Dorothea Dix

Psychiatric Center

QUARTERLY REPORT ON ORGANIZATIONAL PERFORMANCE EXCELLENCE

FIRST FISCAL QUARTER 2015

July, August, September 2014

Sharon Sprague, Superintendent

November 10, 2014

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INTRODUCTION

This edition of the Dorothea Dix Psychiatric Center Quarterly Report on Organizational Performance Excellence is designed to address overall organizational performance in a systems improvement approach instead of a purely compliance approach. The structure of the report also reflects a shift to this focus on meaningful measures of organizational process improvement while maintaining measures of compliance that are mandated though regulatory and legal standards.

This change was inspired, in part by the work done for both Riverview and Dorothea Dix Psychiatric Centers by Courtemanche and Associates during a Joint Commission Mock Survey in February 2012. During this visit, the consultants identified a gap in the methods used to evaluation and improve organizational performance. It was recommended that the methodology used for organizational performance improvement be transitioned from a process that relied completely on meeting regulatory standards, collection, and reporting on information as a matter of routine to a more focused approach that sought out areas for improvement that were clearly identified as performance priorities. In addition, a review of current practices in quality management represented by the work of groups such as 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 modified report:

The first section reflects traditional measures related to Comparative Statistics.

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.

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.

Respectfully Submitted by,

Joseph Riddick

Joseph Riddick

Director of Integrated Quality and Informatics

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COMPARATIVE STATISTICS

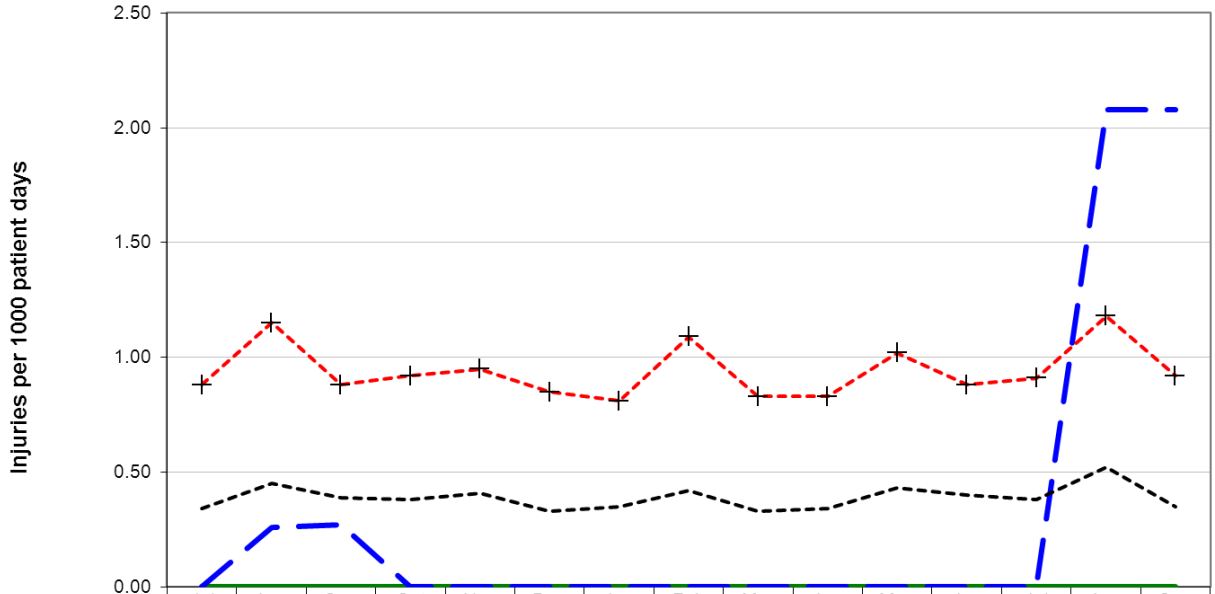
The comparative statistics reports include the following elements:

- Client Injury Rate
- Elopement Rate
- 30 Day Readmit Rate
- Percent of Clients Restrained
- Hours of Restraint
- Percent of Clients Secluded
- Hours of Seclusion
- Confinement Event Breakdown

The comparison of comparative statistics data elements between Dorothea Dix and Riverview utilizes all client data from Dorothea Dix and the civil population segmentation data from Riverview.

COMPARATIVE STATISTICS

Client Injury Rate



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Dorothea Dix	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Riverview	0.00	0.26	0.27	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.08	2.08
Ntl Mean	0.34	0.45	0.39	0.38	0.41	0.33	0.35	0.42	0.33	0.34	0.43	0.40	0.38	0.52	0.35
+1 StDev	0.88	1.15	0.88	0.92	0.95	0.85	0.81	1.09	0.83	0.83	1.02	0.88	0.91	1.18	0.92

Number of client injury incidents that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days. The NRI standards for measuring client injuries differentiate between injuries that are considered reportable to the Joint Commission as a performance measure and those injuries that are of a less severe nature. While all injuries are currently reported internally, only certain types of injuries are documented and reported to NRI for inclusion in the performance measure analysis process.

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

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

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

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

COMPARATIVE STATISTICS

SEVERITY OF INJURY BY MONTH

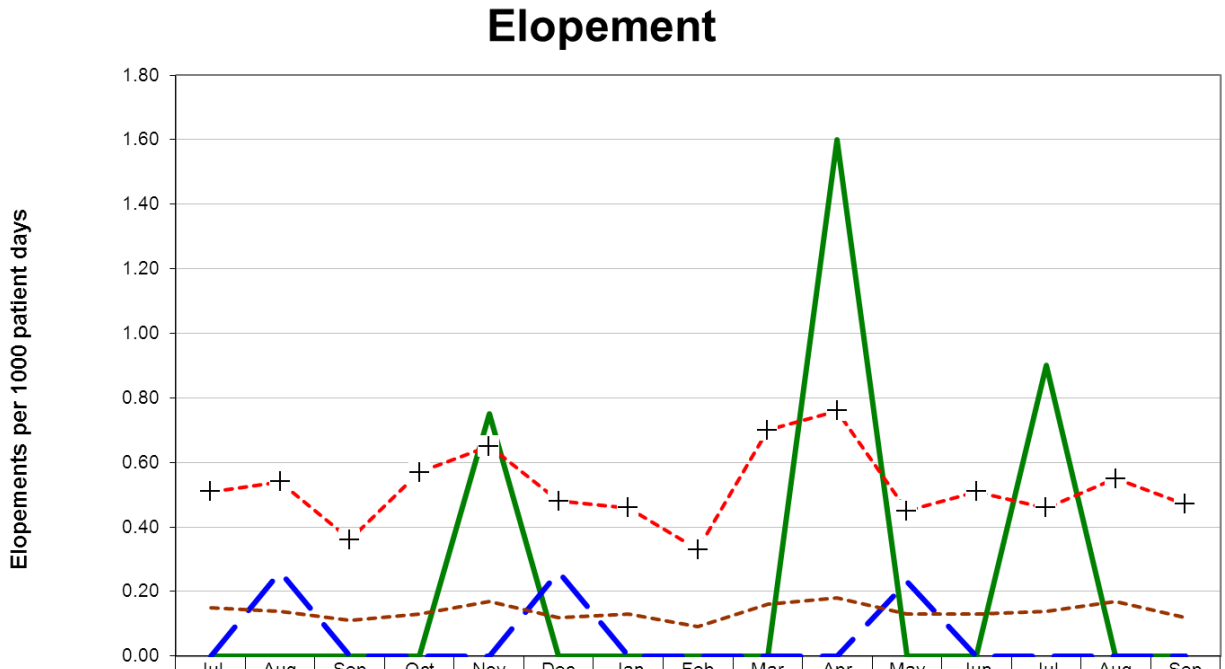
Severity	July	August	September	1Q2015
No Treatment	5	5	5	**15**
Minor First Aid		4		**4**
Medical Intervention Required		4		**4**
Hospitalization Required				
Death Occurred				
Total	**5**	**13**	**5**	**23**

TYPE AND CAUSE OF INJURY BY MONTH

Type – Cause	July	August	September	1Q2015
Accident – Environmental				
Accident – Fall Unwitnessed		1	1	**2**
Accident – Fall Witnessed	3	3	1	**7**
Accident – Other				
Injury - Other		1		**1**
Medical	1	2		**3**
Self-Injurious Behavior	1	6	3	**10**
Total	**5**	**13**	**5**	**23**

Please Note: Numbers in previous reports may have been higher as they included both incidents and injuries. In this report we have only included injuries.

COMPARATIVE STATISTICS



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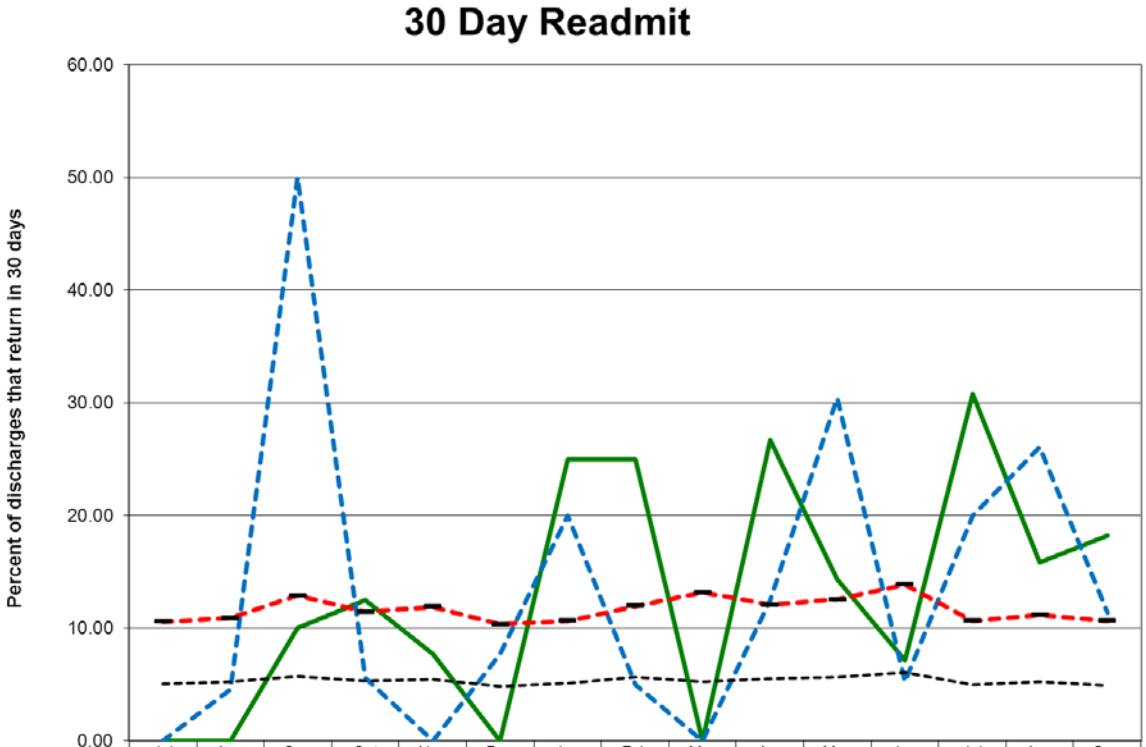
	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Dorothea Dix	0.00	0.00	0.00	0.00	0.75	0.00	0.00	0.00	0.00	1.60	0.00	0.00	0.90	0.00	0.00
Riverview	0.00	0.26	0.00	0.00	0.00	0.26	0.00	0.00	0.00	0.00	0.23	0.00	0.00	0.00	0.00
Ntl Mean	0.15	0.14	0.11	0.13	0.17	0.12	0.13	0.09	0.16	0.18	0.13	0.13	0.14	0.17	0.12
+1 StDev	0.51	0.54	0.36	0.57	0.65	0.48	0.46	0.33	0.70	0.76	0.45	0.51	0.46	0.55	0.47

Number of elopements that occurred for every 1000 inpatient days. For example, a rate of 0.25means that 1 elopement occurred for each 4000 inpatient days.

The increase in elopement rates during the month of July is related to one event involving a client who followed a staff into the stairway when the staff opened the unit door. Staff was present and prompted patient to return.

COMPARATIVE STATISTICS



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Dorothea Dix	0.00	0.00	10.00	12.50	7.69	0.00	25.00	25.00	0.00	26.67	14.29	7.14	30.77	15.79	18.18
Riverview	0.00	4.55	50.00	5.56	0.00	7.69	20.00	5.00	0.00	12.50	30.43	5.26	20.00	26.09	11.39
Ntl Mean	5.04	5.24	5.75	5.30	5.42	4.86	5.12	5.62	5.24	5.54	5.65	6.09	4.97	5.22	4.88
+1 StDev	10.59	10.90	12.87	11.44	11.89	10.36	10.65	11.95	13.13	12.04	12.53	13.87	10.64	11.15	10.66

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.

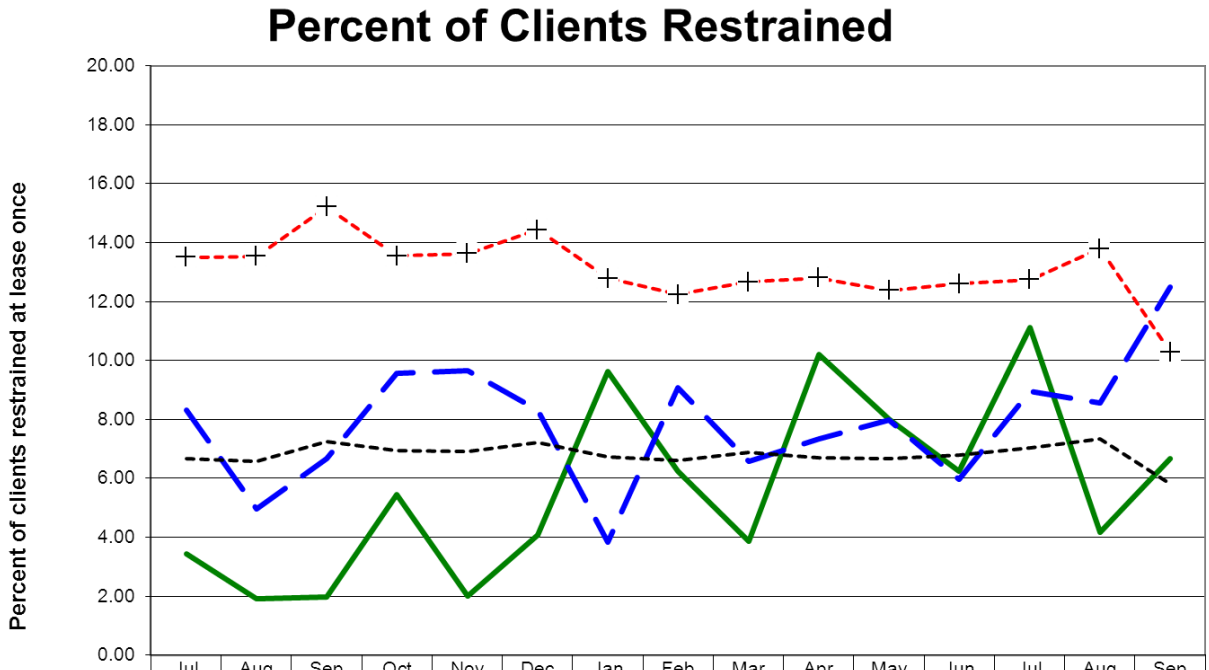
Readmissions may be attributable to several factors including court ordered returns related to non-compliance with PTP parameters. The information contained in this graph does not differentiate between those returns that are court ordered and those that may be attributable to other factors related to client care.

July
PTP: 2
Non-PTP: 1

August
PTP: 3
Non-PTP: 0

September
PTP: 1
Non-PTP: 0

COMPARATIVE STATISTICS



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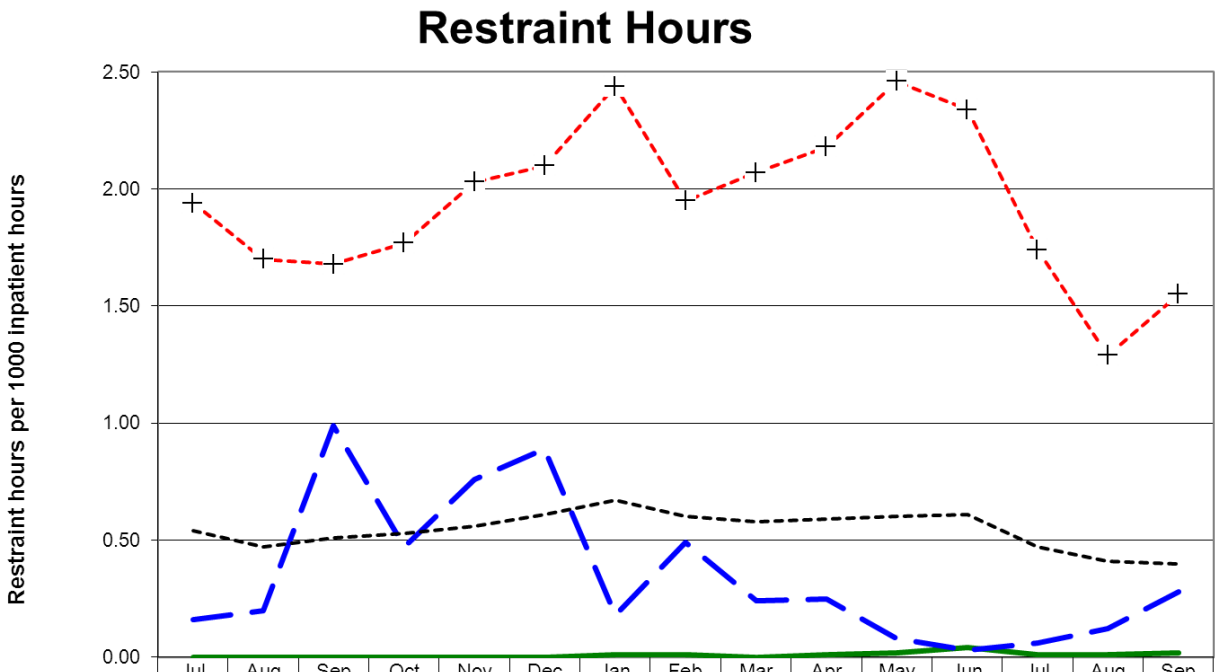
Dorothea Dix	3.45	1.92	1.96	5.45	2.00	4.08	9.62	6.25	3.85	10.20	8.00	6.25	11.11	4.17	6.67
Riverview	8.33	4.96	6.67	9.57	9.65	8.33	3.82	9.09	6.57	7.35	7.97	5.97	8.96	8.55	12.50
Ntl Mean	6.67	6.59	7.24	6.95	6.90	7.22	6.73	6.60	6.87	6.71	6.67	6.80	7.03	7.35	5.81
+1 StDev	13.50	13.54	15.21	13.55	13.63	14.43	12.79	12.24	12.66	12.80	12.38	12.61	12.75	13.79	10.29

Percent of unique clients who were restrained at least once. The NRI and Joint Commission standards require that all types of restraint, including manual holds of less than 5 minutes be included in this indicator. For example, rates of 4.0 means that 4% of the unique clients served were restrained at least once, for any amount of time.

July: 6 patients were restrained at least once
August: 2 patients were restrained at least once
September: 3 patients were restrained at least once

COMPARATIVE STATISTICS



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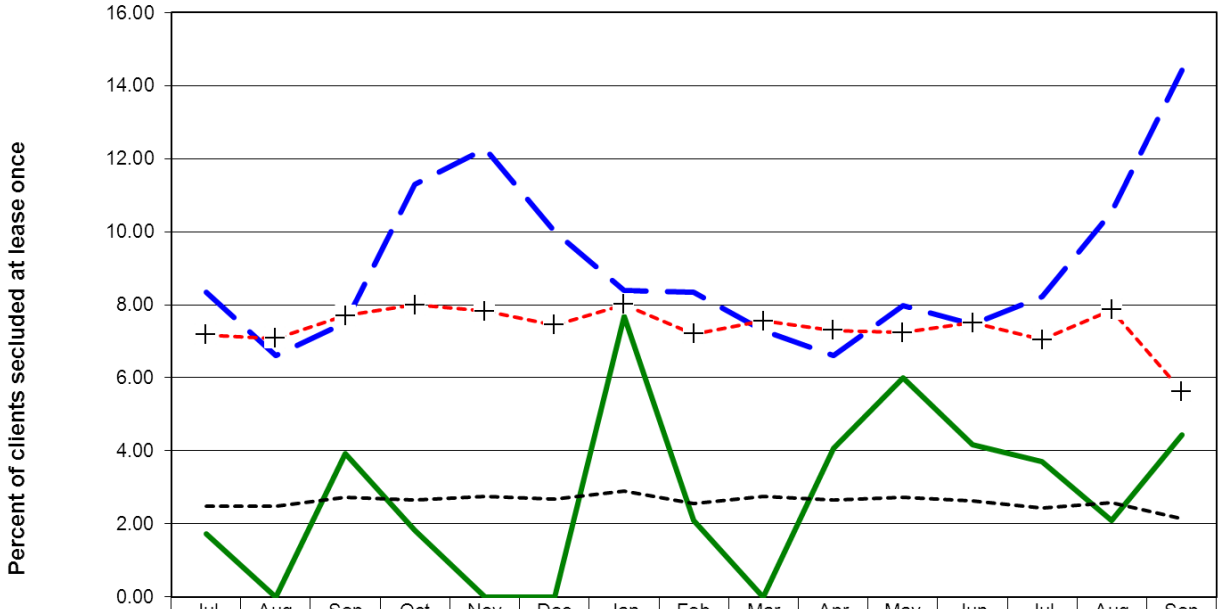
Dorothea Dix	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.01	0.00	0.01	0.02	0.04	0.01	0.01	0.02
Riverview	0.16	0.20	0.99	0.47	0.76	0.89	0.18	0.49	0.24	0.25	0.08	0.03	0.06	0.12	0.28
Ntl Mean	0.54	0.47	0.51	0.53	0.56	0.61	0.67	0.60	0.58	0.59	0.60	0.61	0.47	0.41	0.40
+1 StDev	1.94	1.70	1.68	1.77	2.03	2.10	2.44	1.95	2.07	2.18	2.46	2.34	1.74	1.29	1.55

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

The duration of restraint use remains well below the national mean.

COMPARATIVE STATISTICS

Percent of Clients Secluded



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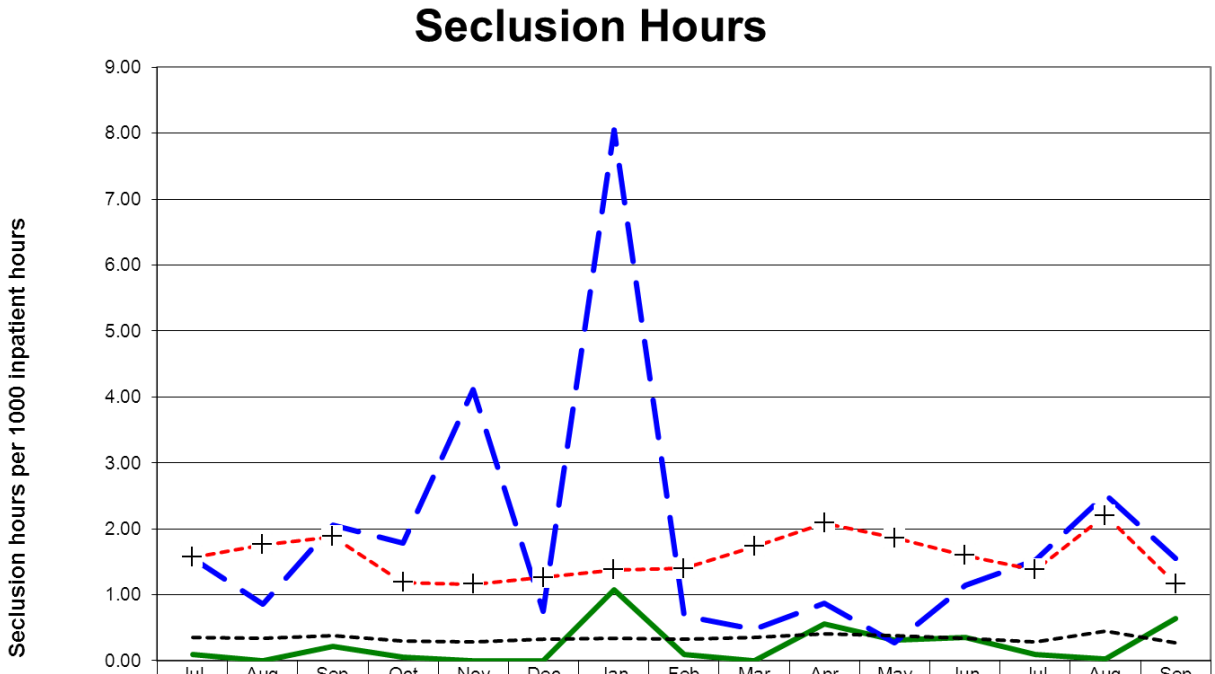
	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Dorothea Dix	1.72	0.00	3.92	1.82	0.00	0.00	7.69	2.08	0.00	4.08	6.00	4.17	3.70	2.08	4.44
Riverview	8.33	6.61	7.50	11.30	12.28	10.00	8.40	8.33	7.30	6.62	7.97	7.46	8.21	10.53	14.42
Ntl Mean	2.49	2.48	2.73	2.65	2.74	2.69	2.89	2.56	2.76	2.66	2.72	2.63	2.43	2.57	2.13
+1 StDev	7.18	7.08	7.70	7.99	7.82	7.44	8.01	7.20	7.56	7.30	7.24	7.51	7.04	7.86	5.62

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.

July: 2 patients were secluded at least once
August: 1 patient was secluded at least once
September: 2 patients were secluded at least once

COMPARATIVE STATISTICS



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Dorothea Dix	0.09	0.00	0.22	0.05	0.00	0.00	1.08	0.10	0.00	0.56	0.31	0.36	0.09	0.03	0.64
Riverview	1.55	0.86	2.05	1.79	4.11	0.75	8.05	0.68	0.48	0.87	0.27	1.14	1.52	2.52	1.55
Ntl Mean	0.36	0.34	0.38	0.30	0.29	0.32	0.34	0.32	0.36	0.41	0.38	0.34	0.28	0.45	0.27
+1 StDev	1.57	1.76	1.88	1.19	1.16	1.26	1.38	1.40	1.73	2.09	1.86	1.60	1.38	2.20	1.17

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

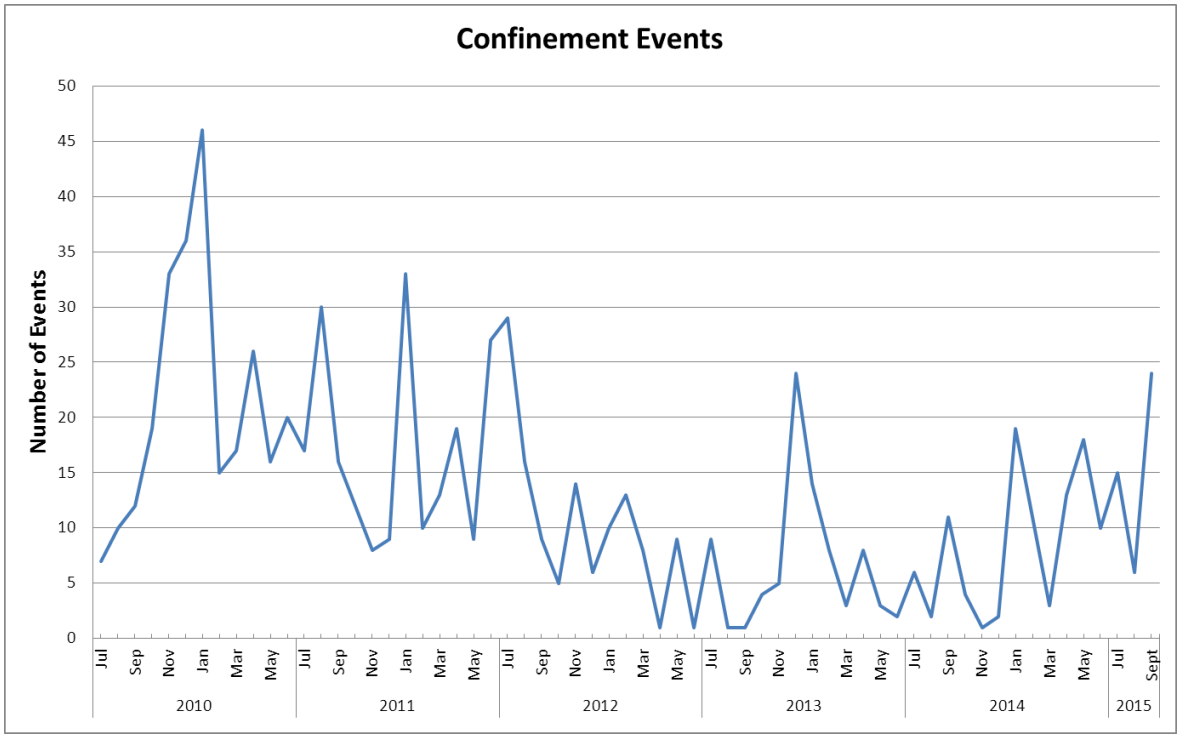
COMPARATIVE STATISTICS

Confinement Event Breakdown

	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
MD00001975	12		7	19	42.22%	42.22%
MD00001705	9		3	12	26.67%	68.89%
MD00001968	5			5	11.11%	80.00%
MD00001451	2			2	4.44%	84.44%
MD00001966	1		1	2	4.44%	88.88%
MD00001955	2			2	4.44%	93.32%
MD00001089	1			1	2.22%	95.55%
MD00000274	1			1	2.22%	97.77%
MD00000091	1			1	2.22%	100%
	34	**0**	**11**	**45**		

Unit	Manual Hold	Locked Seclusion
Chamberlain	15	7
Hamlin	17	4
Knox	2	0

Event	July	Aug	Sept
Manual Hold	13	5	16
Locked Seclusion	2	1	8



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)

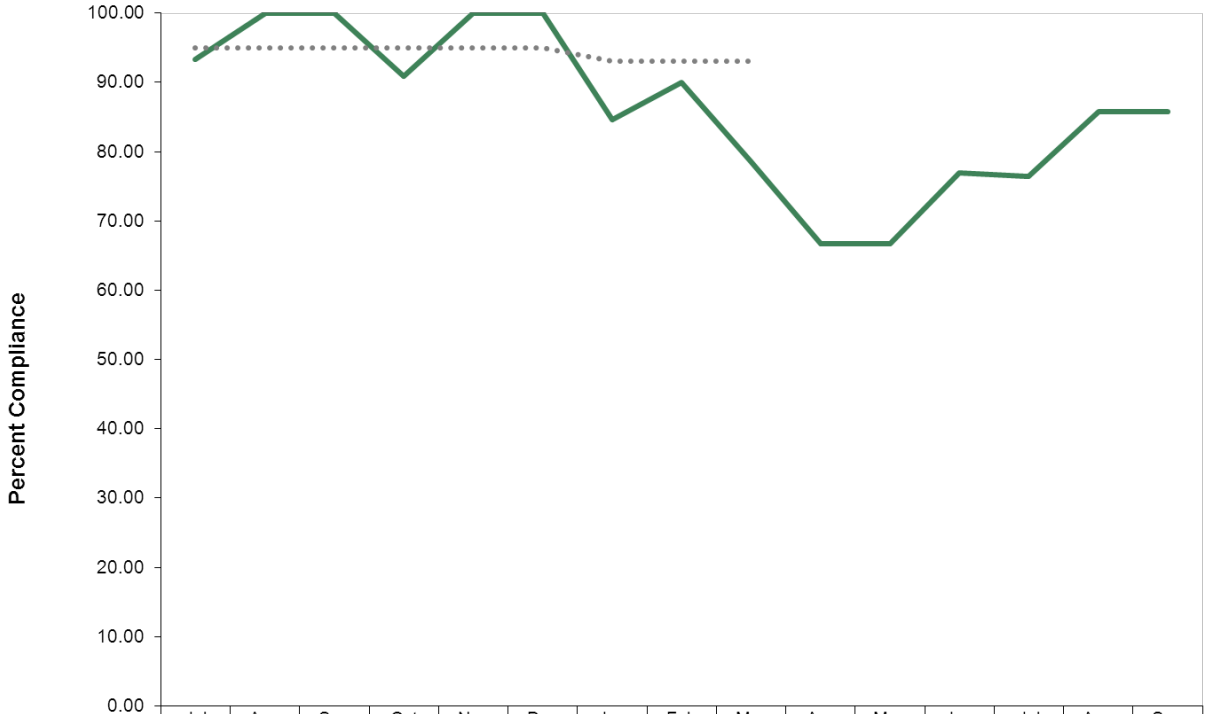
For Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths

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.



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	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
DDPC Rate	93.33	100.00	100.00	90.91	100.00	100.00	84.62	90.00	78.57	66.67	66.67	76.92	76.47	85.71	85.71
TJC Target	95.00	95.00	95.00	95.00	95.00	95.00	93.00	93.00	93.00						

JOINT COMMISSION

Physical Restraint (HBIPS 2)

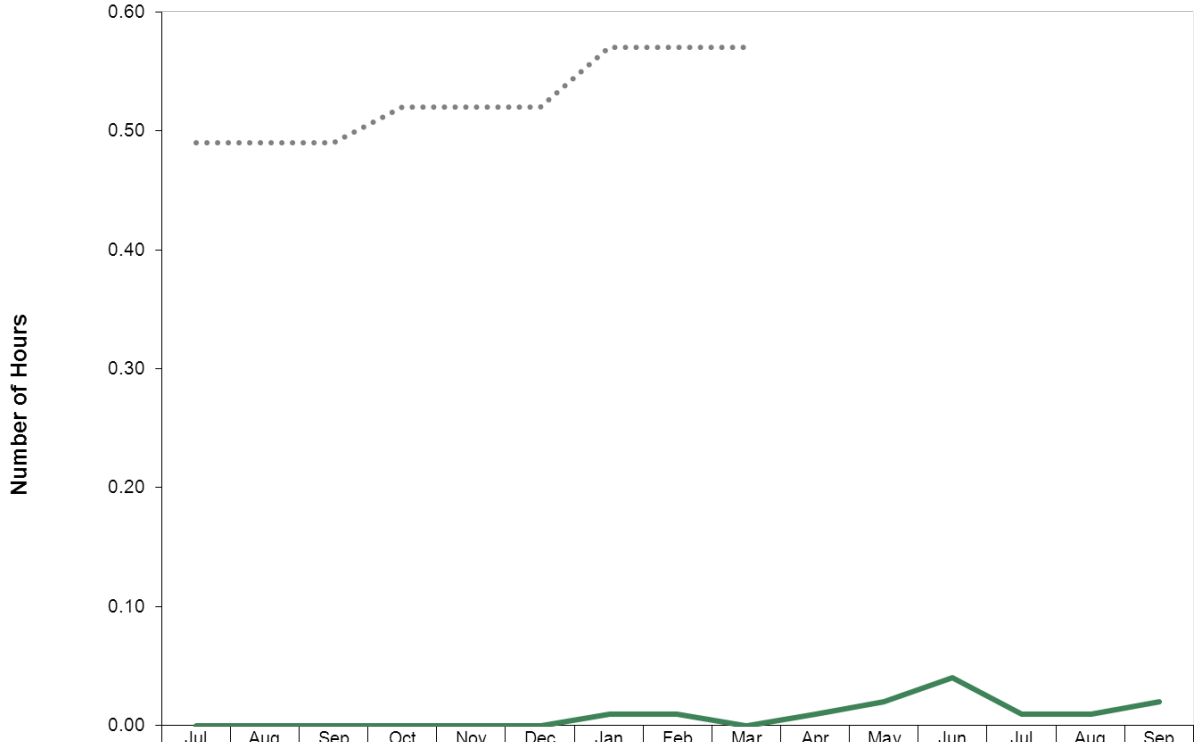
Hours of Use

Description

The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting was 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).



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DDPC Rate	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.01	0.00	0.01	0.02	0.04	0.01	0.01	0.02
TJC Target	0.49	0.49	0.49	0.52	0.52	0.52	0.57	0.57	0.57						

JOINT COMMISSION

Seclusion (HBIPS 3)

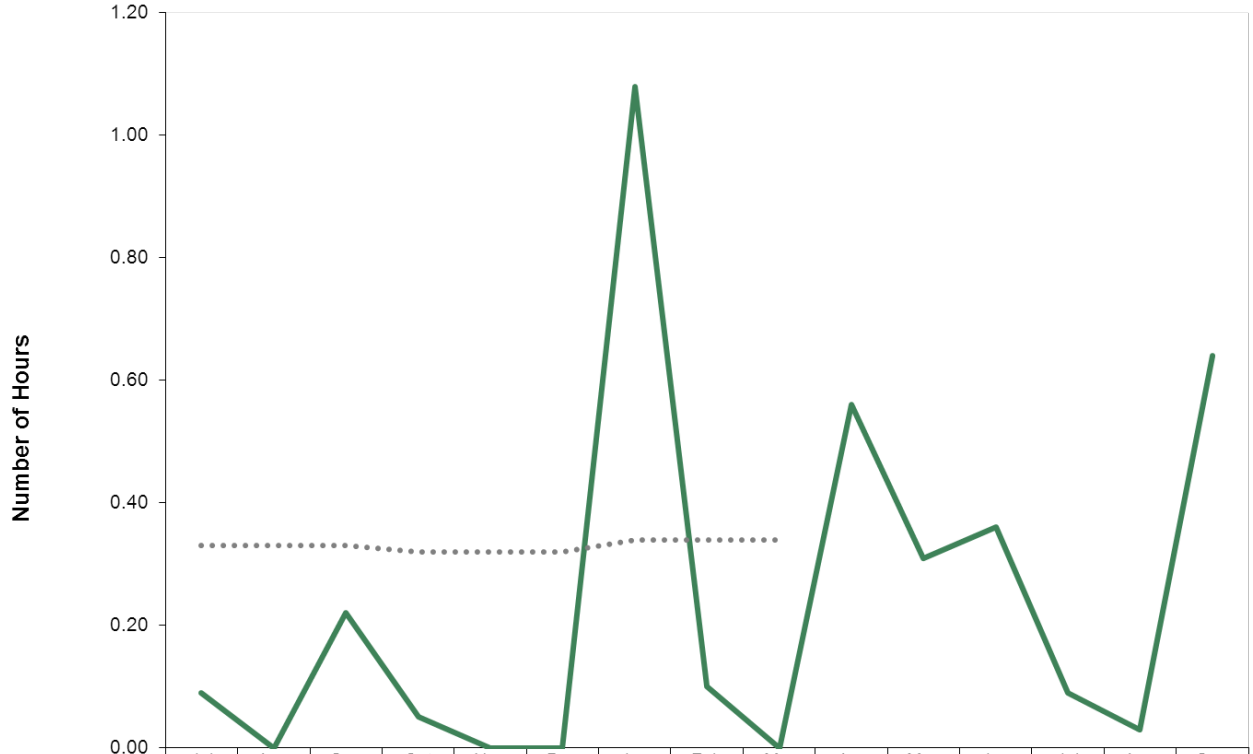
Hours of Use

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).



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DDPC Rate	0.09	0.00	0.22	0.05	0.00	0.00	1.08	0.10	0.00	0.56	0.31	0.36	0.09	0.03	0.64
TJC Target	0.33	0.33	0.33	0.32	0.32	0.32	0.34	0.34	0.34						

Multiple Antipsychotic Medications on Discharge (HBIPS 4)

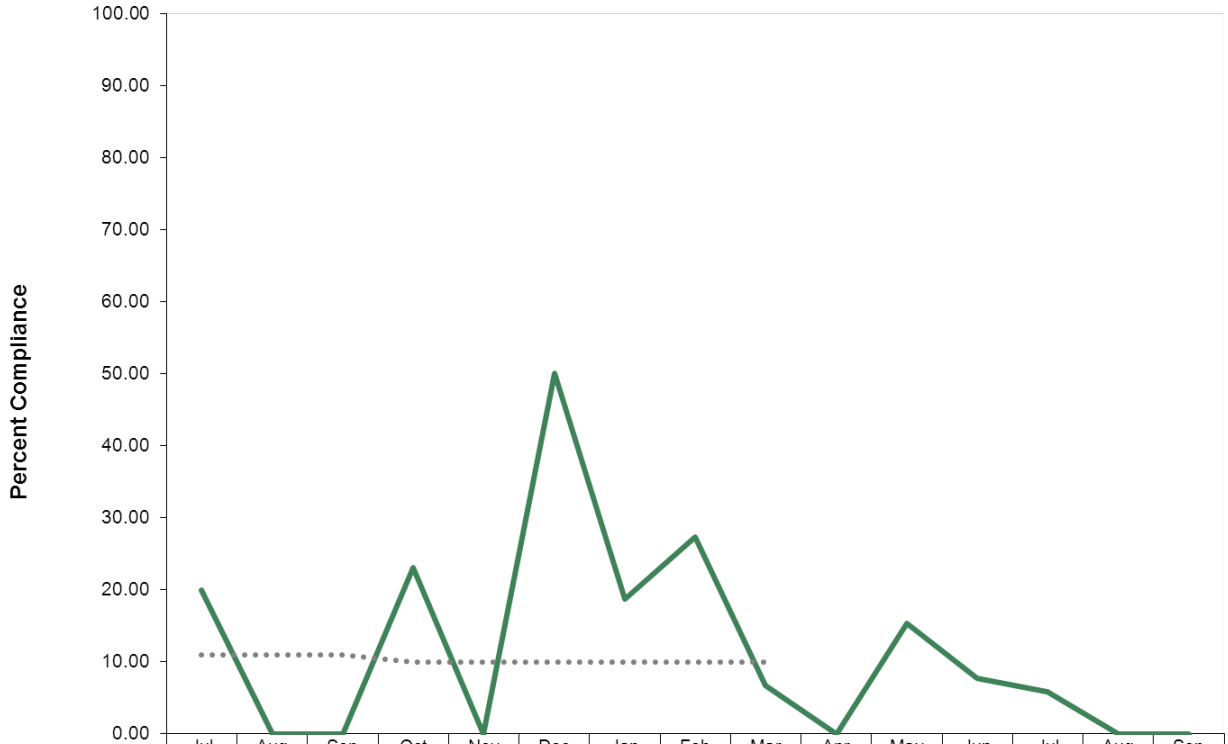
Description

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.

Multiple Antipsychotic Medications on Discharge (HBIPS 4)



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	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
DDPC Rate	20.00	0.00	0.00	23.08	0.00	50.00	18.75	27.27	6.67	0.00	15.38	7.69	5.88	0.00	0.00
TJC Target	11.00	11.00	11.00	10.00	10.00	10.00	10.00	10.00	10.00						

Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)

Description

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

Rationale

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

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

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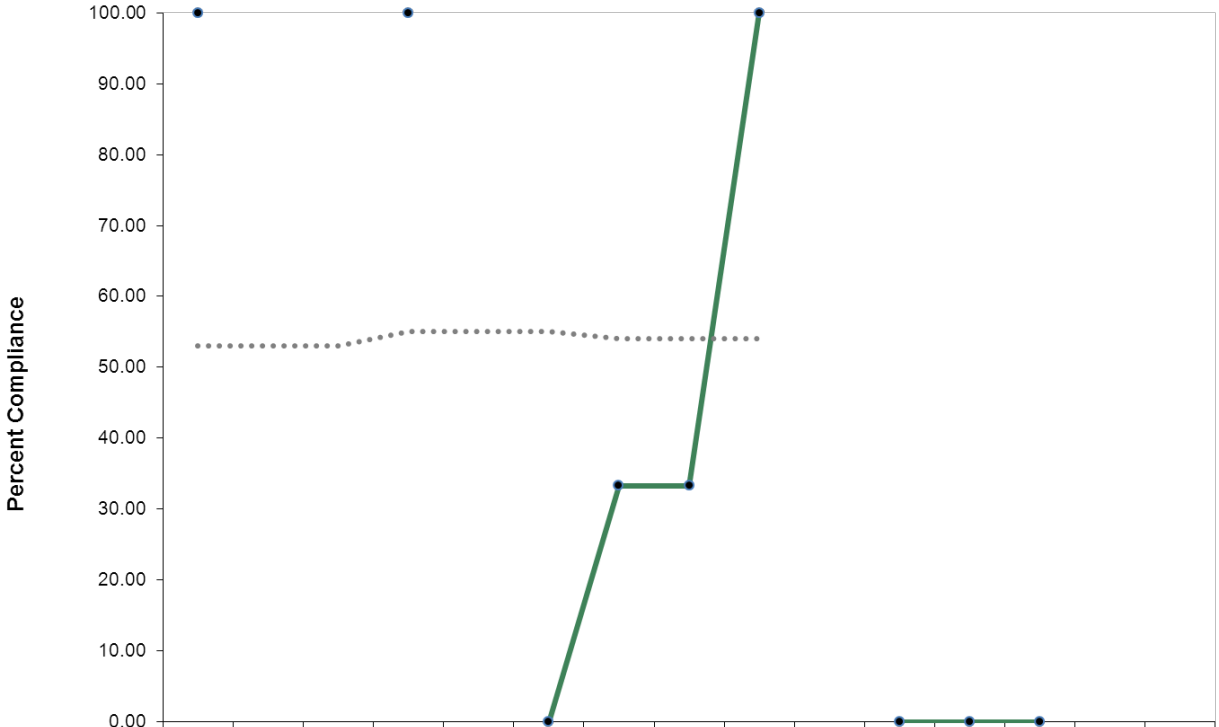
Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)



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	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
DDPC Rate	100.00			100.00		0.00	33.33	33.33	100.00		0.00	0.00	0.00		
TJC Target	53.00	53.00	53.00	55.00	55.00	55.00	54.00	54.00	54.00						

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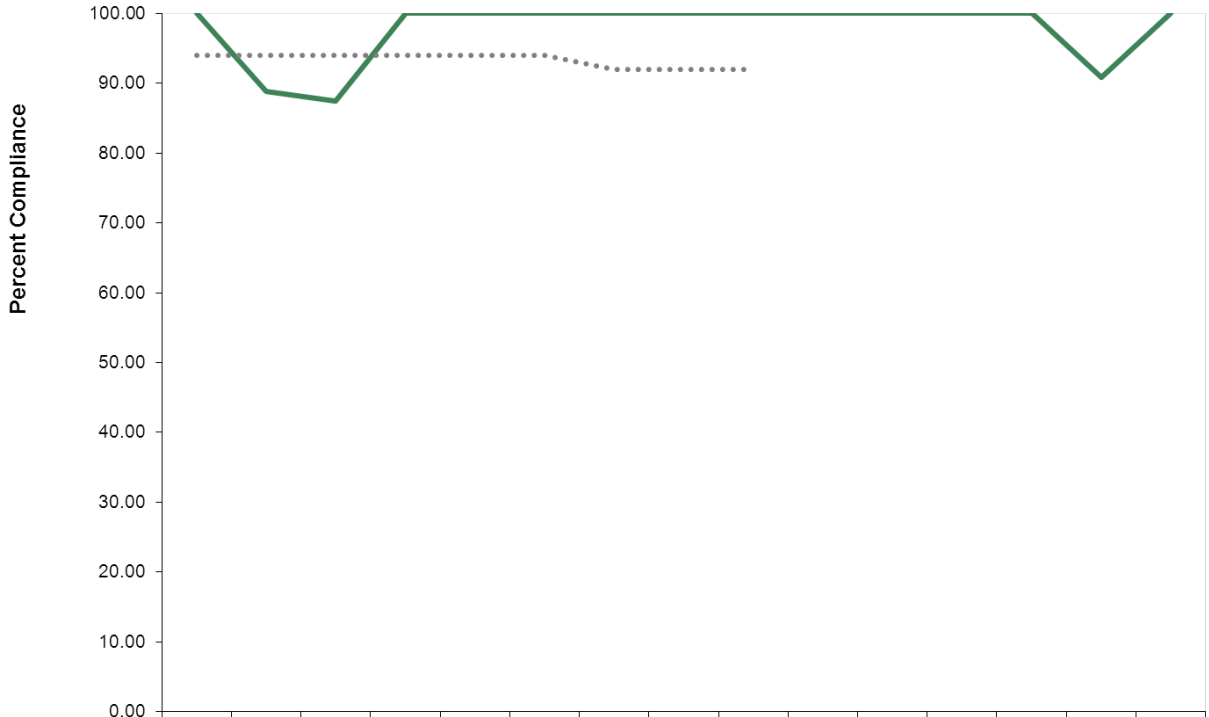
Post Discharge Continuing Care Plan (HBIPS 6)

Description

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

Rationale

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



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
DDPC Rate	100.00	88.89	87.50	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	90.91	100.00
TJC Target	94.00	94.00	94.00	94.00	94.00	94.00	92.00	92.00	92.00						

Post Discharge Continuing Care Plan Transmitted (HBIPS 7)

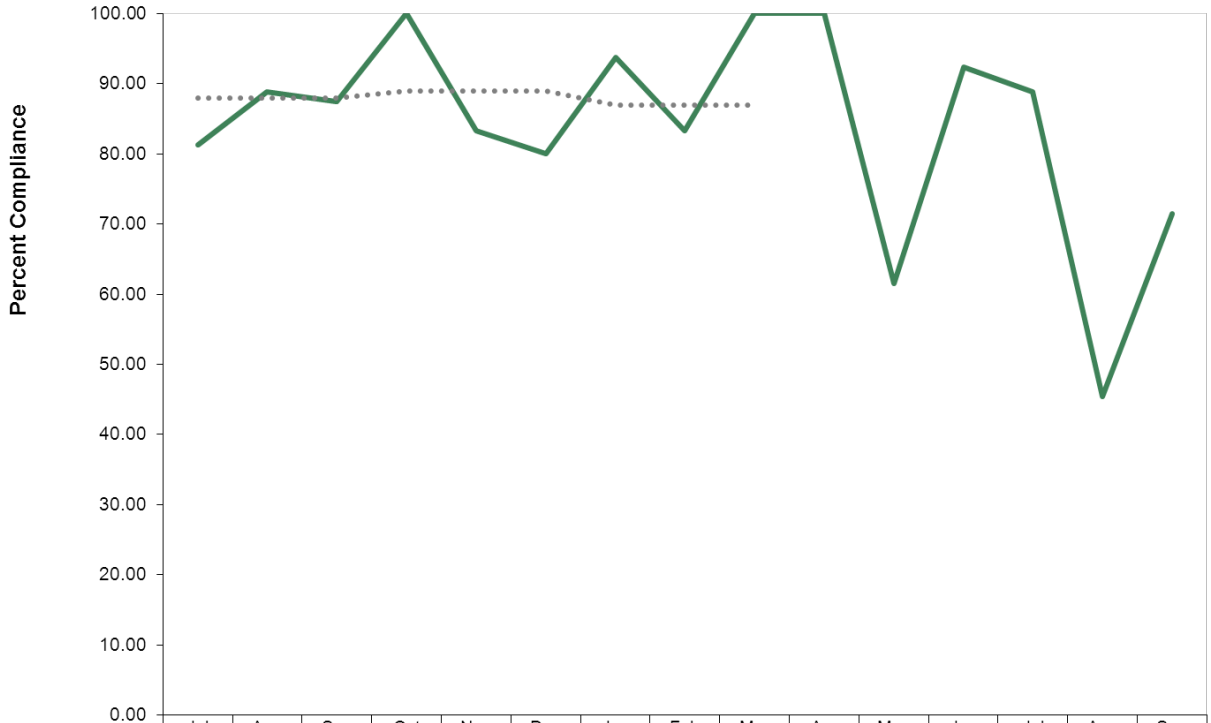
To Next Level of Care Provider on Discharge

Description

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

Rationale

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



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
DDPC Rate	81.25	88.89	87.50	100.00	83.33	80.00	93.75	83.33	100.00	100.00	61.54	92.31	88.89	45.45	71.43
TJC Target	88.00	88.00	88.00	89.00	89.00	89.00	87.00	87.00	87.00						

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Joint Commission Priority Focus Areas

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.

FY 2015 Quarter 1 Results		
Contractor	**Program Administrator**	**Summary of Performance**
ABM	Richard Levesque Director of Support Services	Indicator met standards.
Affiliated Laboratory	Joni Crossman Director of Nursing	All indicators met or exceeded standards.
CES	Richard Levesque Director of Support Services	Indicator met standards.
Comprehensive Pharmacy Services	Sharon Sprague Superintendent	Three indicators did not meet standards, all others met standards.
ePharmPro	Sharon Sprague Superintendent	All indicators met or exceeded standards.
Healing Staff	Dr. Michelle Gardner Medical Director	No services provided during timeframe.
Ilina	Richard Levesque Director of Support Services	Indicator exceeded standards.
Jackson & Coker	Dr. Michelle Gardner Medical Director	All indicators met standards.
Liberty Healthcare Physicians and/or Mid-Levels On Call	Dr. Michelle Gardner Medical Director	All indicators met standards.
Liberty Healthcare Psychiatric Nurse Practitioner	Dr. Michelle Gardner Medical Director	All indicators met standards.
Locum Tenens Psychiatry	Dr. Michelle Gardner Medical Director	No services provided during timeframe.
Norris	Richard Levesque Director of Support Services	All indicators met or exceeded standards.
Northeast Cardiology Associates	Dr. Michelle Gardner Medical Director	All indicators met standards.
Otis Elevator	Richard Levesque Director of Support Services	All indicators met standards.
Penobscot Community Health Care	Dr. Michelle Gardner Medical Director	Indicator exceeded standards.
Pine Tree Waste	Richard Levesque Director of Support Services	Indicator met standards.
Project Staffing	Carol Davis Business Manager	All indicators met standards.
Securitas	Richard Levesque Director of Support Services	All indicators met or exceeded standards.
SW Cole	Richard Levesque Director of Support Services	Indicator met standards.

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FY 2015 Quarter 1 Results		
Contractor	**Program Administrator**	**Summary of Performance**
UniFirst	Richard Levesque Director of Support Services	Indicator met standards.
Vista Staffing	Dr. Michelle Gardner Medical Director	No services provided during timeframe.
WBRC	Richard Levesque Director of Support Services	Indicator met standards.
Worldwide Travel Staffing	Joni Crossman Director of Nursing	All indicators met standards.

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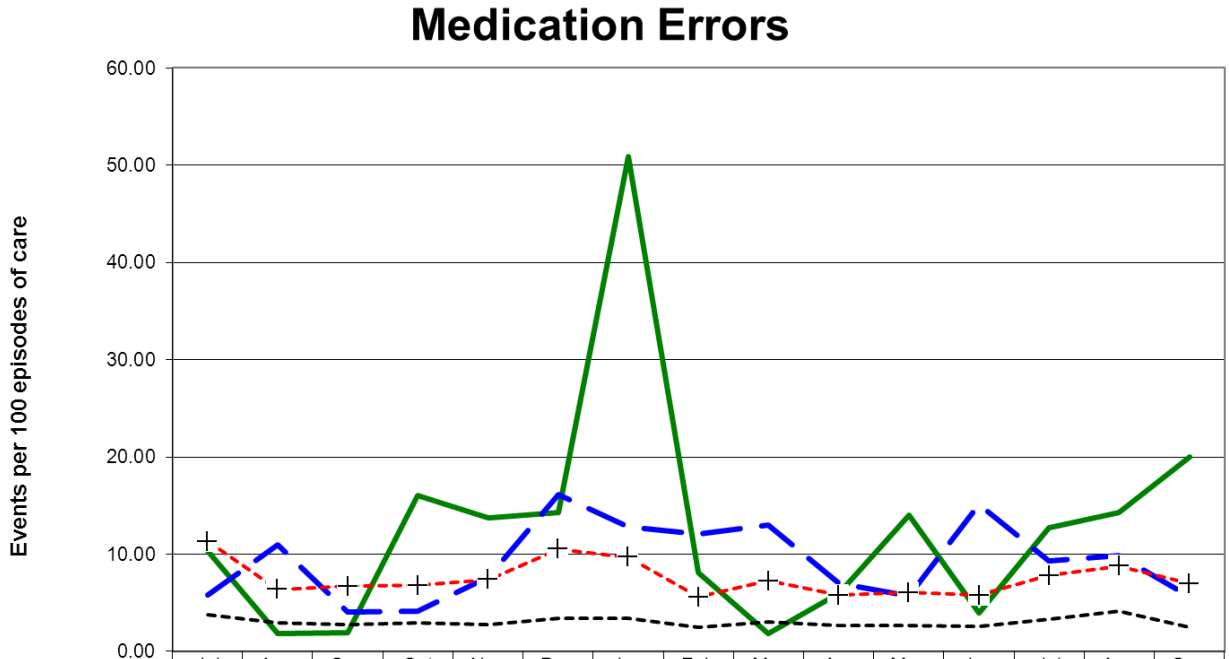
Joint Commission Priority Focus Areas

Medication Management

Medication Errors and Adverse Reactions

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

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



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Dorothea Dix	10.34	1.89	1.92	16.07	13.73	14.29	50.91	8.16	1.85	6.00	14.00	4.00	12.73	14.29	20.00
Riverview	5.79	10.95	4.07	4.17	7.63	16.13	12.78	12.12	13.04	7.04	5.76	15.11	9.35	9.86	5.61
Ntl Mean	3.80	2.91	2.77	2.92	2.74	3.45	3.39	2.52	3.03	2.65	2.66	2.61	3.29	4.16	2.51
+1 StDev	11.31	6.37	6.69	6.79	7.38	10.53	9.69	5.59	7.25	5.78	6.05	5.77	7.83	8.80	6.99

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.

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

Prescribing

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

Dispensing

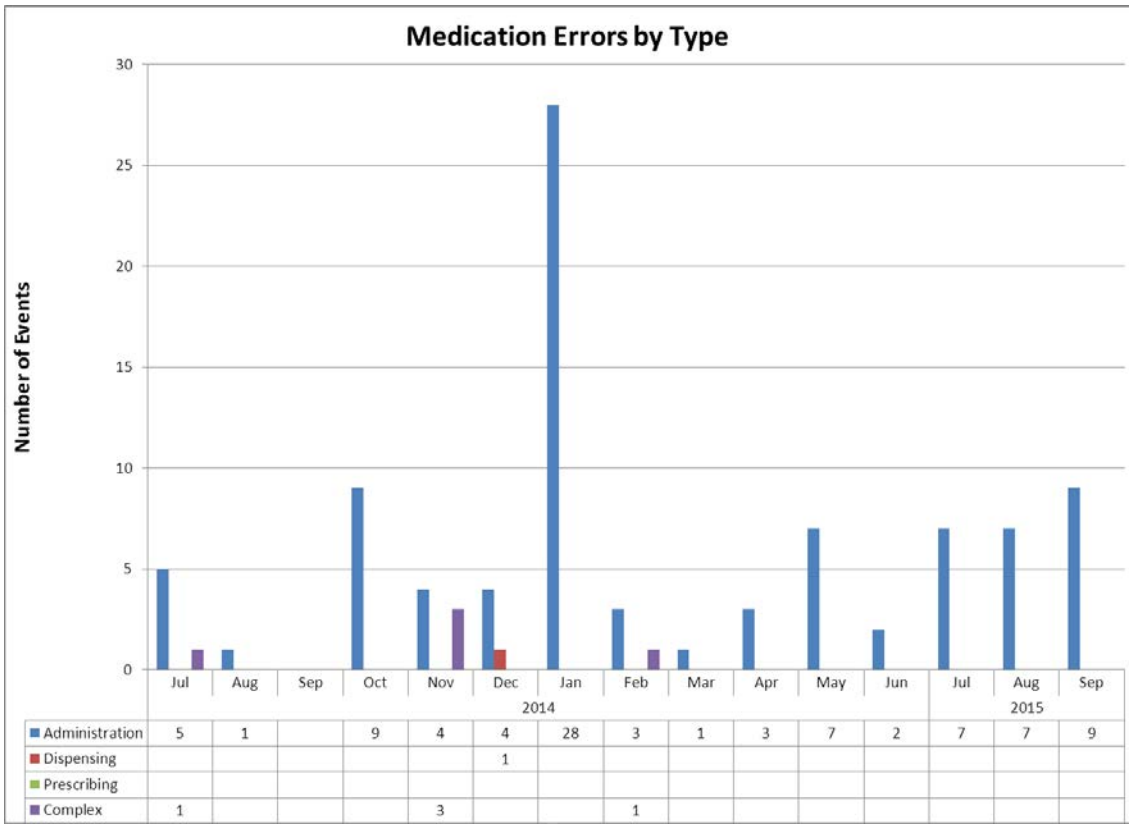
An error of dispensing occurs when the incorrect drug, drug dose or concentration, dosage form, or quantity is formulated and delivered for use to the point of intended use.

Administration

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

Complex

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



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Medication Dispensing Process

Garry Miller, RPh

Joint Commission Measures of Success								
Medication Management	Unit	Baseline 2014	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 no discrepancies in any transactions between Pyxis and CII Safe
Quarterly Results			0%					
Monthly CII Safe Vendor Receipt Report	Rx	0	0	0	0	0	0	No discrepancies between CII Safe and vendor transactions
Quarterly Results			0					
Monthly Pyxis Controlled Drug Discrepancies	All	5/month	0	0	0	0	0	Goal of "0" discrepancies involving controlled drugs dispensed from Pxyis trended from Knowledge Portal
Quarterly Results			20 (7/mo)					
Medication Management Monitoring								
Measures of drug reactions, adverse drug events and other management data	Rx	2/yr	1	0	0	0		1 ADR reported in Q1
Resource Documentation Reports of Clinical Interventions	Rx	51	58					100% of all clinical interventions are documented

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Client Perception of Care Surveys

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.

In order to gain a perspective on the quality of care provided to our clients from the client's perspective, Dorothea Dix Psychiatric Center conducts two client surveys; the Care Transition Measures Survey and the Inpatient Customer Survey.

Care Transition Measures Survey

The Care Transition Measures Survey (CTM-3) is a three question survey that is mandated through statute by the Maine legislature. Data from all hospitals in Maine is collected and analyzed by the Maine Health Data Organization. This survey is designed to ascertain the degree of client understanding of and satisfaction with the discharge planning and preparation process. While most hospitals conduct a mailing to gather the information required, Dorothea Dix conducts a telephone poll of discharged clients approximate one to two weeks after discharge. This provides an opportunity to make a connection with the clients as they transition into the community setting and, on occasion, has provided the discharged client with a support mechanism or safety net on those few occasions when they are having difficulties with the discharge transition and are potentially de-stabilizing.

The Care Transition Measure Survey questions are as follows:

1. The hospital staff took my preference and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital.
2. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
3. When I left the hospital, I clearly understood the purpose for taking each of my medications.

All questions are answered on a four part Likert scale; 1) strongly disagree, 2) disagree, 3) agree, and 4) strongly agree. Clients that answer "I don't' know" or "I don't remember are designated with a "99" score and are considered neutral responses and are not included in the results calculations.

For the period from April to June 2014 the following results on the CTM-3 survey were achieved.

CTM-3 Survey Response Rate

	July	August	September	1Q2015
Number of Clients Discharged	19	11	7	37
Number of Survey Responses	8	4	1	13
Survey Response Rate	42%	36%	14%	35%

CTM-3 Percent of Positive (agree or strongly agree)

	July	August	September	1Q2015
The hospital staff took my preference and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital.	(7) 88%	(4) 100%	(1) 100%	(12) 92%
When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.	(8) 100%	(4) 100%	(1) 100%	(13) 100%
When I left the hospital, I clearly understood the purpose for taking each of my medications.	(7) 88%	(4) 100%	(0) 0%	(11) 85%

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Inpatient Consumer Survey

The **Inpatient Customer 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 six areas or domains of focus. These domains include Outcomes, Dignity, Rights, Participation, Environment, and Empowerment.

NRI Inpatient Consumer Survey (ICS) Response Rate

	July	August	September	1Q2015
Number of clients discharged	19	11	7	37
Number of survey responses	2	3	2	7
Survey response rate	11%	27%	29%	19%

Surveys are distributed to all clients prior to discharge and when returned are tabulated in a database created for the purpose of collecting and uploading the data elements to NRI. On a monthly basis, the data is uploaded to NRI and aggregated with the results of the Riverview Psychiatric Center and other state psychiatric hospitals throughout the country. Reports on the percent of positive responses are returned along with aggregated comparative data from participating hospitals.

Data on the return rate of the survey administered to Dorothea Dix clients and the results of the comparative analysis for the past three months follows.

The data is depicted in three month averages in order to level out the monthly variation in the responses. The smooth line provided with this averaging allows for a more precise analysis of trends over time.

It is becoming problematic that the response rate is low. The Joint Commission has an expectation that the hospital evaluates care from the perspective of the clients served. This can be accomplished through a grievance management process or through a satisfaction survey process. This information also requires review by the organization's governance.

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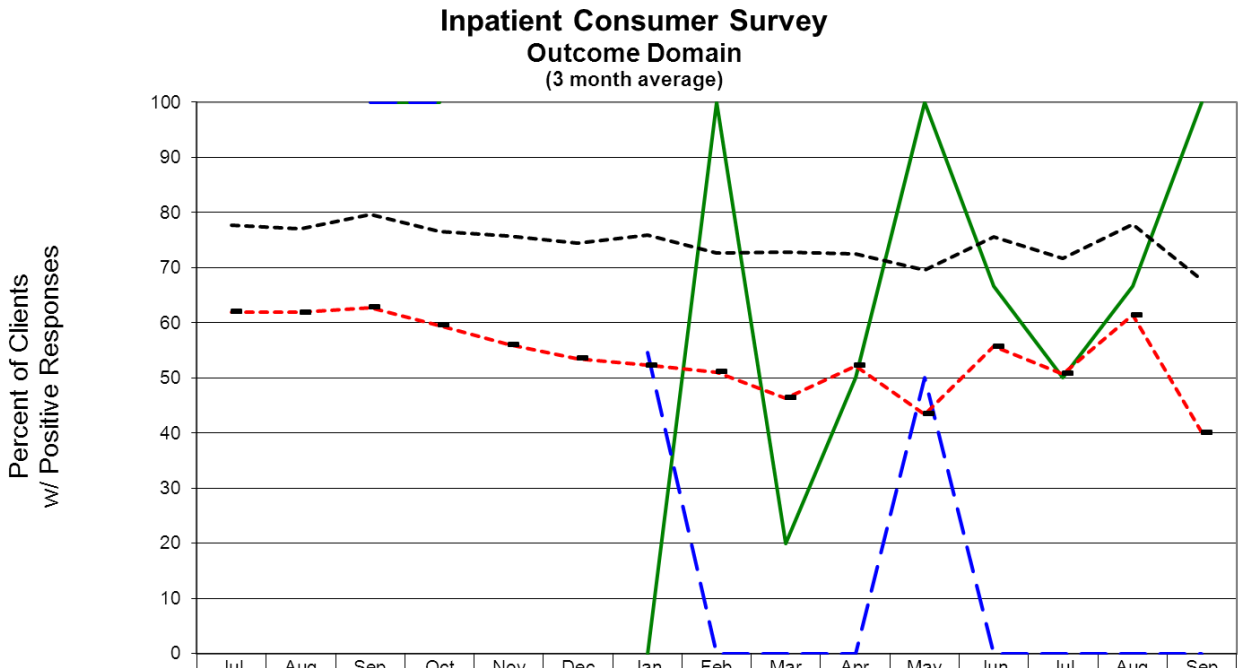

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	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Dorothea Dix	100.00		100.00	100.00			0.00	100.00	20.00	50.00	100.00	66.67	50.00	66.67	100.00
Riverview			100.00	100.00			54.55	0.00	0.00	0.00	50.00	0.00	0.00	0.00	0.00
Ntl Mean	77.70	77.02	79.66	76.53	75.76	74.46	75.84	72.62	72.88	72.49	69.52	75.51	71.66	77.92	67.84
- 1 StDev	61.96	61.85	62.76	59.53	56.01	53.52	52.32	51.03	46.37	52.19	43.40	55.68	50.76	61.37	40.08

Outcome Domain Questions

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

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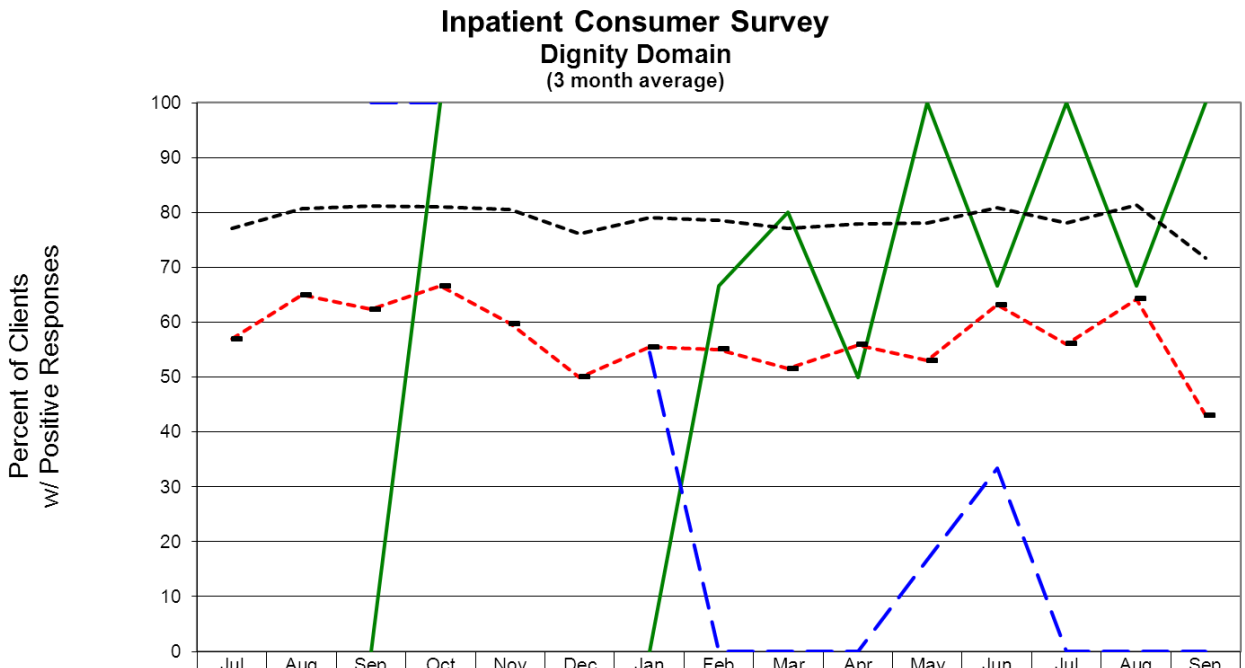

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	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Dorothea Dix	0.00		0.00	100.00			0.00	66.67	80.00	50.00	100.00	66.67	100.00	66.67	100.00
Riverview			100.00	100.00			54.55	0.00	0.00	0.00	16.67	33.33	0.00	0.00	0.00
Ntl Mean	77.03	80.63	81.16	81.11	80.56	76.11	79.02	78.51	77.06	77.90	78.16	80.91	78.08	81.44	71.75
1 StDev	56.92	64.95	62.31	66.61	59.70	50.00	55.45	55.09	51.56	55.84	53.02	63.12	56.06	64.21	42.99

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.

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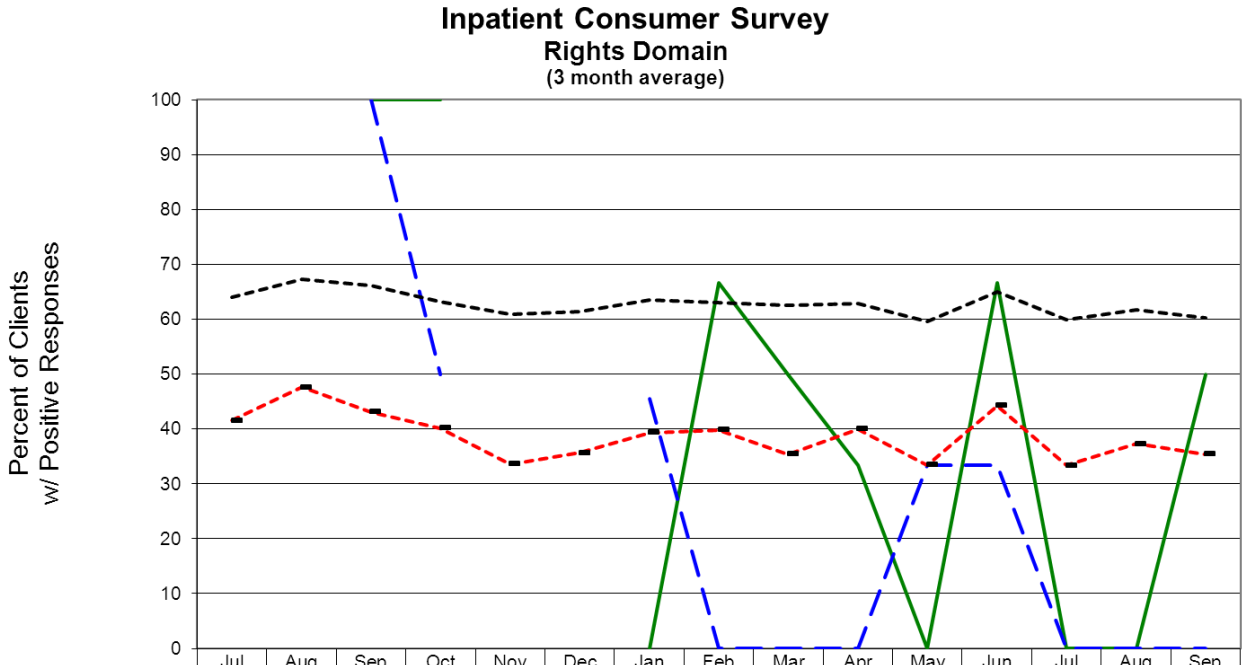

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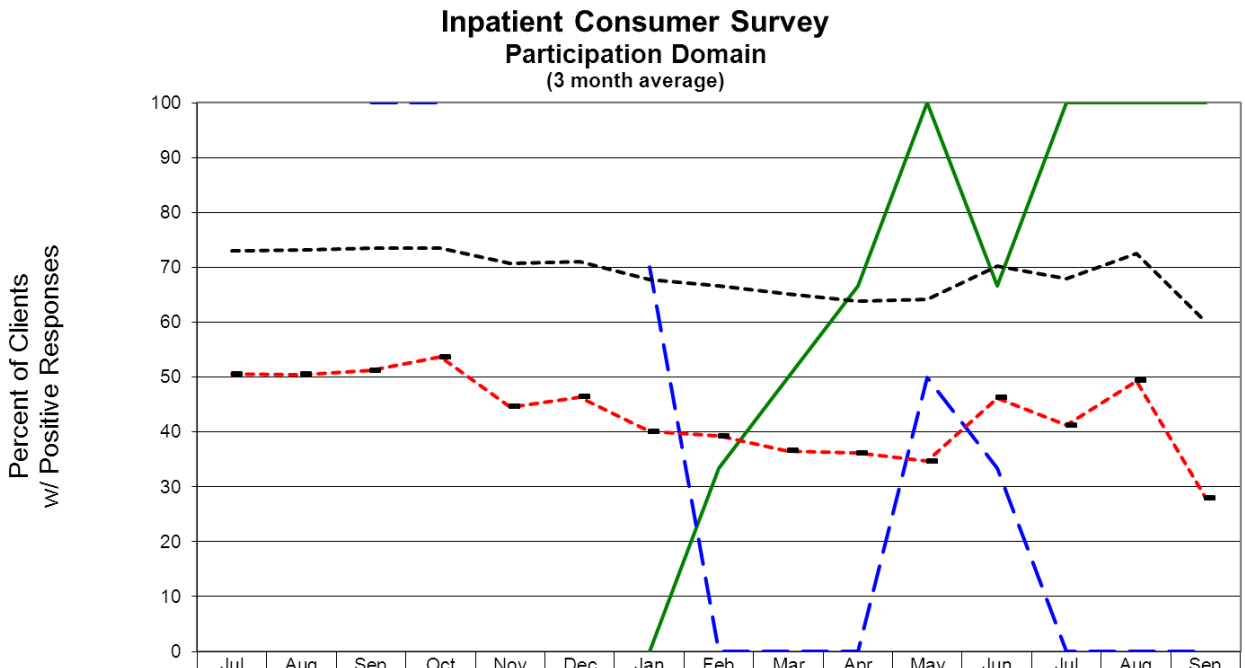
	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Dorothea Dix	0.00		100.00	100.00			0.00	66.67	50.00	33.33	0.00	66.67	0.00	0.00	50.00
Riverview			100.00	50.00			45.45	0.00	0.00	0.00	33.33	33.33	0.00	0.00	0.00
Ntl Mean	63.95	67.27	66.19	63.20	60.89	61.45	63.52	63.01	62.58	62.89	59.54	64.96	59.88	61.77	60.24
- 1 StDev	41.57	47.57	43.10	40.16	33.58	35.62	39.37	39.79	35.43	39.99	33.44	44.28	33.33	37.33	35.38

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.



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	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Dorothea Dix	100.00			100.00			0.00	33.33	50.00	66.67	100.00	66.67	100.00	100.00	100.00
Riverview			100.00	100.00			70.00	0.00	0.00	0.00	50.00	33.33	0.00	0.00	0.00
Ntl Mean	73.05	73.10	73.45	73.48	70.66	71.00	67.75	66.66	65.11	63.93	64.14	70.20	67.97	72.50	60.08
1 StDev	50.57	50.44	51.21	53.64	44.58	46.37	40.11	39.24	36.57	36.13	34.65	46.22	41.25	49.35	27.93

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.

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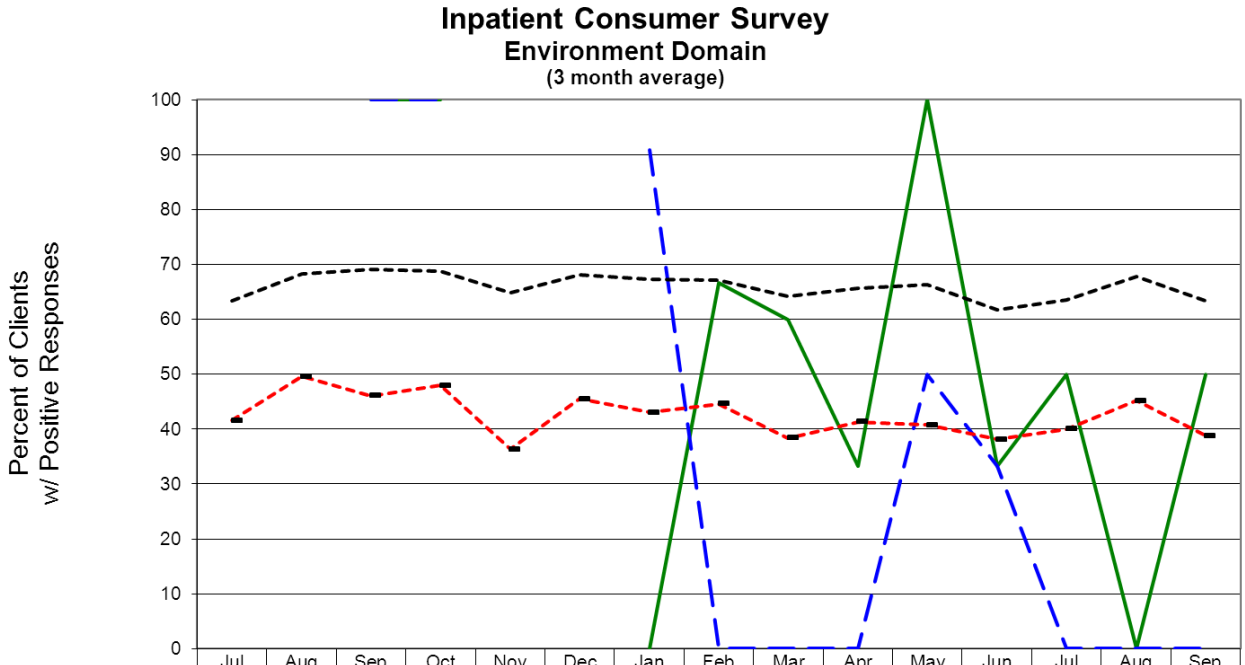

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	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Dorothea Dix	0.00		100.00	100.00			0.00	66.67	60.00	33.33	100.00	33.33	50.00	0.00	50.00
Riverview			100.00	100.00			90.91	0.00	0.00	0.00	50.00	33.33	0.00	0.00	0.00
Ntl Mean	63.35	68.22	69.05	68.81	64.83	68.08	67.23	67.09	64.18	65.73	66.29	61.78	63.48	67.77	63.45
- 1 StDev	41.59	49.61	46.05	47.95	36.30	45.48	43.06	44.60	38.36	41.30	40.75	38.16	40.03	45.18	38.81

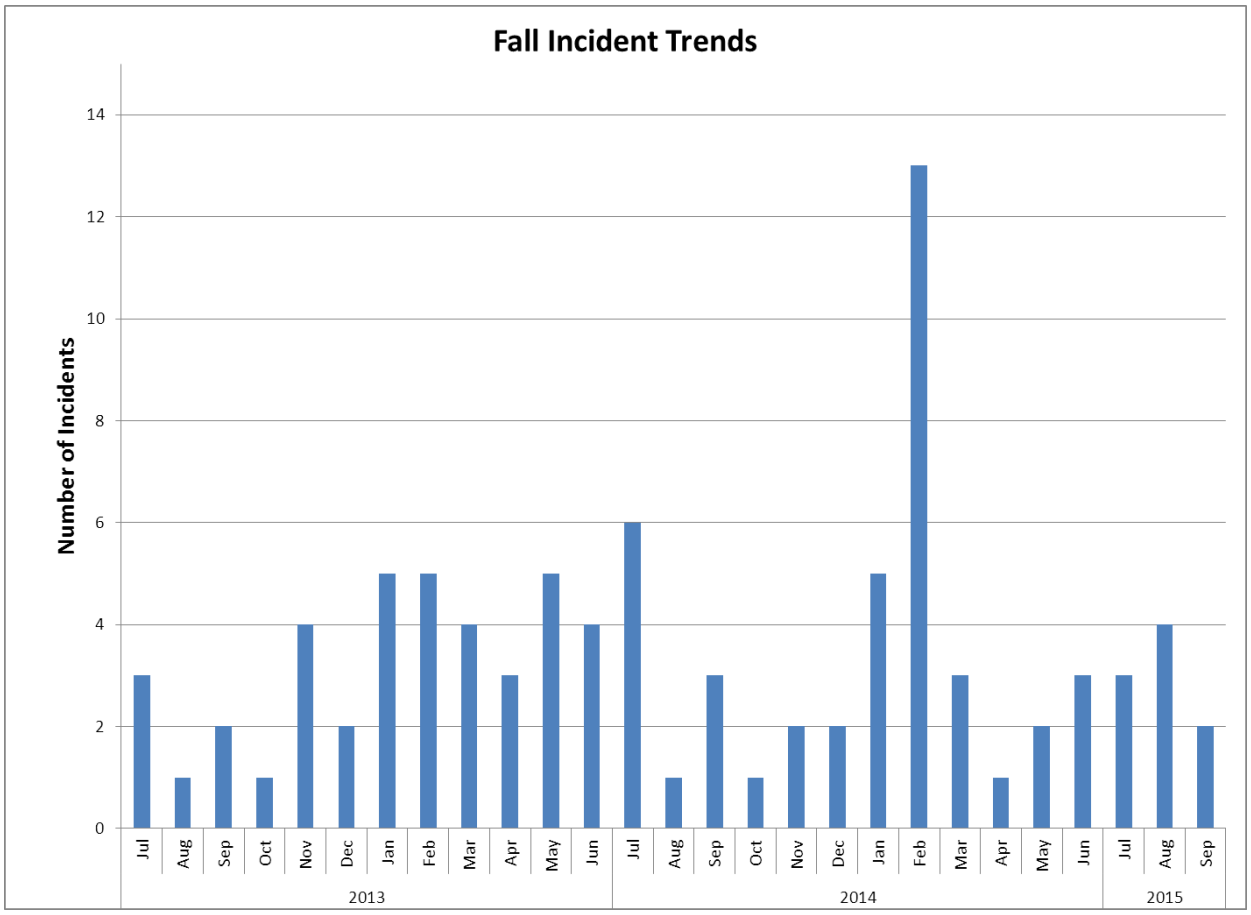
Environment Domain

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.

Fall Reduction Strategies

TJC PI.01.01. EP38 The hospital evaluates the effectiveness of all fall reduction activities including assessment, interventions and education.

Dorothea Dix Psychiatric Center has had a Falls Risk Management Team in existence for several years. 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.



**Includes both witnessed and unwitnessed falls*

JOINT COMMISSION

Falls Reduction Nursing Interventions — Janet Babcock, RN

Falls (ESTABLICHING A CULTURE OF SAFETY)

Up to 50% of hospitalized patients are at risk for falls, and almost half of those who fall suffer an injury {American Nurse Today, Special Supplement to American Nurse Today - Best Practices for Falls Reduction: A Practical Guide. Multiple authors, March 2011, Vol 6. No 2). The objective of Nursing's Fall PI is to ensure compliance with Nursing Procedure F-10 with the overall objective of ensuring that information is gathered about each patient for problem identification in order to ensure health and safety needs are met.

Methodology: All falls will be reviewed by using a tool with check boxes. The chart audits will occur for six consecutive months starting July 1, 2013. The denominator is all patient falls within the audit month. The numerator will be all falls follow-up documentation in compliance. The results of the audits will be reported to the IPEC (Performance Excellence) committee which meets monthly.

Baseline Data: An audit was conducted on each unit on 2/25/13. The audit indicated that there is clearly a process deficit with carrying over falls risk score to treatment plans, implementing modalities and focus fall review process. The Goal will be set once the updated procedure is audited.

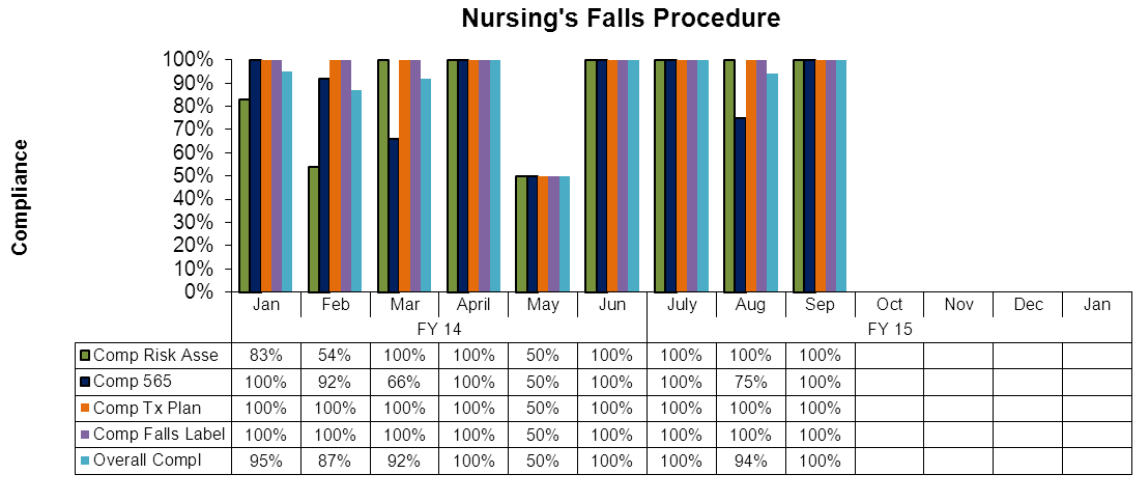
Goal: The goal is to have 90% compliance with Nursing's Fall Procedure F-10 with a threshold of 80%.

All patient falls within the 1st quarter	# Falls risk assessment completed?	# Falls Progress Note 565 completed and in the Pt's medical record?	# Falls risk score of 6 or higher- Is problem 6.1 initiated (164 A & B)?	# Falls risk score documented on kardex and in front of chart	
9	Yes = 9 No = 0 N/A = 0	Yes = 3 No = 1	Yes = 9 No = 0 N/A = 0	Yes = 9 No = 0 N/A = 0	
Overall compliance	**100%**	**92%**	**100%**	**100%**	**98%**

PLAN OF ACTION:

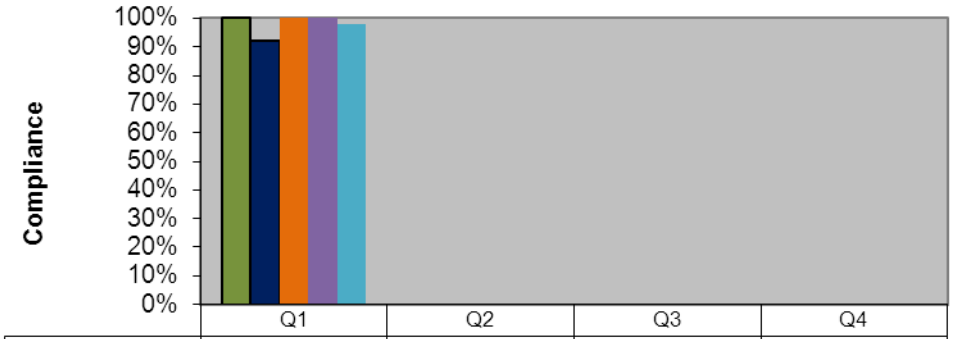
There were 9 falls for the 1st Quarter of FY 2015 for a compliance rate of 98% which is an increase from the 4th Quarter of FY 2014 of 89%. The CNM's have continued to provide education to all new staff and have more closely monitored all staff for compliance with nursing's fall procedure F-10. These measures have been effective, as June's audit shows a compliance rate of 100%. We will continue to monitor and report monthly.

JOINT COMMISSION



	Jan	Feb	Mar	April	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan
	FY 14						FY 15						
Comp Risk Asse	83%	54%	100%	100%	50%	100%	100%	100%	100%				
Comp 565	100%	92%	66%	100%	50%	100%	100%	75%	100%				
Comp Tx Plan	100%	100%	100%	100%	50%	100%	100%	100%	100%				
Comp Falls Label	100%	100%	100%	100%	50%	100%	100%	100%	100%				
Overall Compl	95%	87%	92%	100%	50%	100%	100%	94%	100%				

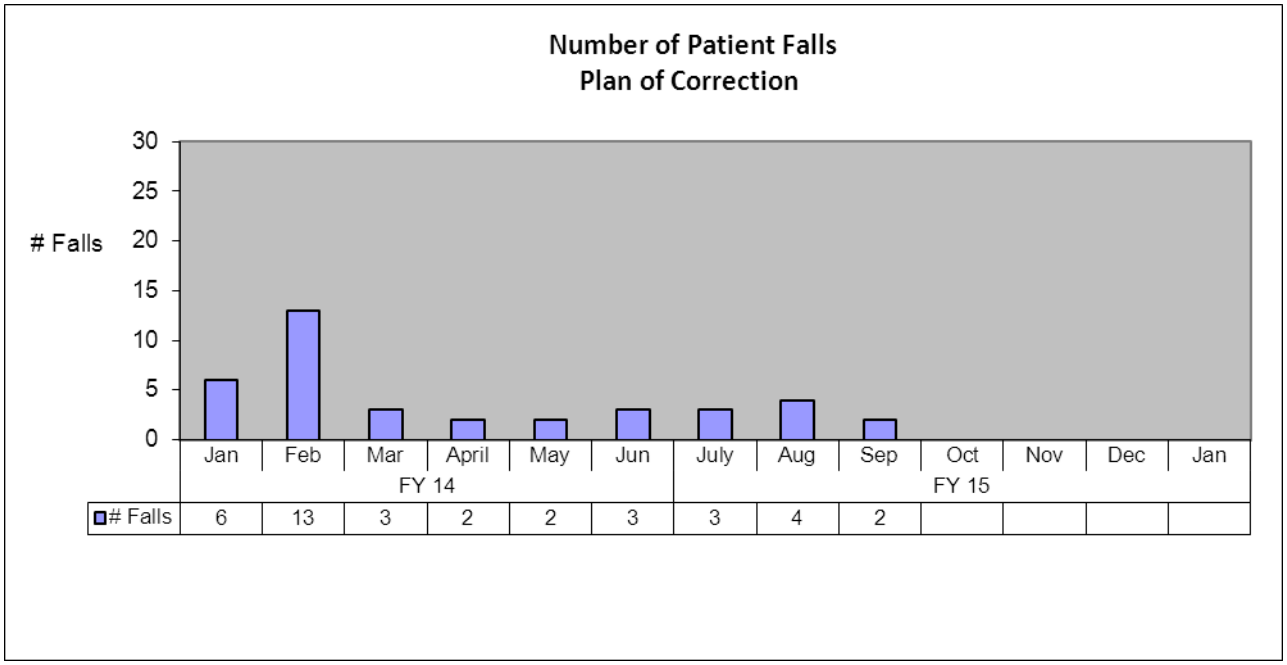
Goal is 90% compliance with Nursing Procedure F-10

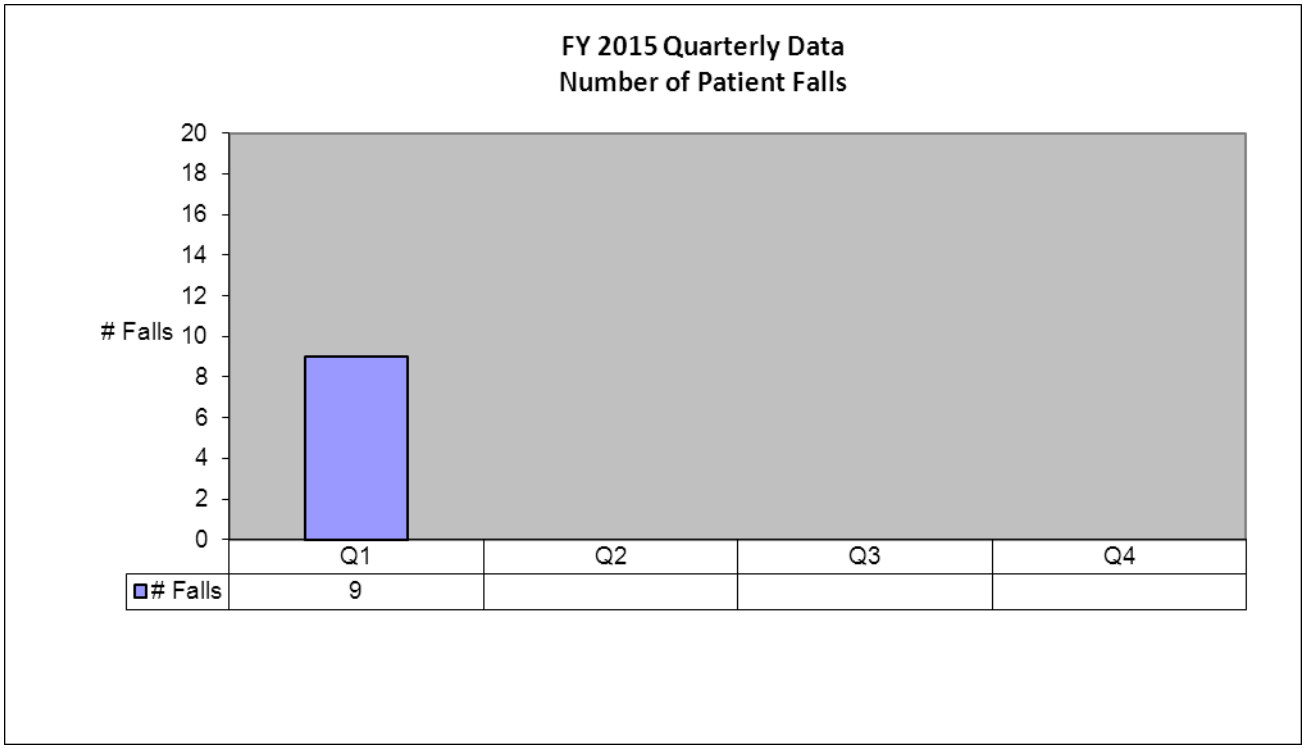


	Q1	Q2	Q3	Q4
Comp Risk Asse	100%			
Comp 565	92%			
Comp Tx Plan	100%			
Comp Falls Label	100%			
Overall Compl	98%			

Goal is 90% Compliance with Nursing Procedure F-10.
Treshold is 80%.

JOINT COMMISSION





JOINT COMMISSION

Pain Assessment Nursing Interventions Janet Babcock, RN

Pain Assessment (Patient Recovery)

Elements of Performance for Joint Commission Standard PC.01.02.07
1. The hospital conducts a comprehensive pain assessment that is consistent with its scope of care, treatment, and services and the patient's condition. (See also PC.01.02.01, EP 2; RI.01.01.01, EP 8)
2. The hospital uses methods to assess pain that are consistent with the patient's age, condition, and ability to understand.
3. The hospital reassesses and responds to the patient's pain, based on its reassessment criteria.
4. The hospital either treats the patient's pain or refers the patient for treatment.

Source: The Joint Commission: The Source. The fifth "vital sign" complying with pain management standard PC. 01.02.07. November 2011, Vol 9. Issue 11.

INITIAL PAIN ASSESSMENT
Moved to surveillance as we have been 100% compliant with this audit.

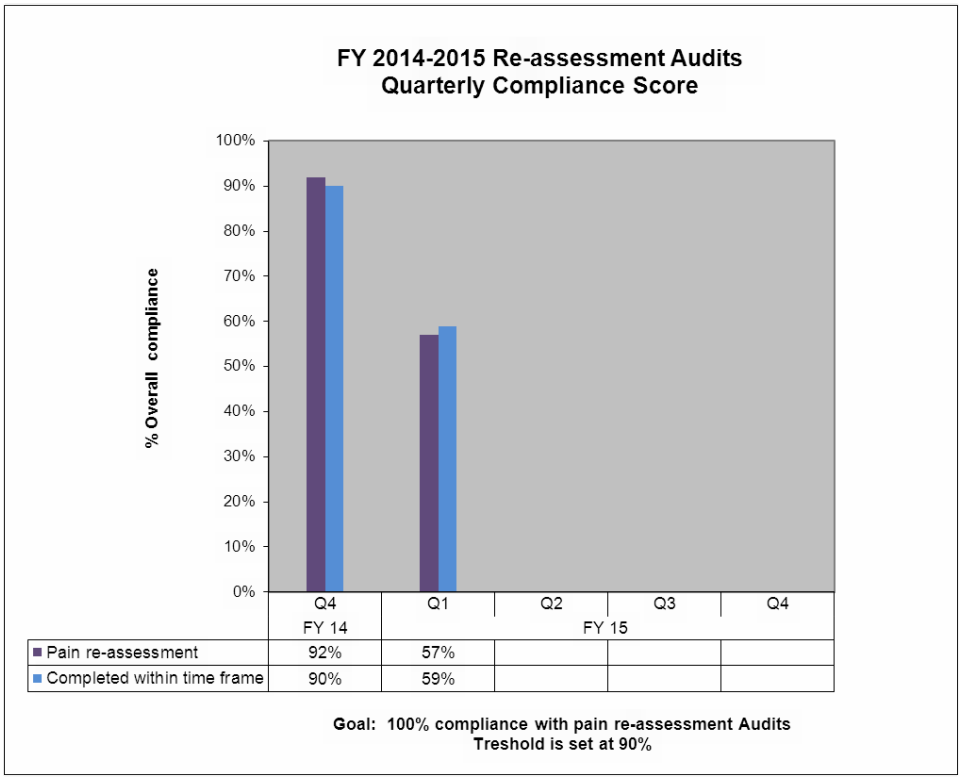
PAIN RE-ASSESSMENT (Initiated in January 2013)

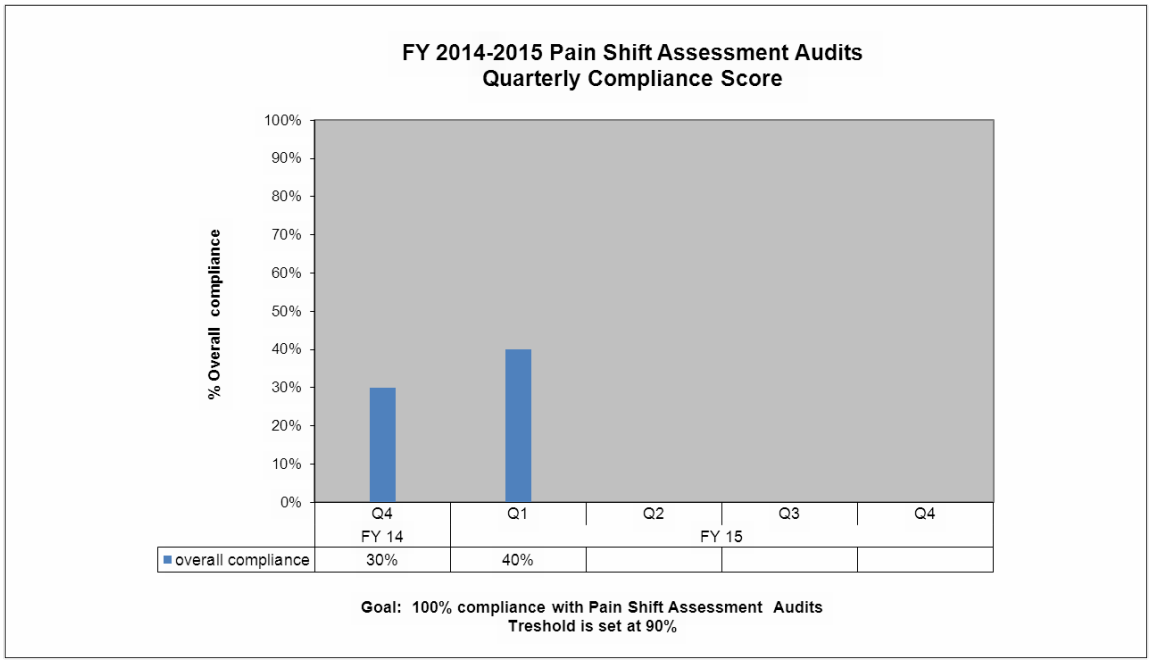
Methodology: MARs are reviewed for any pain reported for the month on form #838 and if there is a re-assessment that correlates to it.

Baseline Data: The audits that were completed in January and February of 2013 indicate a baseline data of 38%

Goal: 100% compliance with Pain re- assessment. Threshold is set at 90%.

JOINT COMMISSION





JOINT COMMISSION

PAIN SHIFT ASSESSMENT (Initiated in January 2013)

Methodology: All charts for each unit, are audited monthly for a 24 hour period. Using the Daily Shift Assessment Form patients are assessed for the presence and intensity of pain at least once every 12 hours. The charts are assessed to ensure there are 2 Pain Assessments completed.

Baseline Data: The audits that were completed in January and February 2013 indicate a baseline data of 33%.

Goal 2015: 100% compliance with assessing for the presence and intensity of pain at least once every 12 hours (Shift Assessment). The threshold is set at 90%.

Evaluation and Plan of Action

1ST Quarter FY 2015:

***Initial Pain Assessment*:** Moved to surveillance.

***Pain Re-assessment*:**
The 1st quarter of FY2015 has a compliance rate of 47%., for each indicator. This is a significant decrease from 4th Quarter FY2014 of 90% and 92% for each indicator. Our threshold is 90%.

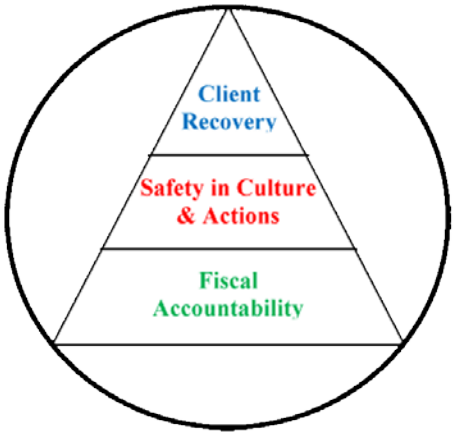
Pain Shift Assessments (2 within 24 hours):
The 1st quarter of FY2015 shows a compliance rate of 40%. This is a slight increase from the 4th quarter of
FY2014. 90% remains our threshold. The CNM's continue to provide close monitoring and education to nurses.

Plan of Correction:
Nursing leadership continues to monitor these results monthly. Pain management is now a standing item at nursing meetings. The CNM's have taken the lead to improve the compliance for this audit. Each CNM has addressed the importance of this process to their nurses and will monitor closely for compliance. The goal of increasing compliance, improving the audit scores and supervising their nurses, has been added to each CNM's Performance Appraisal. Nursing will continue to audit and report monthly.

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

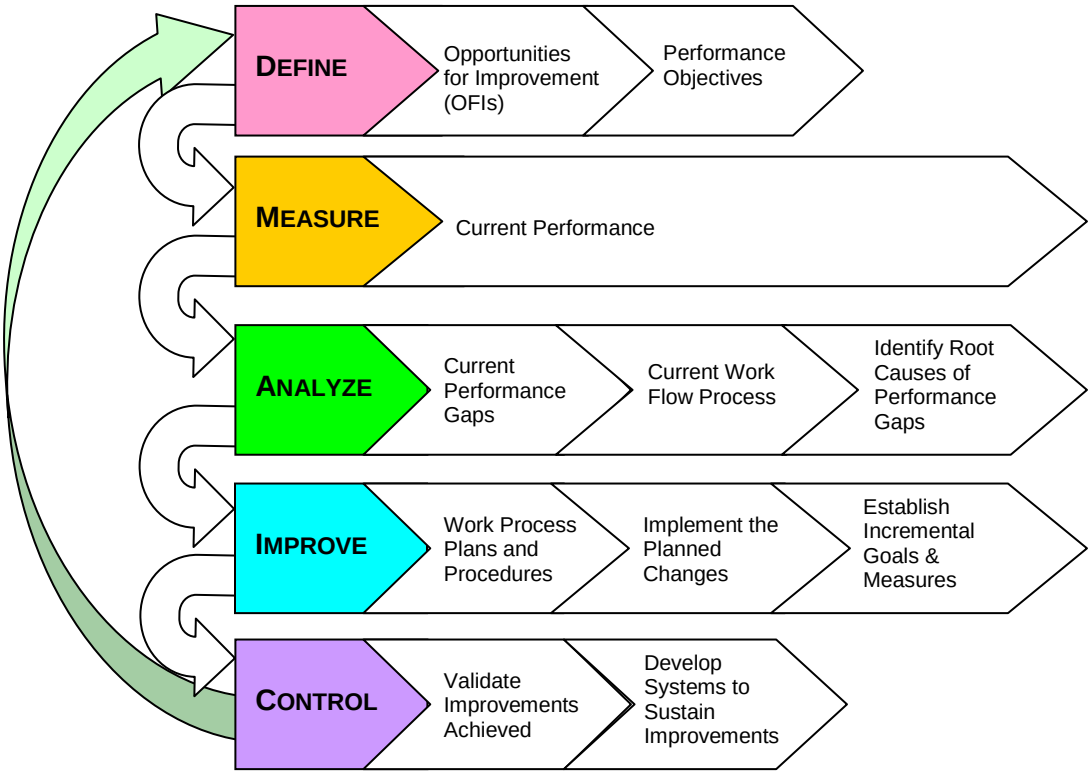
Dorothea Dix and Riverview Psychiatric Centers
Priority Focus Areas

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

Dietary — Wendy Schriver, RD, LD

Identification of Opportunities for Improvement – Patient Education

The number of patient contacts for nutrition education has decreased over the past 3 years most likely due to decrease in patient census and longer patient stays along with a reduction in nutrition WTM groups from 3 to 1 each week. There is also a focus currently on offering more unit based groups.

Measurement Process

The number of patients participating in various forms of nutrition education will be tracked

Baseline Measures

Will start with baseline of 45 contacts each quarter (taken from average number of 1:1 patient contacts added to average number of WTM participants)

Goal and Plan for Improvement

Offer education sessions on the units (informal games/groups) as well as continuing with 1:1 patient education and WTM groups.

Incremental Measures of Success

Success will be measured by an increase in the number of education sessions offered.

Strategic Objectives							
Client Recovery	Unit	Baseline	FY14 Q3 Target	FY14 Q4 Target	FY15 Q1 Target	FY15 Q2 Target	Goal
Nutrition Education Measure will indicate number of patients participating in education session	# of patient contacts	45	50	55	95	100	>297 for year (2013 total)
Quarterly Results			118	90	91		

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Management **Michelle Welch, RHIT**

Regulatory and Compliance Standards in Documentation

Ensuring Fiscal Responsibility in Documentation and Billing Practices

Indicator and Rationale for Selection	2Q2014	3Q2014	4Q2014	1Q2015
Identification Data	100% 25/25	100% 43/43	100% 34/34	37/37 100%
Medical History, including chief complaint; HPI; past, social & family hx., ROS, and physical exam w/in 24 hr, conclusion and plan	100% 25/25	100% 43/43	97% 33/34	37/37 100%
Summary of patient's psychosocial needs as appropriate to the patients *	100% 25/25	95% 41/43	100% 34/34	36/37 97%
Psychiatric Evaluation in patient's record w/in 24 hr of admission	100% 25/25	100% 43/43	100% 34/34	35/37 94.5%
Physician (TO/VO w/in 72 hr.)	Data not available	93% 40/43	90.6% 29/32	36/36 100%
Evidence of appropriate informed consent	80% 20/25	98% 42/43	97% 33/34	36/36 100%
Clinical observations including the results of therapy.	100% 25/25	100% 43/43	100% 34/34	32/32 100%
Nursing discharge Progress Note with time of discharge departure	92% 23/25	100% 43/43	100% 34/34	36/36 100%
Consultation reports, when applicable	100% 25/25	100% 43/43	100% 13/13	20/20 100%
Final Diagnosis (es) DSM-Principal Diagnosis	100% 25/25	100% 43/43	100% 34/34	37/37 100%
Results of autopsy, when performed	N/A	N/A	N/A	N/A
Advance Directive Status on admission and SW follow up after	100% 25/25	100% 43/43	97% 33/34	35/36 97%
Notice of Privacy	100% 25/25	100% 43/43	100% 34/34	36/37 100%
Chart Completion w/in 30 days of discharge date/discharge summary completed within 30 days	100% 25/25	100% 43/43	88.2% 30/34	34/37 92%
Discharge Packet sent to follow up provider within 5 days of discharge.	100% 25/25	100% 43/43	91% 31/34	36/36 100%

* The parameters for this measure will be changed to meet applicable goals as defined by Director of Social Work. The current measure is more stringent than regulatory standards dictate.

STRATEGIC PERFORMANCE EXCELLENCE

Human Resources — Ruth Mullaney

	July 2014	August 2014	September 2014	1Q FY2015 Total
Terminations – Voluntary	1	4	1	6
Terminations – Involuntary	2	0	1	3
New Hires	6	1	2	9
Sick Time Used	1146.4	1000.3	1254.55	3,401.25
FML Used	213.9	142.2	192.15	548.25
Overtime	1516.25	1448	1784.55	4,748.80
AWOL	51.4	173.35	88.10	312.85
Workers Compensation Incidents:				
Lost Time	0	0	1	1
Type of Incident:				
Medical	3	2	0	5
Patient Related	0	3	2	5
Chemical Spill	0	0	1	1
Total # of Events	**3**	**5**	**3**	**11**

STRATEGIC PERFORMANCE EXCELLENCE

Infection Control — Heather Brock, RN

1.) GOAL

Surveillance Data will continue to be gathered on the following hospital acquired infections: **UTI, URI, LRI, and SKIN**. Data will be reviewed monthly and reported quarterly as part of the Performance Improvement Report. A threshold has been set for **0.3** (HAI) per 1000 inpatient days for FY 2014.

HOSPITAL ACQUIRED INFECTIONS

1st Quarter: July – September FY2015 = 0 H.A. Infections
2nd Quarter: October – December FY2015 =
3rd Quarter: January – March FY2015 =
4th Quarter: April – June FY2015 =

H.A.Infections	FY 2013	FY 2014	FY2015
1st Quarter H.A.I. Rate	0	0	0
2nd Quarter H.A.I. Rate	0	0	
3rd Quarter H.A.I. Rate	0	0	
4th Quarter H.A.I. Rate	0	0	
Average H.A. Infection Rate	**0**	**0**	**0**

FY 2013-2015 Hospital Acquired Infections

Type of Infection	Q1 2013	Q1 2014	Q1 2015	Q2 2013	Q2 2014	Q2 2015	Q3 2013	Q3 2014	Q3 2015	Q4 2013	Q4 2014	Q4 2015
UTI	0	0	0	0	0		0	0		0	0	
URI	0	0	0	0	0		0	0		0	0	
LRI	0	0	0	0	0		0	0		0	0	
SKIN	0	0	0	0	0		0	0		0	0	
Totals	0	0	0	0	0		0	0		0	0	
Infection Rate	0	0	0	0	0		0	0		0	0	

Infection Rate per 1000 patient days: $\frac{\text{Total number of infections per unit x 1000}}{\text{Total number of inpatient days}}$ = %

1st Quarter 2013 = 3631
2nd Quarter 2013 = 4101
3rd Quarter 2013= 4052
4th Quarter 2013 = 3802

1st Quarter 2014 = 3712
2nd Quarter 2014 = 3659
3rd Quarter 2014 = 3557
4th Quarter 2014 = 3397

1st Quarter 2014=3256
2nd Quarter 2014=
3rd Quarter 2014 =
4th Quarter 2014 =

2.) HAND HYGIENE

Hand Hygiene Observations being monitored during staff medication passes have been placed on surveillance. At the 6 month check the compliance rate continued to be 100%. Will discontinue monitoring as we continue to achieve our goal of 100% compliance.

3.) INFECTION CONTROL PERFORMANCE ISSUES

I.C. STANDARD IC.02.01.01 AND 01.05.01:

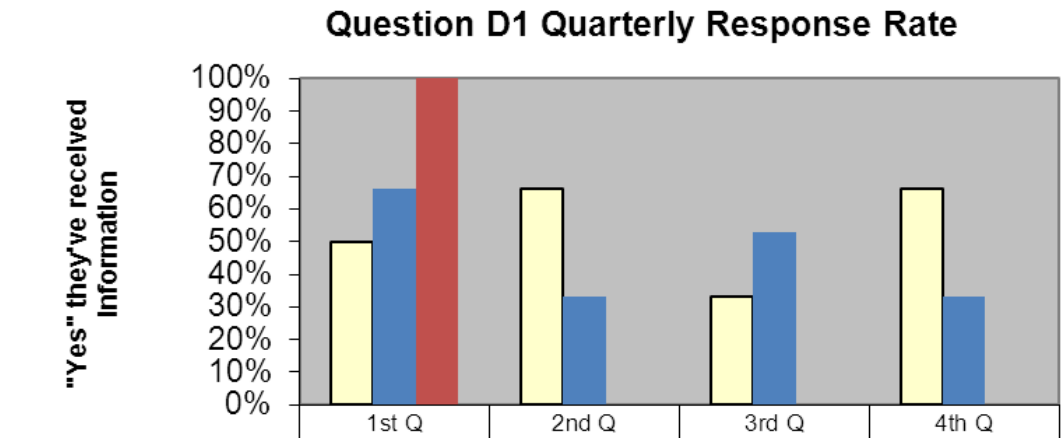
IC Standard 02.01.01 EP #7 and 01.05.01 EP #7 the hospital implement a methods to communicate responsibilities for preventing and controlling infection to visitors, patients, and families? (Information for visitors, patients, and families includes hand and respiratory hygiene practices).

Goal for FY2015

Quarterly response rates for question D1 and D2 agree and strongly agree is set at **80%** with quarterly incremental increases of 5% of the previous quarter or more. The threshold is set at **70%**. *The standard goal is to have a sustained level of compliance that approaches 100%. Once the goal of 80% compliance is met a longer term goal will be set.*

Question D1: I received information on how to stay healthy by washing my hands.

Question D2: I received information on how to cover my cough or sneeze to prevent the spread of illness.

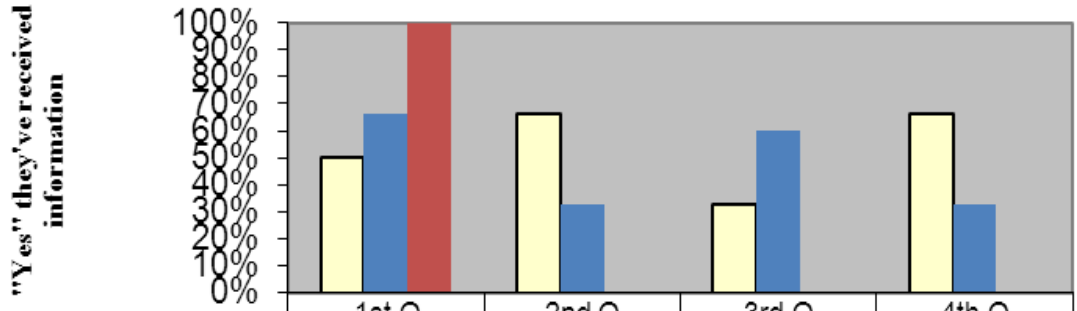


	1st Q	2nd Q	3rd Q	4th Q
FY 2013 response rate	50%	66%	33%	66%
FY 2014 Response Rate	66%	33%	53%	33%
FY 2015 Response Rate	100%			

Quarterly response rate is set at 80% with quarterly incremental increases of 5% of the previous quarter or more. The treshold is set at 70%. The goal is to have a sustained level of compliance that approaches 100%.

STRATEGIC PERFORMANCE EXCELLENCE

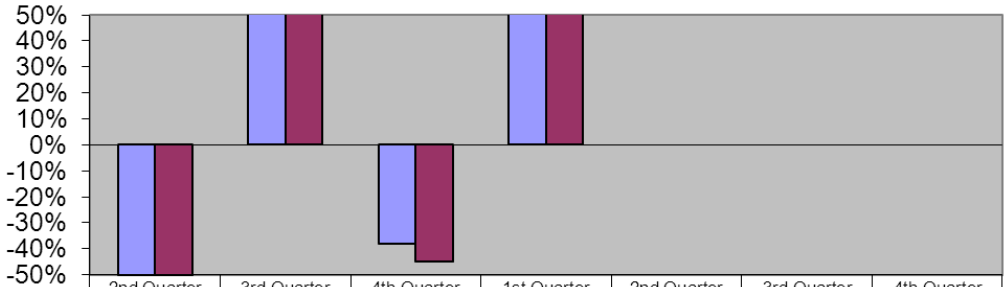
D2 Quarterly Response Rate



	1st Q	2nd Q	3rd Q	4th Q
FY 2013 response rate	50%	66%	33%	66%
FY 2014 Response Rate	66%	33%	60%	33%
FY 2015 Response Rate	100%			

Quarterly response rate is set at 80% with quarterly incremental increases of 5% of the previous quarter or more. The treshold is set at 70%. The goal is to have a sustained level of compliance that approaches 100%

Quarterly Incremental Increases/Decreases



	2nd Quarter 14	3rd Quarter 14	4th Quarter 14	1st Quarter 15	2nd Quarter 15	3rd Quarter 15	4th Quarter 15
D1 Quarterly increamental increases/decreases	-50%	61%	-38%	203%			
D2 Quarterly incremental increases/decreases	-50%	82%	-45%	203%			

Quarterly response rate is set at 80% with quarterly incremental increases of 5% of the previous quarter or more. The treshold is set at 70%. The goal is to have a sustained level of compliance that approaches 100%

PLAN OF ACTION

Question D1: 1st Quarter FY 2015's response rate was 100%, 4th Quarter FY 2014's response rate was 33%, an increase of 203%

Question D2: 1st Quarter FY 2015's response rate was 100%, 4th Quarter FY 2014's response rate was 33%, an increase of 203%

For 1st Quarter FY 2015 there were 36 discharge questionnaires distributed, 9 questionnaires were completed and returned for a quarterly return rate of **25%.**

*Questions D1 and D2 have been removed from the NRI patient discharge survey. IC RN has been tasked with offering a short IC survey that will capture questions D1 and D2. Easier access to the survey may produce an increase in return and response rates. IC will continue to monitor.

Pamphlets on hand hygiene, respiratory etiquette and how to prevent the spread of infection are available in visitors room/lounge on the units, WTM, Main Entrance, Patient Education Room and the Patient's Welcome Baskets. At start up every morning, staff will remind patients to help prevent the spread of germs by covering their coughs and sneezes and washing their hands.

4.) PROMOTION OF 2014-2015 INFLUENZA IMMUNIZATIONS

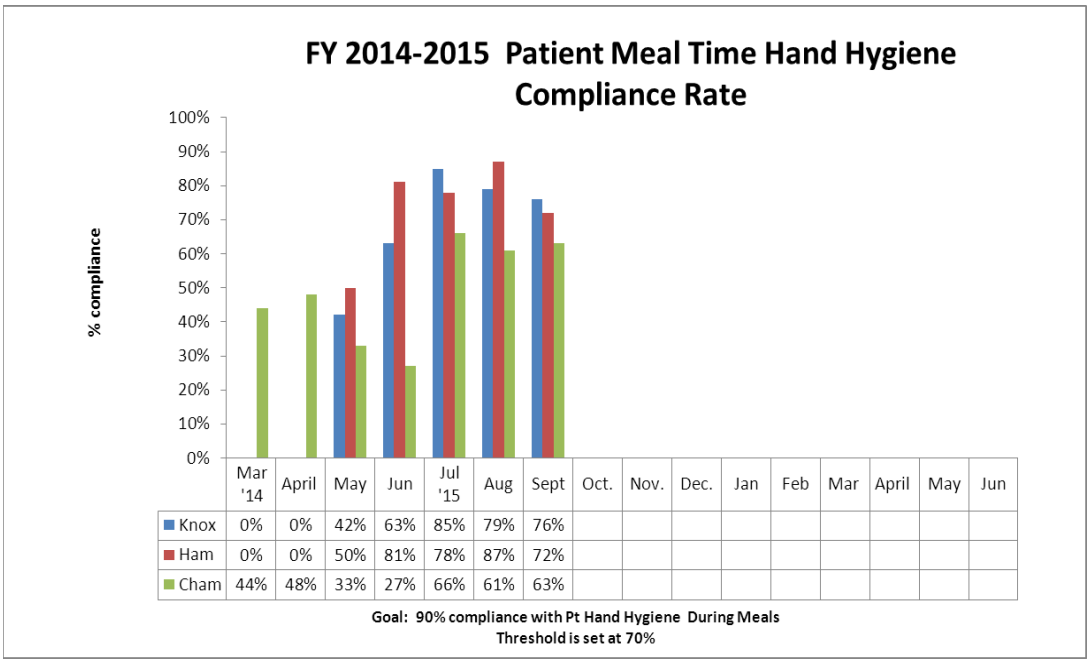
The goal for FY 2015 is to have an incremental increase of 4% of the previous year over the next six years. This would place the facility at the national goal of achieving 90% flu vaccination compliance. The standard goal is to have a sustained level of compliance that approaches and achieves the 90% compliance rate established in the national influenza initiative for 2020. Our compliance rate for 2013-2014 was 72%. IC committee members continue to discuss ways to increase compliance for this year.

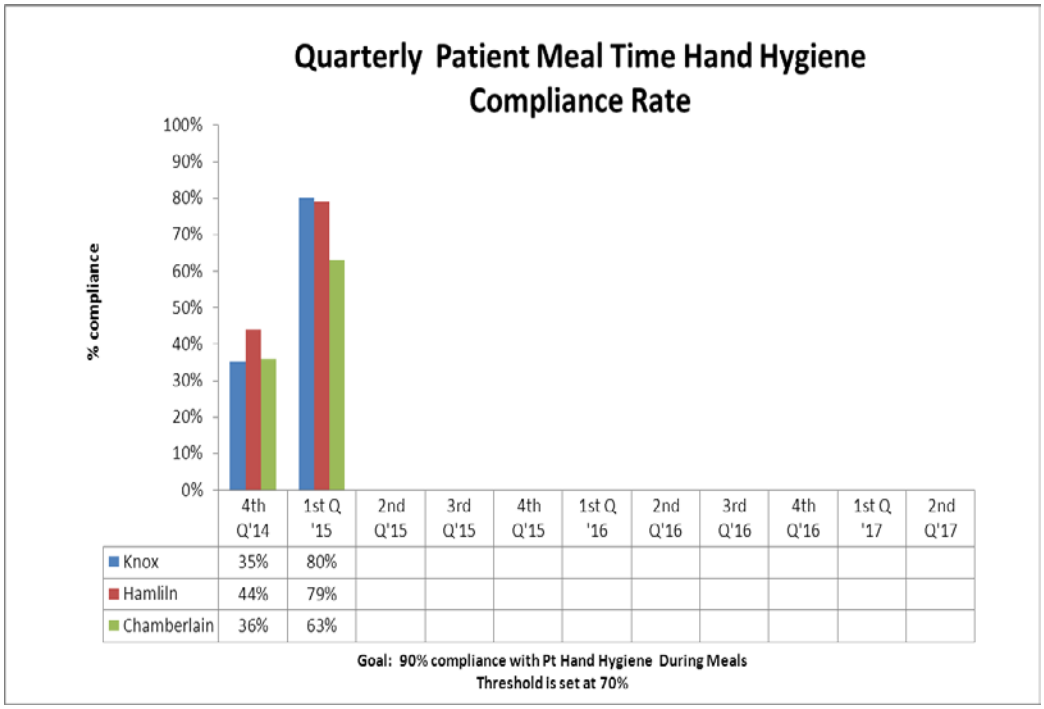
5.) PATIENT HAND HYGIENE

Goal for FY 2015 to have Quarterly aggregated incremental increases of **2%** of the previous month or more. The standard goal is to have a sustained level of compliance that approaches **90%.**

Methodology: The method of measuring compliance with the patients is auditing at least four meal times per unit per month, with a minimum of 10 "direct patient observations" per unit. This is currently the "gold star" and the most reliable method for assessing adherence rates.

Baseline Data: 4th Q 2014
Knox= 35% compliance rate
Hamlin= 44% compliance rate
Chamberlain= 36% compliance rate





Evaluation/Plan of Action:

1st Quarter FY 2015's compliance rate for Knox: 80% an increase of 129% from previous quarter, Hamlin: 79% an increase of 80% from previous quarter, and Chamberlain: 63%, and increase of 75% from previous quarter. Plan of action is to continue to role model and offer hand sanitizer to patients at meal times

STRATEGIC PERFORMANCE EXCELLENCE

Occupational Therapy **Lisa J. Hall, OTR/L**

Strategic Objectives							
Client Recovery, Communication	Unit	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal
Measure 1 Name- Timely completion of initial evaluation to guide OT services. *Measure 1 Description*- OTR/L must complete and document in the medical record initial OT evaluation within 10 calendar days of admission.	Eval complete on time	FY14 89%	90%	90%	90%	90%	100%
Quarterly Results			32/32 100%				
Measure 2 Name- Timely completion of discharge information to next level of care. *Measure 2 Description*- OTR/L must complete and document in the medical record SBAR discharge hand off within 4 calendar days following discharge for any patient who received OT TX during that admission.	Discharge SBAR, on time	FY14 92%	90%	90%	90%	90%	100%
Quarterly Results			15/15 100%				

SBAR not necessary if discharged prior to evaluation being done or treatment occurring.

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services — Garry Miller, RPh

Strategic Objectives								
Safety in Culture and Actions	Unit	Baseline 2014	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	0%	0%	0%	0%	0%	0%	Goal of no discrepancies in any transactions between Pyxis and CII
Quarterly Results			0%					
Veriform Medication Room Audits *Monthly comprehensive audits of 38 criteria*	All	93%	90%	90%	90%	90%	90%	Overall compliance is 91% for Q1.
Quarterly Results			91%					
Pyxis Discrepancies *Monthly monitoring and trending of Pxyis discrepancies.*	All	6.7	0	0	0	0	0	Trending of monthly data from Knowledge Portal.
Quarterly Results			21 (7/mo)					
Fiscal Accountability	Unit	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Discharge Prescriptions *Monitoring and Tracking of dispensed Discharge Prescriptions*	Rx	$353 22 drugs	$114 6 drugs					Significant savings and decrease achieved in discharge prescriptions

STRATEGIC PERFORMANCE EXCELLENCE

Recreational Therapy — Lisa J. Hall, OTR/L

Strategic Objectives							
Client Recovery, Communication	Unit	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal
Measure 1 Name- Timely completion of initial evaluation to guide TR services. *Measure 1 Description*- CTRS must complete and document in the medical record both components of the Recreation Assessment within 10 calendar days of admission.	Assess-ment complete on time	FY 14 78%	90%	90%	90%	90%	100%
Quarterly Results			28/31 90%				
Measure 2 Name- Timely completion of discharge information to next level of care. *Measure 2 Description*- CTRS must complete and document in the medical record SBAR discharge hand off within 4 calendar days following discharge for any patient who received TR TX during that admission.	Discharge SBAR, on time	FY 14 91%	90%	90%	90%	90%	100%
Quarterly Results			29/29 100%				

SBAR not necessary if discharged prior to evaluation being done or treatment occurring.

Comments:
Q1- three out of compliance by 1 day, 1 provider

Oct. 2014- Plan to continue with measures until 90% met for 3 consecutive quarters. Plan to add recovery services by Dec 2014.

Safety and Security — Richard Levesque

INDICATOR: GROUNDS SAFETY/SECURITY INCIDENTS

DEFINITION

Safety/Security incidents occurring on the grounds at Dorothea Dix Psychiatric Center. 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 grounds.* 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, Switchboard staff, Director of Support Services, Plant Maintenance Engineer I, Environmental Services staff, Supervisors, and frontline staff.

METHODS OF MONITORING

Monitoring would be performed by;

- Direct observation
- Cameras
- 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)

UNIT: Hospital grounds as defined above

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

Q2-Q4 TARGETS: Baseline – 5% each Q

STRATEGIC PERFORMANCE EXCELLENCE

Department: **Safety & Security** **Responsible Party:** **Richard Levesque-Chairman Environment of Care Committee (EOC)**

Strategic Objectives							
Safety in Culture and Actions	Unit	Baseline	Q4/14 Target Actual	Q1/15 Target Actual	Q2/15 Target Actual	Q2/15 Target Actual	Goal
Grounds Safety & Security Incidents Safety/Security incidents occurring on the grounds at Dorothea Dix Psychiatric Center, which include "*Acts of thefts, vandalism, injuries, mischief, contraband found, and safety / security breaches*	# of Security / Safety Incidents	Actual – 5% each Q	(2)-5% 1	(1)-5% 4	(4)-5%	Q3-5%	

SUMMARY OF EVENTS

The Q1 Target was not met. In the majority of the instances noted, Security was the first line of defense in making the discovery. Officers continue to demonstrate the value of their presence and their vigilance during patrols. We will continue to target a 5% reduction in events.

We hope that the reporting, which follows below, provides a very clear picture of Safety and Security events, how they are handled, and that the use of surveillance equipment plays an integral part in combating safety and security threats to people and property.

EVENT	DATE	TIME	LOCATION	DISPOSTION	FOLLOW-UP
1. While on patrol, Security found vehicle #6 unsecured	07/08/14	22:00	Main Entrance	Vehicle locked by security	1. Vehicle secured 2. SEC IR # 103 completed.
2. While on foot patrol, security found a white *Bic* lighter	07/22/14	10:00	Outside of the "K" Yard	Lighter was discarded in to the dumpster	1. Lighter removed 2. SEC IR# 105
3. While on patrol, Security found vehicle #6 unsecured	07/22/14	19:17	Main Entrance	Vehicle locked by security	1. Vehicle secured 2. SEC IR # 106 completed.

Continued on next page

STRATEGIC PERFORMANCE EXCELLENCE

EVENT	DATE	TIME	LOCATION	DISPOSTION	FOLLOW-UP
4. Security received a report of a suspicious person	9/6/14	15:59	Staff parking lot (Pooler Area)	Security confronted the person and asked for I.D. Person was intoxicated and asked if this was the veteran's home. Security officer said no and the person left the premises.	1. Bangor Police notified 2. Director of Support Services notified 3. SEC IR# 113 completed

STRATEGIC PERFORMANCE EXCELLENCE

Social Services **Susan Wengrzynek, LMSW-CC**

Strategic Objectives							
Client Recovery	Unit	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal
Measure Name- Completion of the Psychosocial Assessment according to hospital policy is a required standard of the Joint Commission. It is the basis for the social worker's treatment interventions and discharge planning. *Measure Description*- All new admissions will be audited by social workers on an assigned unit each month to determine completion within five days of admission, dated and signed (not in draft form), and is congruent with the PSA approved by the Medical Records Committee.	All New Admissions Starting July 2014	90%	100%	100%	100%	100%	100%
Quarterly Results			97.7% July: 100% Aug: 92.3% Sept: 100%	Oct: Nov: Dec:	Jan: Feb: Mar:	Apr: May: June:	

STRATEGIC PERFORMANCE EXCELLENCE

Staff Education and Development Jenny Bamford-Perkins, MSN, RN

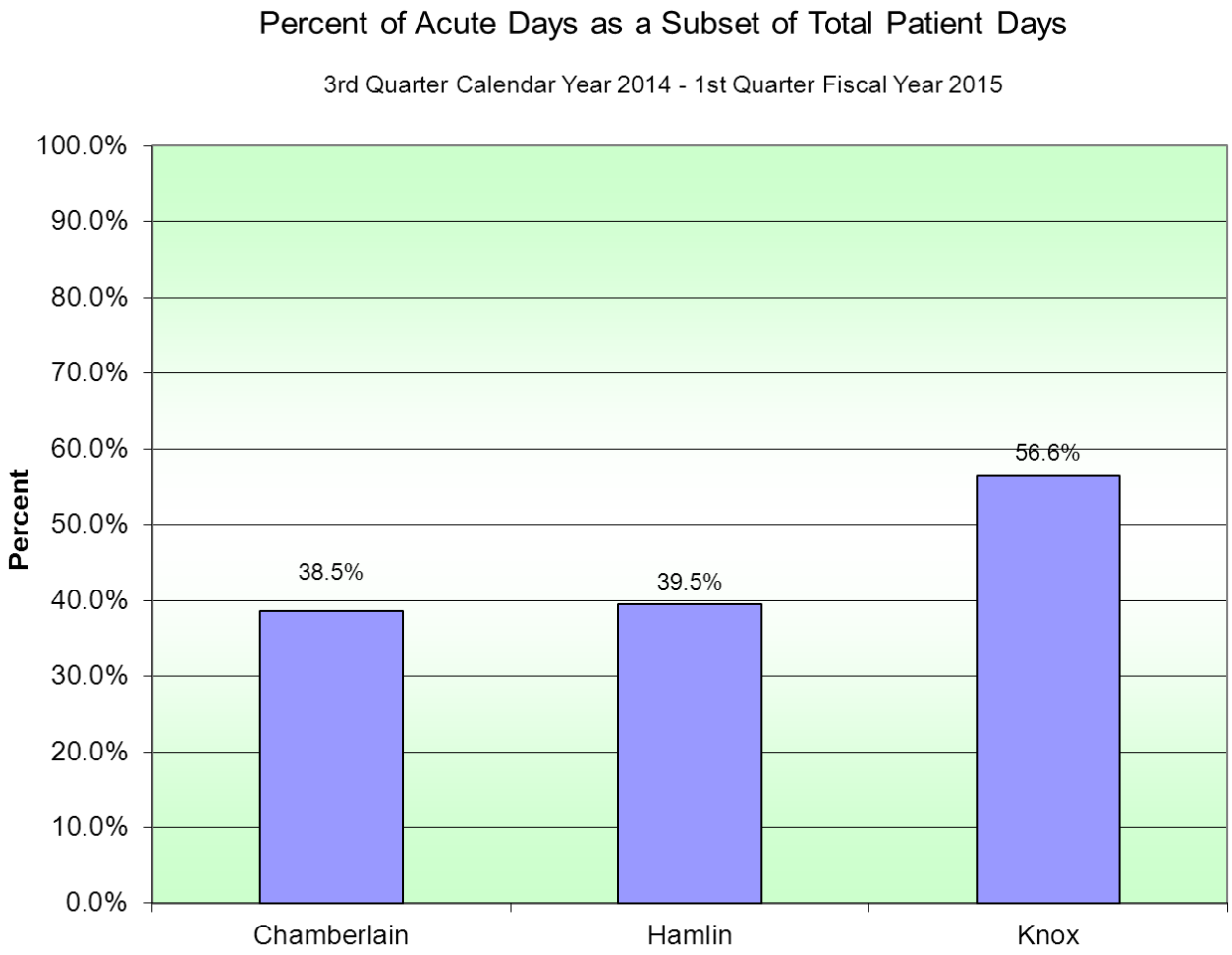
Priority Focus Areas – 1st Quarter FY 2015

Measure Name	Measure Description	Unit	Baseline	Target	Comments
ILP: DDPC and Contract staff will follow hospital policy MS #13 policy and procedure.	All DDPC employees and contract staff are required to read MS #13 policy and procedure.	225 (both DDPC employees and contract staff)	80%	100%	The education year ends Nov 30th. SED will ensure all Staff have completed this requirement.
Pain: DDPC and Contract staff will follow hospital policy P-11 and standards set by TJC.	All DDPC RNs and Medical Staff are required to complete the Managing a person in pain learning packet.	87 (both RNs and Medical Staff)	72% (21 RNs and 4 Medical Staff remain incomplete)	100%	The education year ends Nov 30th. SED will ensure both RNs and Medical Staff have completed this learning packet.
MANDT: DDPC and Contract staff will complete MANDT training annually.	All DDPC employees and contract staff are required to complete MANDT training annually. (Epharm is excluded)	225 (both DDPC employees and contract staff)	90% (all direct care staff are MANDT certified)	100%	Staff Education will work with the training scheduler to facilitate 100% compliance in MANDT training.
CPR: DDPC and Contract staff will maintain CPR certification by attending CPR training biannually.	All DDPC employees and contract staff are required to complete CPR training annually. (Epharm and contract medical staff are excluded.)	225 (both DDPC employees and contract staff)	99% (one dietary staff member)	100%	We will move CPR onto Quality Management for one month. We will spot check in August. If 100% we will recheck at 6 months and 9 months.
New Employee: All new employees will complete new employee orientation within 60 days of hire.	Process will include following up with new employees, review of the orientation record and requirements to determine if	20 New Hires in the 1st quarter	100%	100%	We will move new employee orientation onto Quality Management for one month. We will spot check in August. If 100% we will recheck

Measure Name	Measure Description	Unit	Baseline	Target	Comments
	standard is met.				at 6 months and 9 months.

Since purchasing the CPR posters and hanging them in all chart rooms and kitchens in June, there have been no further concerns of staff members being uncertain of the new CPR 30 compressions/2 breaths during DDPC CPR drills.

- Dr. Gardner has requested the poster to be hung on the side of each CPR cart.
- Lisa Hall has requested 1-2 posters.

STRATEGIC PERFORMANCE EXCELLENCE

Utilization Review **Leanne McLean, RN**