Riverview
PSYCHIATRIC CENTER

PERFORMANCE IMPROVEMENT REPORT

SECOND STATE FISCAL QUARTER 2012
October, November, December 2011

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January 18, 2011

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Glossary of Terms, Acronyms & Abbreviations

ACT	Assertive Community Treatment
ADC	Automated Dispensing Cabinets (for medications)
ADON	Assistant Director of Nursing
AOC	Administrator on Call
CCM	Continuation of Care Management (Social Work Services)
CCP	Continuation of Care Plan
CPI	Continuous Process (or Performance) Improvement
CPR	Cardio-Pulmonary Resuscitation
CSP	Comprehensive Service Plan
GAP	Goal, Assessment, Plan Documentation
HOC	Hand off communications.
IMD	Institute for Mental Disease
ICDCC	Involuntary Civil District Court Commitment
ICDCC-M	Involuntary Civil District Court Commitment, Court Ordered Medications
ICDCC-PTP	Involuntary Civil District Court Commitment, Progressive Treatment Plan
IC-PTP+M	Involuntary Commitment, Progressive Treatment Plan, Court Ordered Medications
ICRDCC	Involuntary Criminal District Court Commitment
INVOL CRIM	Involuntary Criminal Commitment
INVOL-CIV	Involuntary Civil Commitment
ISP	Individualized Service Plan
IST	Incompetent to Stand Trial
LCSW	Licensed Clinical Social Worker
LPN	License Practical Nurse
TJC	The Joint Commission (formerly JCAHO, Joint Commission on Accreditation of Healthcare Organizations)
MAR	Medication Administration Record
MRDO	Medication Resistant Disease Organism (MRSA, VRE, C-Dif)
NAPPI	Non Abusive Psychological and Physical Intervention
NASMHPD	National Association of State Mental Health Program Directors
NCR	Not Criminally Responsible
NOD	Nurse on Duty
NP	Nurse practitioner
NPSG	National Patient Safety Goals (established by the Joint Commission)
NRI	NASMHPD Research Institute, Inc.
OT	Occupational Therapist
PA or PA-C	Physician's Assistant (Certified)
PCHDCC	Pending Court Hearing
PCHDCC+M	Pending Court Hearing for Court Ordered Medications
PPR	Periodic Performance Review – a self-assessment based upon TJC standards that are conducted annually by each department head.
PSD	Program Services Director
PTP	Progressive Treatment Plan

Glossary of Terms, Acronyms & Abbreviations

R.A.C.E.	Rescue/Alarm/Confine/Extinguish
RN	Registered Nurse
RT	Recreation Therapist
SA	Substance Abuse
SBAR	Acronym for a model of concise communications first developed by the US Navy Submarine Command. S = Situation, B = Background, A = Assessment, R = Recommendation
SD	Standard Deviation – a measure of data variability.
Seclusion, Locked	Client is placed in a secured room with the door locked.
Seclusion, Open	Client is placed in a room and instructed not to leave the room.
SRC	Single Room Care (seclusion)
URI	Upper respiratory infection
UTI	Urinary tract infection
VOL	Voluntary – Self
VOL-OTHER	Voluntary – Others (Guardian)
MHW	Mental Health Worker

INTRODUCTION

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

Medication variance, fall risk assessment, and suicide risk assessment have become areas of national concern in all healthcare settings. Riverview is capitalizing on the resources and collaborative opportunities that currently exist to evaluate and modify our practices in these areas in a manner that reflects national standards of care. The Safety and Risk Committee has established a sub-committee tasked with the revision of our current process for evaluating fall risk and the review of all fall incidents utilizing a process engineering method called root cause analysis. Normally this method is used for in-depth analysis of sentinel or serious reportable events but a abbreviated use of this method can be used to ascertain causes for system failures that do not focus on human errors but rather on the systems that allow humans to make errors. This approach is also planned for implementation in the analysis of medication variances.

Work on the internal assessment of the fulfillment of the Consent Decree Standards of Compliance is ongoing and overall success in maintaining these standards has been demonstrated consistently.

ADMISSIONS

Figure CD-06

Client Admission Diagnoses

	2011			2012		
	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Total
ADJUSTMENT DIS W MIXED DISTURBANCE OF EMOTIONS & CONDUCT	1	1		1	2	5
ADJUSTMENT DISORDER WITH DEPRESSED MOOD		1	2	2	3	8
ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED MOOD				1	1	2
ADJUSTMENT REACTION NOS			1		2	3
ALCOH DEP NEC/NOS-REMISS		2				2
ANXIETY STATE NOS				1		1
ATTN DEFICIT W HYPERACT				1		1
BIPOL I DIS, MOST RECENT EPIS (OR CURRENT) MANIC, UNSPEC			1			1
BIPOL I, MOST RECENT EPISODE (OR CURRENT) MIXED, UNSPECIFIED		1				1
BIPOL I, REC EPIS OR CURRENT MANIC, SEVERE, SPEC W PSYCH BEH		1	1		2	4
BIPOLAR DISORDER, UNSPECIFIED	11	10	11	17	17	66
CANNABIS ABUSE-IN REMISS			1			1
CONDUCT DISTURBANCE NOS			1			1
DELUSIONAL DISORDER	2	2	2		4	10
DEPRESS DISORDER-UNSPEC			1		1	2
DEPRESSIVE DISORDER NEC	5	5	7	4	6	27
DRUG ABUSE NEC-IN REMISS				2		2
DRUG ABUSE NEC-UNSPEC			1			1
DYSTHYMIC DISORDER		1	2		1	4
HALLUCINOG ABUSE-REMISS				1		1
HEBEPHRENIA-CHRONIC	1		1			2
IMPULSE CONTROL DIS NOS				1		1
INTERMITT EXPLOSIVE DIS		1		3	3	7
NONPSYCHOT BRAIN SYN NOS		1				1
OPPOSITIONAL DEFIANT DISORDER		1				1
PARANOID SCHIZO-CHRONIC	6	4	5	10	6	31
PARANOID SCHIZO-UNSPEC	4	5	2	1		12
PARANOID STATE NOS		1				1
POSTTRAUMATIC STRESS DISORDER	4	2	3	4	4	17
PSYCHOSIS NOS	7	13	14	6	13	53
REC DEPR DISOR-PSYCHOTIC	2				1	3
RECUR DEPR DISOR-SEVERE				1		1
RECURR DEPR DISORD-UNSP	1	1				2
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED	20	14	13	11	13	71
SCHIZOPHRENIA NOS-CHR	6	4	2	3	1	16
SCHIZOPHRENIA NOS-UNSPEC	1	1		1	1	4
SCHIZOPHRENIFORM DISORDER, UNSPECIFIED		1		1		2
UNSPECIFIED EPISODIC MOOD DISORDER	3	3	5	12	4	25
Total Admissions	74	76	76	84	85	395
% Admitted with primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	0%	2.7%	2.7%	3.6%	0.0%	1.8%

ADMISSIONS

Figure CD-04

Client Legal Status on Admission	2011			2012		
	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Total
ICDCC	17	26	23	39	41	146
ICDCC-M			3	1		4
ICDCC-PTP			1			1
IC-PTP+M		1				1
ICRDCC	1		2			2
INVOL CRIM	20	29	30	32	31	142
INVOL-CIV	2	7	2	1	3	15
PCHDCC	1		2			3
PCHDCC+M		1	1	1	1	4
VOL	34	11	10	13	18	86
VOL-OTHER	1	1	2			4

COMMUNITY FORENSIC ACT TEAM

ASPECT: REDUCTION OF RE-HOSPITALIZATION FOR ACT TEAM CLIENTS

Indicators	Findings	Compliance	Threshold Percentile
1. The ACT Team Director will review all client cases of re-hospitalization from the community for patterns and trends of the contributing factors leading to re-hospitalization each quarter. The following elements are considered during the review: a. Length of stay in community b. Type of residence (i.e.: group home, apartment, etc) c. Geographic location of residence d. Community support network e. Client demographics (age, gender, financial) f. Behavior pattern/mental status g. Medication adherence h. Level of communication with ACT Team	4 clients were re-admitted to RPC; one civil client who had not yet stabilized in the community, 3 forensic clients who were readmitted as jail transfer for elopement and 2 for increased psychiatric sx, respectively	100%	100%
2. ACT Team will work closely with inpatient treatment team to create and apply discharge plan incorporating additional supports determined by review noted in #1.	100%	100%	100%

Summary

1. The PTP client who was re-hospitalized had been living in the community in a supervised apartment program for 4 months and was re-admitted on 10/17/11 when he stopped eating and had refused to come out of the bathroom in his residence. He was successfully treated and released on 12/27/11 when he had stabilized enough to move to a group home in Waterville. He has remained on PTP but it was agreed upon by the inpatient and outpatient psychiatrists that he would no longer be prescribed psychotropic medication if he could continue to manage in the community. The first NCR client who was readmitted had only been in the community a month and was re-admitted with the focus on medication stabilization taking into account the impact of smoking patterns. The second NCR client who was re-admitted was determined by DDPC, his psychiatric providers, to be in need of medication stabilization after a reported 2 missed doses. The client re-compensated quickly, and was released after 3 days. The inpatient psychiatrist and outpatient psychiatrist worked together to create a discharge plan that would reduce the likelihood of future missed medications. The NCR client who eloped on 11/4/11 and was apprehended in Georgia 11/18/11, was then transferred to Kennebec Co Jail 12/5, and re-hospitalized at RPC 1/5/12 while he awaits trial. The review of this elopement did not indicate that there were increased psychiatric symptoms causing the violation of court order, and further, that there had been a period of at least two months that the client was not paying rent and engaging in more work-related activities than he let the treatment team know about.

2. The ACT Team continues to place strong emphasis on collaborative in treatment team meeting participation while clients are in the hospital, particularly regarding recommendations for goals of re-hospitalization and transition back to the community.

COMMUNITY FORENSIC ACT TEAM

ASPECT: INSTITUTIONAL AND ANNUAL REPORTS

Indicators	Findings	Compliance	Threshold Percentile
3. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of notification of submitted petition.	6 of 7 on time	80%	95%
4. The assigned case manager will review the new court order with the client and document the meeting in a progress note or treatment team note.	4 new court orders, all reviewed.	100%	100%
5. Annual Reports (due Nov) to the commissioner for all out-patient Riverview ACT NCR clients are submitted annually	48 of 50	96%	100%

Summary

1. Seven clients petitioned to have their cases heard in Superior Court. Six of seven had Institutional reports completed on time. The process has been improved to include essential reviewers and continued emphasis on deadlines triggered with the receipt of petitions, which we believe has resulted in improved on-time Institutional Reports.

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. Two Annual Reports were submitted late to the Superintendent by the Outlier Case Manager/ACT PSD because of incomplete data on those two clients not resolved until December 1.

ASPECT: SUBSTANCE ABUSE AND ADDICTIVE BEHAVIOR HISTORY

Indicators	Findings	Compliance	Threshold Percentile
1. age of onset documented in Comprehensive Assessment	40/42	95%	95%
2. duration of behavior documented in C.A. and progress notes	40/42	95%	95%
3. pattern of behavior documented in C.A. and progress notes	40/42	95%	95%

Summary

The Co-Occurring Specialist has reviewed all urinalyses for illicit drug/alcohol us, as well as appropriateness of substances screened for. This has streamlined the process of responding to the client with the information and will identify one point-person for the Maine General Lab for drug screens (Co-Occurring Specialist) and one for all other lab work (Nurse).Our randomization of urinalyses for drug/alcohol detection implemented by the Co-Occurring Specialist has been adapted to meet the MaineCare standards in order for lab work to be funded (no more than one time in 7 days).

COMMUNITY FORENSIC ACT TEAM

ASPECT: INDIVIDUAL SERVICE PLANS AND PROGRESS NOTES

Indicators	Findings	Compliance	Threshold Percentile
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly contact with all clients assigned on an active status caseload.	42/42	100%	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.	42/42	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. Clients in transition from ACT to other community resources have had less than weekly direct contact but are discussed weekly in clinical meeting and are seen face to face at least 4 times per month (averaging weekly contacts).
2. ISPs also contain group attendance goals, especially with clients who are petitioning for increased court ordered privileges. Case managers are focused on including group attendance in ISP goals.
3. One client in an outlying status is now seeing the ACT Team Psychiatrist as his State Provider, but is petitioning the court for the privilege of utilizing a community-based psychiatrist nearer his home. Another outlying client is using new skills effectively to maintain a therapeutic level of his psychotropic medication, which will allow him to petition more successfully for increased privileges in the future.

ASPECT: PEER SUPPORT

Indicators	Findings	Compliance	Threshold Percentile
1. Engagement attempt with client within 7 days of admission.	3/3	100%	95%
2. Documented offer of peer support services.	3/3	100%	95%
3. Attendance at treatment team meetings as appropriate.	27/30	90%	95%

Summary

The Peer Support Specialist makes every effort to attend treatment team meetings at ACT offices and in hospital with clients who state they wish him to attend. The only missed treatment team meetings are those that were reschedule for a time the PSS was unable to attend, or those that were scheduled while he was not expected to be at work (vacation, sick time). The number and quality of contacts with clients by Peer Support continues to contribute to the ACT Teams goal of seeing clients face to face three times per week.

CAPITOL COMMUNITY CLINIC

ASPECT: DENTAL CLINIC SURVEY

Indicators	Findings	Compliance	Threshold Percentile
Clients from RPC as well as clients in the community will receive a survey to fill out at the time of appt. The survey has several questions and in those questions we are asking the client how we can better serve there needs.	**October** Fifteen surveys were completed by dental in-house clients as well as outpatient. Of the fifteen surveys, all surveys were positive.	100%	90%
	November Twenty seven client surveys were received. All twenty seven surveys were positive.	100%	90%
	December There was twenty-three client surveys completed. Of the twenty-three surveys returned, all were positive.	100 %	90%

Summary

Fifty-five surveys were returned and all showed positive results for the 2nd quarter 2012.

Actions

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

CAPITOL COMMUNITY CLINIC

ASPECT: DENTAL CLINIC 24 HOUR POST EXTRACTION FOLLOW-UP

Indicators	Findings	Compliance	Threshold Percentile
a. All clients with tooth extractions, will be assessed and have teaching post procedure, on the following topics, as provided by the Dentist or Dental Assistant • Bleeding • Swelling • Pain • Muscle soreness • Mouth care • Diet • Signs/symptoms of infection b. The client, post procedure tooth extraction, will verbalize understanding of the above by repeating instructions given by Dental Assistant/Hygienist.	**October** Ten extractions were performed. Post extraction instructions verbalized to each client. Client repeated back to Dental Assistant that they understood the instructions without difficulty.	100%	100%
	November Five extractions were performed. Post extraction instructions verbalized to each client. Client repeated back to Dental Assistant that they understood the instructions without difficulty.	100%	100%
	December Three extractions were performed. Post extraction instructions verbalized to each client. Client repeated back to Dental Assistant that they understood the instructions without difficulty.	100%	100%

Summary

There were eighteen extractions in the 2nd quarter 2012. All clients had been educated on each topic listed above with post extraction, after care instructions were given both orally and in writing. Clients had no issues repeating and understanding the oral instructions.

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

Action

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

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 ten extractions for the month, The client was given a time out to identify extraction site, and asked to state their name and dob.	100 %	100%
	November There were five extractions done for the month. The each client was given a time out to identify extraction site, and asked to state their name and dob.	100%	100%
	December There were three extractions done for the month. The each client was given a time out to identify extraction site, and asked to state their name and dob.	100%	100%

Summary:

In the 2nd quarter 2012, eighteen clients had extractions. In all eighteen cases there is appropriate documentation of a time-out procedure prior to the extraction. The client was asked to identify the extraction site and was also asked to identify themselves by providing their full name and date of birth.

Actions

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

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** Thirty-one clients that had scheduled appointments had their vitals signs taken before their clinic appointment.	100%	100%
	November There were thirty-one clients scheduled for appointments during the month of February. All clients had vital signs taken before their appointment.	100%	100%
	December There were twenty clients scheduled for appointments. All clients had their vital signs taken before their clinic appointment.	100%	100%

Summary

For the 2nd quarter 2012 there were 82 clients. All clients had their vitals taken before their scheduled appointment. This information was reviewed at monthly staff meetings and reports forwarded quarterly to RPC Quality Council.

Actions

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

CLIENT SATISFACTION

ASPECT: CLIENT SATISFACTION WITH CARE

#	Indicators	Findings	
		Results	% Change
1	I am better able to deal with crisis.	50%	-2%
2	My symptoms are not bothering me as much.	50%	-15%
3	The medications I am taking help me control symptoms that used to bother me.	46%	-8%
4	I do better in social situations.	37%	0%
5	I deal more effectively with daily problems.	50%	0%
6	I was treated with dignity and respect.	47%	+14%
7	Staff here believed that I could grow, change and recover.	56%	+6%
8	I felt comfortable asking questions about my treatment and medications.	25%	-23%
9	I was encouraged to use self-help/support groups.	53%	+10%
10	I was given information about how to manage my medication side effects.	28%	-5%
11	My other medical conditions were treated.	38%	+18%
12	I felt this hospital stay was necessary.	0%	-20%
13	I felt free to complain without fear of retaliation.	22%	+5%
14	I felt safe to refuse medication or treatment during my hospital stay.	10%	+17%
15	My complaints and grievances were addressed.	13%	-17%
16	I participated in planning my discharge.	33%	-2%
17	Both I and my doctor or therapist from the community were actively involved in my hospital treatment plan.	30%	+26%
18	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	14%	+3%
19	The surroundings and atmosphere at the hospital helped me get better.	56%	+19%
20	I felt I had enough privacy in the hospital.	28%	+4%

CLIENT SATISFACTION

#	Indicators	Findings	
		Results	% Change
21	I felt safe while I was in the hospital.	38%	-5%
22	The hospital environment was clean and comfortable.	47%	-5%
23	Staff were sensitive to my cultural background.	17%	+4%
24	My family and/or friends were able to visit me.	41%	-22%
25	I had a choice of treatment options.	13%	-4%
26	My contact with my doctor was helpful.	34%	+1%
27	My contact with nurses and therapists was helpful.	47%	-7%
28	If I had a choice of hospitals, I would still choose this one.	38%	+8%
29	Did anyone tell you about your rights?	10%	-23%
30	Are you told ahead of time of changes in your privileges, appointments, or daily routine?	9%	-2%
31	Do you know someone who can help you get what you want or stand up for your rights?	19%	-22%
32	My pain was managed.	25%	+10%

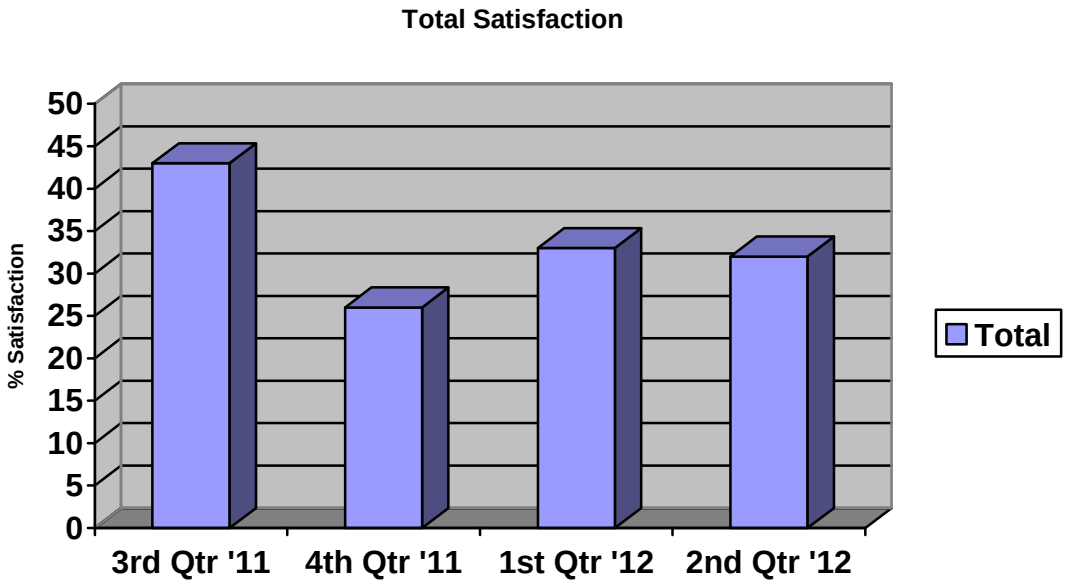
ND = no data

Summary

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

Of the 32 indicators, 14 increased and 18 decreased. The most significant increases were community involvement in treatment, other medical conditions being treated, and hospital atmosphere being helpful. The most significant decreases were around feeling safe to ask questions about treatment and medications, friends and family being able to visit, that the stay was necessary, and education and support with their rights. There are nine indicators that continue to rise (6, 7, 11, 13, 14, 19, 26, 28, and 32) and three that are continuing to drop (16, 25, and 30) over the last 2 quarters.

CLIENT SATISFACTION



COMPARATIVE STATISTICS

The comparative statistics reports include the following elements:

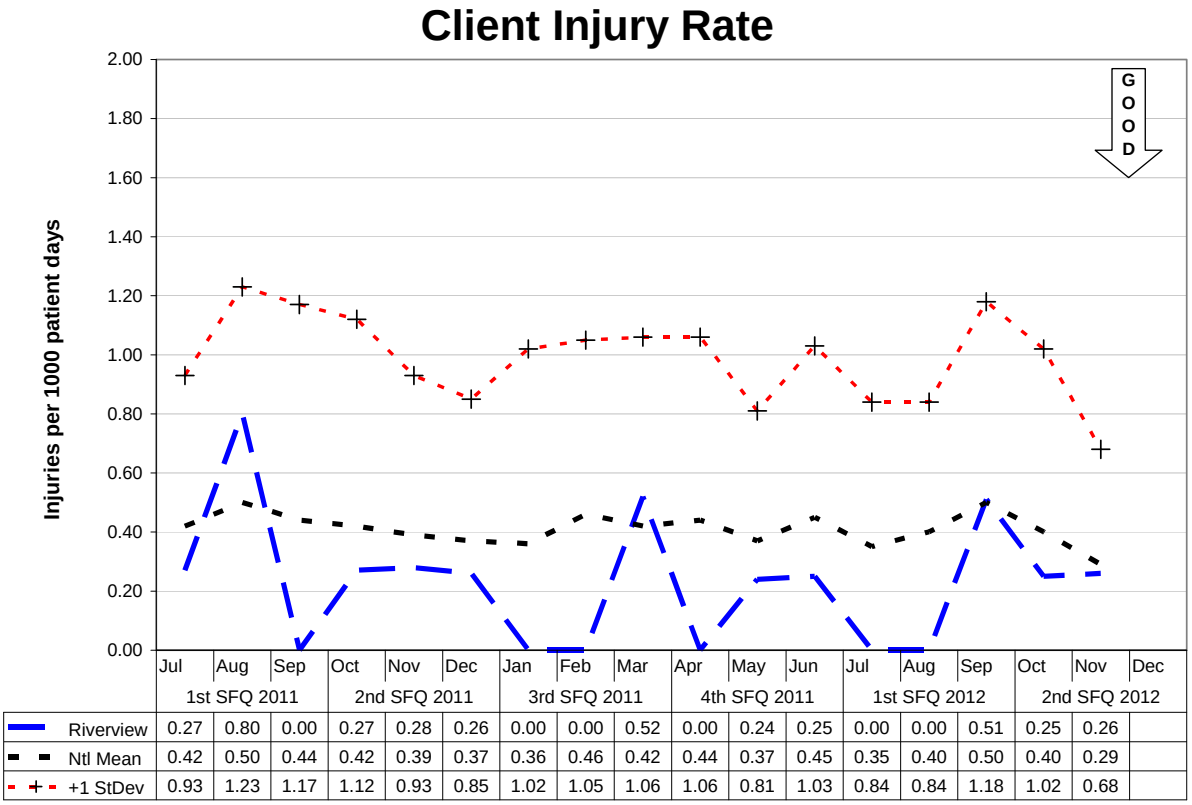
- Client Injury Rate
- Elopement Rate
- Medication Error Rate
- 30 Day Readmit Rate
- Percent of Clients Restrained
- Hours of Restraint
- Percent of Clients Secluded
- Hours of Seclusion
- Confinement Events Analysis
- Confinement Events Management
- Medication Administration during Behavioral Events

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

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

COMPARATIVE STATISTICS

Figure CD-29



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011			1st SFQ 2012			2nd SFQ 2012		
Riverview	0.27	0.80	0.00	0.27	0.28	0.26	0.00	0.00	0.52	0.00	0.24	0.25	0.00	0.00	0.51	0.25	0.26	
Ntl Mean	0.42	0.50	0.44	0.42	0.39	0.37	0.36	0.46	0.42	0.44	0.37	0.45	0.35	0.40	0.50	0.40	0.29	
+1 StDev	0.93	1.23	1.17	1.12	0.93	0.85	1.02	1.05	1.06	1.06	0.81	1.03	0.84	0.84	1.18	1.02	0.68	

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

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

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

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

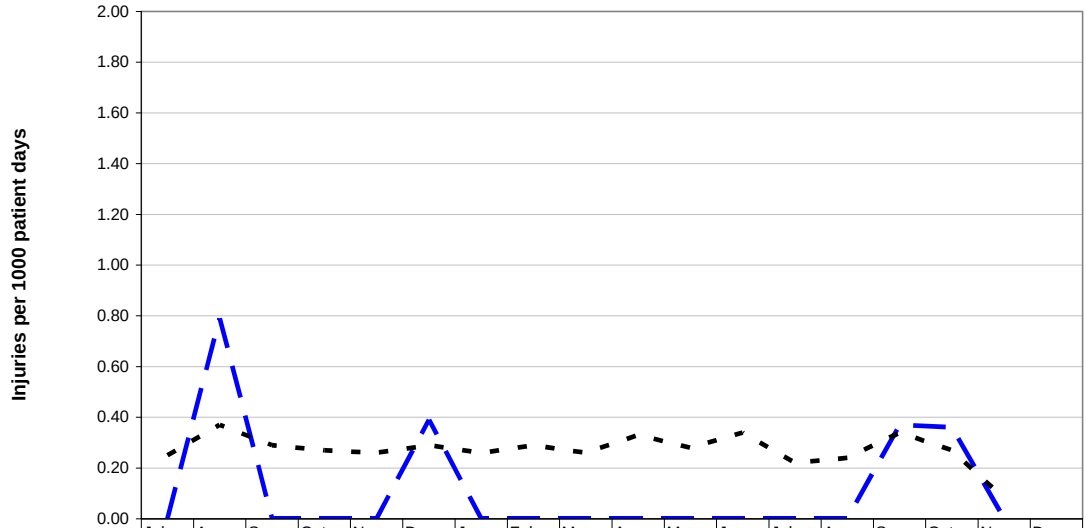
- No Treatment – The injury received by a client may be examined by a clinician but no treatment is applied to the injury.
- Minor First Aid – The injury received is of minor severity and requires the administration of minor first aid.
- Medical Intervention Needed – The injury received is severe enough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

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

COMPARATIVE STATISTICS

Client Injury Rate

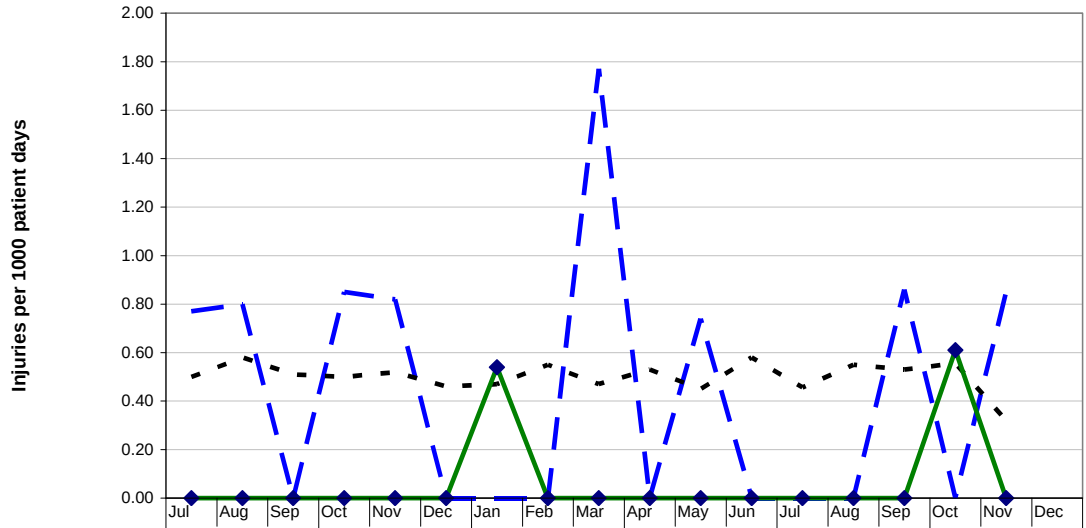
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011			1st SFQ 2012			2nd SFQ 2012		
Riverview	0.00	0.79	0.00	0.00	0.00	0.39	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.37	0.36	0.00	
Ntl Mean	0.25	0.37	0.29	0.27	0.26	0.29	0.26	0.29	0.26	0.33	0.28	0.34	0.22	0.24	0.34	0.27	0.08	

Client Injury Rate

Civil Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011			1st SFQ 2012			2nd SFQ 2012		
Riverview	0.77	0.80	0.00	0.85	0.82	0.00	0.00	0.00	1.77	0.00	0.74	0.00	0.00	0.00	0.86	0.00	0.85	
Ntl Mean	0.50	0.58	0.51	0.50	0.52	0.46	0.47	0.55	0.47	0.53	0.45	0.58	0.46	0.55	0.53	0.56	0.32	
Dorothea Dix	0.00	0.00	0.00	0.00	0.00	0.00	0.54	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.61	0.00	

These graphs depict the number of client injury events stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days. The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

COMPARATIVE STATISTICS

ASPECT: SEVERITY OF INJURY BY MONTH

Severity	Oct	Nov	Dec	2nd FQ 2012
No Treatment	1			1
Minor First Aid		3		3
Medical Intervention Required		1	2	3
Hospitalization Required				0
Death Occurred		1		1
Total	1	5	2	

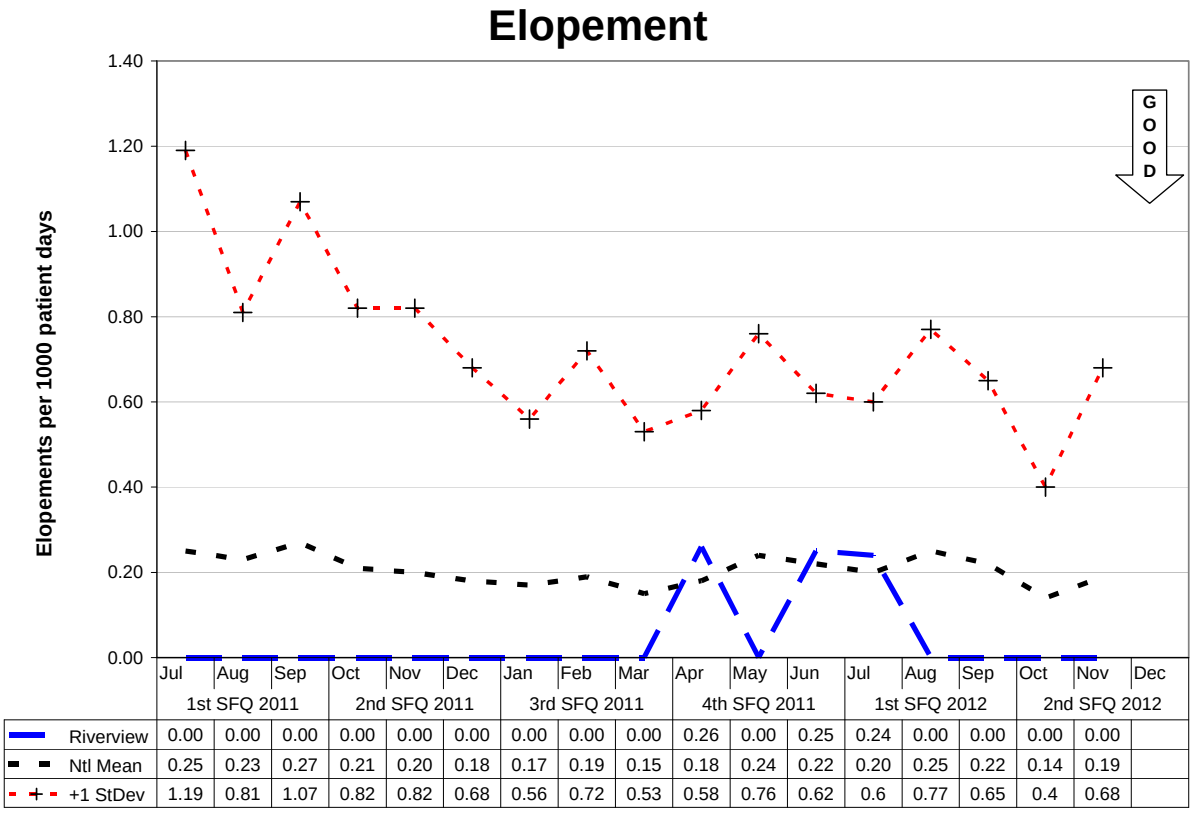
ASPECT: TYPE AND CAUSE OF INJURY BY MONTH

Type - Cause	Oct	Nov	Dec	2nd FQ 2012
Accident – Fall Unwitnessed	1	1	1	3
Accident – Fall Witnessed			1	1
Accident – Other		1		1
Self-Injurious Behavior		3		3

The incident that occurred which resulted in death began on the Lower Saco unit. The client was placed on medical leave prior to the pronouncement of death; therefore the NRI graph for the forensic stratification does not reflect the location of the event as part of the forensic events.

COMPARATIVE STATISTICS

Figure CD-28



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011			1st SFQ 2012			2nd SFQ 2012		
Riverview	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.26	0.00	0.25	0.24	0.00	0.00	0.00	0.00	
Ntl Mean	0.25	0.23	0.27	0.21	0.20	0.18	0.17	0.19	0.15	0.18	0.24	0.22	0.20	0.25	0.22	0.14	0.19	
+1 StDev	1.19	0.81	1.07	0.82	0.82	0.68	0.56	0.72	0.53	0.58	0.76	0.62	0.6	0.77	0.65	0.4	0.68	

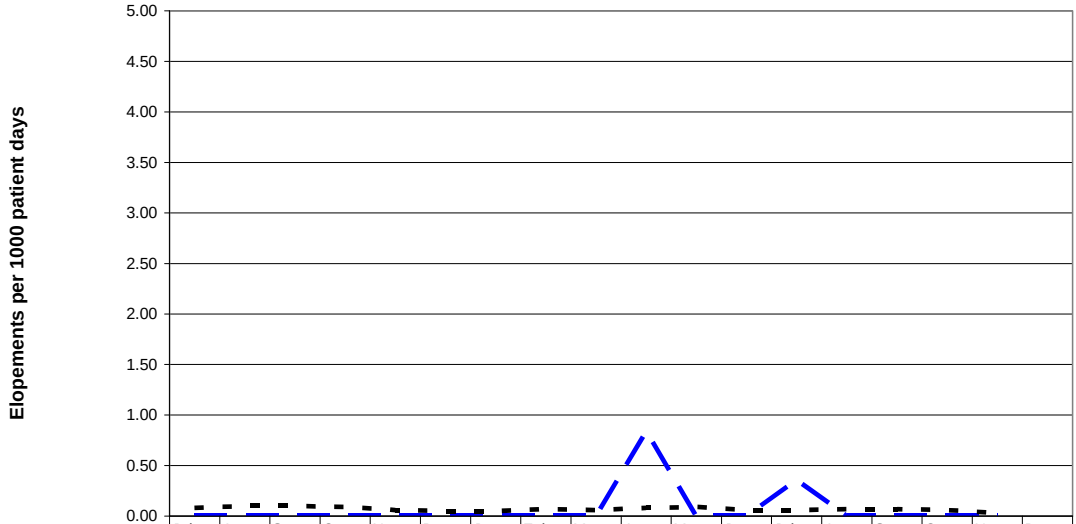
This graph depicts the number of elopements that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days.

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

COMPARATIVE STATISTICS

Elopement

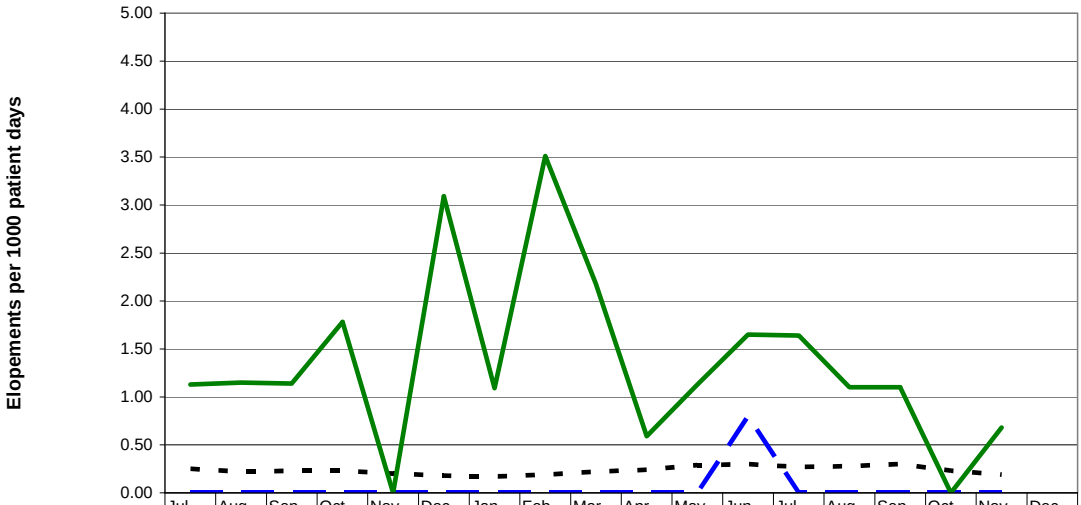
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011			1st SFQ 2012			2nd SFQ 2012		
Riverview	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.84	0.00	0.00	0.36	0.00	0.00	0.00	0.00	
Ntl Mean	0.08	0.10	0.10	0.09	0.06	0.05	0.05	0.07	0.06	0.08	0.09	0.06	0.06	0.07	0.07	0.06	0.03	

Elopement

Civil Stratification

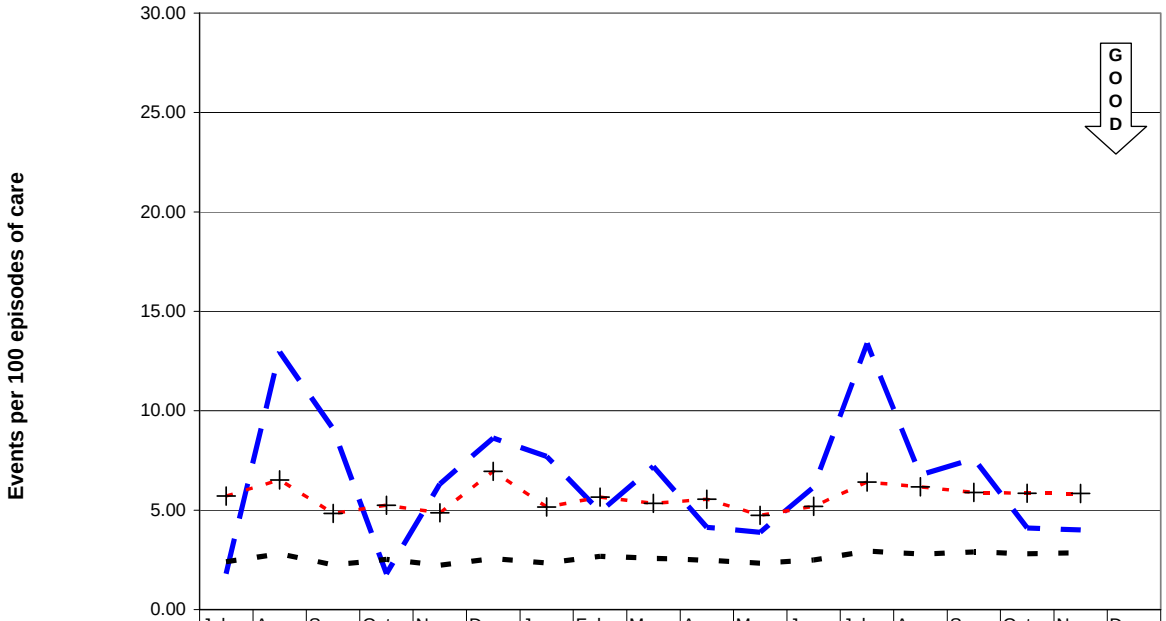


	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011			1st SFQ 2012			2nd SFQ 2012		
Riverview	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.80	0.00	0.00	0.00	0.00	0.00	
Ntl Mean	0.25	0.22	0.23	0.23	0.20	0.18	0.17	0.19	0.22	0.24	0.29	0.30	0.27	0.28	0.30	0.23	0.19	
Dorothea Dix	1.13	1.15	1.14	1.78	0.00	3.09	1.09	3.51	2.18	0.59	1.13	1.65	1.64	1.10	1.10	0.00	0.68	

This graph depicts the number of elopements stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days. The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

COMPARATIVE STATISTICS

Medication Errors



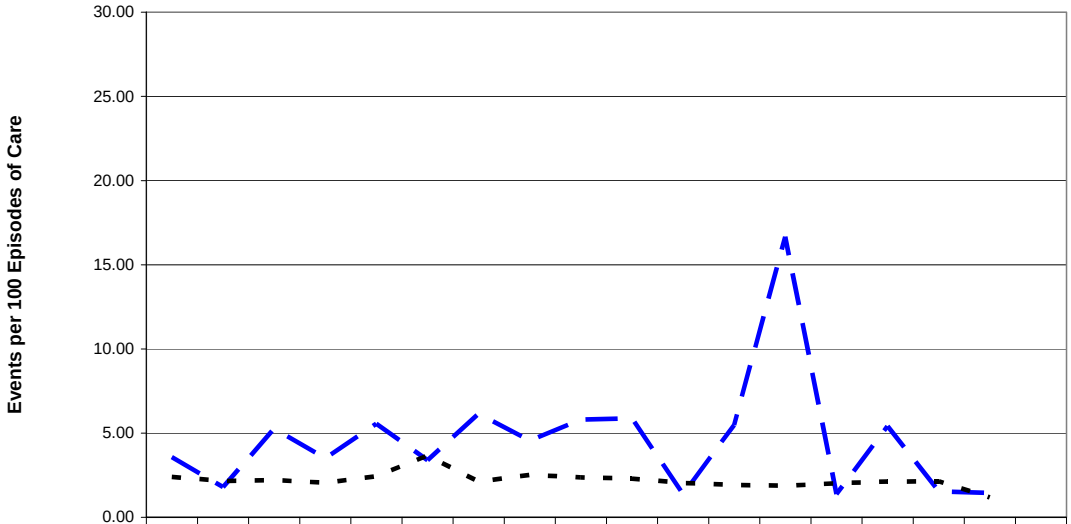
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011			1st SFQ 2012			2nd SFQ 2012		
Riverview	1.80	12.96	9.09	1.79	6.31	8.62	7.69	4.92	7.20	4.13	3.88	6.15	13.39	6.77	7.58	4.10	4.00	
Ntl Mean	2.41	2.79	2.24	2.52	2.23	2.57	2.34	2.68	2.58	2.48	2.33	2.49	2.93	2.80	2.89	2.81	2.86	
Nat Mean +1 StDev	5.71	6.52	4.83	5.25	4.87	6.95	5.16	5.65	5.34	5.55	4.74	5.19	6.41	6.17	5.89	5.85	5.84	

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

COMPARATIVE STATISTICS

Medication Errors

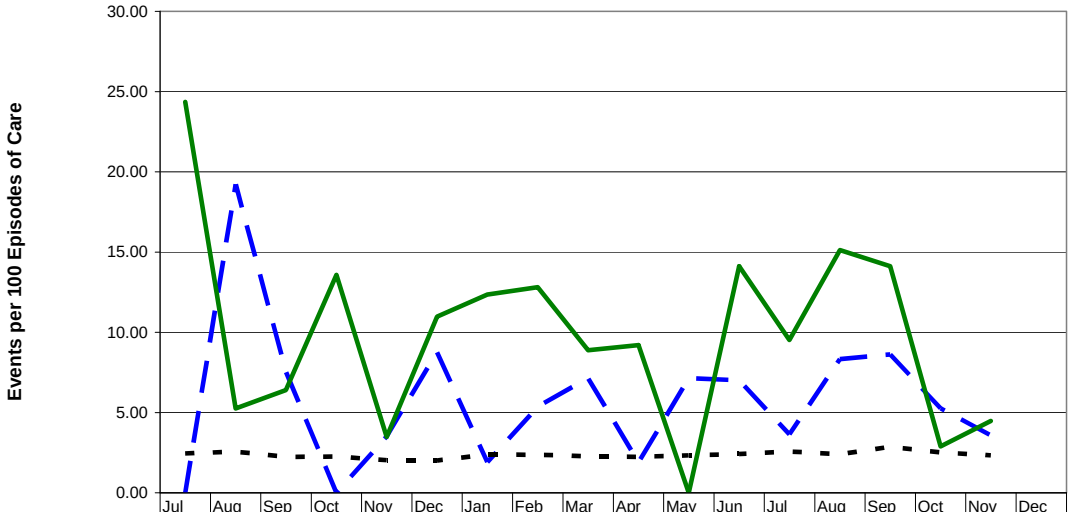
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011			1st SFQ 2012			2nd SFQ 2012		
Riverview	3.57	1.79	5.26	3.51	5.56	3.39	6.15	4.55	5.80	5.88	1.37	5.48	16.67	1.37	5.41	1.54	1.45	
Ntl Mean	2.40	2.16	2.22	2.05	2.44	3.66	2.12	2.51	2.37	2.29	2.04	1.93	1.87	2.02	2.12	2.13	1.18	

Medication Errors

Civil Stratification

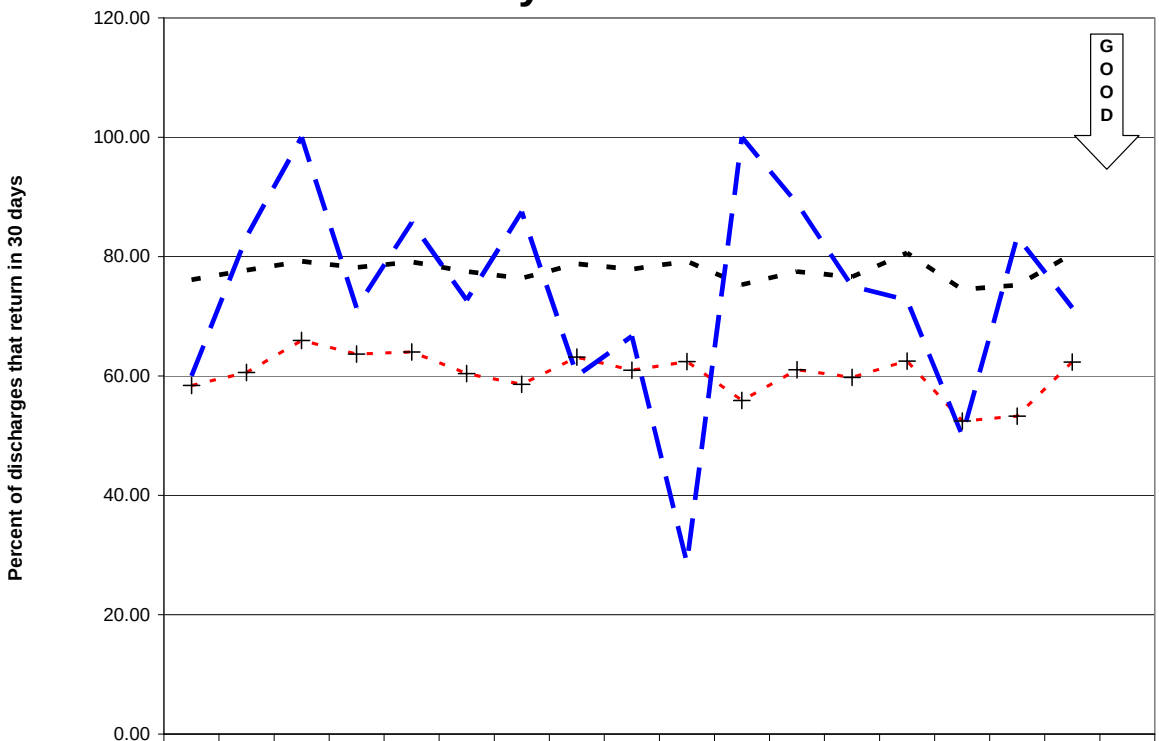


	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011			1st SFQ 2012			2nd SFQ 2012		
Riverview	0.00	19.23	7.55	0.00	3.51	8.77	1.92	5.36	7.14	1.89	7.14	7.02	3.64	8.33	8.62	5.26	3.57	
Ntl Mean	2.46	2.56	2.24	2.26	2.03	2.01	2.39	2.37	2.28	2.24	2.34	2.42	2.57	2.41	2.86	2.52	2.33	
Dorothea Dix	24.36	5.26	6.41	13.58	3.49	10.98	12.36	12.82	8.89	9.21	0.00	14.12	9.52	15.12	14.12	2.90	4.48	

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

COMPARATIVE STATISTICS

30 Day Readmit



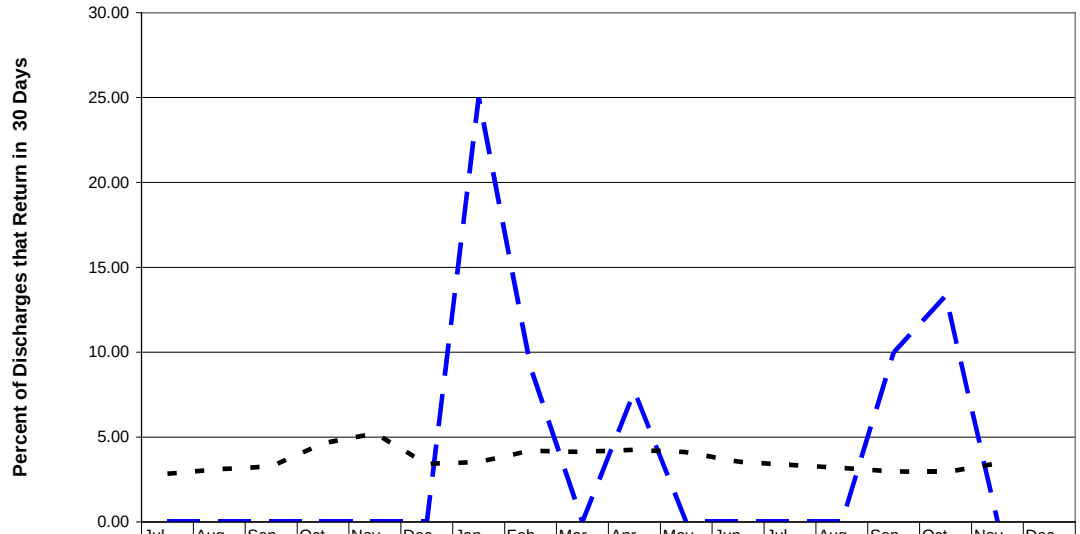
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011			1st SFQ 2012			2nd SFQ 2012		
Ntl Mean	76.12	77.71	79.22	78.19	79.12	77.49	76.35	78.81	77.90	79.21	75.28	77.51	76.63	80.63	74.52	75.21	80.38	
Nat Mean +1 StDec	58.41	60.57	65.96	63.69	64.02	60.38	58.60	63.16	60.99	62.40	55.89	61.04	59.77	62.52	52.45	53.27	62.34	
Riverview	60.00	83.33	100.00	71.43	85.71	72.73	87.50	60.00	66.67	28.57	100.00	88.89	75.00	72.73	50.00	83.33	71.43	

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

COMPARATIVE STATISTICS

30 Day Readmit

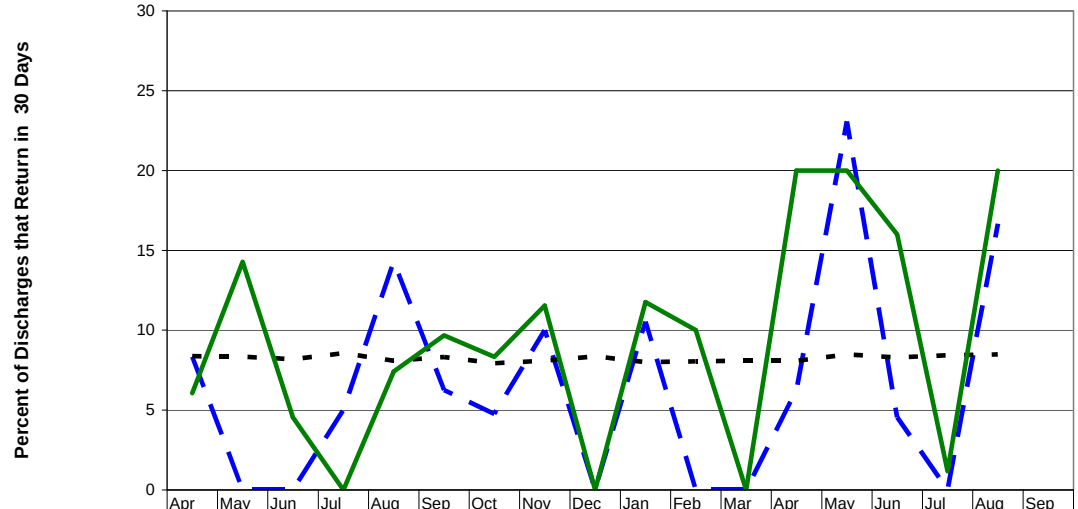
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011			1st SFQ 2012			2nd SFQ 2012		
Riverview	0.00	0.00	0.00	0.00	0.00	0.00	25.00	9.09	0.00	7.69	0.00	0.00	0.00	0.00	10.00	13.33	0.00	
Ntl Mean	2.84	3.11	3.27	4.64	5.21	3.42	3.53	4.19	4.13	4.25	4.11	3.56	3.36	3.18	2.98	2.94	3.45	

30 Day Readmit

Civil Stratification

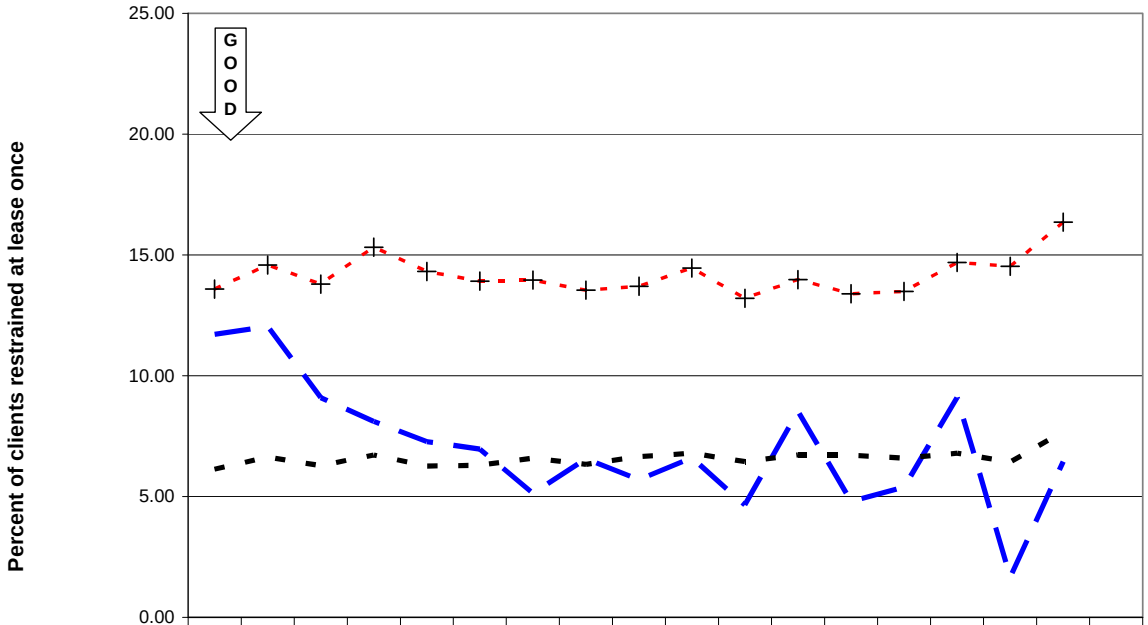


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011			1st SFQ 2012		
Riverview	8.33	0.00	0.00	5.00	14.29	6.25	4.76	10.00	0.00	10.53	0.00	0.00	6.25	23.08	4.55	0.00	16.67	
Ntl Mean	8.38	8.34	8.19	8.56	8.09	8.32	7.93	8.09	8.37	8.01	8.05	8.09	8.09	8.49	8.30	8.43	8.49	
Dorothea Dix	6.06	14.29	4.55	0.00	7.41	9.68	8.33	11.54	0.00	11.76	10.00	0.00	20.00	20.00	16.00	1.17	20.00	

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

COMPARATIVE STATISTICS

Percent of Clients Restrained



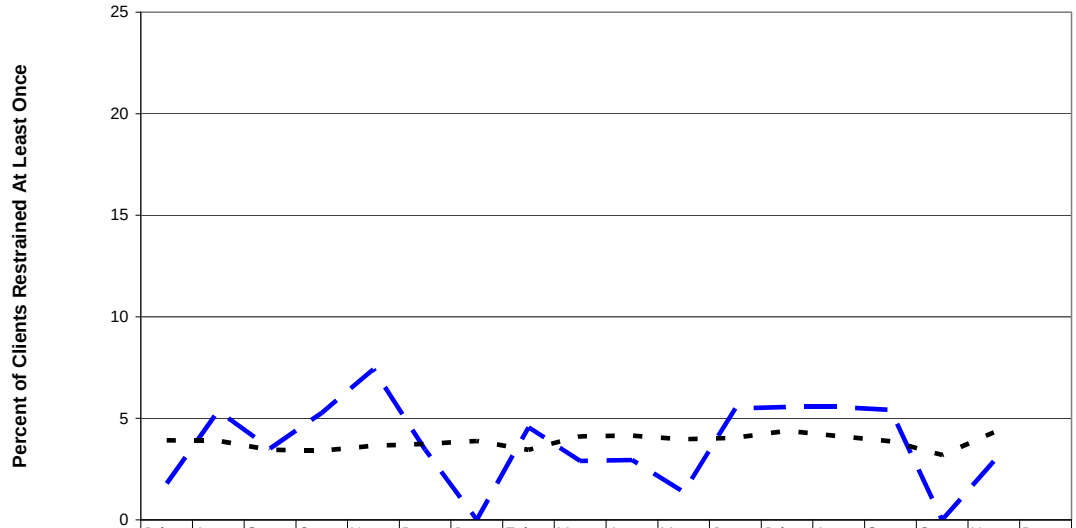
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011			1st SFQ 2012			2nd SFQ 2012		
Riverview	11.71	12.04	9.09	8.11	7.27	6.96	5.13	6.56	5.69	6.61	4.65	8.53	4.80	5.38	9.09	1.65	6.45	
Ntl Mean	6.13	6.63	6.28	6.71	6.26	6.30	6.59	6.33	6.65	6.79	6.45	6.72	6.71	6.59	6.79	6.43	7.68	
Nat Mean +1 St Dev	13.59	14.58	13.79	15.32	14.32	13.92	13.96	13.54	13.7	14.46	13.21	13.98	13.39	13.49	14.69	14.53	16.36	

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

COMPARATIVE STATISTICS

Percent of Clients Restrained

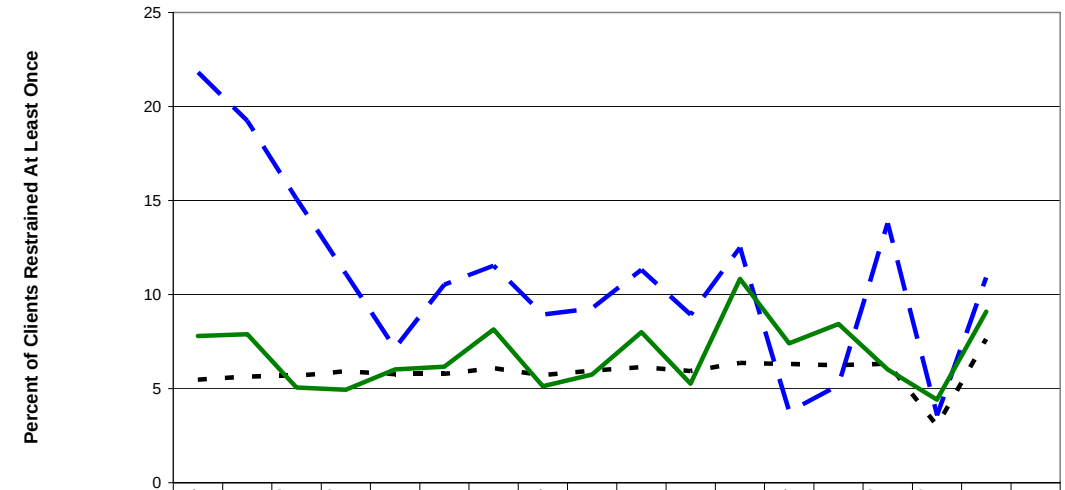
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011			1st SFQ 2012			2nd SFQ 2012		
Riverview	1.79	5.36	3.51	5.26	7.41	3.45	0	4.55	2.9	2.94	1.37	5.48	5.56	5.56	5.41	0	2.9	
Ntl Mean	3.92	3.89	3.45	3.41	3.64	3.74	3.88	3.45	4.11	4.15	3.97	4.04	4.38	4.12	3.87	3.19	4.31	

Percent of Clients Restrained

Civil Stratification

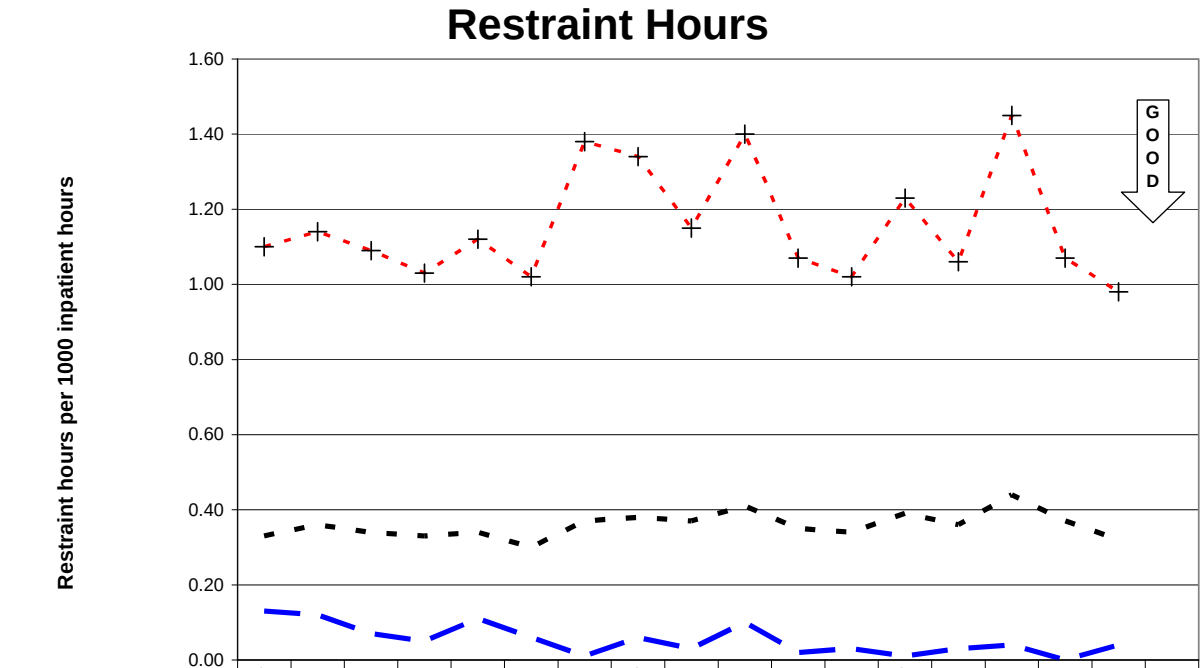


	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011			1st SFQ 2012			2nd SFQ 2012		
Riverview	21.82	19.23	15.09	11.11	7.14	10.53	11.54	8.93	9.26	11.32	8.93	12.5	3.77	5.17	13.79	3.57	10.91	
Ntl Mean	5.48	5.65	5.68	5.93	5.77	5.79	6.09	5.72	5.96	6.14	5.94	6.37	6.31	6.25	6.33	3.02	7.63	
Dorothea Dix	7.79	7.89	5.06	4.94	6.02	6.17	8.14	5.13	5.75	8.00	5.26	10.84	7.41	8.43	6.02	4.41	9.09	

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

COMPARATIVE STATISTICS

Figure CD-24



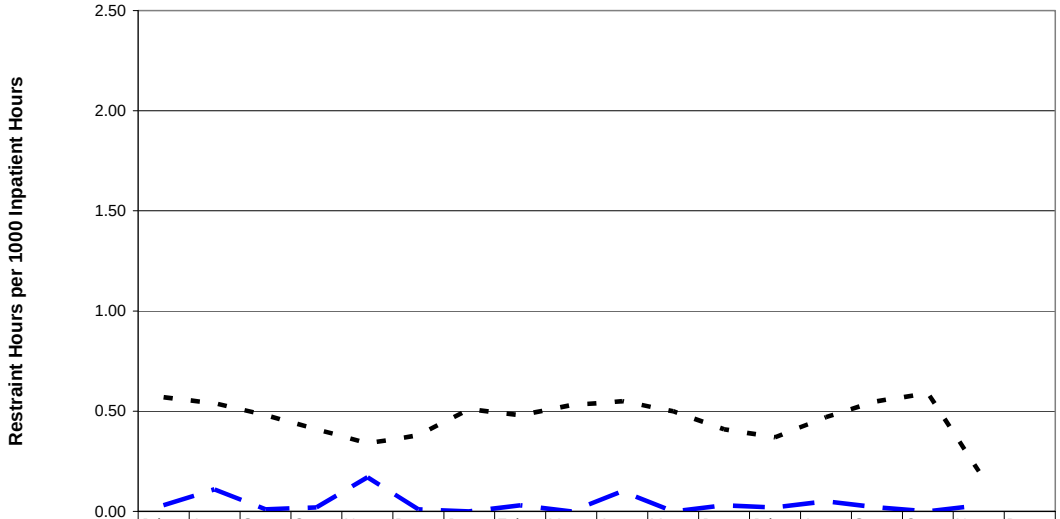
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011			1st SFQ 2012			2nd SFQ 2012		
Riverview	0.13	0.12	0.07	0.05	0.11	0.06	0.01	0.06	0.03	0.10	0.02	0.03	0.01	0.03	0.04	0.00	0.04	
Ntl Mean	0.33	0.36	0.34	0.33	0.34	0.30	0.37	0.38	0.37	0.41	0.35	0.34	0.39	0.36	0.44	0.37	0.32	
Nat Mean +1 StDev	1.1	1.14	1.09	1.03	1.12	1.02	1.38	1.34	1.15	1.4	1.07	1.02	1.23	1.06	1.45	1.07	0.98	

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

COMPARATIVE STATISTICS

Restraint Hours

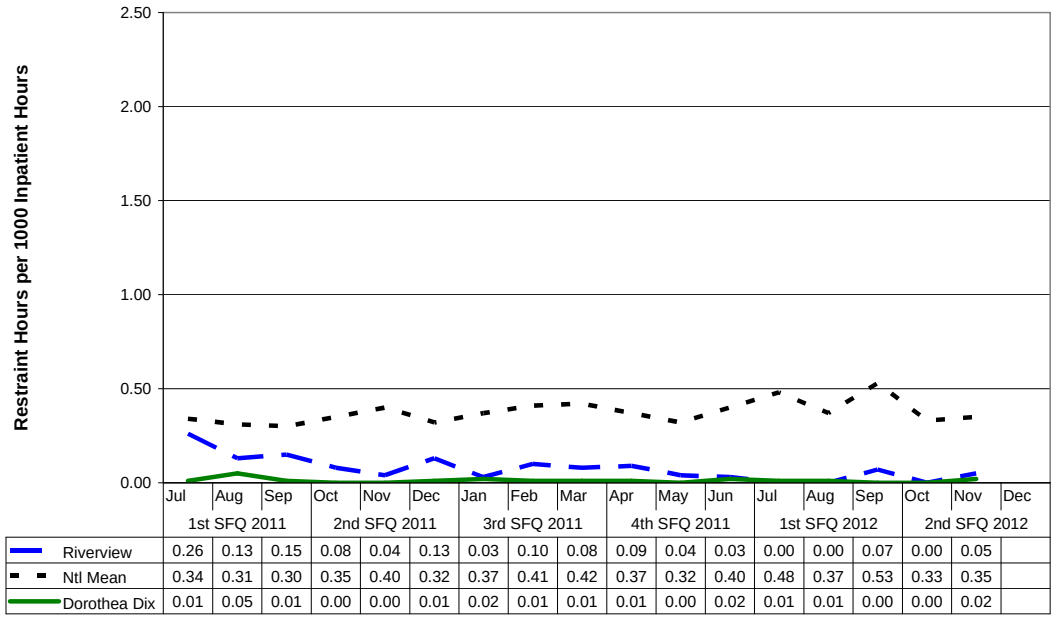
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011			1st SFQ 2012			2nd SFQ 2012		
Riverview	0.03	0.11	0.01	0.02	0.17	0.01	0.00	0.03	0.00	0.10	0.00	0.03	0.02	0.05	0.02	0.00	0.03	
Ntl Mean	0.57	0.54	0.48	0.41	0.34	0.38	0.51	0.48	0.53	0.55	0.50	0.41	0.37	0.47	0.55	0.59	0.20	

Restraint Hours

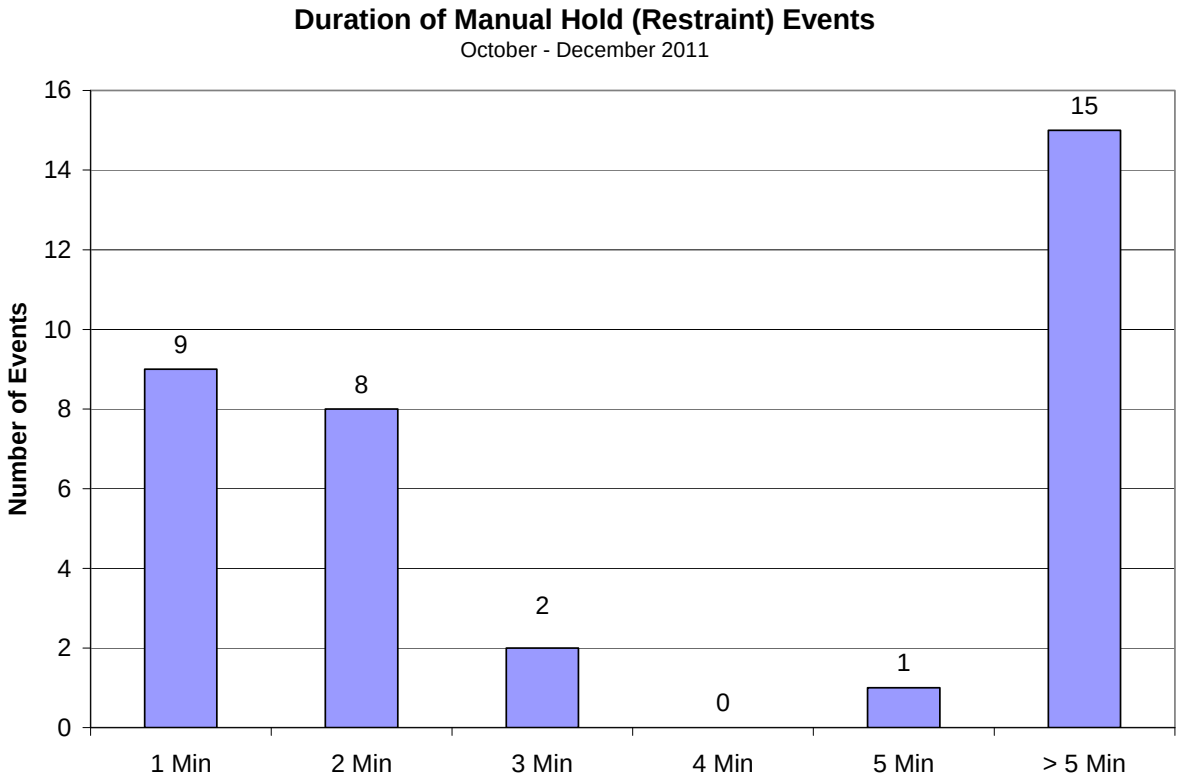
Civil Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011			1st SFQ 2012			2nd SFQ 2012		
Riverview	0.26	0.13	0.15	0.08	0.04	0.13	0.03	0.10	0.08	0.09	0.04	0.03	0.00	0.00	0.07	0.00	0.05	
Ntl Mean	0.34	0.31	0.30	0.35	0.40	0.32	0.37	0.41	0.42	0.37	0.32	0.40	0.48	0.37	0.53	0.33	0.35	
Dorothea Dix	0.01	0.05	0.01	0.00	0.00	0.01	0.02	0.01	0.01	0.01	0.00	0.02	0.01	0.01	0.00	0.00	0.02	

This graph depicts the number of hours clients spent in restraint for every 1000 inpatient hours stratified by forensic or civil classifications - includes all forms of restraint of any duration. For example, a rate of 1.6 means that 2 hours were spent in restraint for each 1250 inpatient hours. The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

COMPARATIVE STATISTICS

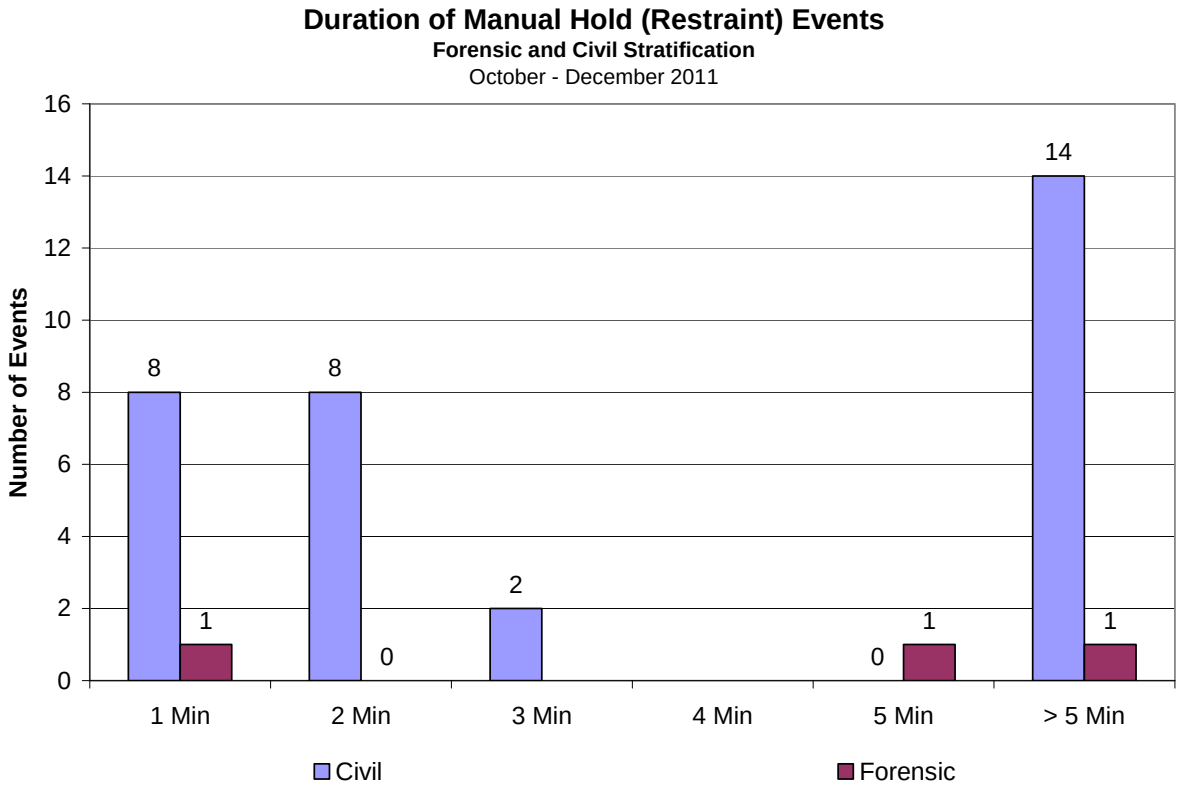


The overall number of manual hold events as well as the number of clients restrained for greater than 5 minutes remained constant during the 1st quarter 2012. The overall decrease in the number of manual holds was 28% during the period (from 45 to 32).

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

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

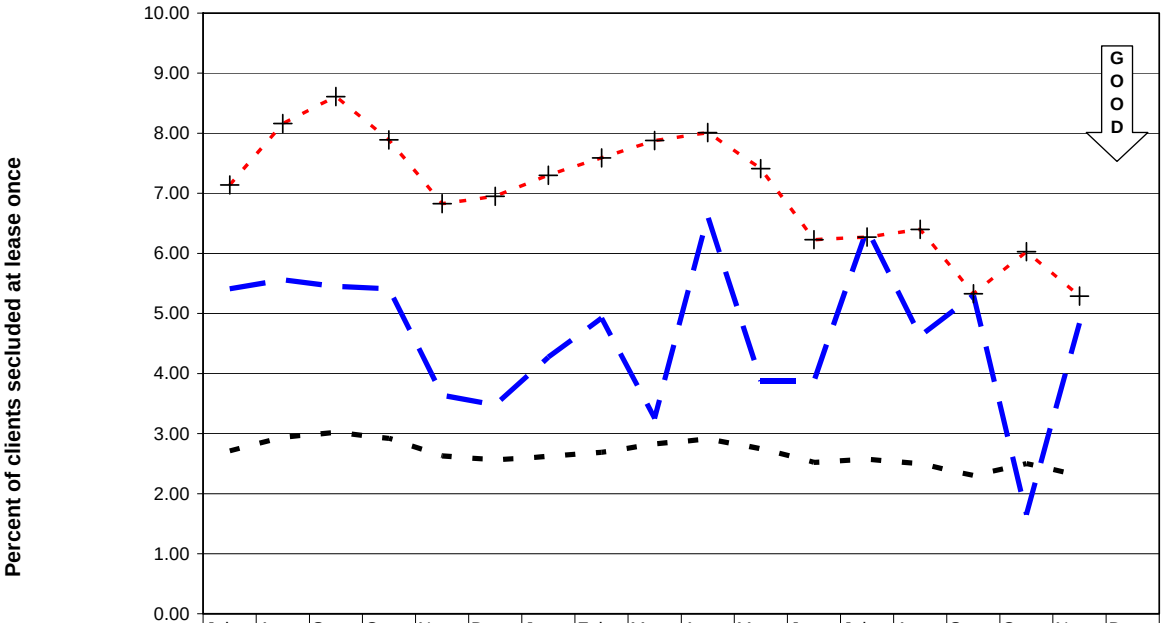
COMPARATIVE STATISTICS



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

COMPARATIVE STATISTICS

Percent of Clients Secluded



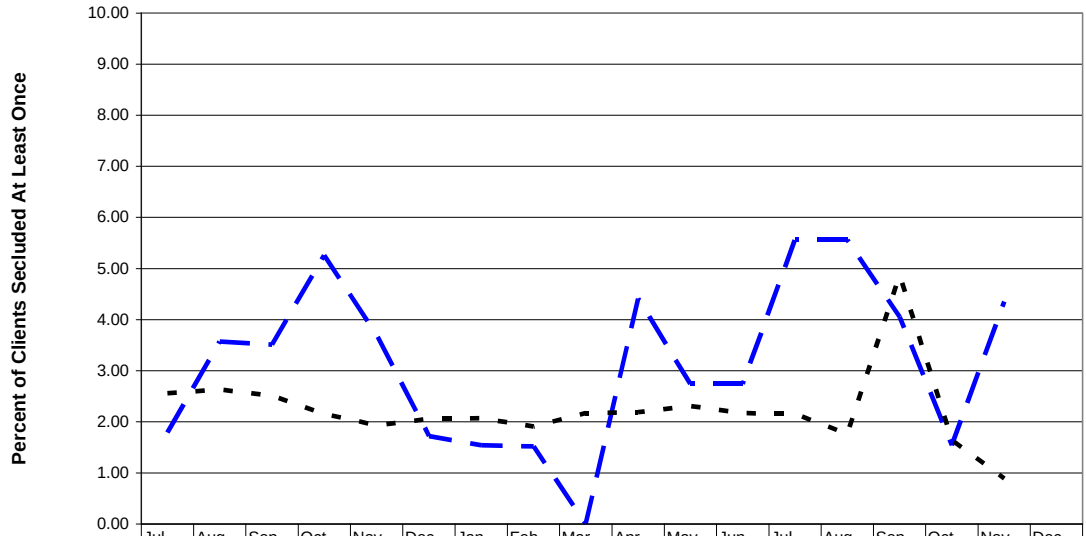
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011			1st SFQ 2012			2nd SFQ 2012		
Riverview	5.41	5.56	5.45	5.41	3.64	3.48	4.27	4.92	3.25	6.61	3.88	3.88	6.40	4.62	5.30	1.65	4.84	
Ntl Mean	2.71	2.94	3.02	2.92	2.63	2.56	2.62	2.69	2.83	2.91	2.75	2.52	2.57	2.50	2.30	2.50	2.30	
Nat Mean +1 St Dev	7.14	8.16	8.61	7.89	6.83	6.95	7.3	7.59	7.88	8.01	7.41	6.23	6.27	6.4	5.33	6.03	5.29	

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

COMPARATIVE STATISTICS

Percent of Clients Secluded

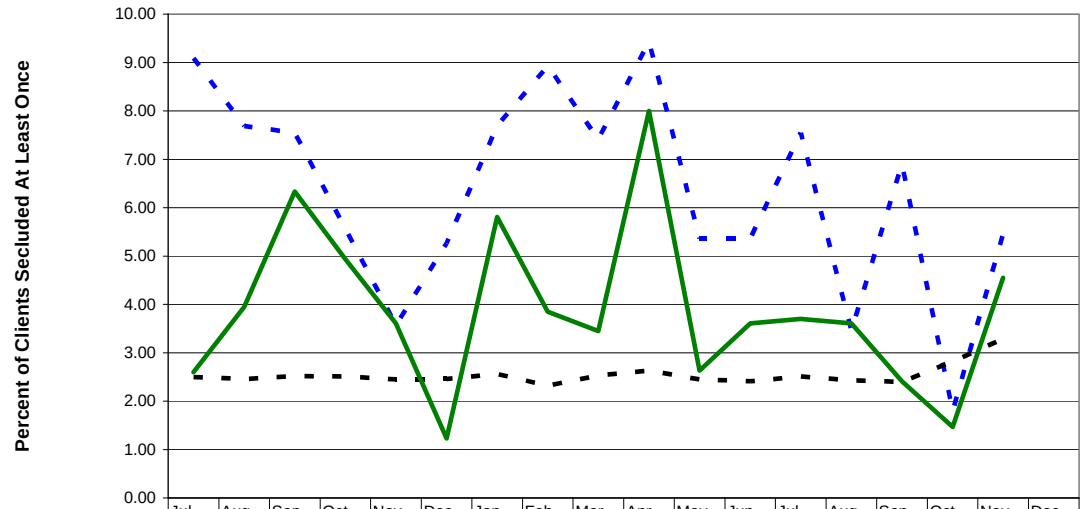
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011			1st SFQ 2012			2nd SFQ 2012		
Riverview	1.79	3.57	3.51	5.26	3.70	1.72	1.54	1.52	0.00	4.41	2.74	2.74	5.56	5.56	4.05	1.54	4.35	
Ntl Mean	2.56	2.63	2.51	2.15	1.93	2.06	2.07	1.91	2.17	2.19	2.31	2.17	2.16	1.76	4.86	1.64	0.89	

Percent of Clients Secluded

Civil Stratification

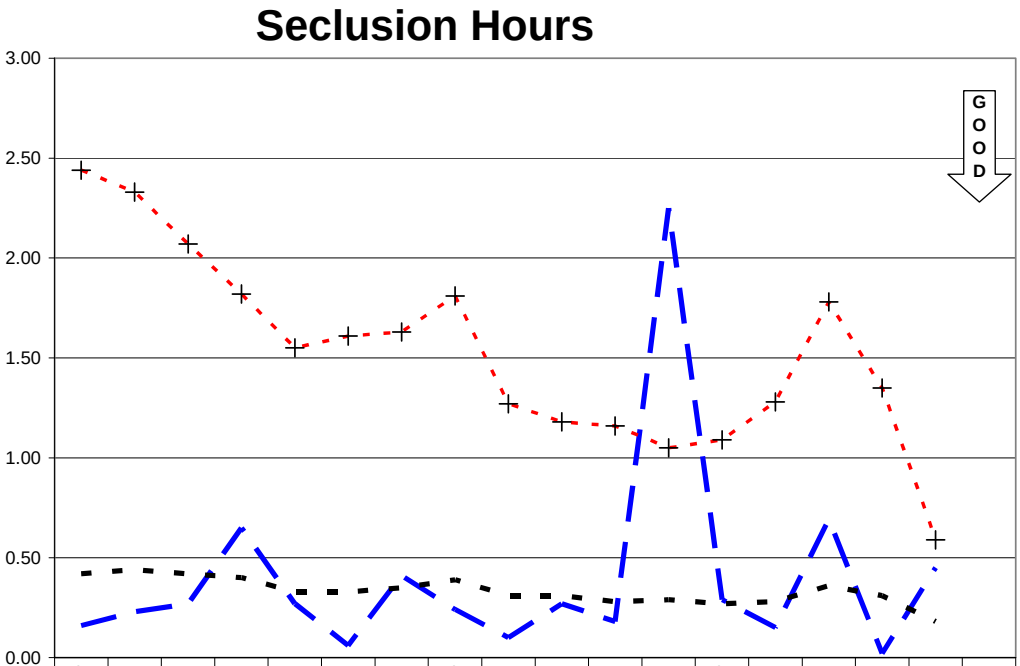


	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011			1st SFQ 2012			2nd SFQ 2012		
Riverview	9.09	7.69	7.55	5.56	3.57	5.26	7.69	8.93	7.41	9.43	5.36	5.36	7.55	3.45	6.9	1.79	5.45	
Ntl Mean	2.50	2.46	2.52	2.51	2.45	2.46	2.56	2.32	2.53	2.63	2.45	2.41	2.51	2.43	2.4	2.82	3.29	
Dorothea Dix	2.60	3.95	6.33	4.94	3.61	1.23	5.81	3.85	3.45	8.00	2.63	3.61	3.70	3.61	2.41	1.47	4.55	

This graph depicts the percent of unique clients who were secluded at least once stratified by forensic or civil classifications. For example, a rate of 3.0 means that 3% of the unique clients served were secluded at least once. The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

COMPARATIVE STATISTICS

Figure CD-23



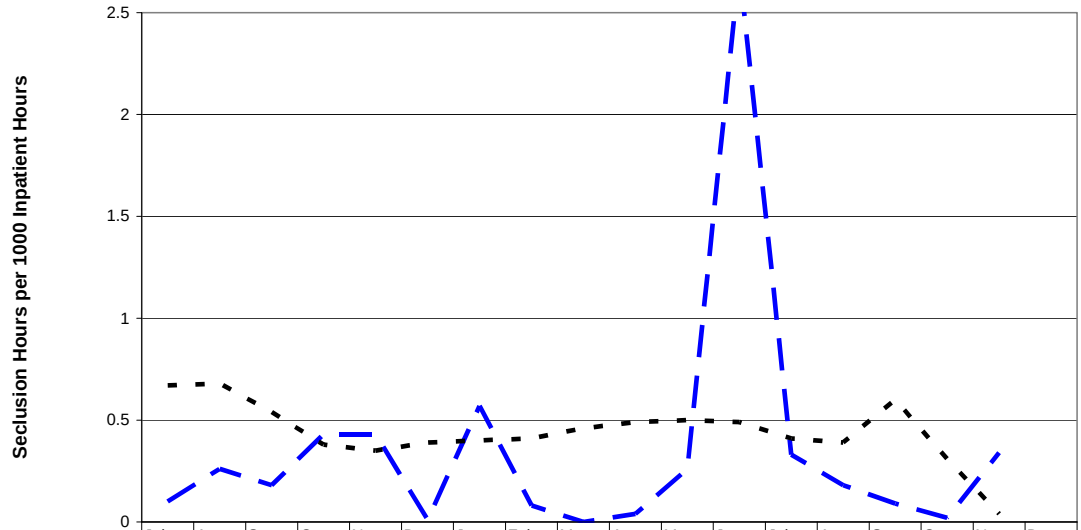
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011			1st SFQ 2012			2nd SFQ 2012		
Riverview	0.16	0.23	0.27	0.65	0.27	0.06	0.41	0.24	0.10	0.27	0.18	2.25	0.29	0.15	0.69	0.02	0.45	
Ntl Mean	0.42	0.44	0.42	0.40	0.33	0.33	0.35	0.39	0.31	0.31	0.28	0.29	0.27	0.28	0.36	0.31	0.18	
Nat Mean +1 StDev	2.44	2.33	2.07	1.82	1.55	1.61	1.63	1.81	1.27	1.18	1.16	1.05	1.09	1.28	1.78	1.35	0.59	

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

COMPARATIVE STATISTICS

Seclusion Hours

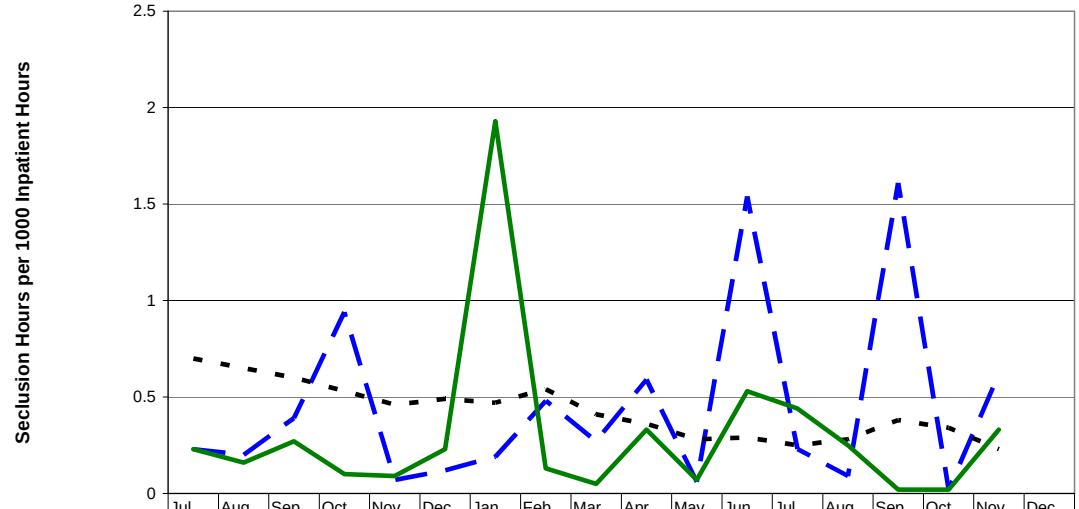
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011			1st SFQ 2012			2nd SFQ 2012		
Riverview	0.1	0.26	0.18	0.43	0.43	0.01	0.57	0.08	0	0.04	0.26	2.72	0.33	0.18	0.09	0.02	0.34	
Ntl Mean	0.67	0.68	0.54	0.38	0.35	0.39	0.4	0.41	0.46	0.49	0.5	0.49	0.41	0.39	0.6	0.31	0.04	

Seclusion Hours

Civil Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011			4th SFQ 2011			1st SFQ 2012			2nd SFQ 2012		
Riverview	0.23	0.2	0.39	0.94	0.07	0.12	0.19	0.48	0.27	0.59	0.06	1.54	0.23	0.09	1.61	0.02	0.62	
Ntl Mean	0.7	0.65	0.6	0.53	0.46	0.49	0.47	0.54	0.41	0.36	0.28	0.29	0.25	0.28	0.38	0.34	0.23	
Dorothea Dix	0.23	0.16	0.27	0.10	0.09	0.23	1.93	0.13	0.05	0.33	0.07	0.53	0.44	0.25	0.02	0.02	0.33	

This graph depicts the number of hours clients spent in seclusion for every 1000 inpatient hours stratified by forensic or civil classifications. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours. The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

COMPARATIVE STATISTICS

Confinement Event Breakdown

	Manual Hold	Mechanical Restraint	Locked Seclusion	Open Seclusion	Grand Total	% of Total	Cumulative %
MR00005267	4		2	1	7	16%	16%
MR00000657	2	2	2		6	14%	30%
MR00003726	2		2		4	9%	40%
MR00005625	4				4	9%	49%
MR00006566	2		2		4	9%	58%
MR00000085			3		3	7%	65%
MR00000116	2				2	5%	70%
MR00002824	1		1		2	5%	74%
MR00004575	1		1		2	5%	79%
MR00006513	1		1		2	5%	84%
MR00000076	1				1	2%	86%
MR00000092	1				1	2%	88%
MR00000145	1				1	2%	91%
MR00000480	1				1	2%	93%
MR00004769			1		1	2%	95%
MR00006517			1		1	2%	98%
MR00006562	1				1	2%	100%
Grand Total	24	2	16	1	43		

22% (18/81) of average hospital population experienced some form of confinement event during the 2nd fiscal quarter 2012. Eleven of these clients (14% of the average hospital population) accounted for 86% of the containment events.

Figure CD-25, CD-26

Factors of Causation Related to All Confinement Events

(Manual Hold, Mechanical Restraint, Seclusion)

Year Ending Sep 2012	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Danger to Others/Self	15	33	27	27	17	57	24	19	42	3	22	16
Danger to Others	4	1		5	1	7				1		
Danger to Self		1		1							1	
% Dangerous Precipitation	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total Events	19	35	27	33	18	64	24	19	42	4	23	16

COMPARATIVE STATISTICS

Figure CD-42

Confinement Events Management

Seclusion Events (17) Events

Standard	Threshold	Compliance
The record reflects that seclusion was absolutely necessary to protect the patient from causing physical harm to self or others, or if the patient was examined by a physician or physician extender prior to implementation of seclusion, to prevent further serious disruption that significantly interferes with other patients' treatment.	95%	100%
The record reflects that lesser restrictive alternatives were inappropriate or ineffective. This can be reflected anywhere in record.	90%	100%
The record reflects that the decision to place the patient in seclusion was made by a physician or physician extender.	90%	100%
The decision to place the patient in seclusion was entered in the patient's records as a medical order.	90%	100%
The record reflects that, if the physician or physician extender was not immediately available to examine the patient, the patient was placed in seclusion following an examination by a nurse.	90%	100%
The record reflects that the physician or physician extender personally evaluated the patient within 30 minutes after the patient has been placed in seclusion, and if there is a delay, the reasons for the delay.	90%	100%
The record reflects that the patient was monitored every 15 minutes. (Compliance will be deemed if the patient was monitored at least 3 times per hour.)	90%	100%
Individuals implementing seclusion have been trained in techniques and alternatives.	90%	100%
The record reflects that reasonable efforts were taken to notify guardian or designated representative as soon as possible that patient was placed in seclusion.	75%	100%
The medical order states time of entry of order and that number of hours in seclusion shall not exceed 4.	85%	100%
The medical order states the conditions under which the patient may be sooner released.	85%	100%
The record reflects that the need for seclusion is re-evaluated at least every 2 hours by a nurse.	90%	100%
The record reflects that the 2 hour re-evaluation was conducted while the patient was out of seclusion room unless clinically contraindicated.	70%	100%
The record includes a special check sheet that has been filled out to document reason for seclusion, description of behavior and the lesser restrictive alternatives considered.	85%	100%
The record reflects that the patient was released, unless clinically contraindicated, at least every 2 hours or as necessary for eating, drinking, bathing, toileting or special medical orders.	85%	100%
Reports of seclusion events were forwarded to medical director and advocate.	90%	100%
The record reflects that, for persons with mental retardation, the regulations governing seclusion of clients with mental retardation were met.	85%	100%
The medical order for seclusion was not entered as a PRN order.	90%	100%
Where there was a PRN order, there is evidence that physician was counseled.	95%	N/A

COMPARATIVE STATISTICS

Figure CD-43

Confinement Events Management

Mechanical Restraint Events (2) Events

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

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

COMPARATIVE STATISTICS

Medication Administration during Behavioral Events

Calendar 2011	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
COURTN		3		1		2	1						7
COURTY					1		1				1		3
GUARDN	2	6	9	12	2	1					1	6	39
GUARDY		7	11	7	4	1		1	1			1	33
PEMEDSN	1	4	1	3	1	8		1	8	2	4		33
PEMEDSY	1	2	5	6	5	13	2	1	3		3	8	50
PRNY	10	14	11	11	12	31	7	6	15	10	12	14	153
Total Meds Admin	14	36	37	40	25	56	11	9	27	12	21	29	317
Percent Unwilling	21.4	35.2	27.0	40.0	12.0	19.6	9.1	11.1	29.6	16.6	23.8	20.7	24.9

2nd FQ 2012	MANUALHOLD	SEC-LOCKED	SEC-OPEN
COURTN	1		
COURTY	1		
GUARDN	6		
GUARDY		1	
PEMEDSN	3	2	
PEMEDSY		4	
PRNY	8	6	1
Total	19	13	1

A manual hold is often required to temporarily secure the client and protect their safety during the administration of an intramuscular injection of ordered medication.

2nd FQ 2012	GUARDN	PEMEDSN	TOTAL
MR00005625	6		6
MR00002824		2	2
MR00000145		1	1
MR00000657		1	1
MR00006513		1	1
MR00006517		1	1
MR00006566	1		1
Total	7	6	13

All unwilling administrations of medications were supported by a court order, a guardian order, or the declaration of a psychiatric emergency.

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

DIETARY

ASPECT: CLEANLINESS OF MAIN KITCHEN

Indicators	Quarterly % Compliance						Threshold Percentile
	Oct. '11-Dec. '11	Jul. '11-Sep. '11	Apr '11-Jun '11	Jan. '11-Mar. '11	Oct. '10-Dec. '10	Jul. '10-Sep. '10	
1. All convection ovens (4) were thoroughly cleaned monthly.	100% (12 of 12)	75% (9 of 12)	100% (12 of 12)	100% (12 of 12)	75% (9 of 12)	92% (11 of 12)	100%
2. Dish machine was de-limed monthly	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100%
3. Shelves (6) used for storage of clean pots and pans were cleaned monthly	100% (18 of 18)	100% (18 of 18)	100% (9 of 9)	100% (18 of 18)	100% (18 of 18)	100% (18 of 18)	100%
4. Knife cabinet was thoroughly cleaned monthly	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100%
5. Walk in coolers were cleaned thoroughly monthly.	100% (6 of 6)	100% (6 of 6)	100% (6 of 6)	100% (6 of 6)	100% (6 of 6)	100% (6 of 6)	100%
6. Steam kettles (2) were cleaned thoroughly on a weekly basis	77% (20 of 26)	54% (14 of 26)	100% (26 of 26)	100% (26 of 26)	69% (18 of 26)	93% (26 of 28)	95%
7. All trash cans (4) and bins (1) were cleaned daily	98.7% (454 of 460)	99% (548 of 552)	97% (530 of 546)	89% (401 of 450)	98.9% (455 of 460)	97% (445 of 460)	95%
8. All carts(9) used for food transport (tiered) were cleaned daily	100% (828 of 828)	100% (828 of 828)	99.4% (814 of 819)	97.7% (792 of 810)	98% (812 of 828)	98% (811 of 828)	100%
9. All hand sinks (4) were cleaned daily	100% (368 of 368)	100% (368 of 368)	100% (364 of364)	100% (360 of 360)	95.6% (352 of 368)	98% (360 of 368)	95%
10. Racks(3) used for drying dishes were cleaned daily	96.7% (267of 276)	98% (270 of 276)	98.9% (270 of 273)	98.8% (267 of 270)	99% (273 of 276)	99% (273 of 276)	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.

DIETARY

- The improvement seen with cleaning of the convection ovens is due to the task being completed by the Food Service Manager and the Clinical Dietitian. This was completed by these job classifications due to a staff shortage in the department.
- The improvement seen with cleaning of the steam kettles was due to a team effort of the Dietary staff.
- There was a slight decrease seen within one area of the cleaning tasks; the racks used for drying dishes.

Overall Compliance: 98.9%

Actions:

- The steam kettles will be cleaned by the FSW classification and the four ovens will be cleaned by each of four different cooks. These changes are due to staffing changes within the department.
- FSM reviews all daily cleaning schedules on a daily basis to assure staff completion.
- FSM will review the status of the all weekly and monthly cleaning tasks and assure completion.
- Cleaning schedules will be modified to reflect changes in staff availability.
- The weekly staff meeting includes review of the past weeks completion rates.
- Results of this CPI indicator will be discussed with staff.

ASPECT: TIMELINESS OF NUTRITIONAL ASSESSMENT

Indicator	Quarterly % Compliance						Threshold Percentile
	Oct. '11-Dec. '11	Jul. '11-Sep. '11	April 2011-June 2011	Jan. '11-Mar. '11	Oct. '10-Dec. '10	Jul. '10-Sep. '10	
A nutrition assessment is completed within 5 days of admission when risk is identified via the nutrition	100% (63 of 63)	100% (87 of 87)	100% (76 of 76)	100% (75 of 75)	97.4% (74 of 76)	100% (59 of 59) (New Indicator)	100%

Summary

All assessments completed within 5 days of admission.

Overall Compliance: 100%

Actions

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

HARBOR TREATMENT MALL

Aspect: Harbor Mall Hand-off Communication

Indicators	Findings	Compliance	Threshold Percentile
1. Hand-off communication sheet was received at the Harbor Mall within the designated time frame.	23 of 42	55%	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.	17 of 42	40%	100%
4. SBAR information completed from the Harbor Mall to the receiving unit.	40 of 42	95%	100%

Summary

This is the second quarterly report for this year. All units were made aware of the criteria that would be monitored in order to ensure that the hand-off communication process for the Harbor Mall is being done properly. Indicator number one was 62% for the first quarter and dropped to 55% for this quarter. Indicator number two was 98% for the first quarter and increased to 100% for this quarter. Indicator number three was 43% in the first quarter and has dropped to 40% for this quarter. Indicator number four was 76% in the first quarter and has increased to 95% for this quarter.

Indicator #1-Nineteen of the hand-off communication sheets did not arrive to the Harbor Mall within the allotted time frame and twenty three did. This sheet is to be brought to the mall no later than 5 minutes before the start of groups and this did not happen on nineteen of the sheets that were reviewed for this quarter. The PSD for the mall will remind each of the units what the protocol is for the hand-off sheet to ensure that the information reaches the mall in time to be relayed to group leaders.
Indicator #2- One of the hand-off communication sheets was not brought to the mall during the first quarter so one RN signature was missing. Indicator#2 was 100% for this quarter.
Indicator #3- Twenty-five of the 42 sheets reviewed did not have any client concerns or comments from the unit(s) written for the Harbor Mall and/or did not state no issues to report on the HOC. Seventeen of the sheets reflected concerns or comments from the unit. The PSD for the Harbor Mall will review the need for accuracy in completing the HOC sheet with each of the units.
Indicator #4 – Two of the 42 sheets reviewed did not have any client concerns or comments from the Harbor Mall back to the units and/or did not state know issues to report on the HOC sheet. Forty of the sheets did reflect concern or comments from the Harbor Mall. The PSD will remind Harbor Mall staff to complete issues/concerns section.

Actions

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

HEALTH INFORMATION MANAGEMENT

ASPECT: DOCUMENTATION & TIMELINESS

Indicators	Findings	2nd Qtr 2012	1st Qtr 2012	4th Qtr 2011	3rd Qtr 2011	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	There were 67 discharges in quarter 2 2012. Of those, 65 were completed by 30 days.	97 %	97 %	79 %	49 %	80%
Discharge summaries will be completed within 15 days of discharge.	67 out of 67 discharge summaries were completed within 15 days of discharge during quarter 2 2012.	100 %	99 %	100 %	100 %	100%
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	2 forms were approved/ revised in quarter 2 2012 (see minutes).	100%	100%	100%	100%	100%
Medical transcription will be timely and accurate.	Out of 1208 dictated reports, 1078 were completed within 24 hours.	89%	93%	86%	84%	90%

Summary

The indicators are based on the review of all discharged records. There was 97% 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 89% compliance with timely & accurate medical transcription services.

Actions

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

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.	2724 requests for information (204 requests for client information and 2520 police checks) were released for quarter 2 2012	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	28 new employees/contract staff in quarter 2 2012.	100%	100%
Confidentiality/Privacy issues tracked through incident reports.	2 privacy-related incident reports during quarter 2 2012.	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 related to release of information from the Health Information department and training of new employees/contract staff, however compliance with current law and HIPAA regulations need to be strictly adhered to requiring training, education and policy development at all levels.

Due to challenges with staffing levels and the need to ensure that requests for information that impact the ongoing psychiatric or medical care of clients or contribute to the legal process for those with legal commitments, several police checks from this quarter are outstanding. Police checks are one step in the process of applying for or renewing applications for concealed weapons permits but are a secondary priority when compared to other clinical or legal needs. Delays in acquiring this information can delay the completion of an application by a Maine resident.

Actions

The above indicators will continue to be monitored.

HOUSEKEEPING

ASPECT: LINEN CLEANLINESS AND QUALITY

Indicators	Quarterly % Compliance						Threshold Percentile
	Oct. '11-Dec. '11	Jul. '11-Sep. '11	Apr. '11-Jun. '11	Jan. '11-Mar. '11	Oct. '10-Dec. '10	Jul. '10-Sep. '10	
1. Was linen clean coming back from vendor?	88% (22 of 25)	80% (24 of 30)	98% (45 of 46)	100% (34 of 34)	100% (53 of 53)	96% (23 of 24)	100%
2. Was linen free of any holes or rips coming back from vendor?	88% (22 of 25)	97% (29 of 30)	98% (45 of 46)	92% (31 of 34)	100% (53 of 53)	92% (22 of 24)	95%
3. Did we have enough linen on units via complaints from unit staff?	100% (25 of 25)	100% (30 of 30)	98% (45 of 46)	88% (30 of 34)	96% (51of 53)	92% (22 of 24)	90%
4. Was linen covered on units?	100% (25 of 25)	100% (30 of 30)	100% (46 of 46)	97% (33 of 34)	100% (53 of 53)	100% (24 of 24)	95%
5. Did vendor provide a 24 hr. turn around service as specified in the contract?	100% (25 of 25)	100% (30 of 30)	96% (44 of 46)	97% (33 of 34)	96% (51 of 53)	79% (19 of 24)	100%
6. Did we receive an adequate supply of mops and rags from vendor?	100% (25 of 25)	100% (30 of 30)	98% (45 of 46)	97% (33 of 34)	100% (53 of 53)	100% (24 of 24)	95%
7. Was linen bins clean returning from vendor?	100% (25 of 25)	93% (28 of 30)	87% (40 of 46)	100% (34 of 34)	100% (53 of 53)	100% (24 of 24)	100%
8. Was the linen manifest accurate from the vendor	40% (10 of 25)	77% (23 of 30)	89% (41 of 46)	88% (30 of 34)	96% (51 of 53)	31% (5 of 16) (New)	85%

Summary

Eight different criteria are to be met for acceptability. The indicators are based on the inspections of linen closets throughout the facility including the returned linen from the vendor. All linen types were reviewed randomly this quarter. All indicators are within threshold percentiles except for indicators #1, #2, & #8.

The overall compliance for this quarter was 89.5%. This is shows a 3.5% decrease from last quarters' report.

HOUSEKEEPING

1. (Indicator #8) inadequate supply of linen (blankets, towels, and wash cloths) were not coming back from vendor
2. Linen coming back from the vendor was pick colored instead of white (3 occurrences) (indicator #1).
3. Linen returned from vendor had holes & rips (Indicator # 2)

Actions

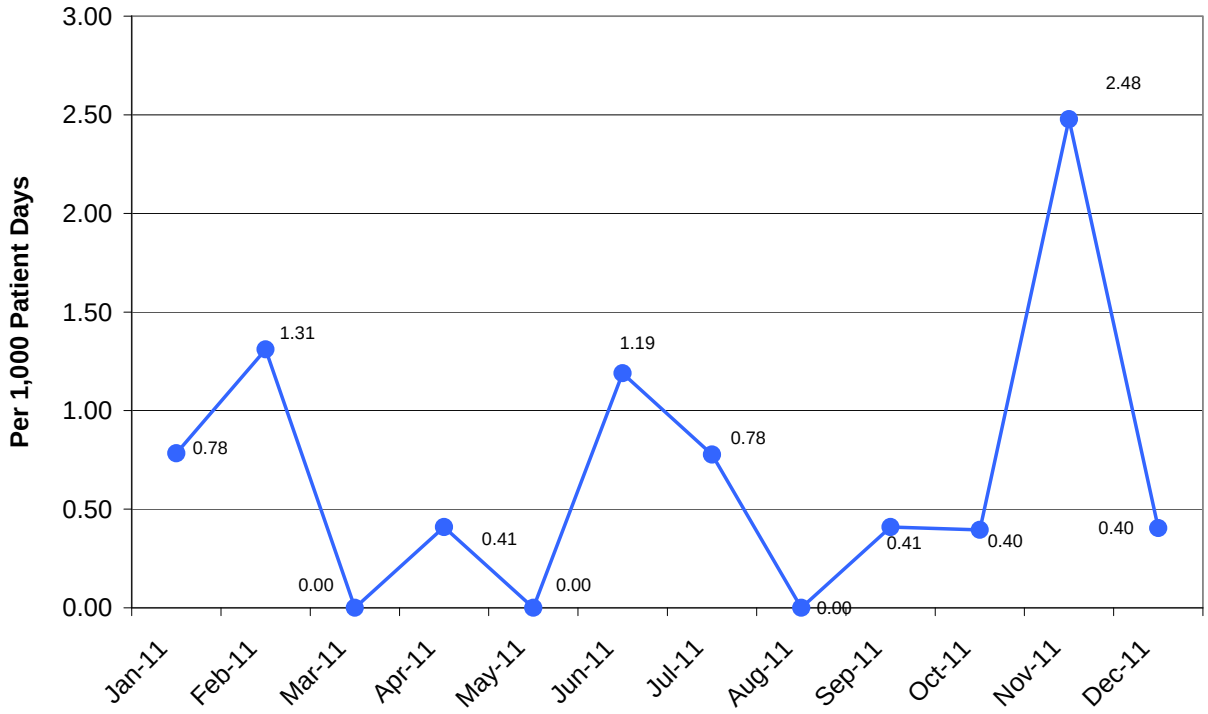
The Housekeeping Department has done the following actions to remedy the above problem indicators:

1. Housekeeping Supervisor will monitor how many blankets are being sent out to be cleaned and how many return from vendor.
2. Housekeeping Supervisor contacted the linen vendor and advised them of the problems with inaccuracies of linen returning from their facility.
3. Communicate to all Housekeeping staff to be aware of the status of this indicator.
4. Housekeeping staff member will continue to document all information regarding to inventory and manifest statistics from the vendor.
5. Housekeeping Supervisor and Director of Support Services did schedule a visit to the linen cleaning facility (Alpine) to see how the linen processing was done. Riverview representatives both gave recommendations to manager to meet infection control standards and the Joint Commission standards.
6. Contract with current linen company was extended for the rest of the year only and Riverview will request for proposals from other companies to begin January of 2012.

HUMAN RESOURCES

ASPECT: DIRECT CARE STAFF INJURIES

Reportable (Lost Time & Medical) Direct Care Staff Injuries



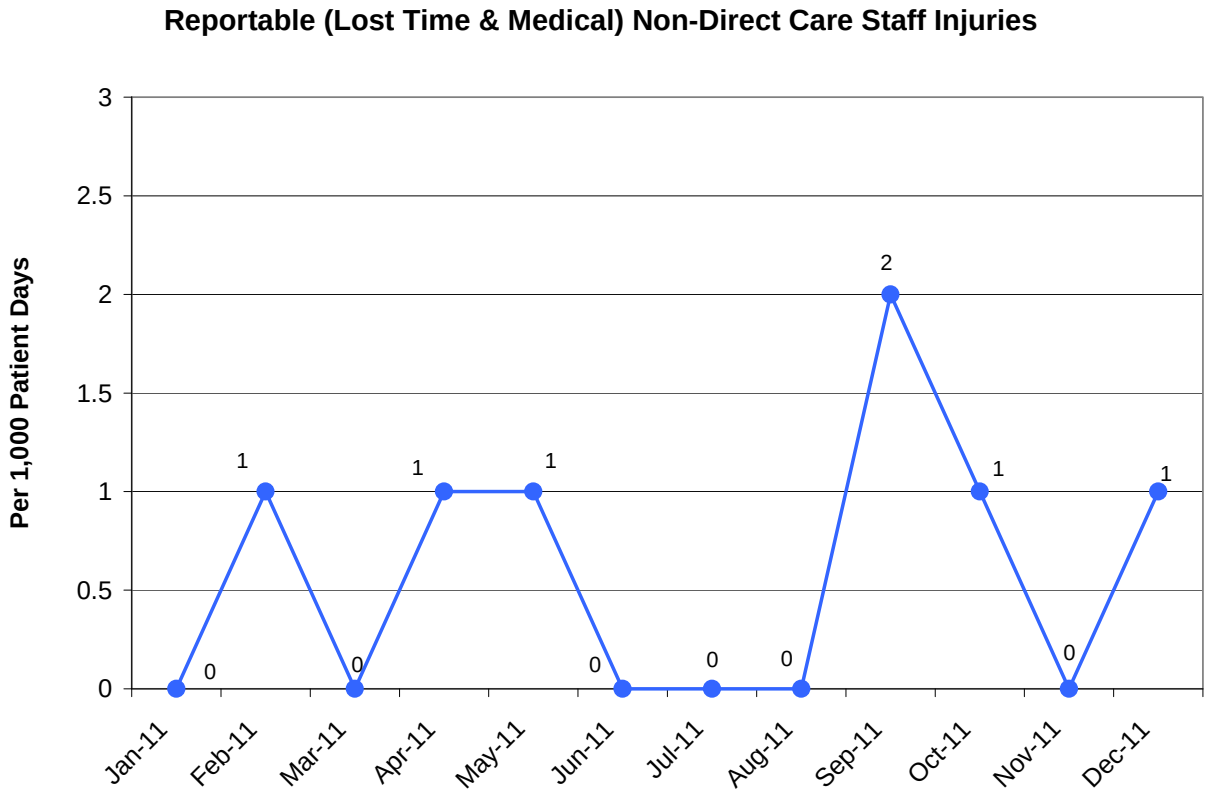
Summary

The trend for reportable injuries sustained by direct care staff remained constant for the past few quarters except for a precipitous spike in November. This was due to one client to staff interaction that resulted in the injury of several staff.

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 is ongoing with overall good results. With the goal of reducing the number of client staff interactions the intent is to reduce the overall number of both client and staff injuries that may result from these interactions.

HUMAN RESOURCES

ASPECT: NON-DIRECT CARE STAFF INJURIES



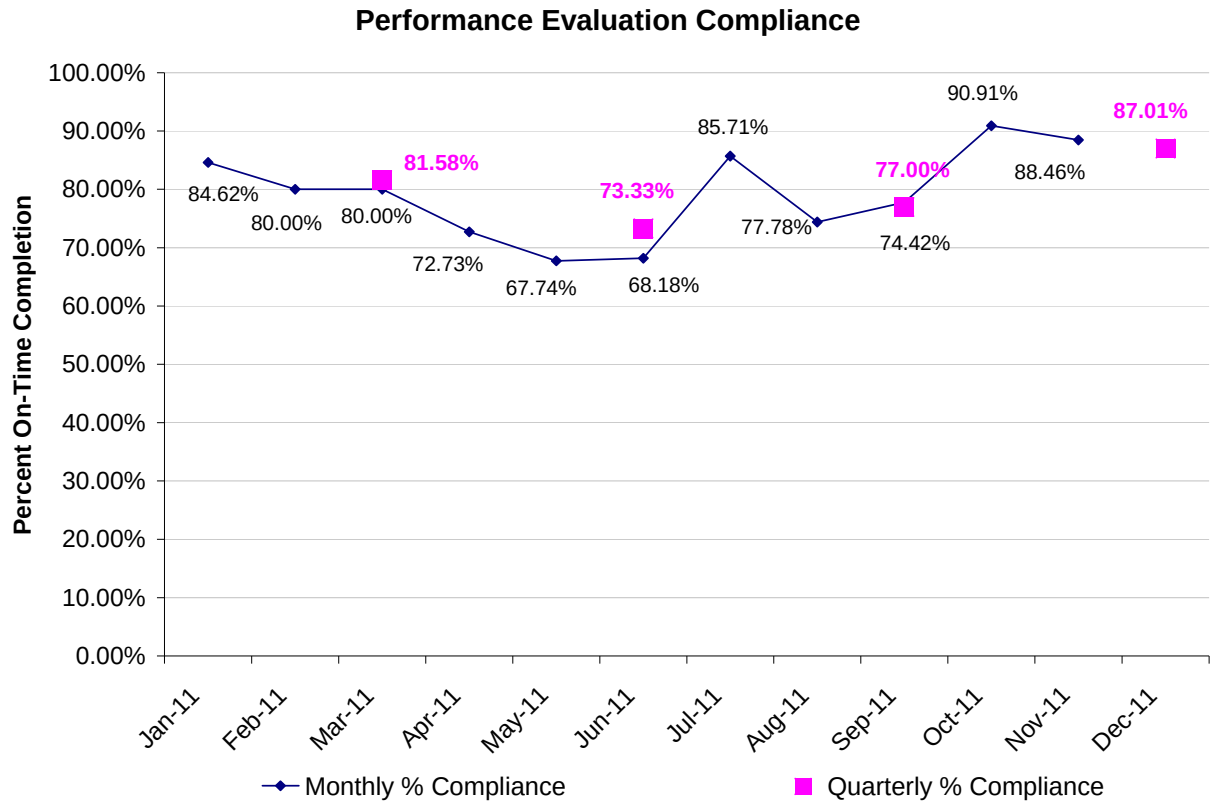
Summary

The average percent of non-direct care staff who sought medical attention or lost time from work remains low. The annual trend 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.

HUMAN RESOURCES

ASPECT: PERFORMANCE EVALUATIONS COMPLETION

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



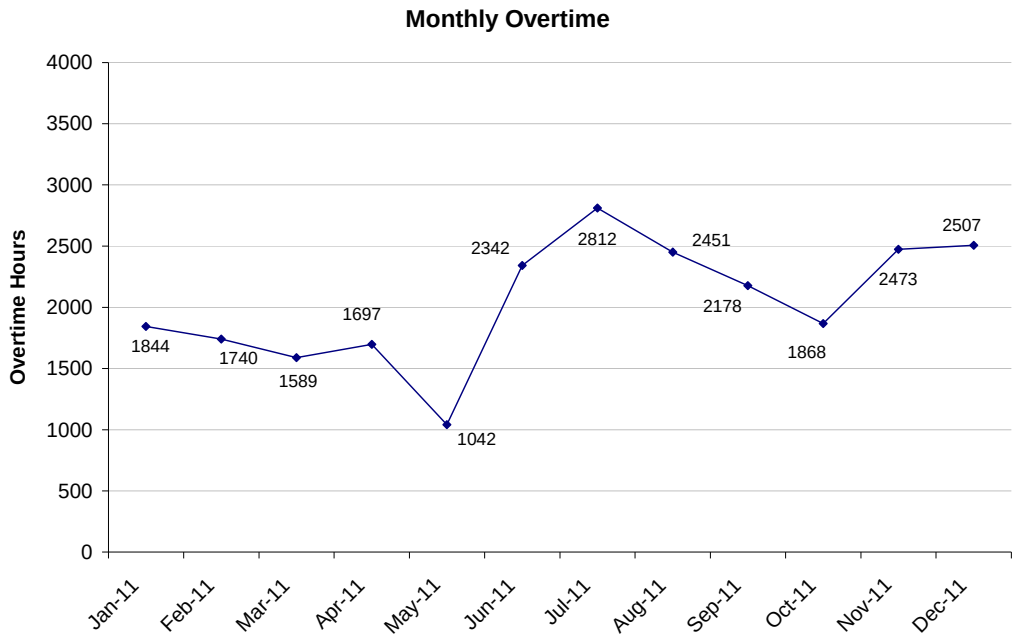
Summary

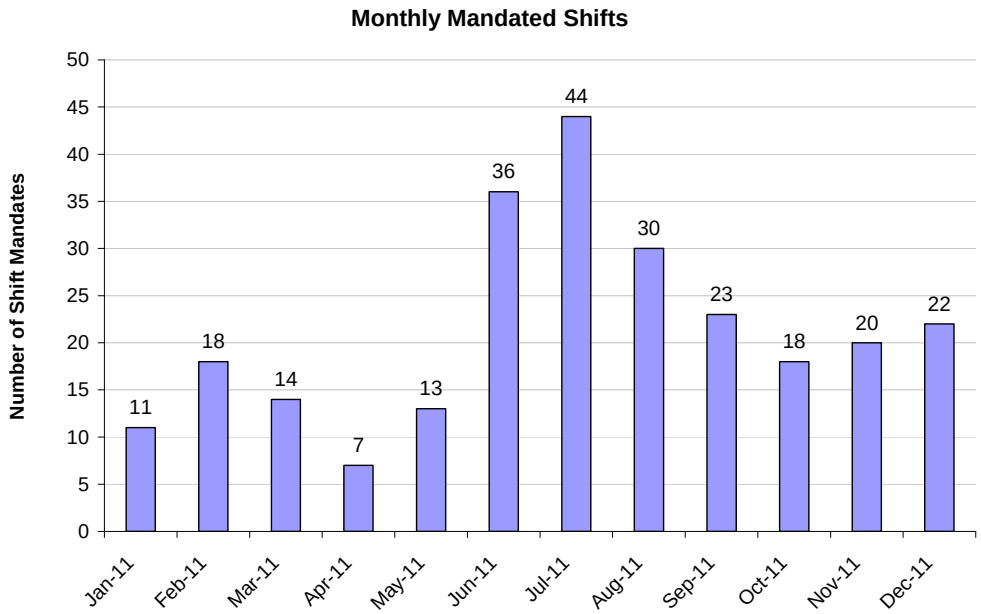
Cumulative results from this quarter (87.01%) are above the planned performance threshold of 85%. The monthly results for compliance have shown a stead increase from the low of 67% in May 2011. Ongoing measurement of performance is indicated. Efforts to insure on time completion of performance evaluations by unit managers will continue in order to achieve the highest possible rate of on-time performance and to maintain a sustainable level of performance above the 85% level.

HUMAN RESOURCES

ASPECT: PERSONNEL MANAGEMENT

Overtime hours and mandated shift coverage





The level of overtime hours and number of mandates for the summer months is consistent with a seasonal variation related to vacation scheduling and other activities. Current staffing patterns are being adjusted to take advantage of the shift from contract staff to regular staff and adjustments are being made to address the issue of lost personnel due to changes related to the retirement incentive; higher than previously trended overtime levels may be associated with this staffing deficit.

INFECTION CONTROL

ASPECT: HOSPITAL ACQUIRED INFECTION

Indicators	Findings	Compliance	Threshold Percentile
Total number of infections for the first quarter of the fiscal year, per 1000 patient days	2.9	100 % within standard	1 SD within the mean
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	0.27	100% within standard	1 SD within the mean

Data

Lower Respiratory Infections – 1
Reproductive Infections – 2
Dental Infections – 5
Skin Infections – 8
Urinary Tract Infections – 2
Wound Infections – One client with an abdominal wound secondary to self-injurious behavior.
GI – One client was diagnosed with hepatitis B.

Despite frequent employee reports of upper respiratory infections and gastrointestinal illness, there have not been any reports of client upper respiratory or GI illness in this quarter.

The Infection Control Nurse met with clients and staff during unit community meetings to encourage good hand hygiene and respiratory hygiene throughout the winter months.

Summary

Total infection rates and hospital associated infection rates remain low with 1/3 the number of skin infections and ½ the number of dental infections this quarter.

Action Plan

1. Continue total house surveillance.
2. Continue to encourage staff and clients to maintain good hand and respiratory hygiene.
3. Last quarter part of the plan was to initiate a procedure to ensure client education on hand hygiene, respiratory hygiene and Athletes Foot within 10 days of admission. This was presented to Nursing Leadership with the decision to add these client education components to the “Patient Orientation to Unit Checklist” under “Patient Education” section. The protocol is not yet in place. The Risk Manager (who also does Meditech) has been asked to add this to the form. Educational materials on hand hygiene, respiratory hygiene and Athletes’ Foot can be found on the common drive in the folder “Infection Control Family, Client and Staff Education Materials”.

LIFE SAFETY

ASPECT: LIFE SAFETY

Indicators	Quarterly % Compliance						Threshold Percentile
	Oct. '11 Dec. '11	Jul. '11 Sep. '11	Apr. '11- Jun. '11	Jan. '11- Mar. '11	Oct. '10- Dec. '10	Jul. '10- Sep. '10	
1. Total number of fire drills and actual alarms conducted during the quarter compared to the total number of alarm activations required per Life Safety Code, that being (1) drill per shift, per quarter.	100% (3/3)	100% (3/3)	100% (3/3)	100% (3/3)	100% (3/3)	100% (3/3)	**100%**
2. Total number of staff who knows what R.A.C.E. stands for.	100% (238/238)	100% (124/124)	100% (159/159)	100% (202/202)	100% (221/221)	100% (285/285)	**95%**
3. Total number of staff who knows how to acknowledge the fire alarm or trouble alarm on the enunciator panel.	100% (238/238)	97% (121/124)	96% (153/159)	100% (202/202)	100% (221/221)	100% (285/285)	**95%**
4. Total number of staff who knows the emergency number.	100% (238/238)	100% (124/124)	100% (159/159)	100% (202/202)	100% (221/221)	100% (285/285)	**95%**
5. During unannounced safety audits conducted by the Safety Officer, this represents the total number of staff who displays identification tags.	100% (105/105)	98% (124/126)	98% (163/165)	98% (204/208)	97% (224/230)	100% (285/285)	**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.	95% (100/105)	99% (125/126)	98% 162/165	97% 206/208	97% 225/230	100% (92/92)	**95%**

Summary

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

LIFE SAFETY

During drills, there were no significant issues. There were some phones that did not have the emergency numbers on them. Other than that, this is the first reporting report that actions were consistent with staff's expectations. Supervisors who wrote the reports also noted that in the 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. The Safety Officer will coordinate with the appropriate people that replace phones to assure that numbers are placed on new phones.
2. We continue to conduct environmental tours and safety audits to assure that staff is in possession of required safety equipment and facility ID's. This area of monitoring has shown improvement.

ASPECT: FIRE DRILLS REMOTE SITES

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

Summary

The Safety Officer conducted an unannounced drill during 2011. This drill satisfies the NFPA requirement.

We continue to perform environmental tours during which time we ask them questions as it relates to what actions they must take in the event of a fire and/or smoke emergency.

Actions

A drill is planned for the 3rd quarter of this reporting period. Results will be reported in April/12

NURSING

ASPECT: SECLUSION/RESTRAINT RELATED TO STAFFING EFFECTIVENESS

Figure CD-27

Indicators	Findings	Compliance
1. Staff mix appropriate	39 of 38	100%
2. Staffing numbers within appropriate acuity level for unit	39 of 38	100%
3. Debriefing completed	35 of 38	92%
4. Dr. Orders	38 of 38	100%

SUMMARY

The indicators of “Seclusion/Restraint Related to Staffing Effectiveness” has increased to 98%

ACTION

Good Progress. We will continue to monitor.

ASPECT: INJURIES RELATED TO STAFFING EFFECTIVENESS

Indicators	Findings	Compliance
1. Staff mix appropriate	38 of 38	100%
2. Staffing numbers within appropriate acuity level for unit	38 of 38	100%

SUMMARY

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

ACTIONS

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

NURSING

ASPECT: MEDICATION ERRORS RELATED TO STAFFING EFFECTIVENESS

NURSING: Staffing levels during medication errors – July - Sept 2011 NASMHPD reportable variances

Date	Omit	Co-mission	Float	New	O/T	Unit Acuity	Staff Mix
9/1/11	Y		No	No		LK	2 RN, 1 LPN, 7 MHW
9/6/11		Acudose was incorrect – Pharmacy error				LS	Pharmacy error
9/8/11		Methadone 15 mg. (dose was 10 mg.)	No	No	No	UK	2 RN, 1 LPN, 4 MHW
9/10/11	Y		No	No	Flex	LK	3 RN, 0 LPN, 7 MHW
9/14/11	Y		No	No	No	LK	2 RN, 1 LPN, 7 MHW
9/15/11		Gave med to wrong client, without using identifiers properly	Yes, is a float	No	No	US	2 RN, 1 LPN, 4 MHW (3-11 shift)
9/15/11	Y		No	No	No	UK	1 RN, 1 LPN, 3 MHW
9/15/11	Y		No	No	No	LK	2 RN, 1 LPN, 7 MHW
9/20/11		Wrong client received meds	Yes	No	No	LK	3 RN, 1 LPN, 7 MHW
9/21/11		Gave med at wrong time	No	No	No	UK	3 RN, 0 LPN, 3 MHW
10/5/11	Y		No	No	No	LS	2 RN, 1 LPN, 6 MHW
10/11/11		Order written to stop med was not done	No	No	No	LS	2 RN, 1 LPN, 6 MHW
10/18/11		Gave 2 extra doses of med not ordered – utilized override – no longer employed	Yes	No	No	LK	2 RN, 1 LPN, 7 MHW
10/20/11		Patch not removed	No	No	No	LS	3 RN, 1 LPN, 7 MHW
10/24/11		Scheduled dose of Benadryl given early	Yes	No	No	LK	3 RN, 1 LPN, 7 MHW
11/4/11	Y		Yes (contract)	No	No	LS	1 RN, 0 LPN, 6 MHW
11/17/11	Y		No	No	No	LK	3 RN, 1 LPN, 7 MHW
11/28/11	Y		No	No	No	LK	3 RN, 1 LPN, 7 MHW
12/2/11		Order stopped in MARS - completing a written order	No	No	No	LS	3 RN, 1 LPN, 6 MHW
12/3/11		Incorrect form of med (caps not liquid) utilized override inappropriately	No	No	Yes	UK	2 RN, 1 LPN, 5 MHW
9/1/11	Y		No	No		LK	2 RN, 1 LPN, 7 MHW
9/6/11		Acudose was incorrect – Pharmacy error				LS	Pharmacy error
9/8/11		Methadone 15 mg. (dose was 10 mg.)	No	No	No	UK	2 RN, 1 LPN, 4 MHW
9/10/11	Y		No	No	Flex	LK	3 RN, 0 LPN, 7 MHW
9/14/11	Y		No	No	No	LK	2 RN, 1 LPN, 7 MHW
9/15/11		Gave med to wrong client, without using identifiers properly	Yes, is a float	No	No	US	2 RN, 1 LPN, 4 MHW (3-11 shift)
9/15/11	Y		No	No	No	UK	1 RN, 1 LPN, 3 MHW

NURSING

SUMMARY

There were a total of 20 reportable errors. This is 5 less reported than last quarter. One involved pharmacy, and did not involve staffing effectiveness. 9 were omissions. Two involved transcription error. Six occurrences involved failure to follow procedure, including failure to compare MAR to Acudose (3), unclear order not clarified (1), and utilizing the override capability of the Acudose machine inappropriately (2). Three other instances involved leaving a client's medications in a med box (3), and one error was the result of a failure to properly identify the client, who had a similar name to another. This nurse was counseled and has since left employment at RPC.

Actions

Review of override procedure with pharmacy input. This procedure was reviewed at Nursing Leadership to be reviewed with all nurses. Client med boxes were removed from med rooms to avoid pre-pulling of meds. The medication administration time was extended to one hour pre and post administration time to facilitate medication administration. All nursing related med variances were noted to have appropriate staffing levels. One med error appeared to be the result of unit acuity.

ASPECT: PAIN MANAGEMENT

Indicator		Findings	Compliance
Pre-administration	Assessed using pain scale	764 OF 765	100%
Post-administration	Assessed using pain scale	616 OF 765	81%

SUMMARY

The "Pre-administration assessment" indicator met the maximum compliance of 100% this quarter and there is a decrease in post-assessment from 92% last quarter to 88% "post-administration" assessment using the pain scale.

ACTION

We believe that the decrease in compliance for "Post-administration" assessment is a ongoing problem. Post assessment will be trended by unit and shift with an actual Root Cause Analysis being done. 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 and Nurse IV's to assure that this is done consistently.

NURSING

ASPECT: CHART REVIEW EFFECTIVENESS

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	**44 of 60**	**73%**
2. STGs/ Interventions relate directly to content of GAP note.	**60 of 60**	**100%**
3. Weekly Summary note completed.	**17 of 60** **5 N/A**	**37%**
4. BMI on every Treatment Plan.	**49 of 60**	**82%**
5. Diabetes education Teaching checklist shows documentation of client teaching (diabetic clients)	**5 of 60** **53 N/A**	**97%**
6. Multidisciplinary Teaching checklist active being completed.	**47 of 60**	**78%**
7. Dental education Teaching checklist	**29 of 60** **2 Ref.**	**52%**

SUMMARY

Indicators #1, 2, 5, 6, 7 have increased in compliance. Indicator 6 has increased greatly from 35% to 78%. There has been decreases in indicator #3 and #4.

ACTION

Review and reeducation on weekly summary notes. Expectations will be placed in individual nurses expectation. ADONs and Nurse IVs will work on this.

NURSING

ASPECT: INITIAL CHART COMPLIANCE

Indicator	Findings	Compliance
1. Universal Assessment completed by RN within 24 hours	61 of 61	100%
2. All sections completed or deferred within document	61 of 61	100%
3. Initial Safety Treatment Plan initiated	61 of 61	100%
4. All sheets required signature authenticated by assessing RN	61 of 61	100%
5. Medical Care Plan initiated if Medical problems identified	14 of 61 47 N/A	100%
6. Informed Consent sheet signed	59 of 61 1 Ref. 1 Unable	100%
7. Potential for violence assessment upon admission	59 of 61	97%
8. Suicide potential assessed upon admission	61 of 61	100%
9. Fall Risk assessment completed upon admission	60 of 61	98%
10. Score of 5 or above incorporated into problem need list	14 of 61 46 N/A	100%
11. Dangerous Risk Tool done upon admission	59 of 61	97%
12. Score of 11 or above incorporated into Safety Problem	43 of 61 18 N/A	100%

SUMMARY

All aspects are at 100% except Dangerous Risk tool at 97% and Fall Risk at 98%.

ACTION

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

PEER SUPPORT

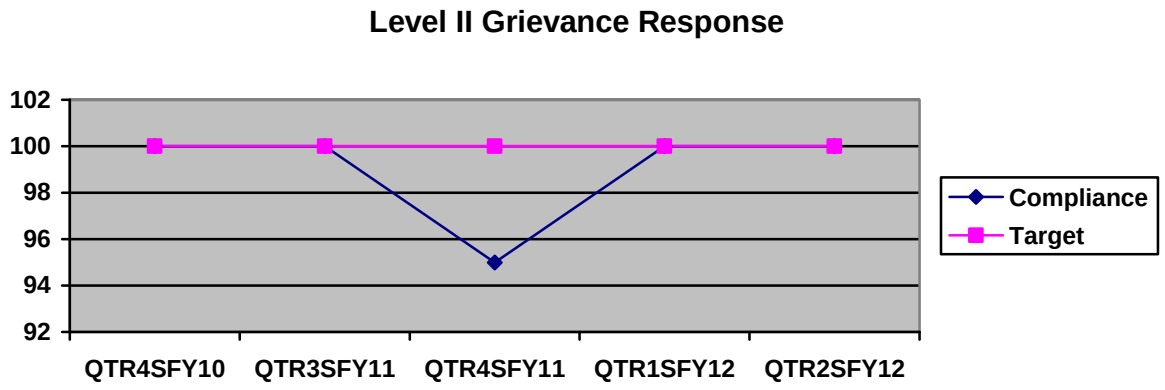
ASPECT: INTEGRATION OF PEER SPECIALISTS INTO CLIENT CARE

Indicators	Findings	Compliance	Threshold Percentile
1. Attendance at Comprehensive Treatment Team meetings.	419 of 456	92%	80%
2. Level II grievances responded to by RPC on time.	2 of 2	100%	100%
3. Attendance at Service Integration meetings.	52 of 52	100%	100%
4. Contact during admission.	63 of 63	100%	100%
5. Level I grievances responded to by RPC on time.	32 of 40	80%	100%
6. Client satisfaction surveys completed.	16 of 22	73%	50%

Summary

Overall compliance is 92%, up 1% from last quarter. Peer support attendance at treatment team meetings and service integration meetings increased due to more efficient staffing schedules. There were eight late responses to level I grievances, ranging from one to eight days late. There were less grievances filed this quarter, dropping 40%. Less satisfaction surveys were completed this quarter by clients. Clients identified the reasons for refusing the surveys as fear that their discharge would be hindered or there would be repercussions for negative ratings. Since the surveys are completed anonymously and administered by the peer support team there is no substantiation for these “fears.”

Figure CD-03



PEER SUPPORT

Figure CD-07

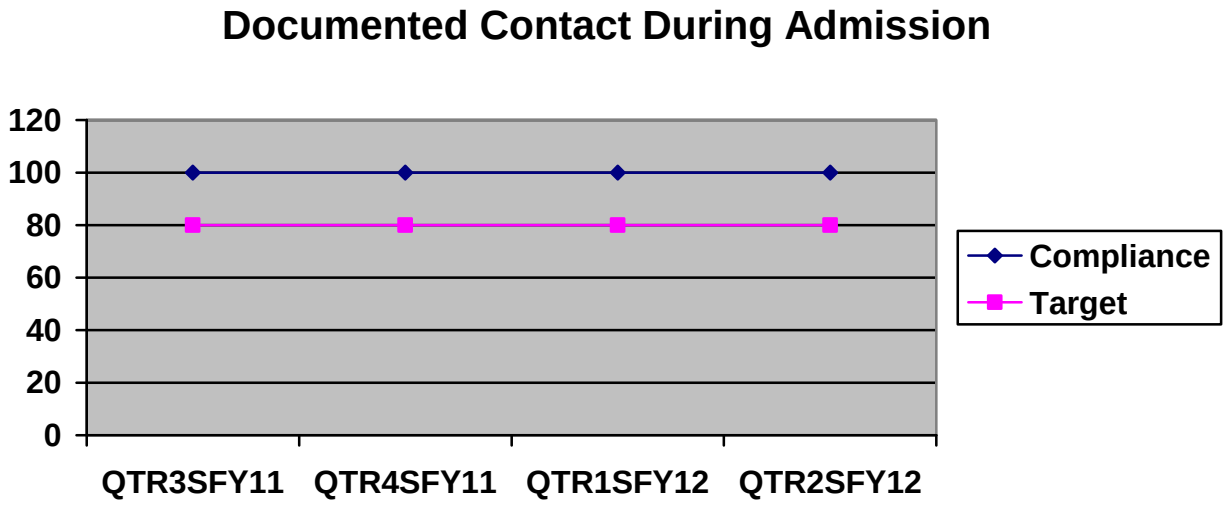
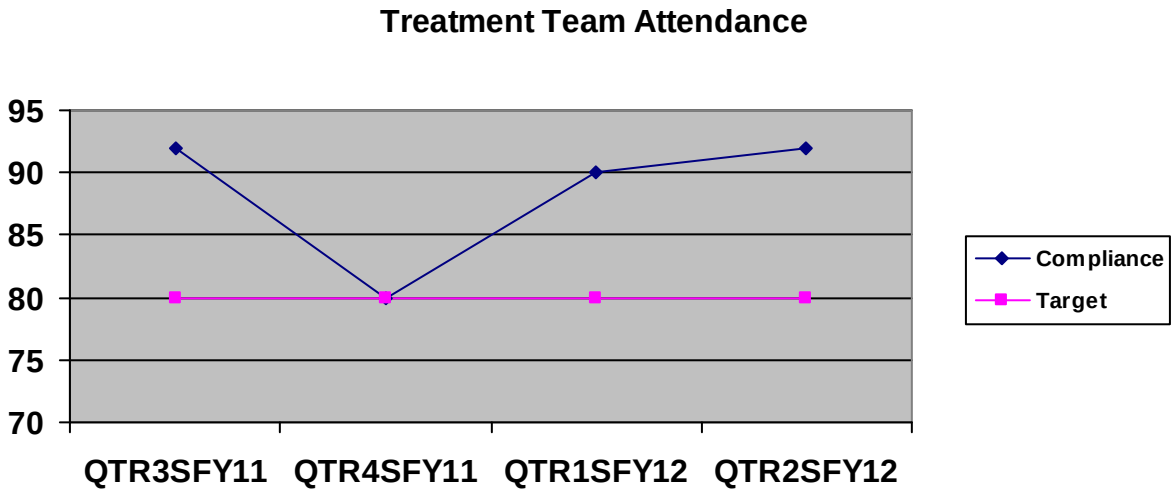


Figure CD-08



PROGRAM SERVICES

ASPECT: ACTIVE TREATMENT IN ALL FOUR UNITS

Figure CD-11

Indicator	Findings		Compliance
1. Documentation reveals that the client attended 50% of assigned psycho-social-educational interventions within the last 24 hours.	62/80	78%	70%
2. A minimum of three psychosocial educational interventions are assigned daily.	65/80	81%	70%
3 A minimum of four groups is prescribed for the weekend.	48/80	60%	70%
4. The client is able to state what his assigned psycho-social-educational interventions are and why they have been assigned.	68/80	85%	60%
5 The client can correctly identify assigned RN and MHW. (Or where the information is available to him / her)	76/80	95%	75%
6. The medical record documents the client's active participation in Morning Meeting within the last 24 hours.	52/80	65%	70% LK/LS 85% UK/US
7. The client can identify personally effective distress tolerance mechanisms available within the milieu.	80/80	100%	65%
8. Level and quality of client's use of leisure within the milieu are documented in the medical record over the last 7 days.	74/80	93%	75%
9. Level and quality of social interactions within the milieu are documented in the medical record over the last 7 days.	74/80	93%	75%
10. Suicide potential moderate or above incorporated into CSP	18/18	100%	90%
11. Allergies displayed on order sheets and on spine of medical record.	80/80	100%	100%
12. By the 7th day if Fall Risk prioritized as active-was it incorporated into CSP	16/17	94%	100%

SUMMARY

Seven of the indicators have increased since last quarter, numbers 2, 5, 6, 8, 9. Two have decreased, numbers 1 and 12.

ACTION

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

PROGRAM SERVICES

Aspect-Milieu Treatment

Indicator	Findings-%
1. Percentage of clients participating in Morning Meeting	72%
2. Percentage of clients who establish a daily goal.	69%
3. Percentage of clients who attend Wrap Up group in the evening or address with primary staff, the status of their daily goal.	58%
4. Percentage of clients attending Community Meeting	67%

Summary

All indicators have increased in compliance since last quarter.

Actions

We will continue to monitor all indicators and encourage clients to meet these goals.

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.	29 of 30	97%
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.

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, 3 & 4-One chart reviewed on a long term client did not have updated goals in the plan and the client is not actively engaged in treatment at this time so therefore the notes do not reflect progress or lack of progress towards the identified goals. Client will need to meet with RT to determine new goals that he/she is willing to address at this time and what services he/she will need to assist them in attaining these goals.

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

SECURITY & SAFETY

ASPECT: SECURITAS/RPC SECURITY TEAM

Indicators	Quarterly % Compliance						Threshold Percentile
	Oct. '11 Dec. '11	Jul. '11 Sep. '11	Apr. '11- Jun. '11	Jan. '11- Mar. '11	Oct. '10- Dec. '10	Jul. '10- Sep. '10	
Security Officer "foot patrols" during Open Hospital times. (Total # of "foot patrols" done vs. total # of "foot patrols" to be done.)	98% (2130/2156)	99% (1981/2002)	98% (1975/2002)	99% (1980/2002)	98% (1964/2002)	89% (1797/2002)	95%

Summary

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

Actions

We continue our attempt to accomplish all foot patrols. After months of investigating the various tour systems available, Riverview has determined that the "Securitas Vision" system will meet the challenges the facility faces with regard to managing facility rounds and accounting for various compliance issues such as Interim Life Safety. We are in hopes that the system will be in place in January/12.

SOCIAL WORK

ASPECT: PRELIMINARY CONTINUITY OF CARE MEETING AND COMPREHENSIVE PSYCHOSOCIAL ASSESSMENTS

Figure CD-05 Indicators	Findings	Compliance	Threshold Percentile
1. Preliminary Continuity of Care meeting completed by end of 3rd day	30/30	100%	100%
2. Service Integration form completed by the end of the 3rd day	30/30	100%	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.	5/5	100%	100%
3a. Client Participation in Preliminary Continuity of Care meeting.	28/30	93%	90%
3b. CCM Participation in Preliminary Continuity of Care meeting.	30/30	100%	100%
3c. Client's Family Member and/or Natural Support (e.g., peer support, advocacy, attorney) Participation in Preliminary Continuity of Care meeting.	29/30	96%	100%
3d. Community Provider Participation in Preliminary Continuity of Care meeting.	6/15	40%	90%
3e. Correctional Personnel Participation in Preliminary Continuity of Care Meeting.	0/15	0%	90%
4a. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	29/30	96%	100%
4b. Annual Psychosocial Assessment completed and current in chart	30/30	100%	100%

SUMMARY

Areas 3d and 3c are consistently low each quarter though area 3d is up from the last quarter. It continues to be discussed in various venues but continues to be an issue for many varying reasons.

SOCIAL WORK

ASPECT: INSTITUTIONAL AND ANNUAL REPORTS

Figure CD-18 Indicators	Findings	Compliance	Threshold Percentile
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	7 /8	87%	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.	5/5	100%	100%
3. Annual Reports (due Dec) to the commissioner for all inpatient NCR clients are submitted annually	N/A	N/A	100%

SUMMARY

Indicator 1 went below 100% compliance for the first time in 5 quarters due to a particular challenging and complex IR that needed extra time to complete.

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%

ASPECT: TREATMENT PLANS AND PROGRESS NOTES

Figure CD-15, CD-16, CD-17 Indicators	Findings	Compliance	Threshold Percentile
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all clients on assigned **CCM** caseload.	43/45	95%	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	12/15	80%	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.	57/60	95%	95%

SUMMARY

Area 2 is being monitored individually through supervision and a plan of correction is in place.

SOCIAL WORK

ASPECT: BARRIERS TO COMMUNITY PLACEMENT OF CIVIL CLIENTS

FY12 Q1 16 % of civil clients discharged faced a barrier

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

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

Clinical Readiness

24 discharged 7days
14 discharged 8-30 days
4 discharged 31-45days
3 discharged post 45 days

Residential Supports (0) 0%

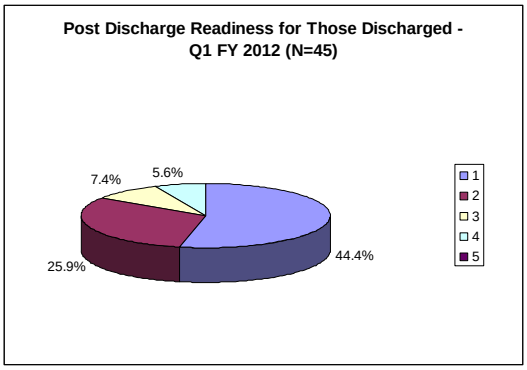
No Barriers in this area this quarter

Treatment Services (0) 0%

No Barriers in this area this quarter

Housing (7) 15 %

1 client discharged 28 days post clinical readiness
1 client discharged 33 days post clinical readiness
2 client discharged 34 days post clinical readiness
1 client discharged 50 days post clinical readiness
1 client discharged 65 days post clinical readiness
1 client discharged 72 days post clinical readiness



This chart shows the percent of civil clients who were discharged within 7 days of their discharge readiness to be at 53.3% for this quarter. Cumulative percentages and targets are as follows:

Within 7 days = (24) 53.3% (target 75%)
Within 30 days = (38) 84.4% (target 90%)
Within 45 days = (42) 93.3% (target 100%)
(3) 6.7% faced a barrier and were discharged post 45 days.

The previous six quarters are displayed in the table below

Quarter	Within 7 days	Within 30days	Within 45 days	45 +days
Target	75%	90%	100%	0%
Q1 2012	68.8%	76.6%	86.0%	14.1%
Q4 2011	54.4%	77.9%	88.2%	11.0%
Q3 2011	67.6%	83.8%	89.2%	10.8%
Q2 2011	51.4%	64.9%	83.8%	16.2%
Q1 2011	47.4%	76.3%	84.2%	15.8%
Q4 2010	57.5%	62.5%	72.5%	27.5%

STAFF DEVELOPMENT

ASPECT: NEW EMPLOYEE AND MANDATORY TRAINING

Figure CD-19 and CD-20

Indicators	Quarterly Findings	YTD Findings	Compliance	Threshold Percentile
1. New employees will complete new employee orientation within 60 days of hire.	28 of 28 completed orientation	47 of 47 scheduled employees completed orientation	100%	100 %
2. New employees will complete CPR training within 30 days of hire.	28 of 28 completed CPR training	47 of 47 scheduled employees completed CPR training	100%	100 %
3. New employees will complete NAPPI training within 60 days of hire.	28 of 28 completed Nappi training	47 of 47 scheduled employees completed NAPPI training	100%	100 %
4. Riverview and Contract staff will attend CPR training bi-annually.	38 of 38 attended scheduled CPR Recertification	74 of 74 scheduled employees completed CPR training	99%	100 %
5. Riverview and Contract staff will attend NAPPI training annually.	148 of 148 have completed NAPPI training	214 of 214 scheduled employees completed NAPPI training	24%	100 %
6. Riverview and Contract staff will attend Annual training.	73 of 73 have completed annual training	289 of 289 have completed annual training	56%	100 %

Findings

The indicators are based on the requirements for all new/current staff to complete mandatory training and maintain current certifications. **28 out 28 of** (100%) new Riverview/Contract employees completed these trainings. **38 of 38** (100%) Riverview/Contract employees attended a CPR certification. **28 of 28** (100%) Riverview/Contract employees attended Nappi training. **73 of 73** (100%) employees complete Annual training. All indicators remained at 100% compliance for quarter 2-FY 2012.

CONSENT DECREE COMPLIANCE

Subject Area	Standard of Substantial Compliance	Efforts to Comply & Evidence of Compliance
Client Rights	Riverview produces documentation that clients are routinely informed of their rights upon admission in accordance with ¶ 150 of the Settlement Agreement	CD-02: *An abstraction process is being developed that will illustrate the degree to which clients are informed of their rights on admission.*
	Grievance tracking data shows that the hospital responds to 90% of Level II grievances within five working days of the date of receipt or within a five-day extension.	CD-03: Report compiled by Peer Support. Information extracted from Grievance tracking database.
Admissions	Quarterly performance data shows that in 4 consecutive quarters, 95% of admissions to Riverview meet legal criteria.	CD-04: Report compiled for Admissions. Information extracted from the Meditech report entitled, "Admission Legal Report."
	Director of Social Work reviews all readmissions occurring within 60 days of the last discharge; and for each client who spent fewer than 30 days in the community, evaluated the circumstances to determine whether the readmission indicated a need for resources or a change in treatment and discharge planning or a need for different resources and, where such a need or change was indicated, that corrective action was taken.	CD-05: This items in reported in the Social Work section under the report entitled, "Preliminary Continuity of Care Meeting and Comprehensive Psychosocial Assessments" under section 2a of that report.
	No more than 5% of patients admitted in any year have a primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	CD-06: Report compiled for Admissions. Information extracted from the Meditech report entitled, "Admission Diagnosis Report by Date."
Peer Support	In 3 out of 4 consecutive quarters: • 80% of all clients have documented contact with a peer specialist during hospitalization	CD-07: Report compiled by Peer Support.
	• 80% of all treatment meetings involve a peer specialist.	CD-08: Report compiled by Peer Support.
Treatment Planning	In 3 out of 4 consecutive quarters • 95% of clients have a preliminary treatment and transition plan developed within 3 working days of admission	CD-09: *A method for the reporting of this compliance standard is currently under development.*
	• 95% of clients also have individualized treatment plans in their records within 7 days thereafter	CD-10: *A method for the reporting of this compliance standard is currently under development.*
	• Riverview certifies that all treatment modalities required by ¶155 are available.	CD-11: Records of client participation in active treatment are maintained by the unit PSD. All required, unit and Harbor Mall treatment schedules are available for review. *A method for the reporting trends of compliance is currently under development.*

CONSENT DECREE COMPLIANCE

Subject Area	Standard of Substantial Compliance	Efforts to Comply & Evidence of Compliance
Treatment Planning (cont'd)	An evaluation of treatment planning and implementation, performed in accordance with **Attachment D**, demonstrates that, for 90% of the cases reviewed quarterly performance data shows that in 4 consecutive quarters:	CD-12: Information on this standard is illustrated in the Social Work performance measures related to the aspect of care entitled, "Barriers to Community Placement of Civil Clients"
	• 70% of clients who remained ready for discharge were transitioned out of the hospital within 7 days of a determination that they had received maximum benefit from inpatient care	
	• 80 % of clients who remained ready for discharge were transitioned out of the hospital within 30 days of a determination that they had received maximum benefit from inpatient care	CD-13: Information on this standard is illustrated in the Social Work performance measured related to the aspect of care entitled, "Barriers to Community Placement of Civil Clients"
	• 90% of clients who remained ready for discharge were transitioned out of the hospital within 45 days of a determination that they had received maximum benefit from inpatient care (with certain clients excepted, by agreement of the parties and court master).	CD-14: Information on this standard is illustrated in the Social Work performance measured related to the aspect of care entitled, "Barriers to Community Placement of Civil Clients"
	• treatment and discharge plans reflect interventions appropriate to address discharge and transition goals	CD-15: This compliance standard is partially addressed in the Social Work report on "Treatment Plans and Progress Notes, standard #3."
	• for patients who have been found not criminally responsible or not guilty by reason of insanity, appropriate interventions include timely reviews of progress toward the maximum levels allowed by court order; and the record reflects timely reviews of progress toward the maximum levels allowed by court order	CD-16: This compliance standard is partially addressed in the Social Work report on "Treatment Plans and Progress Notes, standard #3."
	• interventions to address discharge and transition planning goals are in fact being implemented	CD-17: This compliance standard is partially addressed in the Social Work report on "Treatment Plans and Progress Notes, standard #3."
	• for patients who have been found not criminally responsible or not guilty by reason of insanity, this means that, if the treatment team determines that the patient is ready for an increase in levels beyond those allowed by the current court order, Riverview is taking reasonable steps to support a court petition for an increase in levels.	CD-18: This compliance standard is addressed in the Social Work report on "Institutional and Annual Reports."

CONSENT DECREE COMPLIANCE

Subject Area	Standard of Substantial Compliance	Efforts to Comply & Evidence of Compliance
Staffing and Staff Training	Riverview performance data shows that 95% of all new direct care staff have received 90% of their orientation training before having been assigned to duties requiring unsupervised direct care of patients.	CD-19: Compliance with this standard is documented under the section of Staff Development.
	Riverview certifies that 95% of professional staff have maintained professionally-required continuing education credits and have received the ten hours of annual cross-training required by ¶216	CD-20: Compliance with this standard is documented under the section of Staff Development.
	Riverview certifies that staffing ratios required by ¶202 are met, and makes available documentation that shows actual staffing for up to one recent month.	CD-21: All required staffing ratios are regularly met. Evidence of compliance can be reviewed through staffing office and other human resource records.
	The evaluation of treatment and discharge planning, performed in accordance with **Attachment D**, demonstrates that staffing was sufficient to provide patients access to activities necessary to achieve the patients' treatment goals, and to enable patients to exercise daily and to recreate outdoors consistent with their treatment plans.	CD-22: The Clinical Leaders Team conducted a preliminary review of 28 client records to determine substantial compliance in the areas of: 1) treatment and discharge planning and implementation, and 2) staffing. Areas requiring review are being addressed through the review and revision of the treatment planning model.
Seclusion and Restraint	Quarterly performance data shows that, in 5 out of 6 quarters, total seclusion and restraint hours do not exceed one standard deviation from the national mean as reported by NASMHPD	Report compiled by the Integrated Quality Team and reported in Comparative Statistics section on… CD-23: Seclusion Hours and CD-24: Restraint Hours.
	Riverview demonstrates that, based on a review of two quarters of data, for 95% of seclusion events, seclusion was employed only when absolutely necessary to protect the patient from causing physical harm to self or others or for the management of violent behavior.	CD-25: Report compiled by the Integrated Quality Team and reported in Comparative Statistics
	Riverview demonstrates that, based on a review of two quarters of data, for 95% of restraint events involving mechanical restraints, the restraint was used only when absolutely necessary to protect the patient from serious physical injury to self or others.	CD-26: Report compiled by the Integrated Quality Team and reported in Comparative Statistics
	Riverview demonstrates that, based on a review of two quarters of data, for 95% of seclusion and restraint events, the hospital achieved an acceptable rating for meeting the requirements of paragraphs 182 and 184 of the Settlement Agreement, in accordance with a methodology defined in **Attachments E-1 and E-2.**	CD-42: Seclusion and CD-43 restraint events are reviewed as part of a regular analysis of performance by the Nursing Department.

CONSENT DECREE COMPLIANCE

Subject Area	Standard of Substantial Compliance	Efforts to Comply & Evidence of Compliance
Elopement	Quarterly performance data shows that, in 5 out of 6 quarters, the number of client elopements does not exceed one standard deviation from the national mean as reported by NASMHPD.	CD-27: Report compiled by the Integrated Quality Team and reported in Comparative Statistics section on Elopement.
Client Injuries	Quarterly performance data shows that, in 5 out of 6 quarters, the number of client injuries does not exceed one standard deviation from the national mean as reported by NASMHPD.	CD-28: Report compiled by the Integrated Quality Team and reported in Comparative Statistics section on Client Injuries.
Patient Abuse, Neglect, Exploitation, Injury or Death	Riverview certifies that it is reporting and responding to instances of patient abuse, neglect, exploitation, injury or death consistent with the requirements of ¶¶ 192-201 of the Settlement Agreement.	CD-29: Regular reports of any events related to allegations of abuse, neglect, exploitation, injury or death are submitted to the Disability Rights Center, the Human Rights Committee and the Consent Decree Court Master per the requirements of the Settlement Agreement. Minutes of the Human Rights Committee are available for review by regulators and accreditation agencies upon request. The Superintendent also certifies annually according to 22 MRSA, Chapter 1684, and 10-44 CMR Chapter 114, Rules Governing the Reporting of Sentinel Events that all sentinel and serious reportable events are reported to the DHHS DLRS Sentinel Events Team as required by this law.
Performance Improvement	Riverview maintains JCAHO accreditation	CD-30: A joint commission survey conducted on November 15-19, 2010 resulted in a full accreditation determination for both the hospital and the Community Forensic ACT team. Documentation of this action can be viewed in the office of the Superintendent.
	Riverview maintains its hospital license	CD-40: Documentation of the hospital's licensure status can be viewed in the office of the Superintendent and verified with the Maine DHHS Department of Licensure and Regulatory Services.
	The hospital does not lose its CMS certification (for the entire hospital excluding Lower Saco SCU so long as Lower Saco SCU is a distinct part of the hospital for purposes of CMS certification) as a result of patient care issues	CD-41: Documentation of the hospital's CMS certification status can be viewed in the office of the Superintendent.

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