYTD**
Target	Reconciliation completed per visit.	2Q2015 73%	100%	100%	100%	100%	**100%**
Actual			94% 59/63	97% 57/59	100% 46/46	90% 26/29	**95% 188/197**

Data Analysis: FY2016 demonstrated a 9% improvement over FY2015. During the last quarter of FY2016 three medication reconciliations were missed. Two of these reconciliations were on a long term clinic patient who is developmentally disabled and unable to assist in the reconciliation process - he is escorted to appointments by members of his group home. It is unclear why the third medication reconciliation was missed.

Action Plan: The clinic will continue to track this PI measure with the goal of reaching 100%. Prior to future appointments with the gentleman who did not have documented medication reconciliations, the clinic RN will contact the group home and ask them to fax a medication list.

Comments: The last quarter of FY2016 was a period of transition for the clinic as a new RN and Medical Assistant have started.

STRATEGIC PERFORMANCE EXCELLENCE



II. 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

	Results						
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**FYTD**
Target	Reconciliation completed per visit.	FY2015 77%	100%	100%	100%	100%	**100%**
Actual			92% 58/63	95% 56/59	93% 43/46	90% 26/29	**93% 183/197**

Data Analysis: FY2016 had a 15% improvement from FY2015. During Q4 the vitals that were missed corresponded to the medication reconciliations that were also missed. Two of the vitals that were missed were not documented; historically the patient refuses vitals but nursing documentation did not reflect that they were refused. It is unclear why the third set of vitals was missed.

Action Plan: The clinic will continue to track this PI measure with the goal of reaching 100%. If a patient declines to have vitals taken, staff will document the refusal on the vitals flow sheet.

STRATEGIC PERFORMANCE EXCELLENCE

STRATEGIC PERFORMANCE EXCELLENCE

Dietary Services

Responsible Party: Kristen Piela, Dietetic Services Manager

I. Measure Name: Nutrition Screen Completion

Measure Description: The Registered Dietitian will review each patient's Nursing Admission Data to assess ongoing compliance with the completion of the Nutrition Screen tool; within 24 hours of admission.

Type of Measure: Quality Assurance

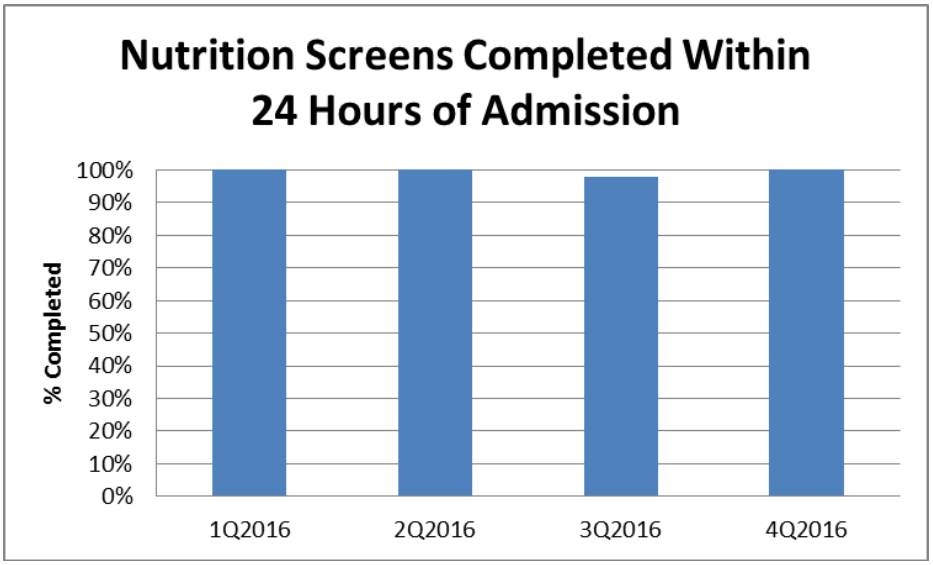
Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of Nutrition screens completed on time	FY 2015 95%	95% 57/60	95% 58/61	95% 60/63	96% 48/50	**95% 223/234**
Actual			100% 60/60	100% 61/61	98% 62/63	100% 50/50	**100% 233/234**

Data Analysis: Completion of the nutrition screens within 24 hours of admission has remained above target levels. This monitor began as an indicator in FY 2013.

Action Plan: To assure optimum care for our patients, this monitor will remain a quality assurance measure. As a follow up to this measure, there has been a performance improvement monitor developed to evaluate the accuracy of the screens being completed.

Comments: This is a multidisciplinary measure that has proven successful.

STRATEGIC PERFORMANCE EXCELLENCE



II. Measure Name: Nutrition Screen Accuracy

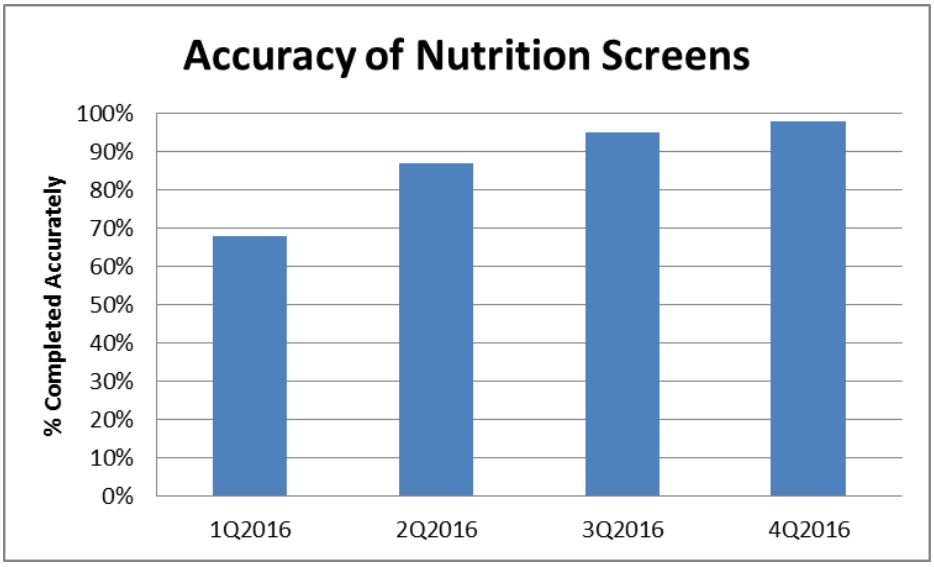
Measure Description: The Registered Dietitian will review every patient's Nursing Admission Data upon admission to assess ongoing compliance with the accuracy of the Nutrition Screen tool. This screen is utilized to attain nutrition indicators that necessitate dietary intervention.

Type of Measure: Performance Improvement

	Results						
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of Nutrition screens completed accurately	FY 2016 Q1 68% 41/60	Baseline Established	95% 58/61	95% 59/62	95% 48/50	**95% 165/173**
Actual			68% 41/60	87% 53/61	95% 59/62	98% 49/50	**93% 161/173**

Data Analysis: These results indicate there has been a 3% improvement in the accuracy of the information gathered on the nutrition screen this quarter. The nutrition screen is completed by the nurse responsible for the admission. The nurse responsible for completing the nutrition screen that contained the inaccuracy is not regularly assigned to this task. The diagnosis on the nutrition screen that was not identified on one occasion was a "BMI>29. A summary of this measure since its implementation shows a positive and steady improvement from 68% 1st quarter baseline to 93% by end of Fy2016.

Action Plan: Met with the admitting nurse responsible for this data collection and provided guidance surrounding the proper method of completing the nutrition screen.



III. Measure Name: Hand Hygiene Compliance

Measure Description: Supervisory staff including the Food Service Manager and Cook III's will observe all dietary employees as they return from break for proper hand hygiene.

Type of Measure: Performance Improvement

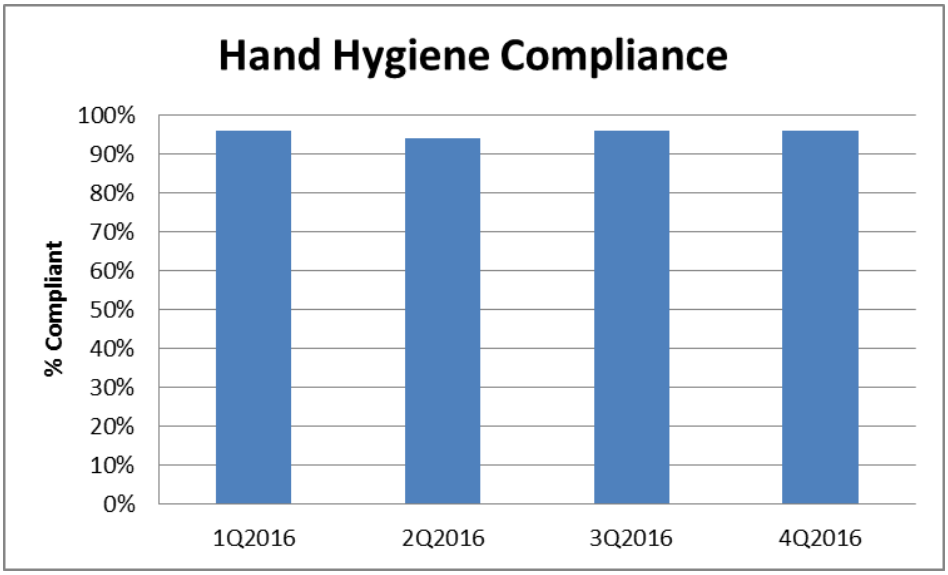
	Results						
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of Dietary employees washing hands after break	FY 2015 98% 338/346	95% 339/356	95% 218/229	95% 274/288	95% 360/377	**95% 1191/1250**
Actual			96% 343/356	94% 215/229	96% 276/288	96% 363/377	**96% 1197/1250**

Data Analysis: The results of this quarter remain above 95%. There was a 0.4% increase in compliance. Total observations increased by 89. Eight employees accounted for the 14 times that handwashing wasn't observed.

STRATEGIC PERFORMANCE EXCELLENCE

Action Plan:

- Continue this monitor as a QUALITY ASSURANCE MEASURE for the next reporting year.
- Provide a review of the proper hand washing times and techniques as quarterly training.
- Encourage front line supervisors to promote hand hygiene with their staff throughout the day.
- Provide this Performance Improvement Measure to staff to highlight the continued success.



Emergency Management

Responsible Party: Robert Patnaude, Emergency Management Coordinator

I. 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**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of timely and appropriate responses	FY2016 90% 144/159	90%	90%	90%	90%	**90%**
Actual			92% 147/159	96% 153/159	93% 148/159	96% 153/159	**94% 601/636**

Data Analysis: With a significant amount of hands-on demonstrations, radio tests, and an increase in the use of radios, data showed that staff has become very familiar with operating the radio once the radios have been deployed. While the actual percentage of compliance is above the set threshold, what continues to be a critical issue is the fact that staff are not receiving the notification to employ the radios. The notification is going out, but either the pager is not on, the battery is dead, or the pager is not being monitored well. We continue to investigate the most appropriate equipment such as non-battery dependent alert devices which are not so dependent on staff oversight and monitor the manner and number of pagers employed at any given time. We recently integrated our two-way radios into our duress system giving us the capability to mass notify staff via a computerized system.

Action Plan:

1. Continued tests and remedial training to staff along with supporting handouts as needed.
2. Increased surveillance of mass notification equipment such as alert pagers.
3. Investigate various media to notify staff to employ radios.

Comments: Over the course of this past year, 94% of assigned radio equipment is placed into service in a timely manner. We attribute this success from our Action Plan and from units such as our Operations Center which constantly monitors the use of the radios and provides immediate remedial instructions to our staff when deficiencies are discovered.
Although this response adequately assures that the majority of occupants will receive timely and critical information, it still leaves a small population of staff who could be at harm's way if they do not receive critical information through mass notification. At times, some units did not respond to the initial notification. We were still able to employ a back-up procedure to get that notification to them in a timely manner.

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STRATEGIC PERFORMANCE EXCELLENCE

Areas/Groups Monitored N=Numerator D=Denominator	JUL 2015	AUG 2015	SEPT 2015	OCT 2015	NOV 2015	DEC 2015	JAN 2016	FEB 2016	MAR 2016	APR 2016	MAY 2016	JUNE 2016
Patient Care Areas/ # of radios												
Job Coach/1	1/1	1/1	1/1	1/1	1/1*	**0/1****	1/1*	1/1*	1/1*	1/1	1/1*	1/1
OPS/2	2/2	2/2	**1/2**	2/2	2/2*	2/2	2/2*	2/2	2/2*	2/2*	2/2*	2/2
Tx Mall, Clinic, Dietary, Med Rec/5	5/5*	5/5	**3/5**	5/5	5/5*	**4/5**5**	5/5*	5/5	**4/5**5**	**4/5**10**	5/5	5/5
US, UK, LS, LSSCU, LK, LKSCU/10	**9/10**	10/10	**8/10**	10/10	**7/10**3**	**9/10**	**9/10**3**	10/10	**7/10**3**	**7/10**12**11**	10/10	**8/10**11**
Support Services/ # of radios												
Administration/3	3/3*	3/3	3/3	3/3	3/3*	3/3	3/3*	3/3	3/3*	3/3*	3/3*	3/3
Housekeeping/ 10	**9/10**	10/10	**9/10**	**9/10*1**	10/10*	10/10	10/10	**9/10*9**	**5/10**8**	10/10	10/10	10/10
Maintenance/14	14/14	14/14	**12/14**	14/14	14/14*	14/14	14/14	14/14	14/14*	14/14*	14/14	14/14*
NOD/1	1/1	1/1	1/1	1/1	**0/1**4**	1/1*	1/1*	1/1*	1/1*	1/1*	1/1	1/1*
Nursing Services/1	1/1	1/1	**0/1**	**0/1**2**	1/1*	**0/1**6**	1/1	1/1	1/1*	1/1*	1/1	1/1
Operations/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1*	1/1	1/1	1/1
Security/4	4/4	4/4	4/4	4/4	4/4	4/4	4/4	4/4	4/4*	4/4*	4/4*	4/4
State Forensic Services/1	1/1	1/1	**0/1**	1/1	1/1*	**0/1**7**	1/1	1/1	1/1*	1/1*	1/1*	1/1
Patient Care Areas	**17/18**	**18/18**	**13/18**	**18/18**	**15/18**	**18/18**	**17/18**	**18/18**	**14/18**	**14/18**	**18/18**	**16/18**
Support Services	**34/35**	**32/35**	**30/35**	**33/35**	**34/35**	**32/35**	**35/35**	**34/35**	**30/35**	**35/35**	**35/35**	**35/35**
Total	**51/53**	**53/53**	**43/53**	**51/53**	**49/53**	**53/53**	**52/53**	**52/53**	**44/53**	**49/53**	**53/53**	**51/53**

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

STRATEGIC PERFORMANCE EXCELLENCE

Key:

**1 Staff did not hear test due to radio being turned down. Remedial training held for staff.

**2 General staff in area were not aware that radio was assigned to that location. EMC educated staff.

**3 Operations had to call some units. Staff did not respond to the Code Triage.

**4 Staff called Operations asking what "Code Triage" meant. Upon further examination, the radio was dead. Not placed in charger properly. EMC educated staff.

**5 Operations called unit since staff did not respond to the "Code Triage". Pager for alert had a dead battery. EMC educated staff. Battery replaced.

**6 Operations had to call unit since staff did not respond to the "Code Triage". No means to receive message. Pager issued to Secretary. EMC educated staff.

**7 Operations had to call unit. Department Director only person in office. EMC to provided remedial training.

**8 Housekeeping staff (Official shift start time of 0600) did not respond to the original test at 0606, but responded at the test done at 0615.

**9 One housekeeper reported that their radio was not working. After remedial training, the test was performed as expected.

**10 Operations called Dietary unit since staff did not respond to the "Code Triage". EMC and unit supervisor provided remedial training.

**11 Operations called LK unit since staff did not respond to the "Code Triage".

**12 US had the same person respond to the test. EMC requested that a different person test the 2nd radio which they complied.

STRATEGIC PERFORMANCE EXCELLENCE

Harbor Treatment Mall

Responsible Party: Marcy Pepin, RN

I. Measure: Harbor Mall Hand-Off Communication

Measure Description: 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.

Type of Measure: Performance Improvement

Objectives	1Q 2016	2Q 2016	3Q 2016	4Q 2016	Total FY2016
Hand-off communication sheet was received at the Harbor Mall within the designated time frame.	79% 44/56	93% 39/42	88% 37/42	80% 33/41	**85% 153/181**
SBAR information completed from the units to the Harbor Mall.	79% 44/56	93% 39/42	86% 36/42	98% 41/42	**88% 160/182**

Data Analysis: Overall compliance has improved from 87% last quarter to 89% this quarter. Indicator one decreased from 88% last quarter to 80% this quarter. Indicator two increased from 86% last quarter to 98% this quarter. Overall compliance for FY2016 is 86%.

Action Plan: Review the results of this audit with RN IVs and RN Vs from each unit. Maintain highlighted statement at the bottom of the HOC reminding unit staff to turn the sheets in by 10 minutes after the hour to ensure Harbor Mall are made aware of any issues with patients.

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Responsible Party: Samantha Brockway, Medical Records Administrator

Documentation and Timeliness:

Indicators	4Q2016 Findings	4Q2016 Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements, and Medical Staff bylaws timeframes.	51 charts for patients released during the quarter were sampled. 49 of the charts were completed within the required timeframe.	96%	80%
Discharge summaries will be completed within 15 days of discharge.	51 out of 51 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.	7 revised forms, 2 new forms, and 2 removed forms in 4Q2016 (see minutes).	100%	100%
Medical transcription will be timely and accurate.	Out of 1661 dictated reports, 1661 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 Medical Director, along with the Superintendent, Risk Manager and the Quality Improvement Manager. There was 100% compliance with timely & accurate medical transcription services

Actions: Continue to monitor.

STRATEGIC PERFORMANCE EXCELLENCE

Confidentiality:

Indicators	3Q2016 Findings	3Q2016 Compliance	Threshold Percentile
All patient information released from the Health Information Department will meet all Joint Commission, State, Federal & HIPAA standards.	2,752 requests for information (143 requests for patient information and 2,609 police checks) were released.	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	All new employees/contract staff attended confidentiality/ HIPAA training.	100%	100%
Patient 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 4Q2016 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 needs 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

Regulatory and Compliance Standards in Documentation

Ensuring Fiscal Responsibility in Documentation and Billing Practices

Indicator and Rationale for Selection	1Q2016	2Q2016	3Q2016	4Q2016
Identification Data	N/A	N/A	100% 65/65	100% 51/51
Medical History, including chief complaint; HPI; past, social & family hx.; ROS, and physical exam w/in 24 hr. conclusion and plan	N/A	N/A	100% 65/65	100% 51/51
Summary of patient's psychosocial needs as appropriate to the patients *	N/A	N/A	88% 57/65	61% 31/51
Psychiatric Evaluation in patient's record w/in 24 hr of admission	N/A	N/A	99% 64/65	100% 51/51
Physician (TO/VO w/in 72 hr.)	N/A	N/A	96% 230/240	92% 23/25
Evidence of appropriate informed consent	N/A	N/A	100% 65/65 13 Refused	100% 51/51 14 Refused
Clinical observations including the results of therapy.	N/A	N/A	100% 65/65	100% 51/51
Nursing discharge Progress Note with time of discharge departure	N/A	N/A	92% 60/65	90% 46/51
Consultation reports, when applicable	N/A	N/A	100% 52/52	81% 26/32
Results of autopsy, when performed	N/A	N/A	N/A	N/A
Advance Directive Status on admission and SW follow up after	N/A	N/A	99% 64/65	88% 28/32
Notice of Privacy	N/A	N/A	94% 61/65	91% 29/32
Chart Completion w/in 30 days of discharge date/discharge summary completed within 30 days	N/A	N/A	100% 65/65	94% 30/32
Discharge Packet sent to follow up provider within 5 days of discharge.	N/A	N/A	100% 65/65	100% 51/51

* The parameters for this measure will be changed to meet applicable goals as defined by Director of Social Work. The current measure is more stringent than regulatory standards dictate.

*N/A: Information not available, data tracking began in 3Q2016

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

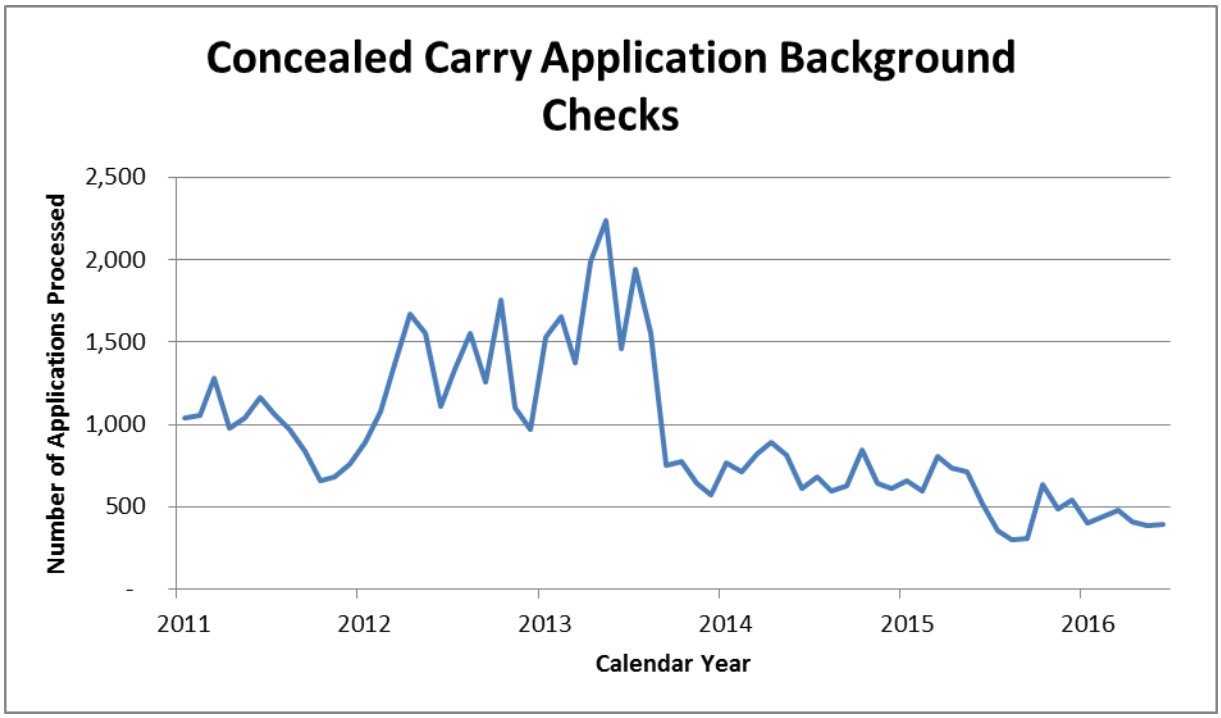
Analyze:
Data collected for the 4Q2016 showed that we received 1184 applications. This is a decrease from last quarter, 3Q2016, when we received 1316 applications.

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. 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.

Note: In July 2015, a new State of Maine law was approved effective October 2015. This law no longer requires citizens to have a concealed carry permit to carry a concealed weapon within the State of Maine. However, if citizens want to carry concealed outside Maine they will still need to apply for a concealed carry permit. We expect this to decrease the number of concealed carry permit applications we receive and process.

Year	**FY2016**												**Total**
Month	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	
# Applications Received	353	302	304	634	489	542	401	439	476	411	384	389	5124

STRATEGIC PERFORMANCE EXCELLENCE



STRATEGIC PERFORMANCE EXCELLENCE

Housekeeping

Responsible Party: Debora Proctor, Housekeeping Supervisor

I. Measure Name: 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	Target	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Lower Saco	85%	89%	94%	92%	93%	**92%**
Upper Saco	85%	87%	88%	88%	90%	**88%**
Lower Kennebec	85%	89%	90%	87%	89%	**89%**
Upper Kennebec	85%	87%	89%	90%	91%	**89%**
Overall Average	**85%**	**88%**	**90%**	**89%**	**91%**	**90%**

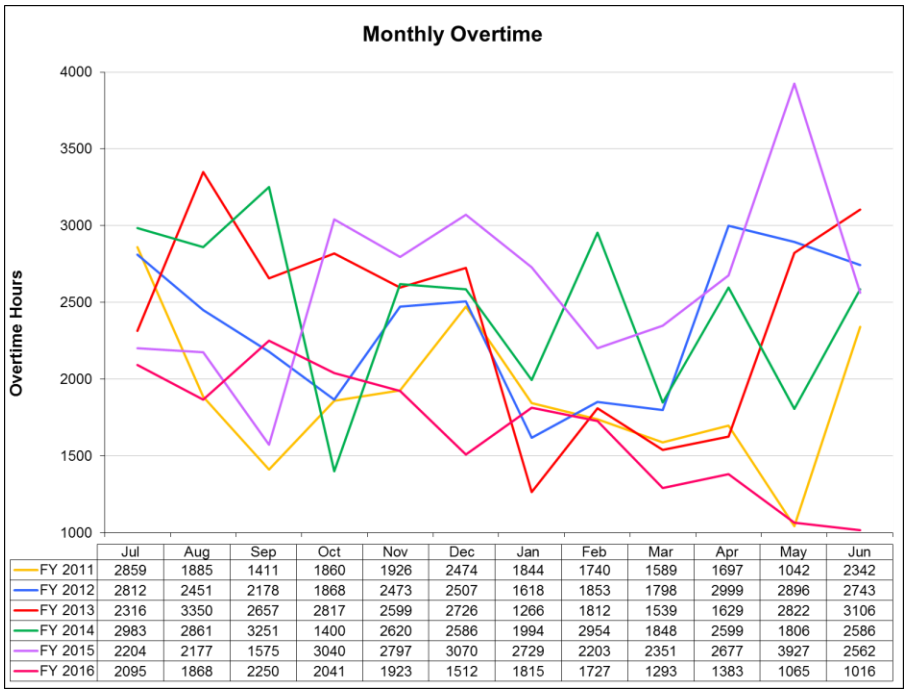
Data Analysis: The Housekeeping Supervisor inspected units monthly and found that window cleaning, dusting, and some floor care in the nurse's station were consistent problem areas.

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

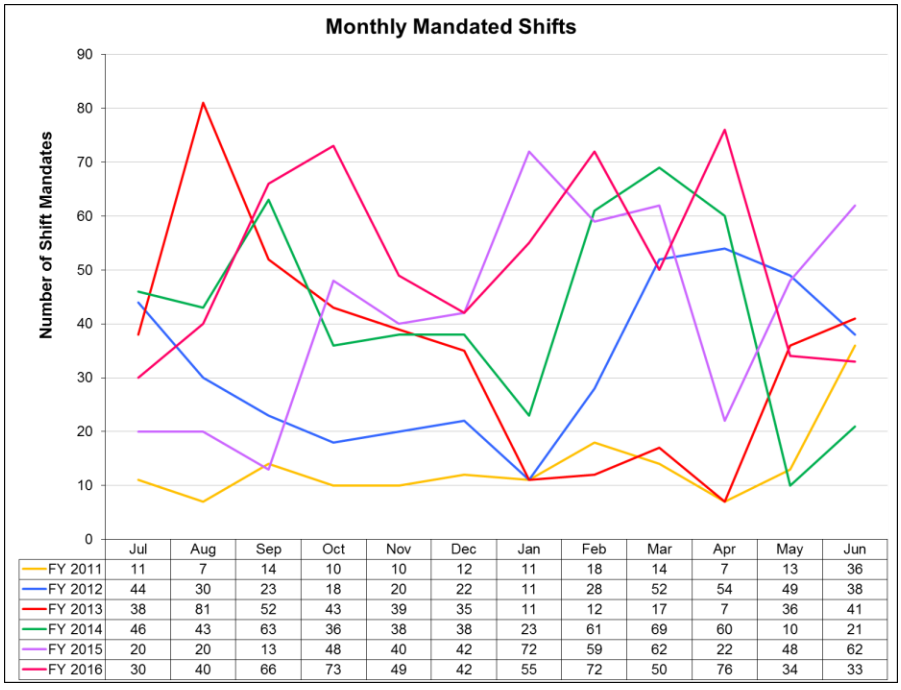
STRATEGIC PERFORMANCE EXCELLENCE

Human Resources

Person Responsible: Aimee Rice, Human Resources Manager



	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
FY 2016	2095	1868	2250	2041	1923	1512	1815	1727	1293	1383	1065	1016



	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
FY 2016	30	40	66	73	49	42	55	72	50	76	34	33

STRATEGIC PERFORMANCE EXCELLENCE

I. Measure Name: License Reviews

Measure Description: Ensuring that licenses/registry entries are verified via the appropriate source prior to hire for all licensed (or potentially licensed) new hires.

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percentage Licenses Reviewed	FY 2014 98%	100%	100%	100%	100%	**100%**
Actual			100% 19/19	100% 6/6	100% 28/28	100% 40/40	**100% 93/93**

Data Analysis: During 4Q2016, there were 45 new hires. Of those, 40 were licensed, or potentially licensed. License and CNA Registry checks were performed prior to hire on all 40.

Action Plan: No action is needed at this time.

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff

Responsible Party: Dr. William Nelson, Acting Clinical Director

Quality Improvement Plan
2015-2016

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.

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

Pharmacy & Therapeutics Committee:	Chair reports monthly
Medical Records Committee:	Chair reports monthly
Infection Control Committee:	Chair reports monthly
Utilization Management Committee:	Chair reports bimonthly
QA/PI/Peer Review Committee and to	Clinical Director reports monthly Individual practitioners as necessary
Research Committee	Clinical Director reports bimonthly
CME Committee	Chair reports bimonthly
Human Rights Committee (Allegations of Abuse, Neglect, and Exploitation)	Clinical Director reports monthly

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**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Justified Polyantipsychotic Therapy	85% (2015)	90%	90%	90%	90%	**90%**
Actual			77%	69%	78%	72%	**76%**

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 we maintained the number of patients on justifiable polyantipsychotic therapy. An analysis of the patients on polyantipsychotic therapy yielded the following results: An average 13% of inpatients were prescribed two scheduled antipsychotics, which has decreased from 27% last quarter. The percentage of scheduled polyantipsychotic therapy versus the use of more than one antipsychotic on an as needed basis only, has evened out with values of 44% and 47% of all patients with polyantipsychotic therapy respectively. We have seen a small decrease in number of patients with triple antipsychotic therapy from 10 patients (4%) to 7 patients (3%). Out of all 78 patients using polyantipsychotic therapy, 10% were using more than two agents, and another 4% of those 78 patients were on more than two standing antipsychotic agents. Of note, 24 of the 78 patients (31%) were using another antipsychotic as adjunct to clozapine therapy. All patients either had regimens which were deemed pharmacologically rational or were documented as being in the cross-taper process.

STRATEGIC PERFORMANCE EXCELLENCE

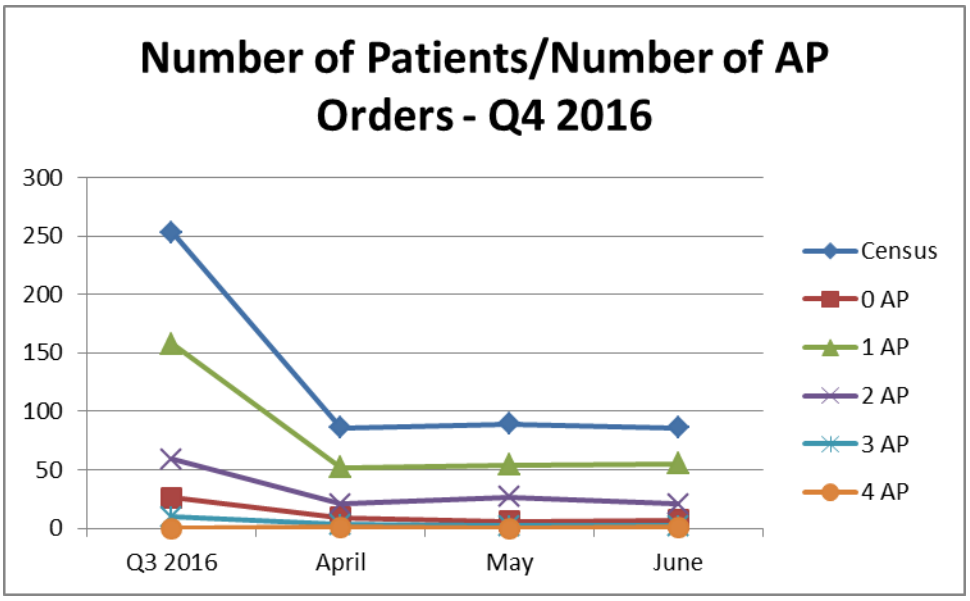
Action Plan: It was decided to continue to monitor polyantipsychotic therapy as a performance improvement as our use has increased over the year. Although our providers have provided justification of polyantipsychotic therapy in a higher percentage of cases, the facility also has increased in number of patients using triple and quadruple therapy. Pharmacy continues alerting providers to provide justifications for polyantipsychotic therapy. It may be beneficial to look more closely at those patients with three and four antipsychotic regimens in the future to lower this number.

Comments: This quarter the number of patients on polyantipsychotic therapy remains steady with appropriate documentation of justification. Of note, a large number of patients are receiving polyantipsychotic therapy as adjunct to clozapine or after failure of clozapine therapy, which is appropriate and may speak to the severity of the current census. Additionally, another large portion of polyantipsychotic therapy is due to the addition of another agent only on an as needed basis, and these agents are not typically carried over to discharge.

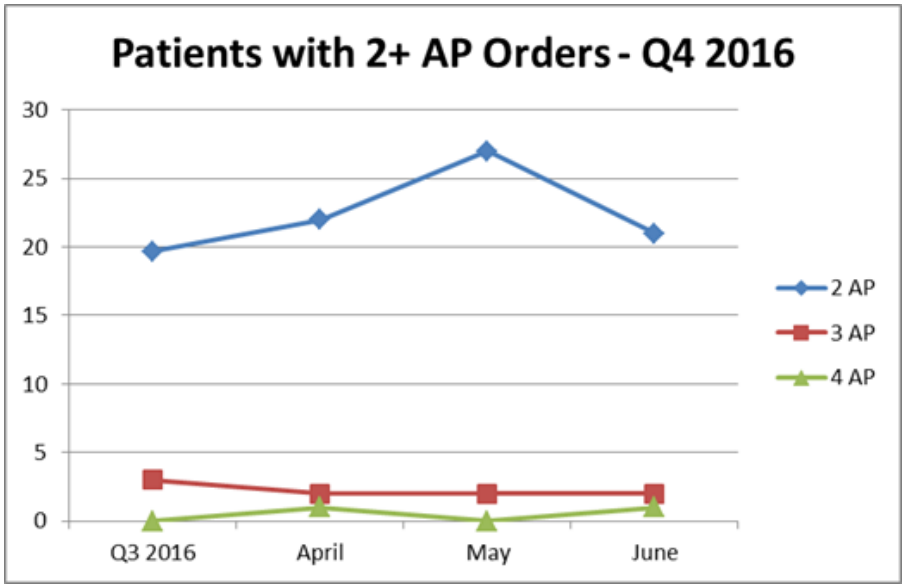
Q4 2016 Report	Q3 2016		April		May		June	
Census	254		86		89		86	
Antipsychotic Orders for Clients	*N*	*%*	*N*	*%*	*N*	*%*	*N*	*%*
No Antipsychotics	26	10	9	10	6	7	7	8
Mono-antipsychotic therapy	158	62	52	60	54	61	55	64
Two Antipsychotics	59	23	21	24	27	30	21	24
Three Antipsychotics	10	4	3	3	2	2	2	2
Four Antipsychotics	0	0	1	1	0	0	1	1
At least 1 antipsychotic	222	87	77	90	83	93	79	92
Total on Poly-antipsychotic therapy	69	27	25	29	29	33	24	28
Percentage of poly-antipsychotic therapy amongst those with orders for antipsychotics		31% (69/222)		32% (25/77)		35 % (29/83)		30% (24/79)
More than 2 antipsychotics	10	5%	3	4%	2	2%	3	4%
Poly-Antipsychotic therapy breakdown	*N*	*%*	*N*	*%*	*N*	*%*	*N*	*%*
SGA + FGA	29	42	7	28	11	38	13	54
2 SGAs ("Pine" + "Done")	9	13	3	12	6	21	2	8
Other (2 antipsychotic regimens)	24	35	11	44	9	31	9	38
Other 2 Antipsychotic Regimen Details	1) Clozapine + Olanzapine X7 2) Haloperidol + Chlorpromazine 3) Aripiprazole + Paliperidone X3 4) Clozapine + Quetiapine X2 5) Aripiprazole + Olanzapine X4		1) Clozapine/ Olanzapine X 4 2) Aripiprazole/ Ziprasidone 3) Aripiprazole/ Olanzapine X 2 4) Aripiprazole/ Quetiapine X 2 5) Paliperidone/ Aripiprazole		1) Aripiprazole/ Quetiapine (x2) 2) Risperidone/ Aripiprazole 2) Aripiprazole/ Olanzapine (x2) 3) Clozapine/ Olanzapine 4) Paliperidone/ Risperidone		1) Aripiprazole/ Quetiapine 2) Haloperidol/ Loxapine 3) Clozapine/ Olanzapine X 3 4) Aripiprazole/ Olanzapine	
3+ Antipsychotic Regimens	10	4.50%	3	4%	2	2%	3	4%
	1) Clozapine/ Haloperidol/ Olanzapine X3 2) Clozapine/ Ziprasidone/ Haloperidol 3)Clozapine/ Quetiapine/ Olanzapine X3 4) Clozapine/ Quetiapine/ Chlorpromazine 5) Chlorpromazine/ Perphenazine/ Quetiapine 6) Aripiprazole/ Haloperidol/		1) Paliperidone/ Risperidone/ Chlorpromazine 2) Paliperidone/ Risperidone/ Quetiapine 3) Clozapine/ Quetiapine/ Chlorpromazine 4) Aripiprazole/ Clozapine/ Olanzapine/ Quetiapine		1) Haloperidol/ Loxapine/ Olanzapine 2) Clozapine/ Quetiapine/ Chlorpromazine		1) Clozapine/ Chlorpromazine/ Olanzapine 2) Clozapine/ Haloperidol/ Ziprasidone 3) Clozapine/ Aripiprazole/ Quetiapine/ Olanzapine	
Justifiable Poly-Antipsychotic Therapy	78% (54/69)		60% (15/25)		76% (22/29)		79% (19/24)	

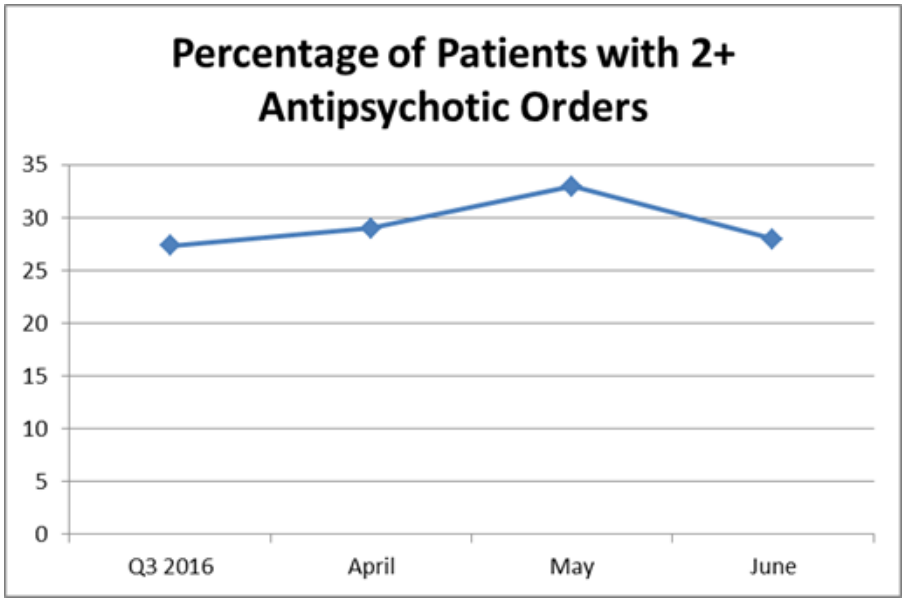
STRATEGIC PERFORMANCE EXCELLENCE

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



Number of Patients with 2+ Antipsychotic orders per Month:





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**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Complete/Up-to-date Metabolic Parameters	73%	75%	75%	75%	75%	**75%**
Actual			73%	63%	57%	81%	**69%**

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. In this last quarter the facility has been able to meet the predetermined goal

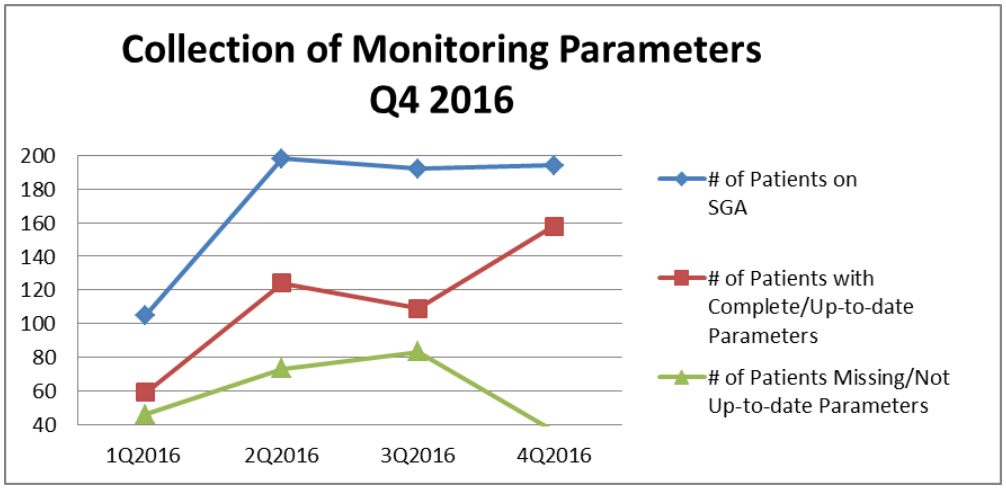
with 81% of patients on atypical antipsychotic therapy having complete and up-to-date laboratory results. Of the 18% of patients who were not up-to-date, 9% had refused blood draws multiple times throughout the quarter.

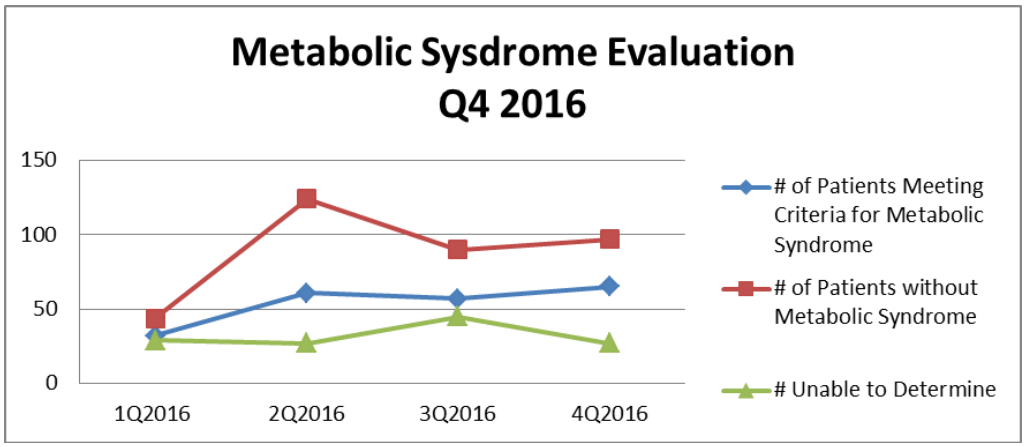
Action Plan: We will continue to monitor for Metabolic Syndrome in patients using SGA therapy. The patient's right to refuse assessment (weight, blood pressure and lab work) has been identified as a contributing factor to not being able to fully assess their metabolic status. Thus the goal of achieving 95% completed metabolic parameters is unrealistic and has been adjusted to a more reasonable goal of 75%. During this last quarter, a renewed effort between pharmacy and the medical service resulted in a significant increase in the number of patients who have complete monitoring parameters. To aid providers with this task, the pharmacy has been updating a flow sheet monthly for the medical service to identify which patients are due for lab work.

Comments: We saw a significant improvement this quarter from 57% to 81%, exceeding our goal of 75%. Of the patients that did not have complete/up-to-date parameters collected, 9% had documented refusals in contrast to 1% from last quarter. For the remaining patients, it is likely that they were recently initiated on the second generation antipsychotic agent at time of assessment and/or were recently admitted to the facility.

	1Q2016	2Q2016	3Q2016	4Q2016
# of Patients on SGA	105	198	192	194
# of Patients with Complete/Up-to-date Parameters	59 (56%)	124 (63%)	109 (57%)	158 (81%)
# of Patients Missing/Not Up-to-date Parameters	46 (44%)	74 (37%)	83 (43%)	36 (19%)
# of Patients Meeting Criteria for Metabolic Syndrome	32 (30%)	61 (31%)	57 (30%)	65 (34%)
# of Patients without Metabolic Syndrome	44 (42%)	124 (63%)	90 (47%)	97 (.5%)
# Unable to Determine	29 (28%)	27 (14%)	45 (23%)	27 (14%)
Documented Refusals	0	27 (14%)	1 (.01%)	17 (.9%)

STRATEGIC PERFORMANCE EXCELLENCE





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: Quality Assurance

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, but it will no longer be reported on a quarterly basis.

Comments: Results this quarter continue to remain similar to previous quarters. The average number of agents has likely increased due to patient specific factors including an increased number of medically fragile patients. The number of medications per patient seems to reflect our current population.

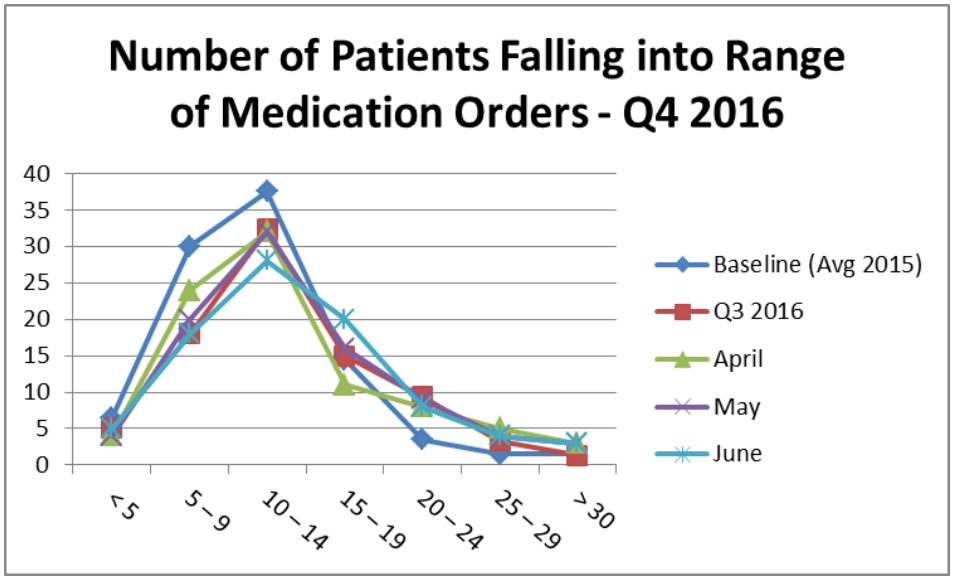
(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

STRATEGIC PERFORMANCE EXCELLENCE

	Baseline Average	Baseline Range	Q32016 Average	Q32016 Range	April Average	April Range	May Average	May Range	June Average	June Range
Total Orders	12.1	0-31	11	1-37	13	1-37	14	2-37	13.8	2-37
Scheduled	4.9	0-17	7	0-21	6	1-20	7	1-20	6.7	0-21
PRNs	5.9	0-19	10	0-21	7	0-21	8	1-21	7.6	1-21

Medication Number Range	Average Number of Patients (Baseline)	3Q2016 Average	April	May	June	4Q2016 Average
< 5	7	5	4	4	5	4
5 – 9	30	18	24	20	18	21
10 – 14	38	32	32	32	28	31
15 – 19	15	15	11	16	20	16
20 – 24	4	9	8	9	8	8
25 – 29	2	3	5	4	4	4
> 30	2	1	3	3	3	3

Number of Patients Falling into Range of Medication Orders



STRATEGIC PERFORMANCE EXCELLENCE

Nursing

Responsible Party: Renee Pfingst, RN, Acting Director of Nursing

I. Measure Name: 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.

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

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.

	Baseline Sept 2013	1Q2016			2Q2016			3Q2016			4Q2016			Goal
		July 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	April 2016	May 2016	June 2016	
Nursing Mandates	14	2	1	8	11	8	10	3	1	5	8	3	1	0
Mental Health Worker (MHW) Mandates	49	28	39	58	62	41	32	52	71	45	68	31	32	0

Nursing mandates increased from 9 last quarter to 12 this quarter.
MHW mandates decreased from 168 last quarter to 131 this quarter.

Analysis: On June 26, 2016, our Mental Health Workers and Acuity Specialists started their new twelve hour shift schedule. This change was initiated due to the number of staff who were mandated to cover vacant shifts and also the facility's charge to decrease the financial implications of overtime paid out.

Objective: Through collaboration with the MSEA and AFSME unions, staff and administration came to desired conclusion of twelve hours shifts which alternate two days on and two days off. RPC now has a flattened schedule where there are no more vacancies on the weekends than during the week. Most days, there is an overage of MHW to cover sick calls and attend required training for maintenance of credentials.

Goal: To essentially eliminate mandates and dramatically decrease the burden of overtime on our current fiscal goals. Staff retention and recruitment is part of this initiative. From April to June our mandates for MHW dropped by 50% and professional nurse mandates have also dropped 50%. Professional nursing staff schedules are presently being assessed to determine if we can offer the same type of schedule. At this time, due to vacancies, it is not feasible until we can hire more state line nursing staff.

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Chart Review Effectiveness

4Q2016 - Lower Saco

Indicators	Findings	Compliance
1. RN Assessment completed within 24 hours	15/15	100%
2. All sheets requiring signature authenticated by assessing RN	15/15	100%
3. Interim plan of care initiated within 8 hours and completed within 24 hours	7/15	47%
4. Medical Care Plan if medical problems are identified initiated within24 hours	6/15 1 N/A	47%
5. Suicide potential assessed upon admission (TASR)	15/15	100%
6. Informed Consent sheet signed	10/15	67%
7. Potential for violence assessed upon admission	15/15	100%
8. Fall Risk assessed upon admission	15/15	100%
9. Score of 6 or above incorporated into problem need list	10 N/A	67%
10. Dangerous Risk Tool done upon admission	15/15	100%
11. Score of 11 or above incorporated into Safety Problem	3/15 6 N/A	60%
12. Evidence of informed of their rights documentation	15/15	100%
13. Medication Reconciliation @ time of admission includes all medications (medical & psychiatric)	15/15	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Chart Review Effectiveness

4Q2016 - Upper Saco

Indicators	Findings	Compliance
1. RN Assessment completed within 24 hours	4/4	100%
2. All sheets requiring signature authenticated by assessing RN	4/4	100%
3. Interim plan of care initiated within 8 hours and completed within 24 hours	2/4	50%
4. Medical Care Plan if medical problems are identified initiated within24 hours	2/4	50%
5. Suicide potential assessed upon admission (TASR)	4/4	100%
6. Informed Consent sheet signed	2/4	50%
7. Potential for violence assessed upon admission	4/4	100%
8. Fall Risk assessed upon admission	4/4	100%
9. Score of 6 or above incorporated into problem need list	1 N/A	25%
10. Dangerous Risk Tool done upon admission	4/4	100%
11. Score of 11 or above incorporated into Safety Problem	1/4 2 N/A	75%
12. Evidence of informed of their rights documentation	3/4	75%
13. Medication Reconciliation @ time of admission includes all medications (medical & psychiatric)	4/4	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Chart Review Effectiveness

4Q2016 - Lower Kennebec

Indicators	Findings	Compliance
1. RN Assessment completed within 24 hours	26/27	96%
2. All sheets requiring signature authenticated by assessing RN	26/27	96%
3. Interim plan of care initiated within 8 hours and completed within 24 hours	23/27	85%
4. Medical Care Plan if medical problems are identified initiated within24 hours	12/27 6 N/A	67%
5. Suicide potential assessed upon admission (TASR)	27/27	100%
6. Informed Consent sheet signed	23/27 1 Refused	89%
7. Potential for violence assessed upon admission	27/27	100%
8. Fall Risk assessed upon admission	27/27	100%
9. Score of 6 or above incorporated into problem need list	1/27 9 N/A	37%
10. Dangerous Risk Tool done upon admission	27/27	100%
11. Score of 11 or above incorporated into Safety Problem	7/27 4 N/A	41%
12. Evidence of informed of their rights documentation	25/27 1 Refused	96%
13. Medication Reconciliation @ time of admission includes all medications (medical & psychiatric)	27/27	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Chart Review Effectiveness

4Q2016 - Upper Kennebec

Indicators	Findings	Compliance
1. RN Assessment completed within 24 hours	4/4	100%
2. All sheets requiring signature authenticated by assessing RN	4/4	100%
3. Interim plan of care initiated within 8 hours and completed within 24 hours	4/4	100%
4. Medical Care Plan if medical problems are identified initiated within24 hours	2/4	50%
5. Suicide potential assessed upon admission (TASR)	4/4	100%
6. Informed Consent sheet signed	4/4	100%
7. Potential for violence assessed upon admission	4/4	100%
8. Fall Risk assessed upon admission	4/4	100%
9. Score of 6 or above incorporated into problem need list	1 N/A	25%
10. Dangerous Risk Tool done upon admission	4/4	100%
11. Score of 11 or above incorporated into Safety Problem	1/4 1 N/A	50%
12. Evidence of informed of their rights documentation	4/4	100%
13. Medication Reconciliation @ time of admission includes all medications (medical & psychiatric)	4/4	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Chart Review Effectiveness

4Q2016 Total – All Units

Indicators	Findings	Compliance
1. RN Assessment completed within 24 hours	49/50	98%
2. All sheets requiring signature authenticated by assessing RN	49/50	98%
3. Interim plan of care initiated within 8 hours and completed within 24 hours	36/50	72%
4. Medical Care Plan if medical problems are identified initiated within24 hours	22/50 7 N/A	58%
5. Suicide potential assessed upon admission (TASR)	50/50	100%
6. Informed Consent sheet signed	39/50 1 Refused	80%
7. Potential for violence assessed upon admission	50/50	100%
8. Fall Risk assessed upon admission	50/50	100%
9. Score of 6 or above incorporated into problem need list	1/50 21 N/A	44%
10. Dangerous Risk Tool done upon admission	50/50	100%
11. Score of 11 or above incorporated into Safety Problem	12/50 13 N/A	50%
12. Evidence of informed of their rights documentation	47/50 1 Refused	96%
13. Medication Reconciliation @ time of admission includes all medications (medical & psychiatric)	49/50	98%

STRATEGIC PERFORMANCE EXCELLENCE

Outpatient Services (OPS)

Responsible Party: Lisa Manwaring, Director

I. Measure Name: Admission Assessments

Measure Description: Within 5 business days of admission initial assessments from Psychiatry, Psychosocial, and Nursing will be complete and in the chart. All three will need to be present to count.

Measure Type: Performance Improvement

	Results						
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of assessments completed on time	FY 2015 0% 0/4	75%	75%	75%	75%	**75%**
Actual			0% 0/3	0% 0/5	0% 0/4	25% 1/4	**.06% 1/16**

Data Analysis: We had three charts with two assessments completed this quarter.

Action Plan: To review data results with the OPS staff to ensure compliance.

Comments: To provide education and admission packets with assessment reminders to help facilitate compliance.

STRATEGIC PERFORMANCE EXCELLENCE

Peer Support

Responsible Party: Julia Duncan, Peer Support Coordinator

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	1Q2016	2Q2016	3Q2016	4Q2016	YTD
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%	44% 7/16	23% 3/13	64% 7/11	9% 1/11	**35%** **18/51**
	LS	5%	50%	0% 0/21	54% 7/13	13% 2/16	0% 0/10	**15%** **9/60**
	UK	45%	50%	18% 3/17	25% 4/16	19% 5/26	13% 3/22	**18%** **15/81**
	US	30%	50%	88% 7/8	100% 7/7	0% 0/5	12% 1/8	**53%** **15/28**
	Overall			**27%** **17/62**	**43%** **21/49**	**24%** **14/58**	**10%** **5/51**	**25%** **57/220**

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 2016	2Q 2016	3Q 2016	4Q 2016	YTD Average
1	I am better able to deal with crisis.	69%	82%	53%	70%	**69%**
2	My symptoms are not bothering me as much.	79%	77%	64%	65%	**71%**
3	The medications I am taking help me control symptoms that used to bother me.	75%	70%	42%	65%	**63%**
4	I do better in social situations.	71%	64%	56%	70%	**65%**
5	I deal more effectively with daily problems.	73%	83%	64%	64%	**71%**
6	I was treated with dignity and respect.	71%	65%	56%	65%	**64%**
7	Staff here believed that I could grow, change and recover.	69%	62%	56%	70%	**64%**
8	I felt comfortable asking questions about my treatment and medications.	68%	68%	72%	70%	**70%**
9	I was encouraged to use self-help/support groups.	72%	75%	58%	70%	**69%**
10	I was given information about how to manage my medication side effects.	68%	53%	64%	70%	**64%**
11	My other medical conditions were treated.	65%	69%	64%	55%	**63%**
12	I felt this hospital stay was necessary.	65%	48%	58%	40%	**53%**

STRATEGIC PERFORMANCE EXCELLENCE

#	Indicators	1Q 2016	2Q 2016	3Q 2016	4Q 2016	YTD Average
13	I felt free to complain without fear of retaliation.	69%	60%	44%	70%	**61%**
14	I felt safe to refuse medication or treatment during my hospital stay.	62%	46%	47%	60%	**54%**
15	My complaints and grievances were addressed.	63%	55%	47%	88%	**63%**
16	I participated in planning my discharge.	75%	43%	72%	88%	**69%**
17	Both I and my doctor or therapists from the community were actively involved in my hospital treatment plan.	63%	30%	53%	75%	**55%**
18	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	63%	32%	56%	60%	**53%**
19	The surroundings and atmosphere at the hospital helped me get better.	68%	63%	50%	65%	**62%**
20	I felt I had enough privacy in the hospital.	64%	61%	58%	60%	**61%**
21	I felt safe while I was in the hospital.	62%	62%	61%	65%	**63%**
22	The hospital environment was clean and comfortable.	66%	63%	56%	65%	**63%**
23	Staff were sensitive to my cultural background.	61%	52%	44%	69%	**56%**
24	My family and/or friends were able to visit me.	69%	64%	58%	75%	**67%**
25	I had a choice of treatment options.	64%	56%	44%	75%	**60%**
26	My contact with my doctor was helpful.	66%	58%	58%	70%	**63%**
27	My contact with nurses and therapists was helpful.	66%	64%	67%	75%	**68%**
28	If I had a choice of hospitals, I would still choose this one.	55%	45%	53%	45%	**50%**
29	Did anyone tell you about your rights?	71%	51%	50%	88%	**65%**
30	Are you told ahead of time of changes in your privileges, appointments, or daily routine?	63%	54%	44%	69%	**57%**
31	Do you know someone who can help you get what you want or stand up for your rights?	74%	77%	50%	81%	**71%**
32	My pain was managed.	62%	75%	50%	**69%**	**64%**
	Overall Score	**67%**	**63%**	**55%**	**68%**	**63%**

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

Responsible Party: Michael Migliore, Director of Pharmacy

I. **Measure Name: Controlled Substance Loss Data**

Measure Description: Daily and monthly comparison of Pyxis vs CII Safe Transaction Report.

Type of Measure: Quality Assurance

	Results						
	Unit	**Baseline FY 2015**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Pharmacy	0.19%	0%	0%	0%	0%	0%
Actual			0%	0%	0%	0%	0%

Data Analysis: All of the controlled substances have been accounted for, resulting in a 0% loss of controlled substances for the fourth quarter.

Action Plan: Remain vigilant and continue to educate staff on proper automated dispensing cabinet procedures to avoid the creation of discrepancies.

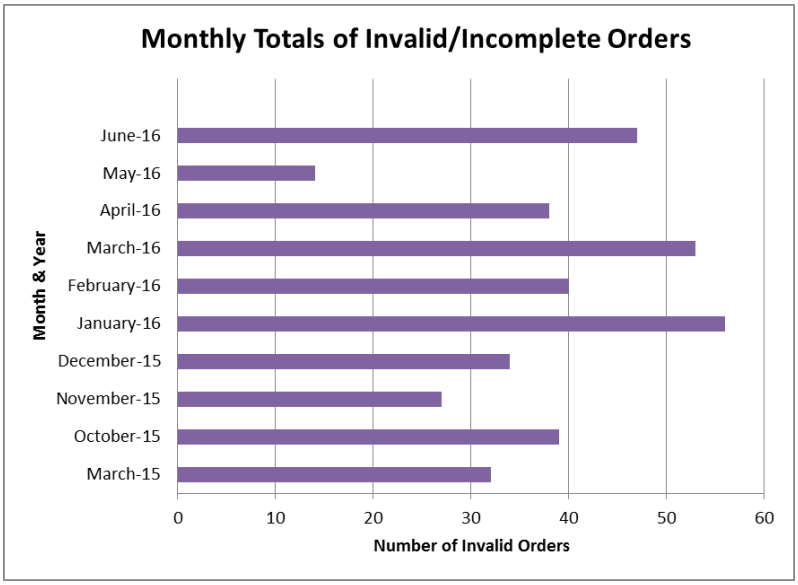
Comments: The action plan is providing the desired results.

STRATEGIC PERFORMANCE EXCELLENCE

II. **Measure Name: Invalid Orders**

Measure Description: Incomplete/Invalid Orders.

Type of Measure: Performance Improvement



*Data not available for April-September 2015

Background: With a zero tolerance policy for invalid orders, every prescribed order must contain the drug name, strength, administration route, dosing frequency, provider signature, order time and date, accurate allergy and adverse drug reaction information, and indication. Receiving an invalid order by the staff pharmacist requires documentation, copying and returning the invalid order to the prescriber for remediation, as well as contacting and informing the unit of the invalided order.

Data Analysis: For the 4Q2016 the number of invalid orders has decreased from last quarter partly due to staffing issues in the month of May and June. June reported 42 invalid/incomplete orders with 14 in May and 38 in April. Again, missing indications recorded high on the list. Although the numbers are lower this quarter, the Pharmacy Department continues to bring heightened awareness to this ongoing issue to all persons involved.

Action Plan: The Pharmacy Department is looking forward to the implementation of the CoCentrix CPOE (computerized physician order entry) system later this year. CPOE will eliminate incomplete orders by not permitting providers to initiate an order that is not complete. Once the conversion has occurred, the need to track incomplete will become obsolete.

STRATEGIC PERFORMANCE EXCELLENCE

III. **Measure Name: Veriform Medication Room Audits**

Measure Description: Comprehensive Unit Compliance Audits

Type of Measure: Quality Assurance

	Results						
	Unit	**Baseline FY 2015**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	All	100%	100%	100%	100%	100%	**100%**
Actual			100%	100%	100%	100%	**100%**

Data Analysis: The medication room audits have been concluded for quarter four without completion deficiencies.

Audit Compliance Findings: The Pharmacy Medication Room Audits for all the units have been completed for the fourth quarter.

Action Plan: No deficiencies were noted with pharmacy's completion of the medication room audits. Pharmacy staff will continue to operate to maintain 100% completion and will continue reporting any noted deficiencies to nursing staff.

Comments: Continuous monitoring of the Medication room audits and approval by the responsible individuals has again provided satisfactory results for this quarter. Excellent communication and cooperation with interdepartmental administration is the key to this favorable report.

STRATEGIC PERFORMANCE EXCELLENCE

IV. **Measure Name: Fiscal Accountability**

Measure Description: Monthly Tracking of Dispensed Discharge Prescriptions

Type of Measure: Quality Assurance

	Results						
	Unit	**Baseline FY 2015**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Actual	All	$15,764 for 861 Rx's	$5,281 for 368 Rx's	$3,720 for 312 Rx's	$7,679 for 461 Rx's	$5,237 for 304 Rx's	**$21,917 for 1445 Rx's**

Data Analysis: Riverview Psychiatric Center's Extended Hospital Pharmacy license permits it to dispense medication to both inpatients and outpatients. The majority of the outpatient prescriptions are for a 7-day supply of discharge medications. Administrative approval is required when a greater than 7 day supply is needed. Discharge prescriptions serve to cover the patient's needs until they are able to obtain medications in the community.

Action Plan: Advance discharge planning would permit patients to obtain prescription coverage prior to discharge, resulting in decreased pharmacy expenditures and a reduction in the volume of outpatient prescriptions provided by the pharmacy.

	Baseline 2015	**1Q206**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**	**Change from 2015**	**Average FY2016**
$ spent	$15,764	$5,281	$3,720	$7,679	$5,237	$21,917	$6,153	$5,479
# RX's	861	368	312	461	304	1445	584	361
$ per Rx	$18.31	$14.35	$11.92	$16.66	$17.23	$15.17	($3.14)	$15.04

Comments: The fourth quarter reported lower overall prescription costs than the 3rd quarter and also reported a lower than average number of Rx's. The cost of a 4th quarter prescription was $17.23, a slight increase from the previous quarter. Comparing YTD vs. Baseline 2015, there was an increase of $6152.60 for 584 additional orders filled compared to the previous year. Although the figures are higher, the cost of an Rx has decreased by $3.14 due to the vigilant selection of medications and purchasing in accordance with the hospital's buying group. The Pharmacy Department is currently at 95% compliance for contract purchasing and is striving to improve that number. Overall, discharge prescriptions have increased in total numbers from the prior year as well as cost from the prior year. The Pharmacy Department is pleased to report an overall decrease in the average cost of each prescription compared to 2015 as represented in the YTD figures.

STRATEGIC PERFORMANCE EXCELLENCE

Psychology

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

I. Measure Name: Outpatient Readiness Scale (ORS)

Measure Description: The ORS will be completed for those patients who reside in the community and are receiving services through OPS. Target is 90%of outpatients will have ORS completed and updated every 6 months.

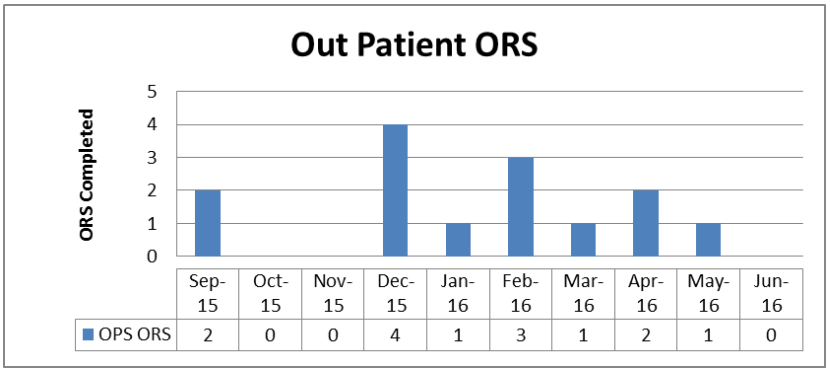
Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of OPS recipients evaluated with ORS	2Q2016 New initiative 2%	75%	75%	75%	75%	**75%**
Actual			4% 2/47	9% 4/47	11% 5/47	6% 3/49	**29% 14/49**

Data Analysis: This is a new initiative and will require training and follow-up with the OPS treatment team. Preliminary efforts have helped produce modest results in the first month. Baseline was measured from September 2015 to December 2015. The start of this initiative was mid-February 2016.

Action Plan: Psychology staff who work with the OPS treatment team will prompt the team to complete the ORS on each OPS recipient.

Comments: While outcomes did not reach projected hopes, we will continue to assess patients on a more frequent basis as staff become more familiar with the assessment instrument. Our goal is double the number evaluated by the middle of next fiscal year.



STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: Treatment Plan Improvement Initiative

Measure Description: Patient treatment plans identifying psychological interventions will contain one or more of the following criteria: clear operational definitions, baseline data (e.g., excess or deficiency), and desired, measurable outcomes. Target is within 4 months 90% of all treatment plans developed with psychologist input will contain key features of proposed model intervention plans.

Type of Measure: Performance improvement

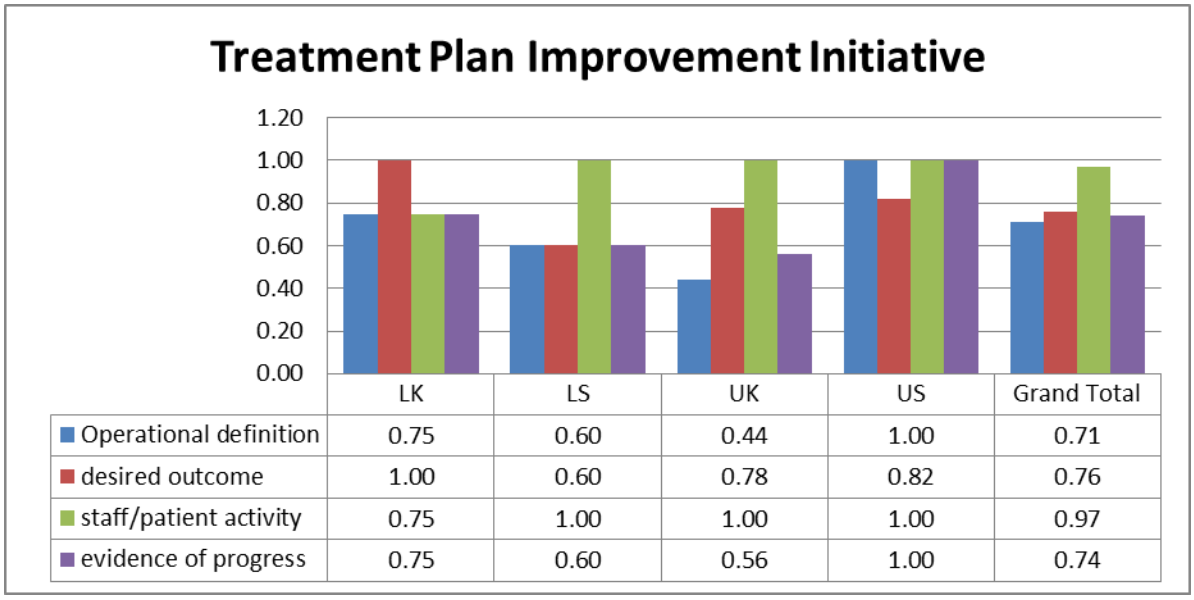
Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of treatment plans which meet new standard	3Q2016 New Initiative 2%	75%	75%	75%	75%	**75%**
Actual				20% 2/10	25% 3/12	79% 108/136	**72% 113/158**

Data Analysis: This initiative focused on the clarity of psychological treatment goals developed by departmental staff that would meet the desired level of thoroughness and conformity with desired standards. Baseline was measured from September 2015 to February 2016. The start of this initiative was February 15, 2016. At the close of the 4 quarter, 34 patients were identified as recipients of individualized psychological interventions. All of their treatment plans were evaluated for evidence of alignment with desired treatment plan qualities.

Action Plan: Psychology staff will work collaboratively in both an intra- and inter-disciplinary manner to achieve clear and practical behavior plans.

Comments: Each treatment plan was rated for the presence of defined characteristics: operational definition, desired outcome, staff/patient activity toward goal, and evidence of progress. The results are presented in the following graph, which allows for separate unit assessment as well.

STRATEGIC PERFORMANCE EXCELLENCE



	LK	LS	UK	US	Grand Total
Operational definition	0.75	0.60	0.44	1.00	0.71
desired outcome	1.00	0.60	0.78	0.82	0.76
staff/patient activity	0.75	1.00	1.00	1.00	0.97
evidence of progress	0.75	0.60	0.56	1.00	0.74

STRATEGIC PERFORMANCE EXCELLENCE

Rehabilitation Services

(Occupational Therapy, Therapeutic Recreation, Vocational Services, Chaplaincy, Patient Education)

Responsible Party: Janet Barrett, CTRS, Director of Rehabilitation Services

I. Measure Name: Occupational Therapy Service Orders

Measure Description: Improving health outcomes/patient care. In order to receive effective treatment, all patients receiving Occupational Therapy Services have a doctor's order and referral sheet completed before services are initiated.

Methodology: Each quarter Rehabilitation Services Director will audit the Occupational Therapy Referral Log and review the list of all patients receiving services to ensure a doctor's order for the service has been written and a referral to OT was completed before the patient began receiving services.

The numerator will be the number of OT Service referrals that include the required MD order, the denominator will be the total number of OT Service referrals received.

Goal: To achieve and maintain an overall goal of 100% for 4 consecutive Quarters

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Each patient receiving OT services has an MD order	FY 2015 97%	100%	100%	100%	100%	**100%**
Actual			100% 25/25	100% 29/29	100% 25/25	100% 36/36	**100% 115/115**

Data Analysis: In review of Occupational Therapy Services Log all patients referred for services from April 1, 2015, to March 31, 2016, had both the referral sheet completed as well at the doctor's order attached to it.

Action Plan: Review the results of the audit with Occupational Therapy staff. This measure will be discontinued starting FY2017.

STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: Vocational Services Documentation

Measure Description: Improving health outcomes/patient care. In order to receive effective treatment, all patients engaged in the Vocational Rehabilitation Program will have updated treatment plans and weekly documentation on the progress towards addressing the intervention outlines in the treatment plan.

Methodology: Each quarter Rehabilitation Services Director will audit the charts of the patients involved in the Vocational Rehabilitation Program to review treatment plans and progress notes to ensure they are being completed in a timely manner and updated on a regular basis.

The numerator will be the number of patient charts with the required documentation and the denominator will be the total number of patients in the Vocational Rehabilitation Program.

Goal: To achieve and maintain an overall goal of 100% for 4 consecutive Quarters

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Each patient working in the Voc. Rehab. Program has the required documentation	60%	100%	100%	100%	100%	**100%**
Actual			50% 6/12	91% 29/32	97% 29/30	90% 27/30	**886%** **91/104**

Data Analysis: Charts were audited using the Rehab. Services –Vocational Services tool. There were only 3 charts in which a weekly note was not done on time.

Action Plan: This will become a Quality Assurance measure beginning July 2016.

STRATEGIC PERFORMANCE EXCELLENCE

Safety & Security

Responsible Party: Philip Tricarico, Safety Officer

I. 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**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**Total**
Target	# of Incidents	*Baseline of 10	2	4	2	2	**10**
Actual			4	2	1	1	**8**

4Q2016: The 4Q2016 Target was (2). Our actual number was (1). We exceeded our goal! 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. Although we had no issues this quarter a new system was implemented, by maintenance, for checking cars in and out. We will monitor and remain vigilant as we all get used to the new system. 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.

Safety & Security Incidents:

Event	Date	Time	Location	Disposition	Comments
1. Safety Concern (Trash dumpster lock and chain broken)	4/12/16	0541	Parking Lot in rear of building	Maintenance immediately repaired the chain and lock.	While doing rounds, security found the dumpster unlocked. The potential for patients to get into the dumpster was very high. This would expose them to numerous items of contraband and would be a huge safety and security issue. NOD notified.