Riverview
PSYCHIATRIC CENTER

QUARTERLY REPORT ON
ORGANIZATIONAL PERFORMANCE EXCELLENCE

THIRD STATE FISCAL QUARTER 2013
January, February, March 2013

Mary Louise McEwen, RN, MBA
Superintendent

April 15, 2013

Please consider the environment before printing this document. It is formatted for double-sided printing.

THIS PAGE INTENTIALLY LEFT BLANK

Table of Contents

Table of Contents

Glossary of Terms, Acronyms & Abbreviations

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

Glossary of Terms, Acronyms & Abbreviations

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

INTRODUCTION

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

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

There are three major sections that make up this report:

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

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

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

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

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

.

. **THIS PAGE INTENTIALLY LEFT BLANK**

CONSENT DECREE

Consent Decree Plan

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

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

Client Rights

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

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

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

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

Indicators	4Q2012	1Q2013	2Q2013	3Q2013
1. Level II grievances responded to by RPC on time.	100% 4/4	100% 1/1	100% 5/5	100% 1/1
2. Level I grievances responded to by RPC on time.	56% 63/112	73% 27/37	60% 64/106	95% 96/101

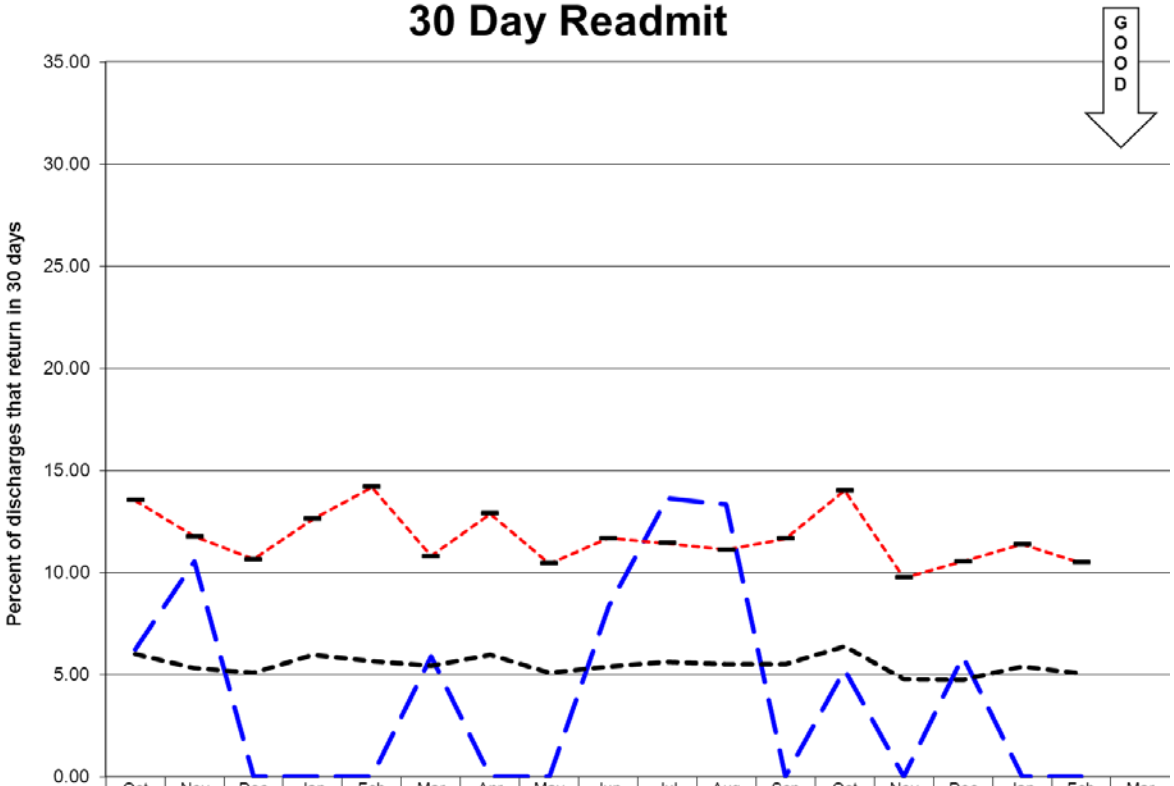
Admissions

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

Legal Status on Admission	4Q2012	1Q2013	2Q2013	3Q2013
ICDCC	19	17	9	20
ICDCC-M				
ICDCC-PTP				
IC-PTP+M				
ICRDCC		3		
INVOL CRIM	39	19	34	21
INVOL-CIV				1
PCHDCC		1		
PCHDCC+M	1		1	1
VOL	4	6		7
VOL-OTHER				

CONSENT DECREE

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



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	6.25	10.53	0.00	0.00	0.00	5.88	0.00	0.00	8.33	13.64	13.33	0.00	5.26	0.00	5.88	0.00	0.00	
Ntl Mean	6.00	5.31	5.08	5.96	5.65	5.42	5.97	5.11	5.39	5.62	5.51	5.50	6.37	4.78	4.75	5.40	5.06	
+1 StDev	13.53	11.76	10.65	12.61	14.18	10.8	12.89	10.45	11.69	11.43	11.11	11.66	14	9.75	10.53	11.38	10.48	

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

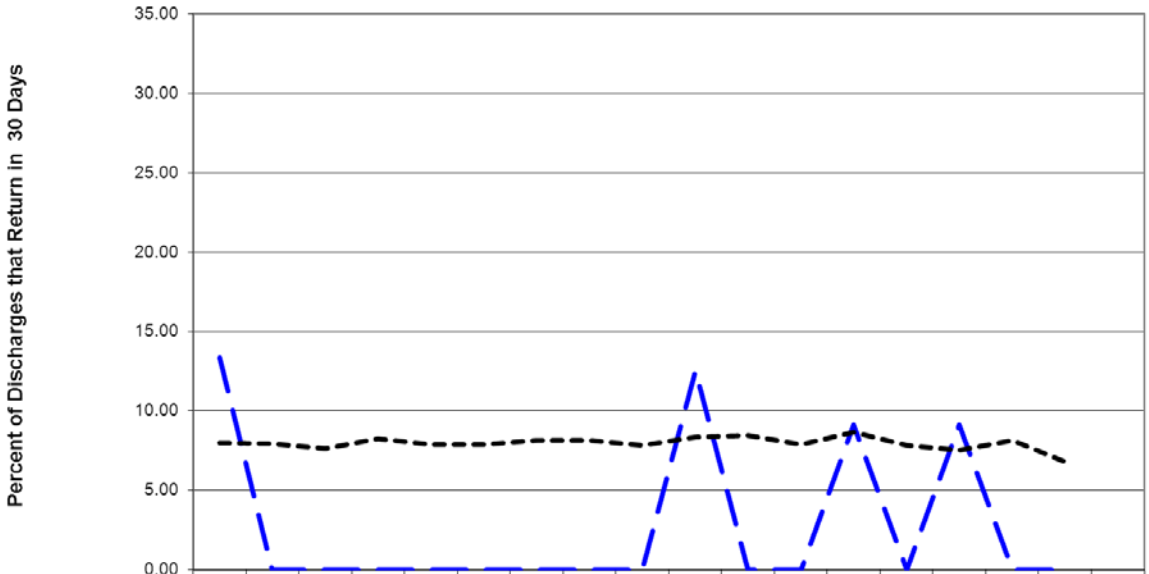
The graphs shown on the next page depict the percent of discharges from the facility that returned within 30 days of a discharge of the same client from the same facility stratified by forensic or civil classifications. For example, a rate of 10.0 means that 10% of all discharges were readmitted within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

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

CONSENT DECREE

30 Day Readmit

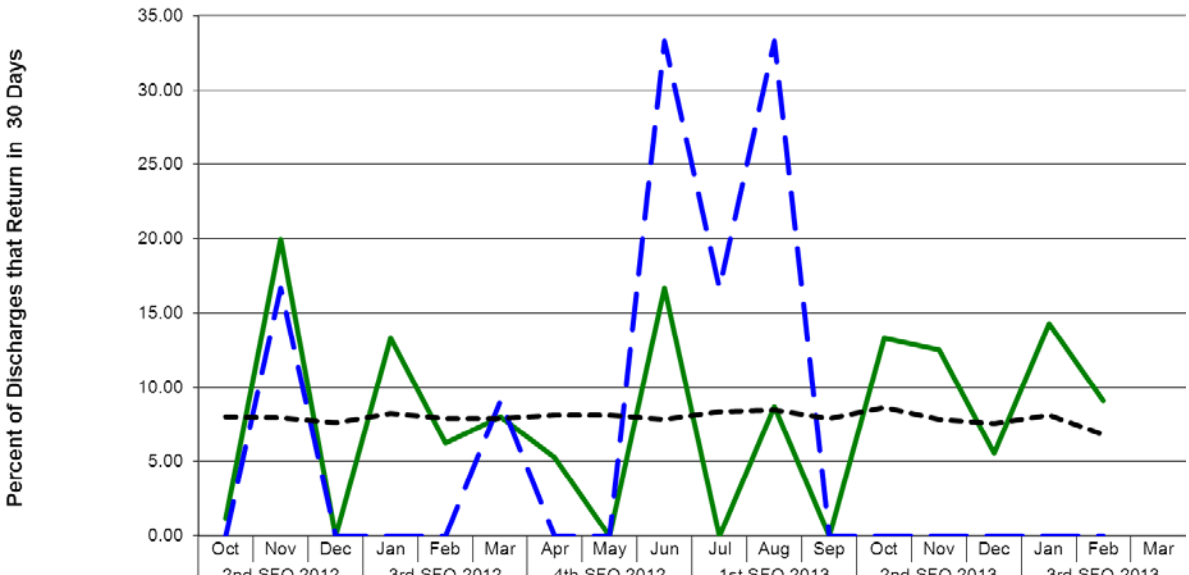
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	13.33	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	12.50	0.00	0.00	9.09	0.00	9.09	0.00	0.00	
National Mean	8.00	7.95	7.63	8.25	7.90	7.88	8.11	8.15	7.84	8.34	8.45	7.88	8.65	7.83	7.54	8.11	6.79	

30 Day Readmit

Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Dorothea Dix	1.17	20.00	0.00	13.33	6.25	8.00	5.26	0.00	16.67	0.00	8.70	0.00	13.33	12.50	5.56	14.29	9.09	
Riverview	0.00	16.67	0.00	0.00	0.00	9.09	0.00	0.00	33.33	16.67	33.33	0.00	0.00	0.00	0.00	0.00	0.00	
National Mean	8.00	7.95	7.63	8.25	7.90	7.88	8.11	8.15	7.84	8.34	8.45	7.88	8.65	7.83	7.54	8.11	6.79	

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

REVIEW OF READMISSION OCCURRING WITHIN 60 DAYS

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

REDUCTION OF RE-HOSPITALIZATION FOR ACT TEAM CLIENTS

Indicators	4Q2012	1Q2013	2Q2013	3Q2013
1. The ACT Team Director will review all client cases of re-hospitalization from the community for patterns and trends of the contributing factors leading to re-hospitalization each quarter. The following elements are considered during the review: a. Length of stay in community b. Type of residence (i.e.: group home, apartment, etc) c. Geographic location of residence d. Community support network e. Client demographics (age, gender, financial) f. Behavior pattern/mental status g. Medication adherence h. Level of communication with ACT Team	100% 4 NCR clients were re-admitted to RPC; 1 for violation of court order, 1 who was readmitted due to elopement and 2 for increased psychiatric symptoms	100% 8 readmissions to RPC, 2 medical admissions to MMC	100% 3 clients were re-admitted to RPC;all were NCR, two due to increased psychiatric symptoms, one for using illicit substance in the forensic group home.	100% 3 clients were returned to RPC; two for substance use and 1 for psychiatric decompensating.
2. ACT Team will work closely with inpatient treatment team to create and apply discharge plan incorporating additional supports determined by review noted in #1.	100%	100%		100%

Current Quarter Summary

1. All readmissions were male, two under the care of the DHHS Commissioner (NCR), one PTP; both NCR clients were living in independent apartments in the Augusta area for over one year, neither had developed community support networks, both appeared to be medication adherent

and one had attended all sessions as scheduled, the other NCR client had sporadic attendance; the PTP client was living in a 24/7 group home within three miles of the office/hospital. Two clients are between 50 and 65, and the third in his mid thirties. The PTP client was a psychiatric readmission and both NCR clients were re-admitted due to using illicit or illegal substances which violated their court orders. The first re-admission remains at Riverview, with an expected discharge within a few weeks. The second (also NCR) was discharged back to his independent apartment after two weeks. The third (PTP) remains in Riverview and may be able to return to his group home although he may be charged for damages he caused by throwing a lamp and table out of a window. The direct care staff of the group home where the PTP client resided were in immediate contact with ACT Staff the evening of the decompensation; the first NCR client was discovered to be using through a drug urinalysis and the second NCR client reported to his case manager he was using and requested to be returned to RPC.

2. The ACT Team and the inpatient unit of RPC (Lower Saco, Lower Kennebec) worked collaboratively to minimize the time spent in Riverview while maximizing the opportunity for success upon their return to the community placements. For the remaining clients on Lower Saco and on Lower Kennebec, the ACT Team case managers and inpatient teams have and will continue to work closely together to develop discharge plans as the last two clients prepare to return to the community.

CONSENT DECREE

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

Client Admission Diagnoses	4Q12	1Q13	2Q13	3Q13	TOT
ADJUSTMENT DIS W MIXED DISTURBANCE OF EMOTIONS & CONDUCT		1			1
ADJUSTMENT DISORDER WITH DEPRESSED MOOD		1	1		2
ADJUSTMENT DISORDER WITH ANXIETY				1	
ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED MOOD	1		3	1	5
ADJUSTMENT REACTION NOS	1	2	1	1	5
ALCOHOL ABUSE-IN REMISS			1		1
ALCOH DEP NEC/NOS-REMISS	1				1
ANXIETY STATE NOS				1	1
ATTN DEFICIT W HYPERACT				1	1
BIPOL I DIS, MOST RECENT EPIS (OR CURRENT) MANIC, UNSPEC		1			1
BIPOLAR DISORDER, UNSPECIFIED	5	6	5	5	21
DELUSIONAL DISORDER	3		1	2	6
DEPRESS DISORDER-UNSPEC	1				1
DEPRESSIVE DISORDER NEC			2	2	4
DRUG ABUSE NEC-IN REMISS	3		1		4
IMPULSE CONTROL DIS NOS		1	1	2	4
INTERMITT EXPLOSIVE DIS			1	1	2
MOOD DISORDER IN CONDITIONS CLASSIFIED ELSEWHERE		1	1		2
OTHER AND UNSPECIFIED BIPOLAR DISORDERS, OTHER		1			1
OTH PERSISTENT MENTAL DIS DUE TO COND CLASSIFIED ELSEWHERE			1		1
PARANOID SCHIZO-CHRONIC	1	7	5	8	21
PARANOID SCHIZO-UNSPEC				1	1
PERSON FEIGNING ILLNESS	1		1		2
POSTTRAUMATIC STRESS DISORDER	4	2	3	3	11
PSYCHOSIS NOS	6	6	4	4	20
REC DEPR DISOR-PSYCHOTIC	1				1
RECUR DEPR DISOR-SEVERE	2				2
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED	10	9	6	9	34
SCHIZOPHRENIA NOS-CHR	3	1		1	5
SCHIZOPHRENIA NOS-UNSPEC				2	2
SCHIZOPHRENIFORM DISORDER, UNSPECIFIED				1	1
UNSPEC PERSISTENT MENTAL DIS DUE TO COND CLASS ELSEWHERE	3				3
UNSPECIFIED EPISODIC MOOD DISORDER	9	7	6	4	26
UNSPECIFIED NONPSYCHOTIC MENTAL DISORDER	2				2
Total Admissions	57	46	44	50	197
Admitted with primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	7.0%	0.0%	4.5%	0%	3.0%

Peer Supports

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

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

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

Indicators	4Q2012	1Q2013	2Q2013	3Q2013
1. Attendance at Comprehensive Treatment Team meetings. (v9)	91% 387/427	90% 410/458	87% 342/395	87% 354/406
2. Attendance at Service Integration meetings. (v8)	93% 52/56	100% 42/42	100% 31/31	98% 48/49
3. Contact during admission. (v8)	100% 63/63	100% 46/46	100% 44/44	100% 50/50

Treatment Planning

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

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

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

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

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

Indicators	4Q2012	1Q2013	2Q2013	3Q2013
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all clients on assigned **CCM** caseload.	95% 43/45	95% 43/45	97% 44/45	93% 43/45
2. On Upper Saco progress notes in GAP/Incidental format will indicate at minimum weekly 1:1 meeting with all clients on assigned **CCM** caseload	100% 15/15	93% 14/15	93% 14/15	95% 14/15
3. Treatment plans will have measurable goals and interventions listing client strengths and areas of need related to transition to the community or transition back to a correctional facility.	96% 58/60	98% 59/60	96% 58/60	96% 58/60

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

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

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

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

CONSENT DECREE

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

V13) The treatment plans reflect

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

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

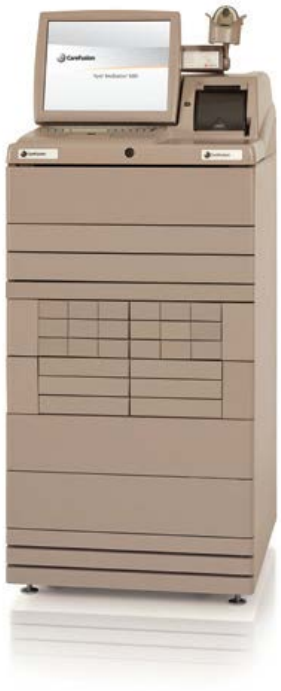
V15) If the record reflects limitations on a patient's rights listed in ¶159, those limitations were imposed consistent with the Rights of Recipients of Mental Health Services

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

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

Medications

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



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

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

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

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

The effectiveness and accuracy of the Pyxis Medstation 4000 System is analyzed regularly through the conduct of process improvement and functional efficiency studies. These studies can be found in the Medication Management and Pharmacy Services sections of this report.

CONSENT DECREE

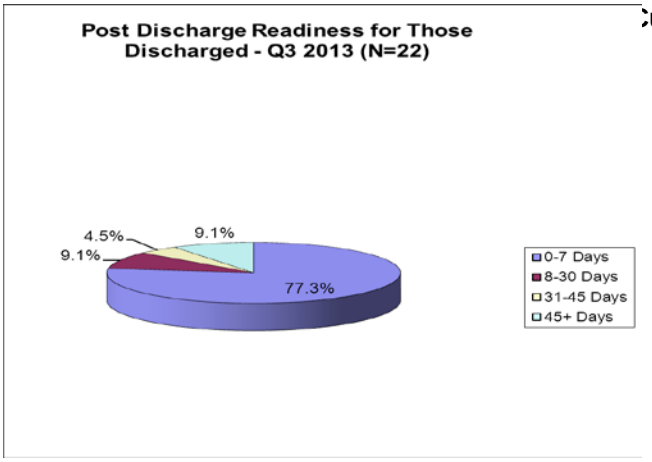
Discharges

Quarterly performance data shows that in 4 consecutive quarters:

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

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

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



Cumulative percentages & targets are as follows:

Within 7 days = (17) 77.3% (target 70%)
Within 30 days = (2) 86.4% (target 80%)
Within 45 days = (1) 90.9% (target 90%)
Post 45 days = (2) 9.1% (target 0%)

Barriers to Discharge Following Clinical Readiness

Residential Supports (0)

Housing (7)

1 client discharged 64 days post clinical readiness
1 client discharged 335 days post clinical readiness

Treatment Services (0)

The previous four quarters are displayed in the table below

		Within 7 days	Within 30days	Within 45 days	45 +days
Target >>		70%	80%	90%	< 10%
2Q2013	N-24	54.2%	70.9%	87.6%	12.5%
1Q2013	N=27	66.7%	85.2%	96.3%	3.7%
4Q2012	N=28	53.6%	89.2%	92.9%	7.1%
3Q2012	N=42	69.0%	85.7%	92.9%	7.1%
2Q2012	N=42	69.0%	85.7%	92.9%	7.1%

CONSENT DECREE

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

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

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

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

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

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

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

Indicators	4Q2012	1Q2013	2Q2013	3Q2013
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	100% 7/7	60% 3/5	100% 3/3	87% 7/8
2. The assigned **CCM** will review the new court order with the client and document the meeting in a progress note or treatment team note.	100% 5/5	100% 9/9	100% 5/5	100$ 9/9
3. Annual Reports (due Dec) to the commissioner for all inpatient NCR clients are submitted annually				

Staffing and Staff Training

V23) Riverview performance data shows that 95% of all new direct care staff have received 90% of their orientation training before having been assigned to duties requiring unsupervised direct care of patients;

Indicators	1Q2013	2Q2013	3Q2013	4Q2013
1. New employees will complete new employee orientation within 60 days of hire.	100% 25/25	100% 21/21	100% 20/20	
2. New employees will complete CPR training within 30 days of hire.	100% 25/25	100% 21/21	100% 20/20	
3. New employees will complete NAPPI training within 60 days of hire.	100% 25/25	100% 21/21	100% 20/20	
4. Riverview and Contract staff will attend CPR training bi-annually.	100% 50/51*	100% 29/31	98% 47/48*	
5. Riverview and Contract staff will attend NAPPI training annually.	100% 118/118	100% 112/134*	100% 99/125	
6. Riverview and Contract staff will attend Annual training.	100% 27/27	100% 238/244*	98% 297/311*	

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

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

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

*Twenty Riverview employees are scheduled to attend training. Six Riverview employees are still on leave of absence or light duty during this quarter will complete this mandatory training prior to returning to regular employ.

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

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

DATE	HRS	TITLE	PRESENTER
3Q2012	14	Jan- March 2012	Winter Semester (see1Q13 Quarterly Report)
4Q2012	11	Apr – June 2012	Spring Semester (see1Q13 Quarterly Report)
1Q2013	3	Jul – Sep 2012	Summer Hiatus (see1Q13 Quarterly Report)
2Q2013	9	Oct – Dec 2012	Winter Semester (see2Q13 Quarterly Report)
1/3/13	1	Pam Miller, PMNHP	Mirror Neurons
1/10/13	1	Paula Jursa, LCPC LADC CCS Patrick Steele, Psy Intern	"I Don't Have a Problem"
1/17/13	1	George Davis, MD	Six Recent Cases Demonstrating Significant Medical Comorbidity in Psychiatric/Forensic Admissions
1/24/13	1	Deborah Wear-Finkle, MD, MPA	Clinicians and Guns: Duties, Dilemmas, Data, Decisions and Opportunities
1/31/13	1	Elise Freeman, MD, MPH	Diabetes Prevention for Persons with Serious Mental Illness: What can we do?
2/7/13	1	Randy Beal, PMHNP	A Case Study: The Dilemma of Chronic Mental Illness and Diabetes
2/14/13	1	James Weathersby	Sacred Cow Cheeseburgers: spiritual assumptions with clients in a mental health facility
2/28/13	1	Alex Raev, MD	Bethlem Royal Hospital: NHS and Management of Treatment-resistant psychosis in UK
3/7/13	1	Ken Beattie, PhD	Delusion or Displacement: Is it psychosis or is it trauma?
3/21/13	1	John Kootz, MD	Physical findings and underlying illness: what the eye can see
3/28/13	1	Miranda Cole, PharmD	Long Acting Injectable Antipsychotics

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

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

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

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

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

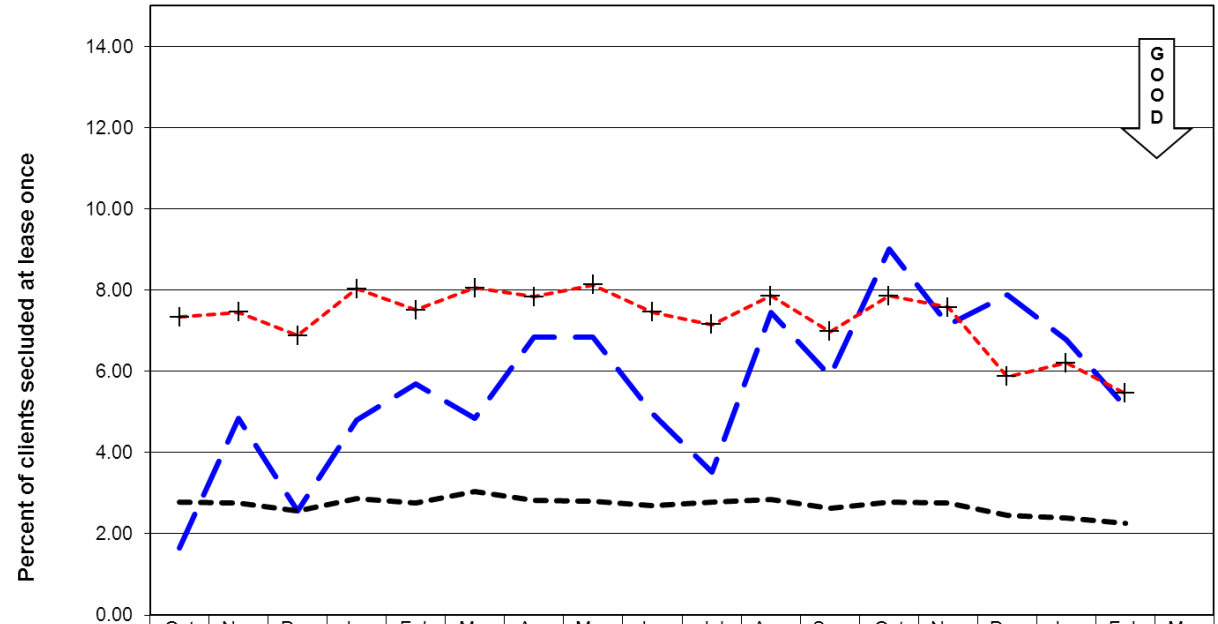
Treatment teams regularly monitor the needs of individual clients and make recommendations for ongoing treatment modalities. Staffing levels are carefully monitored to ensure that all treatment goals, exercise needs, and outdoor activities are achievable. Staffing does not present a barrier to the fulfillment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

CONSENT DECREE

Use of Seclusion and Restraints

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

Percent of Clients Secluded



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	1.65	4.84	2.56	4.80	5.69	4.84	6.84	6.84	4.96	3.51	7.44	5.88	9.01	7.14	7.89	6.78	5.13	
Ntl Mean	2.79	2.77	2.56	2.86	2.77	3.04	2.82	2.81	2.69	2.78	2.85	2.64	2.78	2.76	2.46	2.38	2.27	
+1 StDev	7.34	7.46	6.88	8.03	7.51	8.05	7.84	8.13	7.45	7.15	7.86	6.98	7.86	7.58	5.87	6.21	5.46	

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

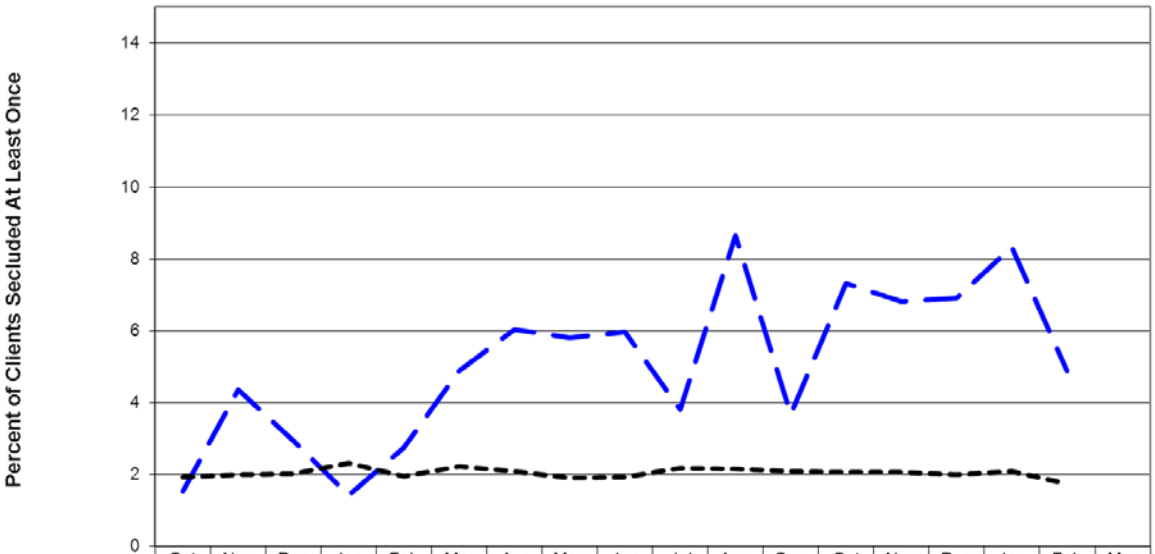
The following graphs depict the percent of unique clients who were secluded at least once stratified by forensic or civil classifications. For example, a rate of 3.0 means that 3% of the unique clients served were secluded at least once.

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

CONSENT DECREE

Percent of Clients Secluded

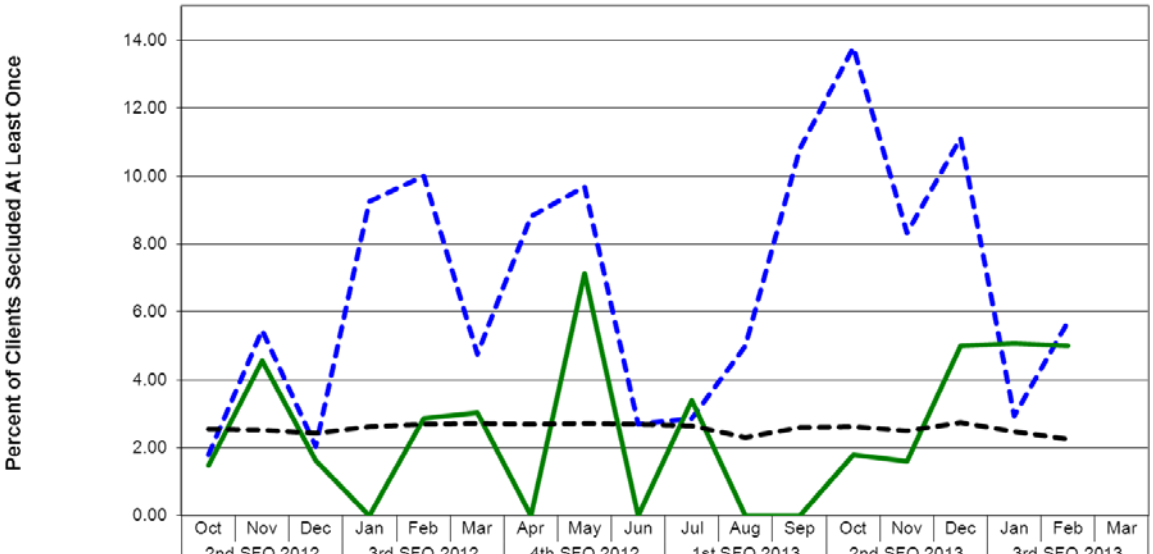
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	1.54	4.35	2.94	1.41	2.74	4.88	6.02	5.81	5.95	3.8	8.64	3.66	7.32	6.82	6.9	8.33	4.88	
Ntl Mean	1.92	1.99	2.02	2.32	1.95	2.21	2.08	1.9	1.92	2.18	2.16	2.08	2.05	2.05	1.99	2.09	1.73	

Percent of Clients Secluded

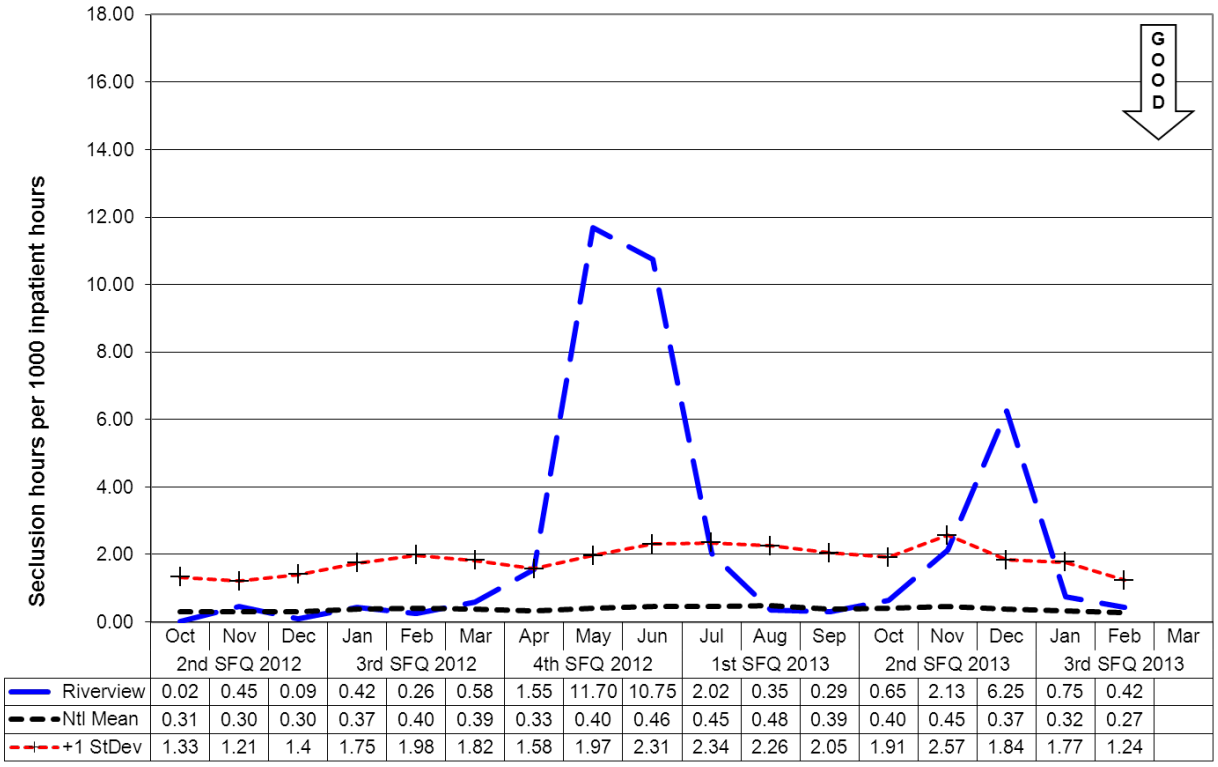
Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	1.79	5.45	2.04	9.26	10	4.76	8.82	9.68	2.7	2.86	5	10.81	13.79	8.33	11.11	2.94	5.71	
Dorothea Dix	1.47	4.55	1.61	0.00	2.86	3.03	0.00	7.14	0.00	3.39	0.00	0.00	1.79	1.59	5.00	5.08	5.00	
Ntl Mean	2.55	2.53	2.43	2.61	2.68	2.71	2.69	2.72	2.69	2.63	2.29	2.58	2.62	2.5	2.74	2.46	2.26	

CONSENT DECREE

Seclusion Hours



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	0.02	0.45	0.09	0.42	0.26	0.58	1.55	11.70	10.75	2.02	0.35	0.29	0.65	2.13	6.25	0.75	0.42	
Ntl Mean	0.31	0.30	0.30	0.37	0.40	0.39	0.33	0.40	0.46	0.45	0.48	0.39	0.40	0.45	0.37	0.32	0.27	
+1 StDev	1.33	1.21	1.4	1.75	1.98	1.82	1.58	1.97	2.31	2.34	2.26	2.05	1.91	2.57	1.84	1.77	1.24	

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

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

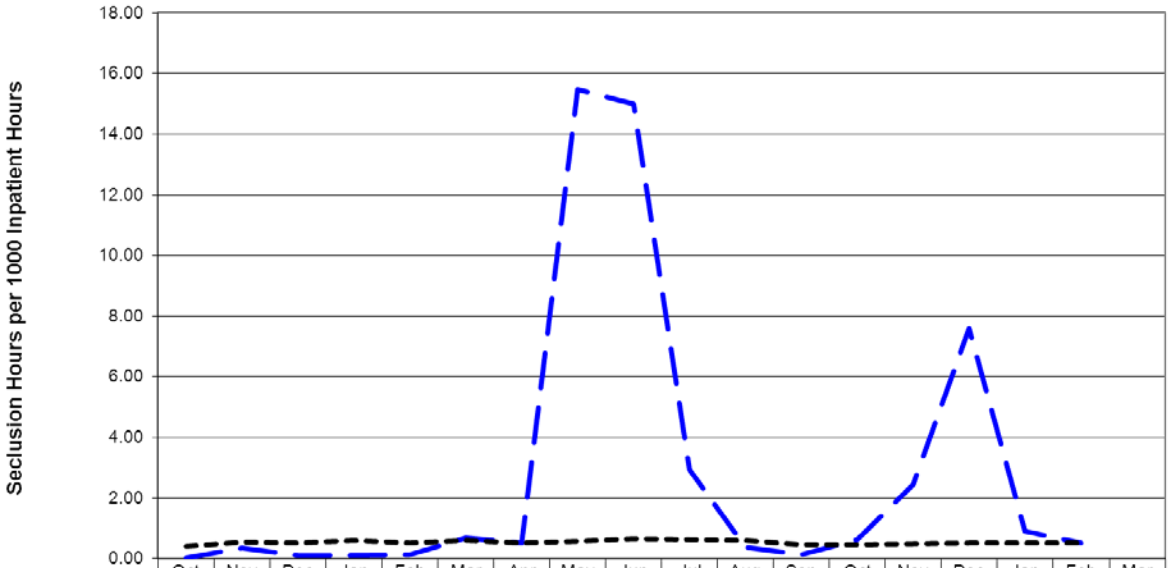
The following graphs depict the number of hours clients spent in seclusion for every 1000 inpatient hours stratified by forensic or civil classifications. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours.

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

CONSENT DECREE

Seclusion Hours

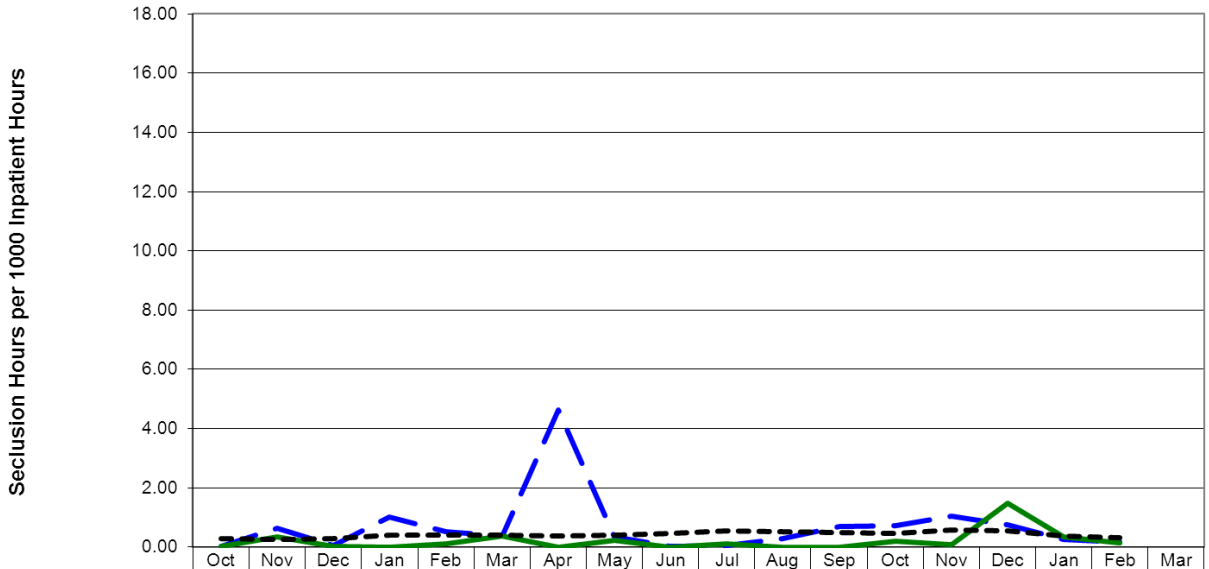
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	0.02	0.34	0.11	0.1	0.12	0.69	0.5	15.47	15.01	2.94	0.37	0.12	0.63	2.43	7.6	0.9	0.52	
Ntl Mean	0.41	0.55	0.51	0.59	0.52	0.59	0.52	0.57	0.64	0.62	0.59	0.46	0.47	0.48	0.51	0.5	0.5	

Seclusion Hours

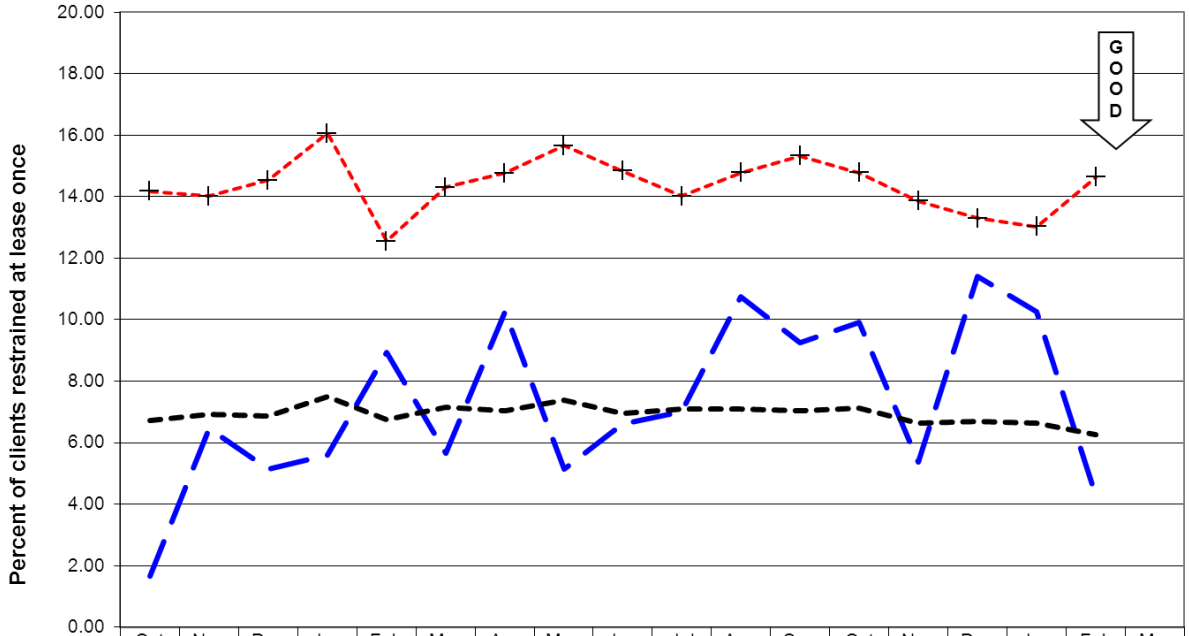
Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	0.02	0.62	0.06	1	0.51	0.37	4.64	0.35	0.03	0.04	0.29	0.68	0.71	1.04	0.74	0.26	0.16	
Dorothea Dix	0.02	0.33	0.02	0.00	0.10	0.38	0.00	0.22	0.00	0.10	0.00	0.00	0.20	0.09	1.47	0.35	0.13	
Ntl Mean	0.28	0.26	0.27	0.4	0.41	0.4	0.37	0.4	0.47	0.54	0.51	0.49	0.46	0.57	0.54	0.36	0.3	

CONSENT DECREE

Percent of Clients Restrained



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	1.65	6.45	5.13	5.60	8.94	5.65	10.26	5.13	6.61	7.02	10.74	9.24	9.91	5.36	11.40	10.26	4.27	
Ntl Mean	6.73	6.92	6.85	7.50	6.74	7.15	7.04	7.39	6.95	7.10	7.08	7.04	7.12	6.62	6.69	6.62	6.27	
+1 StDev	14.18	14.01	14.53	16.06	12.55	14.31	14.76	15.66	14.84	14.01	14.78	15.32	14.78	13.86	13.29	13.02	14.63	

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

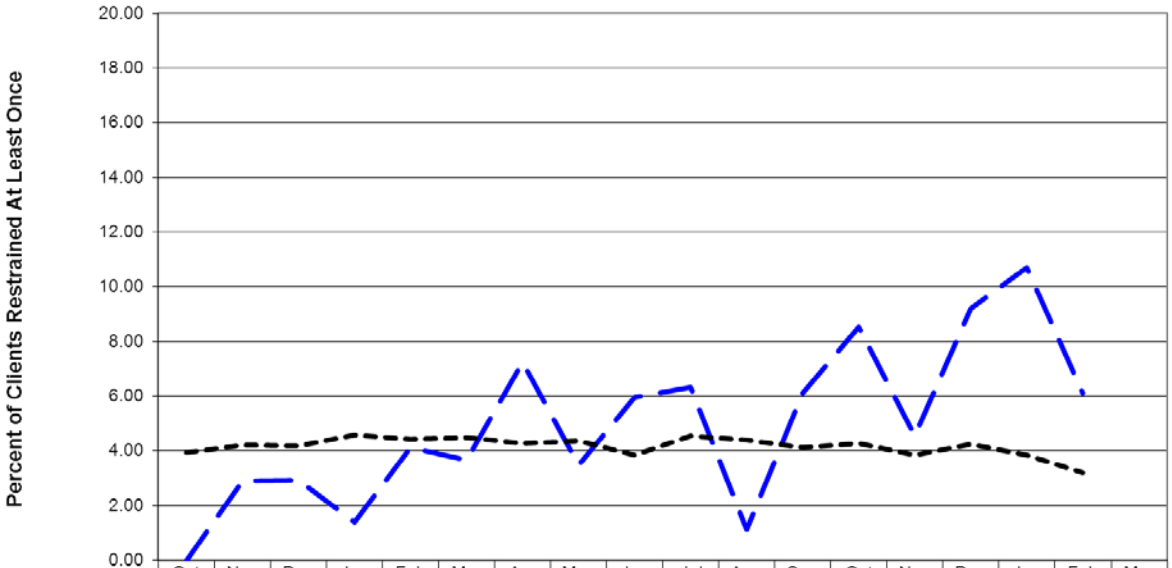
The following graphs depict the percent of unique clients who were restrained at least once stratified by forensic or civil classifications – includes all forms of restraint of any duration. For example, a rate of 4.0 means that 4% of the unique clients served were restrained at least once.

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

CONSENT DECREE

Percent of Clients Restrained

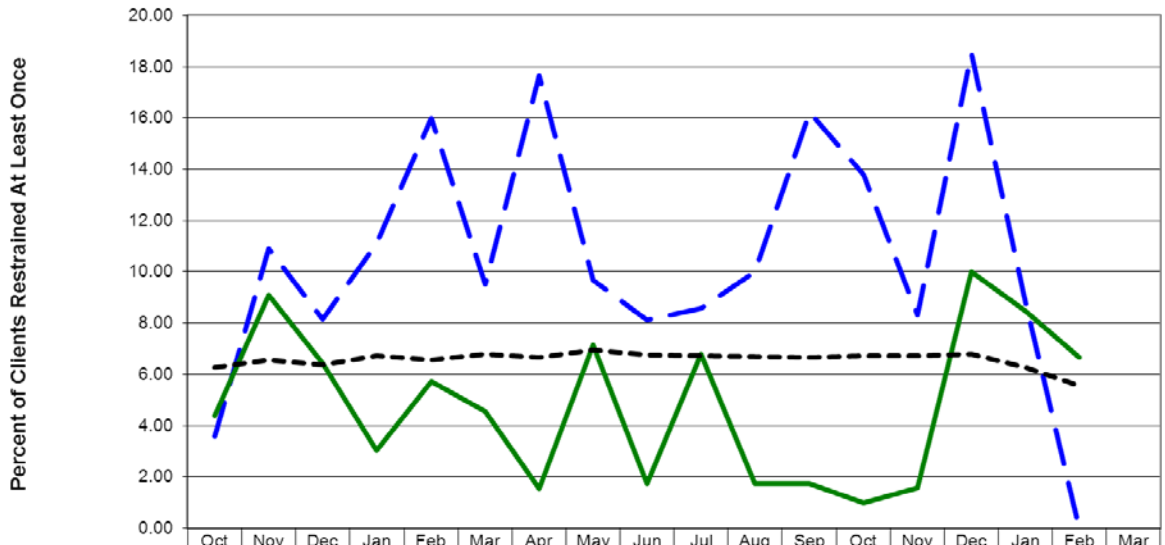
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	0	2.9	2.94	1.41	4.11	3.66	7.23	3.49	5.95	6.33	1.11	6.1	8.54	4.55	9.2	10.71	6.1	
Ntl Mean	3.94	4.22	4.18	4.57	4.44	4.49	4.27	4.37	3.86	4.56	4.41	4.11	4.27	3.86	4.23	3.85	3.19	

Percent of Clients Restrained

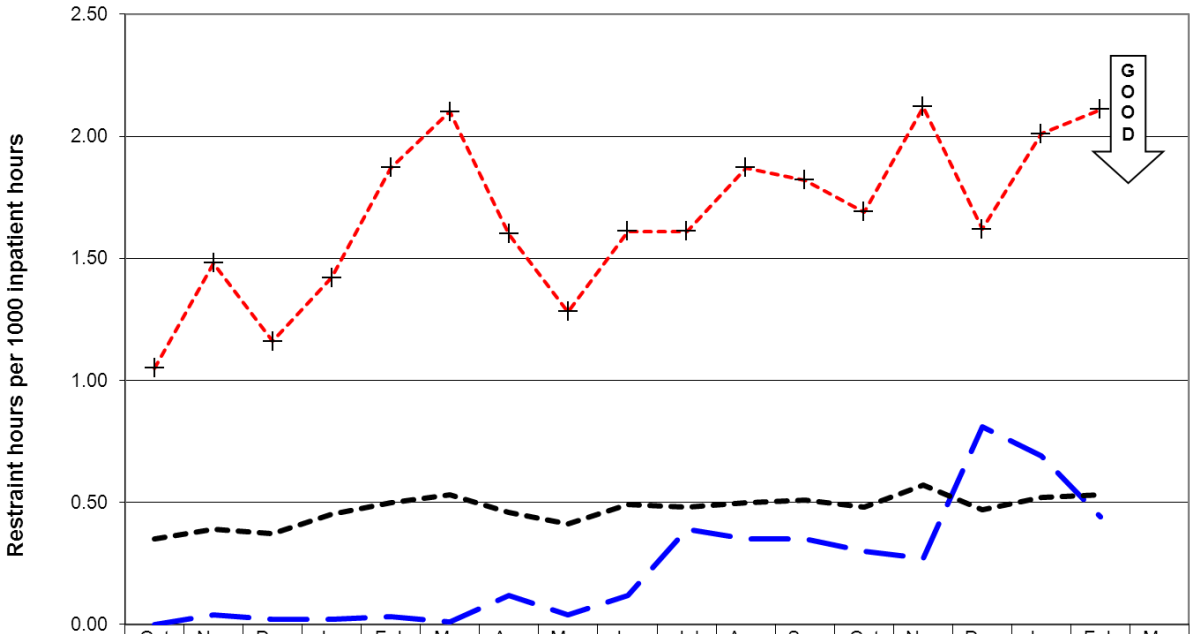
Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	3.57	10.91	8.16	11.11	16	9.52	17.65	9.68	8.11	8.57	10	16.22	13.79	8.33	18.52	8.82	0	
Dorothea Dix	4.41	9.09	6.45	3.03	5.71	4.55	1.54	7.14	1.75	6.78	1.75	1.75	1.00	1.59	10.00	8.47	6.67	
Ntl Mean	6.28	6.56	6.36	6.74	6.57	6.79	6.67	6.95	6.75	6.72	6.7	6.66	6.72	6.72	6.78	6.27	5.55	

CONSENT DECREE

Restraint Hours



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	0.00	0.04	0.02	0.02	0.03	0.01	0.12	0.04	0.12	0.39	0.35	0.35	0.30	0.27	0.81	0.69	0.44	
Ntl Mean	0.35	0.39	0.37	0.45	0.50	0.53	0.46	0.41	0.49	0.48	0.50	0.51	0.48	0.57	0.47	0.52	0.53	
+1 StDev	1.05	1.48	1.16	1.42	1.87	2.1	1.6	1.28	1.61	1.61	1.87	1.82	1.69	2.12	1.62	2.01	2.11	

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

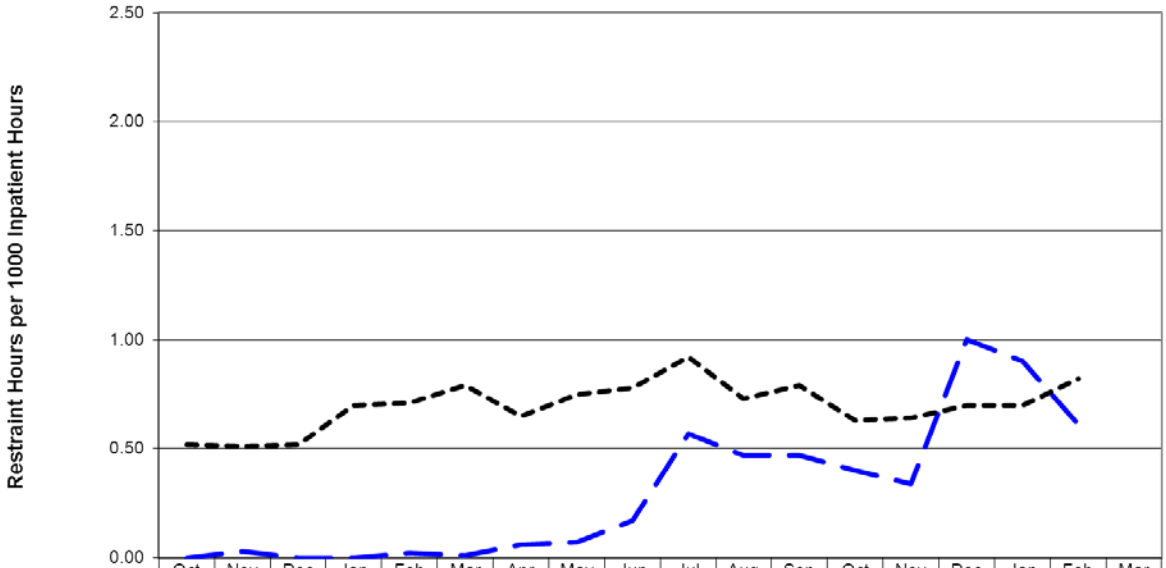
The following graphs depict the number of hours clients spent in restraint for every 1000 inpatient hours stratified by forensic or civil classifications - includes all forms of restraint of any duration. For example, a rate of 1.6 means that 2 hours were spent in restraint for each 1250 inpatient hours.

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

CONSENT DECREE

Restraint Hours

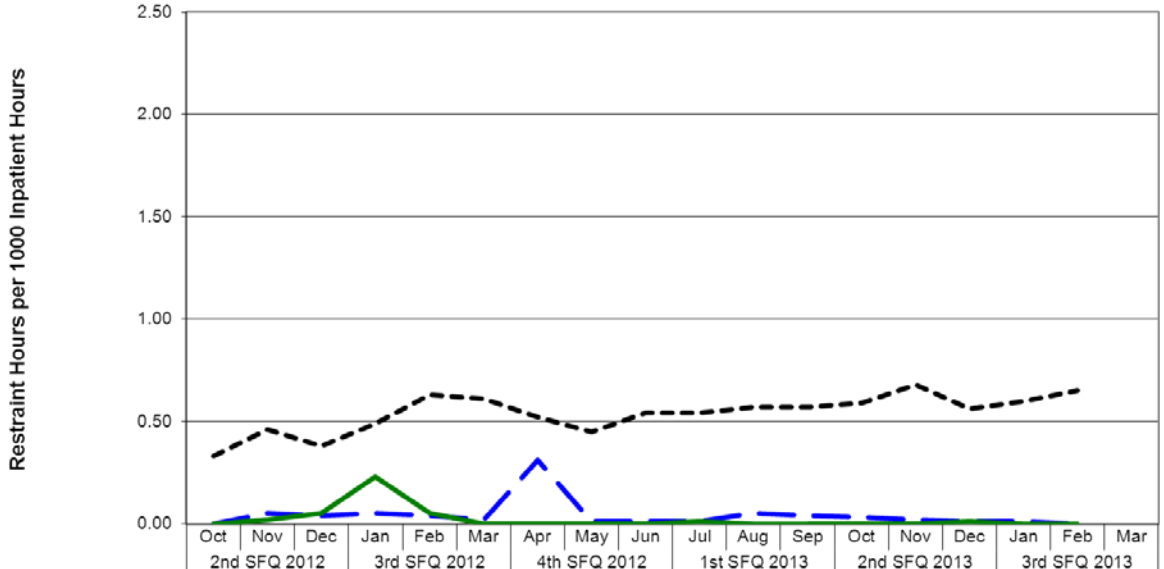
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	0.00	0.03	0.00	0.00	0.02	0.01	0.06	0.07	0.17	0.57	0.47	0.47	0.40	0.34	1.00	0.90	0.61	
Ntl Mean	0.52	0.51	0.52	0.70	0.71	0.79	0.65	0.75	0.78	0.92	0.73	0.79	0.63	0.64	0.70	0.70	0.82	

Restraint Hours

Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	0.00	0.05	0.04	0.05	0.04	0.02	0.31	0.01	0.01	0.01	0.05	0.04	0.03	0.02	0.01	0.01	0	
Dorothea Dix	0.00	0.02	0.05	0.23	0.05	0.00	0.00	0.00	0.00	0.01	0.00	0.00	0.00	0.00	0.01	0.00	0.00	
Ntl Mean	0.33	0.46	0.38	0.49	0.63	0.61	0.52	0.45	0.54	0.54	0.57	0.57	0.59	0.68	0.56	0.60	0.65	

CONSENT DECREE

Confinement Event Detail

3rd Quarter 2013

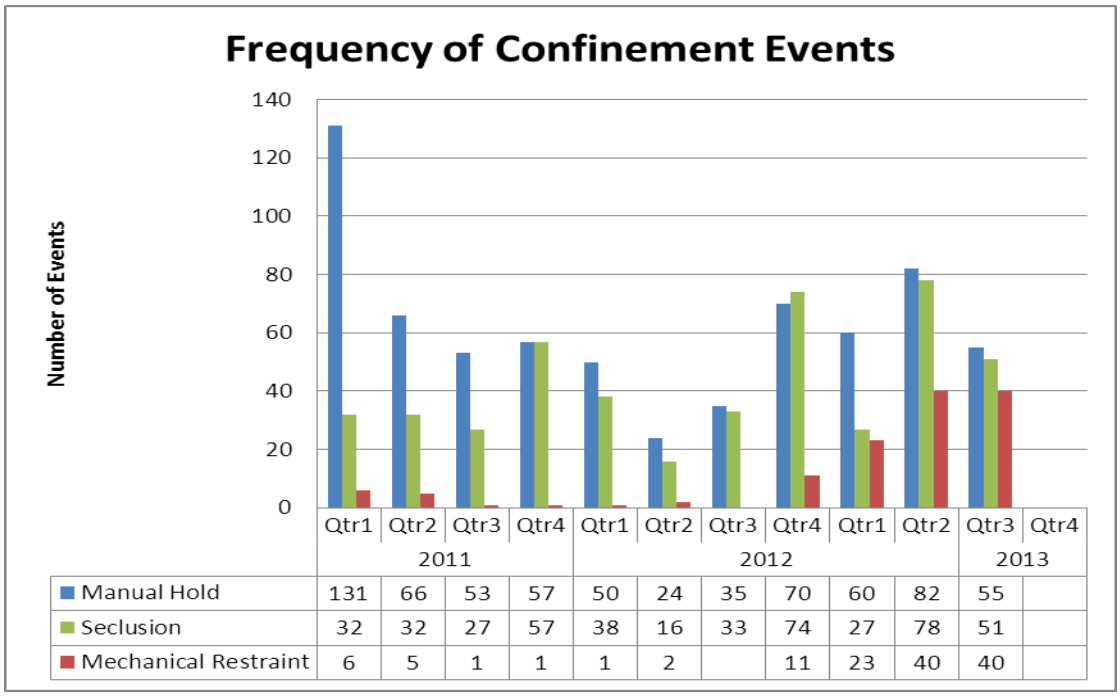
	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
MR00000657	17	27	11	55	38%	38%
MR00003374	14		17	31	21%	59%
MR00000029	2	8	2	12	8%	67%
MR00004974	4	3	3	10	7%	74%
MR00006940	4		2	6	4%	78%
MR00005327	2		2	4	3%	81%
MR00004898			3	3	2%	83%
MR00007121			2	2	1%	84%
MR00006630	1		1	2	1%	86%
MR00000189	1		1	2	1%	87%
MR00004271		1	1	2	1%	88%
MR00000668	2			2	1%	90%
MR00004808	2			2	1%	91%
MR00007148		1	1	2	1%	92%
MR00000477	2			2	1%	94%
MR00000115	1		1	2	1%	95%
MR00005267			1	1	1%	96%
MR00007129			1	1	1%	97%
MR00003726			1	1	1%	97%
MR00006962			1	1	1%	98%
MR00000581	1			1	1%	99%
MR00006993	1			1	1%	99%
MR00007015	1			1	1%	100%
Grand Total	55	40	51	146		

29% (23/80) of average hospital population experienced some form of confinement event during the 3rd fiscal quarter 2013. Eight of these clients (10% of the average hospital population) accounted for 84% of the containment events. The trend in frequency of confinement event, specifically the increase in the trend related to mechanical restraints is due to a few high acute clients requiring special management to ensure the safety of the milieu.

For example, 68% of mechanical restraint events can be attributed to one client. This individual is also attributable to the greatest number of manual hold events, however, it is common to have an accompanying manual hold during the initiation and termination of a mechanical restraint event or a seclusion event

CONSENT DECREE

.



	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4
	2011				2012						2013	
Manual Hold	131	66	53	57	50	24	35	70	60	82	55	
Seclusion	32	32	27	57	38	16	33	74	27	78	51	
Mechanical Restraint	6	5	1	1	1	2		11	23	40	40	

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

Factors of Causation Related to Seclusion Events

	3Q12	4Q12	1Q13	2Q13	3Q13
Danger to Others/Self	31	73	23	78	50
Danger to Others	2		4		
Danger to Self		1			1
% Dangerous Precipitation	100%	100%	100%	100%	100%
Total Events	33	74	27	78	51

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

Factors of Causation Related to Mechanical Restraint Events

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

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

See Pages 26 & 27

CONSENT DECREE

Confinement Events Management

Seclusion Events (51) Events

Standard	Threshold	Compliance
The record reflects that seclusion was absolutely necessary to protect the patient from causing physical harm to self or others, or if the patient was examined by a physician or physician extender prior to implementation of seclusion, to prevent further serious disruption that significantly interferes with other patients' treatment.	95%	100%
The record reflects that lesser restrictive alternatives were inappropriate or ineffective. This can be reflected anywhere in record.	90%	100%
The record reflects that the decision to place the patient in seclusion was made by a physician or physician extender.	90%	100%
The decision to place the patient in seclusion was entered in the patient's records as a medical order.	90%	100%
The record reflects that, if the physician or physician extender was not immediately available to examine the patient, the patient was placed in seclusion following an examination by a nurse.	90%	100%
The record reflects that the physician or physician extender personally evaluated the patient within 30 minutes after the patient has been placed in seclusion, and if there is a delay, the reasons for the delay.	90%	100%
The record reflects that the patient was monitored every 15 minutes. (Compliance will be deemed if the patient was monitored at least 3 times per hour.)	90%	100%
Individuals implementing seclusion have been trained in techniques and alternatives.	90%	100%
The record reflects that reasonable efforts were taken to notify guardian or designated representative as soon as possible that patient was placed in seclusion.	75%	100%

Standard	Threshold	Compliance
The medical order states time of entry of order and that number of hours in seclusion shall not exceed 4.	85%	100%
The medical order states the conditions under which the patient may be sooner released.	85%	100%
The record reflects that the need for seclusion is re-evaluated at least every 2 hours by a nurse.	90%	100%
The record reflects that the 2 hour re-evaluation was conducted while the patient was out of seclusion room unless clinically contraindicated.	70%	100%
The record includes a special check sheet that has been filled out to document reason for seclusion, description of behavior and the lesser restrictive alternatives considered.	85%	100%
The record reflects that the patient was released, unless clinically contraindicated, at least every 2 hours or as necessary for eating, drinking, bathing, toileting or special medical orders.	85%	100%
Reports of seclusion events were forwarded to medical director and advocate.	90%	100%
The record reflects that, for persons with mental retardation, the regulations governing seclusion of clients with mental retardation were met.	85%	100%
The medical order for seclusion was not entered as a PRN order.	90%	100%
Where there was a PRN order, there is evidence that physician was counseled.	95%	N/A

CONSENT DECREE

Confinement Events Management

Mechanical Restraint Events (40) Events

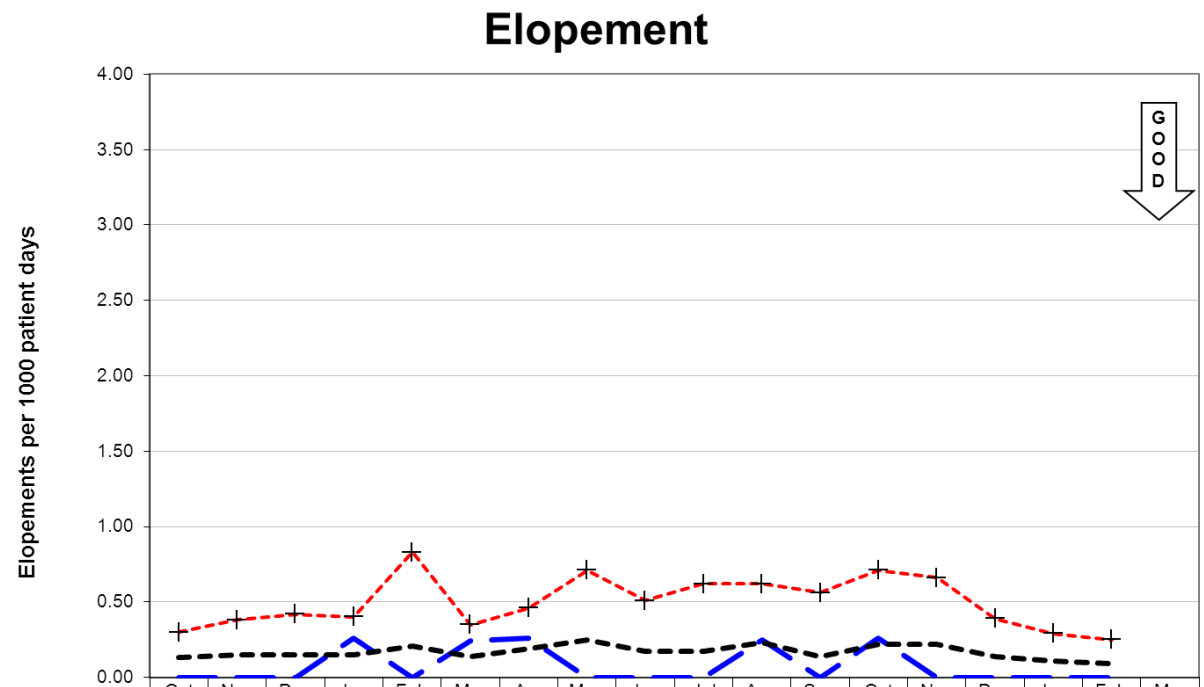
Standard	Threshold	Compliance
The record reflects that restraint was absolutely necessary to protect the patient from causing serious physical injury to self or others.	95%	100%
The record reflects that lesser restrictive alternatives were inappropriate or ineffective.	90%	100%
The record reflects that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

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

CONSENT DECREE

Client Elopements

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



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	0.00	0.00	0.00	0.26	0.00	0.24	0.26	0.00	0.00	0.00	0.25	0.00	0.26	0.00	0.00	0.00	0.00	
Ntl Mean	0.13	0.15	0.15	0.15	0.21	0.14	0.19	0.25	0.17	0.17	0.23	0.14	0.22	0.22	0.14	0.11	0.09	
StDev	0.3	0.38	0.42	0.4	0.83	0.35	0.46	0.71	0.51	0.62	0.62	0.56	0.71	0.66	0.39	0.29	0.25	

.

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

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

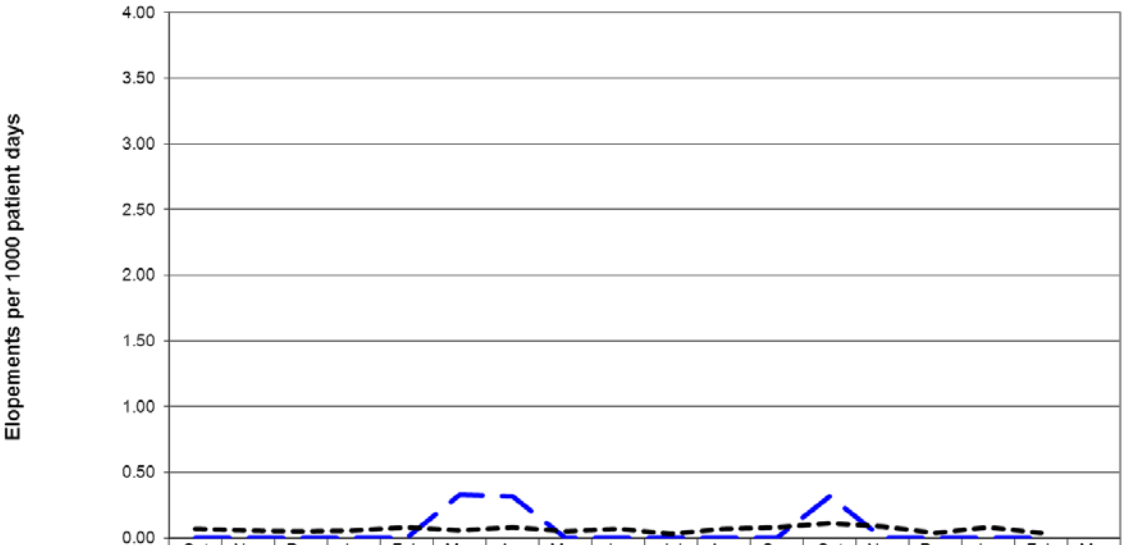
The following graphs depict the number of elopements stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days.

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

CONSENT DECREE

Elopement

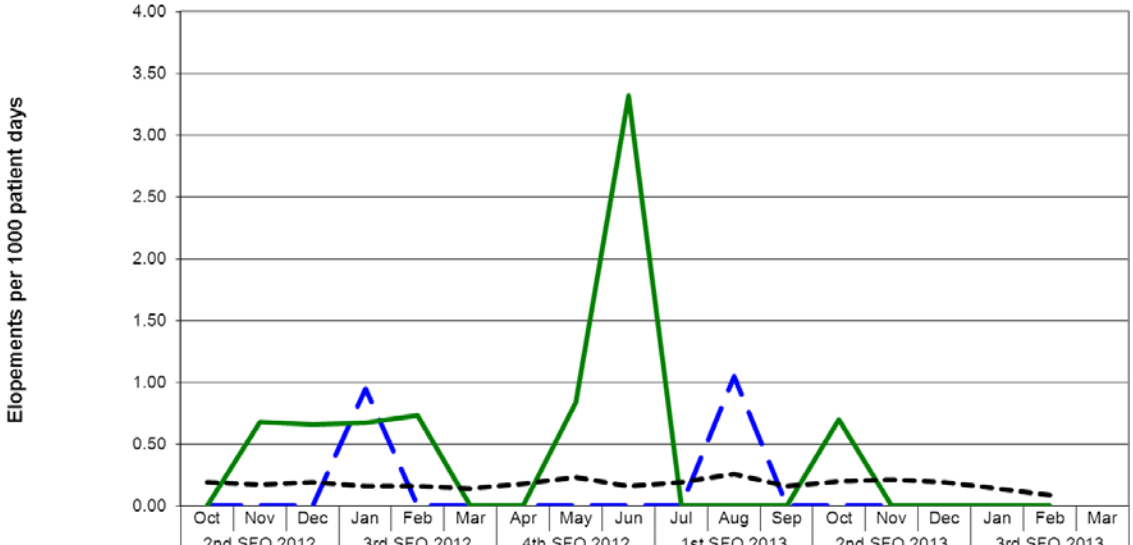
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	0.00	0.00	0.00	0.00	0.00	0.33	0.32	0.00	0.00	0.00	0.00	0.00	0.32	0.00	0.00	0.00	0.00	
Ntl Mean	0.07	0.06	0.05	0.06	0.08	0.06	0.08	0.05	0.07	0.03	0.07	0.08	0.11	0.09	0.04	0.08	0.04	

Elopement

Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	0.00	0.00	0.00	0.95	0.00	0.00	0.00	0.00	0.00	0.00	1.05	0.00	0.00	0.00	0.00	0.00	0.00	
Dorothea Dix	0.00	0.68	0.66	0.67	0.73	0.00	0.00	0.84	3.32	0.00	0.00	0.00	0.70	0.00	0.00	0.00	0.00	
Ntl Mean	0.19	0.17	0.19	0.16	0.16	0.14	0.18	0.23	0.16	0.19	0.26	0.16	0.20	0.21	0.19	0.14	0.09	

Client Injuries

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

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

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

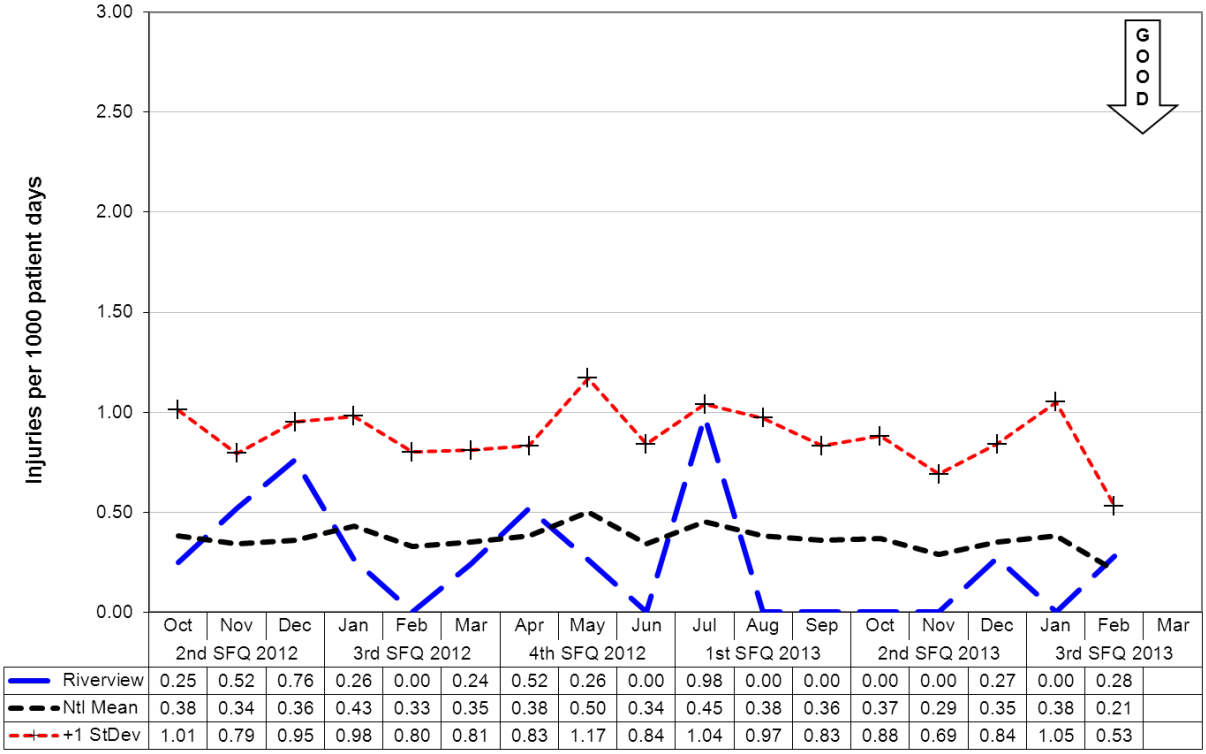
Reportable injuries include those that require: 3) Medical Intervention, 4) Hospitalization or where, 5) Death Occurred.

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

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

CONSENT DECREE

Client Injury Rate



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	0.25	0.52	0.76	0.26	0.00	0.24	0.52	0.26	0.00	0.98	0.00	0.00	0.00	0.00	0.27	0.00	0.28	
Ntl Mean	0.38	0.34	0.36	0.43	0.33	0.35	0.38	0.50	0.34	0.45	0.38	0.36	0.37	0.29	0.35	0.38	0.21	
+1 StDev	1.01	0.79	0.95	0.98	0.80	0.81	0.83	1.17	0.84	1.04	0.97	0.83	0.88	0.69	0.84	1.05	0.53	

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

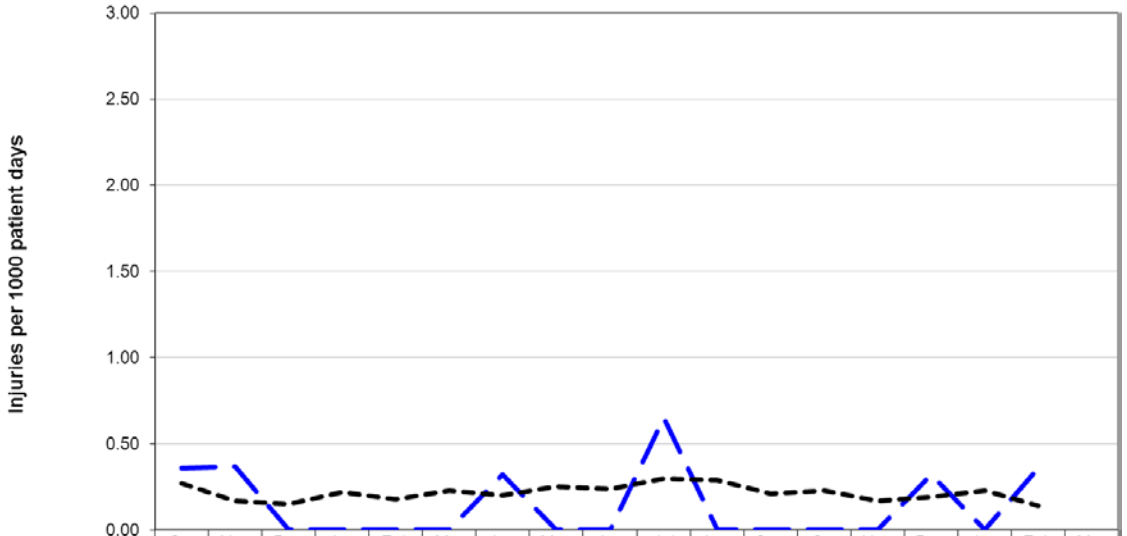
The following graphs depict the number of client injury events stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days.

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

CONSENT DECREE

Client Injury Rate

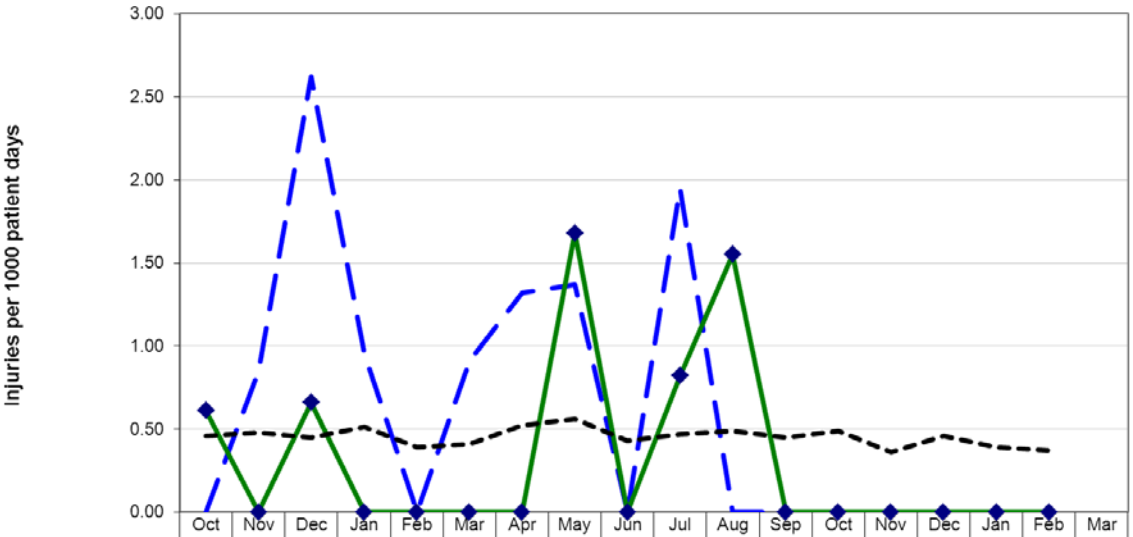
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	0.36	0.37	0.00	0.00	0.00	0.00	0.32	0.00	0.00	0.65	0.00	0.00	0.00	0.00	0.32	0.00	0.36	
Ntl Mean	0.27	0.17	0.15	0.22	0.18	0.23	0.20	0.25	0.24	0.30	0.29	0.21	0.23	0.17	0.19	0.23	0.14	

Client Injury Rate

Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	0.00	0.85	2.62	0.95	0.00	0.91	1.32	1.37	0.00	1.95	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Dorothea Dix	0.61	0.00	0.66	0.00	0.00	0.00	0.00	1.68	0.00	0.82	1.55	0.00	0.00	0.00	0.00	0.00	0.00	
Ntl Mean	0.46	0.48	0.45	0.51	0.39	0.41	0.52	0.56	0.43	0.47	0.49	0.45	0.49	0.36	0.46	0.39	0.37	

CONSENT DECREE

Severity of injury by Month

Severity	JAN	FEB	MAR	3Q2013
No Treatment	10	14	15	39
Minor First Aid	4			4
Medical Intervention Required		1		1
Hospitalization Required				
Death Occurred				
Total	14	15	15	44

The event that required medical intervention involved a client to client assault. The four events that required minor first aid also involved client to client assaults.

Type and Cause of Injury by Month

Type - Cause	JAN	FEB	MAR	3Q2013
Accident - Equipment Use	1	2		3
Accident – Fall Unwitnessed	1	1	1	3
Accident – Fall Witnessed	3	1	2	6
Accident – Other			1	1
Assault – Client to Client	9	9	11	29
Assault – Other		1		1
Self-Injurious Behavior		1		1

Changes in reporting standards related to “criminal” events as defined by the “State of Maine Rules for Reporting Sentinel Events”, effective February 1, 2013 as defined the by “National Quality Forum 2011 List of Serious Reportable Events” the number of reportable “assaults” that occur as the result of client interactions increased significantly. This change is due primarily as a result of the methods and rules related to data collection and abstraction.

Falls continues to be the predominant cause of potentially injurious events not related to the assaults discussed previously. Fall incidents remain a focus of the hospital. None of the fall incidents required treatment of any kind but are address as to causation during the Falls Process Review Team Meeting held each month.

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

Patient Abuse, Neglect, Exploitation, Injury or Death

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

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

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

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

Performance Improvement and Quality Assurance

V34) Riverview maintains Joint Commission accreditation;

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

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

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

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

V35) Riverview maintains its hospital license;

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

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

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

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

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

JOINT COMMISSION

Hospital-Based Inpatient Psychiatric Services (ORYX Data Elements)

The Joint Commission Quality Initiatives

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

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

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

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

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

Assessment

Treatment Planning and Implementation

Hope and Empowerment

Patient Driven Care

Patient Safety

Continuity and Transition of Care

Outcomes

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

JOINT COMMISSION

Admissions Screening (HBIPS 1)

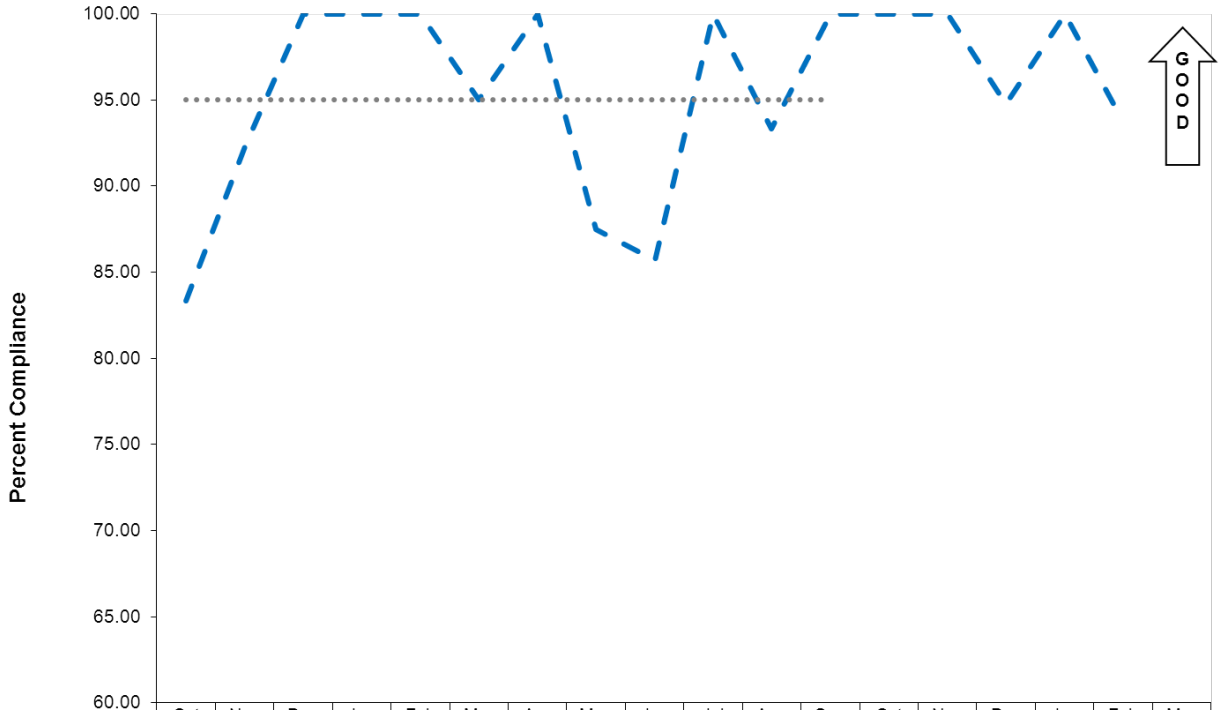
For Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths

Description

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

Rationale

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



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
RPC Rate	83.33	92.31	100.00	100.00	100.00	95.00	100.00	87.50	85.71	100.00	93.33	100.00	100.00	100.00	94.74	100.00	93.75	
TJC Target	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00						

JOINT COMMISSION

Physical Restraint (HBIPS 2)

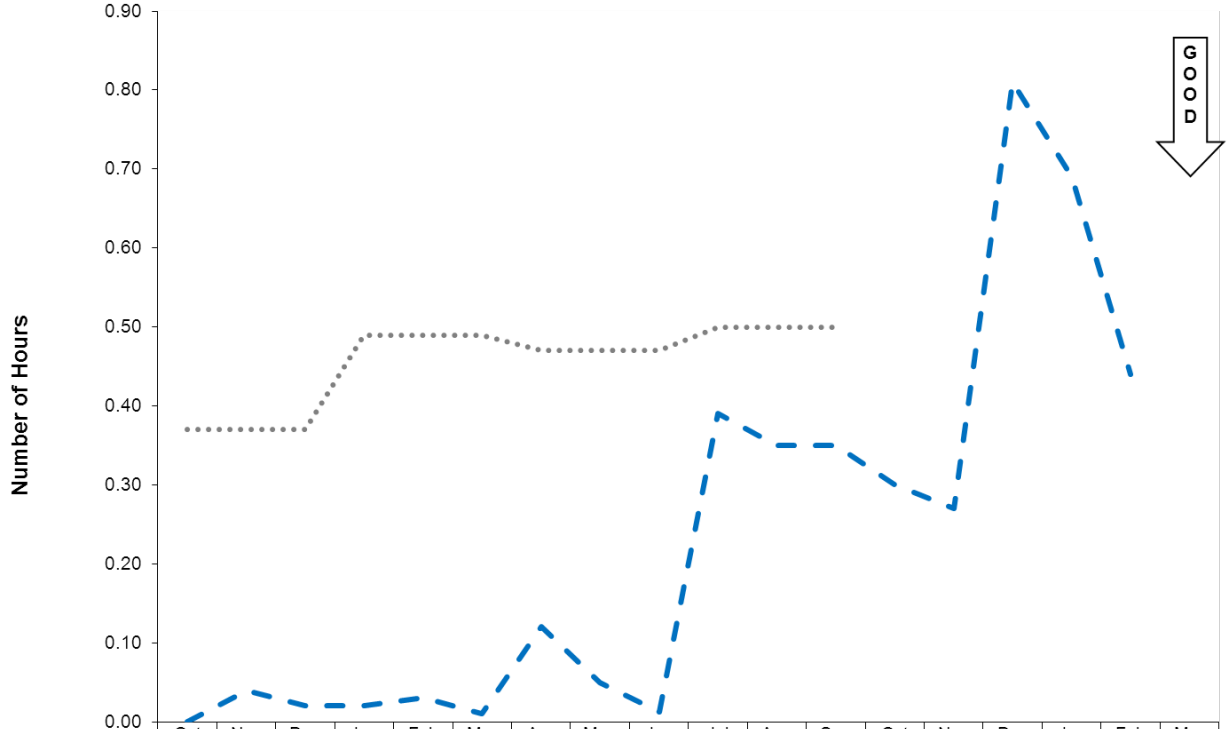
Hours of Use

Description

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

Rationale

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



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
RPC Rate	0.00	0.04	0.02	0.02	0.03	0.01	0.12	0.05	0.01	0.39	0.35	0.35	0.30	0.27	0.81	0.69	0.44	
TJC Target	0.37	0.37	0.37	0.49	0.49	0.49	0.47	0.47	0.47	0.50	0.50	0.50						

JOINT COMMISSION

Seclusion (HBIPS 3)

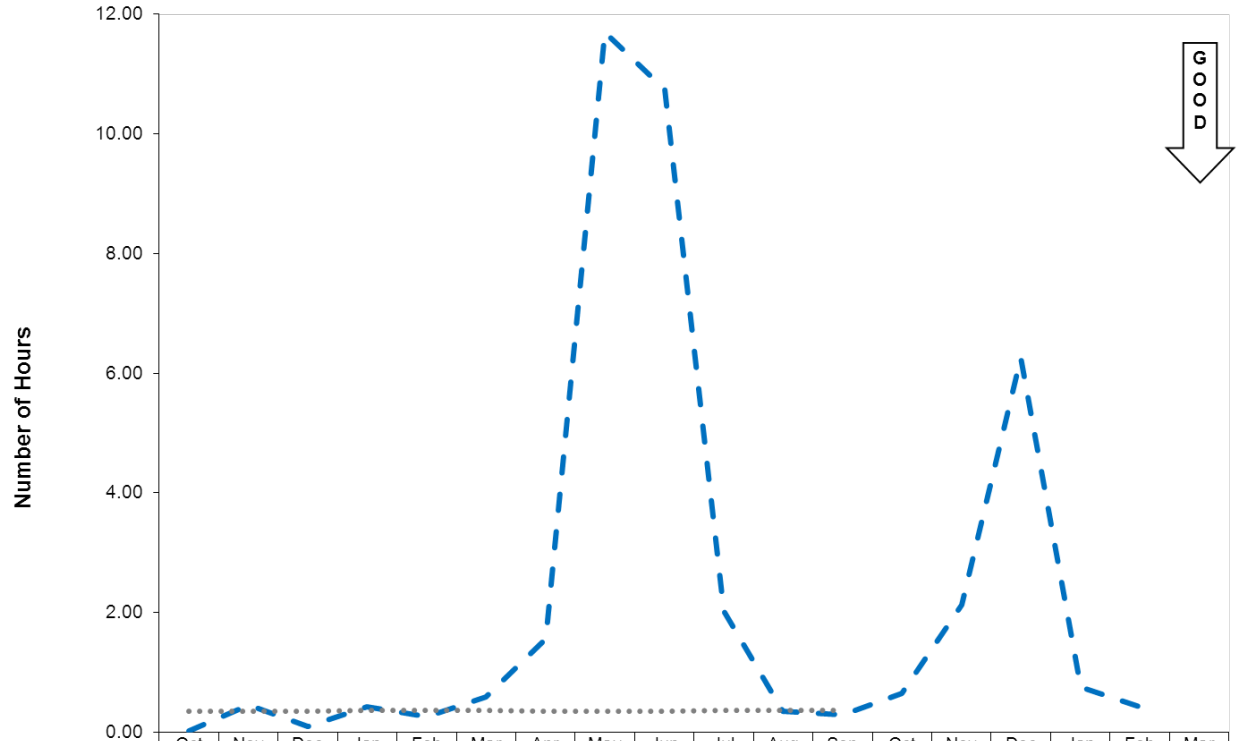
Hours of Use

Description

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

Rationale

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



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
RPC Rate	0.02	0.45	0.09	0.42	0.26	0.58	1.55	11.70	10.75	2.02	0.35	0.29	0.65	2.13	6.25	0.75	0.42	
TJC Target	0.34	0.34	0.34	0.36	0.36	0.36	0.35	0.35	0.35	0.36	0.36	0.36						

JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)

Description

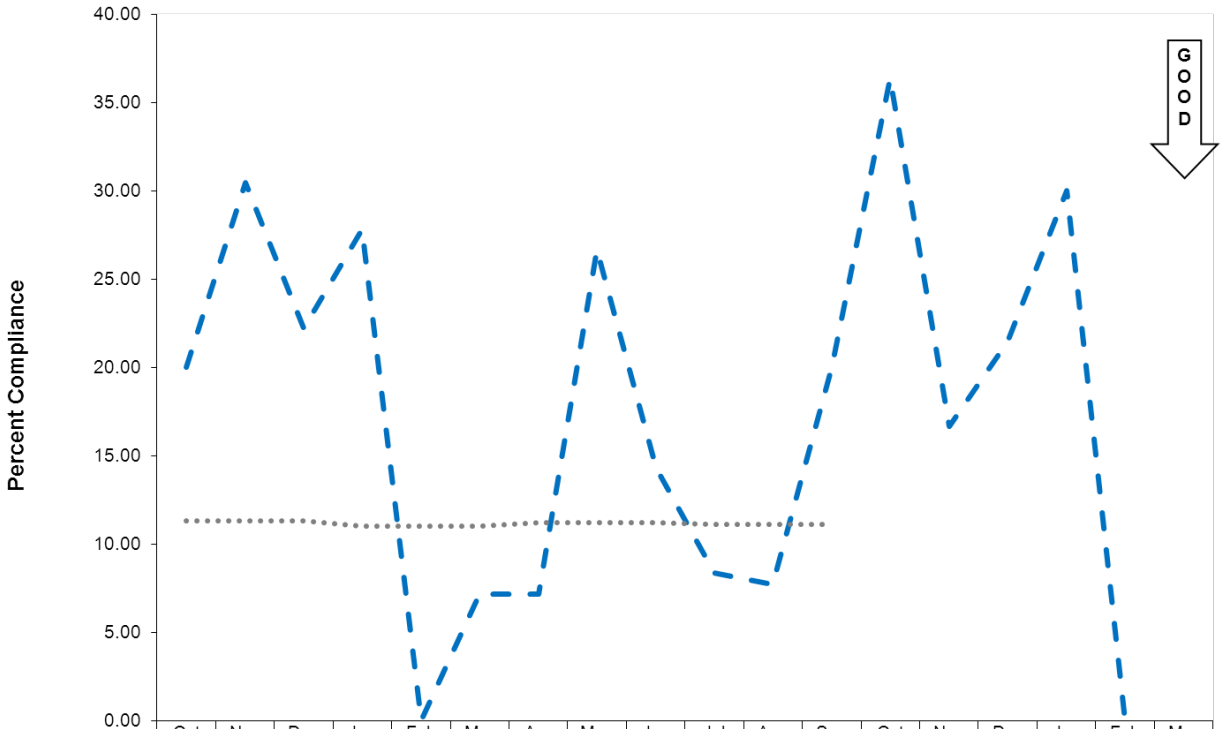
Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications

Rationale

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

JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
RPC Rate	20.00	30.43	22.22	27.78	0.00	7.14	7.14	26.67	14.29	8.33	7.69	20.00	36.36	16.67	21.43	30.00	0.00	
TJC Target	11.30	11.30	11.30	11.00	11.00	11.00	11.20	11.20	11.20	11.10	11.10	11.10						

JOINT COMMISSION

Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)

Description

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

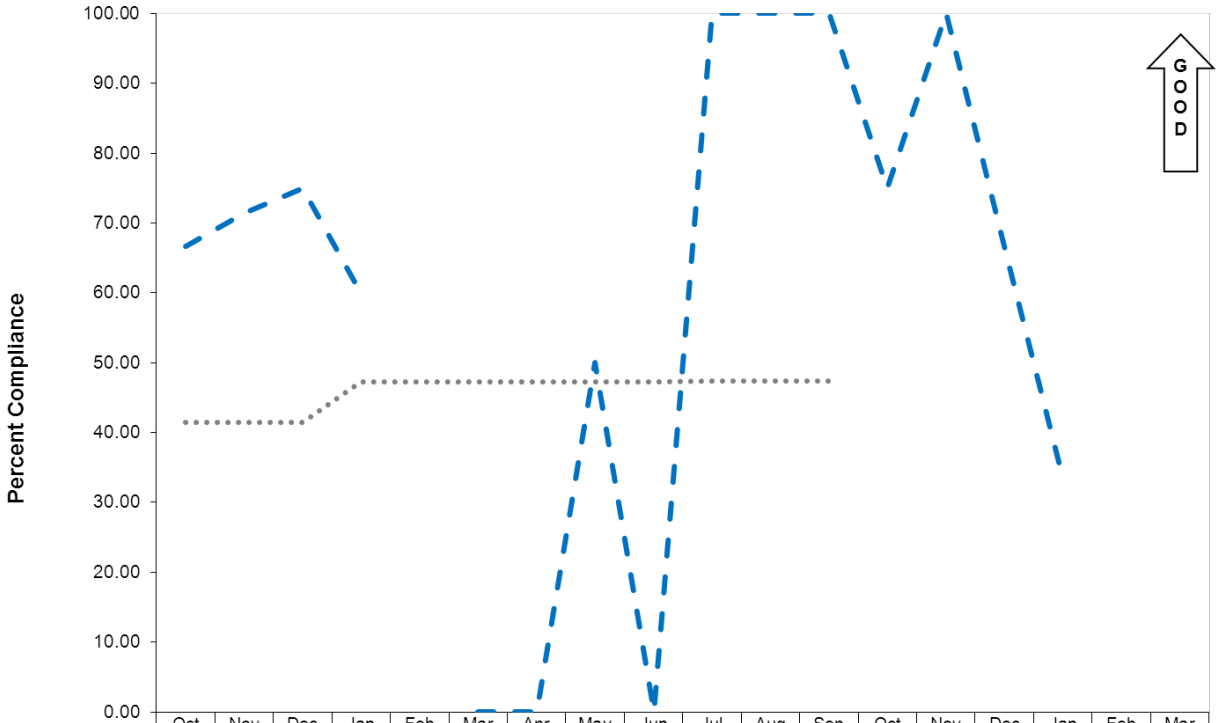
Rationale

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

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

JOINT COMMISSION

Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
RPC Rate	66.67	71.43	75.00	60.00		0.00	0.00	50.00	0.00	100.00	100.00	100.00	75.00	100.00	66.67	33.33		
TJC Target	41.50	41.50	41.50	47.30	47.30	47.30	47.20	47.20	47.20	47.40	47.40	47.40						

JOINT COMMISSION

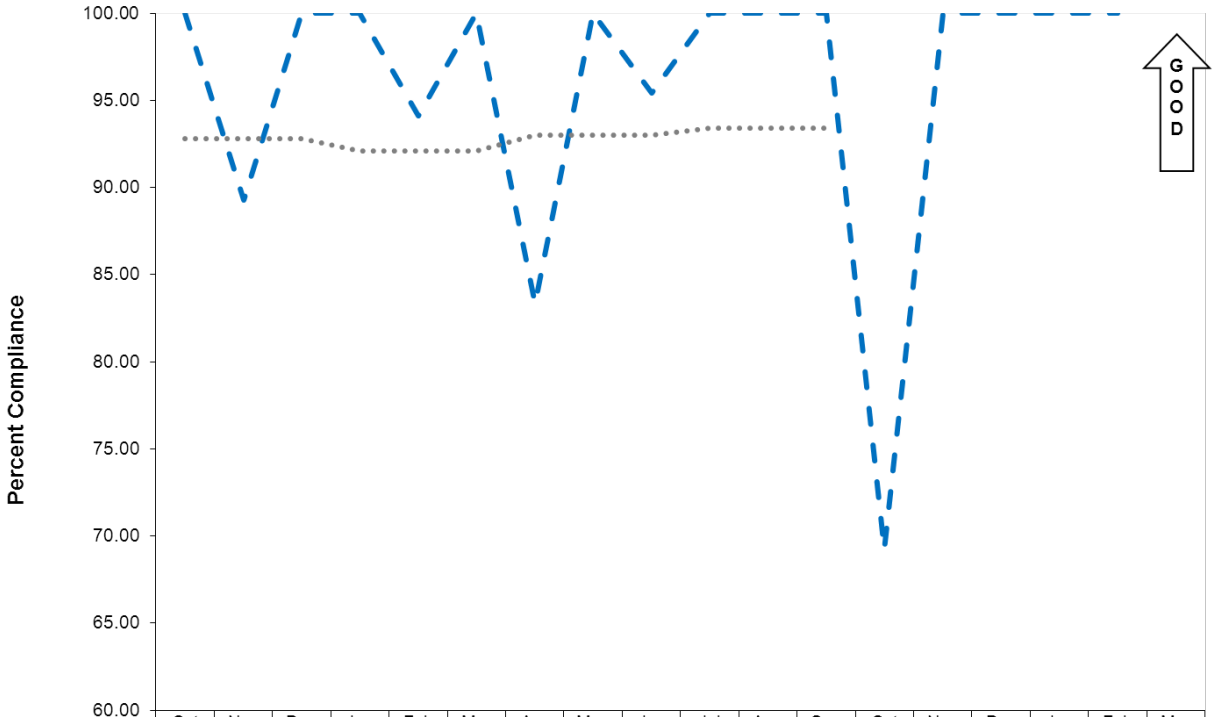
Post Discharge Continuing Care Plan (HBIPS 6)

Description

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

Rationale

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



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
RPC Rate	100.00	89.29	100.00	100.00	94.12	100.00	83.33	100.00	95.45	100.00	100.00	100.00	69.23	100.00	100.00	100.00	100.00	
TJC Target	92.80	92.80	92.80	92.10	92.10	92.10	93.00	93.00	93.00	93.40	93.40	93.40						

JOINT COMMISSION

Post Discharge Continuing Care Plan Transmitted (HBIPS 7)

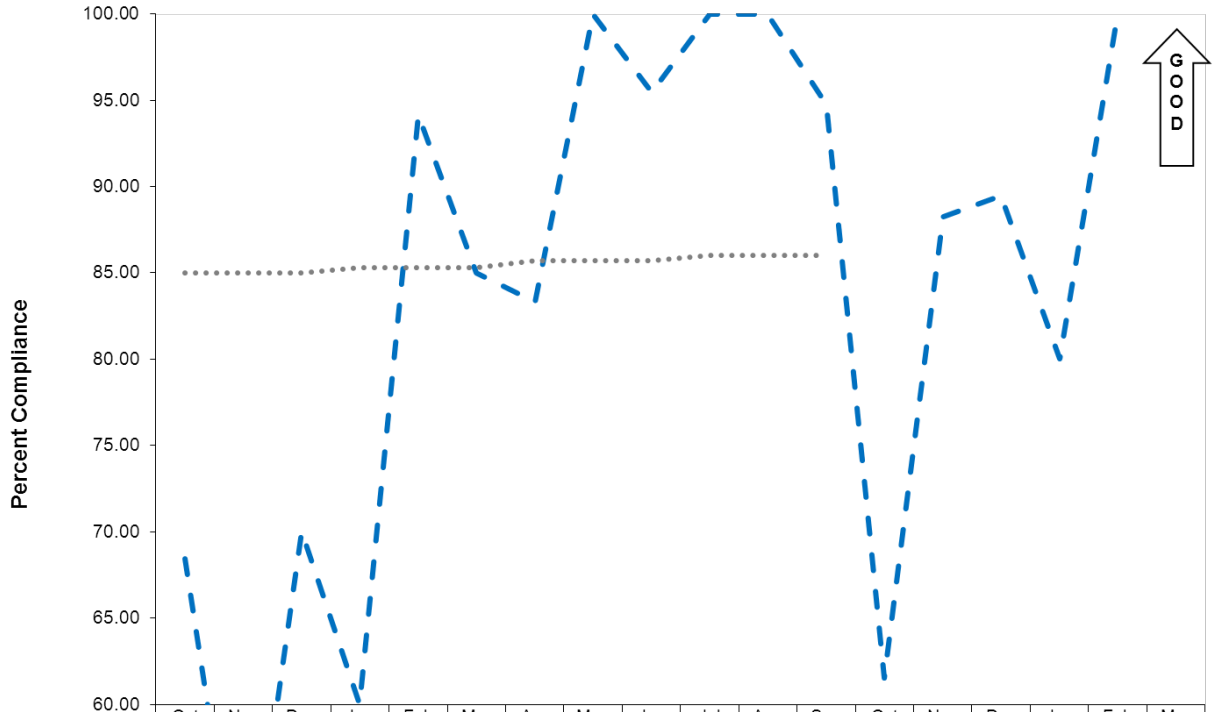
To Next Level of Care Provider on Discharge

Description

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

Rationale

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



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
RPC Rate	68.42	46.43	70.00	60.00	94.12	85.00	83.33	100.00	95.45	100.00	100.00	94.74	61.54	88.24	89.47	80.00	100.00	
TJC Target	85.00	85.00	85.00	85.30	85.30	85.30	85.70	85.70	85.70	86.00	86.00	86.00						

JOINT COMMISSION

Joint Commission Priority Focus Areas

Capital Community Clinic

Adverse Reactions to Sedation or Anesthesia

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

Dental Clinic Timeout/Identification of Client

Indicators	1Q2013	2Q2013	3Q2013	4Q2013
National Patent Safety Goals Goal 1: Improve the accuracy of Client Identification. Capital Community Dental Clinic assures accurate client identification by: asking the client to state his/her name and date of birth. A time out will be taken before the procedure to verify location and numbered tooth. The time out section is in the progress notes of the patient chart. This page will be signed by the Dentist as well as the dental assistant.	**July** 100% 14/14 **August** 100% 4/4 **September** 100% 5/5 **Total** 100% 23/23	**October** 100% 5/5 **November** 100% 3/3 **December** 100% 4/4 **Total** 100% 12/12	**January** 100% 7/7 **February** 100% 3/3 **March** 100% 9/9 **Total** 100% 19/19	**April** **May** **June** **Total**

Dental Clinic Post Extraction Prevention of Complications and Follow-up

Indicators	1Q2013	2Q2013	3Q2013	4Q2013
1. All clients with tooth extractions, will be assessed and have teaching post procedure, on the following topics, as provided by the Dentist or Dental Assistant • Bleeding • Swelling • Pain • Muscle soreness • Mouth care • Diet • Signs/symptoms of infection 2. The client, post procedure tooth extraction, will verbalize understanding of the above by repeating instructions given by Dental Assistant/Hygienist. 3. Post dental extractions, the clients will receive a follow-up phone call from the clinic within 24hrs of procedure to assess for post procedure complications	**July** 100% 14/14 **August** 100% 4/4 **September** 100% 5/5 **Total** 100% 23/23	**October** 100% 5/5 **November** 100% 3/3 **December** 100% 4/4 **Total** 100% 12/12	**January** 100% 7/7 **February** 100% 3/3 **March** 100% 9/9 **Total** 100% 19/19	**April** **May** **June** **Total**

JOINT COMMISSION

Healthcare Acquired Infections Monitoring and Management

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

Indicators	Findings	Compliance	Threshold Percentile
Total number of infections for the third quarter of the fiscal year, per 1000 patient days	5.1	100 % within standard	1 SD within the mean
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	0.94	100% within standard	1 SD within the mean

Data:

Upper Respiratoy Infection (URI): 5
Lower Respiratory Infection (LRI): 1
Gastrointestinal (GI): 2
Reproductive: 4
Dental: 4
Skin: 18
Ear: 1
UTI: 2
Eye: 1
Wound: 0

Hospital Associated Infections (HAI): 7

*Sinusitis-2
*Viral Gastitis-1
*Cellulitis- 2
*Pneumonia-1
*Asymptomatic UTI - 1

Community Acquired Infections (CAI): 31
One client on LOK diagnosed with latent TB.
Infestation: Lice - 1

Lower Saco: 18 CAI and 2 HAI
Lower Saco Scu (LOSSCU): 1CAI
Upper Saco (UPS): 3 HAI and 4 CAI
Lower Kennebec (LOK): 2 HAI and 3 CAI
Lower Kennebec Scu (LOKSC): 1 CAI
Upper Kennebec (UPK): 4 CAI

Summary

Hospital associated infection rates remain low and within one standard deviation of the mean. The type and number of infections is scattered throughout the hospital. Upper and lower respiratory infections are typical for this time of year; as is gastrointestinal infections. One client infestation with lice was treated and quickly contained. One client was diagnosed with latent TB.

Action Plan

Continue total house surveillance (client and employee). Encourage hand hygiene and respiratory hygiene.

JOINT COMMISSION

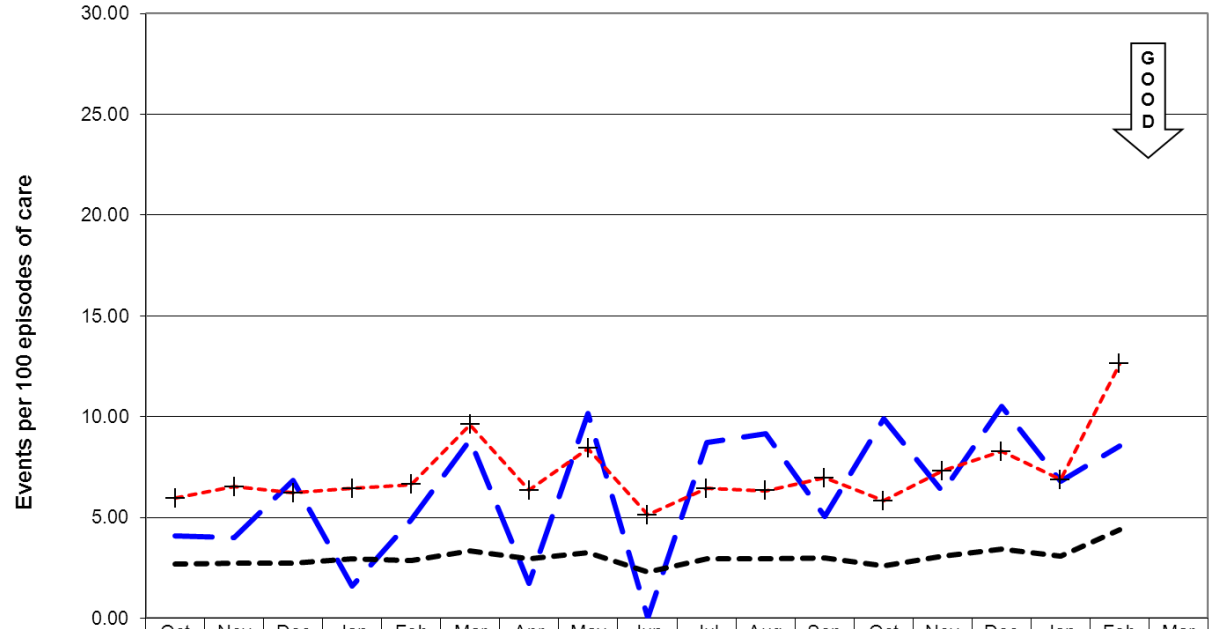
Medication Management

Medication Errors and Adverse Reactions

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

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

Medication Errors



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	4.10	4.00	6.84	1.60	4.88	8.87	1.71	10.17	0.00	8.70	9.17	5.04	9.91	6.25	10.53	6.78	8.55	
Ntl Mean	2.68	2.71	2.71	2.95	2.85	3.36	2.93	3.26	2.30	2.94	2.94	2.99	2.60	3.06	3.45	3.08	4.39	
+1 StDev	5.95	6.52	6.22	6.43	6.63	9.6	6.34	8.43	5.13	6.44	6.33	6.96	5.83	7.31	8.28	6.87	12.62	

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

JOINT COMMISSION

MEDICATION ERRORS RELATED TO STAFFING EFFECTIVENESS

Date	OMIT	Co-mission	Float	New	O/T	Unit Acuity	Staff Mix
1/1/13	N	Klonopin 1 mg given 0.5 mg ordered	Y	Y	N	LS	5 RN, 0 LPN, 8 MHW
1/3/13	Y	Seroquil 300 PRN extra dose	Y	N	N	LK	3 RN, 1 LPN, 7 MHW
1/5/13	N	Extra dose – Chloral Hydrate @ 0300	Y	N	Y	UK	1 RN, 0 LPN, 3 MHW
1/9/13	N	Minipress – extra dose	N	Y	N	LS	4 RN, 1 LPN, 7 MHW
1/9/13	N	Wrong time	N	N	N	UK	3 RN, 4 MHW
1/10/13	Y	Vistaril 50 mg missed x2; Vistaril 25 mg missed x1	N	N	N	LS	3 RN, 1 LPN, 8 MHW
1/11/13	N	Wrong time x1	Y	Y	N	LK	3 RN, 1 LPN, 8 MHW
1/14/13	Y	Debrox ear gtts 6 doses	N	N	N	LK	2 RN, 1 LPN, 7 MHW
2/4/13	N	Fazaclo – wrong dose	N	Y	N	LS	3 RN, 8 MHW
2/4/13	N	Biotin Alpha – wrong dose	N	N	N	UK	3-4 RN, 1 LPN, 4 MHW
2/5/13	Y	2 meds omitted x 1 Abilify / Vitamin D	N	Y	N	LS	4 RN, 1 LPN, 8 MHW
2/5/13	Y	Geodon omitted x1	N	Y	N	LS	4 RN, 1 LPN, 8 MHW
2/11/13	Y	Scheduled Doxepin 100 mg omitted, PRN Doxepin 25 mg given	N	Y	Y	UK	2 RN, 4 MHW
2/14/13	N	Zydis – wrong dose given	N	N	N	LS	3 RN, 8 MHW
2/16/13	N	Topamax wrong dose x 6	N	Y	N	LS	4 RN, 1 LPN, 8 MHW
2/18/13	N	Septra given without current order x2	N	Y	N	US	2 RN, 1 LPN, 4 MHW
2/19/13	N	Tramadol wrong dose given	N	N	N	US	2 RN, 1 LPN, 3 MHW
2/25/13	N	Keppra wrong dose given	N	N	N	LS	4 RN, 1 LPN, 7 MHW
Totals	6	12	4	50%	2	LS-9 US-2 LK-3 UK-4	
Percent	33%	67%	22%	70%	11%		

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

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

Prescribing

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

Dispensing

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

Administration

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

Complex

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

Review, Reporting and Follow-up Process

The Medication Variances Process Review Team (PRT) meets weekly to evaluate the causation factors related to the medication variances reported on the units and in the pharmacy and makes recommendations, through its multi-disciplinary membership, for changes to workflow, environmental factor, and client care practices. The team consists of the Medical Director (or designee), the Director of Nursing (or designee), the Director of Pharmacy (or designee), and the Clinical Risk Manager or the Performance Improvement Manager.

The activities and recommendations of the Medication Variances PRT are reported monthly to the Integrated Performance Excellence Committee.

JOINT COMMISSION

Joint Commission Measures of Success

Medication Management		Baseline (July-Sept)	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Controlled Substances Loss Data *Daily Pyxis-CII Safe Compare Report*	All	0%	0%	0%			0%	Goal of "0" discrepancies between Pyxis and CII Safe transactions
Quarterly Results								
Monthly CII Safe Vendor Receipt Report	Rx	0	0	0			0	*No discrepancies between CII Safe and vendor transactions for December.
Quarterly Results				0*				
Monthly Pyxis Controlled Drug discrepancies	All	9	0	0			0	Goal of "0" discrepancies involving controlled drugs dispensed from Pxyis
Quarterly Results			9	13				
Medication Management Monitoring								
Measures of drug reactions, adverse drug events and other management data	Rx	17/year	0	0				4 ADR's reported in Q1 and Q2
Quarterly Results			3	1				
Resource Documentation Reports of Clinical Interventions	Rx	134 reports in 2012						100% of all clinical interventions are documented
Quarterly Results			16	36				

JOINT COMMISSION

Inpatient Consumer Survey

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

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

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

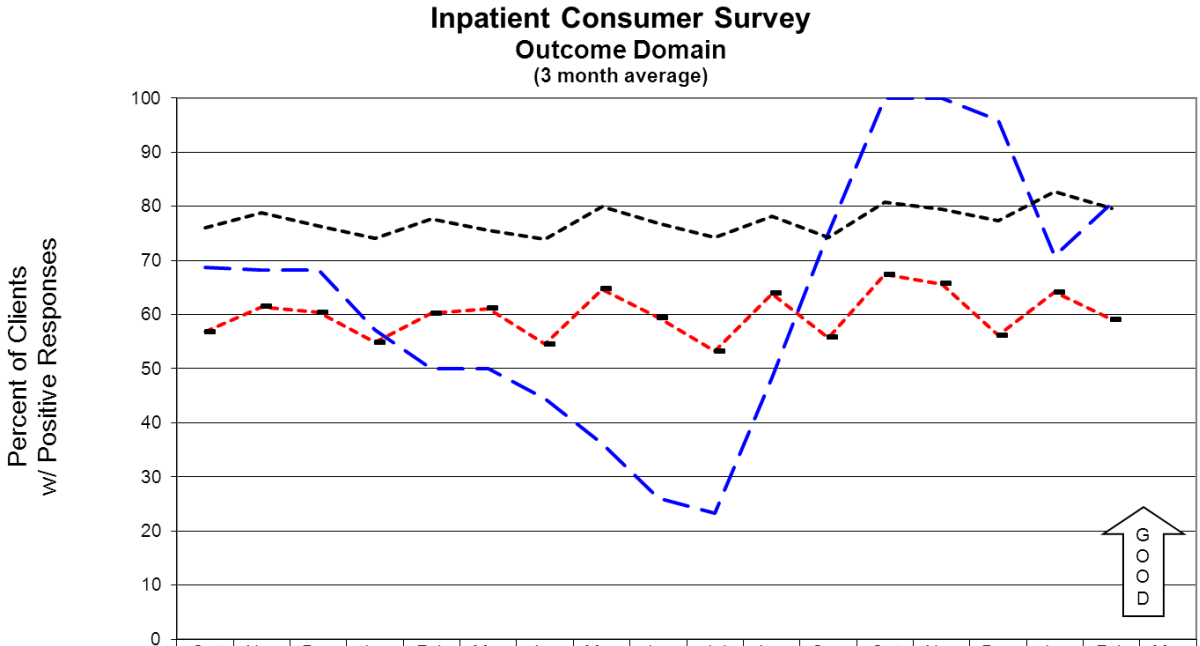
Rate of Response for the Inpatient Consumer Survey

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

The Peer Support group has identified a need to improve the overall response rate for the survey. This process improvement project is defined and described in the section on Client Satisfaction Survey Return Rate of this report.

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

JOINT COMMISSION

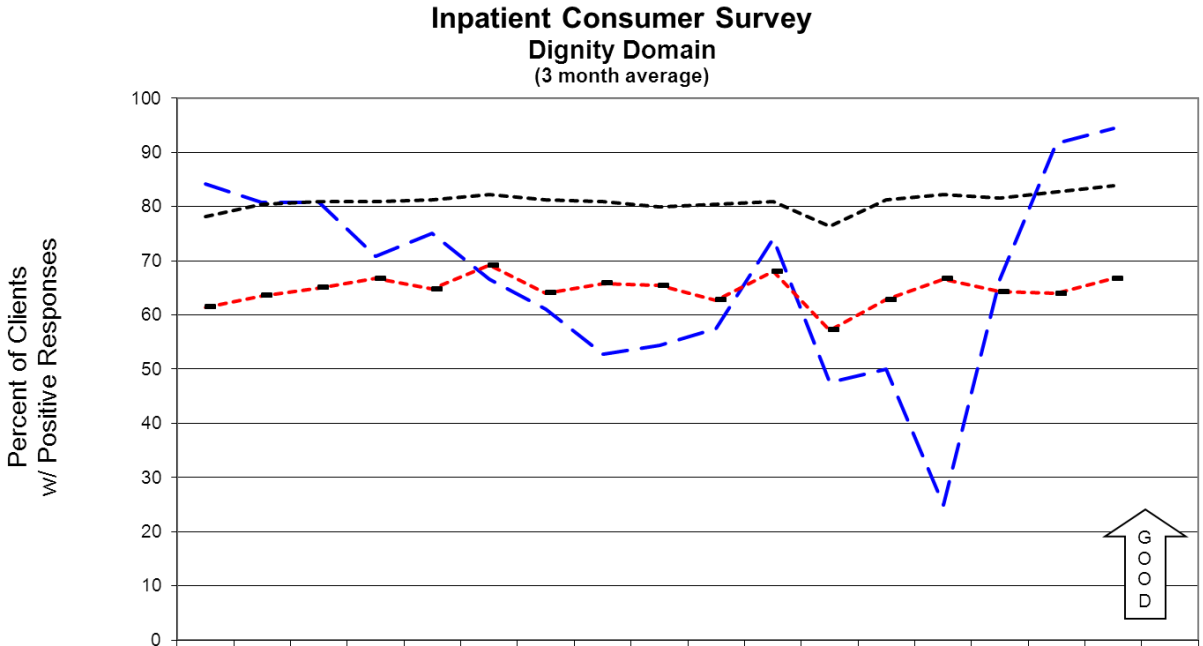


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	68.69	68.25	68.25	57.14	50.00	50.00	44.44	36.11	26.11	23.33	48.33	75.00	100.0	100.0	95.84	70.84	80.56	
Ntl Mean	76.06	78.76	76.42	74.02	77.68	75.51	73.94	80.01	76.92	74.26	78.08	74.22	80.77	79.52	77.33	82.67	79.69	
1 StDev	56.79	61.43	60.35	54.81	60.24	61.09	54.51	64.66	59.39	53.19	63.85	55.72	67.40	65.68	56.11	64.16	59.11	

Outcome Domain Questions

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

JOINT COMMISSION

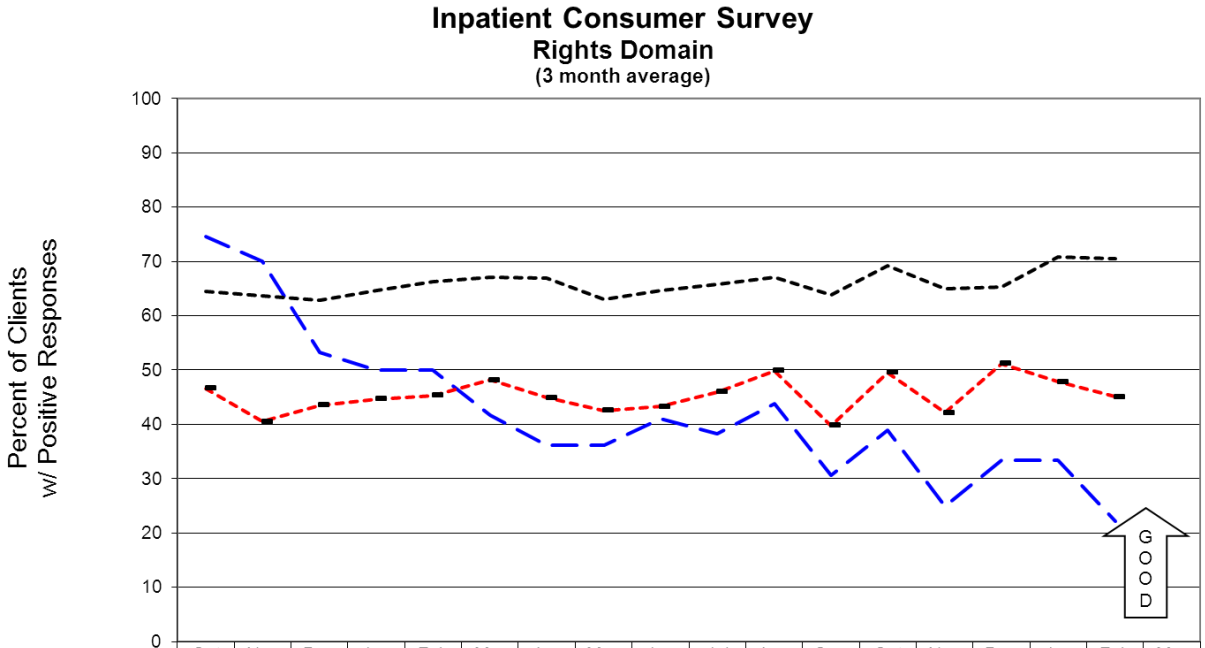


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	84.24	80.83	80.83	70.83	75.00	66.67	61.11	52.78	54.44	57.50	74.17	47.50	50.00	25.00	66.67	91.67	94.44	
Ntl Mean	78.16	80.42	80.87	80.98	81.24	82.20	81.29	80.96	79.96	80.49	80.99	76.45	81.22	82.16	81.61	82.70	83.84	
- 1 StDev	61.46	63.54	65.00	66.73	64.78	69.18	64.01	65.80	65.44	62.76	68.01	57.23	62.82	66.61	64.32	63.98	66.70	

Dignity Domain Questions

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

JOINT COMMISSION

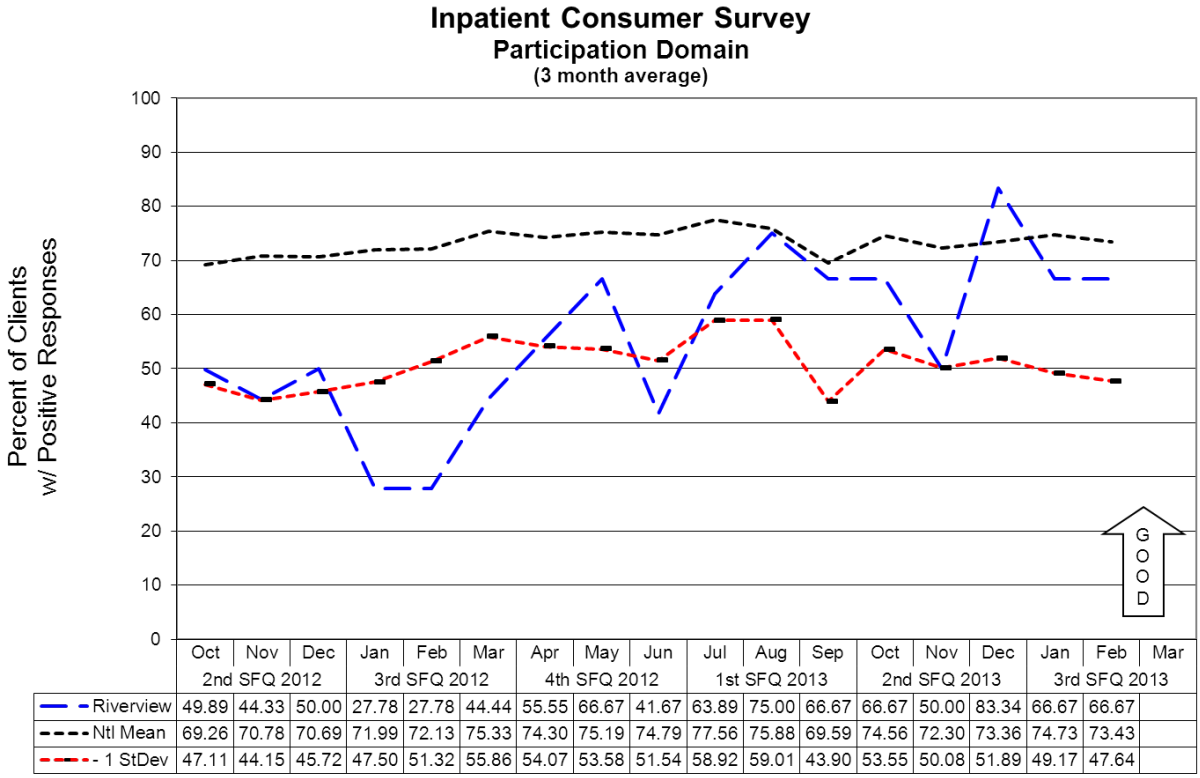


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	74.55	70.00	53.33	50.00	50.00	41.67	36.11	36.11	41.11	38.33	43.89	30.56	38.89	25.00	33.34	33.34	22.22	
Ntl Mean	64.42	63.65	62.80	64.70	66.20	67.12	66.94	63.08	64.62	65.81	67.05	63.77	69.19	64.95	65.36	70.76	70.45	
1 StDev	46.65	40.51	43.50	44.66	45.35	48.14	44.91	42.51	43.25	45.95	49.85	39.74	49.54	42.12	51.20	47.82	45.04	

Rights Domain Questions

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

JOINT COMMISSION

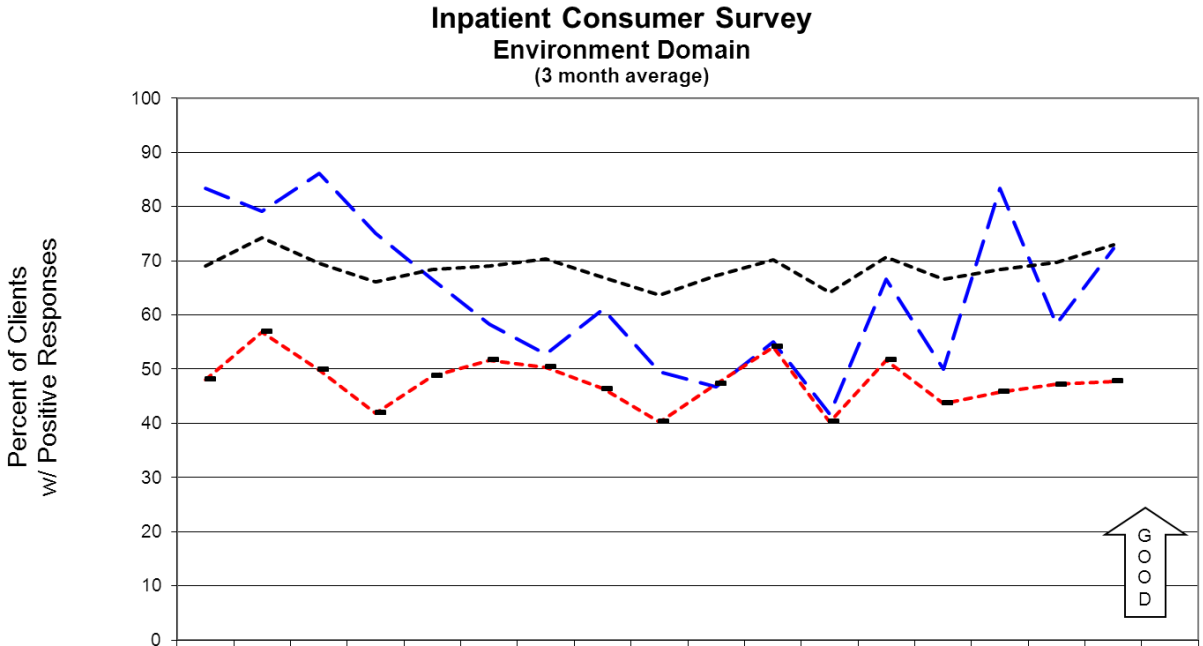


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	49.89	44.33	50.00	27.78	27.78	44.44	55.55	66.67	41.67	63.89	75.00	66.67	66.67	50.00	83.34	66.67	66.67	
Ntl Mean	69.26	70.78	70.69	71.99	72.13	75.33	74.30	75.19	74.79	77.56	75.88	69.59	74.56	72.30	73.36	74.73	73.43	
1 StDev	47.11	44.15	45.72	47.50	51.32	55.86	54.07	53.58	51.54	58.92	59.01	43.90	53.55	50.08	51.89	49.17	47.64	

Participation Domain Questions

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

JOINT COMMISSION



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	83.33	79.17	86.11	75.00	66.67	58.33	52.78	61.11	49.44	46.67	55.00	41.67	66.67	50.00	83.34	58.34	72.22	
Ntl Mean	68.99	74.31	69.59	66.19	68.46	69.02	70.34	66.92	63.60	67.32	70.11	64.13	70.65	66.54	68.42	69.74	72.98	
- 1 StDev	48.11	56.84	49.86	41.90	48.73	51.64	50.37	46.41	40.28	47.25	54.11	40.30	51.68	43.72	45.78	47.16	47.76	

Environment Domain

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

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

JOINT COMMISSION

Fall Reduction Strategies

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

TJC PC.01.02.08 The hospital assesses and manages the patient's risks for falls.
EP01: The hospital assesses the patient's risk for falls based on the patient population and setting.
EP02: The hospital implements interventions to reduce falls based on the patient's assessed risk.

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

Type of Fall by Client and Month

Fall Type	Client	JAN	FEB	MAR	3Q2013
Un-witnessed	MR00005121	1			1
	MR00006695		1		1
	MR00007157			1	1
Witnessed	MR00004212		1		1
	MR00006963	2		2	4
	MR00007015	1			1

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

Review, Reporting and Follow-up Process

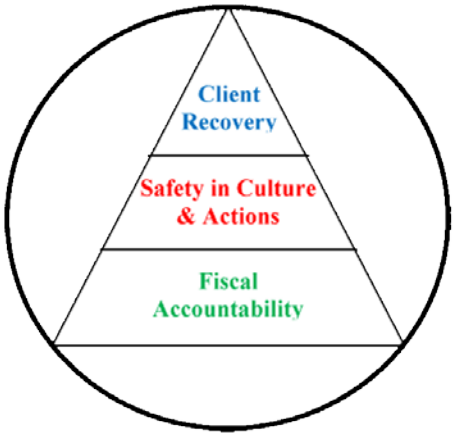
The Falls Assessment and Prevention Process Review Team (PRT) meets monthly to evaluate the causation factors related to the falls reported on the units and makes recommendations, through its multi-disciplinary membership, for changes to workflow, environmental factor, and client care practices.

The activities and recommendations of the Falls PRT are reported monthly to the Integrated Performance Excellence Committee.

STRATEGIC PERFORMANCE EXCELLENCE

Priority Focus Areas
for Strategic Performance Excellence

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



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

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

STRATEGIC PERFORMANCE EXCELLENCE

Strategic Performance Excellence Model Reporting Process

Department of Health and Human Services Goals

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

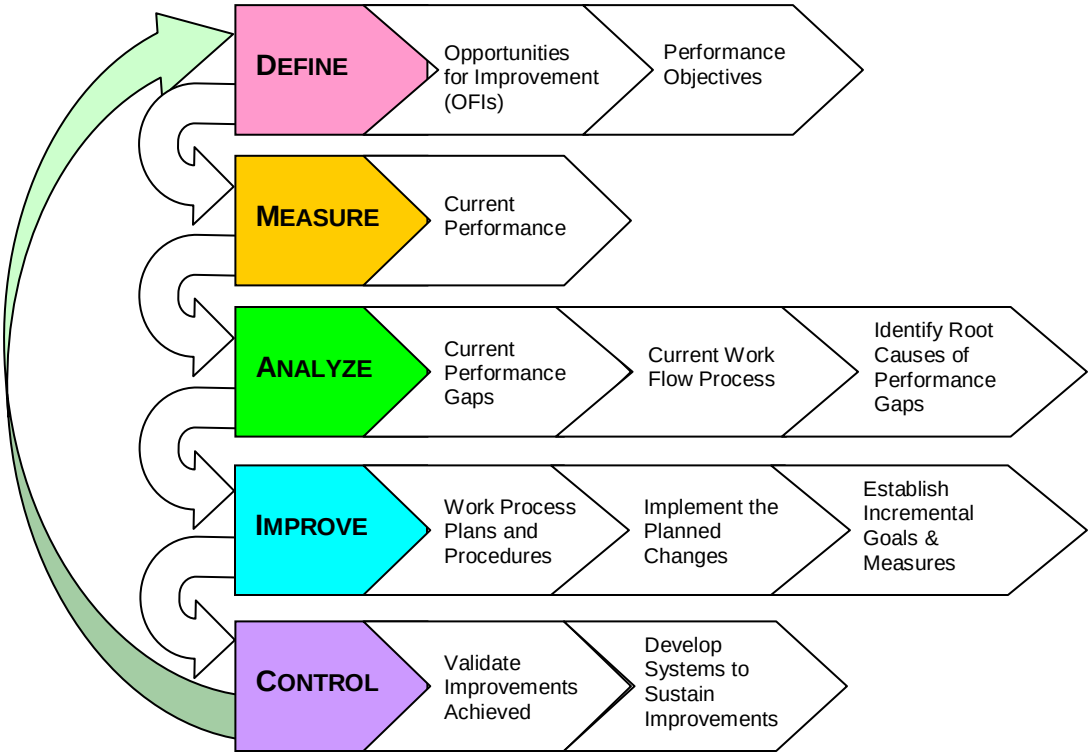
Dorothea Dix and Riverview Psychiatric Centers
Priority Focus Areas

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

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

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

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



STRATEGIC PERFORMANCE EXCELLENCE

Admissions

DEFINE

OPPORTUNITIES FOR IMPROVEMENT (OFI'S)

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

PERFORMANCE OBJECTIVES

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

MEASURE

Based on a survey:

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

ANALYZE

CURRENT PERFORMANCE GAPS:

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

CURRENT WORK FLOW PROCESS:

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

IDENTIFY ROOT CAUSES OF PERFORMANCE GAPS:

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

STRATEGIC PERFORMANCE EXCELLENCE

IMPROVE:

WORK PROCESS PLANS AND PROCEDURES:

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

IMPLEMENT THE PLANNED PROCEDURES:

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

CONTROL:

VALIDATE IMPROVEMENTS ACHIEVED

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

DEVELOP SYSTEMS TO SUSTAIN IMPROVEMENTS:

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

Admissions Pilot PSFA Form

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

STRATEGIC PERFORMANCE EXCELLENCE

Admissions Process Improvement Activities
3Q2013

- Over the past few months the admissions department has been working on making some changes to the PASF forms.
- A third information sheet was added based on an identified need for more specific information prior to admission of a new client. The form was created and adjustments were made to accommodate these needs.
- Staff were surveyed regarding the changes and feedback was taken. The form was once again revised based on staff input.
- The final draft of the new PASF form is now being piloted and staff will once again be surveyed on their satisfaction with the new forms.
- Admissions has also collaborated with medical records to streamline the admission process for the units.
- Old forms were archived and duplication was eliminated.
- Patient packets have been added to the admission process to ensure that the clients are receiving the information they need upon arrival.
- Feedback has been positive from the staff regarding these changes.
- We are once again open to accepting civil admissions and we have managed to keep our waiting lists down for both forensic and civil referrals.
- We are continuing to build relationships with the jails, keeping open communication so information is passed on in a timely manner.
- I have also created a step by step check sheet for our NOD's. They are now able to reference this document to help them navigate through meditech from an admissions standpoint. This has helped facilitate smoother transitioning of clients returning from CS to the hospital and ensured that data is being entered in correctly.

STRATEGIC PERFORMANCE EXCELLENCE

Dietary Services

Responsible Party: Kristen Piela DSM

Strategic Objective: Safety in Culture and Actions												
Hand Hygiene Compliance: In an effort to monitor, sustain and improve hand hygiene compliance, the Dietary department measures its results through observations of Dietary staff when returning from a scheduled break.												
1st Quarter			2nd Quarter			3rd Quarter			4th Quarter			Goal
Baseline Established	Findings	Compliance	Target – Q1 + 12%	Findings	Compliance	Target – Q2 + 10%	Findings	Compliance	Target – Q3 + 10%	Findings	Compliance	
58%	22/43	N/A	70%	18/34	53%	63%	41/49	84%				80-90%

Data

41 compliant observations / 49 hand hygiene observations = 84% hand hygiene compliance rate

Summary

- Review of the importance of data collection occurred with the Food Service Manager and Clinical Dietitian.
- A hand hygiene in-service was provided in January. All employees attended the training.
- Dietary employees completed ServSafe training (national food safety course)
- Hand hygiene compliance increased by 31%

Action Plan

- Continue discussion with Food Service Manager and Dietitian regarding the importance of consistency and quantities of data collection.
- Encourage employees to adhere hand hygiene via verbal interaction.
- Present quarterly report at departmental staff meeting.

STRATEGIC PERFORMANCE EXCELLENCE

Environment of Care

INDICATOR

GROUNDS SAFETY/SECURITY INCIDENTS

DEFINITION

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

OBJECTIVE

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

THOSE RESPONSIBLE FOR MONITORING

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

METHODS OF MONITORING

Monitoring would be performed by;

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

METHODS OF REPORTING

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

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

UNIT

Hospital grounds as defined above

BASELINE

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

Q2-Q4 TARGETS

Baseline – 5% each Q

STRATEGIC PERFORMANCE EXCELLENCE

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

Strategic Objectives								
Safety in Culture and Actions	Unit	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Grounds Safety & Security Incidents Safety/Security incidents occurring on the grounds at Riverview, which include "*Acts of thefts, vandalism, injuries, mischief, contraband found, and safety / security breaches*	# of Incidents	* Baseline of 10 was determined in the months of Aug. & Sept. of 2012	*	(10) -5% (13)	(13) -5% (6)			

SUMMARY OF EVENTS

The Q3 Target was (13)-5%. Our actual number was (6); a reduction of 55%. We feel that the reporting, which follows below, continues to provide a very clear picture of Safety and Security events, how they are handled, and that the use of surveillance equipment plays an integral part in combating safety and security threats to people and property. Our additional cameras and improved exterior lighting has positively impacted our surveillance capabilities.

EVENT	DATE	TIME	LOCATION	DISPOSTION	COMMENTS
1. Safety Threat (keys found in lot)	01/04/13	1536	Staff Lot	Turned into Operations	1. Set of Ford keys found in snow bank 2. Turned into Operations 3. Facility-wide email sent out
2. Safety Threat (items in back of truck)	02/23/13	0945	Staff Lot	Owner responded and moved vehicle to another lot off site	1. Security notified Operations 2. Operations notified staff/owner 3. Moved to another lot 4. IR completed 5. Supervisor called
3. Safety Threat (items in back of truck)	03/02/13	0913	Staff Lot	Owner responded and secured	1. System-wide email sent to claim. 2. Reminded owner of risks 3. Supervisor notified 4. Safety notified by IR
4. Safety Threat (Loose dog)	03/13/13	1025	Staff Lot	Taken to animal shelter	1. Staff took animal to shelter
5. Safety Threat (Loose dog)	03/21/13	0956	Staff Lot	Augusta PD responded and took to shelter	1. Augusta PD called, investigated, and took dog to shelter
6. Security Concern (discarded empty beer can on lawn by Kennebec Wing)	03/28/13	0650	Lawn off Kennebec Wing	Placed in redemption container	1. Security found during patrol 2. IR completed 3. Can properly disposed of 4. Communicated to Security team

STRATEGIC PERFORMANCE EXCELLENCE

Harbor Treatment Mall

Objectives	*2Q2013*	*3Q2013*	*4Q2013*	*1Q2014*
1. Hand-off communication sheet was received at the Harbor Mall within the designated time frame.	*45% 19 of 42*	*67% 28 of 42*		
2. SBAR information completed from the units to the Harbor Mall.	*67% 28 of 42*	*76% 32 of 42*		

DEFINE

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

MEASURE

Indicator number one has increased from 45% last quarter to 67% for this quarter. Indicator number two has increased from 67% last quarter to 76% this quarter.

ANALYZE

Overall compliance has increased. For indicator one the time frames for being late was between one and fifteen minutes. This is an overall improvement in the range of specific times the sheets were late. Continue to concentrate on both indicators to improve current performance gaps.

IMPROVE

On January 23rd I attended a meeting with the Kennebec PSD, all four Nurse IV's, three Treatment Team Coordinators, one floor nurse and one milieu manager. This meeting was scheduled to educate the Treatment Team Coordinators on the Hand-off Communication sheets since this is one of their responsibilities. We reviewed policy, protocol, forms, performance improvement data collected and current results and the reasons why we have this policy.

CONTROL

The plan is to continue to monitor the data and follow up with any unit(s) who may be having difficulties in developing a system that works for them to meet the objectives. I will meet with the Nurse IV from one unit that has shown improvement but continues to have difficulties meeting the objectives.

Department: Harbor Mall Responsible Party: Lisa Manwaring, PSD

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

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Documentation of Client Encounters in Support of Superbills Submitted

Define

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

Measure

26 providers submitted superbills to the Health Information department for quarter 3.

Analyze

One provider (NH) submitted superbills for the month of January with no documentation found. The provider had been providing hand written documentation instead of documenting in the EMR. There were 8 superbills with no documentation for one provider (RK). There were 18 superbills with an incorrect date of service. There were 2 duplicate superbills.

Improve

Spoke with the Medical Director regarding the written documentation issue. In regards to the incorrect dating issue, superbills are all being returned to the providers for correction. Continue to work with providers on appropriate/consistent documentation.

Control

Continue auditing 10 (at minimum) superbills & documentation per provider. For quarter 3, 100% of superbills were audited.

Process Deficiencies Identified	2Q2013	3Q2013	4Q2013	1Q2014
Superbill Submission without supporting documentation	18/25 72%	9/26 35%		
Superbills with incorrect information		18/26 69%		
Duplicate Superbills	19/25 76%	2/26 8%		

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Release of Information for Concealed Carry Permits

Define

The process of conducting background checks on applicants for concealed carry permits is the responsibility of the two State psychiatric hospitals. Clients admitted to private psychiatric hospitals, voluntarily or by court order, are not subject to this review. Delays in the processing of background checks has become problematic due to an increasing volume of applications and complaints received regarding delays in the processing of these requests

Measure

To evaluate the validity of the perceived delays a process was established to measure the date the application was signed by the application and the date the application was received for processing by the hospital. This measure produces data on the number of days the application is in the hands of the issuing agency before being referred to the hospitals for review. In addition, the date that application was returned to the issuing agency is also recorded to measure the delay in processing by the hospital.

Analyze

Baseline data on delays in receipt and processing was collected beginning March 13, 2013.

- Maine State Police forwarded a total of 526 applications for the month with an average processing delay prior to receipt by the hospital of 72 days. The maximum delay for any application was 124 days
- The greatest delay in receipt of an application was 381 days from the Bridgton PD.
- The average number of days for hospital processing of applications was 11 days. The maximum number of days was 13.

Improve

Several improvements have been implemented to facilitate the workflow within the department including the immediate sorting of the applications as they arrive so the alphabetic records can be reviewed more efficiently.

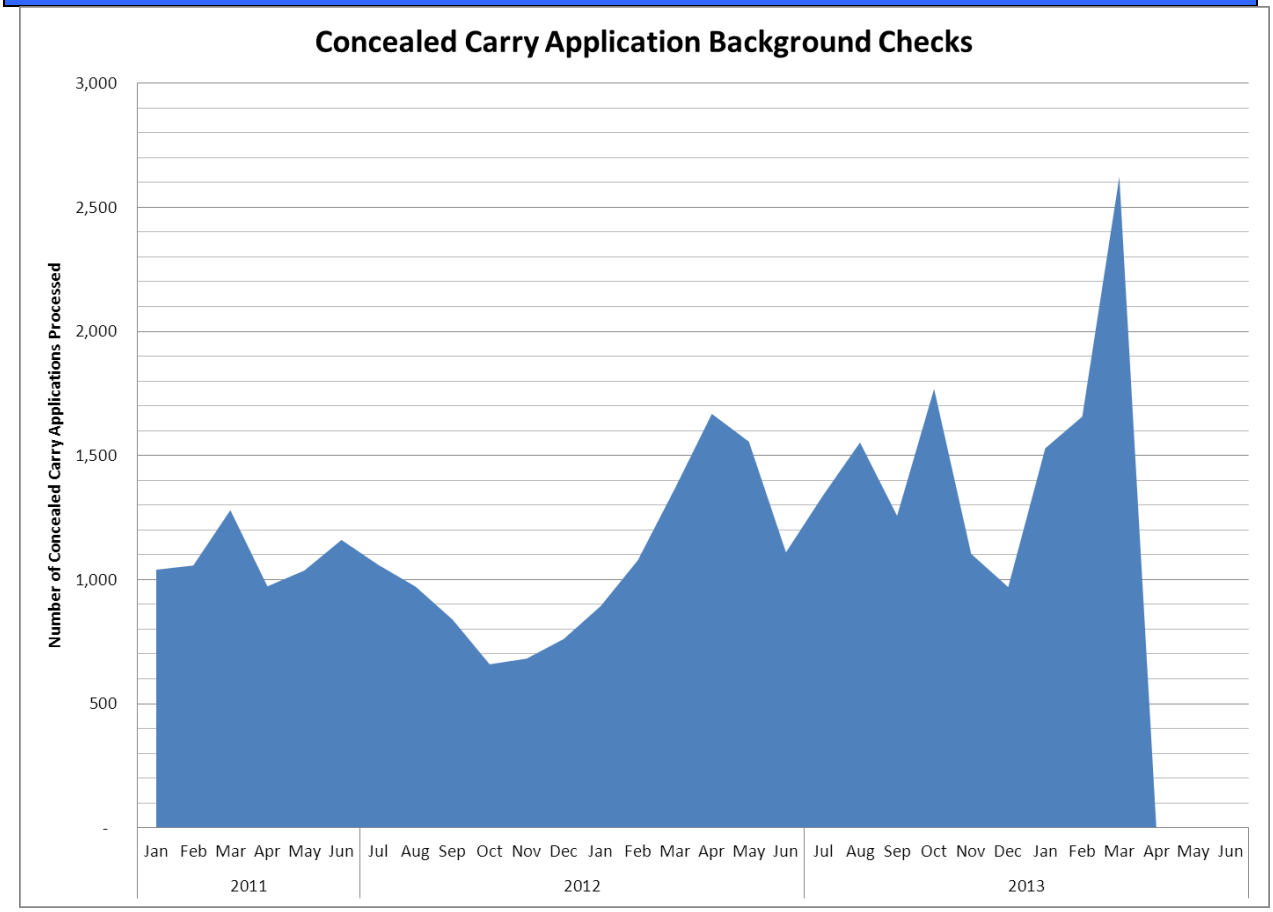
Other improvements being considered include transforming the existing archival records to a digital format. Barriers to be considered in this change include the significant time and fiscal impact required.

Control

While not always the case, many of the significant delays in processing the concealed carry applications originate with the workflow of the issuing agency. Ongoing monitoring of the process will be conducted and staff input on improvements will be solicited for the purpose of enhancing the timeliness of applications processes by hospital staff.

FY 2013	Jul	Aug	Sep	Oct	Nov	Dec	Jan`	Feb	Mar	Apr	May	Jun
# Applications Received	1339	1553	1257	1757	1104	970	1529	1657	2623			
Avg Receipt Delay	--	--	--	--	--	--	--	--	35			
Max Receipt Delay	--	--	--	--	--	--	--	--	381			
Avg Processing Time	--	--	--	--	--	--	--	--	11			
Max Processing Time	--	--	--	--	--	--	--	--	13			

STRATEGIC PERFORMANCE EXCELLENCE



Over the past two years the number of applications for concealed carry permits has increased significantly. While there is a seasonal drop in applications during the winter months the overall trend has been upward with March 2013 showing the highest volume of applications to date.

STRATEGIC PERFORMANCE EXCELLENCE

Human Resources

Define

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

Measure

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

Analyze

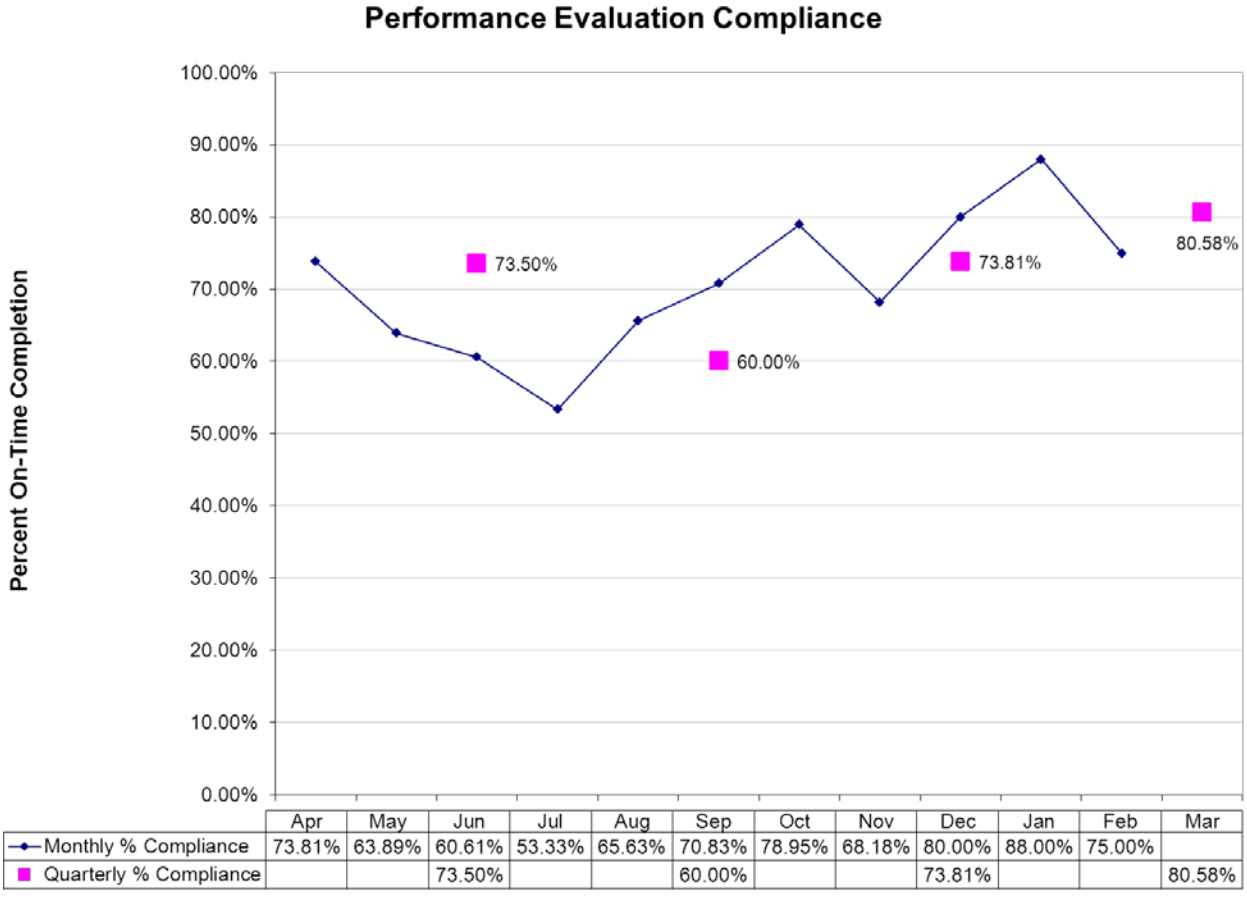
A thorough analysis of the root causes for lack of compliance with this performance standard is indicated. This analysis

Improve

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

Control

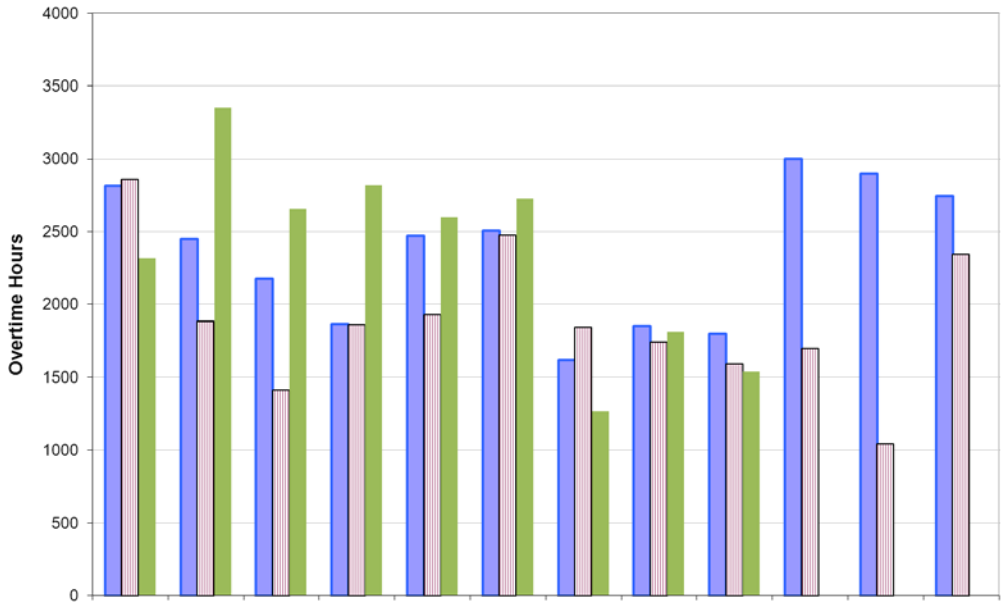
Plans to modify hospital performance evaluation goals for supervisory personnel will include the completion of subordinate performance evaluations in a timely manner as a critical supervisory function.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Monthly % Compliance	73.81%	63.89%	60.61%	53.33%	65.63%	70.83%	78.95%	68.18%	80.00%	88.00%	75.00%	
Quarterly % Compliance			73.50%			60.00%			73.81%			80.58%

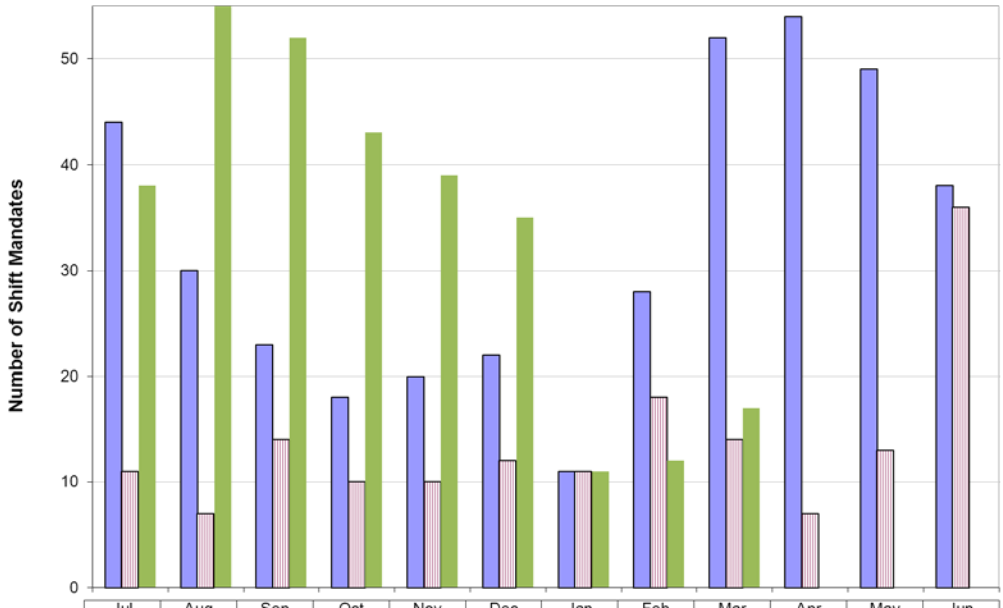
STRATEGIC PERFORMANCE EXCELLENCE

Monthly Overtime



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2012	2812	2451	2178	1868	2473	2507	1618	1853	1798	2999	2896	2743
FY 2011	2859	1885	1411	1860	1926	2474	1844	1740	1589	1697	1042	2342
FY 2013	2316	3350	2657	2817	2599	2726	1266	1812	1539			

Monthly Mandated Shifts

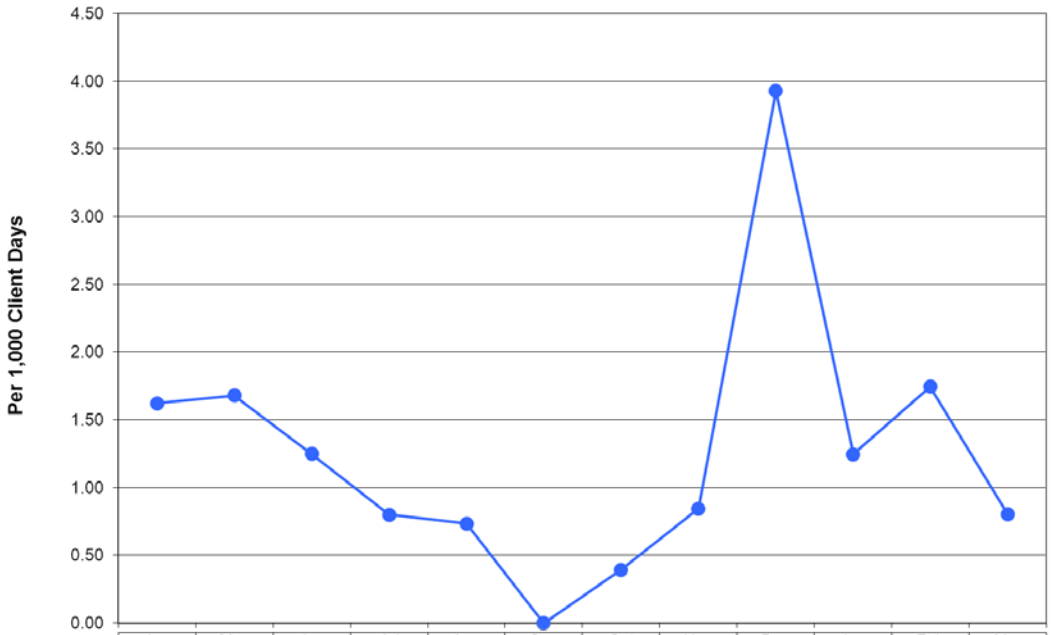


	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2012	44	30	23	18	20	22	11	28	52	54	49	38
FY2011	11	7	14	10	10	12	11	18	14	7	13	36
FY 2013	38	81	52	43	39	35	11	12	17			

The nursing department has implemented a staffing patterns study in an attempt to minimize the incidence of mandates. Further information on this study can be viewed on page 75 of this report.

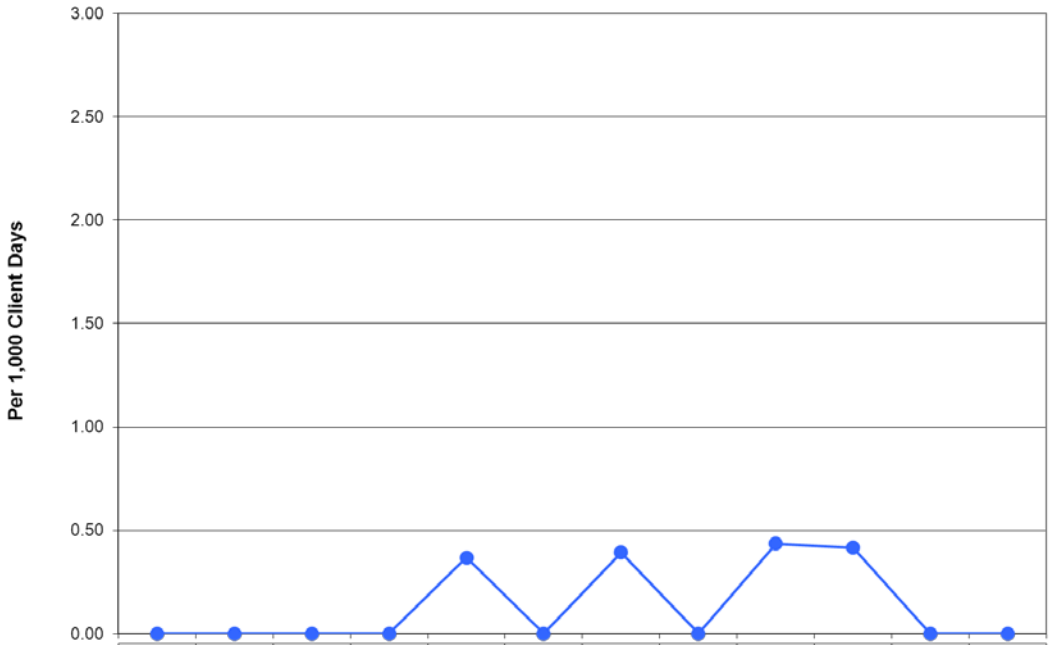
STRATEGIC PERFORMANCE EXCELLENCE

Reportable (Lost Time & Medical) Direct Care Staff Injuries



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Lost Time Ratio	1.62	1.68	1.25	0.80	0.74	0.00	0.39	0.85	3.93	1.25	1.75	0.81

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Lost Time Ratio	0.00	0.00	0.00	0.00	0.37	0.00	0.39	0.00	0.44	0.42	0.00	0.00

STRATEGIC PERFORMANCE EXCELLENCE

Infection Prevention and Control

Responsible Party: Kathleen Mitton RN

Strategic Objective: Safety in Culture and Actions		
Hand Hygiene Measurement: To gain an accurate and consistent perspective on employee hand hygiene practice, an effective measurement process needs to be in place. Current experience has demonstrated that the collection of observations of employee hand hygiene practice is inconsistent and incomplete. The measure will strive to improve the process of data collection and measurement.		
	Hand Hygiene Compliance	Date Collection Compliance
Indicator:	Each unit will do 80 hand hygiene observations per month	To improve the process of data collection
Goal:	Increase hand hygiene compliance rate to 80%	95% data collection
January 2013		
Number of Observations:	256	320 Observations per Month
Compliance	171	256 Observations done
% Compliance	68% hand hygiene compliance rate	80% Compliance with Data Collection
February 2013		
Number of Observations	486	320 Observations per Month
Compliance	262	486 Observations done
% Compliance	54% hand hygiene compliance rate	>100% Compliance with Data Collection
March 2013		
Number of Obvservations	242	320 observations per Month
Compliance	145	242
% Compliance	60% hand hygiene compliance rate	77% compliance with Data Collection
3rd Quarter Mean Compliance	61%	81%

Summary

The hospital mean hand hygiene rate is consistently 60 – 65%. This is based on an average of 86% data collection for the last three quarters. As previously expressed in quarterly reports, collecting data to measure hand hygiene practice is not as easy a task as one may think. Data collection is based on observations of hand hygiene before and after client care. Staff/client interactions are typically verbal with very little physical hands on care. The manager of Central Supply reports that hand sanitizer is "flying off the shelves". I frequently observe staff using hand sanitizer at the nursing station, in the chart room, and in the conference rooms. I question how valid this process is.

Plan of Action

Continue to collect and measure hand hygiene practice; and consider changing the focus of observation to medication passes at the beginning of the fiscal year.

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff

1. Identification of Opportunities for Improvement:

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

2. The Measurement Process:

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

3. Baseline Measures:

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

4. Goal of Improvement and Measures of Success:

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

Quarterly Update

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

STRATEGIC PERFORMANCE EXCELLENCE

Nursing

INDICATOR

Mandate Occurrences

DEFINITION

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

OBJECTIVE

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

THOSE RESPONSIBLE FOR MONITORING

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

METHODS OF MONITORING

Monitoring would be performed by;

- Staffing Office Database Tracking System

METHODS OF REPORTING

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

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

UNIT

Mandate shift occurrences

BASELINE

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

MONTHLY TARGETS

Baseline –10% each month

STRATEGIC PERFORMANCE EXCELLENCE

Department:	Nursing	**Responsible Party:**	Coleen Cutler, Acting DON; Staffing Improvement Task Force

Strategic Objectives

Safety in Culture and Actions	Unit	Baseline Aug 2012	Mth 1: Sep 2012	Mth 2: Oct 2012	Mth 3: Nov 2012	Mth 4: Dec 2012	Goal	Comments
Mandate Occurrences - Nurses When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy.	# of shifts	24	10	5	0	6	16 (10% reduction monthly x4 from baseline)	Goal exceeded.
Mandate Occurrences – Mental Health Workers When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy.	# of shifts	53	38	36	34	28	35 (10% reduction monthly x4 from baseline)	Goal exceeded
Safety in Culture and Actions	# of shifts	Mth 5 Jan 2013	Mth 6 Feb 2013	Mth 7 Mar 2013				
Mandate Occurrences - Nurses		1	2	1				Goal Exceeded
Mandate Occurrences – Mental Health Workers	# of shifts	8	8	15				Goal Exceeded

STRATEGIC PERFORMANCE EXCELLENCE

Peer Support

INDICATOR

Client Satisfaction Survey Return Rate

DEFINITION

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

OBJECTIVE

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

THOSE RESPONSIBLE FOR MONITORING

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

METHODS OF MONITORING

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

METHODS OF REPORTING

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

UNIT

All client care/residential units

BASELINE

Determined from previous year's data.

QUARTERLY TARGETS

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

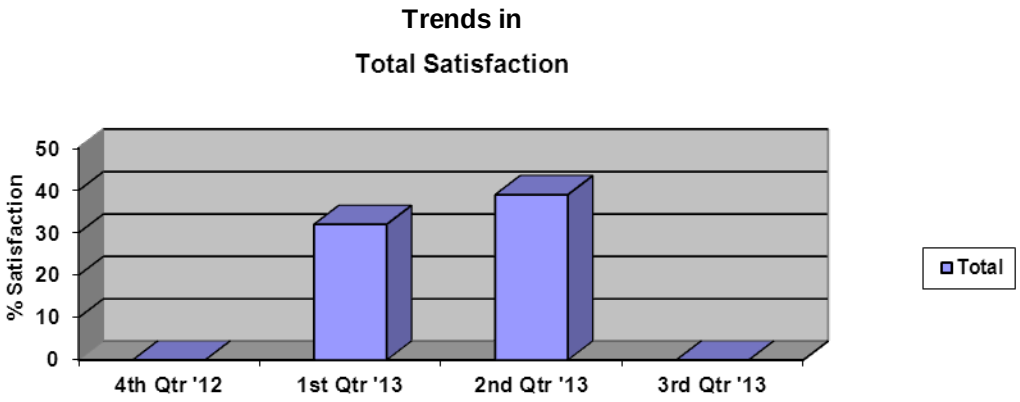
STRATEGIC PERFORMANCE EXCELLENCE

Department: Peer Support Responsible Party: Holly Dixon

Strategic Objectives								
Client Recovery	Unit	Baseline	Q1	Q2	Q3	Q4 Target	Goal	Comments
CSS Return Rate	LK	15%	ND	9%	8%	25%	50%	
The client satisfaction survey is the primary tool for collecting data on how clients feel about the services they are provided at the hospital. Data collection has been low on all units and the way in which the surveys are administered has challenges based on the unit operations and performance of the peer support worker.	LS	5%	ND	0%	0%	25%	50%	*Percentages are calculated based on number of people eligible to receive a survey vs. the number of people who completed the surveys.*
	UK	45%	ND	44%	27%	50%	50%	
	US	30%	ND	78%	60%	50%	50%	

Summary

Compliance on LK remained relatively the same this quarter. Although a number of surveys were offered to clients, the number of refusals brought the potential compliance from 17% to 8%, which would have been closer to the 3rd quarter target of 25%. LS continues to have a 0% return rate. This is primarily due to the nature of the unit population and the lack of staff administration of the surveys, despite reminders. Protocols are being put into place for 4th quarter to ensure that surveys are offered on a regular basis. The return rate on UK dropped significantly, as the number of refusals to complete surveys increased. There was also a drop in compliance on US as well due to the same reason.



STRATEGIC PERFORMANCE EXCELLENCE

Summary of Inpatient Client Survey Results

#	Indicators	Findings Total	
1	I am better able to deal with crisis.	29%	-31%
2	My symptoms are not bothering me as much.	57%	-6%
3	The medications I am taking help me control symptoms that used to bother me.	36%	-4%
4	I do better in social situations.	14%	-36%
5	I deal more effectively with daily problems.	36%	-14%
6	I was treated with dignity and respect.	79%	+26%
7	Staff here believed that I could grow, change and recover.	64%	-3%
8	I felt comfortable asking questions about my treatment and medications.	50%	+7%
9	I was encouraged to use self-help/support groups.	57%	+4%
10	I was given information about how to manage my medication side effects.	29%	-24%
11	My other medical conditions were treated.	50%	+10%
12	I felt this hospital stay was necessary.	7%	-50%
13	I felt free to complain without fear of retaliation.	7%	-6%
14	I felt safe to refuse medication or treatment during my hospital stay.	-7%	-7%
15	My complaints and grievances were addressed.	14%	-6%
16	I participated in planning my discharge.	29%	-8%
17	Both I and my doctor or therapist from the community were actively involved in my hospital treatment plan.	0%	-23%
18	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	-7%	-30%
19	The surroundings and atmosphere at the hospital helped me get better.	36%	-7%
20	I felt I had enough privacy in the hospital.	57%	+34%
21	I felt safe while I was in the hospital.	36%	-11%
22	The hospital environment was clean and comfortable.	50%	-3%
23	Staff were sensitive to my cultural background.	14%	-16%
24	My family and/or friends were able to visit me.	50%	+10%
25	I had a choice of treatment options.	21%	-6%
26	My contact with my doctor was helpful.	50%	+3%
27	My contact with nurses and therapists was helpful.	64%	+14%
28	If I had a choice of hospitals, I would still choose this one.	21%	-19%
29	Did anyone tell you about your rights?	25%	-8%
30	Are you told ahead of time of changes in your privileges, appointments, or daily routine?	19%	+9%
31	Do you know someone who can help you get what you want or stand up for your rights?	44%	+11%
32	My pain was managed.	25%	+5%

Summary

Overall satisfaction dropped by 45%. 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 7. The first column indicates the score for 3rd quarter and the second column shows increases/decreases from 2nd quarter. Of the 32 indicators, 21 went down this quarter. The most significant decreases in satisfaction were with indicators 1, 4, 12, and 18. The most significant increases were in indicators 6 and 20. Indicators 13 and 14 continue to have low satisfaction. Two indicators indicated dissatisfaction this quarter, indicators number 14 and 18.

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

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

Strategic Objectives

Safety in Culture and Actions		Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Pyxis CII Safe Comparison	Rx							
Daily and monthly comparison of Pyxis vs CII Safe transactions								
Quarterly Results								
Veriform Medication Room Audits	All	Apr-June 100%	100%	100%	100%		90%	
Monthly comprehensive audits of 14 criteria								
Quarterly Results			92%	99%				
Pyxis Discrepancies	All	Aug-Nov 107/mth	107	107	50	50	50/mo	
Monthly monitoring and trending of Pxyis discrepancies.								
Quarterly Results			128	96				
Pyxis Overrides – Controlled Drugs	All	Aug-Nov 25/mth	25	25	10	10	10	
Monthly monitoring and trending of Pyxis overrides for Controlled Drugs								
Quarterly Results			32	17				
Fiscal Accountability		Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Discharge Prescriptions	Rx	$12412 361drugs	$5809 345 drugs	$19015 377 drugs				Significant costs are incurred in providing discharge drugs.
Monitoring and Tracking of dispensed Discharge Prescriptions								

STRATEGIC PERFORMANCE EXCELLENCE

Program Services

Define

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

Measure

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

Analyze

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

Improve

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

Control

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

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

STRATEGIC PERFORMANCE EXCELLENCE

Lower Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	12/14	84%	**14 weekly**
2. **Number of clients attending day groups on unit or facilitated by day staff** (# of clients in all of day groups divided by # of day groups provided**)**	4	80%	5/group
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**	5	100%	5/group
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	7/10	70%	**100%**
5. **The client can identify distress tolerance tools on the unit**	5/10	50%	**100%**
7. **The client is able to state who his primary staff is**	8/10	80%	**100%**

EVALUATION OF EFFECTIVENESS

There are on unit groups seven days a week on Lower Kennebec. There is one on the day shift and one on the evening shift daily. These groups are open to all Clients on the unit. Clients who do not have a level to attend the Treatment Mall are strongly encouraged to attend the on unit groups. Participation in on unit groups is a consideration in advancing to a higher level. 8/10 Clients could identify their primary worker for the shift. One client was unable to process the question. The other knew where the assignment board was posted.

ISSUES

Daily on unit groups have been scheduled. Each group has an assigned group leader. When the primary group leader was absent or floated to another unit, the group was sometimes not conducted. The RV 4 on LK assigned an alternate leader to each group. In addition the PSD has promoted the importance of the groups and assisted in unit coverage to ensure that the groups are taking place. The on unit Focus group was being conducted by the Psychology Department. Due to a reduction in staff of that department, the group is now conducted by the unit staff and not the Psychology Department. 7/10 treatment plans listed on unit groups. A team effort has been established to capture on unit groups at the seven day treatment plan review. 50% of the Clients could not identify the distress tolerance tools on the unit. Awareness, visibility and availability are a factor, as well as promotion.

ACTIONS

Unit leadership will continue to promote the on unit groups. An up to date listing of each group schedule and focus will be posted for staff and clients. Documentation will be monitored for compliance. Attendance will continue to be encouraged On unit groups will be addressed at each treatment team meeting. Inventory of distress tolerance tools will be conducted and needed items will be obtained. Staff will be encouraged and expected to introduce themselves to their assigned clients at the beginning of each shift.

STRATEGIC PERFORMANCE EXCELLENCE

Upper Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	14/14	100%	14weekly
2. **Number of clients attending day groups on unit or facilitated by day staff** (# of clients in all of day groups divided by # of day groups provided**)**	4/5	80%	5/group
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**	5/5	100%	5/group
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	9/10	90%	100%
5. **The client can identify distress tolerance tools on the unit**	8/10	80%	100%
7. **The client is able to state who his primary staff is**	10/10	100%	100%

EVALUATION OF EFFECTIVENESS

Upper Kennebec has implemented much organization to the on unit groups. With the addition of an RN Treatment Team Coordinator, a formalized group listing and focus has been posted on the unit for reference. UK typically has more of a treatment mall attending milieu. Evenings groups remain more of leisure in nature. Most clients on UK have a level to leave the unit and attend the treatment mall during the day.

Many of the Clients on UK have a preference for the computer lab and the gym. Others have expressed a need to unwind in the evening due to a busy treatment mall schedule during the day. Evening participation in on unit groups averages 5/group which is the threshold.

ISSUES

Consistency in on unit groups has improved. Unexpected changes in unit acuity cause a challenge to conduct groups when the unit is staffed at core staffing levels.

ACTIONS

Continue to promote on unit groups. Continue to monitor documentation for compliance. Explore client interests in on unit groups. Request suggestions from the direct care staff.

STRATEGIC PERFORMANCE EXCELLENCE

Lower Saco

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	Main/SCU 5 / 5 5 / 5	 71% 71%	 **7 / 7 = 14** **7 / 7 = 14**
2. **Number of clients attending day groups on unit or facilitated by day staff** (# of clients in all of day groups divided by # of day groups provided**)**	3 / 1.5		N/A
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**	3.5/ 1		N/A
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	5	50%	**100%**
5. **The client can identify distress tolerance tools on the unit**	30/30	100%	**100%**
7. **The client is able to state who his primary staff is**	27/30	90%	**100%**

EVALUATION OF EFFECTIVENESS

ISSUES

The Lower Saco unit has made a start at offering on-unit groups by MHWS, although the documentation in the Electronic Medical Record is sporadic. There is evidence that this treatment effort is being reflected in the treatment plans but the RT staff is much more consistent in documenting participation than nursing staff.

ACTIONS

I will meet with the unit Nursing leadership and the Treatment Team Coordinator to make sure these groups get prescribed in the treatment plans (including on-unit groups by MHWs and nursing) and bring documentation shortfalls to the staff meeting agendas through the RN4.

STRATEGIC PERFORMANCE EXCELLENCE

Upper Saco

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	 5 8	 71% 100%	**Days/ Even.** **7 / 7 = 14**
2. **Number of clients attending day groups on unit or facilitated by day staff** (# of clients in all of day groups divided by # of day groups provided**)**	2 Avg.		N/A
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**	4 Avg.		N/A
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	2	20%	**100%**
5. **The client can identify distress tolerance tools on the unit**	30/30	100%	**100%**
7. **The client is able to state who his primary staff is**	30/30	100%	**100%**

EVALUATION OF EFFECTIVENESS

ISSUES

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

ACTIONS

I am meeting with the unit nursing leadership, MHWs and the Treatment Team Coordinator to make sure these groups get prescribed in the treatment plans and bring documentation shortfalls to the staff meeting agendas.

STRATEGIC PERFORMANCE EXCELLENCE

Rehabilitation Services

Department: Rehabilitation Services Responsible Party: Janet Barrett

Strategic Objectives							
Client Recovery	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Vocational Incentive Program Treatment Plans *The objective of this improvement project is to ensure vocational treatment plans are initiated on all clients within 5 days of beginning work and will be reviewed and updated if necessary every 30 days. Documentation on interventions in the treatment plans will reflect progress towards interventions and will be documented on weekly.*	55%	70%	85%	100%	100%	The treatment plans will be reviewed more regularly and updated at each client 30 day treatment team meeting.	Treatment plans were completed in a timely fashion but the review and updates were not consistent. Documentation is not always done on a weekly basis. Goal for next quarter is to increase by 19%.
Quarterly Results		77%	81%				

Safety in Culture and Actions	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Client/Staff Injuries in the Gym (to start in the second quarter) *The objective of this improvement project is to reduce/eliminate staff/client injury in the gym by increasing education on the proper techniques for equipment use as well as proper techniques for other activities in done in the gym. This will also include education on performing environmental checks of the area to ensure there are no safety issues.*							It was discovered that the reporting of incidents in the gym are not identified as happening in that area on the incident report sheets. This has been remedied and more accurate data will be available next quarter.
Quarterly Results		No injuries during the quarter	No injuries during the quarter				