Riverview
PSYCHIATRIC CENTER

PERFORMANCE IMPROVEMENT REPORT

2ND QUARTER FISCAL YEAR 2011
Oct, Nov, Dec 2010

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January 13, 2010

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INTRODUCTION

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

Peer support continues to maintain a high degree of contact with clients and regularly participates in the treatment planning and delivery process. Peer support participated in 91% of treatment team meetings, 96% of service integration meetings, and made contact with new clients during the admission process 100% of the time. During the last four quarters, the performance of the peer support group in these areas met or was consistently higher than the 80% required level of compliance.

The use of seclusion and restraint as a safety mechanism for clients and staff in the clinical setting has remained a focus of risk and process improvement activities. Both the number and duration of client incidents managed with restraint and seclusion techniques is variable and often dependent upon client acuity and concerns for maintaining client safety. For the past five quarters, the duration of both seclusion and restraint have remained well below the national mean as determined by the National Association of State Mental Health Program Directors Research Institute (NRI). For the same period, the average quarterly number of restraint and seclusion incidents has been within one standard deviation of the national mean as determined by NRI.

There continues to be ongoing efforts to modify analysis and treatment methods to reflect a more proactive, instead of reactive, response to client agitation and escalation. Tools designed to provide a method of sharing organizational knowledge about specific client needs as well as lessons learned from the interaction of staffs with clients in the milieu are being developed and are expected to be piloted and eventually implemented during the coming calendar year. It is expected that a proactive approach to mitigating aggressive responses by clients will have an impact on the incidence of restraint and seclusion as well as potentially reduce client and staff injury rates.

Client elopement rates remain extremely low—well below the national mean.

Client injury rates are below the national mean and, as discussed previously, it is expected that these rates will continue to decline as proactive strategies for managing client aggression and escalation are deployed throughout the hospital.

While it appears that staffing demands have stabilized, the degree of overtime and mandated shift coverage continues to be variable depending upon seasonal demands. The stressors related to maintaining staff levels and required evaluations of performance were demonstrated during the month of December with a 25% increase in overtime staffing, a 20% increase in mandated shift coverage, and a severe decline in the completion of performance evaluations. This variation appears to be a seasonal effect that is related to the holiday season and should be corrected as long as staffing levels remain stable and staff depletion through normal attrition factors is managed through a practice of proactive staff replacement.

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COMMUNITY FORENSIC ACT TEAM

ASPECT: REDUCTION OF RE-HOSPITALIZATION FOR ACT TEAM CLIENTS

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

Summary

1. Two male clients were re-admitted to Riverview this past quarter. One resides in a forensic 24 hour, 7 day per week supervised group home, the other in a supported apartment under civil outpatient commitment (PTP).

2. The ACT Team has become more consistent in attending treatment team meetings while clients are in the hospital, specifically including increased communication between ACT Psychiatrist and inpatient treatment providers, and with re-starting therapy with ACT Psychologist prior to discharge. The ACT Team Peer Support Specialist continues to be particularly adept at meeting with clients prior to discharge in both treatment team settings and individually.

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COMMUNITY FORENSIC ACT TEAM

ASPECT: INSTITUTIONAL AND ANNUAL REPORTS

Indicators	Findings	Compliance	Threshold Percentile
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of notification of submitted petition.	7/9	67%	95%
2. The assigned case manager will review the new court order with the client and document the meeting in a progress note or treatment team note.	5/5	100%	100%
3. Annual Reports (due Nov) to the commissioner for all out-patient Riverview ACT NCR clients are submitted annually	40/40	100%	100%

Summary

1. Six clients petitioned to have their cases heard on the 10/29/10 court date, 3 clients for the 12/10/10 court date, of those, one withdrew petition each time. Seven of nine had Institutional reports completed on time.
2. ACT Team Leader delivers all new Court Orders to Case Managers upon receipt, who then reviews with both client and supported housing staff involved in compliance with order. This is documented in progress notes and/or reviewed in ISP treatment team.
3. Annual Reports were all submitted within the appropriate time frame.

ASPECT: INDIVIDUAL SERVICE PLANS AND PROGRESS NOTES

Indicators	Findings	Compliance	Threshold Percentile
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly contact with all clients assigned on an active status caseload.	39/40	95%	95%
2. Individual Service Plans will have measurable goals and interventions listing client strengths and areas of need related to community integration and increased court ordered privileges based on risk reduction activities.	40/40	100%	95%
3. Case notes will indicate at minimum monthly contact with all NCR clients who remain under the care of the Commissioner. These clients receive treatment services by community providers and RPC ACT monitors for court order and annual report compliance only.	10/10	100%	95%

Summary

1. The ACT Team currently offers two co-occurring groups and one therapy group. Another group will start 1/24/11 to assist clients in navigation of the forensic system. This will again create increased capacity for face-to-face contacts and supporting documentation.
2. ISPs also contain group attendance goals, especially with clients who are petitioning for increased court ordered privileges. Case managers have made it a priority to be consistent with group attendance and goals of ISP.
3. One additional client entered the outlying NCR this past quarter.

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COMMUNITY FORENSIC ACT TEAM

ASPECT: SUBSTANCE ABUSE AND ADDICTIVE BEHAVIOR HISTORY

Indicators	Findings	Compliance	Threshold Percentile
1. Age of onset documented in Comprehensive Assessment	40/40	100%	95%
2. Duration of behavior documented in C.A. and progress notes	40/40	100%	95%
3. Pattern of behavior documented in C.A. and progress notes	40/40	100%	95%

Summary

Our randomization of urinalyses for drug/alcohol detection has been improved by the Co-Occurring Specialist to both increase total number of tests (rather than minimum) as well as decreased predictability for clients.

ASPECT: PEER SUPPORT

Indicators	Findings	Compliance	Threshold Percentile
1. Engagement attempt with client within 7 days of admission.	4/4	100%	95%
2. Documented offer of peer support services.	40/40	100%	95%
3. Attendance at treatment team meetings as appropriate.	30/35	85%	95%

Summary

As in prior reports, Peer Support Specialist makes every effort to attend treatment team meetings at ACT offices and in hospital; absent only if client expresses desire not to have Peer Support present when asked or due to unanticipated schedule conflict/change. Of particular note is the rate at which the peer Support Specialist is able to engage with clients while still in the hospital and to an even greater degree when they are living in the community. The number and quality of contacts with clients by Peer Support contributes in large measure to the ACT Teams goal of seeing clients face to face three times per week.

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CAPITOL COMMUNITY CLINIC

ASPECT: DENTAL CLINIC SURVEY

Indicators	Findings	Compliance	Threshold Percentile
Clients from RPC as well as clients in the community will receive a survey to fill out at the time of their appointment. The survey has several questions and in those questions we are asking the client how we can better serve there needs.	October Fifteen surveys were done by in-house clients as well as outpatient clients. Of the fifteen surveys received, all were positive.	100%	90%
	November Seventeen surveys were done by in-house clients as well as outpatient clients. Of the seventeen surveys received, all were positive.	100%	90%
	December Forty surveys were done by in-house clients as well as outpatient clients. Of the forty surveys received, all were positive.	100 %	90%

Summary

Surveys returned numbered seventy-two for the 2nd quarter. All seventy-two surveys received showed positive responses to the question asked regarding satisfaction and improvement.

Actions

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

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CAPITOL COMMUNITY CLINIC

ASPECT: DENTAL CLINIC 24 HOUR POST EXTRACTION FOLLOW-UP

Indicators	Findings	Compliance	Threshold Percentile
After dental extractions, the clients will receive a follow-up phone call from the clinic within 24hrs of procedure to assess for post procedure complications.	October There were two extractions during the month with 24 hour follow up phone call placed for each of the clients. The clients reported no post procedure complications.	100%	100%
	November There were two extractions during the month with 24 hour follow up phone call placed for each of the clients. The clients reported no post procedure complications.	100%	100%
	December There were six extractions during the month with 24 hour follow up phone call placed for each of the clients. The clients reported no post procedure complications.	100%	100%

Summary

There were ten extractions in the second quarter. Clients were called 24 hours post extraction. All ten clients that were called reported no post procedure complications.

Action

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

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CAPITOL COMMUNITY CLINIC

ASPECT: DENTAL CLINIC TIMEOUT/IDENTIFICATION OF CLIENT

Indicators	Findings	Compliance	Threshold Percentile
National Patent Safety Goals Goal 1: Improve the accuracy of Client Identification. Capital Community Dental Clinic assures accurate client identification by asking the client to state his/her name and date of birth. Goal 2: Verify the correct procedure and site for each procedure. A time out will be taken before the procedure to verify location and number of the tooth to be extracted. The time out section is in the progress notes of the patient chart. This page will be signed by the Dentist as well as the dental assistant.	October There were two extractions done for the month. A time out was taken prior to the procedure to identify the extraction site and the client was asked to state their name and date of birth to verify identification of the client.	100 %	100%
	November There were two extractions done for the month. A time out was taken prior to each procedure to identify the extraction site and the client was asked to state their name and date of birth to verify identification of the client.	100%	100%
	December There were six extractions done for the month. A time out was taken prior to each procedure to identify the extraction site and the client was asked to state their name and date of birth to verify identification of the client.	100%	100%

Summary:

In October, November and December ten clients had extractions. All ten procedures included a time out to identify the extraction site. Each client was asked to state their full name and date of birth in order to verify the identity of the client.

Actions

The dental clinic staff will continue to report and monitor progress.

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CAPITOL COMMUNITY CLINIC

ASPECT: MED MANAGEMENT CLINIC APPOINTMENT ASSESSMENT

Indicators	Findings	Compliance	Threshold Percentile
All Outpatient clients will have Vital Signs and Weight recorded upon arrival for appointment.	October There were thirty-one clients scheduled for the month. All had their vitals taken before their clinic appointment.	100%	100%
	November There were thirty-five clients scheduled in the month. thirty clients had vitals taken before their appointment with the P.A.	86%	100%
	December There were thirty-two clients scheduled for the month. All had their vitals taken before their clinic appointment.	100%	100%

Summary

For the second quarter there were ninety-three clients. Five did not have their vitals taken before their appointment. One of the five clients refused to have the vitals done. Four did not have their vitals taken due to staff meetings.

Actions

Will try and coordinate meetings during non visit times.
Review of monthly staff meetings and forward reports quarterly to RPC.

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CLIENT SATISFACTION

ASPECT: CLIENT SATISFACTION WITH CARE

#	Indicators	Findings LK		Findings UK		Findings LS		Findings US	Findings Total	
1	I am better able to deal with crisis.	50%	0%	50%	-27%	75%	-25%	90%	-10%	59%
2	My symptoms are not bothering me as much.	30%	-53%	35%	-29%	50%	-50%	80%	-20%	43%
3	The medications I am taking help me control symptoms that used to bother me.	25%	-8%	40%	-19%	50%	-50%	70%	-30%	41%
4	I do better in social situations.	20%	-5%	45%	-28%	50%	-50%	50%	-50%	37%
5	I deal more effectively with daily problems.	55%	-12%	45%	-10%	50%	-50%	60%	-40%	52%
6	I was treated with dignity and respect.	45%	+12%	45%	-5%	50%	-50%	50%	0%	46%
7	Staff here believed that I could grow, change and recover.	45%	-22%	40%	-45%	75%	-25%	88%	-12%	52%
8	I felt comfortable asking questions about my treatment and medications.	45%	-22%	45%	-20%	75%	-25%	70%	+20%	52%
9	I was encouraged to use self-help/support groups.	50%	+83%	30%	-35%	25%	-75%	70%	+20%	44%
10	I was given information about how to manage my medication side effects.	15%	+48%	15%	-25%	50%	-50%	40%	+40%	22%
11	My other medical conditions were treated.	35%	+86%	30%	-45%	75%	-25%	60%	+160%	41%
12	I felt this hospital stay was necessary.	40%	+40%	-10%	-80%	75%	-25%	50%	-50%	26%
13	I felt free to complain without fear of retaliation.	20%	+70%	35%	-30%	25%	-75%	10%	+60%	24%
14	I felt safe to refuse medication or treatment during my hospital stay.	10%	+10%	5%	-55%	-50%	-150%	20%	+70%	6%
15	My complaints and grievances were addressed.	35%	+35%	25%	-25%	50%	-50%	20%	+70%	30%
16	I participated in planning my discharge.	45%	+28%	50%	-25%	25%	-75%	40%	+40%	44%
17	Both I and my doctor or therapist from the community were actively involved in my hospital treatment plan.	20%	+20%	20%	-35%	0%	-100%	20%	+20%	19%
18	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	15%	+15%	25%	-30%	0%	-100%	30%	+30%	20%

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CLIENT SATISFACTION

#	Indicators	Findings LK		Findings UK		Findings LS		Findings US	Findings Total	
19	The surroundings and atmosphere at the hospital helped me get better.	15%	+32%	30%	-35%	75%	-25%	50%	0%	31%
20	I felt I had enough privacy in the hospital.	25%	+25%	30%	-45%	75%	-25%	30%	+30%	31%
21	I felt safe while I was in the hospital.	50%	+33%	40%	-20%	50%	-50%	70%	+20%	50%
22	The hospital environment was clean and comfortable.	25%	+8%	40%	-30%	50%	-50%	50%	0%	37%
23	Staff were sensitive to my cultural background.	35%	+18%	35%	-5%	75%	-25%	40%	+40%	39%
24	My family and/or friends were able to visit me.	35%	+10%	40%	-25%	75%	+75%	70%	-30%	46%
25	I had a choice of treatment options.	15%	-18%	30%	-15%	75%	+125%	30%	+80%	28%
26	My contact with my doctor was helpful.	40%	+7%	50%	-17%	75%	-25%	50%	0%	48%
27	My contact with nurses and therapists was helpful.	40%	-10%	50%	-30%	50%	-50%	50%	0%	46%
28	If I had a choice of hospitals, I would still choose this one.	20%	+20%	25%	-40%	50%	%-50	50%	-50%	30%
29	Did anyone tell you about your rights?	10%	+27%	35%	-25%	75%	+75%	50%	0%	31%
30	Are you told ahead of time of changes in your privileges, appointments, or daily routine?	55%	+72%	45%	-20%	50%	-50%	50%	+150%	50%
31	Do you know someone who can help you get what you want or stand up for your rights?	40%	+23%	50%	-30%	75%	-25%	50%	-50%	48%
32	My pain was managed.	25%	0%	50%	-30%	75%	+75%	30%	+130%	39%

Summary

Positive scores indicate satisfaction, while negative scores indicate dissatisfaction. Percentages are calculated using actual weighted scores and highest possible score for each indicator. The total number of respondents was 27: 10 on UK, 10 on LK, 5 on US, and 2 on LS. The first column for each unit indicates the score for 2nd quarter and the second column for each unit shows increases/decreases from 1st quarter. Overall satisfaction for 2nd quarter decreased significantly, 16%.

The most significant drop in satisfaction appears to be on Lower Saco, but the response rate was low for both 1st (1) and 2nd (2) quarter and likely does not provide an accurate view of client satisfaction. Upper Kennebec's satisfaction rate also dropped significantly, down 29%. Satisfaction on Lower Kennebec and Upper Saco increased as well as the response rate for 2nd quarter. All but three indicators dropped in satisfaction across the facility.

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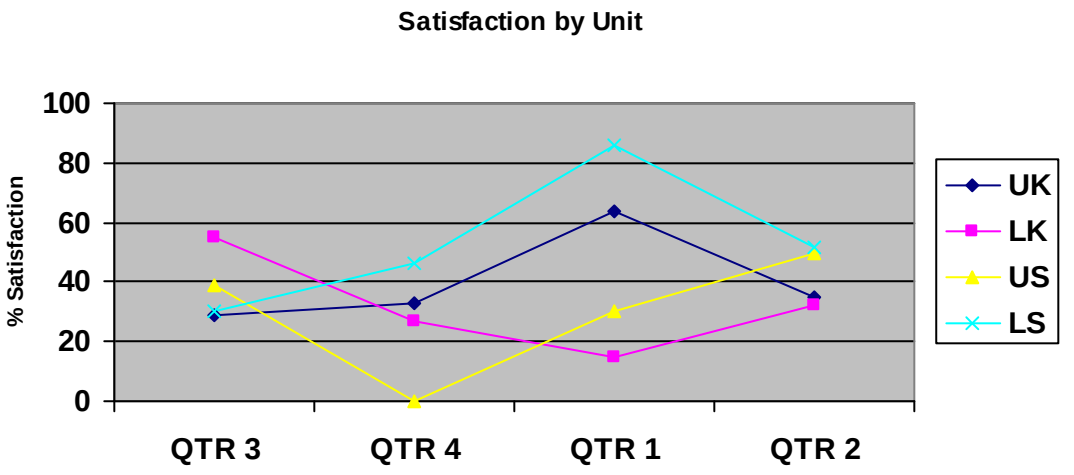
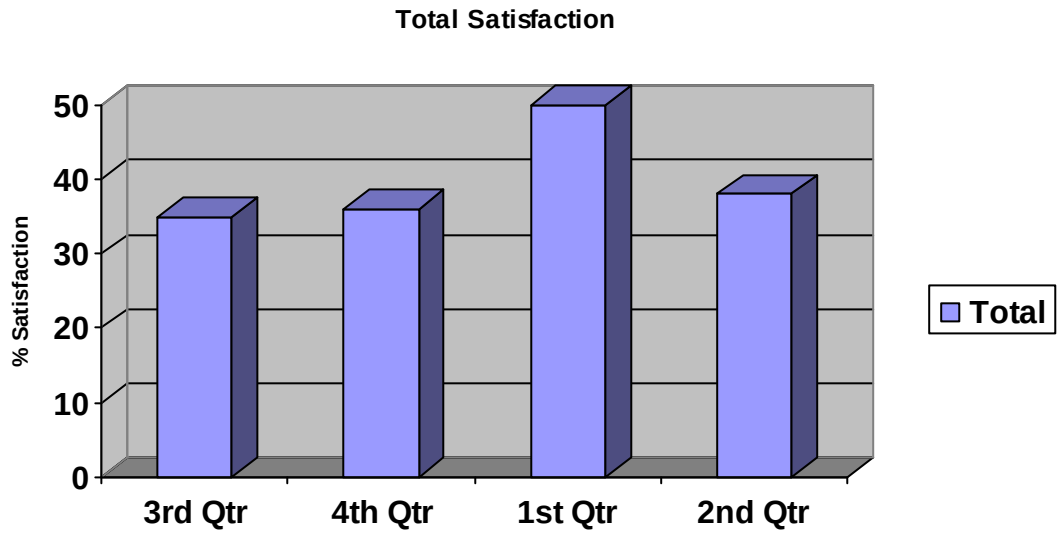
CLIENT SATISFACTION





Actions

1. Department heads will make recommendations and changes on how to improve satisfaction of care in areas that are indicated.
2. Superintendent will utilize client forums to get input from clients for areas of improvement.
3. Peer support will implement new strategies for soliciting responses from clients related to satisfaction with care.

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COMPARATIVE STATISTICS

The comparative statistics reports include the following elements:

- Client Injury Rate
- Elopement Rate
- Medication Error Rate
- 30 Day Readmit Rate
- Percent of Clients Restrained
- Hours of Restraint
- Percent of Clients Secluded
- Hours of Seclusion
- Prevalence of Co-occurring Psychiatric and Substance Abuse Disorders

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

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

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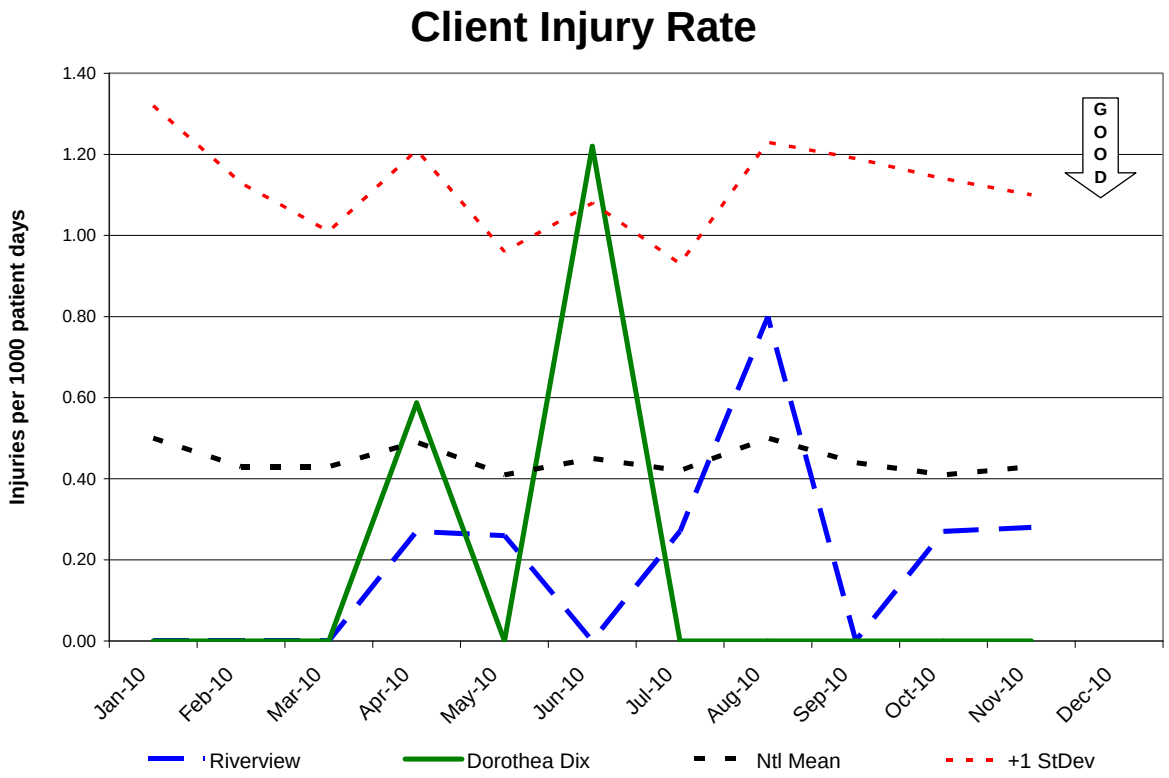
COMPARATIVE STATISTICS



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

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

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

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

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

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

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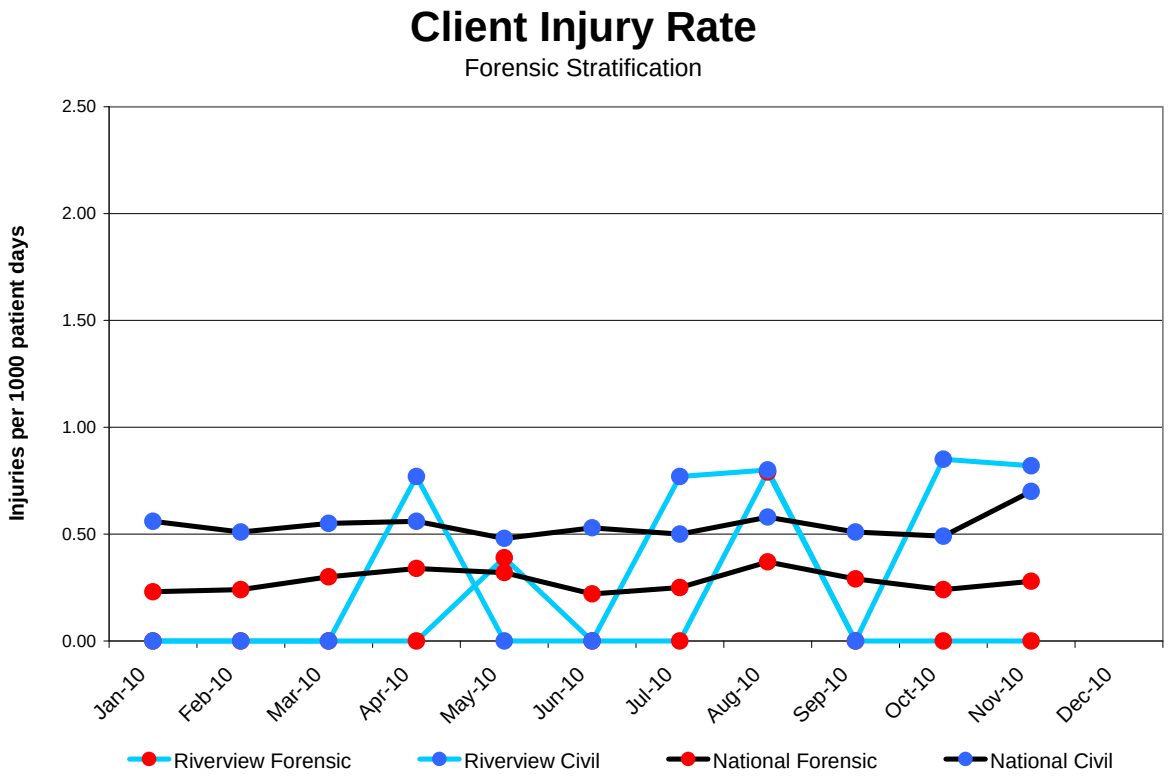
COMPARATIVE STATISTICS



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

Client Injuries	Oct	Nov	Dec	2nd Qtr 2011
Total	21	6	6	33

ASPECT: SEVERITY OF INJURY BY MONTH

Severity	Oct	Nov	Dec	2nd Qtr 2011
No Treatment	15	1	2	18
Minor First Aid	5	4	4	13
Medical Intervention Required	1	1		2
Hospitalization Required				0
Death Occurred				0

ASPECT: TYPE AND CAUSE OF INJURY BY MONTH

Type - Cause	Oct	Nov	Dec	2nd Qtr 2011
Accident – Unwitnessed Fall	1	2		3
Accident – Witnessed Fall	6		1	7
Accident – Choking	1		2	3
Accident – Other	1	2	1	4
Accident – Unknown	1			1
Assault – Client to Client	9			9
Self Injury – Agitation	1			1
Self Injury – Choking			1	1
Self Injury – Other	1	2	1	4

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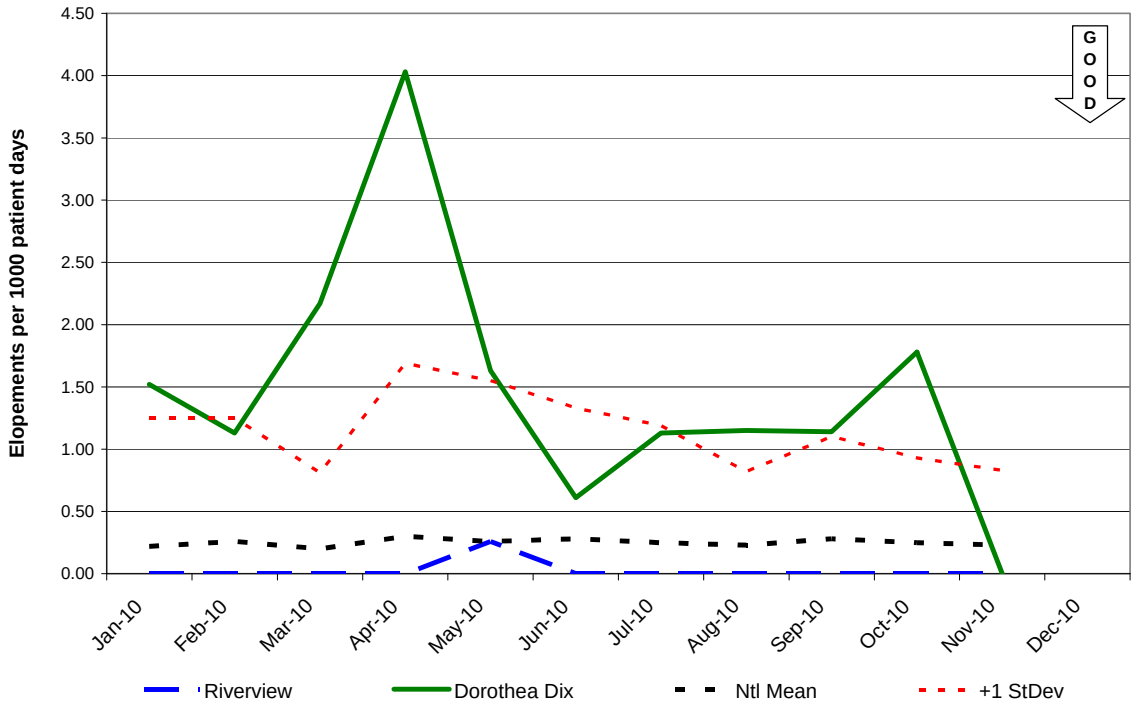
COMPARATIVE STATISTICS

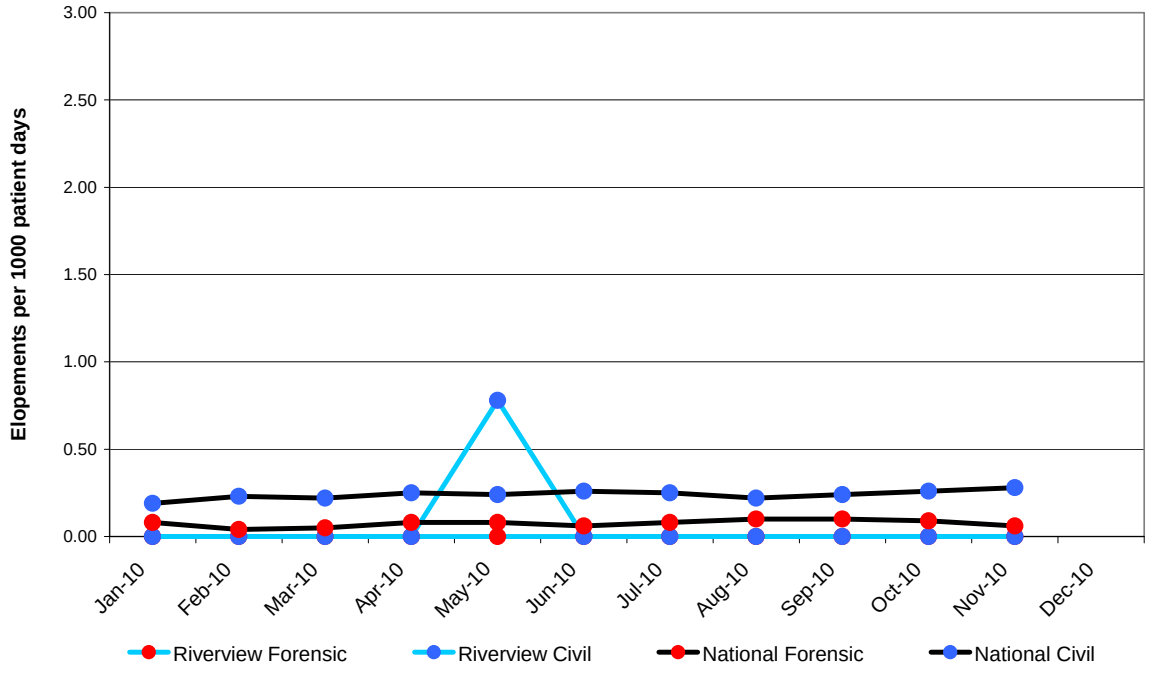
Elopement



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.

Elopement

Forensic Stratification



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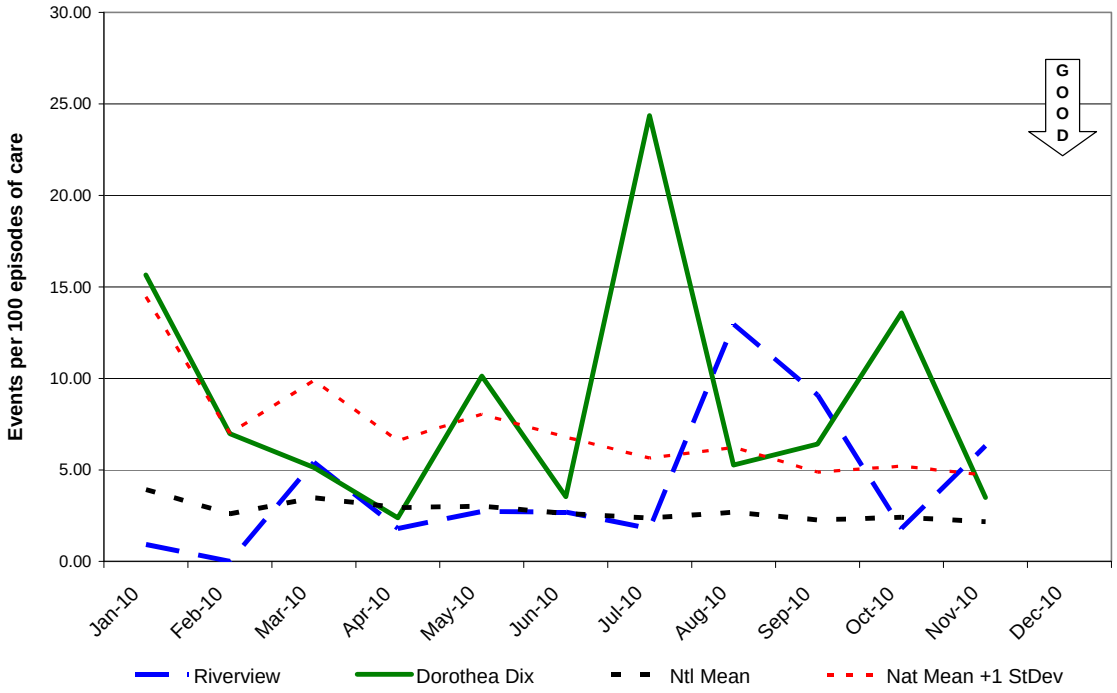
COMPARATIVE STATISTICS

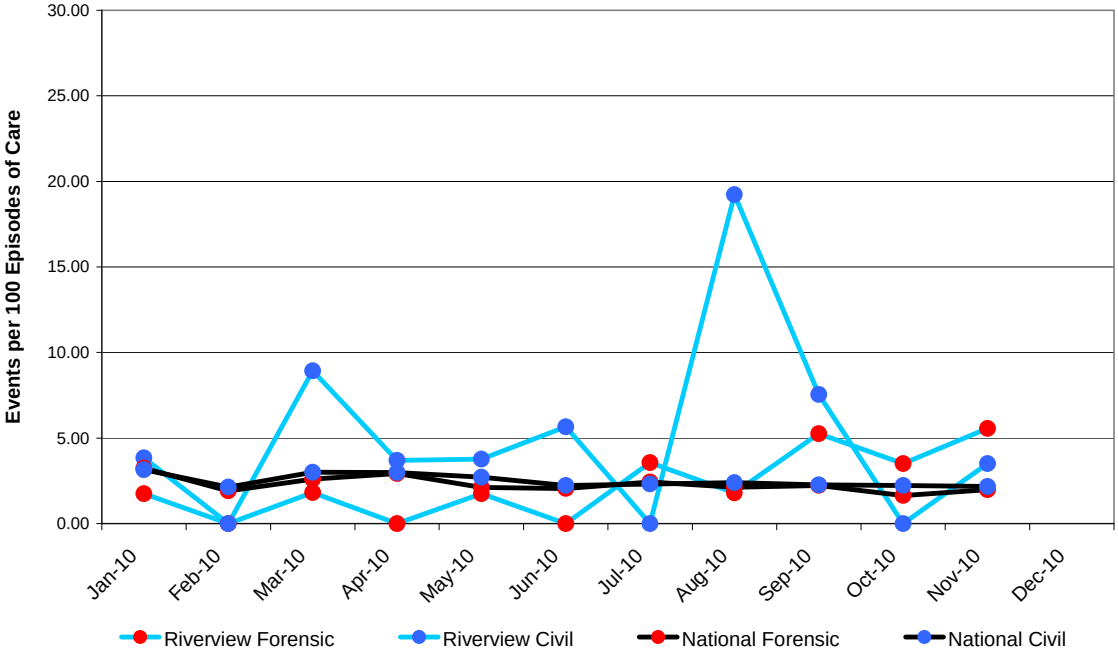
Medication Errors



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

Medication Errors

Forensic Stratification



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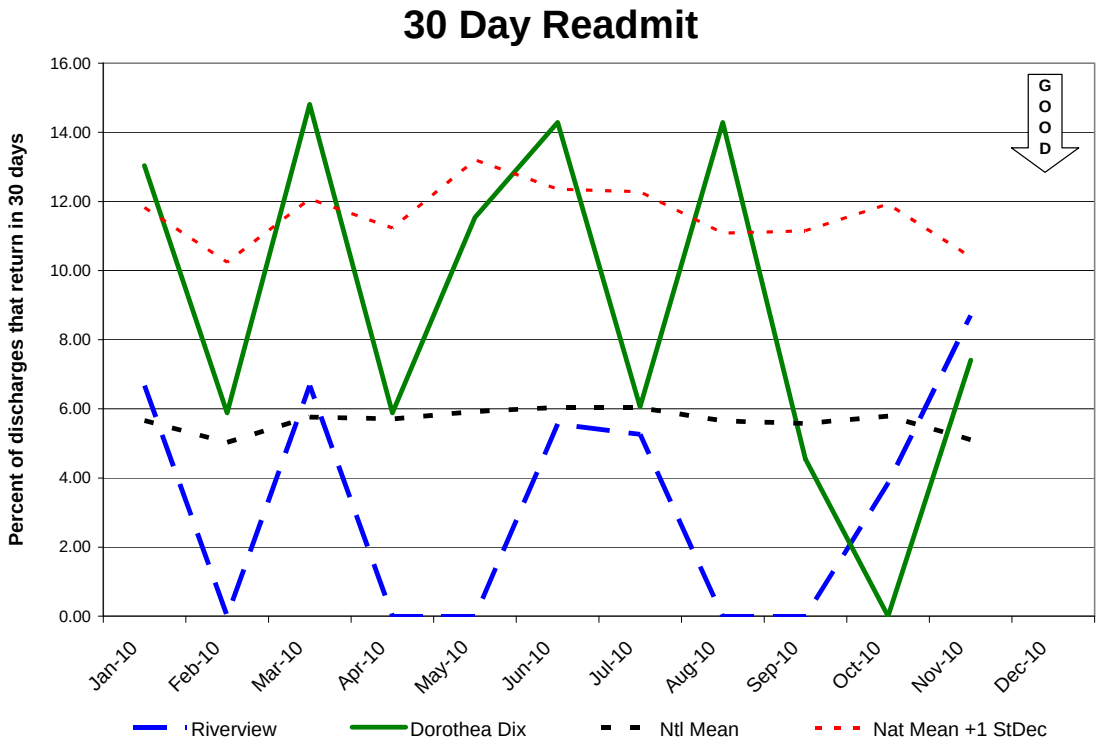
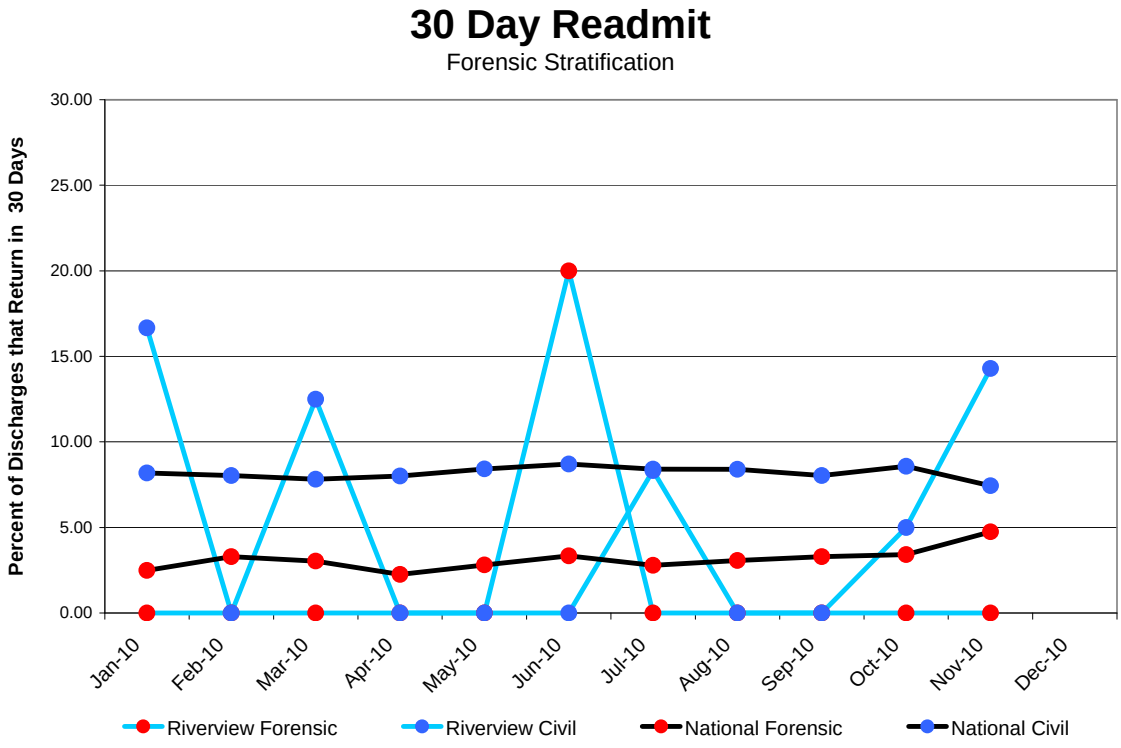
COMPARATIVE STATISTICS



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



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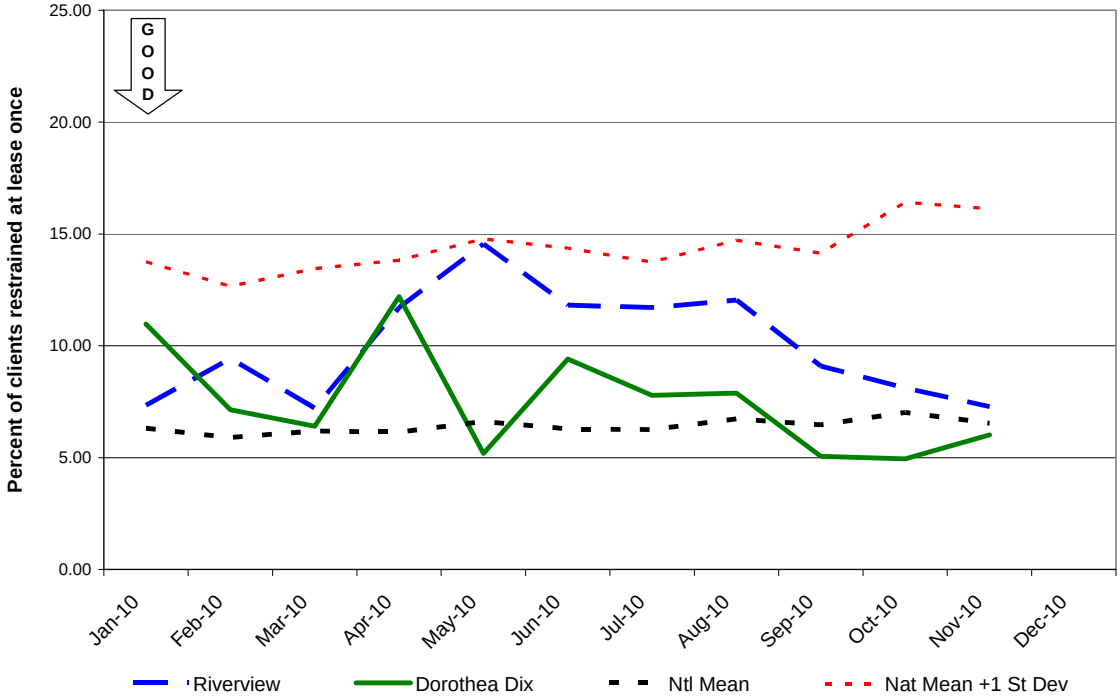
COMPARATIVE STATISTICS

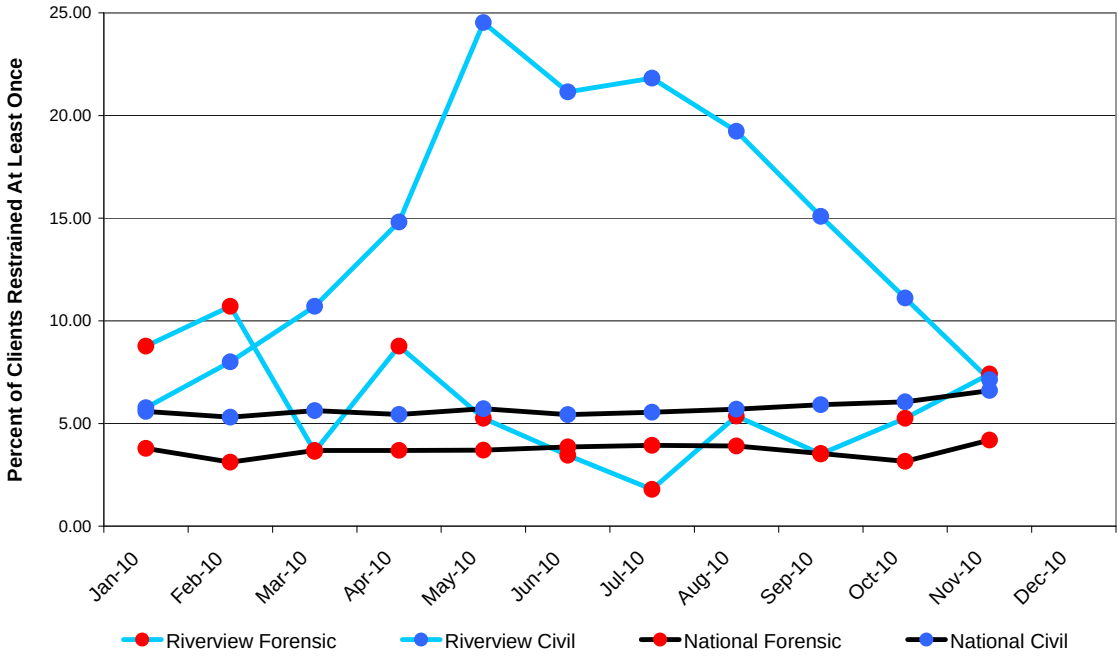
Percent of Clients Restrained



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

Percent of Clients Restrained

Forensic Stratification



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COMPARATIVE STATISTICS

Clients Status and Coercive Event Breakdown

	Civil/ Forensic	Manual Hold	Mechanical Restraint	Locked Seclusion	Open Seclusion	Grand Total	% of Total	Cum %
45	C	18		10		28	27%	27%
5035	F	7		4		11	10%	37%
5450	C	5		4		9	9%	46%
3726	F	5	1	2		8	8%	53%
92	C	6				6	6%	59%
115	F	2		4		6	6%	65%
3457	C	5		1		6	6%	70%
2115	F	2		2	1	5	5%	75%
5746	F	3	2			5	5%	80%
5199	C	2		2		4	4%	84%
4780	C	2	1			3	3%	87%
58	C	1		1		2	2%	89%
2748	C	1			1	2	2%	90%
3374	C	1		1		2	2%	92%
3751	C	2				2	2%	94%
5624	C	1		1		2	2%	96%
5625	C	2				2	2%	98%
177	F		1			1	1%	99%
406	C	1				1	1%	100%

25% (19/76) of average hospital population experienced some form of confinement/coercive event during 2nd quarter 2011. As in the previous quarter, ten of these clients (13% of the average hospital population) accounted for nearly 85% of the containment/coercive events.

Coercive Events by Time of Day

	0000-0359	0400-0759	0800-1159	1200-1559	1600-1959	2000-2400
45		7	15	3	3	
5035		1	6	2	2	
5450		1	1		5	2
3726			4		3	1
92		1	2	3		
115			4	2		
3457		2	2	2		
2115			3	2		
5746			2	1	2	
5199		2	2			
4780				2	1	
58				2		
2748			2			
3374			2			
3751			2			
5624					2	
5625						2
177					1	
406				1		
		14	47	20	19	5

Analysis of coercive events by client and time of day continues and the information is being utilized to identify trends related to client triggers and coping mechanisms that the treatment team can use to modify treatment modalities in an effort to reduce the incidence of escalating behaviors and the use of confinement techniques that often result from efforts to protect clients and staff from injury during aggressive outbursts.

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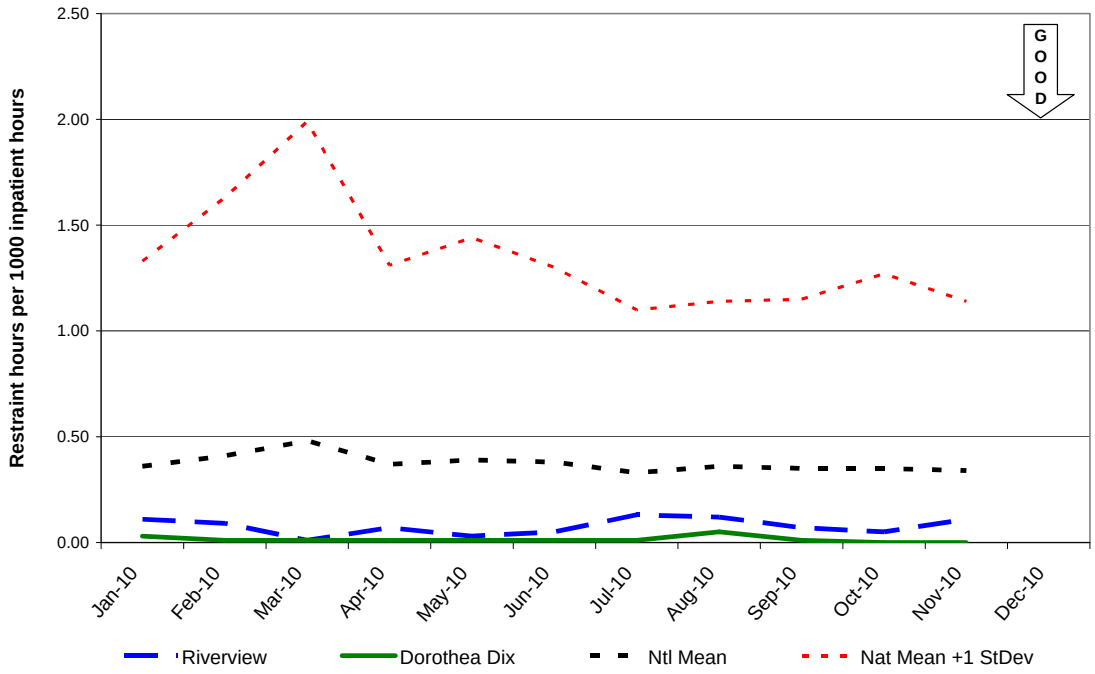
COMPARATIVE STATISTICS

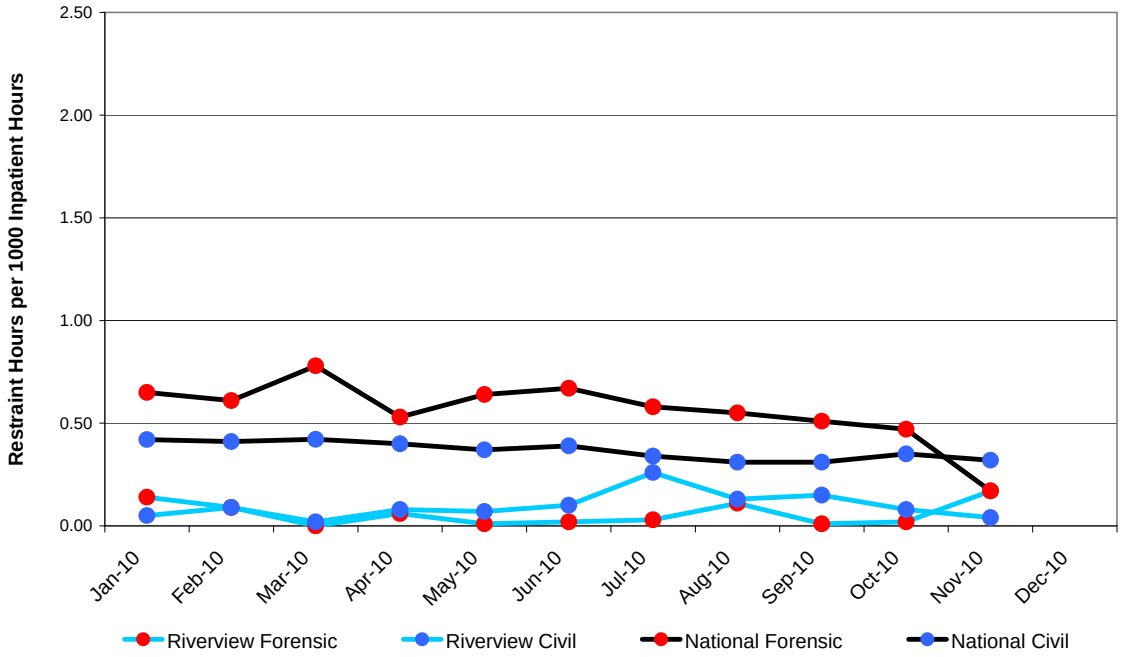
Restraint Hours



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

Restraint Hours

Forensic Stratification



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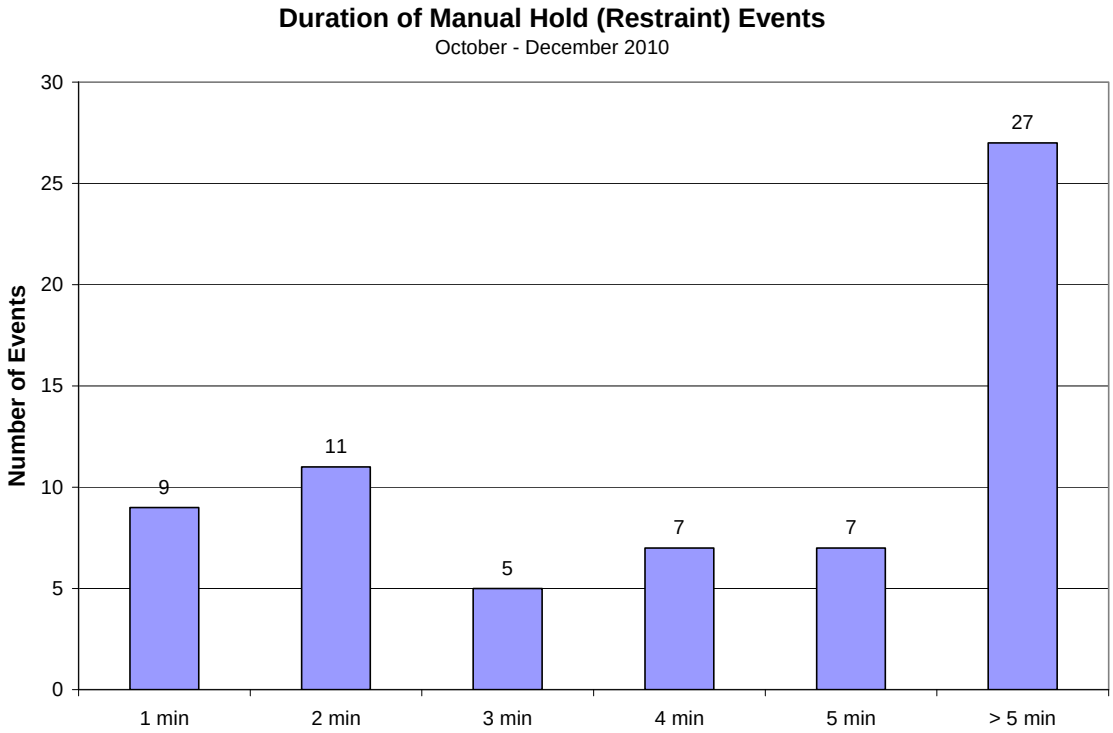
COMPARATIVE STATISTICS



The overall number of manual hold events as well as the number of clients restrained for greater than 5 minutes declined significantly during the 2nd quarter 2011. The overall reduction in the number of manual holds was 47% during the period and the reduction in manual holds greater than 5 minutes was 50%.

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

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

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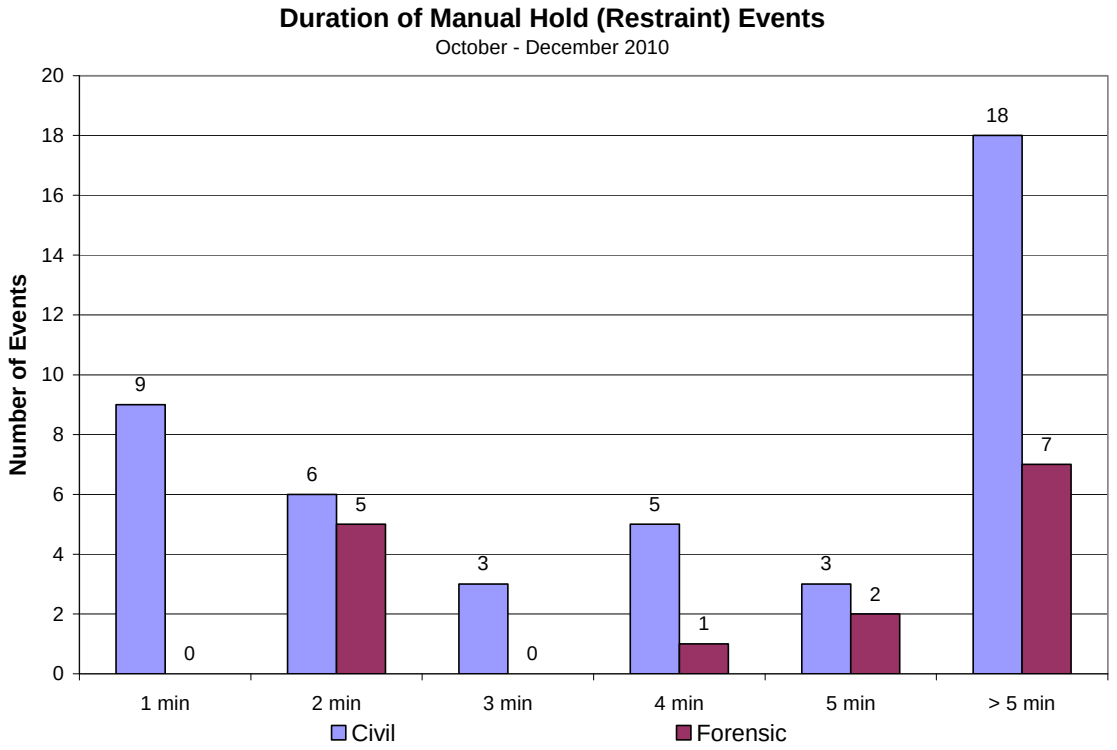
COMPARATIVE STATISTICS



The mix of manual hold incidents in this chart depicts the differentiation between the civil and forensic units. The difference in the total number of manual hold incidents between the previous chart and this chart is due to several events occurring in an area of the hospital that is not specifically designated as civil or forensic (e.g. dining hall, yard). A total of seven incidents occurred in areas of the hospital other than the civil or forensic units.

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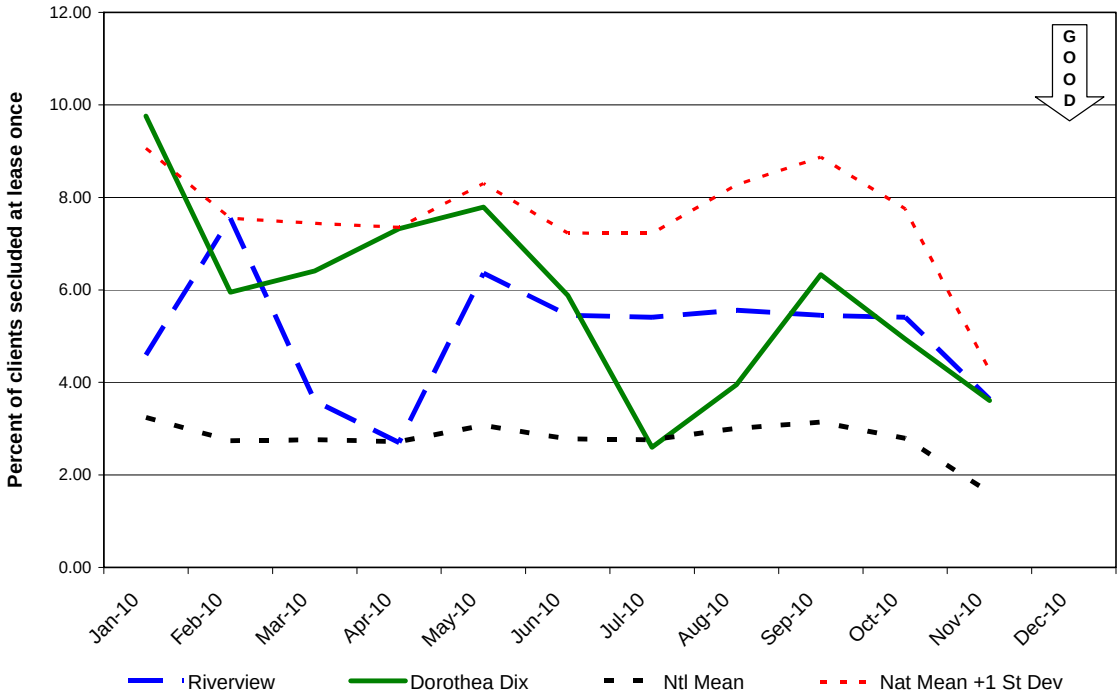
COMPARATIVE STATISTICS

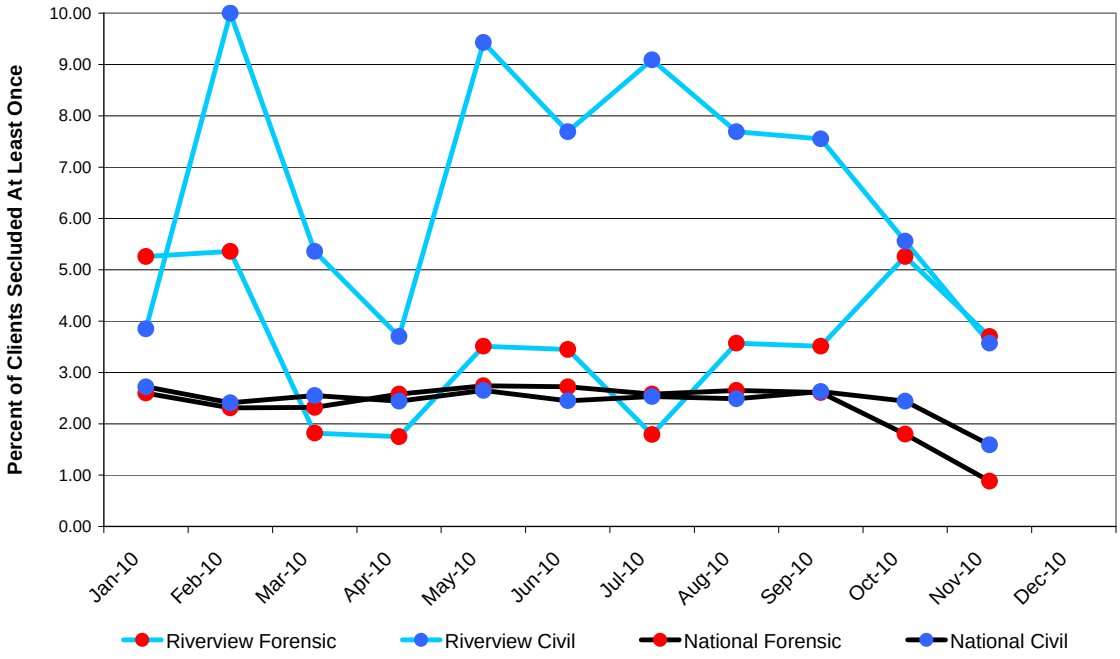
Percent of Clients Secluded



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

Percent of Clients Secluded

Forensic Stratification



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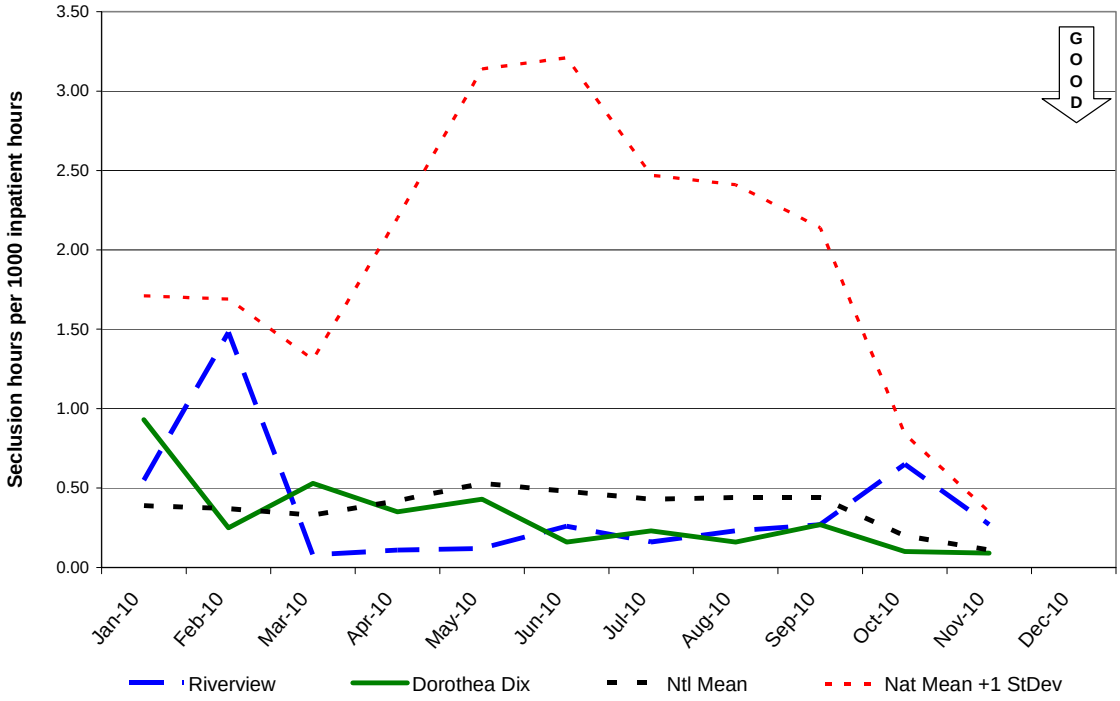
COMPARATIVE STATISTICS

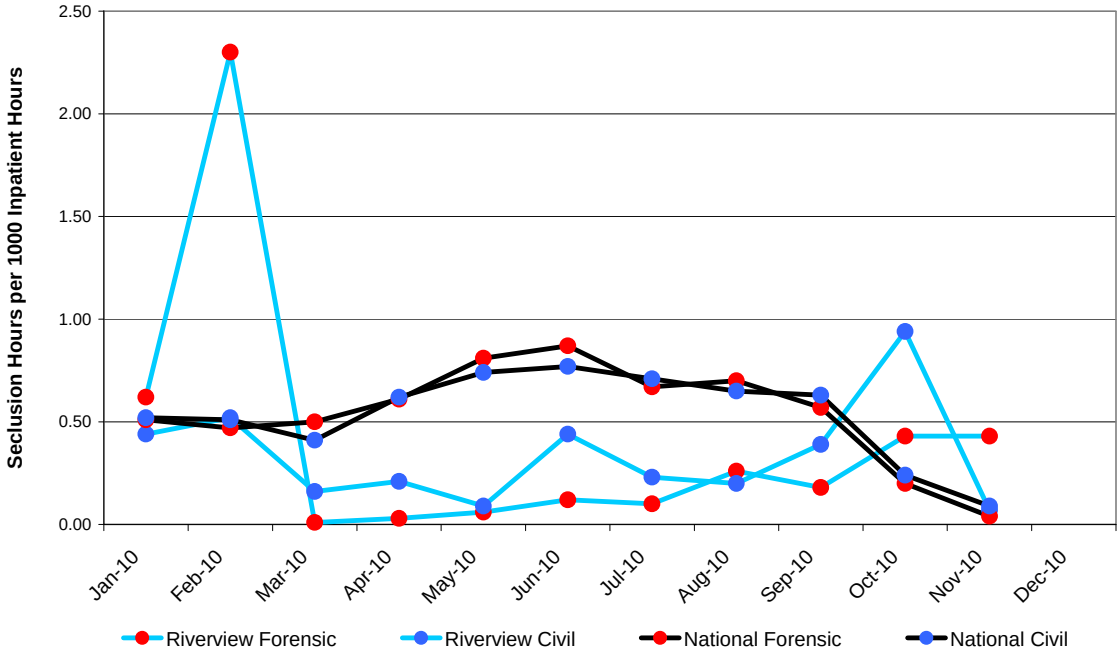
Seclusion Hours



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

Seclusion Hours

Forensic Stratification



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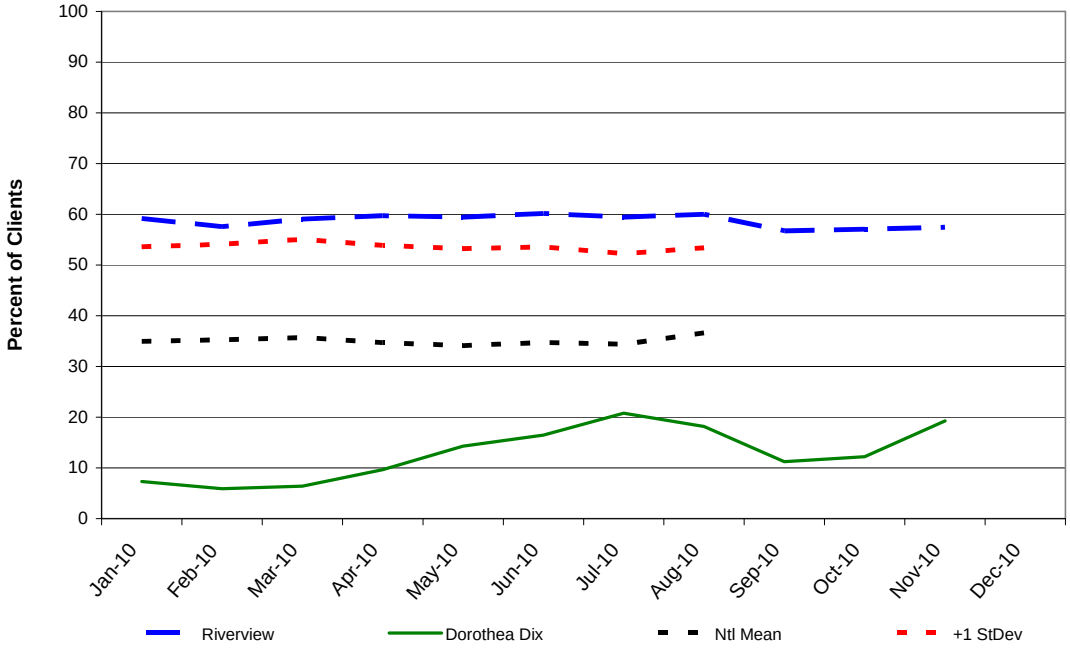
COMPARATIVE STATISTICS

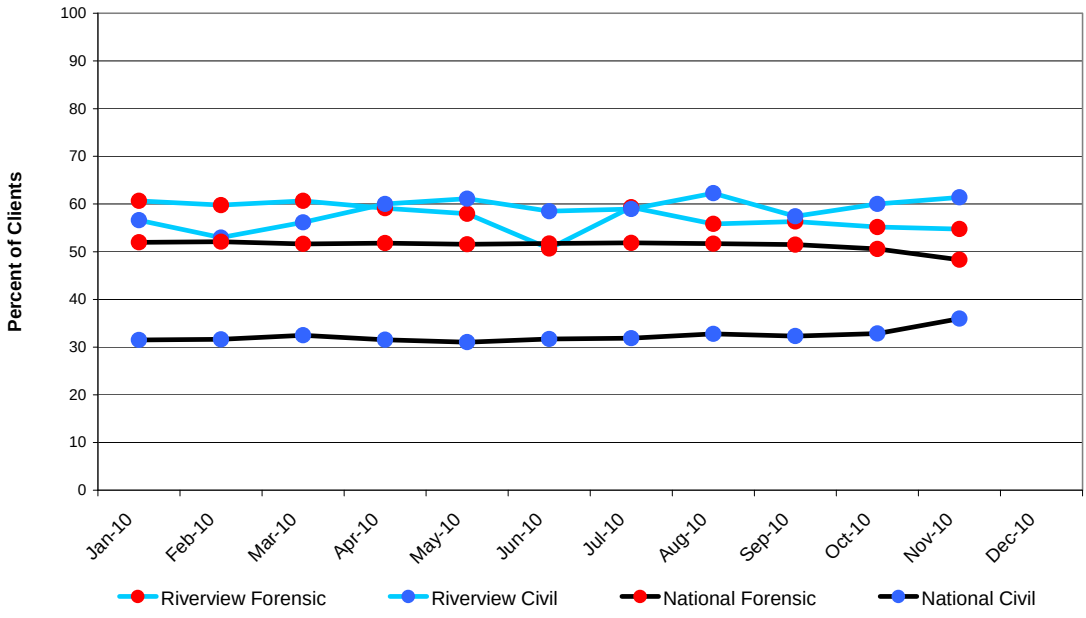
Prevalence of Co-occurring Psychiatric and Substance Abuse Disorders



Prevalence of all clients served during the months shown that are reported with Co-occurring Psychiatric and Substance Disorders (COPSD).

Prevalence of Co-occurring Psychiatric and Substance Abuse Disorders

Forensic Stratification



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DIETARY

ASPECT: CLEANLINESS OF MAIN KITCHEN

Indicators	Findings	Compliance	Threshold Percentile
1. All convection ovens (4) were thoroughly cleaned monthly.	9 of 12	75%	100%
2. Dish machine was de-limed monthly	3 of 3	100%	100%
3. Shelves (6) used for storage of clean pots and pans were cleaned monthly	18 of 18	100%	100%
4. Knife cabinet was thoroughly cleaned monthly	3 of 3	100%	100%
5. Walk in coolers were cleaned thoroughly monthly.	6 of 6	100%	100%
6. Steam kettles (2) were cleaned thoroughly on a weekly basis	18 of 26	69%	95%
7. All trash cans (4) and bins (1) were cleaned daily	455 of 460	98.9%	95%
8. All carts(9) used for food transport (tiered) were cleaned daily	812 of 828	98%	100%
9. All hand sinks (4) were cleaned daily	352 of 368	95.6%	95%
10. Racks(3) used for drying dishes were cleaned daily	273 of 276	99%	100%

Summary

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

- There was no reason identified for the poor outcome regarding the oven that did not get cleaned.
- The steam kettles were not cleaned according to standards due to the other work related demands of the staff person assigned to the task.
- Overall Compliance: 97.4%

Actions

1. The task of cleaning the steam kettles will be reassigned.
2. FSM reviews all cleaning schedules on a daily basis to assure staff completion.
3. Cleaning schedules are modified to reflect changes in staff availability.
4. Weekly staff meetings include review of the past weeks completion rates.
5. Staff member responsible for cleaning the oven will complete this task throughout the next quarter.
6. Results of this CPI indicator will be discussed with staff.
7. There are currently 1.5 vacant positions and one employee on consistent leave within the Dietary Department

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DIETARY

Indicator	Findings	Compliance	Threshold Percentile
A nutrition assessment is completed within 5 days of admission when risk is identified via the nutrition screen.	74 of 76	97.4%	100%

Summary

Two clients identified as being at risk did not receive a nutrition assessment within five days of admission.

Client A

- BMI > 29
- Client stated a food allergy to “sour candy: apple flavor”.

Client B

- BMI > 29

These risks did not require immediate nutrition intervention. Assessments were completed seven days after admission due to a consecutive stretch of: illness, State shut down, holiday, weekend and cancelation of state offices due to weather conditions.

Overall Compliance: 97.4%

Actions

The nutrition screen, which is part of the Initial Nursing Assessment and Admission Data, will be completed by nursing within 24 hours of admission.

The Dietitian reviews the nutrition screening to determine whether the client is at nutrition risk.

Nursing will contact the Dietary Department at 287-7248 if an Urgent consult is required. Dietary staff will then contact the Registered Dietitian/Dietetic Technician Registered. This includes weekends and holidays. The RD/DTR will respond by telephone or with an on-site follow-up as deemed appropriate within 24 hours. Nursing must document in the progress notes any recommendations made by the RD/DTR.

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HEALTH INFORMATION MANAGEMENT

ASPECT: DOCUMENTATION & TIMELINESS

Indicators	Findings	Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	There were 68 discharges in quarter 2 2011. Of those, 37 were completed by 30 days.	54 %	80%
Discharge summaries will be completed within 15 days of discharge.	68 out of 68 discharge summaries were completed within 15 days of discharge during quarter 2 2011.	100 %	100%
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	0 forms were approved/ revised in quarter 2 2011 (see minutes).	100%	100%
Medical transcription will be timely and accurate.	Out of 853 dictated reports, 713 were completed within 24 hours.	84%	90%

Summary

The indicators are based on the review of all discharged records. There was 54% compliance with record completion. There was 100% compliance with discharge summary completion. Weekly “charts needing attention” lists are distributed to medical staff, including the Medical Director, along with the Superintendent, Risk Manager and the Quality Improvement Manager. There was 84% compliance with timely & accurate medical transcription services.

Actions

Continue to monitor.

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HEALTH INFORMATION MANAGEMENT

ASPECT: CONFIDENTIALITY

Indicators	Findings	Compliance	Threshold Percentile
All client information released from the Health Information department will meet all Joint Commission, State, Federal & HIPAA standards.	2349 requests for information (118 requests for client information and 2231 police checks) were released for quarter 2 2011.	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	10 new employees/contract staff in quarter 2 2011.	100%	100%
Confidentiality/Privacy issues tracked through incident reports.	0 privacy-related incident reports during quarter 2 2011.	100%	100%

Summary

The indicators are based on the review of all requests for information, orientation for all new employees/contract staff and confidentiality/privacy-related incident reports. No problems were found in quarter 2, however compliance with current law and HIPAA regulations need to be strictly adhered to requiring training, education and policy development at all levels.

Actions

The above indicators will continue to be monitored.

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HOUSEKEEPING

ASPECT: LINEN CLEANLINESS AND QUALITY

Indicators	Findings	Compliance	Threshold Percentile
1. Was linen clean coming back from vendor?	**53 of 53**	100%	100%
2. Was linen free of any holes or rips coming back from vendor?	**53 of 53**	100%	95%
3. Did we have enough linen on units via complaints from unit staff?	**51 of 53**	96%	90%
4. Was linen covered on units?	**53 of 53**	100%	95%
5. Did vendor provide a 24 hr. turn around service as specified in the contract?	**51 of 53**	96%	100%
6. Did we receive an adequate supply of mops and rags from vendor?	**53 of 53**	100%	95%
7. Were linen bins clean returning from vendor?	**53 of 53**	100%	100%
8. Was the linen manifest accurate from the vendor	**51 of 53**	96%	85%

Summary

Eight different criteria are to be met for acceptability. The indicators are based on the inspections of linen closets throughout the facility including the returned linen from the vendor. All linen types were reviewed randomly this quarter. All indicators are within threshold percentiles.

The overall compliance for this quarter was 98.5%. This is shows a 12.5% increase from last quarters' report.

1. Complaints from 2 units (indicator #3) regarding an inadequate supply of linen (blankets)
2. Linen was not coming back from the vendor with accurate manifests (indicator # 8)
3. Linen coming back from the vendor was not delivered to Riverview in a timely fashion (2 occurrences) (indicator # 5)

Actions

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

- ✓ Housekeeping supervisor purchased 50 more blankets to supplement our inventory. Housekeeping staff will monitor unit inventory on a daily basis.
- ✓ The housekeeping staff will check linen rooms daily to ensure that all linen is in good condition.
- ✓ Communicate to all Housekeeping staff to be aware of the status of this indicator.
- ✓ Housekeeping staff member will continue to document all information regarding to inventory and manifest statistics from the vendor.
- ✓ Housekeeping Supervisor will monitor the timeliness of linen deliveries.

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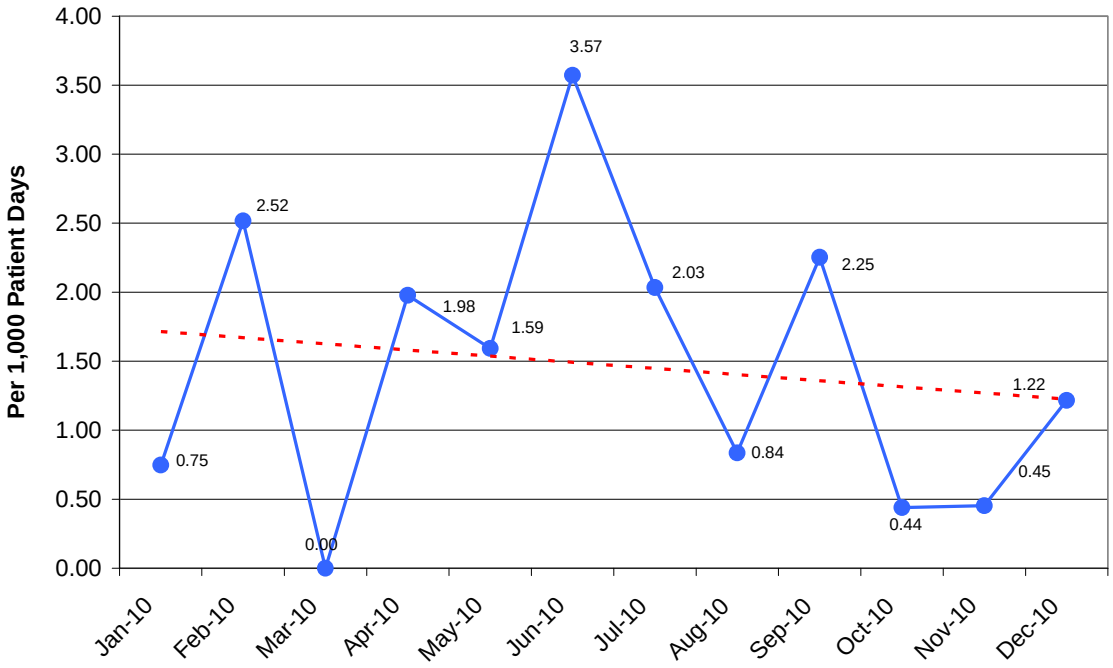
HUMAN RESOURCES

ASPECT: DIRECT CARE STAFF INJURIES

Reportable (Lost Time & Medical) Direct Care Staff Injuries



Summary

The trend line for reportable injuries sustained by direct care staff has continued downward as the number of direct care staff injuries has decreased significantly from the last quarter.

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

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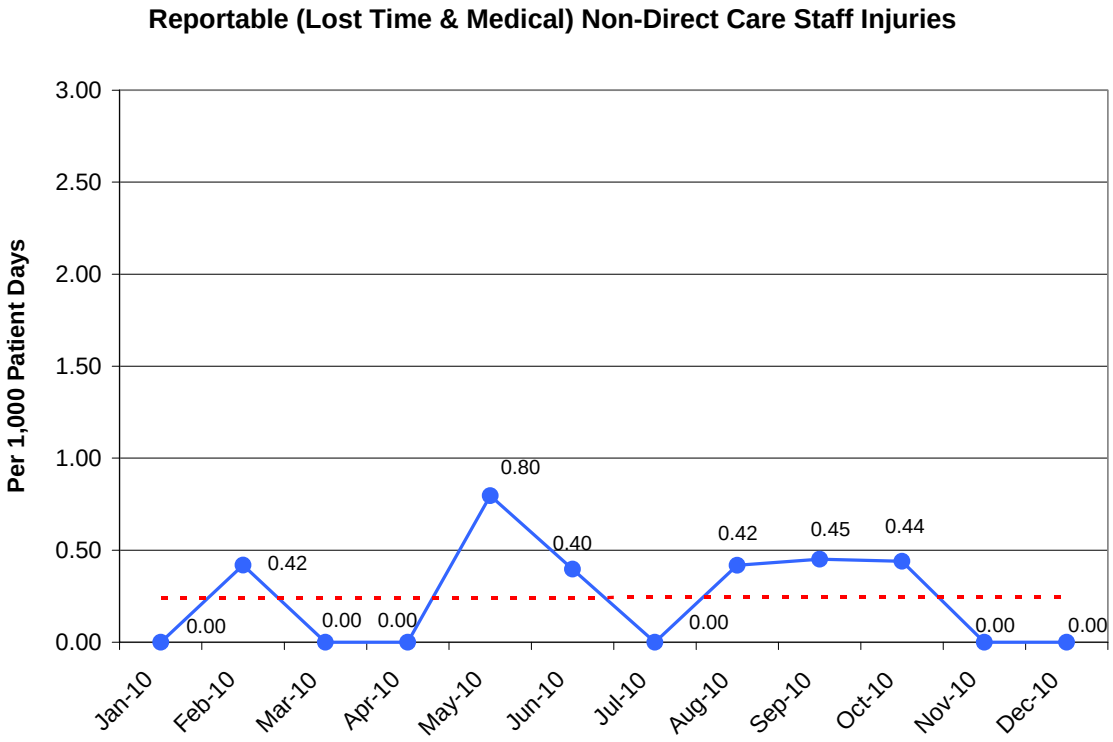
HUMAN RESOURCES

ASPECT: NON-DIRECT CARE STAFF INJURIES



Summary

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

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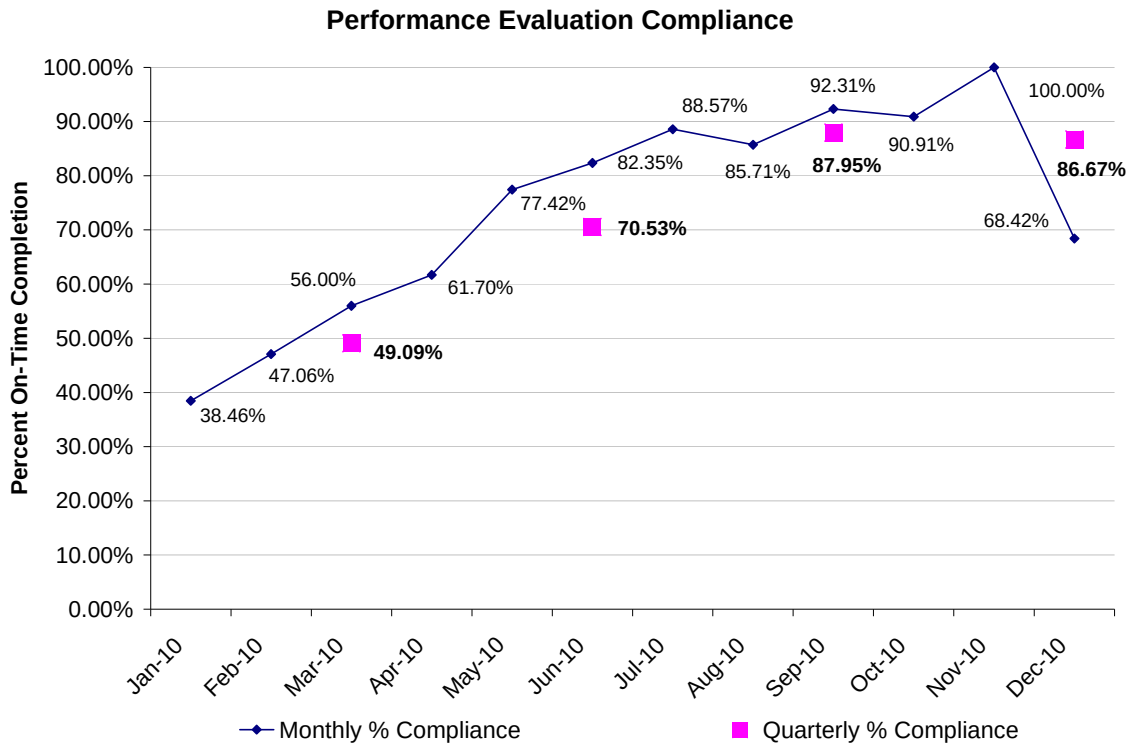
HUMAN RESOURCES

ASPECT: PERFORMANCE EVALUATIONS COMPLETION

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



Summary

This quarter has shown significant improvement in the completion of performance evaluations.

Cumulative results from this quarter (86.67%) have remained above the planned performance threshold of 85%. Results for December are significantly less than the threshold however this performance could be an anomaly due to special cause variation. Ongoing measurement of performance is indicated for at least two quarters of monthly performance above the planned performance threshold. Ongoing efforts to insure on time completion of performance evaluations will continue in order to achieve the highest possible rate of on-time performance and to maintain a sustainable level of performance above the 85% level.

ASPECT: PERSONNEL MANAGEMENT

Overtime hours and mandated shift coverage

Reporting Period	Overtime Hours	Mandated Shift Coverage
October 2010	1860	10
November 2010	1926	10
December 2010	2474	12

Staffing levels have achieved a high degree of stability with only a few positions open each month due to normalized attrition. Significant decreases in the level of overtime staffing should be able to be sustained moving forward.

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INFECTION CONTROL

ASPECT: HOSPITAL ACQUIRED INFECTION

Indicators	Findings	Compliance	Threshold Percentile
Total number of infections for the fourth quarter of the fiscal year, per 1000 patient days	39/5.6	100 % within standard	1 SD within the mean
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	11/1.5	100% within standard	1 SD within the mean

Data

- 13 skin infections-12 are community acquired
- 9 GI infections-only 1 is community acquired
- 4 dental infections-all community acquired
- 3 ear infections-two are community acquired and one is idiosyncratic
- 3 eye infections-all are community acquired
- 3 wound infections-two are community acquired
- 2 reproductive infections-both are community acquired
- 1 UTI-community acquired
- 1 URI-community acquired
- No multi drug-resistant (MDRO) infections
- No influenza

Summary

Riverview Psychiatric Center maintains a total house surveillance. The total number of infections doubled this quarter with a significant increase in hospital acquired infections (HAI) as well. There were two hospital acquired infections in the first quarter; and 11 hospital acquired infections this quarter. This increase is due to a norovirus outbreak on the Upper Kennebec Unit. Housekeeping and unit staff immediately began to increase environmental disinfection and especially so after client (sick) use of unit bathrooms. Although 11 employees were also sick with similar symptoms that same week, the outbreak was contained to Upper Kennebec.

Action

- Continue to encourage hand hygiene
- Continue surveillance

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LIFE SAFETY

ASPECT: LIFE SAFETY

Indicators	Findings	Compliance	Threshold Percentile
1. Total number of fire drills and actual alarms conducted during the quarter compared to the total number of alarm activations required per Life Safety Code, that being (1) drill per shift, per quarter.	3/3	100%	100%
2. Total number of staff who knows what R.A.C.E. stands for	221/221	100%	95%
3. Total number of staff who knows how to acknowledge the fire alarm or trouble alarm on the enunciator panel	221/221	100%	95%
4. Total number of staff who knows the emergency number.	221/221	100%	95%
5. During unannounced safety audits conducted by the Safety Officer, this represents the total number of staff who displays identification tags.	224/230	97%	95%
6. During unannounced safety audits conducted by the Safety Officer, this represents the total number of direct care staff who carries a personal duress transmitter.	225/230	97%	95%

Summary

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

During drills, the following was discovered and noted:

1. Some staff was missing their red key identifier attached to the fire key.
2. Two staff were having difficulty operating the two-way radio, more specifically the mike activation button and not keying the mike button for a brief moment to open up the repeater.
3. One unit discovered a two-way did not function properly due to a weak battery.
4. There was a significant improvement in the completeness of and timely submission of fire reports.

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

Actions

Actions taken after drills were the following:

1. Affected staff were given a red key identifier.
2. Staff having difficulty was given remedial instruction on the use of the two-way radio. The Safety Officer will continue to conduct drills with the two-way radios for the purposes of conducting census activities and the proper use of the two-way radios.

LIFE SAFETY

3. The two-way radio was repaired and returned to the unit. The employee, along with a copy to their supervisor, was sent an email of appreciation for the quick response to the handling of the event.
4. No action required.

We continue to conduct environmental tours and safety audits to assure that staff is in possession of required safety equipment and facility ID's. This area of monitoring has shown improvement. The Safety Officer credits the training fairs with the competencies demonstrated as they relate to staff response during fire/smoke emergencies.

ASPECT: FIRE DRILLS REMOTE SITES

Indicators	Findings	Compliance	Threshold Percentile
1. Total number of fire drills and actual alarms conducted at Portland Clinic compared to the total number of alarm activations required per Life Safety Code (3) drills per year based on the fact that it is business occupancy.	1 drill	100%	100%

Summary

There was an unannounced drill conducted by the Safety Officer during the year, satisfying the NFPA requirement. Unfortunately, due to dental services being performed on clients during (2) environmental tours, we made the decision to not interrupt those services for the purpose of conducting the drill utilizing the alarms throughout the building. We will make an attempt to accomplish that during the 3rd quarter. We continue to perform environmental tours during which time we ask them questions as it relates to what actions they must take in the event of a fire and/or smoke emergency. Questions are still posed to staff who are not caring for clients when the decision is made to not conduct a drill.

Actions

No actions are required at this time other than coordinate the next planned drill with other participants sometime during the next quarter.

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MEDICAL STAFF

ASPECT: COMPLETION OF AIMS

The measure of this aspect of care has been retired due to consistent results above the planned compliance threshold.

ASPECT: JUSTIFICATION FOR DISCHARGE ON MULTIPLE ANTIPSYCHOTICS

Indicators	Findings	Compliance	Threshold Percentile
Patients discharged on multi-antipsychotic medications will have clinical justification documented in the discharge summary.	Over a 3-mo period (Aug-Oct) 68 discharges had 14 patients on 2 or more antipsychotics; 4 were justified according to HBPIS and NQF standards.	29%	80%

Summary

The number of clients discharged on multiple antipsychotics is remaining low, though there continue to be one or two cases a month which are not justified. Statistical significance in the number of cases in the sample due to low numbers of clients discharged on multiple antipsychotic medications makes achieving statistical significance for this measure difficult.

Actions

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

*HBIPS = Hospital Based Inpatient Psychiatric Services Core Measures

#NQF = National Quality Forum

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NURSING

ASPECT: SECLUSION/RESTRAINT RELATED TO STAFFING EFFECTIVENESS

Indicators	Findings	Compliance
1. Staff mix appropriate	67 of 67	100%
2. Staffing numbers within appropriate acuity level for unit	67 of 67	100%
3. Debriefing completed	63 of 67	98%
4. Dr. Orders	67 of 67	100%

SUMMARY

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

ACTION

Good Progress. We will continue to monitor.

ASPECT: INJURIES RELATED TO STAFFING EFFECTIVENESS

Indicators	Findings	Compliance
1. Staff mix appropriate	19 of 19	100%
2. Staffing numbers within appropriate acuity level for unit	19 of 19	100%

SUMMARY

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

ACTIONS

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

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NURSING

ASPECT MEDICATION ERRORS AS IT RELATES TO STAFFING EFFECTIVENESS

NURSING: Staffing levels during medication errors – October to December 2010 NASMHPD reportable variances

Date	Omit	Co-mission	Float	New	O/T	Unit Acuity	Staff Mix
9/27/10 10/1/10 Re/port	Y		N	N	N	LK-SCU	3 RN,1 LPN, 7 MHW
10/24/10	Y		Y	N	N	US	3 RN,4 MHW
10/30/10	Y		N	N	N	US	3 RN, 4 MHW
11/3/10	Y		N	N	N	LS	3 RN, 6 MHW
11/5/10	Y		N	N	N	UK	3 RN, 3 MHW
11/16/10	Y		N	N	N	UK	2 RN, 4 MHW
11/27/10	Y		N	N	N	LS	3 RN, 1 LPN, 7 MHW
11/27/10	Y		N	N	N	US	2 RN, 4 MHW
12/3/10	Y		N	N	N	LK	2 RN, 1 LPN, 8 MHW
12/3/10	Y		N	N	N	LK	2 RN,1 LPN, 8 MHW
12/4/10	Y		N	Y	N	LK	3 RN,1 LPN, 8 MHW
12/9&12/ 10	N	ANAFRANIL omitted, AMANTADINE given,wrong med	N	N	N	LK-SCU	3 RN,1 LPN, 7 MHW
12/15/10	Y		Y	N	Y	US	1RN, 3 MHW
12/16 & 12/17/10	N	Triamclinolone cream – 2 extra doses, medication was discontinued	N	N	N	US	2 RN, 1 LPN, 4 MHW
12/20/10	N	Klonopin 1 mg. - given to wrong client	N	Y	N	LJ	3 RN, 1 LPN, 7 MHW
9/27/10 10/1/10 Re/port	Y		N	N	N	LK-SCU	3 RN,1 LPN, 7 MHW
10/24/10	Y		Y	N	N	US	3 RN,4 MHW
10/30/10	Y		N	N	N	US	3 RN, 4 MHW
11/3/10	Y		N	N	N	LS	3 RN, 6 MHW
11/5/10	Y		N	N	N	UK	3 RN, 3 MHW
11/16/10	Y		N	N	N	UK	2 RN, 4 MHW
11/27/10	Y		N	N	N	LS	3 RN, 1 LPN, 7 MHW
11/27/10	Y		N	N	N	US	2 RN, 4 MHW
12/3/10	Y		N	N	N	LK	2 RN, 1 LPN, 8 MHW

SUMMARY

There were a total of 15 reportable individual nursing errors, 7 med variances involved multiple dose omission or co-mission, reported as NASMHPD errors. There were 25 errors during the last quarter. One error involved a dispensing device (ACCUDOSE), 12 were omissions, one involved a wrong med being given, one involved a med being given to the wrong client, and one involved administering a discontinued medication. One nurse with multiple errors received further education regarding practice due to being a new employee. Occurrences by unit were divided nearly equally between acute admissions units and transitional (upper) units. Floating to another unit was involved in two of the 15 reports. Overtime was involved in one of the 15 reports. All nursing-related med variances were noted to have appropriate staffing levels at the time they occurred on the given shift they occurred on.

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NURSING

ACTION

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

ASPECT: PAIN MANAGEMENT

Indicator		Findings	Compliance
Pre-administration	Assessed using pain scale	1249 of 1261	99%
Post-administration	Assessed using pain scale	1082 of 1261	97%

SUMMARY

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

ACTION

We believe that the increase in compliance for “Post-administration” assessment is a result of strategy implemented in the past quarter. Nursing will continue to place a great deal of attention and effort on post administration assessment and management of the related documentation. Nursing will continue to track this indicator and strive for increase in post assessment in the next quarter. The two ADONs will continue to work with unit nursing staff to assure that this is done consistently.

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NURSING

ASPECT: CHART REVIEW EFFECTIVENESS

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	**31 of 55**	**56%**
2. STGs/ Interventions relate directly to content of GAP note.	**60 of 60**	**100%**
3. Weekly Summary note completed.	**60 of 60**	**100%**
4. BMI on every Treatment Plan.	**59 of 60**	**98%**
5. Diabetes education Teaching checklist shows documentation of client teaching (diabetic clients)	**60 of 60**	**100%**
6. Multidisciplinary Teaching checklist active being completed..	**56 of 60**	**93%**
7. Dental education Teaching checklist	**55 of 60**	**92%**

SUMMARY

There is a total compliance of 91%. Reliability continues to be enhanced by the utilization of a single reviewer. The one area that showed a great increase was the weekly note. That reflection is due to providing nursing staff with a weekly note template. These indicators were changed during this quarter and therefore will be compared for changes during the next quarter. The indicators that have remained are improved.

ACTION

As in the current measurement period, unit RNs will audit 1 chart per RN and discuss during supervision. The Nurse Educator responsible for chart audit will continue to meet with individual nurses following each chart audit. The PSD/ Nurse IV will continue to discuss and review chart audit results at staff meetings**.**

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NURSING

ASPECT: INITIAL CHART COMPLIANCE

Indicator	Findings	Compliance
1. Universal Assessment completed by RN within 24 hours	73 of 74	99%
2. All sections completed or deferred within document	72 of 74	97%
3. Initial Safety Treatment Plan initiated	55 of 74	85%
4. All sheets required signature authenticated by assessing RN	73 of 74	99%
5. Medical Care Plan initiated if Medical problems identified	14 of 74 23 N/A	50%
6. Informed Consent sheet signed	69 of 74 2 refused 1 N/A	97%
7. Potential for violence assessment upon admission	72 of 74	97%
8. Suicide potential assessed upon admission	74 of 74	100%
9. Fall Risk assessment completed upon admission	72 of 74	97%
10. Score of 5 or above incorporated into problem need list	6 of 74 68 N/A	100%

SUMMARY

This area is monitored upon admission. All areas have improved.

ACTION

Continue to work with the Professional staff to increase awareness of the interdependence of each subsection in this category. Review sample size to seek a constant statistically significant numerical representation for analysis.

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PEER SUPPORT

ASPECT: INTEGRATION OF PEER SPECIALISTS INTO CLIENT CARE

Indicators	Findings	Compliance	Threshold Percentile
1. Attendance at Comprehensive Treatment Team meetings.	377 of 415	91%	80%
2. Level II grievances responded to by RPC on time.	0 of 0	100%	100%
3. Attendance at Service Integration meetings.	64 of 67	96%	100%
4. Contact during admission.	76 of 76	100%	100%
5. Level I grievances responded to by RPC on time.	50 of 55	91%	100%
6. Client satisfaction surveys completed.	27 of 35	77%	50%

Summary

Overall compliance is 92%, up 8% from last quarter.

Attendance at treatment team meetings increased by 8% and remains above threshold, primarily due to an increase in peer support staff. Contact during admission and return rate for client satisfaction surveys also increased in compliance and meet or exceed the threshold established.

RPC's compliance with level 1 grievance response time increased by 16%, but still remains below threshold. The number of grievances for 2nd quarter decreased, with no level 2 grievances filed.

There were 3 service integration meetings not attended by peer support. One was due to peer support not being available and two were because peer support was not notified of that meeting.

Actions

- Peer specialists will actively seek out social work staff to be informed about upcoming service integrations meetings.
- Peer specialists will work with social work staff to coordinate meeting schedule to allow for consistent attendance.

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PHARMACY & THERAPEUTICS

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

ASPECT: ORDER WRITING POLICY

Indicators	Findings	Compliance	Threshold Percentile
All order sheets are required to have the patient's allergies listed at the top of the sheet	**October** 9 orders received by pharmacy without allergies listed and an estimated 1325 orders total received by pharmacy.	99.3%	98.0%
	November 3 orders received by pharmacy without allergies listed and an estimated 1280 orders total received by pharmacy.	98.8%	98.0%
	December 7 orders received by pharmacy without allergies listed and an estimated 1325 orders total received by pharmacy	99.5%	98.0%

Summary

There were a total of 19 orders sent to the pharmacy during 2011Q2 without allergy information written at the top of the page. An estimated 3930 total orders were received during that time period. Total compliance during this time period is 99.6%. All orders received without allergies listed were faxed back to their respective units for clarification.

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PHARMACY & THERAPEUTICS

ASPECT: DIVERSION OF CONTROLLED SUBSTANCES

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

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

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

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

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

The goal of this report is to review all ADC discrepancies from April 1, 2010 through June 30, 2010 and ensure that controlled substances are not being diverted from unit stock and discrepancies are being addressed in a timely manner.

Discrepancies Recorded	Incidences	Pharmacy Corrected	NOD Correction	Suspected Diversion	Actual Diversion
33	23	9	14	0	0

A review of the AcuDose-Rx Discrepancy By Station Report showed not active discrepancies reported.

All of the 33 discrepancies recorded were all accounted for by user error and correction of previously created error. (A discrepancy will sometimes be purposely created to correct a previous mistake. For example, if there was 1 tablet in the ADC and the nurses finger slips and presses both the "1" and "2" key at the same time thus accidently entering a quantity of 12. The computer will them believe that 12 is the correct quantity. A second discrepancy will have to be created to correct the computer quantity to 1.)

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

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PROGRAM SERVICES

ASPECT: ACTIVE TREATMENT IN ALL FOUR UNITS

Indicator	Findings	Compliance
1. Documentation reveals that the client attended 50%of assigned psycho-social-educational interventions within the last 24 hours.	52 of 70	70%
2. A minimum of three psychosocial educational interventions are assigned daily.	40 of 70	70%
3 A minimum of four groups is prescribed for the weekend.	57 of 70	81%
4. The client is able to state what his assigned psycho-social-educational interventions are and why they have been assigned.	50 of 70	71%
5 The client can correctly identify assigned RN and MHW. (Or where the information is available to him / her)	62 of70	86%
6. The medical record documents the client's active participation in Morning Meeting within the last 24 hours.	35 of 70	50%
7. The client can identify personally effective distress tolerance mechanisms available within the milieu.	62 of 70	86%
8. Level and quality of client's use of leisure within the milieu are documented in the medical record over the last 7 days.	70 of 70	100%
9. Level and quality of social interactions within the milieu are documented in the medical record over the last 7 days.	64 of 70	91%
10. Suicide potential moderate or above incorporated into CSP	18 of 19	90%
11. Allergies displayed on order sheets and on spine of medical record.	70 of 70	100%
12. By the 7th day if Fall Risk prioritized as active-was it incorporated into CSP	17 of 17	100%

SUMMARY

Overall compliance for all indicators is 83% which is an decrease from 89%. Client attending psychosocial education is at 85%, which is up from 81% last quarter. The indicator that the client is able to state what his assigned psychosocial education interventions is at 81%, which is down from 84% last quarter. The indicator suicide potential moderate or above is incorporated into the CSP is at 100% which is a increase from 87% last quarter. Nine indicator numbers 1, 3, 4, 5, .6, 7. 9, 10, and 12 have improved since last quarter. Two indicator has decreased slightly.

ACTION

Continue to focus on the area that has been below threshold over the next quarter with continuous pressure to improve. This will be addressed through staff meetings and community meetings. Continued work with the clients on daily group assignment and weekend group assignment. There will be work done with staff on documentation of client's active participation.

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REHABILITATION SERVICES

ASPECT: READINESS ASSESSMENTS, COMPREHENSIVE SERVICE PLANS & PROGRESS NOTES

Indicators	Findings	Compliance
1 Readiness assessment and treatment plan completed within 7 days of admission.	30 of 30	100%
2 Rehabilitation short term goals on Comprehensive Service Plan are measurable and time limited.	30 of 30	100%
3. Rehabilitation progress notes indicate treatment being offered as prescribed on Comprehensive Service Plan.	29 of 30	97%
4. Rehabilitation progress notes indicate progress towards addressing identified goals on the Comprehensive Service Plan.	29 of 30	97%

Summary

This is the second quarter review of the above indicators and will continue to be focused on and monitored to ensure continuity of care from assessment to progress notes as this is a

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

Indicator #2 –Comprehensive Service Plans reviewed had goals that were measurable and time limited. The CSP's have been reviewed and updated in a timely fashion for the charts that were reviewed

Indicator #3 & 4-One of the charts reviewed had progress notes being written off of the previous CSP for that particular client. Director of Rehab. Services will review at the next Dept. meeting the need to communicate changes in the treatment plan to the Rehab. Services staff working with the client whose treatment plan has been revised.

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

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REHABILITATION SERVICES

ASPECT: HARBOR MALL HAND-OFF COMMUNICATIONS

Indicators	Findings	Compliance	Threshold Percentile
1. Hand-off communication sheet was received at the Harbor Mall within the designated time frame.	22 of 42	52 %	100%
2. RN signature/Harbor Mall staff signatures present.	42 of 42	100%	100%
3. SBAR information completed from the units to the Harbor Mall.	37 of 42	88%	100%
4. SBAR information completed from the Harbor Mall to the receiving unit.	40 of 42	95%	100%

SUMMARY

This is the second quarter review of the above indicators and will continue to be focused on and monitored to ensure information is accurately communicated between the Harbor Mall and the client units. The data collected this quarter is reflective of three months of data from the Hand-off Communication sheets received from the units.

Indicator #1- 18 of the hand-off communication sheets did not arrive to the Harbor Mall within the allotted time frame. The sheet is to be brought to the mall no later than 5 minutes before the start of groups and this did not happen on 18 of the sheets that were reviewed in the past three months. The times ranged from being 5-22 minutes late. Two of the days reviewed had one unit that did not send a hand-off communication sheet whatsoever to the Harbor Mall. Director of Rehabilitation Services will remind each of the units what the protocol is for the hand-off sheet to ensure that the information reaches the mall in time to be relayed to group leaders.

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

Indicator #3- On five of the 42 sheets reviewed, the information from the unit was either incomplete or inaccurate. The clients were checked off as attending the mall and they did not attend on that day or nothing was checked as attended, refused or excused. Director of Rehabilitation Services will review the need for accuracy in completing the Hand-off sheet with each of the units.

Indicator #4- Two of the 42 sheets reviewed did not have information from the treatment mall back to a unit as the sheets were never received even after attempts to call the unit to remind them to bring the sheets down were made. All the others had no issues to report documented.

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

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SECURITY

ASPECT: SECURITAS/RPC SECURITY TEAM

Indicators	Findings	Compliance	Threshold Percentile
Security Officer “foot patrols” during Open Hospital times. (Total # of “foot patrols” done vs. total # of “foot patrols” to be done.)	1964/2002	98%	95%

Summary

Foot patrols continue to be done despite those rare times that the officers are on other details which take priority over the “foot patrol”. It was reported on the SSPIQ2SFY11 that the compliance rate for this indicator was 89%. We continue our work to putting together the “tour system”.

Actions

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

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SOCIAL WORK

ASPECT: PRELIMINARY CONTINUITY OF CARE MEETING AND COMPREHENSIVE PSYCHOSOCIAL ASSESSMENTS

Indicators	Findings	Compliance	Threshold Percentile
1. Preliminary Continuity of Care meeting completed by end of 3rd day	28/30	93%	100%
2. Service Integration form completed by the end of the 3rd day	28/30	93%	100%
2a. Director of Social Services reviews all readmissions occurring within 60 days of the last discharge and for each client who spent fewer than 30 days in the community, evaluated the circumstances of the readmission to determine an indicated need for resources or a change in treatment and discharge planning or the need for alternative resources. In cases where such a need or change was indicated that corrective action was taken.	6/6	100%	100%
3a. Client Participation in Preliminary Continuity of Care meeting.	28/30	93%	90%
3b. CCM Participation in Preliminary Continuity of Care meeting.	28/30	93%	100%
3c. Client's Family Member and/or Natural Support (e.g., peer support, advocacy, attorney) Participation in Preliminary Continuity of Care meeting.	28/30	93%	100%
3d. Community Provider Participation in Preliminary Continuity of Care meeting.	9/15	60%	90%
3e. Correctional Personnel Participation in Preliminary Continuity of Care Meeting.	3/15	20%	90%
4a. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	28/30	93%	100%
4b. Annual Psychosocial Assessment completed and current in chart	30/30	100%	100%

SUMMARY

Aspect areas 3d and 3e remain low and the trend will likely continue given recent restructuring of the adult mental health department. We continue to foster positive communication and collaboration with the community and corrections.

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SOCIAL WORK

ASPECT: INSTITUTIONAL AND ANNUAL REPORTS

Indicators	Findings	Compliance	Threshold Percentile
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	10/10	100%	95%
2. The assigned **CCM** will review the new court order with the client and document the meeting in a progress note or treatment team note.	6/6	100%	100%
3. Annual Reports (due Dec) to the commissioner for all inpatient NCR clients are submitted annually	36/36	100%	100%

SUMMARY

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

ASPECT: CLIENT DISCHARGE PLAN REPORT/REFERRALS

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

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SOCIAL WORK

ASPECT: TREATMENT PLANS AND PROGRESS NOTES

Indicators	Findings	Compliance	Threshold Percentile
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all clients on assigned **CCM** caseload.	41/45	91%	95%
2. On Upper Saco progress notes in GAP/Incidental format will indicate at minimum bi- weekly 1:1 meeting with all clients on assigned **CCM** caseload	15/15	100%	95%
3. Treatment plans will have measurable goals and interventions listing client strengths and areas of need related to transition to the community or transition back to a correctional facility.	54/60	90%	95%

SUMMARY

Area 1 and 3 are being addressed in the Social Work Team Meeting and individually through supervision.

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STAFF DEVELOPMENT

ASPECT: NEW EMPLOYEE AND MANDATORY TRAINING

Indicators	Findings	Compliance	Threshold Percentile
1. New employees will complete new employee orientation within 60 days of hire.	10 of 10 hired during the quarter completed orientation	100%	100 %
2. New employees will complete CPR training within 30 days of hire.	10 of 10 hired during the quarter completed CPR training	100%	100 %
3. New employees will complete NAPPI training within 60 days of hire.	10 of 10 hired during the quarter completed Nappi training	100%	100 %
4. Riverview and Contract staff will attend CPR training bi-annually.	326 of 326 are current in CPR certifications	100%	100 %
5. Riverview and Contract staff will attend NAPPI training annually. Goal to be at 100% by end of fiscal training year 2011 on June 30th. **Fiscal year 10 was at 99.7%**	252 of 375 staff have completed annual training year to date.	67%	100 %
6. Riverview and Contract staff will attend Annual training. Goal is to be at 100% by end of fiscal training year 2011 on June 30th. **Fiscal year 10 was at 100%**	335 of 386 have completed annual training year to date.	87%	100 %

Findings

The indicators are based on the requirements for all new/current staff to complete mandatory training and maintain current certifications. **10 out 10 of** (100%) new Riverview/Contracted employees completed these trainings. **326 of 326** (100%) Riverview/Contracted employees are current with CPR certification. **252 of 375** (67%) Riverview/Contracted employees are current in Nappi training. **335 of 386** (87%) employees are current in Annual training. All indicators remained at 100% compliance for quarter 2-FY 2011.

Problem

No identified problems at this time.

Status

This is the second quarter of report for these indicators. Continue to monitor.

Actions

No actions needed at this time.