Riverview
PSYCHIATRIC CENTER

QUARTERLY REPORT ON
ORGANIZATIONAL PERFORMANCE EXCELLENCE

FIRST STATE FISCAL QUARTER 2014
July, August, September 2013

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Superintendent

October 21, 2013

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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.

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CONSENT DECREE

Consent Decree Plan

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

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

Client Rights

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

Indicators	2Q2013	3Q2013	4Q2013	1Q2014
1. Clients are routinely informed of their rights upon admission	91% 42/46	91% 42/46	100% 19/20 1 refusal	98% 52/55 2 refused

This measure has shown improvement in the past two quarters. 98% this quarter and 100% last quarter. Clients are informed of their rights and asked to sign that information has been provided to them. If they refuse, the staff documents the refusal and sign, date & time the refusal.

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	2Q2013	3Q2013	4Q2013	1Q2014
1. Level II grievances responded to by RPC on time.	100% 5/5	100% 1/1	0/0	50% 3/6
2. Level I grievances responded to by RPC on time.	60% 64/106	95% 96/101	98% 58/59	98% 59/60

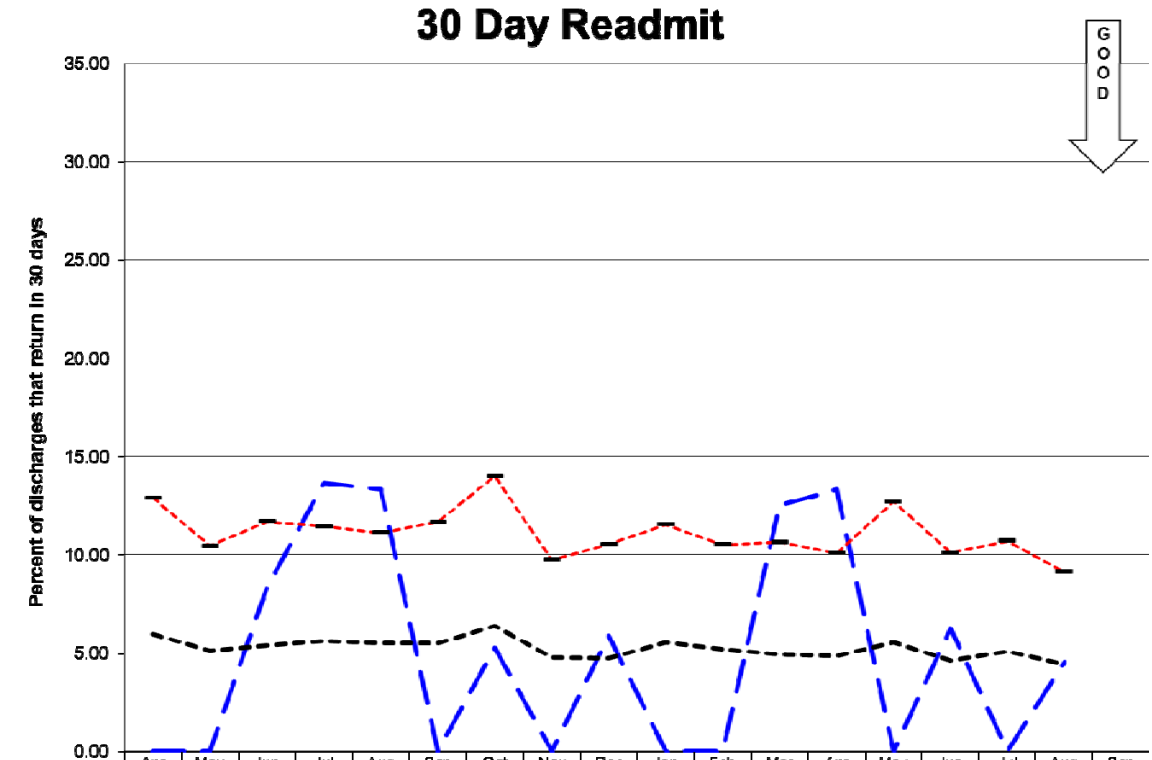
Admissions

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

Legal Status on Admission	2Q2013	3Q2013	4Q2013	1Q2014
ICDCC	9	20	17	30
ICRDCC				
INVOL CRIM	34	21		
INVOL CRIM – Forensic Evaluation			16	24
INVOL CRIM – IST			3	5
INVOL CRIM – NCR				3
INVOL CRIM – Jail Transfer				
INVOL-CIV		1		1
PCHDCC			3	
PCHDCC+M	1	1		
PCHDSS-PTP-R			1	
VOL		7	3	

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	0.00	0.00	8.33	13.64	13.33	0.00	5.26	0.00	5.88	0.00	0.00	12.50	13.33	0.00	6.25	0.00	4.55	
N:I Mean	5.97	5.11	5.39	5.62	5.51	5.50	6.37	4.78	4.75	5.53	5.21	4.94	4.84	5.54	4.62	5.08	4.44	
+1 StDev	12.89	10.45	11.69	11.43	11.11	11.66	14	9.75	10.53	11.54	10.51	10.84	10.08	12.69	10.1	10.69	9.13	

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.

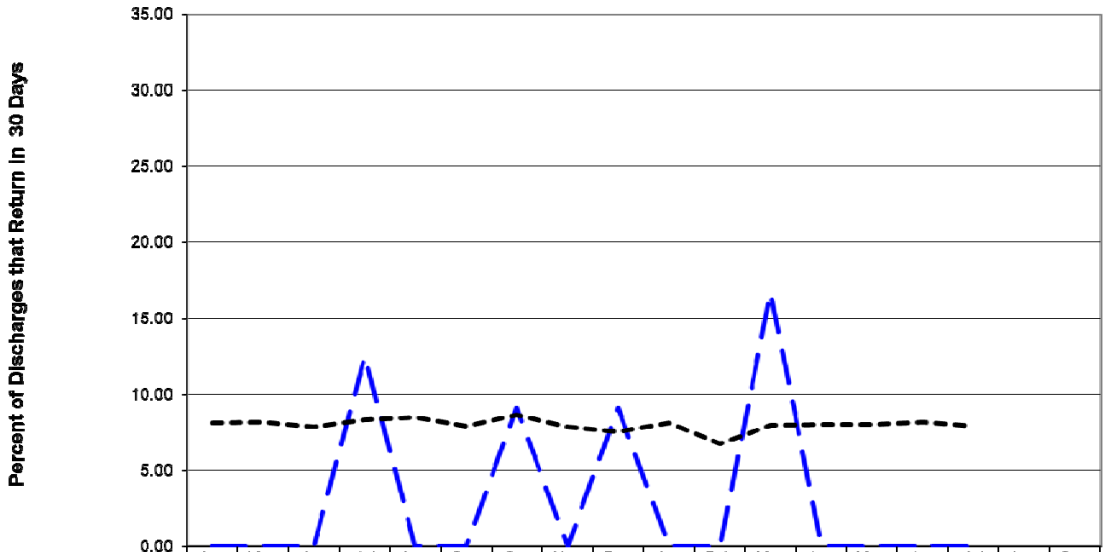
The graphs shown on the next page depict the percent of discharges from the facility that returned within 30 days of a discharge of the same client from the same facility stratified by forensic or civil classifications. For example, a rate of 10.0 means that 10% of all discharges were readmitted within 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

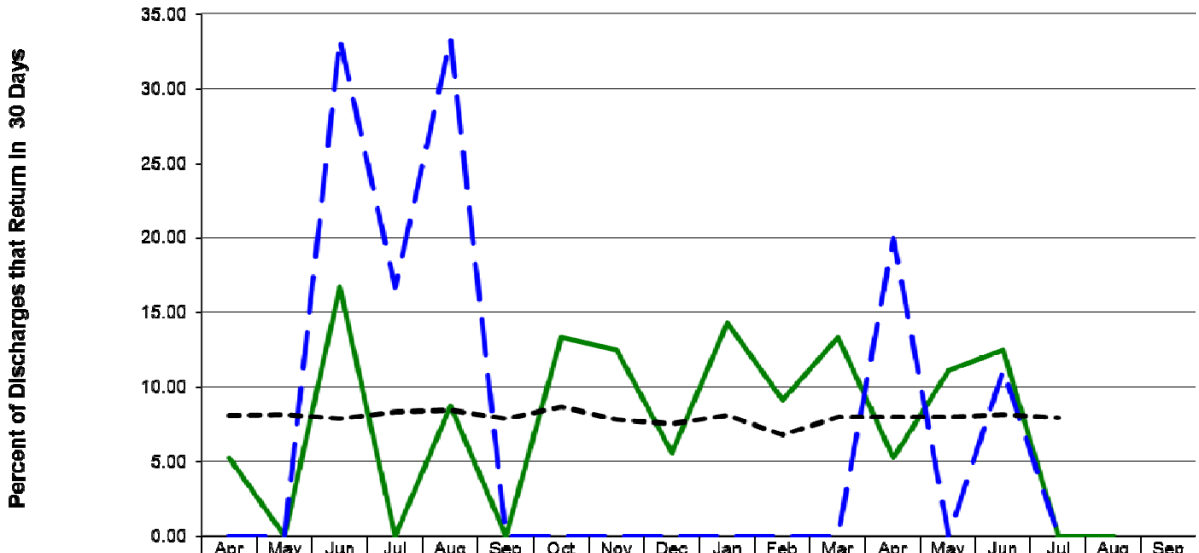
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	0.00	0.00	0.00	12.50	0.00	0.00	9.09	0.00	9.09	0.00	0.00	16.67	0.00	0.00	0.00	0.00		
National Mean	8.11	8.15	7.84	8.34	8.45	7.88	8.65	7.83	7.54	8.11	6.79	7.98	7.99	7.99	8.14	7.9		

30 Day Readmit

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Dorothea Dix	5.26	0.00	16.67	0.00	8.70	0.00	13.33	12.50	5.56	14.29	9.09	13.33	5.26	11.11	12.50	0.00	0.00	
Riverview	0.00	0.00	33.33	16.67	33.33	0.00	0.00	0.00	0.00	0.00	0.00	0.00	20.00	0.00	11.11	0.00		
National Mean	8.11	8.15	7.84	8.34	8.45	7.88	8.65	7.83	7.54	8.11	6.79	7.98	7.99	7.99	8.14	7.9		

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	2Q2013	3Q2013	4Q2013	1Q2014
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.	n/a 0/0	100% 2/2	100% 3/3	100% 2/2

In this aspect area one of the clients that returned is on the Progressive Treatment program with the Riverview ACT team and as part of his court ordered treatment plan was returned to the hospital after displaying increased symptoms in his current group home. Client will remain on PTP and return to placement once stable. The second client is under Progressive Treatment with a provider in Portland he eloped from his group home placement and was re-admitted to Riverview as part of his court ordered treatment plan for increased symptomology. Client will also return to his placement under the PTP. The third client was discharged at his request to the Oxford St Shelter after refusing all placement offerings from his team. Client was assigned to a case manager and psychiatric providers. Client left the shelter and was re-admitted to Riverview after he was found wandering in the community exhibiting aggressive behaviors and psychotic symptoms. Team will work with client to identify needs and wants and set up a discharge plan if client will accept that provides him with a more stable living environment that can provide a compliment of mental health services.

CONSENT DECREE

REDUCTION OF RE-HOSPITALIZATION FOR ACT TEAM CLIENTS

Indicators	2Q2013	3Q2013	4Q2013	1Q2014
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% 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.	100% 5 clients were returned to RPC; 4 for psychiatric symptoms, one for relapse while in supervised apartment.	100% 2 clients were returned to RPC for psychiatric instability,
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. Both readmissions were male, between the ages of 40 and 50, median age being 45; one PTP admitted in Q41013 remains in the hospital, as do two NCR patients. One client readmitted is socioeconomically disadvantaged, one is not. All clients re-admitted appeared to be medication adherent and had been attending appointments as scheduled with the ACT Team.
2. The ACT Team and the inpatient unit of RPC (Lower Saco, Upper Saco, Lower Kennebec and Upper Kennebec) worked collaboratively to minimize the time spent in Riverview while maximizing the opportunity for success upon their return to their community placements.

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	1Q13	2Q13	3Q13	1Q14	TOT
ADJUSTMENT DIS W MIXED DISTURBANCE OF EMOTIONS & CONDUCT	1				0
ADJUSTMENT DISORDER WITH DEPRESSED MOOD	1	1			1
ADJUSTMENT DISORDER WITH ANXIETY			1		1
ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED MOOD		3	1	2	6
ADJUSTMENT REACTION NOS	2	1	1	1	4
ALCOHOL ABUSE-IN REMISS		1			1
ANXIETY STATE NOS			1		1
ATTN DEFICIT W HYPERACT			1	1	2
BIPOL I DIS, MOST RECENT EPIS (OR CURRENT) MANIC, UNSPEC	1				0
BIPOL I, REC EPIS OR CURRENT MANIC, SEVERE, SPEC W PSYCH BEH					1
BIPOLAR DISORDER, UNSPECIFIED	6	5	5	9	23
DELUSIONAL DISORDER		1	2		3
DEPRESS DISORDER-UNSPEC					1
DEPRESSIVE DISORDER NEC		2	2	6	11
DRUG ABUSE NEC-IN REMISS		1			1
IMPULSE CONTROL DIS NOS	1	1	2		4
INTERMITT EXPLOSIVE DIS		1	1	2	4
MOOD DISORDER IN CONDITIONS CLASSIFIED ELSEWHERE	1	1			1
OTHER AND UNSPECIFIED BIPOLAR DISORDERS, OTHER	1				0
OTH PERSISTENT MENTAL DIS DUE TO COND CLASSIFIED ELSEWHERE		1			1
PARANOID SCHIZO-CHRONIC	7	5	8	10	28
PARANOID SCHIZO-UNSPEC			1	2	3
PERSON FEIGNING ILLNESS		1		1	2
POSTTRAUMATIC STRESS DISORDER	2	3	3	4	12
PSYCHOSIS NOS	6	4	4	5	20
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED	9	6	9	12	39
SCHIZOPHRENIA NOS-CHR	1		1		1
SCHIZOPHRENIA NOS-UNSPEC			2		4
SCHIZOPHRENIFORM DISORDER, UNSPECIFIED			1		1
UNSPECIFIED EPISODIC MOOD DISORDER	7	6	4	8	23
Total Admissions	46	44	50	63	199
Admitted with primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	0.0%	4.5%	0%	0%	1%

Peer Supports

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

V8) 100% of all clients have documented contact with a peer specialist during hospitalization;

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

Indicators	2Q2013	3Q2013	4Q2013	1Q2014
1. Attendance at Comprehensive Treatment Team meetings. (v9)	87% 342/395	87% 354/406	87% 362/418	84% 408/488
2. Attendance at Service Integration meetings. (v8)	100% 31/31	98% 48/49	79% 26/33	95% 53/56
3. Contact during admission. (v8)	100% 44/44	100% 50/50	100% 46/46	100% 56/56

Treatment Planning

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

Indicators	2Q2013	3Q2013	4Q2013	1Q2014
1. Preliminary Continuity of Care meeting completed by end of 3rd day	100% 30/30	100% 30/30	100% 30/30	100% 30/30
2. Service Integration form completed by the end of the 3rd day	100% 30/30	100% 30/30	100% 30/30	100% 30/30
3a. Client Participation in Preliminary Continuity of Care meeting.	96% 29/30	96% 29/30	100% 30/30	100% 30/30
3b. CCM Participation in Preliminary Continuity of Care meeting.	100% 30/30	100% 30/30	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.	100% 30/30	100% 30/30	100% 30/30	93% 28/30
4a.Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	93% 28/30	93% 28/30	90% 27/30	96% 29/30
4b. Initial Comprehensive Assessment contains summary narrative with conclusion and recommendations for discharge and social worker role	100% 30/30	100% 30/30	100% 30/30	96% 29/30
4c. Annual Psychosocial Assessment completed and current in chart	N/A	N/A	N/A	100% 15/15

Individual social worker was addressed regarding timeliness of documentation for areas 4a and 4b.

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

Indicators	2Q2013	3Q2013	4Q2013	1Q2014
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all clients on assigned **CCM** caseload.	97% 44/45	93% 43/45	96% 44/45	96% 29/30
2. On Upper Saco progress notes in GAP/Incidental format will indicate at minimum weekly 1:1 meeting with all clients on assigned **CCM** caseload	93% 14/15	95% 14/15	100% 15/15	N/A
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	96% 58/60	91% 55/60	100% 30/30

No issues in this area.

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

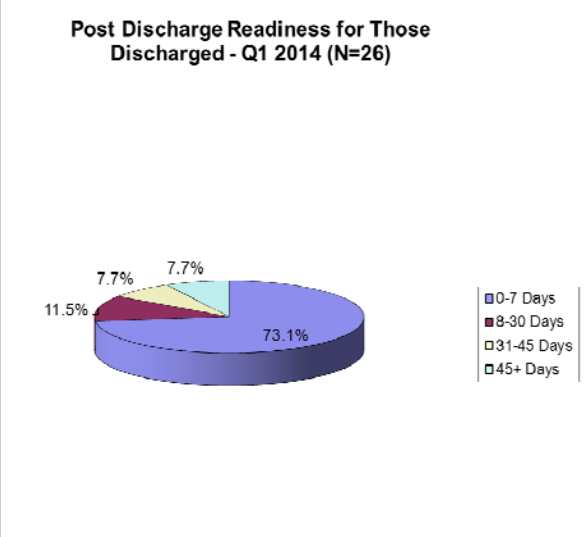
Discharges

Quarterly performance data shows that in 3 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 = (19) 73.1% (target 70%)
Within 30 days = (22) 84.6% (target 80%)
Within 45 days = (24) 92.3% (target 90%)
Post 45 days = (2) 7.7% (target 0%)

Barriers to Discharge Following Clinical Readiness

Residential Supports (1%)

1 client discharged 41 days post clinical readiness

Housing (10%)

1 client discharged 34 days post clinical readiness
1 client discharged 111 days post clinical readiness

Treatment Services (0)

No barriers in this area

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%
4Q2013	N=30	70%	86.7%	93.3%	6.7%
3Q2013	N=22	77.3%	86.4%	90.0%	9.1%
2Q2013	N-24	54.2%	70.9%	87.6%	12.5%
1Q2013	N=27	66.7%	85.2%	96.3%	3.7%

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	2Q2013	3Q2013	4Q2013	1Q2014
1. The Client Discharge Plan Report will be updated/reviewed by each **Social Worker minimally one time per week.**	100% 12/12	100% 12/12	100% 13/13	100% 12/12
2. The Client Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	100% 12/12	100% 12/12	100% 13/13	100% 12/12
2a. The Client Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	100% 12/12	100% 12/12	100% 13/13	91% 11/12
3. Each week the Social Work team and Director will meet and discuss current housing options provided by the respective regions and prioritize referrals.	100% 12/12	100% 12/12	100% 13/13	91% 11/12

The meeting was cancelled one week in the quarter due to a CMS visit. A two week report was sent out the following week.

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	2Q2013	3Q2013	4Q2013	1Q2014
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	100% 3/3	87% 7/8	80% 8/10	12% 1/8
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% 4/4	100% 2/2
3. Annual Reports (due Dec) to the commissioner for all inpatient NCR clients are submitted annually				

Area 1. The unit PSD and the Social Work Director have meet with the Superintendent to address this issue in the next quarter.

Staffing and Staff Training

V23) Riverview performance data shows that 95% of direct care staff have received 90% of their annual training.

Indicators	1Q2014	2Q2014	3Q2014	4Q2014	2014 Total
1. Riverview and Contract staff will attend CPR training bi-annually.	*40/46				87%
2. Riverview and Contract staff will attend NAPPI training annually.	*101/120				84%
3. Riverview and Contract staff will attend Annual training.	*11/25				73%

1Q 2014

1. *Of the six employees who are not in compliance, two staff are on Workers Compensation status, two staff are on Family Medical Leave, one transferred and missed training due to family emergency. All are scheduled for next available training. One staff is out of the country,

2. *Of the nineteen employees who are not in compliance two are on Workers Compensation leave, one is on LOA. Those remaining are scheduled for the next available training.

3. *Of the eleven staff who are not in compliance; two staff are on Workers Compensation, one is out of the country, one has transferred to another department. Supervisors of remaining staff have been informed they are in non-compliance and corrective actions have been taken.

Goal: SD will provide opportunities for employees to gain, develop, and renew skills knowledge and aptitudes.
Objective: 100% of employees will be provided with an opportunity both formal and informal training and/or learning experiences that contribute to individual growth and improved performance in current position.
SD will survey staff annually and develop trainings to address training needs as identified by staff.
Current Status: 1Q 2014
Employee Education needs survey distributed to employees in March of 2013.
As a result of identified needs, the training entitled ***Personality Disorder Characteristics and Effective* Interventions** was developed and presented in August 2013.
August 19 & 26, 2013:Susan C. Righthand, Ph.D, a nationally recognized speaker and consultant in the field of psychological assessment and treatment of sex offenders, conducted a *two part* training entitled: ***Working Effectively with Adult Sexual Offenders:*** *Characteristics, Assessment, and Interventions* available to all Riverview Psychiatric Center Employees.
August 20, 2013: Dr. Kenneth Beattie provided an in-service entitled: ***The Psychology of Working with Emotionally Challenging and Emotionally Challenged Clients.*** This training was developed in response to the Employee Education needs survey distributed to employees in March of 2013 and made available to all Riverview Psychiatric Center employees.
August 5, 2013, ***Single Wrist Restraint Application*** training was held to provide an opportunity to practice skills taught in the Initial NAPPI course provided to New Employees and NAPPI Recertification Class provided on a monthly basis through-out the year to Riverview Psychiatric Center employees. Over sixty unit staff attended.

Goal: SD will develop and implement a comprehensive mentoring program to assist new employees in gaining the skills necessary to do their job.
Objective: 100% of new Mental Health Workers will be paired with a mentor and will satisfactorily complete 12 competency areas on the unit orientation prior to being assigned regular duties requiring direct care of patients.
Current Status: 1Q 2014
100% of new Mental Health Workers were paired with a mentor and satisfactorily completed competency areas in the Unit Orientation.

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	Fall Semester (see2Q13 Quarterly Report)
3Q2013	11	Jan – Mar 2013	Winter Semester (see 3Q13 Quarterly Report)
4Q2013	12	Apr – June 2013	Spring Semester (see 4Q13 Quarterly Report)
8/19/13 or 8/26/13	3.5	Working Effectively with Adult Sexual Offenders: Characteristics, Assessment and Interventions	Susan Righthand, PhD
8/20/13	1	The Psychology of Working with Emotionally-Challenging & Emotionally-Challenged Clients	Ken Beattie, PhD
9/26/13	1	If alcohol kills millions of brain cells, how come it never kills the ones that make people want to drink?	Jennifer Brotsky, PsyD Paula Jursa, LCPC, LADC, CCS

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 unit acuity, individual monitoring needs of the clients who residing on specific units, and unit census.

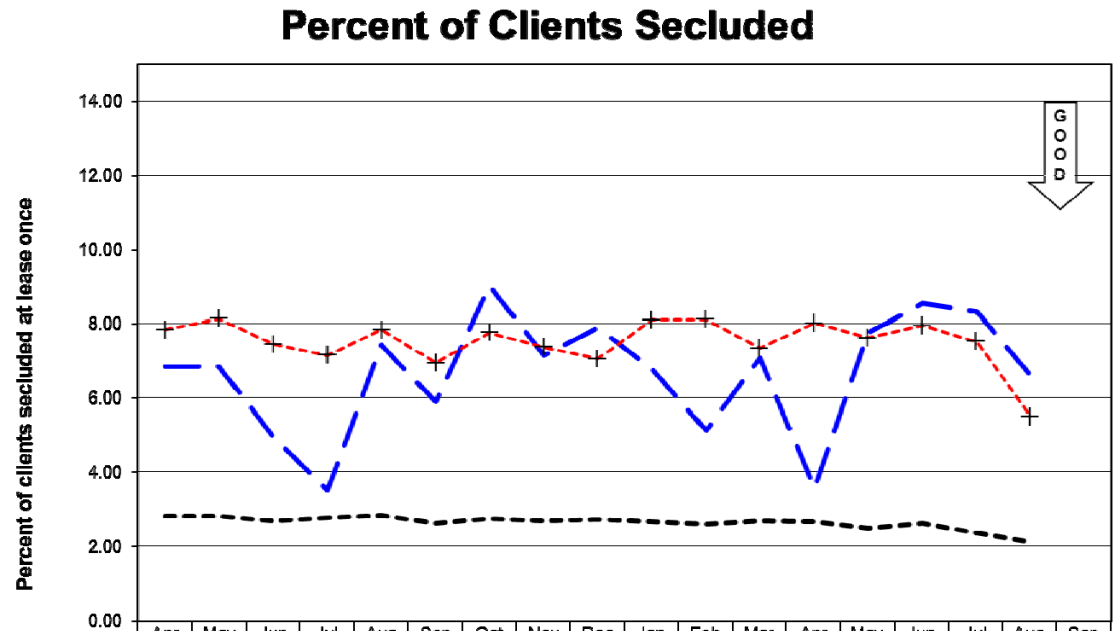
V26) The evaluation of treatment and discharge planning, performed in accordance with **Attachment D**, demonstrates that staffing was sufficient to provide patients access to activities necessary to achieve the patients' treatment goals, and to enable patients to exercise daily and to recreate outdoors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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	6.84	6.84	4.96	3.51	7.44	5.88	9.01	7.14	7.89	6.78	5.13	7.08	3.57	7.76	8.55	8.33	6.61	
Ntl Mean	2.82	2.81	2.69	2.78	2.84	2.62	2.76	2.70	2.74	2.66	2.61	2.68	2.66	2.50	2.62	2.37	2.13	
+1 StDev	7.84	8.13	7.45	7.15	7.84	6.95	7.76	7.37	7.06	8.1	8.11	7.34	8.01	7.62	7.95	7.52	5.49	

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.

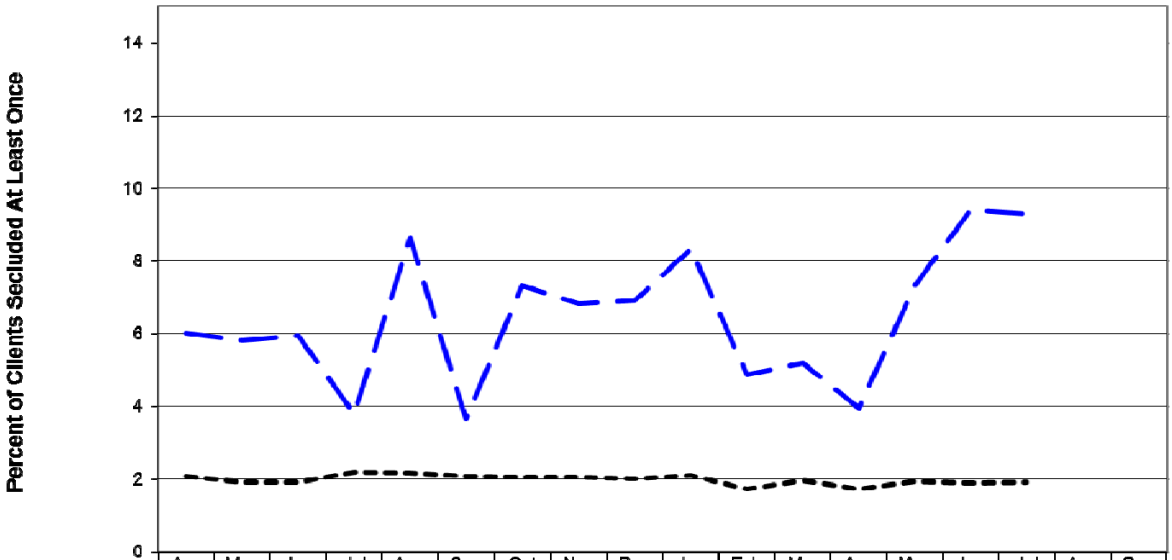
The following graphs depict the percent of unique clients who were secluded at least once stratified by forensic or civil classifications. For example, a rate of 3.0 means that 3% of the unique clients served were secluded at least once.

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

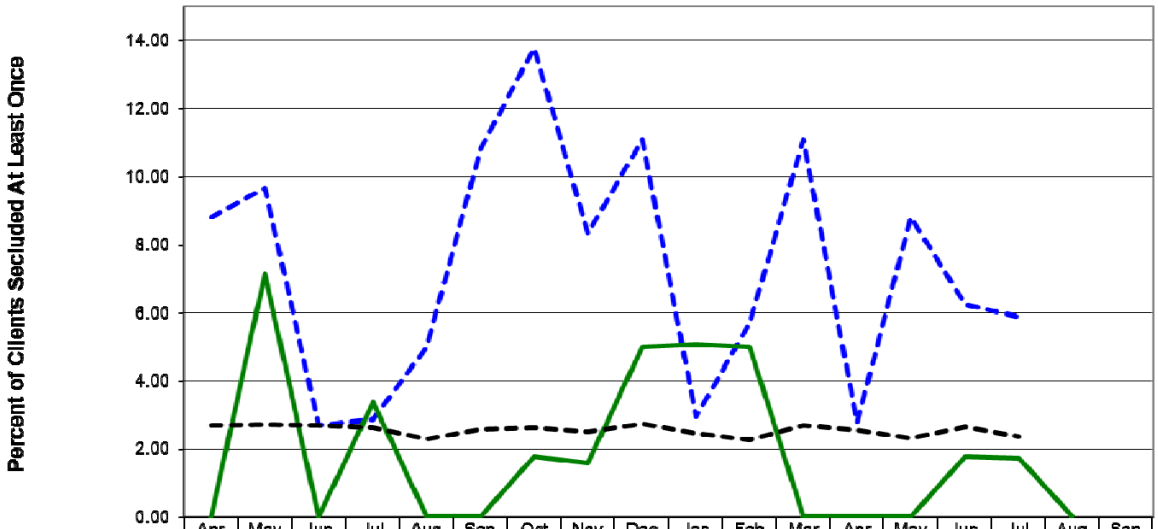
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	6.02	5.81	5.95	3.8	8.64	3.66	7.32	6.82	6.9	8.33	4.68	5.19	3.95	7.32	9.41	9.3		
Ntl Mean	2.08	1.9	1.92	2.18	2.16	2.08	2.05	2.05	1.99	2.09	1.73	1.95	1.72	1.94	1.89	1.91		

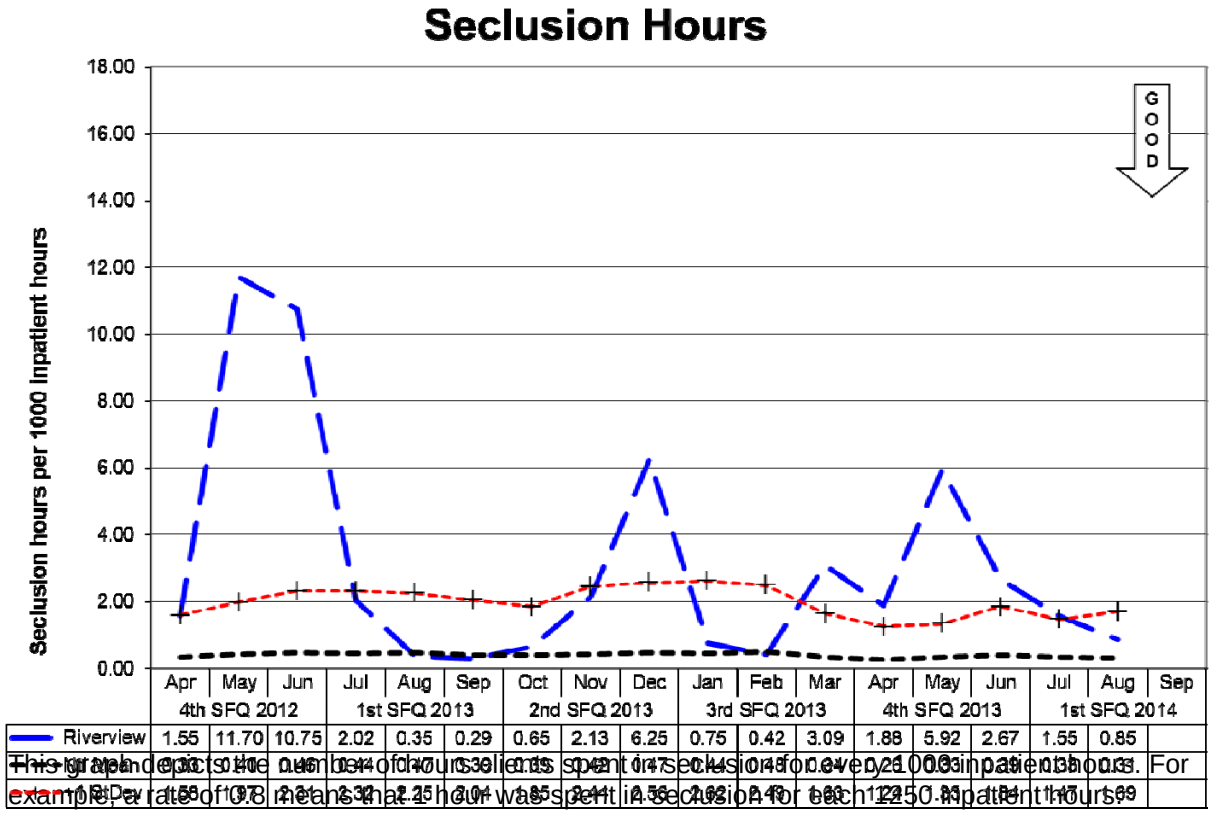
Percent of Clients Secluded

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	8.62	9.66	2.7	2.86	5	10.81	13.79	8.33	11.11	2.94	5.71	11.11	2.78	8.62	6.25	5.66		
Dorothea Dix	0.00	7.14	0.00	3.39	0.00	0.00	1.79	1.59	5.00	5.08	5.00	0.00	0.00	0.00	1.79	1.72	0.00	
Ntl Mean	2.69	2.72	2.69	2.63	2.29	2.56	2.62	2.5	2.74	2.46	2.26	2.69	2.56	2.31	2.66	2.36		

CONSENT DECREE



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.

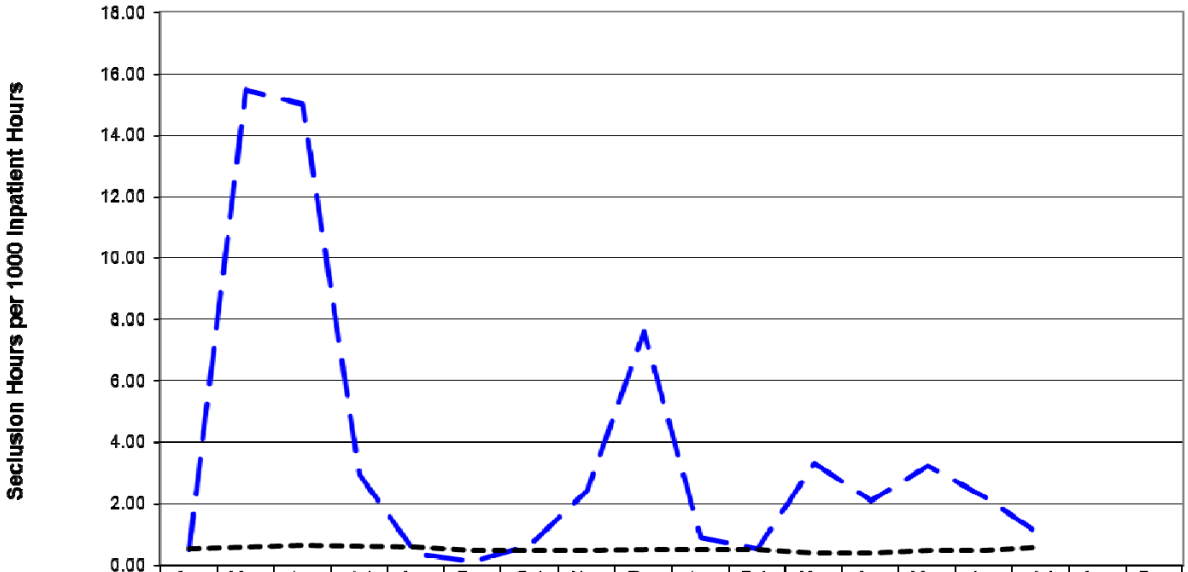
The following graphs depict the number of hours clients spent in seclusion for every 1000 inpatient hours stratified by forensic or civil classifications. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours.

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

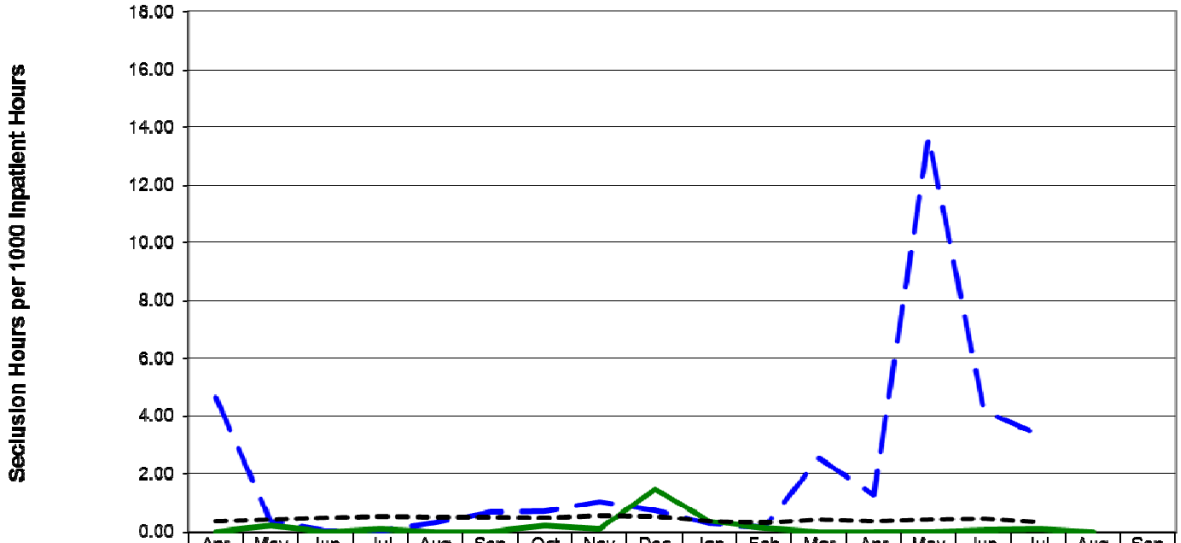
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	0.5	15.47	15.01	2.94	0.37	0.12	0.63	2.43	7.6	0.9	0.52	3.32	2.11	3.23	2.2	0.97		
Ntl Mean	0.52	0.57	0.64	0.62	0.59	0.46	0.47	0.48	0.51	0.5	0.5	0.39	0.4	0.46	0.46	0.58		

Seclusion Hours

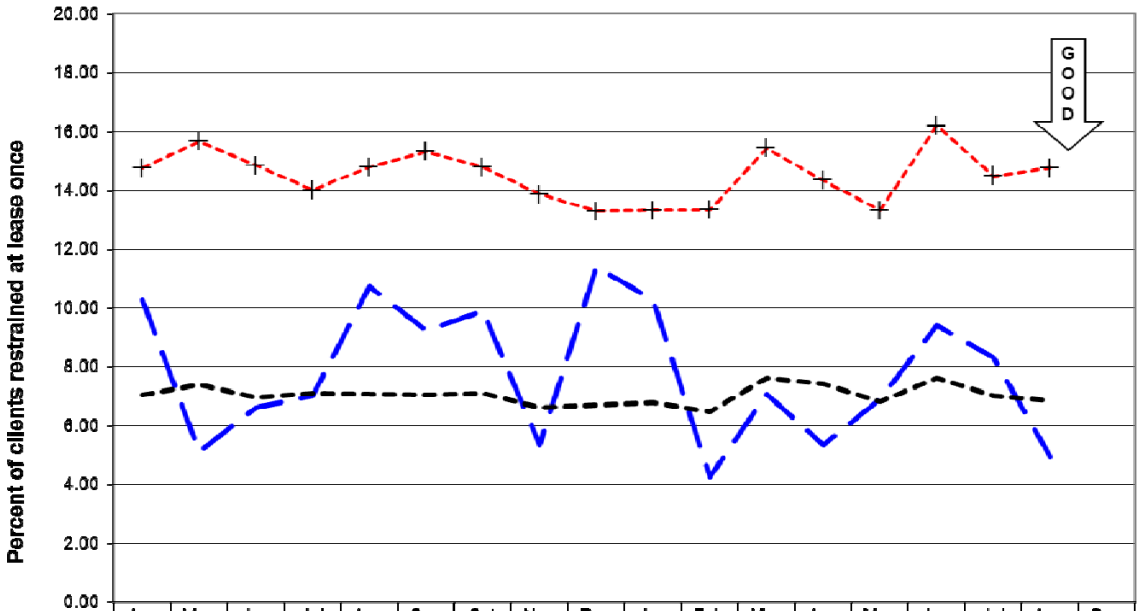
Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	4.64	0.35	0.03	0.04	0.29	0.68	0.71	1.04	0.74	0.26	0.16	2.53	1.26	13.65	4.18	3.37		
Dorothea Dix	0.00	0.22	0.00	0.10	0.00	0.00	0.20	0.09	1.47	0.35	0.13	0.00	0.00	0.00	0.06	0.09	0.00	
Ntl Mean	0.37	0.4	0.47	0.54	0.51	0.49	0.46	0.57	0.54	0.36	0.3	0.4	0.36	0.4	0.43	0.34		

CONSENT DECREE

Percent of Clients Restrained



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	10.26	5.13	6.61	7.02	10.74	9.24	9.91	5.36	11.40	10.26	4.27	7.08	5.36	6.90	9.40	6.33	4.96	
Ntl Mean	7.04	7.39	6.95	7.10	7.08	7.04	7.12	6.62	6.69	6.76	6.46	7.63	7.43	6.61	7.63	7.02	6.65	
+1 StDev	14.76	15.66	14.84	14.01	14.78	15.32	14.76	13.66	13.29	13.32	13.33	15.43	14.34	13.32	16.2	14.48	14.76	

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.

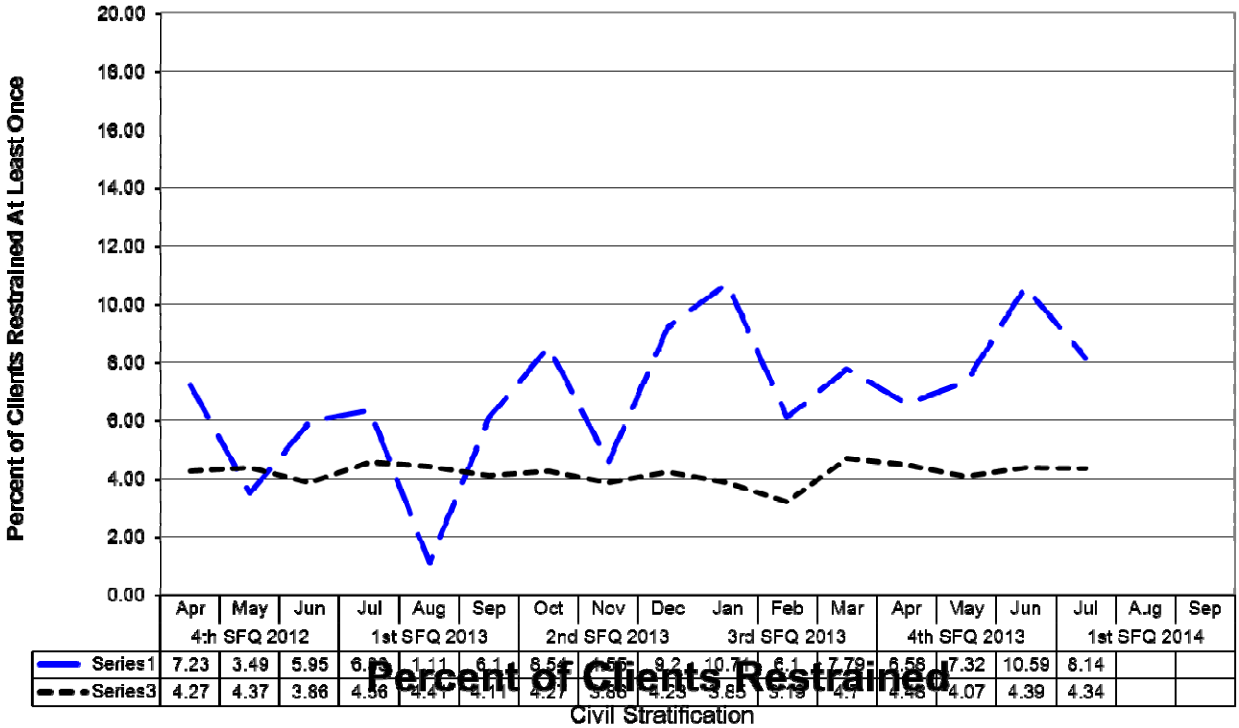
The following graphs depict the percent of unique clients who were restrained at least once stratified by forensic or civil classifications – includes all forms of restraint of any duration. For example, a rate of 4.0 means that 4% of the unique clients served were restrained at least once.

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

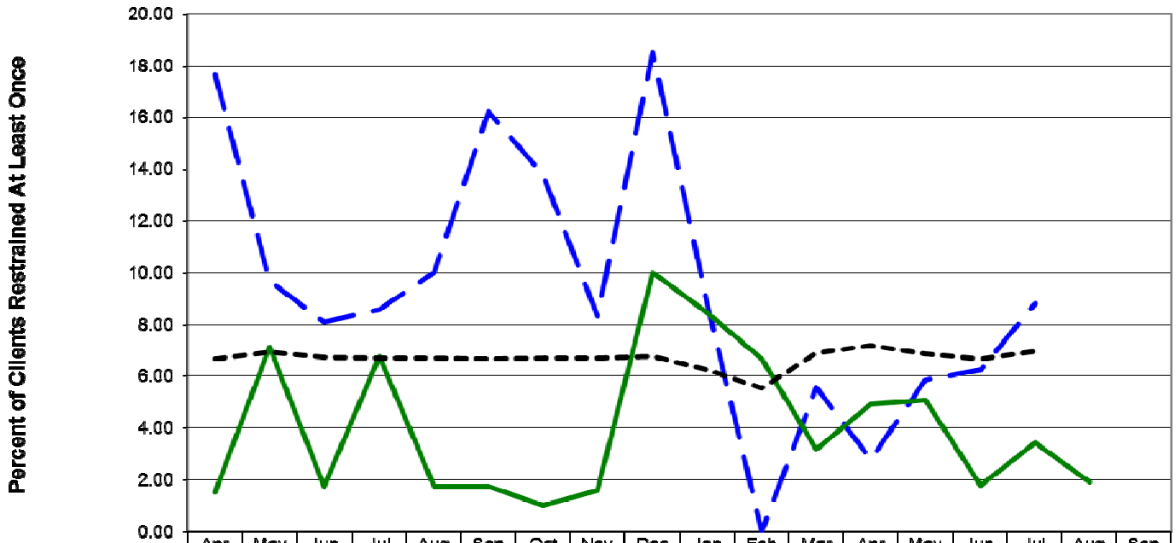
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Series1	7.23	3.49	5.95	6.56	1.11	6.1	8.54	4.56	9.2	10.79	6.1	7.79	6.58	7.32	10.59	8.14		
Series3	4.27	4.37	3.86	4.56	4.41	4.11	4.27	3.86	4.23	3.85	3.19	4.7	4.48	4.07	4.39	4.34		

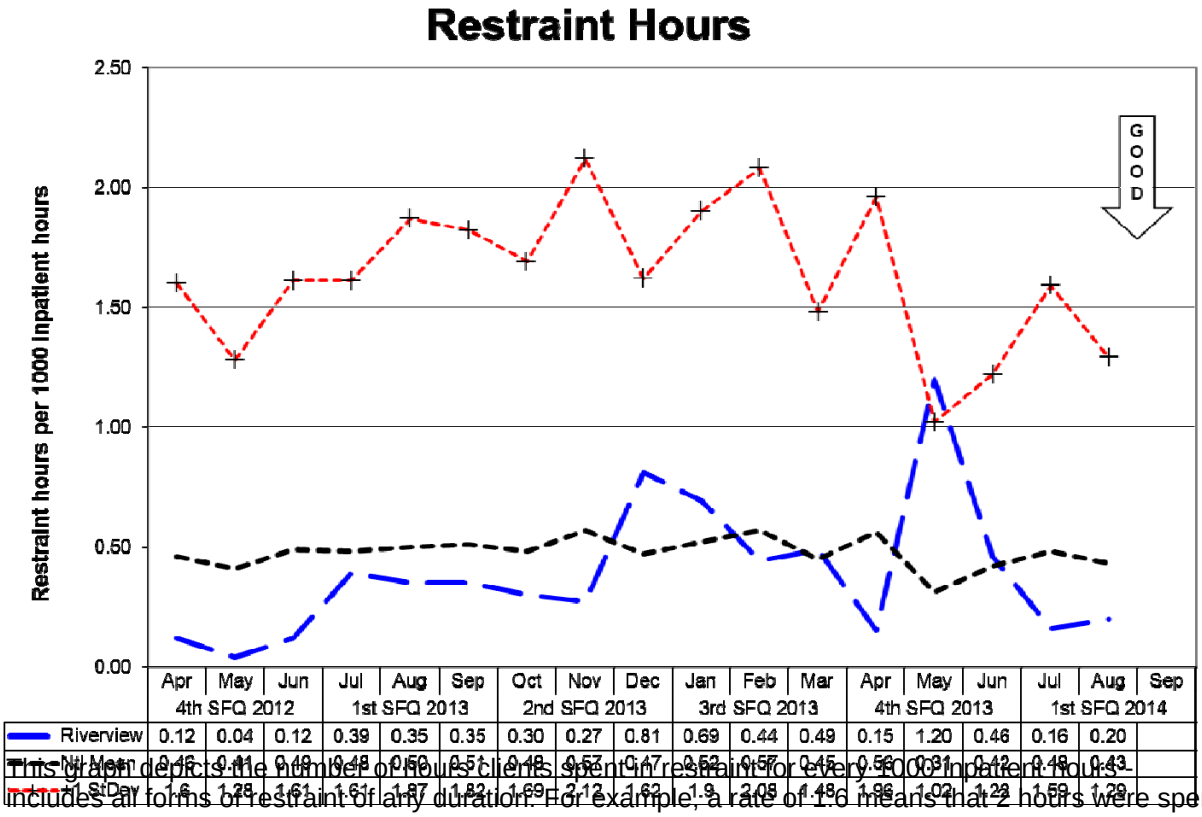
Percent of Clients Restrained

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	17.65	9.68	8.11	8.57	10	16.22	13.79	8.33	18.52	8.82	0	5.56	2.78	5.88	6.25	8.82		
Dorothea Dix	1.54	7.14	1.75	6.78	1.75	1.75	1.00	1.59	10.00	6.47	6.67	3.17	4.92	5.08	1.79	3.45	1.92	
Ntl Mean	6.67	6.95	6.75	6.72	6.7	6.66	6.72	6.72	6.78	6.27	5.55	6.9	7.18	6.87	6.68	6.98		

CONSENT DECREE



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.

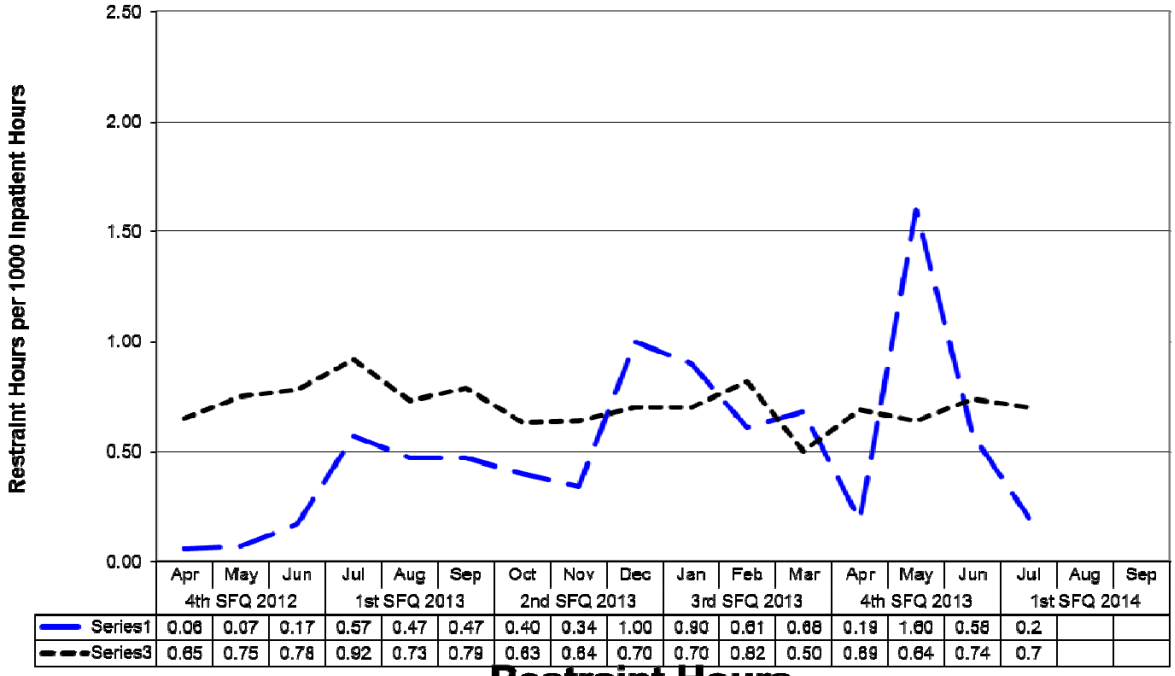
The following graphs depict the number of hours clients spent in restraint for every 1000 inpatient hours stratified by forensic or civil classifications - includes all forms of restraint of any duration. For example, a rate of 1.6 means that 2 hours were spent in restraint for each 1250 inpatient hours.

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

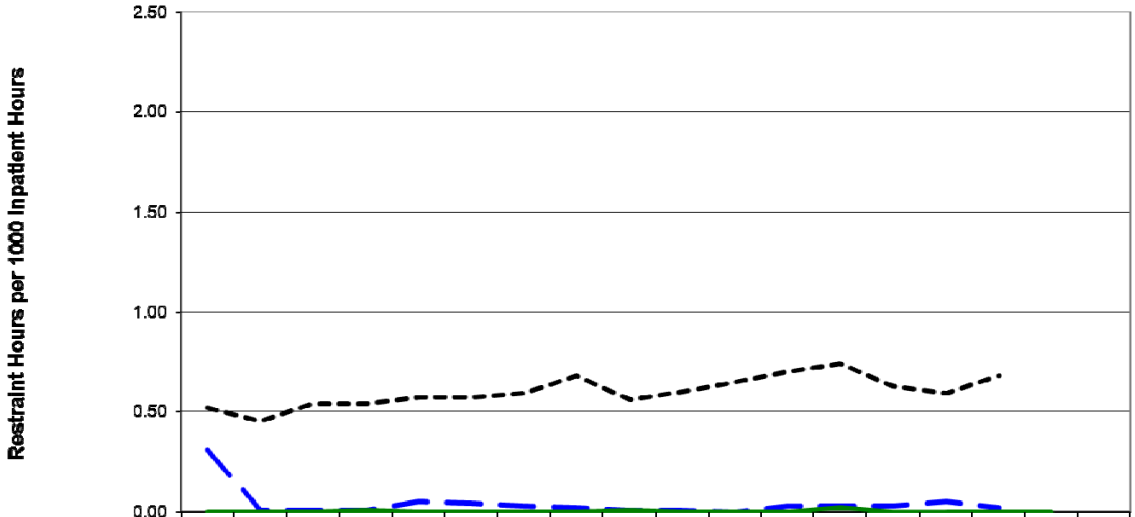
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Series1	0.06	0.07	0.17	0.57	0.47	0.47	0.40	0.34	1.00	0.90	0.61	0.68	0.19	1.60	0.56	0.2		
Series3	0.65	0.75	0.78	0.92	0.73	0.79	0.63	0.64	0.70	0.70	0.82	0.50	0.69	0.64	0.74	0.7		

Restraint Hours

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	0.31	0.01	0.01	0.01	0.05	0.04	0.03	0.02	0.01	0.01	0	0.03	0.03	0.03	0.05	0.02		
Dorothea Dix	0.00	0.00	0.00	0.01	0.00	0.00	0.00	0.00	0.01	0.00	0.00	0.00	0.02	0.00	0.00	0.00	0.00	
Ntl Mean	0.52	0.45	0.54	0.54	0.57	0.57	0.59	0.68	0.56	0.60	0.65	0.70	0.74	0.63	0.59	0.68		

CONSENT DECREE

Confinement Event Detail

1st Quarter 2014

	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
MR00006963	22		37	59	36.2%	36.2%
MR00000657	26	23	4	53	32.5%	68.7%
MR00006799	1	1	4	6	3.7%	72.4%
MR00004080	2	1	2	5	3.1%	75.5%
MR00004637	1		4	5	3.1%	78.5%
MR00000814		2	2	4	2.5%	81.0%
MR00004271			4	4	2.5%	83.4%
MR00007340	2		2	4	2.5%	85.9%
MR00003726	1		2	3	1.8%	87.7%
MR00004287	1		2	3	1.8%	89.6%
MR00000025	1	1		2	1.2%	90.8%
MR00000091	1		1	2	1.2%	92.0%
MR00007323	2			2	1.2%	93.3%
MR00007326	1		1	2	1.2%	94.5%
MR00007375	1		1	2	1.2%	95.7%
MR00000029			1	1	0.6%	96.3%
MR00000076			1	1	0.6%	96.9%
MR00006978		1		1	0.6%	97.5%
MR00007200			1	1	0.6%	98.2%
MR00007341	1			1	0.6%	98.8%
MR00007389			1	1	0.6%	99.4%
MR00007394			1	1	0.6%	100.0%
	63	29	71	163		

29% (22/77) of average hospital population experienced some form of confinement event during the 1st fiscal quarter 2014. Five of these clients (6% of the average hospital population) accounted for 79% 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.

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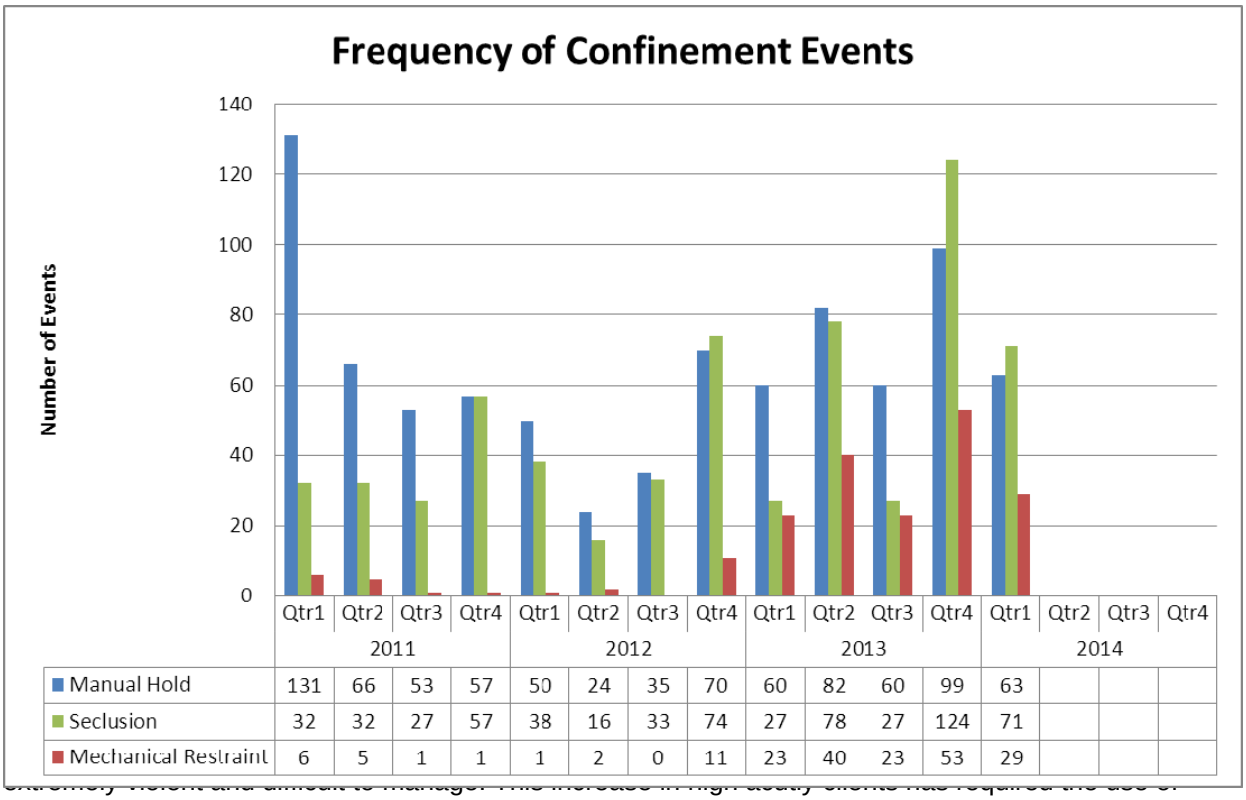

	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4
	2011				2012				2013				2014			
Manual Hold	131	66	53	57	50	24	35	70	60	82	60	99	63			
Seclusion	32	32	27	57	38	16	33	74	27	78	27	124	71			
Mechanical Restraint	6	5	1	1	1	2	0	11	23	40	23	53	29			

specialized management techniques that ensure the safety of these clients, other clients, and staff while attempting to maintain a therapeutic mileau.

Best practices from other forensic facilities and recommendations from experts in forensic client management from other State of Maine departments have been considered in the management of these clients.

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

	1Q13	2Q13	3Q13	4Q13	1Q14
Danger to Others/Self	23	78	50	124	71
Danger to Others	4				
Danger to Self			1		
% Dangerous Precipitation	100%	100%	100%	100%	100%
Total Events	27	78	51	124	71

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

	1Q13	2Q13	3Q13	4Q13	1Q14
Danger to Others/Self	22	40	40	53	29
Danger to Others	1				
Danger to Self					
% Dangerous Precipitation	100%	100%	100%	100%	100%
Total Events	23	40	40	53	29

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 28 & 29

Confinement Events Management

Seclusion Events (71) 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 (29) 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

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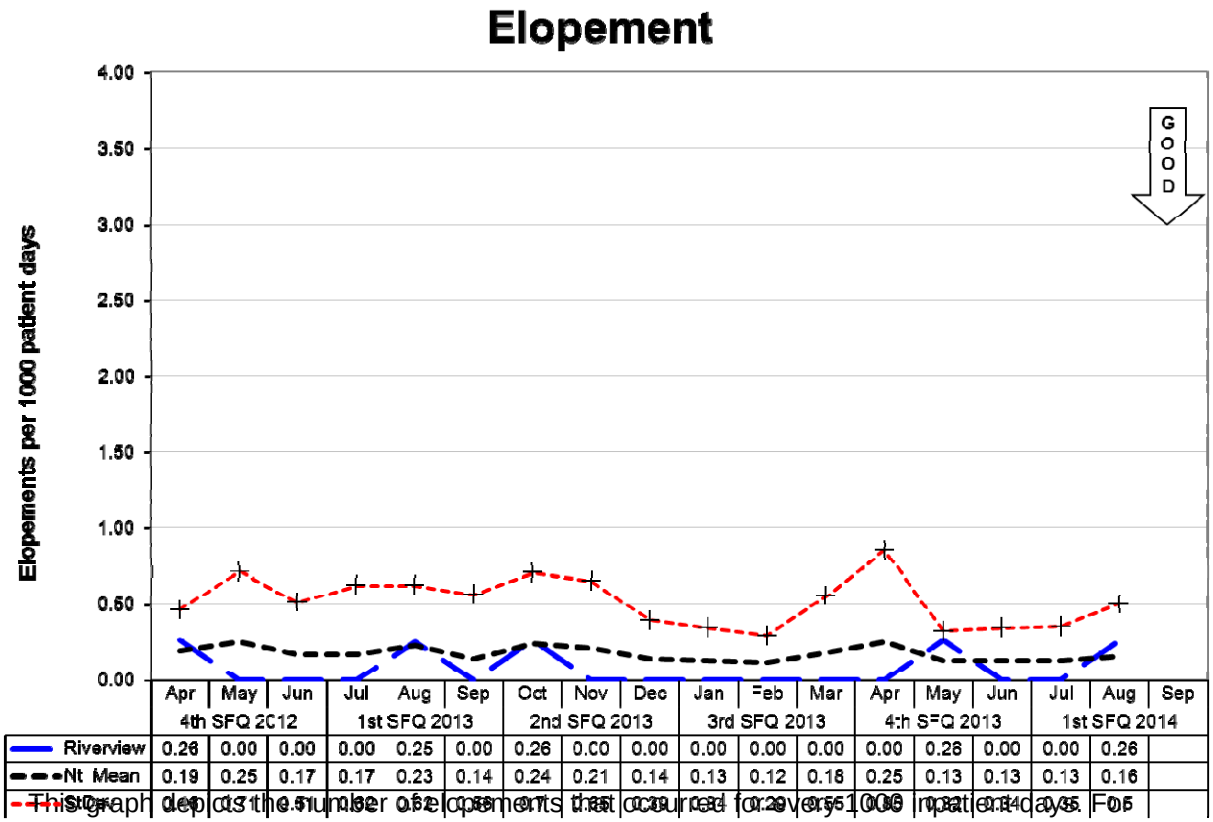


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	0.26	0.00	0.00	0.00	0.25	0.00	0.26	0.00	0.00	0.00	0.00	0.00	0.00	0.26	0.00	0.00	0.26	
Nt Mean	0.19	0.25	0.17	0.17	0.23	0.14	0.24	0.21	0.14	0.13	0.12	0.16	0.25	0.13	0.13	0.13	0.16	
StDev	0.11	0.15	0.12	0.12	0.08	0.11	0.09	0.09	0.08	0.08	0.08	0.09	0.14	0.09	0.09	0.09	0.05	

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.

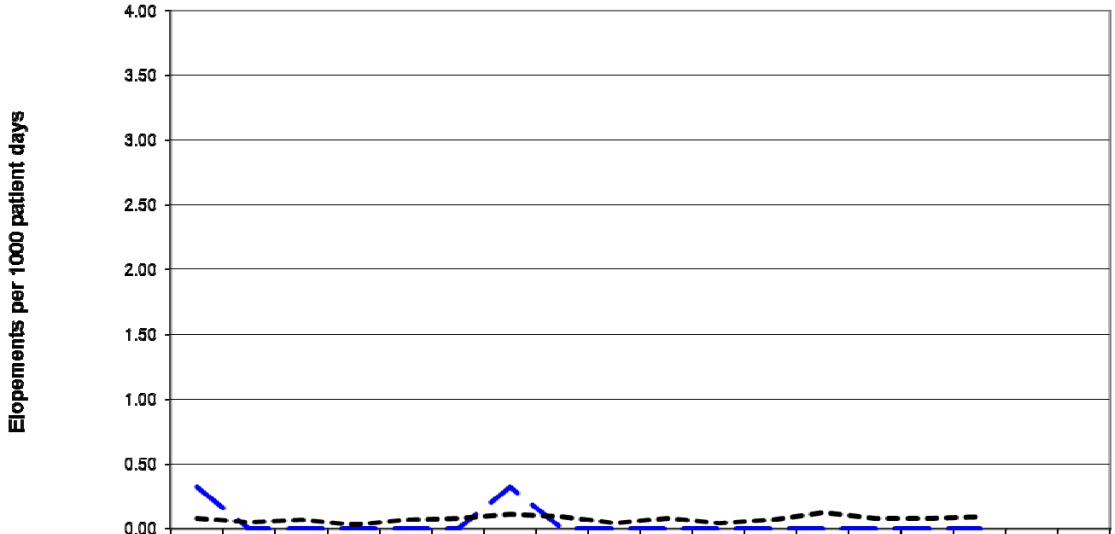
An elopement is defined as any time a client is “absent from a location defined by the client’s privilege status regardless of the client’s leave or legal status.”

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.

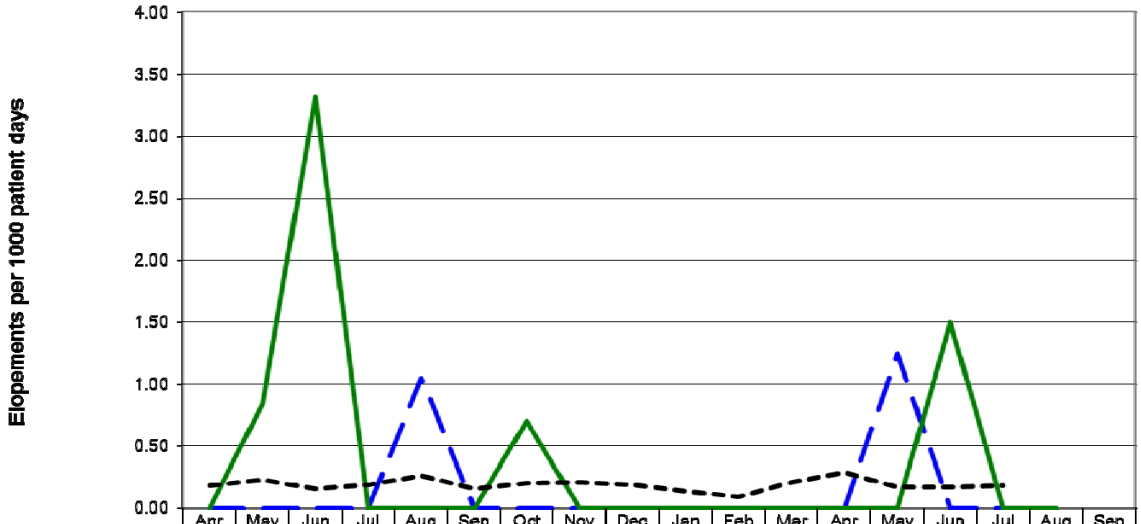
CONSENT DECREE

Elopement
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Series1	0.32	0.00	0.00	0.00	0.00	0.00	0.32	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
Series3	0.08	0.05	0.07	0.03	0.07	0.08	0.11	0.09	0.04	0.08	0.04	0.07	0.12	0.08	0.08	0.09		

Elopement
Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	0.00	0.00	0.00	0.00	1.05	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.25	0.00	0.00		
Dorothea Dix	0.00	0.84	3.32	0.00	0.00	0.00	0.70	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.50	0.00	0.00	
Ntl Mean	0.18	0.23	0.16	0.19	0.26	0.16	0.20	0.21	0.19	0.14	0.09	0.21	0.29	0.17	0.17	0.18		

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

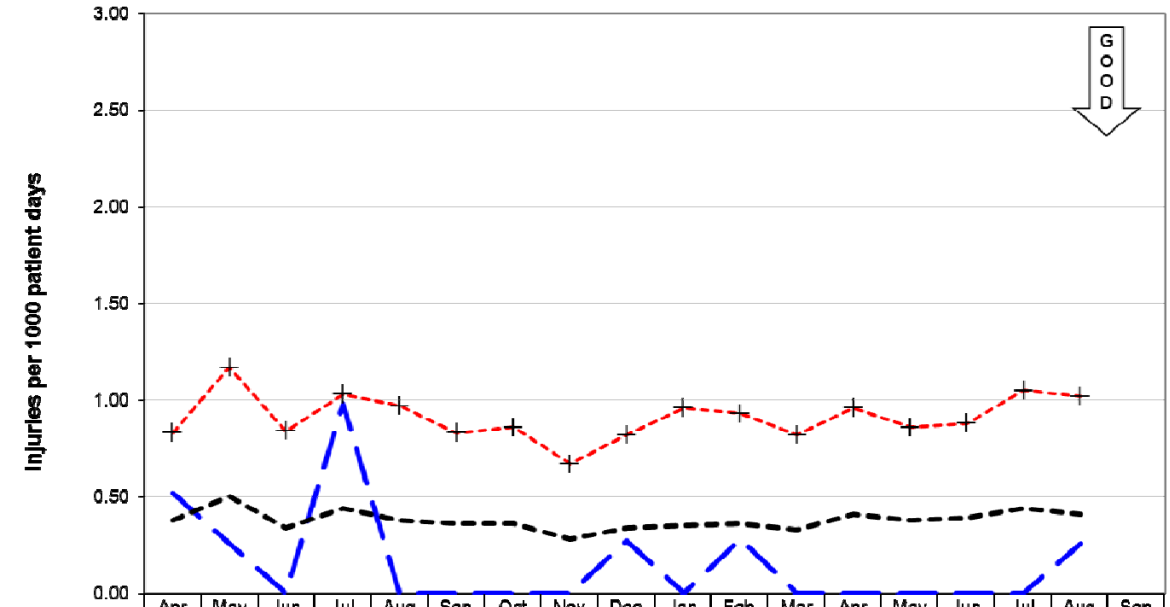
Reportable injuries include those that require: 3) Medical Intervention, 4) Hospitalization or where, 5) Death Occurred.

- 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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	0.52	0.26	0.00	0.98	0.00	0.00	0.00	0.00	0.27	0.00	0.28	0.00	0.00	0.00	0.00	0.00	0.26	
Ntl Mean	0.38	0.50	0.34	0.44	0.38	0.36	0.36	0.28	0.34	0.35	0.36	0.33	0.41	0.38	0.39	0.44	0.41	
+1 StDev	0.83	1.17	0.84	1.03	0.97	0.83	0.86	0.67	0.82	0.96	0.93	0.82	0.96	0.86	0.88	1.05	1.02	

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.

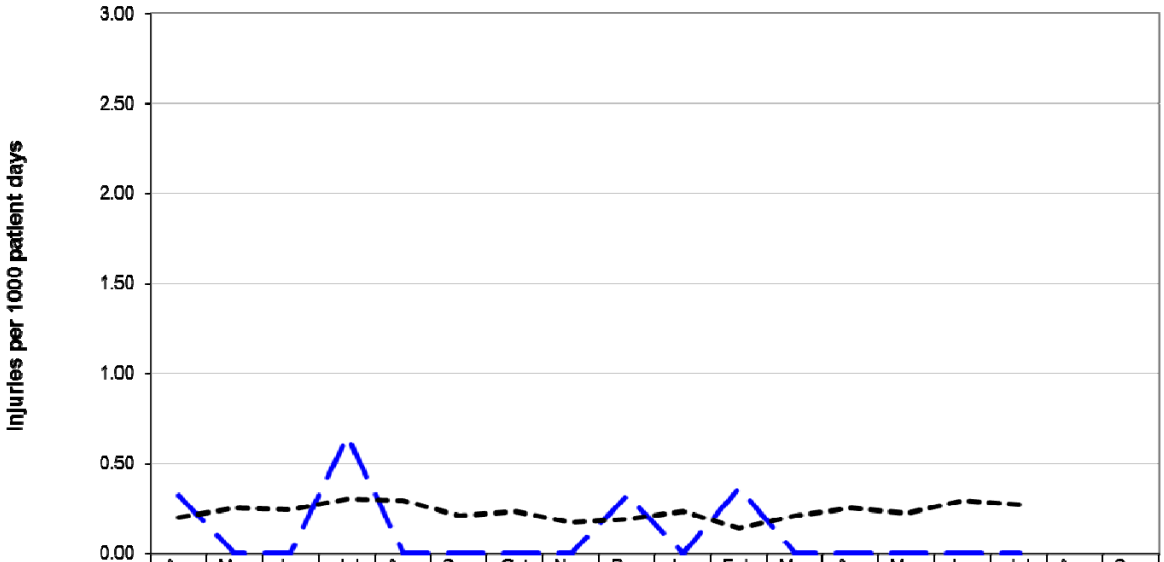
The following graphs depict the number of client injury events stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days.

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

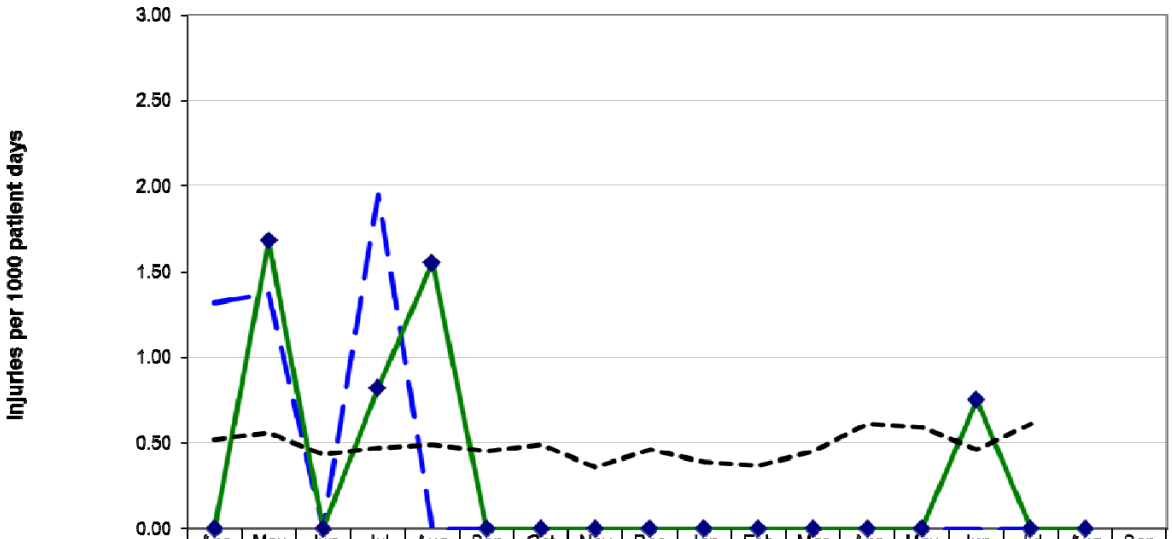
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Series1	0.32	0.00	0.00	0.65	0.00	0.00	0.00	0.00	0.32	0.00	0.36	0.00	0.00	0.00	0.00	0.00		
Series3	0.20	0.25	0.24	0.30	0.29	0.21	0.23	0.17	0.19	0.23	0.14	0.21	0.25	0.22	0.29	0.27		

Client Injury Rate

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	1.32	1.37	0.00	1.95	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
Dorothea Dix	0.00	1.68	0.00	0.82	1.55	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.75	0.00	0.00	
Ntl Mean	0.52	0.56	0.43	0.47	0.49	0.45	0.49	0.36	0.46	0.39	0.37	0.45	0.61	0.59	0.46	0.61		

CONSENT DECREE

Severity of injury by Month

Severity	JULY	AUG	SEP	1Q2014
No Treatment	28	27	20	75
Minor First Aid				
Medical Intervention Required				
Hospitalization Required				
Death Occurred				
Total	28	27	20	75

Type and Cause of Injury by Month

Type - Cause	JULY	AUG	SEP	1Q2014
Accident – Fall Unwitnessed	5	2	1	8
Accident – Fall Witnessed	4	2		6
Accident – Other			1	1
Assault – Client to Client	12	19	13	44
Self-Injurious Behavior	7	4	5	16

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	2Q2013	3Q2013	4Q2013	1Q2014
Abuse Physical	5	2	3	3
Abuse Sexual	2	2	5	4
Abuse Verbal	1			1
Coercion/Exploitation			1	
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, and the Medical Executive Committee receive 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. A triennial accreditation survey is expected to occur in November 2013 or earlier.

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;

The hospital was terminated from the Medicare Provider Agreement on September 2, 2013 for failing to show evidence of substantial compliance by August 27, 2013. A revisit by CMS occurred on September 16th and 17th, 2013. The Medicare Provider Agreement will not be accepted unless CMS finds that the reason for termination of the previous agreement has been removed and there is reasonable assurance that it will not recur; and that the hospital has fulfilled, or has made satisfactory arrangements to fulfill, all of its statutory and regulatory responsibilities of its previous agreement. See Section 1866(c) of the Social Security Act and 42 C.F.R.§489.57. Riverview is currently in the process of applying for recertification.

V37) Riverview conducts quarterly monitoring of performance indicators in key areas of hospital administration, in accordance with the Consent Decree Plan, the accreditation standards of the Joint Commission, and according to a QAPI plan reviewed and approved by the Advisory Board each biennium, 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 the current Integrated Plan for Performance Excellence, the data and reports presented in this document, the work of the Integrated Performance Excellence Committee and sub-groups of this committee that are engaged in 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)

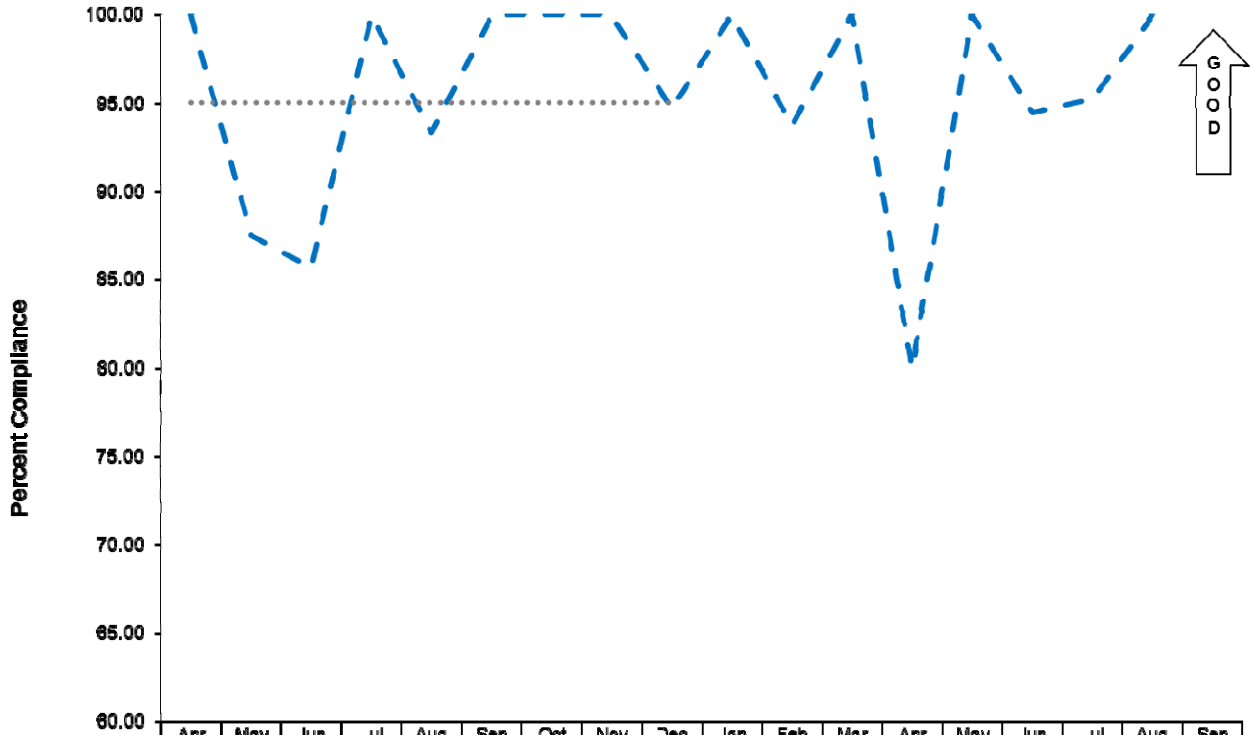
For Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths

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.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			's: SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			's: SFQ 2014		
RPC Rate	100.00	87.50	85.71	100.00	93.33	100.00	100.00	100.00	94.74	100.00	93.75	100.00	90.00	100.00	94.44	95.25	100.00	
TJC Target	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00									

JOINT COMMISSION

Physical Restraint (HBIPS 2)

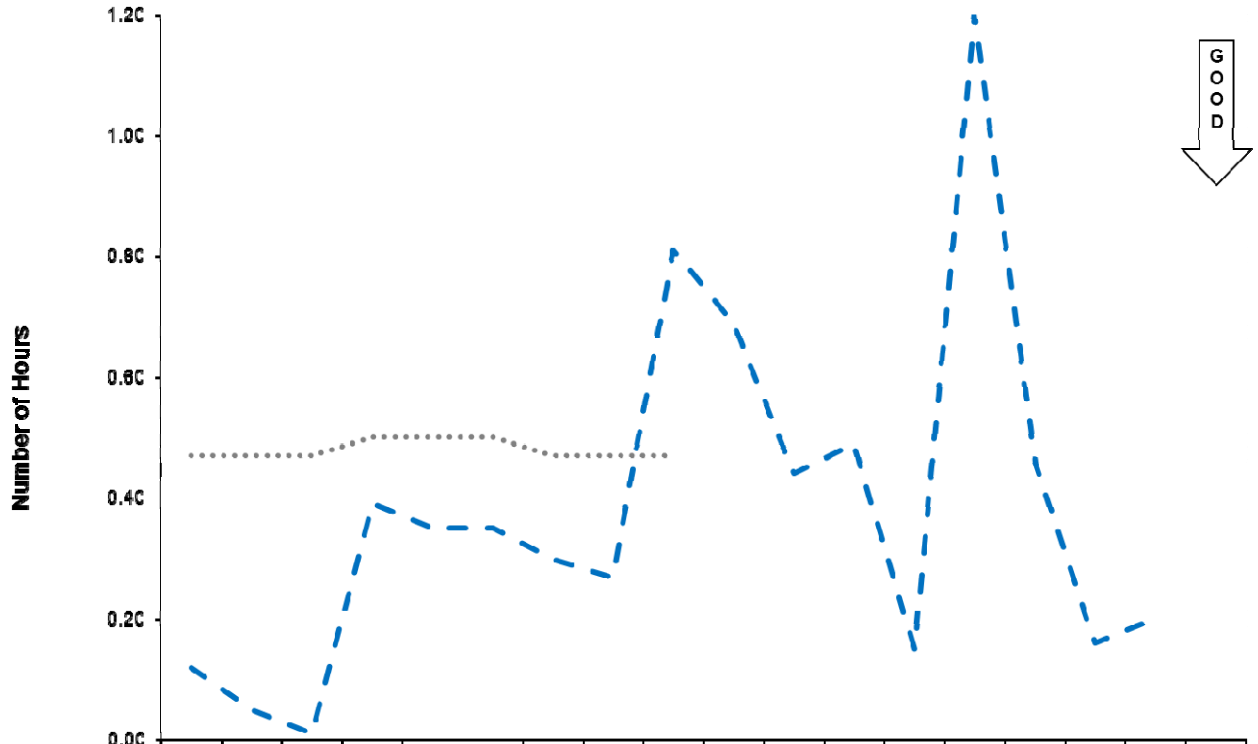
Hours of Use

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).



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
RPC Rate	0.12	0.05	0.01	0.39	0.35	0.35	0.30	0.27	0.81	0.69	0.44	0.49	0.15	1.20	0.45	0.16	0.20	
TJC Target	0.47	0.47	0.47	0.50	0.50	0.50	0.47	0.47	0.47									

JOINT COMMISSION

Seclusion (HBIPS 3)

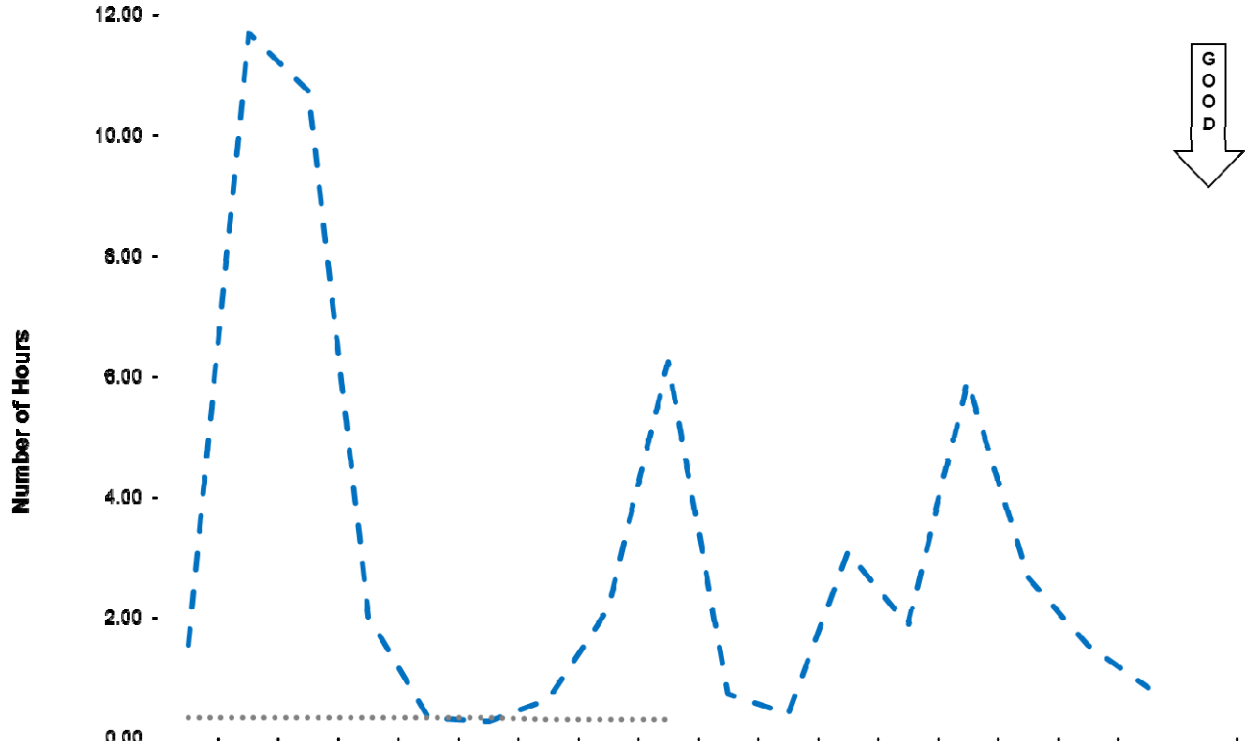
Hours of Use

Description

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

Rationale

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
RPC Rate	1.55	11.70	10.75	2.02	0.35	0.29	0.65	2.13	6.25	0.75	0.42	3.09	1.88	5.92	2.67	1.55	0.85	
TJC Target	0.35	0.35	0.35	0.36	0.36	0.36	0.32	0.32	0.32									

JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)

Description

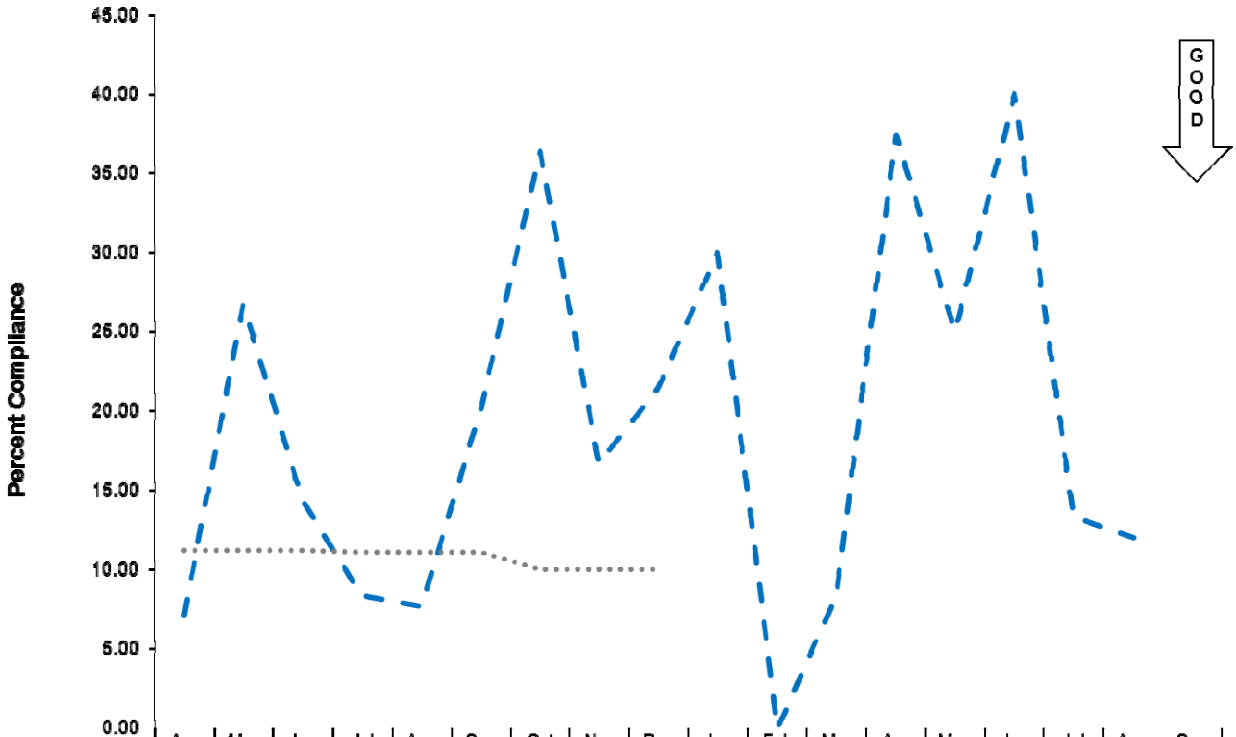
Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications

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)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Series1	7.14	26.67	14.29	8.33	7.69	20.00	36.36	16.67	21.43	30.00	0.00	8.33	37.50	25.00	40.00	13.33	12.00	
Series3	11.20	11.20	11.20	11.10	11.10	11.10	10.00	10.00	10.00									

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).

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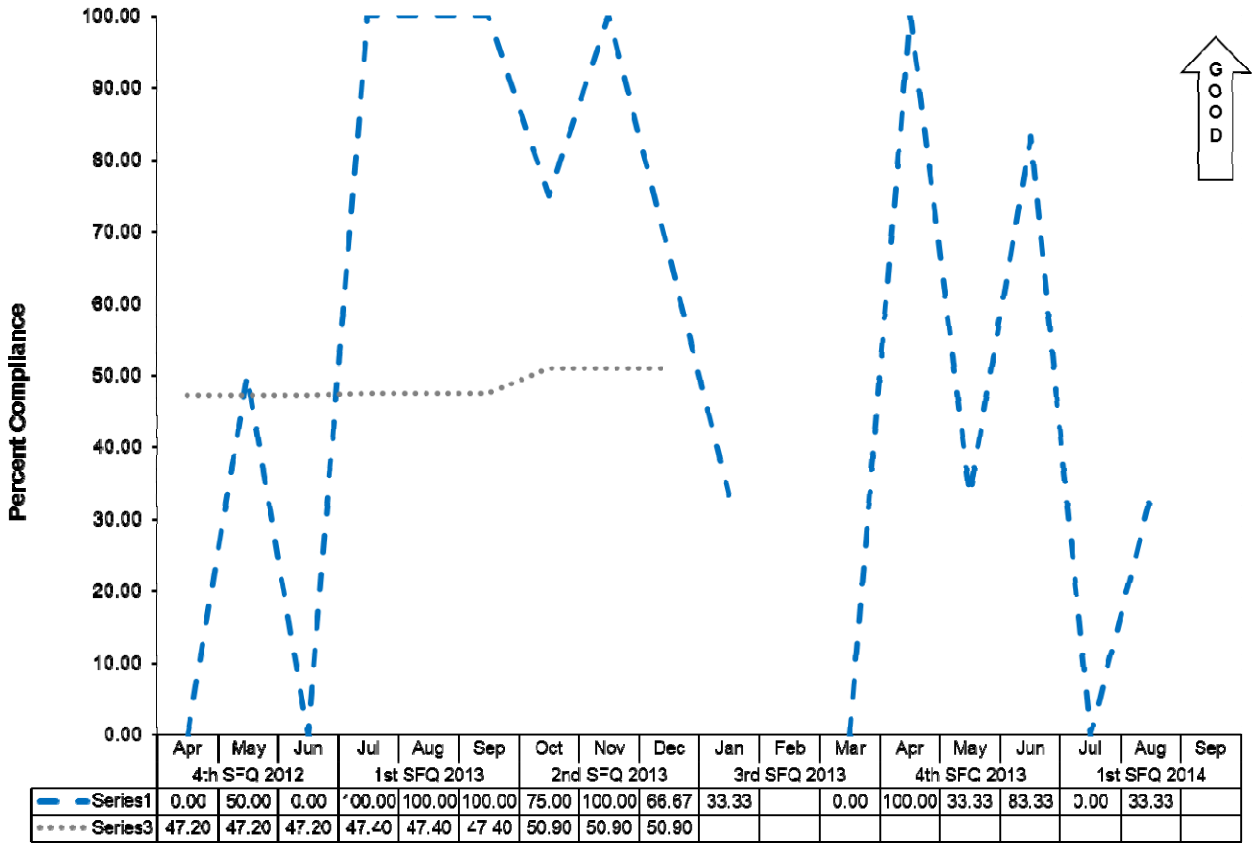
JOINT COMMISSION

Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Series1	0.00	50.00	0.00	100.00	100.00	100.00	75.00	100.00	66.67	33.33		0.00	100.00	33.33	83.33	0.00	33.33	
Series3	47.20	47.20	47.20	47.40	47.40	47.40	50.90	50.90	50.90									

JOINT COMMISSION

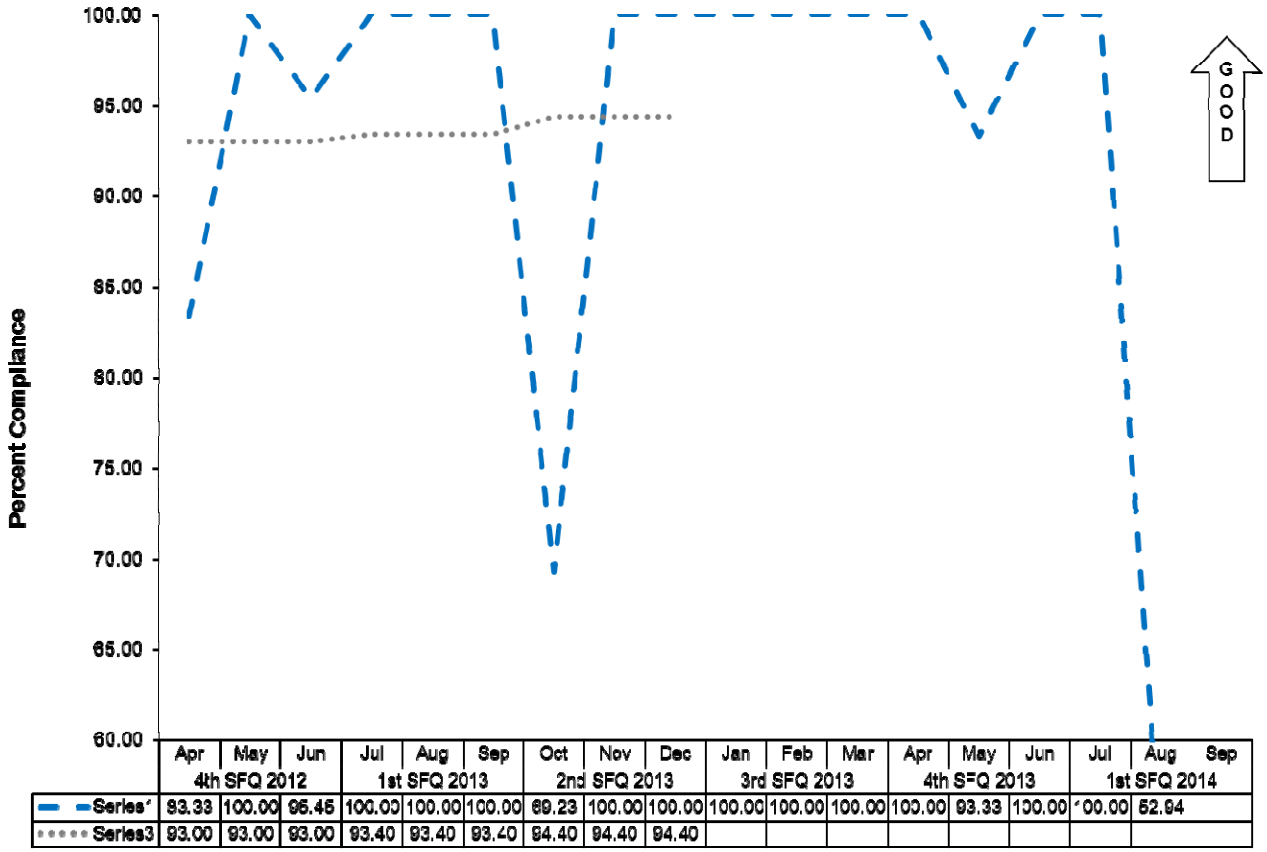
Post Discharge Continuing Care Plan (HBIPS 6)

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).



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Series'	93.33	100.00	95.45	100.00	100.00	100.00	89.23	100.00	100.00	100.00	100.00	100.00	100.00	93.33	100.00	'00.00	52.94	
Series3	93.00	93.00	93.00	93.40	93.40	93.40	94.40	94.40	94.40									

JOINT COMMISSION

Post Discharge Continuing Care Plan Transmitted (HBIPS 7)

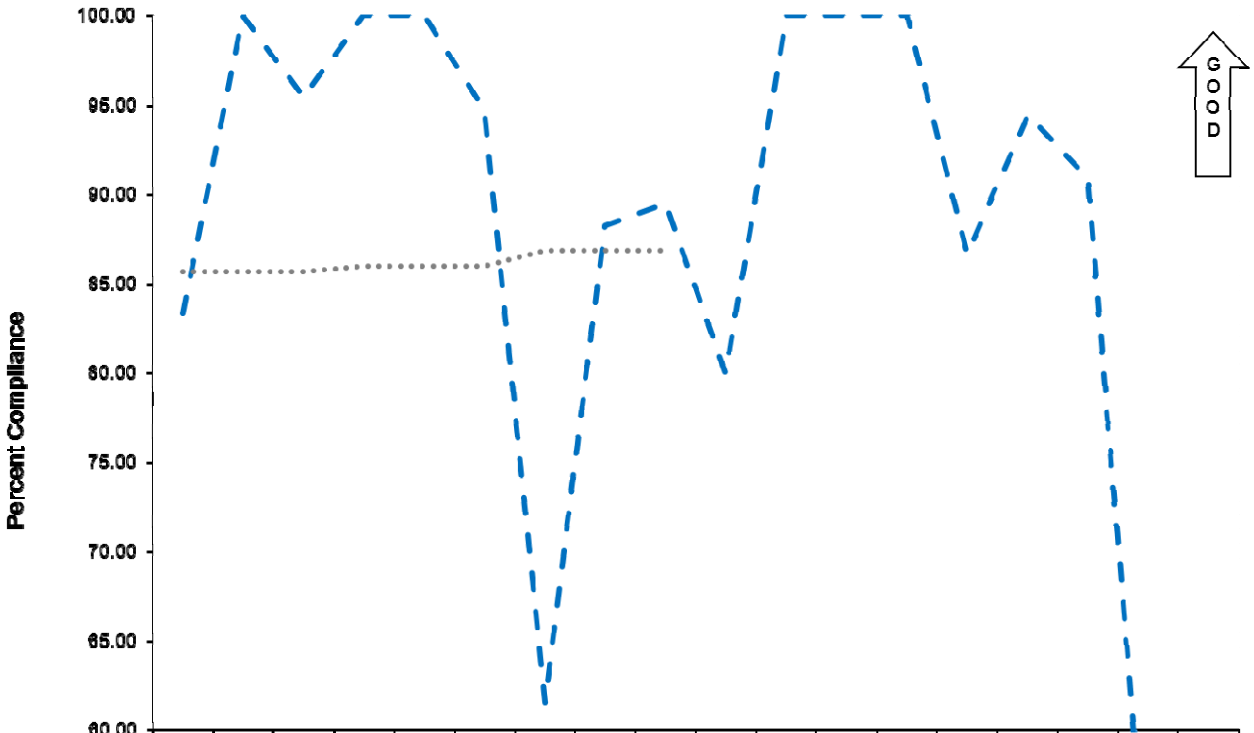
To Next Level of Care Provider on Discharge

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).



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 20'3			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Series1	83.33	100.00	95.45	100.00	100.00	94.74	61.54	88.24	89.47	80.00	100.00	100.00	100.00	86.67	94 44	90.91	50.00	
Series3	85.70	85.70	85.70	86.00	86.00	86.00	86.90	86.90	86.90									

JOINT COMMISSION

Management of Contracted Care, Treatment and Services

TJC LD.04.03.09 The same level of care should be delivered to patients regardless of whether services are provided directly by the hospital or through contractual agreement. Leaders provide oversight to make sure that care, treatment, and services provided directly are safe and effective. Likewise, leaders must also oversee contracted services to make sure that they are provided safely and effectively.

Final Report of FY 2014 Clinical Contracts		
Contractor	**Program Administrator**	**Summary of Performance**
Amistad Peer Support Services	Stephanie George-Roy Director of Social Services	One indicator did not meet expectations; this indicator stated that all grievances are responded to on time. 4 of 66 grievances were not responded to on time in 1Q2014. A new Director for Amistad was recently hired; the lack of on time grievances may have been related to having this position vacant. All other indicators met or exceeded standards.
Community Dental, Region II	Dr. William Nelson Medical Director	All indicators met standards.
Comprehensive Pharmacy Services	Dr. William Nelson Medical Director	All indicators met standards.
Dartmouth Medical School	MaryLouise McEwen Superintendent	All indicators met or exceeded standards.
Disability Rights Center	MaryLouise McEwen Superintendent	All indicators met standards.
Healthreach	Dr. William Nelson Medical Director	All indicators met standards.
Kennebec County Correctional Facility	MaryLouise McEwen Superintendent	All indicators met or exceeded standards.
Liberty Staffing	Dr. William Nelson Medical Director	All indicators met standards.
MaineGeneral Medical Center – Laboratory Services	Dr. William Nelson Medical Director	All indicators met standards.
MD-IT	Amy Tasker Health Information Management Director	Indicator met standards.
Medical Staffing and Services of Maine, Inc.	Dr. William Nelson Medical Director	All indicators met standards.
Motivational Services	Dr. William Nelson Medical Director	All indicators met standards.
Occupational Therapy Consultation and Rehab Services	Janet Barrett Director of Rehabilitation	All indicators met standards.
Securitas Security Services	Robert Patnaude Director of Security	All indicators met or exceeded standards
Spring Harbor	Dr. William Nelson Medical Director	All indicators met or exceeded standards.

JOINT COMMISSION

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	2Q2013	3Q2013	4Q2013	1Q2014
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.	**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** 100% 2/2 **May** 100% 7/7 **June** 100% 7/7 **Total** 100% 16/16	**July** 100% 6/6 **August** 100% 2/2 **September** 100% 4/4 **Total** 100% 12/12

Dental Clinic Post Extraction Prevention of Complications and Follow-up

Indicators	2Q2013	3Q2013	4Q2013	1Q2014
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	**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% 19/19I	**April** 100% 2/2 **May** 100% 7/7 **June** 100% 7/7 **Total** 100% 16/16	**July** 100% 6/6 **August** 100% 2/2 **September** 100% 4/4 **Total** 100% 12/12

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	3.8	100 %	1 SD within the mean
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	0.48	100%	1 SD within the mean

Data:
Sinusitis: 1 →URI
Latent TB: 1→URI
Question Diverticulitis: 1 GI→
Genital Herpes: 1 →Reproductive
Prostatitis: 1 → Reproductive
Dental: 1
Skin: 13

- *Superficial* Abraison→laceration→pulled sutures out→ER
- Skin abraison
- Boil – History of MRSA
- Right Inguinal Intertriginous Monilial Dermatitis
- Paronychia Rt, Great Toe
- Chronic Folliculitis – flare up
- Severe Intertrigo of pannus with ulceration & eythema
- Right 3rd Finger Paronychis
- Impetiginous lesion on face
- Intertrigo in both groins
- Onychomycosis & gryposis of toe nails
- Athlete's Foot
- Impetigo

Ear: 2
UTI: 1
Wound: 3

- Sebaceious Gland-prophylaxis post op: 2
- Left ingrown toemail, partial excision
- Severe intertrigo with ulceration and erythema

Prophylactic/treatment for bladder cancer→BCG→not counted as an infection

Hospital Associated Infections (HAI): 3 - 0.48

Community Acquired Infections (CAI): 21 –2.3
Self Injury: 1 – 0.15
Total Infections: 25 – 3.8

Summary: Hospital associated infection rates remain low and within one standard deviation of the mean. No trending. No unusual infections.

Action Plan: Continue total house surveillance (client and employee). The flu season is rapidly approaching. Encourage hand hygiene, respiratory hygiene and influenza vaccination.

JOINT COMMISSION

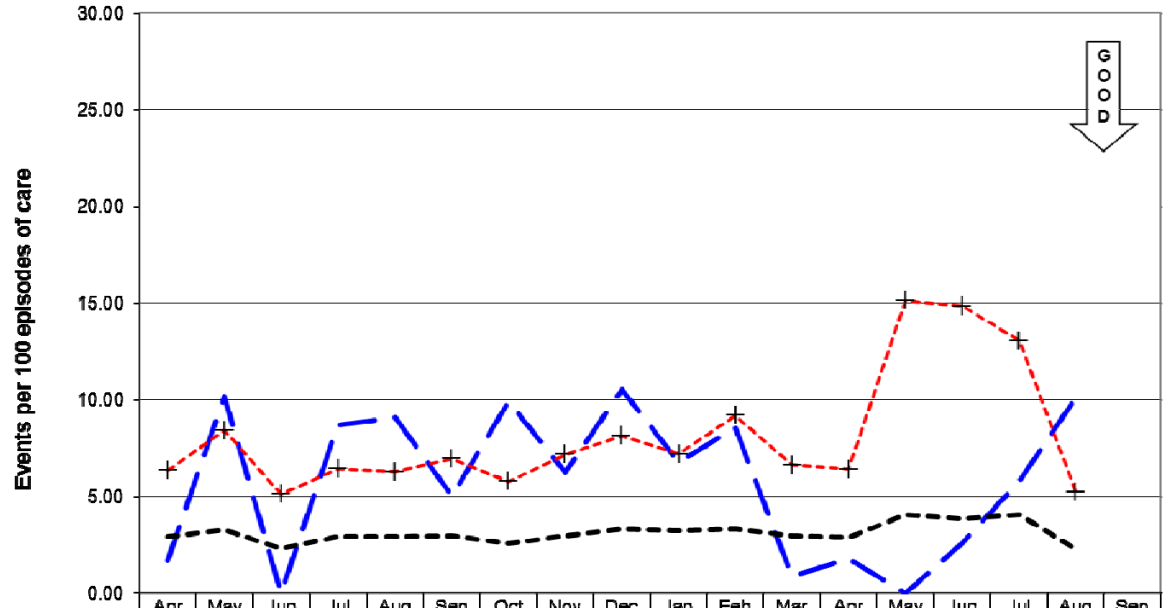
Medication Management

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	1.71	10.17	0.00	8.70	9.09	5.04	9.91	6.25	10.53	6.78	8.55	0.88	1.79	0.00	2.56	5.79	10.14	
Ntl Mean	2.93	3.26	2.30	2.94	2.92	2.99	2.56	2.97	3.34	3.24	3.32	2.97	2.87	4.06	3.83	4.05	2.26	
+1 StDev	6.34	8.43	5.13	6.43	6.29	6.96	5.77	7.17	8.13	7.2	9.19	6.62	6.4	15.12	14.84	13.06	5.21	

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.

Medication variances 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

Medication Management - Administration Process
Medication Errors Related to Staffing Effectiveness

Date	OMIT	Co-mission	Float	New	O/T	Unit Acuity	Staff Mix
7/1/2013 & 7/2/2013	N	Wrong dose x 1	N	Y	N	LS	4 RN, 8 MHW
7/3/2013	N	Extra dose Haldol	Y	Y	Y	LK	3 RN, 1 LPN, 7 MHW
7/24/2013	N	Wrong form	N	Y	N	LS	2 RN, 6 MHW
7/24/2013	N	Wrong dose Tramadol	N	Y	N	UK	1 RN, 4 MHW
7/24/2013	Y	Simvastatin x1	N	N	N	UK	2 RN, 4 MHW
7/26/2013	Y	Darunavir omitted x1	Y	N	N	LS	3 RN, 1 LPN, 8 MHW
7/26/2013	Y	Mepron omitted x1	Y	Y	N	LS	3 RN, 8 MHW
7/30/2013	N	Extra dose / Ativan	N	N	Y	UK	2 RN, 4 MHW
7/31/2013	Y	Vicoden x1	N	N	N	US	2 RN, 6 MHW
8/2/2013	Y	Colace x1	N	N	N	LK	3 RN, 1 LPN, 7 MHW
8/6/2013	Y	Omission x 1	N	Y	N	LS	3 RN, 7 MHW
8/15/2013	N	Wrong dose	N	N	Y	LS	3 RN, 8 MHW
8/16/2013	N	Wrong time	N	N	N	LK	3 RN, 1 LPN, 7 MHW
8/21/2013	Y	Omission x1	Y	N	N	LS	4 RN, 6 MHW
8/26/2013	N	Wrong dose	N	N	N	UK	2 RN, 4 MHW
8/26/2013	N	Wrong time x 3 meds	N	N	Y	LS	3 RN, 1 LPN, 7 MHW
8/27/2013	N	Wrong time	N	N	N	UK	3 RN, 4 MHW
8/27/2013	Y	Omission x1	N	Y	N	LK	2 RN, 5 MHW
8/27/2013	N	Wrong dose	N	N	N	US	2 RN, 4 MHW
8/29/2013	Y	Concerta omitted x 1	Y	Y	N	LK	2 RN, 5 MHW
8/29/2013	N	Without valid order	N	N	N	US	2 RN, 4 MHW
8/31/2013	N	Wrong dose	N	N	N	US	2 RN, 5 MHW
8/31/2013	N	Med without valid order	N	N	N	US	2 RN, 5 MHW
9/6/2013	N	Med without valid order	N	N	N	US	1 RN, 1 LPN, 4 MHW
9/6/2013	Y	Omission x1	N	N	N	LS	4 RN 1 LPN 7 MHW
9/9/2013	Y	Omission x1	N	Y	N	LS	3 RN, 1 LPN, 7 MHW
9/9/2013	Y	Synthroid	Y	N	N	LS	2 RN, 6 MHW
9/9/2013	N	Wrong dose x2	N	N	N	US	2 RN, 3 MHW
9/14/2013	N	Prescribing	N	Y	N	LS	2 RN, 4 MHW
9/14/2013	Y	Omission x2	Y	Y	N	LK	3 RN, 1 LPN, 7 MHW
9/15/2013	N	Wrong form	N	N	N	LS	3 RN, 7 MHW
9/25/2013 & 9/26/2013	Y	Omission x1	N	Y	N	UK	3 RN, 1 LPN, 4 MHW
Totals	**14**		**7**	**11**	**4**	LS: 13	US: 7 LK: 6 UK: 6
Percent	**44%**		**22%**	**34%**	**13%**	**40%**	**22% 19% 19%**

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

JOINT COMMISSION

Summary

There were a total of 32 medication errors this quarter (28 last quarter and 20 the quarter before). 14 of the med errors were omissions. 9 errors were dose related. 3 errors involved wrong time. 3 were errors of medications given without a valid order. 2 errors were wrong form given and there was 1 prescribing error due to a “range order”. Six of the medication errors were committed by staff floating to another unit or by staff who have been designated as “floats.” 11 of the 32 errors were by new staff here at RPC.

Actions

All nursing related medication errors were noted to have appropriate staffing levels. One of the actions to consider may be to return to a designated medication nurse for each unit. Nurse Pharmacy Committee meets monthly and is working towards identifying issues with medication management and identifying solutions to issues identified. Medication errors are reviewed weekly by Pharmacist, Medical Director, Risk Manager and Executive Nurse after the RN IV on the unit reviews the error with the staff person responsible for individual teaching and issue / process identification. Two of the nurses received counseling from their immediate supervisor.

JOINT COMMISSION

Medication Management - Dispensing Process

Medication Management	Unit	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%	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	0	0	*No discrepancies between CII Safe and vendor transactions for December.
Quarterly Results				0*	0	0		
Monthly Pyxis Controlled Drug discrepancies	All	9	0	0	0	0	0	Goal of "0" discrepancies involving controlled drugs dispensed from Pxyis
Quarterly Results			9	13	9	12		
Med Mgmt Monitoring								
Measures of drug reactions, adverse drug events and other management data	Rx	17/ year	0	0	0	0		1 ADR reported in Q4
Quarterly Results			3	1	3	1		
Resource Documentation Reports of Clinical Interventions	Rx	134 reports in 2012						100% of all clinical interventions are documented
Quarterly Results			16	36	69	64		

The key indicators in Medication Management are focused on preventing Controlled Substances loss and monitoring/trending of adverse drug reactions and clinical interventions. *Controlled Substances Loss* reviews two key reports generated by the Pyxis CII Safe which compare controlled drug transactions between the pharmacy's CII Safe and the various Pyxis Medstations; and, the purchasing data from our drug wholesaler and the corresponding CII Safe transactions. In both instances, we are looking for zero variation. *Medication Management Monitoring* is comprised of the reporting, review and monitoring of adverse drug reactions (ADR's) and Clinical Interventions as documented in the Resource Documentation tool to generate historical and graphical analysis which is reported to the P&T Committee regularly. TJC requires ongoing reporting and surveillance of adverse drug reactions, medication errors and medication related issues to the hospital wide performance improvement program with the goal of strategies to minimize their occurrence.

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.

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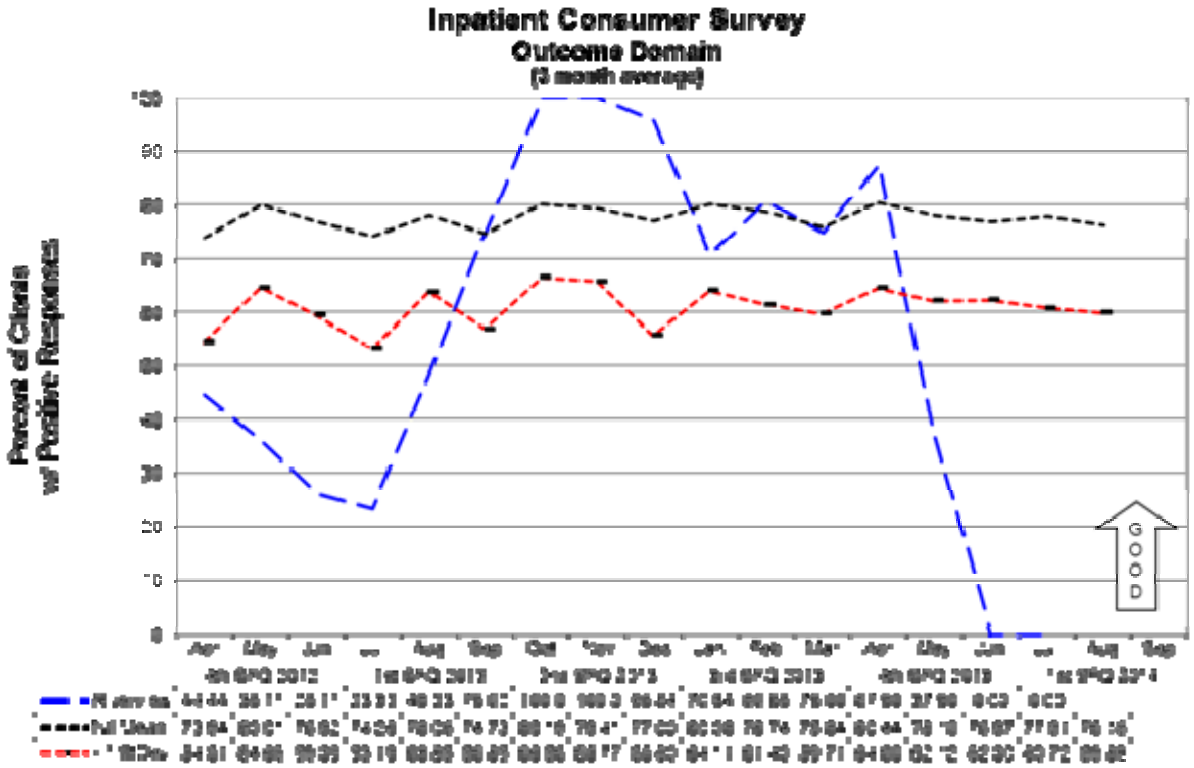
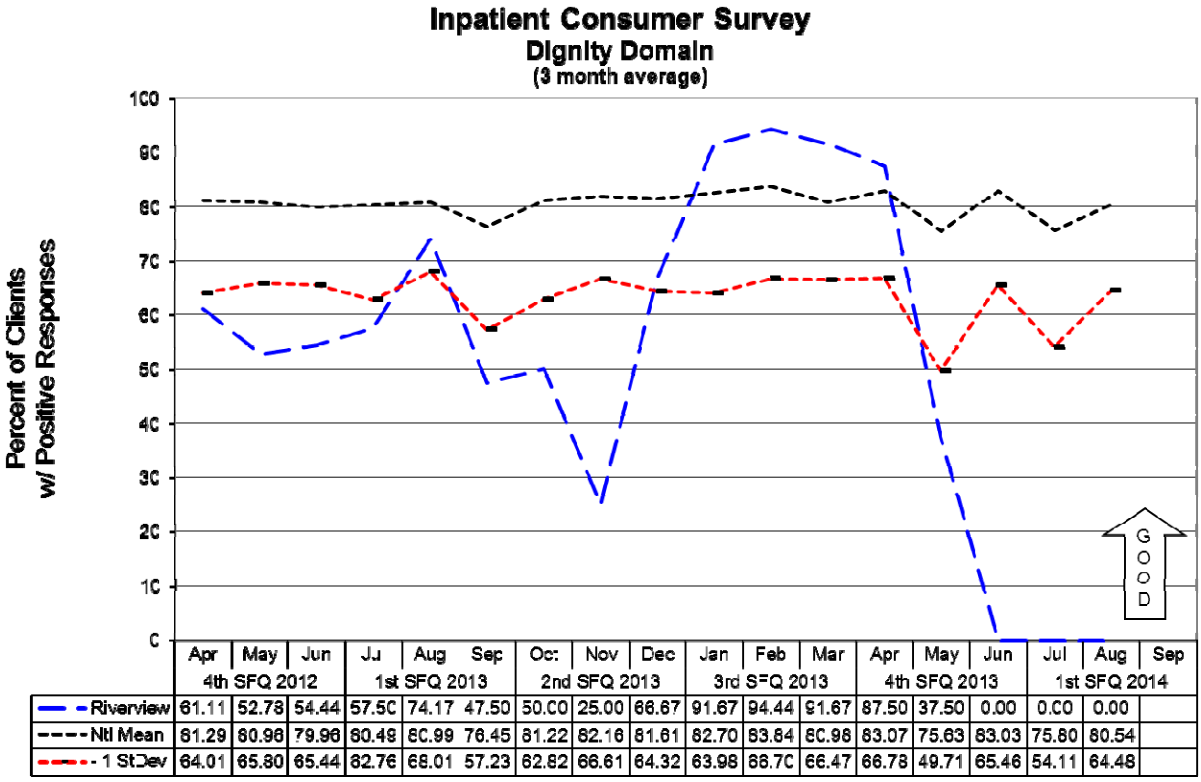


Outcome Domain Questions

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

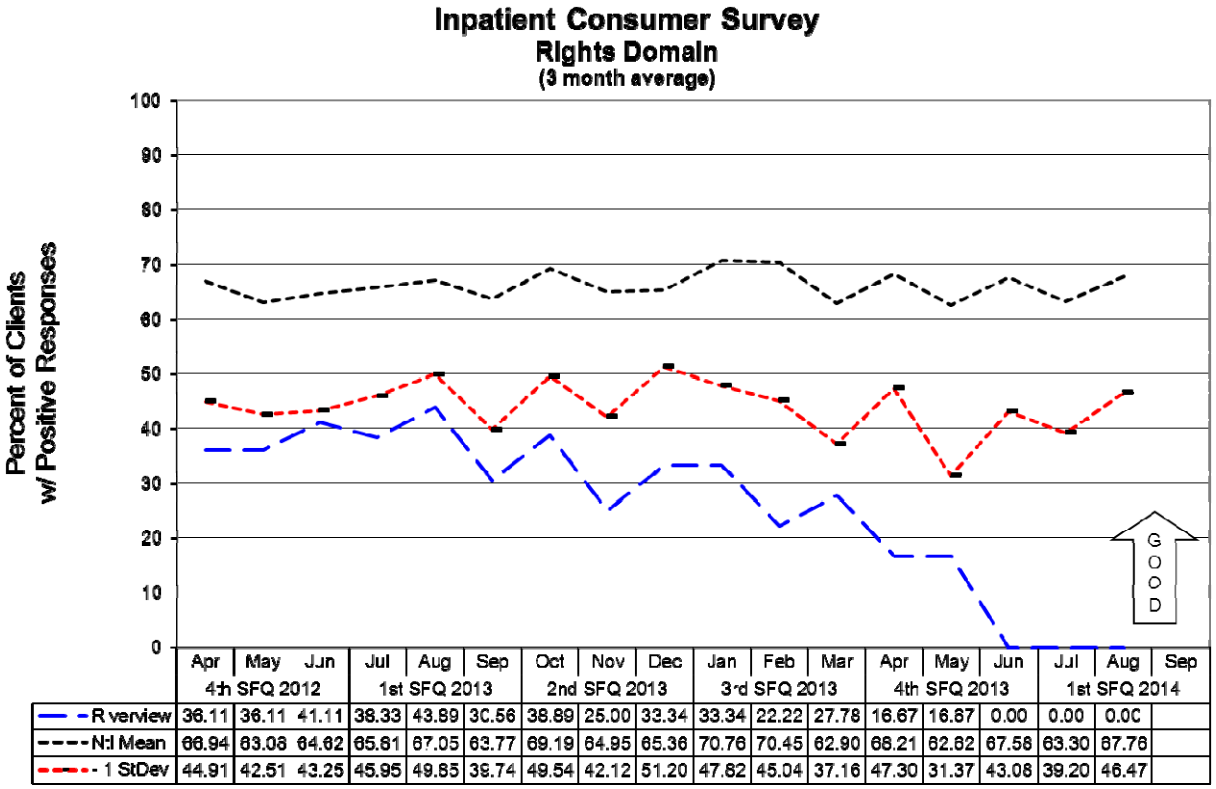


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	61.11	52.78	54.44	57.50	74.17	47.50	50.00	25.00	66.67	91.67	94.44	91.67	87.50	37.50	0.00	0.00	0.00	
Ntl Mean	81.29	80.98	79.96	80.48	80.99	76.45	81.22	82.16	81.61	82.70	83.64	80.98	83.07	75.63	83.03	75.80	80.54	
1 StDev	64.01	65.80	65.44	62.76	68.01	57.23	62.62	66.61	64.32	63.98	66.70	66.47	66.78	49.71	65.46	54.11	64.48	

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



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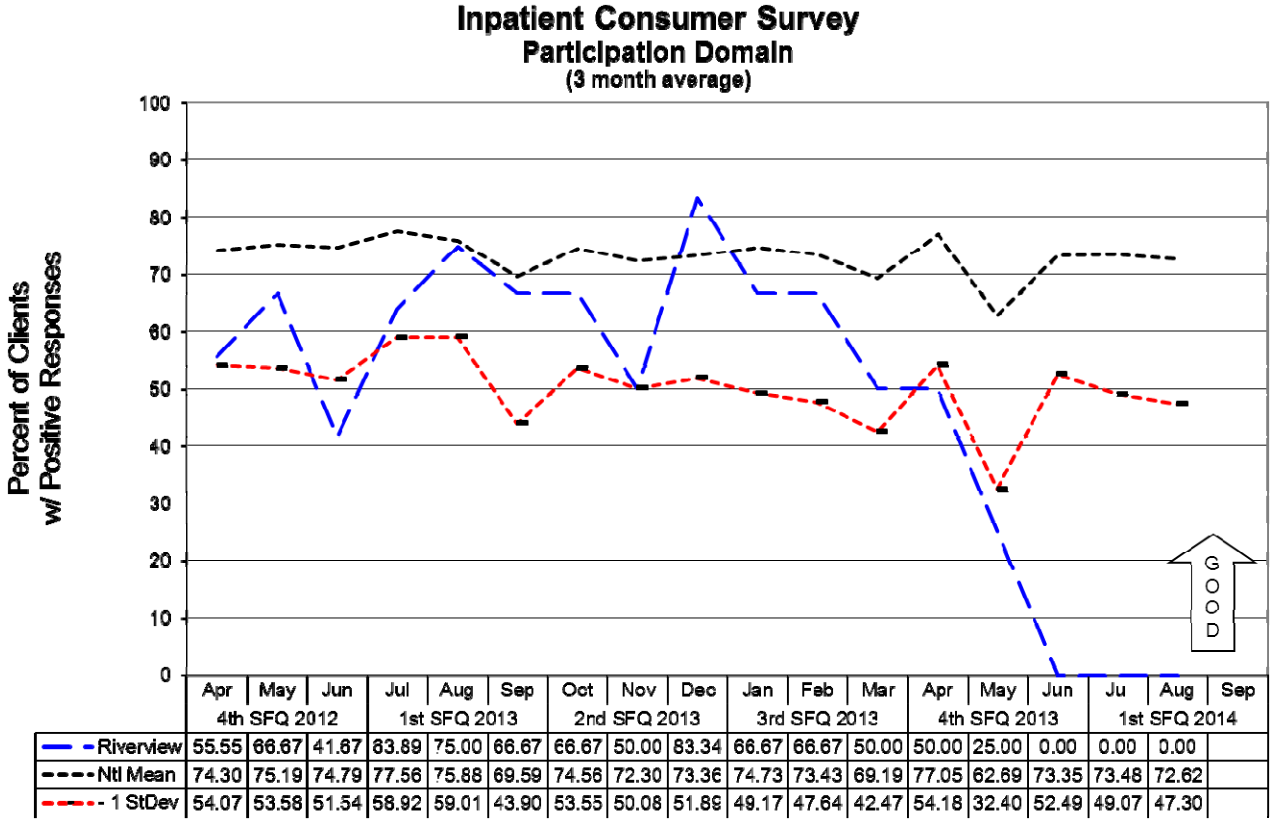
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
R verview	36.11	36.11	41.11	38.33	43.89	30.56	38.89	25.00	33.34	33.34	22.22	27.78	16.67	16.67	0.00	0.00	0.00	
N:l Mean	66.94	63.08	64.62	65.61	67.05	63.77	69.19	64.95	65.36	70.76	70.45	62.90	68.21	62.62	67.58	63.30	67.76	
1 StDev	44.91	42.51	43.25	45.95	49.85	38.74	49.54	42.12	51.20	47.82	45.04	37.16	47.30	31.37	43.08	39.20	46.47	

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



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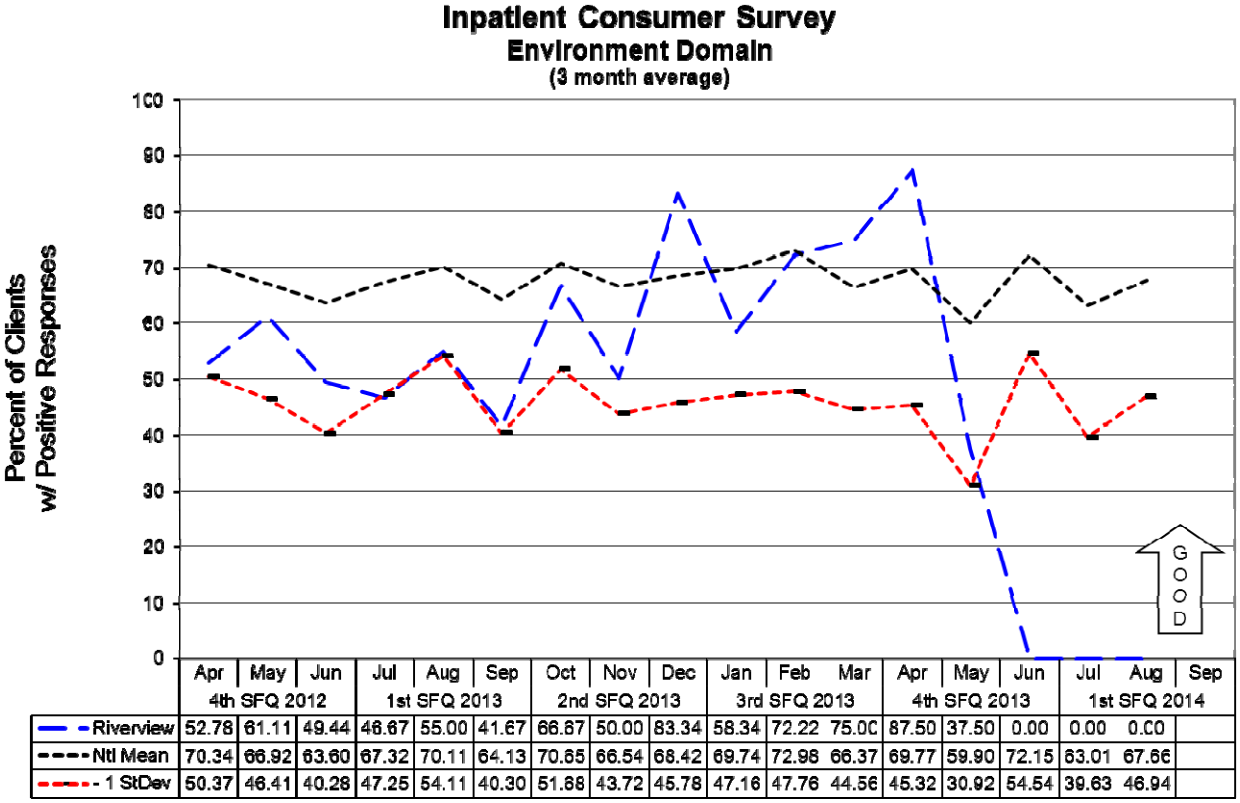
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	55.55	66.67	41.67	83.89	75.00	66.67	66.67	50.00	83.34	66.67	66.67	50.00	50.00	25.00	0.00	0.00	0.00	
Ntl Mean	74.30	75.19	74.79	77.56	75.88	69.59	74.56	72.30	73.36	74.73	73.43	69.19	77.05	62.69	73.35	73.48	72.62	
1 StDev	54.07	53.58	51.54	58.92	59.01	43.90	53.55	50.08	51.89	49.17	47.64	42.47	54.18	32.40	52.49	49.07	47.30	

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



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	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	52.78	61.11	49.44	46.67	55.00	41.67	66.67	50.00	83.34	58.34	72.22	75.00	87.50	37.50	0.00	0.00	0.00	
Ntl Mean	70.34	66.92	63.60	67.32	70.11	64.13	70.65	66.54	68.42	69.74	72.98	66.37	69.77	59.90	72.15	63.01	67.66	
1 StDev	50.37	46.41	40.28	47.25	54.11	40.30	51.88	43.72	45.78	47.16	47.76	44.56	45.32	30.92	54.54	39.63	46.94	

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

Pain Management

TJC **PC.01.02.07:** The hospital assesses and manages the patient's pain.

Indicator	3Q2013	4Q2013	1Q2014	2Q2014
Pre-administration	91%	68%	70%	
Post-administration	81%	59%	60%	

SUMMARY

Both “Pre” and “Post” assessments were up slightly from last quarter but still significantly lower than the previous quarter. The number of pain medications given this quarter was up again, (last quarter 2350). There were only 1011 pain meds given in second quarter of FY 2013. There have also been significant changes in staffing personnel and assignments these past two quarters as well as a new staff person doing the audits of pain management. Neither of these factors should affect the percentages; however it is a change that needs to be looked at.

ACTIONS

Will meet with the nurse IVs to set up a system for more frequent monitoring of the assessing process. We will meet with all the nurses and reiterate the importance of assessing pain pre and post analgesics. Will review the audit process with the newly assigned staff to determine whether or not there has been a change in the way that we audit the information. Did follow up with pharmacy to see whether they could identify possible reasons for the increase in PRN pain medications being used. Pharmacy could not explain the significant increase over the last two quarters in the pain meds used .

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	APR	MAY	JUN	4Q2013
Un-witnessed	MR00000016		1		1
	MR00000814	1			1
	MR00004287	1			1
	MR00006828			1	1
	MR00006963*	2			2
	MR00007323*	1	1		2
Witnessed	MR00000076		1		1
	MR00000477	1			1
	MR00004637		1		1
	MR00006963*	1			1
	MR00007323*	2			2

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

Review, Reporting and Follow-up Process

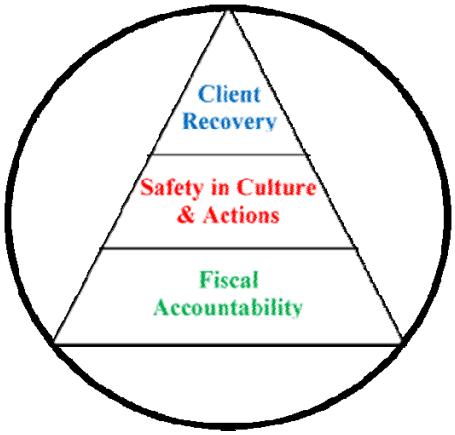
The Falls Assessment and Prevention Process Review Team (PRT) meets monthly to evaluate the causation factors related to the falls reported on the units and makes recommendations, through its multi-disciplinary membership, for changes to workflow, environmental factor, and client care practices.

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

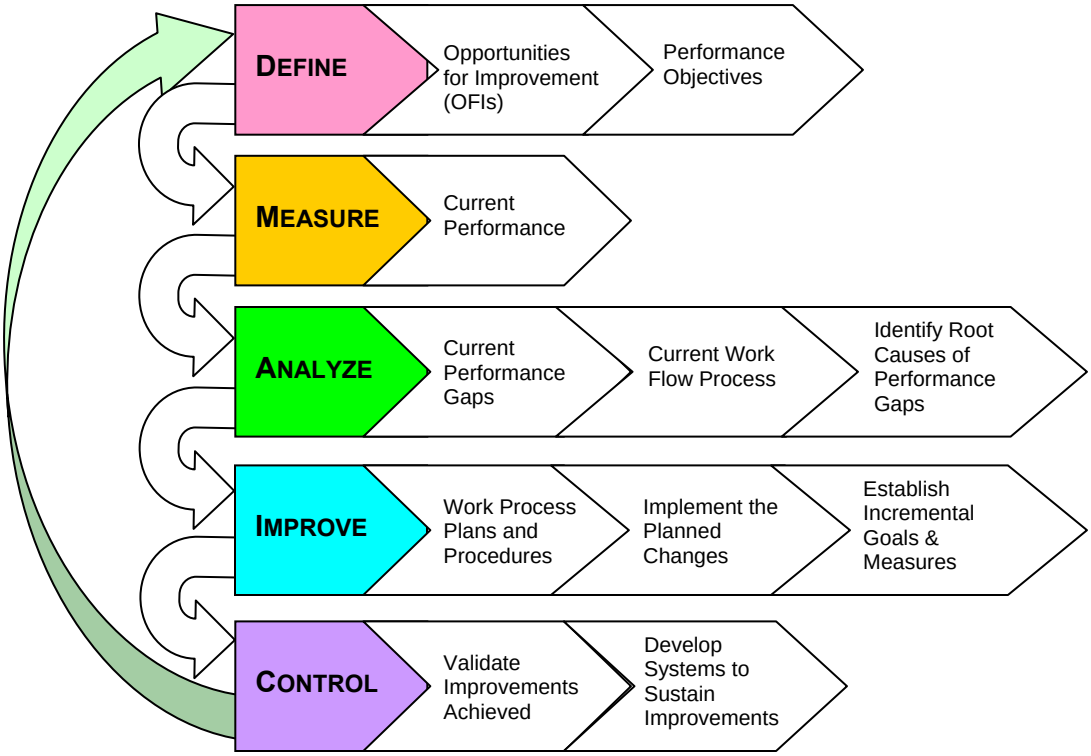
Dorothea Dix and Riverview Psychiatric Centers
Priority Focus Areas

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

1Q2014

- Over the past few months the admissions department has made additional changes to the PASF form, working in collaboration with medical records. The new PASF form now has a section that addressing preferred language for both written and verbal for new admissions.
- Admissions continues to collaborate with medical records to streamline the admission process for the units. Many of the admission forms have been updated to include signature pages with both date and times on the form.
- We have also worked with medical records to update the SBAR form so it can now be used to replace the nursing discharge paperwork previously used.
- The Health Info Net paperwork has been added to the admission packets.
- We have been able to decrease both the wait time and the list for forensic referrals.
- We are continuing to build relationships with the jails, keeping open communication so information is passed on in a timely manner.
- I have worked with RN's on the unit to complete a training on Admissions for those who asked for a refresher.
- Lower Saco unit guidelines were updated to include the rules regarding the decertified unit.
- All clients were discharged from the Lower Saco unit and readmitted to the decertified Lower Saco Unit.
- Our civil referral list has been manageable and we have continued to get them in, in a timely manner.
- Admissions continues to work with the education department on orienting new employees and students.
- Admissions has collaborated with medical records to get all the admissions packets on the common drive for staff to utilize.

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.

2nd Quarter 2013			3rd Quarter 2013			4th Quarter 2013			1st Quarter 2014			Goal
Target – Q1 + 12%	Findings	Compliance	Target – Q2 + 10%	Findings	Compliance	Target – Q3 + 10%	Findings	Compliance	Target	Findings	Compliance	
70%	18/34	53%	63%	41/49	84%	94%	22/26	85%	85%	16/30	53%	80-90%

Data

16 compliant observations / 30 hand hygiene observations = 53% hand hygiene compliance rate

Summary

- Hand hygiene compliance has decreased by 32%.
- Hand hygiene observations have marginally increased; 22 observations last quarter to 30 observations this first quarter.
- Utilizing an alternate means of data collection in the month of July did not increase the occurrences of hand hygiene observations. Self-documentation proved to be cumbersome and time consuming for the employees. Thus, the accuracy of the log cannot be validated.
- Self-documentation was not used as a means of data collection in the months of August and September.
- Reformatting the Hand Hygiene Tool simplified the observation process and aided with the increase of observations for the months of August and September.

Action Plan

- Continue use of the improved Hand Hygiene Tool.
- Encourage employees to adhere to hand hygiene via verbal interaction.
- Food Service Manager provide employee education in the month of October: Interactive Hand Hygiene education.

- The Dietetic Services Manager will review the following publication:

(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

STRATEGIC PERFORMANCE EXCELLENCE

Dietary Services

Measuring Hand Hygiene Adherence: Overcoming the Challenges
Authored by The Joint Commission in collaboration with The Association for Professionals in Infection Control and Epidemiology, Inc., The Centers for Disease Control and Prevention, The Institute for Healthcare Improvement, The National Foundation for Infectious Diseases, The Society for Healthcare Epidemiology of America, and The World Health Organization World Alliance for Patient Safety

- Additionally, the Food Service Manager will present this quarterly report at the departmental staff meeting and IPEC meeting.

Strategic Objective: Safety in Culture and Actions

Hand Hygiene Compliance: In an effort to monitor, improve and sustain timely completion of the nutrition screen for all admissions to RPC, the Registered Dietitian will review each Nutrition Screen within the Initial Nursing Admission Data. This screen will be completed by Nursing within 24 hours of admission.

1st Quarter 2014			2nd Quarter 2014			3rd Quarter 2014			4th Quarter 2014			
Established Baseline	Findings	Compliance	Target	Findings	Compliance	Target	Findings	Compliance	Target	Findings	Compliance	Goal
93.5%	29/13	93.5%	94%			94%			94%			90-95%

Data
29 Nutrition screens completed within 24 hours of admissions
31 Total Admissions = 93.5% of nutrition screens completed within 24 hours of admission

Summary
- The Registered Dietitian reviewed the nutrition screens of 31 client admissions for this quarter
- Upon review, the RD discovered 4 nutrition screens incomplete
- RD spoke with the admitting nurse and requested completion of the screen resulting in two of the four being complete within 24 hours of admission

Action Plan
- RD will continue correspondence with nursing staff regarding the discovery of an incomplete nutrition screen
- Present quarterly report at departmental staff meeting and IPEC 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 from July 2013 to June 2014.

2014 Q1-Q4 TARGETS

Baseline – 5% each Q

STRATEGIC PERFORMANCE EXCELLENCE

Environment of Care

Department: Safety & Security

Responsible Party: Bob Patnaude, Safety Officer

Strategic Objectives								
Safety in Culture and Actions	Unit	Baseline	Q1 Target Actual	Q2 Target Actual	Q3 Target Actual	Q4 Target Actual	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	(16) -5% (24)	(24) -5%			Baseline -5%	****See below

SUMMARY OF EVENTS

The Q4 Target was (16)-5%. Our actual number was (24); a significant increase again this quarter. ****Although we would like to report that our incident rate has decreased, we are pleased that in all the cases, our Security staff or clinical staff have discovered items before those items get into the hands of anyone who would have an ill intent with the items. In fact, one incident was reported by a responsible client. 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 aggressive rounds by Security continues to prove its' worth with regard to Security's presence and patrol techniques.

EVENT	DATE	TIME	LOCATION	DISPOSTION	COMMENTS
1. Safety Threat (Item Posey key) found outside by Door #5	7/7/13	0835	By door #5	Turned over to RN and then NOD	1. Security found during rounds 2. RN and NOD immediately notified 3. Safety Notified 4. IR # 4045 completed
2. Safety Threat (Metal Coffee Mug)	7/7/13	1330	Saco Yard	Given to NOD	1. MHW found during yard break 2. Item turned over to NOD 3. IR # 5069 completed/Safety notified 4. Cup later picked up by owner/advised
3. Property Damage (Sign light broken)	7/9/13	1800	Facility Sign	Maintenance secured and replaced	1. NOD notified 2. Maintenance secured and later replaced 3. IR # 1141 completed/Safety notified
4. Safety Threat (Plastic dental pick by bench outside Sebago Room)	7/10/13	1200	Sitting area by Staff Entrance	Security removed	1. Security found during rounds 2. Secured items 3. IR # 517 completed/Safety notified
5. Security Threat (Fire gate by sheds not locked)	7/13/13	0145	Fire Lane	Security secured	1. Security discovered during rounds 2. Security secured 3. Operations and NOD notified IR # 519 completed/Safety notified

Environment of Care

EVENT	DATE	TIME	LOCATION	DISPOSTION	COMMENTS
6. Safety Concern (Key found near cargo containers)	7/15/13	1100	By cargo container	Secured by Security, turned into Operations lost & found	1. Security discovered during rounds 2. Security checked with facilities/unsure who it belongs to 3. Turned into Operations/lost & found 4. IR # 520 completed/Safety notified
7. Safety Concern (Items, spool of wire, rope, piece of wood)	7/16/13	0120	Parking lot #4, lower lot	Secured by Security	1. Security found during rounds 2. NOD notified 3. IR # 521 completed/Safety notified 4. Email sent out to determine owner/not located
8. Security Concern (Outsider by staff entrance seeking assistance)	7/17/13	0331	Staff Entrance	Security called Capital Police and Augusta Police, transported to shelter	1. Operations notified Security 2. Security assessed 3. NOD notified 4. Capitol Police called 5. Person transported to shelter by APD 6. IR # 522 completed/Safety notified
9. Safety Concern (Metal shims by fence, adjacent to loading dock)	7/17/13	0700	Fence along loading dock/ chiller	Security turned over to Maintenance	1. Security discovered during rounds 2. Turned over to Maintenance 3. IR # 523 completed/Safety notified
10. Safety Threat (Items in open back of truck) (2 claw hammers)	7/20/13	0930	Staff Lot	Securing secured, email sent, owner secured	1. Security discovered during rounds 2. Email sent for owner to respond 3. Owner secured 4. IR # 525 completed/Safety notified
11. Safety Concern (Items in open back of truck) (Ratchet strap)	7/20/13	2330	Staff Lot	Security secured	1. Security discovered during rounds 2. Secured at Security 3. Email to locate owner/NOD notified 4. No response/turned over to Operations 5. IR # 526 completed/Safety notified
12. Safety Concern (Electrical Box unlocked and padlock laying on top)	7/24/13	0645	By Admissions A Door	Security Secured	1. Security discovered during rounds 2. Maintenance locked box 3. Turned over to Maintenance Supervision to ascertain who is responsible 4. IR # 528 completed/Safety notified
13. Safety Concern (Gunshots from AMHI campus)	7/24/13	2353	AMHI Campus	Security monitored	1. Security discovered during rounds 2. Capitol Police on scene immediately 3. Nothing further/NOD notified 4. IR # 5029 completed/Safety notified

STRATEGIC PERFORMANCE EXCELLENCE

Environment of Care

EVENT	DATE	TIME	LOCATION	DISPOSTION	COMMENTS
14. Safety Concern (Items in back of staff vehicle) (Ratchet straps, bungee cord, golf tees)	7/25/13	0925	Staff Lot	Security removed items and secured, Owner later secured	1. Security discovered during rounds 2. Email sent/NOD notified 3. Secured items/Owner later picked up 4. Security spoke to owner 5. IR # 530 completed/Safety notified
15. Safety Concern (Beer can in back of staff vehicle)	7/28/13	0153	Staff Lot	Security secured	1. Security discovered during rounds 2. Security secured/Owner identified 3. Disposed by Security 4. IR # 531 completed/Safety, NOD notified
16. Safety Concern (Soda can outside by generator room)	7/29/13	1400	Outside by generator room	Security disposed of	1. Security discovered during rounds 2. Security disposed of 3. Maintenance Supervisor notified 4. IR # 533 completed/Safety notified
17. Security Concern (Rifle in plain view of staff vehicle)	7/30/13	0920	Staff Lot	Security stood by, called Capitol Police	1. Security notified by other staff person 2. Responded and stood by for Police to respond 3. Owner identified by police/Report taken 4. Capitol Police took possession 5. IR # 535 completed/Safety notified
18. Safety Concern (Items in back of staff vehicle) (Heavy metal chain with books)	7/30/13	0940	Staff Lot	Security stood by, Owner removed items	1. Security discovered during rounds 2. Stood by while owner responded 3. Owner removed items and secured 4. Immediate supervisor spoke to staff owner 5. IR # 536 completed/Safety notified
19. Safety Concern (Vehicle had broken window)	8/6/13	1340	Staff Lot	Security stood by, Owner removed	1. Security notified Operations 2. Stood by while owner responded 3. Discovered window broken by grounds crew weed whacking 4. Grounds supervisor spoke to crew 5. IR # 539 completed/Safety notified
20. Safety Concern (State vehicle with window down)	8/17/13	0138	State Vehicle Lot	Security closed window	1. Security discovered during rounds 2. Security obtained keys and secured 3. Last known driver's supervisor notified IR # 543 completed/Safety notified

STRATEGIC PERFORMANCE EXCELLENCE

Environment of Care

EVENT	DATE	TIME	LOCATION	DISPOSTION	COMMENTS
21. Security Concern (Suspicious person on property)	8/19/13	2100	Adjacent to walkway	Security called Police	1. Security notified by staff of suspicious person 2. Security called police 3. Police escorted from property 4. IR # 544 completed/Safety notified
22. Safety Concern (Items in back of staff vehicle) (cans)	8/21/13	1705	Staff Lot	Security secured	1. Security discovered during rounds 2. Owner located 3. Owner secured property 4. IR # 545 completed/Safety notified
23. Safety Concern (Items on ground) (2 ½" pin)	9/9/13	1300	Visitor's Lot	Security secured	1. Staff discovered/turned into Security 2. NOD notified 3. IR # 1178 completed/Safety notified
24. Hit and Run Accident	9/10/13	1630	Staff Lot	Capitol Police Called	1. Staff discovered midday 2. Safety and Capitol Police notified 3. IR # 551 completed
25. Safety Concern (Storage shed missing screen)	9/26/13	0934	Storage shed	Maintenance notified	1. Security discovered during rounds 2. Maintenance and Safety notified by email 3. IR # 545 completed/Safety notified
26. Safety Concern (Items in open back of truck) (Wrenches, hammer, golf clubs)	9/26/13	0935	Staff Lot	Safety and Security secured	1. Security discovered during rounds 2. Safety and Capitol Police notified to ID 3. Did not ID owner immediately after emails sent 4. Safety and Security brought items in 5. Incident presented to IP/Vehicle ID issue 6. Staff Person later identified and secured 7. IR # 558 completed

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*	*60% 25/42*	*71% 30/41*
2. SBAR information completed from the units to the Harbor Mall.	*67% 28 of 42*	*76% 32 of 42*	*88% 37/42*	*86% 36/42*

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 60% last quarter to 71% for this quarter. Indicator number two has decreased from 88% last quarter to 86% this quarter.

ANALYZE

Overall compliance has increased from 74 % last quarter to 79% this quarter. For indicator number one the designated time for the sheets to be received is not in compliance. The amount of time the sheets are late has decreased. Continue to concentrate on both indicators to improve current performance gaps.

IMPROVE

I met with the Nurse IV on US to review June's data since they had the most HOC sheets that were not received on time or not received at all. On July 17th I reviewed the results of April/May/June quarterly report at Nursing Leadership.

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 consistent system that works for them to meet the objectives. I will review the results of this quarterly report at Nursing Leadership.

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

14 providers submitted superbills to the Health Information department for quarter 1.

Analyze

A total of eight superbills submitted were duplicates coming from four different providers this quarter (JK-3, KB -2, GD-1, EH-1, BK-1). Eight superbills had date of service discrepancies i.e.; missing DOS and two of those with incorrect dates submitted by 6 providers (JK-3, EH-1, GD-1, BM-1, SU-1, PM-1). Twelve superbills were submitted missing the procedures codes by five providers (KB- 1, GD- 5, MD- 1, AR - 2, BM- 1, JJ – 1, PM- 1).

Improve

Superbills are all being returned to the providers for correction. Continue to work with providers on appropriate/consistent documentation.

Control

100% of the superbills are being audited.

Process Deficiencies Identified	2Q2013	3Q2013	4Q2013	1Q2014
Superbill Submission without supporting documentation	72% 18/25	35% 9/26	4% 1/24	0%
Superbills with incorrect information		69% 18/26	75% 18/24	71% 20/28
Duplicate Superbills	76% 19/25	8% 2/26	13% 3/24	29% 8/28

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

Data collected for the 1st quarter 2014 showed the following results:

- Maine State Police forwarded the greatest number of applications, a total of 2243 applications for the quarter with an average processing delay prior to receipt by the hospital of 133 days. The maximum delay for any application was 1568 days as measured from the date the application was signed by the applicant to the date received by the hospital.
- The average number of days for hospital processing of applications was 9 days. The maximum number of days was 45.

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.

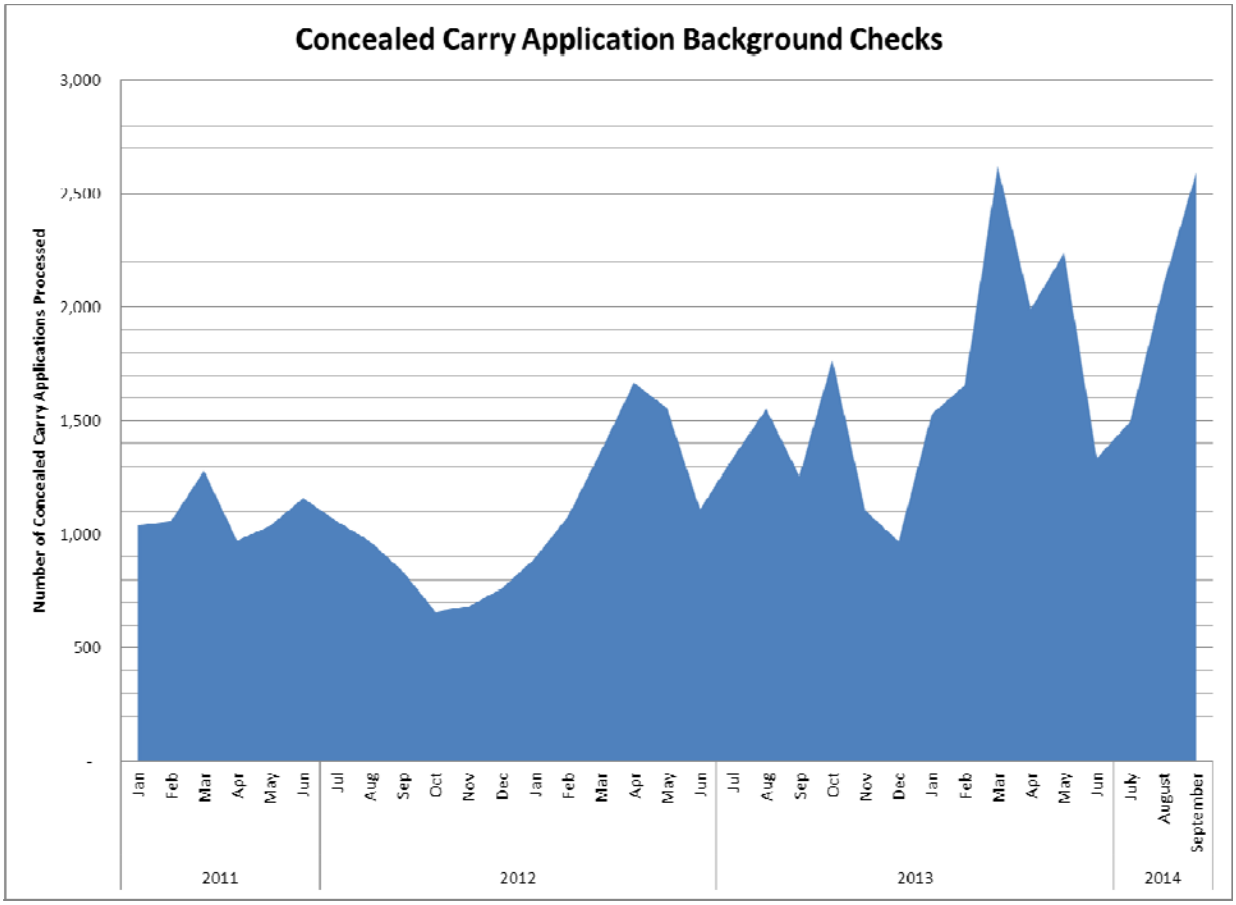
Other improvements being considered include transforming the existing archival records to a digital format. Barriers to be considered in this change include the significant time and fiscal impact required.

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 2013/2014	Oct	Nov	Dec	Jan`	Feb	Mar	Apr	May	Jun	July	Aug	Sep
# Applications Received	1757	1104	970	1529	1657	2623	1993	2239	1336	1497	2096	2596
Avg Receipt Delay	--	--	--	--	--	35	26	42	66	82	76	30
Max Receipt Delay	--	--	--	--	--	381	451	504	1694	1568	258	508
Avg Processing Time	--	--	--	--	--	11	8	13	15	13	11	3
Max Processing Time	--	--	--	--	--	13	11	20	19	45	15	7

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

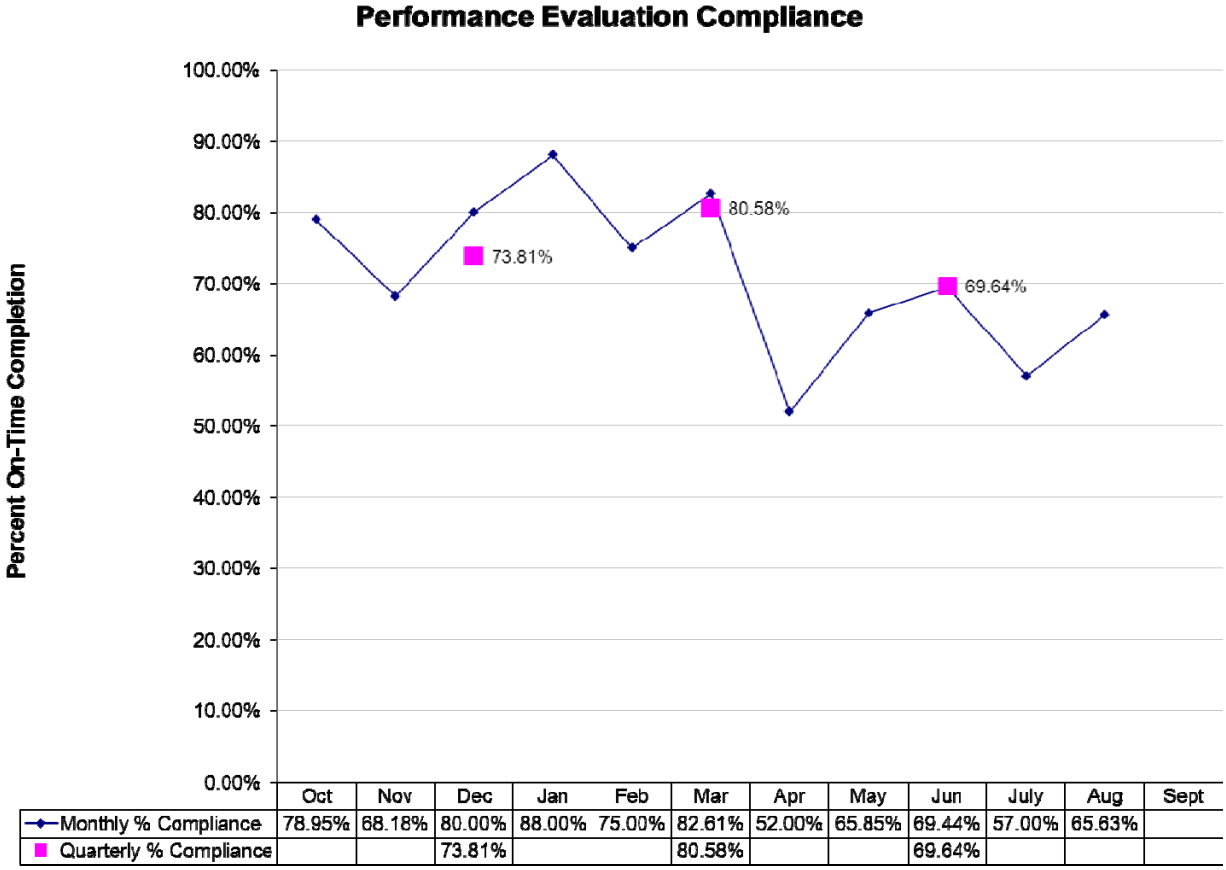
A thorough analysis of the root causes for lack of compliance with this performance standard is indicated. This analysis

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

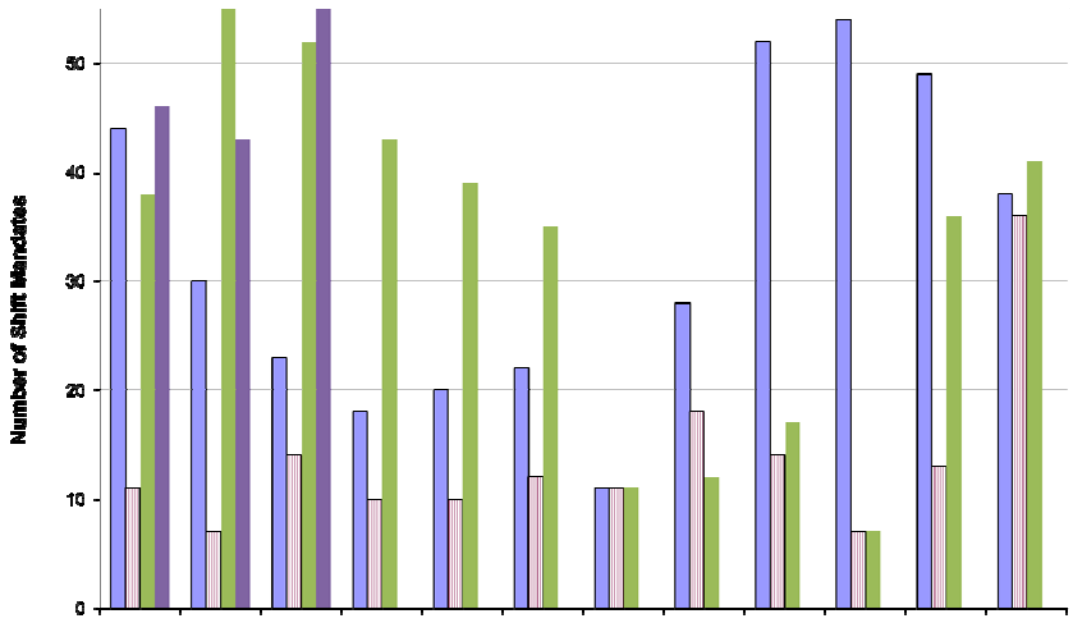
Plans to modify hospital performance evaluation goals for supervisory personnel will include the completion of subordinate performance evaluations in a timely manner as a critical supervisory function.



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept
Monthly % Compliance	78.95%	68.18%	80.00%	88.00%	75.00%	82.61%	52.00%	65.85%	69.44%	57.00%	65.63%	
Quarterly % Compliance			73.81%			80.58%			69.64%			

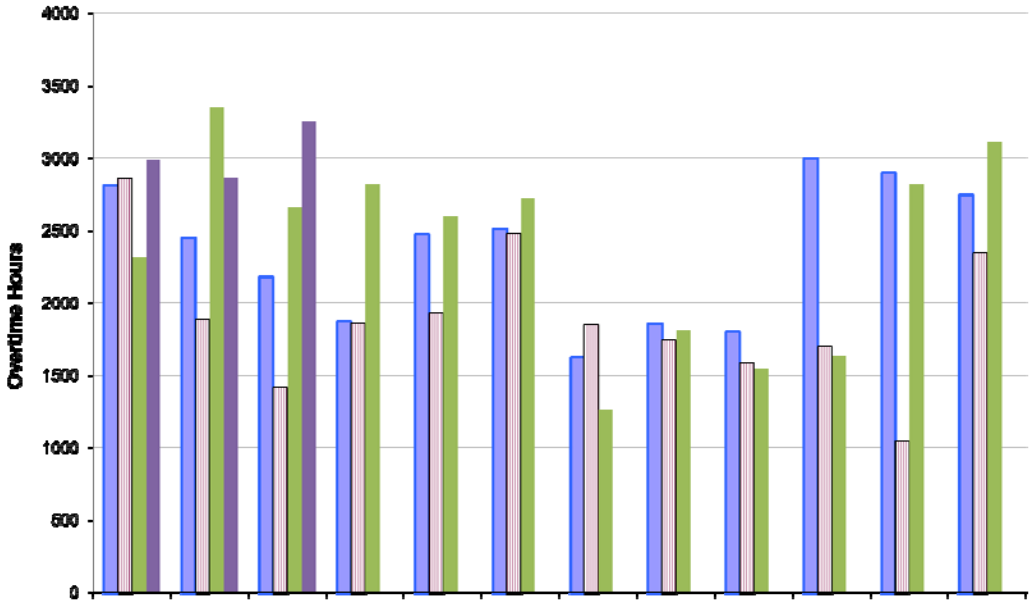
STRATEGIC PERFORMANCE EXCELLENCE

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
FY 2011	11	7	14	10	10	12	11	18	14	7	13	36
FY 2013	38	81	52	43	39	35	11	12	17	7	36	41
FY 2014	46	43	69									

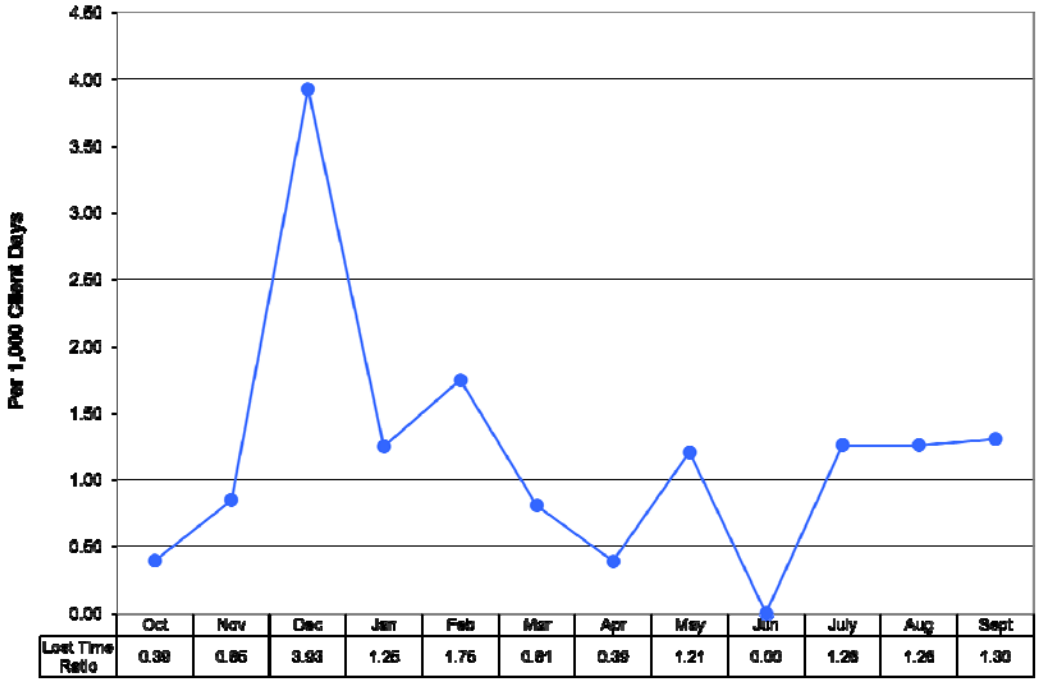
Monthly Overtime



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2012	2812	2451	2178	1866	2473	2507	1618	1853	1798	2999	2896	2743
FY 2011	2859	1865	1411	1860	1926	2474	1844	1740	1589	1697	1042	2342
FY 2013	2319	3350	2657	2817	2599	2720	1269	1812	1539	1629	2822	3109
FY 2014	2983	2861	3251									

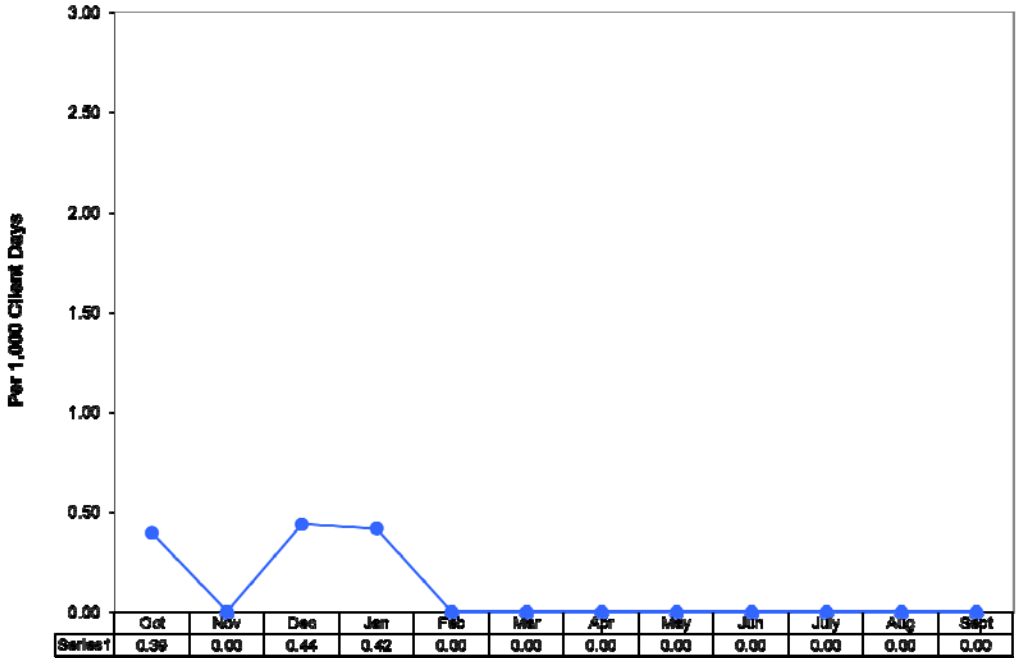
STRATEGIC PERFORMANCE EXCELLENCE

Reportable (Lost Time & Medical) Direct Care Staff Injuries



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept
Lost Time Ratio	0.39	0.85	3.93	1.25	1.75	0.81	0.39	1.21	0.00	1.26	1.26	1.30

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



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept
Series1	0.39	0.00	0.44	0.42	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff
Timeliness of Psychological Testing

Data Collection
All requests for psychological testing or evaluation were reviewed during the time period of July, August, and September 2013. The date of medical staff request, date the requested service was initiated by the appropriate psychologist, and date of final completion of requested task (including a written report) were determined and compared to target norms.

Findings
During the period there were 4 requests for psychological testing or evaluation. All of the evaluations were initiated by the psychologist within 7 days of request and exceeded threshold of 90%. Two of three requests (67%) were completed within 30 days (the 4th request was pending at the end of the quarter) after initiation. We did note that the client who took longer than 30 days to complete was intermittently declining to complete the tests.

Analysis
There was a definite decline in the number of requested psychological tests this quarter no doubt partially influenced by a temporary reduction in the number of psychologists following the resignation of the Director. However the timeliness of initiation of testing remained above threshold, and time to completion was below threshold of 90%, but attributable to one client who was disinclined to cooperate with the process.

Plan
We will continue this monitor especially in light of a reduction (hopefully temporary) in force of the Psychology Department. We will continue to work with the Psychology Department to most efficiently use their limited resources and to work with the Medical Staff to make certain only necessary referrals are made to the Department

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff
Polyantipsychotic Medication Monitoring

Data Collection

All medication profiles in the hospital were reviewed on three occasions this quarter in July, August, and September. We were particularly interested in the proportion of clients who were receiving more than one antipsychotic medication, since practice guidelines by the American Psychiatric Association clearly discourage this practice. When a case of polypharmacy was encountered we further required the prescriber to justify the practice based on pre-agreed upon clinical elements required to make the justification. The Medical Director was the final arbiter of justification.

Findings

Over the quarter we found that 59 of 183 clients (32.2%) receiving at least one antipsychotic medication were receiving more than one such agent, and by definition was a case of polypharmacy. Within this overall percentage we noted that in July the percentage was 37.3, in August it was 33.3, and in September it was 26.6. The average justification percentage for the 59 total clients was 89.8%. Again we noted improvement over the quarter with justifications in August and September above the threshold of 90%.

Analysis

We were just below our target of 90% justified for the quarter at 89.8%. The trend line showed improvement over the quarter and was above threshold in September at 94%. A secondary finding was that the overall percentage clients receiving polypharmacy had also significantly declined from baseline. We also had reduced significantly the numbers of clients receiving ultrahigh numbers of medications (greater than 3 antipsychotics). The medical staff performance did improve on this monitor over the quarter.

Plan

We will continue this monitor for another quarter since appropriate antipsychotic prescribing is both a common task in the hospital as well as one fraught with many potential negative sequellae. We will continue to give feedback to medical staff and to look closely at all cases where it has been difficult to wean the client off high doses of multiple drugs.

Medical Staff
Antibiotic Use Monitoring

Data Collection

During the quarter we created an antibiotic monitoring form consisting of a special doctor's order sheet with details of the antibiotic indication, drug, and strength, and giving agreed upon prescribing guidelines to the medical staff. The guidelines were approved by the Medical Executive Committee and disseminated to all medical staff. The monitoring form was first used beginning late in September. In September only four orders for antibiotics had been initiated by medical staff. We have not yet analyzed the findings on these few forms, thinking we will have a 100% review by the Medical Services Department going forward and including the results of this quarter in next quarter's data.

Plan

This is the first quarter for this monitor and most of the activity was related to setting up the infrastructure to allow proper monitoring. Going forward we will collect all antibiotic orders and peer review the proper use and indications for the antibiotic. Our threshold for this monitor is that 90% of all antibiotic orders will meet clinical guidelines as developed by the Medical Executive Committee.

Medical Staff
Metabolic Monitoring of Atypical Antipsychotics

Data Collection

The pharmacy completed its initial data base of metabolic monitoring parameters for all clients in the hospital who were receiving atypical antipsychotics during the quarter. Data elements collected on all clients included BMI and BP plus lab results including HDL cholesterol, trigycerides, fasting blood sugar, and hemoglobin A1c. Also collected were the dates of the last tests and the names of the atypical drugs each client was receiving. The data collection was completed by September 30 and presented to all medical staff. The pharmacy plans to continuously update the data base as new clients are admitted and as new data elements are recorded in the medical record and/or received from laboratory reports. A written copy of the data base will be presented monthly, in writing, to all medical staff members although they may access it at any time via the pharmacy drive on the computer.

Findings

During the monitoring period there were 52 clients receiving at least one atypical antipsychotic agent. Data was completely recorded for all desired data elements for 38 of 52 (or 73%) clients. Missing data elements were primarily related to lab studies, with only one client missing BMI data.

Analysis

At 73% we were below our target of 95% of clients on antipsychotics having a complete metabolic profile available to the pharmacist and to the medical staff. This was primarily due to missing laboratory values in the data base. Upon conversations with medical staff some of these missing data elements were because the labs had been obtained at referring hospitals just prior to admission to RPC and were not readily available to the pharmacy data base manager. At the P and T Committee we discussed how medical staff could forward such data to the pharmacy, and other ways to improve the data base.

Plan

This is a new monitor for the medical staff and the above data should be considered a baseline value. Much effort was expended over the quarter to get the data base up and running. Going forward we will refine our data entry techniques and make other improvements to the data base. We will continue this monitor until we have successfully input 95% of clients on a consistent basis for two quarters.

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

Nursing Department Mandates

Staffing Improvement Task Force

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

Safety in Culture and Actions	**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.	24	10	5	0	6	16 (10% reduction monthly x4 from baseline)	Goal exceeded.
Mandate Occurrences – Mental Health Workers When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy.	53	38	36	34	28	35 (10% reduction monthly x4 from baseline)	Goal exceeded
Safety in Culture and Actions	**Mth 5 Jan 2013**	**Mth 6 Feb 2013**	**Mth 7 Mar 2013**	**Mth 8 April 2013**	**Mth 9 May 2013**	**Mth 10 June 2013**	
Mandate Occurrences - Nurses	1	2	1	0	1	4	Goal Exceeded
Mandate Occurrences – Mental Health Workers	8	8	15	7	35	41	Increase in MHW mandates – increased acuity and 1-1 coverage ordered
Safety in Culture and Actions	**Mth 11 July 2013**	**Mth 12 Aug 2013**	**Mth 13 Sep 2013**				
Mandate Occurrences - Nurses	4	5	3				Increase due to vacancies and leaves.
Mandate Occurrences – Mental Health Workers	37	55	37				Increase due to increased acuity, 1:1 coverage, vacancies, workers comp and FML

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

Peer Support

Inpatient Client Survey – Improving the Rate of Return

Department: Peer Support Responsible Party: Chris Monahan

Strategic Objectives								
Client Recovery	Unit	Baseline	Q1	Q2	Q3	Q4	Goal	Comments
CSS Return Rate	LK	15%	ND	9%	8%	5%	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%	4%	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%	39%	50%	
	US	30%	ND	78%	60%	100%	50%	

STRATEGIC PERFORMANCE EXCELLENCE

Summary of Inpatient Client Survey Results

#	Indicators	1Q2014 Findings
1	I am better able to deal with crisis.	70%
2	My symptoms are not bothering me as much.	78%
3	The medications I am taking help me control symptoms that used to bother me.	65%
4	I do better in social situations.	69%
5	I deal more effectively with daily problems.	70%
6	I was treated with dignity and respect.	70%
7	Staff here believed that I could grow, change and recover.	73%
8	I felt comfortable asking questions about my treatment and medications.	63%
9	I was encouraged to use self-help/support groups.	65%
10	I was given information about how to manage my medication side effects.	65%
11	My other medical conditions were treated.	63%
12	I felt this hospital stay was necessary.	63%
13	I felt free to complain without fear of retaliation.	60%
14	I felt safe to refuse medication or treatment during my hospital stay.	39%
15	My complaints and grievances were addressed.	58%
16	I participated in planning my discharge.	67%
17	Both I and my doctor or therapist from the community were actively involved in my hospital treatment plan.	58%
18	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	72%
19	The surroundings and atmosphere at the hospital helped me get better.	68%
20	I felt I had enough privacy in the hospital.	68%
21	I felt safe while I was in the hospital.	65%
22	The hospital environment was clean and comfortable.	73%
23	Staff were sensitive to my cultural background.	63%
24	My family and/or friends were able to visit me.	78%
25	I had a choice of treatment options.	58%
26	My contact with my doctor was helpful.	70%
27	My contact with nurses and therapists was helpful.	60%
28	If I had a choice of hospitals, I would still choose this one.	58%
29	Did anyone tell you about your rights?	58%
30	Are you told ahead of time of changes in your privileges, appointments, or daily routine?	60%
31	Do you know someone who can help you get what you want or stand up for your rights?	58%
32	My pain was managed.	64%
	Overall Score	**64%**

Summary

Due to employee turnover we have started a new method for calculating results in the 1st quarter of 2014. We will continue to use this method going forward and will be comparing changes in results from quarter to quarter.

1 = Strongly Disagree = 0%
2 = Disagree = 25%
3 = Neutral = 50%
4 = Agree = 75%
5 = Strongly Agree = 100%

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

The IPEC reporting reflects three major areas of focus for performance improvement that have pharmacy specific indicators: **Safety in Culture and Actions, Fiscal Accountability and Medication Management** (see Medication Management – Dispensing Process)**.** The pharmacy specific indicators for each of the priority focus areas utilizes measurable and objective data that is trended and analyzed to support performance improvement efforts and medication safety, as well as, ensure regulatory compliance and best practice in key areas.

Safety in Culture and Actions

RPC's primary medication distribution system uses the Pyxis Medstations to provide an electronic "closed loop" system to dispense medications for patients. Within the Pyxis system, key data elements are reported, trended and analyzed to ensure medication safety and regulatory compliance are maintained. *Pyxis Discrepancies* created by nursing staff are monitored daily and analyzed by Pharmacy with follow up to Nursing as needed for resolution. A monthly summary is provided to the Nursing-Pharmacy Committee for further review and discussion of trends and ideas to minimize the occurrence of discrepancies by Nursing. *Pyxis Overrides of Controlled Drugs* by nursing staff is another indicator that is closely monitored and trended with follow up for resolution as needed. A monthly summary is also reviewed by the Nursing-Pharmacy Committee for action steps. The goal with each of these indicators is to minimize the occurrence of either discrepancies or overrides by action steps to address performance issues via education or system changes which help satisfy TJC requirements for monitoring the effectiveness of the Medication Management system. *Veriform Medication Room Audits* are performed on each medication room to determine compliance with established medication storage procedures and requirements. The results of the audits are shared with the nursing managers for their respective corrective actions or staff education.

Fiscal Accountability

The *Discharge Prescriptions* indicator tracks the cost and number of prescription drugs dispensed to patients at discharge. This baseline data will be used to determine the best approach to implement steps to decrease this expense. The lack of a resource to perform insurance verification and research prior authorizations needed so clinicians' can make timely and informed prescribing decisions is believed to be inherent in the discharge process. Without this resource, RPC is obliged to provide discharge medications to prevent a gap in medication coverage as the patient is being transitioned to another facility. The plan of correction is to explore options and propose a resolution to RPC's Medical Director.

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

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

Safety in Culture & Actions	Unit	Baseline (Sept-Oct)	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Pyxis CII Safe Comparison *Daily and monthly comparison of Pyxis vs CII Safe transactions*	Rx							Goal of no discrepancies between Pyxis and CII Safe transactions.
Quarterly Results								
Veriform Medication Room Audits *Monthly comprehensive audits of 14 criteria*	All	Apr-June 100%	100%	100%	100%	100%	90%	Overall compliance is 99% for Q4
Quarterly Results			92%	99%	98%	99%		
Pyxis Discrepancies *Monthly monitoring and trending of Pxyis discrepancies.*	All	Aug-Nov 107/mo	107	107	50	50	50/mo	Target goal is 50/month discrepancies after 6 months of Pyxis use
Quarterly Results			128	96	156	376		*March 2013
Pyxis Overrides – Controlled Drugs *Monthly monitoring and trending of Pyxis overrides for Controlled Drugs*	All	Aug-Nov 25/month	25	25	10	10	10	Target goal is 10/month after 6 months of Pyxis use
Quarterly Results			32	17	79	54		
Fiscal Accountability	Unit	July-Dec Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Discharge Prescriptions *Monitoring and Tracking of dispensed Discharge Prescriptions*	Rx	$12412 361 drugs	$5809 345 drugs	$19015 377 drugs	$4977 297 drugs	$3959 317 drugs		Significant costs are incurred in providing discharge drugs.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services

Define

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

Measure

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

Analyze

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

Improve

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

Control

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

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

STRATEGIC PERFORMANCE EXCELLENCE

Program Services Lower Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	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**)**	4/7	57%	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**)**	4/7	57%	5/group
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	5/10	50%	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**	10/10	100%	100%

EVALUATION OF EFFECTIVENESS

ISSUES

There are on unit groups conducted by the direct care staff on lower Kennebec 7 days a week. There is one group on the day shift and one on the evening shift. The RNs do a clinical centered group Monday through Friday and the MHWs do a leisure orientated group each shift on the weekend. We are currently meeting the threshold and the average attendance on the day shift has improved by one client from the average of 6 attending last quarter to 7 this quarter. Staff has added the intervention of going back to clients who initially refuse and re ask and encourage participation. On 3-11 we are still meeting the threshold but the numbers attending have decreased from 6 last quarter to 5 this quarter. In addition, the RN4 does one group per week on the 7-3 shift. 8 out of 10 client's treatment plans included on unit groups. This is an increase from the last quarter when the numbers were 5 out of 10. Chart reviews by the RN4 and PSD have reflected a need to improve this number and treatment plans were up dated to address this inclusion. Identification of distress tolerance tools has remained at 50%. There has been a decrease in Client's ability to identify their primary RN and MHW from 9/10 last quarter to 8/10 this quarter.

ACTIONS

We are meeting the goal for the number of on unit groups and participation. We anticipate no change in structure or format but will continue to welcome and encourage feedback from Clients and Staff for additions and or improvements. Resumption of Bingo with prizes on the 3-11 shifts, in response to Client's request, may increase the participation in the 3-11 group attendance. The 3rd quarter figures reflect a need to inform Clients and Staff about distress tolerance tools. The 50% figure indicates an underutilization of these tools. An effort will be made to encourage the use of these tools and include them in the plan of care. Staff on lower Kennebec was advised to greet their assigned clients at the beginning of the shift and introduce themselves as the primary worker for the shift.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services Upper Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	14 7	100%	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**)**	6/6	100%	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**)**	6/6	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**	4/10	40%	100%
7. **The client is able to state who his primary staff is**	6/10	60%	100%

EVALUATION OF EFFECTIVENESS

ISSUES

The number of weekly on unit groups on the day shift is 14. This exceeds the threshold of 7. On Sundays, the religious services, gym time and on unit groups overlap. This provides Clients with a choice of which to attend. The Clients on UK suggested that these activities be scheduled at different times during the day. Some benefits were identified with having a choice of more than one group to attend. One client preferred to not have the groups overlap. It was suggested that the direct care staff could hold additional gym times in the afternoon. Currently the gym time on Sunday mornings is conducted by the TRS staff.

ACTIONS

The RNs on the unit conduct groups that are clinical in nature rather than leisure Monday through Friday. The MHWs conduct weekend groups that are more leisure based. Bingo groups once a week with prizes will resume for the next quarter. This is in response to a request made by the Clients. Attendance for the on unit groups has improved from 57% last quarter to 100%+ this quarter. This may be the result of reinforcing where the groups are posted on the unit and additional attempts by the staff to encourage the clients to attend beyond an initial refusal. Chart audits reflected that improvement was evident in capturing on unit groups on the treatment plans. The plans will continue to be reviewed by the RN4 which will include these specific criteria. The identification of distress tolerance tools has decreased from 80% last quarter to 40 % for this time frame. A contributing factor to this might be the term distress tolerance. Data collecting for the next quarter will include the description of coping tools which is consistent with the treatment plans and more commonly used when referring to these tools. In addition hand held game boy devices and games will be purchased and available to the clients. The game boys were identified by the clients as beneficial to promote relaxation and reduce stress. Identification of primary staff has decreased from 100% last quarter to 60% this quarter. The staff have been instructed to be more deliberate in greeting the clients at the beginning of the shift and introducing themselves.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services Lower Saco

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	Main/SCU 36 / 12 27 / 10	 100% 100%	 **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**)**	6 / 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**)**	6 / 1		N/A
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	10	100%	100%
5. **The client can identify distress tolerance tools on the unit**	20/30	67%	100%
6. **The client is able to state who his primary staff is**	30/30	100%	100%

EVALUATION OF EFFECTIVENESS

ISSUES

The Lower Saco unit shifted to all treatment being delivered on the unit during this past quarter. The Lower Saco unit improved significantly with on-unit groups by MHWS and professional staff. Documentation in both Meditech and the hard copy record reflect this treatment delivery.

ACTIONS

The on-unit groups have been increased dramatically since mid-May 2013 and this will be maintained. The number of groups offered since last quarter increased slightly and the level of attendance improved dramatically, again because in part all treatment is delivered on the unit. The team coordinator is incorporating these on-unit groups in to the Rx plans. Some of our distress tolerance equipment (like MP3 headsets) has been difficult to obtain, though we are working with the supplier to make these available

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STRATEGIC PERFORMANCE EXCELLENCE

Program Services Upper Saco

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	 14 12	 100% 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**)**	4/14	29%	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**)**	6/12	50%	N/A
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	4	40%	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 continued to increase offering on-unit groups. Documentation by nursing in Meditech continues to improve. TR documentation is evident in all charts for both on and off unit treatment activity. Nearly all of the clients on Upper Saco attend the hospital treatment mall and there is a high level of participation and attendance with this off-unit treatment.

ACTIONS

Continued efforts are being made to offer groups to those clients that have less activity at the hospital treatment mall. We now have a new treatment team coordinator who is now including planned on-unit treatment groups in the client treatment plans.

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%	92%	95%	98%	100%	The treatment plans will be reviewed more regularly and updated at each client 30 day treatment team meeting.	2 charts of all those reviewed did not have an updated plan and this was remedied within 24 hrs after reported to the job coach
Quarterly Results		95					

Safety in Culture and Actions	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Recreational Therapy Assessments & Treatment Plans *The objective of this improvement project is to ensure that Recreational Therapy assessments are completed within 7 days of admission and that a treatment plan is initiated after the assessment 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.*	75%					The treatment plans will be reviewed more regularly and updated at each client treatment team meeting or if there is any change in client status	All assessments reviewed were done within allotted time frame but there were 10 charts that did not have an updated treatment plan on a long term care unit. Unit RT notified and plans were updated
Quarterly Results		85%					

STRATEGIC PERFORMANCE EXCELLENCE

Rehabilitation Services

Department: Rehabilitation Services Responsible Party: Janet Barrett

Strategic Objectives							
Client Recovery & Safety in Culture and Actions	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Occupational Therapy referrals and doctors orders. *The objective of this improvement project is to ensure each client receiving Occupational Therapy Services from RPC OT staff has a doctor's order as well as a referral form completed prior to the initiation of services.*	33%	50% 39 of 43	75%	100%	100%	To increase the percentage of referrals and doctor's orders by 25 % each quarter until we attain 100% compliance.	The 3 clients who did not have a MD order prior to the initiation of services were clients who were already receiving services prior to the approval of the new forms and procedures
Quarterly Results		91 %					