Riverview
PSYCHIATRIC CENTER

QUARTERLY REPORT ON
ORGANIZATIONAL PERFORMANCE EXCELLENCE

SECOND STATE FISCAL QUARTER 2013
October, November, December 2012

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Superintendent

January 22, 2013

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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
CMS	Centers for Medicare & Medicaid Services
CoP	Community of Practice or Conditions of Participation (CMS)
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

Glossary of Terms, Acronyms & Abbreviations

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

INTRODUCTION

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

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

There are three major sections that make up this report:

The first section reflects compliance factors related to the Consent Decree and includes those performance measure described in the Order Adopting Compliance Standards dated October 29, 2007.

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

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

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

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

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CONSENT DECREE

Consent Decree Plan

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

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

Client Rights

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

Indicators	3Q2012	4Q2012	1Q2013	2Q2013
1. Clients are routinely informed of their rights upon admission	--	--	74% 37/50	91% 42/46

This measure has recently been established. The practice of informing clients of their rights is often delayed as a result of admission acuity. While this process is usually completed after the initial assessment and stabilization, documentation of the act may not be readily available for abstraction. Further refinement of the process is warranted.

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

Indicators	3Q2012	4Q2012	1Q2013	2Q2013
1. Level II grievances responded to by RPC on time.	100% 3/3	100% 4/4	100% 1/1	100% 5/5
2. Level I grievances responded to by RPC on time.	87% 39/45	56% 63/112	73% 27/37	60% 64/106

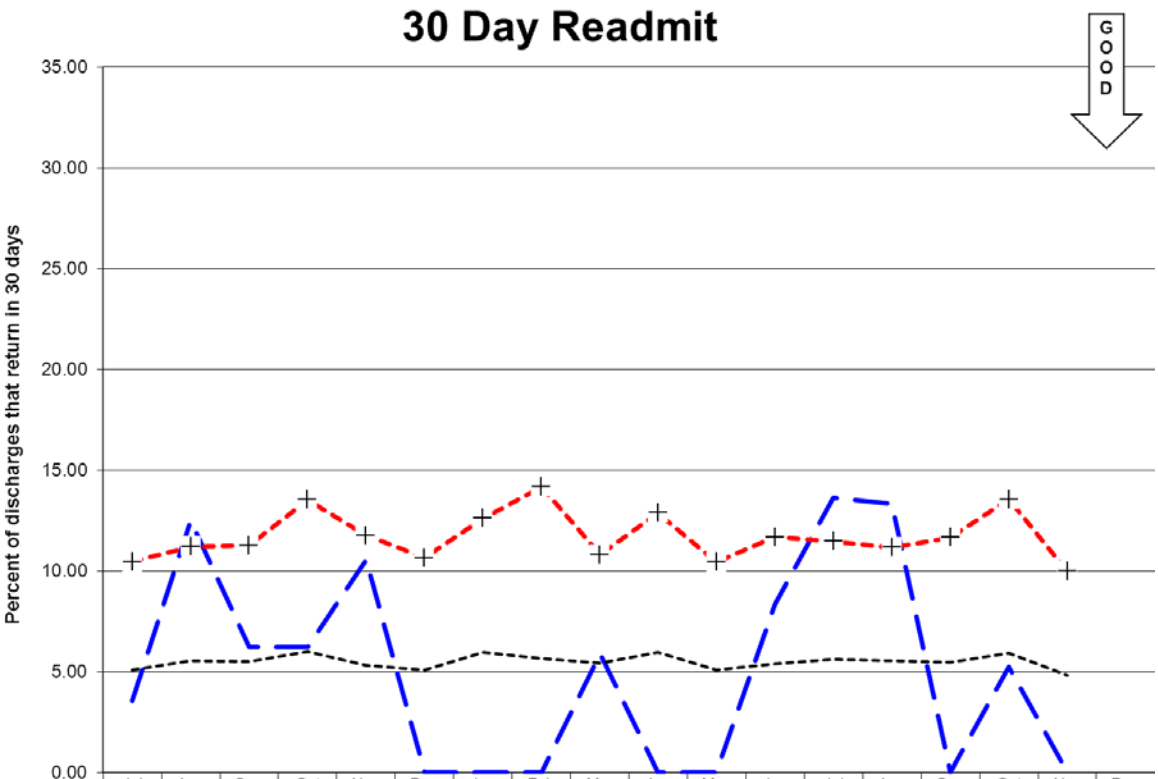
Admissions

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

Client Legal Status on Admission	3Q2012	4Q2012	1Q2013	2Q2013
ICDCC	29	19	17	9
ICDCC-M	1			
ICDCC-PTP				
IC-PTP+M				
ICRDCC			3	
INVOL CRIM	33	39	19	34
INVOL-CIV	3			
PCHDCC			1	
PCHDCC+M		1		1
VOL	2	4	6	
VOL-OTHER	1			

CONSENT DECREE

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



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	3.57	12.50	6.25	6.25	10.53	0.00	0.00	0.00	5.88	0.00	0.00	8.33	13.64	13.33	0.00	5.26	0.00	
Ntl Mean	5.09	5.53	5.51	6.00	5.31	5.08	5.96	5.65	5.42	5.97	5.11	5.39	5.64	5.54	5.48	5.92	4.82	
+1 StDev	10.47	11.21	11.26	13.53	11.76	10.65	12.61	14.18	10.8	12.89	10.45	11.69	11.47	11.17	11.67	13.55	9.99	

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

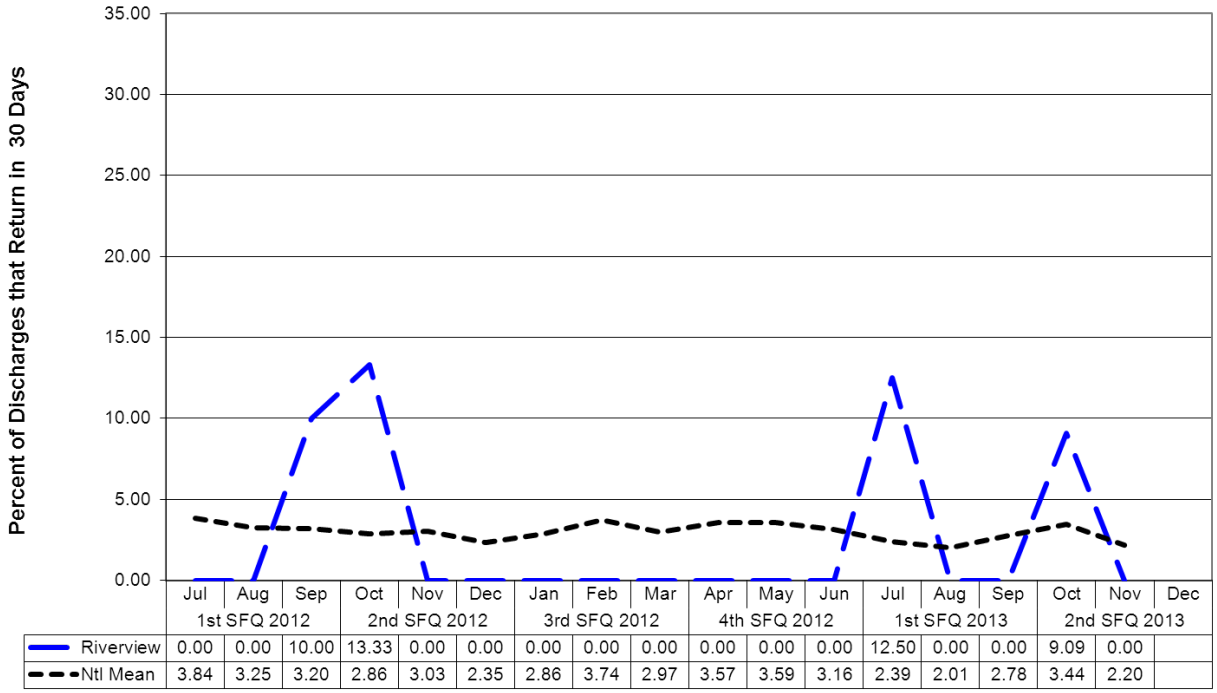
The graphs shown on the next page depict the percent of discharges from the facility that returned within 30 days of a discharge of the same client from the same facility stratified by forensic or civil classifications. For example, a rate of 10.0 means that 10% of all discharges were readmitted within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

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

CONSENT DECREE

30 Day Readmit

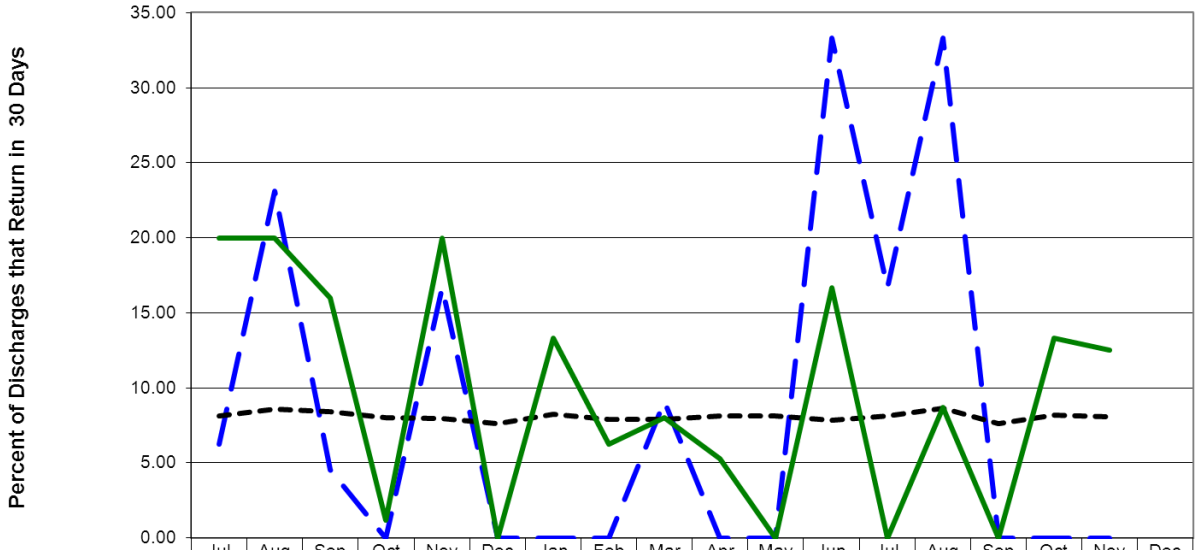
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	0.00	0.00	10.00	13.33	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	12.50	0.00	0.00	9.09	0.00	
Ntl Mean	3.84	3.25	3.20	2.86	3.03	2.35	2.86	3.74	2.97	3.57	3.59	3.16	2.39	2.01	2.78	3.44	2.20	

30 Day Readmit

Civil Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	6.25	23.08	4.55	0.00	16.67	0.00	0.00	0.00	9.09	0.00	0.00	33.33	16.67	33.33	0.00	0.00	0.00	
Ntl Mean	8.12	8.55	8.39	8.00	7.95	7.63	8.25	7.90	7.88	8.11	8.15	7.84	8.12	8.64	7.60	8.18	8.06	
Dorothea Dix	20.00	20.00	16.00	1.17	20.00	0.00	13.33	6.25	8.00	5.26	0.00	16.67	0.00	8.70	0.00	13.33	12.50	

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

REVIEW OF READMISSION OCCURRING WITHIN 60 DAYS

Indicators	3Q2012	4Q2012	1Q2013	2Q2013
Director of Social Services reviews all readmissions occurring within 60 days of the last discharge and for each client who spent fewer than 30 days in the community, evaluated the circumstances of the readmission to determine an indicated need for resources or a change in treatment and discharge planning or the need for alternative resources. In cases where such a need or change was indicated that corrective action was taken.	100% 1/1	100% 3/3	100% 3/3	n/a 0/0

REDUCTION OF RE-HOSPITALIZATION FOR ACT TEAM CLIENTS

Indicators	3Q2012	4Q2012	1Q2013	2Q2013
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	100% 4 NCR clients were re-admitted to RPC; 1 for violation of court order, 1 who was readmitted due to elopement and 2 for increased psychiatric symptoms.	100% 4 NCR clients were re-admitted to RPC; 1 for violation of court order, 1 who was readmitted due to elopement and 2 for increased psychiatric symptoms	100% 8 readmissions to RPC, 2 medical admissions to MMC	100% 3 clients were re-admitted to RPC;all were NCR, two due to increased psychiatric symptoms, one for using illicit substance in the forensic group home.
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%	

Current Quarter Summary

1. All readmissions were male, under the care of the DHHS Commissioner (NCR) and living in group homes/assisted living within two miles of the office/hospital. Two clients are between 50 and 65, and the third in his mid thirties. Two were psychiatric readmissions; one who had been

generally stable in the community with few readmissions for several years, the other had not yet fully stabilized since initial discharge from RPC approximately one year ago. The latter has had acute and chronic medical issues that required medical hospitalization. The third used an illicit substance on the property of his group home where he had been living without incident for eight months. The first re-admission was discharged successfully back to his group home after two weeks, the second remains in Riverview and the third was discharged back to his group home after 10 weeks. In all cases, the direct care staff of the group homes, and the ACT Team were carefully monitoring behavior changes prior to re-admission.

2. The ACT Team and the inpatient unit of RPC (Lower Saco) worked collaboratively to minimize the time spent in Riverview while maximizing the opportunity for success upon their return to the community placements. For the remaining client on Lower Saco, there is a plan in place to secure housing through the Veterans Administration system. In addition, Peer Support Specialists from the inpatient units and the ACT Team collaborated effectively in order to assist clients with their transitions.

CONSENT DECREE

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

Client Admission Diagnoses	3Q12	4Q12	1Q13	2Q13	TOT
ADJUSTMENT DIS W MIXED DISTURBANCE OF EMOTIONS & CONDUCT	1		1		2
ADJUSTMENT DISORDER WITH DEPRESSED MOOD	1		1	1	3
ADJUSTMENT DISORDER WITH DISTURBANCE OF CONDUCT	1				1
ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED MOOD	2	1		3	6
ADJUSTMENT REACTION NOS	2	1	2	1	6
ALCOHOL ABUSE-IN REMISS				1	1
ALCOH DEP NEC/NOS-REMISS		1			1
BIPOL I, REC EPIS OR CURRENT MANIC, SEVERE, SPEC W PSYCH BEH	1				1
BIPOL I DIS, MOST RECENT EPIS (OR CURRENT) MANIC, UNSPEC			1		1
BIPOLAR DISORDER, UNSPECIFIED	6	5	6	5	22
DELUSIONAL DISORDER		3		1	4
DEPRESS DISORDER-UNSPEC	2	1			3
DEPRESSIVE DISORDER NEC				2	2
DRUG ABUSE NEC-IN REMISS		3		1	4
DRUG MENTAL DISORDER NOS	1				1
HEBEPHRENIA-CHRONIC	1				1
IMPULSE CONTROL DIS NOS	1		1	1	3
INTERMITT EXPLOSIVE DIS				1	1
MOOD DISORDER IN CONDITIONS CLASSIFIED ELSEWHERE			1	1	2
OTHER AND UNSPECIFIED BIPOLAR DISORDERS, OTHER			1		1
OTH PERSISTENT MENTAL DIS DUE TO COND CLASSIFIED ELSEWHERE				1	1
PARANOID SCHIZO-CHRONIC	9	1	7	5	22
PARANOID SCHIZO-UNSPEC	1				1
PERSON FEIGNING ILLNESS		1		1	2
POSTTRAUMATIC STRESS DISORDER	3	4	2	3	12
PSYCHOSIS NOS	13	6	6	4	29
REC DEPR DISOR-PSYCHOTIC		1			1
RECUR DEPR DISOR-SEVERE		2			2
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED	16	10	9	6	35
SCHIZOPHRENIA NOS-CHR	2	3	1		6
SCHIZOPHRENIFORM DISORDER, UNSPECIFIED	1				1
UNSPEC PERSISTENT MENTAL DIS DUE TO COND CLASS ELSEWHERE		3			3
UNSPECIFIED EPISODIC MOOD DISORDER	4	9	7	6	26
UNSPECIFIED NONPSYCHOTIC MENTAL DISORDER		2			2
Total Admissions	69	57	46	44	216
Admitted with primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	1.4%	7.0%	0.0%	4.5%	3.2%

Peer Supports

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

V8) 80% of all clients have documented contact with a peer specialist during hospitalization;

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

Indicators	3Q2012	4Q2012	1Q2013	2Q2013
1. Attendance at Comprehensive Treatment Team meetings. (v9)	91% 427/471	91% 387/427	90% 410/458	87% 342/395
2. Attendance at Service Integration meetings. (v8)	100% 65/65	93% 52/56	100% 42/42	100% 31/31
3. Contact during admission. (v8)	100% 69/69	100% 63/63	100% 46/46	100% 44/44

Treatment Planning

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

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

Indicators	3Q2012	4Q2012	1Q2013	2Q2013
1. Preliminary Continuity of Care meeting completed by end of 3rd day	100% 30/30	96% 29/30	93% 28/30	100% 30/30
2. Service Integration form completed by the end of the 3rd day	100% 30/30	100% 30/30	93% 28/30	100% 30/30
3a. Client Participation in Preliminary Continuity of Care meeting.	96% 29/30	96% 29/30	93% 28/30	96% 29/30
3b. CCM Participation in Preliminary Continuity of Care meeting.	100% 30/30	100% 30/30	93% 28/30	100% 30/30
3c. Client's Family Member and/or Natural Support (e.g., peer support, advocacy, attorney) Participation in Preliminary Continuity of Care meeting.	96% 29/30	93% 28/30	93% 28/30	100% 30/30
4a. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	93% 28/30	96% 29/30	96% 29/30	93% 28/30
4b. Annual Psychosocial Assessment completed and current in chart	100% 30/30	100% 30/30	100% 30/30	100% 30/30

Medical Staff, Nursing, and Rehabilitation Services are all engaged in the initial review process. Evidence of fulfilling the standard can be found through a review of individual charts.

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

Indicators	3Q2012	4Q2012	1Q2013	2Q2013
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all clients on assigned **CCM** caseload.	93% 42/45	95% 43/45	95% 43/45	97% 44/45
2. On Upper Saco progress notes in GAP/Incidental format will indicate at minimum weekly 1:1 meeting with all clients on assigned **CCM** caseload	93% 14/15	100% 15/15	93% 14/15	93% 14/15
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.	95% 57/60	96% 58/60	98% 59/60	96% 58/60

Medical Staff, Nursing, and Rehabilitation Services are all engaged in the treatment planning process. Evidence of fulfilling the standard can be found through a review of individual charts.

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

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

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

CONSENT DECREE

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

V13) The treatment plans reflect

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

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

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

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

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

Medications

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

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

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

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

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

CONSENT DECREE

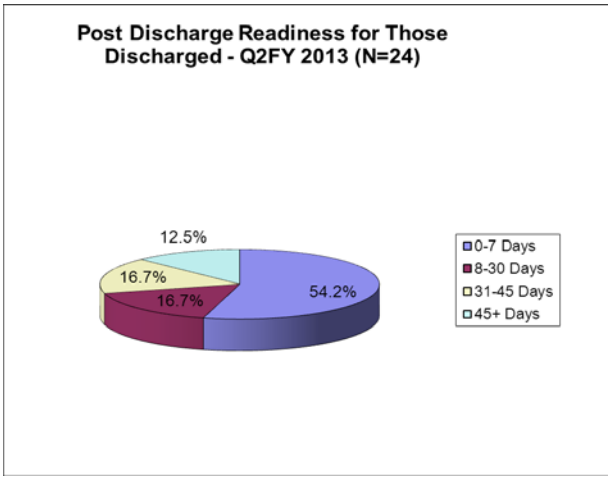
Discharges

Quarterly performance data shows that in 4 consecutive quarters:

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

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

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



Cumulative percentages & targets are as follows:

Within 7 days = (13) 54.2% (target 70%)
Within 30 days = (4) 70.9% (target 80%)
Within 45 days = (4) 87.6% (target 90%)
Post 45 days = (3) 12.5% (target 0%)

Barriers to Discharge Following Clinical Readiness

Residential Supports (0)

Treatment Services (1)

1 client discharged 44 days post clinical readiness

Housing (7)

1 client discharged 2 days post clinical readiness
1 client discharged 15 days post clinical readiness
1 client discharged 16days post clinical readiness
1 client discharged 33 days post clinical readiness
1 client discharged 44 days post clinical readiness
1 client discharged 72 days post clinical readiness
1 client discharged 208 days post clinical readiness

The previous four quarters are displayed in the table below

		Within 7 days	Within 30days	Within 45 days	45 +days
Target >>		70%	80%	90%	< 10%
1Q2013	N=27	66.7%	85.2%	96.3%	3.7%
4Q2012	N=28	53.6%	89.2%	92.9%	7.1%
3Q2012	N=42	69.0%	85.7%	92.9%	7.1%
2Q2012	N=42	69.0%	85.7%	92.9%	7.1%

CONSENT DECREE

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

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

V21a) For patients who have been found not criminally responsible or not guilty by reason of insanity, appropriate interventions include timely reviews of progress toward the maximum levels allowed by court order; and the record reflects timely reviews of progress toward the maximum levels allowed by court order;

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

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

Indicators	3Q2012	4Q2012	1Q2013	2Q2013
1. The Client Discharge Plan Report will be updated/reviewed by each **Social Worker minimally one time per week.**	100% 12/12	100% 13/13	100% 13/13	100% 12/12
2. The Client Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	100% 12/12	100% 13/13	100% 13/13	100% 12/12
2a. The Client Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	100% 12/12	100% 13/13	100% 13/13	100% 12/12
3. Each week the Social Work team and Director will meet and discuss current housing options provided by the respective regions and prioritize referrals.	100% 12/12	100% 13/13	100% 13/13	100% 12/12

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

Indicators	3Q2012	4Q2012	1Q2013	2Q2013
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	100% 3/3	100% 7/7	60% 3/5	100% 3/3
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.	100% 3/3	100% 5/5	100% 9/9	100% 5/5
3. Annual Reports (due Dec) to the commissioner for all inpatient NCR clients are submitted annually				

Staffing and Staff Training

V23) 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;

Indicators	1Q2013	2Q2013	3Q2013	4Q2013
1. New employees will complete new employee orientation within 60 days of hire.	100% 25/25	100% 21/21		
2. New employees will complete CPR training within 30 days of hire.	100% 25/25	100% 21/21		
3. New employees will complete NAPPI training within 60 days of hire.	100% 25/25	100% 21/21		
4. Riverview and Contract staff will attend CPR training bi-annually.	100% 50/51*	100% 29/31		
5. Riverview and Contract staff will attend NAPPI training annually.	100% 118/118	100% 112/134*		
6. Riverview and Contract staff will attend Annual training.	100% 27/27	100% 238/244*		

The indicators are based on the requirements for all new/current staff to complete mandatory training and maintain current certifications.

*****One Riverview employee is out of compliance due to being out of work on a medical leave one employee is out of compliance on light duty.

*Two Riverview employees on Leave of Absence Status, will complete this requirement upon return to regular duty.

*Seventeen Riverview employees scheduled to attend training on December 27 were prohibited due to a state inclement weather shutdown day. All scheduled to attend on January 24 or January 30, 2013. Five Riverview employees on leave of absence or light duty during this quarter will complete this mandatory training prior to returning to regular employ.

*Six employees on leave of absence during this quarter will not return to work until their Annual Training is complete.

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

DATE	HRS	TITLE	PRESENTER
3Q2012	14	Jan- March 2012	Winter Semester (see1Q13 Quarterly Report)
4Q2012	11	Apr – June 2012	Spring Semester (see1Q13 Quarterly Report)
1Q2013	3	Jul – Sep 2012	Summer Hiatus (see1Q13 Quarterly Report)
10/4/12	1	Adverse drug reactions and reporting	Miranda Cole, PharmD, BCPP
10/11/12	1	To Hope or To Elope	Teresa Mayo, PsyD
10/11/12	1	NAPPI Recertification	Jeff Freeman
10/18/12	1	Continuation of Presentation on Transvestic Fetishism	Randy Beal, PMHNP
10/25/12	1	Client Centered, Stage Matched Treatment Planning	Michael Morse, LCSW, CCS
11/8/12	1	Illicit Drugs of New England	Benjamin Nordstrom, MD, PhD
11/15/12	1	A Newly Minted NCR	Brendan Kirby, MD
11/29/12	1	Columbia Suicide Severity Rating Scale	Douglas Noordsy, MD
12/20/12	1	NPSG.03.05.01: Meeting the Anticoagulation Standard in the Psychiatric Setting	Miranda Cole, PharmD, BCPP Elizabeth Dragatsi, RPh

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

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

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

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

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

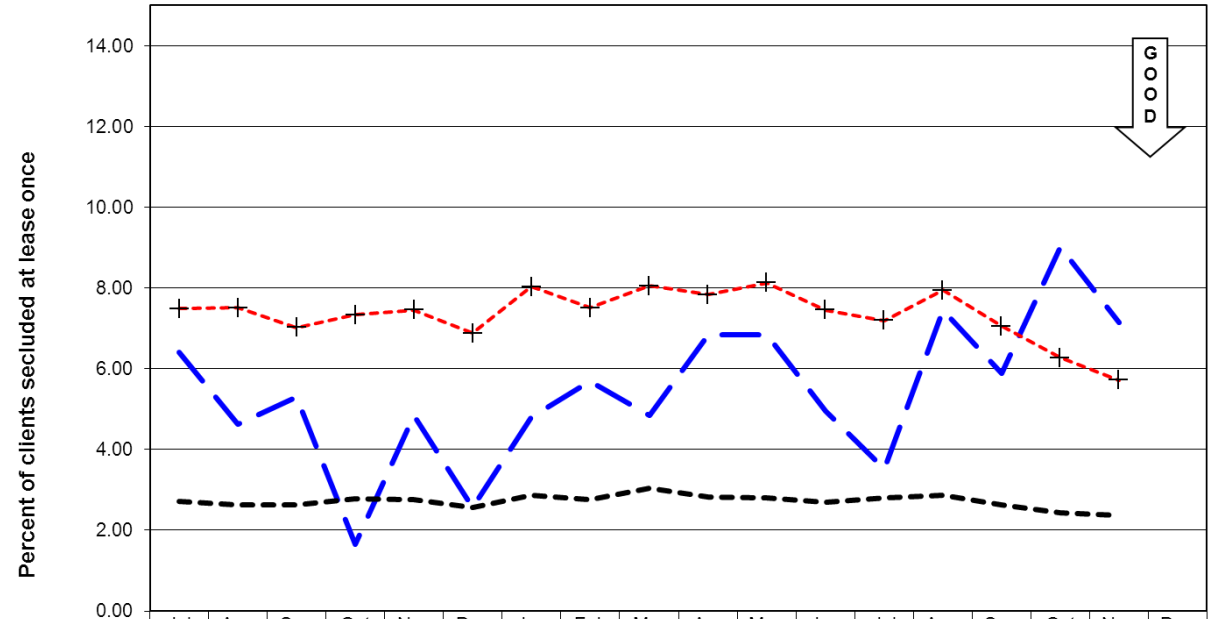
Treatment teams regularly monitor the needs of individual clients and make recommendations for ongoing treatment modalities. Staffing levels are carefully monitored to ensure that all treatment goals, exercise needs, and outdoor activities are achievable. Staffing does not present a barrier to the fulfillment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

CONSENT DECREE

Use of Seclusion and Restraints

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

Percent of Clients Secluded



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	6.40	4.62	5.30	1.65	4.84	2.56	4.80	5.69	4.84	6.84	6.84	4.96	3.51	7.44	5.88	9.01	7.14	
Ntl Mean	2.71	2.63	2.62	2.79	2.77	2.56	2.86	2.77	3.04	2.82	2.81	2.69	2.80	2.87	2.64	2.43	2.36	
+1 StDev	7.49	7.51	7.02	7.34	7.46	6.88	8.03	7.51	8.05	7.84	8.13	7.45	7.19	7.94	7.05	6.27	5.72	

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.

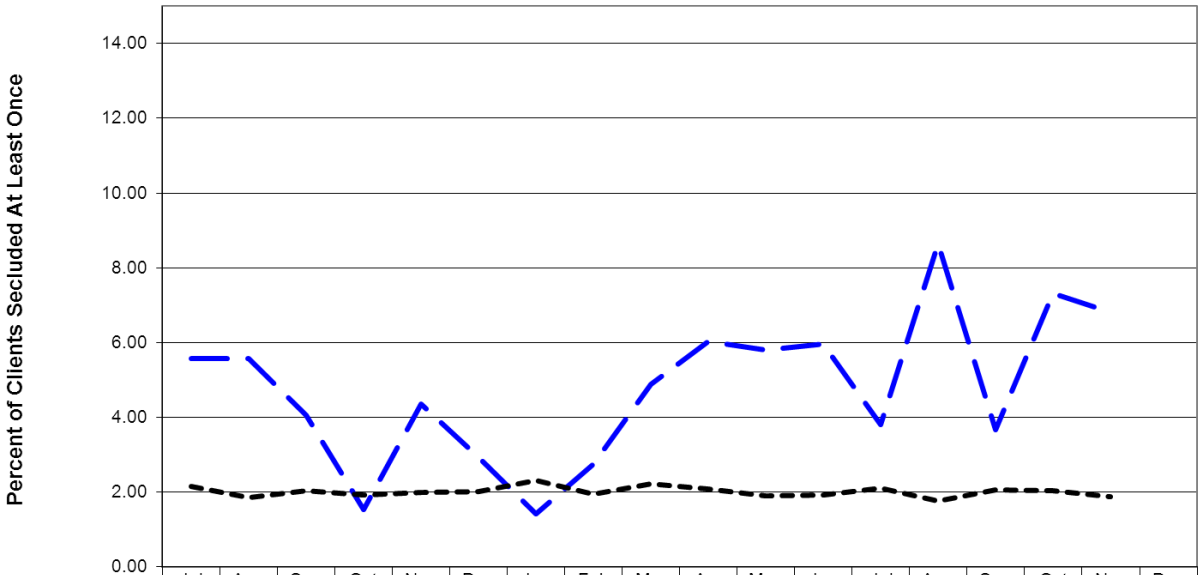
The following graphs depict the percent of unique clients who were secluded at least once stratified by forensic or civil classifications. For example, a rate of 3.0 means that 3% of the unique clients served were secluded at least once.

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.

CONSENT DECREE

Percent of Clients Secluded

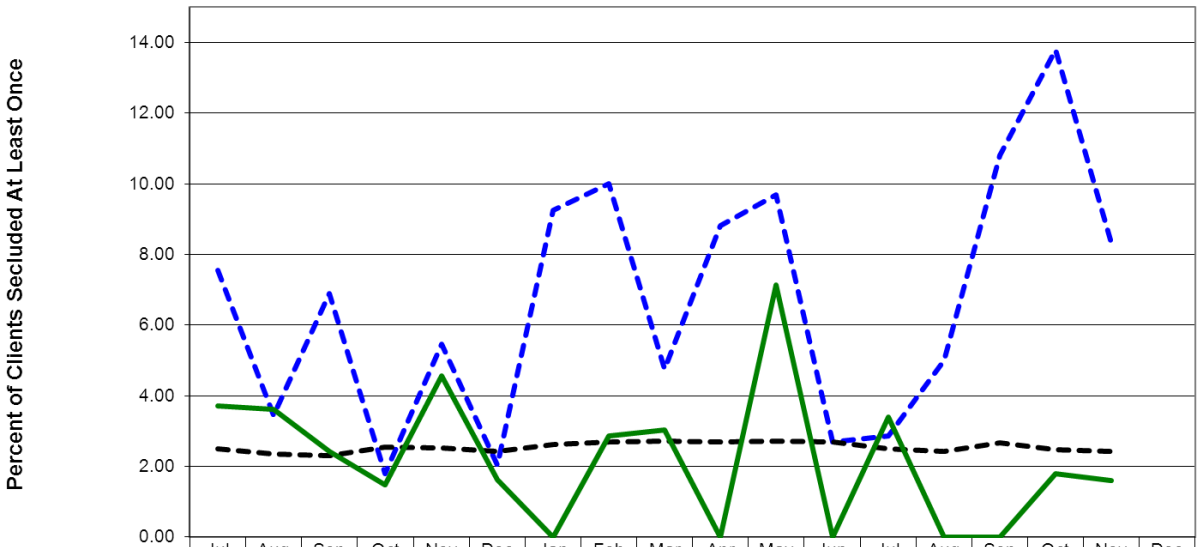
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	5.56	5.56	4.05	1.54	4.35	2.94	1.41	2.74	4.88	6.02	5.81	5.95	3.8	8.64	3.66	7.32	6.82	
Ntl Mean	2.14	1.85	2.03	1.92	1.99	2.02	2.32	1.95	2.21	2.08	1.9	1.92	2.1	1.75	2.06	2.04	1.88	

Percent of Clients Secluded

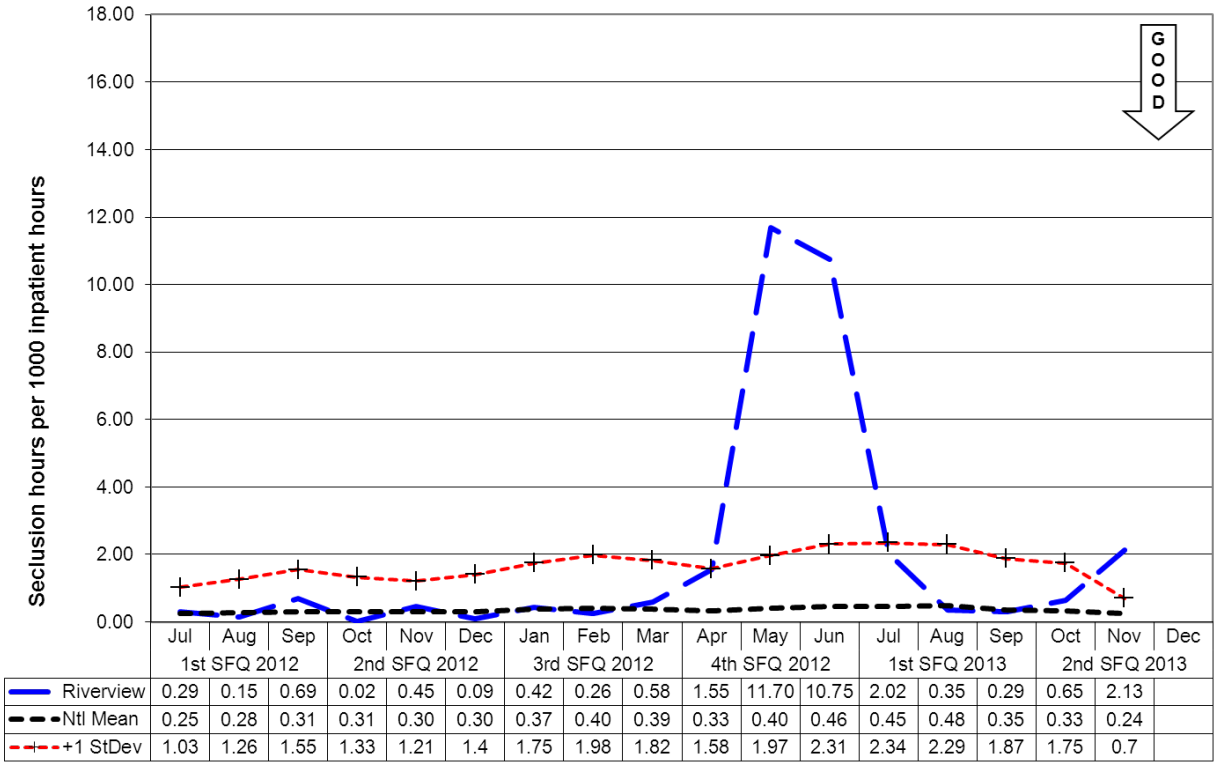
Civil Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	7.55	3.45	6.9	1.79	5.45	2.04	9.26	10	4.76	8.82	9.68	2.7	2.86	5	10.81	13.79	8.33	
Ntl Mean	2.5	2.36	2.29	2.55	2.53	2.43	2.61	2.68	2.71	2.69	2.72	2.7	2.5	2.43	2.67	2.47	2.41	
Dorothea Dix	3.70	3.61	2.41	1.47	4.55	1.61	0.00	2.86	3.03	0.00	7.14	0.00	3.39	0.00	0.00	1.79	1.59	

CONSENT DECREE

Seclusion Hours



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	0.29	0.15	0.69	0.02	0.45	0.09	0.42	0.26	0.58	1.55	11.70	10.75	2.02	0.35	0.29	0.65	2.13	
Ntl Mean	0.25	0.28	0.31	0.31	0.30	0.30	0.37	0.40	0.39	0.33	0.40	0.46	0.45	0.48	0.35	0.33	0.24	
+1 StDev	1.03	1.26	1.55	1.33	1.21	1.4	1.75	1.98	1.82	1.58	1.97	2.31	2.34	2.29	1.87	1.75	0.7	

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

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

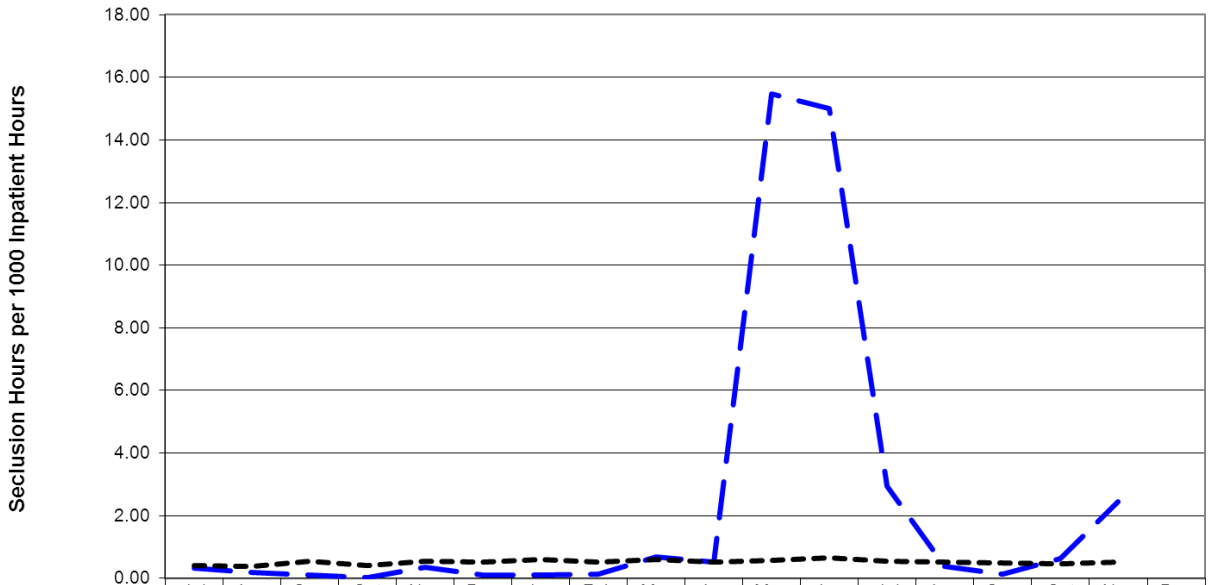
The following graphs depict the number of hours clients spent in seclusion for every 1000 inpatient hours stratified by forensic or civil classifications. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours.

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

CONSENT DECREE

Seclusion Hours

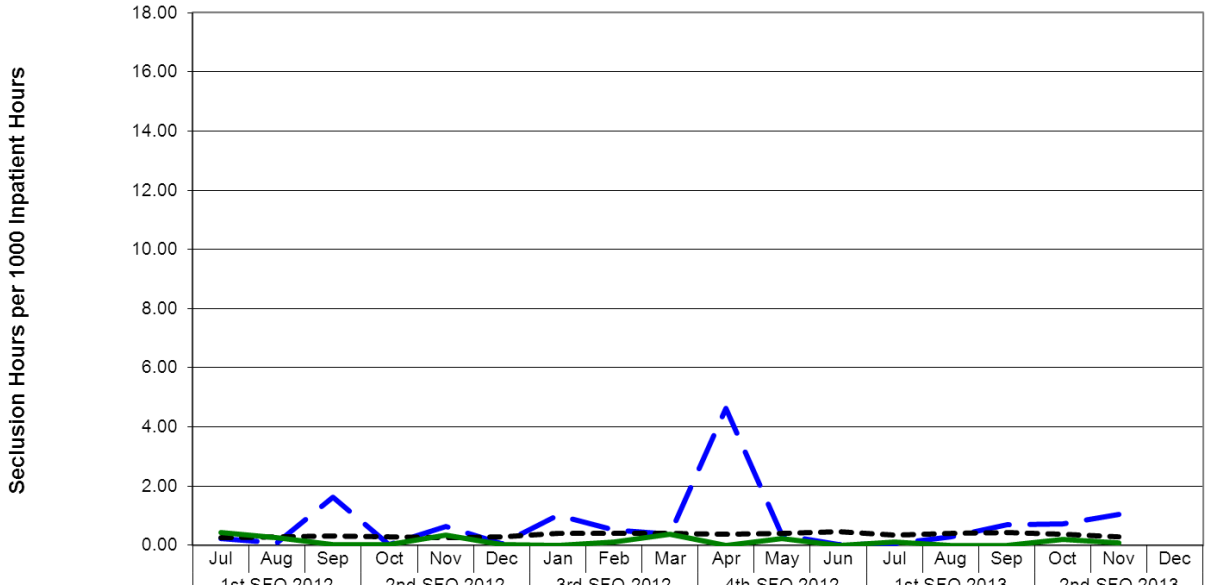
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	0.33	0.18	0.09	0.02	0.34	0.11	0.1	0.12	0.69	0.5	15.47	15.01	2.94	0.37	0.12	0.63	2.43	
Ntl Mean	0.4	0.38	0.53	0.41	0.55	0.51	0.59	0.52	0.59	0.52	0.57	0.64	0.55	0.5	0.49	0.448	0.5	

Seclusion Hours

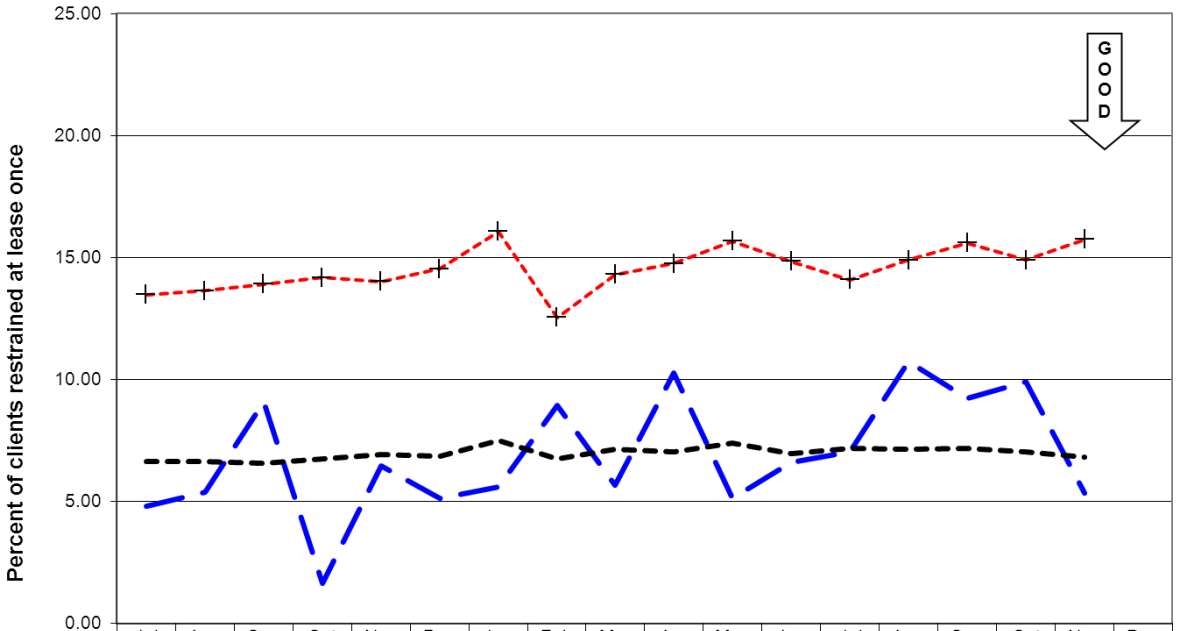
Civil Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	0.23	0.09	1.61	0.02	0.62	0.06	1	0.51	0.37	4.64	0.35	0.03	0.04	0.29	0.68	0.71	1.04	
Ntl Mean	0.24	0.27	0.31	0.28	0.26	0.27	0.4	0.41	0.4	0.37	0.4	0.47	0.35	0.39	0.42	0.37	0.27	
Dorothea Dix	0.44	0.25	0.02	0.02	0.33	0.02	0.00	0.10	0.38	0.00	0.22	0.00	0.10	0.00	0.00	0.20	0.09	

CONSENT DECREE

Percent of Clients Restrained



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	4.80	5.38	9.09	1.65	6.45	5.13	5.60	8.94	5.65	10.26	5.13	6.61	7.02	10.74	9.24	9.91	5.36	
Ntl Mean	6.64	6.64	6.58	6.73	6.92	6.85	7.50	6.74	7.15	7.04	7.39	6.95	7.17	7.14	7.17	7.02	6.80	
+1 StDev	13.47	13.63	13.91	14.18	14.01	14.53	16.06	12.55	14.31	14.76	15.66	14.84	14.09	14.89	15.6	14.89	15.74	

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

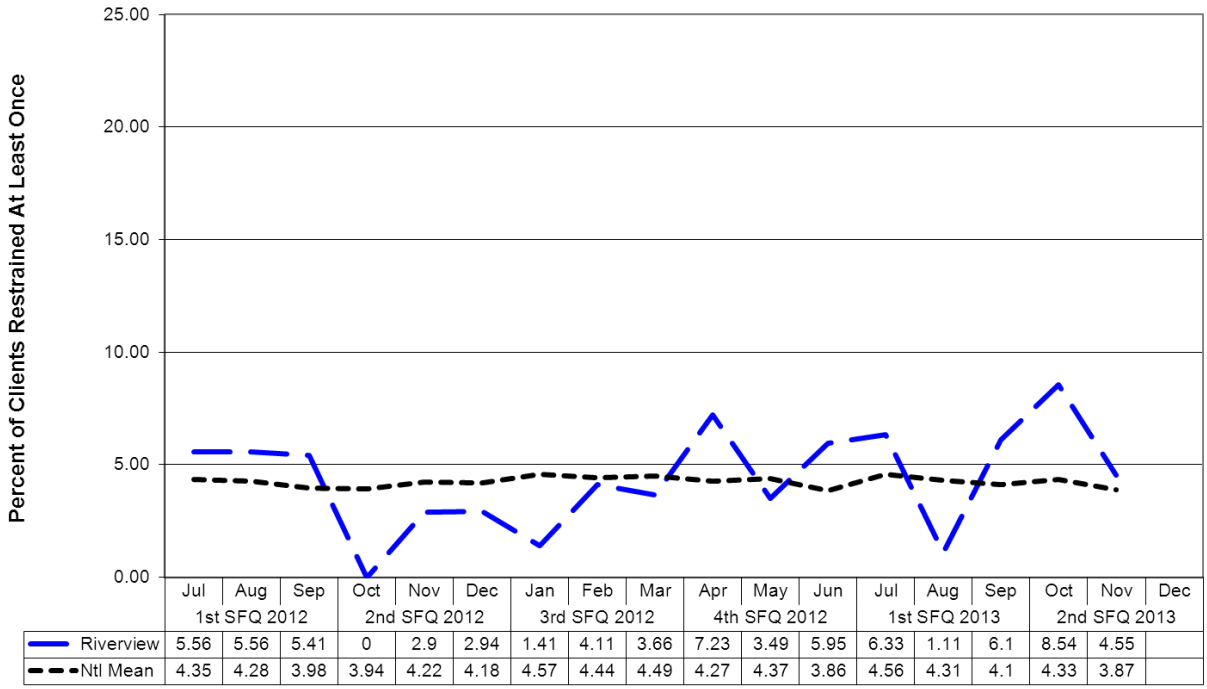
The following graphs depict the percent of unique clients who were restrained at least once stratified by forensic or civil classifications – includes all forms of restraint of any duration. For example, a rate of 4.0 means that 4% of the unique clients served were restrained at least once.

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

CONSENT DECREE

Percent of Clients Restrained

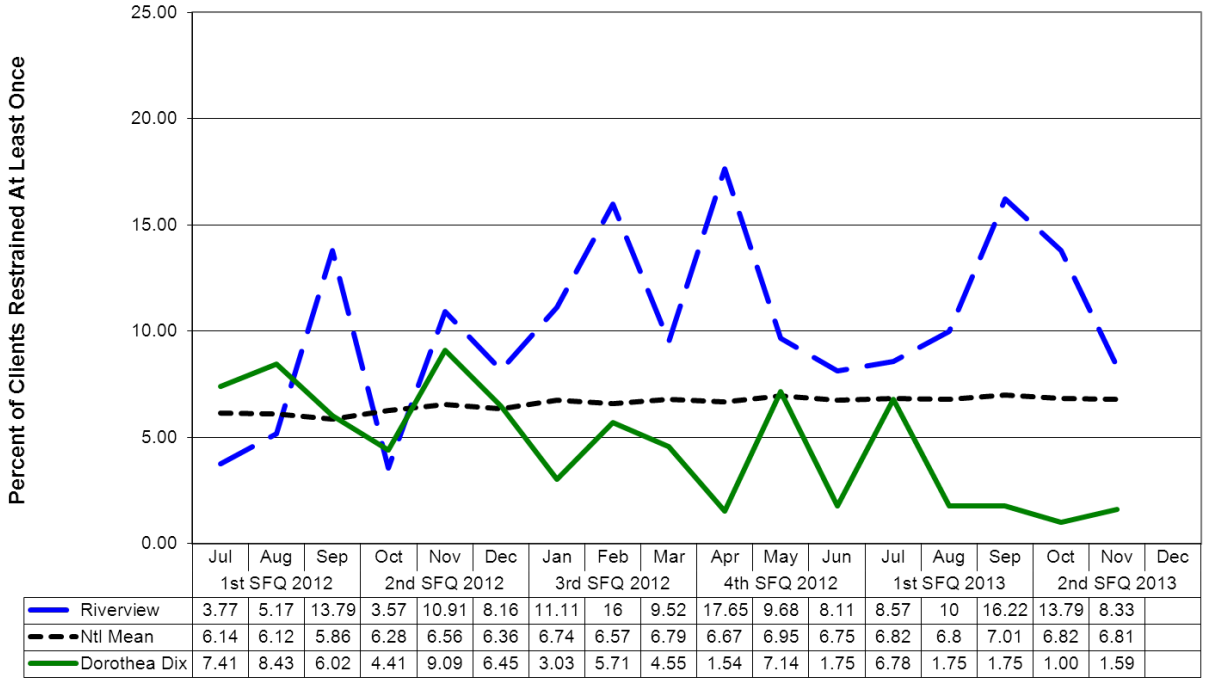
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	5.56	5.56	5.41	0	2.9	2.94	1.41	4.11	3.66	7.23	3.49	5.95	6.33	1.11	6.1	8.54	4.55	
Ntl Mean	4.35	4.28	3.98	3.94	4.22	4.18	4.57	4.44	4.49	4.27	4.37	3.86	4.56	4.31	4.1	4.33	3.87	

Percent of Clients Restrained

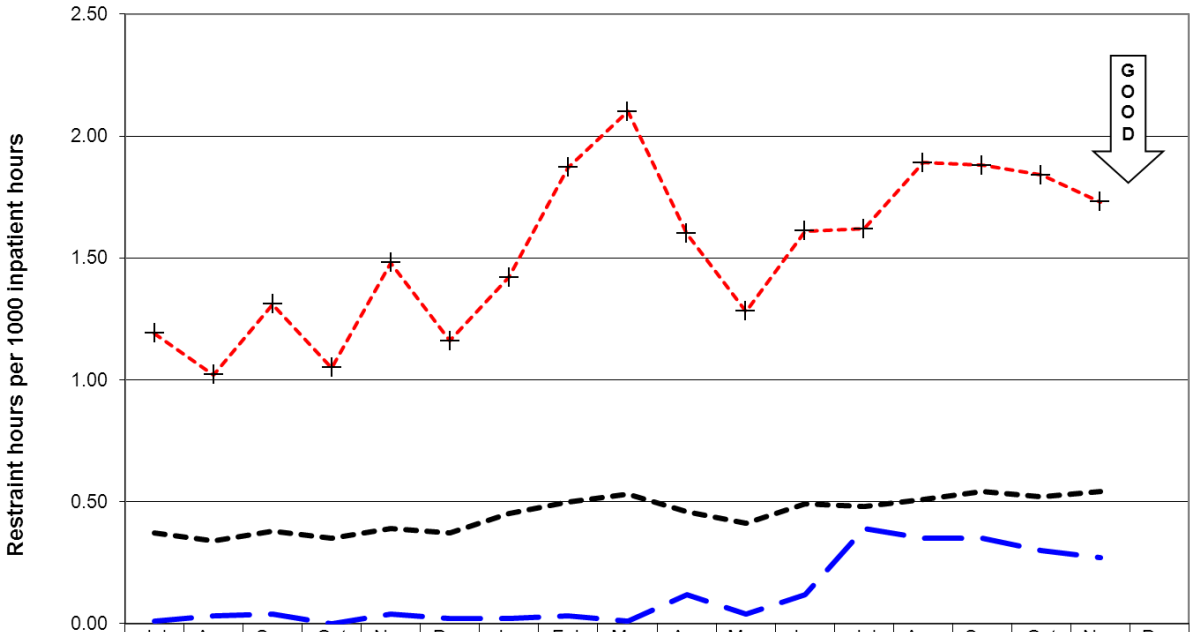
Civil Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	3.77	5.17	13.79	3.57	10.91	8.16	11.11	16	9.52	17.65	9.68	8.11	8.57	10	16.22	13.79	8.33	
Ntl Mean	6.14	6.12	5.86	6.28	6.56	6.36	6.74	6.57	6.79	6.67	6.95	6.75	6.82	6.8	7.01	6.82	6.81	
Dorothea Dix	7.41	8.43	6.02	4.41	9.09	6.45	3.03	5.71	4.55	1.54	7.14	1.75	6.78	1.75	1.75	1.00	1.59	

CONSENT DECREE

Restraint Hours



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	0.01	0.03	0.04	0.00	0.04	0.02	0.02	0.03	0.01	0.12	0.04	0.12	0.39	0.35	0.35	0.30	0.27	
Ntl Mean	0.37	0.34	0.38	0.35	0.39	0.37	0.45	0.50	0.53	0.46	0.41	0.49	0.48	0.51	0.54	0.52	0.54	
+1 StDev	1.19	1.02	1.31	1.05	1.48	1.16	1.42	1.87	2.1	1.6	1.28	1.61	1.62	1.89	1.88	1.84	1.73	

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.

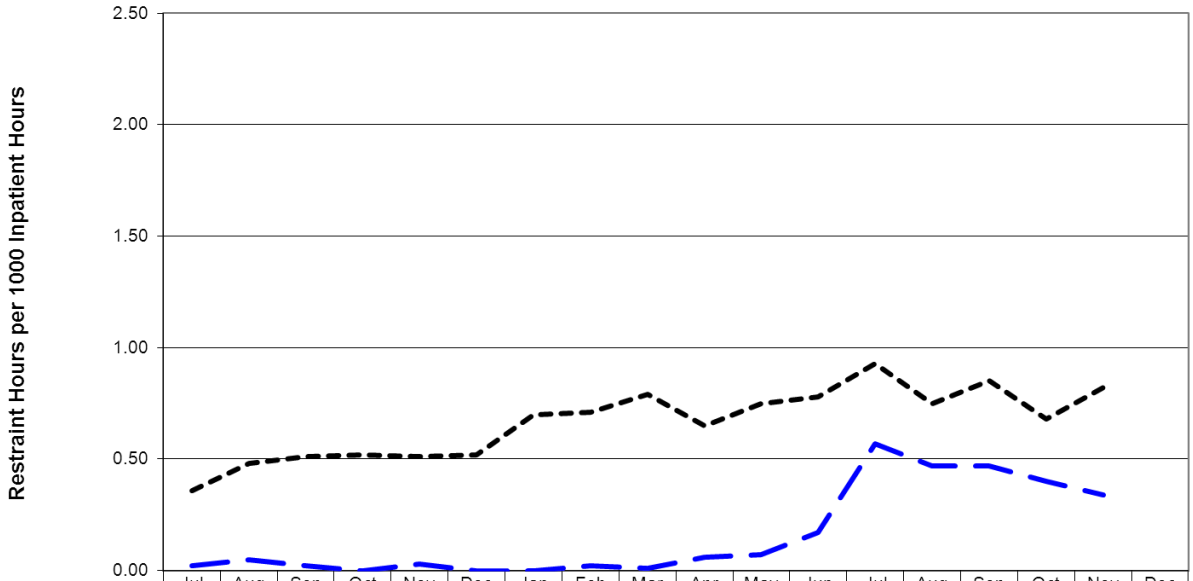
The following graphs depict the number of hours clients spent in restraint for every 1000 inpatient hours stratified by forensic or civil classifications - includes all forms of restraint of any duration. For example, a rate of 1.6 means that 2 hours were spent in restraint for each 1250 inpatient hours.

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.

CONSENT DECREE

Restraint Hours

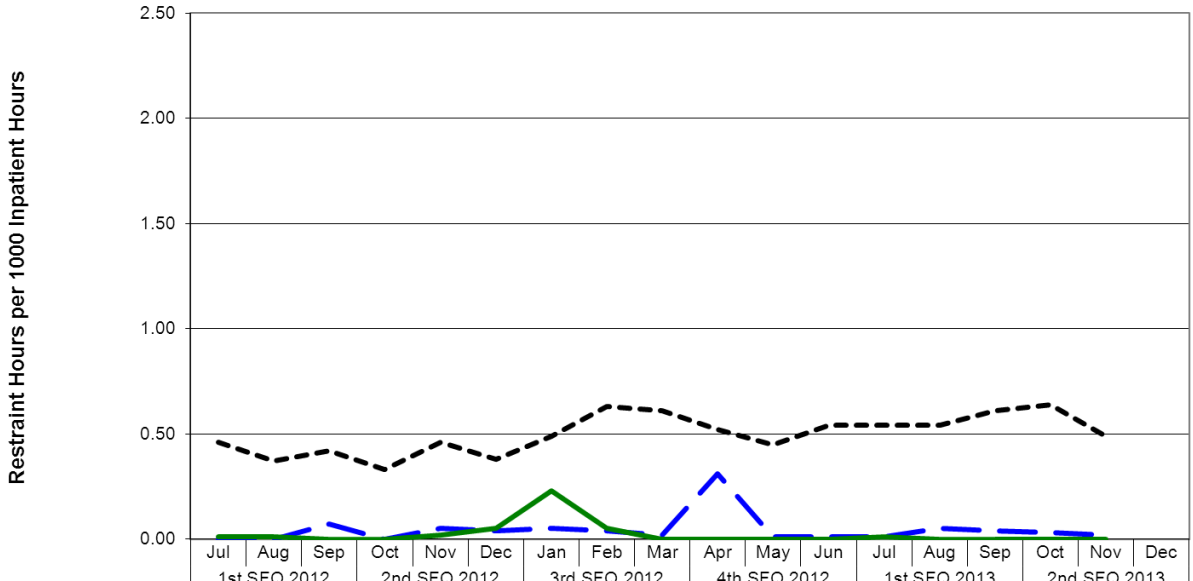
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	0.02	0.05	0.02	0.00	0.03	0.00	0.00	0.02	0.01	0.06	0.07	0.17	0.57	0.47	0.47	0.40	0.34	
Ntl Mean	0.36	0.48	0.51	0.52	0.51	0.52	0.70	0.71	0.79	0.65	0.75	0.78	0.93	0.75	0.85	0.68	0.82	

Restraint Hours

Civil Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	0.00	0.00	0.07	0.00	0.05	0.04	0.05	0.04	0.02	0.31	0.01	0.01	0.01	0.05	0.04	0.03	0.02	
Ntl Mean	0.46	0.37	0.42	0.33	0.46	0.38	0.49	0.63	0.61	0.52	0.45	0.54	0.54	0.54	0.61	0.64	0.49	
Dorothea Dix	0.01	0.01	0.00	0.00	0.02	0.05	0.23	0.05	0.00	0.00	0.00	0.00	0.01	0.00	0.00	0.00	0.00	

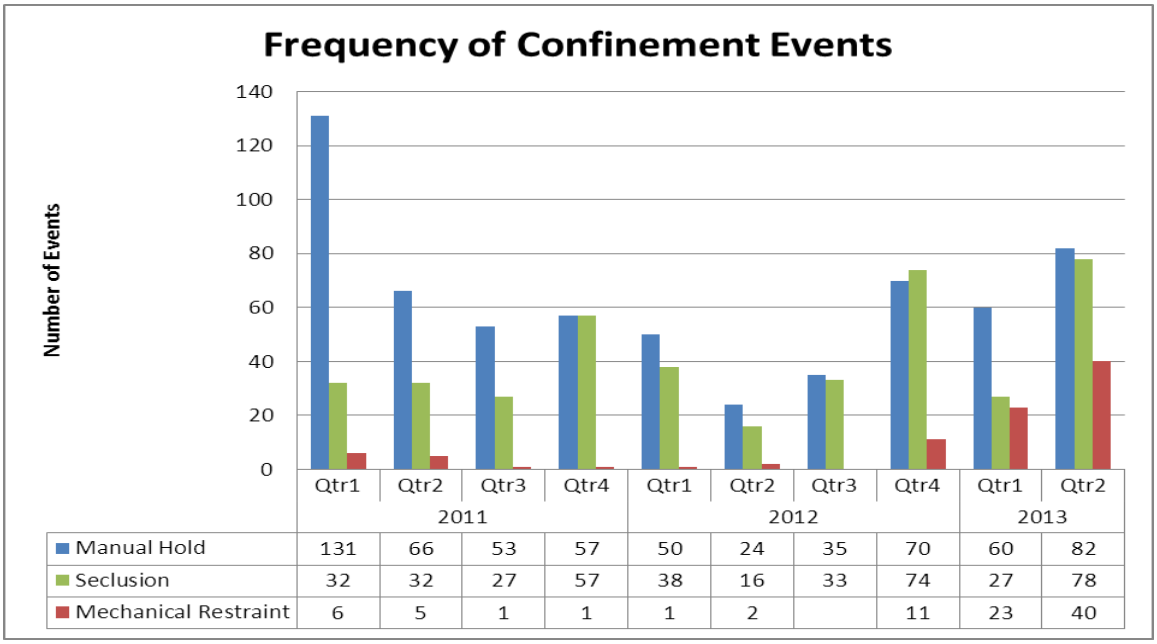
CONSENT DECREE

Confinement Event Detail

2nd Quarter 2013

	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
FR0000312892	32	13	29	74	37%	37%
FR0000289611	11	23	7	41	21%	58%
FR0000366310	9		12	21	11%	68%
FR0000374611	4		7	11	6%	74%
FR0000386581	3		5	8	4%	78%
FR0000344234	3		3	6	3%	81%
FR0000363754	2	2	1	5	3%	83%
FR0000387175	3	1		4	2%	85%
FR0000390369	1		3	4	2%	87%
FR0000363713	3		1	4	2%	89%
FR0000307819	1		2	3	2%	91%
FR0000372664	3			3	2%	92%
FR0000368050	2		1	3	2%	94%
FR0000387951		1	1	2	1%	95%
FR0000328245	1		1	2	1%	96%
FR0000377945	1		1	2	1%	97%
FR0000385542			2	2	1%	98%
FR0000366096			1	1	1%	98%
FR0000387837	1			1	1%	99%
FR0000374801			1	1	1%	99%
FR0000372250	1			1	1%	100%
FR0000000232	1			1	1%	100%
Grand Total	82	40	78	200		

28% (22/78) of average hospital population experienced some form of confinement event during the 2nd fiscal quarter 2013. Eight of these clients (10% of the average hospital population) accounted for 85% of the containment events. The trend in frequency of confinement event, specifically the increase in the trend related to mechanical restraints is due to a few high acute clients requiring special management to ensure the safety of the milieu.



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

Factors of Causation Related to Seclusion Events

	2Q12	3Q12	4Q12	1Q13	2Q13
Danger to Others/Self	15	31	73	23	78
Danger to Others	1	2		4	
Danger to Self			1		
% Dangerous Precipitation	100%	100%	100%	100%	100%
Total Events	16	33	74	27	78

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

Factors of Causation Related to Mechanical Restraint Events

	2Q12	3Q12	4Q12	1Q13	2Q13
Danger to Others/Self	2		11	22	40
Danger to Others				1	
Danger to Self					
% Dangerous Precipitation	100%	--	100%	100%	100%
Total Events	2	0	11	23	40

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

See Pages 26 & 27

CONSENT DECREE

Confinement Events Management

Seclusion Events (78) 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

CONSENT DECREE

Confinement Events Management

Mechanical Restraint Events (40) Events

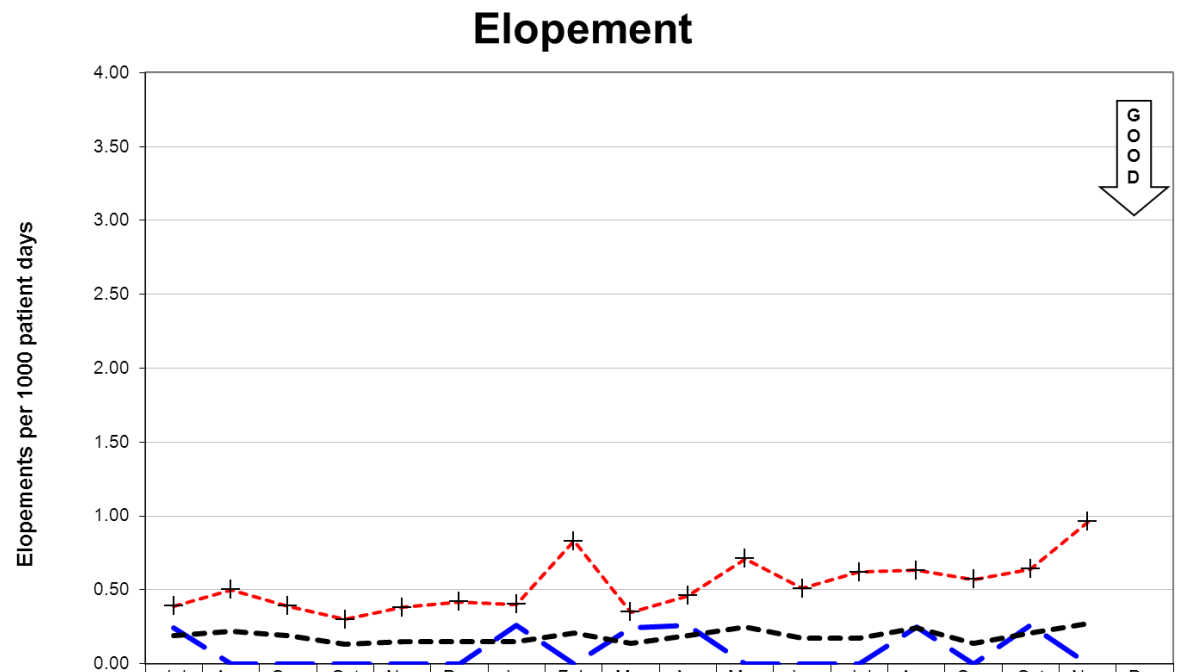
Standard	Threshold	Compliance
The record reflects that restraint was absolutely necessary to protect the patient from causing serious physical injury to self or others.	95%	100%
The record reflects that lesser restrictive alternatives were inappropriate or ineffective.	90%	100%
The record reflects that 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%

CONSENT DECREE

Client Elopements

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



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	0.24	0.00	0.00	0.00	0.00	0.00	0.26	0.00	0.24	0.26	0.00	0.00	0.00	0.25	0.00	0.26	0.00	
Ntl Mean	0.19	0.22	0.19	0.13	0.15	0.15	0.15	0.21	0.14	0.19	0.25	0.17	0.17	0.24	0.14	0.21	0.27	
StDev	0.39	0.5	0.39	0.3	0.38	0.42	0.4	0.83	0.35	0.46	0.71	0.51	0.62	0.63	0.57	0.64	0.96	

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

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

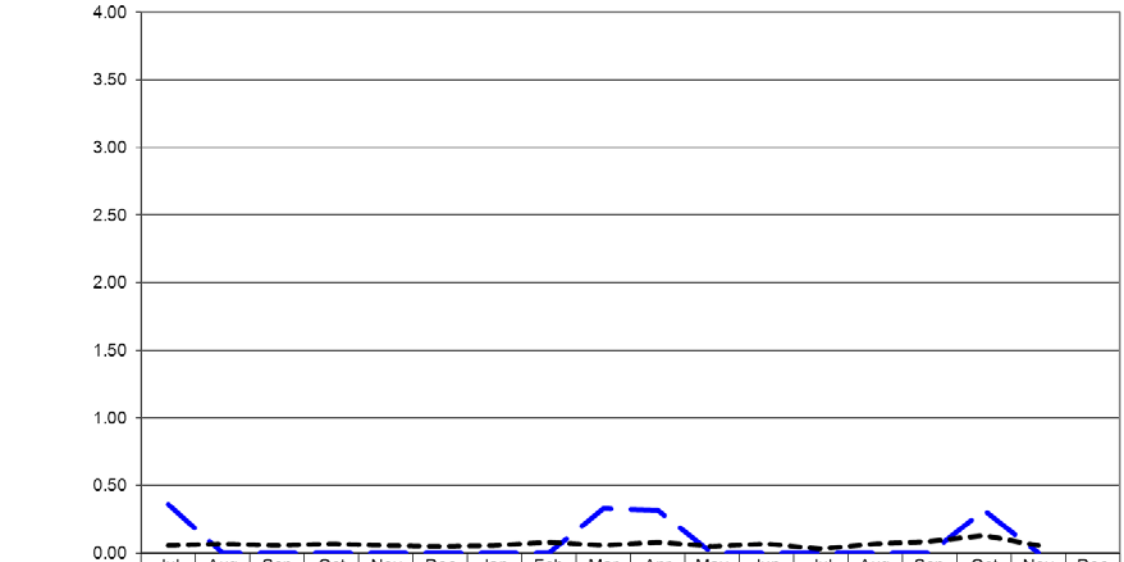
The following graphs depict the number of elopements stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days.

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

CONSENT DECREE

Elopement

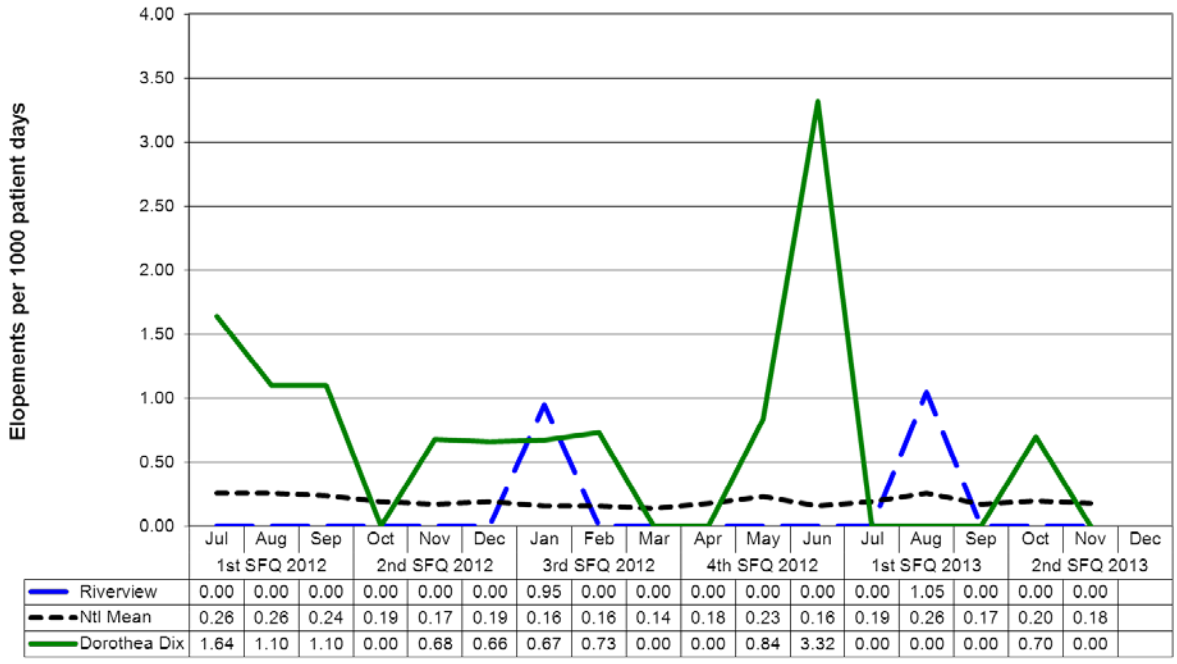
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	0.36	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.33	0.32	0.00	0.00	0.00	0.00	0.00	0.32	0.00	
Ntl Mean	0.06	0.07	0.06	0.07	0.06	0.05	0.06	0.08	0.06	0.08	0.05	0.07	0.03	0.07	0.09	0.13	0.06	

Elopement

Civil Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	0.00	0.00	0.00	0.00	0.00	0.00	0.95	0.00	0.00	0.00	0.00	0.00	0.00	1.05	0.00	0.00	0.00	
Ntl Mean	0.26	0.26	0.24	0.19	0.17	0.19	0.16	0.16	0.14	0.18	0.23	0.16	0.19	0.26	0.17	0.20	0.18	
Dorothea Dix	1.64	1.10	1.10	0.00	0.68	0.66	0.67	0.73	0.00	0.00	0.84	3.32	0.00	0.00	0.00	0.70	0.00	

Client Injuries

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

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

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

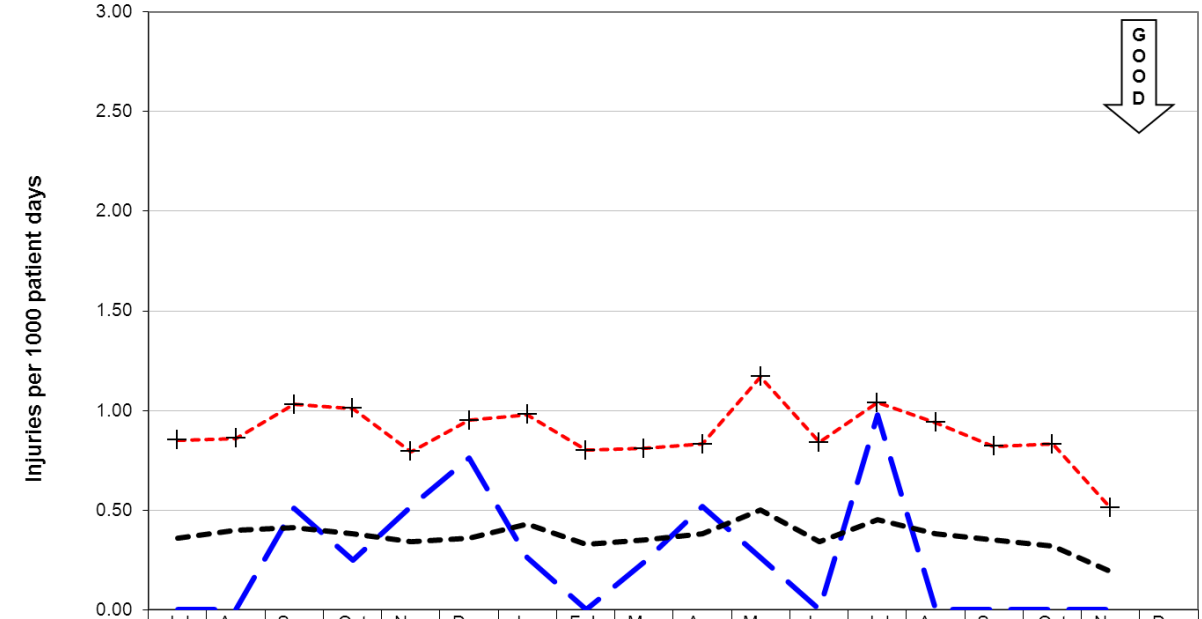
Reportable injuries include those that require: 3) Medical Intervention, 4) Hospitalization or where, 5) Death Occurred.

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

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

CONSENT DECREE

Client Injury Rate



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	0.00	0.00	0.51	0.25	0.52	0.76	0.26	0.00	0.24	0.52	0.26	0.00	0.98	0.00	0.00	0.00	0.00	
Ntl Mean	0.36	0.40	0.41	0.38	0.34	0.36	0.43	0.33	0.35	0.38	0.50	0.34	0.45	0.38	0.35	0.32	0.19	
+1 StDev	0.85	0.86	1.03	1.01	0.79	0.95	0.98	0.80	0.81	0.83	1.17	0.84	1.04	0.94	0.82	0.83	0.51	

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

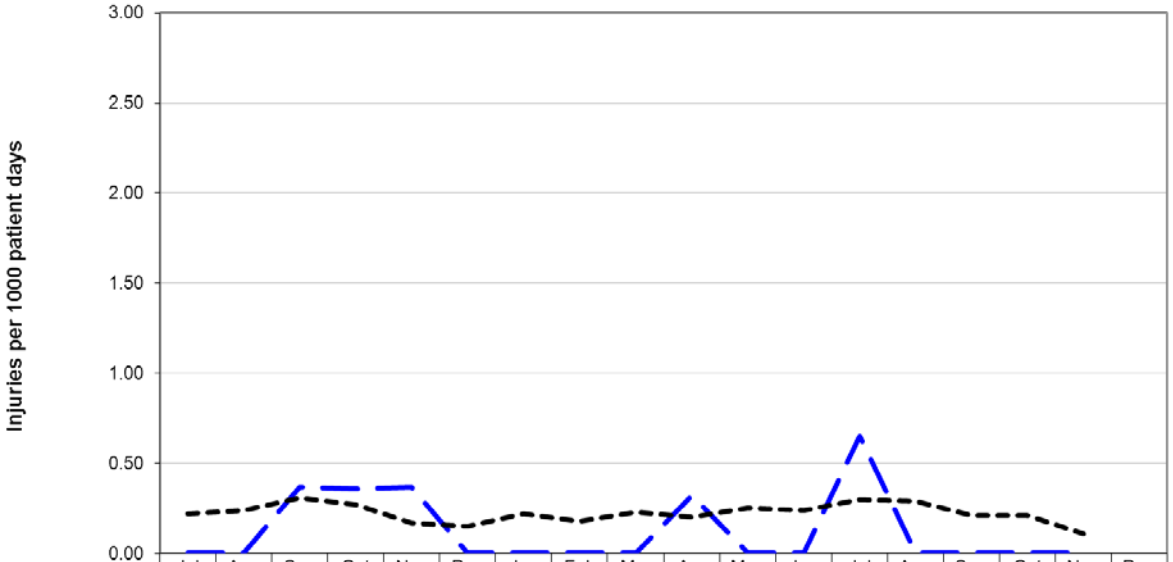
The following graphs depict the number of client injury events stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days.

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

CONSENT DECREE

Client Injury Rate

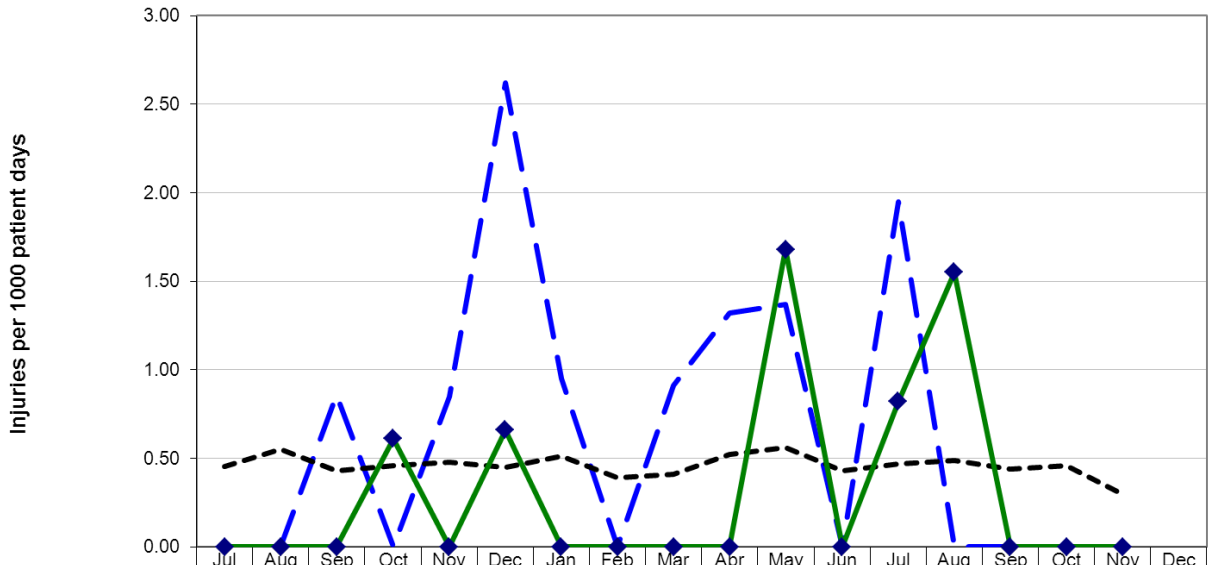
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	0.00	0.00	0.37	0.36	0.37	0.00	0.00	0.00	0.00	0.32	0.00	0.00	0.65	0.00	0.00	0.00	0.00	
Ntl Mean	0.22	0.24	0.31	0.27	0.17	0.15	0.22	0.18	0.23	0.20	0.25	0.24	0.30	0.29	0.21	0.21	0.11	

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 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	0.00	0.00	0.86	0.00	0.85	2.62	0.95	0.00	0.91	1.32	1.37	0.00	1.95	0.00	0.00	0.00	0.00	
Ntl Mean	0.46	0.55	0.43	0.46	0.48	0.45	0.51	0.39	0.41	0.52	0.56	0.43	0.47	0.49	0.44	0.46	0.30	
Dorothea Dix	0.00	0.00	0.00	0.61	0.00	0.66	0.00	0.00	0.00	0.00	1.68	0.00	0.82	1.55	0.00	0.00	0.00	

Severity of injury by Month

Severity	OCT	NOV	DEC	2Q2013
No Treatment	15	10	13	38
Minor First Aid		1		1
Medical Intervention Required			1	1
Hospitalization Required				
Death Occurred				
Total	15	11	14	40

The event that required medical intervention involved a client to client assault.

Type and Cause of Injury by Month

Type - Cause	OCT	NOV	DEC	2Q2013
Accident – Fall Unwitnessed	8	4	7	19
Accident – Fall Witnessed	5	4	5	14
Accident – Other	1	3	2	6
Assault				0
Self-Injurious Behavior	1			1

Due to the potential for injury and since falls are the predominant cause of potentially injurious events, fall incidents remain a focus of the hospital. Three of the fall incidents that occurred during the last quarter required medical intervention by an in-house provider, four required minor first aid. The remainder required no treatment.

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

Patient Abuse, Neglect, Exploitation, Injury or Death

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

Type of Allegation	3Q2012	4Q2012	1Q2013	2Q2013
Abuse Physical	3	2	3	5
Abuse Sexual	3	10	6	2
Abuse Verbal				1
Coercion	1	2		
Neglect	1			

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

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

Performance Improvement and Quality Assurance

V34) Riverview maintains Joint Commission accreditation;

Riverview successfully completed an accreditation survey with the Joint Commission on November 15-19, 2010.

The surveyors identified four areas of direct impact that required a review and revision of hospital processes within 45 days.

The surveyors identified nine areas of indirect impact that required a review and revision of hospital processes within 60 days.

Riverview received notification of full accreditation status on October 3, 2011 with an effective date of November 20, 2010.

V35) Riverview maintains its hospital license;

Riverview maintains licensing status as required through the Department of Health and Human Services Division of Licensing and Regulatory Services Centers for Medicare and Medicaid Services.

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

Centers for Medicare and Medicaid Services certification is ongoing and applicable for all units, including the Lower Saco SCU. Lower Saco SCU received CMS Certification in January 2011. This certification is required to ensure reimbursement under Medicare, Medicaid, and through the Disproportionate Share Process.

V37) Riverview conducts quarterly monitoring of performance indicators in key areas of hospital administration, in accordance with the Consent Decree Plan, and demonstrates through quarterly reports that management uses that data to improve institutional performance, prioritize resources and evaluate strategic operations.

Riverview complies with this element of substantial compliance as evidenced by this document and a transition to an improvement orientated methodology that is support by the Joint Commission and is consistent with modern principles of process management and strategic methods of promoting organizational performance excellence.

JOINT COMMISSION

Hospital-Based Inpatient Psychiatric Services (ORYX Data Elements)

The Joint Commission Quality Initiatives

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

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

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

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

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

Assessment

Treatment Planning and Implementation

Hope and Empowerment

Patient Driven Care

Patient Safety

Continuity and Transition of Care

Outcomes

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

JOINT COMMISSION

Admissions Screening (HBIPS 1)

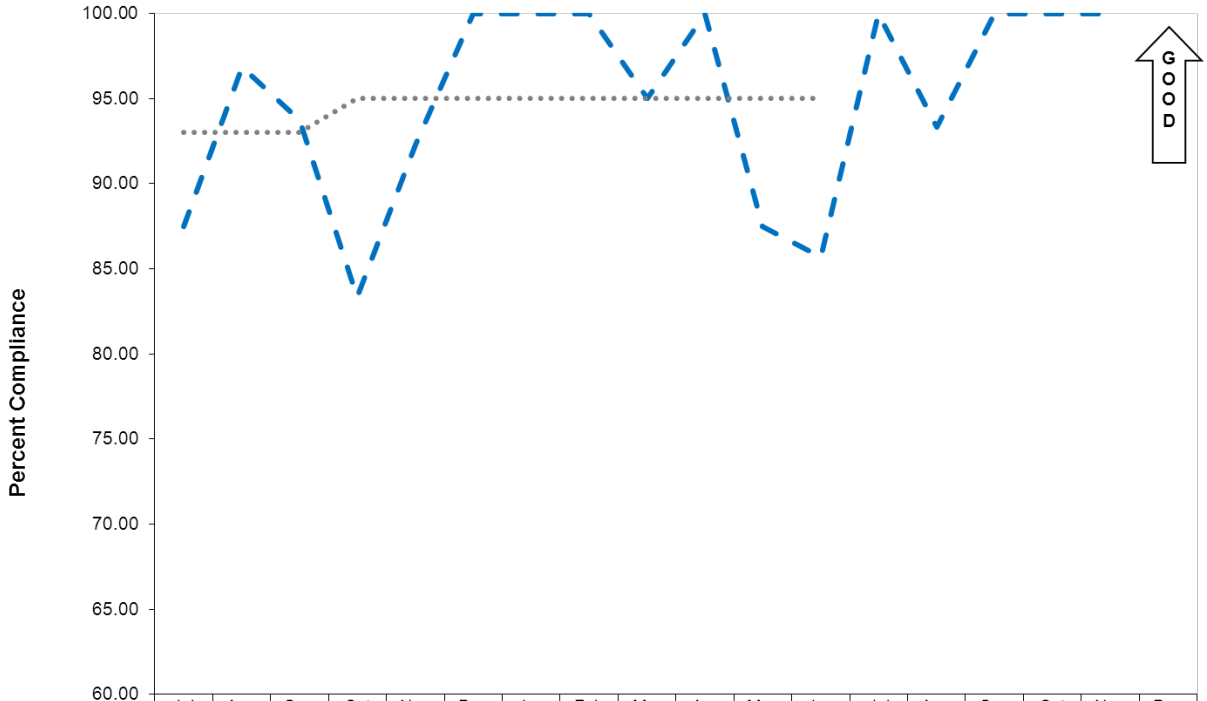
For Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths

Description

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

Rationale

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



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
RPC Rate	87.50	96.88	93.75	83.33	92.31	100.00	100.00	100.00	95.00	100.00	87.50	85.71	100.00	93.33	100.00	100.00	100.00	
TJC Target	93.00	93.00	93.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00						

JOINT COMMISSION

Physical Restraint (HBIPS 2)

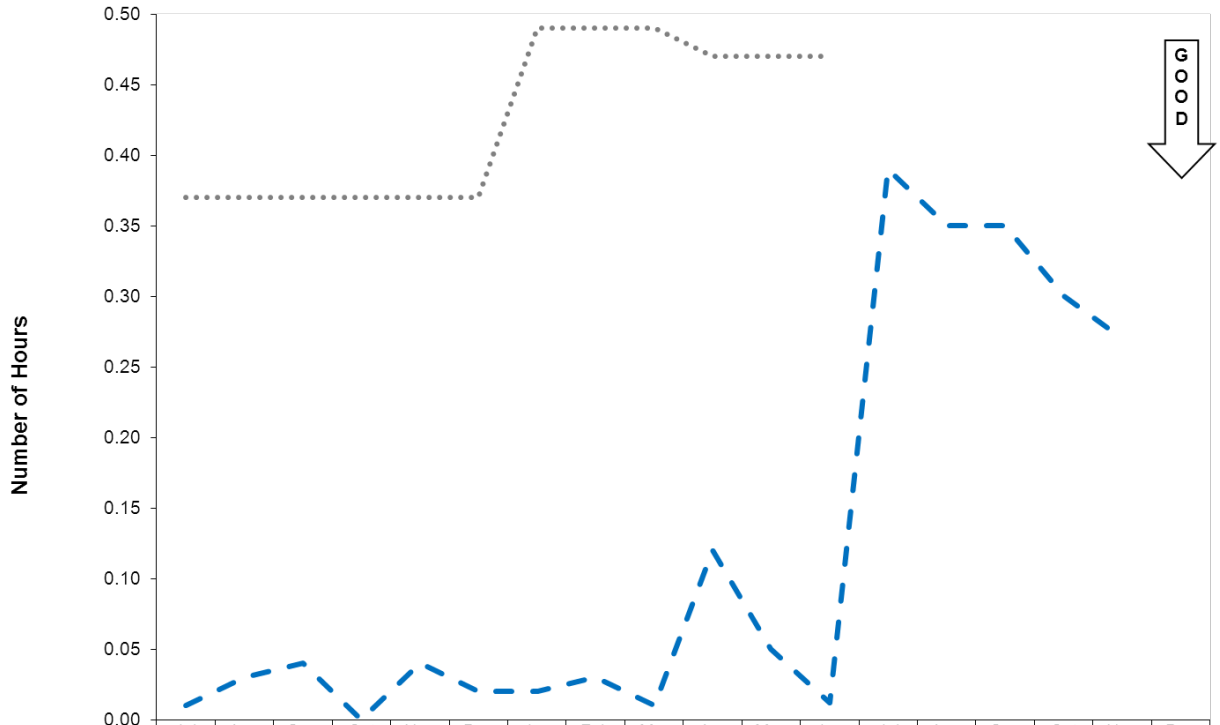
Hours of Use

Description

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

Rationale

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



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
RPC Rate	0.01	0.03	0.04	0.00	0.04	0.02	0.02	0.03	0.01	0.12	0.05	0.01	0.39	0.35	0.35	0.30	0.27	
TJC Target	0.37	0.37	0.37	0.37	0.37	0.37	0.49	0.49	0.49	0.47	0.47	0.47						

JOINT COMMISSION

Seclusion (HBIPS 3)

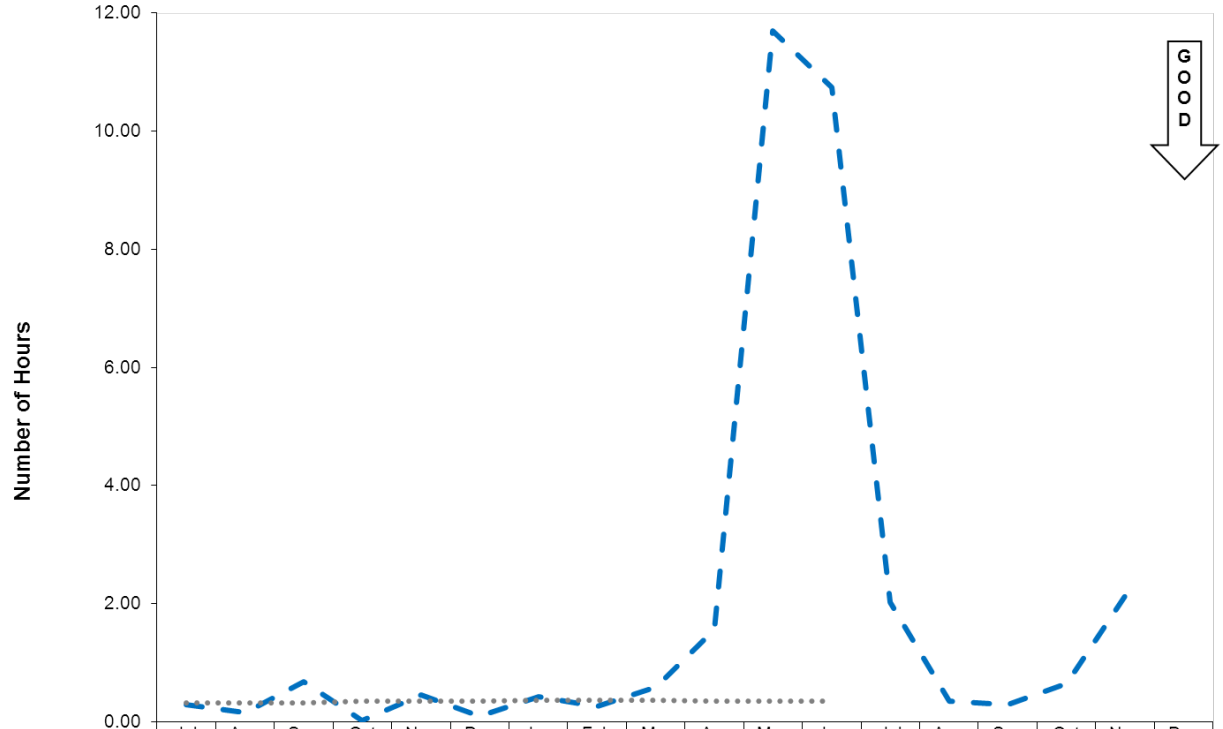
Hours of Use

Description

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

Rationale

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



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
RPC Rate	0.29	0.15	0.68	0.02	0.45	0.09	0.42	0.26	0.58	1.55	11.70	10.75	2.02	0.35	0.29	0.65	2.13	
TJC Target	0.31	0.31	0.31	0.34	0.34	0.34	0.36	0.36	0.36	0.35	0.35	0.35						

JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)

Description

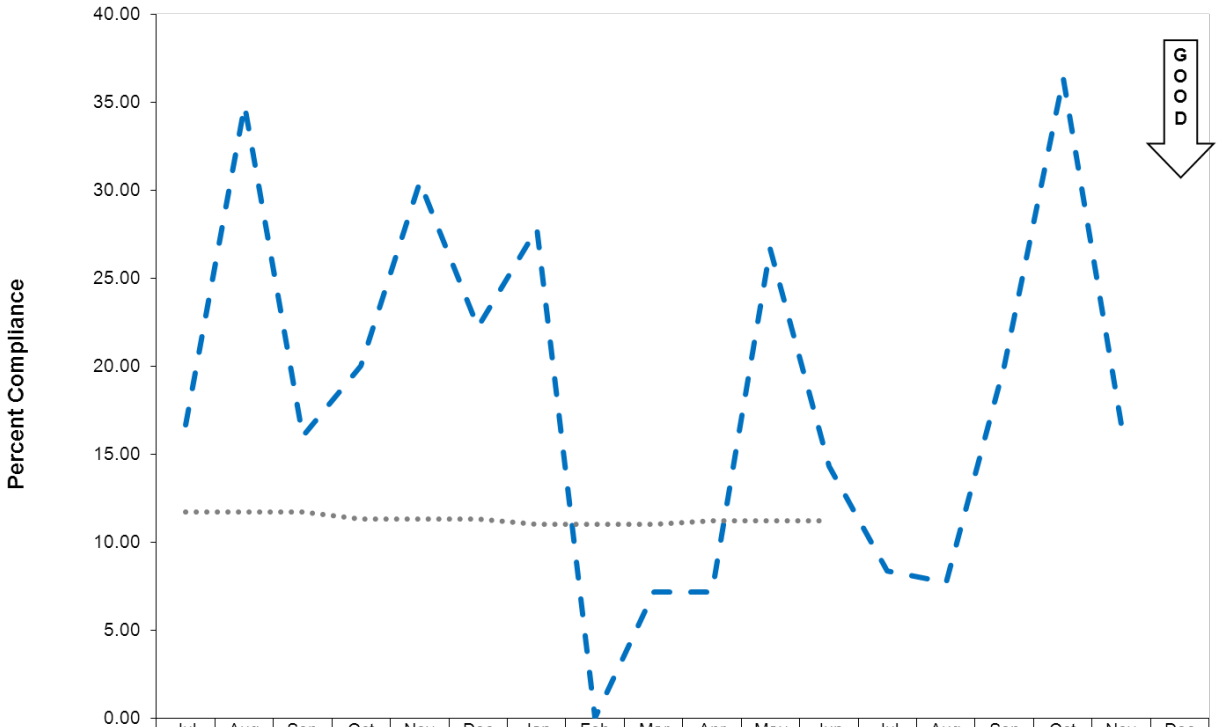
Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications

Rationale

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

JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
RPC Rate	16.67	34.78	16.00	20.00	30.43	22.22	27.78	0.00	7.14	7.14	26.67	14.29	8.33	7.69	20.00	36.36	16.67	
TJC Target	11.70	11.70	11.70	11.30	11.30	11.30	11.00	11.00	11.00	11.20	11.20	11.20						

JOINT COMMISSION

Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)

Description

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

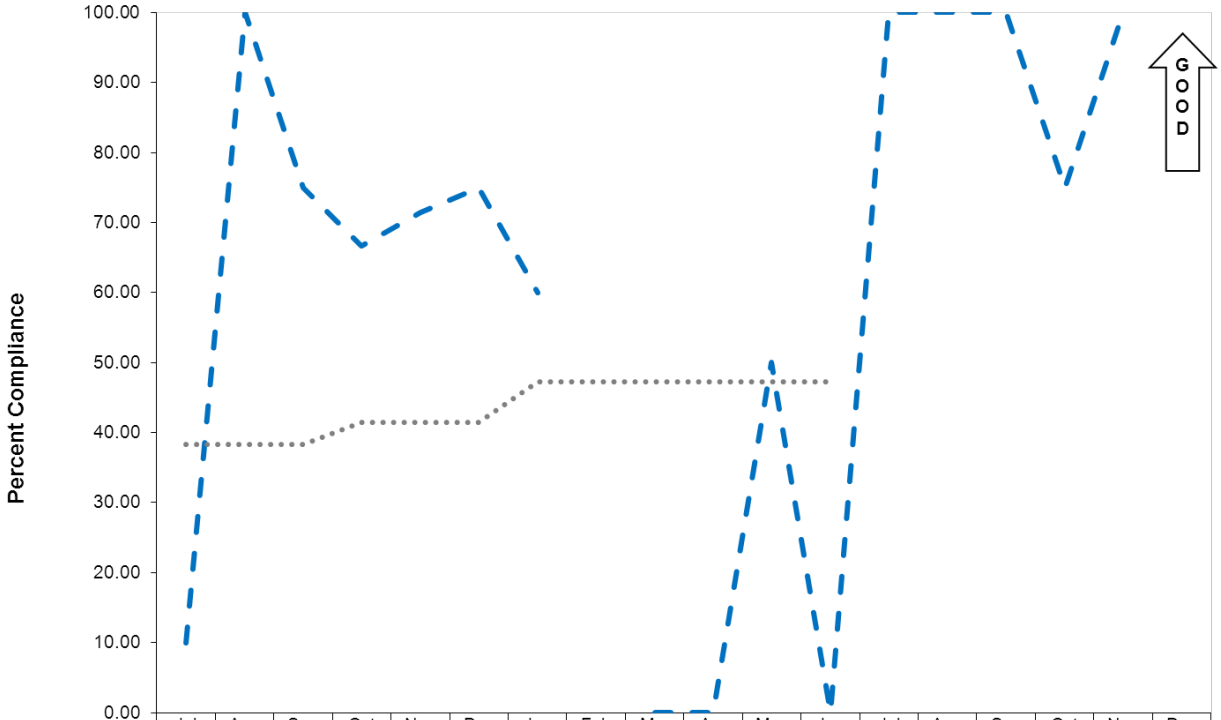
Rationale

Research studies have found that 4-35% of outpatients and 30-50% of inpatients treated with an antipsychotic medication concurrently received 2 or more antipsychotics (Covell, Jackson, Evans, & Essock, 2002; Ganguly, Kotzan, Miller, Kennedy, & Martin, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; Kreyenbuhl, Valenstein, McCarthy, Ganocyz, & Blow, 2006; Stahl & Grady, 2004). One study reported 4.6% of patients concurrently received 3 or more antipsychotics (Jaffe & Levine, 2003). These findings are seen across diverse sectors: state mental health authorities, the Veterans Health System and Medicaid-financed care. Antipsychotic polypharmacy can lead to greater side effects, often without improving clinical outcomes (Ananth, Parameswaran, & Gunatilake, 2004; Stahl & Grady, 2004). As a result, a range of stakeholders have called for efforts to reduce unnecessary use of multiple antipsychotics (Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; National Association of State Mental Health Program Directors, 2001; University HealthSystem Consortium, 2006).

Practice guidelines recommend the use of a second antipsychotic only after multiple trials of a single antipsychotic have proven inadequate (American Psychiatric Association [APA] Practice Guidelines, 2004). Randomized controlled trials (RCTs) provide some evidence to support augmentation with a second antipsychotic in *treatment resistant* patients. Most of these studies were limited to augmentation of clozapine with another second-generation antipsychotic (Tranulis, Skalli, Lalonde, & Nicole, 2008). Among patients *without* a documented history of previous treatment failures of antipsychotic monotherapy, multiple RCTs and other controlled trials failed to show a benefit of antipsychotic polypharmacy over monotherapy (Ananth, Parameswaran, & Gunatilake, 2004; Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Potkin, Thyrum, Alva, Bera, Yeh, & Arvanitis, 2002; Shim et al., 2007; Stahl,& Grady, 2004). Clinical circumstances, such as shorter inpatient stays, may require hospitals to discharge a patient on multiple antipsychotics with an aftercare plan to transition to monotherapy. In such cases, effective communication between the inpatient and aftercare clinician is an essential element of care.

JOINT COMMISSION

Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
RPC Rate	10.00	100.00	75.00	66.67	71.43	75.00	60.00		0.00	0.00	50.00	0.00	100.00	100.00	100.00	75.00	100.00	
TJC Target	38.30	38.30	38.30	41.50	41.50	41.50	47.30	47.30	47.30	47.20	47.20	47.20						

JOINT COMMISSION

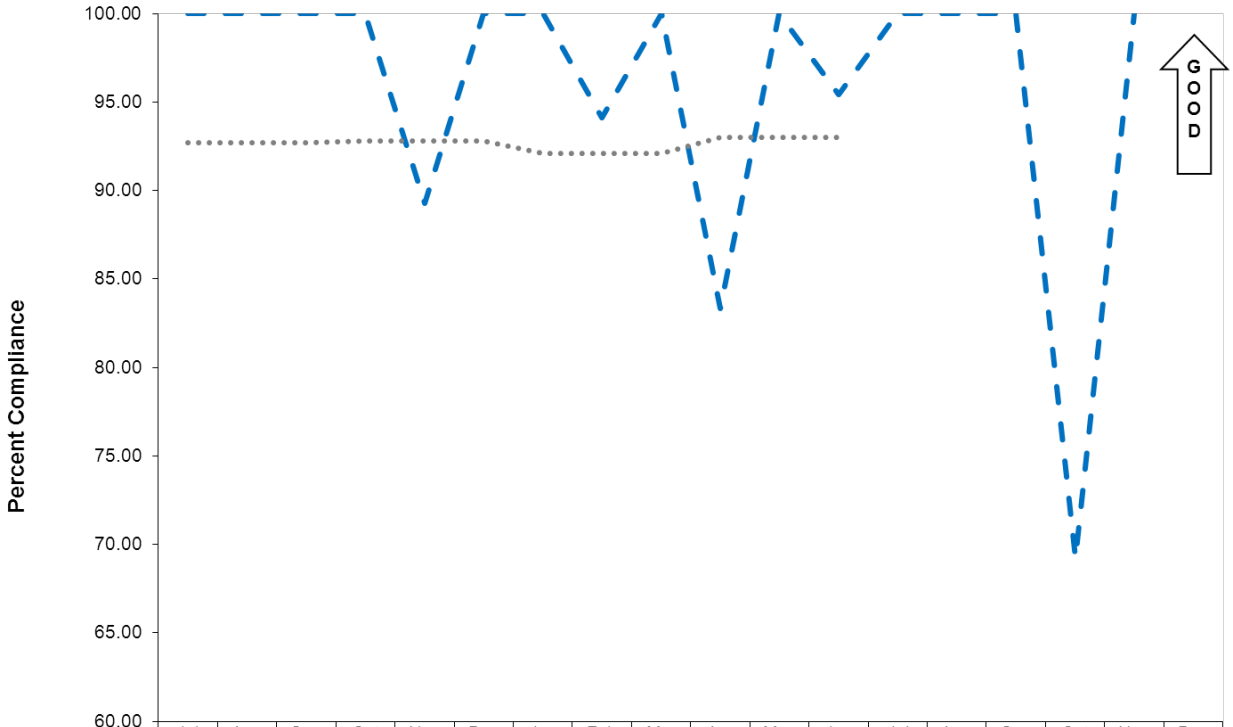
Post Discharge Continuing Care Plan (HBIPS 6)

Description

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

Rationale

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



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
RPC Rate	100.00	100.00	100.00	100.00	89.29	100.00	100.00	94.12	100.00	83.33	100.00	95.45	100.00	100.00	100.00	69.23	100.00	
TJC Target	92.70	92.70	92.70	92.80	92.80	92.80	92.10	92.10	92.10	93.00	93.00	93.00						

JOINT COMMISSION

Post Discharge Continuing Care Plan Transmitted (HBIPS 7)

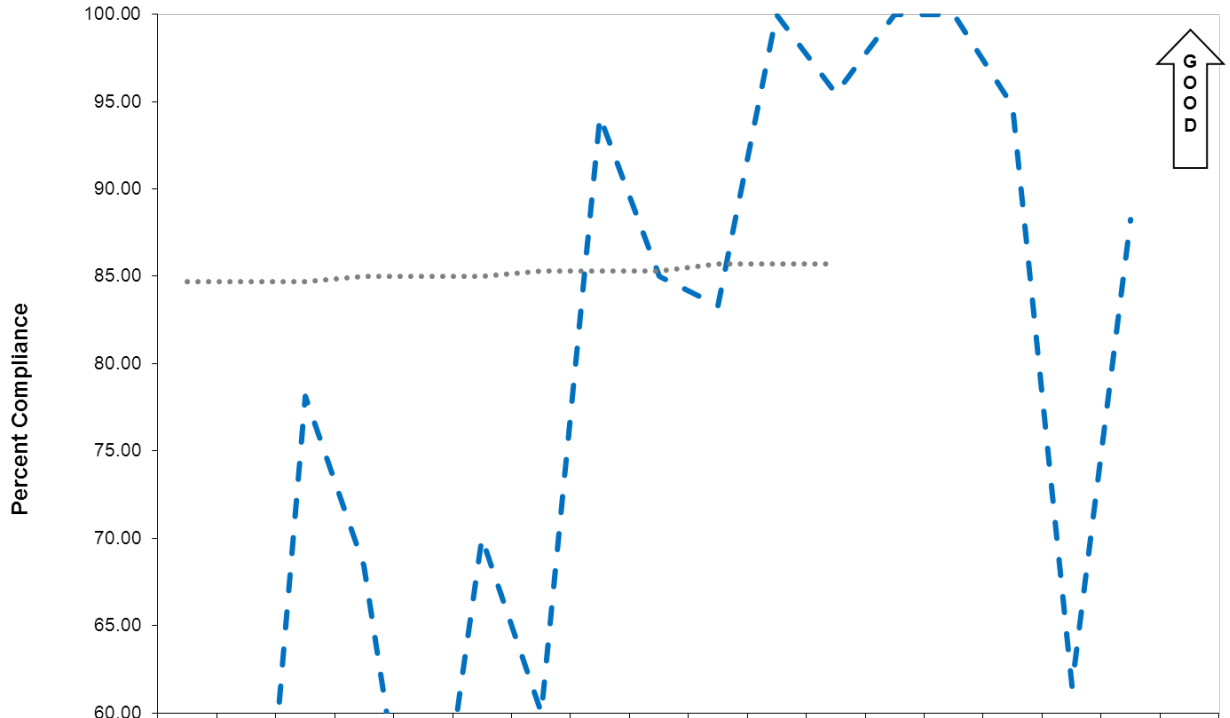
To Next Level of Care Provider on Discharge

Description

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

Rationale

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



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
RPC Rate	45.83	38.71	78.13	68.42	46.43	70.00	60.00	94.12	85.00	83.33	100.00	95.45	100.00	100.00	94.74	61.54	88.24	
TJC Target	84.70	84.70	84.70	85.00	85.00	85.00	85.30	85.30	85.30	85.70	85.70	85.70						

JOINT COMMISSION

Joint Commission Priority Focus Areas

Capital Community Clinic

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

Dental Clinic Timeout/Identification of Client

Indicators	1Q2013	2Q2013	3Q2013	4Q2013
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. A time out will be taken before the procedure to verify location and numbered tooth. The time out section is in the progress notes of the patient chart. This page will be signed by the Dentist as well as the dental assistant.	**July** 100% 14/14 **August** 100% 4/4 **September** 100% 5/5 **Total** 100% 23/23	**October** 100% 5/5 **November** 100% 3/3 **December** 100% 4/4 **Total** 100% 12/12	**January** **February** **March** **Total**	**April** **May** **June** **Total**

Dental Clinic Post Extraction Prevention of Complications and Follow-up

Indicators	1Q2013	2Q2013	3Q2013	4Q2013
1. All clients with tooth extractions, will be assessed and have teaching post procedure, on the following topics, as provided by the Dentist or Dental Assistant • Bleeding • Swelling • Pain • Muscle soreness • Mouth care • Diet • Signs/symptoms of infection 2. The client, post procedure tooth extraction, will verbalize understanding of the above by repeating instructions given by Dental Assistant/Hygienist. 3. Post dental extractions, the clients will receive a follow-up phone call from the clinic within 24hrs of procedure to assess for post procedure complications	**July** 100% 14/14 **August** 100% 4/4 **September** 100% 5/5 **Total** 100% 23/23	**October** 100% 5/5 **November** 100% 3/3 **December** 100% 4/4 **Total** 100% 12/12	**January** **February** **March** **Total**	**April** **May** **June** **Total**

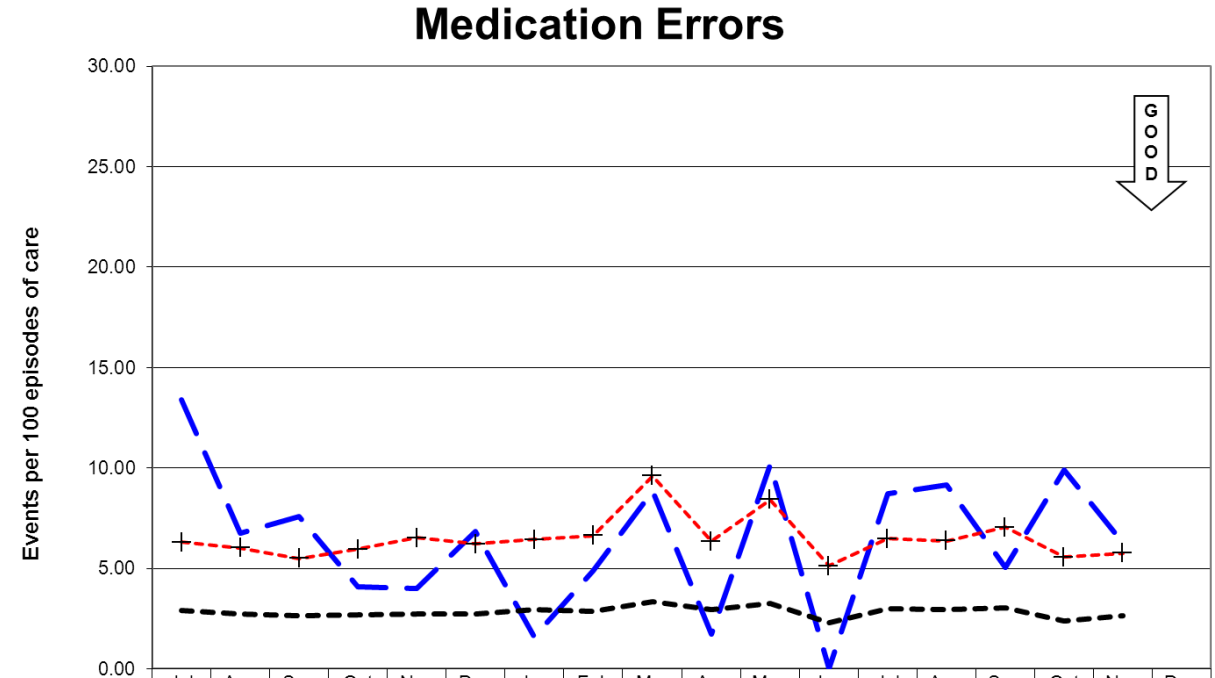
JOINT COMMISSION

Medication Management

Medication Errors and Adverse Reactions

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

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



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	13.39	6.77	7.58	4.10	4.00	6.84	1.60	4.88	8.87	1.71	10.17	0.00	8.70	9.17	5.04	9.91	6.25	
Ntl Mean	2.89	2.73	2.65	2.68	2.71	2.71	2.95	2.85	3.36	2.93	3.26	2.30	2.97	2.96	3.05	2.36	2.62	
+1 StDev	6.31	6.03	5.49	5.95	6.52	6.22	6.43	6.63	9.6	6.34	8.43	5.13	6.47	6.36	7.05	5.55	5.75	

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

JOINT COMMISSION

MEDICATION ERRORS RELATED TO STAFFING EFFECTIVENESS

Date	Co-mission	Omit	Float	New	O/T	Unit Acuity	Staff Mix
7/9/12	7 meds omitted once	Y	N	Y	N	UK	1 RN, 1 LPN, 4 MHW
9/5/12	Benadryl given wrong time	N	Y	Y	N	LK	3 RN, 1 LPN, 7 MHW
9/12/12	Novolog insulin	Y	N	Y	N	UK	1 RN, 1 LPN, 3.5 MHW
9/12/12	2 meds, Melatonin and Benadryl omitted x4 doses	Y	N	N	N	LS	2 RN, 0 LPN, 8 MHW
9/28/12	IM Lasix not given	Y	Y	Y	Y	LK	4.5 RN, 0.5 LPN, 7 MHW
10/1/12	6 meds omitted x1	Y	Y	Y	N	US	2 RN, 4 MHW
10/4/12	Zyprexa IM back up given late	N	Y	Y	N	US	2 RN, 3 MHW
10/8/12	Diazapine given	N	N	Y	N	UK	2 RN, 5 MHW
10/8/12	Lithium x1 dose	Y	Y	N	Y	LS	2 RN, 1 LPN, 7 MHW
10/8/12	Lamotrigine without order in wrong pocket	N	Y	N	Y	LS	2 RN, 1 LPN, 7 MHW
10/8/12	Beano x 7 doses	Y	N	N	N	US	2 RN, 1 LPN, 4 MHW
10/10/12	Lasix 40 mg. IM	Y	Y	Y	N	LK	3 RN, 1 LPN, 7 MHW
10/16/12	Symbicort inhaler x 3 doses	Y	N	N	N	LS	3 RN, 1 LPN, 7 MHW
10/23/12	Budesomide 9 mg.	Y	N	Y	N	LS	3 RN, 1 LPN, 8 MHW
10/25/12	Wrong time x 29 variances	N	N	N	N	US	3 RN, 4 MHW
10/26/12	Tylenol omitted x 4 doses	Y	N	Y	Y	LKS	3 RN, 1 LPN, 7 MHW
10/31/12	Reglan 10 mg.	Y	Y	Y	N	LS	4 RN, 1 LPN, 7 MHW
11/6/12	Thorazine given, exceeding amount ordered	N	N	N	N	LS	1 RN, 1 LPN, 3 MHW
11/6/12	Novolog insulin	Y	N	Y	N	UK	3 RN, 5 MHW
11/13/12	Benadryl	Y	Y	Y	N	LS	4 RN, 1 LPN, 7 MHW
11/16/12	Proctofoam HC x 6 variances	Y	N	Y	N	LS	2 RN, 3 MHW
11/20/12	Trazadone given, order was Thorazine	N	N	Y	N	LS	3 RN, 7 MHW
11/22/12	Celexa 40 mg.	Y	N	N	N	LS	4 RN, 1 LPN, 8 MHW
12/4/12	Navane 5 mg.	Y	N	Y	N	LK	4 RN, 7 MHW
12/8/12	4 meds omitted x 1	Y	N	Y	N	US	2 RN, 3 MHW
11/13/12	Ativan wasted and marked as given	Y	Y	Y	N	LS	4RN, 1 LPN, 8 MHW
12/12/12	Haldol Dec missed	Y	Y	Y	N	LK	3 RN, 1 LPN, 7 MHW
Totals		20	21	19	4		
Percent		74%	78%	70%	15%		

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

JOINT COMMISSION

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

Prescribing

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

Dispensing

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

Administration

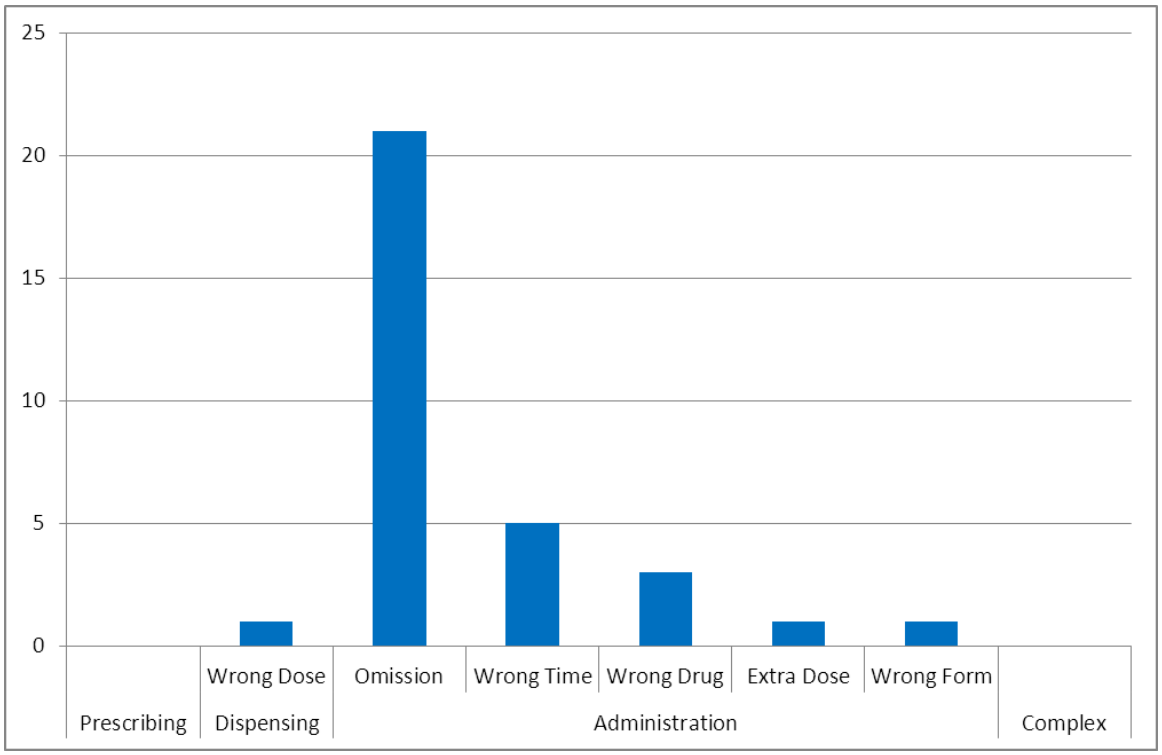
An error of administration occurs when there is an incorrect selection and administration of drug, drug dose, dosage form, quantity, route, concentration, rate of administration, or instructions for use of a drug product ordered or authorized by physician or other legitimate prescriber.

Complex

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

Causes of Medication Variances

2nd Quarter 2013



JOINT COMMISSION

Inpatient Consumer Survey

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

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

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

Rate of Response for the Inpatient Consumer Survey

Indicators	3Q2012	4Q2012	1Q2013	2Q2013
Client satisfaction surveys completed.	48% 10/21	46% 12/26	80% 8/10	65% 15/23

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

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

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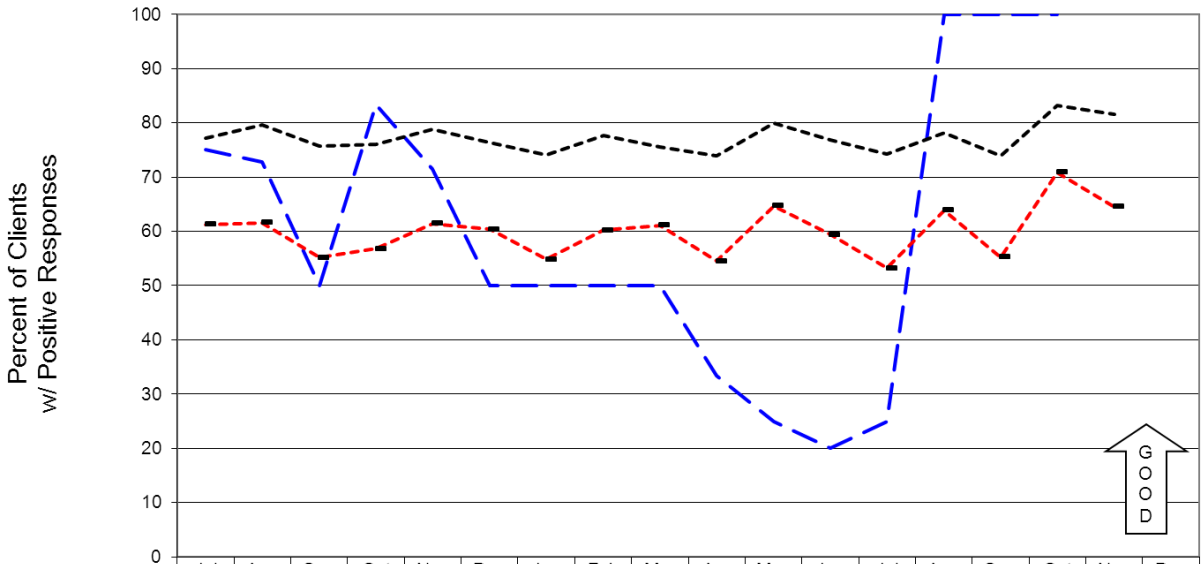
Inpatient Consumer Survey
Outcome Domain



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	75.00	72.73	50.00	83.33	71.43	50.00	50.00	50.00	50.00	33.33	25.00	20.00	25.00	100.0	100.0	100.0		
Ntl Mean	77.16	79.65	75.78	76.06	78.76	76.42	74.02	77.68	75.51	73.94	80.01	76.92	74.26	78.21	73.88	83.27	81.62	
- 1 StDev	61.26	61.62	55.17	56.79	61.43	60.35	54.81	60.24	61.09	54.51	64.66	59.39	53.19	63.90	55.28	70.87	64.53	

Outcome Domain Questions

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

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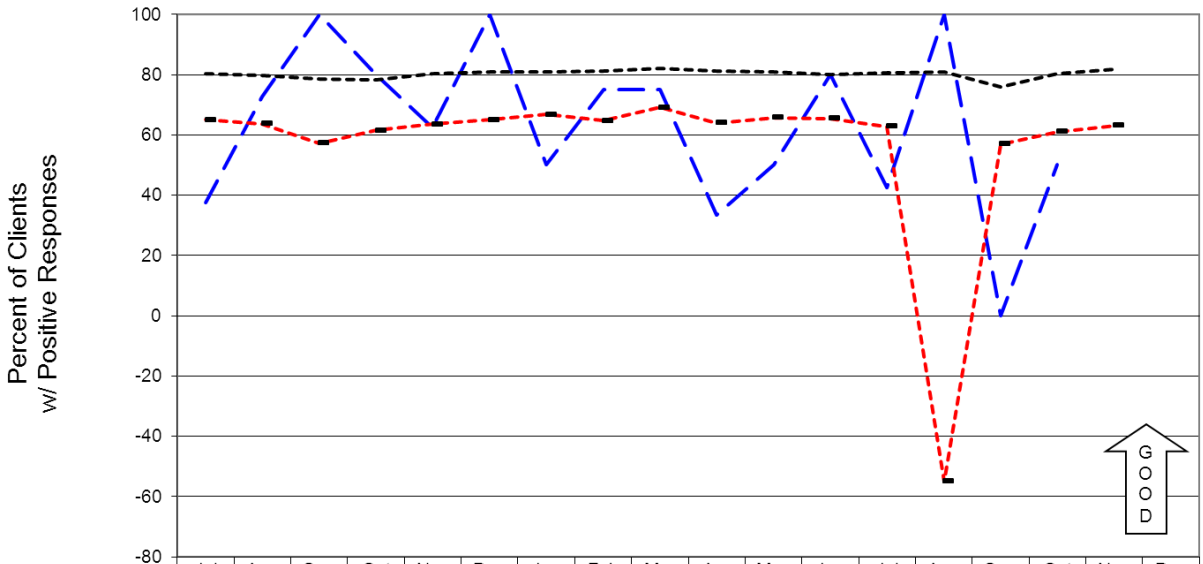
Inpatient Consumer Survey
Dignity Domain



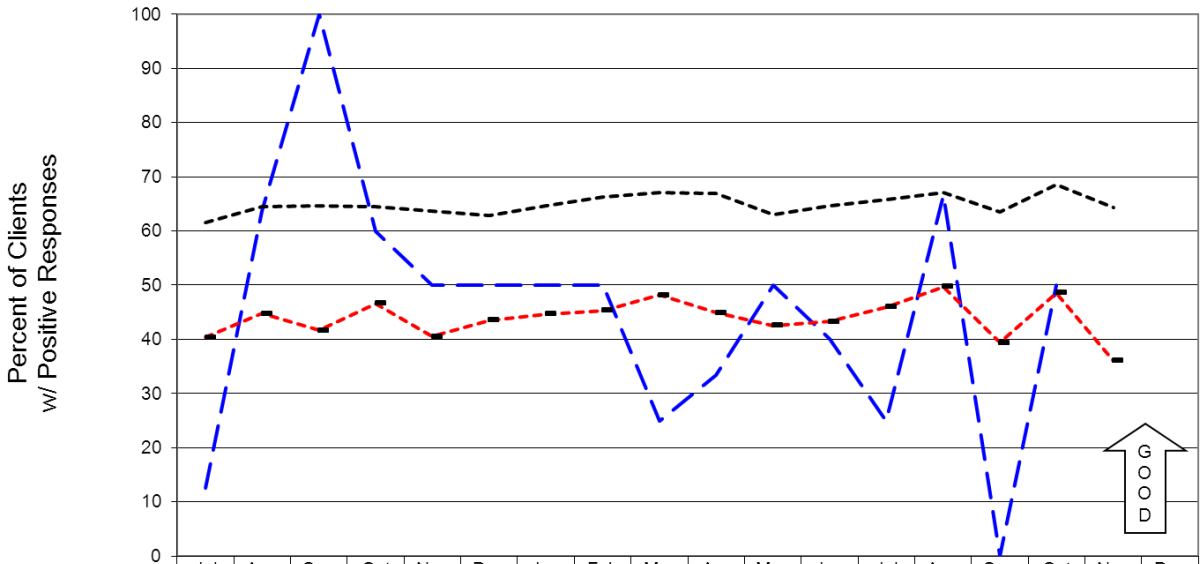
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	37.50	72.73	100.0	80.00	62.50	100.0	50.00	75.00	75.00	33.33	50.00	80.00	42.50	100.0	0.00	50.00		
Ntl Mean	80.36	79.72	78.51	78.16	80.42	80.87	80.98	81.24	82.20	81.29	80.96	79.96	80.49	81.02	76.06	80.21	81.66	
1 StDev	64.98	63.68	57.26	61.46	63.54	65.00	66.73	64.78	69.18	64.01	65.80	65.44	62.76	-55.0	56.93	61.05	63.09	

Dignity Domain Questions

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

JOINT COMMISSION

Inpatient Consumer Survey
Rights Domain



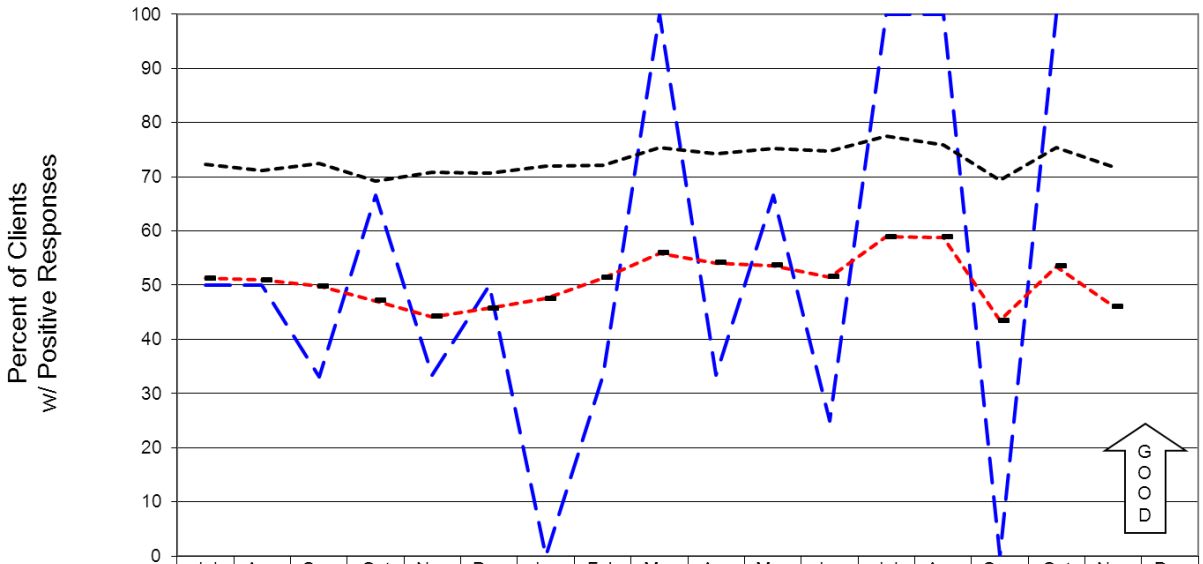
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	12.50	63.64	100.0	60.00	50.00	50.00	50.00	50.00	25.00	33.33	50.00	40.00	25.00	66.67	0.00	50.00		
Ntl Mean	61.57	64.46	64.61	64.42	63.65	62.80	64.70	66.20	67.12	66.94	63.08	64.62	65.81	67.06	63.55	68.59	64.29	
- 1 StDev	40.38	44.71	41.65	46.65	40.51	43.50	44.66	45.35	48.14	44.91	42.51	43.25	45.95	49.72	39.38	48.59	36.03	

Rights Domain Questions

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

JOINT COMMISSION

Inpatient Consumer Survey
Participation Domain

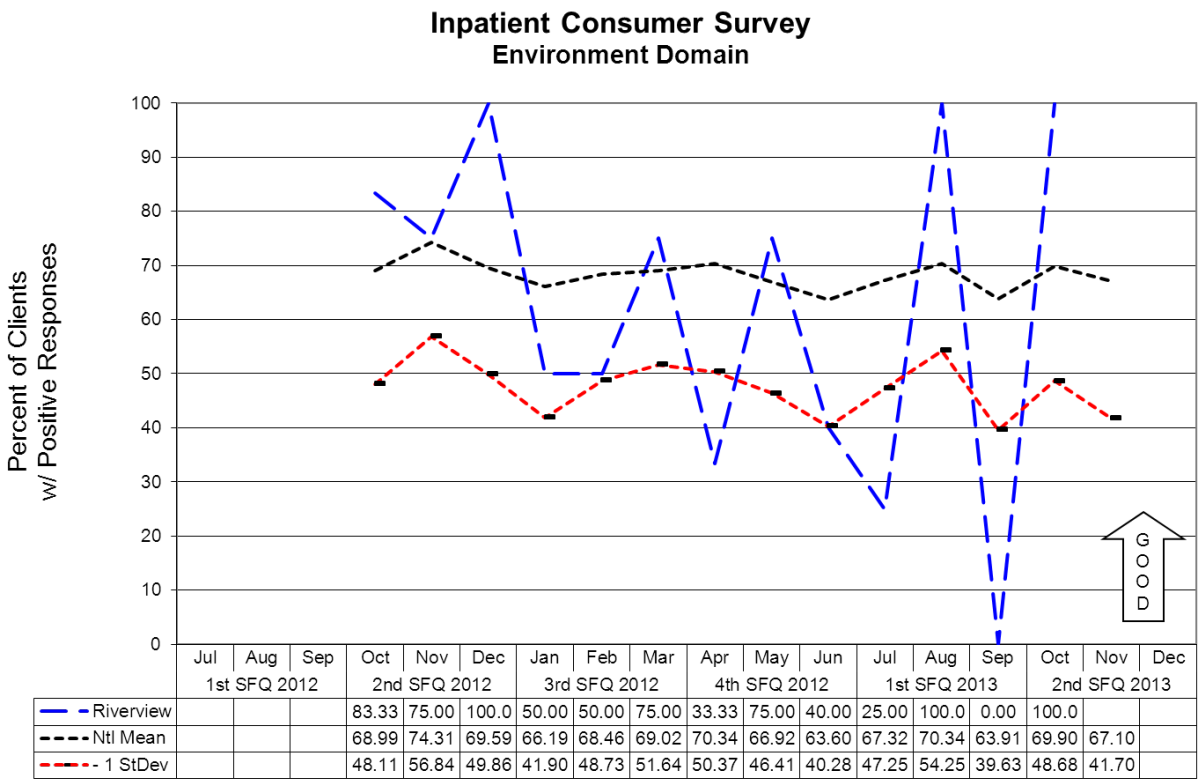


	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	50.00	50.00	33.00	66.67	33.33	50.00	0.00	33.33	100.0	33.33	66.67	25.00	100.0	100.0	0.00	100.0		
Ntl Mean	72.31	71.18	72.43	69.26	70.78	70.69	71.99	72.13	75.33	74.30	75.19	74.79	77.56	75.88	69.30	75.40	71.80	
- 1 StDev	51.23	50.96	49.76	47.11	44.15	45.72	47.50	51.32	55.86	54.07	53.58	51.54	58.92	58.84	43.45	53.43	46.05	

Participation Domain Questions

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

JOINT COMMISSION



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview				83.33	75.00	100.0	50.00	50.00	75.00	33.33	75.00	40.00	25.00	100.0	0.00	100.0		
Ntl Mean				68.99	74.31	69.59	66.19	68.46	69.02	70.34	66.92	63.60	67.32	70.34	63.91	69.90	67.10	
1 StDev				48.11	56.84	49.86	41.90	48.73	51.64	50.37	46.41	40.28	47.25	54.25	39.63	48.68	41.70	

Environment Domain

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

Data aggregation on this domain began in October 2011. A trend analysis pattern related to this data is only now becoming apparent.

JOINT COMMISSION

Fall Reduction Strategies

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

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

Type of Fall by Client and Month

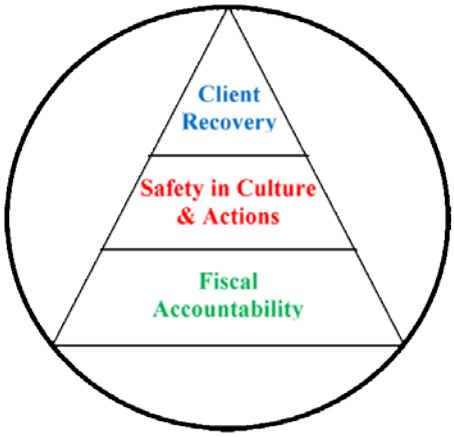
Fall Type	Client	Location	OCT	NOV	DEC	2Q2013
Un-witnessed	FR0000328245*	UK	3		1	4
	FR0000366310*	LKSCU	1	1	1	3
	FR0000390369	LKCIV			2	2
	FR0000370213	UK	1		1	2
	FR0000250266*	LKCIV	1	1		2
	FR0000329516	UK		1		1
	FR0000307819	UK	1			1
	FR0000379255	LSSCU		1		1
	FR0000312579	CCC			1	1
	FR0000368050	UK			1	1
	FR0000366682	UK	1			1
Witnessed	FR0000377945	UK		3		3
	FR0000328245*	UK	2	1		3
	FR0000250266*	LKCIV	2			2
	FR0000371724	LKCIV	1			1
	FR0000372250	UK			1	1
	FR0000356600	LKCIV			1	1
	FR0000379214	LKSCU			1	1
	FR0000359323	UK			1	1
	FR0000366310*	LKSCU			1	1

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

STRATEGIC PERFORMANCE EXCELLENCE

Priority Focus Areas
for Strategic Performance Excellence

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



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

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

STRATEGIC PERFORMANCE EXCELLENCE

Strategic Performance Excellence Model Reporting Process

Department of Health and Human Services Goals

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

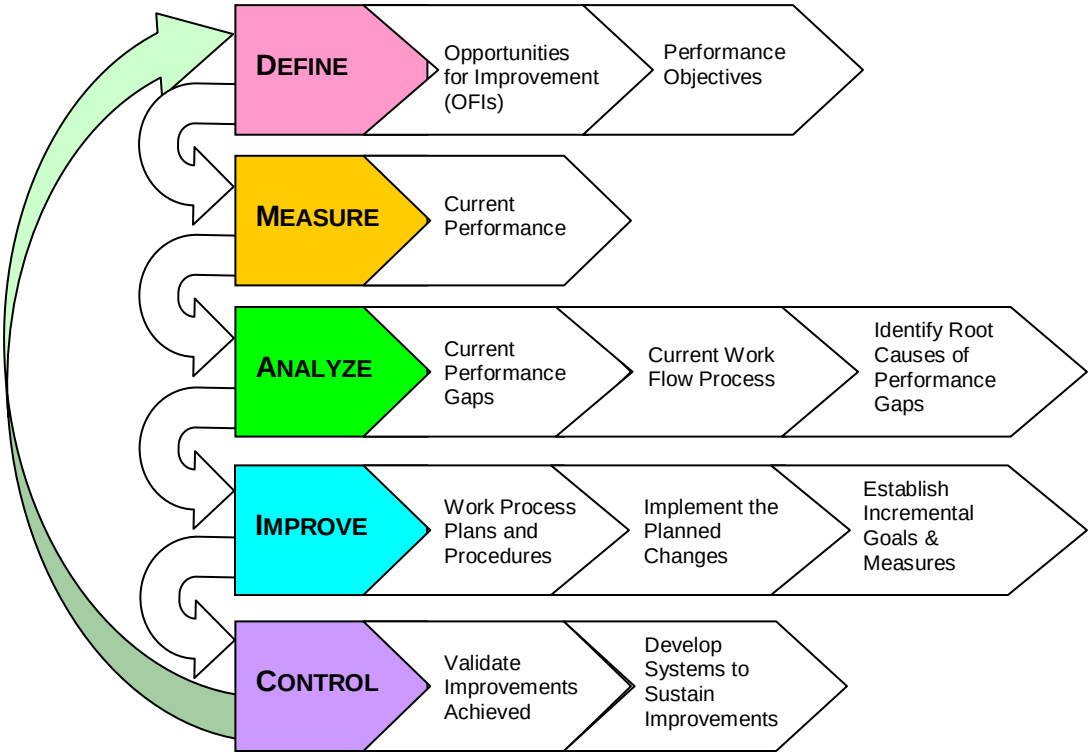
Dorothea Dix and Riverview Psychiatric Centers
Priority Focus Areas

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

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

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

Each Department Determines Unique Opportunities and Methods
to Address the Hospital Goals
The Quarterly Report Consists of the Following



STRATEGIC PERFORMANCE EXCELLENCE

Admissions

DEFINE

OPPORTUNITIES FOR IMPROVEMENT (OFI'S)

- Streamline Pre-Admission Face Sheet (PAFS) and remove obsolete items.

PERFORMANCE OBJECTIVES

- Decrease paperwork redundancy due to repetitive information on current worksheet.
- Increase provider satisfaction with information gathered and accessibility of information.

MEASURE

Based on a survey:

- How happy are the employees with the new PASF forms?
- Does it contain the proper/needed information?
- Is it easy to find the information needed?
- Is it well organized?
- Is it legible?
- Is it easier/faster to complete than the previous forms?
- Overall improvement of the forms?

ANALYZE

CURRENT PERFORMANCE GAPS:

- Duplication of the same information required.
- Wasted space on the PSAF.
- Time consuming to complete multiple forms.
- Disorganized, hard to read and find information.
- Lacking important information needed.

CURRENT WORK FLOW PROCESS:

- Based on the amount of history faxed from the referral source, at times, 50-100 pages or more of information is sent per client. This may come in several packets over a period of time, which needs to be reviewed to determine if the client is appropriate for admission.
- The average wait period is 24 days for an admission (based on figures of Sept, 2012 Forensic Referral List) and many clients decompensate further and have to be medically cleared an additional time.

IDENTIFY ROOT CAUSES OF PERFORMANCE GAPS:

- Time and duplication of client information.
- Lacking important information needed.

STRATEGIC PERFORMANCE EXCELLENCE

IMPROVE:

WORK PROCESS PLANS AND PROCEDURES:

- Talk to the Nurse IV and other direct care staff to gather opinions on Admission form revision.
- Hand out survey's to be completed and get feedback regarding the new forms.

IMPLEMENT THE PLANNED PROCEDURES:

- Rearrange the needed information.
- Remove non-applicable items from the PAFS.
- Attend the scheduled meeting with Medical Records staff and obtain approval for 1st draft of changes.
- Add additional information needed by the units upon admission.

CONTROL:

VALIDATE IMPORVEMENTS ACHIEVED

- Based on interviews and surveys completed by staff: Is it working?

DEVELOP SYSTEMS TO SUSTAIN IMPORVEMENTS:

- A new form will be used to support the previous Admission forms.
- It will be reviewed each year to determine if it continues to support the admission process adequately.
- Any feedback from direct staff will be discussed and implemented as necessary for improvements.

Admissions Pilot PSFA Form

Please rate the new forms .
1. The new admission pilot forms contain the information needed upon admission. Strongly Disagree Disagree Agree Strongly Agree
2. It is easy to find the information needed on the new admission pilot forms. Strongly Disagree Disagree Agree Strongly Agree
3. The new admission pilot forms are well organized. Strongly Disagree Disagree Agree Strongly Agree
4. The information is legible on the new admission pilot forms. Strongly Disagree Disagree Agree Strongly Agree
5. For those of you who have to complete the new form: It now takes less time to complete the new PASF form than it did to complete the old PASF form. Strongly Disagree Disagree Agree Strongly Agree
6. I would not make any changes to the new admission pilot forms. Strongly Disagree Disagree Agree Strongly Agree
Comments Section: (Any suggestions are welcomed)

STRATEGIC PERFORMANCE EXCELLENCE

Dietary Services

Responsible Party: Kristen Piela DSM

Strategic Objective: Safety in Culture and Actions												
Hand Hygiene Compliance: In an effort to monitor, sustain and improve hand hygiene compliance, the Dietary department measures its results through observations of Dietary staff when returning from a scheduled break.												
1st Quarter			2nd Quarter			3rd Quarter			4th Quarter			Goal
Baseline Established	Findings	Compliance	Target – Q1 + 12%	Findings	Compliance	Target – Q2 + 10%	Findings	Compliance	Target – Q3 + 10%	Findings	Compliance	
58%	22/43	N/A	70%	18/34	53%							80-90%

Data

18 compliant staff / 34 hand hygiene observations = 53% hand hygiene compliance rate

Summary

The data collection rate is too low to determine the actual hand hygiene compliance rate over time.

Action Plan

Discuss the percent data collection with Food Service Manager and Dietitian and encourage greater consistency.

Provide Hand Hygiene In-service to all Dietary staff. Assure attendance by all employees.

STRATEGIC PERFORMANCE EXCELLENCE

Environment of Care

INDICATOR

GROUNDS SAFETY/SECURITY INCIDENTS

DEFINITION

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

OBJECTIVE

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

THOSE RESPONSIBLE FOR MONITORING

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

METHODS OF MONITORING

Monitoring would be performed by;

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

METHODS OF REPORTING

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

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

UNIT

Hospital grounds as defined above

BASELINE

To be determined after compilation of data during the months on August/12 to September/12.

Q2-Q4 TARGETS

Baseline – 5% each Q

STRATEGIC PERFORMANCE EXCELLENCE

Department: Safety & Security Responsible Party: Rick Levesque
Environment of Care Committee

Strategic Objectives								
Safety in Culture and Actions	Unit	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Grounds Safety & Security Incidents Safety/Security incidents occurring on the grounds at Riverview, which include "*Acts of thefts, vandalism, injuries, mischief, contraband found, and safety / security breaches*	# of Incidents	* Baseline of 10 was determined in the months of Aug. & Sept. of 2012	*	(10) -5%	(13) -5%			

SUMMARY OF EVENTS

Originally, the Q2 Target was (10)-5%. When reviewing the Q2 Quarter, we realized that since July was not part of the computation of the Baseline, and August and September were the only months used, we actually set a very high goal of the Q2 Target. Q2's Actual number was slightly lower at (13) when you consider that (13) actually covered an entire quarter. We feel that having tracked a full quarter, we are well positioned with regard to reporting this new indicator and that the Q3 Target is more realistic. We hope that the reporting, which follows below, provides a very clear picture of Safety and Security events, how they are handled, and that the use of surveillance equipment plays an integral part in combating safety and security threats to people and property. We have also placed signage throughout the property, added additional cameras, and improved exterior lighting by upgrading the type of bulbs used.

EVENT	DATE	TIME	LOCATION	DISPOSTION	COMMENTS
Vehicle driving erratically in area	10/12/12	2000	Roadway	Local PD Called	Alerted Security and Operations to monitor future
Possible Criminal Mischief (gas cap removed) from vehicle	10/14/12	1815	Staff Lot	Operator refused call to PD	1. Reviewed camera. Nothing found. 2. Alerted Security and Operations
Safety Threat (part of yard gate)	10/28/12	2045	Kennebec Yard	Item secured by Security	1. Security checked for other items 2. Maintenance notified 3. Repair completed

STRATEGIC PERFORMANCE EXCELLENCE

Harbor Treatment Mall

Objectives	*Findings*	*Compliance*
1. Hand-off communication sheet was received at the Harbor Mall within the designated time frame.	*19 of 42*	*45%*
2. RN signature/Harbor Mall staff signatures present.	*28 of 28*	*100%*
3. SBAR information completed from the units to the Harbor Mall.	*28 of 42*	*67%*
4. SBAR information completed from the Harbor Mall to the receiving unit.	*28 of 28*	*100%*

DEFINE

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

MEASURE

Indicator number one was 55% for the first quarter and decreased to 45% for this quarter. Indicator number two was 100% for the first quarter and remains at 100% for this quarter. Indicator number three was 64% for the first quarter and increased to 67% for this quarter. Indicator number four was 95% for the first quarter and increased to 100% for this quarter.

ANALYZE

Due to high performance and consistency indicator data was not collected for indicators two and four for December. Continue to concentrate on indicators one and three to improve current performance gaps.

IMPROVE

On September 11, 2012 I attended the charge nurse meeting to present the hand of communication sheets results from April thru August 2012. We made a change on Lower Saco so they would have one sheet instead of two. One charge nurse is going to initiate an earlier time for the sheets to be completed so they will arrive at the mall on time. Some changes have not been implemented which may account for not achieving objective number one.

CONTROL

Treatment team coordinators on three units are nurses we are expecting our fourth in January. The Hand off Communication sheets is one of their responsibilities. The plan is to meet with all four treatment team coordinators to explain the Hand of Communication policy for the Harbor Mall.

Department: Harbor Mall Responsible Party: Lisa Manwaring, PSD

Strategic Objectives							
Hand of Communication	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
95% of HOC sheets were received at the Harbor Mall within the designated time frame.	55	60	70	80	90	95%	
95% of SBAR information completed from the units to the Harbor Mall	64	60	70	80	90	95%	

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Define

The opportunity for improvement selected for the Health Information Department is cross-auditing the coding of medical staff charges and discharges with Dorothea Dix Psychiatric Center.

Measure

Each month, ten medical staff charges and ten discharges will be randomly selected. Coding staff at Dorothea Dix Psychiatric Center (DDPC) will audit Riverview Psychiatric Center's (RPC) coding, and RPC will audit DDPC's charges.

Analyze

Comparing values with DDPC may point out areas of improvement in our coding processes.

Improve

At this point, there is no baseline as this is a new process. The baseline will be defined with data gathered for the quarter 2 report.

Control

To be defined after 3 months of data.

Department: Medical Records Responsible Party: Nicole Ginka

Strategic Objectives								
Fiscal Accountability	Unit	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Billing Compliance Audit Process A method of conducting an audit of the accuracy and validity of bills submitted for reimbursement to Medicare, Medicaid, and third part payers is an integral function of the CMS Compliance Program as recommended by the CMS Office of the Inspector General.	This is an integrate process that includes the participation of both the RPC and DDPC Medical Records Departments	* Baseline will be determined the 2nd quarter 2013	*	*				

Note

During the discovery process of the original plan for process improvement, A different area of needed improvement was found. As a result the original plan has been amended. Cross-auditing with DDPC will still continue with regard to coding compliance standards, but process improvement measures will be focused on improving documentation & charges at RPC.

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

(Revised Performance Excellence Project)

Define

The opportunity for improvement in the Health Information Department is auditing the charges submitted, along with documentation of those charges.

Measure

25 providers submitted superbills to the Health Information department for quarter 2.

Analyze

One provider submitted 10 superbills in October with no documentation found. After discussions with the provider, the November audits improved-there were notes for all submitted superbills. In December, 10 superbills were submitted, with only 2 having notes documented. Another issue found was the amount of duplicate superbills being submitted. In October, there were 16 duplicates submitted. There were no duplicates in November. In December, there were 3. There are 2 providers involved in the duplicates issued.

Improve

Work with above provider on appropriate/consistent documentation. In regard to the duplicate issue, documentation seems to be sporadic. Instead of noting/completing superbills when visit occurs, it appears to be happening all at once with some providers. Speak with Medical Director for recommendations.

Control

Continue auditing 10 superbills & documentation per provider.

STRATEGIC PERFORMANCE EXCELLENCE

Human Resources

Define

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

Measure

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

Analyze

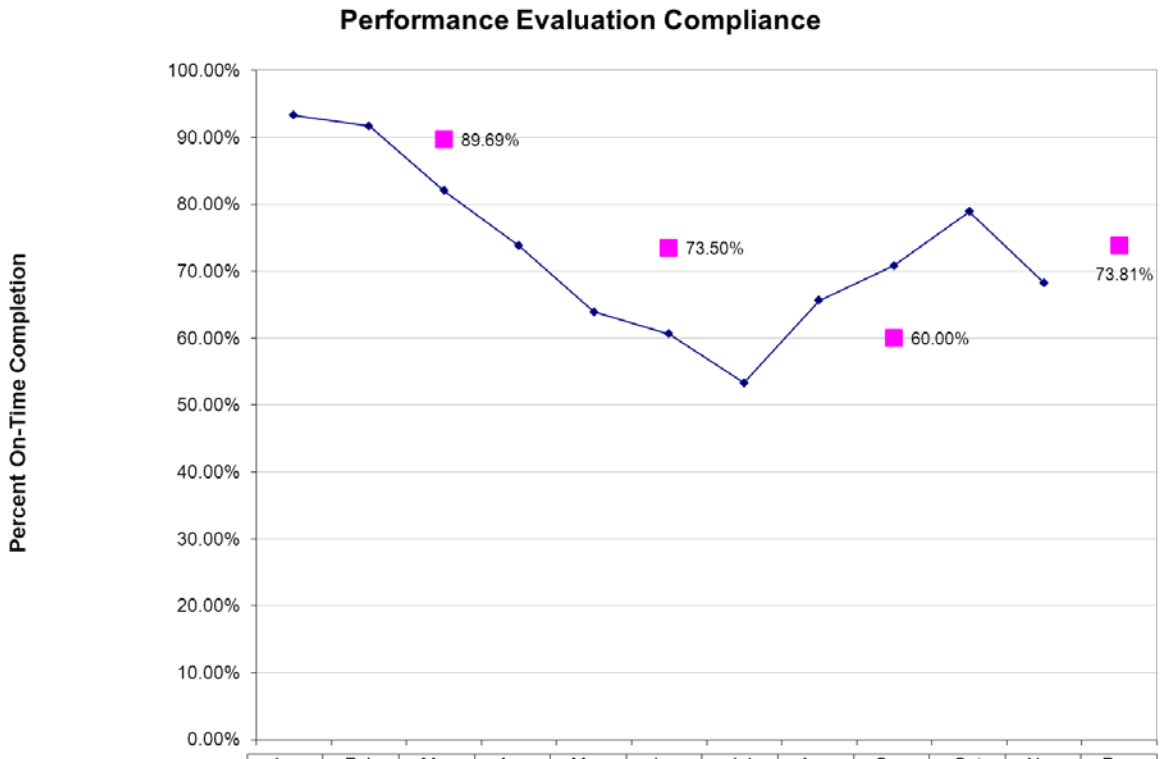
A thorough analysis of the root causes for lack of compliance with this performance standard is indicated. This analysis

Improve

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

Control

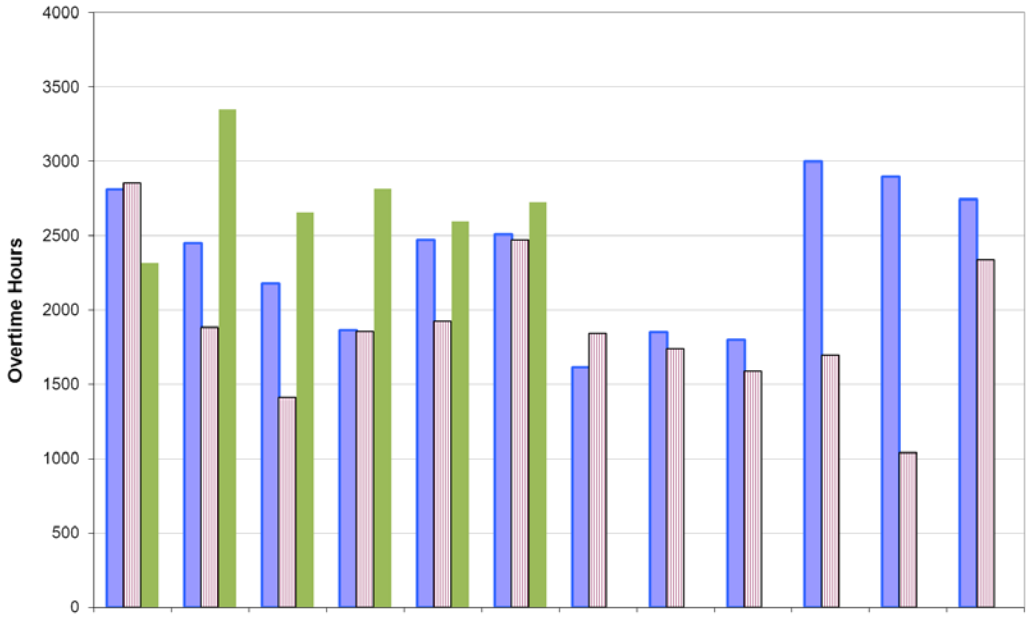
Plans to modify hospital performance evaluation goals for supervisory personnel will include the completion of subordinate performance evaluations in a timely manner as a critical supervisory function.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Monthly % Compliance	93.33%	91.67%	82.05%	73.81%	63.89%	60.61%	53.33%	65.63%	70.83%	78.95%	68.18%	
Quarterly % Compliance			89.69%			73.50%			60.00%			73.81%

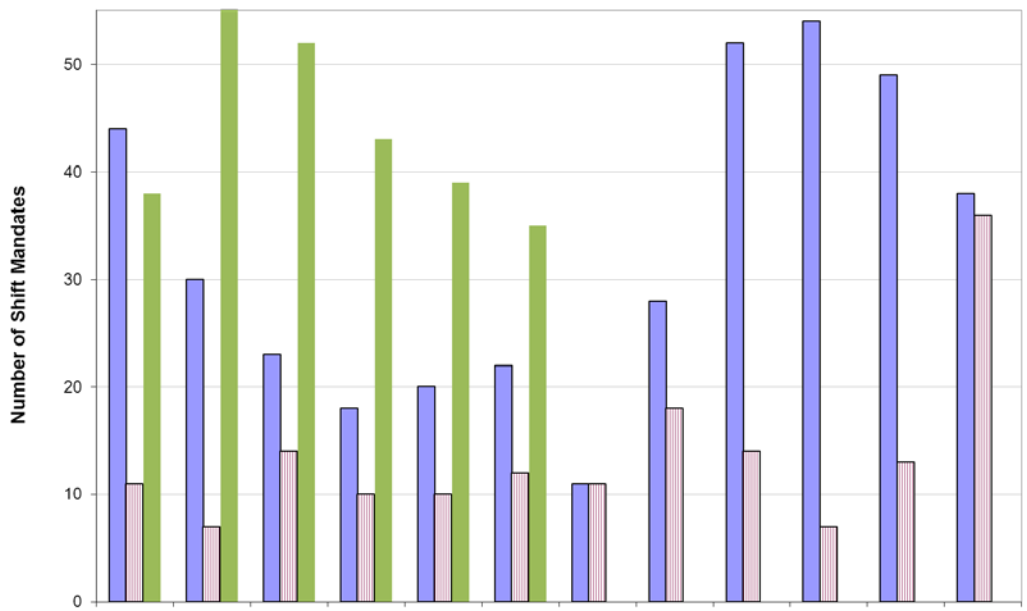
STRATEGIC PERFORMANCE EXCELLENCE

Monthly Overtime



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2012	2812	2451	2178	1868	2473	2507	1618	1853	1798	2999	2896	2743
FY 2011	2859	1885	1411	1860	1926	2474	1844	1740	1589	1697	1042	2342
FY 2013	2316	3350	2657	2817	2599	2726						

Monthly Mandated Shifts

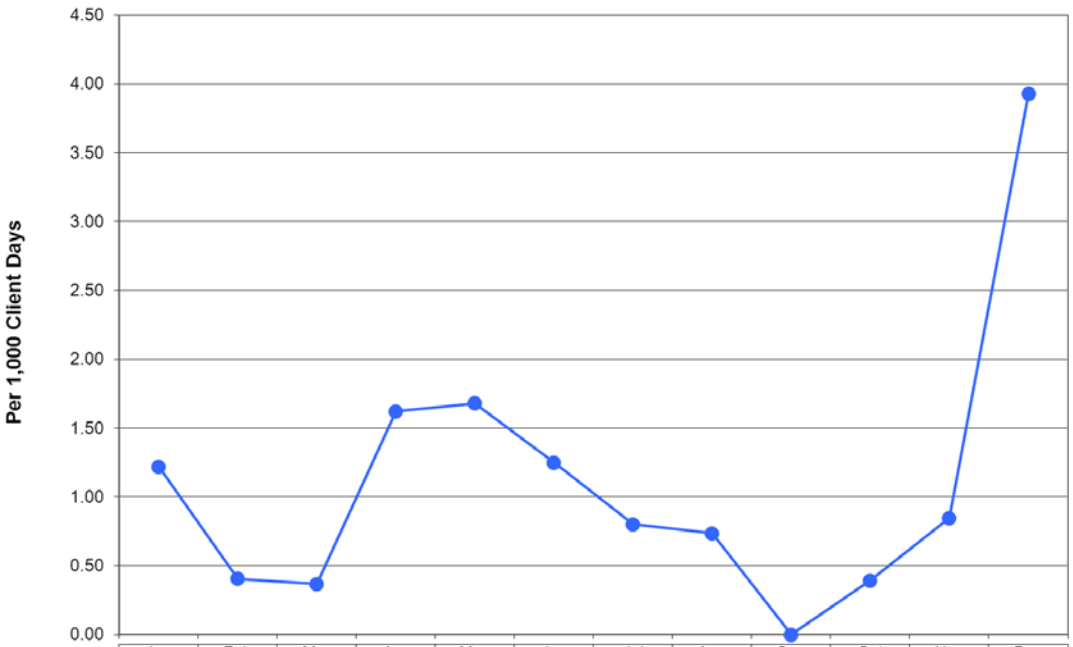


	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2012	44	30	23	18	20	22	11	28	52	54	49	38
FY2011	11	7	14	10	10	12	11	18	14	7	13	36
FY 2013	38	81	52	43	39	35						

The nursing department has implemented a staffing patterns study in an attempt to minimize the incidence of mandates. Further information on this study can be viewed on page 72 of this report.

STRATEGIC PERFORMANCE EXCELLENCE

Reportable (Lost Time & Medical) Direct Care Staff Injuries



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Lost Time Ratio	1.22	0.40	0.37	1.62	1.68	1.25	0.80	0.74	0.00	0.39	0.85	3.93

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

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Lost Time Ratio	0.00	0.40	0.37	0.00	0.00	0.00	0.00	0.37	0.00	0.39	0.00	0.44

STRATEGIC PERFORMANCE EXCELLENCE

Infection Prevention and Control

Responsible Party: Kathleen Mitton RN

Strategic Objective: Safety in Culture and Actions

Hand Hygiene Measurement: To gain an accurate and consistent perspective on employee hand hygiene practice, an effective measurement process needs to be in place. Current experience has demonstrated that the collection of observations of employee hand hygiene practice is inconsistent and incomplete. The measure will strive to improve the process of data collection and measurement.

Unit	Baseline	Q1-Target	Compliance	Q2-Target	Compliance	Q3 - Target	Compliance	Q4 - Target	Compliance	Goal	Comment
Lower Kennebec	71%	B + 6%	**83%** ↑	Q1 +6%	**100%** ↑	Q2 +6%		Q3 +6%		95%	
Upper Kennebec	74%	B + 5%	**83%** ↑	Q1 +5%	**100%** ↑	Q2 +5%		Q3 +5%		95%	
Lower Saco	34%	B +15%	**33%** ↓	Q1 +15%	**75%** ↑	Q2 +15%		Q3 +16%		95%	
Upper Saco	59%	B +9%	**54%** ↓	Q1 +9%	**98%**↑	Q2 +9%		Q3 +9%		95%	

Mean hand hygiene compliance rate: 70%

Indicator

Each unit will do 80 hand hygiene observations per month.

Indicator

Increase hand hygiene compliance rate to 80%.

Summary

All units have improved significantly in data collection this quarter. A somewhat accurate hand hygiene compliance rate can be determined if data collection remains constant (95%+) over time

Medical Staff

1. Identification of Opportunities for Improvement:

   Some members of the medical staff have long complained about lack of timeliness and difficulty in obtaining certain psychological services. For example there is an nuclear process for requesting or ordering such services as individual psychotherapy, psychological testing, and related activities for individual clients. Furthermore there continued to be anecdotal complaints of the quality and responsiveness of some services. A review of the process did determine that there was a "Request Form for Psychological Services" in existence but it was not widely disseminated amongst all units and providers. There was also a "Psychological Services Satisfaction Survey" in existence, but again, it was neither widely known nor utilized. Initial work by the Medical Executive Committee was done to improve both forms and to mandate their use by all medical and nursing staff when requesting any psychological service.

2. The Measurement Process:

   The Medical Executive Committee is in the process of revising both the Referral Form and the Satisfaction Survey to better articulate the ordering clinician's specific need for a service, the clinical question to be addressed, and the time acuity of the need. It was agreed that the ordering clinicians would always utilize this form and no procedure would be conducted without one. It was further agreed that there would be a central point of contact in the Psychology Section Office for the review of the requests for service, a triage function, and the assignment of requested tasks (therapy or testing or consultation) to individual psychologists for completion. The Chief of Section, Dr. DiRocco, will oversee the process and track the time from assignment to completion (or in the case of psychotherapy until the first session has been completed). He will also make certain ordering medical staff complete a Satisfaction Questionnaire upon completion of the requested task, and he will track the outcome of this rating scale. We will therefore be tracking two data sets: one of timeliness of completion of requested service and one on the quality and usefulness of the completed work product.

3. Baseline Measures:

   Dr. DiRocco is in the process of obtaining additional baseline data on the averages and range of time to completion of a given service, and on the averages and range of ratings on the Satisfaction Survey. An initial accounting found that over the period of mid-June to mid-August the average time to completion of requested psychological testing was 9.6 working days, with a range of 2 to 31 working days. Additional baseline data, incorporating all requested services (not just testing), is necessary. Once these are obtained we will determine our goals of improvement for the next 4 quarters.

4. Goal of Improvement and Measures of Success:

   We will monitor on a monthly basis the average waiting time for completion of the requested service, and the ratings of satisfaction with the service. Our goal obviously is to improve both timeliness and quality of the reports and interventions. We will make further process improvements as needed based on the data obtained over the next 4 quarters.

Quarterly Update

2nd Quarter 2013	Due to a significant loss of Psychology providers during the past few months this study has been delayed until replacements can be recruited.

STRATEGIC PERFORMANCE EXCELLENCE

Nursing

INDICATOR

Mandate Occurrences

DEFINITION

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

OBJECTIVE

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

THOSE RESPONSIBLE FOR MONITORING

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

METHODS OF MONITORING

Monitoring would be performed by;

- Staffing Office Database Tracking System

METHODS OF REPORTING

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

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

UNIT

Mandate shift occurrences

BASELINE

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

MONTHLY TARGETS

Baseline –10% each month

STRATEGIC PERFORMANCE EXCELLENCE

Department: Nursing Responsible Party: Holly Harmon, DON Staffing Improvement Task Force

Strategic Objectives							
Safety in Culture and Actions	Baseline August 2012	Mth 1 Sep 2012	Mth 2 Oct 2012	Mth 3 Nov 2012	Mth 4 Dec 2012	Goal	Comments
Mandate Occurrences - Nurses When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy.	24	10	5	0	6	16 (10% reduction monthly x4 from baseline)	Goal exceeded.
Mandate Occurrences – Mental Health Workers When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy.	53	38	36	34	28	35 (10% reduction monthly x4 from baseline)	Goal exceeded

STRATEGIC PERFORMANCE EXCELLENCE

Peer Support

INDICATOR

Client Satisfaction Survey Return Rate

DEFINITION

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

OBJECTIVE

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

THOSE RESPONSIBLE FOR MONITORING

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

METHODS OF MONITORING

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

METHODS OF REPORTING

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

UNIT

All client care/residential units

BASELINE

Determined from previous year's data.

QUARTERLY TARGETS

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

STRATEGIC PERFORMANCE EXCELLENCE

Department: Peer Support Responsible Party: Holly Dixon

Strategic Objectives								
Client Recovery	Unit	Baseline	Q1	Q2 Result	Q3 Target	Q4 Target	Goal	Comments
CSS Return Rate								
The client satisfaction survey is the primary tool for collecting data on how clients feel about the services they are provided at the hospital. Data collection has been low on all units and the way in which the surveys are administered has challenges based on the unit operations and performance of the peer support worker.	LK	15%	ND	*9%*	25%	50%	50%	*Percentages are calculated based on number of people eligible to receive a survey vs. the number of people who completed the surveys.*
	LS	5%	ND	*0%*	25%	50%	50%	
	UK	45%	ND	*44%*	50%	50%	50%	
	US	30%	ND	*78%*	50%	50%	50%	

Summary

Compliance on LK dropped below baseline this quarter. This was primarily due to the shift in population from mostly civil to mostly forensic. Administering surveys with the forensic population is different and adjustments were not made quickly enough to capture more data. The return rate on LS continues to be very low, primarily due to a staffing issue. Closer monitoring will be put into place to ensure increased compliance. The return rate on UK remained near baseline and increased significantly on US. The increase on US was primarily due to a change in staffing on that unit. Targets for 3rd quarter have been established.

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

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

Strategic Objectives							
Safety in Culture and Actions	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Pyxis CII Safe Comparison *Daily and monthly comparison of Pyxis vs CII Safe transactions*	Sept-Oct 2	0	0	0	0	0	CII Safe implemented 8/28/12 with goal of zero inaccurate transactions occurring; 100% resolution of errors
Quarterly Results	1						
Medication Room Audits *Monthly comprehensive audits of 14 criteria*	Apr-June 100%	100%	100%	100%	100%	100%	
Quarterly Results		92%					Unit inspections completed for July and August only.
Pyxis Discrepancies *Monthly monitoring and trending of Pxyis discrepancies.*	Aug-Nov 107/mo	107	107	50	50	50/mo	Target goal is 50/month discrepancies after 6 months of Pyxis use
Quarterly Results		128					
Pyxis Overrides *Monthly monitoring and trending of Pyxis overrides for controlled drugs*	Aug-Nov 25/month	25	25	10	10	10/mo	Target goal is 10/month after 6 months of Pyxis use
Quarterly Results		32					
Fiscal Accountability	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Discharge Prescriptions *Monitoring and Tracking of dispensed Discharge Prescriptions*							Data collection and analysis being implemented and will be reported retrospectively

STRATEGIC PERFORMANCE EXCELLENCE

Program Services

Define

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

Measure

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

Analyze

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

Improve

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

Control

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

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

STRATEGIC PERFORMANCE EXCELLENCE

Program Services
Lower Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	 7-5-5 7-7-7	 85% 100%	**14 weekly**
2. **Number of clients attending day groups on unit or facilitated by day staff** (# of clients in all of day groups divided by # of day groups provided**)**	6-6-5		
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**	7-7-7		
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	3/ 30 0-0-30%	10%	**100%**
5. **The client can identify distress tolerance tools on the unit**	30/30	100%	**100%**
7. **The client is able to state who his primary staff is**	30/30	100%	**100%**

EVALUATION OF EFFECTIVENESS

Evenings groups have remained the same and attendance the same in spite of a lower census in December and November. Day groups have been less stable with facilitators not always the same and the groups sometimes changed at the last moment due to acuity on the unit. The clients attending seem to enjoy the groups.

ISSUES

This is the first month with any of the on unit groups being reflected in the treatment plans. 3 out of 10 charts have the on units groups reflected for a 30% monthly but only 10% for the quarter. LK still needs to come up with a group offering on the unit for the weekends.

ACTIONS

Have developed two templates that staff can use to document client attendance. One is already in Meditech while the other is formatted in Microsoft and must be copied and pasted into Meditech. Will continue to work on consistency and capturing active treatment on unit before attempting to increase the number of group offerings. Again, this indicator reflects only the on unit groups facilitated by nursing and MHWs. Four active treatment groups are offered Monday through Friday on the unit for those unable to attend the treatment mall. Will discuss with the PSD and RN IVs the need to provide active treatment 7 days a week for the clients unable to attend the treatment mall.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services
Upper Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	 5-5-0 5-5-5	 35% 71%	**14 weekly**
2. **Number of clients attending day groups on unit or facilitated by day staff** (# of clients in all of day groups divided by # of day groups provided**)**	3-3-0		
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**	4-3-2		
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	0/ 0 0-0-0%	0%	**100%**
5. **The client can identify distress tolerance tools on the unit**	30/30	100%	**100%**
7. **The client is able to state who his primary staff is**	30/30	100%	**100%**

EVALUATION OF EFFECTIVENESS

Upper Kennebec has struggled with on unit groups. In October, Focus Group was offered 5 days a week with a fair response. UK typically has more of a treatment mall attending milieu. Evenings groups were more of a leisure nature and again, showed fair response in October.

November and December, group facilitation was sporadic at best. Many of the clients on UK attend the mall during the day and afternoon. In the evening, they prefer the computer lab and gym rather than the unit groups.

ISSUES

Inconsistency of groups being provided especially on first shift. Minimal documentation in Meditech.

Second shift has been more consistent in providing groups, more leisure in nature but attendance is sparse. Some of the clients report that since they routinely attend the treatment mall during the day and afternoon that they prefer not to go to groups on the unit in the evening.

ACTIONS

Will have RN IV meet with staff to look at what offerings might be made to encourage especially clients who do not attend the treatment mall to engage in some type of therapeutic activity on the unit. Will recommend perhaps an off unit activity or group that clients with a level 3A might attend if the preference is to do something off unit. As long as it is an offering for those who cannot attend the mall, it would benefit the clients in need.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services
Lower Saco

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	Main/SCU 4 / 5 5 / 5	 64% 71%	 **7 / 7 = 14** **7 / 7 = 14**
2. **Number of clients attending day groups on unit or facilitated by day staff** (# of clients in all of day groups divided by # of day groups provided**)**	3 / 1.5		N/A
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**	3.5/ 1		N/A
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	0	0%	**100%**
5. **The client can identify distress tolerance tools on the unit**	30/30	100%	**100%**
7. **The client is able to state who his primary staff is**	27/30	90%	**100%**

EVALUATION OF EFFECTIVENESS

ISSUES

The Lower Saco unit has made a start at offering on-unit groups, although the documentation in the medi-tech is sporadic. There is no evidence that this treatment effort is being reflected in the treatment plans.

ACTIONS

I have discussed this issue with some of the staff. I will meet with the Nursing leadership and the Treatment Team Coordinator to make sure these groups get prescribed in the treatment plans and bring documentation shortfalls to the staff meeting agendas.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services
Upper Saco

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	6 10	86% 100%	**Days/ Even.** **7 / 7 = 14**
2. **Number of clients attending day groups on unit or facilitated by day staff** (# of clients in all of day groups divided by # of day groups provided**)**	2 Avg.		N/A
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**	4 Avg.		N/A
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	0	0%	**100%**
5. **The client can identify distress tolerance tools on the unit**	30/30	100%	**100%**
7. **The client is able to state who his primary staff is**	30/30	100%	**100%**

EVALUATION OF EFFECTIVENESS

ISSUES

The Upper Saco unit has made a good start at offering on-unit groups, although the documentation in the Medi-tech is sporadic. There is no evidence that this treatment effort is being reflected in the treatment plans.

ACTIONS

I have discussed this issue with some of the staff. I will meet with the Nursing leadership and the Treatment Team Coordinator to make sure these groups get prescribed in the treatment plans and bring documentation shortfalls to the staff meeting agendas.

STRATEGIC PERFORMANCE EXCELLENCE

Rehabilitation Services

Department: Rehabilitation Services Responsible Party: Janet Barrett

Strategic Objectives							
Client Recovery	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Vocational Incentive Program Treatment Plans *The objective of this improvement project is to ensure vocational treatment plans are initiated on all clients within 5 days of beginning work and will be reviewed and updated if necessary every 30 days. Documentation on interventions in the treatment plans will reflect progress towards interventions and will be documented on weekly.*	55%	70%	85%	100%	100%	The treatment plans will be reviewed more regularly and updated at each client 30 day treatment team meeting.	Treatment plans were completed in a timely fashion but the review and updates were not consistent. Documentation is not always done on a weekly basis. Goal for next quarter is to increase by 15%.
Quarterly Results		77%					

Safety in Culture and Actions	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Client/Staff Injuries in the Gym (to start in the second quarter) *The objective of this improvement project is to reduce/eliminate staff/client injury in the gym by increasing education on the proper techniques for equipment use as well as proper techniques for other activities in done in the gym. This will also include education on performing environmental checks of the area to ensure there are no safety issues.*							
Quarterly Results		No injuries during the quarter					