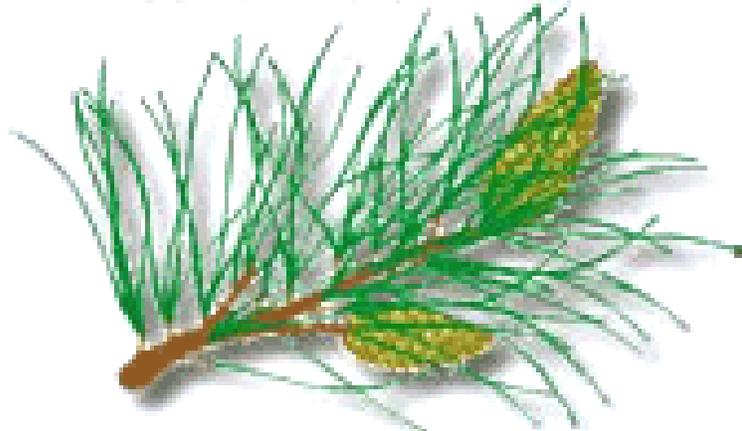


Dorothea Dix



Psychiatric Center

**QUARTERLY REPORT ON
ORGANIZATIONAL PERFORMANCE EXCELLENCE**

SECOND STATE FISCAL QUARTER 2016
October, November, December 2015

Sharon Sprague
Superintendent
February 12, 2016



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Introduction

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



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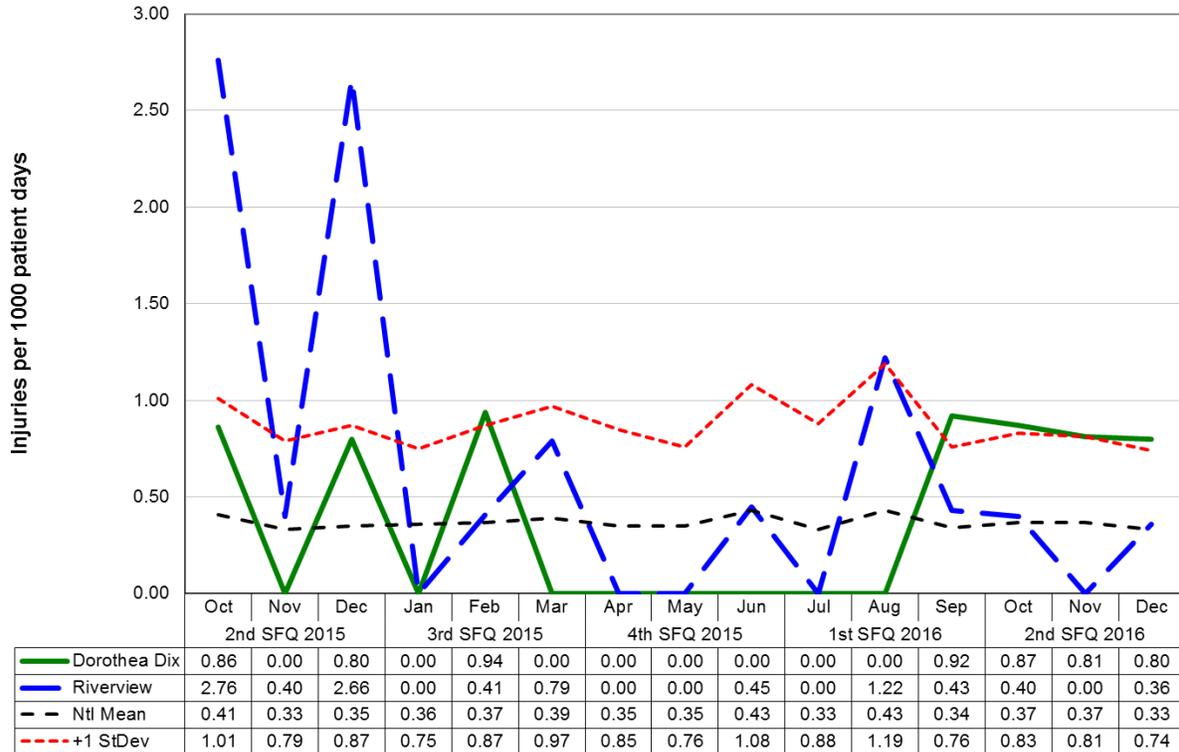
COMPARATIVE STATISTICS

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

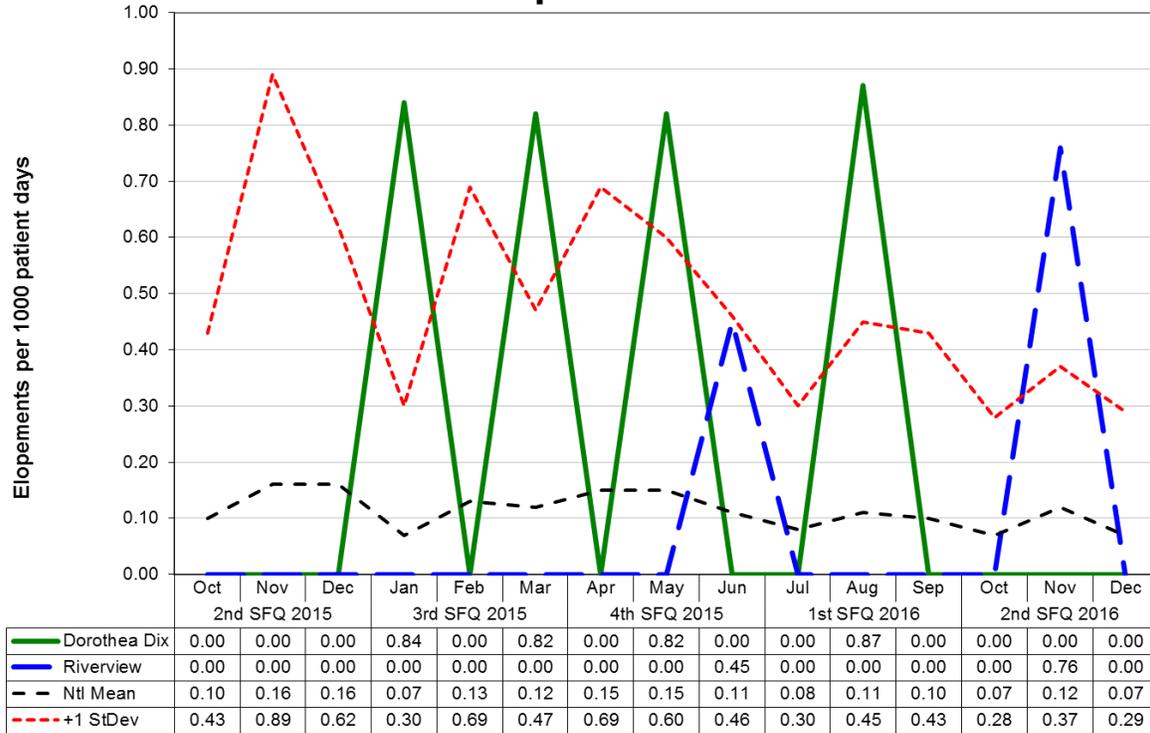
Type - Cause	OCT	NOV	DEC	2Q2016
Accident – Fall	4	5	1	10
Accident – Other	2	2	3	7
Assault – Patient to Patient		1	2	3
Injury – Other		2	3	5
Self-Injurious Behavior	2		2	4
Total	8	10	11	29

Severity of Injury by Month

Severity	OCT	NOV	DEC	2Q2016
No Treatment	2	5	3	10
Minor First Aid	5	4	8	17
Medical Intervention Required	1	1		2
Hospitalization Required				
Death Occurred				
Total	8	10	11	29

COMPARATIVE STATISTICS

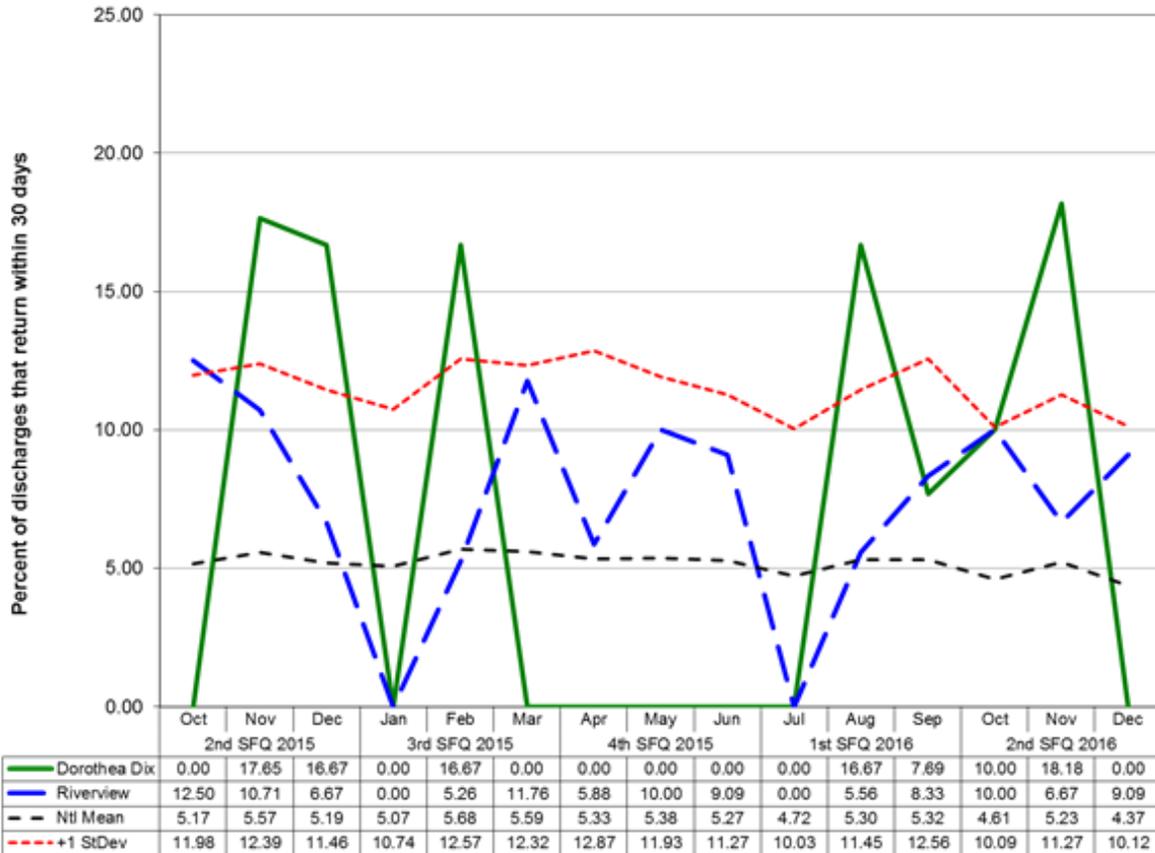
Elopement



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

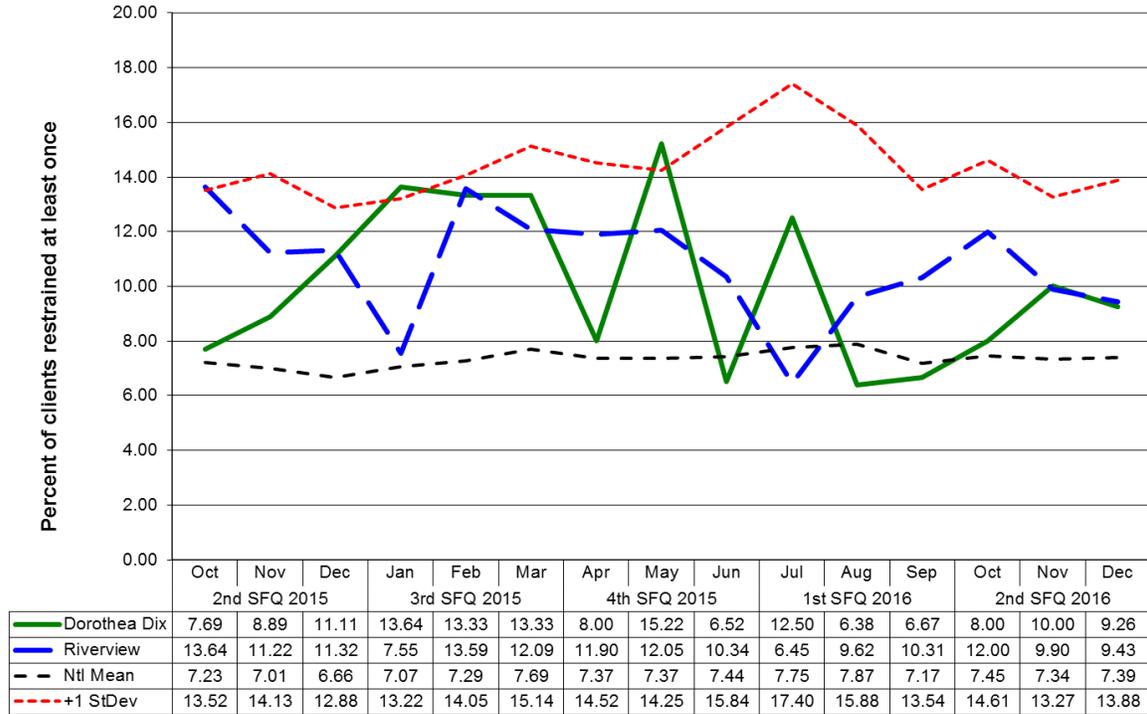


Percent of discharges from the facility that returned within 30 days of a discharge of the same patient from the same facility. For example, a rate of 10.0 means that 10% of all discharges were readmitted within 30 days.

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

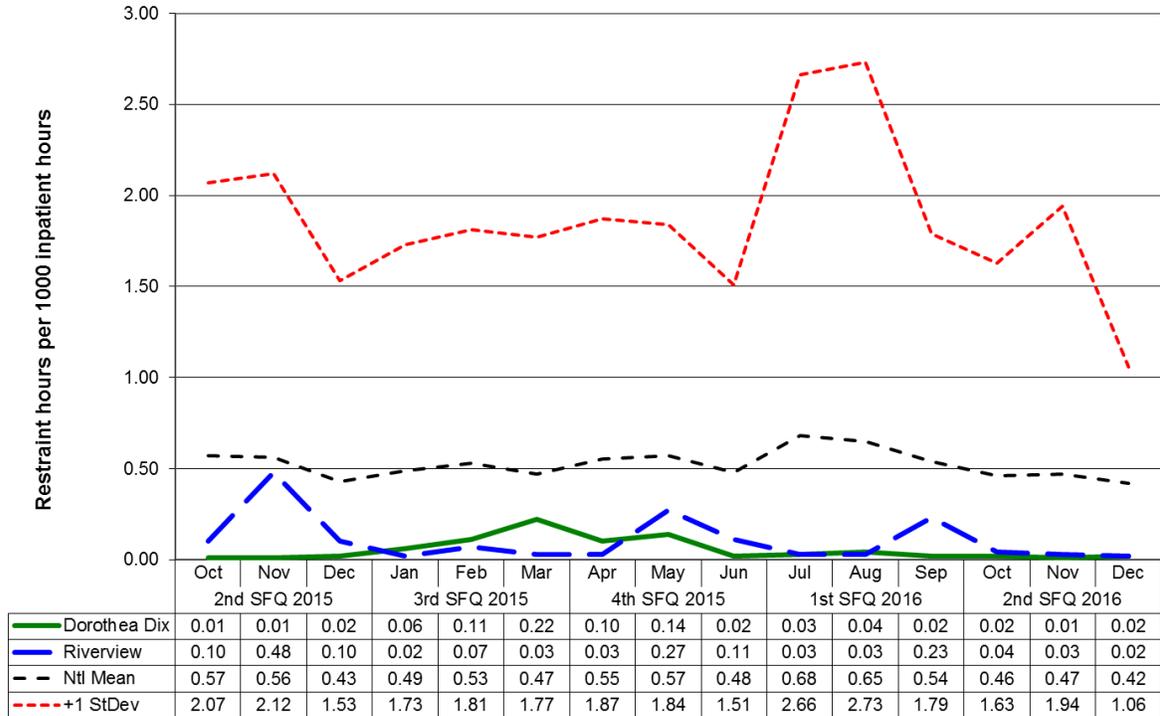
Percent of Clients Restrained



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

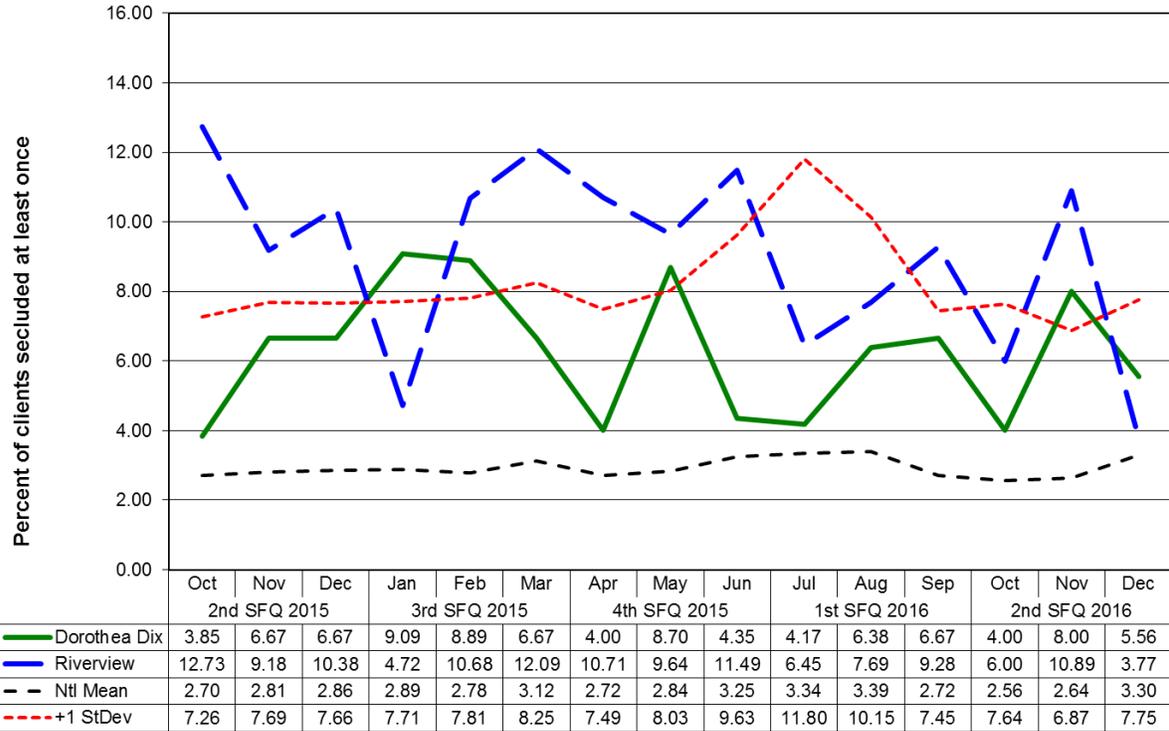
Restraint Hours



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

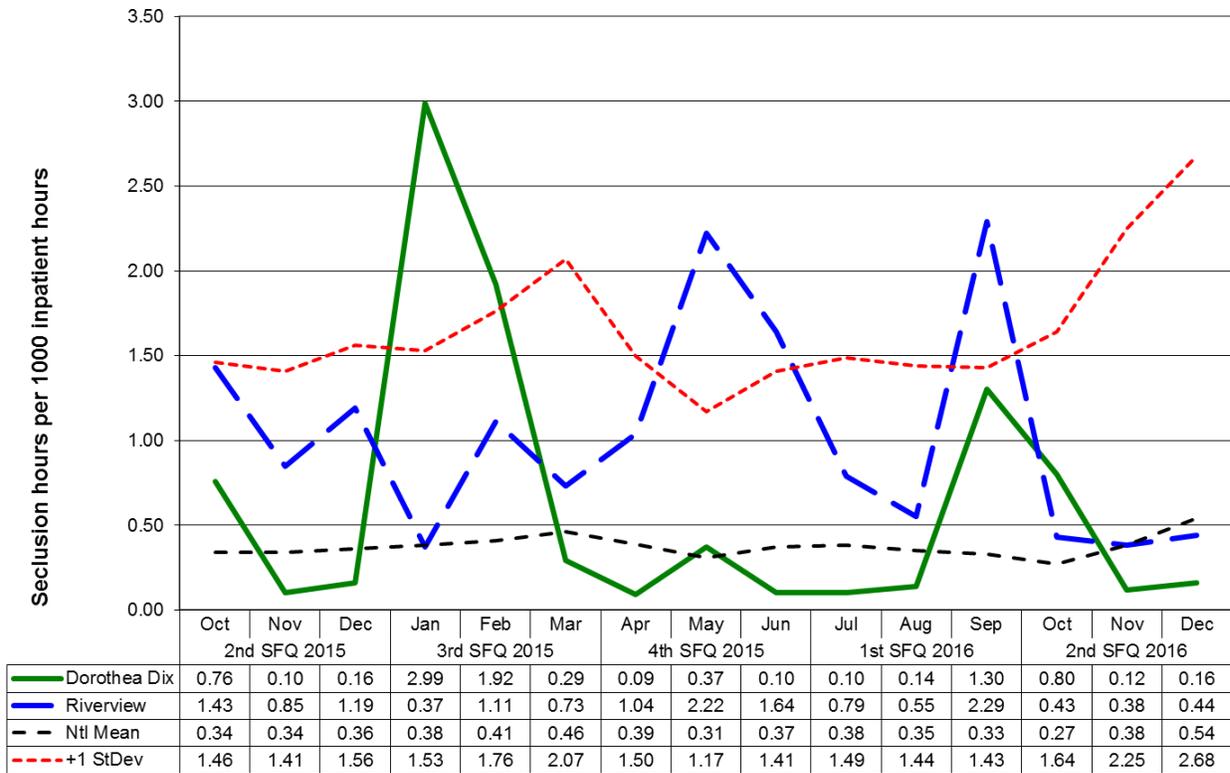
Percent of Clients Secluded



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.

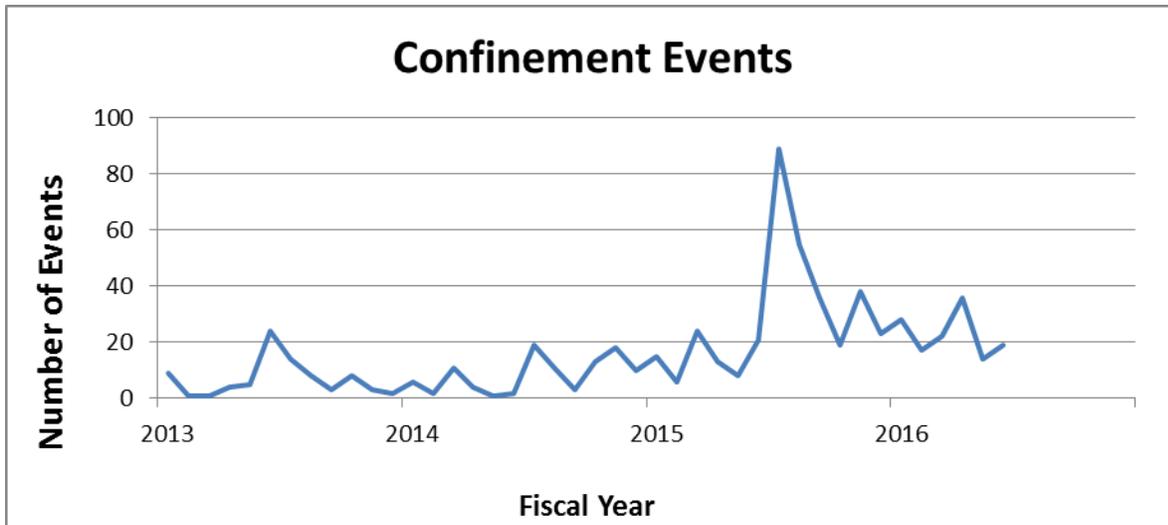
COMPARATIVE STATISTICS

Confinement Event Breakdown

	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
MD2020	22		18	40	57.97%	58.00%
MD1889	8		2	10	14.49%	72.49%
MD1305	4		2	6	8.70%	81.19%
MD1708	3			3	4.35%	85.54%
MD1983	1		1	2	2.90%	88.43%
MD2032	2			2	2.90%	91.33%
MD902	1		1	2	2.90%	94.23%
MD2018	1		1	2	2.90%	97.13%
MD103	1			1	1.44%	98.57%
MD797	1			1	1.43%	100.00%
	44	0	25	69		

Unit	Manual Hold	Locked Seclusion
Chamberlain	29	20
Hamlin	7	3
Knox	8	2

Event	Oct	Nov	Dec
Manual Hold	20	10	14
Locked Seclusion	16	4	5



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

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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.

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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.

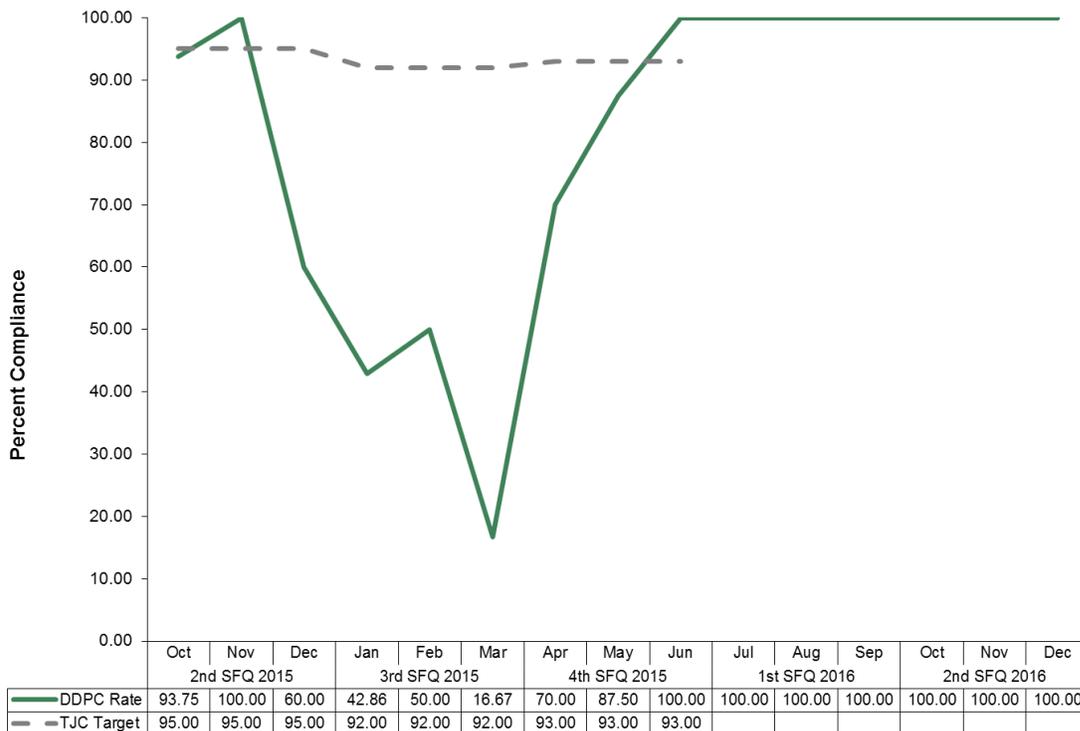
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Admissions Screening (HBIPS 1)

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

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

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



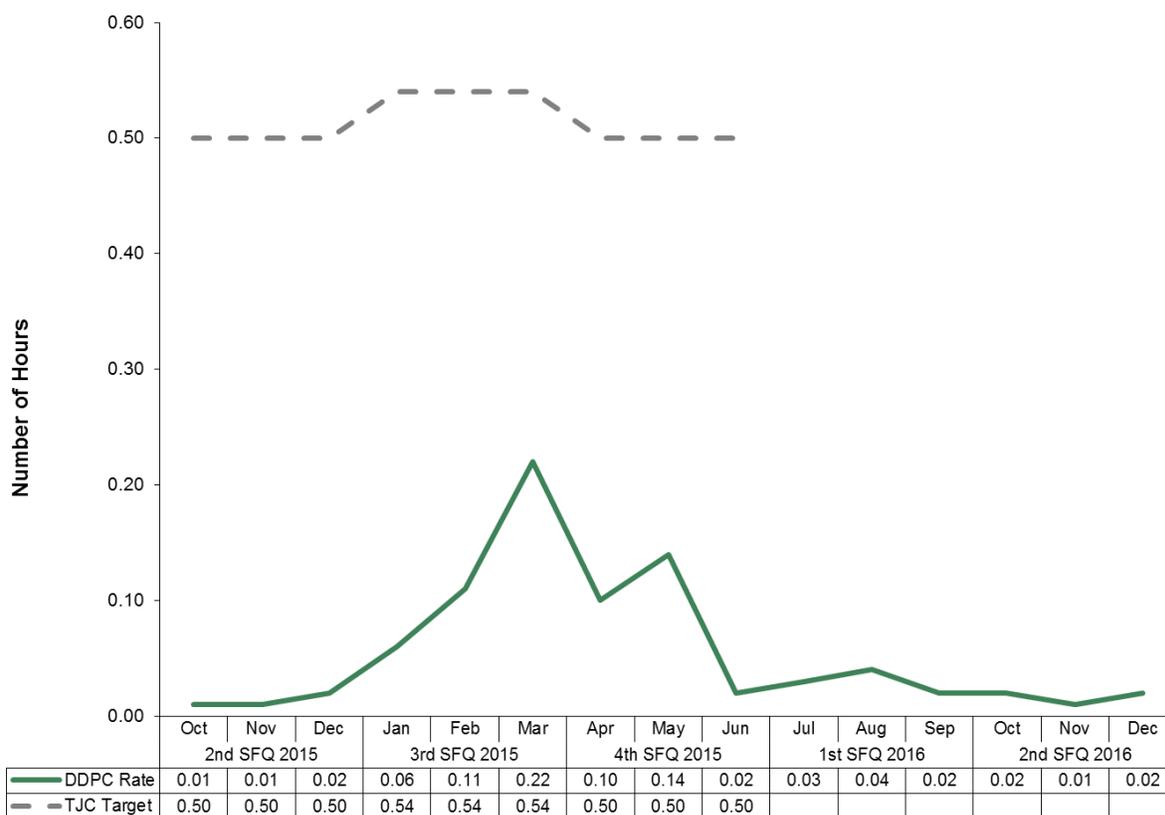
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Physical Restraint (HBIPS 2)

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).



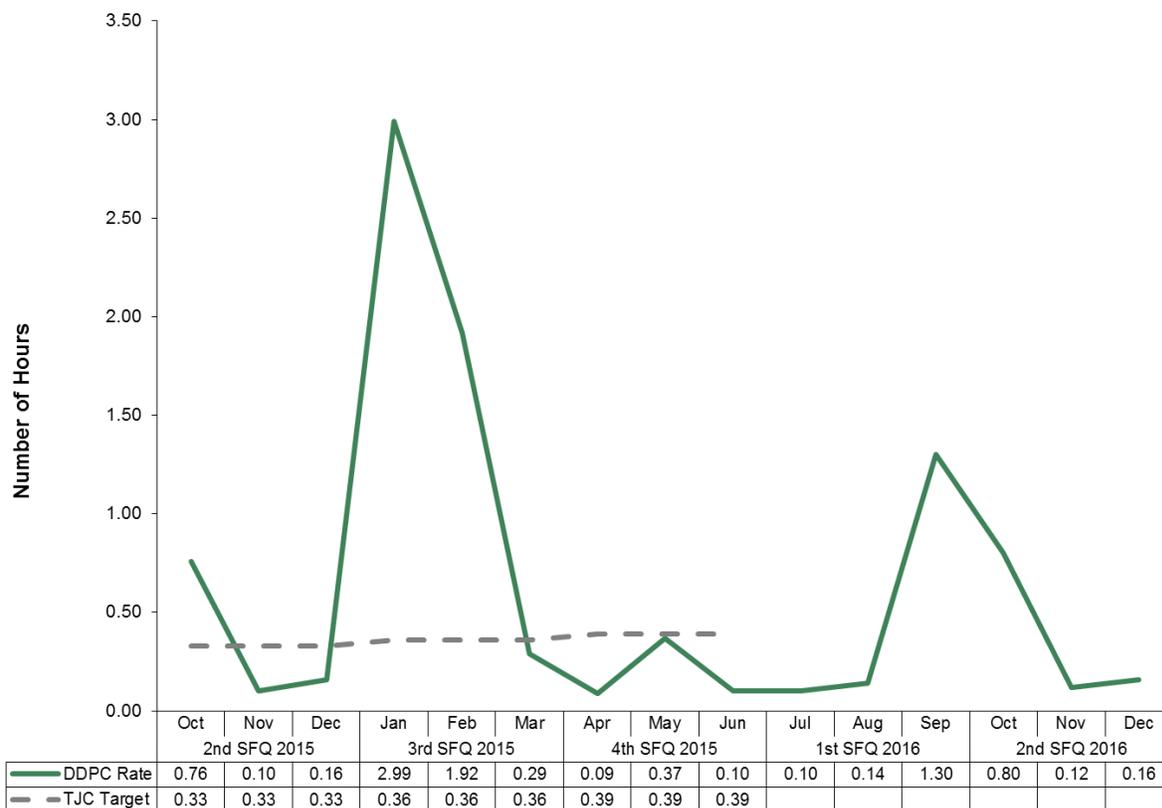
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Seclusion (HBIPS 3)

Hours of Use

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

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



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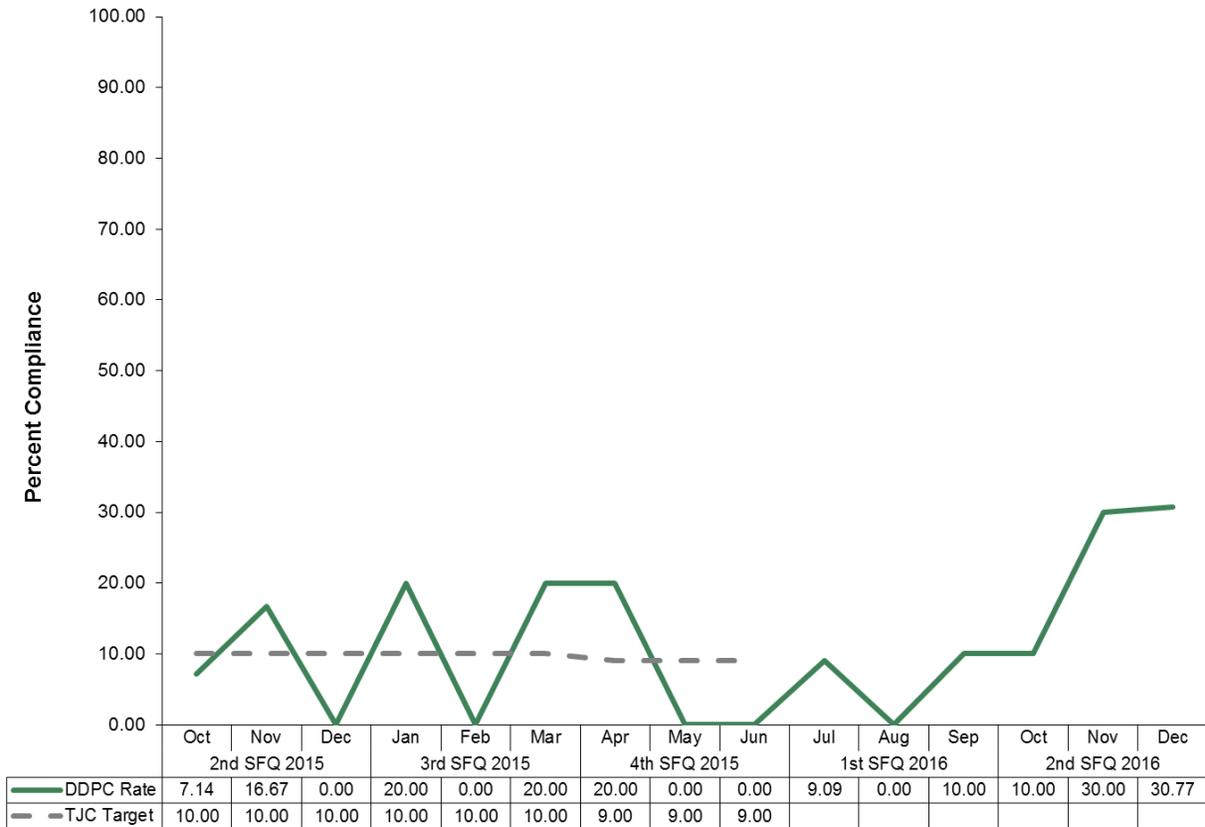
Multiple Antipsychotic Medications on Discharge (HBIPS 4)

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.

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Multiple Antipsychotic Medications on Discharge (HBIPS 4)



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Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)

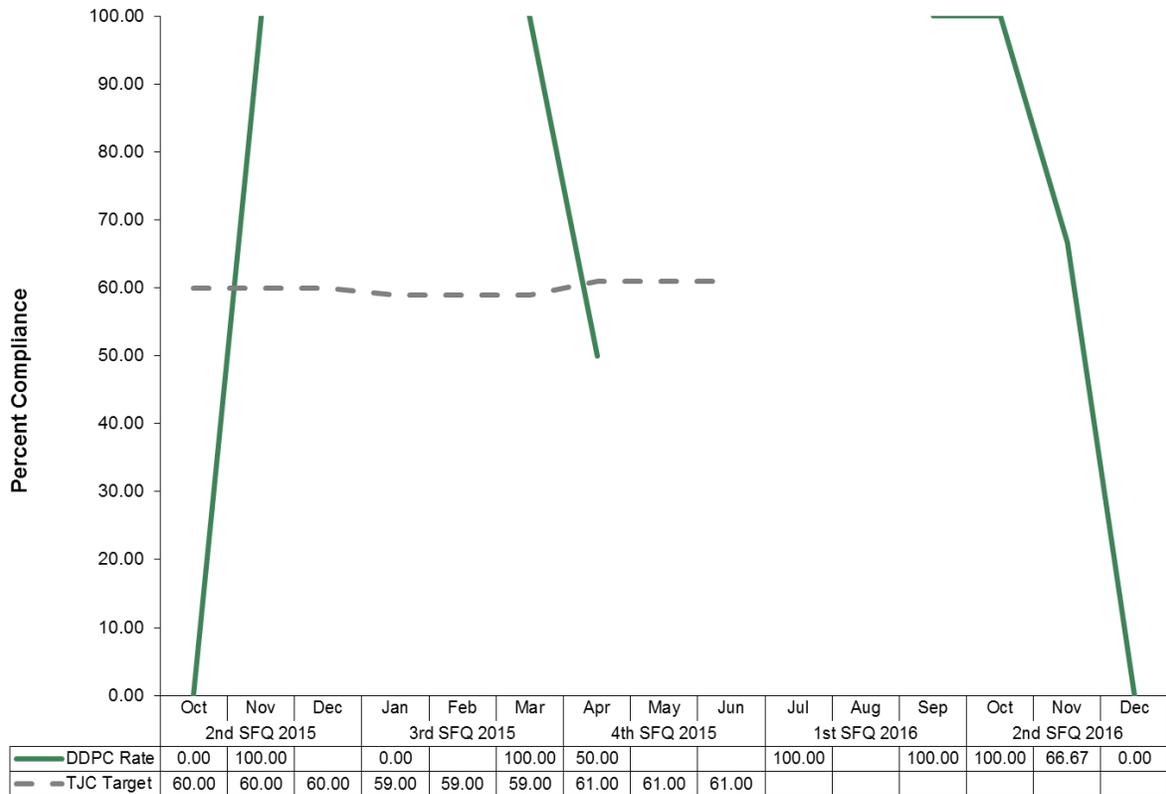
Description: Patients discharged from a hospital based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification.

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).

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Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)

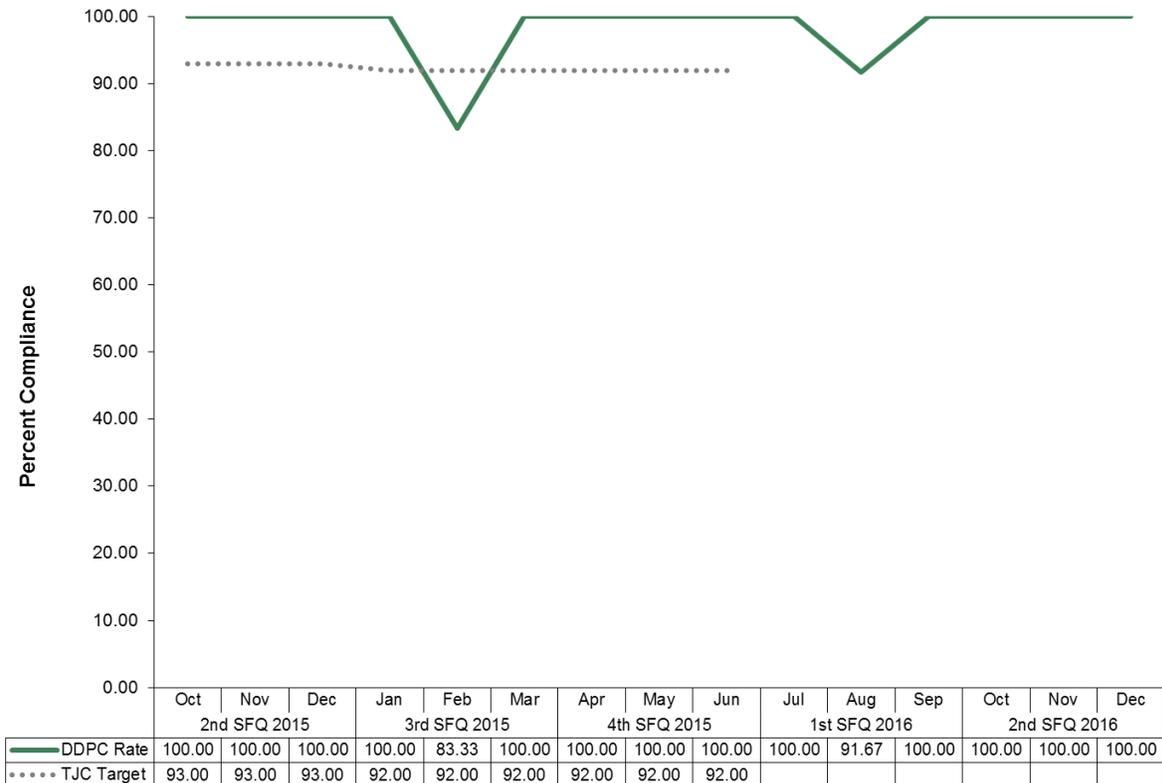


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Post Discharge Continuing Care Plan (HBIPS 6)

Description: Patients discharged from a hospital based inpatient psychiatric setting with a continuing care plan created.

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



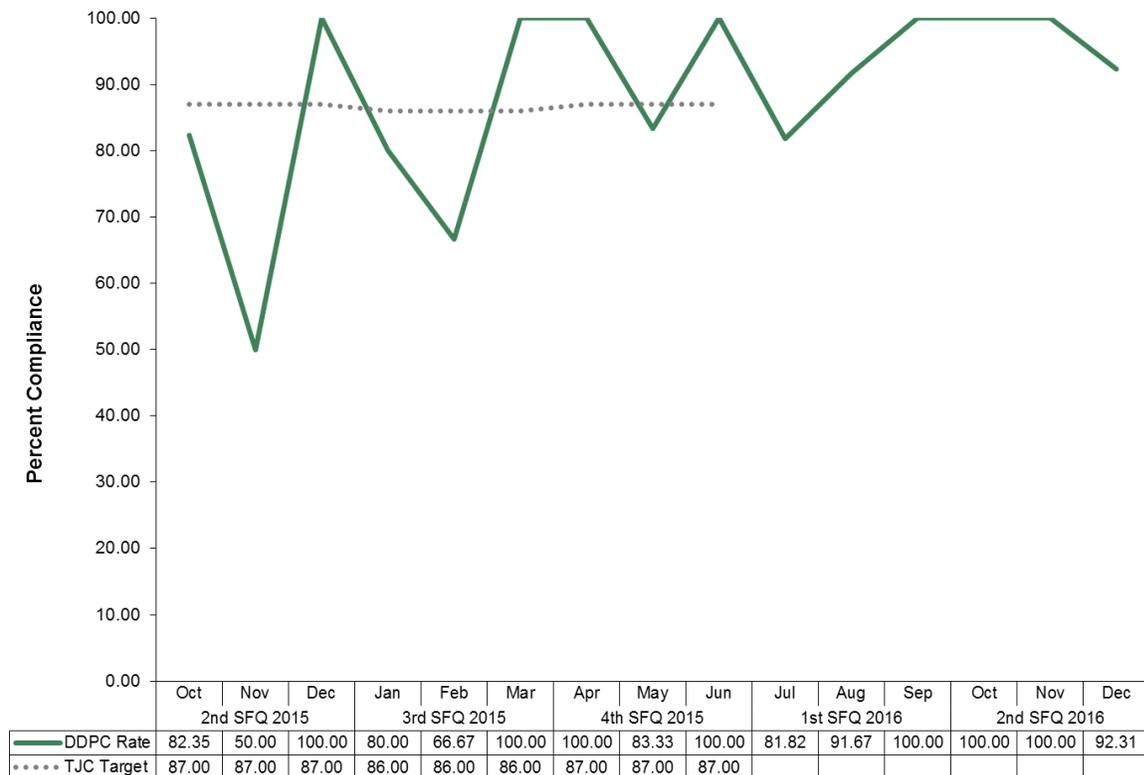
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Post Discharge Continuing Care Plan Transmitted (HBIPS 7)

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 [AAP], 2001).



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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.

2Q2016 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 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.
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.

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2Q2016 Results		
Contractor	Program Administrator	Summary of Performance
Locum Tenens Psychiatry	Dr. Michelle Gardner Clinical Director	Contract not utilized during timeframe.
MD-IT Transcription	Michelle Welch Medical Records Admin	All indicators met standards.
Northeast Cardiology Associates (NECA)	Dr. Michelle Gardner Clinical Director	All indicators met or exceeded 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 or exceeded standards.

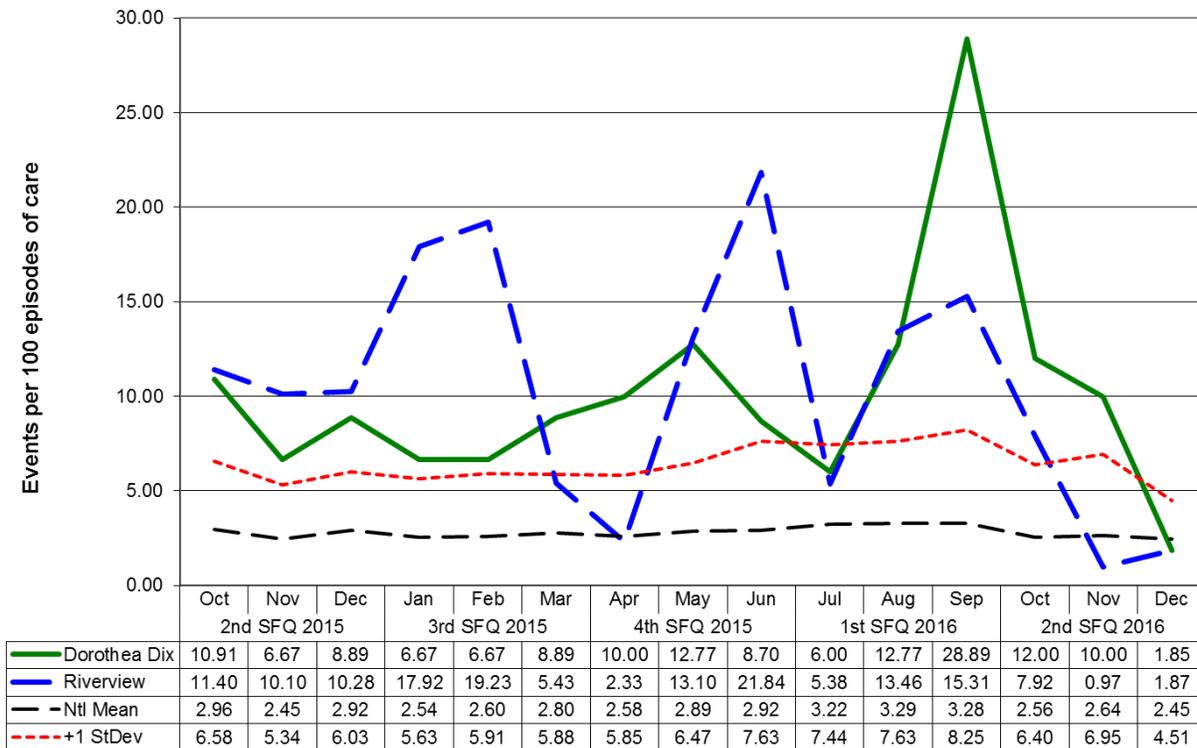
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Medication Management Medication Errors and Adverse Reactions

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

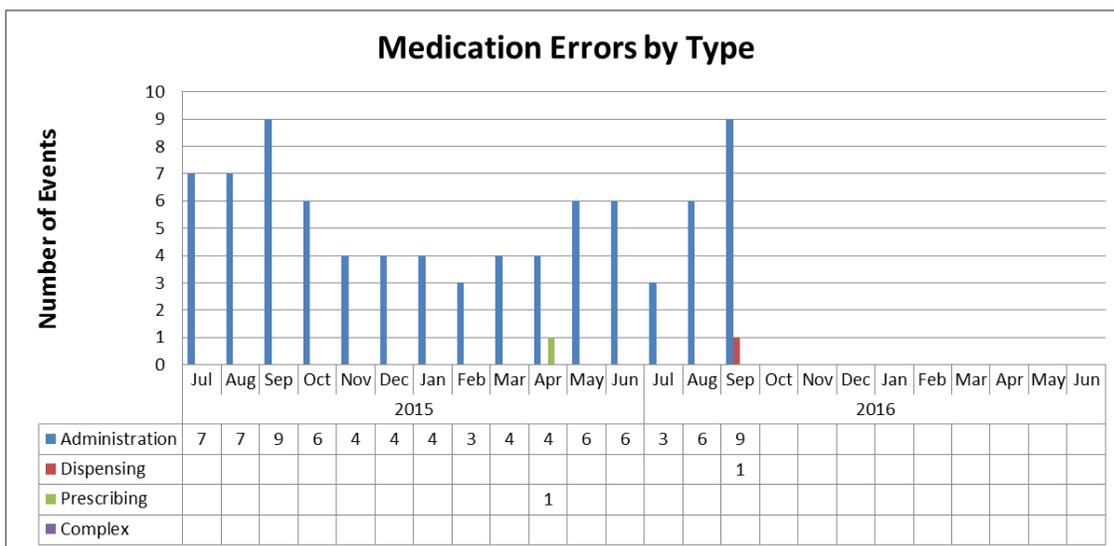


Number of medication error events that occurred for every 100 episodes of care (duplicated patient count). For example, a rate of 1.6 means that 2 medication error events occurred for each 125 episodes of care.

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

- **Prescribing:** An error of prescribing occurs when there is an incorrect selection of drug, drug dose, dosage form, quantity, route, concentration, rate of administration, or instructions for use of a drug product ordered or authorized by physician or other legitimate prescriber. Errors may occur due to improper evaluation of indications, contraindications, known allergies, existing drug therapy and other factors. Illegible prescriptions or medication orders that lead to 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%	0%
Monthly CII Safe Vendor Receipt Report.	Rx	0	0 Target: Actual:	0 0	0 0	0	0
Monthly Pyxis Controlled Drug discrepancies.	All	5.7/ month	0 Target: Actual:	0 41 (14/mo)	0 34 (11/mo*)	0	0
Medication Management Monitoring:							
Measures of drug reactions, adverse drug events and other management data.	Rx	1.25	Actual:	0	TBD		
Resource Documentation Reports of Clinical Interventions.	Rx	60	Actual:	68	103		

*None of the 34 controlled discrepancies were due to anything other than simple miscounts. All of the controlled substances have been accounted for, resulting in a 0% loss of controlled substances for the 2nd Quarter.

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:

	October	November	December	2Q2016
Number of Patients Discharged	11	10	13	34
Number of Survey Responses	3	4	1	8
Survey Response Rate	27%	40%	8%	24%

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

	October	November	December	2Q2016
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) 100%	(3) 75%	(1) 100%	(7) 88%
When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.	(3) 100%	(4) 100%	(1) 100%	(8) 100%
When I left the hospital, I clearly understood the purpose for taking each of my medications.	(3) 100%	(4) 100%	(1) 100%	(8) 100%

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Inpatient Consumer Survey

The **Inpatient Customer Survey (ICS)** is a standardized national survey of customer satisfaction. The National Association of State Mental Health Program Directors Research Institute (NRI) collects data from state psychiatric hospitals throughout the country in an effort to compare the results of 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:

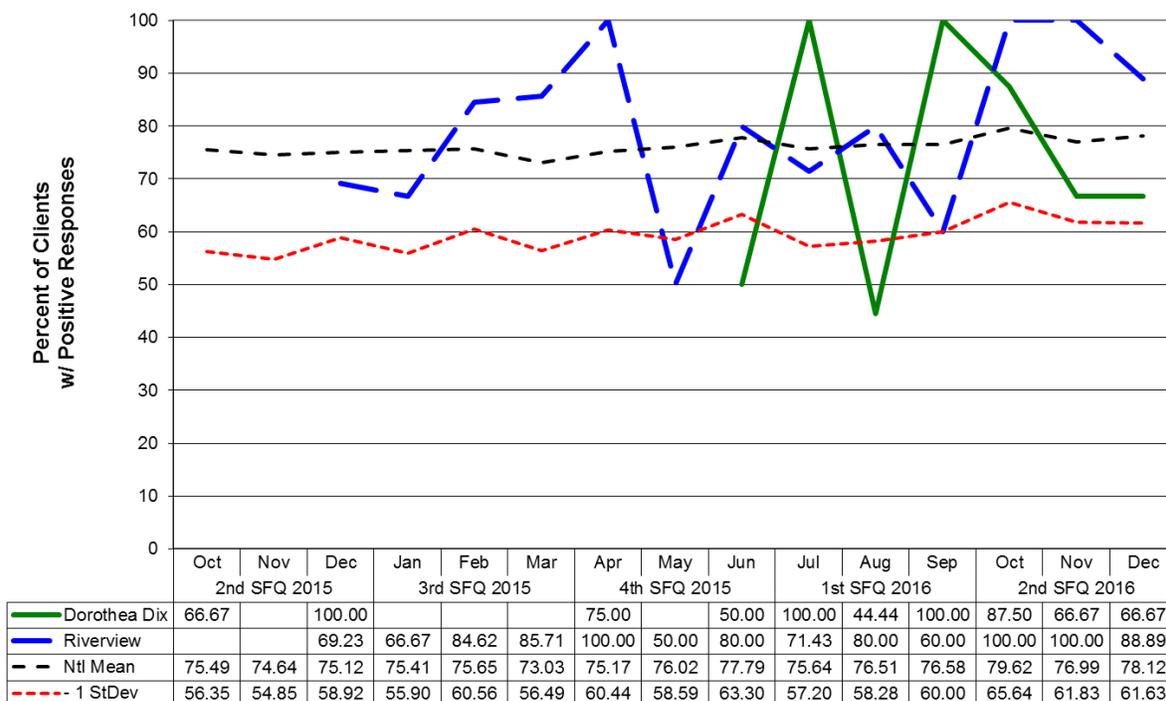
	October	November	December	2Q2016
Number of patients discharged	11	10	13	34
Number of survey responses	10	3	6	19
Survey response rate	91%	30%	46%	56%

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.

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Inpatient Consumer Survey Outcome Domain

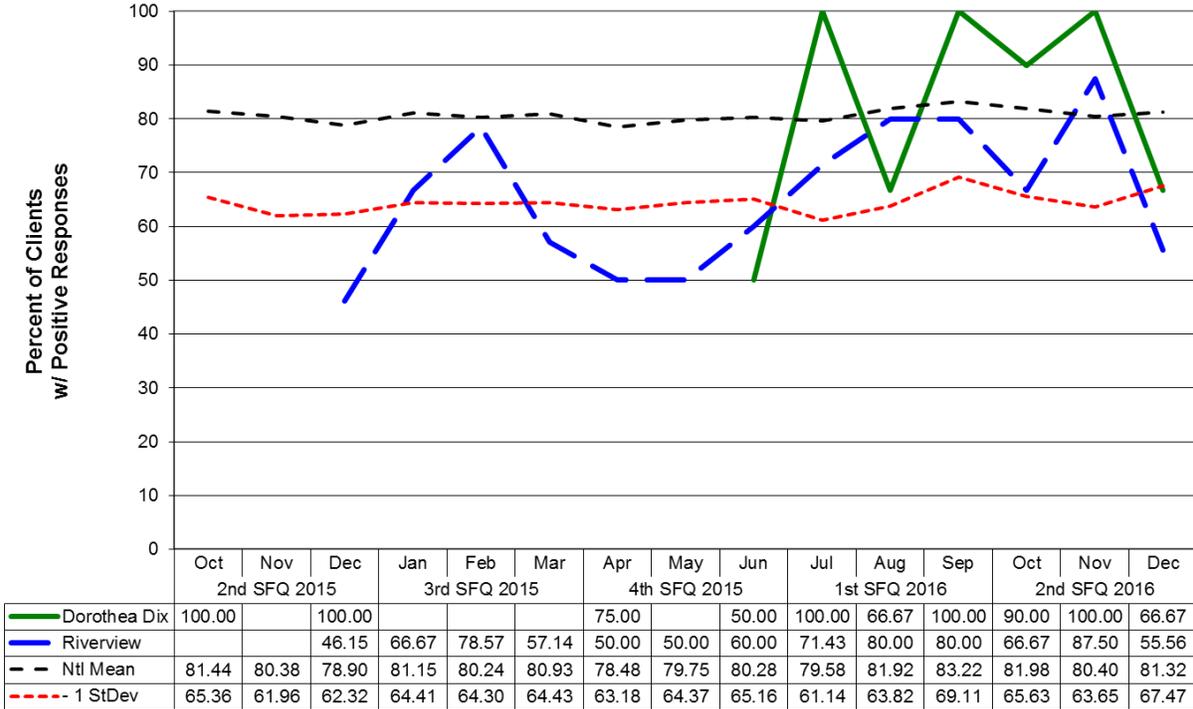


Outcome Domain

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.

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Inpatient Consumer Survey Dignity Domain

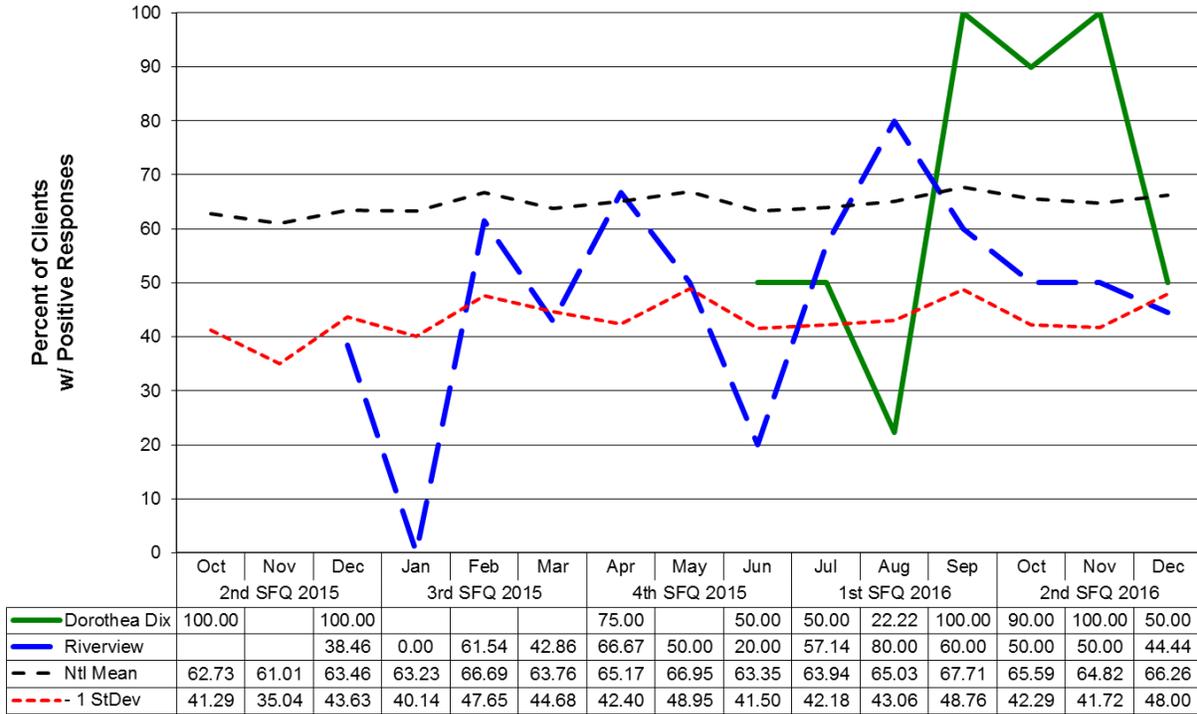


Dignity Domain

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.

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Inpatient Consumer Survey Rights Domain

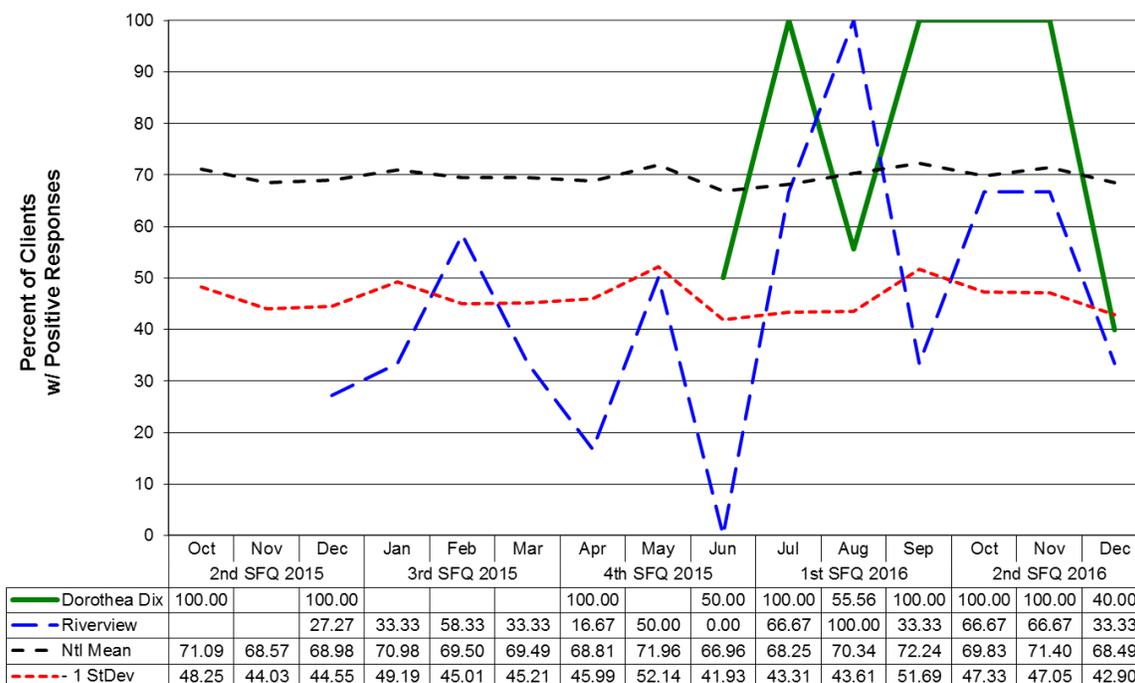


Rights Domain

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.

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Inpatient Consumer Survey Participation Domain

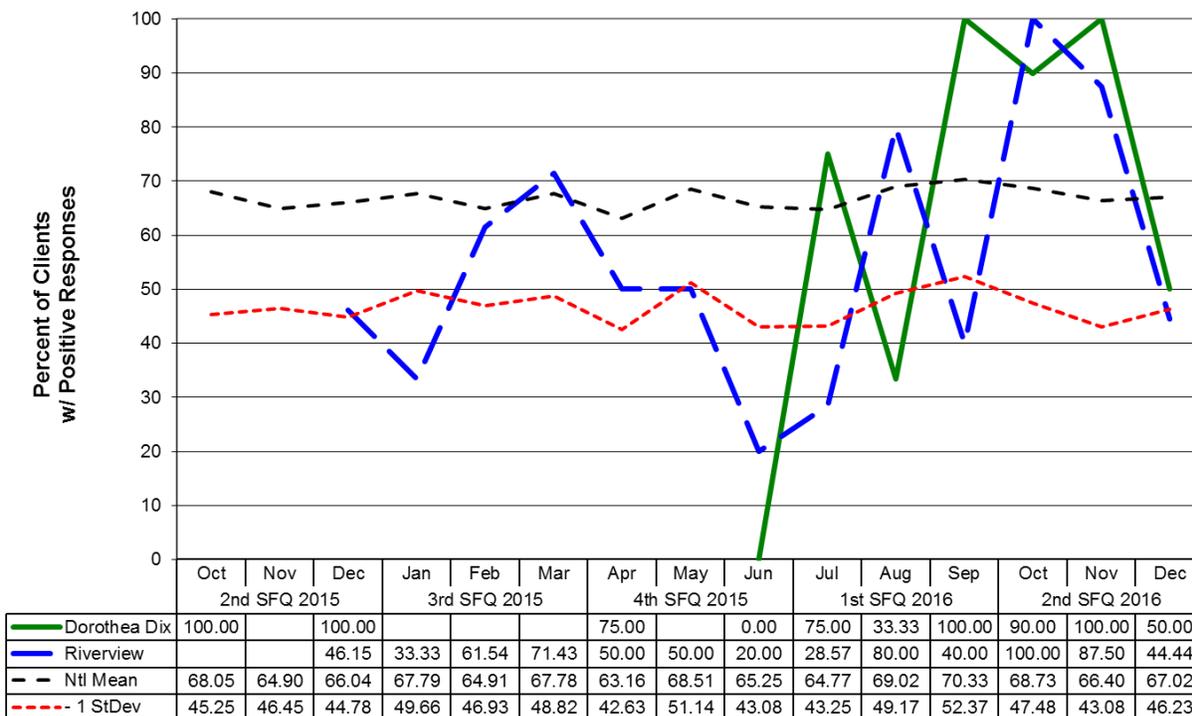


Participation Domain

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.

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Inpatient Consumer Survey Environment Domain

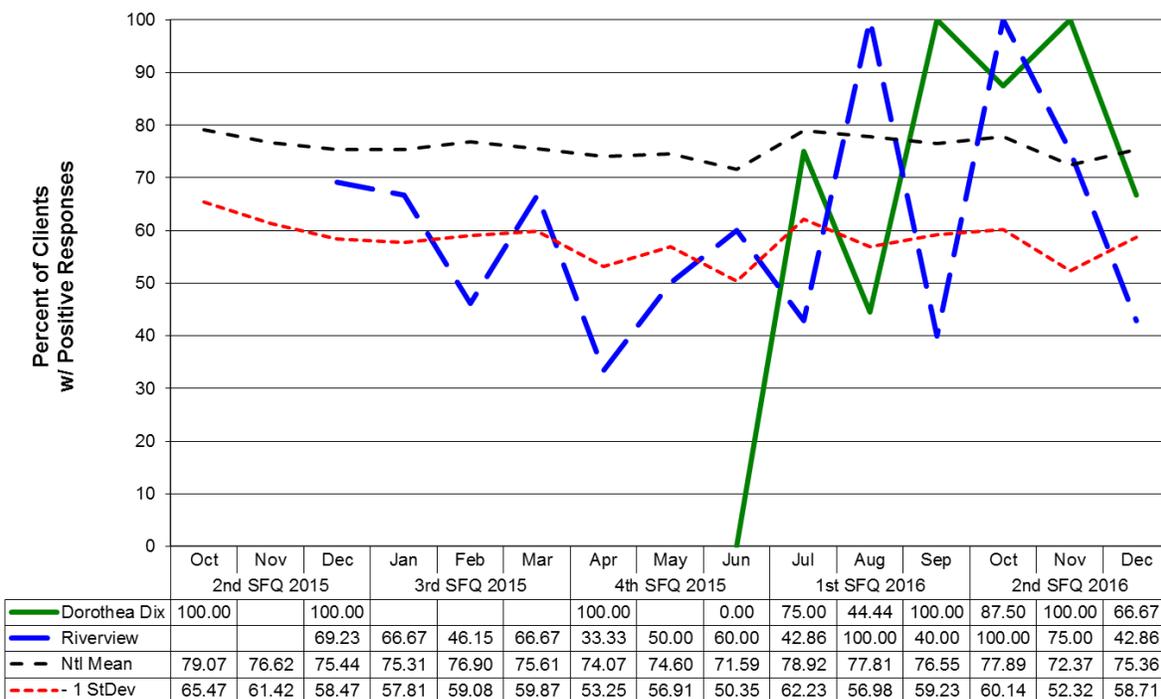


Environment Domain

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.

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**Inpatient Consumer Survey
Empowerment Domain**



Empowerment Domain

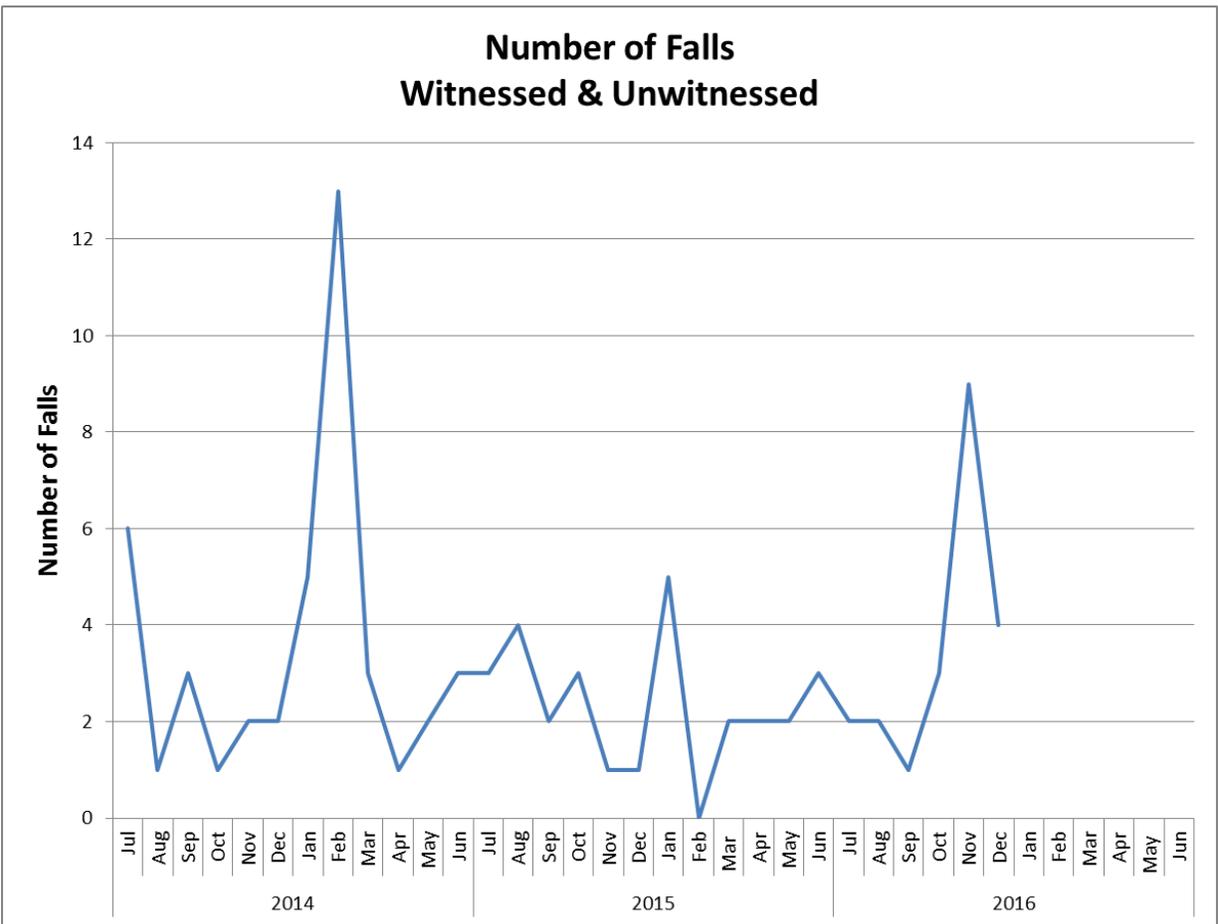
1. I had a choice of treatment options.
2. My contact with my doctor was helpful.
3. My contact with nurses and therapists was helpful.

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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.



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Fall Reduction Nursing Interventions

Janet Babcock, RN

I. **Measure Name: Patient Falls - Establishing a Culture of Safety**

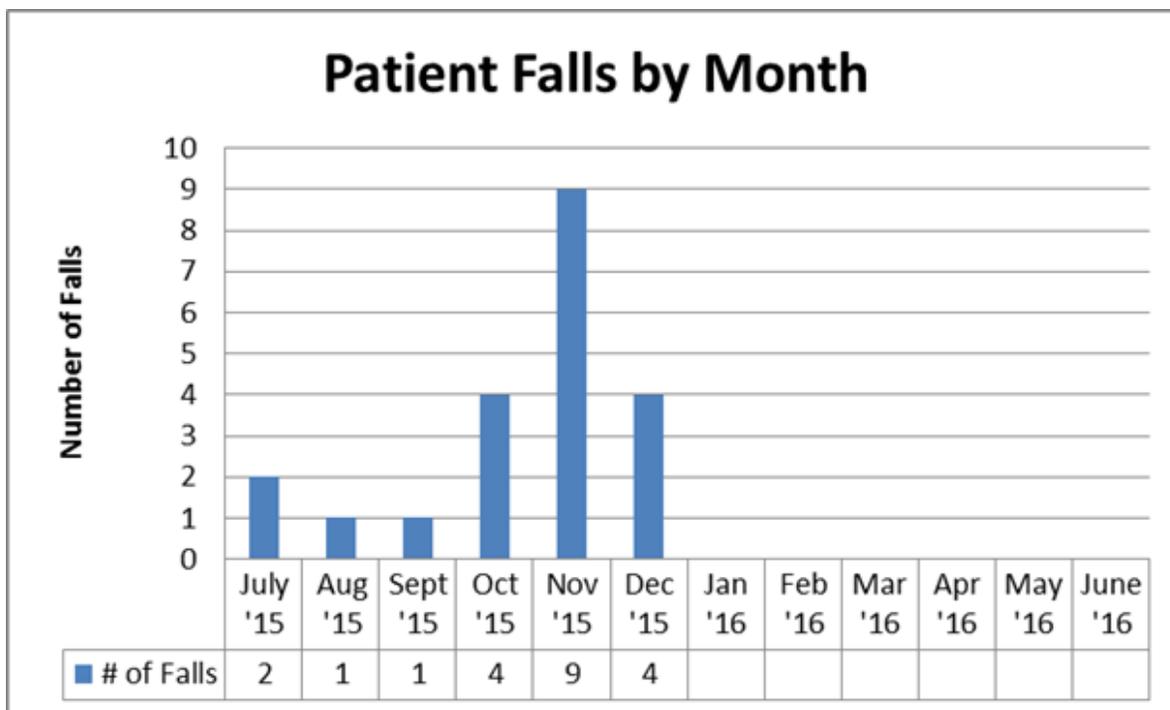
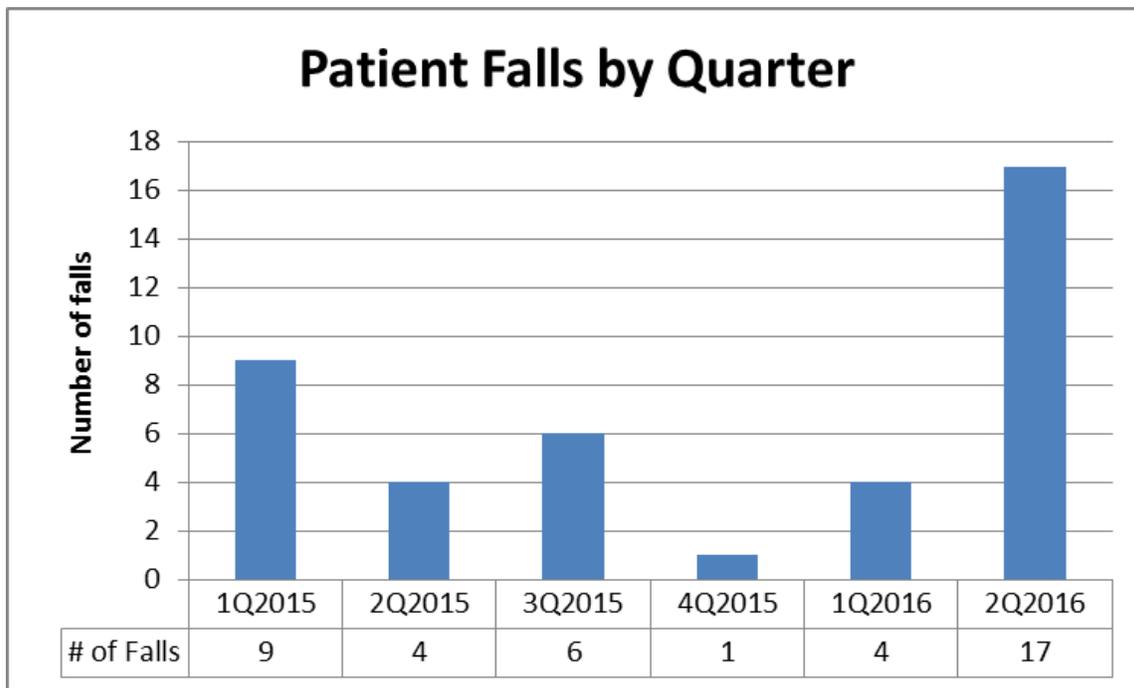
Measure Description: Up to 50% of hospitalized patients are at risk for falls, and almost half of those who fall suffer an injury (American Nurse Today, Special Supplement to American Nurse Today - Best Practices for Falls Reduction: A Practical Guide. Multiple authors, March 2011, 6. No 2). The objective 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

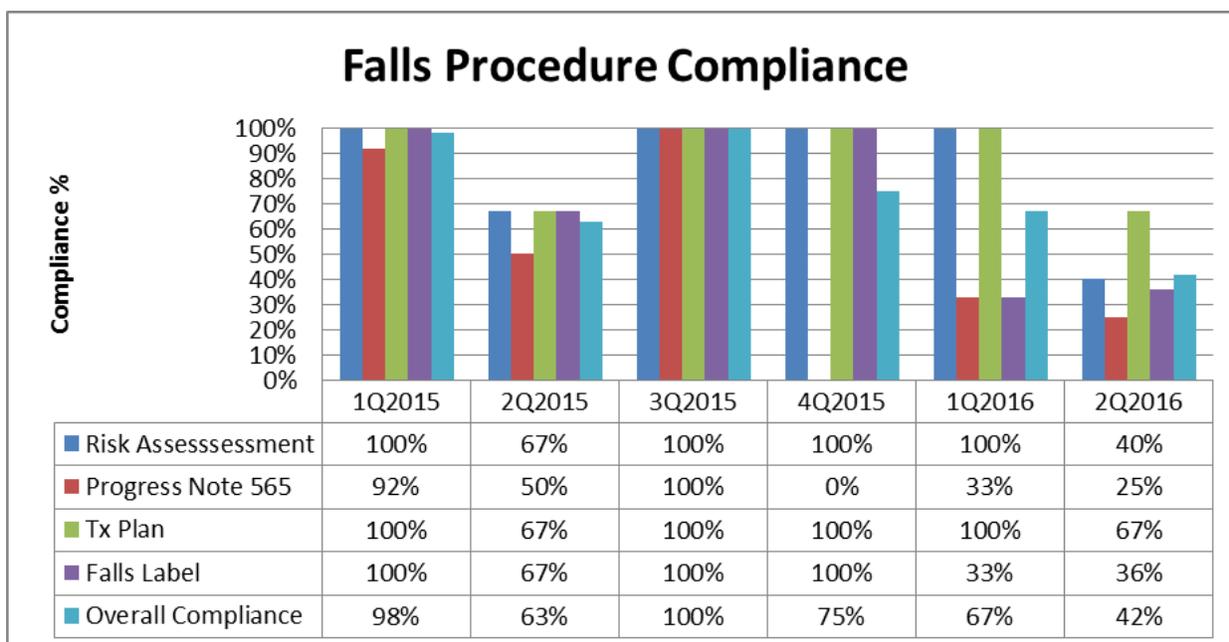
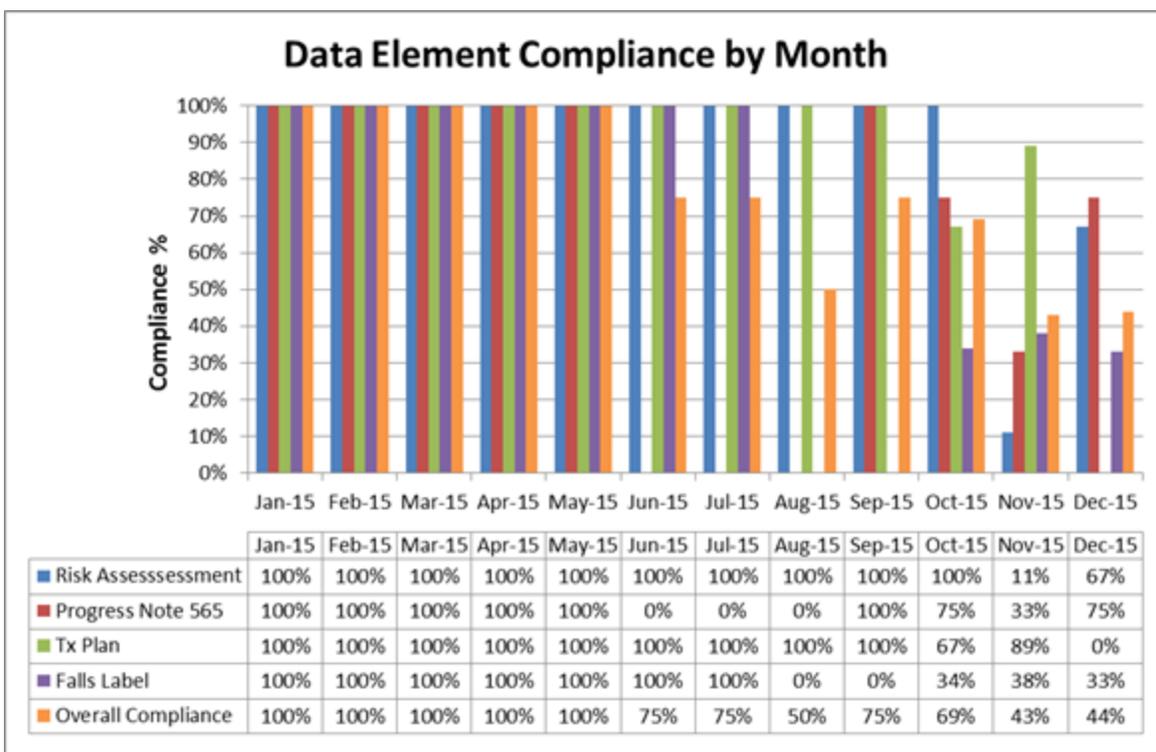
All patient falls in 2Q2016	Falls risk assessment completed	Falls Progress Note 565 completed and in patient's medical record	Falls risk score of 6 or higher: problem 6.1 initiated (164 A & B)	Falls risk score documented on kardex and in front of chart	
17 (including falls that do not meet definition)	Yes: 6 No: 9 N/A: 2	Yes: 1 No: 3	Yes: 10 No: 5 N/A: 2	Yes: 5 No: 9 N/A: 3	
Overall Compliance	40%	25%	67%	36%	42%

Data Analysis: There were 17 falls in the 2nd Quarter of FY 2016, with two not meeting the definition. October had 4 falls with a 69% overall compliance rate, November had 8 falls with a 43% overall compliance rate, and December had 4 falls and a 44% overall compliance rate. The 2nd Quarter combined compliance rate is 42%; a 27% decrease from the 1st Quarter. The increased number of falls may be attributed to additional admitted patients with numerous co-morbidities and highly complex medical problems.

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Plan of Action: Auditing that the Nurse Supervisor provides education to staff during auditing process. Nursing will continue to follow up and audit all falls.

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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.

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I. 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.

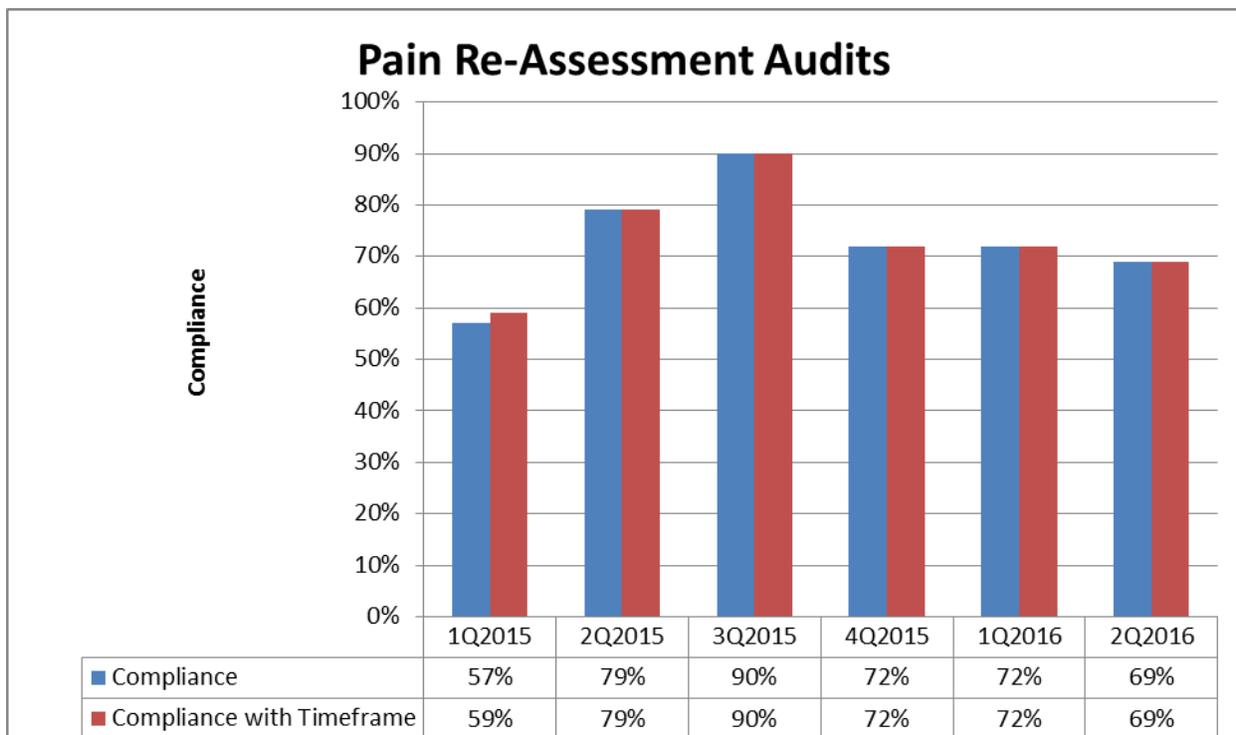
Type of Measure: Performance Improvement

Results							
	Data elements	Base line	4Q 2015	1Q 2016	2Q 2016	3Q 2016	YTD
Target 100% Compliance	Number of audits performed	89	106	93	121		320
	Number of patients with pain reported on Form 838	29	57	46	65		168
	Number of reassessments completed	11	41	33	45		119
	Number of reassessments reported within clinically appropriate timeframe (1-2 hours after oral medication and within 1 hour of intramuscular injection)	11	41	33	45		119
	Compliance with reassessment	38%	72%	72%	69%		71%
	Compliance with reassessment timeframe	38%	72%	72%	69%		71%

***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%. The 2nd Quarter shows a 2% decrease from the previous quarter and a 31% increase from baseline.

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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 Re-Assessments 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

II. 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.

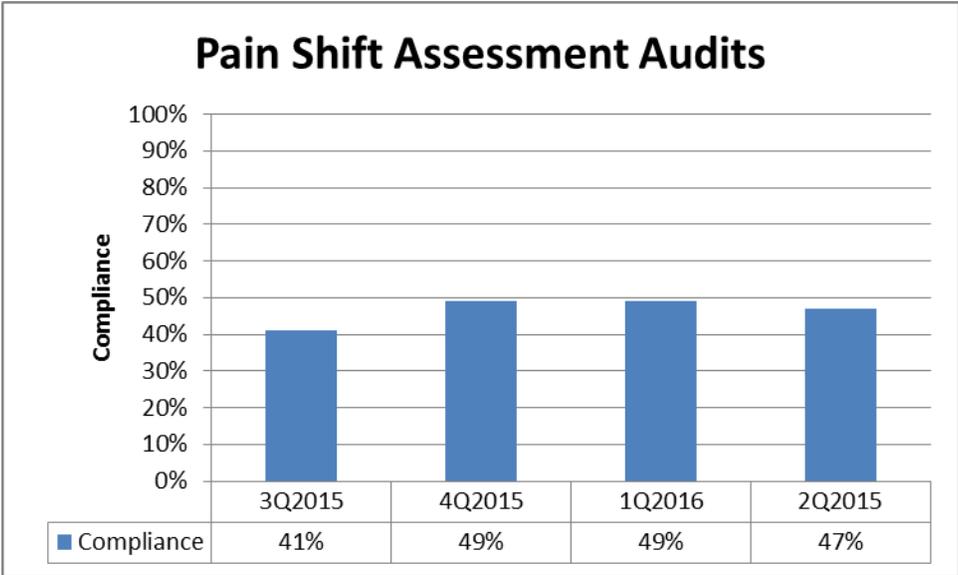
Type of Measure: Performance Improvement

Results							
	Data elements	Base line	4Q 2015	1Q 2016	2Q 2016	3Q 2016	YTD
Target 100% Compliance	Number of audits completed	36	106	93	103		302
	Number of audits having 2 shift assessments completed that assesses for the presence and intensity of pain within 24 hours	12	52	46	48		146
	Overall Compliance	33%	49%	49%	47%		48%

***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%. 2nd Quarter shows a 2% decrease in compliance from 1st Quarter and an increase of 14% from baseline.

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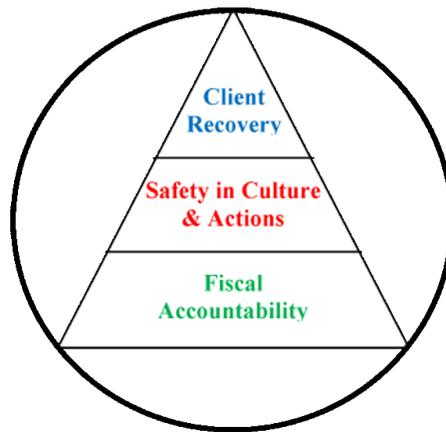
Plan of Action: Nursing remains below the goal of 100% compliance. Nursing Administration continues to address this issue and will reinforce with the Clinical Nurse Managers to ensure that pain is being assessed at least every 12 hours for every patient. Clinical Nurse Managers will address staff members 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.

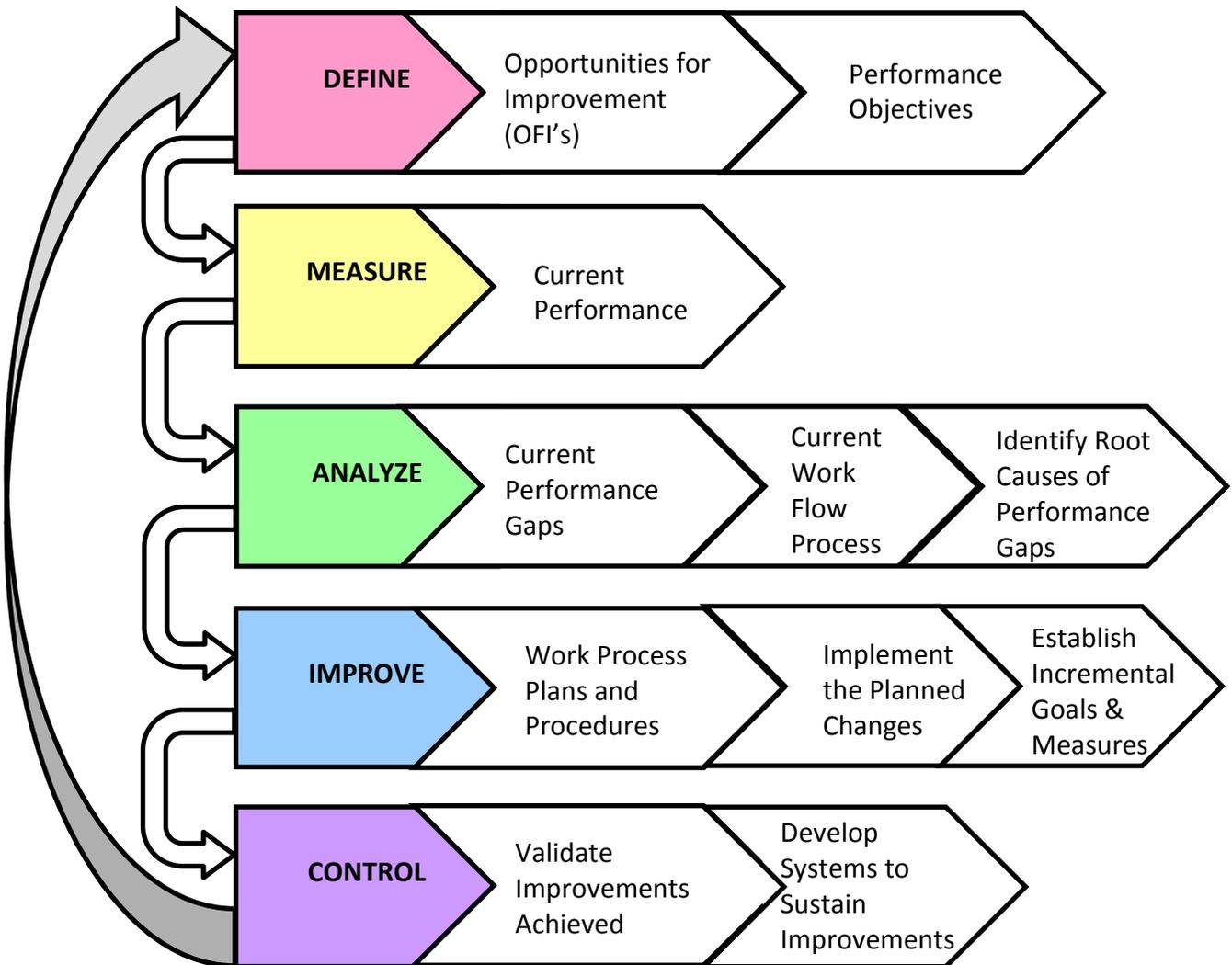
Enhance Patient Recovery by...

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

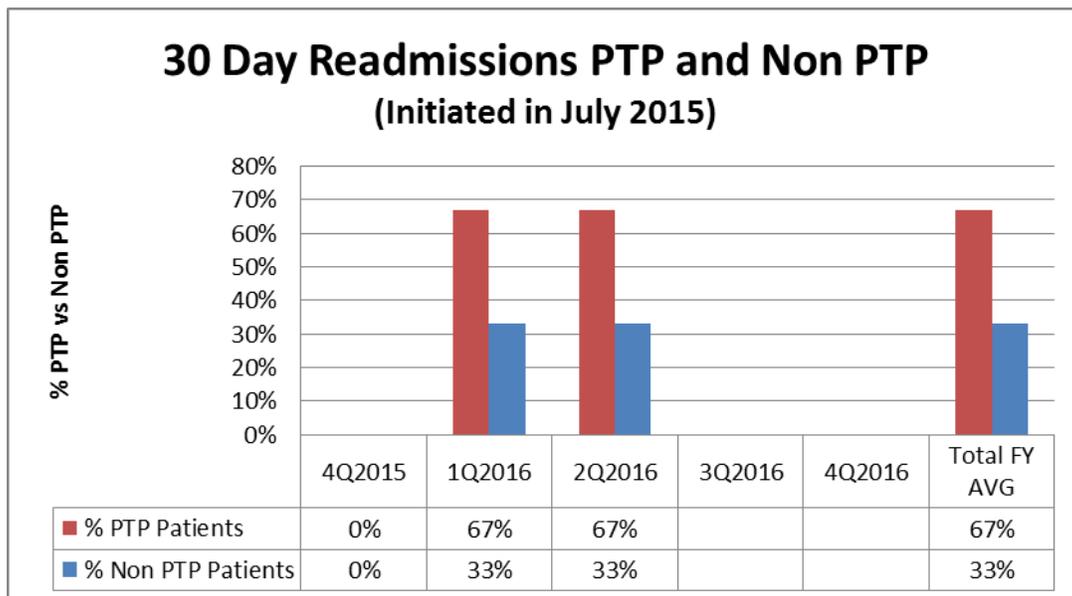
Robyn Fransen, LSW-C

I. 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			6
	Is this readmission a PTP patient?	67%	67%			67%
	Is this readmission a Non-PTP patient?	33%	33%			33%



*There were no readmissions in 4Q2015.

STRATEGIC PERFORMANCE EXCELLENCE

Data Analysis: Data from 2nd Quarter remains unchanged from the 1st quarter, at 67% for PTP readmission and 33% for Non-PTP readmission.

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

I. 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	71% 30/42			71% 61/86

Data Analysis: The data indicates that we fell short of our goal of 100% certification by 29%

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 soon. 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 are 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

I. Measure Name: Security Response to Hospital Incidents

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%	100%	98%

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 and did not respond*. The denominator will be the number of DAR reports that indicated response to the incidents *where Security was specifically requested*. The performance percentage will be the numerator divided by the denominator x 100 -100 ($N \div D \times 100 - 100$)

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 (12) 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	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Identification Data	35/35 100%	34/34 100%			100% 69/69
Medical History, including chief complaint; HPI; past, social & family hx., ROS, and physical exam w/in 24 hrs, conclusion and plan.	35/35 100%	34/34 100%			100% 69/69
Summary of patient's psychosocial needs as appropriate to the patients *	30/35 86%	29/34 85%			86% 59/69
Psychiatric Evaluation in patient's record w/in 24 hr of admission	35/35 100%	33/34 97%			99% 68/69
Physician (TO/VO w/in 72 hrs.)	30/35 86%	27/34 79%			83% 57/69
Evidence of appropriate informed consent	30/30 100% 5 Refused	34/34 100%			100% 64/64
Clinical observations including the results of therapy.	35/35 100%	34/34 100%			100% 69/69
Nursing discharge Progress Note with time of discharge departure	35/35 100%	32/32 100%			100% 67/67
<i>Consultation reports, when applicable</i>	14/15 93%	13/14 93%			93% 27/29
Final Diagnosis(es) DSM-Principal Diagnosis Measure was discontinued as of 10/1/15	35/35 100%	N/A	N/A	N/A	100% 35/35
Results of autopsy, when performed	N/A	N/A			N/A
<i>Advance Directive Status on admission and SW follow up after</i>	34/35 97%	34/34 100%			99% 68/69
Notice of Privacy	33/35 94%	32/34 94%			94% 65/69

STRATEGIC PERFORMANCE EXCELLENCE

<i>Chart Completion w/in 30 days of discharge date/discharge summary completed within 30 days</i>	33/35 94%	33/34 97%			96% 66/69
Discharge Packet sent to follow up provider within 5 days of discharge.	33/35 94%	33/34 97%			96% 66/69

* 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).

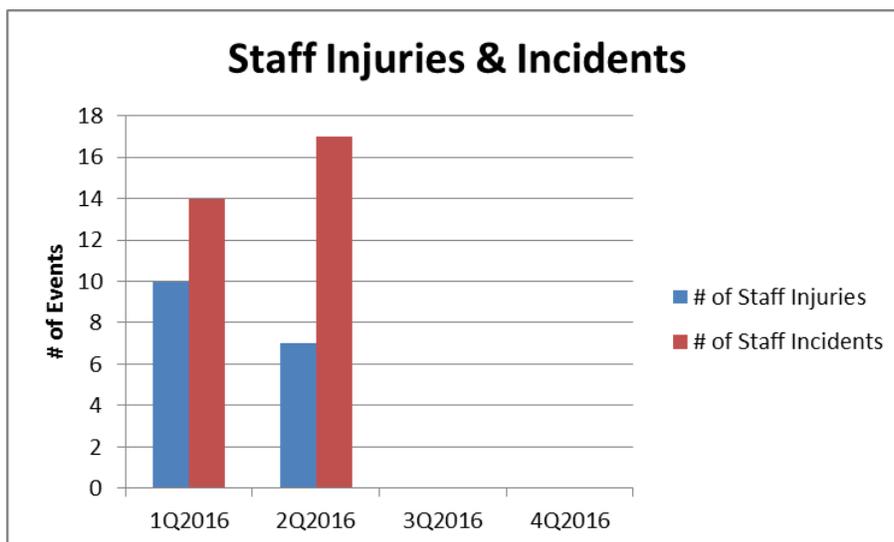
Measure Description: Staff safety is central to DDPC. While staff safety events may not be completely eliminated, events can be reduced by reviewing trends related to injuries.

Type of Measure: Performance Improvement

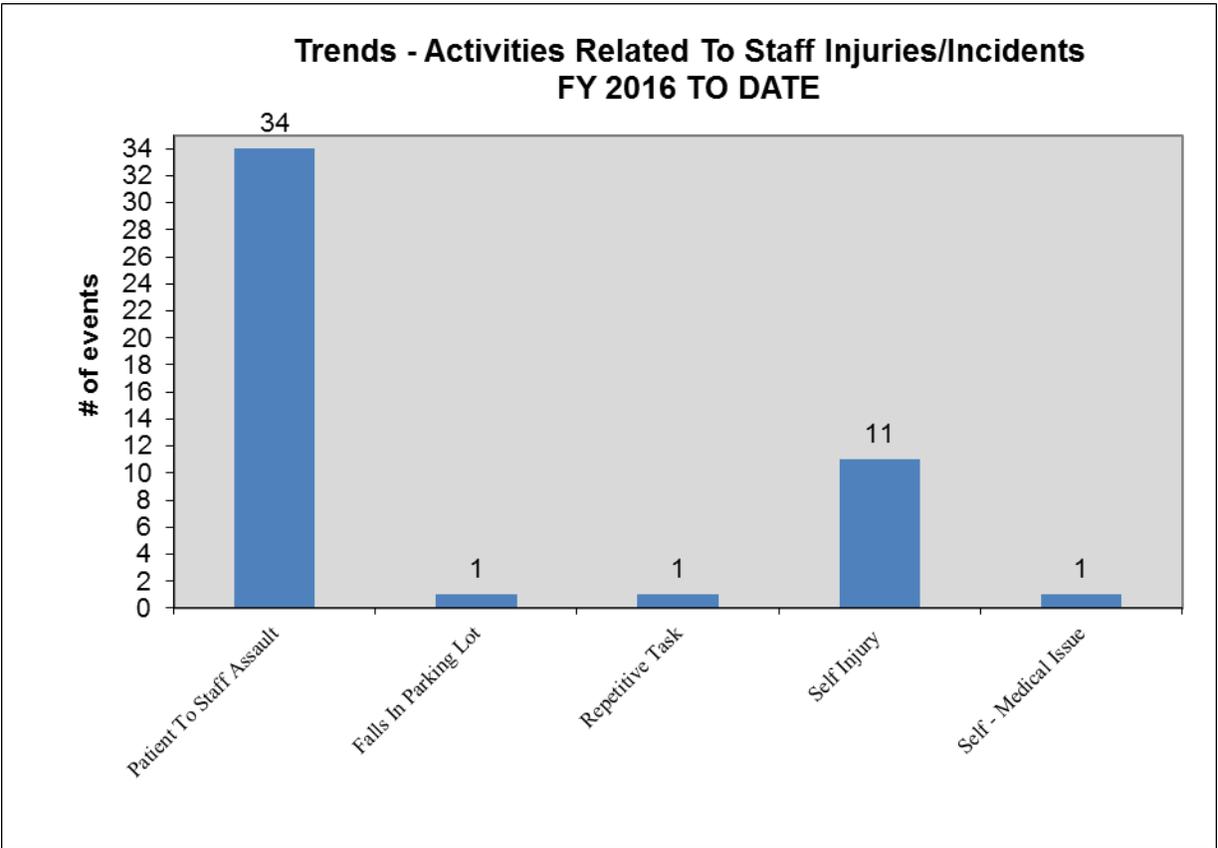
		Results				
	Baseline	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	Established 1Q2016	TBD	TBD			
Actual # of Staff Injuries		10	7			17
Actual # of Staff Incidents		14	17			31

Data Analysis: In the 2nd quarter, DDPC had 7 staff injuries and 17 staff incidents; 14 of these were patient related, 1 fall/trip in parking lot, and 9 were self-related.

Plan of Action: A baseline has been established. We 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



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 %	22%	21%	11%			16%
# Vacancies Posted	1	15	11			26
# Vacancies Filled Within 45 Days	0	3	5			8
% Posted & Filled Within 45 Days	0%	20%	45%			33%

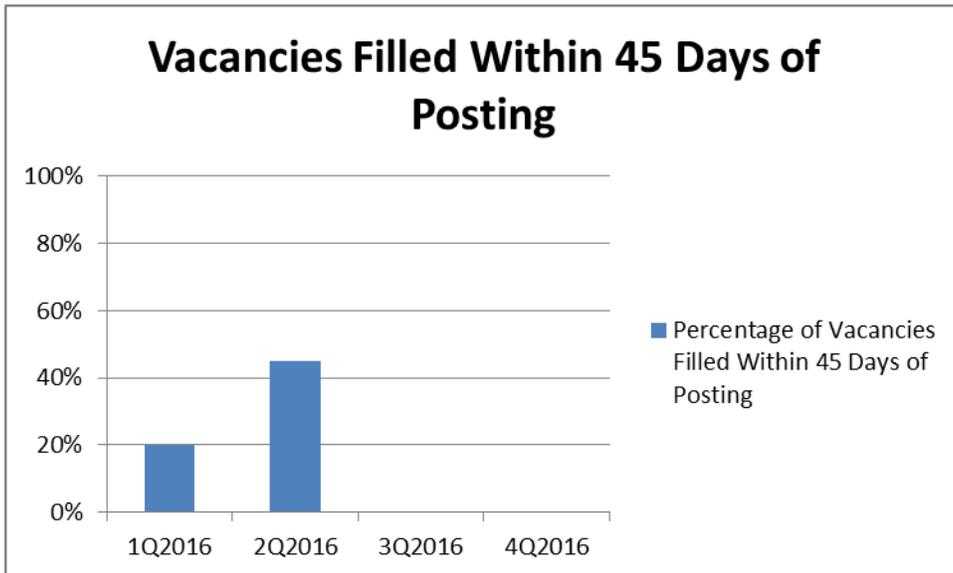
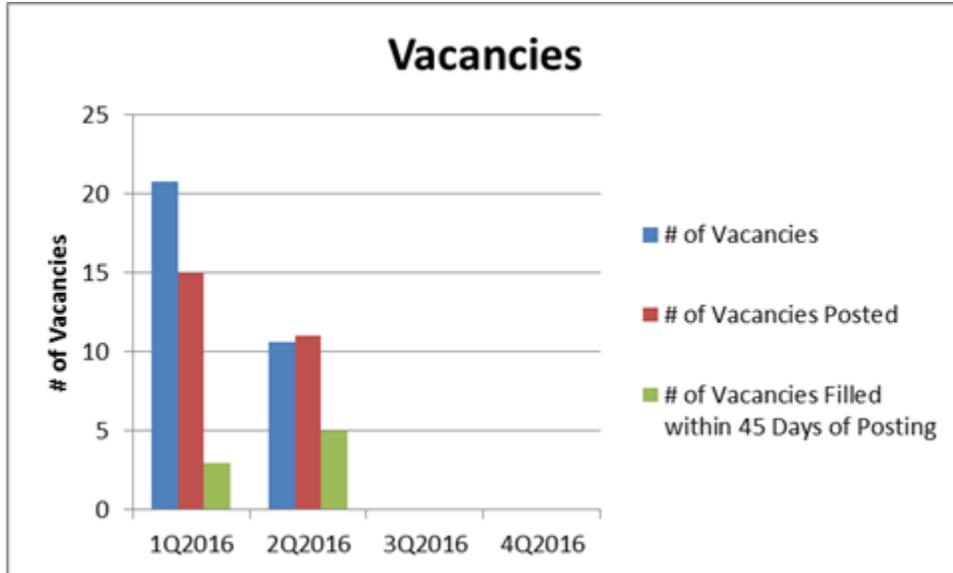
Data Analysis: Increase percentage rate of filled quarterly posted vacancies within 45 days of posting.

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

Note:

- One position is in process of class exchange/downgrade and will be posted at completion so is included in the vacancy rate.
- New Employee Orientation will be held twice per month instead of once per month starting in February 2016 so new employees can be brought in at a quicker rate and not wait an extended time period for an orientation date.

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

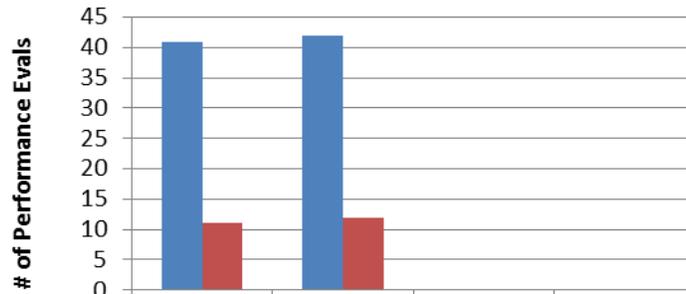
Results						
	Baseline	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	Established June 2015	100%	100%	100%	100%	100%
# Due	14	41	42			83
# Completed on Time	3	11	12			23
% Completed on Time	21%	27%	29%			28%

Data Analysis: In the 2nd quarter 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.

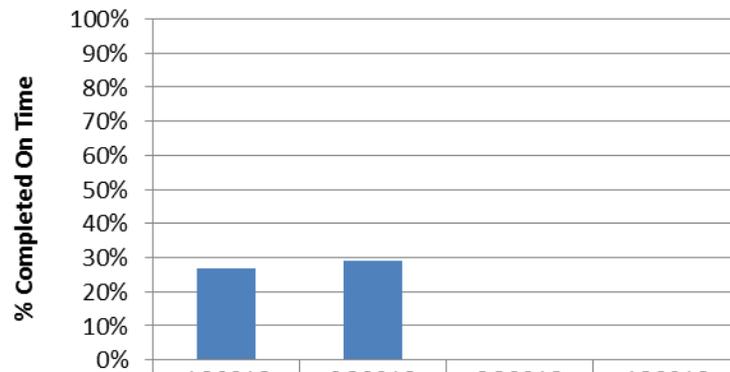
STRATEGIC PERFORMANCE EXCELLENCE

Performance Evaluations Completed On Time



	1Q2016	2Q2016	3Q2016	4Q2016
# of Performance Reviews Due	41	42		
# of Performance Reviews completed on time	11	12		

Performance Reviews Completed On Time



	1Q2016	2Q2016	3Q2016	4Q2016
% Performance Reviews Completed On Time	27%	29%		

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	3Q2015	4Q2015	1Q2016	2Q2016	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 2nd quarter.

Action Plan: Continue to monitor infection rates.

H. A. Infections	FY 2014	FY 2015	FY 2016
1 st Quarter H.A.I. Rate	0	0	0
2 nd Quarter H.A.I. Rate	0	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	0	
URI	0	0	0	0	0	0	0	0		0	0	
LRI	0	0	0	0	0	0	0	0		0	0	
Skin	0	0	0	0	0	0	0	0		0	0	
Totals	0	0	0	0	0	0	0	0		0	0	
Infection Rate	0	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 = 3508

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

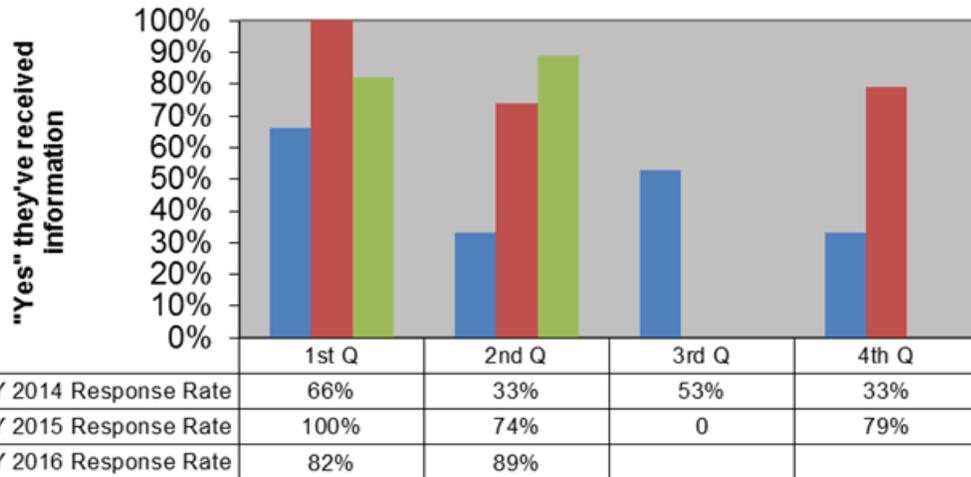
		Results					
	Unit	Baseline	3Q2015	4Q2015	1Q2016	2Q2016	YTD
Target: D1 80%	Quarterly response rate “agree/strongly agree” for D1 & D2 is set at 80%	2012: D1 response rate: 80%	0%	79%	82%	89%	63%
Target: D2 80%		2012: D2 response rate: 80%	0%	75%	82%	89%	62%

Data Analysis: 2nd Quarter response rate for question D1 was 89%, an increase of 7% from the previous quarter. 2nd Quarter response rate for question D2 was 89%, an increase of 7% from the previous quarter.

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

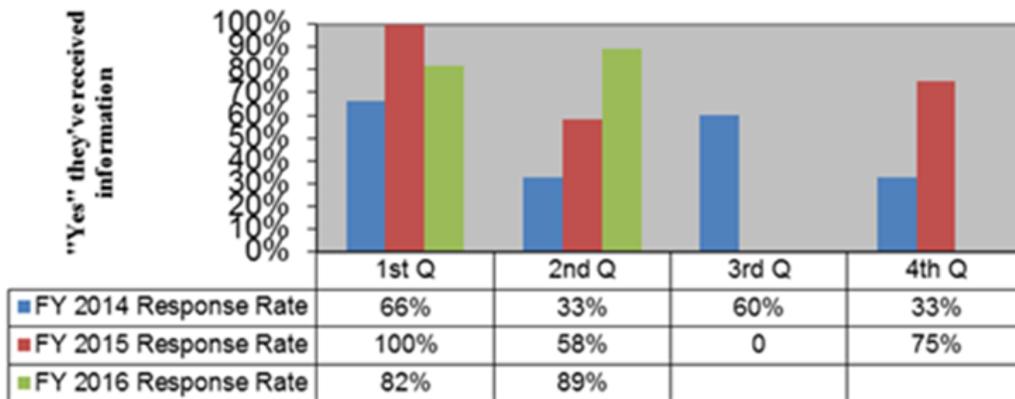
STRATEGIC PERFORMANCE EXCELLENCE

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%.

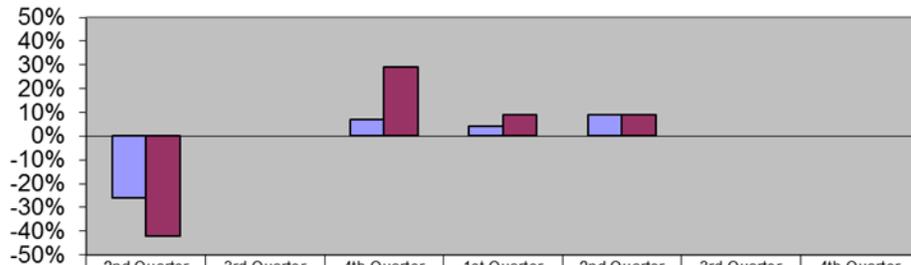
D2 Quarterly Response Rate



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%	9%		
D2 Quarterly incremental increases/decreases	-42%	0	29%	9%	9%		

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

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.

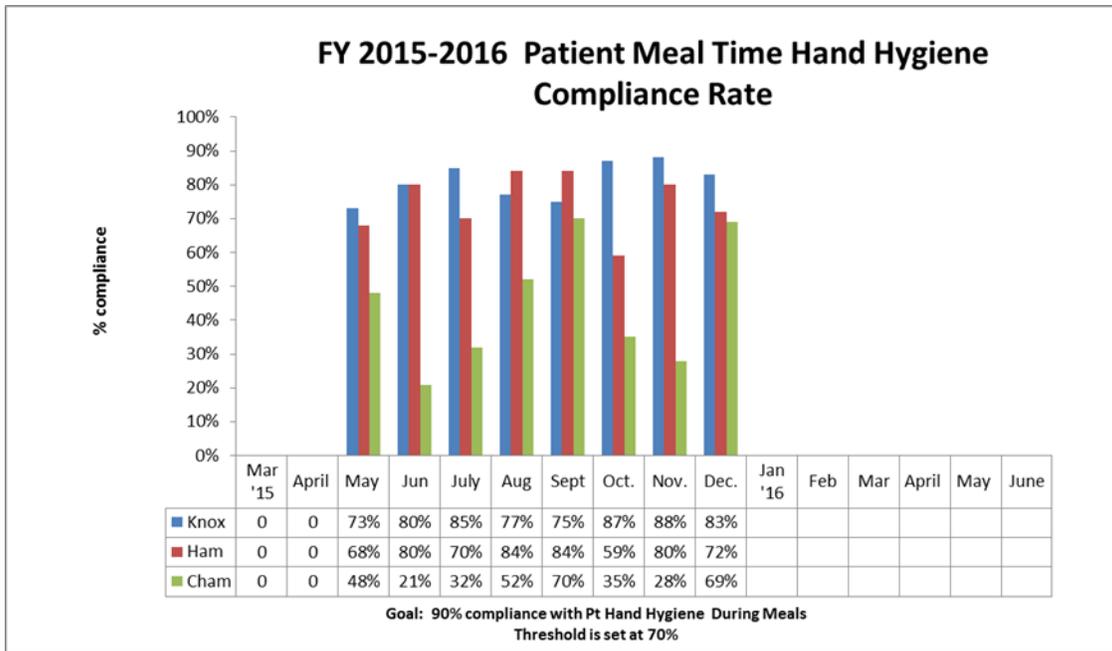
Type of Measure: Performance Improvement

		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%	86%		72%
		Hamlin: 44%	49%	79%	70%		66%
		Chamberlain: 36%	23%	51%	44%		39%

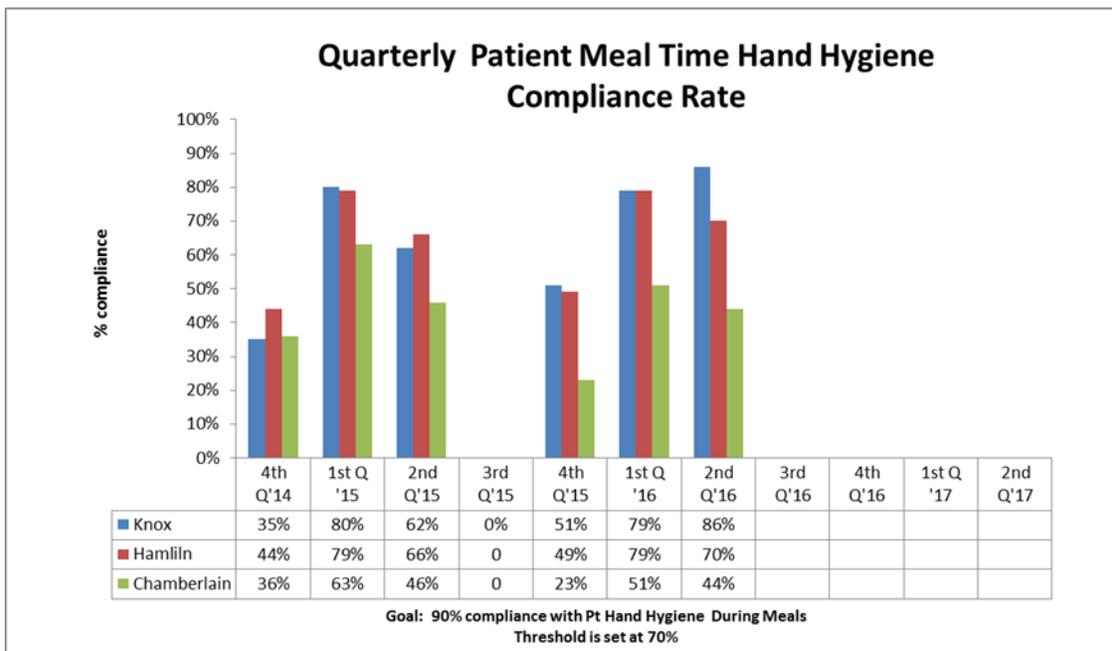
Data Analysis: For the 2nd quarter Knox’s compliance rate was 86%, an increase of 7% from the previous quarter. Hamlin’s compliance rate was 70%, a decrease of 11% from the previous quarter. Chamberlain’s compliance rate was 44%, a decrease of 14% from the previous quarter.

Action Plan: 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	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target: 90%	Percent of employees who receive the flu vaccination	FY 2015 81%	63% (as of Dec.)				

Data Analysis: Employee flu vaccination compliance rate was 81% for FY 2015. So far DDPC is at a 63% compliance rate for FY 2016.

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

Comments: DDPC is still offering the flu vaccine to employees.

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.**

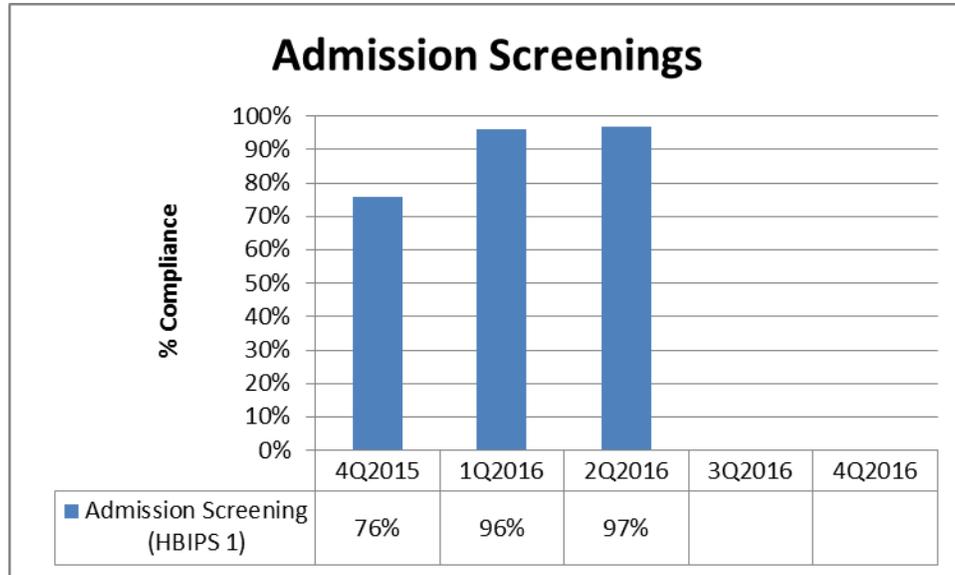
Measure Description: Review of all discharged medical records for the given month for the following screening of HBIPS data elements within the first three days after admission, relying on the documentation in the psychiatric admission evaluation: risk of violence to self or others; substance use, psychological 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		100%	100%	90%	90%	90%
Actual	compliance during the months of July, August and September 2015 based on the admission psychiatric evaluation only	Q42015 76%	96%	97%			97%

* The goal was changed on 1/28/16 to 90% compliance for 4 consecutive months with a threshold of 85%. This goal aligns itself with TJC measure of success requirements.

STRATEGIC PERFORMANCE EXCELLENCE



Data Analysis: The 2nd quarter compliance rate was 97%, up from the 1st quarter’s compliance rate of 96%. The monthly compliance rate of 90% for 4 consecutive months for the completion of HBIPS 1 – Psychiatric evaluations only has not yet been achieved as September had a compliance rate of 89%.

Action Plan: There has been significant improvement in compliance with the inclusion of the elements of HBIPS1, including the timeframe components with the new psychiatric evaluation template. The monthly compliance rates for the 2nd quarter remains above 90%, therefore we will continue to monitor at the point.

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 100%*	>85%	>85%	>85%	>85%	>85%
Actual			100%	100%			100%

Data Analysis: The 2Q2016 ORYX Report indicated a compliance rate of 100% with HBIPS1 core measures, above the required compliance rate of 85% as determined by The Joint Commission.

Action Plan: It was quickly determined that only data from the Psychiatric Evaluations were being used to measure compliance with the HBIPS 1 core measure. It was agreed upon that for extraction of data for NRI compliance purposes, assessments done by all disciplines within the first three days after admission would be included in the data extracted 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

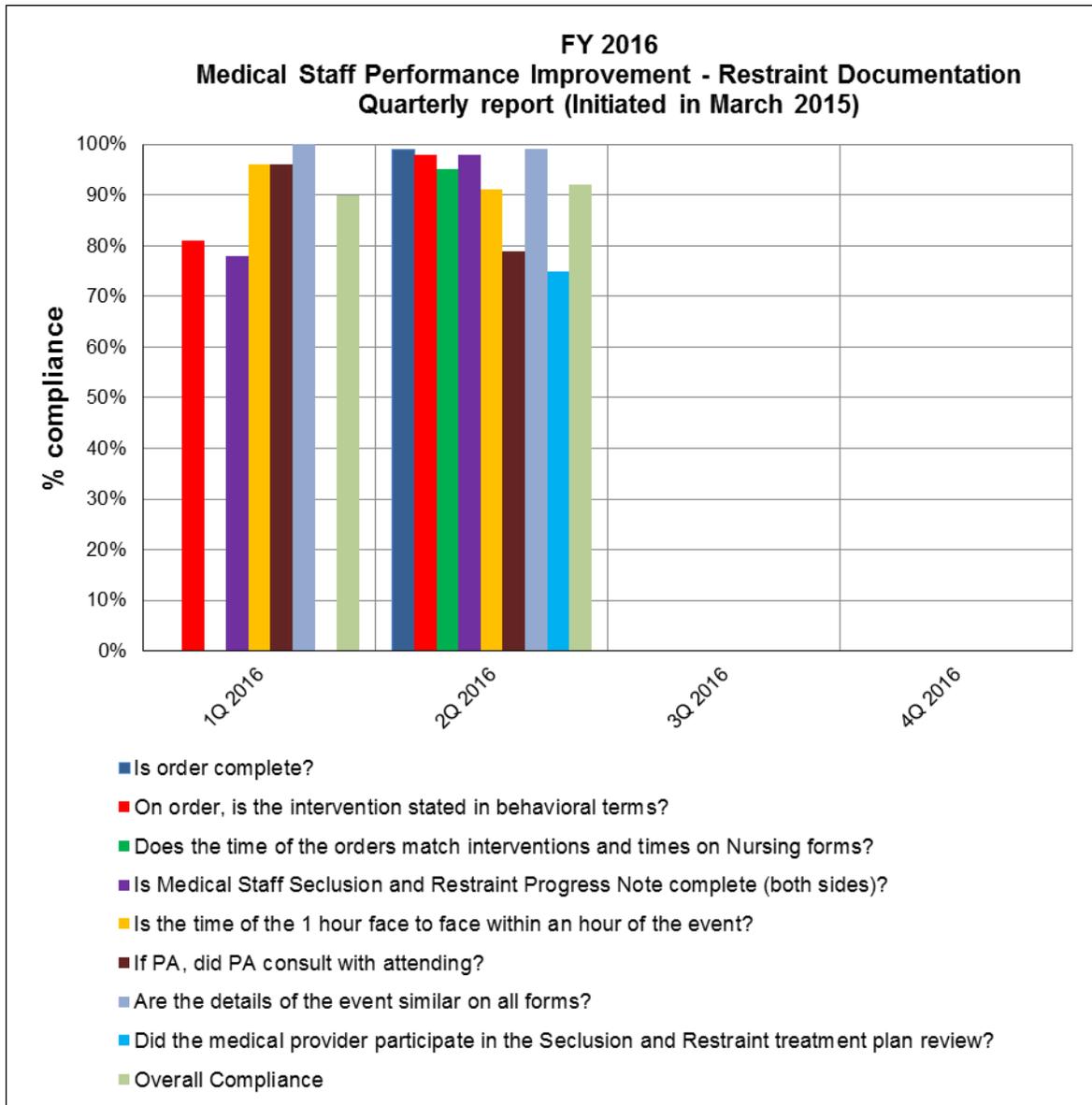
II. Measure Name: Restraint Documentation

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		Baseline	1Q	2Q	3Q	4Q	YTD
	Restrainats	(March 2015)	2016	2016	2016	2016	2016
	Total Restraints	12	39	28			67
	Is order complete?	N/A	N/A	99%			99%
	On order, is the intervention stated in behavioral terms?	100%	81%	98%			90%
100%	Does the time of the orders match interventions and times on Nursing forms?	N/A	N/A	95%			95%
	Is <u>Medical Staff Seclusion and Restraint Progress Note</u> complete (both sides)?	100%	78%	98%			88%
	Is the time of the 1 hour face to face within an hour of the event?	100%	96%	91%			94%
	If PA, did PA consult with attending?	100%	96%	79%			88%
	Are the details of the event similar on all forms?	100%	100%	99%			100%
	Did the medical provider participate in the Seclusion and Restraint treatment plan review?	N/A	N/A	75%			75%
	Overall Compliance	100%	90%	92%			91%

STRATEGIC PERFORMANCE EXCELLENCE



Goal 100% Compliance with Medical Staff Documentation

A new audit tool was implemented in October 2015. Audit questions: Is the order completed? Did the medical provider participate in S&R treatment plan review? Does the time on the orders match interventions and times on the nursing forms? These were not questions on the audit tool prior to 2Q2016.

STRATEGIC PERFORMANCE EXCELLENCE

Data Analysis: It is important to note that the 3 areas of 0% in the first quarter are not a compliance score of 0%, rather they are data elements that were not applicable until the start of the second quarter for fiscal year 2016.

There were 28 restraints in 2Q2016. All data elements for the 2nd quarter have remained above 90% except: If PA, did the PA consult with attending? had a compliance score of 79%; and, Was the seclusion and restraint treatment plan reviewed within 24 hours? had a compliance score of 75%

Plan of Action: The plan moving forward is to continue to monitor compliance with all of the above data elements. Participation in S & R treatment plan review will be added to medical staff's performance expectations along with the expectation that PAs consult the attending during an S & R event.

STRATEGIC PERFORMANCE EXCELLENCE

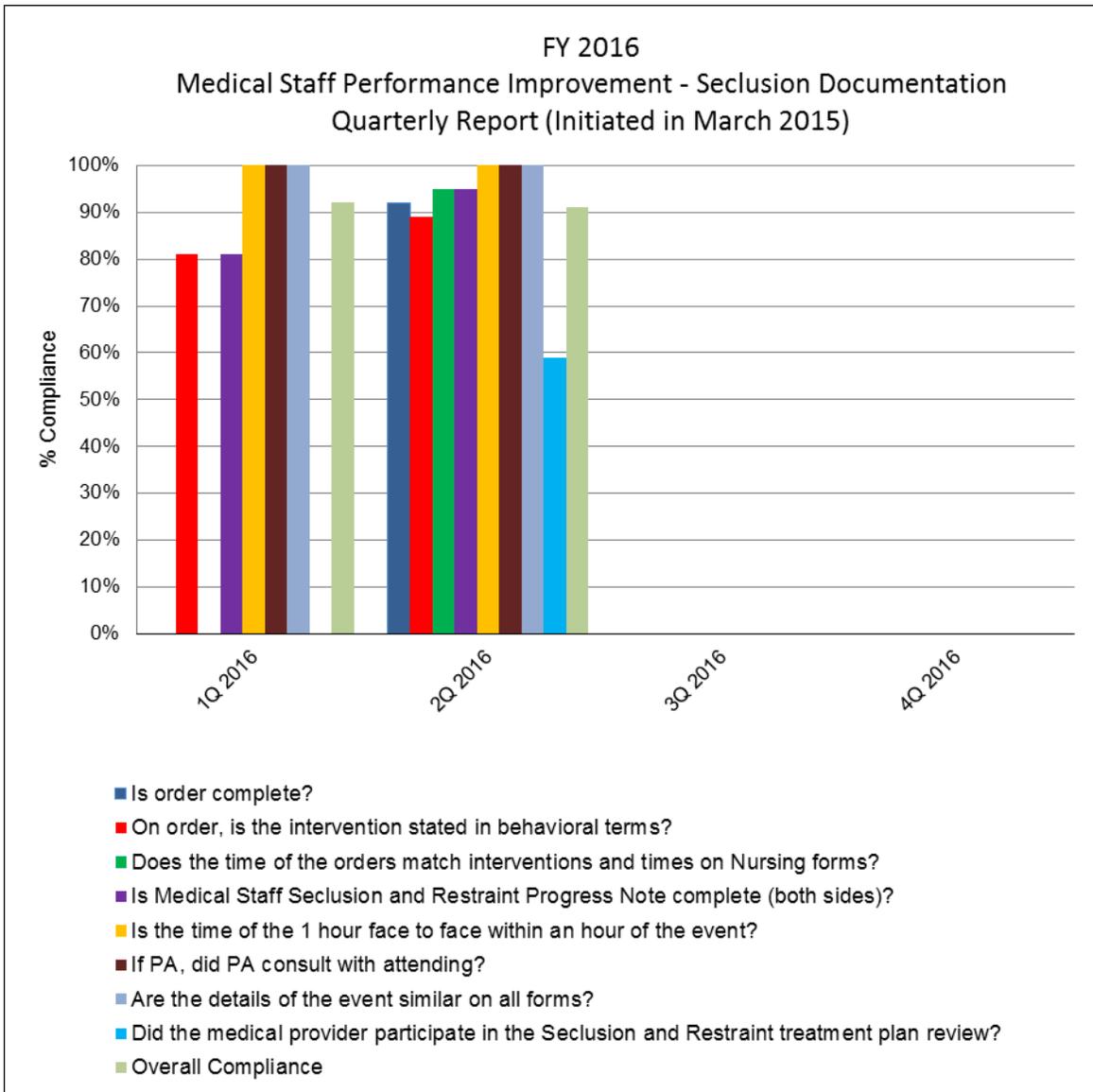
III. Measure Name: Seclusion Documentation

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		Baseline	1Q	2Q	3Q	4Q	YTD
	Seclusions	(March 2015)	2016	2016	2016	2016	2016
	Total Seclusions	7	20	9			29
	Is order complete?	N/A	N/A	92%			92%
	On order, is the intervention stated in behavioral terms?	92%	81%	89%			85%
100%	Does the time of the orders match interventions and times on Nursing forms?	N/A	N/A	95%			95%
	Is <u>Medical Staff Seclusion and Restraint Progress Note</u> complete (both sides)?	100%	81%	95%			88%
	Is the time of the 1 hour face to face within an hour of the event?	100%	100%	100%			100%
	If PA, did PA consult with attending?	92%	100%	100%			100%
	Are the details of the event similar on all forms?	100%	100%	100%			100%
	Did the medical provider participate in the Seclusion and Restraint treatment plan review?	N/A	N/A	59%			59%
	Overall Compliance	96%	92%	91%			90%

STRATEGIC PERFORMANCE EXCELLENCE



Goal: 100% Compliance with Medical Staff Documentation

A new audit tool was implemented in October 2015. Audit questions: Is the order completed? Did the medical provider participate in S&R treatment plan review? Does the time on the orders match interventions and times on the nursing forms? These were not questions on the audit tool prior to 2Q2016.

STRATEGIC PERFORMANCE EXCELLENCE

Data Analysis: It is important to note that the 3 areas of 0% in the first quarter are not a compliance score of 0%, rather they are data elements that were not applicable until the start of the second quarter for fiscal year 2016.

There were 9 seclusions in the 2nd quarter. All data elements for the 2nd quarter of FY 2016 have remained above 90% except: “On the order, is the interventions stated in behavioral terms?” had a compliance score of 89%; and, “Was the seclusion and restraint treatment plan review completed within 24 hours?” had a compliance score of 59%.

Plan of Action: The plan moving forward is to continue to monitor compliance with all of the above data elements. Participation in S & R treatment plan review will be added to medical staff’s performance expectations. With the implementation of new S & R orders, the next quarter will most likely have an increase in compliance with orders having interventions in behavioral terms.

STRATEGIC PERFORMANCE EXCELLENCE

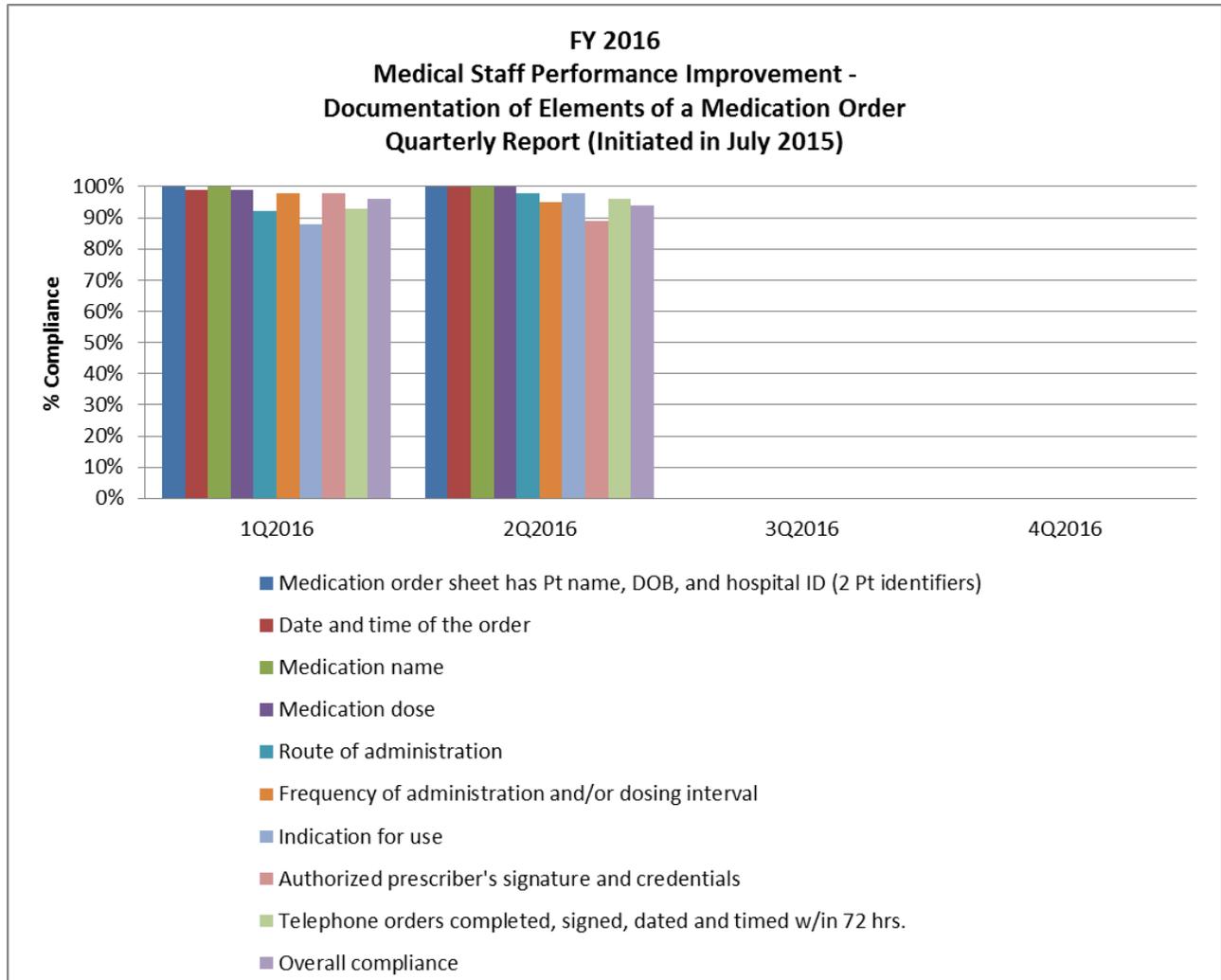
IV. Measure Name: All elements of a medication order are complete.

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	243			517
	Medication order sheet has patient name, DOB and hospital number ID (2 patient identifiers)?	100%	100%	100%			100%
	Date and time of the order	100%	99%	100%			100%
	Medication name	100%	100%	100%			100%
	Medication dose	99%	99%	100%			100%
	Route of administration	94%	92%	98%			95%
	Frequency of administration and/or dosing interval	98%	98%	95%			97%
	Indication for use	80%	88%	98%			93%
	Authorized prescribers signature and credentials	96%	98%	89%			94%
	Telephone orders completed, signed, dated and timed w/in 72 hr.	90%	93%	96%			95%
	Overall Compliance	95%	96%	97%			97%

STRATEGIC PERFORMANCE EXCELLENCE



Data Analysis: 5 data elements were found to be below the established goals of 100% for the 2nd quarter, and “Authorized prescriber’s signature and credentials” is below the threshold of 90%. The overall compliance has decreased from 96% to 94%.

Plan of Action: The plan is to take the above data to the January 2016 Medical Staff Meeting and discuss with medical staff the goal and current data elements that have not met the goal of 100% compliance.

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

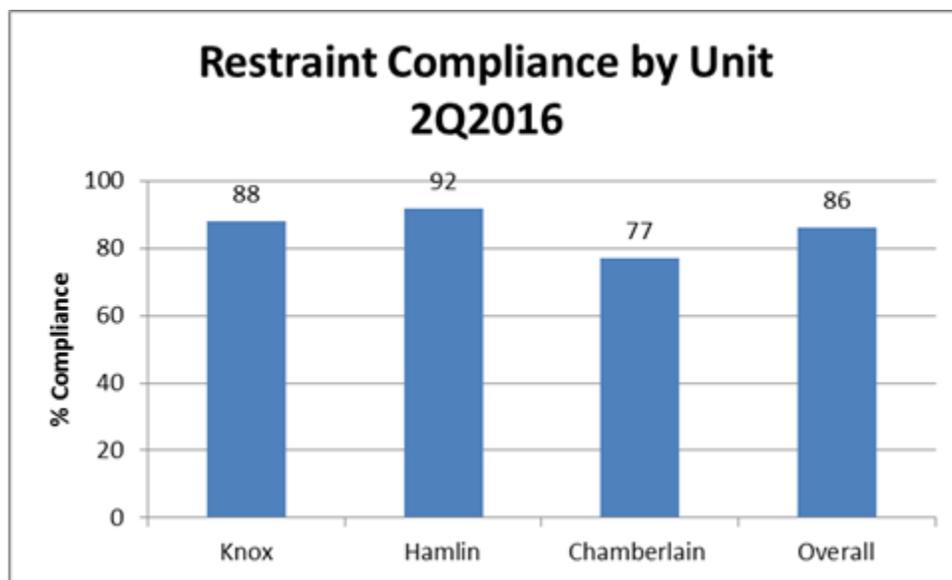
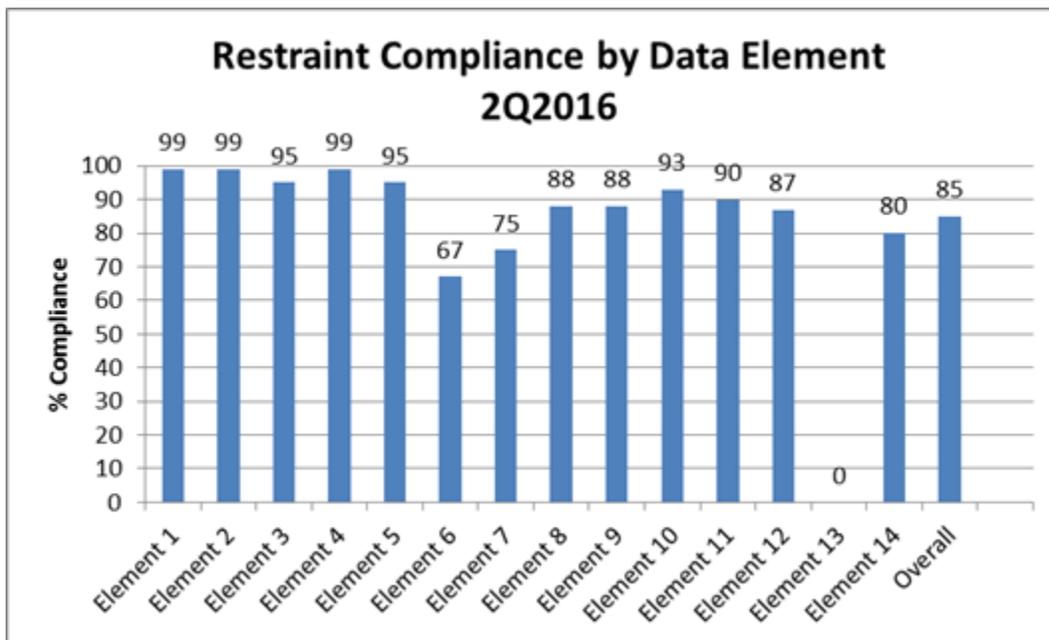
Results							
Target	Data Elements	Baseline	Q1 2016	Q2 2016	Q3 2016	Q4 2016	YTD
100% Compliance	# of Events	11	39	28			67
	Each order obtained within 15 minutes of the intervention?	100%	89%	99%			94%
	Is Form 408 Nursing Seclusion/Restraint Progress Note complete?	50%	83%	99%			91%
	On Form 408 Nursing 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%	95%			96%
	Are details of event similar on all forms without discrepancies 408, 409, and Order sheets?	100%	97%	99%			98%
	Is Form 470 Nursing Assessment Protocol for Seclusion and Restraint completed?	95%	98%	95%			97%

STRATEGIC PERFORMANCE EXCELLENCE

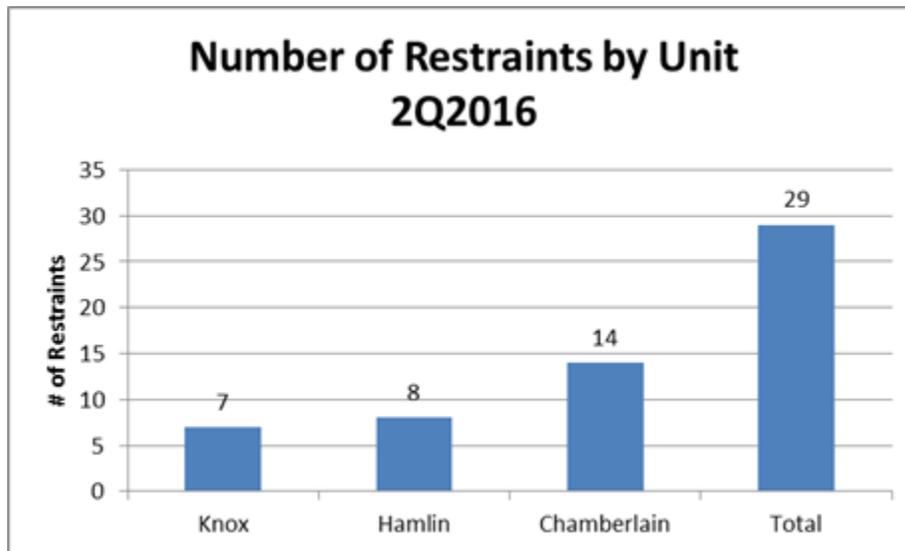
	Data Elements	Baseline	Q1 2016	Q2 2016	Q3 2016	Q4 2016	YTD
	On Form 407RN 2 Hour Seclusion and Restraint Breaks 2 hour breaks are completed at appropriate intervals and signed by RN?	100%	100%	67%			84%
	On Form 407RN 2 Hour Seclusion and Restraint Breaks is time ended for S/R completed and signed by RN	100%	100%	75%			88%
	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%	88%			94%
	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%	88%			94%
	Were debriefings DB1 & DB2 completed at appropriate times?	100%	73%	93%			83%
	Is patient debriefing in the chart?	100%	81%	90%			86%
	Was legal guardian or agent made aware of time of debriefing?	N/A	N/A	87%			87%
	Did legal guardian or agent attend debriefing?	N/A	N/A	0%			0%
	Was Form 470 TX Focused Treatment Plan Review completed within 24 hours?	5%	31%	80%			56%
	Overall Compliance	88%	87%	83%			85%

STRATEGIC PERFORMANCE EXCELLENCE

Data Analysis: Baseline data compiled August 2015 with updates to Seclusion and Restraint procedure, forms, and audit tool since that time. Five elements increased, six show a decrease, and two regarding debriefing after coercive event were implemented this quarter showing 87% and 0% respectively. “Did legal guardian or agent attend debriefing?” is included in data if there was no notification of debriefing event beginning this quarter. Overall a 4% decrease in compliance total from previous quarter with a 5% decrease from baseline.



STRATEGIC PERFORMANCE EXCELLENCE



Plan of Action: 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?” as these are shared comparable documentation responsibilities. Nursing will compare data gathered from Meditech reporting to ensure all coercive events are captured. There is a possibility that prior to beginning this cross-check in December that events were not captured for data collection.

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

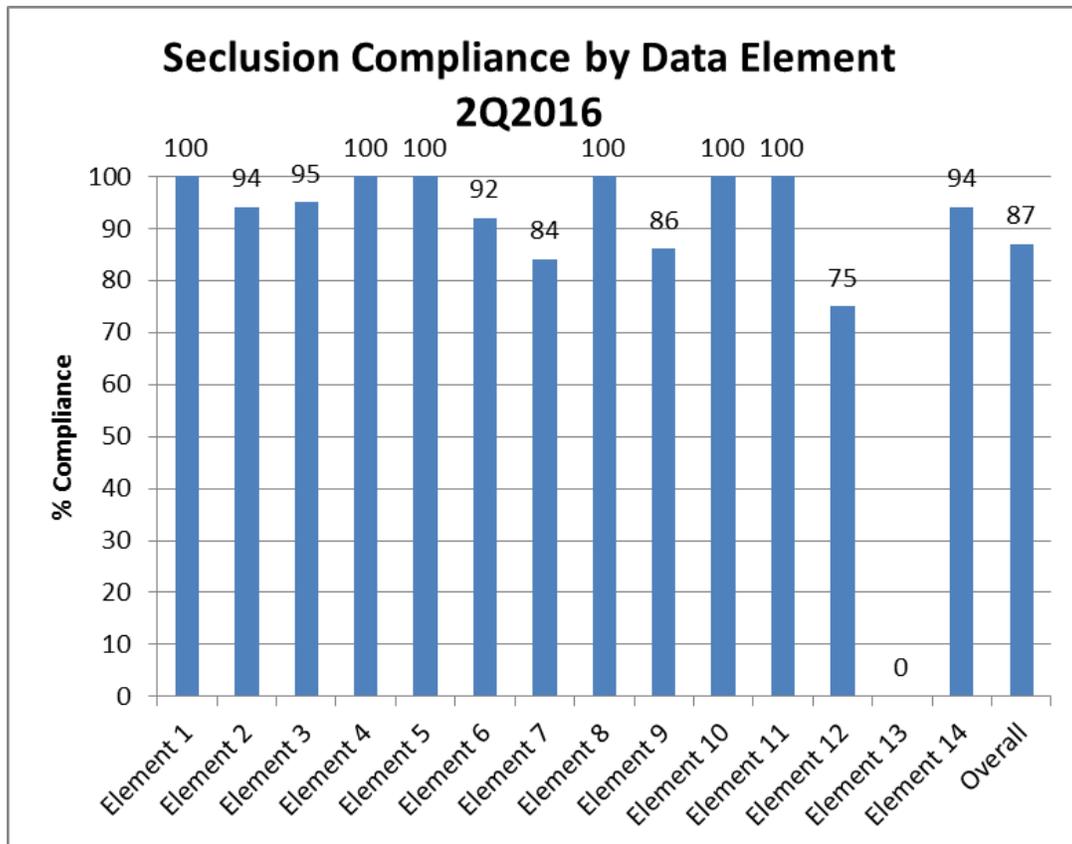
		Results					
Target	Data Elements	Baseline	Q4 2016	Q2 2016	Q3 2016	Q4 2016	YTD
100% Compliance	# of Events	7	14	9			23
	Each order obtained within 15 minutes of the intervention?	100%	100%	100%			100%
	Is form #408 Nursing Seclusion/Restraint Progress Note complete?	50%	64%	94%			79%
	On Form #408 Nursing 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%	95%			88%
	Are details of event similar on all forms without discrepancies #408, #409, and Order sheets?	100%	89%	100%			95%
	Is Form # 470 Nursing Assessment Protocol for Seclusion and Restraint completed?	100%	92%	100%			96%
	On Form # 407RN 2 Hour Seclusion and Restraint Breaks 2 hour breaks are completed at appropriate intervals and signed by RN?	50%	25%	92%			59%

STRATEGIC PERFORMANCE EXCELLENCE

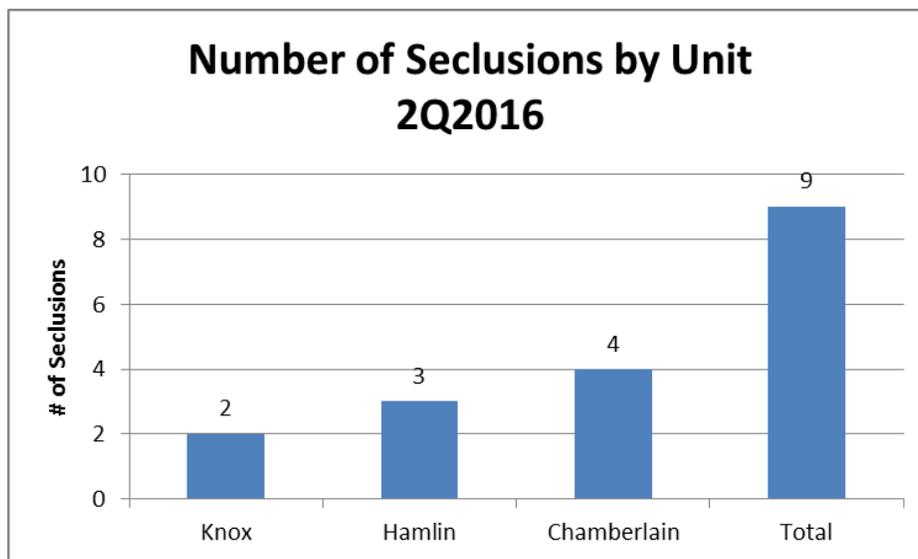
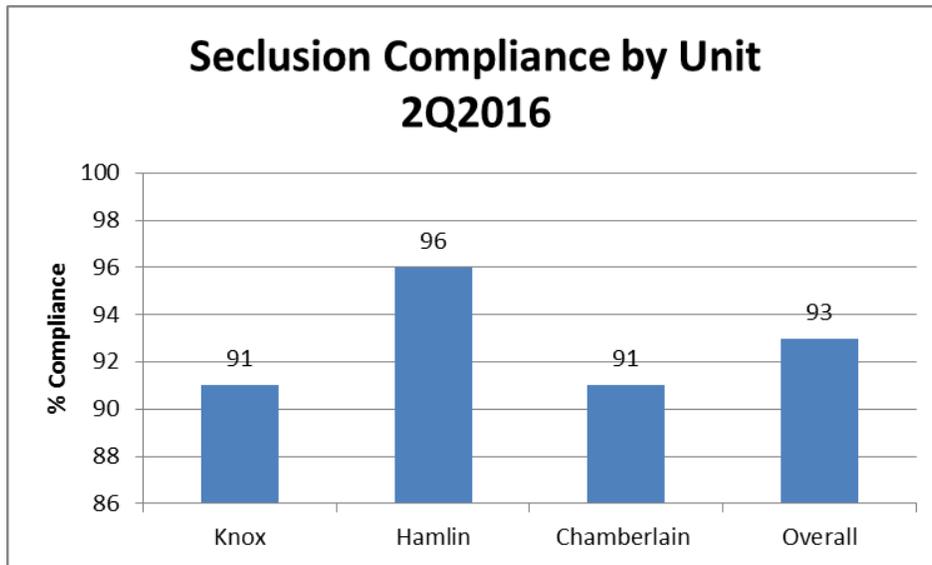
		Results					
Target	Data Elements	Baseline	Q1 2016	Q2 2016	Q3 2016	Q4 2016	YTD
100% Compliance	On Form #407RN 2 Hour Seclusion and Restraint Breaks is time ended for S/R completed and signed by RN	50%	25%	84%			55%
	On Form #407 Seclusion & Restraint Monitoring and Assessment 15 minute checks are completed 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%	100%			98%
	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%	86%			68%
	Were debriefings DB1 & DB2 completed at appropriate times?	100%	89%	100%			95%
	Is patient debriefing in the chart?	100%	95%	100%			98%
	Was legal guardian or agent made aware of time of debriefing?	N/A	N/A	75%			75%
	Did legal guardian or agent attend debriefing?	N/A	N/A	0%			0%
	Was Form # 470 TX Focused Treatment Plan Review completed within 24 hours?	17%	39%	94%			67%
	Overall Compliance	80%	70%	87%			79%

STRATEGIC PERFORMANCE EXCELLENCE

Data Analysis: Baseline data compiled August 2015 with updates to Seclusion and Restraint procedure, forms, and audit tool since that time. Twelve elements increased, the remaining two were previously N/A. Legal guardian/agent is 75% with no legal guardians/agents attending debriefings. Compliance increase from 70% in first quarter to 87%; a 17% increase in the 2nd quarter and a 7% increase from baseline.



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

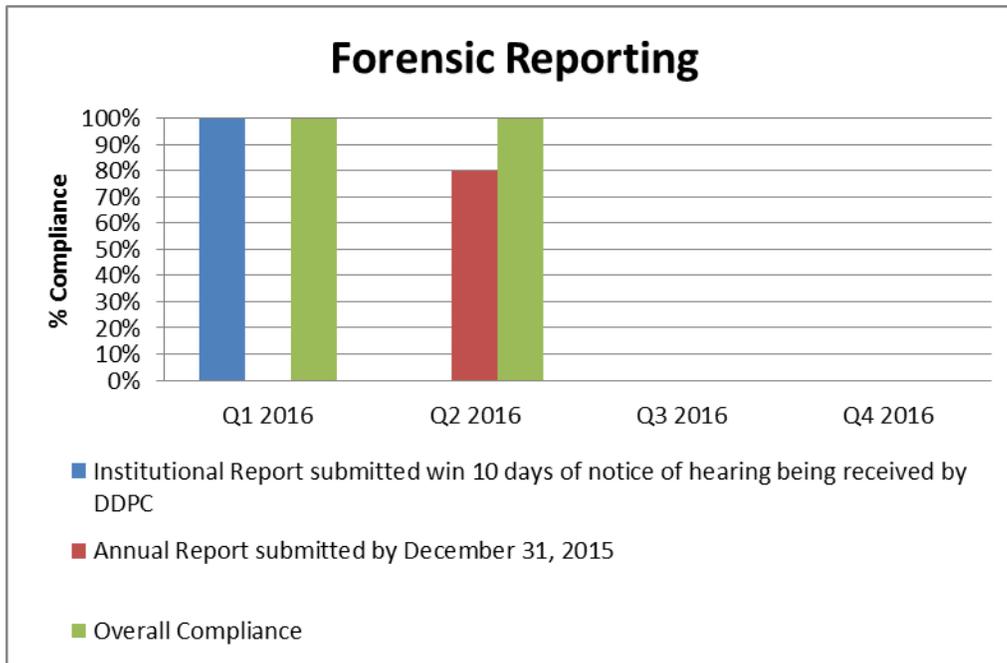
I. Measure Name: Timeliness of Institutional Reports and Annual Reports.

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 FY 2015	1Q 2016	2Q 2016	3Q 2016	4Q 2016	YTD
100% Compliance	# of Reports	3	1/1	4/6			5/7
	Institutional Report submitted within 10 days of notice of hearing being received by DDPC?	0%	100%	0%			50%
	Annual Report Submitted by December 31 st , 2015?	N/A	N/A	80%			80%
	Overall Compliance	0%	100%	67%			71%

STRATEGIC PERFORMANCE EXCELLENCE



Data Analysis: The data element “Institutional Report Submitted within 10 days of notice of hearing being received by DDPC” has decreased since the 1st quarter; although it should be noted that there was only one IR due during that time period. The data element “Annual Report Submitted by December 31st, 2015” is at 80% compliance based on 5 reports due. The overall compliance decreased from 100% to 67% for the 2nd quarter.

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

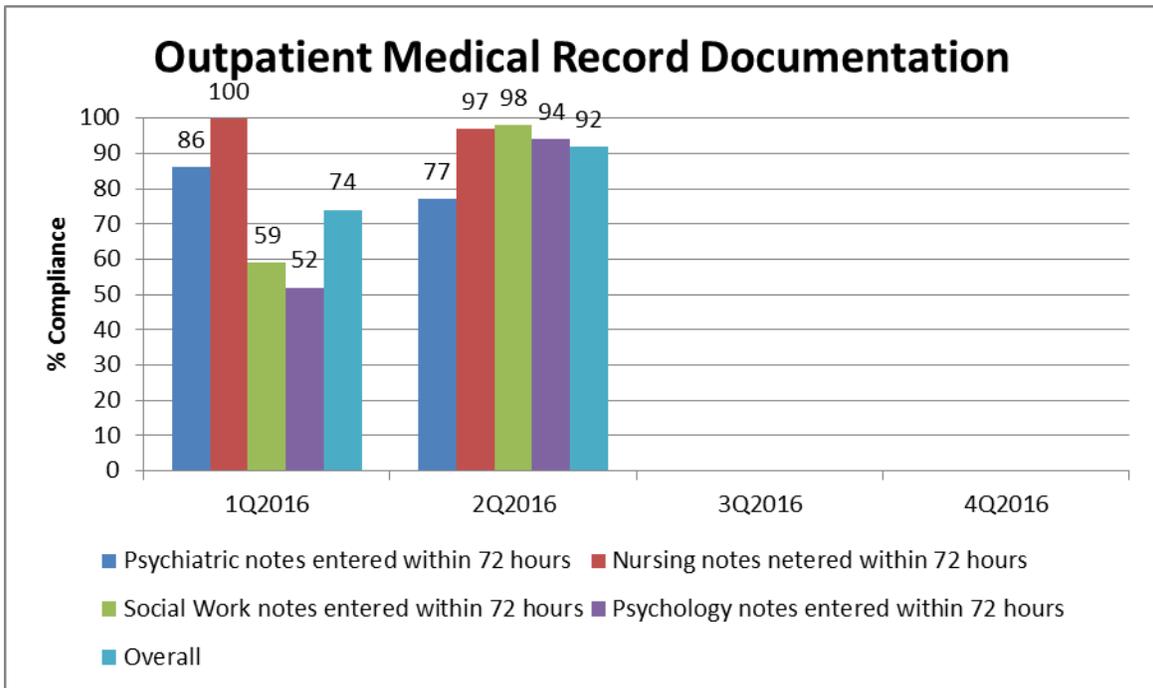
II. Measure Name: Timeliness of Medical Record Documentation for Outpatient Services.

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	210			435
	Psychiatric notes entered within 72 hours?	43%	86%	77%			82%
	Nursing notes entered within 72 hours?	88%	100%	97%			99%
	Social Work notes entered within 72 hours?	85%	59%	98%			79%
	Psychology notes entered within 72 hours?	67%	52%	94%			73%
	Overall Compliance	76%	74%	92%			83%

STRATEGIC PERFORMANCE EXCELLENCE



Data Analysis: Data elements “Psychiatric Notes Entered with 72 hours” and “Nursing Notes Entered within 72 hours” decreased in compliance from the 1st quarter to 2nd quarter. Data elements “Social Work notes entered within 72 hours” and “Psychology notes entered within 72 hours” increased in compliance significantly as did the overall compliance, which increased from 73% to 94% which is above the goal of 90%.

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.

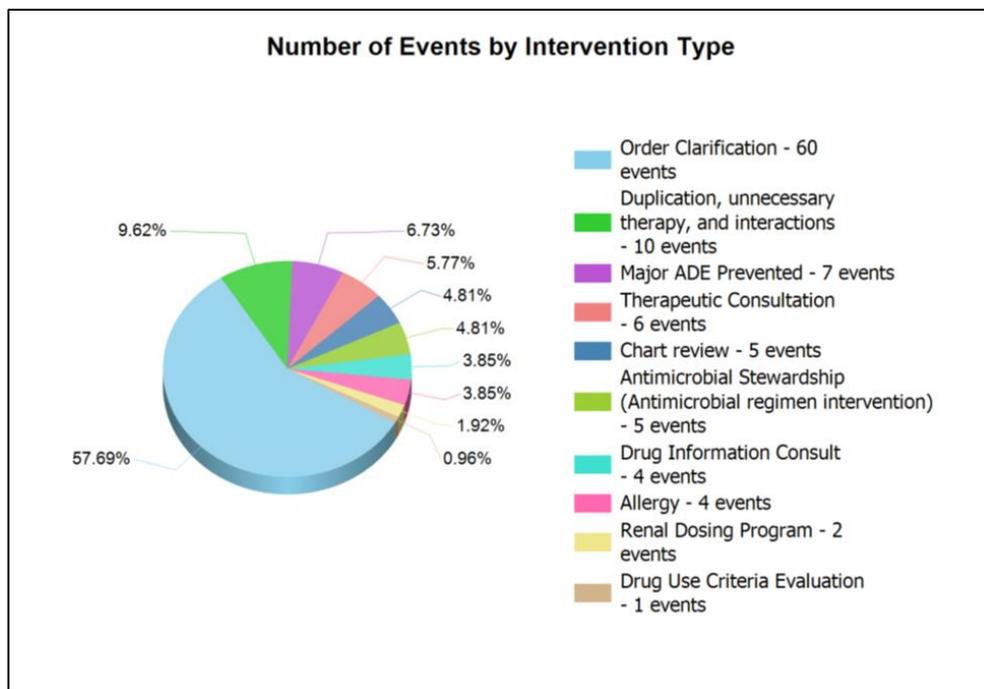
STRATEGIC PERFORMANCE EXCELLENCE

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	103			171



Data Analysis: For the second quarter, DDPC pharmacists checked for indications each week on the 30 day renewals. This led to 60 order clarifications. There were a total of 10 duplicate/unnecessary and interaction interventions. There were 6 therapeutic consultations, 5 chart reviews, 5 antimicrobial regimen interventions, 4 drug information consults, 4 allergy preventions, 2 renal dosing, and one drug use criteria evaluation intervention.

Action Plan: Utilizing dual screens will enhance the real-time operation of documenting clinical interventions.

Comments: Intervention documentation will improve with our new full-time staff pharmacist.

STRATEGIC PERFORMANCE EXCELLENCE

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	Reason for non-compliance
Target	Pharmacy received PE orders		1	100%	100%	100%	100%	
Actual					6			
Target	Did RPh need to resolve PE orders		1	0	100%	100%	100%	
Actual					No			
Target	Were PE meds Clearly identified when clarified		1	100%	100%	100%	100%	
Actual					N/A			
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					Yes			
Target	Was a one-time PE intervention specified as an Emergency Med?		1	100%	100%	100%	100%	
Actual						No		
Target	Did any Emergency Med not end in 72 hours?	1		0	0	0	0	
Actual						No		
Target	Was PE co-signed by psychiatrist if ordered by a PA?		1	100%	100%	100%	100%	
Actual					No			

Data Analysis: This performance improvement measure started late in the 1st quarter. Pharmacy recorded 6 psychiatric emergencies for the second quarter. All orders were written for up to 72 hours. Pharmacist did not have to resolve any of the orders as they were clearly identified. Three of the six PE's were stopped by writing, "Discontinue Emergency Meds"; however, only 1 out of the 3 were actually being stopped before the 72 hours was up. There were zero one time PE interventions specified as an Emergency Medication. All ended within 72 hours. Only 1 PE was not followed up with a co-signature from a psychiatrist after being ordered by a nurse practitioner.

STRATEGIC PERFORMANCE EXCELLENCE

Action Plan: RPC's psychiatric emergency order policy will continue to be monitored and enforced and metrics reported at the Pharmacy and Therapeutics Committee.

Comments: Pharmacy will continue to collect all PE orders this third quarter.

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%	44%			56%
Yes		12	12	8			20
No		4	7	10			17

Data Analysis: For the second quarter, only 8 of the 18 variances were reported to the on call provider within 15 minutes of the discovery of a variance. This is a decrease from last quarter which reported 63%. During this second quarter 15 of the 18 variances reached the patient but caused no harm. Two potential variances, did not reach the patient. One variance reached the patient which required a blood draw for valproic acid levels. The level returned within normal limits and the patient suffered no harm.

Action Plan: To inform the provider of a medication variance within 15 minutes so that the necessary processes can be initiated.

Comments: It is imperative to communicate a medication variance to the provider within 15 minutes to insure optimum patient care.

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	18			37
7am-3pm		9	13	10			23
3-11pm		3	4	7			11
11pm-7am		5	2	1			3

STRATEGIC PERFORMANCE EXCELLENCE

Data Analysis: Again, more than half of our variances are taking place during the 7am to 3pm shift. There is more activity during this time. There were 7 variances from 3pm to 11pm and only 1 from 11pm to 7am.

Action Plan: Focus on utilizing the tools at hand to prevent the occurrence of a variance, such as red lining, double checking the MAR for parameters, and scheduling new orders correctly. The initiation of electronic health records and computerized physician order entry later this year will alleviate much of the issues related to our hybrid system currently in place.

Comments: Keeping focused, avoiding distractions and interruptions, and practicing the five rights are proven methods of decreasing variance occurrences.

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	18			37
Not Yellowed on MAR		(1)					
MAR print out wrong		(1)					
Not faxed		(2)	1	2			3
New order overlooked		(1)		1			1
Med Overlooked		(8)	9	2			11
Distraction			4	3			7
Procedure not followed			1	7			8
Transcription		(5)	4	3			7

Data Analysis: The most frequent cause of medication variances this quarter was 7 for “Procedure not followed.” There were 3 each for “Transcription” and “Distractions” reported, 2 each of “Orders Not Faxed” and “Medication Overlooked” and one reported for “New Order Overlooked.”

STRATEGIC PERFORMANCE EXCELLENCE

Action Plan: Keep well documented MARS as well as never processing an order that is lacking a signature or indication for use.

Comments: The number of variances this quarter resulted in no patient harm. Reporting and trending our finding can only provide opportunities for education and awareness leading to decreasing future occurrences.

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	0	0	0	0	0	0
Totals		17	19	18			37
Wrong Dose		5	2	11			13
Wrong Drug			3				3
Wrong Form		1					
Frequency		2					
Omission		7	7	7			14
Wrong patient		1	1				1
Schedule		1	2				2
Expired Drug			1				1
Procedure not followed			3	1			4
Dispensing		2	8	2			10
Administrative		13	12	15			27

Data Analysis and Action Plan: There were a total of 18 variances, 11 of which were for a Wrong Dose. There were also 7 Omissions.

1. In transcribing an order for Lorazepam Intensol 2mg, two entries should have been made on the MAR; however, there was only one, and a dose was missed. Double checking transcription entries and Electronic MARS are known to prevent this from occurring.
2. Checking the Med Rec form upon admission with the new admission orders would have prevented a dosing error that resulted in the patient receiving less of a dose than intended.
3. Med was not on unit and not administered to patient. No call was made to pharmacy. Communication will be enhanced to prevent future occurrences.

STRATEGIC PERFORMANCE EXCELLENCE

4. Coreg and Lopressor were given because nurse assumed BP and pulse were low and, therefore, administered meds. Checking BP parameters and highlighting them prior to administration of medications are effective methods of preventing a reoccurrence.
5. Med nurse was doing a 1 on 1 and so missed a 1300 dose of lorazepam. Check MAR for scheduled meds.
6. Tylenol and Coreg were overlooked. Use Med Minder.
7. Klonopin p.o. was initially refused resulting in an ordered IM dose. An oral dose was later requested by the patient and administered. Double checking and proper documentation in the MAR would have prevented this occurrence.
8. Haldol 2.5mg BID order decreased to 8pm only. Pt. received extra dose due to incorrect scheduling documentation.
9. Melatonin 3mg was overlooked. Pt. was sleeping at the time. Obtain order to hold.
10. Miconazole/triamcinolone with Maalox was not stopped when ordered. The stop order was not faxed. Check that faxes have gone through. Sometimes the line is busy and fax will not go through.

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			0	0	0	0	0
Actual	Rx	5.7/month	13.7/month	11.3/month			12.5/month

Data Analysis: There were 34 controlled substance discrepancies out of 5596 total controlled substances dispensed from the five different Pyxis machines. There is one machine on each unit: Knox, Hamlin, and Chamberlain, as well as the night cabinet, and the one in the pharmacy. For the second quarter FY 2016, 11.3 discrepancies per month were reported, a decrease from last quarter. All of the controlled substances have been accounted for, resulting in a 0% loss of controlled substances for the second quarter.

Action Plan: Educate staff on automatic dispensing cabinet procedures and best practices to avoid the creation of discrepancies.

Comments: The current quarterly average is an improvement over the last quarter report 13.7/month. Second quarter results still require improvement to reach our baseline.

STRATEGIC PERFORMANCE EXCELLENCE

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

	Unit	Baseline FY 2015	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	All	\$1992 for 48 meds	0	0	0	0	0
Actual			\$713.07/ 20 meds	\$6.51/ 4 meds			\$719.58/ 24 meds

Data Analysis: In December we had a patient being discharged and transitioning into a group home. There was going to be a short delay before the group home could provide this patient's medications. This patient needed 4 different medications for a total cost of \$6.51. Our year to date total is \$719.58/24 medications equaling $\$719.58/24 = \$29.98/\text{med}$, a decrease from last quarter's results of $\$713.07/20 = \$35.65/\text{med}$.

Action Plan: Pharmacy together with the medical care team is focused on providing discharged patients the ability to obtain their prescriptions with their own coverage. This multidisciplinary approach leads to increased patient care as well as cost containment measures.

Comments: We will continue this process and monitoring of the DDPC discharge medications and report any trends or outliers.

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 FY 2015	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	All	93%	100%	100%	100%	100%	100%
Actual			85%	53%			69%

Data Analysis: Eight out of fifteen units were inspected for the second quarter. The 3 units of Knox, Hamlin, and Chamberlin were only inspected in October and November.

- On Chamberlin the pharmacy technician found expired and discontinued medications still in the patient's basket.
- On Hamlin, discontinued medications were also found in a patient basket.

STRATEGIC PERFORMANCE EXCELLENCE

- The pharmacy technician was unable to locate the metric conversion chart on the Knox unit. Ear drops were found with inhalers. A discontinued insulin and discontinued miconazole powder were left in the patient basket. A vial of insulin was found not initialed or dated when opened / expires.

Action Plan: Communicate with Nursing Supervisors inconsistencies of findings and remind nursing to remove discontinued bulk meds from patient’s own baskets. January’s inspections were performed immediately in all areas and reports were provided directly to the Director of Pharmacy. The Pharmacy Technician involved was counseled and instructed to ask for help if they were unable to complete the inspections in a timely fashion. Double checking the status of unit inspections and following up with the responsible individuals as well as adding and removing individuals from the report distribution list on a monthly basis will bring our next quarterly report closer to target levels.

Comments: Since adding the Director of Pharmacy to the report distribution list and counseling the pharmacy staff, monitoring the unit inspections will achieve favorable compliance reporting for the next quarter.

- 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			0	0	0	0	0
Actual	All	8.9/month 0.067%	10.1/month 0.071%	13.4/month 0.089%			11.75/ month

Data Analysis: Knowledge Portal showed an average of 40.1 non-controlled discrepancies for the 2nd quarter of FY 2016. There were a total of 44,926 doses dispensed of non-controls from the Pyxis MedStation System. Second quarter dispensed 2,708 more doses than first quarter which reflects an increase of 0.018% over first quarter.

Action Plan: Assist Nursing by reporting the metrics on a monthly basis. Reinforce the use of the Five Rights method.

Comments: With an increase in non-controlled doses dispensed, the number of discrepancies would also increase. It is the goal, through monitoring, education and information transfer to report a decrease in the metrics.

STRATEGIC PERFORMANCE EXCELLENCE

Social Services

Robyn Fransen, LSW-C

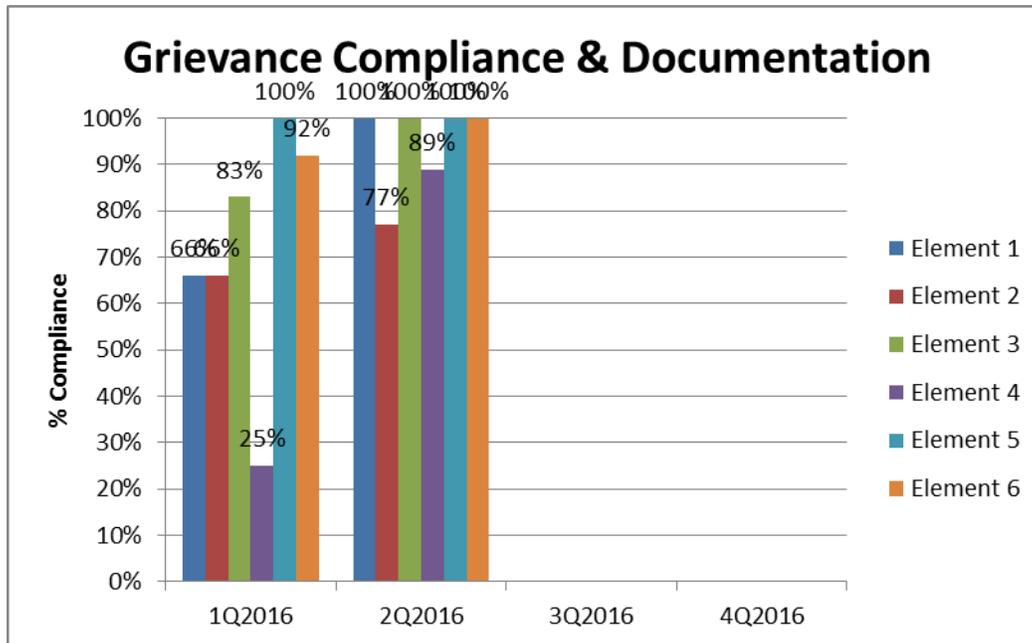
I. Measure Name: Grievance Compliance and Documentation.

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	9			21
	Unit Staff compliant with addressing grievance?		66%	100%			83%
	Unit Staff completed form correctly (boxes checked, dated/timed, all signatures completed, Nurse Supervisor notified)?		66%	77%			72%
	*Nursing Supervisor compliant with addressing grievance within 4 hours?		83%	100%			92%
	Nurse Supervisor completed form correctly (boxes checked, dated/timed, all signatures completed, forwarded to Social Worker)?		25%	89%			57%
	*Social Worker compliant with addressing grievance within 5 days or within 5 more days if extension is requested?		100%	100%			100%
	*Overall Compliance of Nursing Supervisor and Social Worker addressing grievance		64%	92%	100%		

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 and 4th quarter of FY 2015. Starting with the 1st quarter of 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

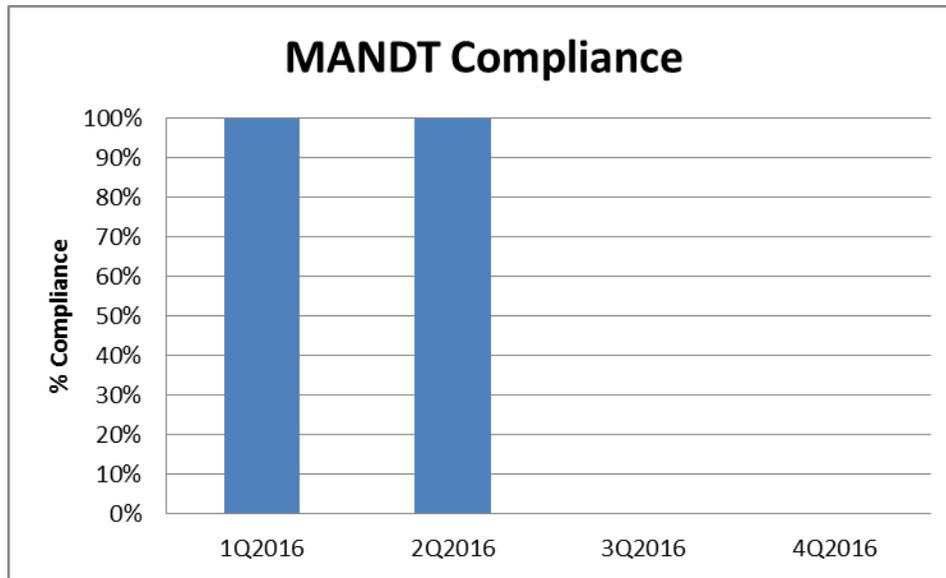
		Results					
	Unit	Baseline	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	Number of employees (213)	91% 4Q2015	100%	100%	100%	100%	100%
Actual			100% 212/213	100% 224/224			100% 436/437

Data Analysis: Overall analysis of the data reveals 100% MANDT compliance rate when direct care and non-direct care are combined. It is the goal of SED for 90% MANDT training amongst both direct and non-direct care staff.

Action Plan:

- Staff education will complete monthly audits
- Staff education will send monthly reports to department heads and Superintendent of employees out of compliance.

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

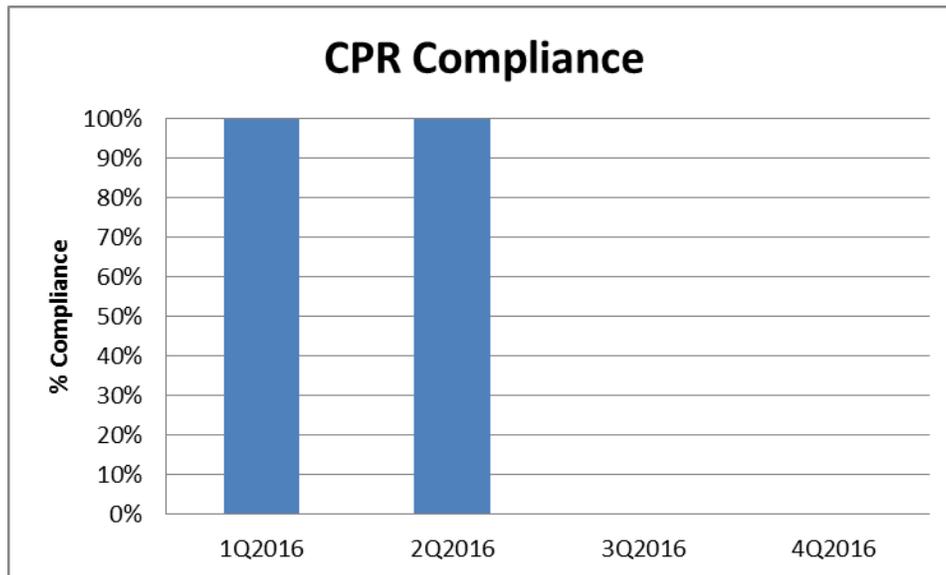
Results							
	Unit	Baseline	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	Number of Employees (225)	99% FY 2015	100%	100%	100%	100%	100%
Actual			100% 224/225	100% 215/216			100% 439/441

STRATEGIC PERFORMANCE EXCELLENCE

Data Analysis: Overall analysis of the data reveals 99.5% CPR compliance rate when direct care and non-direct care are combined. Direct care staff continue to remain at 100% compliance. This reflects one non-direct care staff member from facilities who was unable to attend the December 2015 class due to staff member forgetting. It is the goal of SED for 90% CPR training amongst both direct and non-direct care staff.

Action Plan:

- The employee out of compliance was scheduled to attend the January 2016 CPR training.
- Staff education will complete monthly audits
- Staff education will send monthly reports to department heads and Superintendent of employees out of compliance.
- Staff education will increase the number of instructors in the hospital to make classes more available. At this time, there are three instructors and a fourth in the process of becoming certified.



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

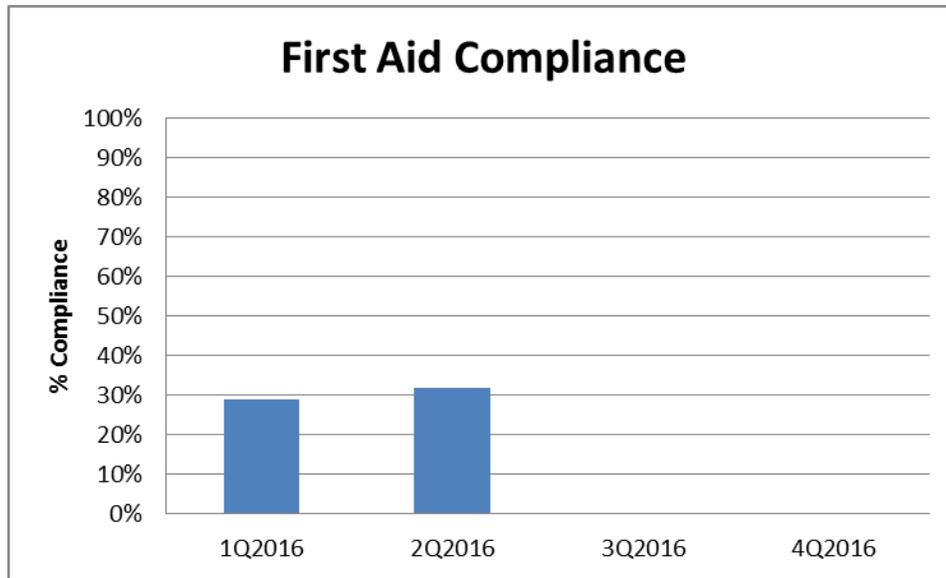
		Results					
	Unit	Baseline	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	Number of Employees	20% 4Q2015	0%	30%	60%	90%	90%
Actual			29% 64/221	32% 71/223			30% 135/444

Data Analysis: Overall analysis of the data reveals 32% First Aid compliance rate amongst both direct care staff and non-direct care staff, a 3% increase over the 1st quarter. 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 send monthly reports to department heads and Superintendent of employees out of compliance.
- 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. At this time, there are three instructors and fourth in the process of becoming certified.
- 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. The fourth instructor is in the process of becoming certified at this time.

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

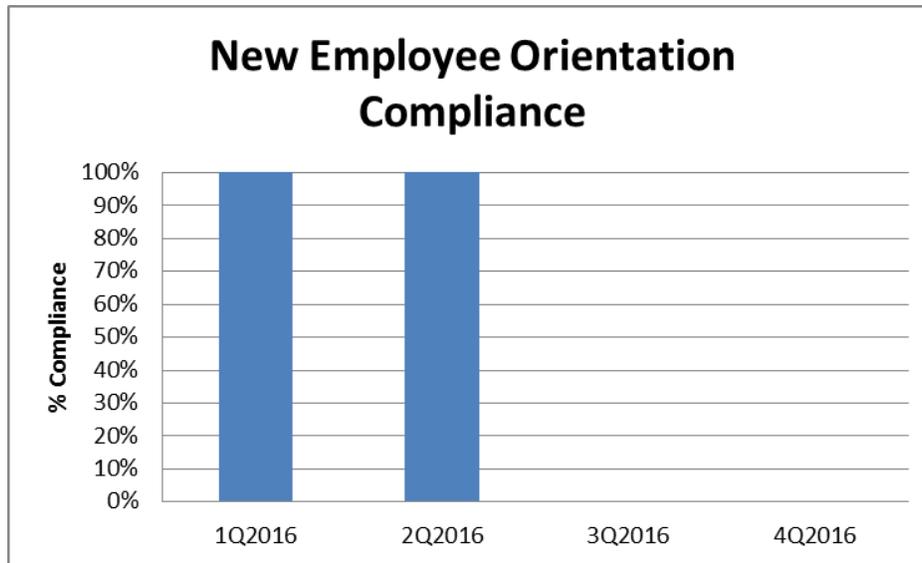
Results							
	Unit	Baseline	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	Number of Employees	100% 4Q2015	100%	100%	100%	100%	100%
Actual			100% 13/13	100% 24/24			100% 37/37

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
- Staff education will send monthly reports to department heads and Superintendent of employees out of compliance.
- Staff education will begin spot checks on NEO.

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

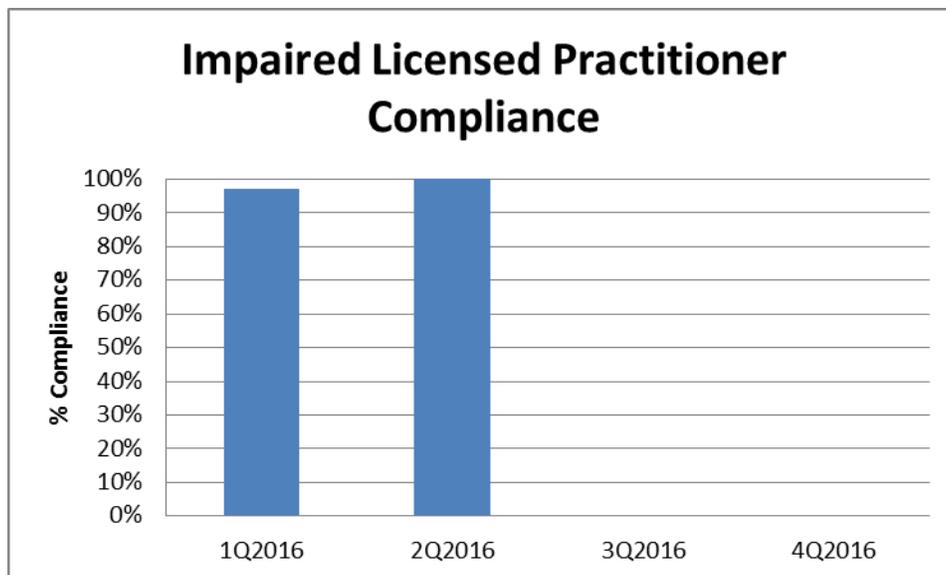
Results							
	Unit	Baseline	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target			100%	100%	100%	100%	100%
Actual	Number of employees	97% 4Q2015	97% 217/224	100% 223/223			98% 440/447

STRATEGIC PERFORMANCE EXCELLENCE

Data Analysis: Overall analysis of the data reveals 100% compliance rate. This requirement has been included in new employee orientation. It is the goal of SED for 90% compliance. Staff education will continue to strive for this goal.

Action Plan:

- Staff education will complete monthly audits
- Staff education will send monthly reports to department heads and Superintendent of employees out of compliance.
- Staff education will begin spot checks on ILP.



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

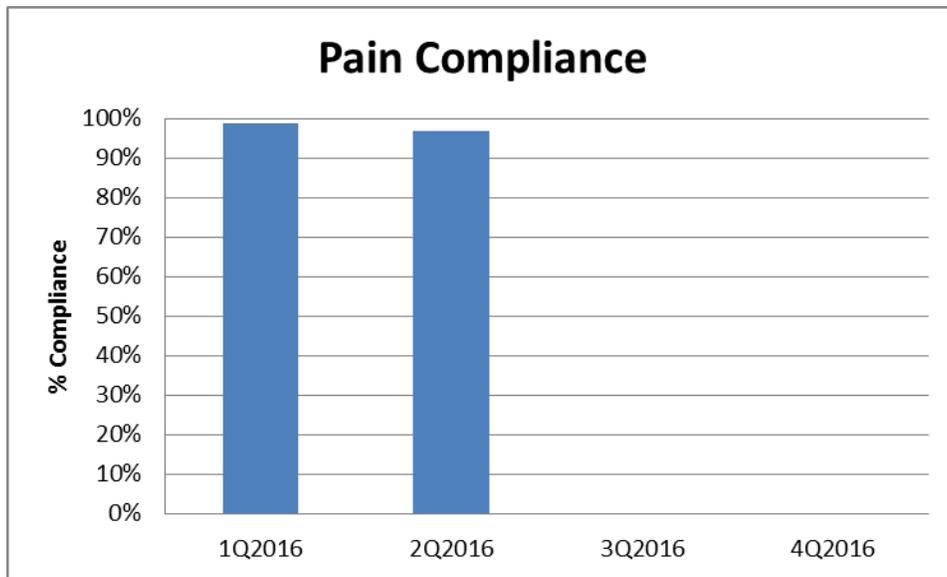
STRATEGIC PERFORMANCE EXCELLENCE

		Results					
	Unit	Baseline	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	Number of Employees	94% 4Q2015	100%	100%	100%	100%	100%
Actual			99% 78/79	97% 72/74			99% 78/79

Data Analysis: Overall analysis of the data reveals 97% compliance rate amongst RN's and medical provider staff. This reflects two RN's, one whom is a per diem employee. It is the goal of SED for 90% of staff to be compliant. Staff education will continue to strive for this goal.

Action Plan:

- Staff education will complete monthly audits
- Staff education will send monthly reports to department heads and Superintendent of employees out of compliance.
- Staff education will begin spot checks on Pain.



STRATEGIC PERFORMANCE EXCELLENCE

Therapeutic Services

Lisa J. Hall, OTR/L

I. Measure Name: Direct Patient Contact

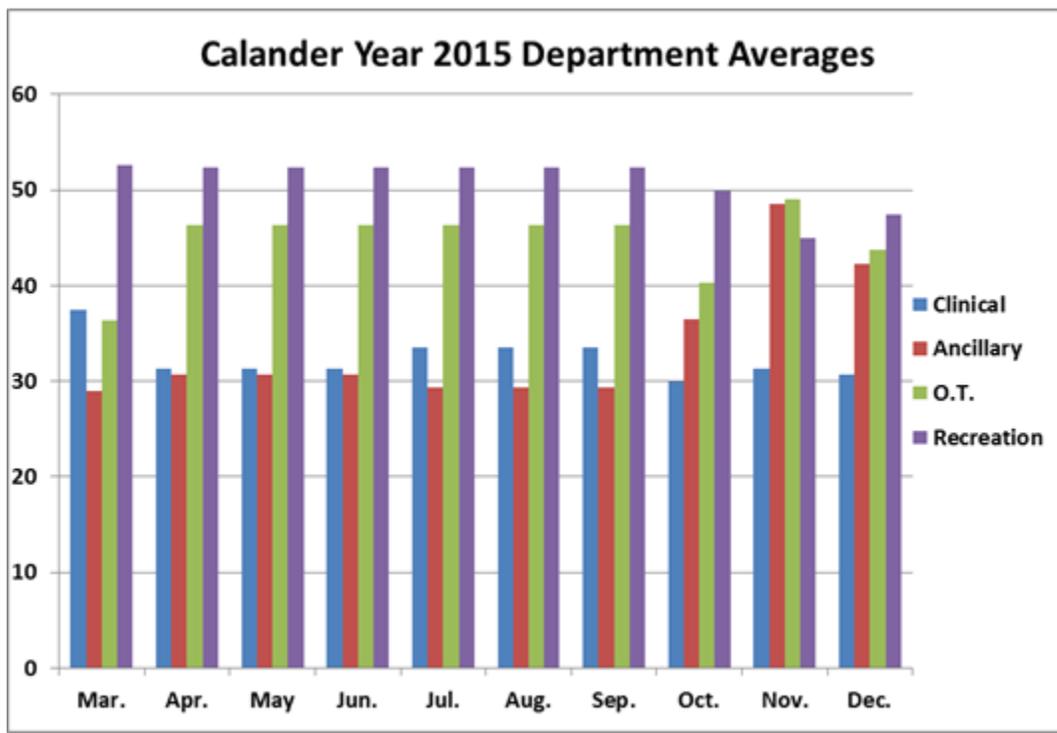
Measure Description: Improving health outcomes/patient care. In order to receive effective treatment that will allow patients to return to a satisfying and meaningful life in their chosen community; staff must provide engagement, assessment and treatment that is targeted to meet their individual needs. 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	July 2015	Aug 2016	Sept 2016	Oct 2015	Nov 2015	Dec 2015
44%	42%	43%	44%	39%	44%	42%

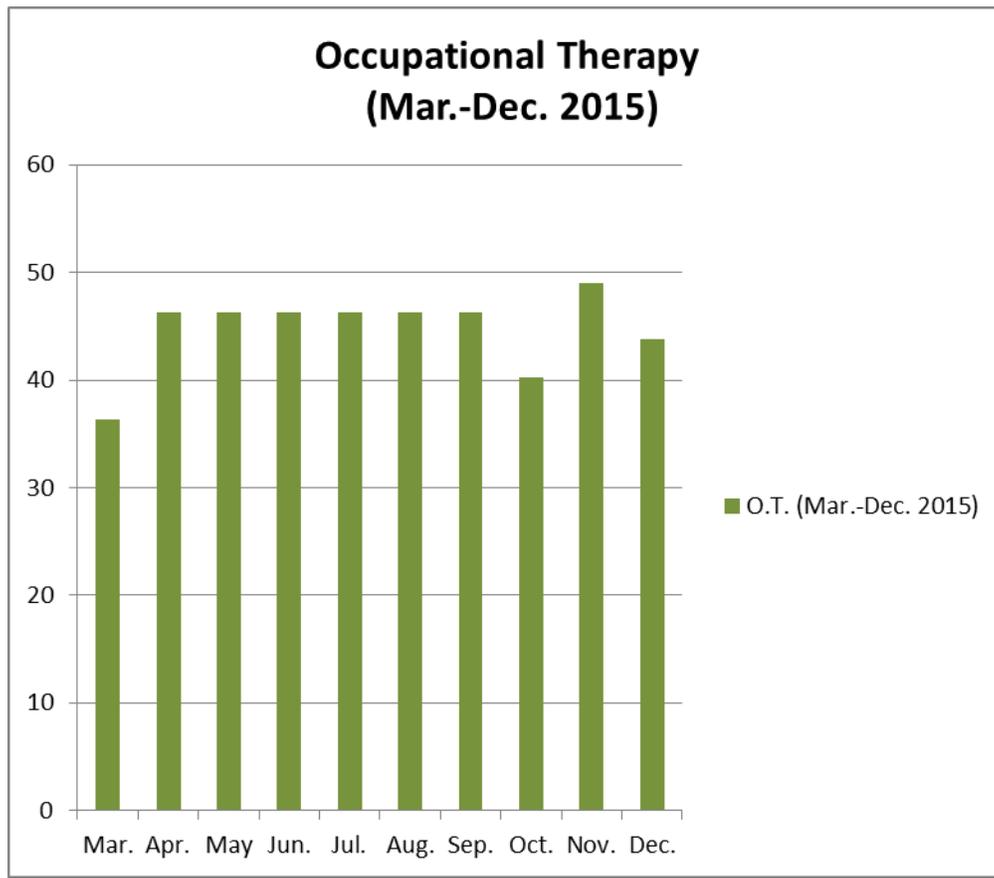


STRATEGIC PERFORMANCE EXCELLENCE

B. Measure Name: Direct Patient Contact - Occupational Therapy

Results							
	Unit	Baseline	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	Percent of time spent in direct patient contact.	36% March 2015	65%	50%	50%	50%	50%
Actual			46%	44%			45%

Provider Range: 43%-52%



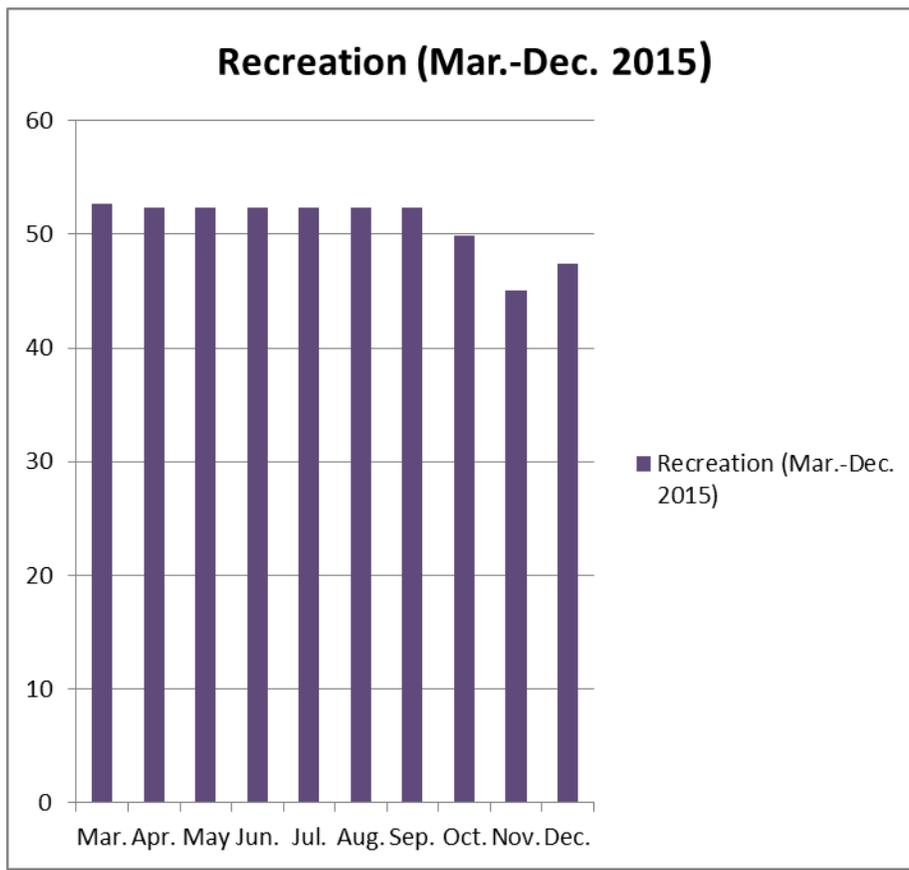
STRATEGIC PERFORMANCE EXCELLENCE

C. Measure Name: Direct Patient Contact - Therapeutic Recreation

Results							
	Unit	Baseline	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	Percent of time spent in direct patient contact.	55% March 2015	65%	50%	50%	50%	50%
Actual			52%	47%			50%

RT Range: 34%-64%

Hab. Aide Range: 39%-57%

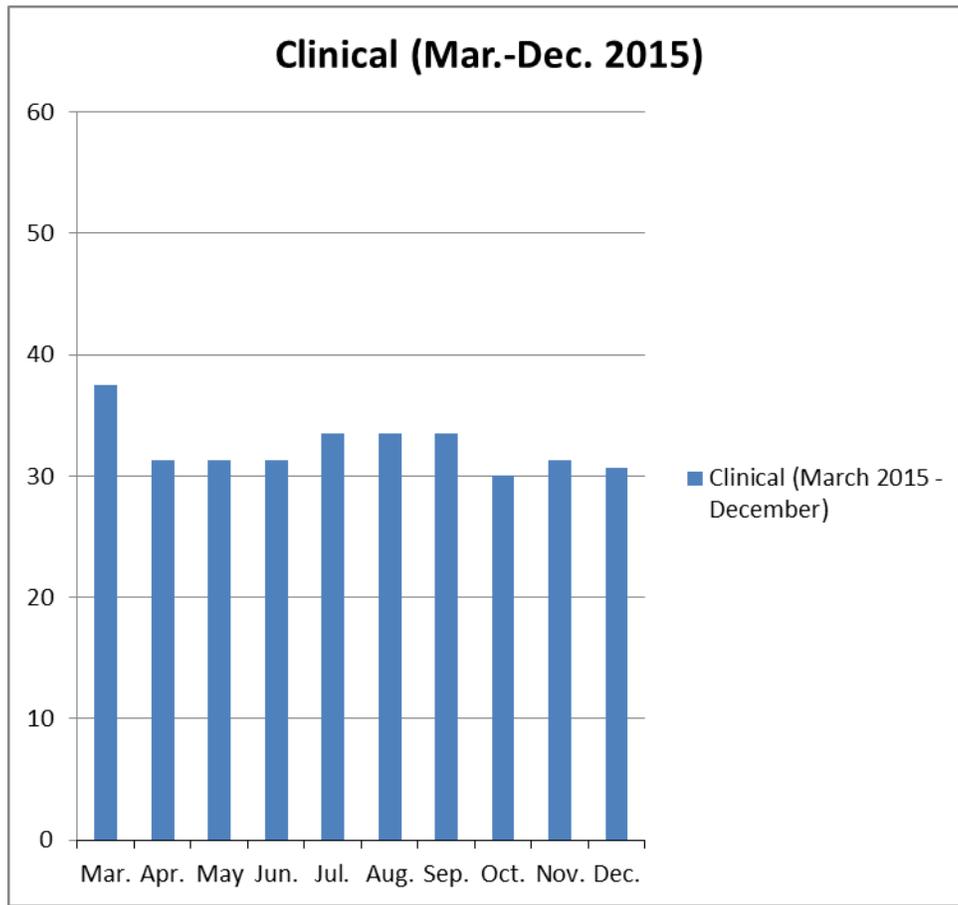


STRATEGIC PERFORMANCE EXCELLENCE

D. Measure Name: Direct Patient Contact - Clinical Services

Results							
	Unit	Baseline	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	Percent of time spent in direct patient contact.	35% March 2015	65%	40%	50%	50%	50%
Actual			33%	30%			32%

Provider range: 23%-37%

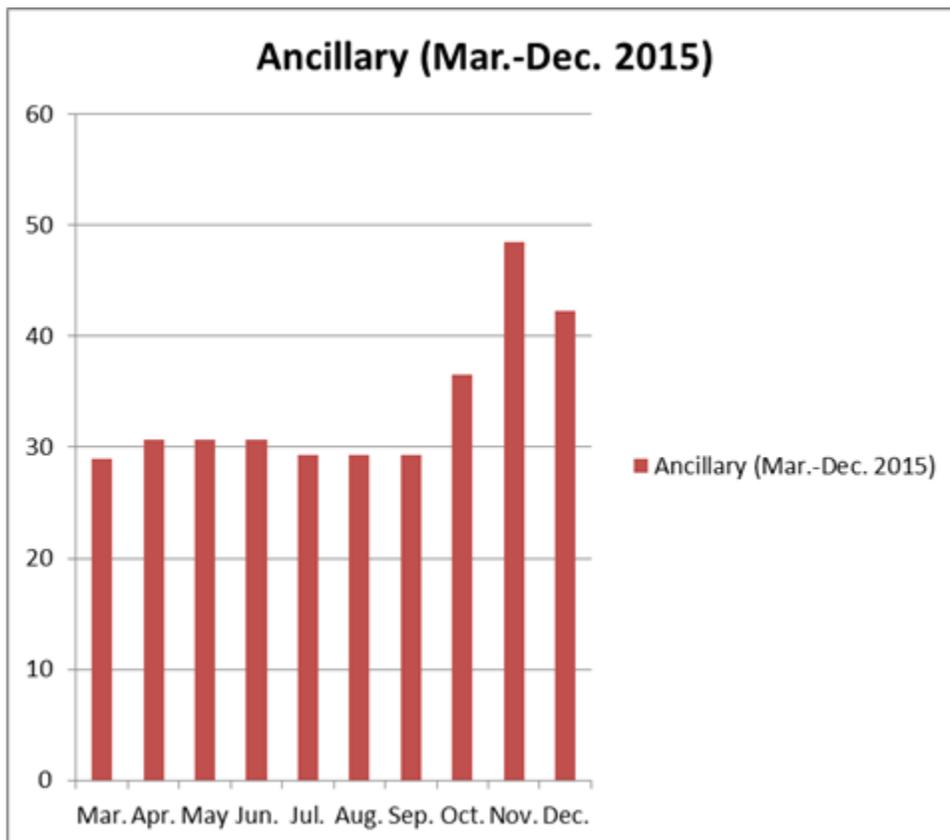


STRATEGIC PERFORMANCE EXCELLENCE

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

Results							
	Unit	Baseline	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Target	Percent of time spent in direct patient contact.	31% March 2015	65%	40%	50%	50%	50%
Actual			28%	42%			29%

Provider range: 30%-51%



Data Analysis: Additional task of providing patients with daily schedules was added in the 2nd quarter, a decrease in direct care hours for OT and Rec was expected as a result. OT dipped to 44% with one provider meeting the 50% goal. Recreation dipped to 47%, however this may be a more accurate reflection due to the extensive amount of missing data for quarter 1. Clinical

STRATEGIC PERFORMANCE EXCELLENCE

services decrease is likely due to one member being on FML for 8 of the 12 weeks and the habilitation aide leaving clinical services and moving to ancillary services to reflect the significant time spent in “milieu management” on the WTM. Ancillary services increased as a result, now including 4 distinct services instead of individual reports.

Action Plan:

1. Focus on accurate data collection by getting data weekly, counseling if data is late.
2. Explore pilot treatment flow sheet for documentation, requires approval of med staff, medical records committee and billing / reimbursement specialist.
3. Provide each staff with weekly feedback on their performance.
4. Conduct counseling for each staff member not improving by at least 2% or maintaining 50% per month.
5. Explore requirement for treatment plan participation – can the clinical social worker represent all therapeutic services providers if discipline specific TX plan note is in the record.

II. Measure Name: Timely 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 each treatment plan meeting staff is expected to come prepared to share their area of expertise and propose what treatment offerings they will make available to the patient. To best guide treatment, discipline specific assessments must be complete and available in the patient record.

Type of Measure: Quality Improvement

A. Measure Name: Therapeutic Recreation Evaluations completed by initial RTP.

Goal: All patients will have a therapeutic recreation assessment in the record prior to the first treatment plan meeting. (New expectation February 2016)

Numerator: Rec evaluations in the record by initial RTP

Denominator: All initial RTP meetings held

STRATEGIC PERFORMANCE EXCELLENCE

		Results					
	Unit	Baseline	1Q2016 (Jul-Sept 2015)	2Q2016 (Oct-Dec 2015)	3Q2016 (Jan-Mar 2016)	4Q2016 (Apr-Jun 2016)	YTD
Target	Percent of Initial Rec Assessments in the record prior to the initial RTP.	2Q2016 49%	NA	Baseline	90%	90%	90%
Actual			N/A	49%			49%

Data Analysis: Prior to February 2016, staff were expected to complete the initial recreation assessment within 7 days of admission.

Action Plan: On January 11, 2016 Recreation Therapists were asked to complete their initial assessment prior to the initial RTP meeting.

B. Measure Name: Substance Abuse Evaluations completed within 10 days of referral. (Effective February, 2016)

Goal: All patients will have a substance abuse assessment in the record within 10 calendar days of the referral.

Numerator: Substance abuse evaluations in the record within 10 days of referral being completed.

Denominator: All substance abuse referrals received.