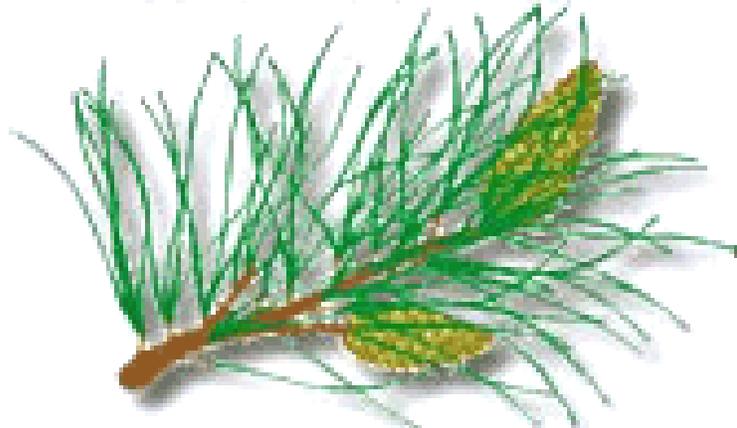


Dorothea Dix



Psychiatric Center

**QUARTERLY REPORT ON
ORGANIZATIONAL PERFORMANCE EXCELLENCE**

FIRST STATE FISCAL QUARTER 2016
July, August, September 2015

Sharon Sprague
Superintendent
November 17, 2015



THIS PAGE INTENTIONALLY LEFT BLANK



Table of Contents

Introduction	1
Comparative Statistics	4
Joint Commission Performance Measures	
Hospital Based Inpatient Psychiatric Services (ORYX Measures)	15
Admissions Screening	17
Physical Restraint	18
Seclusion	19
Multiple Antipsychotic Medications	20
Justification of Multiple Antipsychotic Medications	22
Post Discharge Continuing Care Plan	24
Transmission of Post Discharge Continuing Care Plan	25
Joint Commission Priority Focus Areas	
Contracts Management	26
Medication Management	28
Consumer Surveys.....	31
Fall Reduction Strategies	40
Pain Assessment	44
Strategic Performance Excellence	
Process Improvement Plans.....	49
Admissions	52
Dietary.....	54
Facilities.....	55
Health Information Management.....	56
Human Resources	57
Infection Control	62
Medical Staff	70
Nursing.....	80
Outpatient Services	87
Pharmacy Services	91
Social Services	101
Staff Education and Development	103
Therapeutic Services.....	111
Utilization Review	114



THIS PAGE INTENTIONALLY LEFT BLANK



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 through 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 evaluate 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,

Joseph Riddick

Joseph Riddick

Director of Integrated Quality and Informatics



THIS PAGE INTENTIONALLY LEFT BLANK

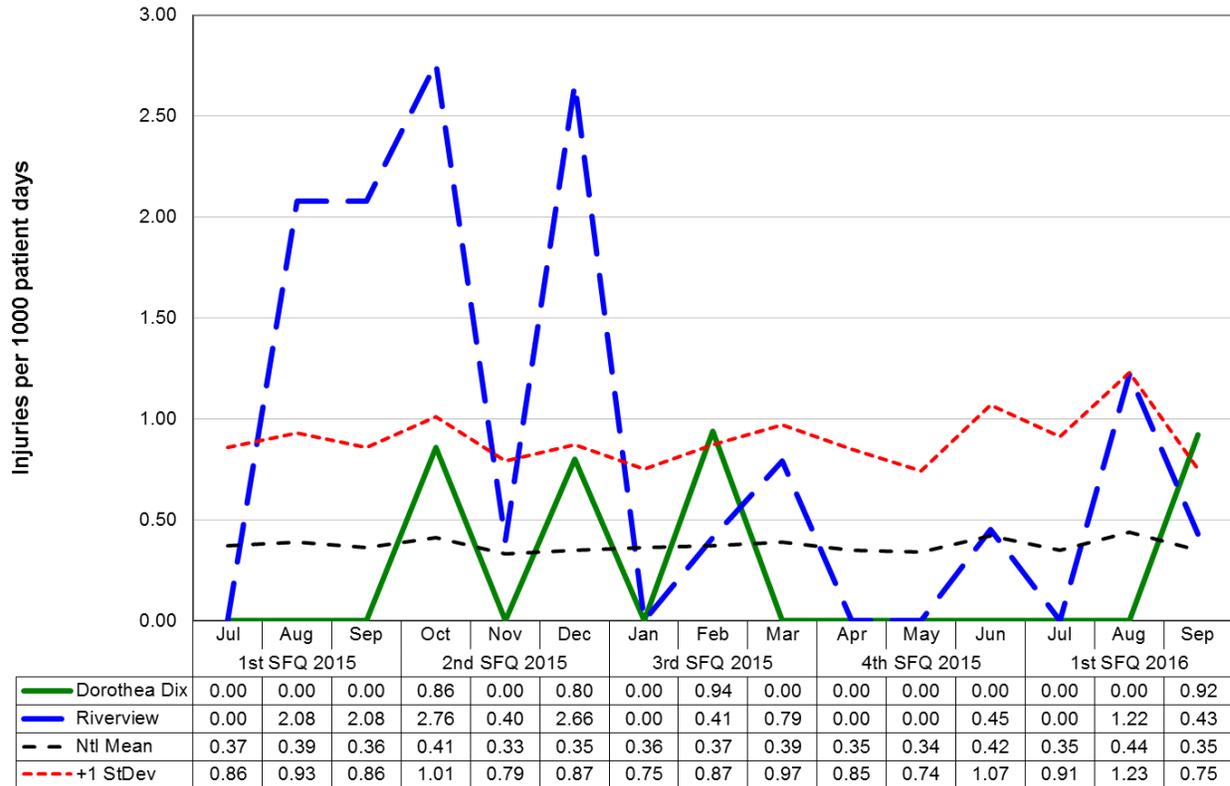
COMPARATIVE STATISTICS

The comparative statistics reports include the following elements:

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

COMPARATIVE STATISTICS

Client Injury Rate



Number of patient 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 patient 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.

This comparative statistic graph only includes those events that are considered “Reportable” by NRI.

COMPARATIVE STATISTICS

“Reportable” injuries include those that require:

- Medical Intervention
- Hospitalization
- Death Occurred

“Non-reportable” injuries include those that require:

- No Treatment
- Minor First Aid

- No Treatment – The injury received by a patient 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 patient 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 patient 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 it resulted in, or complications of the injury lead to, the termination of the life of the injured patient.

COMPARATIVE STATISTICS

Type and Cause of Injury by Month

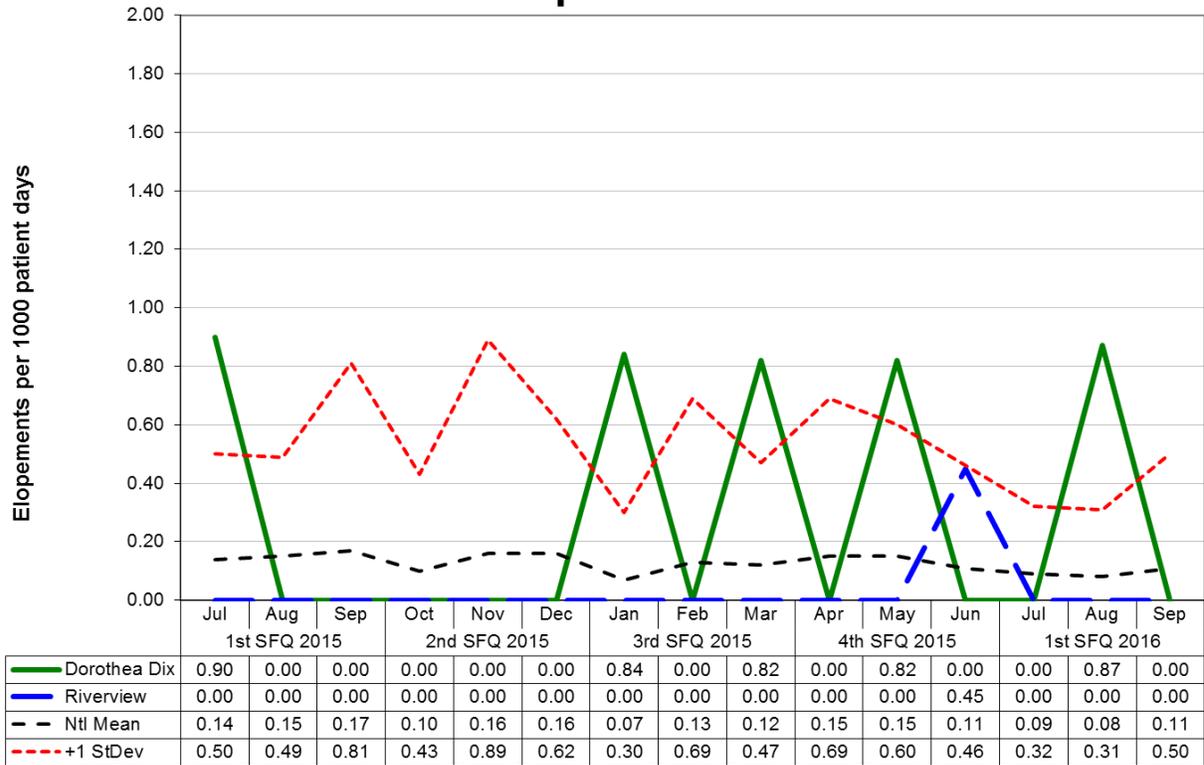
Type - Cause	JULY	AUG	SEPT	1Q2016
Accident – Fall		1		1
Accident – Other	2	2	1	5
Assault – Patient to Patient	1		4	5
Injury – Other			2	2
Self-Injurious Behavior	2	1	1	4
Total	5	4	8	17

Severity of Injury by Month

Severity	JULY	AUG	SEPT	1Q2016
No Treatment	2		3	5
Minor First Aid	3	4	5	12
Medical Intervention Required				
Hospitalization Required				
Death Occurred				
Total	5	4	8	17

COMPARATIVE STATISTICS

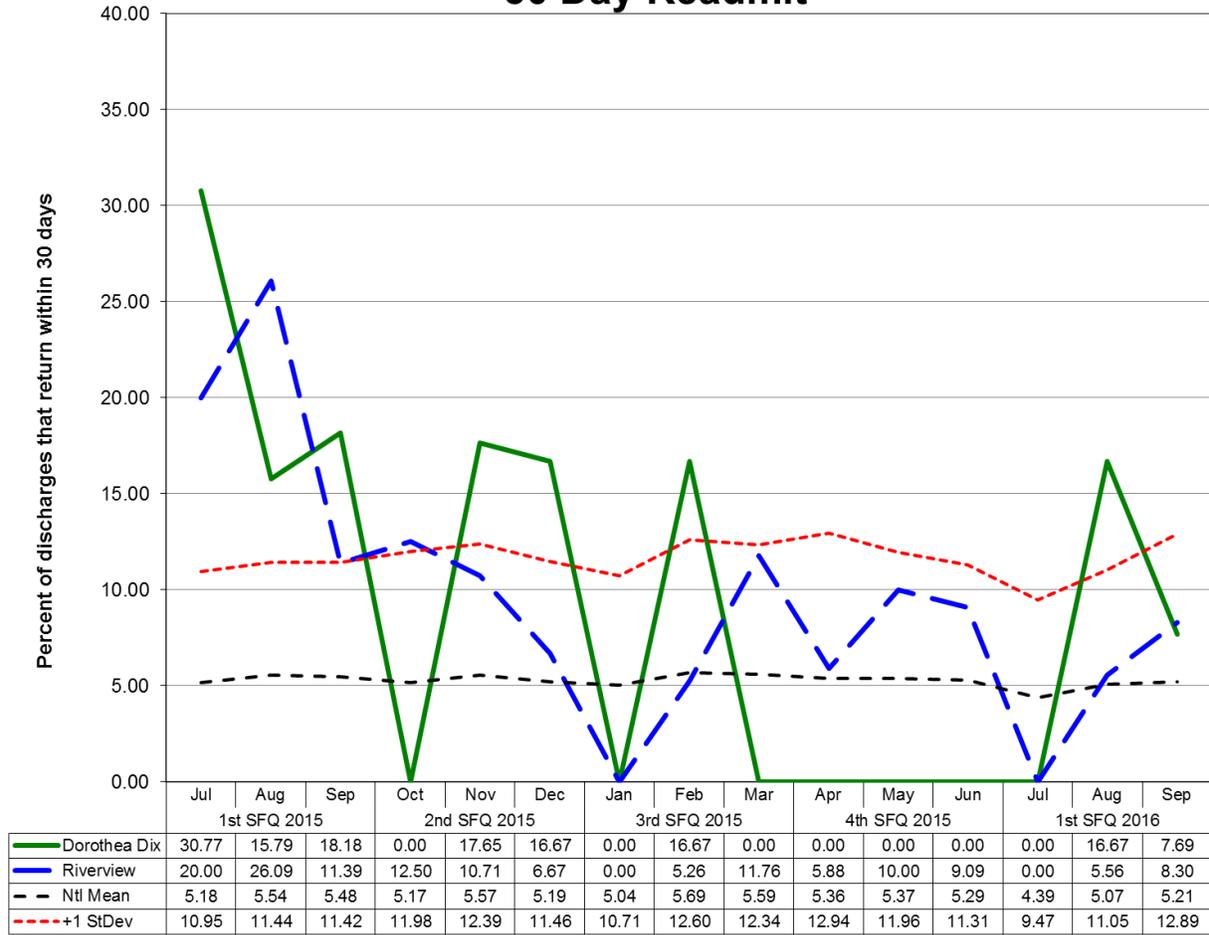
Elopement



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

COMPARATIVE STATISTICS

30 Day Readmit

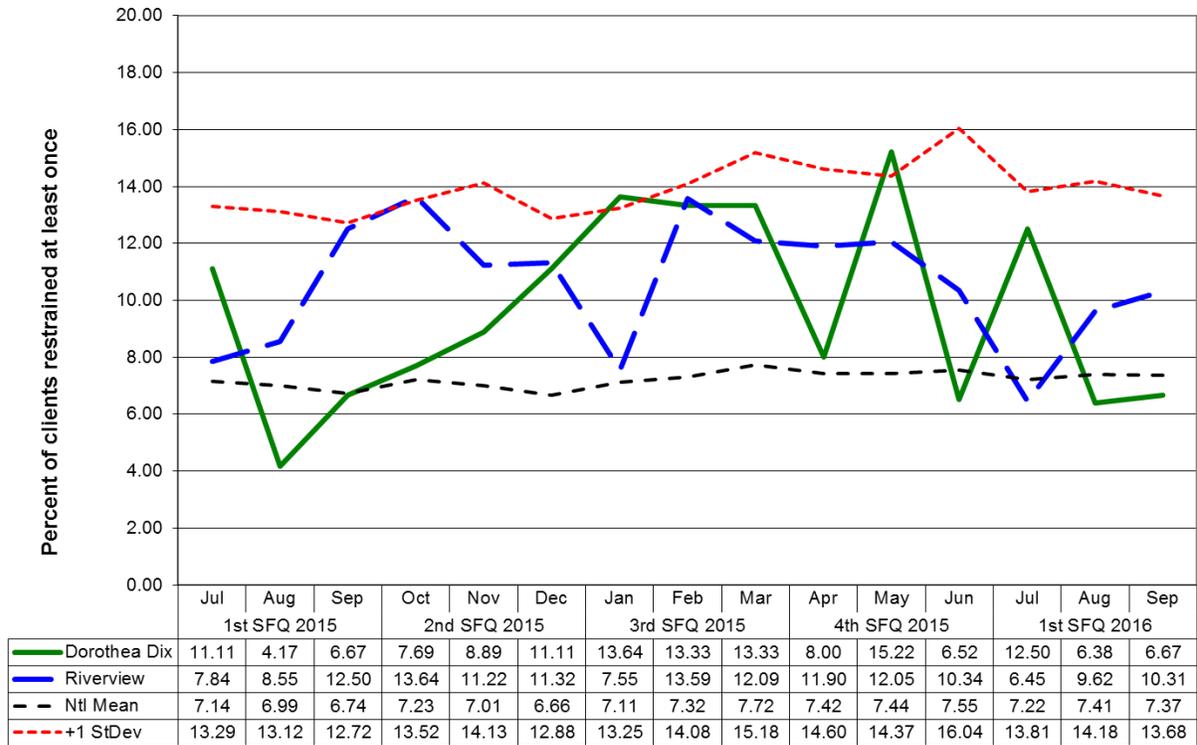


Percent of discharges from the facility that returned within 30 days of a discharge of the same patient from the same facility. For example, a rate of 10.0 means that 10% of all discharges were readmitted within 30 days.

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 patient care.

COMPARATIVE STATISTICS

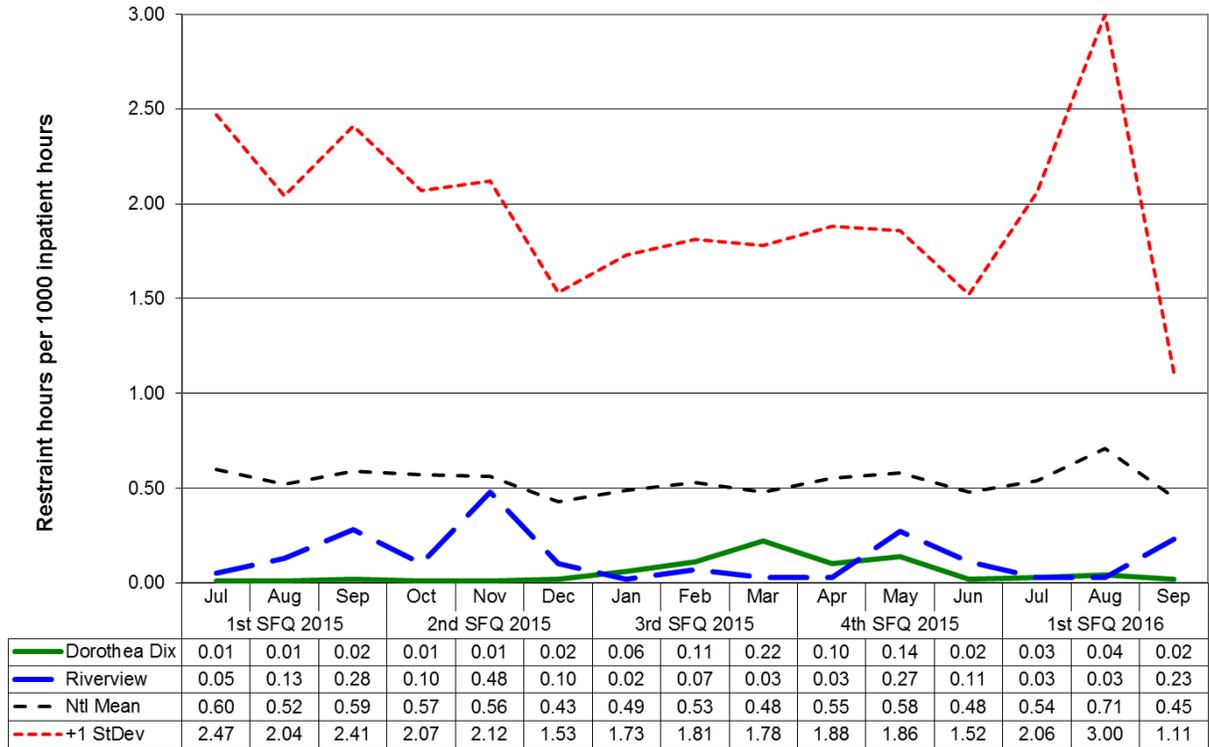
Percent of Clients Restrained



Percent of unique patients 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 patients served were restrained at least once, for any amount of time.

COMPARATIVE STATISTICS

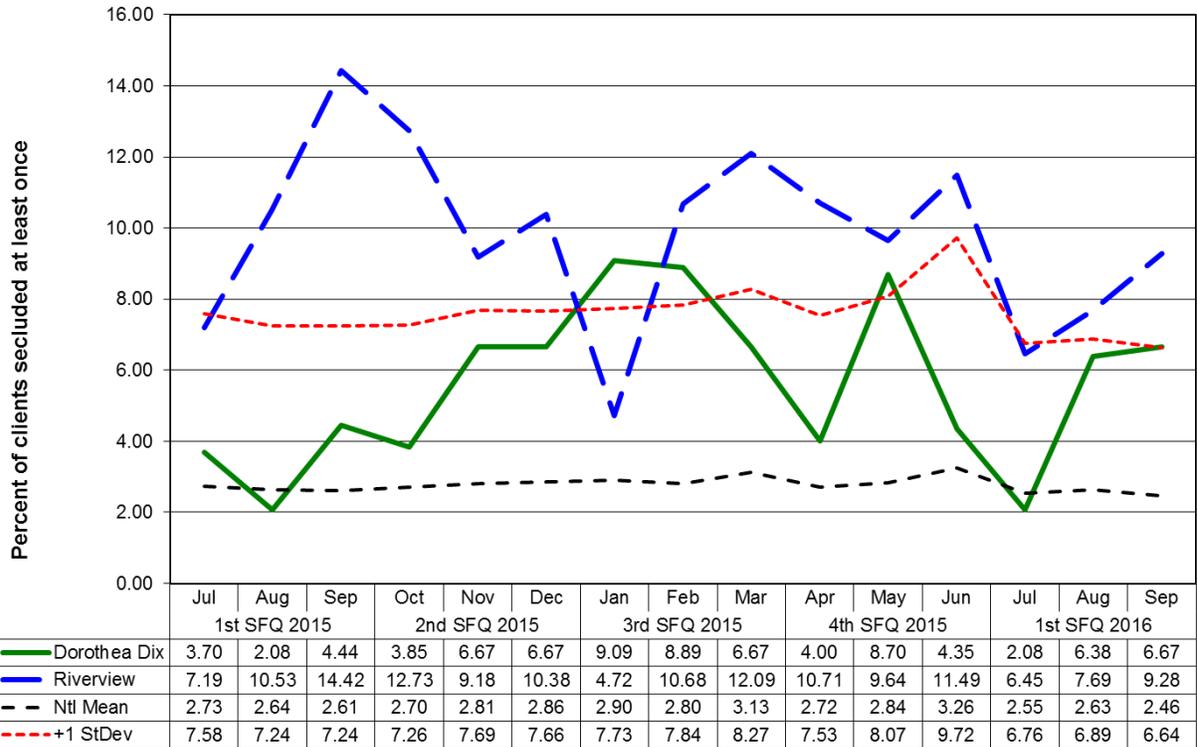
Restraint Hours



Number of hours patients 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.

COMPARATIVE STATISTICS

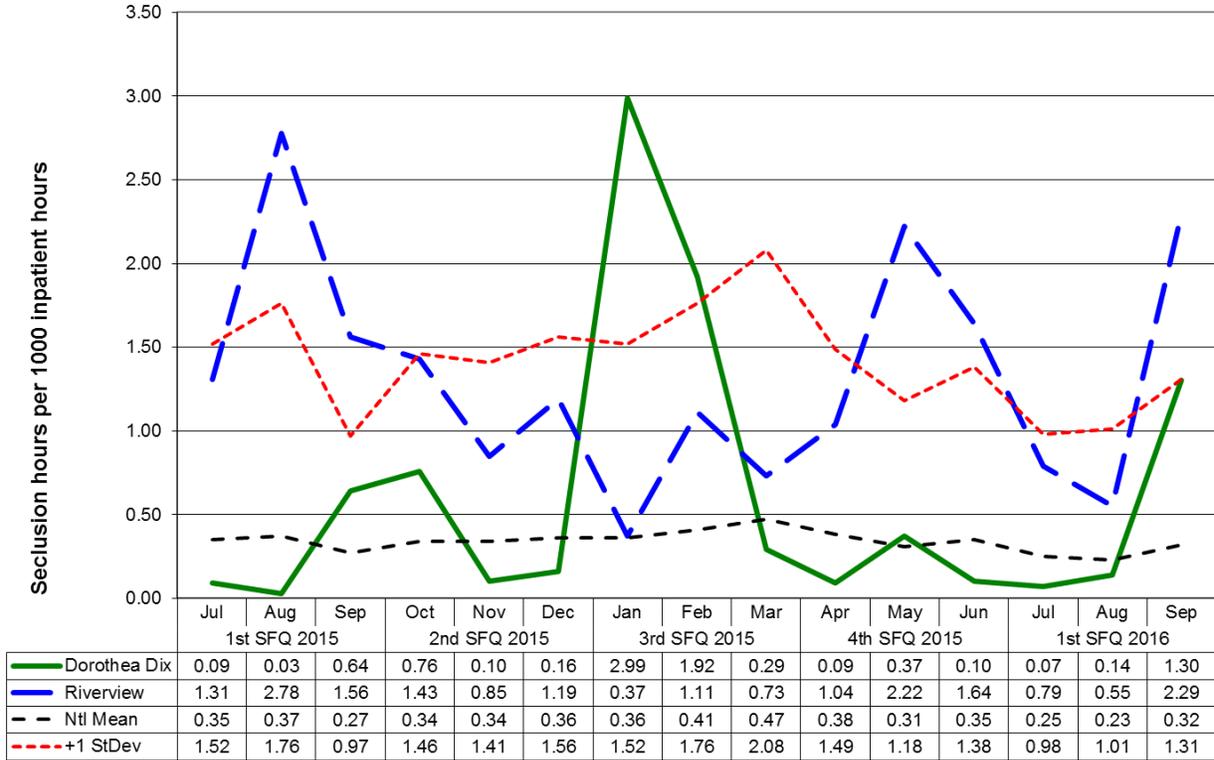
Percent of Clients Secluded



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

COMPARATIVE STATISTICS

Seclusion Hours



Number of hours patients 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.

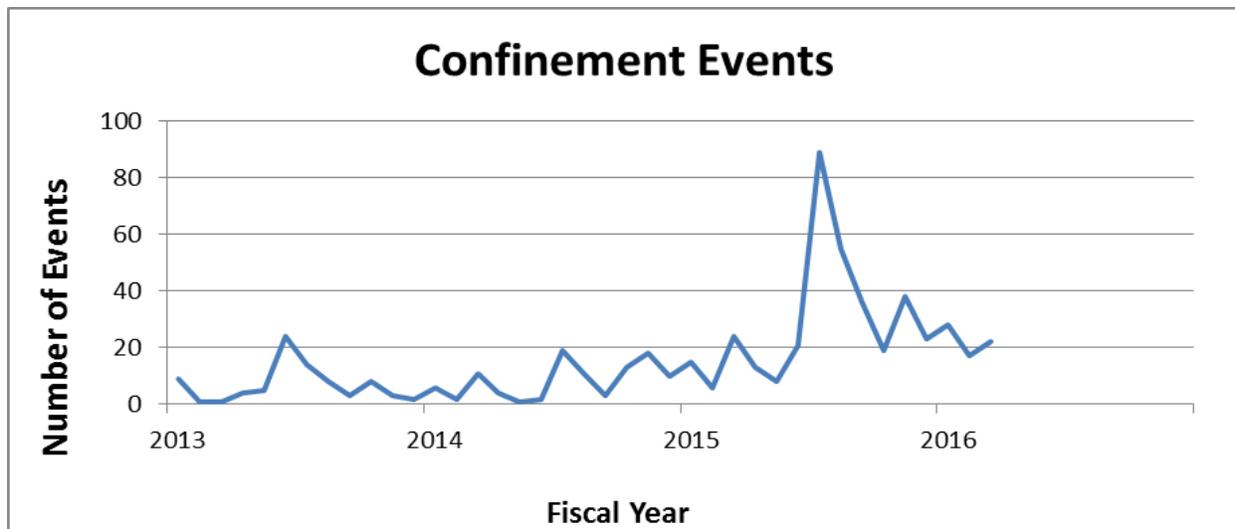
COMPARATIVE STATISTICS

Confinement Event Breakdown

	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
MD1705	24	1	4	29	43.28%	43.28%
MD2020	9		9	18	26.87%	70.15%
MD1708	10			10	14.93%	85.07%
MD1983	2		1	3	4.48%	89.55%
MD884	1		1	2	2.99%	92.53%
MD2025	1		1	2	2.99%	95.52%
MD103	1			1	1.49%	97.01%
MD1305			1	1	1.49%	98.50%
MD1995	1			1	1.49%	100.00%
	49	1	17	67		

Unit	Manual Hold	Locked Seclusion
Chamberlain	38	15
Hamlin	10	1
Knox	1	1

Event	July	Aug	Sept
Manual Hold	25	13	11
Locked Seclusion	3	3	11



Note: Graph includes Manual Holds, Mechanical Restraints, Locked and Open Door Seclusions

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.

JOINT COMMISSION

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 are designed to reflect these core domains in the delivery of psychiatric care.

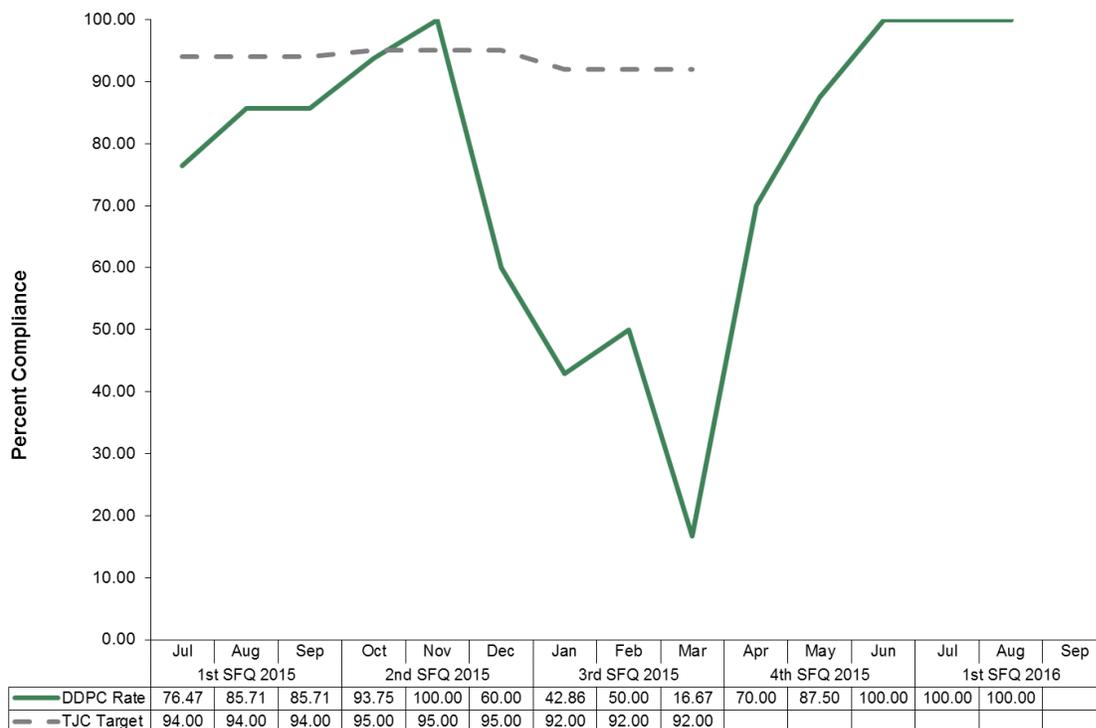
JOINT COMMISSION

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.



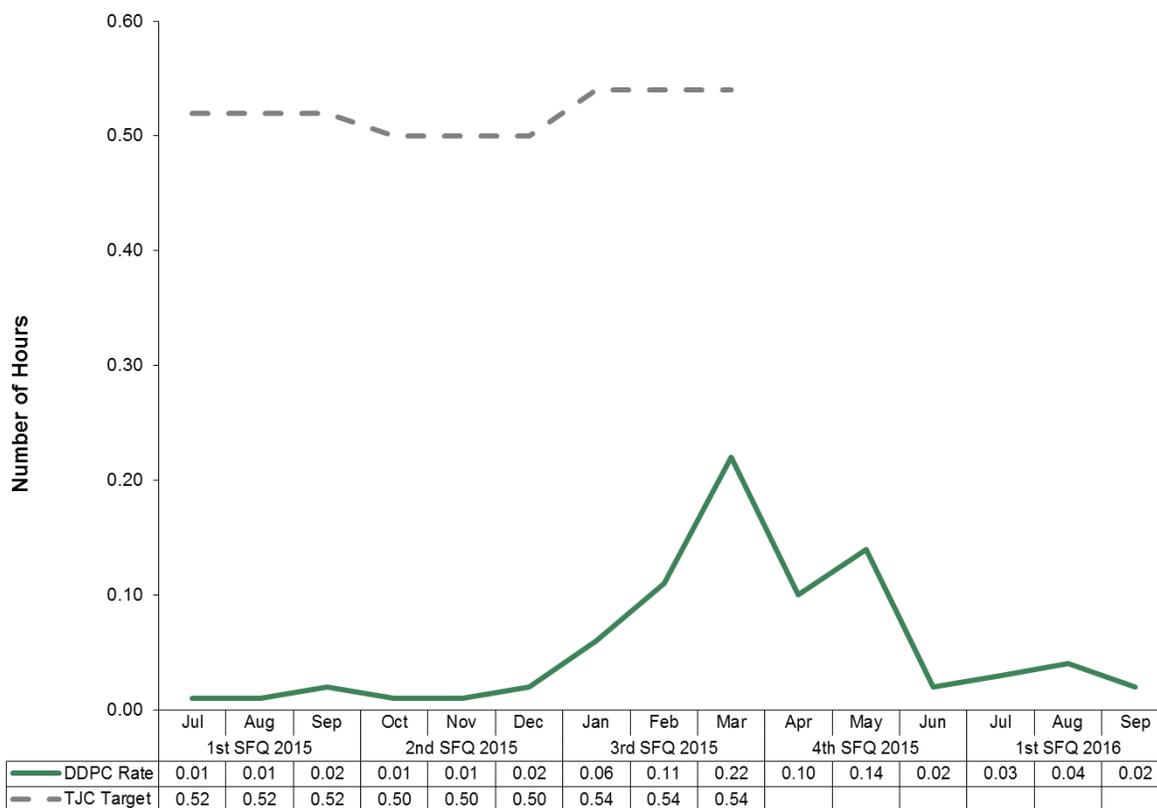
JOINT COMMISSION

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).



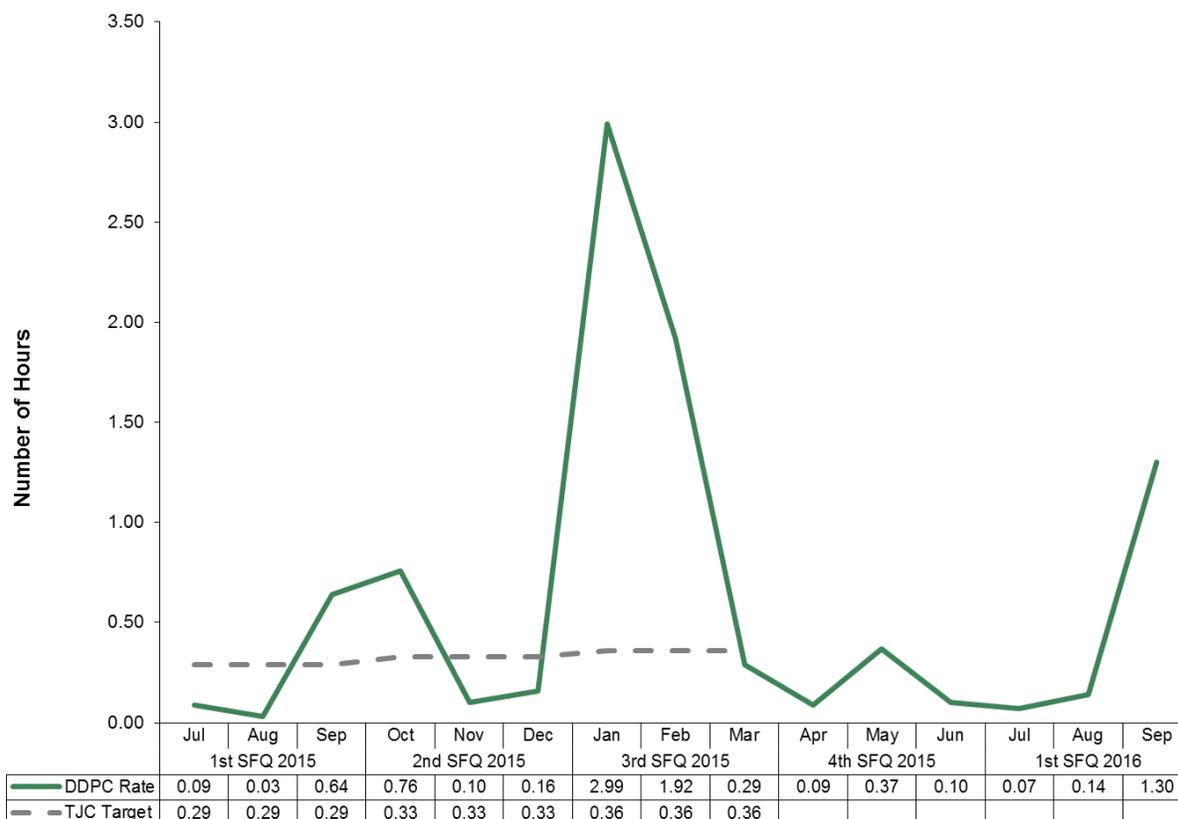
JOINT COMMISSION

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).



JOINT COMMISSION

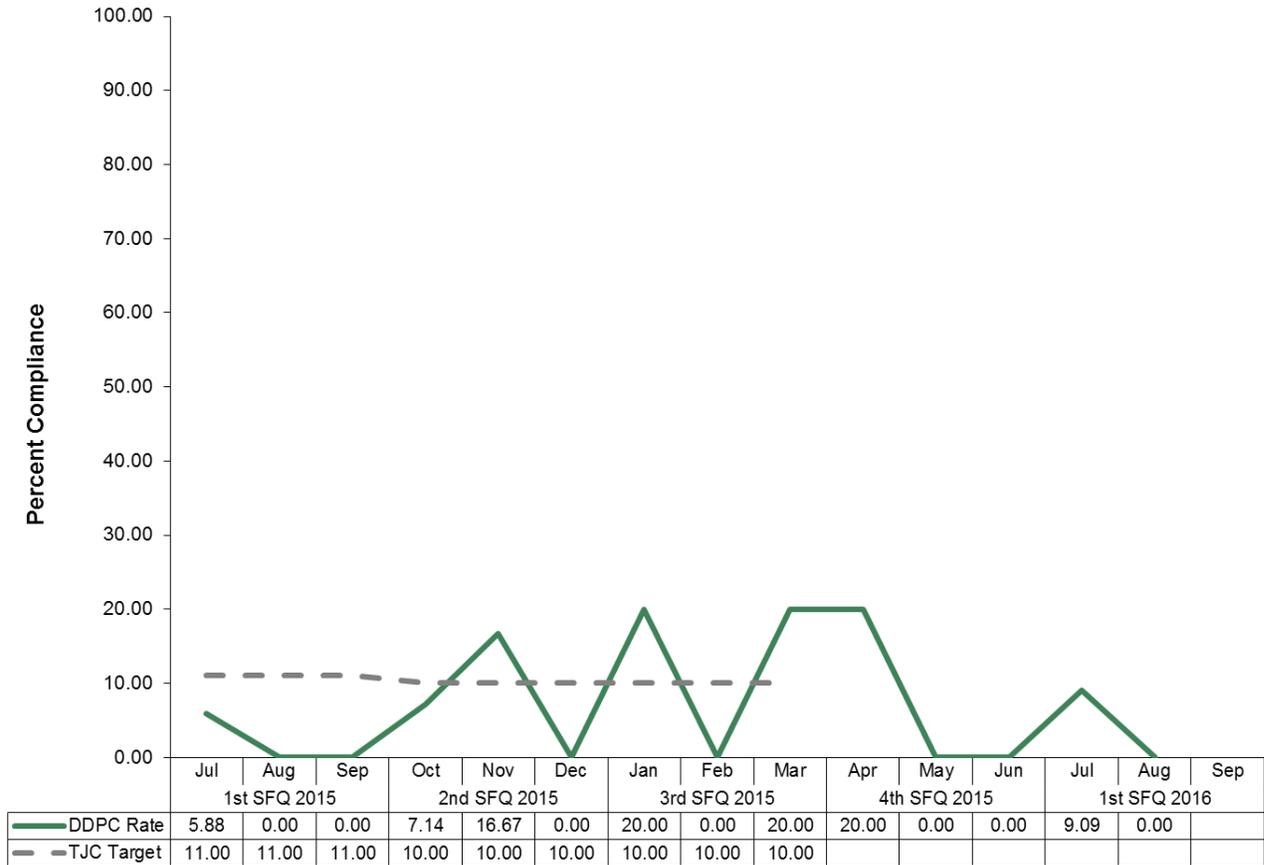
Multiple Antipsychotic Medications on Discharge (HBIPS 4)

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, Ganocy, & 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)



JOINT COMMISSION

Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)

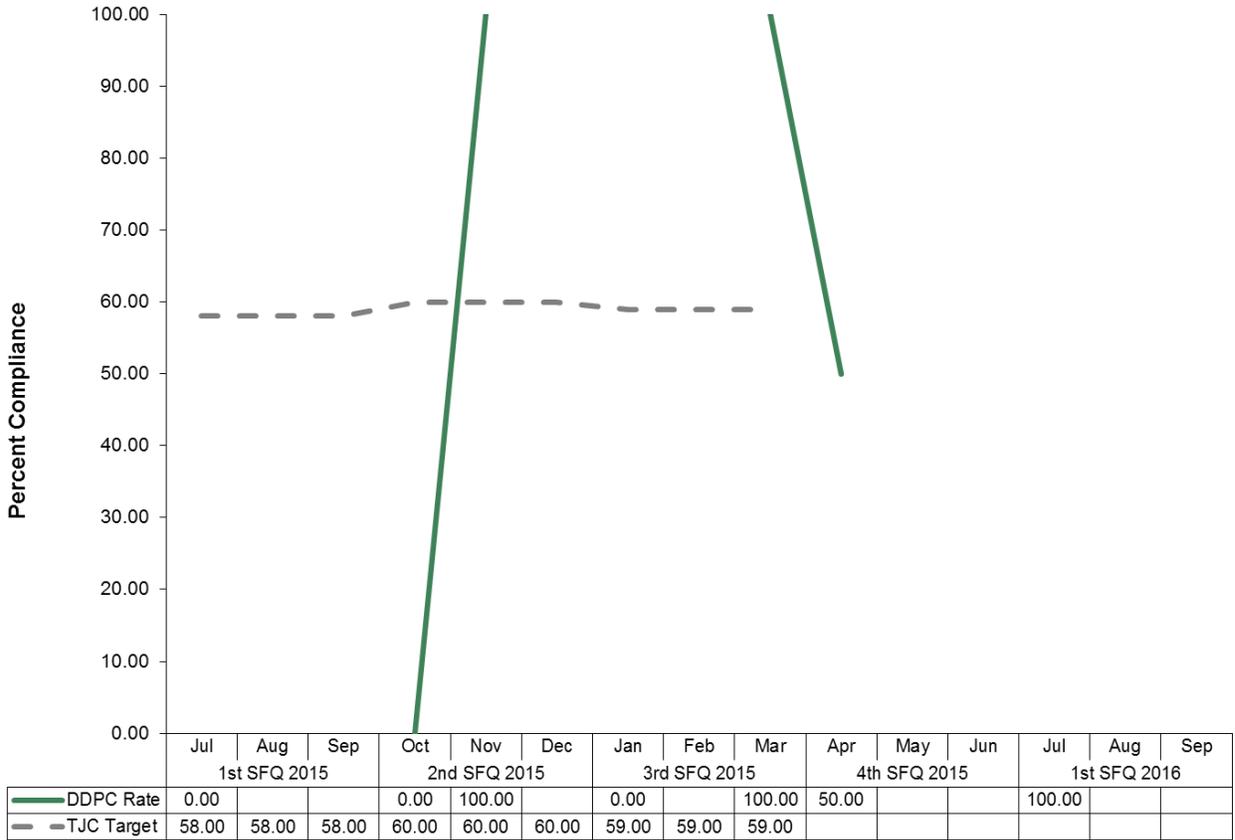
Description: Patients discharged from a hospital based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification.

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, Ganocy, & Blow, 2006; Stahl & Grady, 2004). One study reported 4.6% of patients concurrently received 3 or more antipsychotics (Jaffe & Levine, 2003). These findings are seen across diverse sectors: state mental health authorities, the Veterans Health System and Medicaid-financed care. Antipsychotic polypharmacy can lead to greater side effects, often without improving clinical outcomes (Ananth, Parameswaran, & Gunatilake, 2004; Stahl & Grady, 2004). As a result, a range of stakeholders have called for efforts to reduce unnecessary use of multiple antipsychotics (Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; National Association of State Mental Health Program Directors, 2001; University HealthSystem Consortium, 2006).

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

JOINT COMMISSION

Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)

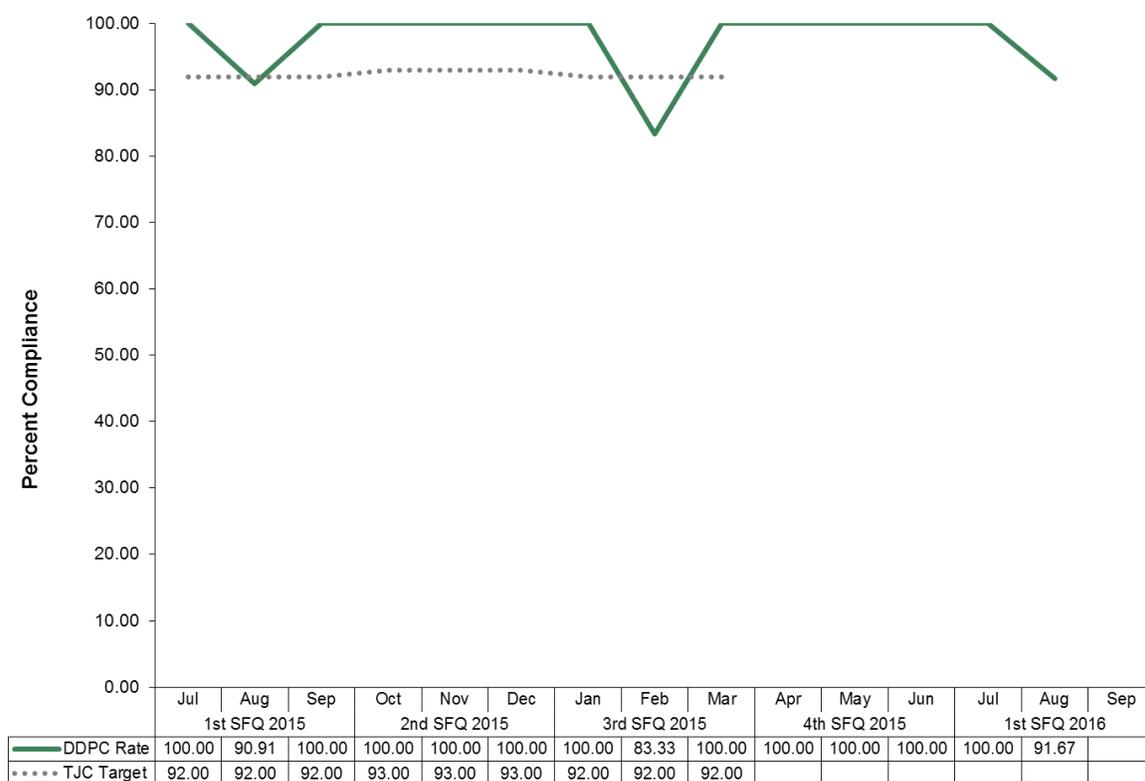


JOINT COMMISSION

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 [AAP], (2001).



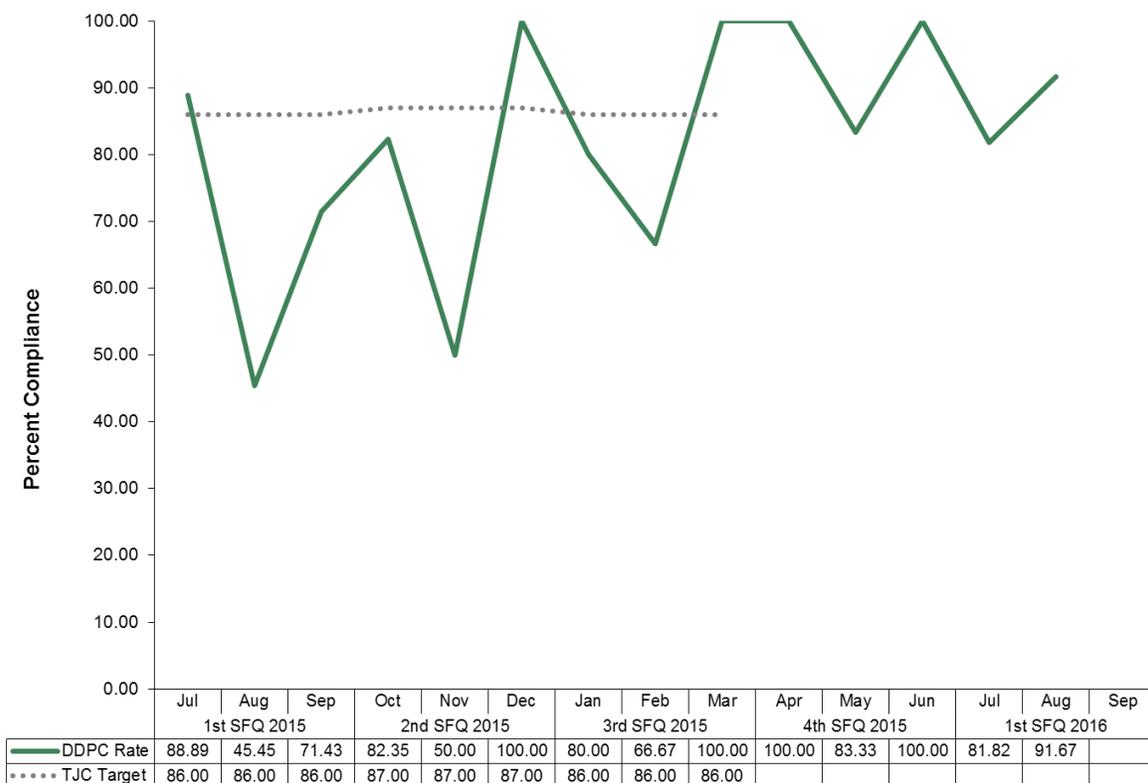
JOINT COMMISSION

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).



JOINT COMMISSION

Contracts Management

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 2016 Quarter 1 Results		
Contractor	Program Administrator	Summary of Performance
ABM Mechanical	Herbert Gibson Director of Facilities	All indicators exceeded standards.
Affiliated Laboratory	Janet Babcock Director of Nursing	All indicators exceeded standards.
Cardinal Health <i>*Contract was terminated 9/30/2015</i>	Sharon Sprague Superintendent	Three indicators did not meet standards: (1) Services and required reports to be provided in a timely manner, (2) Providing documents for the Pharmacists before commencement of contracted services, and (3) Providing HR with annual packet including evaluations. All others met or exceeded standards.
Casella Waste Systems	Herbert Gibson Director of Facilities	All indicators met or exceeded standards.
CES, Inc.	Herbert Gibson Director of Facilities	All indicators met standards.
Comprehensive Pharmacy Services	Sharon Sprague Superintendent	One indicator did not meet standards: Providing discharge counseling on the Wilson Treatment Mall. All others met or exceeded standards.
Harriman Associates	Herb Gibson Director of Facilities	All indicators exceeded standards.

JOINT COMMISSION

Contractor	Program Administrator	Summary of Performance
The Healing Staff	Dr. Michelle Gardner Clinical Director	Contract not utilized during timeframe.
Illina Engineering	Herbert Gibson Director of Facilities	All indicators met or exceeded standards.
Jackson & Coker	Dr. Michelle Gardner Clinical Director	Contract not utilized during timeframe.
Liberty Healthcare Physicians and/or Mid-Levels On Call	Dr. Michelle Gardner Clinical Director	All indicators met standards.
Liberty Healthcare Psychiatric Nurse Practitioner	Dr. Michelle Gardner Clinical Director	All indicators met standards.
Locum Tenens Psychiatry	Dr. Michelle Gardner Clinical Director	Contract not utilized during timeframe.
MD-IT Transcription	Michelle Welch Medical Records Administrator	All indicators met standards.
Northeast Cardiology Associates (NECA)	Dr. Michelle Gardner Clinical Director	All indicators met standards.
Norris, Inc.	Herbert Gibson Director of Facilities	All indicators met or exceeded standards.
Otis Elevator	Herbert Gibson Director of Facilities	All indicators met standards.
Penobscot Community Health Care	Dr. Michelle Gardner Clinical Director	Indicator exceeded standards.
Project Staffing	Carol Davis Business Manager	All indicators met or exceeded standards.
Securitas	Herbert Gibson Director of Facilities	All indicators met or exceeded standards.
S.W. Cole Engineering	Herbert Gibson Director of Facilities	Indicator met standards.
UniFirst	Herbert Gibson Director of Facilities	All indicators met standards.
Vista Staffing	Dr. Michelle Gardner Clinical Director	Contract not utilized during timeframe.
WBRC Architects Engineers	Herbert Gibson Director of Facilities	Indicator met standards.
Worldwide Travel Staffing	Janet Babcock Director of Nursing	All indicators met standards.

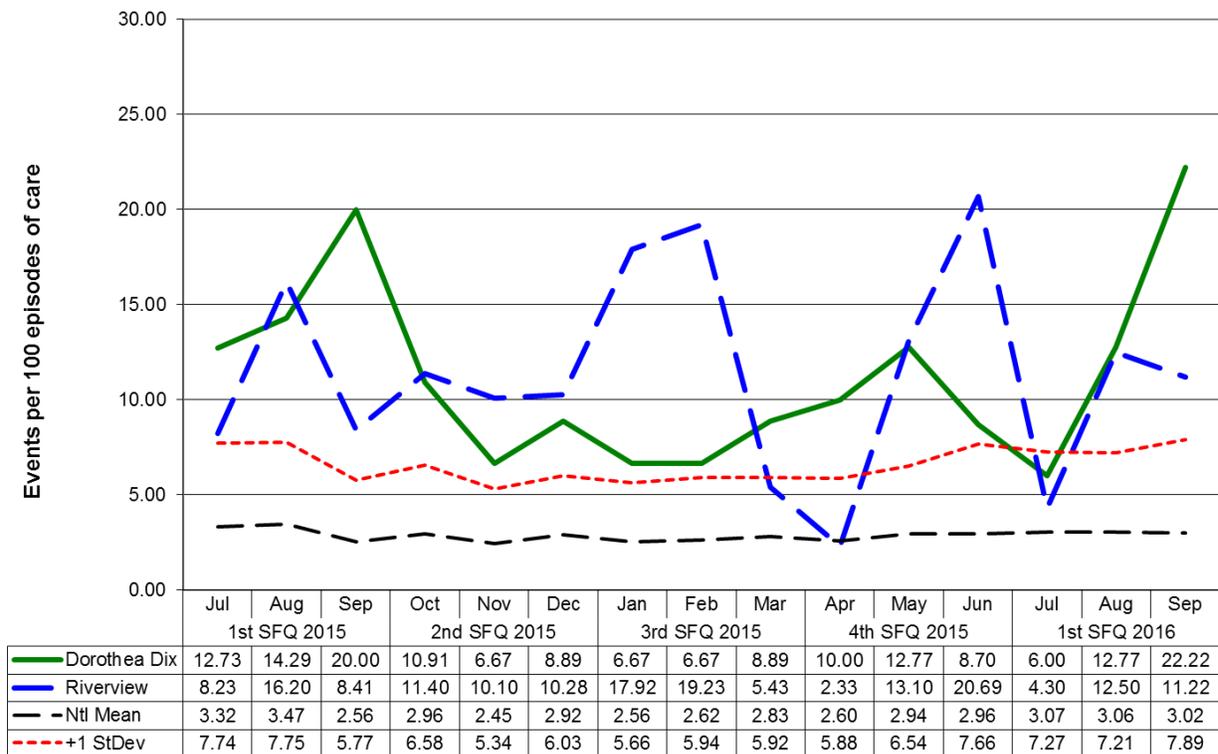
JOINT COMMISSION

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

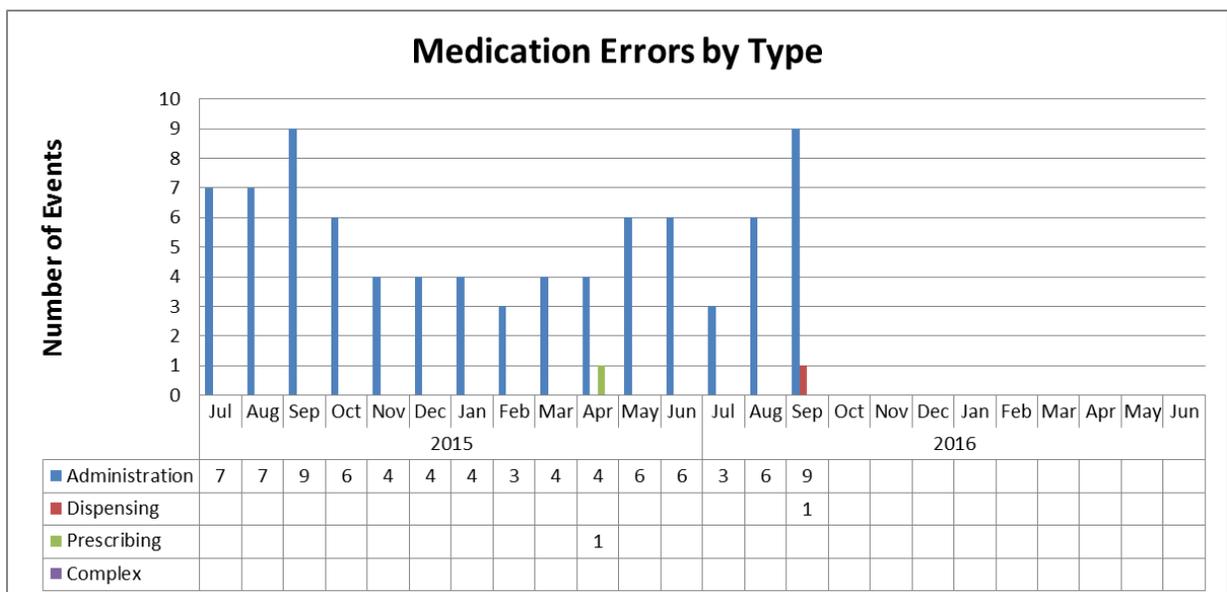


Number of medication error events that occurred for every 100 episodes of care (duplicated patient count). For example, a rate of 1.6 means that 2 medication error events occurred for each 125 episodes of care.

JOINT COMMISSION

Medication errors 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 patient level errors are also defined as errors of prescribing in identifying and ordering the appropriate medication to be used in the care of the patient.
- **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.



JOINT COMMISSION

Medication Dispensing Process

Michael Migliore, RPh

Measure	Unit	Baseline 4Q2015	Goal	1Q2016	2Q2016	3Q2016	4Q2016
Controlled Substance Loss Data:							
Daily Pyxis-CII Safe Compare Report.	All	0.175%	0% Target: Actual:	0% 0%	0%	0%	0%
Monthly CII Safe Vendor Receipt Report.	Rx	0	0 Target: Actual:	0 0	0	0	0
Monthly Pyxis Controlled Drug discrepancies.	All	5.7/ month	0 Target: Actual:	0 41 (14/mo)	0	0	0
Medication Management Monitoring:							
Measures of drug reactions, adverse drug events and other management data.	Rx	1.25	Actual:	0			
Resource Documentation Reports of Clinical Interventions.	Rx	60	Actual:	68			

JOINT COMMISSION

Consumer 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 patients from the patient's perspective, Dorothea Dix Psychiatric Center conducts two patient 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 designed to ascertain the degree of patient understanding of and satisfaction with the discharge planning and preparation process. Dorothea Dix conducts a telephone poll of discharged patients approximate one to two weeks after discharge. This provides an opportunity to make a connection with the patients as they transition into the community setting and, on occasion, has provided the discharged patient 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. Patients 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.

CTM-3 Survey Response Rate:

	July	August	September	1Q2016
Number of Patients Discharged	11	9	11	31
Number of Survey Responses	4	1	3	8
Survey Response Rate	36%	11%	27%	26%

JOINT COMMISSION

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

	July	August	September	1Q2016
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.	(3) 75%	(1) 100%	(3) 100%	(7) 88%
When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.	(4) 100%	(1) 100%	(3) 100%	(8) 100%
When I left the hospital, I clearly understood the purpose for taking each of my medications.	(4) 100%	(1) 100%	(3) 100%	(7) 100%

JOINT COMMISSION

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 patient 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:

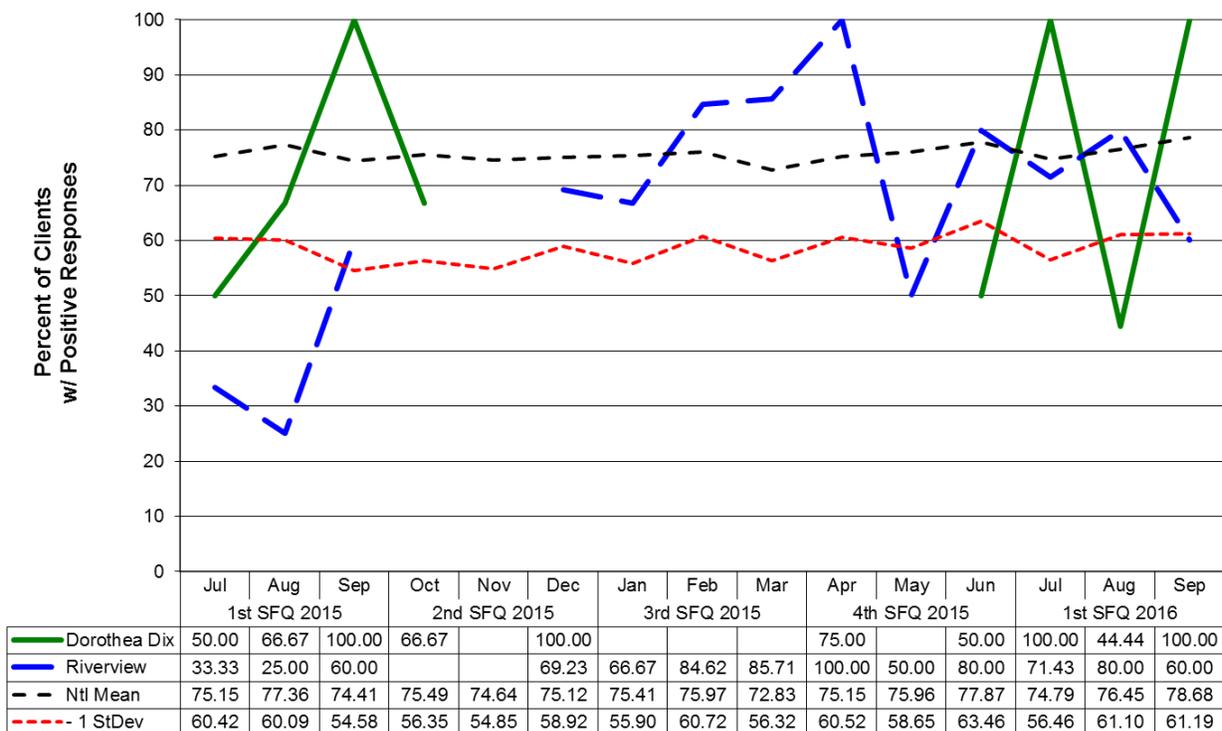
	July	August	September	1Q2016
Number of patients discharged	11	9	11	31
Number of survey responses	5	9	6	20
Survey response rate	45%	100%	55%	65%

Surveys are distributed to all patients 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 patients and the results of the comparative analysis follows. When the results are blank for a month on the following graphs, it means that no surveys were completed during that month.

JOINT COMMISSION

Inpatient Consumer Survey Outcome Domain

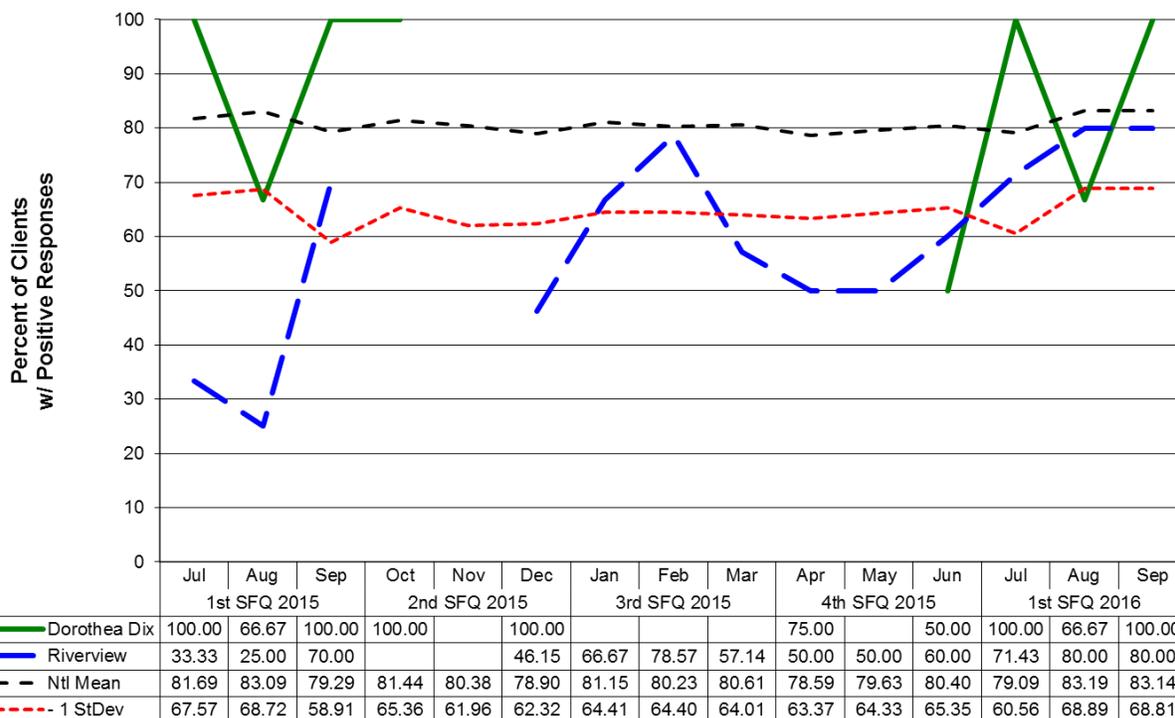


Outcome Domain

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

Inpatient Consumer Survey Dignity Domain

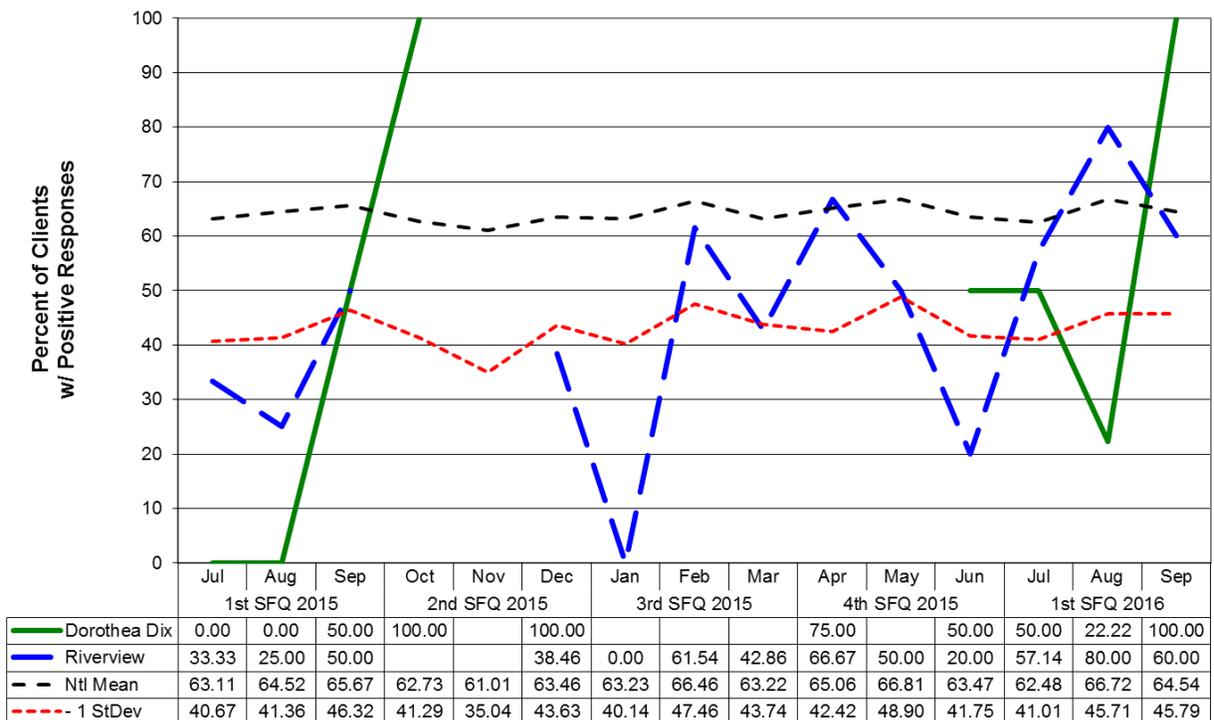


Dignity Domain

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

JOINT COMMISSION

Inpatient Consumer Survey Rights Domain

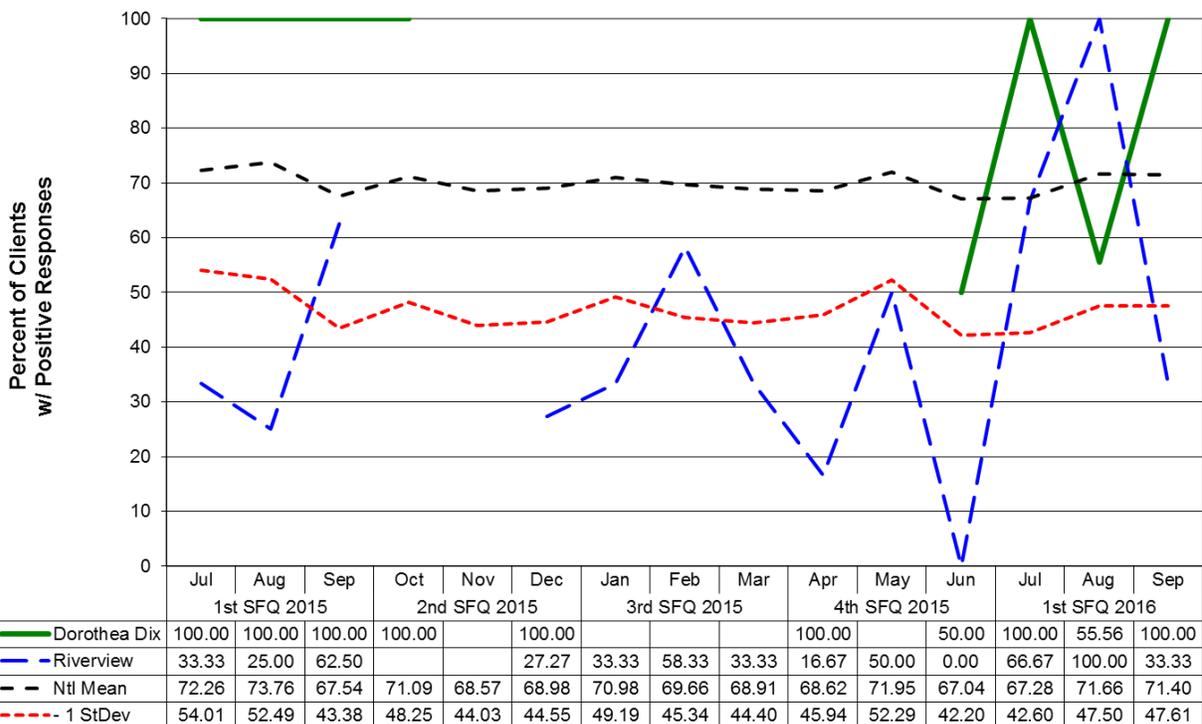


Rights Domain

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

JOINT COMMISSION

Inpatient Consumer Survey Participation Domain

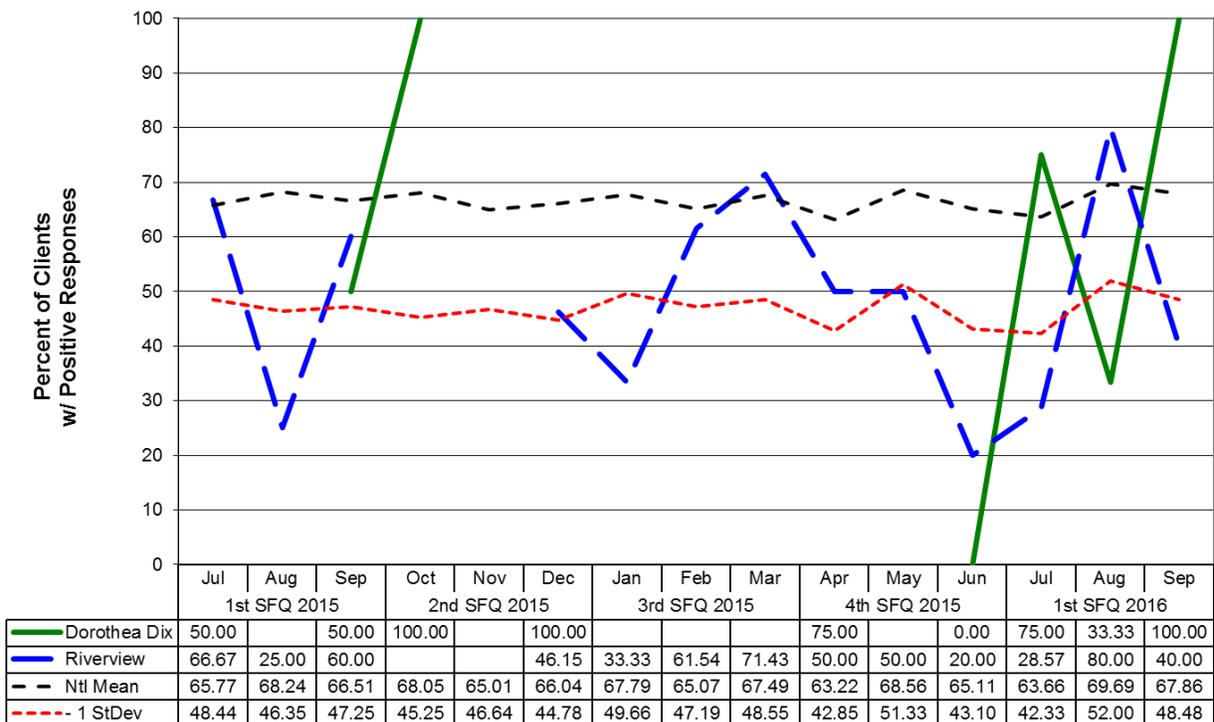


Participation Domain

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

Inpatient Consumer Survey Environment Domain

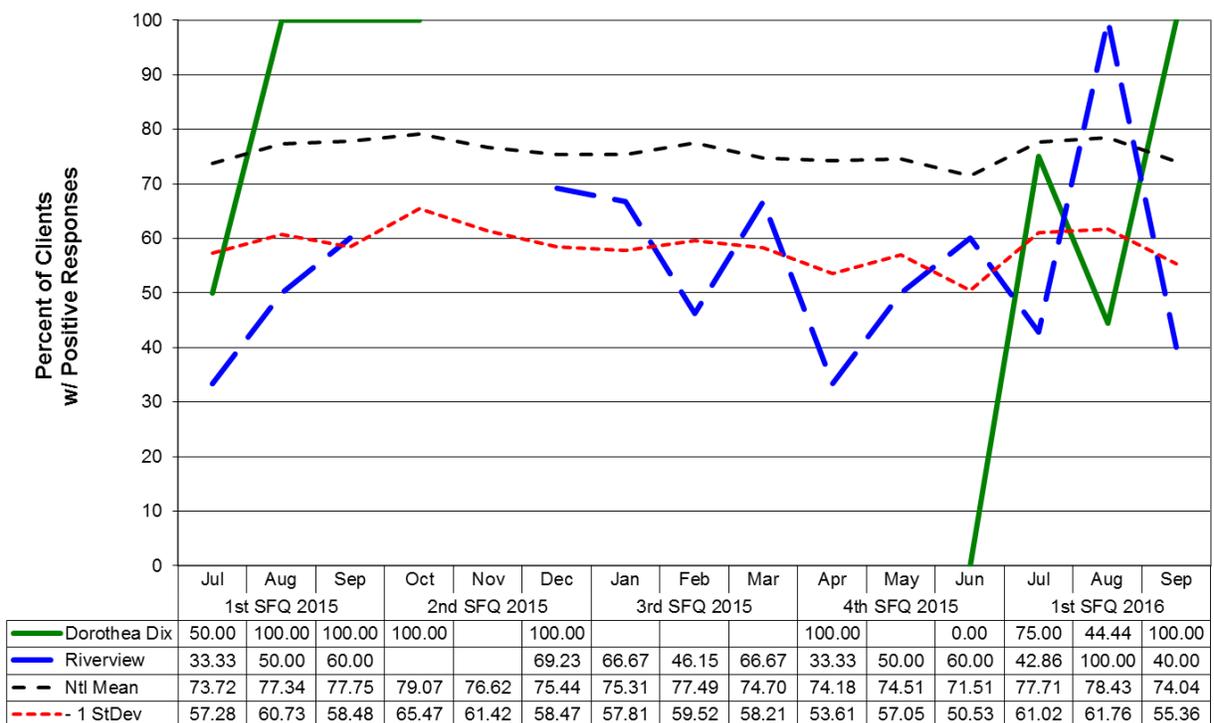


Environment Domain

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.

JOINT COMMISSION

Inpatient Consumer Survey Empowerment Domain



Empowerment Domain

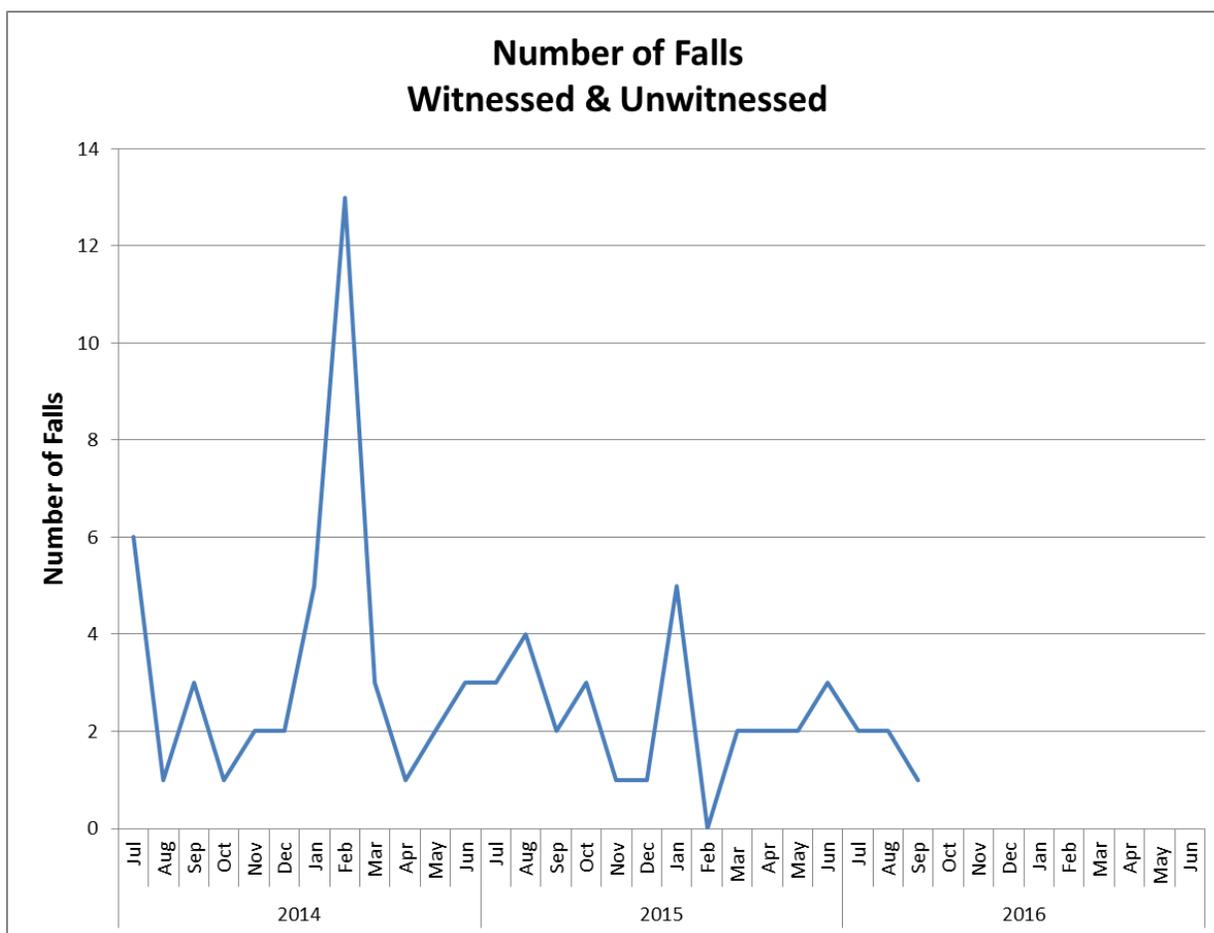
1. I had a choice of treatment options.
2. My contact with my doctor was helpful.
3. My contact with nurses and therapists was helpful.

JOINT COMMISSION

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 patients identified as having a high potential for falls.



JOINT COMMISSION

Falls Reduction Nursing Interventions

Janet Babcock, RN

Measure Name: Patient Falls - Establishing a Culture of Safety

Measure Description: 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, 6. No 2). The objective of Nursing's Fall Performance Improvement measure 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.

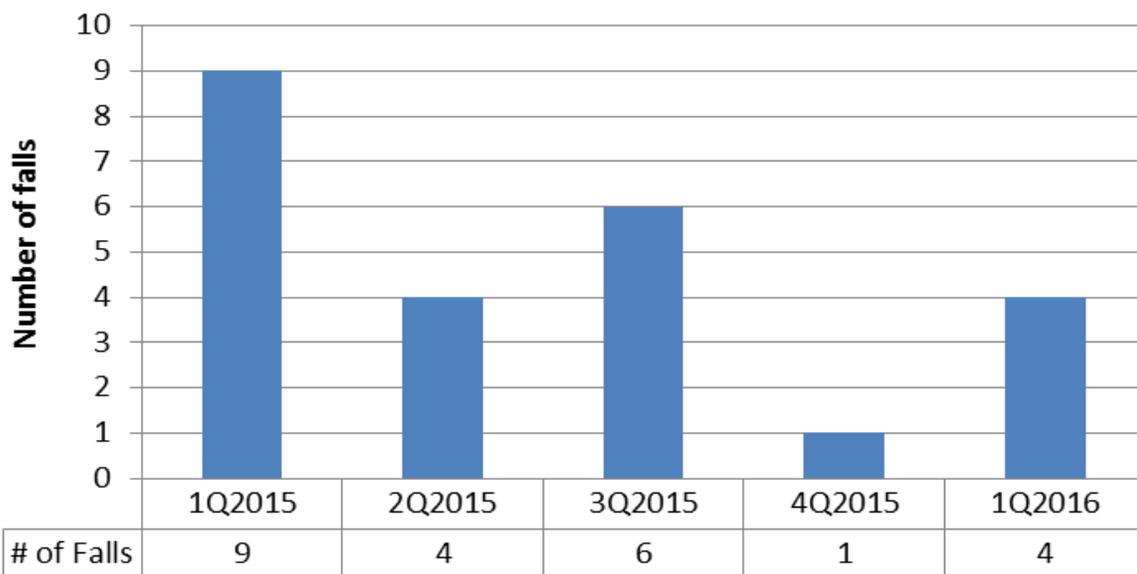
Type of Measure: Performance Improvement

All patient falls in 1Q2016	Falls risk assessment completed	Falls Progress Note 565 completed and in patient's medical record	Falls risk score of 6 or higher: problem 6.1 initiated (164 A & B)	Falls risk score documented on kardex and in front of chart	
4 (including falls that do not meet definition)	Yes: 4 No: 0 N/A: 0	Yes: 1 No: 3	Yes: 4 No: 0 N/A: 0	Yes: 2 No: 2 N/A: 0	
Overall Compliance	100%	25%	100%	50%	69%

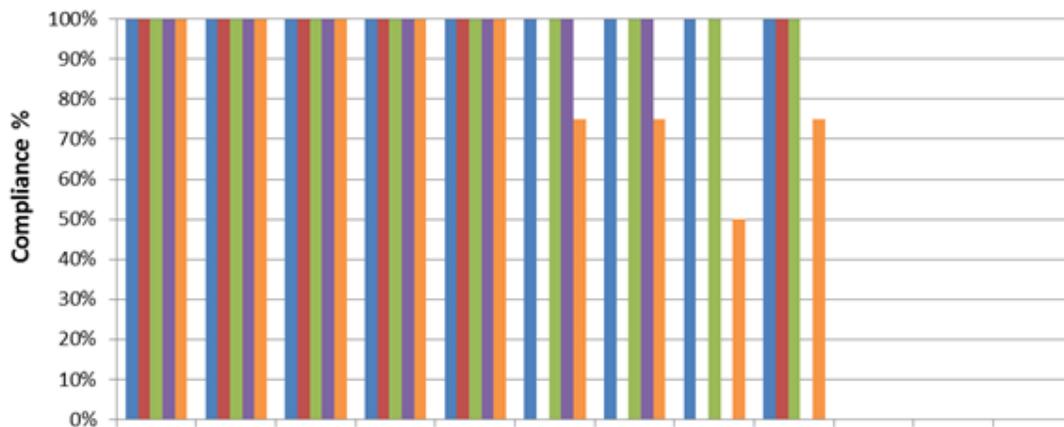
Data Analysis: There were 4 falls in the 1st Quarter of FY2016. In July there were 2 falls, August 1 fall, and September 1 fall. Compliance with Nursing Falls Procedure F-10 for entire 1st Quarter was 69% which is a decrease from previous quarters.

JOINT COMMISSION

Patient Falls by Quarter

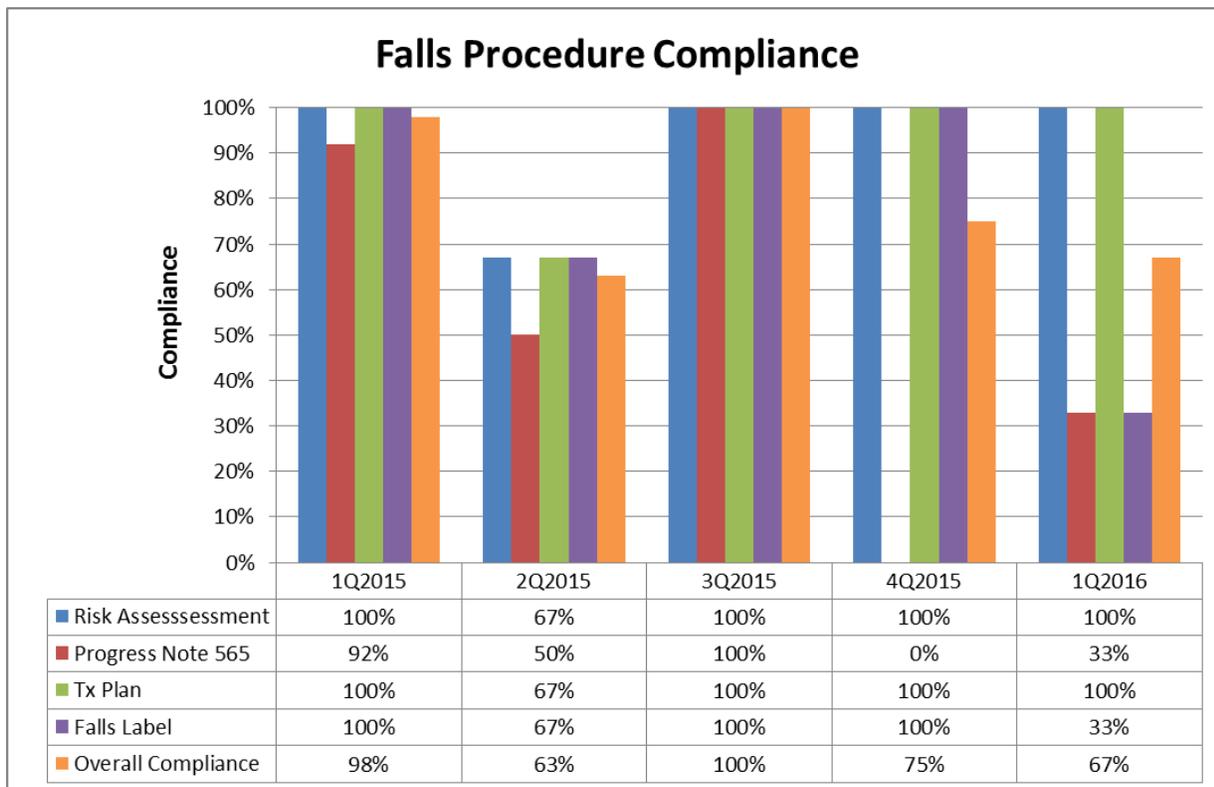


Data Element Compliance by Month



	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Risk Assessment	100%	100%	100%	100%	100%	100%	100%	100%	100%			
Progress Note 565	100%	100%	100%	100%	100%	0%	0%	0%	100%			
Tx Plan	100%	100%	100%	100%	100%	100%	100%	100%	100%			
Falls Label	100%	100%	100%	100%	100%	100%	100%	0%	0%			
Overall Compliance	100%	100%	100%	100%	100%	75%	75%	50%	75%			

JOINT COMMISSION



Plan of Action: Nursing remains below the goal of 90% compliance. Nursing Administration continues to address this issue and will reinforce it with the Clinical Nurse Managers to ensure that pain is being assessed at least every 12 hours for every patient. Clinical Nurse Managers will address staff members that are not completing these assessments.

JOINT COMMISSION

Pain Assessment

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.

Pain Re-Assessment Audit Form

Janet Babcock, RN

Pain Assessment (Patient Recovery)

Pain is common. About 9 in 10 Americans regularly suffer from pain, and pain is the most common reason individuals seek health care. Each year, an estimated 25 million Americans experience acute pain due to injury or surgery and another 50 million suffer chronic pain (Berry. P., Chapman. C., Covington. E., Dahl. J., Katz. J., Miaskowski. C., Mc Lean. M., 2001. Pain: Current understanding of assessment, Management, and treatment).

Pain is often undertreated, with recent studies, reports, and a position statement suggesting that many types of pain (e.g., postoperative pain, cancer pain, chronic non-cancer pain) and patient populations (e.g., elderly patients, children, minorities, substance abusers) are undertreated. Data from a 1999 survey suggest that only 1 in 4 individuals with pain receive appropriate therapy (Berry. P., Chapman. C., Covington. E., Dahl. J., Katz. J., Miaskowski. C., Mc Lean. M., 2001. Pain: Current understanding of assessment, Management, and treatment).

Untreated pain impairs an individual's ability to carry out their activities of daily living diminishing their quality of life; it can cause anxiety, fear, anger, or depression. Nursing acknowledges the impact of untreated pain on patient recovery and for this reason the objective of Nursing's Pain PI is to ensure patients are being assessed for pain and re-assessed if required.

JOINT COMMISSION

Measure Name: Pain Reassessment Audit - Patient Recovery

Measure Description: Untreated pain impairs an individual’s ability to carry out their activities of daily living diminishing his or her quality of life; it can cause anxiety, fear, anger, or depression. Nursing acknowledges the impact of untreated pain on patient recovery and for this reason the objective of Nursing’s Pain PI is to ensure patients are being assessed for pain and re-assessed if required.

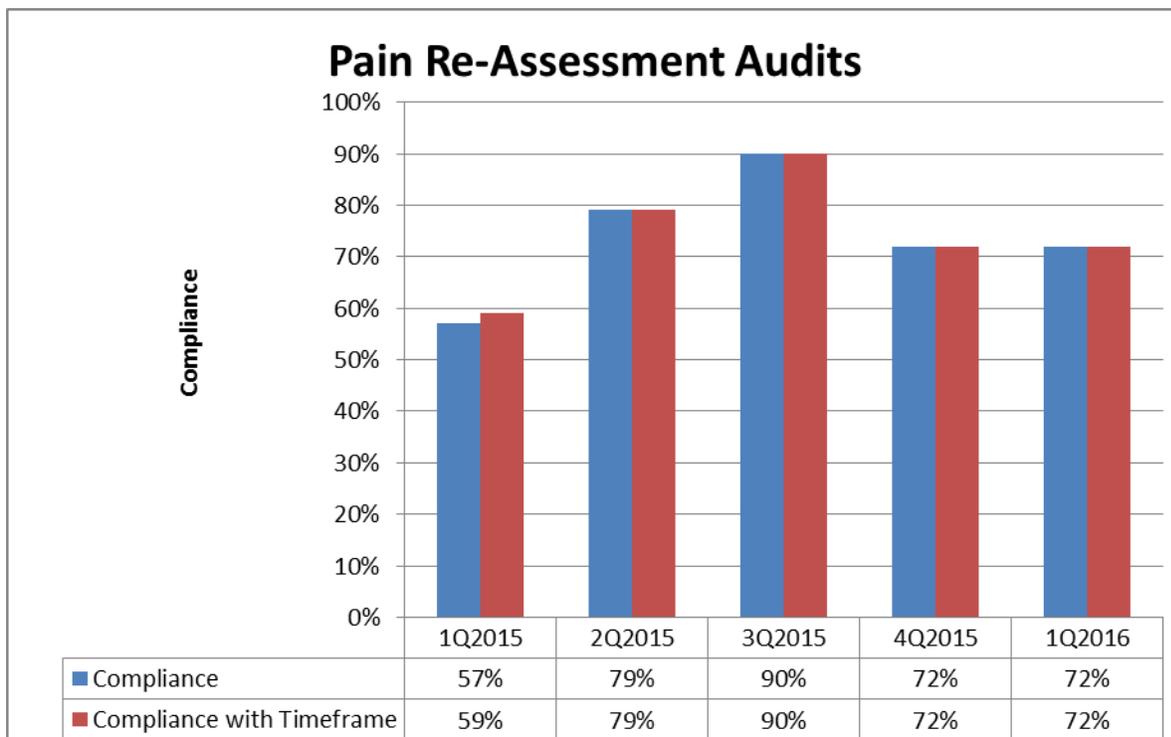
Type of Measure: Performance Improvement

Results							
	Data elements	Base line	4Q 2015	1Q 2016	2Q 2016	3Q 2016	YTD
Target 100% Compliance	Number of audits performed	89	106	93			199
	Number of patients with pain reported on Form 838	29	57	46			103
	Number of reassessments completed	11	41	33			74
	Number of reassessments reported within clinically appropriate timeframe (1-2 hours after oral medication and within 1 hour of intramuscular injection)	11	41	33			74
	Compliance with reassessment	38%	72%	72%			72%
	Compliance with reassessment timeframe	38%	72%	72%			72%

***Baseline established January 2013**

Data Analysis: All MARs are reviewed for the month for pain reported and corresponding reassessment; the information is located on form #838 ‘Pain Flow Sheet’. The information is documented on the ‘Pain Assessment and Re-assessment Audit Form’ for monthly, quarterly, and yearly calculation. Audits were initiated in January 2013, January and February 2013 comprise the baseline data of 38%. There was an increase of 34% from the baseline for both Compliance with reassessment and Compliance with reassessment timeframe from 38% to 72% for 1st Quarter FY 2016.

JOINT COMMISSION



Plan of Action: Nursing remains below the goal of 100% compliance. Nursing administration continues to address this issue and will reinforce with the clinical nurse managers to ensure that pain reassessments are being completed for each documented report of pain and within the clinically appropriate timeframe. Clinical nurse managers will address staff members that are not completing these assessments.

JOINT COMMISSION

Measure Name: Pain Audit Shift Assessment - Patient Recovery

Measure Description: Untreated pain impairs an individual’s ability to carry out their activities of daily living diminishing his or her quality of life; it can cause anxiety, fear, anger, or depression. Nursing acknowledges the impact of untreated pain on patient recovery and for this reason the objective of Nursing’s Pain PI is to ensure patients are being assessed for pain and re-assessed if required.

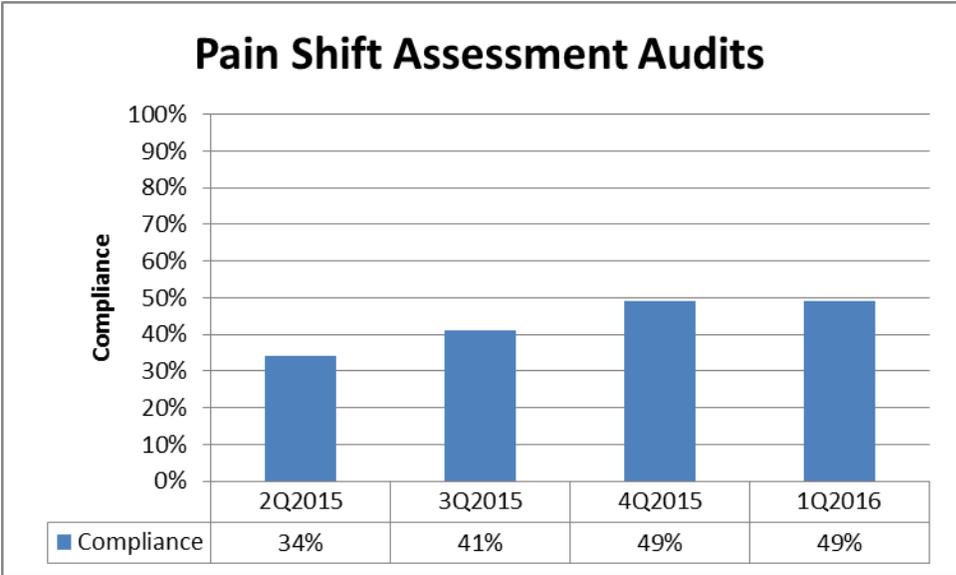
Type of Measure: Performance Improvement

Results							
	Data elements	Base line	4Q 2015	1Q 2016	2Q 2016	3Q 2016	YTD
Target 100% Compliance	Number of audits completed	36	106	93			199
	Number of audits having 2 shift assessments completed that assesses for the presence and intensity of pain within 24 hours	12	52	46			98
	Overall Compliance	33%	49%	49%			49%

***Baseline established January 2013**

Data Analysis: All Medication Administration Records (MARs) for each unit will be audited for a 24 hour period. Form #841 ‘Daily Shift Assessment for the Presence of Pain’ is used at least once every 12 hours to assess each patient for the presence and intensity of pain. The form is audited to ensure there are 2 pain assessments completed each 24 hour period. Audits were initiated in January 2013, January and February 2013 comprise the baseline data of 33%. 1st Quarter 2016 shows an increase in compliance by 16 percent from baseline.

JOINT COMMISSION



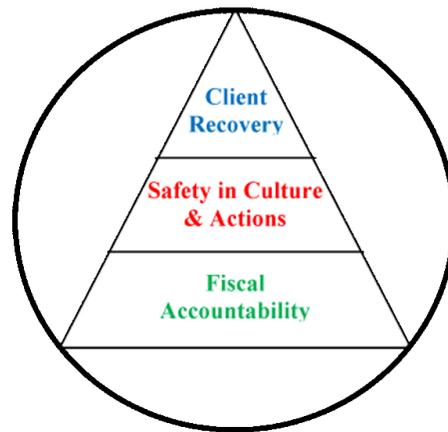
Plan of Action: Nursing remains below the goal of 100% compliance. Nursing Administration continues to address this issue and will reinforce with the Clinical Nurse Managers to ensure that pain is being assessed at least every 12 hours for every patient. Clinical Nurse Managers will address staff members that are not completing these assessments

STRATEGIC PERFORMANCE EXCELLENCE

Process Improvement Plans

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 patient recovery by ensuring fiscal accountability and a culture of organizational safety through the promotion of...

- The conviction that staff members are concerned with doing the right thing in support of patient 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 staff members and patients 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;

STRATEGIC PERFORMANCE EXCELLENCE

- 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 patients before, during, and after care;
- A just culture that supports the emotional and physical needs of staff members, patients, and family members that are impacted by serious, acute, and cumulative events.

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 staff members.

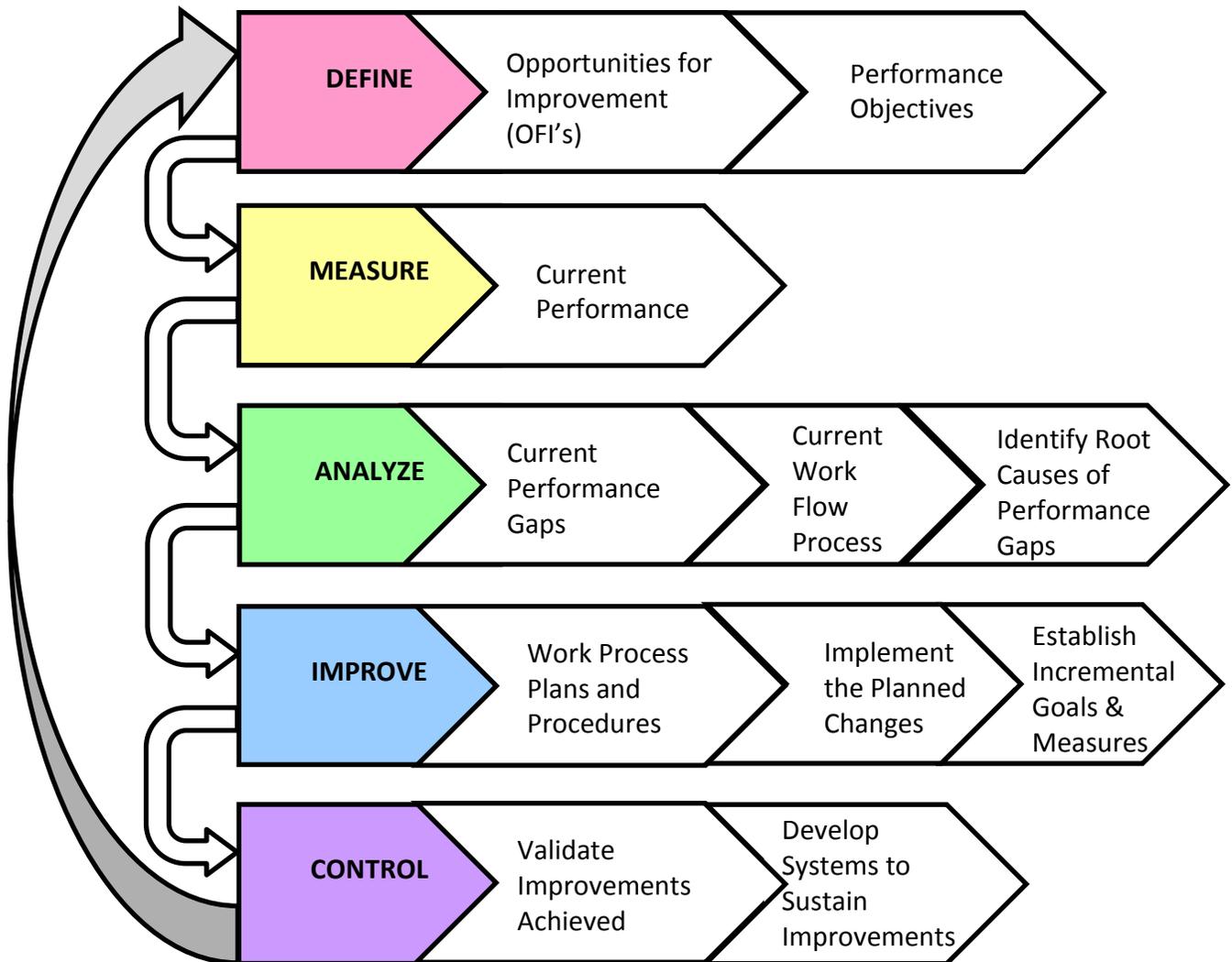
Enhance Patient Recovery by...

Develop active treatment programs and options for patients.
Supporting patients in their discovery of personal coping and improvement activities.

STRATEGIC PERFORMANCE EXCELLENCE

Each department determines unique opportunities and methods to address the hospital goals.

The Quarterly Report consists of the following:



STRATEGIC PERFORMANCE EXCELLENCE

Admissions

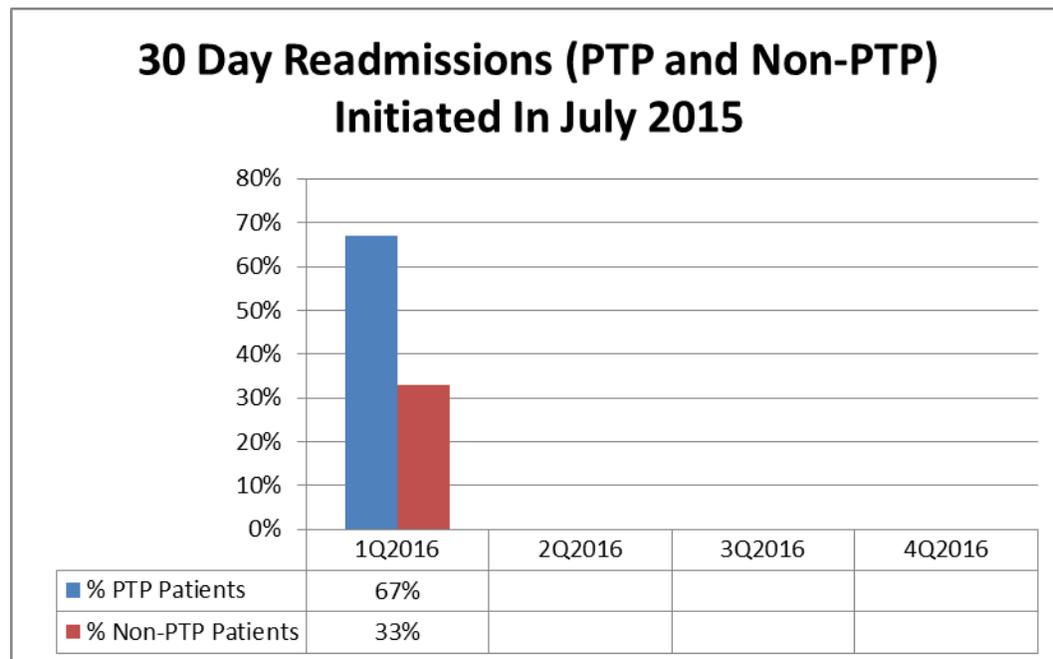
Robyn Fransen, LSW-C

Measure Name: Patients Readmitted Within 30 Days of Discharge

Measure Description: Tracking all readmissions within 30 days of discharge will allow for a modified Root Cause Analysis to be completed trends in discharge planning or community services can be addressed which will improve patient discharge outcomes.

Type of Measure: Performance Improvement

Target	Data elements	1Q 2016	2Q 2016	3Q 2016	4Q 2016	YTD
TBD	# of Readmissions	3				3
	Is this readmission a PTP patient?	67%				67%
	Is this readmission a Non-PTP patient?	33%				33%



*There were no readmissions in 4Q2015

STRATEGIC PERFORMANCE EXCELLENCE

Data Analysis: DDPC will complete a modified RCA on all 30-day readmits to determine if there was an appropriate discharge planning evaluation, discharge plan, and implementation of the discharge plan. Data will be gathered and analyzed to identify trends that may require more follow-up analysis and potential remedial actions.

Action Plan: In July 2015 Social Services began tracking 30 day readmissions for both PTP and non-PTP patients and completing Modified Root Cause Analysis' to determine any areas of discharge planning that need improvement

STRATEGIC PERFORMANCE EXCELLENCE

Dietary

Bobbie Lindsey

Measure Name: ServSafe Training

Measure Description: ServSafe is a food and beverage safety training and certificate program administered by the National Restaurant Association

Type of Measure: Quality Assurance

Results						
	Baseline	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	100%	100%	100%	100%	100%	100%
Actual	70% 1Q2016	70% 31/44				70% 31/44

Data Analysis: The data indicates that we fell short of our goal of 100% certification by 30%

Action Plan: Set up a class to complete all certifications for both those who are not certified and for those who have certificates that are going to expire. I would like to include other staff members in the hospital that handle food for patients.

Comments: ServSafe proctors require 10 students for a class. Dietary is unable to send all staff at once and not all of the staff is due for recertification. If I can add other staff members this would give me the opportunity to have 10 students for the class.

STRATEGIC PERFORMANCE EXCELLENCE

Facilities

Herbert Gibson

Measure Name: Security Response to Hospital Incidence

Measure Description: Analyze security response and follow-up to Hospital Incidents through comparison of the Hospital's Incident Reports that are relevant with the Security Officer's Daily Activity Report (DAR).

Type of Measure: Performance Improvement

		Results				
	Baseline	3Q2015	4Q2015	1Q2016	2Q2016	YTD
Target	90%	100%	100%	100%	100%	100%
Actual		94%	97%	100%		97%

Methodology: The Incident Report-DAR comparative analysis will look to gather information on post-incident procedures to understand that best practice and policy was followed and to encourage feedback and recommendations from the Security Staff for betterment where there is potential.

Performance Ratio Evaluation: The numerator will be the number of quarterly incident reports received from the QAPI staff for Hospital incidents *where Security was specifically requested*. The denominator will be the number of DAR reports that indicated response to the incidents *where Security was specifically requested and responded to the incident*. The performance percentage will be the numerator divided by the denominator.

Performance Goals and Objectives: The performance goal will be 100%. The *Baseline Percentage* is defined as the minimum expectation for performance of this measure. The *Target Percentage* is defined as the anticipated performance that expected for this measure.

Data Analysis: Security staff assistance was requested during this quarter on (37) incidents. Security staff responded to all incidents where requested.

Action Plan: No action required.

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	2Q2015	3Q2015	4Q2015	1Q2016	YTD
Identification Data	100% 29/29	100% 19/19	100% 25/25	100% 35/35	100% 108/108
Medical History, including chief complaint; HPI; past, social & family hx., ROS, and physical exam w/in 24 hours, conclusion and	93% 27/29	100% 19/19	100% 25/25	100% 35/35	98% 106/108
Summary of patient's psychosocial needs as appropriate to the patients *	86% 25/29	84% 16/19	76% 19/25	86% 30/35	83% 90/108
Psychiatric Evaluation in patient's record w/in 24 hours of admission	100% 29/29	100% 19/19	100% 25/25	100% 35/35	100% 108/108
Physician Orders (TO/VO w/in 72 hr.)	97% 28/29	84% 16/19	84% 21/25	86% 30/35	88% 95/108
Evidence of appropriate informed consent Unable or refused 4Q2015 = 6	93% 25/27	100% 19/19	100% 19/19	100% 30/30 5 refused	98% 106/108
Clinical observations including the results of therapy.	100% 27/27	100% 19/19	100% 25/25	100% 35/35	100% 108/108
Nursing discharge Progress Note with time of discharge departure	100% 29/29	100% 19/19	100% 25/25	100% 35/35	100% 108/108
<i>Consultation reports, when applicable</i>	100% 16/16	91% 10/11	100% 11/11	93% 14/15	96% 51/53
Final Diagnosis (es) DSM-Principal Diagnosis	100% 29/29	100% 19/19	100% 25/25	100% 35/35	100% 108/108
Results of autopsy, when performed	N/A	N/A	N/A	N/A	N/A
<i>Advance Directive Status on admission and Social Worker follow up after admission</i>	90% 26/29	95% 18/19	100% 25/25	97% 34/35	95% 103/108
Notice of Privacy	100% 29/29	89% 17/19	100% 25/25	94% 33/35	96% 104/108
<i>Chart Completion w/in 30 days of discharge date/discharge summary completed within 30 days</i>	93% 27/29	95% 18/19	92% 23/25	94% 33/35	94% 101/108
Discharge Packet sent to follow up provider within 5 days of discharge	93% 27/29	94% 15/16	96% 24/25	94% 33/35	92% 99/108

* 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

Tamra Hanson

- I. **Measure Name:** Number of work related employee injuries (treatment related) and incidents (no treatment).

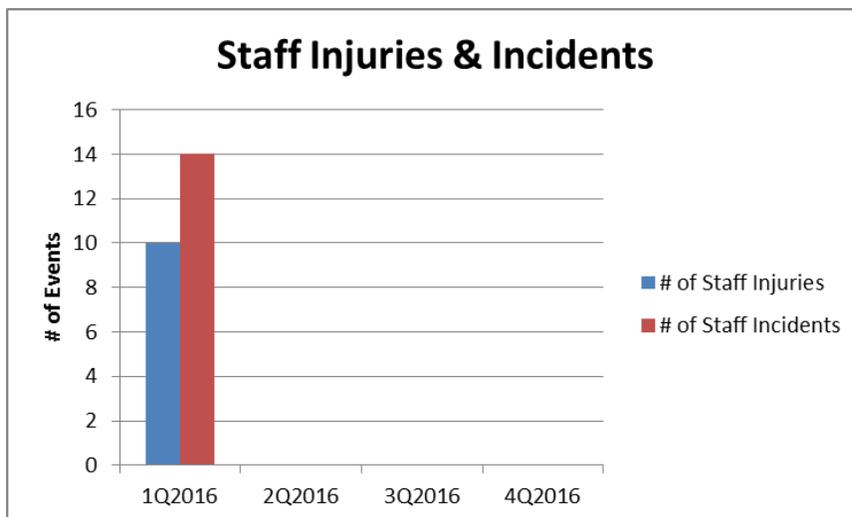
Measure Description: Staff safety is central to DDPC. While staff safety events may not be completely eliminated, events can be reduced by reviewing trends related to injuries.

Type of Measure: Performance Improvement

		Results				
	Baseline	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	Established 1Q2016	TBD				100%
Actual # of Staff Injuries		10				10
Actual # of Staff Incidents		14				14

Data Analysis: In the first quarter of the year 2016 DDPC had 10 staff injuries and 14 staff incidents; 20 of these were patient related and 4 were self-related.

Plan of Action: A baseline has been established. I will start reporting at IPEQ to inform leadership of staff safety events and trending data to look for opportunities to reduce the likelihood of injuries in the future.



STRATEGIC PERFORMANCE EXCELLENCE

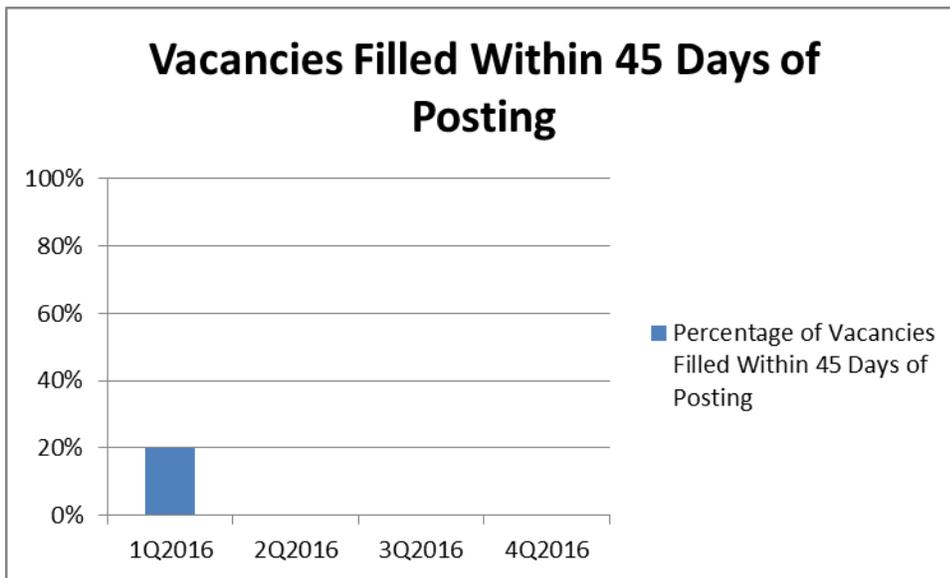
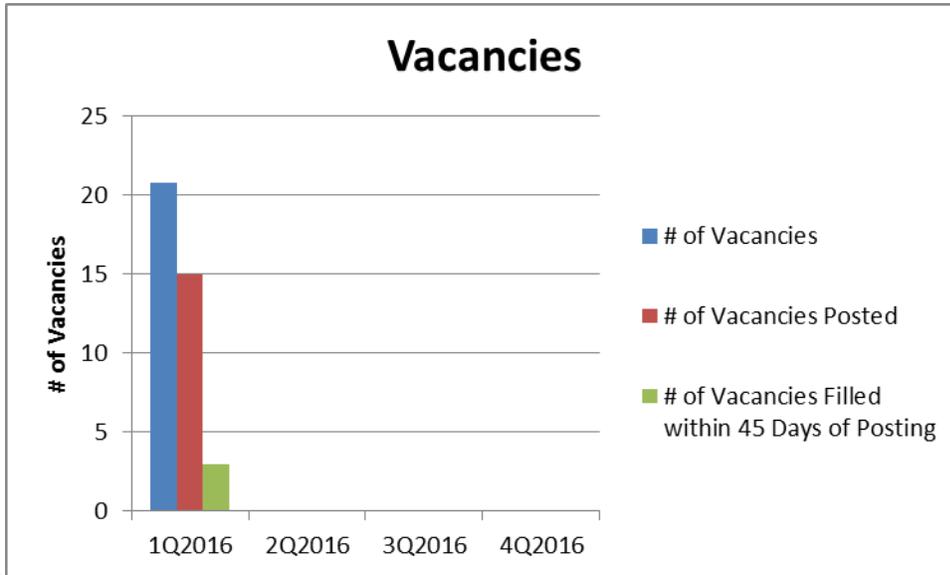
- II. Measure Name:** Vacancies filled within 45 days of posting.
Measure Description: The hospital will maintain an adequate workforce to maintain safety and provide therapeutic care for patients.
Type of Measure: Performance Improvement

Results						
	Baseline	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	Established June 2015	100%	100%	100%	100%	100%
% Vacancy Rate	21.5%	20.8%				20.8%
# Vacancies Posted	1	15				15
# Vacancies Filled Within 45 Days	0	3				3
% Posted & Filled Within 45 Days	0%	20%				20%

Data Analysis: Increase percentage rate of filled quarterly posted vacancies within 45 days of posting.

Plan of Action: This is new data collection in an effort to reduce extended time periods of vacant positions

STRATEGIC PERFORMANCE EXCELLENCE



STRATEGIC PERFORMANCE EXCELLENCE

- III. Measure Name:** Performance Evaluations completed by due date.
Measure Description: DDPC evaluates staff based on performance expectations that reflect their job responsibilities. This evaluation is documented in the HR Personnel File by is due date.
Type of Measure: Performance Improvement

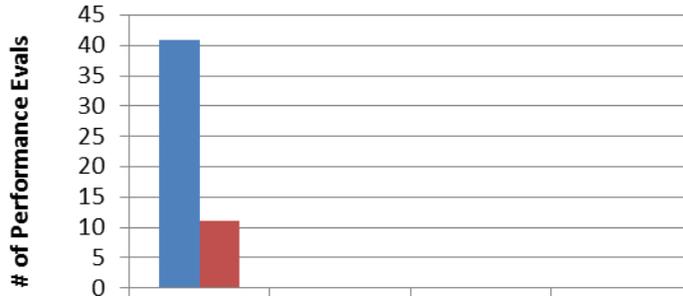
Results						
	Baseline	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	Established June 2015	100%	100%	100%	100%	100%
# Due	14	41				41
# Completed on Time	3	11				11
% Completed on Time	21%	27%				27%

Data Analysis: In the first quarter of the year 2016 we had many evaluations due and many back later than the evaluations due date. We are below the target of 100%.

Plan of Action: This is new data collection. We will start reporting at IPEC so that managers are aware of the data. This will hopefully start increasing our compliance rates.

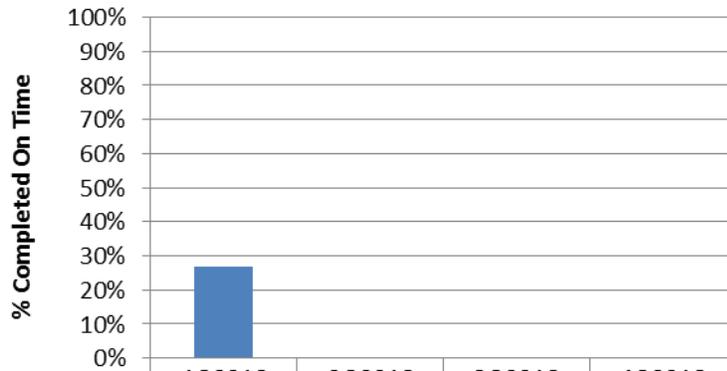
STRATEGIC PERFORMANCE EXCELLENCE

Performance Evaluations Completed On Time



	1Q2016	2Q2016	3Q2016	4Q2016
# of Performance Reviews Due	41			
# of Performance Reviews completed on time	11			

Performance Reviews Completed On Time



	1Q2016	2Q2016	3Q2016	4Q2016
% Performance Reviews Completed On Time	27%			

STRATEGIC PERFORMANCE EXCELLENCE

Infection Control

Heather Brock, RN

I. Measure Name: Hospital Acquired Infections

Measure Description: 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.

Type of Measure: Quality Assurance

Results							
	Unit	Baseline	2Q2015	3Q2015	4Q2015	1Q2016	YTD
Target: 0 HAI	# of HAI per quarter	FY 2012 0 HAI	0 HAI	0 HAI	0 HAI	0 HAI	0 HAI

Data Analysis: There were zero hospital acquired infections for 1st Quarter FY 2016.

Action Plan: Continue to monitor infection rates.

H. A. Infections	FY2014	FY2015	FY2016
1 st Quarter H.A.I. Rate	0	0	0
2 nd Quarter H.A.I. Rate	0	0	
3 rd Quarter H.A.I. Rate	0	0	
4 th Quarter H.A.I. Rate	0	0	
Average H.A. Infection Rate	0	0	

STRATEGIC PERFORMANCE EXCELLENCE

FY 2014-2016 Hospital Acquired Infections

Type of Infection	1Q 2014	1Q 2015	1Q 2016	2Q 2014	2Q 2015	2Q 2016	3Q 2014	3Q 2015	3Q 2016	4Q 2014	4Q 2015	4Q 2016
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: $\frac{\text{Total number of infections per unit} \times 1000}{\text{Total number of inpatient days}} = \%$

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

1st Quarter 2015=3256
 2nd Quarter 2015=3550
 3rd Quarter 2015 = 3453
 4th Quarter 2015 = 3422

1st Quarter 2016= 3361
 2nd Quarter 2016=
 3rd Quarter 2016=
 4th Quarter 2016=

STRATEGIC PERFORMANCE EXCELLENCE

- II. Measure Name:** Patient & Family Education on Hand Hygiene/Cough Etiquette
Measure Description: Prior to discharge, a questionnaire will be distributed to each patient that includes the following questions:

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

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

Type of Measure: Performance Improvement

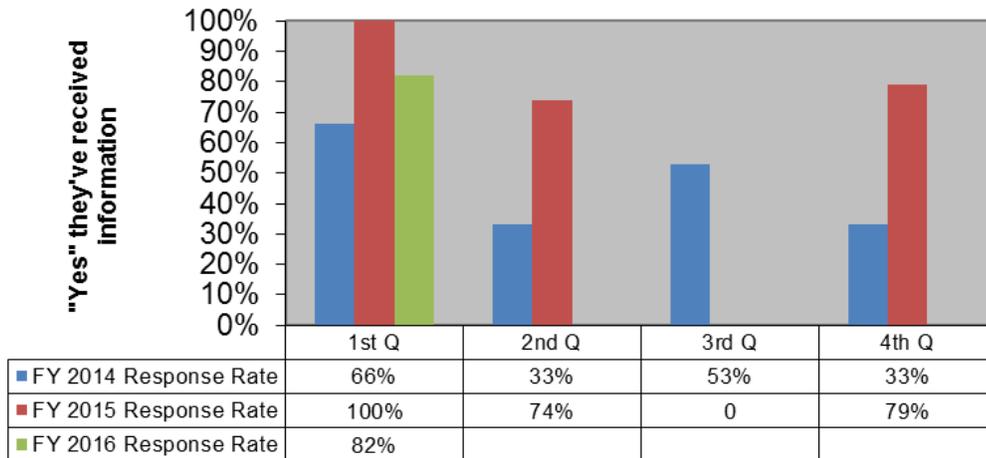
		Results					
	Unit	Baseline	2Q2015	3Q2015	4Q2015	1Q2016	YTD
Target: D1 80%	Quarterly response rate "agree/strongly agree" for D1 & D2 is set at 80%	2012: D1 response rate: 80%	74%	0%	79%	82%	59%
Target: D2 80%		2012: D2 response rate: 80%	58%	0%	75%	82%	71%

Data Analysis: 1st Quarter FY2016 response rate for question D1 was 82%, an increase of 4% from the previous quarter. 1st Quarter FY2016 response rate for question D2 was 82%, an increase of 9% from the previous quarter.

Action Plan: Continue to monitor for consistent 80% compliance rate with patient and family education.

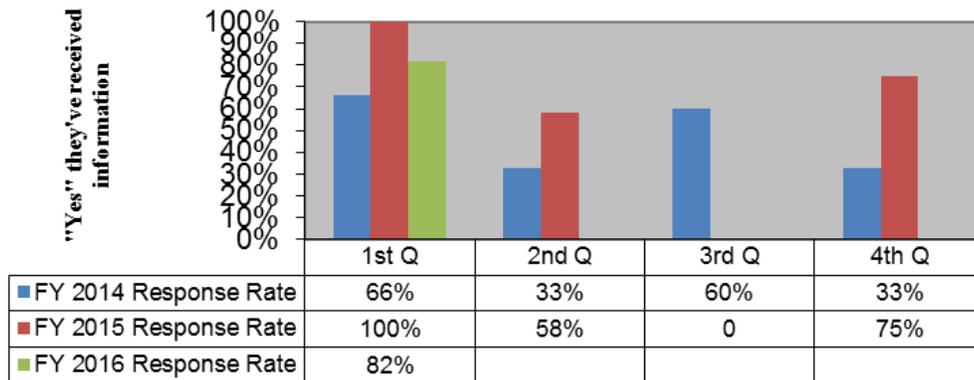
STRATEGIC PERFORMANCE EXCELLENCE

Question D1 Quarterly Response Rate



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

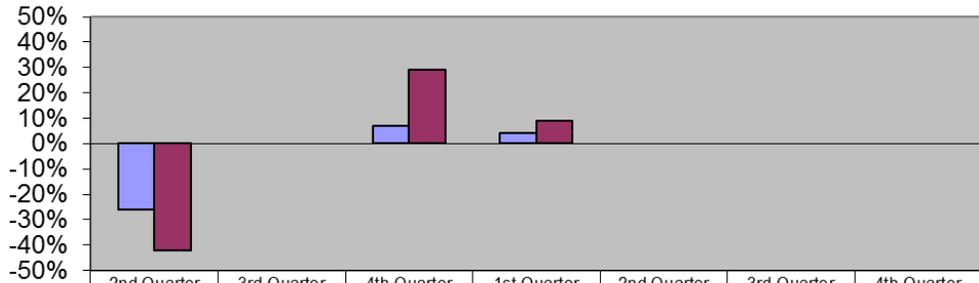
D2 Quarterly Response Rate



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

STRATEGIC PERFORMANCE EXCELLENCE

Quarterly Incremental Increases/Decreases



	2nd Quarter 15	3rd Quarter 15	4th Quarter 15	1st Quarter 16	2nd Quarter 16	3rd Quarter 16	4th Quarter 16
D1 Quarterly incremental increases/decreases	-26%	0	7%	4%			
D2 Quarterly incremental increases/decreases	-42%	0	29%	9%			

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

III. Measure Name: Patient Hand Hygiene

Measure Description: Patient hand hygiene is being monitored during 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.

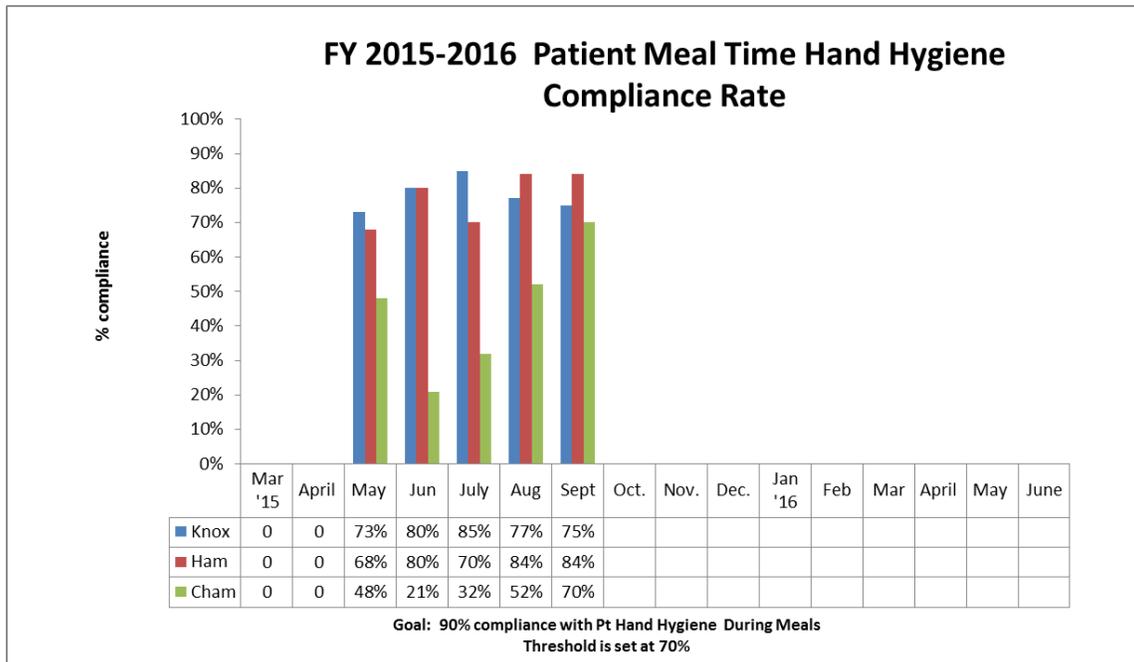
Type of Measure: Performance Improvement

		Results					
	Unit	Baseline 4Q2014	4Q2015	1Q2016	2Q2016	3Q2016	YTD
Target: sustained level of compliance that approaches 90%	Patient hand hygiene compliance during 4 meal times per unit per month	Knox: 35%	51%	79%			65%
		Hamlin: 44%	49%	79%			64%
		Chamberlain: 36%	23%	51%			37%

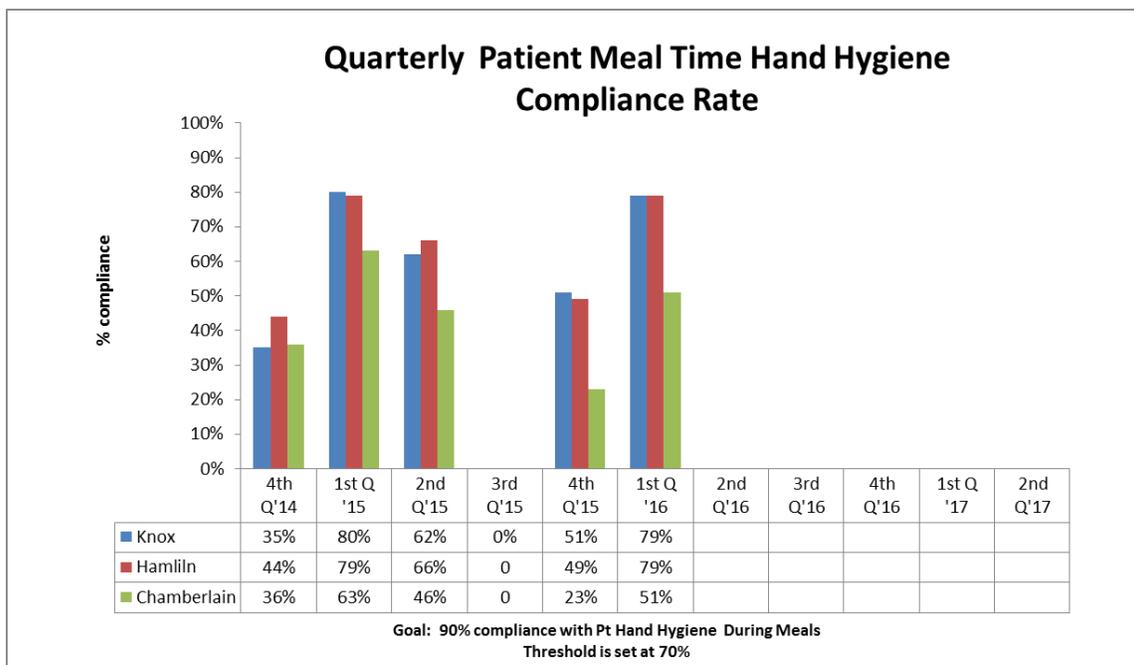
Data Analysis: For 1st Quarter 2016 Knox’s compliance rate was 79%, an increase of 55% from the previous quarter. Hamlin’s compliance rate was 79%, an increase of 61% from the previous quarter. Chamberlain’s compliance rate was 51%, an increase of 122% from the previous quarter.

Action Plan: Plan of action is to continue to role model and offer hand sanitizer to patients at meal times.

STRATEGIC PERFORMANCE EXCELLENCE



*Data not available for March and April 2015 due to the Infection Control Nurse being out of work on leave.



*Data not available for 3Q2015 due to the Infection Control Nurse being out of work on leave.

STRATEGIC PERFORMANCE EXCELLENCE

IV. Measure Name: Influenza Immunizations

Measure Description: The standard goal is to have a sustained level of compliance that approaches and achieves the 90% compliance rate established in the National Flu Initiative for 2020. Employee flu vaccination compliance is measured annually.

Type of Measure: Performance Improvement

Results							
	Unit	Baseline	FY2016	FY2017	FY2018	FY2019	FY2020
Target: 90%	Percent of employees who receive the flu vaccination	FY2015 81%	50% (as of Oct.)				

Data Analysis: Employee flu vaccination compliance rate was 81% for FY2015. So far DDPC is at a 50% compliance rate for FY2016.

Action Plan: Continue to educate staff and promote influenza vaccinations.

Comments: It is still early in the season. DDPC just started offering flu vaccinations to employees October 13th, 2015.

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff

Dr. Michelle Gardner

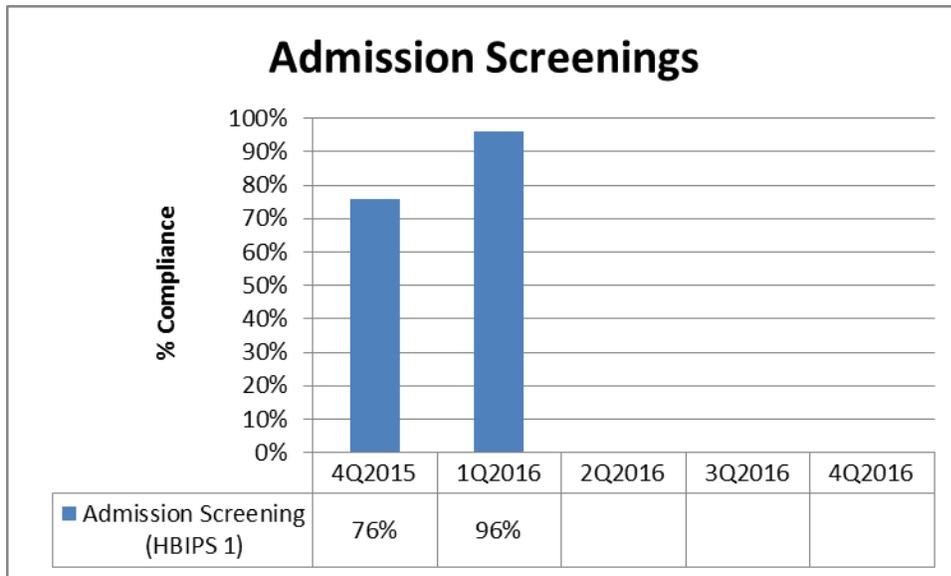
I. Measure Name: Medical Staff compliance with admission screenings within the first three days after admission for all of the following HBIPS data elements: risk of violence to self or others, substance use, psychological trauma history and patient strengths.

Measure Description: Review of all discharged medical records for the given month for the following screening of HBIPS data elements within the first three days after admission, relying on the documentation in the psychiatric admission evaluation: risk of violence to self or others; substance use, psychological trauma history; and patient strengths. The numerator will be medical records with all of the following HBIPS data elements: risk of violence to self or others; substance use, psychological trauma history; and patient strengths. The denominator will be all discharged medical records for the given month.

Type of Measure: Performance Improvement

		Results					
	Unit	Baseline	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Goal	Admission screenings for HBIPS data element compliance during the months of July, August and September 2015 based on the admission psychiatric evaluation only	Q42015 76%	100%	100%	100%	100%	100%
Actual			96%				96%

STRATEGIC PERFORMANCE EXCELLENCE



Data Analysis: 96% overall compliance for all admission screenings based on the admission psychiatric evaluation. Though this is a significant improvement from the baseline data, and above the threshold of 90%, it is still below the goal of 100% overall compliance.

Comments: Beginning in January 2015, NRI revised the definitions of HBIPS1 core measures such that the “form or contextual data must include the stated time component.” Data reported out in ORYX reports revealed that, when based on the admission psychiatric evaluation only, the scores were below the threshold of 85%.

Action Plan: The template used by the psychiatric providers to frame the admission psychiatric evaluation was revised by Med Staff to address each of the HBIPS screenings, including the time components, and the entire med staff was provided with education on the importance of addressing the components of the screenings.

STRATEGIC PERFORMANCE EXCELLENCE

ADDITIONAL INFORMATION BEING MONITORED:

ORYX Report Compliance with HBIPS1 Data

Results							
	Unit	Baseline	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Goal	ORYX Report on HBIPS1 Compliance	4Q2015 76%	>85%	>85%	>85%	>85%	>85%
Actual			TBD				

Data Analysis: 4th Quarter FY2015 ORYX Report indicated a compliance rate of 76% with HBIPS1 core measures, below the required compliance rate of 85% as determined by The Joint Commission.

Action Plan: It was quickly determined that, for extraction of data for NRI compliance purposes, assessments done by all disciplines within the first three days after admission would be included to extract the data for the core measures. The HBIPS1 core measures for January through June of 2015 were revised and re-uploaded to NRI in September 2015 based on this change.

STRATEGIC PERFORMANCE EXCELLENCE

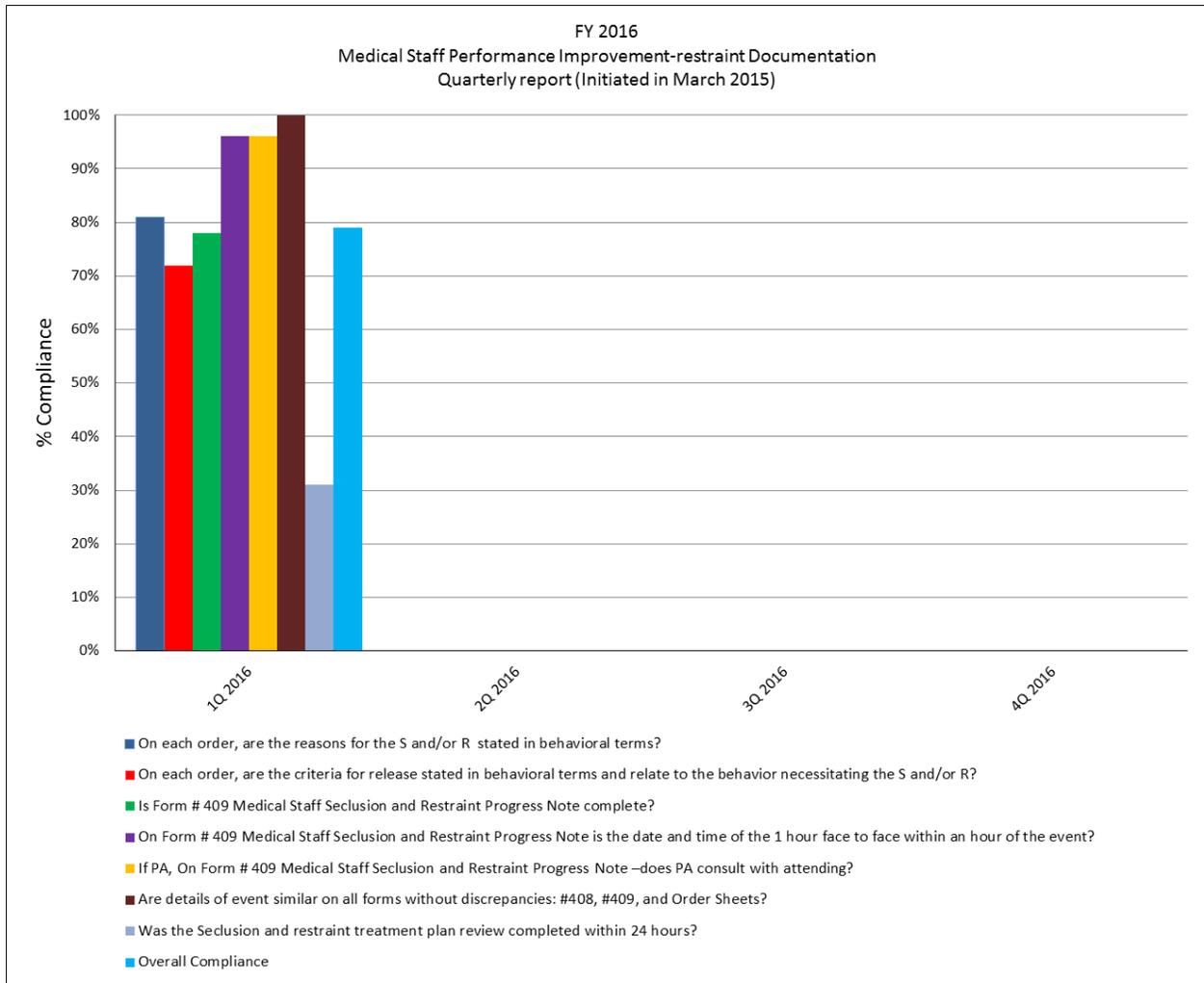
II. Measure Name: Restraint Documentation

Measure Description: Proper documentation is the only way to demonstrate and provide a record that the clinical criteria and assessments for seclusion/restraint have been met. Documentation is critical for patient care/safety, as it validates the care that was provided.

Type of Measure: Performance Improvement

		Results					
Target	Restrains	Baseline (July 2015)	1Q 2016	2Q 2016	3Q 2016	4Q 2016	YTD
100%	Number of Events	21	39				39
	On each order, are the reasons for the S and/or R stated in behavioral terms?	100%	81%				81%
	On each order, are the criteria for release stated in behavioral terms and relate to the behavior necessitating the S and/or R?	100%	72%				72%
	Is Form 409 Medical Staff Seclusion and Restraint Progress Note complete (both sides)?	91%	78%				78%
	On Form 409 Medical Staff Seclusion and Restraint Progress Note, is the date and time of the 1 hour face to face within an hour of the event?	87%	96%				96%
	If PA, On Form 409 Medical Staff Seclusion and Restraint Progress Note – does PA consult with attending?	92%	96%				96%
	Are the details of the event similar without discrepancies on Form 408 and 409 and the order set?	100%	100%				100%
	Was the Seclusion and restraint treatment plan review completed within 24 hours?	87%	31%				31%
	Overall Compliance	94%	79%				79%

STRATEGIC PERFORMANCE EXCELLENCE



Goal 100% Compliance with Medical Staff Documentation

Data Analysis: All data elements have decreased in compliance from the baseline in March except for the data element “Are the details of the event similar without discrepancies on Form 408 and 409 and the order set?” The overall compliance has also decreased from 95% to 79%.

*It’s important to note that not all S & R event audits were included in the September data as some audits were not transcribed over to the audit tool for data input.

STRATEGIC PERFORMANCE EXCELLENCE

Plan of Action: The plan moving forward is to change the data element related to the seclusion and restraint treatment plan being completed within 24 hours to “did a medical provider attend the S & R treatment plan review?” This data element will change when the updated S & R procedure and revised forms go into effect in mid-October. An annual Medical Provider meeting is set for the week when these changes go into effect to review the changes with all medical staff. The updated changes to the S & R procedure, forms and the annual meeting will hopefully generate compliance with the above data elements.

STRATEGIC PERFORMANCE EXCELLENCE

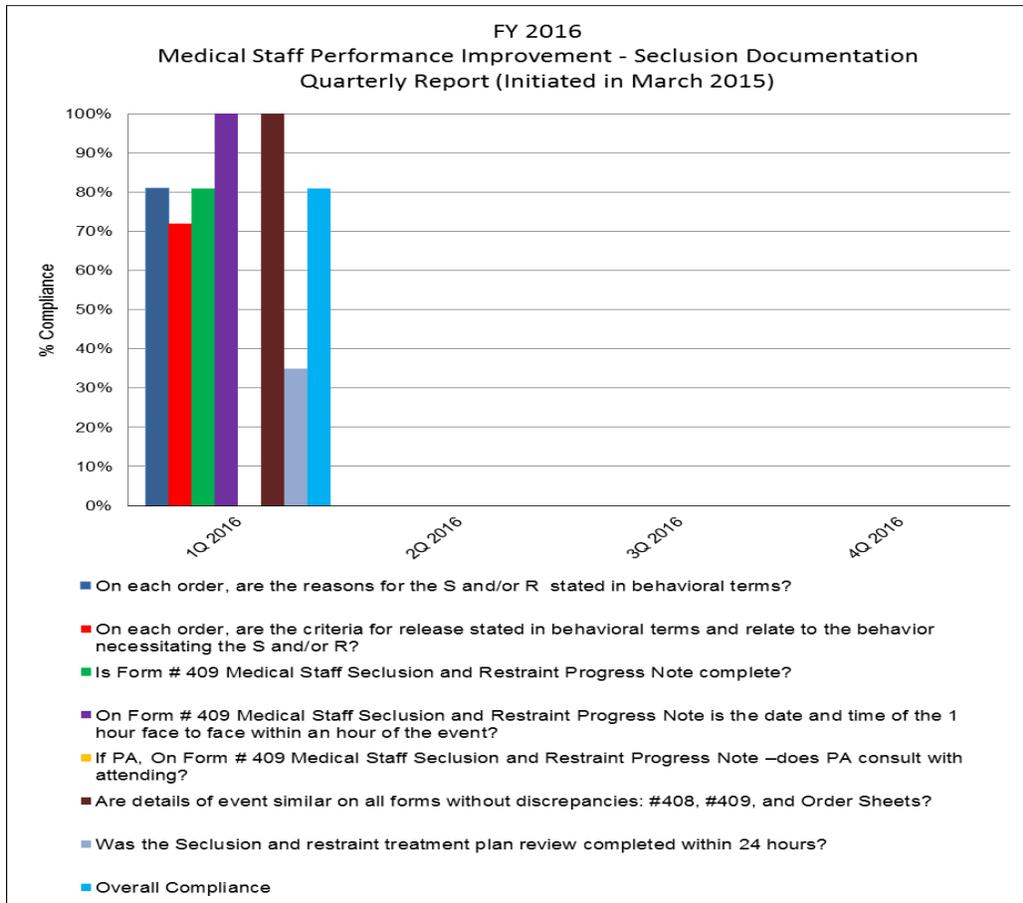
III. **Measure Name:** Seclusion Documentation

Measure Description: Proper documentation is the only way to demonstrate and provide a record that the clinical criteria and assessments for seclusion/restraint have been met. Documentation is critical for patient care/safety, as it validates the care that was provided.

Type of Measure: Performance Improvement

		Results					
Target	Seclusion	Baseline July 2015	1Q 2016	2Q 2016	3Q 2016	4Q 2016	YTD
100%	Number of Events	2	20				20
	On each order, are the reasons for the S and/or R stated in behavioral terms?	100%	81%				81%
	On each order, are the criteria for release stated in behavioral terms and relate to the behavior necessitating the S and/or R?	100%	72%				72%
	Is Form # 409 Medical Staff Seclusion and Restraint Progress Note complete?	100%	81%				81%
	On Form # 409 Medical Staff Seclusion and Restraint Progress Note is the date and time of the 1 hour face to face within an hour of the event?	100%	100%				100%
	If PA, On Form # 409 Medical Staff Seclusion and Restraint Progress Note –does PA consult with attending?	100%	N/A				N/A
	Are details of event similar on all forms without discrepancies: #408, #409, and Order Sheets?	100%	100%				100%
	Was the Seclusion and restraint treatment plan review completed within 24 hours?	100%	35%				35%
	Overall Compliance	100%	81%				81%

STRATEGIC PERFORMANCE EXCELLENCE



Goal: 100% Compliance with Medical Staff Documentation

Data Analysis: 2 Out of the 7 data elements remained at 100% compliance from the baseline compliance rate. 1 data element increased from 92% to 100% compliance and all other data elements decreased in their compliance rate. The overall compliance rate also decreased from the baseline rate of 93% to 81 % compliance. *It’s important to note that not all S & R event audits were included in the September data as some audits were not transcribe over to the audit tool for data input.

Plan of Action: The plan moving forward is to change the data element related to the seclusion and restraint treatment plan being completed within 24 hours to “did a medical provider attend the S & R treatment plan review?” This data element will change when the updated S & R procedure and revised forms go into effect in mid-October. An annual Medical Provider meeting is set for the week when these changes go into effect to review the changes with all medical staff. The updated changes to the S & R procedure, forms and the annual meeting will hopefully generate compliance with the above data elements.

STRATEGIC PERFORMANCE EXCELLENCE

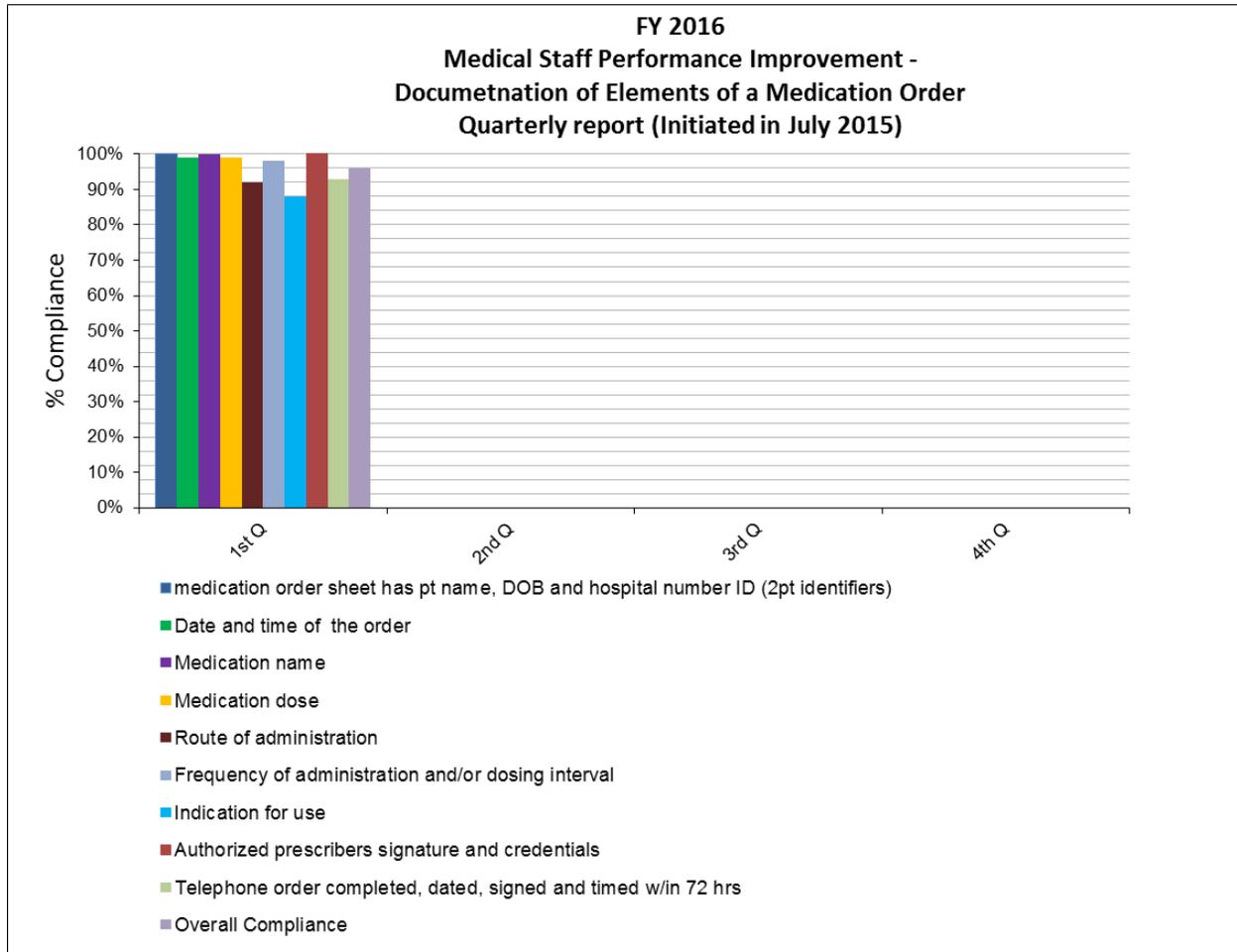
IV. Measure Name: All elements of a medication order are complete

Measure Description: To promote safe medication ordering by defining the required elements of a complete medication order.

Type of Measure: Performance Improvement

		Results					
Target	Data elements	Baseline July 2015	1Q 2016	2Q 2016	3Q 2016	4Q 2016	YTD
100%	# of medication orders reviewed	90	274				274
	Medication order sheet has patient name, DOB and hospital number ID (2 patient identifiers)?	100%	100%				100%
	Medication order has allergies listed?	79%	NA				NA
	Date and time of the order	100%	99%				99%
	Medication name	100%	100%				100%
	Medication dose	99%	99%				99%
	Route of administration	94%	92%				92%
	Frequency of administration and/or dosing interval	98%	98%				98%
	Indication for use	80%	88%				88%
	Authorized prescribers signature and credentials	96%	98%				98%
	Telephone orders completed, signed, dated and timed w/in 72 hr.	90%	93%				93%
	Overall Compliance	85%	96%				96%

STRATEGIC PERFORMANCE EXCELLENCE



Data Analysis: 7 data elements were found to be below the established goals of 100% for the 1st FY 2016 quarterly report and “indication for use” is below the threshold of 90%.

Plan of Action: The above are new performance indicators for Medical Staff. The plan is to take the above to the annual Medical Provider meeting that is set for mid-October and review the above PI with Medical Staff. Making Med Staff aware of the new performance indicators and the compliance issues will hopefully generate compliance with the above data elements.

STRATEGIC PERFORMANCE EXCELLENCE

Nursing

Janet Babcock, RN

I. Measure Name: Restraint Audits – Patient Safety

Measure Description: Proper documentation is the only way to demonstrate and provide a record that the clinical criteria and assessments for seclusion/restraint have been met. Documentation is critical for patient care/safety, as it validates the care that was provided. The audits were initiated January of 2015.

Type of Measure: Performance Improvement

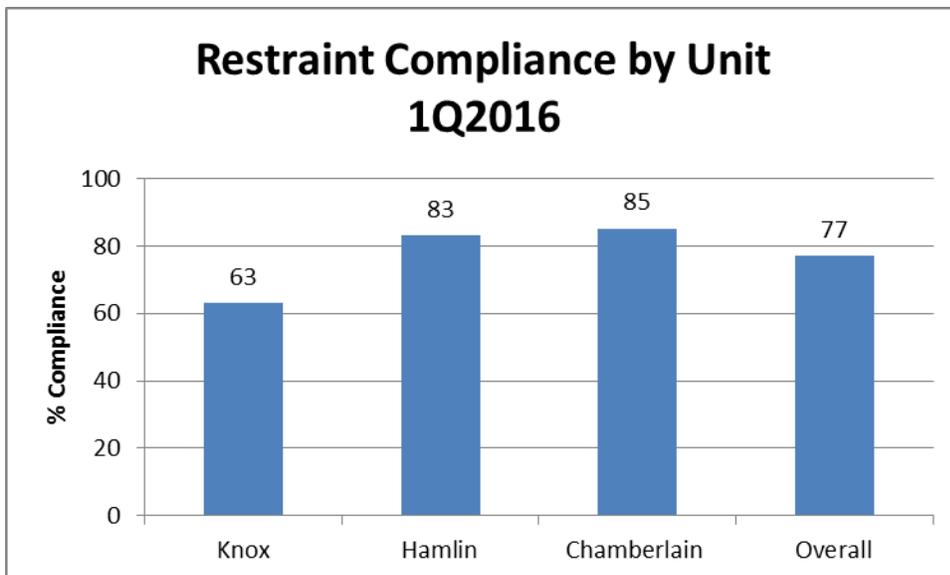
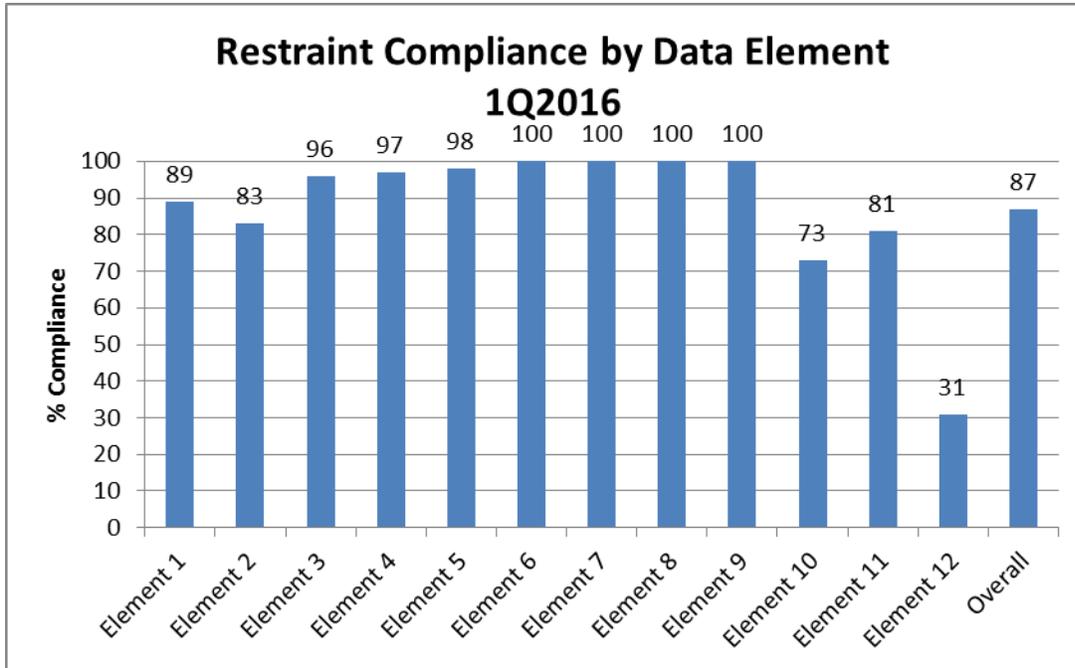
Results							
Target	Data Elements	Baseline	Q1 2016	Q2 2016	Q3 2016	Q4 2016	YTD
100% Compliance	# of Events	11	39				39
	Each order obtained within 15 minutes of the intervention?	100%	89%				89%
	Is Form 408 Nursing Seclusion/Restraint Progress Note complete?	50%	83%				83%
	On Form 408 Nursing Seclusion/Restraint Progress Note, Form 470 Nursing Assessment Protocol for Seclusion and Restraint, and Physician Orders do times match for interventions initiated and time of events?	100%	96%				96%
	Are details of event similar on all forms without discrepancies 408, 409, and Order sheets?	100%	97%				97%
	Is Form 470 Nursing Assessment Protocol for Seclusion and Restraint completed?	95%	98%				98%

STRATEGIC PERFORMANCE EXCELLENCE

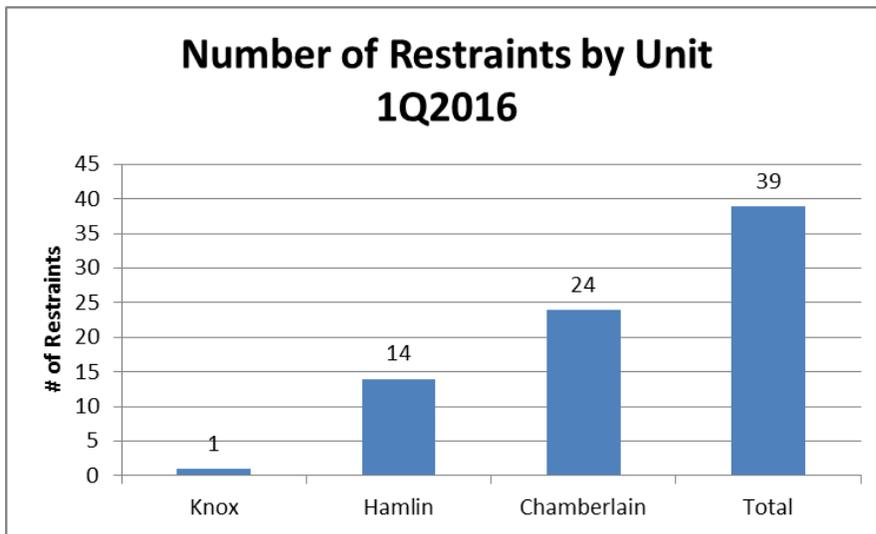
	Data Elements	Baseline	Q1 2016	Q2 2016	Q3 2016	Q4 2016	YTD
	On Form 407RN 2 Hour Seclusion and Restraint Breaks 2 hour breaks are completed at appropriate intervals and signed by RN?	100%	100%				100%
	On Form 407RN 2 Hour Seclusion and Restraint Breaks is time ended for S/R completed and signed by RN	100%	100%				100%
	On Form 407 Seclusion & Restraint Monitoring and Assessment 15 minute checks are completed at appropriate intervals, with Pt's behavior documented in behavioral terms as it pertains to release criteria, times, dated, and initialed by staff?	100%	100%				100%
	On Form 407 Seclusion & Restraint Monitoring and Assessment did each staff member that initialed 15 minute checks complete last page of form with signature and title?	100%	100%				100%
	Were debriefings DB1 & DB2 completed at appropriate times?	100%	73%				73%
	Is patient debriefing in the chart?	100%	81%				81%
	Was legal guardian or agent made aware of time of debriefing?	N/A	N/A				N/A
	Did legal guardian or agent attend debriefing?	N/A	N/A				N/A
	Was Form 470 TX Focused Treatment Plan Review completed within 24 hours?	5%	31%				31%
	Overall Compliance	88%	87%				87%

STRATEGIC PERFORMANCE EXCELLENCE

Data Analysis: Baseline data compiled August 2015 with updates Seclusion and Restraint procedure, forms, and audit tool since that time. Four elements remained the same, three increased, the rest show a decrease. One percent decrease in Restraint documentation first quarter compared to baseline 88% to 87%. Two elements not in computation that have yet to be implemented will be measured in the October Seclusion and Restraint audit.



STRATEGIC PERFORMANCE EXCELLENCE



II. Measure Name: Seclusion Documentation

Measure Description: Proper documentation is the only way to demonstrate and provide a record that the clinical criteria and assessments for seclusion/restraint have been met. Documentation is critical for patient care/safety, as it validates the care that was provided.

Type of Measure: Performance Improvement

Results							
Target	Data Elements	Baseline	Q1 2016	Q2 2016	Q3 2016	Q4 2016	YTD
100% compliance	# of Events	7	14				14
	Each order obtained within 15 minutes of the intervention?	100%	100%				100%
	Is form #408 Nursing Seclusion/Restraint Progress Note complete?	50%	64%				64%
	On Form #408 Nursing Seclusion/Restraint Progress Note, Form #470 Nursing Assessment Protocol for Seclusion and Restraint, and Physician Orders do times match for interventions initiated and time of events?	100%	81%				81%

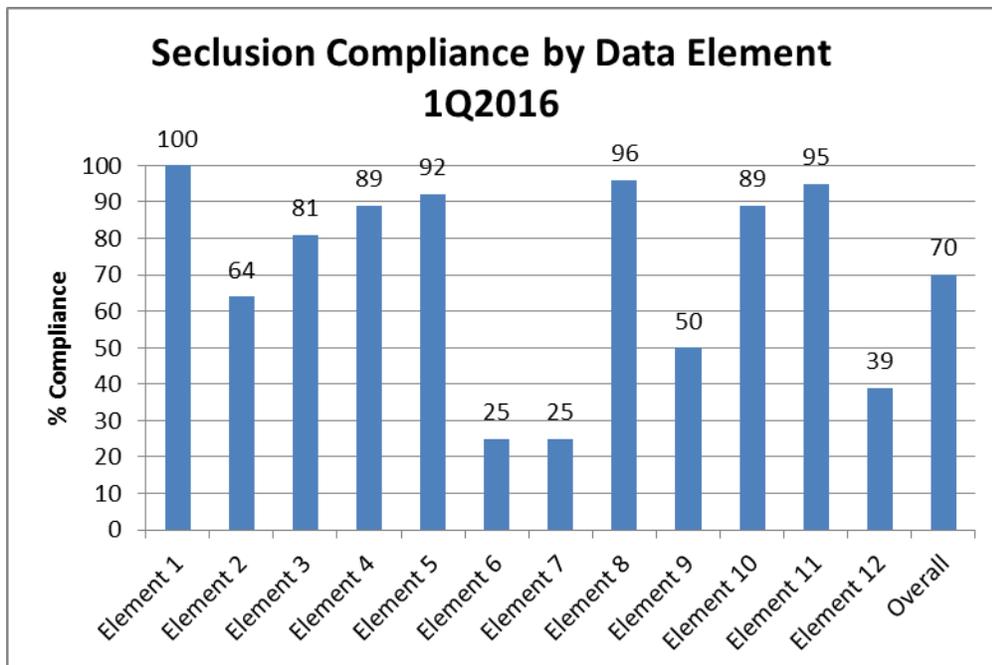
STRATEGIC PERFORMANCE EXCELLENCE

	Data Elements	Baseline	Q1 2016	Q2 2016	Q3 2016	Q4 2016	YTD
	Are details of event similar on all forms without discrepancies #408, #409, and Order sheets?	100%	89%				89%
	Is Form # 470 Nursing Assessment Protocol for Seclusion and Restraint completed?	100%	92%				92%
	On Form # 407RN 2 Hour Seclusion and Restraint Breaks 2 hour breaks are completed at appropriate intervals and signed by RN?	50%	25%				25%
	On Form #407RN 2 Hour Seclusion and Restraint Breaks is time ended for S/R completed and signed by RN	50%	25%				25%
	On Form #407 Seclusion & Restraint Monitoring and Assessment 15 minute checks are completed at appropriate intervals, with Pt's behavior documented in behavioral terms as it pertains to release criteria, times, dated, and initialed by staff?	92%	96%				96%
	On Form #407 Seclusion & Restraint Monitoring and Assessment did each staff member that initialed 15 minute checks complete last page of form with signature and title?	100%	50%				50%
	Were debriefings DB1 & DB2 completed at appropriate times?	100%	89%				89%

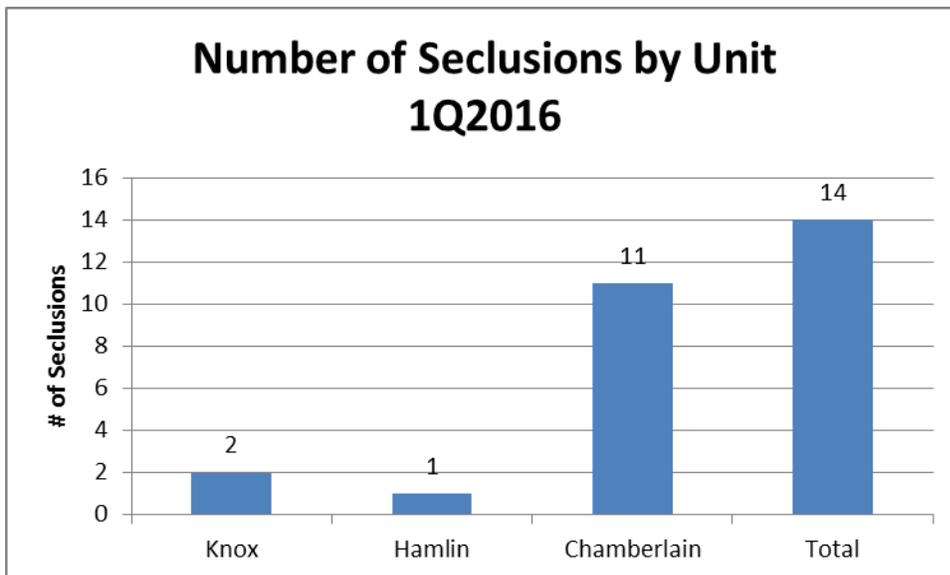
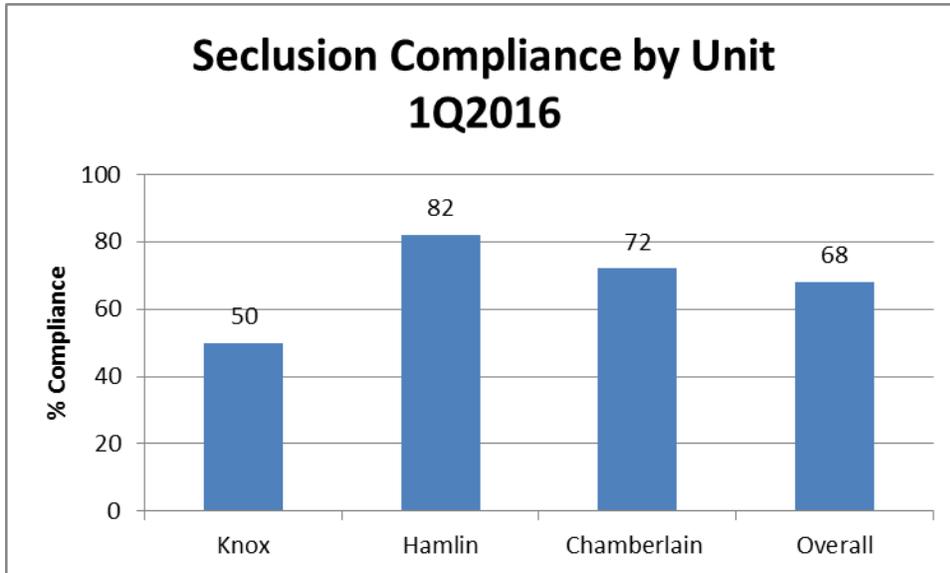
STRATEGIC PERFORMANCE EXCELLENCE

	Data Elements	Baseline	Q1 2016	Q2 2016	Q3 2016	Q4 2016	YTD
	Is patient debriefing in the chart?	100%	95%				95%
	Was legal guardian or agent made aware of time of debriefing?	N/A	N/A				N/A
	Did legal guardian or agent attend debriefing?	N/A	N/A				N/A
	Was Form # 470 TX Focused Treatment Plan Review completed within 24 hours?	17%	39%				39%
	Overall Compliance	80%	70%				70%

Data Analysis: Baseline data compiled August 2015 with updates Seclusion and Restraint procedure, forms, and audit tool since that time. One element remained the same, three increased, and the rest declined from the baseline compliance rate. The overall compliance rate decreased from baseline rate of 80% to 70%. Two elements not in computation that have yet to be implemented will be measured in the October Seclusion and Restraint audit.



STRATEGIC PERFORMANCE EXCELLENCE



Plan of Action: Nursing staff will continue to audit the documentation of patient seclusions on a monthly basis and re-evaluate quarterly and yearly. Nursing documentation will be extracted and separated from Medical Staff documentation except for two data elements, #4 “Are details of event similar on all forms without discrepancies #408, #409, and Order sheets?” and current #12 “Was Form # 470 TX Focused Treatment Plan Review completed within 24 hours?”

STRATEGIC PERFORMANCE EXCELLENCE

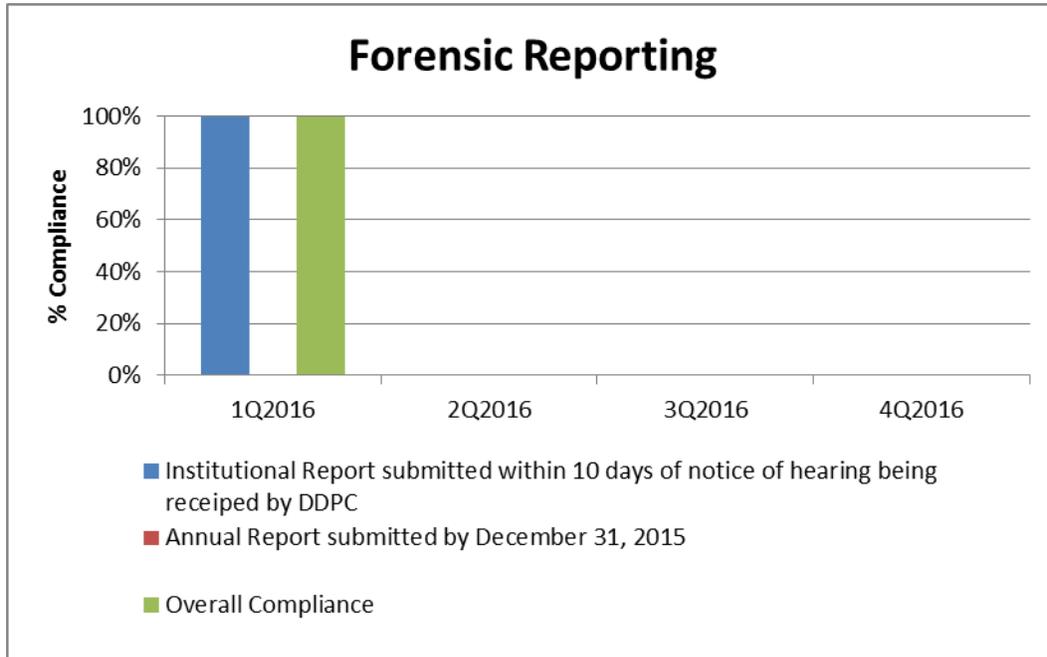
Outpatient Services

Robyn Fransen, LSW-C

- I. **Measure Name:** Timeliness of Institutional Reports and Annual Reports.
Measure Description: All annual reports are due yearly by December 31st as required by Maine Statute Title 15. Institutional reports are due within 10 days after receiving notice of a filed petition. A tardy filing of an institutional report would delay a forensic patient's evaluation and ability for increased privileges, modified release, and ultimately release and discharge from the custody of the Commissioner
Type of Measure: Performance Improvement

Results							
Target	Data elements	Baseline Q3-Q4 FY2015	1Q 2016	2Q 2016	3Q 2016	4Q 2016	YTD
100% Compliance	# of Reports	3	1				1
	Institutional Report submitted within 10 days of notice of hearing being received by DDPC?	0%	100%				100%
	Annual Report Submitted by December 31 st , 2015?	N/A	N/A				N/A
	Overall Compliance	0%	100%				100%

STRATEGIC PERFORMANCE EXCELLENCE



Data Analysis: The data element “Institutional Report Submitted within 10 days of notice of hearing being received by DDPC” have increased in compliance from the baseline data collected from 3rd and 4th Q FY 2015. The data element “Annual Report Submitted by December 31st, 2015” does not have data at this time and does not apply for 1st Q FY 2016. The overall compliance increased from 0% to 100% for 1Q2016.

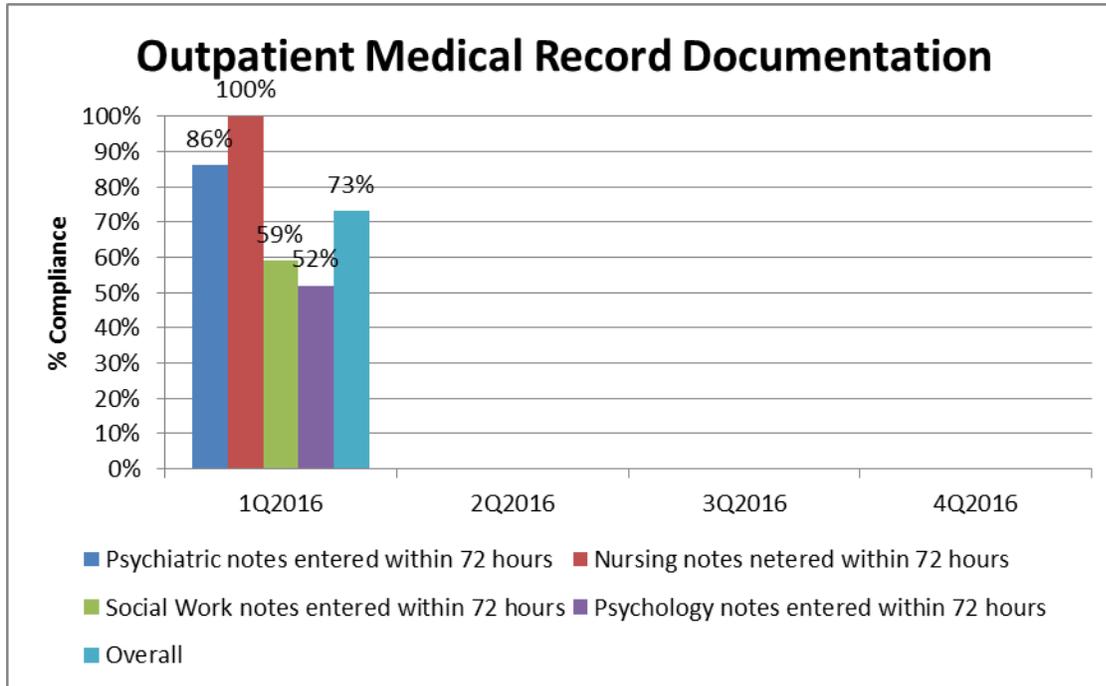
Plan of Action: The plan moving forward is continue to track and monitor the completion and submission of the Institutional and Annual Reporting using a Forensic Timeline Report which will assist in keeping staff notified of upcoming dates.

STRATEGIC PERFORMANCE EXCELLENCE

- II. Measure Name:** Timeliness of Medical Record Documentation for Outpatient Services.
Measure Description: All progress notes are promptly filed and readily available in the patient’s medical record. This information is necessary to monitor the patient’s condition and this and other necessary information must be in the patient’s medical record. In order for necessary information to be used it must be promptly filed and available in the medical record so that health care staff involved in the patient’s care can access/retrieve this information in order to monitor the patient’s condition and provide appropriate treatment and client services.
Type of Measure: Performance Improvement

Results							
Target	Data elements	Baseline June 2015	1Q 2016	2Q 2016	3Q 2016	4Q 2016	YTD
90%	# of Notes	38	225				225
	Psychiatric notes entered within 72 hours?	43%	86%				86%
	Nursing notes entered within 72 hours?	88%	100%				100%
	Social Work notes entered within 72 hours?	85%	59%				59%
	Psychology notes entered within 72 hours?	67%	52%				52%
	Overall Compliance	76%	73%				73%

STRATEGIC PERFORMANCE EXCELLENCE



Data Analysis: All data elements have increased in compliance from the baseline established in June 2015 except for the data element “Social Work notes entered within 72 hours” and “Psychology notes entered within 72 hours.” The overall compliance also decreased from 76% to 73%.

Plan of Action: The plan moving forward is to continue to audit notes on a monthly basis, remind staff of the policy for completing notes and holding monthly meetings during which documentation will be an ongoing discussion.

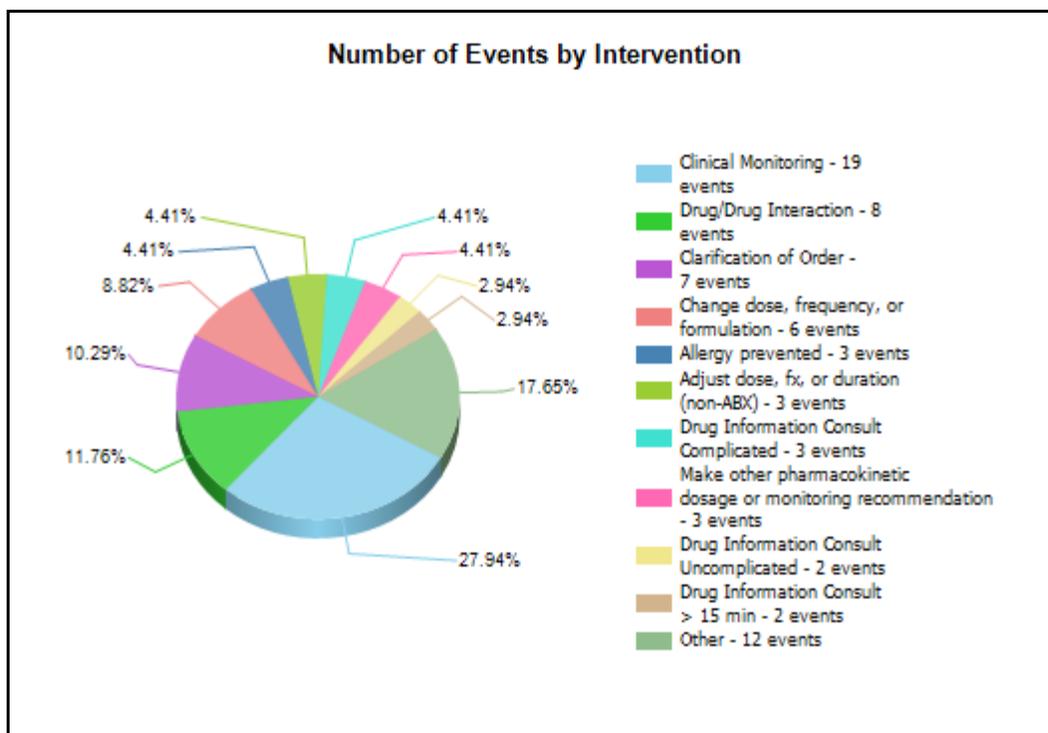
STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

Michael Migliore, RPh

- I. **Measure Name:** Medication Management Monitoring
Measure Description: Documentation of Clinical Interventions
Type of Measure: Performance Improvement

	Unit	Baseline 4Q2015	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Actual	RX	52	68				68



Data Analysis: For the 1Q2016 for DDPC there were 19 clinical monitoring events, 8 drug-drug interaction events, 7 clarifications of orders, 6 change dose, frequency or formulation, 3 events of allergies prevented, 3 events to adjust dose or duration, 3 complicated drug consults for drug information, 3 more pharmacokinetic dosage recommendations, 2 uncomplicated drug information consults and 14 other events.

Action Plan: With new admissions also put into Rx Document Solutions patient's name to be ready to easily document interventions when need be.

STRATEGIC PERFORMANCE EXCELLENCE

Comments: Fourth quarter was staffed by Cordelia Saunders for half the quarter then staffed by another new pharmacist. The interventions could have been documented more consistently.

- II. Measure Name:** Medication Management Monitoring
Measure Description: The Psychiatric Emergency Order
Type of Measure: Performance Improvement

	Process Element	No	Yes	1Q 2016	2Q 2016	3Q 2016	4Q 2016	% compliant	Reason for non- compliance
Target	Pharmacy received PE orders		1	100%	100%	100%	100%		
Actual									
Target	Did RPh need to resolve PE orders		1	0	0	0	0		
Actual									
Target	Were PE meds clearly identified when clarified		1	100%	100%	100%	100%		
Actual									
Target	Was any PE written for up to 72 hours, stopped by writing "Discontinue Emergency Meds"?			100%	100%	100%	100%		This PE was not written for 72 hours
Actual									
Target	Was a one-time PE intervention specified as an Emergency Med?		1	100%	100%	100%	100%		
Actual									
Target	Did any Emergency Med not end in 72 hours?	1		0	0	0	0		
Actual									
Target	Was PE co-signed by psychiatrist if ordered by a PA?		1	100%	100%	100%	100%		
Actual									

Data Analysis: This performance improvement got a late start in the first quarter. DDPC had more than one PE; however, due to staff changes, not all of them were collected. The one PE that we are reporting on did need some clarification. This PE was written after hours. Dr. Ryan tried to advise the night prescriber; however, pharmacy still clarified in the morning which meds were to be identified as emergency meds according to med staff policy. Dr. Ryan immediately wrote the clarification.

STRATEGIC PERFORMANCE EXCELLENCE

Action Plan: To collect all psychiatric emergency orders for the whole quarter. Dr. Burk would like to follow up with this PI. There has been some discussion regarding Riverview’s PE policy as well. DDPC may adopt some of their policy for PE’s.

Comments: We will continue to work on this.

- III. **Measure Name:** Medication Management Monitoring
Measure Description: Was Variance Reported within 15 Minutes?
Measure Type: Performance Improvement

	Units	Baseline 4Q2015	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	All	16	90%	90%	90%	90%	90%
Actual			63%				63%
Yes		12	12				12
No		4	7				7

Data Analysis: Of the 1Q2016 variances, nine of the twelve variances that were reported within 15 minutes were categorized as an event that reached the patient but caused no harm. The other 3 variances were not categorized. Three of the seven that were not reported within 15 minutes were categorized as an event that occurred, but the event did not reach the patient. The other 4 variances were not categorized.

Action Plan: The pharmacist has started writing up variances, has learned the process, and will notify the prescriber as soon as the variance is discovered.

Comments: It is encouraging that our variances have not brought patient harm. We need to be more diligent in letting our prescribers know sooner when there has been any variance of any type.

STRATEGIC PERFORMANCE EXCELLENCE

- IV. Measure Name:** Medication Management Monitoring
Measure Description: Shift the Variance occurred on
Measure Type: Performance Improvement

	Units	Baseline 4Q2015	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	All	17	0	0	0	0	0
Actual			19				19
7am-3pm		9	13				13
3-11pm		3	4				4
11pm-7am		5	2				2

Data Analysis: Most variances are taking place during the day and decreases as the day turns to evening. Staff is busier during this time.

Action Plan: Again with E-mars and CPOE starting within the next year, our variances should decrease. However, in the meantime, we will be more aware of what we are doing that causes our variances and be more proactive in decreasing them. I recommend looking at our MARS more often and having all of staff double checks.

Comments: May we learn what causes us to make variances in order to prevent them in the future.

STRATEGIC PERFORMANCE EXCELLENCE

- V. Measure Name:** Medication Management Monitoring
Measure Description: Cause of Variance
Measure Type: Performance Improvement

	Units	Baseline 4Q2015	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	All		0	0	0	0	0
Actual			19				19
Not Yellowed on MAR		(1)					
MAR print out wrong		(1)					
Not faxed		(2)	1				1
New order overlooked		(1)					
Med Overlooked		(8)	9				9
Distraction			4				4
Procedure not followed			1				1
Transcription		(5)	4				4

Data Analysis: Our most frequent cause of med variances is the med is overlooked. Distractions and transcriptions are the next common reason, followed by the order not being faxed, and the procedure not being followed.

Action Plan:

- 1) Become aware what distracts us, especially around the time medications are administered.
- 2) I recommend in our med variance reporting that we write why the med was overlooked: what is pulling us away from finishing the med administration?
- 3) Improve upon the system for faxing orders. Some charts have tabs on the binder that can be pushed to the left or right to visibly show orders have or have not been faxed and noted.
- 4) Do more follow up on new nurse orientation.

STRATEGIC PERFORMANCE EXCELLENCE

- 5) At the end of each day, nurses will check new orders from charts and compare them with MAR to confirm all new orders have been recorded in the MAR. This will still be an important step after starting eMARs.
- 6) Staff will always read labels with each administration.
- 7) If the order is not written clearly from the prescriber or on MAR, staff will call to clarify penmanship.
- 8) When reviewing orders, Pharmacists will let pharmacy techs know when an order has been stopped so the med will get pulled from the patient's individual basket in the cupboard.
- 9) Pharmacists will check they have all pages returned from the 30 day renewals.

Comments: I believe by focusing on the “why” our variances are happening, we can learn how to prevent them from happening again.

VI. Measure Name: Medication Management Monitoring

Measure Description: Type of Variance

Type of Measure: Performance Improvement

	Units	Baseline 4Q2015	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	All						
Totals		17	19				19
Wrong Dose		5	2				2
Wrong Drug			3				3
Wrong Form		1					
Frequency		2					
Omission		7	7				7
Wrong patient		1	1				1
Schedule		1	2				2
Expired Drug			1				1
Procedure not followed			3				3
Dispensing		2	8				8
Administrative		13	12				12

Methodology: Variance reports are collected and the data is collected.

STRATEGIC PERFORMANCE EXCELLENCE

Data Analysis and Action Plan: These are the various reasons for the variances listed and planned actions.

- 1) A pill was found still sitting on the counter, i.e. overlooked. Nurse must have been pulled away. Try to prevent being distracted, or remember to go back to previous job after a distraction.
- 2) MARS were dated wrong – when preparing to print Friday’s MARS for the nurses for the following week, it was noted that wrong dates were submitted. Be careful of dates.
- 3) RN in orientation missed giving 14:00 meds. This nurse called in after shift and got an order to give meds late. Meds were given at 16:25. Patient took fine, just a little late.
- 4) Discontinued/expired Nitro for a patient was not removed from the floor. RN did not see Nitro had been yellowed out on MAR. Pt. came and asked for nitro and nurse gave it. Again, check the MAR for any possible changes.
- 5) RN did not give scheduled risperidone. Recommend checking MAR to see if all scheduled meds have been administered.
- 6) Nurse noticed that Seroquel was entered as sertraline in remote pharmacy. Correct med was given.
- 7) One medication was given early. Again, be more attentive in reviewing MAR.
- 8) Benadryl order was not in Friday’s printed MAR from pharmacy. Upon review, Nurse found the order had not been faxed.
- 9) Two 30-day renewals were sent for the same person. Sometimes the first fax is incomplete. The second 30 day renewal had been checked to continue Loratadine, whereas the previous had been checked to stop Loratadine. Do not work with incomplete 30-day renewals. All meds must be filled in on the 30 day renewals before faxing.
- 10) Three mg. dose of Invega missed for 20:00. Order was written at 10:05. Order noted it was not faxed until 23:45. Missed a 20:00 dose. Need to fax orders more promptly.
- 11) Wrong Suboxone dose given on 9/21/15. Pharmacy entered order at 08:55 on 9/21/15. Order was written on Thursday the 17th, to start Suboxone 10mg SL at noon on 9/21/15. Pharmacy didn’t enter order until 9/21; therefore, was not on MAR as it should have been.
- 12) Pharmacy dispensed wrong Birth Control. Pt. was using tri-phasic, received 0.25/0.035 mg each day. Need to be more attentive to details.
- 13) Time for a med was put in for daily which shows up at 08:00 on MAR. Order should have been for 20:00. Daily at DDPC means 08:00.
- 14) Night nurse noticed 16:00 dose of Zyprexa was not signed off, nor had it been pulled from Pyxis. Staff need to pay more attention to scheduled medications, checking to confirm everything is signed off and dispensed.

Comments: EMARS and CPOE are coming. This should bring about big improvement.

STRATEGIC PERFORMANCE EXCELLENCE

VII. Measure Name: Medication Management – Controlled Substance Loss Data
Measure Description: Monthly Pyxis Controlled Drug Discrepancies
Type of Measure: Quality Assurance

	Unit	Baseline 4Q2015	1Q2016	2Q2016	3Q2016	4Q2016	YTD Average
Target	Rx	5.7/month	0	0	0	0	0
Actual			13.7/month				13.7/month

Data Analysis: There were 41 controlled substances (CS) discrepancies out of a total of 5564 controlled substances dispensed from Pyxis CII Safe for the first quarter FY2016. For the quarter, this gives us an average of 13.7 discrepancies per month. We are above our baseline from last year which is 8.5 /month.

Action Plan: Pharmacy will start regularly auditing our floor Pyxis narcotic count to which we reconcile the documentation with nursing administration.

Comments: We will work to decrease the number of our discrepancies.

VIII. Measure Name: Safety in Culture and Actions: Fiscal Accountability
Measure Description: Tracking of Dispensed Discharged Prescriptions
Type of Measure: Quality Assurance

	Unit	Baseline FY2015	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	All	\$1992 for 48 meds	0	0	0	0	0
Actual			\$713.07/ 20 meds				\$713.07/ 20 meds

Data Analysis: In July, DDPC provided 7 prescriptions to the cost of \$353.62 to one patient upon discharge. This patient had no plan in place. Also, we were informed of his discharge the day of discharge. In September we were asked to provide medicine again, as this person was now an outpatient. Our computer system was down at the time, and we later learned that the Maine Care program had not yet been turned on for this patient. At that time, we provided 5 prescriptions to the cost of \$295.90. Otherwise, our discharge prescriptions would have been held to \$63.55.

STRATEGIC PERFORMANCE EXCELLENCE

Action Plan: The medical care team will try to inform the pharmacy as soon as it is aware of a potential discharge. Better timeliness will aid the techs in preparing patients' prescriptions prior to discharge for them to obtain with their own prescription coverage.

Comments: The effort already in play by our medical staff and pharmacy tech is wonderful. Keep up the great work.

- IX. Measure Name:** Safety in Culture and Actions – Veriform Medication Room Audits
Measure Description: Monthly Comprehensive Audits of 45 Criteria
Type of Measure: Quality Assurance

	Unit	Baseline FY2015	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	All	93%	100%	100%	100%	100%	100%
Actual			85%				85%

Methodology: Pharmacy Technician prints off list of criteria from Veriform. Technician also prints off patients' profiles to check for bulk medications to confirm with criteria requirements. She then puts this data into the computer database and submits report.

Data Analysis: There were eight criteria from 3 units over a period of 3 months that fell short.

Action Plan: Communicate with Nursing where we are not meeting the standards for these criteria.

Comments: Our goal is to continue striving for excellent and achieve 100% consistently for 4 months.

- X. Measure Name:** Medication Management – Non Controlled Pyxis Discrepancies
Measure Description: Monthly Monitoring and Pyxis Non-Controlled Discrepancies
Type of Measure: Quality Assurance

	Unit	Baseline 4Q2015	1Q2016	2Q2016	3Q2016	4Q2016	YTD Average
Target	All	8.9/month 0.067%	0	0	0	0	0
Actual			10.1/month 0.071%				10.1/ month

STRATEGIC PERFORMANCE EXCELLENCE

Data Analysis: Knowledge Portal showed an average of 30.3 non-controlled discrepancies for the 1st quarter of FY2016. This is out of 42,218 doses dispensed from the Pyxis MedStation System.

Action Plan: We are going to start documenting our discrepancies, in order to learn how to reduce them.

Comments: Our number is up slightly from the average for FY2015. Hopefully we can bring this down and improve upon FY2015.

STRATEGIC PERFORMANCE EXCELLENCE

Social Services

Robyn Fransen, LSW-C

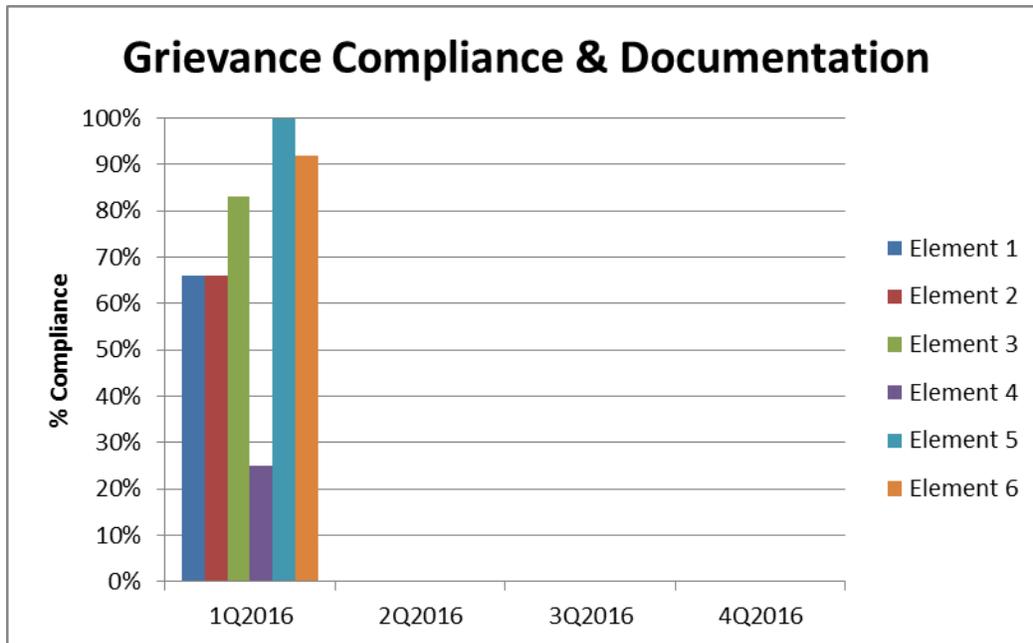
Measure Name: Grievance Compliance and Documentation.

Measure Description: Addressing grievances in a timely manner allows potential rights violations to be resolved quickly therefore allowing patients and staff to continue to focus on treatment. A Nurse Supervisor must speak with the patient within four hours of notification of the grievance. Social Services must deliver a response to the patient within five days, with five days more if the grievant is notified, and with agreement of the Patient Advocate.

Measure Type: Performance Improvement

Results							
Target	Data elements	Baseline 3 rd -4 th Q FY 2015	1Q 2016	2Q 2016	3Q 2016	4Q 2016	YTD
100%	# of Events	47	12				12
	Unit Staff compliant with addressing grievance?		66%				66%
	Unit Staff completed form correctly (boxes checked, dated/timed, all signatures completed, Nurse Supervisor notified)?		66%				66%
	Nursing Supervisor compliant with addressing grievance within 4 hours?		83%				83%
	Nurse Supervisor completed form correctly (boxes checked, dated/timed, all signatures completed, forwarded to Social Worker)?		25%				25%
	Social Worker compliant with addressing grievance within 5 days or within 5 more days if extension is requested?		100%				100%
	Overall Compliance of Nursing Supervisor and Social Worker addressing grievance	64%	92%				92%

STRATEGIC PERFORMANCE EXCELLENCE



- Element 1: Unit Staff compliant with addressing grievance
- Element 2: Unit Staff completed form correctly and notified Nurse Supervisor
- Element 3: Nurse Supervisor addressed grievance within 4 hours
- Element 4: Nurse Supervisor completed form correctly and forwarded to Social Worker
- Element 5: Social Worker addressed grievance within 5 days or more than 5 days if extension is requested
- **Element 6: Overall Compliance of Nursing Supervisor and Social Worker Addressing Grievance**

Data Analysis: The data elements of “Nurse Supervisor compliant with addressing grievance within 4 hours” and “Social Worker compliant with addressing grievances within 5 days or within 5 more days if extension is requested” have increased in compliance from the baseline of 3rd & 4th Q FY 2015. Starting with the 1st Q FY 2016 data, further breakdown of correct completion of the grievance form by all staff will be tracked as well.

Plan of Action: The plan moving forward is to review all data elements listed to further understand where there is any non-compliance with addressing or completing grievance forms so that changes can be made to the form and/or process in order to increase the overall compliance with addressing grievances in a timeframe that meets the requirements of the Rights of Recipients of Mental Health Services.

STRATEGIC PERFORMANCE EXCELLENCE

Staff Education and Development

Jenny Bamford-Perkins, MSN, RN

I. Measure Name: MANDT Training

Measure Description: Both direct and non-direct care employees of Dorothea Dix Psychiatric Center (DDPC) are trained annually and at new employee orientation in the use of MANDT techniques in accordance with staff education policies. The MANDT system stresses the use of verbal and other non-physical de-escalation techniques. (Wale, Belkin, & Moon, 2011). The purpose of this indicator is to track the compliance of all DDPC staff members in their completion of MANDT certification and re-certification courses. The Staff Education Department (SED) will conduct quarterly audits of employee MANDT certification status using the education database.

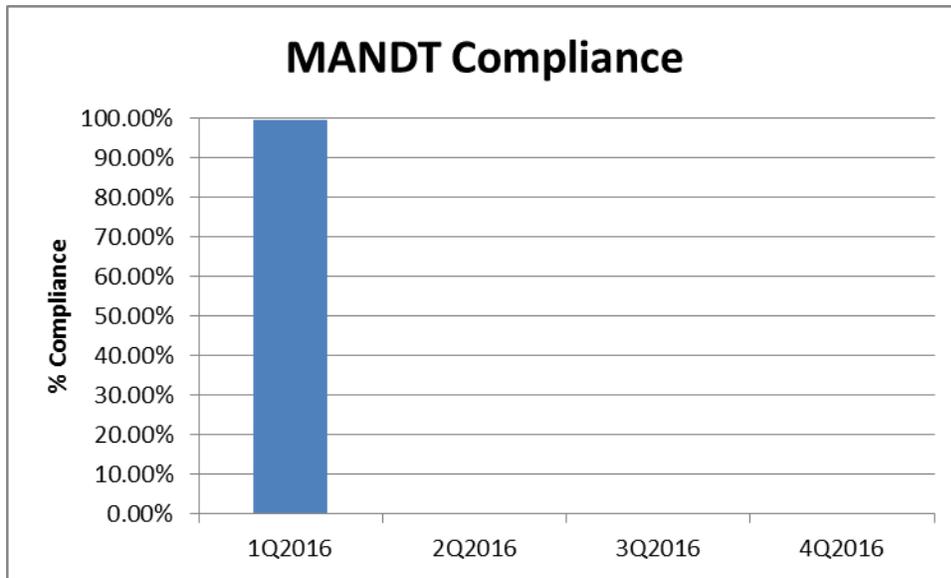
Type of Measure: Performance Improvement

		Results					
	Unit	Baseline	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	Number of employees (213)	91% 4Q2015	100%	100%	100%	100%	100%
Actual			99.5% 212/213				99.5% 212/213

Data Analysis: Overall analysis of the data reveals a 99.5% MANDT compliance rate when direct care and non-direct care are combined. The data reveals a deficiency of 0.5%. This reflects one non-direct care staff member from facilities who was unable to attend the July 2015 class due to department needs, as his co-workers were scheduled for a vacation requiring him to be in his department that day. August 2015 this employee could not attend as his co-worker was scheduled for a class that day. September 2015 this employee could not attend as his co-worker was scheduled for a class that day. It is the goal of SED for 100% MANDT training amongst both direct and non-direct care staff.

Action Plan: The employee out of compliance is scheduled to attend October 2015 SRST training. Staff education will complete monthly audits and collaborate to ensure all staff meet the MANDT requirement or, if they qualify, the Safety Response Skills Training (SRST) version, which includes MANDT relational and defensive skills. Staff education will send monthly reports to department heads and the Superintendent of employees out of compliance and continue to schedule MANDT and SRST classes.

STRATEGIC PERFORMANCE EXCELLENCE



II. Measure Name: CPR Training

Measure Description: All employees of Dorothea Dix Psychiatric Center (DDPC) are trained every two years and at new employee orientation to be CPR certified in accordance with staff education policy. The use of CPR in cardiac emergencies has been shown to positively impact patient survival rates (Sasson, Rogers, Dahl, & Kellermann, 2010). DDPC employees need to be trained in CPR so that they may be able to effectively respond to life-threatening cardiac events. The purpose of this indicator is to track the status of all DDPC employees in CPR certification compliance to ensure that DDPC patients can receive quality care from fully-trained professionals.

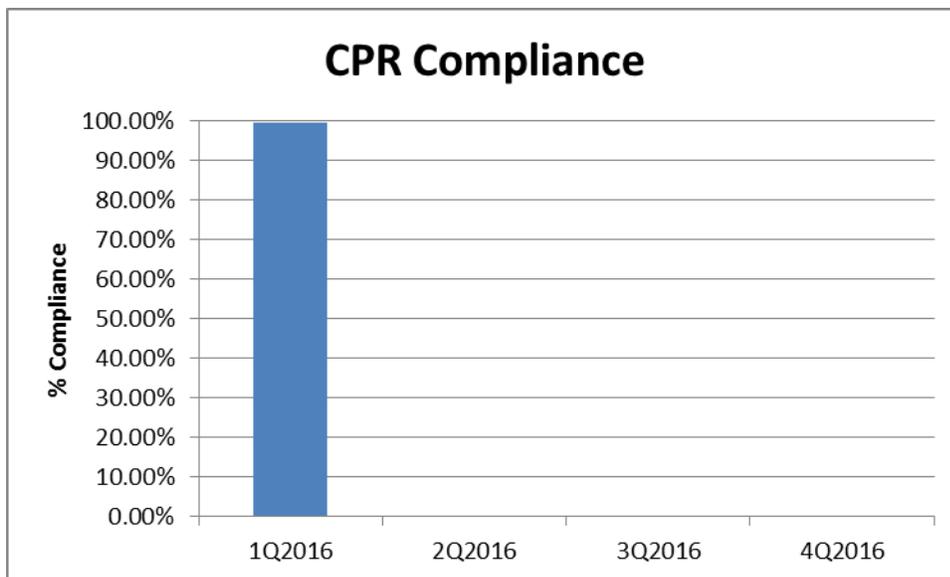
Measure Type: Performance Improvement

Results							
	Unit	Baseline	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	Number of Employees (225)	99% FY2015	100%	100%	100%	100%	100%
Actual			99.6% 224/225				99.6% 224/225

STRATEGIC PERFORMANCE EXCELLENCE

Data Analysis: Overall analysis of the data reveals 99.6% CPR compliance rate when direct care and non-direct care are combined. Direct care staff continues to remain at 100% compliance. The data reveals a deficiency of 0.4%. This reflects one non-direct care staff member from facilities who was unable to attend the September 2015 class due to illness. It is the goal of SED for 100% CPR training amongst both direct and non-direct care staff

Action Plan: The employee out of compliance is scheduled to attend October 2015 CPR training. Staff education will complete monthly audits. Staff education will send monthly reports to department heads and Superintendent of employees out of compliance and continue to schedule CPR classes. Staff education will increase the number of instructors in the hospital to make classes more available. The goal is for staff education to have two additional instructors certified by December 2015, doubling the numbers of instructors in the hospital. SED RN's are in the process of receiving their instructor training. One is scheduled to complete this in November 2015 and the other will complete by December 2015.



STRATEGIC PERFORMANCE EXCELLENCE

III. **Measure Name:** First Aid Training

Measure Description: All employees of Dorothea Dix Psychiatric Center (DDPC) are trained every two years and at new employee orientation to be First Aid certified in accordance with regulatory requirements. The American Heart Association defines first aid as, “the immediate care that you give someone with an illness or injury before someone with more advanced training arrives and takes over, which can mean the difference between life and death.” (2011, p. 3). The purpose of this indicator is to track the status of all DDPC employees in First Aid certification compliance to ensure that DDPC patients can receive quality care from fully-trained professionals.

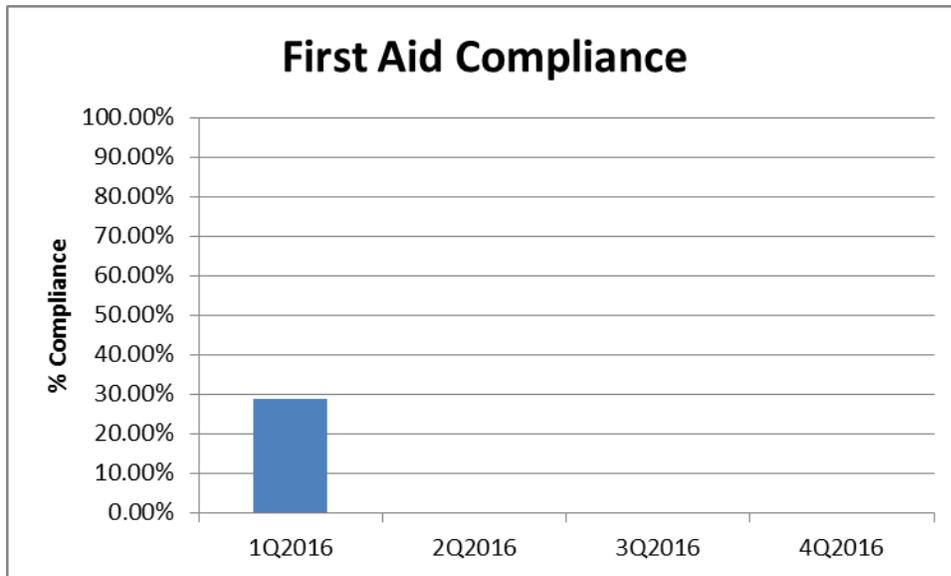
Type of Measure: Performance Improvement

		Results					
	Unit	Baseline	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	Number of Employees	20% 4Q2015	0%	30%	60%	90%	90%
Actual			29% 64/221				29% 64/221

Data Analysis: Overall analysis of the data reveals 29% First Aid compliance rate amongst both direct care staff and non-direct care staff. Goal for Q1 is 0% as this is a new requirement for 2015. It is the ultimate goal of SED for 100% of staff to be certified by July 2016. Staff education will continue to strive for this goal.

Action Plan: Staff education will complete monthly audits. Staff education will collaborate with department heads to increase the number of staff that are First Aid certified by 10% per month. Staff education will increase the number of instructors in the hospital to make classes more available. The goal is for staff education to have two additional instructors certified by December 2015, doubling the numbers of instructors in the hospital, with the ultimate goal of 100% compliance on July 31, 2016.

STRATEGIC PERFORMANCE EXCELLENCE



IV. Measure Name: New Employee Orientation

Measure Description: New employees will complete new employee orientation within 60 days of hire in accordance with staff education policy. Process includes new employee audits to ensure they have met all requirements.

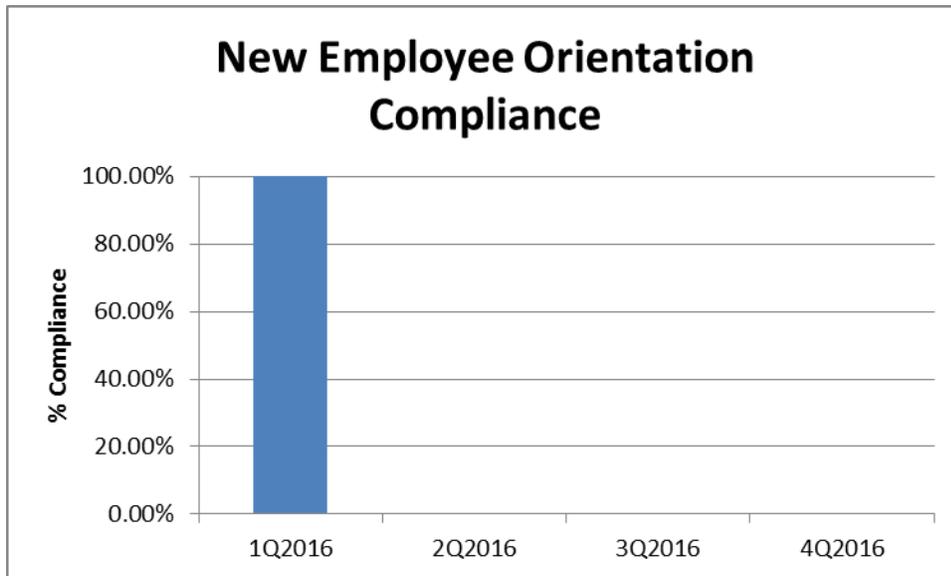
Type of Measure: Quality Assurance

		Results					
	Unit	Baseline	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	Number of Employees	100% 4Q2015	100%	100%	100%	100%	100%
Actual			100% 13/13				100% 13/13

Data Analysis: Overall analysis of the data reveals 100% New Employee Orientation compliance rate amongst both direct care staff and non-direct care staff. It is the goal of SED for 100% of staff to be compliant. Staff education will continue to strive for this goal.

Action Plan: Staff education will complete monthly audits and collaborate to ensure all staff meet the New Employee Orientation requirement. Staff education will send monthly reports to department heads and Superintendent of employees out of compliance and continue to follow-up with the employee and their direct supervisor on this requirement.

STRATEGIC PERFORMANCE EXCELLENCE



V. Measure Name: Impaired Licensed Practitioner

Measure Description: All employees will complete this initial requirement and new employees will complete during orientation. Staff are provided with DDPC policy MS-13 and sign memo regarding this policy and Joint Commission Medical Staff Standard MS.11.01.01. This is documented as course ID: ILP in the employee’s SED database. Process includes an audit of Impaired Licensed Practitioner from the SED database to ensure employees have met this requirement.

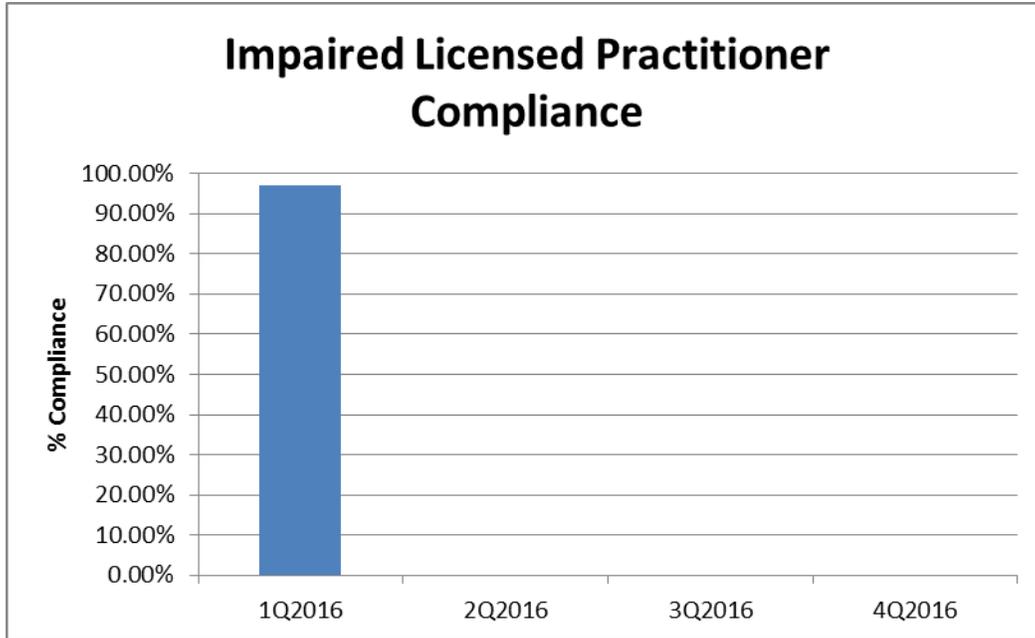
Type of Measure: Quality Assurance

Results							
	Unit	Baseline	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	Number of employees	97% 4Q2015	100%	100%	100%	100%	100%
Actual			97% 217/224				97% 217/217

Data Analysis: Overall analysis of the data reveals 97% compliance rate. The data reveals a deficiency of 3%. This reflects seven staff member, two whom are per diem employees. The same seven persons were deficient in July, August and September 2015. This requirement has been included in new employee orientation. It is the goal of SED for 100% compliance. Staff education will continue to strive for this goal.

STRATEGIC PERFORMANCE EXCELLENCE

Action Plan: The employees out of compliance will be provided via email with a copy of the documentation and memo with a notice to return the signed memo to SED. A copy of this will be cc'd to their direct supervisor. Staff education will complete monthly audits and collaborate to ensure all staff meet this requirement.



VI. Measure Name: Pain

Measure Description: All RN's and medical providers will complete this annual requirement and new employees who are RN's and/or medical providers will complete this during orientation. Staff are provided with this earning packet from the SED department and required to review the material and complete a quiz with an 80% pass rate. This is documented as course ID: PAIN in the employee's SED database. Process includes an audit of PAIN from the SED database to ensure employees have met this requirement.

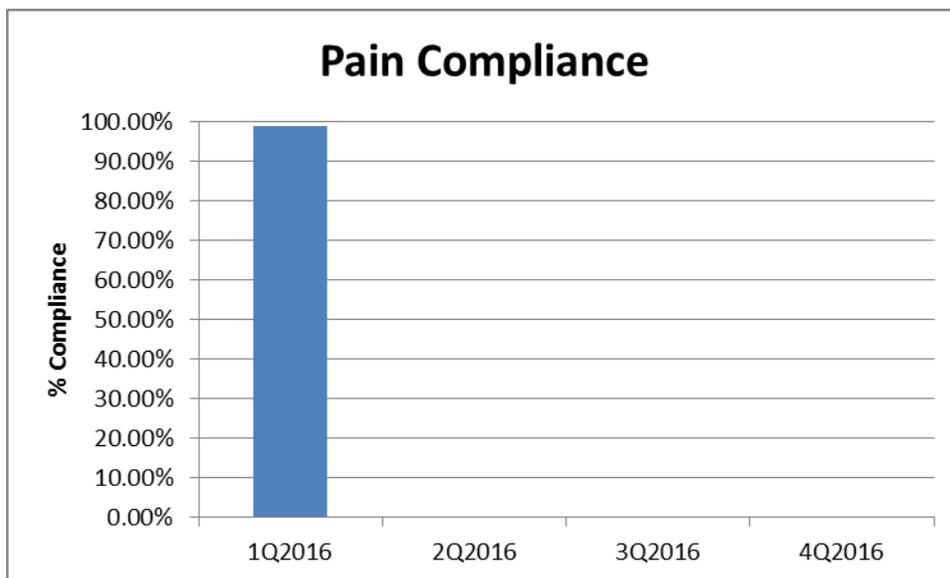
Type of Measure: Quality Assurance

		Results					
	Unit	Baseline	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	Number of Employees	94% 4Q2015	100%	100%	100%	100%	100%
Actual			99% 78/79				99% 78/79

STRATEGIC PERFORMANCE EXCELLENCE

Data Analysis: Overall analysis of the data reveals 99% compliance rate amongst RN's and medical provider staff. The data reveals a deficiency of 1%. This reflects four RN's, one whom is a per diem employee. The same four persons were deficient in July, August and September 2015. It is the goal of SED for 100% of staff to be compliant. Staff education will continue to strive for this goal.

Action Plan: The employees out of compliance will be provided via email with a copy of the LP required along with a notice to return completed item to SED. A copy of this will be cc'd to their direct supervisor. Staff education will complete monthly audits and collaborate to ensure staff meet the PAIN requirement.



STRATEGIC PERFORMANCE EXCELLENCE

Therapeutic Services

Lisa J. Hall, OTR/L

I. Measure Name: Direct Patient Contact

Measure Description: Improving health outcomes/patient care. In order to receive effective treatment that will allow patients to return to a satisfying and meaningful life in their chosen community; staff must provide engagement, assessment and treatment that is targeted to meet their individual needs. The first step of this performance improvement is increasing weekly direct contact with patients.

Type of Measure: Performance Improvement

Comments: Once the overall goal of 70% direct patient contact is met for 4 consecutive months, the next phase of this performance improvement initiative will be implemented. *(Please see revised goal effective October, 2015)*

A. Department Overall By Month:

Baseline 3/28/15	April 2015	May 2015	June 2015	July 2015	August 2015	September 2015
44%	47%	43%	40%	42%	43%	44%

B. Measure Name: Direct Patient Contact - Occupational Therapy

Results							
	Unit	Baseline	4Q2015	1Q2016	2Q2016	3Q2016	YTD
Target	Percent of time spent in direct patient contact.	36% March 2015	55%	65%	50%	50%	
Actual			46%	46%			46%

Provider Range: 39%-55%

STRATEGIC PERFORMANCE EXCELLENCE

C. Measure Name: Direct Patient Contact - Therapeutic Recreation

Results							
	Unit	Baseline	4Q2015	1Q2016	2Q2016	3Q2016	YTD
Target	Percent of time spent in direct patient contact.	55% March 2015	55%	65%	50%	50%	
Actual			52%	52%			52%

RT Range: 31%-65%

Hab. Aide Range: 46%-70%

D. Measure Name: Direct Patient Contact - Clinical Services

Results							
	Unit	Baseline	4Q2015	1Q2016	2Q2016	3Q2016	YTD
Target	Percent of time spent in direct patient contact.	35% March 2015	55%	65%	40%	50%	
Actual			32%	33%			33%

Provider range: 24%-50%

E. Measure Name: Direct Patient Contact- Ancillary Services (Dietician, Chaplain)

Results							
	Unit	Baseline	4Q2015	1Q2016	2Q2016	3Q2016	YTD
Target	Percent of time spent in direct patient contact.	31% March 2015	55%	65%	40%	50%	
Actual			30%	28%			29%

Provider range: 19%-36%

Data Analysis: October 2015- Specific providers have shown growth consistently, however overall there has been no significant change. Given the amount of missing data for several members, the validity of the data must be questioned. Data must be analyzed more timely and addressed individually for meaningful change.

STRATEGIC PERFORMANCE EXCELLENCE

Action Plan:

- Attempting to hire an Office Specialist who can assist in timely data aggregation and in depth analysis.
- Ongoing discussion to promote a culture change to understand, respect and value the role of non-pharmacological treatment in overall service delivery.

PI plan revision and rationale: Given the increased expectation to provide documentation per occurrence on all services and the clarified expectation to prepare for each individual patient prior to engaging in treatment, a lower direct care standard is reasonable.

Revised Goal - October 2015: Expectation for each discipline/department to reach and maintain 50% direct care productivity standard.

II. Measure Name: Timely Initial Assessment

Measure Description: In order to receive effective treatment that will allow patients to return to a satisfying and meaningful life in their chosen community; staff must provide engagement, assessment and treatment that is targeted to meet their individual needs. The formal beginning to a treatment relationship begins with an assessment of strengths and needs to guide the treatment plan. At DDPC the initial treatment plan is held within 7 days of admission, staff is expected to come prepared to share their area of expertise and propose what treatment offerings they will make available to the patient.

Measure Type: Quality Assurance

		Results					
	Unit	Baseline	4Q2015	1Q2016	2Q2016	3Q2016	YTD
Target	Percent of Initial OT and Rec Assessments in the record within 7 days of admission.	96% FY2015 Q1, Q2, & Q3	90%	90%	90%	90%	90%
Actual			N/A	97%			97%

Data Analysis: Staff achieved 100% compliance for Jan-March 2015, 97% July-September 2015.

Action Plan: Stop the measure

STRATEGIC PERFORMANCE EXCELLENCE

Utilization Review

Leanne McLean, RN

