Riverview
PSYCHIATRIC CENTER

PERFORMANCE IMPROVEMENT REPORT

THIRD STATE FISCAL QUARTER 2011
January, February, March 2011

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April 22, 2011

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INTRODUCTION

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

Many features of this report have changed significantly with the intent of providing a more complete picture of change and progress toward performance excellence. Several of the reports are now showing trending over several quarters. This process allows for a clear picture of success in initiatives of improvement in the long term. The trending process also assists the individual departments in identifying factors that lead to success as well as barriers to continued improvement.

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

Ongoing efforts to modify analysis and treatment methods to respond to client agitation and escalation have produced some examples of success with individual clients. Efforts to widely adopt these proactive methods throughout the milieu are being considered and implemented on a case by case basis.

The comparative statistics section contains a new measure that reflects the number of and circumstances related to the incidence of medication administration to clients during behavioral events.

Another new feature to this report is the section on Consent Decree Compliance. In this section we hope to address the Standards of Substantial Compliance determined by the court to be consistent with the intent of the Consent Decree on October 29, 2007. The elements of substantial compliance abstracted from this document are listed with an explanation of how current operations fulfill the standards described. Several of the compliance standards require specific evidence or documentation of compliance that are currently being developed. Other compliance standards are illustrated as part of this quarterly report. It is planned that subsequent reports will address all of the standards of substantial compliance in a manner that demonstrates a good faith effort to maintain continual compliance with all of the elements of the Consent Decree and to maintain an environment and treatment methods that are both safe and therapeutic and focused on the recovery of the client.

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ADMISSIONS

Figure CD-04 Client Legal Status on Admission	2010 Qtr 4	2011 Qtr1	 Qtr2	 Qtr3	 Total
ICDCC		3	17	26	46
ICDCC-PTP	2				2
IC-PTP+M				1	1
ICRDCC			1		1
INVOL CRIM	12	19	20	29	80
INVOL-CIV		1	2	7	10
PCHDCC			1		1
PCHDCC+M				1	1
VOL	36	34	31	10	111
VOL-OTHER	1	1	1	1	4
Total Admissions	51	58	73	75	257

Figure CD-06 Client Admission Diagnoses	2010 Qtr 4	2011 Qtr1	 Qtr2	 Qtr3	 Total
ADJUSTMENT DIS W MIXED DISTURBANCE OF EMOTIONS & CONDUCT			1	1	2
ADJUSTMENT DISORDER WITH DEPRESSED MOOD	1	1		1	3
ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED MOOD	1	1			2
ADJUSTMENT REACTION NOS	1	1			2
ALCOH DEP NEC/NOS-REMISS				2	2
BIPOL I, MOST RECENT EPISODE (OR CURRENT) MIXED, UNSPECIFIED	1			1	2
BIPOL I, REC EPIS OR CURRENT MANIC, SEVERE, SPEC W PSYCH BEH	1			1	2
BIPOLAR DISORDER, UNSPECIFIED	8	11	11	10	40
DELUSIONAL DISORDER		2	2	2	6
DEPRESSIVE DISORDER NEC	3	4	5	5	17
DYSTHYMIC DISORDER				1	1
HEBEPHRENIA-CHRONIC			1		1
INTERMITT EXPLOSIVE DIS				1	1
NONPSYCHOT BRAIN SYN NOS				1	1
OPPOSITIONAL DEFIANT DISORDER				1	1
PARANOID SCHIZO-CHRONIC	5	7	6	4	22
PARANOID SCHIZO-UNSPEC	1	2	4	5	12
POSTTRAUMATIC STRESS DISORDER	5	4	4	2	15
PSYCHOSIS NOS	4	4	6	13	27
REC DEPR DISOR-PSYCHOTIC		2	2		4
RECURR DEPR DISORD-UNSP			1	1	2
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED	15	13	20	14	62
SCHIZOPHRENIA NOS-CHR	2	1	6	4	13
SCHIZOPHRENIA NOS-UNSPEC		2	1	1	4
SCHIZOPHRENIFORM DISORDER, UNSPECIFIED				1	1
UNSPECIFIED EPISODIC MOOD DISORDER	3	3	3	3	12
Total Admissions	51	58	73	75	257
% Admitted with primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	0%	0%	0%	2.67%	0.78%

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COMMUNITY FORENSIC ACT TEAM

ASPECT: REDUCTION OF RE-HOSPITALIZATION FOR ACT TEAM CLIENTS

Indicators	Findings	Compliance	Threshold Percentile
1. The ACT Team Director will review all client cases of re-hospitalization from the community for patterns and trends of the contributing factors leading to re-hospitalization each quarter. The following elements are considered during the review: a. Length of stay in community b. Type of residence (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	3 NCR clients re-admitted, 1 twice in quarter; 2 PTP clients re-admitted, one then discharged from PTP	100%	100%
2. ACT Team will work closely with inpatient treatment team to create and apply discharge plan incorporating additional supports determined by review noted in #1.	100%	100%	100%

Summary

1. Two NCR clients were re-hospitalized for using a non-prescribed substance which became illegal after their re-admissions. One of those NCR clients had been in the community under one year living in a group home, the other had been in the community almost 2 years and was living in a supported apartment. The third client, who has been admitted twice in the quarter for threat to self or others, has been living successfully in a group home for several years without re-admission. All clients were medication adherent, 2 are men in their late 20s- early 30s, the other in his 40s. All had regular communication with ACT Team.

   The 2 PTP clients were both men in their 30s-40s living within a few miles of the ACT Team; one was new to PTP the other has participated for over one year. One lived in a group home and had excellent communication with ACT and house staff, the other lived in an independent apartment and avoided contact prior to re-admission. Medication adherence and/or substance abuse may have been a factor in both re-admissions but that remains unconfirmed.

2. The ACT Team has become more collaborative in treatment team meeting participation while clients are in the hospital, particularly regarding recommendations for goals of re-hospitalization. The ACT Team Peer Support Specialist has also been on leave for approximately ½ of this quarter yet maintained a high level of interaction with clients while they were in transition from the hospital and on the ACT Team during the time he was working.

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COMMUNITY FORENSIC ACT TEAM

ASPECT: INSTITUTIONAL AND ANNUAL REPORTS

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

Summary

1. Ten clients petitioned to have their cases heard on the 3/17/11 court date, three withdrew the petition. 5 of 10 had Institutional reports completed on time. The major factor influencing this poor outcome was the internal process for writing/filing reports which did not include clear deadlines and provide needed reminders for case managers. The process has been improved to include explicit time lines triggered with the receipt of petitions.

2. ACT Team Leader delivers all new Court Orders to Case Managers upon receipt, who then reviews with both client and supported housing staff involved in compliance with order. This is documented in progress notes and/or reviewed in ISP treatment team.

3. Annual Reports were not due within this quarter.

ASPECT: SUBSTANCE ABUSE AND ADDICTIVE BEHAVIOR HISTORY

Indicators	Findings	Compliance	Threshold Percentile
1. age of onset documented in Comprehensive Assessment	39/39	100%	95%
2. duration of behavior documented in C.A. and progress notes	36/39	85%	95%
3. pattern of behavior documented in C.A. and progress notes	38/39	90%	95%

Summary

Our randomization of urinalyses for drug/alcohol detection implemented by the Co-Occurring Specialist has been adapted to meet the MaineCare standards in order for lab work to be funded (no more than one time in 7 days). This does not diminish the unpredictability but does create awareness that urinalyses triggered by suspicion of use may not be covered by client's insurance.

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COMMUNITY FORENSIC ACT TEAM

ASPECT: INDIVIDUAL SERVICE PLANS AND PROGRESS NOTES

Indicators	Findings	Compliance	Threshold Percentile
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly contact with all clients assigned on an active status caseload.	37/39	100%	95%
2. Individual Service Plans will have measurable goals and interventions listing client strengths and areas of need related to community integration and increased court ordered privileges based on risk reduction activities.	39/39	100%	95%
3. Case notes will indicate at minimum monthly contact with all NCR clients who remain under the care of the Commissioner. These clients receive treatment services by community providers and RPC ACT monitors for court order and annual report compliance only.	10/10	100%	95%

Summary

1. Team now offers four groups, creating increased capacity for face-to-face contacts and supporting documentation. Clients in transition from ACT to other community resources have had less than weekly direct contact but are discussed weekly in clinical meeting and are seen face to face at least 4 times per month (averaging weekly contacts).
2. ISPs also contain group attendance goals, especially with clients who are petitioning for increased court ordered privileges. Case managers are focused on including group attendance in ISP goals.
3. One client in an outlying status successfully petitioned for increased privileges this quarter.

ASPECT: PEER SUPPORT

Indicators	Findings	Compliance	Threshold Percentile
1. Engagement attempt with client within 7 days of admission.	1/2	50%	95%
2. Documented offer of peer support services.	2/2	100%	95%
3. Attendance at treatment team meetings as appropriate.	15/30	50%	95%

Summary

As in prior report, Peer Support Specialist makes every effort to attend treatment team meetings at ACT offices and in hospital; this quarter a combination of vacation and FML created a gap in services in no way the responsibility of the Peer Support Specialist. The number and quality of contacts with clients by Peer Support continues to contribute to the ACT Teams goal of seeing clients face to face three times per week, and when needed, Peer Support Specialists from the hospital have met with clients of the ACT Team in the absence of the ACT PSP.

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CAPITOL COMMUNITY CLINIC

ASPECT: DENTAL CLINIC SURVEY

Indicators	Findings	Compliance	Threshold Percentile
Clients from RPC as well as clients in the community will receive a survey to fill out at the time of appt. The survey has several questions and in those questions we are asking the client how we can better serve there needs.	**January** Seventeen surveys completed by in-patient clients as well as outpatients. Of the seventeen surveys, all were positive.	100%	90%
	February Twenty-one clients were surveyed. All twenty-one surveys showed positive results.	100%	90%
	March Twenty-three clients were surveyed. Of the twenty-three surveys returned, all showed positive results.	100 %	90%

Summary

Sixty-one surveys were returned and all showed positive results for the third quarter.

Actions

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

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CAPITOL COMMUNITY CLINIC

ASPECT: DENTAL CLINIC 24 HOUR POST EXTRACTION FOLLOW-UP

Indicators	Findings	Compliance	Threshold Percentile
After dental extractions, the clients will receive a follow-up phone call from the clinic within 24hrs of procedure to assess for post procedure complications.	**January** There were twenty-two extractions during the month. A 24-hour phone call to all post procedure clients was completed. All clients reported no post procedure complications	100%	100%
	February There were eighteen extractions during the month. A 24-hour phone call to all post procedure clients was completed. All clients reported no post procedure complications	100%	100%
	March There were thirty-one extractions during the month. A 24-hour phone call to all post procedure clients was completed. All clients reported no post procedure complications .	100%	100%

Summary

There were seventy-one extractions in the third quarter. Clients were called 24 hours post extraction. All clients who were called reported no post procedure complications.

Action

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

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CAPITOL COMMUNITY CLINIC

ASPECT: DENTAL CLINIC TIMEOUT/IDENTIFICATION OF CLIENT

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

Summary:

In the 3rd quarter 2011, seventy-one clients had extractions. In all seventy one cases there is appropriate documentation of a time-out procedure prior to the extraction. The client was asked to identify the extraction site and was also asked to identify themselves by providing their full name and date of birth.

Actions

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

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CAPITOL COMMUNITY CLINIC

ASPECT: MED MANAGEMENT CLINIC APPOINTMENT ASSESSMENT

Indicators	Findings	Compliance	Threshold Percentile
All Outpatient clients will have Vital Signs and Weight recorded upon arrival for appointment.	**January** Twenty-six clients that had scheduled appointments had their vitals signs taken before their clinic appointment.	100%	100%
	February There were thirty clients scheduled for appointments during the month of February. All thirty clients had vital signs taken before their appointment.	100%	100%
	March There were thirty-eight clients scheduled for appointments. All thirty-eight had their vital signs taken before their clinic appointment.	100%	100%

Summary

For the third quarter there were 94 clients. Of the 94, all had their vitals taken before their scheduled appointment. This information was reviewed at monthly staff meetings and reports forwarded quarterly to RPC Quality Council.

Actions

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

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CLIENT SATISFACTION

ASPECT: CLIENT SATISFACTION WITH CARE

#	Indicators	Findings LK		Findings UK		Findings LS		Findings US	Findings Total	
1	I am better able to deal with crisis.	60%	+10%	23%	-27%	ND	ND	ND	ND	34%
2	My symptoms are not bothering me as much.	80%	+50%	55%	+20%	ND	ND	ND	ND	63%
3	The medications I am taking help me control symptoms that used to bother me.	80%	+55%	55%	+15%	ND	ND	ND	ND	63%
4	I do better in social situations.	60%	+40%	32%	-13%	ND	ND	ND	ND	41%
5	I deal more effectively with daily problems.	60%	+5%	36%	-9%	ND	ND	ND	ND	44%
6	I was treated with dignity and respect.	70%	+25%	32%	-13%	ND	ND	ND	ND	44%
7	Staff here believed that I could grow, change and recover.	70%	+25%	64%	+24%	ND	ND	ND	ND	66%
8	I felt comfortable asking questions about my treatment and medications.	80%	+35%	55%	+10%	ND	ND	ND	ND	63%
9	I was encouraged to use self-help/support groups.	80%	+30%	45%	+15%	ND	ND	ND	ND	56%
10	I was given information about how to manage my medication side effects.	30%	+15%	23%	+8%	ND	ND	ND	ND	25%
11	My other medical conditions were treated.	30%	-5%	45%	+15%	ND	ND	ND	ND	41%
12	I felt this hospital stay was necessary.	40%	+0%	27%	+37%	ND	ND	ND	ND	31%
13	I felt free to complain without fear of retaliation.	30%	+10%	27%	-8%	ND	ND	ND	ND	28%
14	I felt safe to refuse medication or treatment during my hospital stay.	30%	+20%	14%	+9%	ND	ND	ND	ND	19%
15	My complaints and grievances were addressed.	30%	-5%	32%	+7%	ND	ND	ND	ND	31%
16	I participated in planning my discharge.	80%	+35%	59%	+9%	ND	ND	ND	ND	66%
17	Both I and my doctor or therapist from the community were actively involved in my hospital treatment plan.	20%	0%	45%	+25%	ND	ND	ND	ND	38%
18	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	10%	-5%	23%	-2%	ND	ND	ND	ND	19%

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CLIENT SATISFACTION

#	Indicators	Findings LK		Findings UK		Findings LS		Findings US	Findings Total	
19	The surroundings and atmosphere at the hospital helped me get better.	40%	+25%	32%	+2%	ND	ND	ND	ND	34%
20	I felt I had enough privacy in the hospital.	60%	+35%	32%	+2%	ND	ND	ND	ND	41%
21	I felt safe while I was in the hospital.	60%	+10%	23%	-17%	ND	ND	ND	ND	34%
22	The hospital environment was clean and comfortable.	70%	+45%	5%	-35%	ND	ND	ND	ND	25%
23	Staff were sensitive to my cultural background.	10%	-25%	23%	-12%	ND	ND	ND	ND	19%
24	My family and/or friends were able to visit me.	50%	+15%	55%	+15%	ND	ND	ND	ND	53%
25	I had a choice of treatment options.	30%	+15%	50%	+20%	ND	ND	ND	ND	44%
26	My contact with my doctor was helpful.	70%	+30%	55%	+5%	ND	ND	ND	ND	59%
27	My contact with nurses and therapists was helpful.	70%	+30%	55%	+5%	ND	ND	ND	ND	59%
28	If I had a choice of hospitals, I would still choose this one.	50%	+30%	36%	+11%	ND	ND	ND	ND	41%
29	Did anyone tell you about your rights?	50%	+40%	50%	+15%	ND	ND	ND	ND	50%
30	Are you told ahead of time of changes in your privileges, appointments, or daily routine?	50%	-5%	32%	-13%	ND	ND	ND	ND	38%
31	Do you know someone who can help you get what you want or stand up for your rights?	60%	+20%	41%	-9%	ND	ND	ND	ND	47%
32	My pain was managed.	40%	+15%	45%	-5%	ND	ND	ND	ND	44%

ND = no data

Summary

Positive scores indicate satisfaction, while negative scores indicate dissatisfaction. Percentages are calculated using actual weighted scores and highest possible score for each indicator. The total number of respondents was 16: 5 from LK and 11 from UK. There was no data available for Upper and Lower Saco for this quarter. The first column for each unit indicates the score for 3rd quarter and the second column for each unit shows increases/decreases from 2nd quarter. Overall satisfaction for 3rd quarter increased slightly, up 5% from last quarter.

The most significant increase in satisfaction was on LK, up 19%. Several indicators continue to drop: indicators 1, 5, 6, 18, 21, 22, and 31. Data from the first two months of the quarter show that the outcome and dignity domains have dropped in satisfaction, while the rights and participation domains increased. The most significant decrease was in the outcomes domain and most significant increase was in the participation domain.

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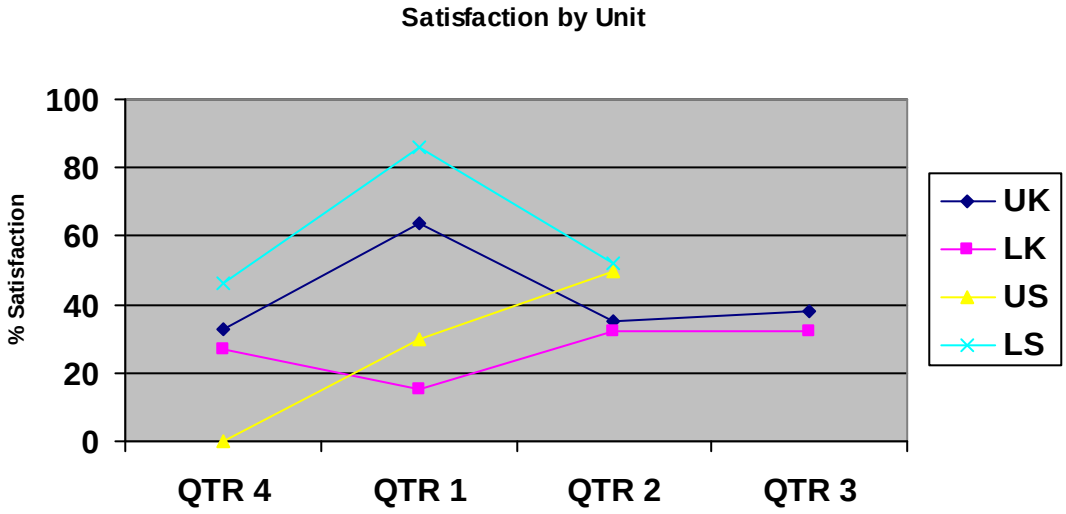
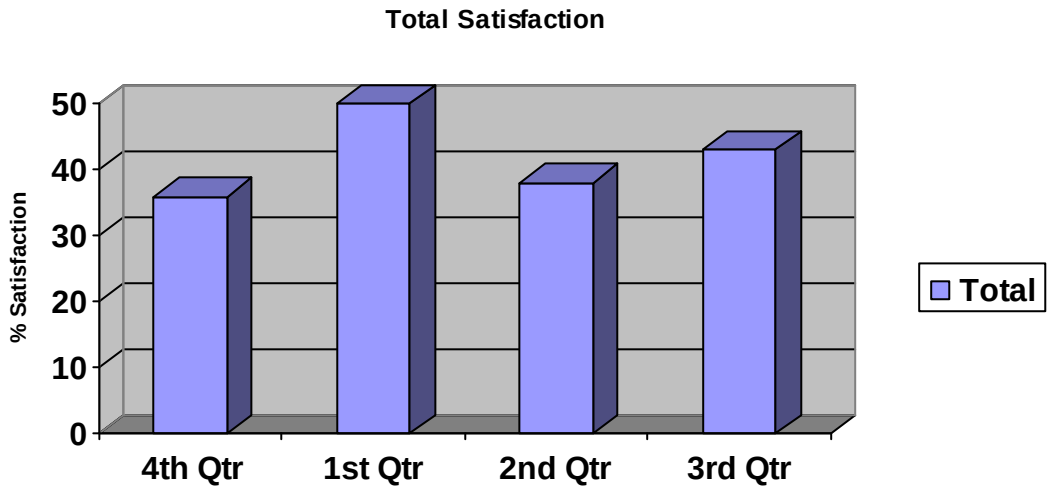
CLIENT SATISFACTION





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COMPARATIVE STATISTICS

The comparative statistics reports include the following elements:

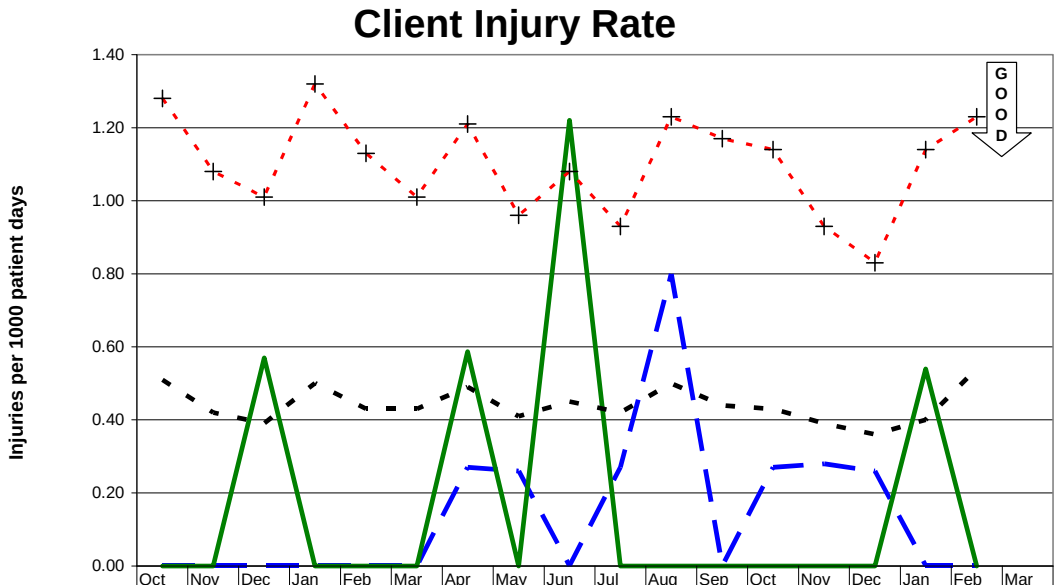
- Client Injury Rate
- Elopement Rate
- Medication Error Rate
- 30 Day Readmit Rate
- Percent of Clients Restrained
- Hours of Restraint
- Percent of Clients Secluded
- Hours of Seclusion
- Coercive Events Analysis
- Medication Administration during Behavioral Events

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

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

COMPARATIVE STATISTICS

Figure CD-29



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2010			3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011		
Riverview	0.00	0.00	0.00	0.00	0.00	0.00	0.27	0.26	0.00	0.27	0.80	0.00	0.27	0.28	0.26	0.00	0.00	
Dorothea Dix	0.00	0.00	0.57	0.00	0.00	0.00	0.59	0.00	1.22	0.00	0.00	0.00	0.00	0.00	0.00	0.54	0.00	
Ntl Mean	0.51	0.42	0.39	0.50	0.43	0.43	0.49	0.41	0.45	0.42	0.50	0.44	0.43	0.39	0.36	0.40	0.54	
+1 StDev	1.28	1.08	1.01	1.32	1.13	1.01	1.21	0.96	1.08	0.93	1.23	1.17	1.14	0.93	0.83	1.14	1.23	

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

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

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

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

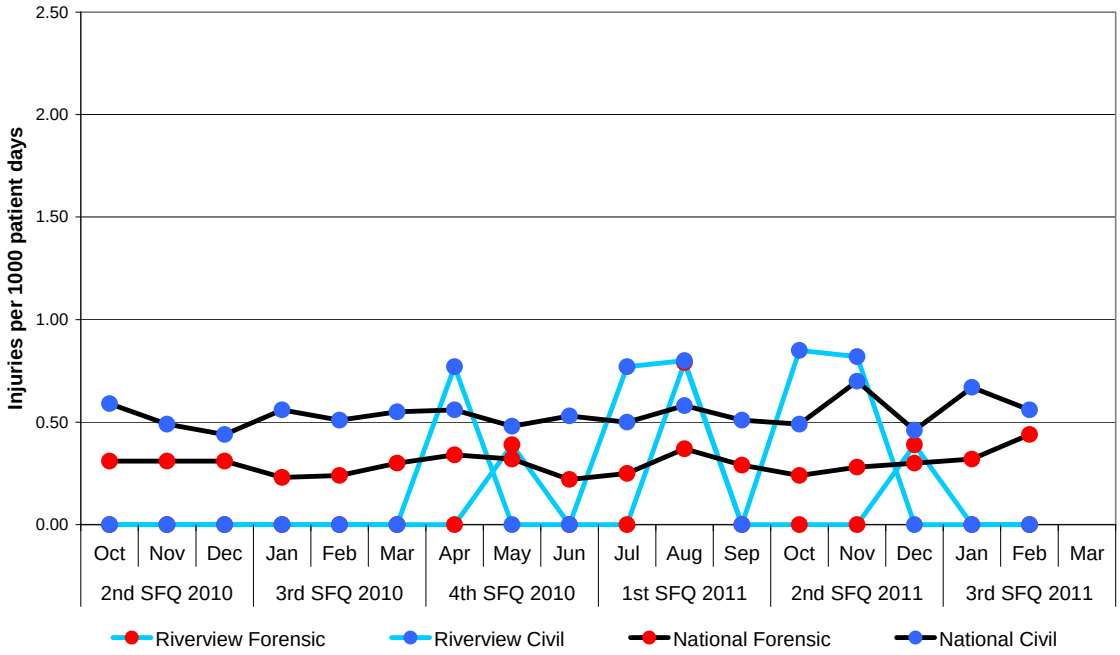
- No Treatment – The injury received by a client may be examined by a clinician but no treatment is applied to the injury.
- Minor First Aid – The injury received is of minor severity and requires the administration of minor first aid.
- Medical Intervention Needed – The injury received is severe enough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

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

COMPARATIVE STATISTICS

Client Injury Rate

Forensic Stratification



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

Client Injuries	Jan	Feb	Mar	3rd SFQ 2011
Total	3	20	16	39

ASPECT: SEVERITY OF INJURY BY MONTH

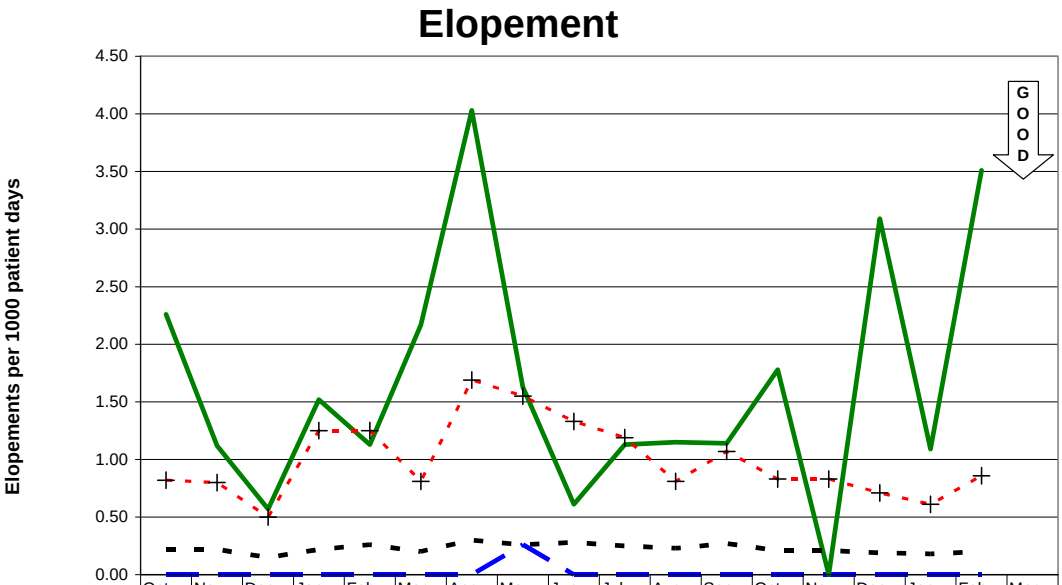
Severity	Jan	Feb	Mar	3rd SFQ 2011
No Treatment	3	13	7	23
Minor First Aid	--	7	7	14
Medical Intervention Required	--	--	2	2
Hospitalization Required	--	--	--	--
Death Occurred	--	--	--	--

ASPECT: TYPE AND CAUSE OF INJURY BY MONTH

Type - Cause	Jan	Feb	Mar	3rd SFQ 2011
Accident-Equipment Use			2	2
Accident-Fall Unwitnessed	1	5		6
Accident-Fall Witnessed		1	6	7
Accident-Other	1	2		3
Accident-Unknown		1		1
Assault-Client to Client		3	2	5
Self Injurious-Agitation		3		3
Self Injurious-Fall Unwitnessed		2		2
Self Injurious-Fall Witnessed			3	3
Self Injurious-Other		3	3	6

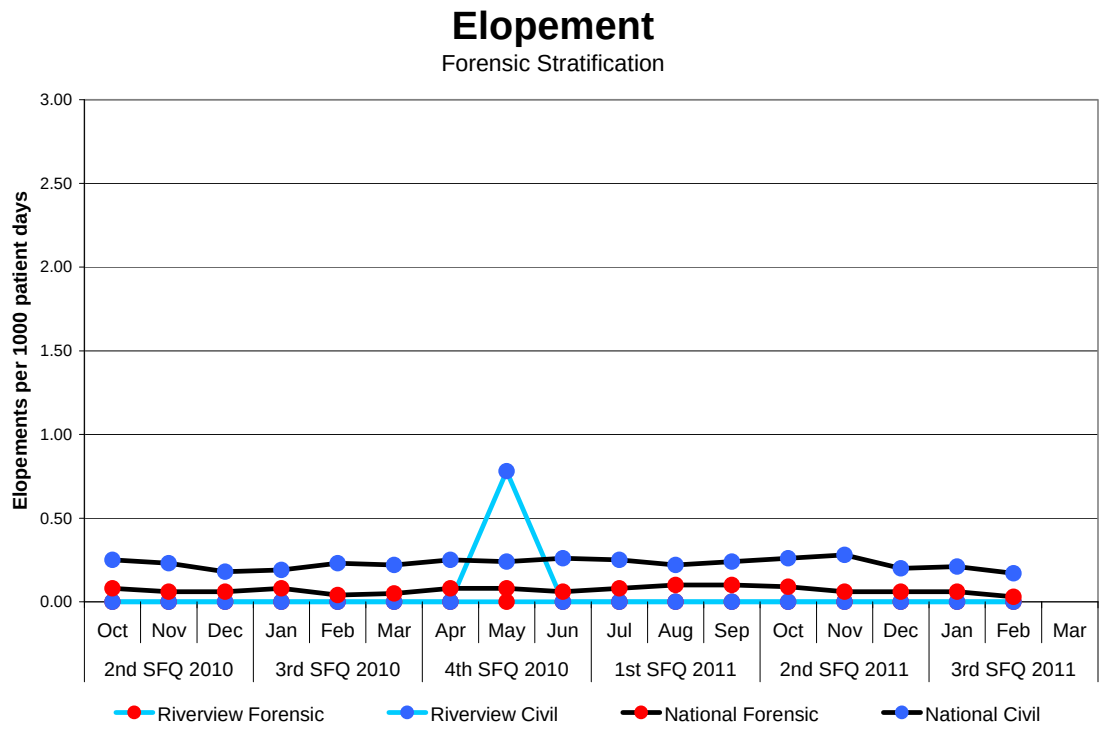
COMPARATIVE STATISTICS

Figure CD-28



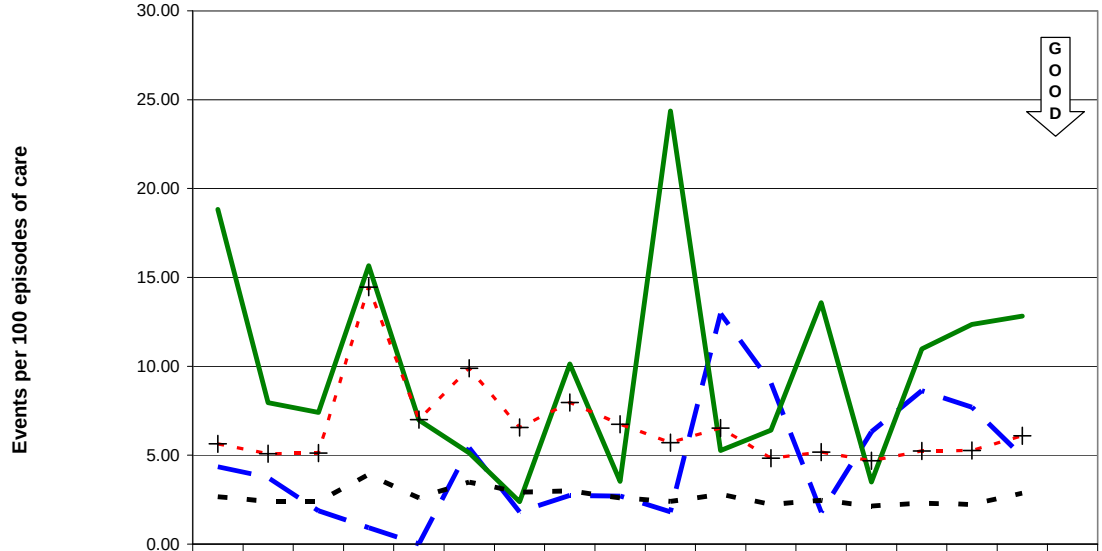
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2010			3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011		
Riverview	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.26	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Dorothea Dix	2.26	1.12	0.57	1.52	1.13	2.17	4.03	1.63	0.61	1.13	1.15	1.14	1.78	0.00	3.09	1.09	3.51	
Ntl Mean	0.22	0.22	0.15	0.22	0.26	0.20	0.30	0.26	0.28	0.25	0.23	0.27	0.21	0.21	0.19	0.18	0.20	
+1 StDev	0.82	0.80	0.50	1.25	1.25	0.81	1.69	1.55	1.33	1.19	0.81	1.07	0.83	0.83	0.71	0.61	0.86	

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.



COMPARATIVE STATISTICS

Medication Errors

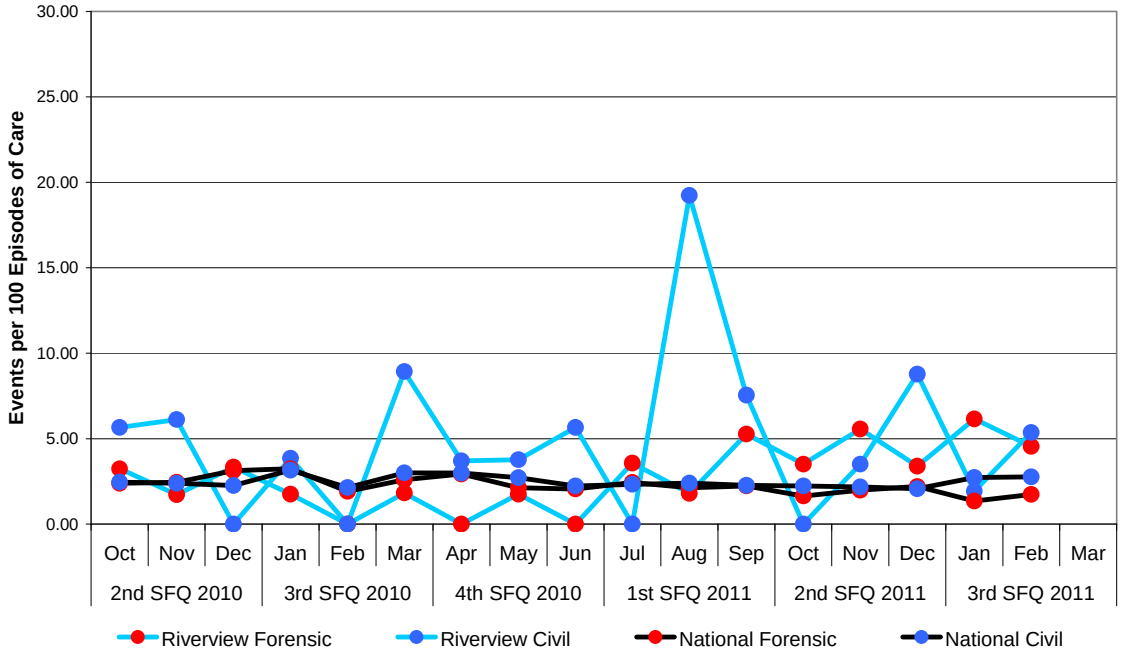


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2010			3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011		
Riverview	4.35	3.74	1.87	0.92	0.00	5.41	1.80	2.73	2.70	1.80	12.96	9.09	1.79	6.31	8.62	7.69	4.92	
Dorothea Dix	18.82	7.95	7.41	15.66	6.98	5.13	2.38	10.13	3.53	24.36	5.26	6.41	13.58	3.49	10.98	12.36	12.82	
Ntl Mean	2.67	2.41	2.39	3.92	2.60	3.48	2.92	2.99	2.60	2.41	2.79	2.24	2.46	2.15	2.30	2.24	2.86	
Nat Mean +1 StDev	5.64	5.08	5.12	14.46	7.00	9.89	6.56	7.97	6.74	5.71	6.52	4.83	5.17	4.69	5.24	5.26	6.09	

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

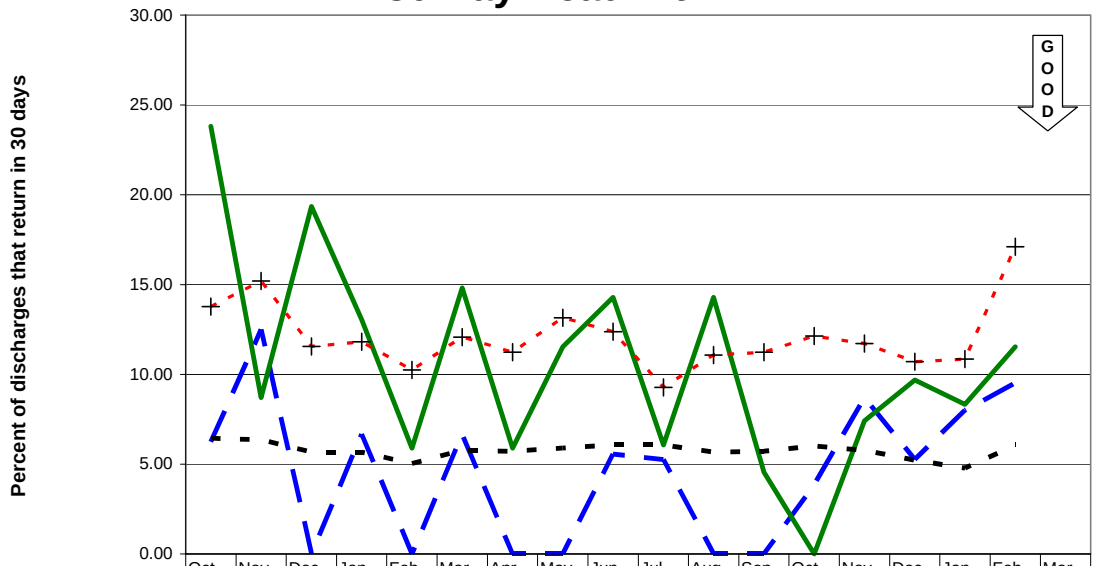
Medication Errors

Forensic Stratification



COMPARATIVE STATISTICS

30 Day Readmit

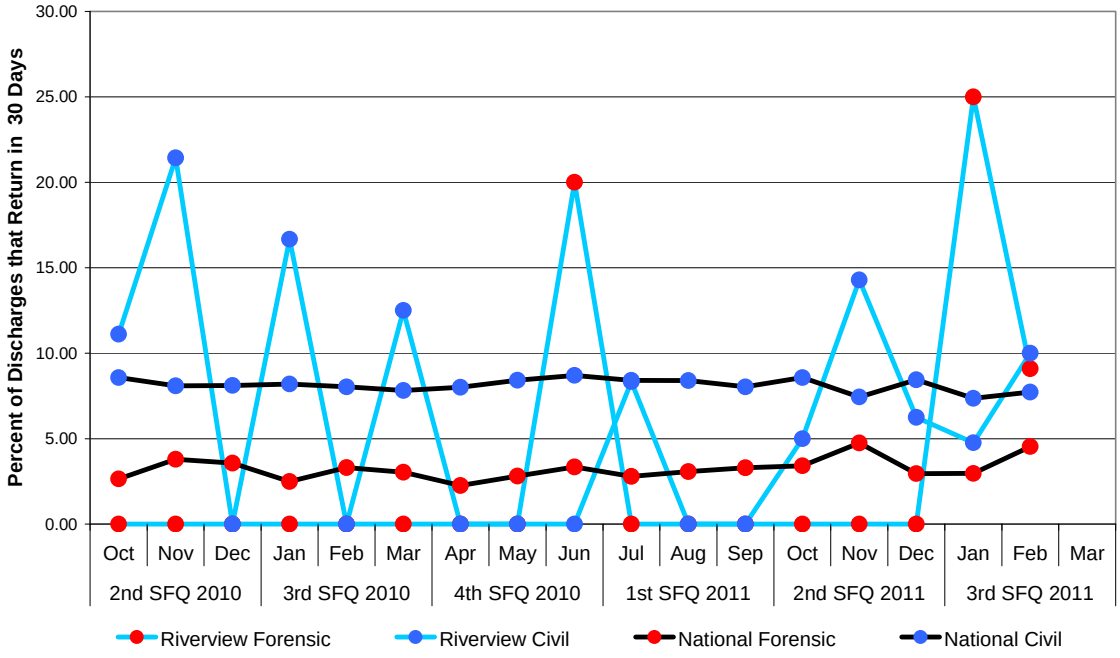


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2010			3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011		
Riverview	6.25	12.50	0.00	6.67	0.00	6.67	0.00	0.00	5.56	5.26	0.00	0.00	3.85	8.70	5.26	8.00	9.52	
Dorothea Dix	23.81	8.70	19.35	13.04	5.88	14.81	5.88	11.54	14.29	6.06	14.29	4.55	0.00	7.41	9.68	8.33	11.54	
Ntl Mean	6.45	6.36	5.67	5.66	5.03	5.76	5.72	5.90	6.08	6.06	5.67	5.72	6.01	5.77	5.22	4.79	6.07	
Nat Mean +1 StDec	13.77	15.20	11.56	11.82	10.24	12.07	11.23	13.15	12.38	9.28	11.07	11.23	12.13	11.72	10.7	10.85	17.11	

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.

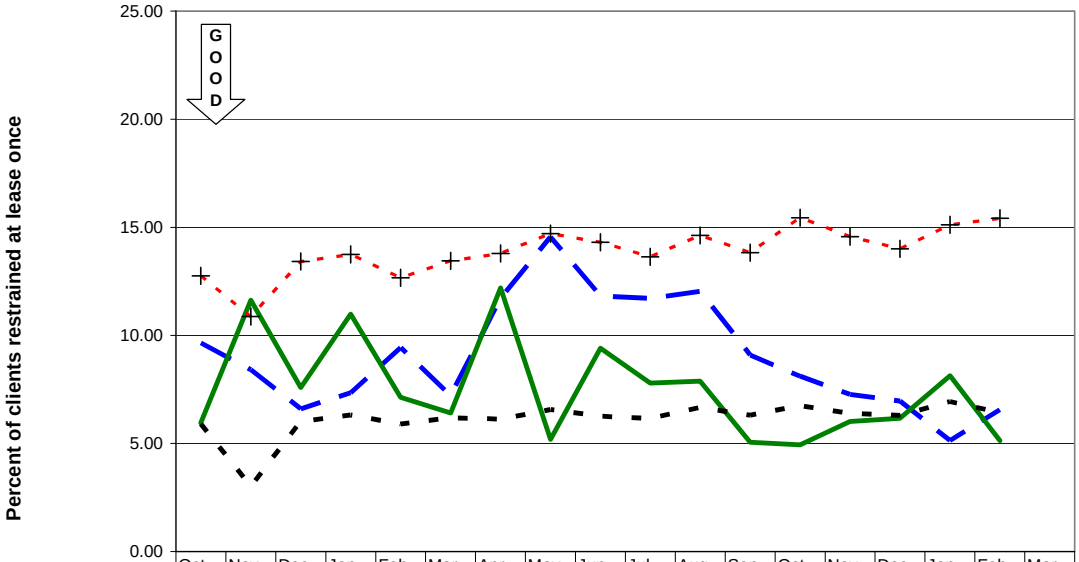
30 Day Readmit

Forensic Stratification



COMPARATIVE STATISTICS

Percent of Clients Restrained

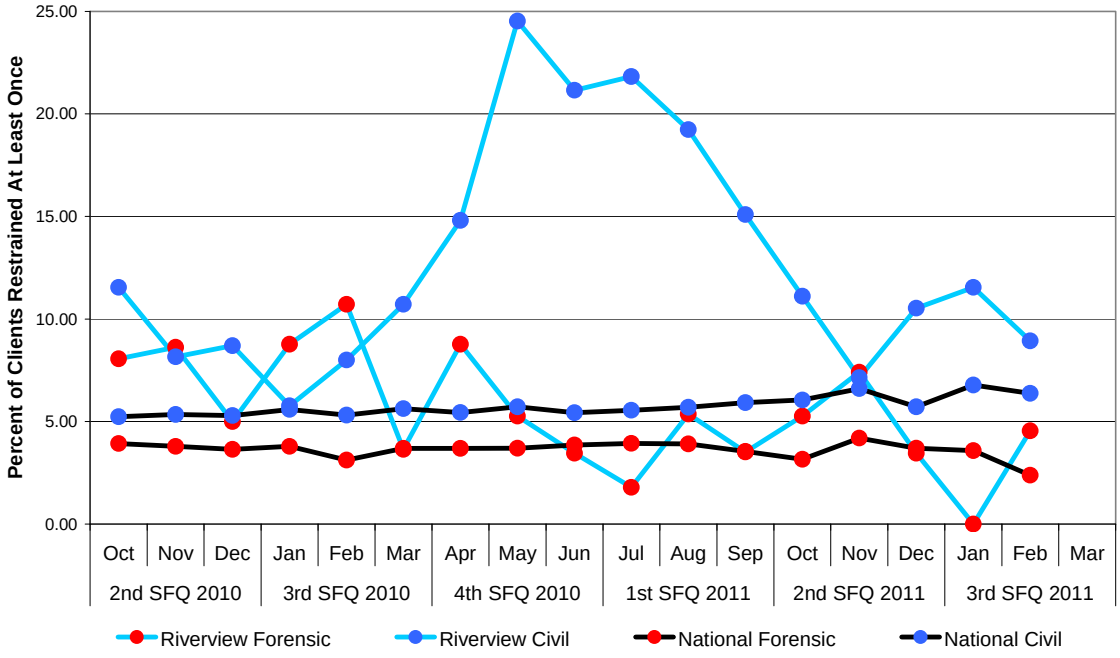


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2010			3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011		
Riverview	9.65	8.41	6.60	7.34	9.43	7.21	11.71	14.55	11.82	11.71	12.04	9.09	8.11	7.27	6.96	5.13	6.56	
Dorothea Dix	5.95	11.63	7.59	10.98	7.14	6.41	12.20	5.19	9.41	7.79	7.89	5.06	4.94	6.02	6.17	8.14	5.13	
Ntl Mean	5.90	3.01	6.02	6.32	5.90	6.19	6.13	6.57	6.26	6.16	6.66	6.31	6.75	6.39	6.30	6.93	6.42	
Nat Mean +1 St Dev	12.76	10.87	13.42	13.75	12.66	13.45	13.79	14.71	14.31	13.63	14.62	13.83	15.44	14.57	14.01	15.12	15.42	

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

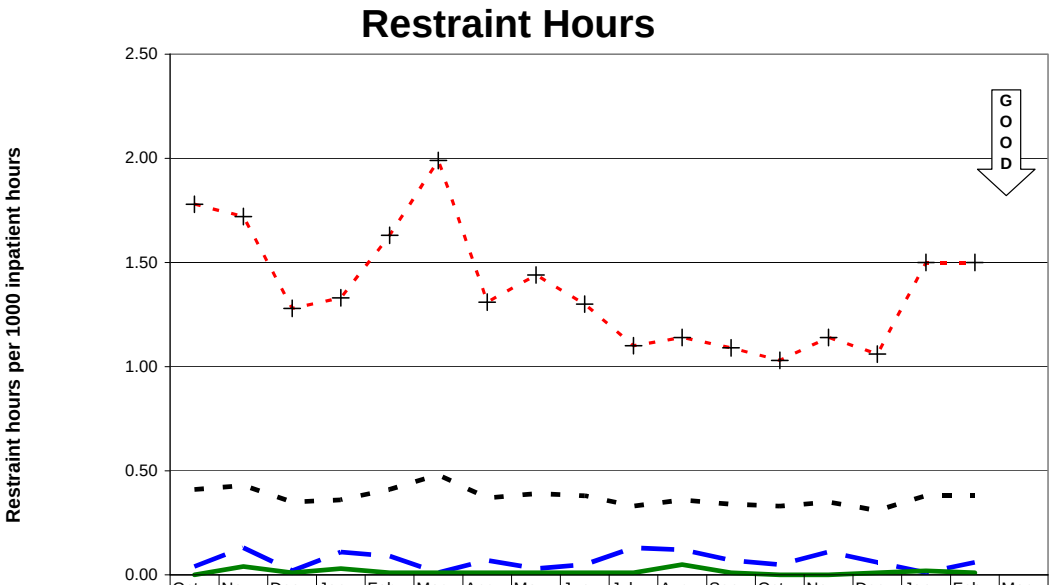
Percent of Clients Restrained

Forensic Stratification



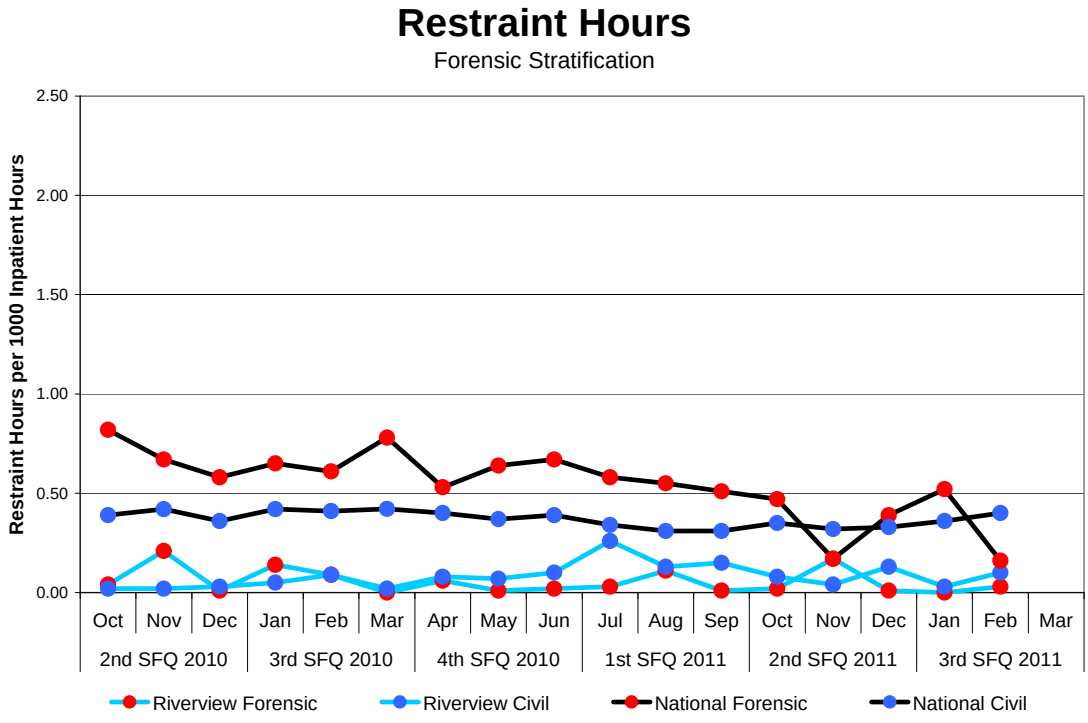
COMPARATIVE STATISTICS

Figure CD-24



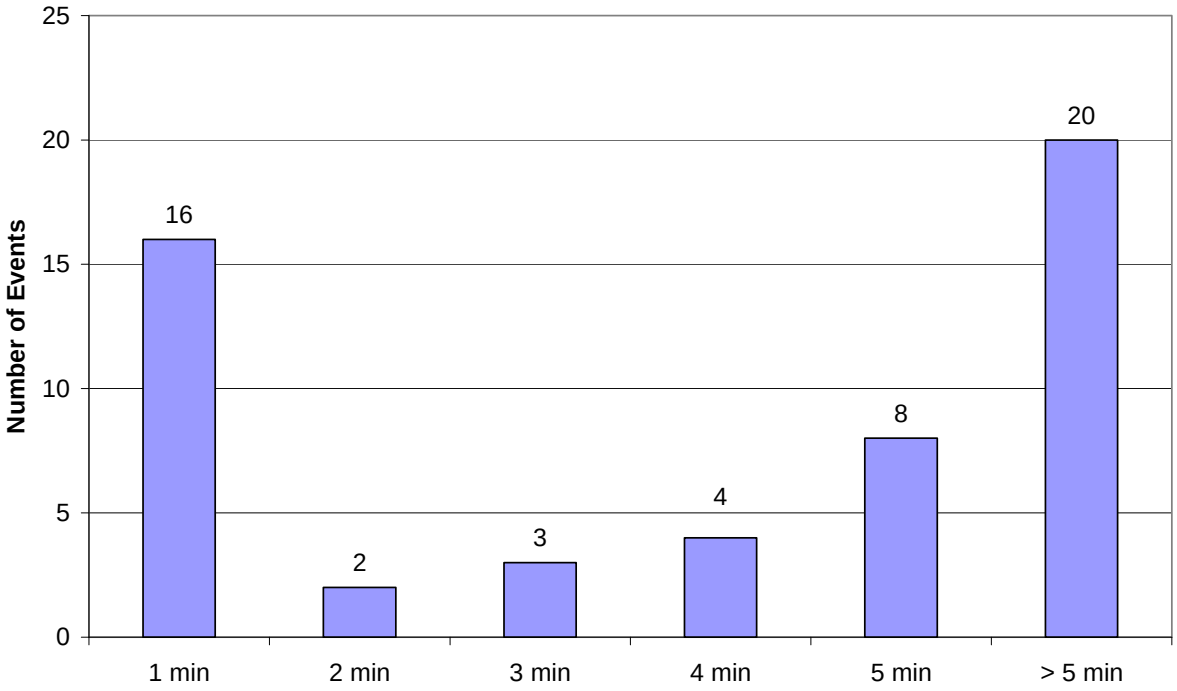
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2010			3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011		
Riverview	0.04	0.13	0.02	0.11	0.09	0.01	0.07	0.03	0.05	0.13	0.12	0.07	0.05	0.11	0.06	0.01	0.06	
Dorothea Dix	0.00	0.04	0.01	0.03	0.01	0.01	0.01	0.01	0.01	0.01	0.05	0.01	0.00	0.00	0.01	0.02	0.01	
Ntl Mean	0.41	0.43	0.35	0.36	0.41	0.48	0.37	0.39	0.38	0.33	0.36	0.34	0.33	0.35	0.31	0.38	0.38	
Nat Mean +1 StDev	1.78	1.72	1.28	1.33	1.63	1.99	1.31	1.44	1.3	1.1	1.14	1.09	1.03	1.14	1.06	1.5	1.5	

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



COMPARATIVE STATISTICS

Duration of Manual Hold (Restraint) Events
Jan - March 2011



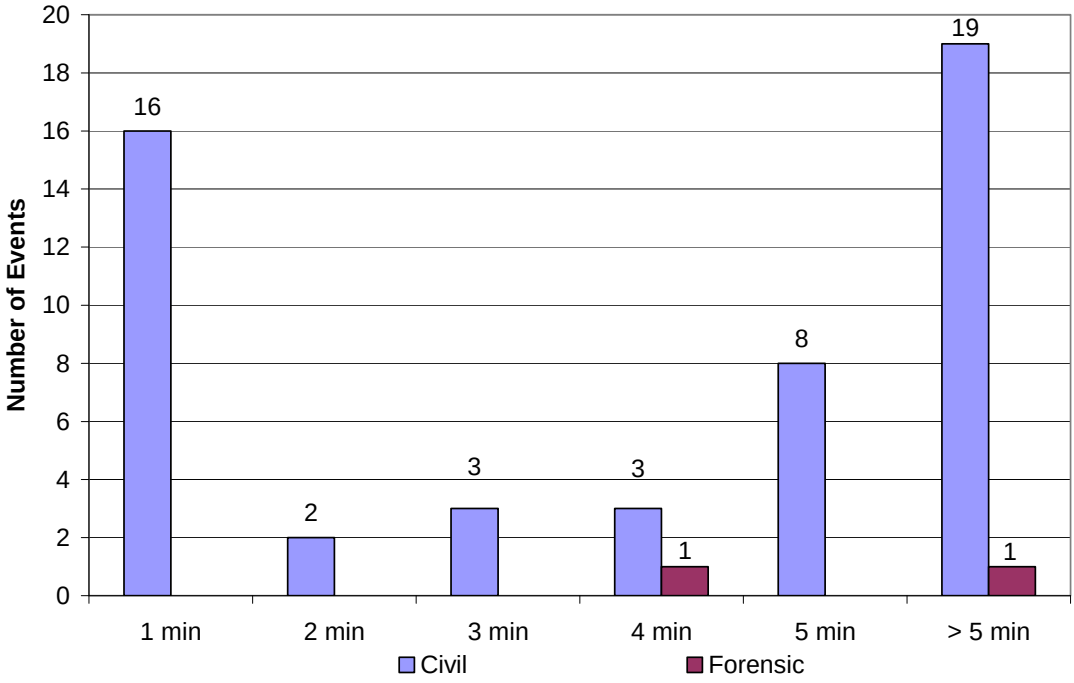
The overall number of manual hold events as well as the number of clients restrained for greater than 5 minutes declined slightly during the 3rd quarter 2011. The overall reduction in the number of manual holds was 20% during the period (from 66 to 53) and the reduction in manual holds greater than 5 minutes was 25% (from 27 to 20).

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

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

COMPARATIVE STATISTICS

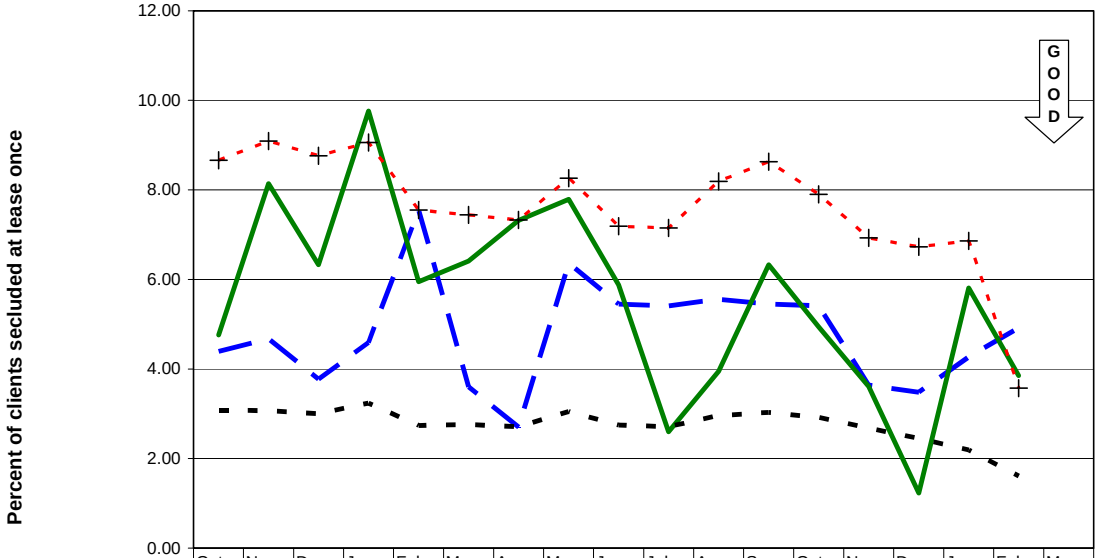
Duration of Manual Hold (Restraint) Events
Forensic Stratification
Jan - March 2011



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

COMPARATIVE STATISTICS

Percent of Clients Secluded

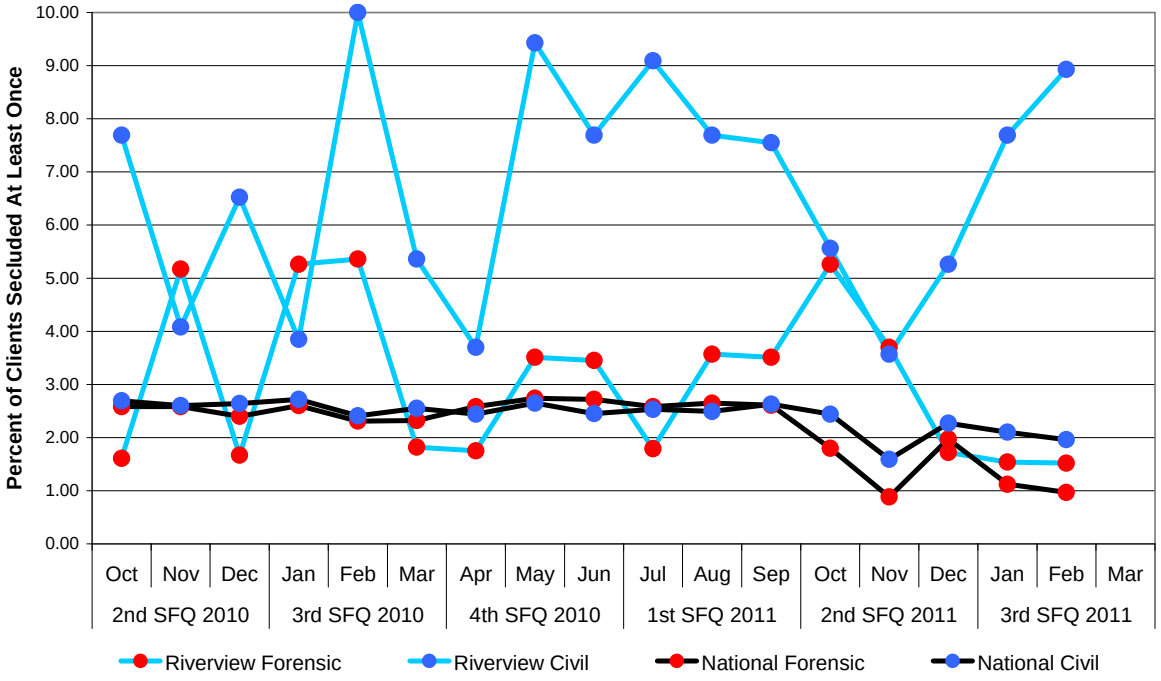


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2010			3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011		
Riverview	4.39	4.67	3.77	4.59	7.55	3.60	2.70	6.36	5.45	5.41	5.56	5.45	5.41	3.64	3.48	4.27	4.92	
Dorothea Dix	4.76	8.14	6.33	9.76	5.95	6.41	7.32	7.79	5.88	2.60	3.95	6.33	4.94	3.61	1.23	5.81	3.85	
Ntl Mean	3.08	3.07	3.00	3.24	2.74	2.76	2.71	3.05	2.75	2.71	2.96	3.03	2.92	2.68	2.45	2.19	1.61	
Nat Mean +1 St Dev	8.66	9.09	8.76	9.06	7.55	7.44	7.33	8.26	7.19	7.15	8.19	8.63	7.9	6.93	6.73	6.86	3.57	

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

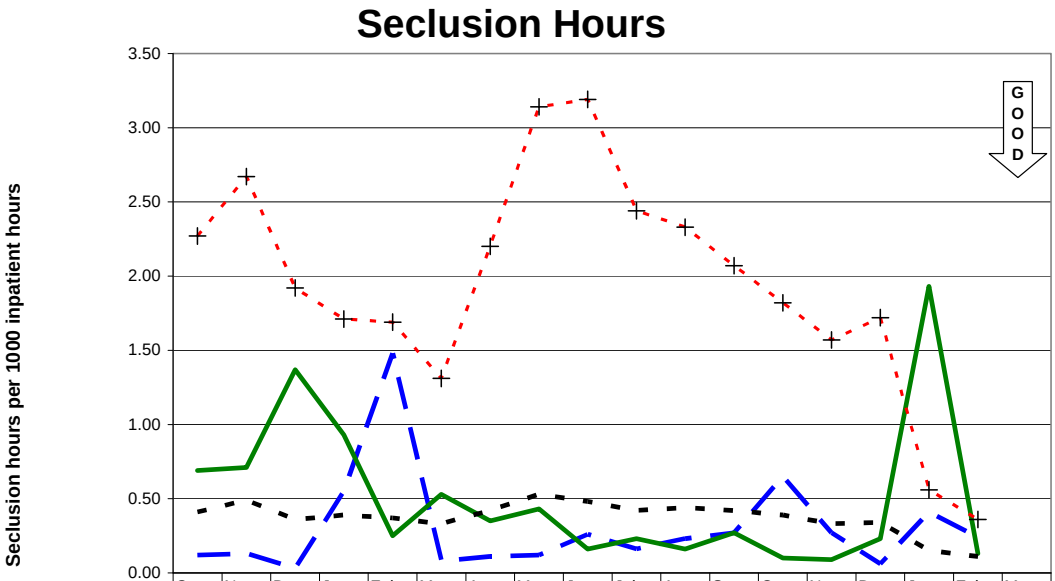
Percent of Clients Secluded

Forensic Stratification



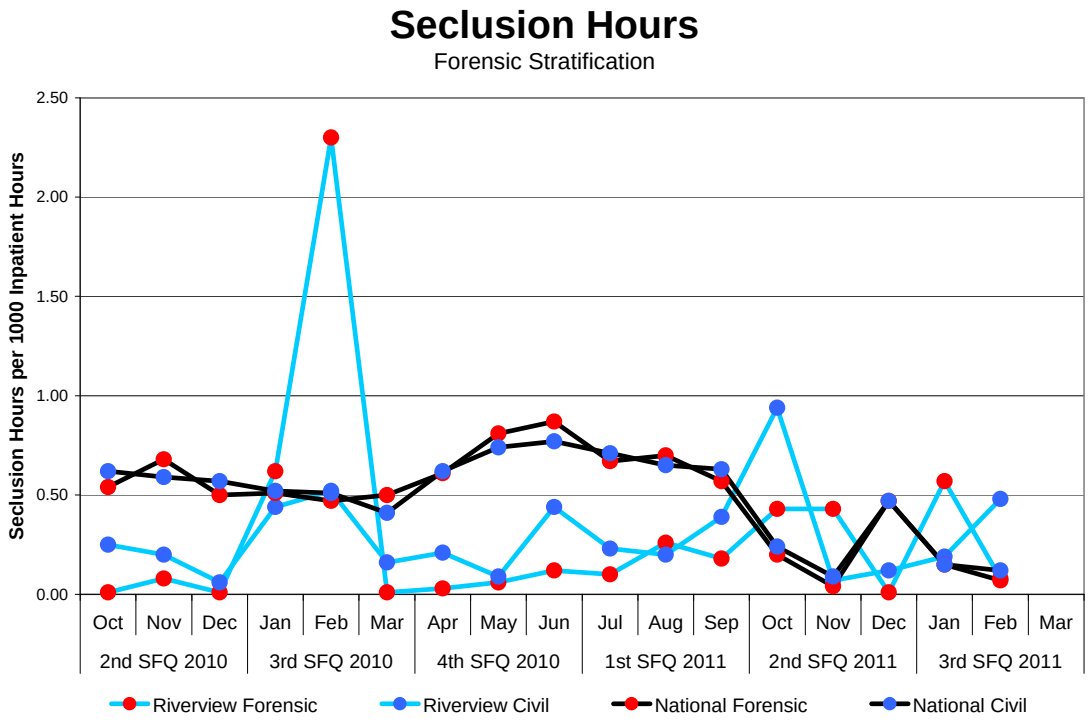
COMPARATIVE STATISTICS

Figure CD-23



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2010			3rd SFQ 2010			4th SFQ 2010			1st SFQ 2011			2nd SFQ 2011			3rd SFQ 2011		
Riverview	0.12	0.13	0.03	0.55	1.48	0.08	0.11	0.12	0.26	0.16	0.23	0.27	0.65	0.27	0.06	0.41	0.24	
Dorothea Dix	0.69	0.71	1.37	0.93	0.25	0.53	0.35	0.43	0.16	0.23	0.16	0.27	0.10	0.09	0.23	1.93	0.13	
Ntl Mean	0.41	0.49	0.36	0.39	0.37	0.33	0.42	0.53	0.48	0.42	0.44	0.42	0.39	0.33	0.34	0.15	0.11	
Nat Mean +1 StDev	2.27	2.67	1.92	1.71	1.69	1.31	2.2	3.14	3.19	2.44	2.33	2.07	1.82	1.57	1.72	0.56	0.36	

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



COMPARATIVE STATISTICS

Clients Status and Coercive Event Breakdown

		Manual Hold	Mechanical Restraint	Locked Seclusion	Open Seclusion	Grand Total	% of Total	Cumulative %
MR00000092	C	19		4		23	28%	28%
MR00004814	C	15		1		16	20%	48%
MR00005001	C	6		6		12	15%	63%
MR00003726	F	1		6		7	10%	73%
MR00005964	F	1		3		4	5%	78%
MR00000406	F			3		3	4%	81%
MR00003374	C	3				3	4%	85%
MR00000045	C	2				2	2%	88%
MR00003960	C	1		1		2	2%	90%
MR00004506	C	1		1		2	2%	93%
MR00006002	C	1		1		2	2%	95%
MR00000477	C		1			1	1%	96%
MR00000814	C	1				1	1%	98%
MR00003198	C	1				1	1%	99%
MR00003592	F	1				1	1%	100%

19% (15/81) of average hospital population experienced some form of confinement/coercive event during the 3rd fiscal quarter 2011. Seven of these clients (9% of the average hospital population) accounted for 85% of the containment/coercive events.

Coercive Events by Time of Day

	0000-0359	0400-0759	0800-1159	1200-1559	1600-1959	2000-2359
MR00000092		6	4	6	6	1
MR00004814	3		2		5	6
MR00005001			2	5	2	3
MR00003726		3	1	2	1	1
MR00005964			3	1		
MR00000406			1		2	
MR00003374			1	2		
MR00000045			1	1		
MR00003960				2		
MR00004506		2				
MR00006002			2			
MR00000477			1			
MR00000814				1		
MR00003198						1
MR00003592			1			

An example of the work being conducted in identifying the times and frequency of escalating behaviors and to modify treatment modalities in an effort to reduce the incidence of these behaviors can be seen in the work done with client MR00000045. This client, for several past quarters has exhibited extremely aggressive behaviors and specific times of the day. This quarter shows a significant reduction in the number of coercive events required (28 events last quarter to 2 events during the current quarter).

Figure CD-25, CD-26

Factors of Causation Related to All Coercive Events

(Manual Hold, Mechanical Restraint, Seclusion)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Danger to Others/Self	7	5	5	6	18	6	5	2	1	15	33	27
Danger to Others	17	11	17	8	11	7	3	5	6	4	1	
Danger to Self	2			3	1	3	4	1	2		1	
% Dangerous Precipitation	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total Coercive Events	26	16	22	17	30	16	12	8	9	19	35	27

COMPARATIVE STATISTICS

Medication Administration during Behavioral Events

	Jan	Feb	Mar	Total
COURTN		3		3
GUARDN	2	6	9	17
GUARDY		7	11	18
PEMEDSN	1	4	1	6
PEMEDSY	1	2	5	8
PRNY	10	14	11	35
Total Meds Admin	14	36	37	87
Percent Unwilling	21.43%	35.22%	27.03%	29.89%

	Manual Hold	Patient Incident	Patient Injury	Mechanical Restraint	Locked Seclusion
COURTN	3				
GUARDN	15		1		1
GUARDY	7	8			3
PEMEDSN		2	1	1	2
PEMEDSY	1	4	1		2
PRNY	8	13	3		11
Total	34	27	6	1	19

The high incidence of co-occurring manual holds and medication administrations, especially those that were given unwillingly, may have resulted from the need to temporarily secure the client and protect their safety during the administration of an intramuscular injection of ordered medication.

	COURTN	GUARDN	PEMEDSN	TOTAL
MR00004814	3	8		11
MR00000092		5		5
MR00000165			2	2
MR00000406		2		2
MR00005001			2	2
MR00000814			1	1
MR00004535			1	1
MR00005746		1		1
MR00006002		1		1
Total	3	17	6	26

Average daily census for the period was 81 clients per day. The number of clients that received medication unwillingly was 32% of the average client census. All unwilling administrations of medications were supported by a court order, a guardian order, or the declaration of a psychiatric emergency.

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

(Back to Table of Contents)

DIETARY

ASPECT: CLEANLINESS OF MAIN KITCHEN

Indicators	Quarterly % Compliance						Threshold Percentile
	Jan. '11-Mar. '11	Oct. '10-Dec. '10	Jul. '10-Sep. '10	Apr. '10-Jun. '10	Jan. '10-Mar. '10	Oct. '09-Dec. '09	
1. All convection ovens (4) were thoroughly cleaned monthly.	100% (12 of 12)	75% (9 of 12)	92% (11 of 12)	83% (10 of 12)	92% (11 of 12)	67% (8 of 12)	100%
2. Dish machine was de-limed monthly	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100%
3. Shelves (6) used for storage of clean pots and pans were cleaned monthly	100% (18 of 18)	100% (18 of 18)	100% (18 of 18)	100% (18 of 18)	89% (16 of 18)	100% (18 of 18)	100%
4. Knife cabinet was thoroughly cleaned monthly	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100%
5. Walk in coolers were cleaned thoroughly monthly.	100% (6 of 6)	100% (6 of 6)	100% (6 of 6)	100% (6 of 6)	100% (6 of 6)	100% (6 of 6)	100%
6. Steam kettles (2) were cleaned thoroughly on a weekly basis	100% (26 of 26)	69% (18 of 26)	93% (26 of 28)	93% (26 of 28)	79% (19 of 24)	75% (18 of 24)	95%
7. All trash cans (4) and bins (1) were cleaned daily	89% (401 of 450)	98.9% (455 of 460)	97% (445 of 460)	85% (462 of 546)	63% (341 of 540)	66% (365 of 552)	95%
8. All carts(9) used for food transport (tiered) were cleaned daily	97.7% (792 of 810)	98% (812 of 828)	98% (811 of 828)	97% (794 of 819)	85% (686 of 810)	87% (717 of 828)	100%
9. All hand sinks (4) were cleaned daily	100% (360 of 360)	95.6% (352 of 368)	98% (360 of 368)	92% (794 of 819)	84% (304 of 360)	80% (296 of 368)	95%
10. Racks(3) used for drying dishes were cleaned daily	98.8% (267 of 270)	99% (273 of 276)	99% (273 of 276)	81% 222 of 273	77% (207 of 270)	96% (264 of 276)	100%

Summary

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

- The improvement seen regarding the cleaning of the oven is attributed to communication and

teamwork of the Dietary employees.

- The improvement seen regarding the cleaning of the steam kettles is attributed to the reassignment of the task.
- The decrease seen in the cleaning of the trash cans and bins is due to redefining the task.
- Cleaning the food transport carts and cleaning the racks used for drying dishes remains around 98%

Actions:

- The task of cleaning the drying racks will be reassigned.
- FSM reviews all cleaning schedules on a daily basis to assure staff completion.
- Cleaning schedules are modified to reflect changes in staff availability.
- Weekly staff meetings include review of the past weeks completion rates.
- Results of this CPI indicator will be discussed with staff.
- The department will be fully staffed as of April 2011.

ASPECT: TIMELINESS OF NUTRITIONAL ASSESSMENT

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

Summary

During the 3rd quarter 2011, one client was discharged within 2 days of admission. There were 76 total admissions.

Actions

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

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

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

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HEALTH INFORMATION MANAGEMENT

ASPECT: DOCUMENTATION & TIMELINESS

Indicators	Findings	Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	There were 75 discharges in the 3rd quarter 2011. Of those, 37 were completed within 30 days.	49 %	80%
Discharge summaries will be completed within 15 days of discharge.	75 out of 75 discharge summaries were completed within 15 days of discharge during the 3rd quarter 2011.	100 %	100%
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	2 forms were approved/ revised during the 3rd quarter 2011 (see minutes).	100%	100%
Medical transcription will be timely and accurate.	Out of 1154 dictated reports, 967 were completed within 24 hours.	84%	90%

Summary

The indicators are based on the review of all discharged records. There was 49% compliance with record completion. There was 100% compliance with discharge summary completion. Weekly “charts needing attention” lists are distributed to medical staff, including the Medical Director, along with the Superintendent, Risk Manager and the Quality Improvement Manager. There was 84% compliance with timely & accurate medical transcription services.

Actions

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

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HEALTH INFORMATION MANAGEMENT

ASPECT: CONFIDENTIALITY

Indicators	Findings	Compliance	Threshold Percentile
All client information released from the Health Information department will meet all Joint Commission, State, Federal & HIPAA standards.	3397 requests for information (105 requests for client information and 3292 police checks) were released for the 3rd quarter 2011.	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	Seven new employees/contract staff received training in the 3rd quarter 2011.	100%	100%
Confidentiality/Privacy issues tracked through incident reports.	There were 0 privacy-related incident reports during the 3rd quarter 2011.	100%	100%

Summary

The indicators are based on the review of all requests for information, orientation for all new employees/contract staff and confidentiality/privacy-related incident reports. No problems were found in the 3rd quarter, however compliance with current law and HIPAA regulations need to be strictly adhered to requiring training, education and policy development at all levels.

Actions

The above indicators will continue to be monitored.

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HOUSEKEEPING

ASPECT: LINEN CLEANLINESS AND QUALITY

Indicators	Quarterly % Compliance						Threshold Percentile
	Jan. '11-Mar. '11	Oct. '10-Dec. '10	Jul. '10-Sep. '10	Apr. '10-Jun. '10	Jan. '10-Mar. '10	Oct. '09-Dec. '09	
1. Was linen clean coming back from vendor?	100% (34 of 34)	100% (53 of 53)	96% (23 of 24)	100% (37 of 37)	100% (32 of 32)	100% (37 of 37)	100%
2. Was linen free of any holes or rips coming back from vendor?	92% (31 of 34)	100% (53 of 53)	92% (22 of 24)	81% (30 of 37)	97% (31 of 32)	97% (36 of 37)	95%
3. Did we have enough linen on units via complaints from unit staff?	88% (30 of 34)	96% (51of 53)	92% (22 of 24)	97% (36 of 37)	94% (30 of 32)	100% (37 of 37)	90%
4. Was linen covered on units?	97% (33 of 34)	100% (53 of 53)	100% (24 of 24)	100% (37 of 37)	88% (28 of 32)	100% (37 of 37)	95%
5. Did vendor provide a 24 hr. turn around service as specified in the contract?	97% (33 of 34)	96% (51 of 53)	79% (19 of 24)	95% (35 of 37)	94% (30 of 32)	100% (37 of 37)	100%
6. Did we receive an adequate supply of mops and rags from vendor?	97% (33 of 34)	100% (53 of 53)	100% (24 of 24)	100% (37 of 37)	97% (31 of 32)	89% (33 of 37)	95%
7. Was linen bins clean returning from vendor?	100% (34 of 34)	100% (53 of 53)	100% (24 of 24)	97% (36 of 37)	100% (32 of 32)	100% (37 of 37)	100%
8. Was the linen manifest accurate from the vendor	88% (30 of 34)	96% (51 of 53)	31% (5 of 16) (New)				85%

Summary

Eight different criteria are to be met for acceptability. The indicators are based on the inspections of linen closets throughout the facility including the returned linen from the vendor. All linen types were reviewed randomly this quarter. All indicators are within threshold percentiles except for # 2 & # 3.

The overall compliance for this quarter was 95%. This is shows a 3% decrease from last quarters' report.

1. Complaints from 2 units (indicator #2) regarding holes in linen. Torn linen was removed from unit and disposed.
2. Replenished supply of linen of both Upper Kennebec and Lower Kennebec to maintain minimum par level (indicator # 3)
3. Linen was not coming back from the vendor with accurate manifests (indicator # 8)

HOUSEKEEPING

4. Linen coming back from the vendor (3 occurrences) was not delivered to Riverview in a timely fashion (indicator # 5).

Actions

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

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

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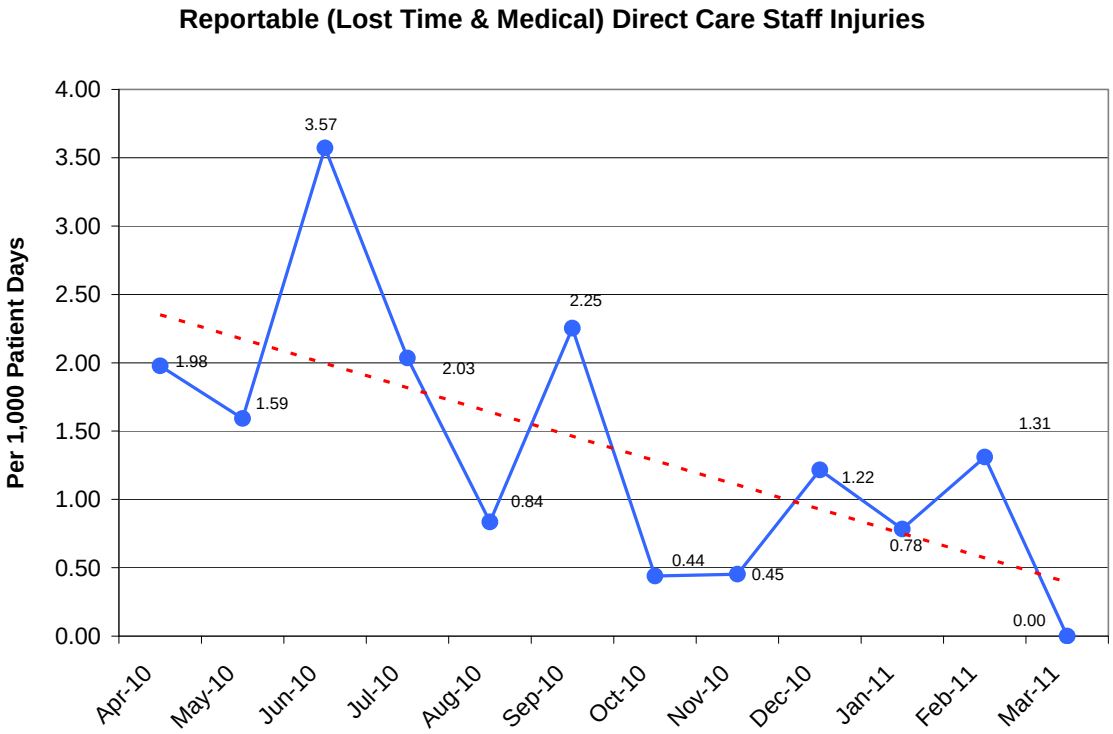
HUMAN RESOURCES

ASPECT: DIRECT CARE STAFF INJURIES



Summary

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

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

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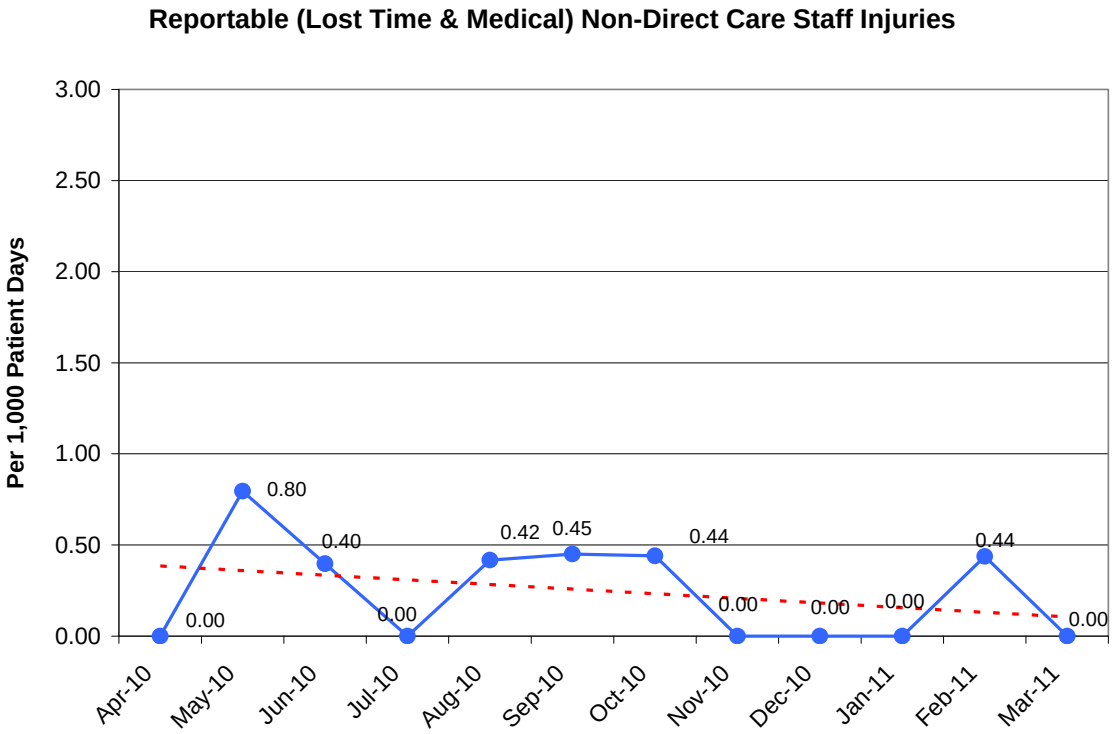
HUMAN RESOURCES

ASPECT: NON-DIRECT CARE STAFF INJURIES



Summary

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

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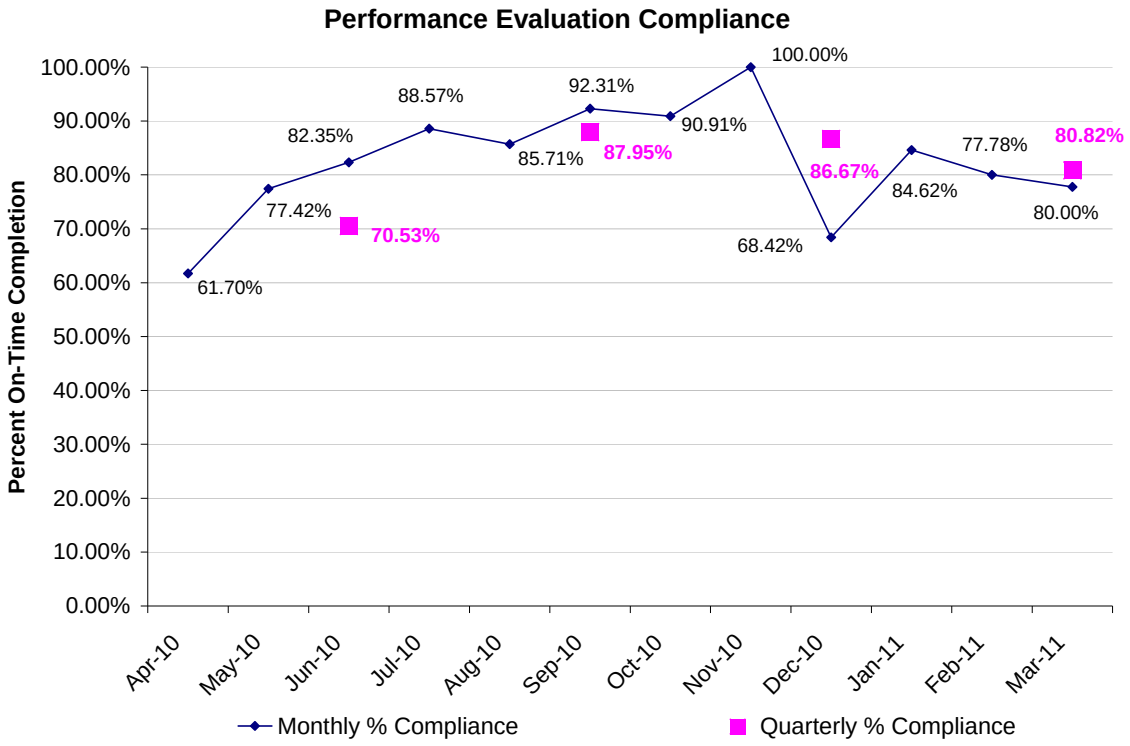
HUMAN RESOURCES

ASPECT: PERFORMANCE EVALUATIONS COMPLETION

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



Summary

This quarter has shown some difficulties in maintaining a high degree of completion of performance evaluations.

Cumulative results from this quarter (80.82%) are below the planned performance threshold of 85%. The monthly results for compliance are also all below the planned performance threshold. These results are too few to identify a trend. Ongoing measurement of performance is indicated for the remainder of the calendar year. Ongoing efforts to insure on time completion of performance evaluations will continue in order to achieve the highest possible rate of on-time performance and to maintain a sustainable level of performance above the 85% level.

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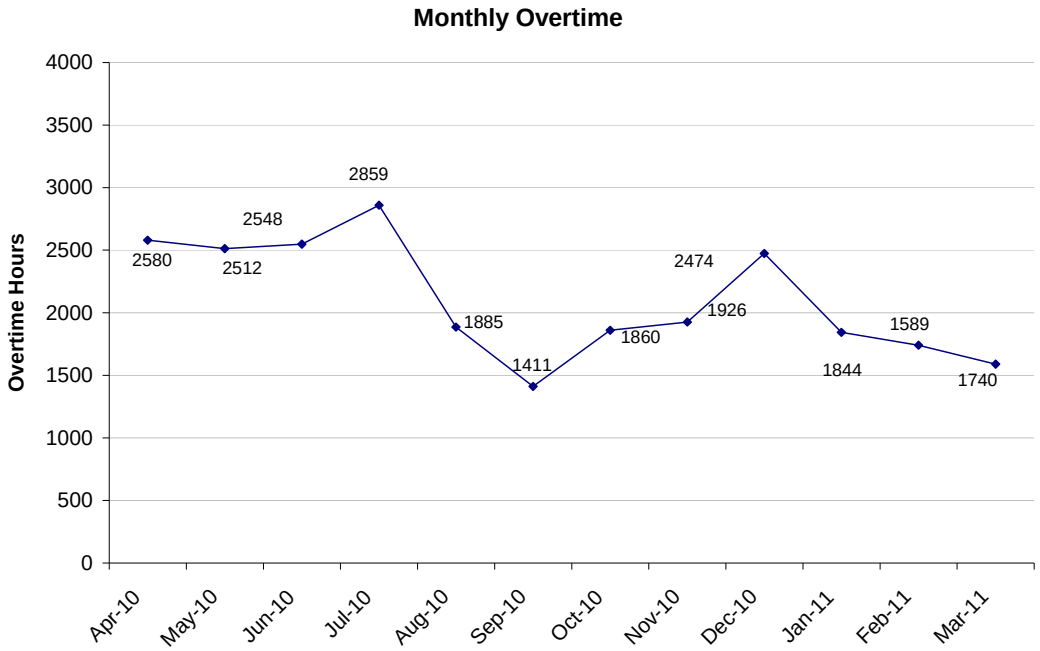
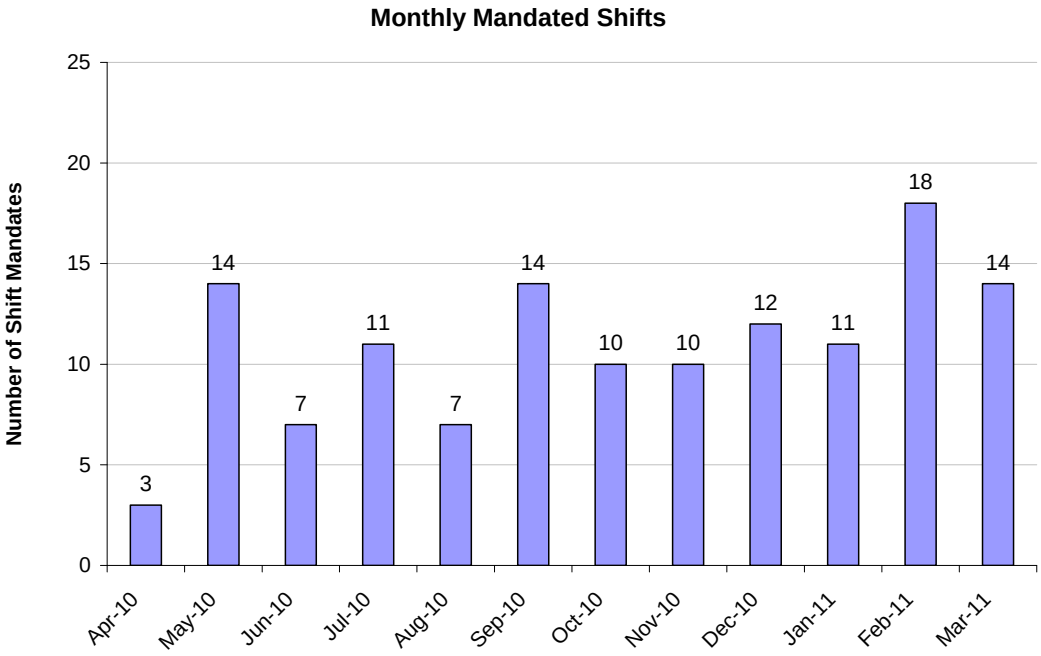
HUMAN RESOURCES

ASPECT: PERSONNEL MANAGEMENT

Overtime hours and mandated shift coverage





As anticipated, the level of overtime hours continues to decline as staffing levels stabilize. The number of mandated shifts is slightly higher than anticipated although not outside of the span of normal experience.

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INFECTION CONTROL

ASPECT: HOSPITAL ACQUIRED INFECTION

Indicators	Findings	Compliance	Threshold Percentile
Total number of infections for the fourth quarter of the fiscal year, per 1000 patient days	32/4.4	100 % within standard	1 SD within the mean
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	11/1.4	100% within standard	1 SD within the mean

Data

- Upper Respiratory Infections – 2
- Lower Respiratory Infections – 2
- Gastrointestinal Infections – 4
- Reproductive Infections – 2 .
- Dental Infections – 6
- Skin Infections – 9
- Ear Infections – 4
- Urinary Tract Infections – 1
- Eye Infections – 0
- Wound Infections – 1
- HIV – 1

October 2010: Spike in total infection rate due to unusually high number of community acquired skin infections on the Saco Units.
December 2010: Spike in hospital acquired infection rate above one standard deviation due to a norovirus outbreak.
January 2011: Spike in hospital acquired infection rate above one standard deviation due to a norovirus outbreak.

Summary

House Keeping and staff were able to contain the norovirus outbreaks in January and February with enhanced disinfection and hand hygiene. The virus did not spread to adjacent units. Despite the outbreaks the hospital acquired infection rates this quarter remained consistent with last quarter rates, and within one standard deviation of the mean. No trending noted.

One client was newly diagnosed with HIV. This information was reported to the Maine CDC.

Action Plan

Continue total house surveillance. Continue hand hygiene observation on the units with an emphasis on standard and transmission based precautions (as indicated) to prevent transmission within the hospital environment.

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LIFE SAFETY

ASPECT: LIFE SAFETY

Indicators	Quarterly % Compliance						Threshold Percentile
	Jan. '11-Mar. '11	Oct. '10-Dec. '10	Jul. '10-Sep. '10	Apr. '10-Jun. '10	Jan. '10-Mar. '10	Oct. '09-Dec. '09	
1. Total number of fire drills and actual alarms conducted during the quarter compared to the total number of alarm activations required per Life Safety Code, that being (1) drill per shift, per quarter.	100% (3/3)	100% (3/3)	100% (3/3)	100% (3/3)	100% (3/3)	100% (3/3)	**100%**
2. Total number of staff who knows what R.A.C.E. stands for.	100% (202/202)	100% (221/221)	100% (285/285)	100% (160/160)	100% (107/107)	100% (148/148)	**95%**
3. Total number of staff who knows how to acknowledge the fire alarm or trouble alarm on the enunciator panel.	100% (202/202)	100% (221/221)	100% (285/285)	100% (160/160)	93% (100/107)	100% (148/148)	**95%**
4. Total number of staff who knows the emergency number.	100% (202/202)	100% (221/221)	100% (285/285)	100% (160/160)	100% (107/107)	93% (139/148)	**95%**
5. During unannounced safety audits conducted by the Safety Officer, this represents the total number of staff who displays identification tags.	98% (204/208)	97% (224/230)	100% (285/285)	96% (164/170)	92% (99/107)	94% (159/168)	**95%**
6. During unannounced safety audits conducted by the Safety Officer, this represents the total number of direct care staff who carries a personal duress transmitter.	97% 206/208	97% 225/230	100% (92/92)	98% (167/170)	91% (98/107)	95% (94/98)	**95%**

Summary

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

During drills, the following was discovered and noted:

1. One staff person was missing their red key identifier attached to the fire key.
2. One staff person was unsure where the nearest fire alarm pull station was located.

3. One staff person was not fully depressing the mike button during the census taking.
4. There continues to be a significant improvement in the completeness of and timely submission of fire reports.
5. Three staff did not have an updated emergency sticker on the back of their key card.

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

Actions

Actions taken after drills were the following:

1. The staff person was given a red key identifier.
2. The unit received a refresher on the locations of fire alarm pull stations and other emergency equipment.
3. The staff person having difficulty was given remedial instruction on the use of the two-way radio. The Safety Officer will continue to conduct drills with the two-way radios for the purposes of conducting census activities and the proper use of the two-way radios.
4. No action required.
5. The three staff members were given the newest sticker.

We continue to conduct environmental tours and safety audits to assure that staff is in possession of required safety equipment and facility ID's. This area of monitoring has shown improvement.

ASPECT: FIRE DRILLS REMOTE SITES

Indicators	Quarterly % Compliance						Threshold Percentile
	Jan. '11-Mar. '11	Oct. '10-Dec. '10	Jul. '10-Sep. '10	Apr. '10-Jun. '10	Jan. '10-Mar. '10	Oct. '09-Dec. '09	
Total number of fire drills and actual alarms conducted at Portland Clinic compared to the total number of alarm activations required per Life Safety Code (3) drills per year based on the fact that it is business occupancy.	100% (1 drill)	100% (1 drill)	100% (1 drill)	100% (1 drill)	100% (1 drill)	100% (1 drill)	100%

Summary

On 1/28/11, the Safety Officer attempted to perform an unannounced drill. Due to extensive client services being performed, the decision was made to not conduct the drill at that time since a drill would have greatly impacted the services being performed. There had already been an unannounced drill conducted by the Safety Officer during the year, satisfying the NFPA requirement.

On 3/30/11, the Safety Officer conducted an unannounced drill. There were dental and psychiatric services being performed at that time. The Safety Officer allowed the (3) staff members conducting those to continue since rescheduling those would have had a negative impact on those clients. During the drill with the remaining staff and for a time thereafter, time was spent with staff, especially with the recently hired receptionist, covering their role as it relates to the securing of the Receptionist area and the records cabinets within that area. Education was given with regard to closing the cabinets if time permits, but not if that act could in any way jeopardize their safety.

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LIFE SAFETY

We continue to perform environmental tours during which time we ask them questions as it relates to what actions they must take in the event of a fire and/or smoke emergency. Questions are later posed to staff that are not caring for clients when the decision is made to not conduct a drill.

Actions

No actions are required at this time. The required drills have been performed.

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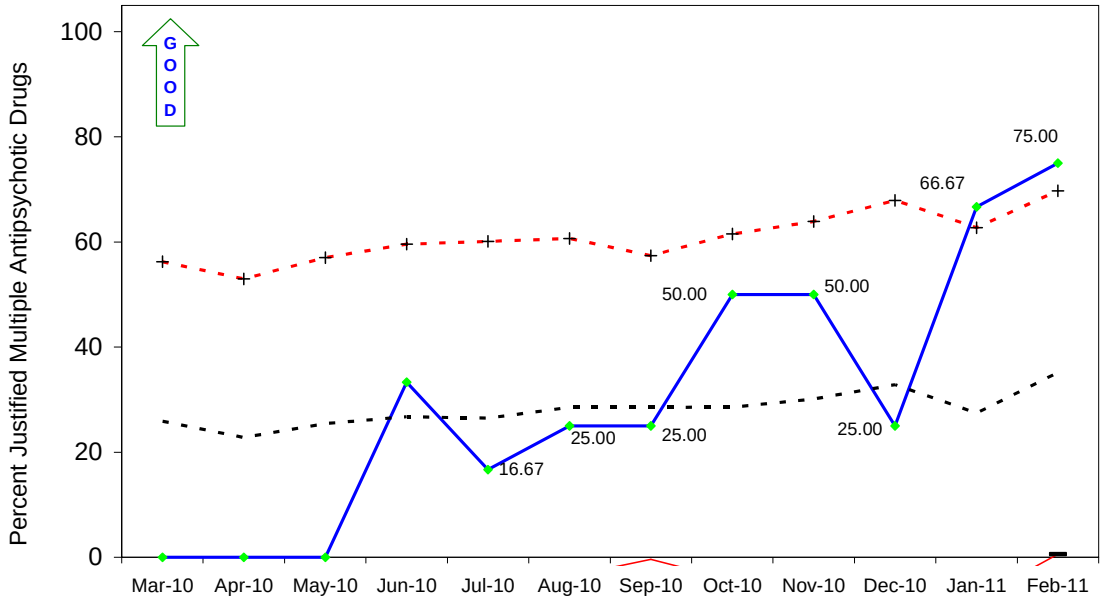
MEDICAL STAFF

ASPECT: JUSTIFICATION FOR DISCHARGE ON MULTIPLE ANTIPSYCHOTICS

Indicators	Findings	Compliance	Threshold Percentile
Patients discharged on multi-antipsychotic medications will have clinical justification documented in the discharge summary.	Over a 3-mo period (Nov-Jan) 66 discharges had 16 patients on 2 or more antipsychotics; 9 were justified.	56%	80%

Multiple Antipsychotics Justified

Percent of Clients Discharged on Multiple Antipsychotic Drugs
With Appropriate Justification



	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11
RPC%	0.00	0.00	0.00	33.33	16.67	25.00	25.00	50.00	50.00	25.00	66.67	75.00
Ntl Mean	25.89	22.79	25.44	26.75	26.48	28.53	28.51	28.55	30.14	32.84	27.44	35.15
+1 St Dev	56.25	52.98	57	59.59	60.1	60.67	57.39	61.49	63.89	67.9	62.7	69.72
-1 StDev	-4.47	-7.40	-6.12	-6.09	-7.14	-3.61	-0.37	-4.39	-3.61	-2.22	-7.82	0.58

Summary

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

Actions

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

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NURSING

ASPECT: SECLUSION/RESTRAINT RELATED TO STAFFING EFFECTIVENESS

Figure CD-27

Indicators	Findings	Compliance
1. Staff mix appropriate	67 of 67	100%
2. Staffing numbers within appropriate acuity level for unit	67 of 67	100%
3. Debriefing completed	65 of 67	98%
4. Dr. Orders	67 of 67	100%

SUMMARY

The indicators of “Seclusion/Restraint Related to Staffing Effectiveness” has remained at 99.5%.as it was last quarter.

ACTION

Good Progress. We will continue to monitor.

ASPECT: INJURIES RELATED TO STAFFING EFFECTIVENESS

Indicators	Findings	Compliance
1. Staff mix appropriate	39 of 39	100%
2. Staffing numbers within appropriate acuity level for unit	39 of 39	100%

SUMMARY

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

ACTIONS

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

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NURSING

ASPECT: PAIN MANAGEMENT

Indicator		Findings	Compliance
Pre-administration	Assessed using pain scale	802 of 806	99.5%
Post-administration	Assessed using pain scale	740 of 806	92%

SUMMARY

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

ACTION

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

Nursing will continue to place a great deal of attention and effort on post administration assessment and management of the related documentation. Nursing will continue to track this indicator and strive for increase in post assessment in the next quarter. The two ADONs will continue to work with unit nursing staff to assure that this is done consistently.

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NURSING

ASPECT: CHART REVIEW EFFECTIVENESS

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	31 of 60	52%
2. STGs/ Interventions relate directly to content of GAP note.	51 of 60	85%
3. Weekly Summary note completed.	55 of 60	92%
4. BMI on every Treatment Plan.	40 of 60 1 N/A	67%
5. Diabetes education Teaching checklist shows documentation of client teaching (diabetic clients)	11 of 60 36 N/A 1 Ref.	48%
6. Multidisciplinary Teaching checklist active being completed.	35 of 60 5 N/A	64%
7. Dental education Teaching checklist	49 of 60	82%

SUMMARY

There is a total compliance of 70%. Reliability has changed this quarter due to a change in reviewer part way through the rating period. All monitored indicators have decreased this quarter. The decrease in diabetes education is the most concerning.

ACTION

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

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NURSING

ASPECT: INITIAL CHART COMPLIANCE

Indicator	Findings	Compliance
1. Universal Assessment completed by RN within 24 hours	77 of 77	100%
2. All sections completed or deferred within document	77 of 77	100%
3. Initial Safety Treatment Plan initiated	52 of 77	68%
4. All sheets required signature authenticated by assessing RN	77 of 77	100%
5. Medical Care Plan initiated if Medical problems identified	15 of 77 10 N/A	19%
6. Informed Consent sheet signed	73 of 77	95%
7. Potential for violence assessment upon admission	75 of 77	97%
8. Suicide potential assessed upon admission	77 of 77	100%
9. Fall Risk assessment completed upon admission	70 of 77	91%
10. Score of 5 or above incorporated into problem need list	6 of 77 66 N/A	8%

SUMMARY

This area is monitored upon admission. Improvements are seen in # 1, 2, 3 and 10. Numbers 3, 5, 6 and 9 have decreased in compliance.

ACTION

Work on the areas that are lower than last quarter.

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PEER SUPPORT

ASPECT: INTEGRATION OF PEER SPECIALISTS INTO CLIENT CARE

Indicators	Findings	Compliance	Threshold Percentile
1. Attendance at Comprehensive Treatment Team meetings.	437 of 475	92%	80%
2. Level II grievances responded to by RPC on time.	0 of 0	100%	100%
3. Attendance at Service Integration meetings.	63 of 63	100%	100%
4. Contact during admission.	76 of 76	100%	100%
5. Level I grievances responded to by RPC on time.	60 of 61	98%	100%
6. Client satisfaction surveys completed.	16 of 27	59%	50%

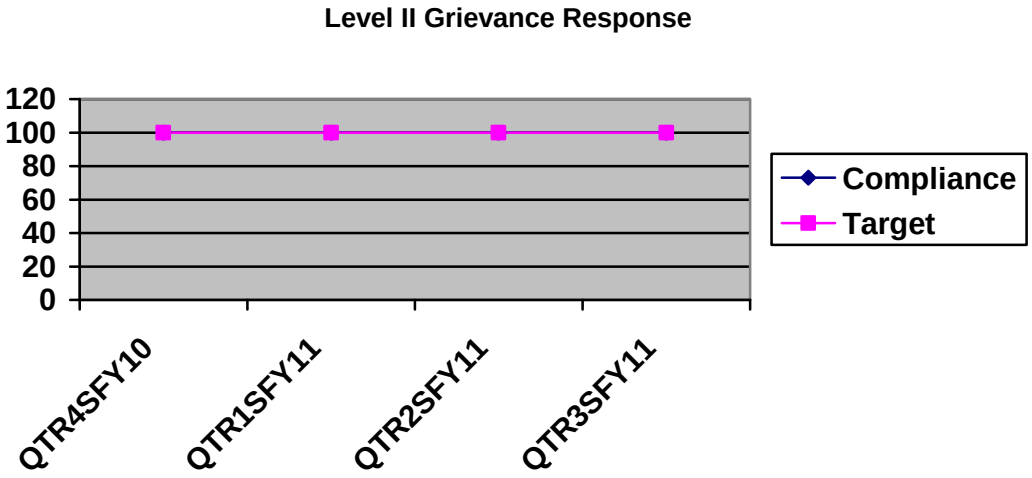
Summary

Overall compliance is 93%, up 2% from last quarter. All indicators remain stable and all but one indicate compliance. Response to Level I grievances has not met its threshold, but did increase in compliance from last quarter by 7%. The most significant change was the number of client satisfaction surveys offered and completed. Return rate was down 18%, with no data available on two units.

Actions

- Problem-solve with peer specialists on strategies for getting more satisfaction surveys offered and completed

Figure CD-03



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PEER SUPPORT

Figure CD-07

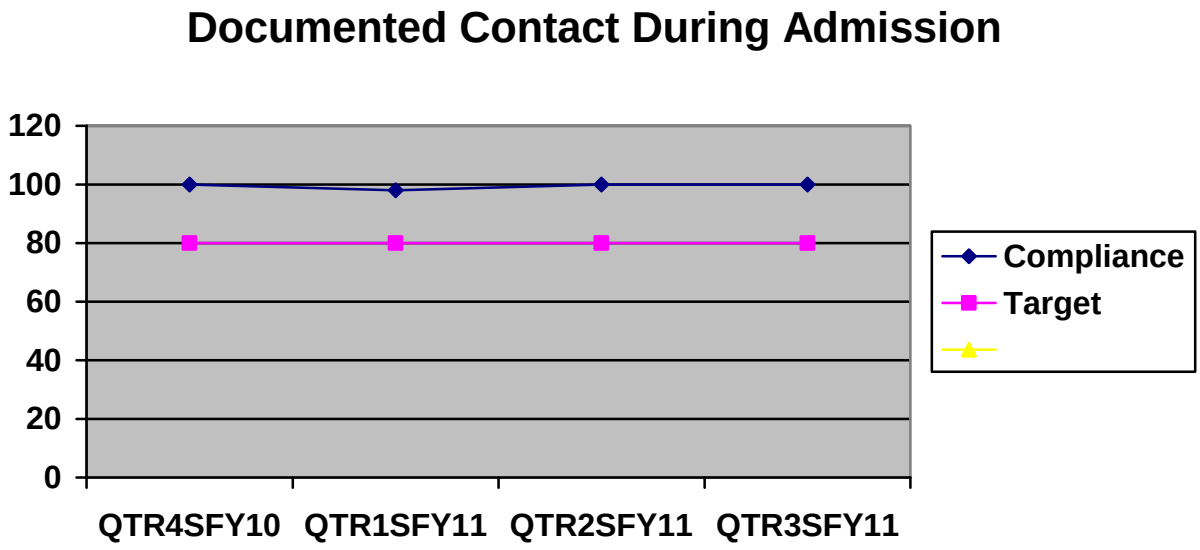
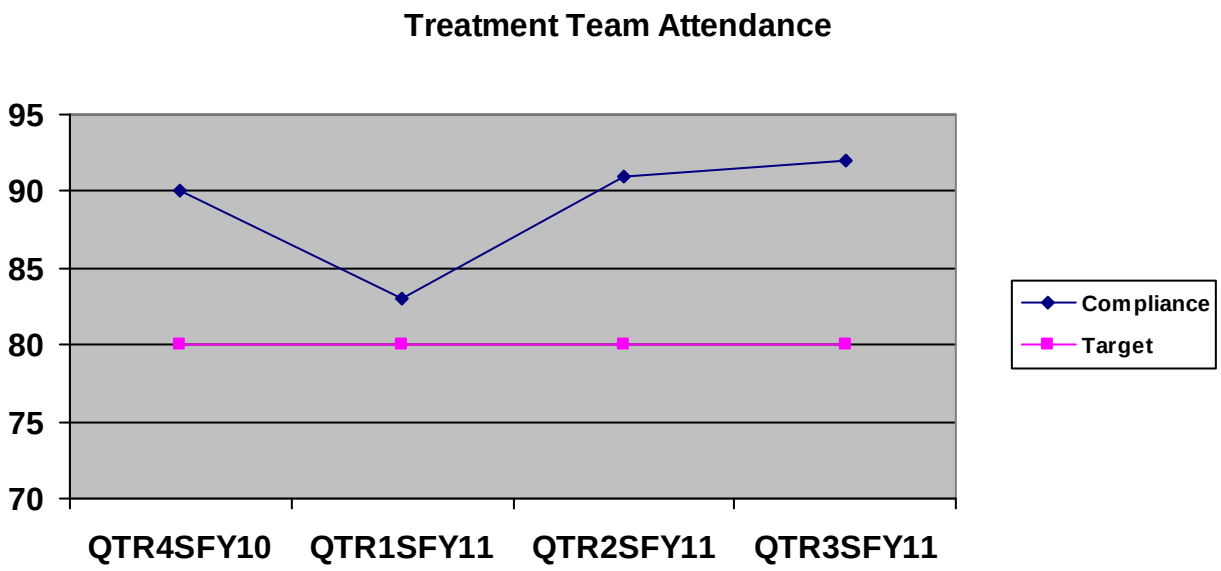


Figure CD-08



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PHARMACY & THERAPEUTICS

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

ASPECT: ORDER WRITING POLICY

Indicators	Findings	Compliance	Threshold Percentile
All order sheets are required to have that patient's allergies listed at the top of the sheet	**January** Three orders received by pharmacy without allergies listed and an estimated 1325 orders total received by pharmacy.	99.8%	98.0%
	February Nine orders received by pharmacy without allergies listed and an estimated 1200 orders total received by pharmacy.	99.3%	98.0%
	March Twenty-one orders received by pharmacy without allergies listed and an estimated 1325 orders total received by pharmacy	98.4%	98.0%

Summary

There were a total of 33 orders sent to the pharmacy during Q3 without allergy information written at the top of the page. An estimated 3885 total orders were received during that time period. Total compliance during this time period is 99.2%. All orders received without allergies listed were faxed back to their respective units for clarification.

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PHARMACY & THERAPEUTICS

ASPECT: DIVERSION OF CONTROLLED SUBSTANCES

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

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

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

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

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

The goal of this report is to review all ADC discrepancies from January 1, 2011 through March 31, 2011 and ensure that controlled substances are not being diverted from unit stock and discrepancies are being addressed in a timely manner.

Discrepancies Recorded	Incidences	Pharmacy Corrected	NOD Correction	Suspected Diversion	Actual Diversion
25	18	9	9	0	0

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

All of the 25 discrepancies recorded were all accounted for by user error and correction of previously created error. (A discrepancy will sometimes be purposely created to correct a previous mistake. For example, if there was 1 tablet in the ADC and the nurses finger slips and presses both the "1" and "2" key at the same time thus accidently

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PROGRAM SERVICES

ASPECT: ACTIVE TREATMENT IN ALL FOUR UNITS

Figure CD-11

Indicator	Findings	Compliance
1. Documentation reveals that the client attended 50% of assigned psycho-social-educational interventions within the last 24 hours.	65 of 80	81%
2. A minimum of three psychosocial educational interventions are assigned daily.	72 of 80	90%
3 A minimum of four groups is prescribed for the weekend.	53 of 80	67%
4. The client is able to state what his assigned psycho-social-educational interventions are and why they have been assigned.	56 of 80	70%
5 The client can correctly identify assigned RN and MHW. (Or where the information is available to him / her)	77 of 80	96%
6. The medical record documents the client's active participation in Morning Meeting within the last 24 hours.	57 of 80	71%
7. The client can identify personally effective distress tolerance mechanisms available within the milieu.	80 of 80	100%
8. Level and quality of client's use of leisure within the milieu are documented in the medical record over the last 7 days.	51 of 80	64%
9. Level and quality of social interactions within the milieu are documented in the medical record over the last 7 days.	73 of 80	91%
10. Suicide potential moderate or above incorporated into CSP	15 of 15	100%
11. Allergies displayed on order sheets and on spine of medical record.	77 of 80	96%
12. By the 7th day if Fall Risk prioritized as active-was it incorporated into CSP	10 of 10	100%

SUMMARY

Overall compliance for all indicators is 86% which is an increase from 83%. Client attending psychosocial education is at 81%, which is a decrease from 85%% last quarter. The indicator that the client is able to state what his assigned psychosocial education interventions is at 70%, which is down from 71% last quarter. The indicator suicide potential moderate or above is incorporated into the CSP is at 100%. Four indicator numbers 1, 2, 5, .and, 10, have improved since last quarter. Six indicator has decreased slightly. Two indicators have remained the same.

ACTION

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

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REHABILITATION SERVICES

ASPECT: READINESS ASSESSMENTS, COMPREHENSIVE SERVICE PLANS & PROGRESS NOTES

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

Summary

This is the third quarter review of the above indicators and will continue to be focused on and monitored to ensure continuity of care from assessment to progress notes.

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

Indicator #2, 3 & 4- One chart reviewed had a CSP for a long term client that had not been reviewed or changed within the time frame set on the treatment plan. The treatment plan did not reflect the current groups that the client was attending. The progress notes for the client did not indicate the current treatment the client was involved in. The notes did however reflect the progress the client was making in the groups the client is attending; they just did not address the correct groups in his treatment.

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

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REHABILITATION SERVICES

ASPECT: HARBOR MALL HAND-OFF COMMUNICATIONS

Indicators	Findings	Compliance	Threshold Percentile
1. Hand-off communication sheet was received at the Harbor Mall within the designated time frame.	26 of 42	62%	100%
2. RN signature/Harbor Mall staff signatures present.	42 of 42	100%	100%
3. SBAR information completed from the units to the Harbor Mall.	22 of 42	52%	100%
4. SBAR information completed from the Harbor Mall to the receiving unit.	23 of 42	55%	100%

SUMMARY

This is the third quarter of evaluating this performance measure. All units were made aware of the criteria that would be monitored in order to ensure that the hand-off communication process for the Harbor Mall is being done properly. Overall compliance has decreased.

Indicator #1- Sixteen of the hand-off communication sheets did not arrive to the Harbor Mall within the allotted time frame. The sheet is to be brought to the mall no later than 5 minutes before the start of groups and this did not happen on sixteen of the sheets that were reviewed for this quarter. The PSD for the mall will remind each of the units what the protocol is for the hand-off sheet to ensure that the information reaches the mall in time to be relayed to group leaders.

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

Indicator #3- Twenty-two of the 42 sheets reviewed had information from the unit related to clients concerns or comments completed. PSD for the Harbor Mall will review the need for accuracy in completing the HOC sheet with each of the units.

Indicator #4 – Twenty-three out of the 42 sheets reviewed did not have any client concerns or comment information from the treatment mall back to a unit and did state no issues to report on the HOC sheet. PSD will remind Harbor Mall staff to complete issues/concerns section.

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

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SECURITY & SAFETY

ASPECT: SECURITAS/RPC SECURITY TEAM

Indicators	Quarterly % Compliance						Threshold Percentile
	Jan. '11-Mar. '11	Oct. '10-Dec. '10	Jul. '10-Sep. '10	Apr. '10-Jun. '10	Jan. '10-Mar. '10	Oct. '09-Dec. '09	
Security Officer "foot patrols" during Open Hospital times. (Total # of "foot patrols" done vs. total # of "foot patrols" to be done.)	99% (1980/ 2002)	98% (1964/ 2002)	89% (1797/ 2002)	98% (1973/ 2002)	97% (1944/ 2002)	97% (1895/ 1848)	95%

Summary

Foot patrols continue to be done despite those rare times that the officers are on other details which take priority over the "foot patrol". Compliance rate since SSPIQ2SFY11 has increased by 10%.

Actions

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

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SOCIAL WORK

ASPECT: PRELIMINARY CONTINUITY OF CARE MEETING AND COMPREHENSIVE PSYCHOSOCIAL ASSESSMENTS

Figure CD-05 Indicators	Findings	Compliance	Threshold Percentile
1. Preliminary Continuity of Care meeting completed by end of 3rd day	29/30	96%	100%
2. Service Integration form completed by the end of the 3rd day	29/30	96%	100%
2a. Director of Social Services reviews all readmissions occurring within 60 days of the last discharge and for each client who spent fewer than 30 days in the community, evaluated the circumstances of the readmission to determine an indicated need for resources or a change in treatment and discharge planning or the need for alternative resources. In cases where such a need or change was indicated that corrective action was taken.	4/4	100%	100%
3a. Client Participation in Preliminary Continuity of Care meeting.	29/30	96%	90%
3b. CCM Participation in Preliminary Continuity of Care meeting.	30/30	100%	100%
3c. Client's Family Member and/or Natural Support (e.g., peer support, advocacy, attorney) Participation in Preliminary Continuity of Care meeting.	28/30	93%	100%
3d. Community Provider Participation in Preliminary Continuity of Care meeting.	3/15	20%	90%
3e. Correctional Personnel Participation in Preliminary Continuity of Care Meeting.	0/15	0%	90%
4a. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	29/30	96%	100%
4b. Annual Psychosocial Assessment completed and current in chart	30/30	100%	100%

SUMMARY

Aspect areas 3d and 3e remain low and the trend will likely continue given recent restructuring of the adult mental health department. We continue to foster positive communication and collaboration with the community and corrections. Under the new restructuring we have a contact that oversees all the forensic and Community ICM staff and will continue to work with having their presence at meetings.

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SOCIAL WORK

ASPECT: INSTITUTIONAL AND ANNUAL REPORTS

Figure CD-18 Indicators	Findings	Compliance	Threshold Percentile
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	6/6	100%	95%
2. The assigned **CCM** will review the new court order with the client and document the meeting in a progress note or treatment team note.	7/7	100%	100%
3. Annual Reports (due Dec) to the commissioner for all inpatient NCR clients are submitted annually	N/A	N/A	100%

SUMMARY

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

ASPECT: CLIENT DISCHARGE PLAN REPORT/REFERRALS

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

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SOCIAL WORK

ASPECT: TREATMENT PLANS AND PROGRESS NOTES

Figure CD-15, CD-16, CD-17 **Indicators**	**Findings**	**Compliance**	**Threshold Percentile**
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all clients on assigned **CCM** caseload.	43/45	95%	95%
2. On Upper Saco progress notes in GAP/Incidental format will indicate at minimum bi- weekly 1:1 meeting with all clients on assigned **CCM** caseload	15/15	100%	95%
3. Treatment plans will have measurable goals and interventions listing client strengths and areas of need related to transition to the community or transition back to a correctional facility.	56/60	93%	95%

SUMMARY

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

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SOCIAL WORK

ASPECT: BARRIERS TO COMMUNITY PLACEMENT OF CIVIL CLIENTS

FY11 Q3 22 % of civil clients discharged faced a barrier

44 civil clients discharged in the quarter.
10 faced identified barrier

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

Clinical Readiness

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

Residential Supports (0) 0%

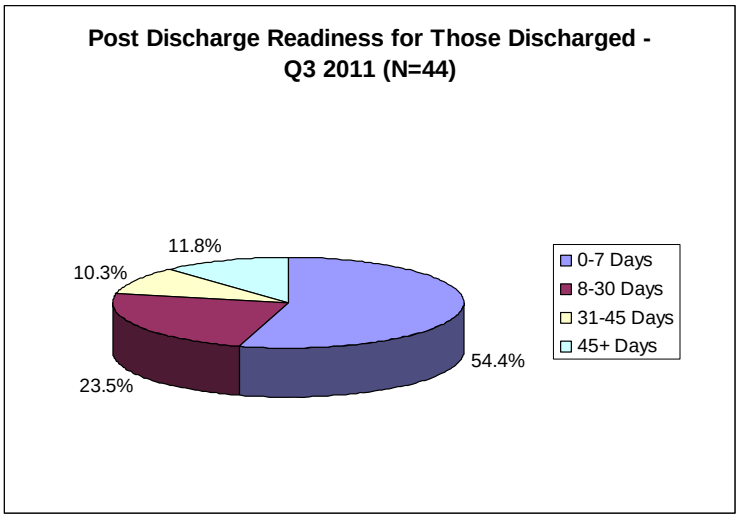
No Barriers in this area this quarter

Treatment Services (1) 2%

1 client discharged 38 days post clinical readiness

Housing (9) 20 %

1 client discharged 11 days post clinical readiness
1 client discharged 15days post clinical readiness
1 client discharged 16 days post clinical readiness
1 client discharged 17 days post clinical readiness
1 client discharged 18 days post clinical readiness
1 client discharged 38 days post clinical readiness
1 client discharged 47days post clinical readiness
1 client discharged 51days post clinical readiness
1 client discharged 92days post clinical readiness



This chart shows the percent of civil clients who were discharged within 7 days of their discharge readiness to be at 54.4% for this quarter. Cumulative percentages and targets are as follows:

Within 7 days = 54.4% (target 75%)
Within 30 days = 77.9% (target 90%)
Within 45 days = 88.2% (target 100%)

The previous four quarters are displayed in the table below

Quarter	Within 7 days	Within 30days	Within 45 days	45 +days
Target	75%	90%	100%	0%
Q2 2011	67.6%	83.8%	89.2%	10.8%
Q1 2011	51.4%	64.9%	83.8%	16.2%
Q4 2010	47.4%	76.3%	84.2%	15.8%
Q3 2010	57.5%	62.5%	72.5%	27.5%

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STAFF DEVELOPMENT

ASPECT: NEW EMPLOYEE AND MANDATORY TRAINING

Figure CD-19 and CD-20

Indicators	Findings	Compliance	Threshold Percentile
1. New employees will complete new employee orientation within 60 days of hire.	100%	100 %	12 of 12 completed orientation
2. New employees will complete CPR training within 30 days of hire.	100%	100 %	12 of 2 completed CPR training
3. New employees will complete NAPPI training within 60 days of hire.	100%	100 %	12 of 12 completed Nappi training
4. Riverview and Contract staff will attend CPR training bi-annually.	100%	100 %	325 of 325 are current in CPR certifications
5. Riverview and Contract staff will attend NAPPI training annually. Goal to be at 100% by end of fiscal training year 2011 on June 30th. **Last Fiscal Year (2010) at 99.7%**	88%	100 %	329 of 375 have completed annual NAPPI training
6. Riverview and Contract staff will attend Annual training. Goal is to be at 100% by end of fiscal training year 2011 on June 30th. **Last Fiscal Year (2010) at 100%**	99%	100 %	376 of 381 have completed annual training
7. Riverview nursing and medical staff will complete 10 hours of training each year in the psychiatric aspects of their treatment responsibilities. Goal is to be at 100% by end of fiscal training year 2011 on June 30th.	98%	100 %	231 of 236 have received a minimum of 10 hours annually

Findings

The indicators are based on the requirements for all new/current staff to complete mandatory training and maintain current certifications. **12 of 12** (100%) new Riverview/Contracted employees completed these trainings. **325 of 325** (100%) Riverview/Contracted employees are current with CPR certification. **329 of 375** (88%) Riverview/Contracted employees are current in Nappi training. **376 of 381** (99%) employees are current in Annual training. **231 of 236** (98%) Riverview nursing and medical staff will complete 10 hours of training each year in the psychiatric aspects of their treatment responsibilities. All indicators remained at 100% compliance for quarter 3-FY 2011.

Problem

No identified problems at this time.

Actions

No actions needed at this time.

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CONSENT DECREE COMPLIANCE

Subject Area	Standard of Substantial Compliance	Efforts to Comply & Evidence of Compliance
ACT Team	90% of ACT providers statewide meet 1:10 caseload ratio (based on filled direct care staff positions excluding psychiatrist or advanced nurse practitioner and peer specialist)	CD-01: *Data on the Riverview Forensic ACT Team caseload will be available in subsequent reports.*
Client Rights	Riverview produces documentation that clients are routinely informed of their rights upon admission in accordance with ¶ 150 of the Settlement Agreement	CD-02: *An abstraction process is being developed that will illustrate the degree to which clients are informed of their rights on admission.*
	Grievance tracking data shows that the hospital responds to 90% of Level II grievances within five working days of the date of receipt or within a five-day extension.	CD-03: Report compiled by Peer Support. Information extracted from Grievance tracking database.
Admissions	Quarterly performance data shows that in 4 consecutive quarters, 95% of admissions to Riverview meet legal criteria.	CD-04: Report compiled for Admissions. Information extracted from the Meditech report entitled, "Admission Legal Report."
	Director of Social Work reviews all readmissions occurring within 60 days of the last discharge; and for each client who spent fewer than 30 days in the community, evaluated the circumstances to determine whether the readmission indicated a need for resources or a change in treatment and discharge planning or a need for different resources and, where such a need or change was indicated, that corrective action was taken.	CD-05: This items in reported in the Social Work section under the report entitled, "Preliminary Continuity of Care Meeting and Comprehensive Psychosocial Assessments" under section 2a of that report.
	No more than 5% of patients admitted in any year have a primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	CD-06: Report compiled for Admissions. Information extracted from the Meditech report entitled, "Admission Diagnosis Report by Date."
Peer Support	In 3 out of 4 consecutive quarters: • 80% of all clients have documented contact with a peer specialist during hospitalization	CD-07: Report compiled by Peer Support.
	• 80% of all treatment meetings involve a peer specialist.	CD-08: Report compiled by Peer Support.
Treatment Planning	In 3 out of 4 consecutive quarters • 95% of clients have a preliminary treatment and transition plan developed within 3 working days of admission	CD-09: *A method for the reporting of this compliance standard is currently under development.*
	• 95% of clients also have individualized treatment plans in their records within 7 days thereafter	CD-10: *A method for the reporting of this compliance standard is currently under development.*
	• Riverview certifies that all treatment modalities required by ¶155 are available.	CD-11: Records of client participation in active treatment are maintained by the unit PSD. All required, unit and Harbor Mall treatment schedules are available for review. *A method for the reporting trends of compliance is currently under development.*

CONSENT DECREE COMPLIANCE

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

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CONSENT DECREE COMPLIANCE

Subject Area	Standard of Substantial Compliance	Efforts to Comply & Evidence of Compliance
Staffing and Staff Training	Riverview performance data shows that 95% of all new direct care staff have received 90% of their orientation training before having been assigned to duties requiring unsupervised direct care of patients.	CD-19: Compliance with this standard is documented under the section of Staff Development.
	Riverview certifies that 95% of professional staff have maintained professionally-required continuing education credits and have received the ten hours of annual cross-training required by ¶216	CD-20: Compliance with this standard is documented under the section of Staff Development.
	Riverview certifies that staffing ratios required by ¶202 are met, and makes available documentation that shows actual staffing for up to one recent month.	CD-21: All required staffing ratios are regularly met. Evidence of compliance can be reviewed through staffing office and other human resource records.
	The evaluation of treatment and discharge planning, performed in accordance with **Attachment D**, demonstrates that staffing was sufficient to provide patients access to activities necessary to achieve the patients' treatment goals, and to enable patients to exercise daily and to recreate outdoors consistent with their treatment plans.	CD-22: *A process for the review of the requisite 28 client records is being developed and will be conducted on a quarterly basis. To determine substantial compliance in the areas of: 1) treatment and discharge planning and implementation, and 2) staffing.*
Seclusion and Restraint	Quarterly performance data shows that, in 5 out of 6 quarters, total seclusion and restraint hours do not exceed one standard deviation from the national mean as reported by NASMHPD	Report compiled by the Integrated Quality Team and reported in Comparative Statistics section on… CD-23: Seclusion Hours and CD-24: Restraint Hours.
	Riverview demonstrates that, based on a review of two quarters of data, for 95% of seclusion events, seclusion was employed only when absolutely necessary to protect the patient from causing physical harm to self or others or for the management of violent behavior.	CD-25: Report compiled by the Integrated Quality Team and reported in Comparative Statistics
	Riverview demonstrates that, based on a review of two quarters of data, for 95% of restraint events involving mechanical restraints, the restraint was used only when absolutely necessary to protect the patient from serious physical injury to self or others.	CD-26: Report compiled by the Integrated Quality Team and reported in Comparative Statistics
	Riverview demonstrates that, based on a review of two quarters of data, for 95% of seclusion and restraint events, the hospital achieved an acceptable rating for meeting the requirements of paragraphs 182 and 184 of the Settlement Agreement, in accordance with a methodology defined in **Attachments E-1 and E-2.**	CD-27: Seclusion and restraint events are reviewed as part of a regular analysis of performance by the Nursing Department. *A formal audit process utilizing Attachments E-1 and E2 of the Settlement Agreement is currently being developed.*

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CONSENT DECREE COMPLIANCE

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

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