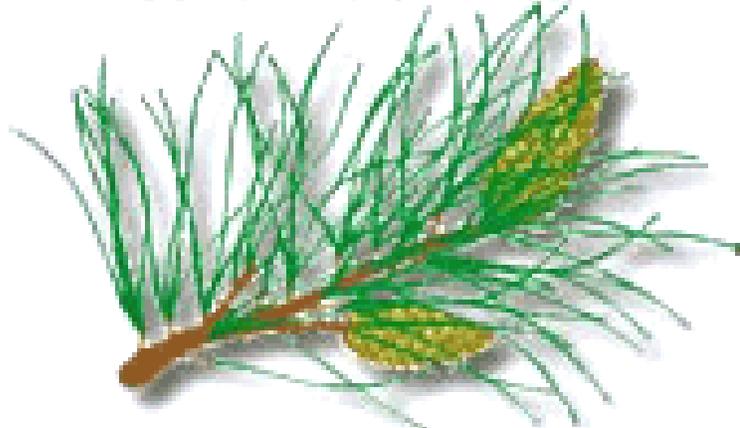


Dorothea Dix



Psychiatric Center

QUARTERLY REPORT ON
ORGANIZATIONAL PERFORMANCE EXCELLENCE

THIRD FISCAL QUARTER 2015

January, February, March 2015

Sharon Sprague, Superintendent

May 11, 2015



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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 by,

Joseph Riddick

Joseph Riddick

Director of Integrated Quality and Informatics



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COMPARATIVE STATISTICS

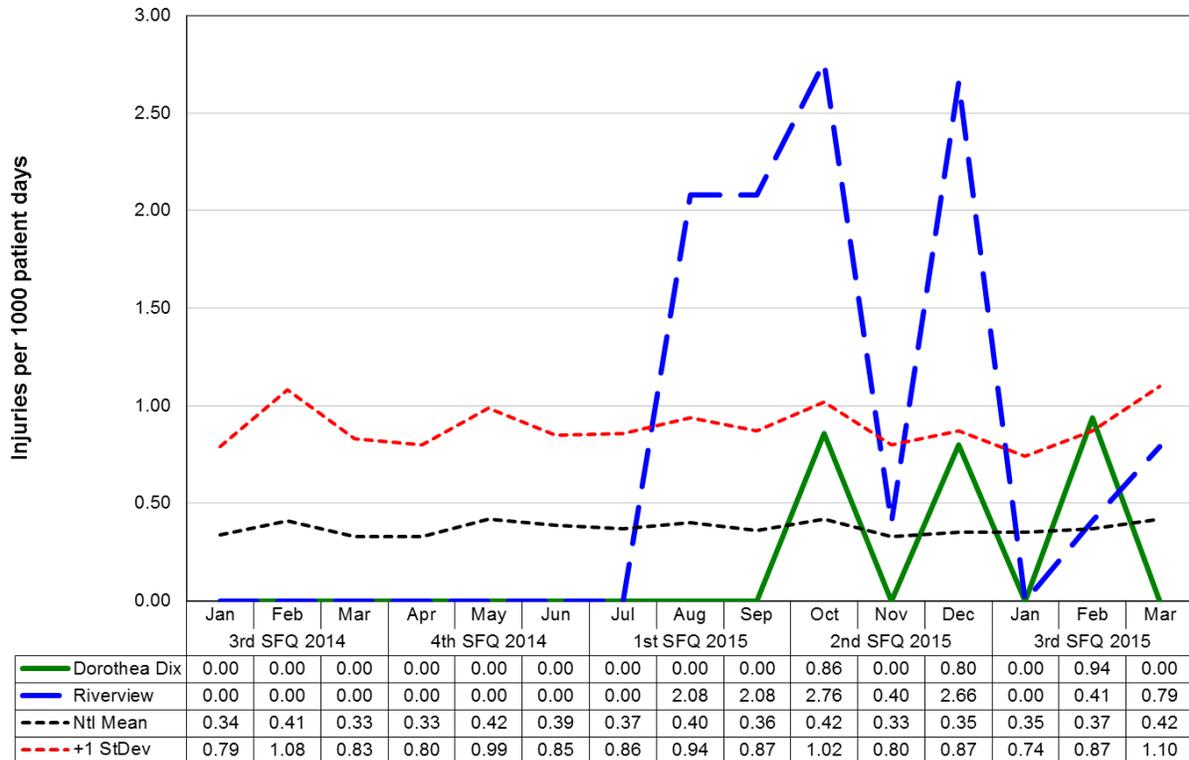
The comparative statistics reports include the following elements:

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

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

COMPARATIVE STATISTICS

Client Injury Rate



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

“Non-reportable” injuries include those that require: 1) No Treatment, or 2) Minor First Aid; Reportable injuries include those that require: 3) Medical Intervention, 4) Hospitalization or where, 5) Death Occurred. No Treatment – The injury received by a client may be examined by a clinician but no treatment is applied to the injury.

- Minor First Aid – The injury received is of minor severity and requires the administration of minor first aid.
- Medical Intervention Needed – The injury received is severe enough to require the treatment of the client by a licensed practitioner, but does not require hospitalization.
- Hospitalization Required – The injury is so severe that it requires medical intervention and treatment as well as care of the injured client at a general acute care medical ward within the facility or at a general acute care hospital outside the facility.
- Death Occurred – The injury received was so severe that if resulted in, or complications of the injury lead to, the termination of the life of the injured client.

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

COMPARATIVE STATISTICS

SEVERITY OF INJURY BY MONTH

Severity	January	February	March	3Q2015
No Treatment	1		2	3
Minor First Aid	1	1	3	5
Medical Intervention Required		2		2
Hospitalization Required				
Death Occurred				
Total	2	3	5	10

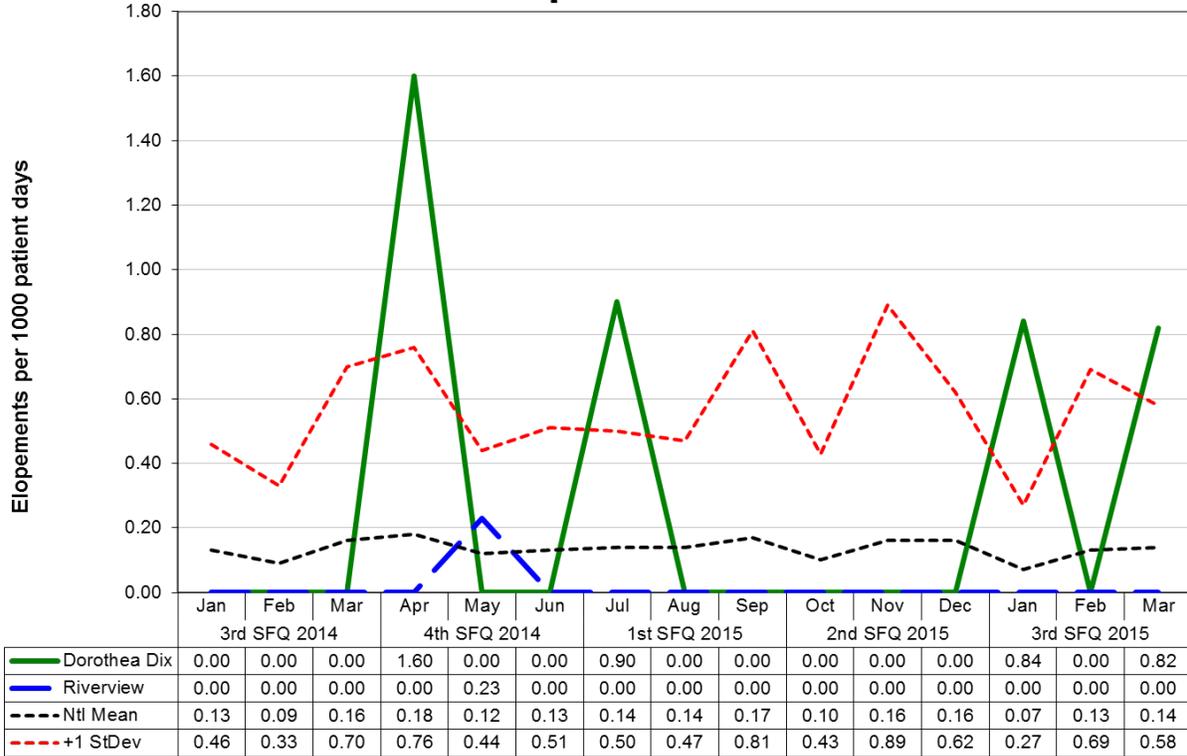
TYPE AND CAUSE OF INJURY BY MONTH

Type – Cause	January	February	March	3Q2015
Accident – Environmental				
Accident – Fall Unwitnessed				
Accident – Fall Witnessed				
Accident – Other		1	1	2
Assault – Patient to Patient			1	1
Injury – Other	1	1	1	3
Medical				
Self-Injurious Behavior	1	1	2	4
Total	2	3	5	10

Note: Previous quarterly report numbers may have been higher as they included data on incidents as well as injuries. This report has been modified to only include injuries. Per NASMHPD, injuries occur when harm or damage is done.

COMPARATIVE STATISTICS

Elopement

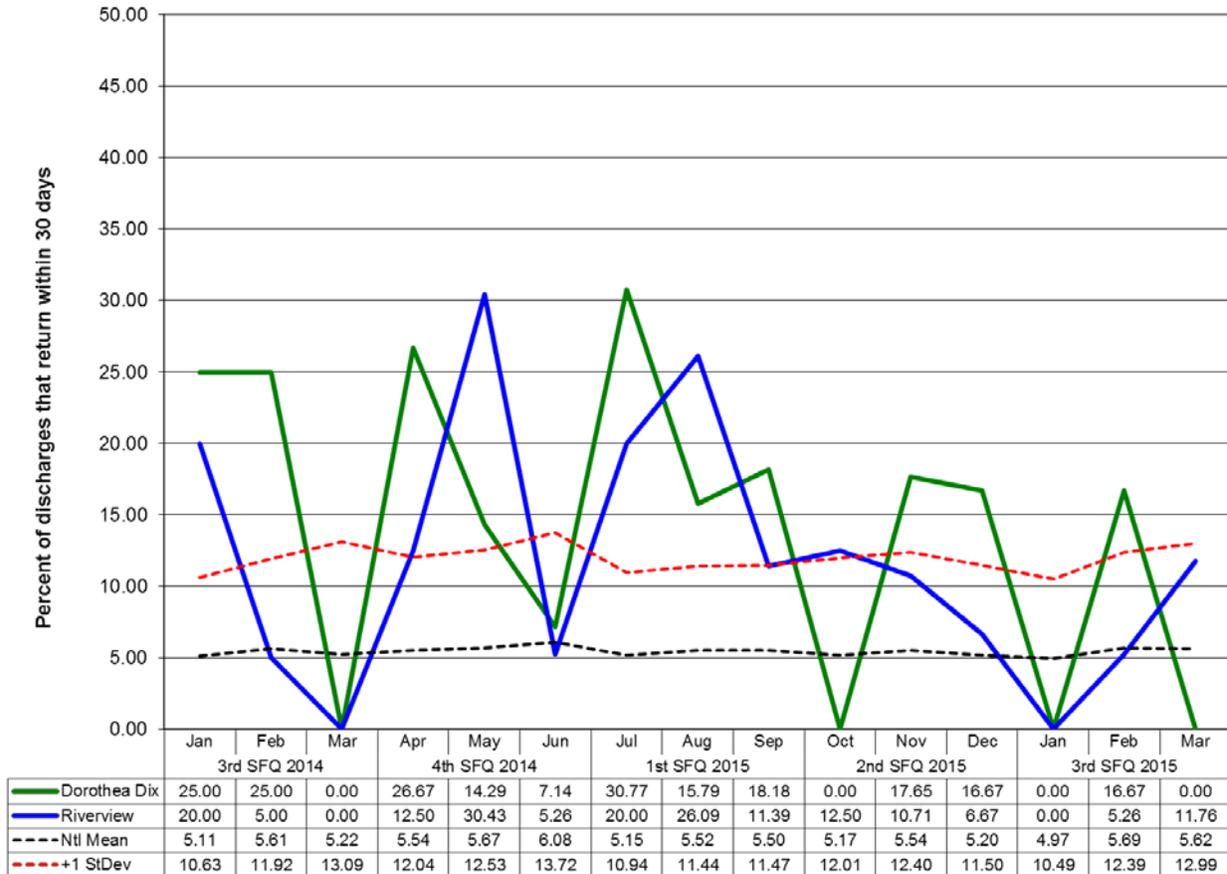


Number of elopements that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days.

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

COMPARATIVE STATISTICS

30 Day Readmit

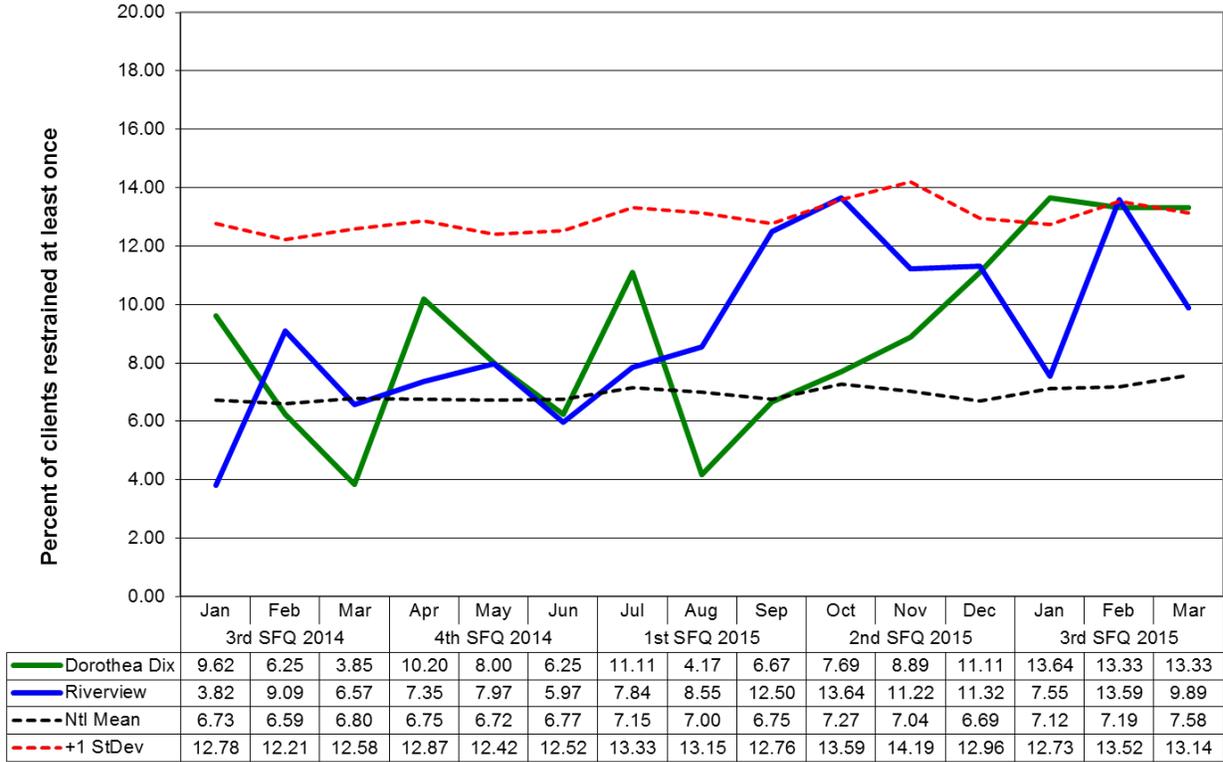


Percent of discharges from the facility that returned within 30 days of a discharge of the same client from the same facility. For example, a rate of 10.0 means that 10% of all discharges were readmitted within 30 days.

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

COMPARATIVE STATISTICS

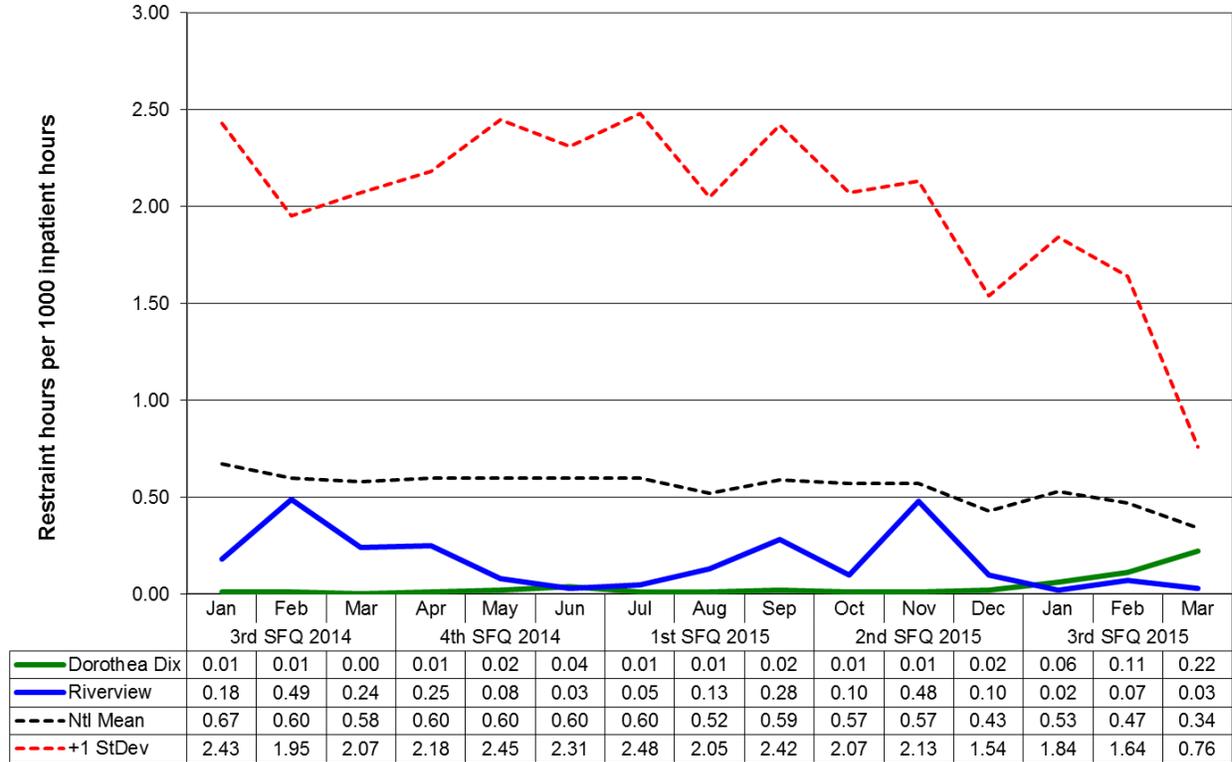
Percent of Clients Restrained



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

COMPARATIVE STATISTICS

Restraint Hours

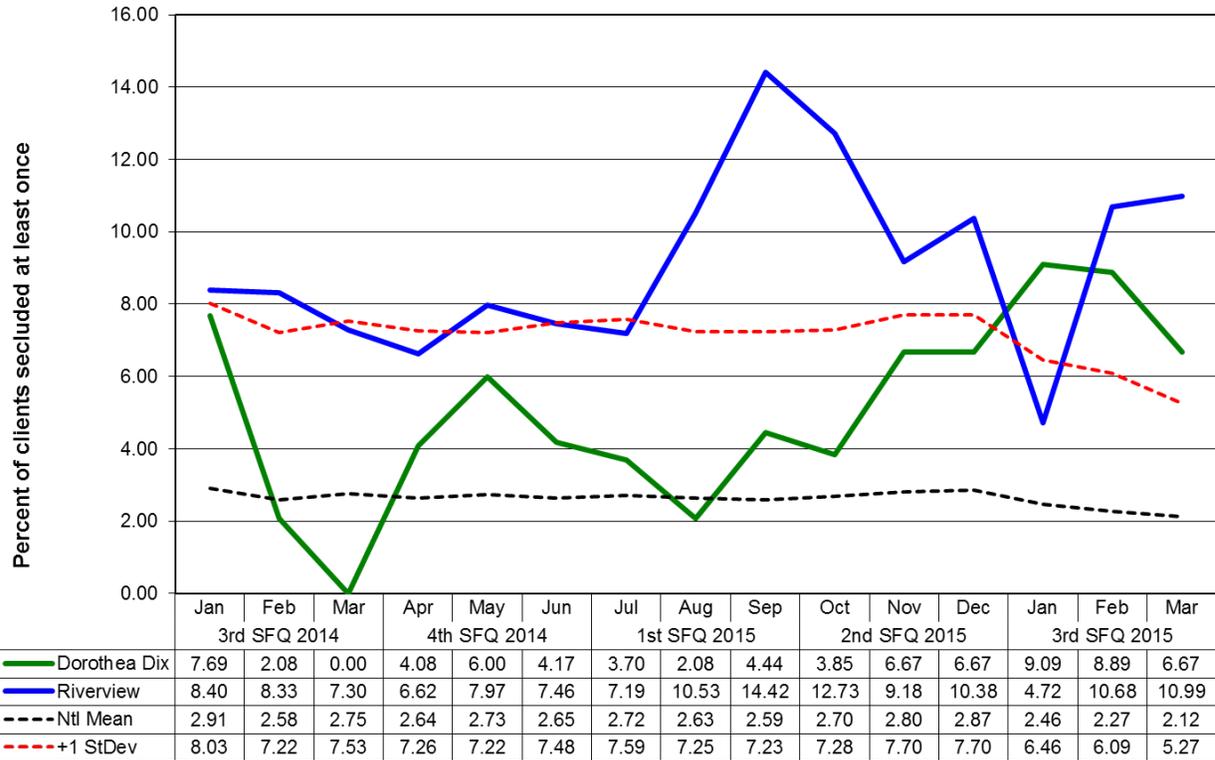


Number of hours clients spent in restraint for every 1000 inpatient hours. For example, a rate of 1.6 means that 2 hours were spent in restraint for each 1250 inpatient hours.

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

COMPARATIVE STATISTICS

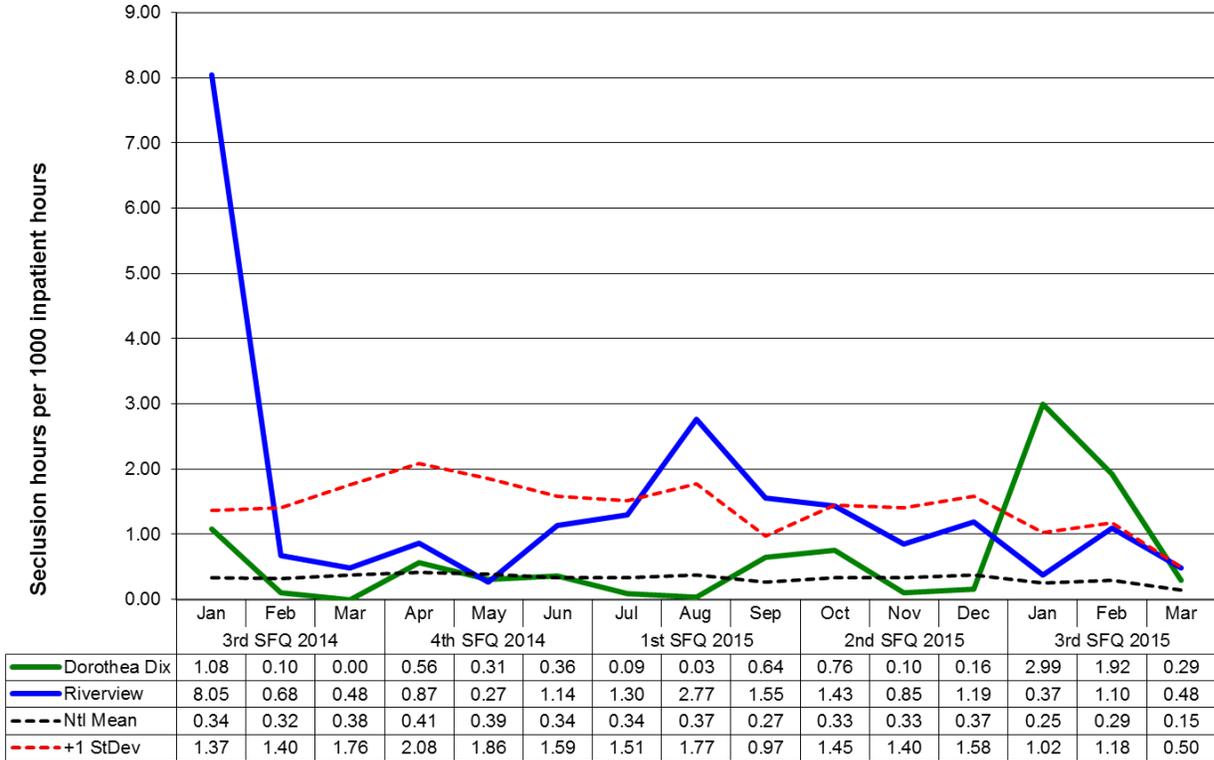
Percent of Clients Secluded



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

COMPARATIVE STATISTICS

Seclusion Hours



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

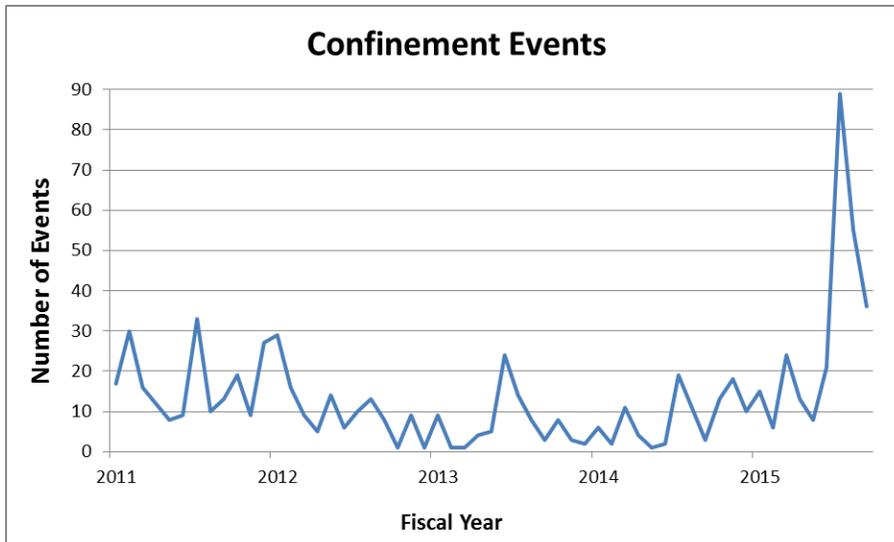
COMPARATIVE STATISTICS

Confinement Event Breakdown

Patient ID	Manual Hold	Mechanical Restraints	Locked Seclusion	Grand Total	% of Total	Cumulative %
MD00001933	1			1	1%	0.58%
MD00001917	1			1	1%	1.16%
MD00000885	1			1	1%	1.73%
MD00000535	1			1	1%	2.31%
MD00001982	1		1	2	1%	3.47%
MD00001968	2			2	1%	4.62%
MD00001955	2		1	3	2%	6.36%
MD00001303	3		1	4	2%	8.67%
MD00001174	4		1	5	3%	11.56%
MD00001892	4		1	5	3%	14.45%
MD00001990	6	2	4	12	7%	21.39%
MD00001705	28	7	13	48	28%	49.13%
MD00001403	46		42	88	51%	100.00%
	100	9	64	173		

Unit	Manual Hold	Locked Seclusion
Chamberlain	56	47
Hamlin	13	3
Knox	31	14

Event	Jan	Feb	Mar
Manual Hold	50	27	23
Locked Seclusion	38	22	4



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

JOINT COMMISSION

Hospital-Based Inpatient Psychiatric Services (ORYX Data Elements)

The Joint Commission Quality Initiatives

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

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

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

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

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 HBIPS standards reflected in this report are designed to reflect these core domains in the delivery of psychiatric care.

JOINT COMMISSION

Admissions Screening (HBIPS 1)

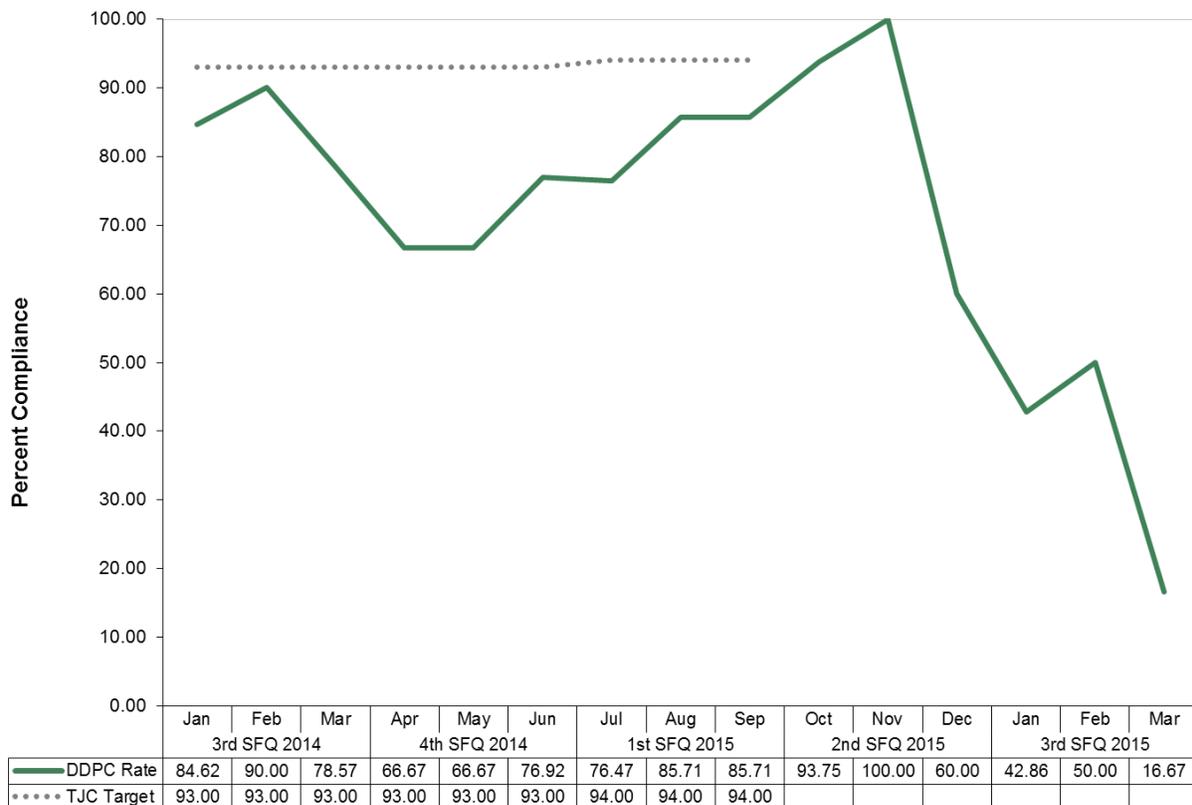
For Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths

Description

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

Rationale

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



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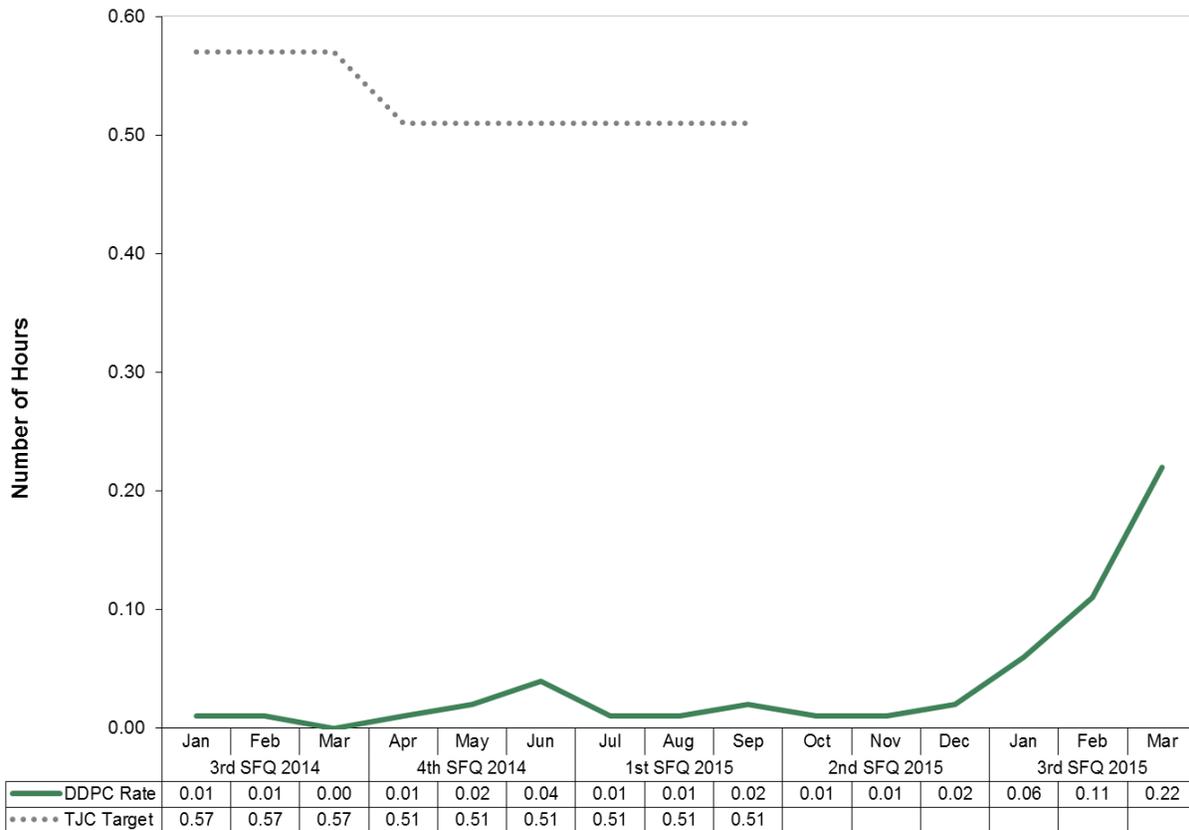
Physical Restraint (HBIPS 2) Hours of Use

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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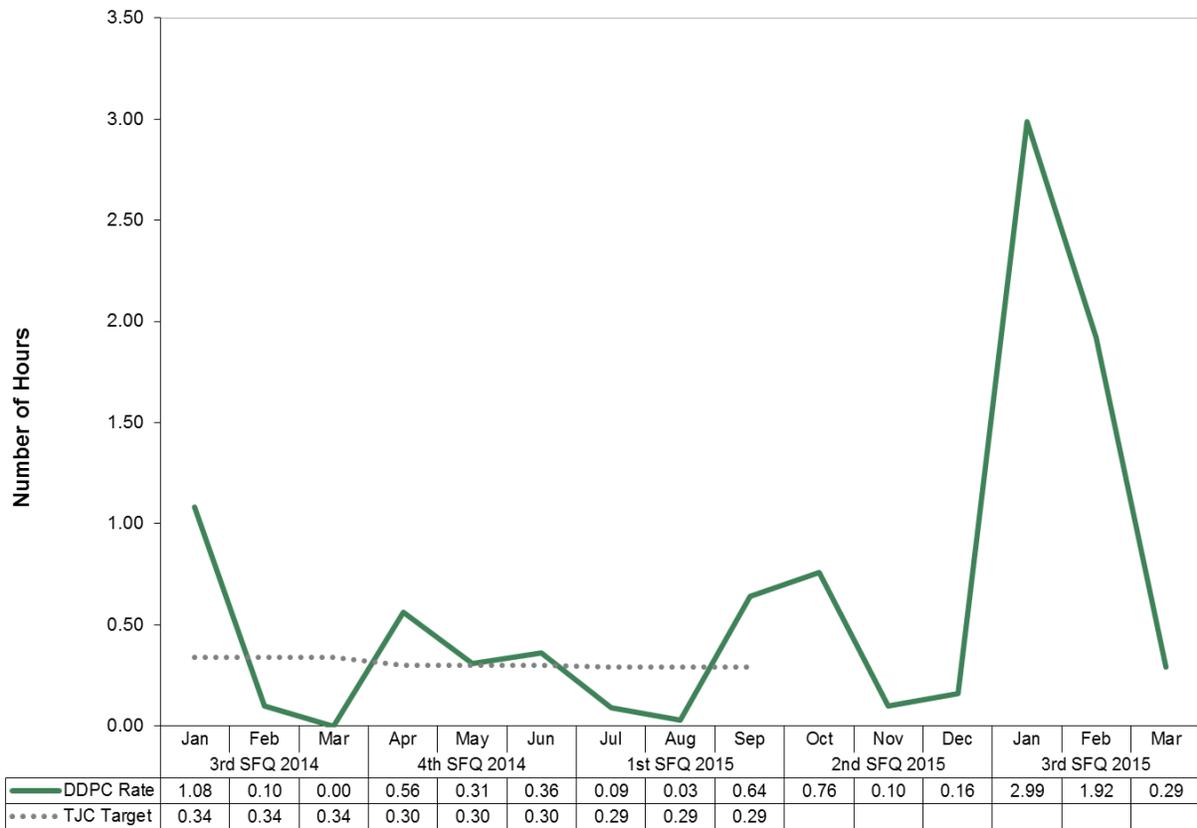
Seclusion (HBIPS 3) Hours of Use

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).



JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)

Description

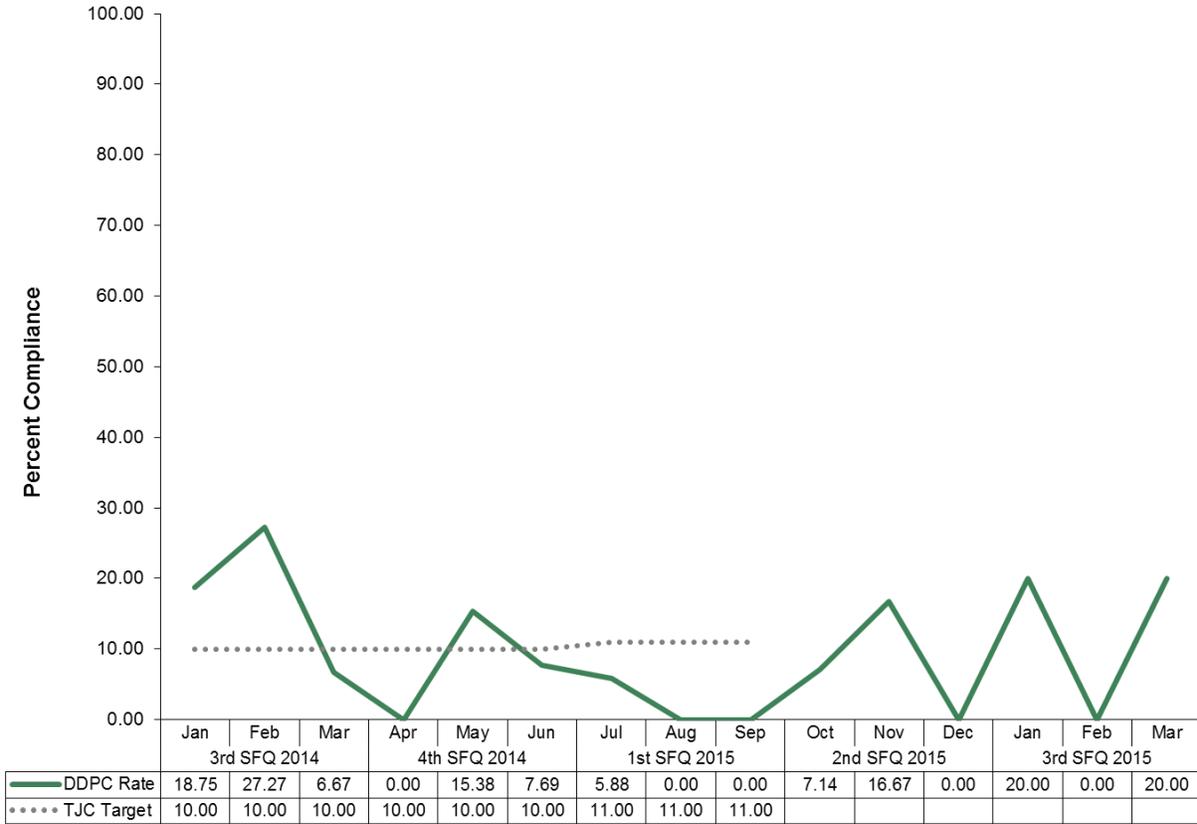
Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications.

Rationale

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

JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)



JOINT COMMISSION

Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)

Description

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

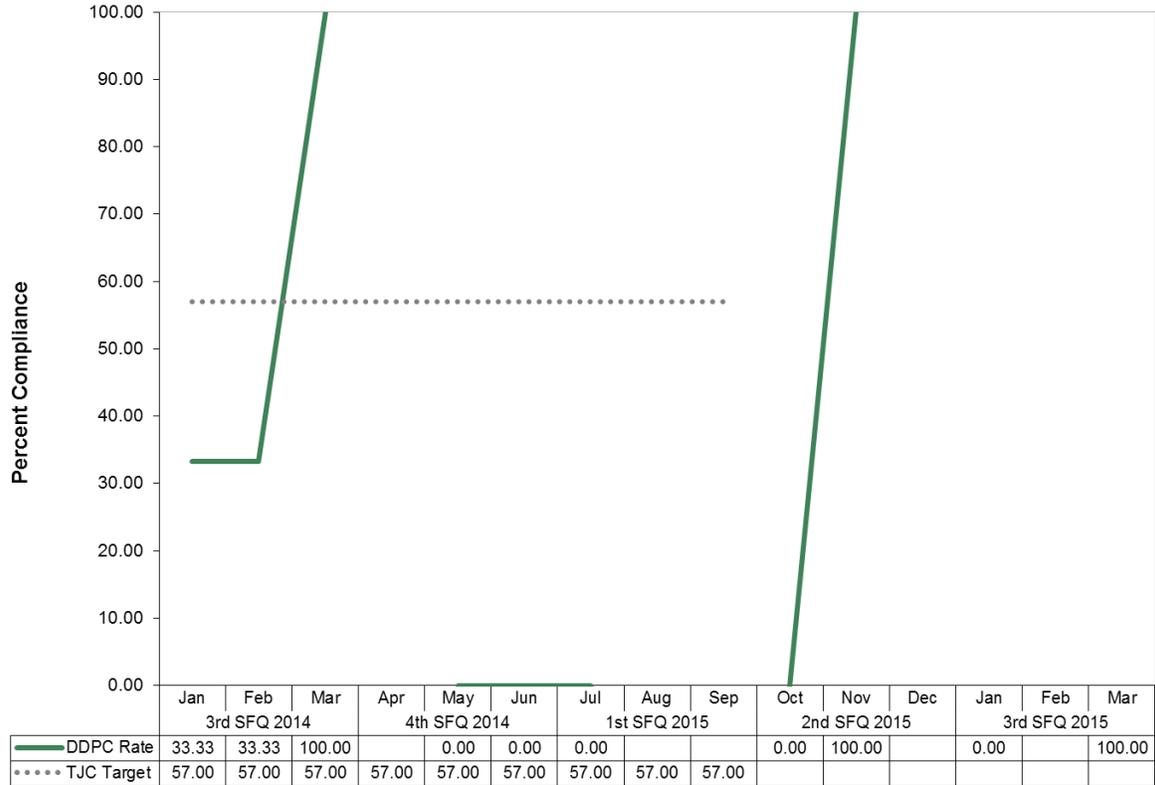
Rationale

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

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JOINT COMMISSION

Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)



JOINT COMMISSION

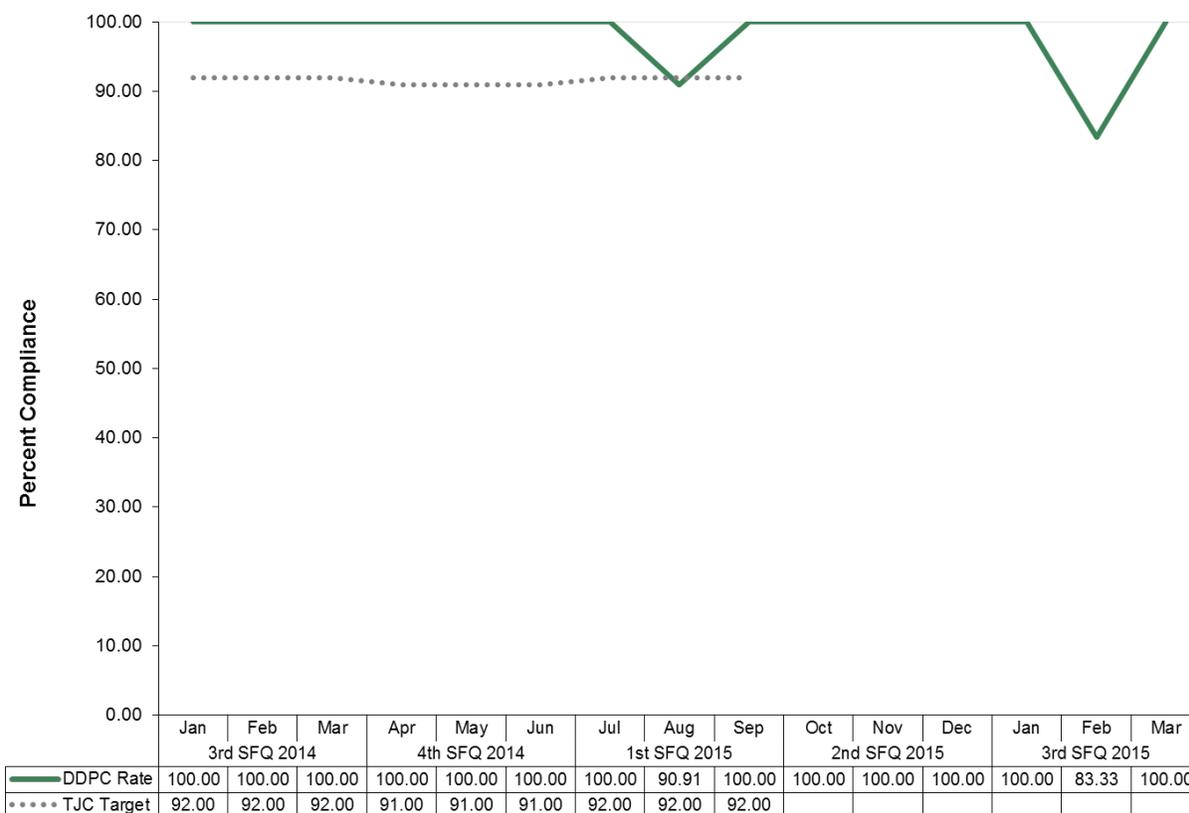
Post Discharge Continuing Care Plan (HBIPS 6)

Description

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

Rationale

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



JOINT COMMISSION

Post Discharge Continuing Care Plan Transmitted (HBIPS 7)

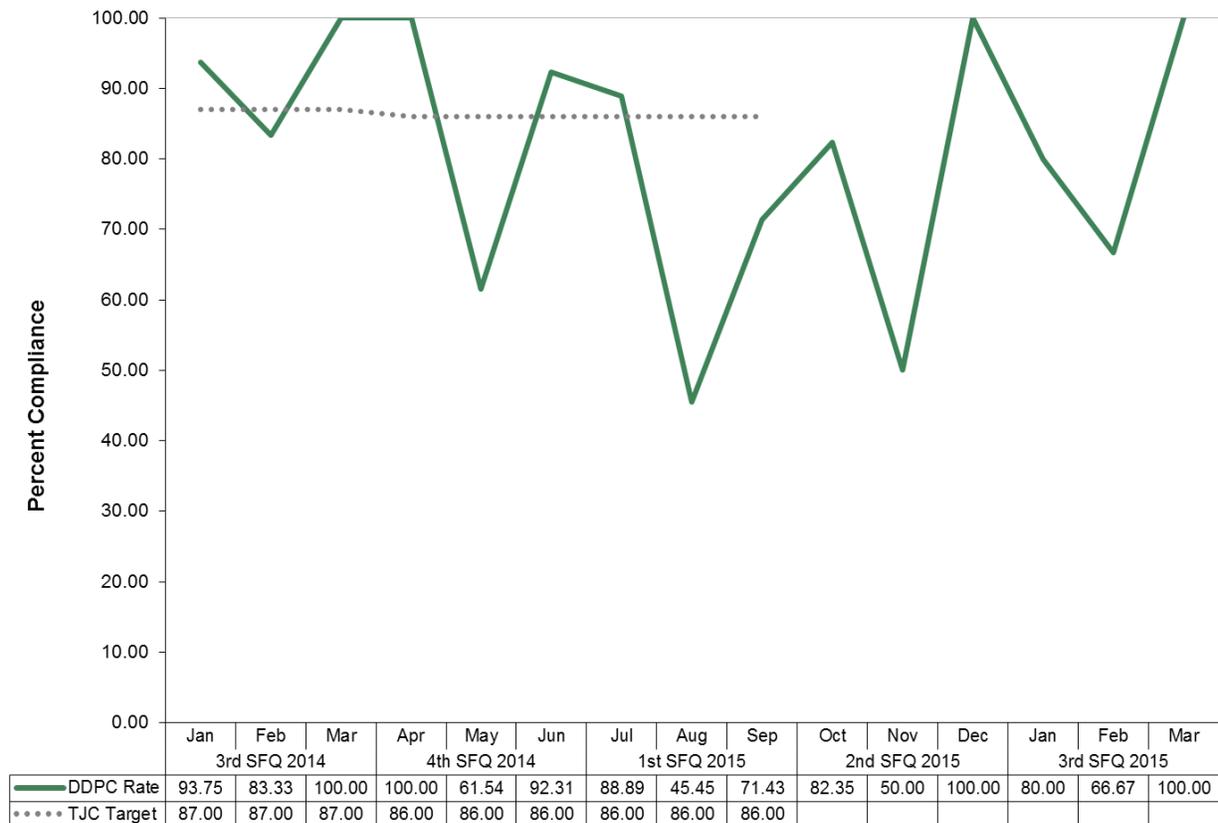
To Next Level of Care Provider on Discharge

Description

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

Rationale

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



JOINT COMMISSION

Joint Commission Priority Focus Areas

Management of Contracted Care, Treatment and Services

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

FY 2015 Quarter 3 Results		
Contractor	Program Administrator	Summary of Performance
ABM	Herbert Gibson Director of Facilities	All indicators met or exceeded standards.
Affiliated Laboratory	Janet Babcock Acting Director of Nursing	All indicators met or exceeded standards.
Casella Waste	Herbert Gibson Director of Facilities	Indicator met 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.
ePharmPro	Sharon Sprague Superintendent	One indicator did not meet standards: Providing required documentation to the DDPC Human Resource Department. All others met or exceeded standards.
Harriman Associates	Herb Gibson Director of Facilities	All indicators exceeded standards.
The Healing Staff	Dr. Michelle Gardner Medical Director	Contract not utilized during timeframe.
Iliina Engineering	Herbert Gibson Director of Facilities	All indicators met standards.
Jackson & Coker	Dr. Michelle Gardner Medical Director	Contract not utilized during timeframe.
Liberty Healthcare Physicians and/or Mid-Levels On Call	Dr. Michelle Gardner Medical Director	All indicators met standards.
Liberty Healthcare Psychiatric Nurse Practitioner	Dr. Michelle Gardner Medical Director	All indicators met standards.
Locum Tenens Psychiatry	Dr. Michelle Gardner Medical Director	Contract not utilized during timeframe.
Norris, Inc.	Herbert Gibson Director of Facilities	All indicators met or exceeded standards.
Northeast Cardiology Associates (NECA)	Dr. Michelle Gardner Medical Director	One indicator did not meet standards: EKG's being read and faxed back to the hospital within 24 hours. All others met standards.

JOINT COMMISSION

FY 2015 Quarter 3 Results		
Contractor	Program Administrator	Summary of Performance
Otis Elevator	Herbert Gibson Director of Facilities	All indicators met standards.
Penobscot Community Health Care	Dr. Michelle Gardner Medical Director	Indicator exceeded standards.
Project Staffing	Carol Davis Business Manager	All indicators meet standards.
Securitas	Herbert Gibson Director of Facilities	All indicators met standards.
SW 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 Medical Director	Contract not utilized during timeframe.
WBRC Architects Engineers	Herbert Gibson Director of Facilities	Indicator met standards.
Worldwide Travel Staffing	Janet Babcock Acting Director of Nursing	All indicators met standards.

JOINT COMMISSION

Joint Commission Priority Focus Areas

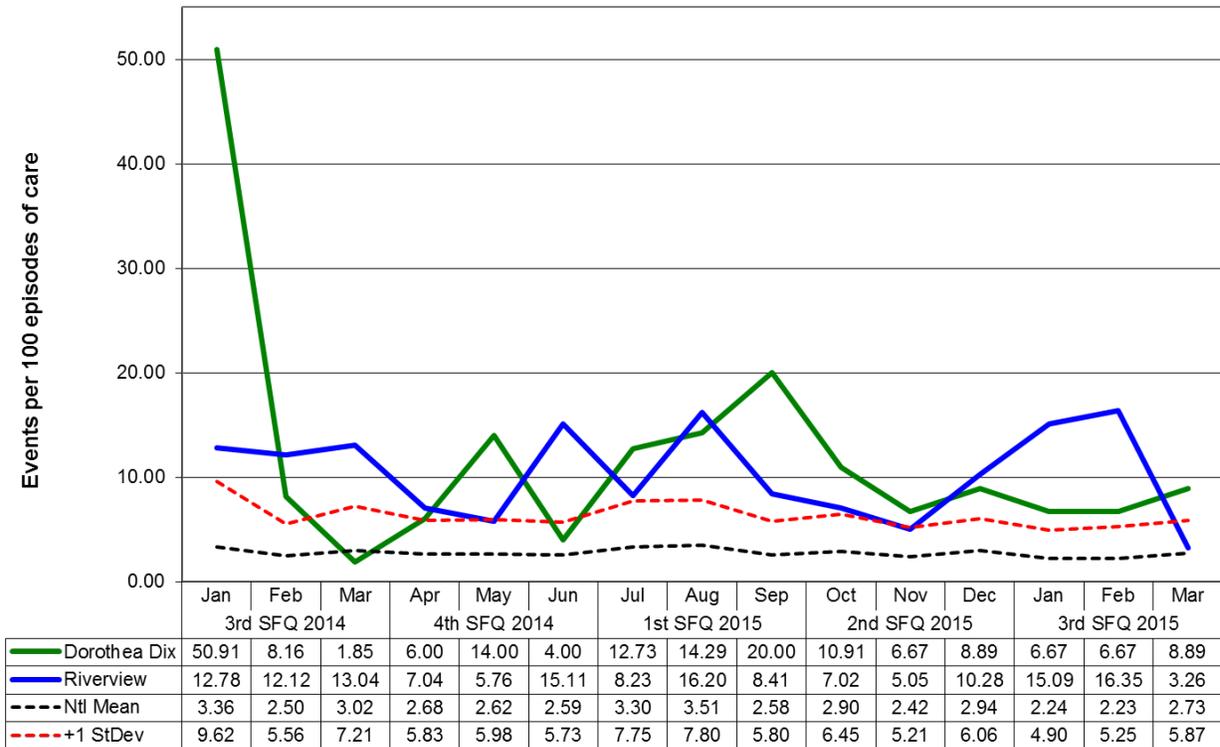
Medication Management

Medication Errors and Adverse Reactions

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

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

Medication Errors



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

JOINT COMMISSION

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

Prescribing

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

Dispensing

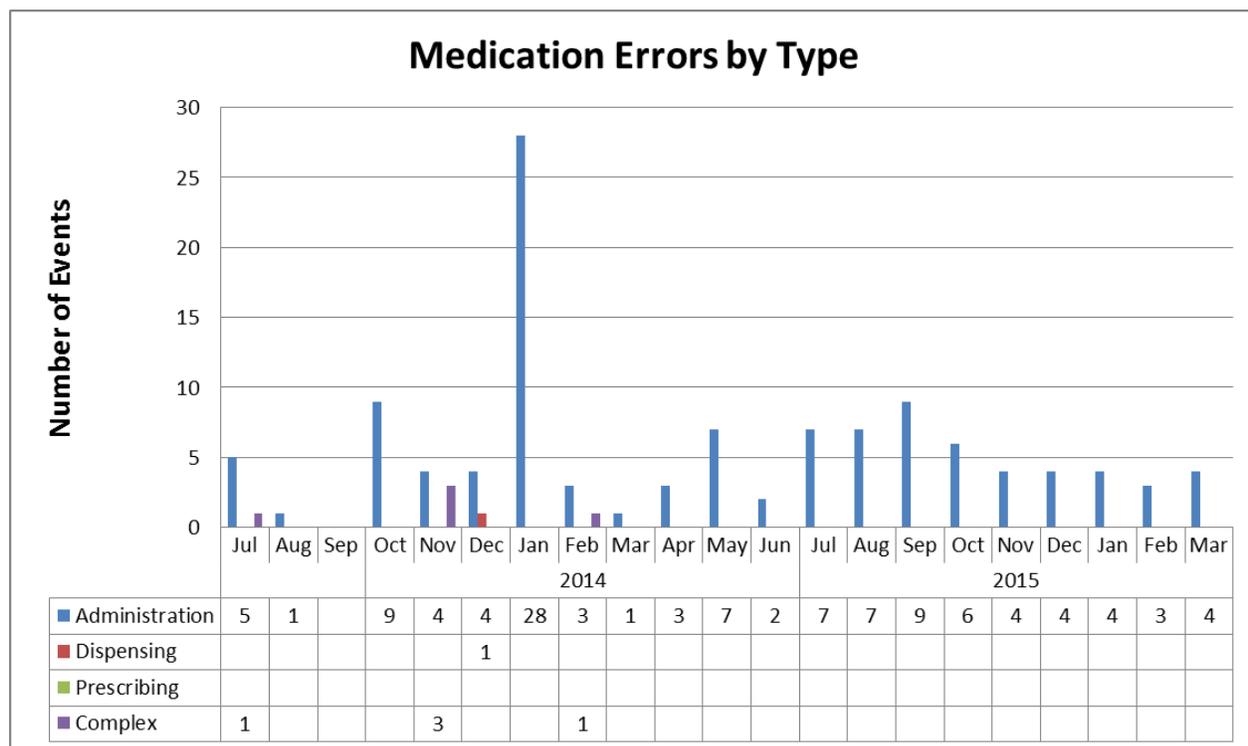
An error of dispensing occurs when the incorrect drug, drug dose or concentration, dosage form, or quantity is formulated and delivered for use to the point of intended use.

Administration

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

Complex

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



JOINT COMMISSION

Medication Dispensing Process

Garry Miller, RPh

Joint Commission Measures of Success								
Medication Management	Unit	Baseline 2014	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Controlled Substances Loss Data								
<i>Daily Pyxis-CII Safe Compare Report</i>	All	0%	0%	0%	0%	0%	0%	Goal of no discrepancies in any transactions between Pyxis and CII Safe
Quarterly Results			0%	0%	0.7%			1 discrepancy found and resolved
<i>Monthly CII Safe Vendor Receipt Report</i>	Rx	0	0	0	0	0	0	No discrepancies between CII Safe and vendor transactions
Quarterly Results			0	0	0			
<i>Monthly Pyxis Controlled Drug Discrepancies</i>	All	5/month	0	0	0	0	0	Goal of "0" discrepancies involving controlled drugs dispensed from Pyxis trended from Knowledge Portal
Quarterly Results			20 (7/mo)	35 (12/mo)	30 (10/mo)			
Medication Management Monitoring								
<i>Measures of drug reactions, adverse drug events and other management data</i>	Rx	2/yr	1	1	3	0		3 ADR reported in Q3
<i>Resource Documentation Reports of Clinical Interventions</i>	Rx	51	58	63	79			100% of all clinical interventions are documented

JOINT COMMISSION

Client Perception of Care Surveys

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

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

Care Transition Measures Survey

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

The Care Transition Measure Survey questions are as follows:

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

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

CTM-3 Survey Response Rate

	January	February	March	3Q2015
Number of Clients Discharged	7	6	6	19
Number of Survey Responses	2	2	2	6
Survey Response Rate	29%	33%	33%	32%

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

	January	February	March	3Q2015
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) 100%	(1) 50%	(0) 0%	(3) 50%
When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.	(2) 100%	(2) 100%	(2) 100%	(6) 100%
When I left the hospital, I clearly understood the purpose for taking each of my medications.	(2) 100%	(2) 100%	(2) 100%	(6) 100%

JOINT COMMISSION

Inpatient Consumer Survey

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

NRI Inpatient Consumer Survey (ICS) Response Rate

	January	February	March	3Q2015
Number of clients discharged	7	6	6	19
Number of survey responses	0	0	0	0
Survey response rate	0%	0%	0%	0%

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

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

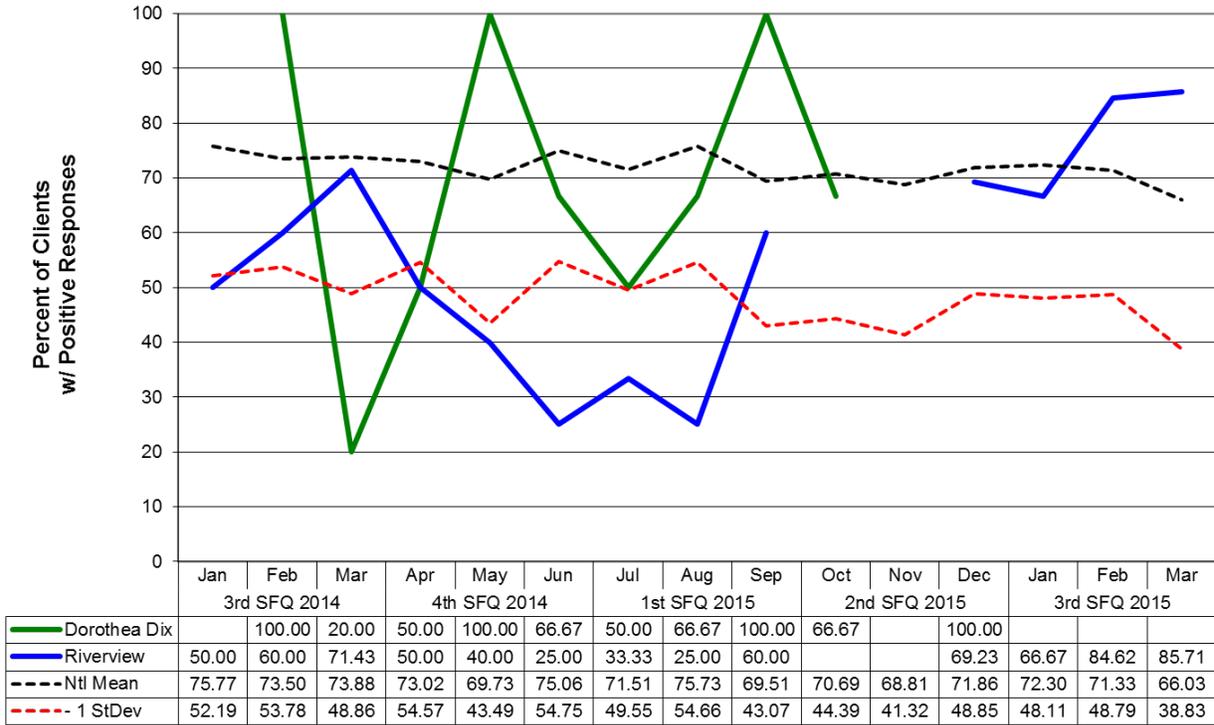
The data is depicted in three month averages in order to level out the monthly variation in the responses. The smooth line provided with this averaging allows for a more precise analysis of trends over time.

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

Leadership is aware of the low survey response rate and they are looking at various methods to increase the rate including the possibility of hiring a Peer Support person to assist patients with completing the consumer surveys.

JOINT COMMISSION

Inpatient Consumer Survey Outcome Domain

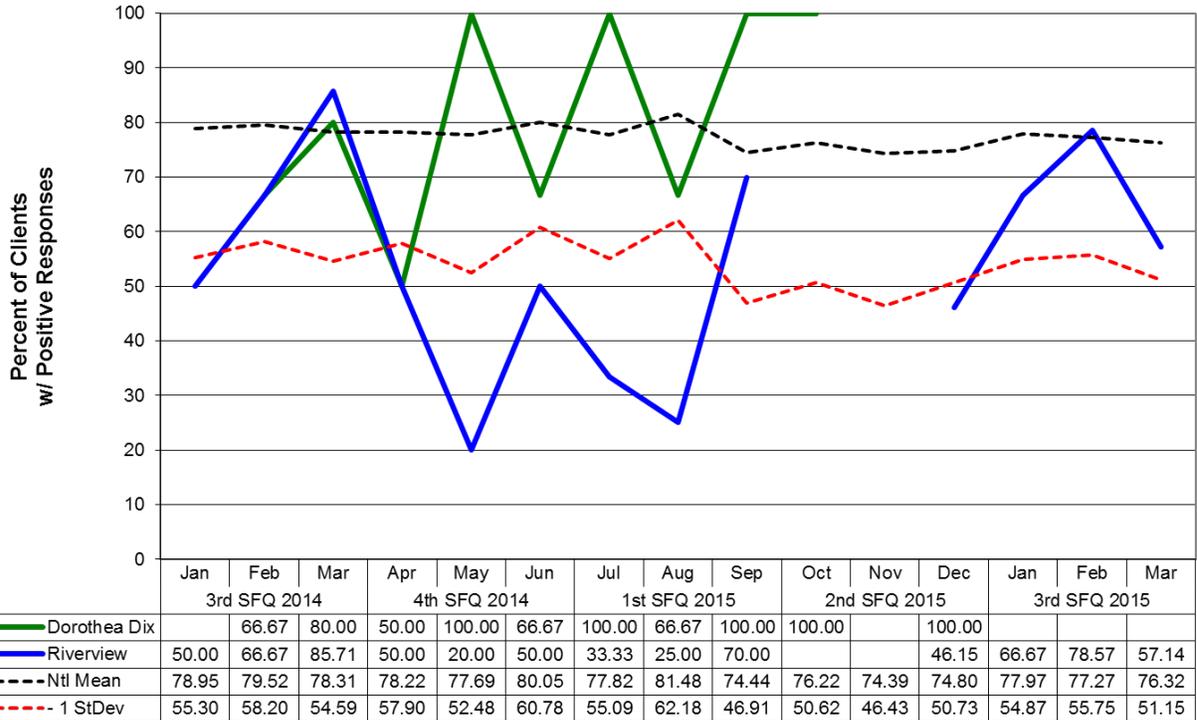


Outcome Domain

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

JOINT COMMISSION

Inpatient Consumer Survey Dignity Domain

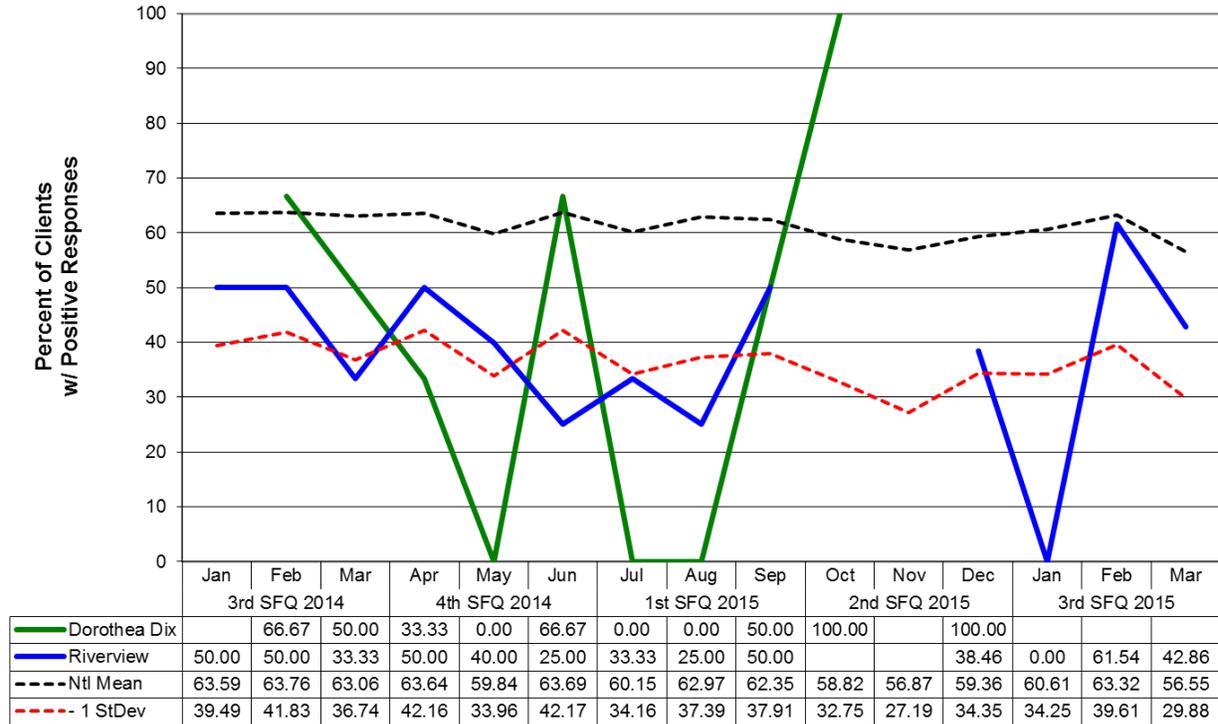


Dignity Domain

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

JOINT COMMISSION

Inpatient Consumer Survey Rights Domain

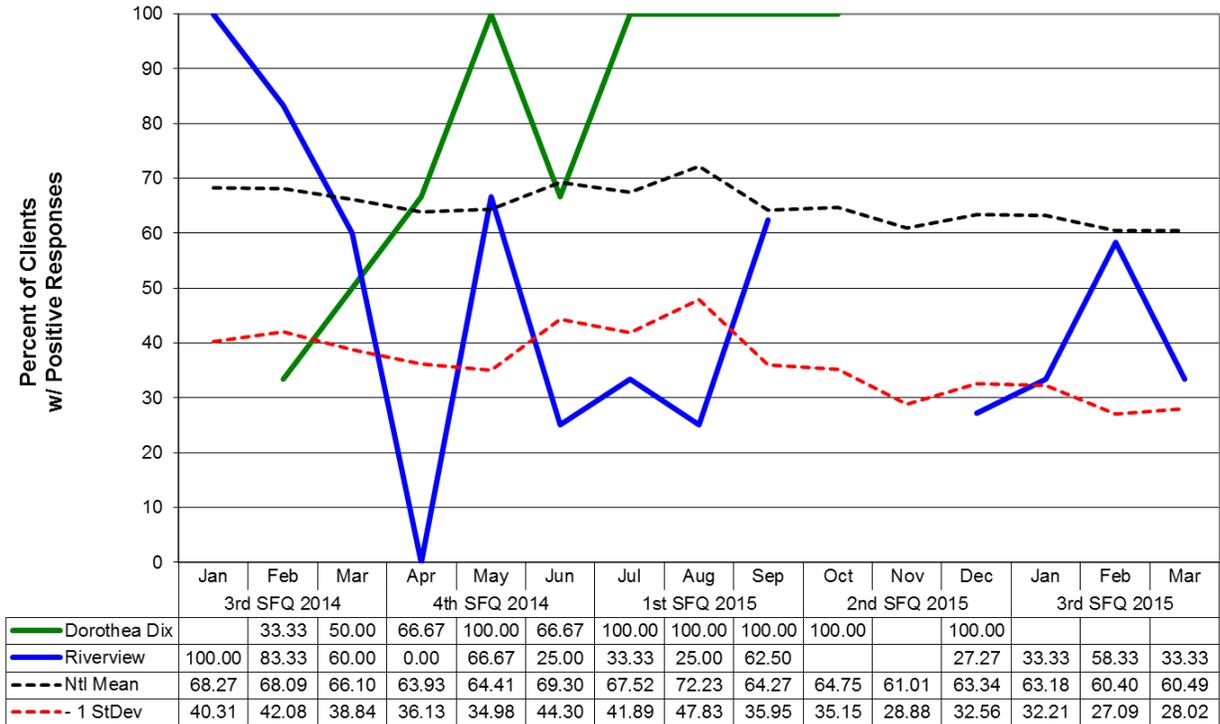


Rights Domain

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

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Inpatient Consumer Survey Participation Domain

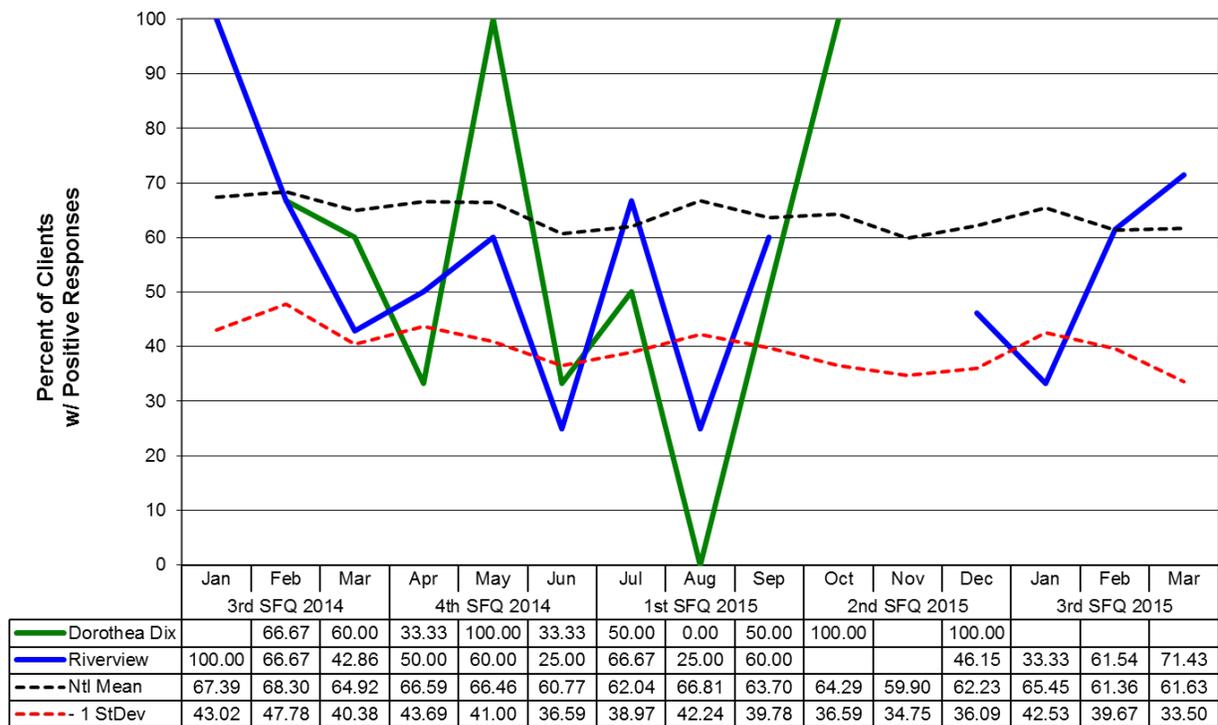


Participation Domain

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

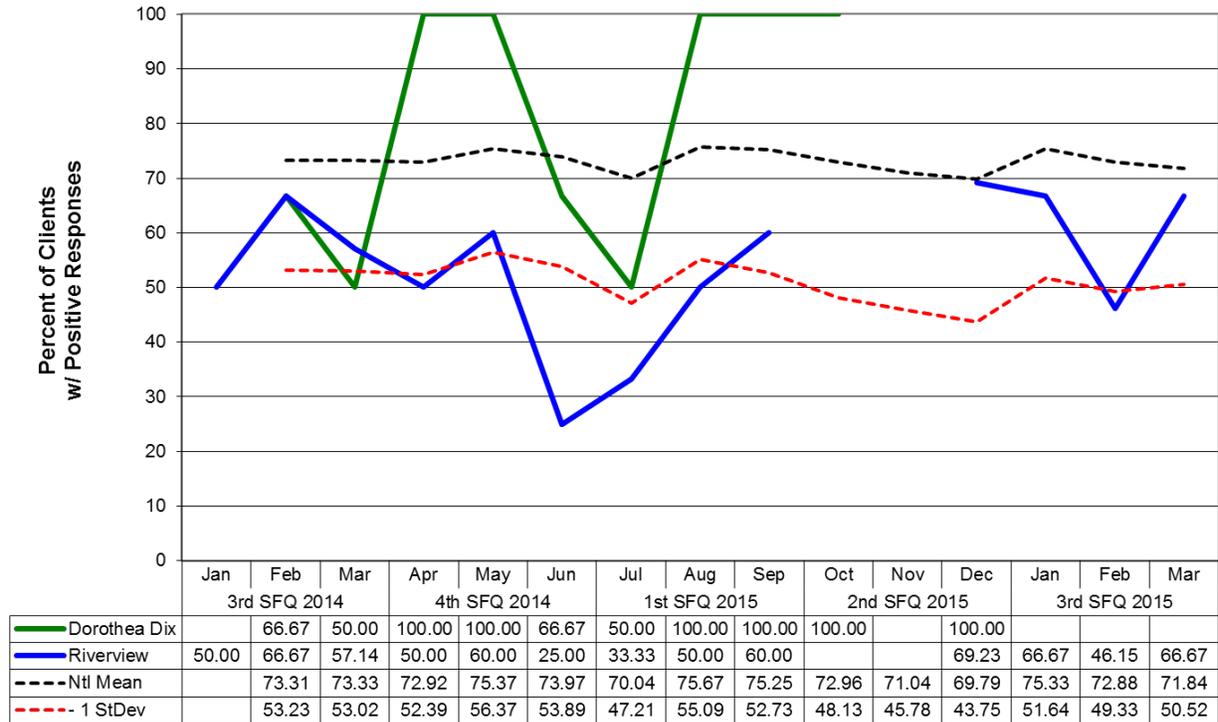


Environment Domain

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.

JOINT COMMISSION

Inpatient Consumer Survey Empowerment Domain



Empowerment Domain

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

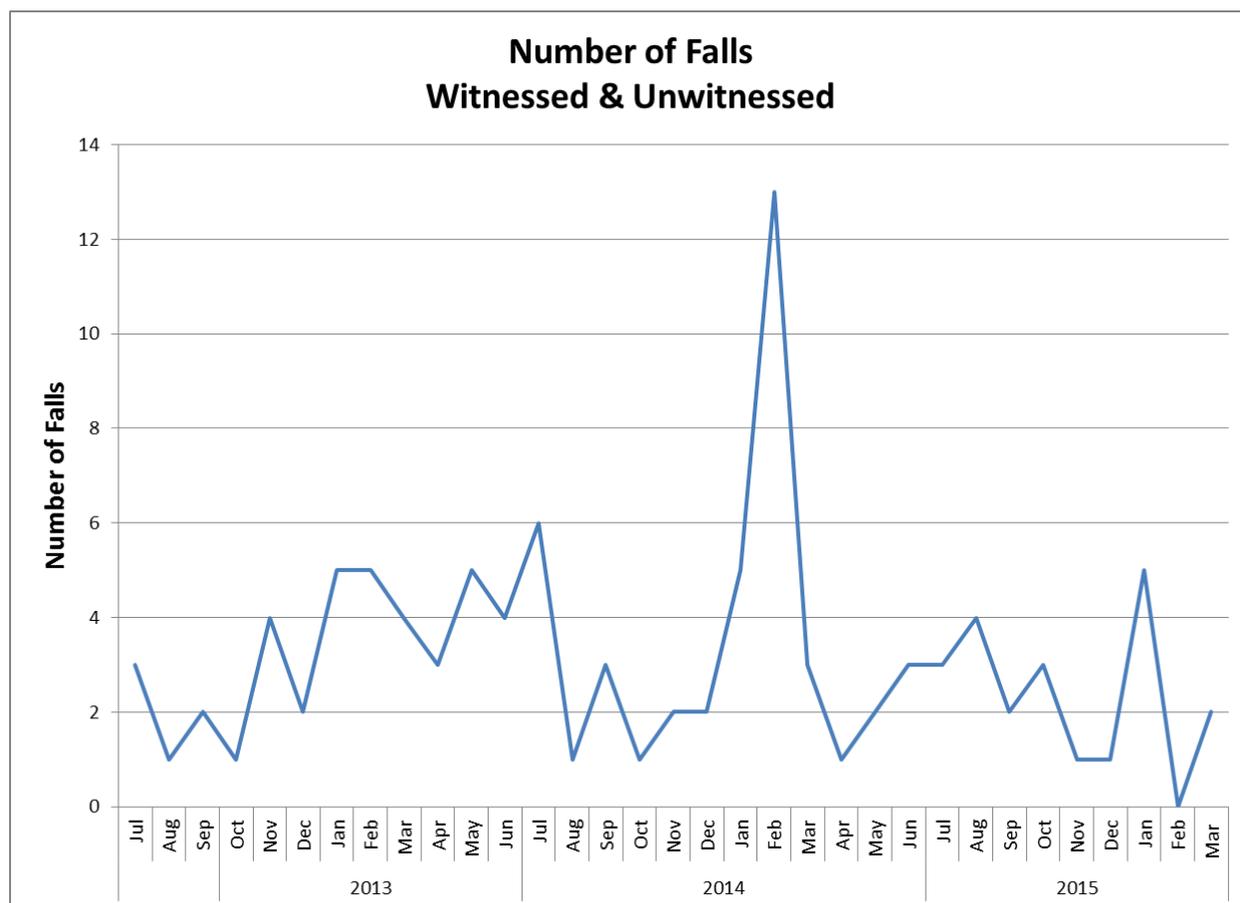
Note: National Mean and Standard Deviation are unavailable for January 2014.

JOINT COMMISSION

Fall Reduction Strategies

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

Dorothea Dix Psychiatric Center has had a Falls Risk Management Team in existence for several years. The role of this team is to conduct root cause analyses on each of the falls incidents and to identify trends and common contributing factors and to make recommendations for changes in the environment and process of care for those clients identified as having a high potential for falls.



JOINT COMMISSION

Falls Reduction Nursing Interventions

Janet Babcock, RN

3rd Quarter FY 2015 Patient Falls Report Initiated in June 2013 (POC) - Baseline data gathered in February 2013

Falls (Establishing a Culture of Safety)

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

Methodology: All falls will be reviewed by using a tool with check boxes. A tool will be used to audit elements of the falls procedure. The denominator is all patient falls within the audit month. The numerator will be all falls that are in compliance with the procedure. The results of the audits will be reported to the IPEC (Performance Excellence) committee which meets monthly.

Baseline Data: Effective March 2014, Nursing has been compliant with the POC from 6/13. It is still evident that nurses continue to struggle with the implementation of some elements of this procedure.

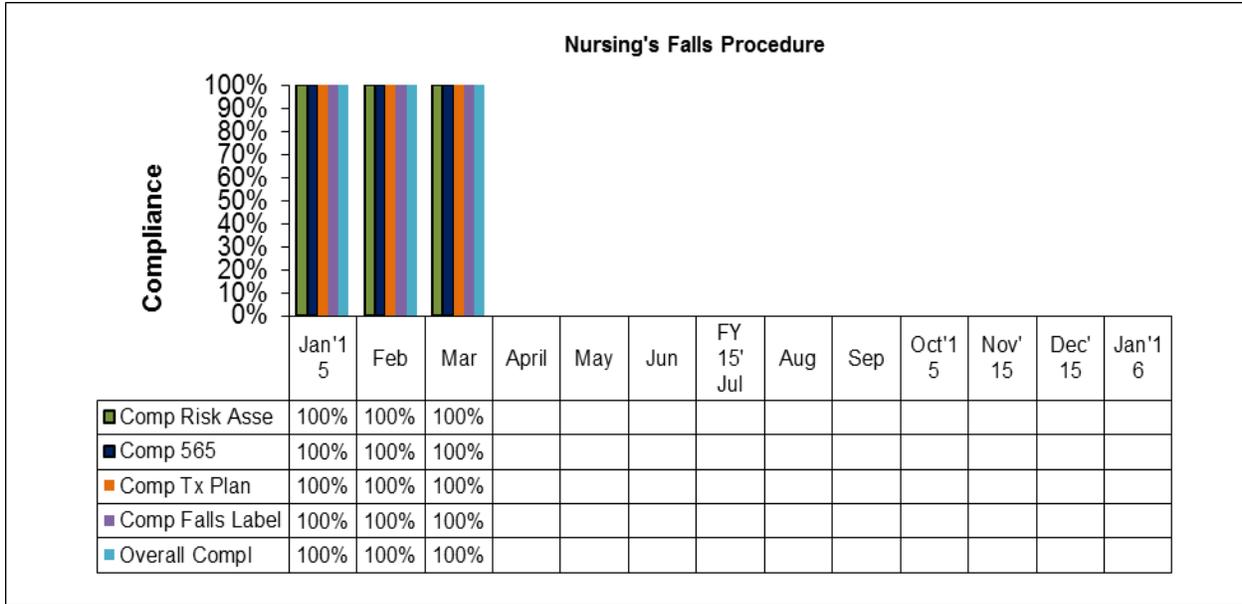
Goal: The goal is to have 90% compliance with Nursing's Fall Procedure F-10 with a threshold of 80.

All patient falls within the audit Quarter	# Falls risk assessment completed?	# Falls Progress Note 565 completed and in the Pt's medical record?	# Falls risk score of 6 or higher- Is problem 6.1 initiated (164 A & B)?	# Falls risk score documented on kardex and in front of chart	
6 (including falls that do not meet definition)	Yes: 6 No: 0 N/A: 0	Yes: 6 No: 0	Yes: 6 No: 0 N/A: 0	Yes: 5 No: 0 N/A: 1	
Overall compliance	100%	100%	100%	100%	100%

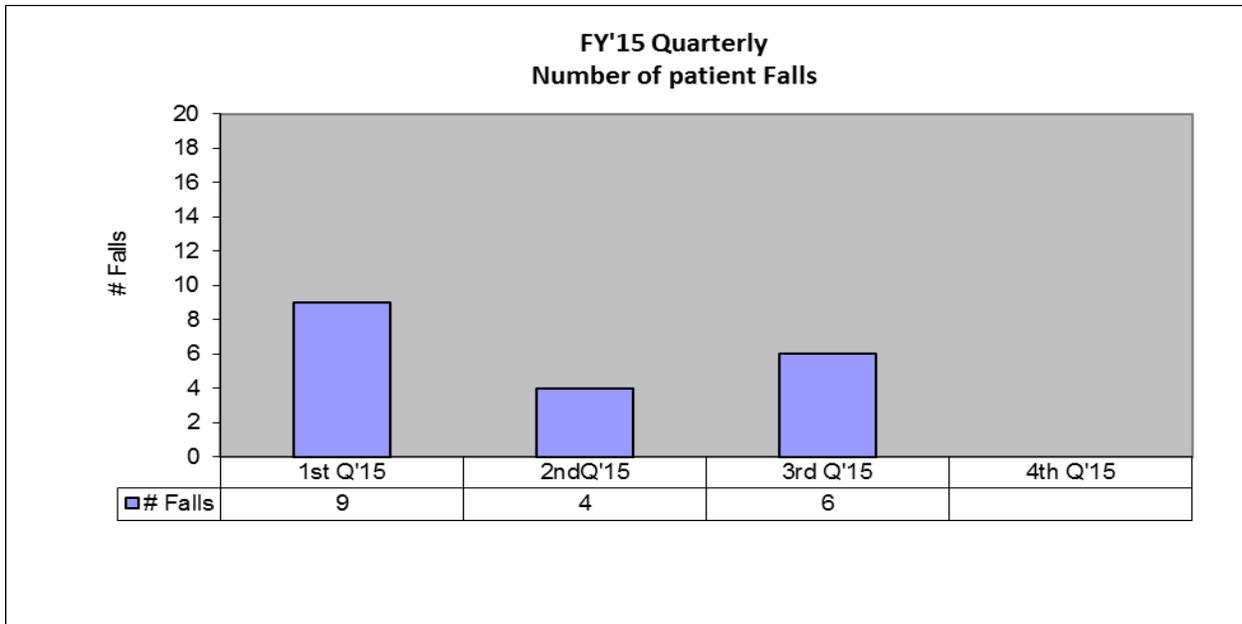
Plan of Action:

There were 6 falls in the 3rd Quarter of FY 2015. In January there were 5 falls, February had 0 falls, and March had 1 fall. Compliance with Nursing Falls Procedure F-10 for entire 3rd Quarter was 100% which is a vast improvement over the 2nd Quarter, which was at 63% compliance. Will continue to follow up and audit all falls.

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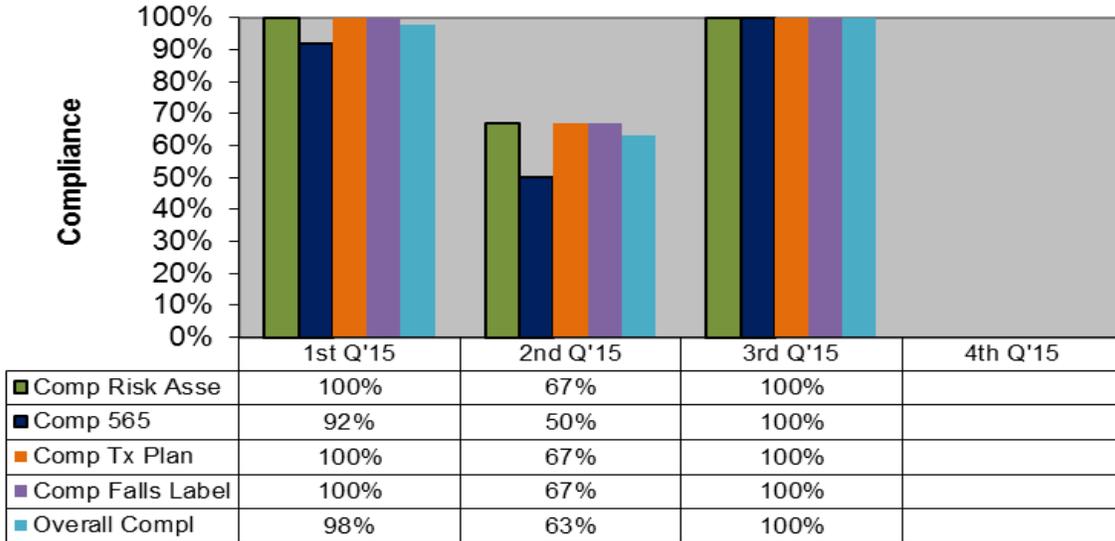


Goal is 90% compliance with Nursing Procedure F-10



JOINT COMMISSION

FY 2015 Quarterly Data



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

JOINT COMMISSION

Pain Assessment Nursing Interventions

Janet Babcock, RN

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

Pain Assessment (Patient Recovery)

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

Baseline Data:

Initiated in January 2013.

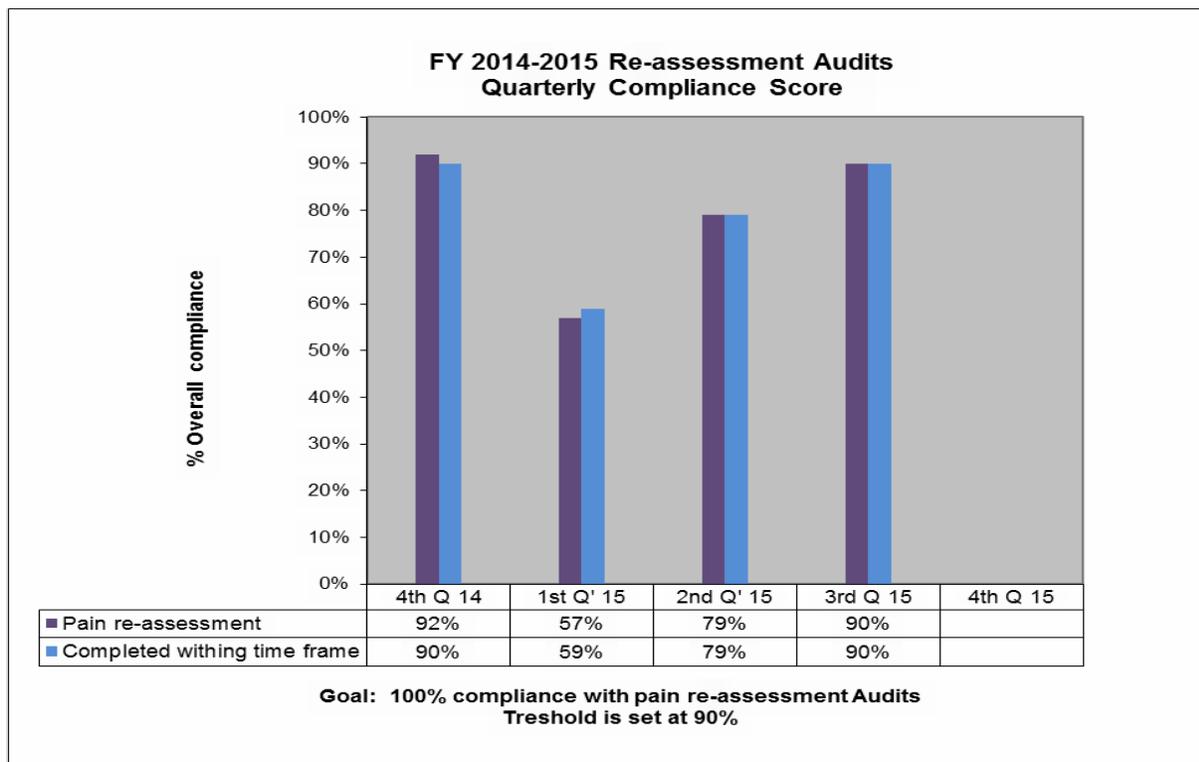
The audits that were completed in January and February of 2013 indicate a baseline data of 38%

Goal for FY 2015: 100% compliance with Pain re-assessment. Threshold is set at 90%.

# of audits performed	# of patients with pain reported on Form #838?	# of re-assessments completed?	# of re-assessments reported within clinically appropriate timeframe? (1-2 hours after oral med and within 1 hour of IM)	Compliance With re-assessment	Compliance With re-assessment time-frame
108	66	59	59	90%	90%

Plan of Action: The compliance rate for the 3rd Quarter was 90%, compared to 79% in the 2nd Quarter. The CNM's will continue to monitor that pain is being assessed every shift and CNM's will address staff that are not completing these assessments.

JOINT COMMISSION



Assessment for Pain and Intensity of Pain At Least Once Every 12 Hours (Shift Assessment) Audit

Pain Assessment: (Patient Recovery)

Methodology: All MAR'S for each unit, will be audited for a 24 hour period. Using the (Form 841) Daily Shift Assessment For the presence of pain form, patients are assessed for the presence and intensity of pain at least once every 12 hours. Form 841 is audited to ensure there are 2 pain assessments completed.

Baseline Data:

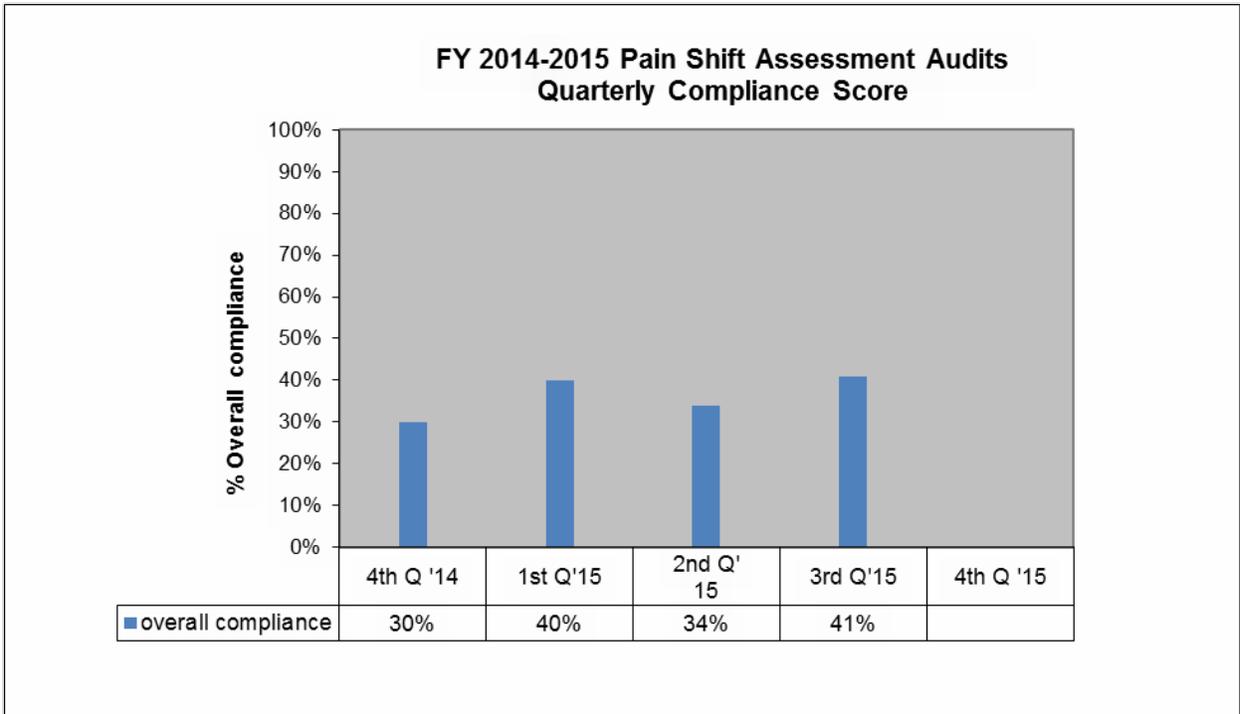
Initiated in January 2013.

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

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

# of audits completed	# of audits having 2 shift assessments completed that assess for the presence and intensity of pain within 24 hours?	Compliance
108	44	41%

JOINT COMMISSION



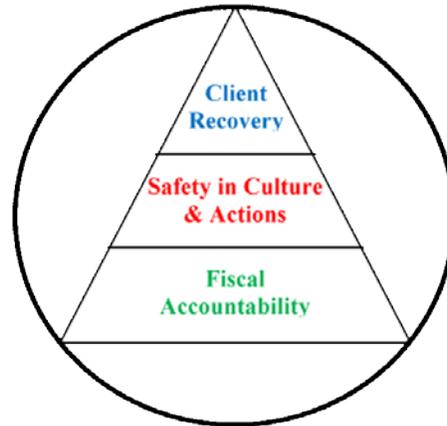
Plan of Action

We are still below our goal of 90%. Nursing Management has addressed this and will reinforce with the CNM's to monitor that pain is being assessed and reassessed every shift and CNM's will address staff that are not completing these assessments.

STRATEGIC PERFORMANCE EXCELLENCE

Priority Focus Areas for Strategic Performance Excellence

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



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

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

STRATEGIC PERFORMANCE EXCELLENCE

Strategic Performance Excellence Model Reporting Process

Department of Health and Human Services Goals

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

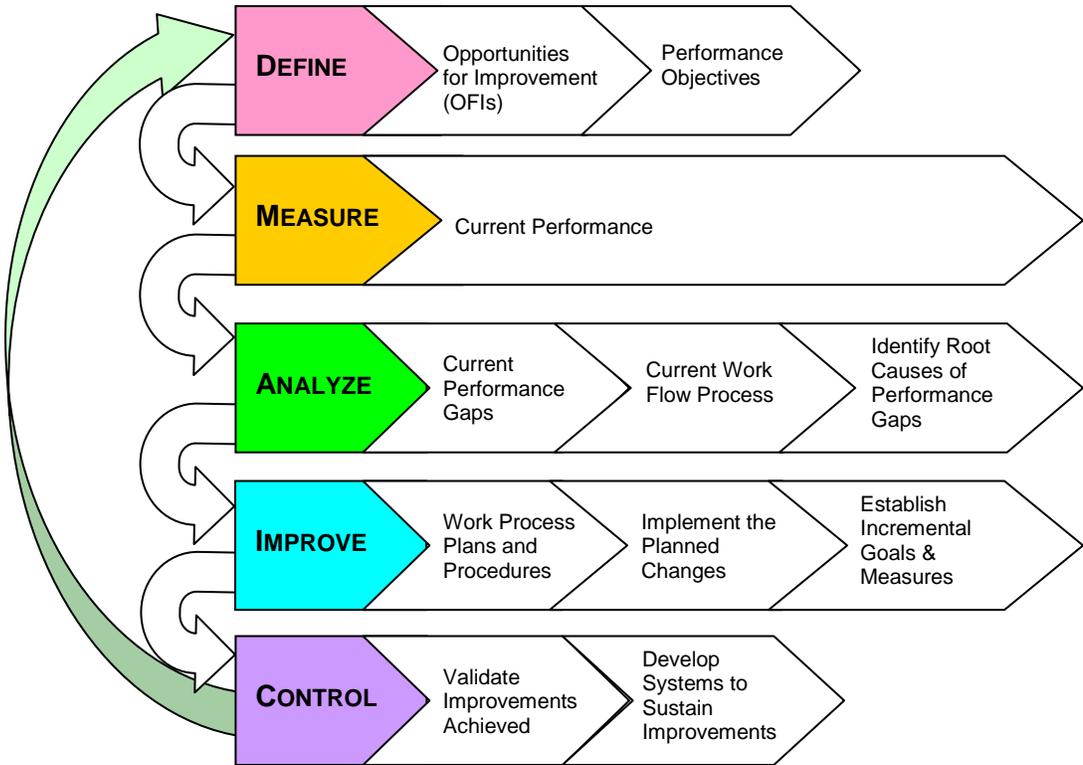
↑ Dorothea Dix and Riverview Psychiatric Centers ↑
Priority Focus Areas

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

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

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

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



STRATEGIC PERFORMANCE EXCELLENCE

Facilities

Herbert Gibson

Compliance Plan for Bureau of Labor Standards

DDPC Facilities - RE: Ref BLS # 176053 Citation Correction Tracking Log		Citation correction check	Citation correction completed	Supporting Documentation Attachment (notation)
LOCATION	29 CFR			
CITATION NUMBER AND ACTIVITY	1910 Ref			
Administrative Department				
1. ID of ACM + PACM materials within Facility	1910.1001(j)(3)(i)	✓	✓	ACM procedure in place and approved 3/5/2015
2. ACM + PACM Awareness Training	1910.1001(j)(7)(iv)	✓	✓	ACM training completed, correction verified 3/26/2015
3. Hearing Conservation testing and monitoring	1910.95(d)(1)	✓	✓	correction verified 4/14/2015
4. Blood and other pathogens annual training	1910.1030(g)(2)(iv)	✓	✓	correction verified 4/14/2015
5. PPE hazard assessment plan	1910.132(d)(2)	✓	✓	correction verified 4/24/2015
6. Hazard Communications Plan + Training	1910.1200(e)(1)	✓	✓	correction verified 4/23/2015
7. Respiratory Protection Program	1910.1001(j)(3)(i)	✓	✓	DDPC Policy 3-9
8. Hazard Energy Plan for machinery + equipment	1910.147(c)(4)(i)	✓	✓	correction verified 4/22/2015
9. Electrical Lock-Out/Tag-Out Plan	1910.333(b)(2)	✓	✓	procedure established, correction verified 3/26/2015
Employee Complaint				
Recommend opening communication lines between employees and union representation	**post Notice			
Facility				
1. Elec protective equipment testing (gloves)	1910.137(c)(1)	✓	✓	gloves tested, correction verified 3/26/2015
2. Establish inspection program for scaffolding	1910.28(d)(14)	✓	✓	correction verified 4/24/2015
3. Eyewash station rqmt at chem mixing areas	1910.151c	✓	✓	correction verified 4/3/2015
4. Gym LP access	1910.303(b)(2)	✓	✓	correction verified 3/5/2015
5. 1st Floor Men's Shower LP not labeled	1910.303(f)	✓	✓	correction verified 3/5/2015
6. Protective guards required for lighting lamps	1910.303(g)(2)(ii)	✓	✓	corrections verified 3/12/2015
7. Install exit signage at HR Office	1910.37(b)(2)	✓	✓	correction verified 3/18/2015
8. Elec wiring, energized contacts to have covers	1910.1001(j)(3)(i)	✓	✓	corrections verified 3/5/2015
9. LP + JB unused opening protection	1910.303(b)(1)(ii)	✓	✓	corrections verified 3/5/2015

STRATEGIC PERFORMANCE EXCELLENCE

10.Egress pathway at Med record Storage	1910.37(a)(3)	✓	✓	correction verified 4/3/2015
11.Room 016 LP clear path	1910.303(g)(1)(i)	✓	✓	correction verified 3/10/2015
12.Defective ladders	1910.25(d)(1)(x)	✓	✓	corrections verified 3/11/2015
13.Proper goggles in vegetable prep work	1910.132	✓	✓	correction verified 3/13/2015
14.Modify hand guard for Basement UH	1910.212(a)(5)	✓	✓	correction verified 4/2/2015
15.Grounding for exposed non-current metal parts	1910.304(g)(6)(vi)	✓	✓	corrections verified 3/5/2015
16.Grinder tongue guard at PM + Metal Fab shops	1910.215(b)(9)	✓	✓	corrections verified 3/11/2015
17.Grinder work rest in PM shop	1910.215(a)(4)	✓	✓	correction verified 4/2/2015
18.Fix drill presses at PM + Electrical shops	1910.212(b)	✓	✓	corrections verified 3/16/2015
19.Elec GFC protection + damaged drill cord	1910.303(b)(1)	✓	✓	corrections verified 3/5/2015
20.FR cab vent plugs Metal Fab shop, Boiler Hse	1910.106(d)(3)(ii)	✓	✓	corrections verified 3/11/2015
21.Guards for shop saw and lathe	1910.212(a)(3)(ii)	✓	✓	corrections verified 3/12/2015
22.Pipe Room heat tape splice	1910.305(g)(2)(ii)	✓	✓	correction verified 3/10/2015
Maintenance Building Motor Pool	1910.1001(j)(3)(i)			
1. FR Cabinet vent polugs	1910.106(d)(3)(ii)	✓	✓	correction verified 3/20/2015
2. Grinder work rest adjustment	1910.215(a)(4)	✓	✓	correction verified 3/20/2015
3. Grinder tongue guard adjustment	1910.251(b)(9)	✓	✓	correction verified 3/20/2015
4. Correct deficiencies with ladders	1910.25(d)(1)(x)	✓	✓	correction verified 4/1/2015
5. Inspection for bottle anf floor jacks	1910.244(a)(2)(vi)(a)	✓	✓	correction verified 4/1/2015
6. Vehicle lift inspection	1970 Section (5)(a)(1)	✓	✓	correction verified 4/1/2015
7. Install backup alarm on JD backhoe	1910.602(a)(9)(ii)	✓	✓	correction verified 4/1/2015
8. Snow removal at 2nd floor egress door	1910.36(h)(2)	✓	✓	correction made. Procedure put in place. 3/12/2015

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	4Q2014	1Q2015	2Q2015	3Q2015
Identification Data	100% 34/34	37/37 100%	29/29 100%	19/19 100%
Medical History, including chief complaint; HPI; past, social & family hx., ROS, and physical exam w/in 24 hr, conclusion and plan	97% 33/34	37/37 100%	27/29 93%	19/19 100%
Summary of patient's psychosocial needs as appropriate to the patients *	100% 34/34	36/37 97%	25/29 86%	16/19 84.2%
Psychiatric Evaluation in patient's record w/in 24 hr of admission	100% 34/34	35/37 94.5%	29/29 100%	19/19 100%
Physician (TO/VO w/in 72 hr.)	90.6% 29/32	36/36 100%	28/29 96.5%	16/19 84.2%
Evidence of appropriate informed consent	97% 33/34	36/36 100%	25/27 92.5%	19/19 100%
Clinical observations including the results of therapy.	100% 34/34	32/32 100%	27/27 100%	19/19 100%
Nursing discharge Progress Note with time of discharge departure	100% 34/34	36/36 100%	29/29 100%	19/19 100%
<i>Consultation reports, when applicable</i>	100% 13/13	20/20 100%	16/16 100%	10/11 90.9%
Final Diagnosis (es) DSM-Principal Diagnosis	100% 34/34	37/37 100%	29/29 100%	19/19 100%
Results of autopsy, when performed	N/A	N/A	N/A	N/A
<i>Advance Directive Status on admission and SW follow up after</i>	97% 33/34	35/36 97%	26/29 89.7%	18/19 94.7%
Notice of Privacy	100% 34/34	36/37 100%	29/29 100%	17/19 89.4%
<i>Chart Completion w/in 30 days of discharge date/discharge summary completed within 30 days</i>	88.2% 30/34	34/37 92%	27/29 93%	18/19 94.7%
Discharge Packet sent to follow up provider within 5 days of discharge.	91% 31/34	36/36 100%	27/29 93%	15/19 78.9%

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

STRATEGIC PERFORMANCE EXCELLENCE

Human Resources

Ruth Mullaney

	2Q FY 2015 Total	Jan 2015	Feb 2015	Mar 2015	3Q FY 2015 Total
Terminations – Voluntary	5	0	0	1	1
Terminations – Involuntary	2	0	0	0	0
New Hires	13	1	2	1	4
Sick Time Used	2,644.95	1,243.40	923.65	951.45	3,118.50
FML Used	1,534.50	266.00	384.40	672.55	1,322.95
Overtime	5,279.45	1,621.50	2,594.15	1,840.00	6,055.65
AWOL	511.00	215.80	237.05	60.80	513.65
Lost Time	1	1	1	1	3
Type of Incident:					
Medical	5	2			2
Fall	2	1	1	1	3
Patient Related	8	4	4	2	10
Chemical Spill					
Total # of Events	15	7	5	3	15

STRATEGIC PERFORMANCE EXCELLENCE

Infection Control

Heather Brock, RN

1.) GOAL

Surveillance Data will continue to be gathered on the following hospital acquired infections: **UTI, URI, LRI, and SKIN**. Data will be reviewed monthly and reported quarterly as part of the Quality Management Report. A threshold has been set for **0.3** (HAI) per 1000 inpatient days for FY 2015.

HOSPITAL ACQUIRED INFECTIONS

1st Quarter: July - September FY 2015 = 0 H.A. Infections
 2nd Quarter: October – December FY 2015 = 0 H.A. Infections
 3rd Quarter: January – March FY 2015 = 0 H.A. Infections
 4th Quarter: April – June FY 2015 = _ H.A. Infections

H. A. Infections	FY 2013	FY 2014	FY 2015
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	0
4 th Quarter H.A.I. Rate	0	0	
Average H.A. Infection Rate	0	0	

FY 2013-2015 Hospital Acquired Infections

Type of Infection	1Q 2013	1Q 2014	1Q 2015	2Q 2013	2Q 2014	2Q 2015	3Q 2013	3Q 2014	3Q 2015	4Q 2013	4Q 2014	4Q 2015
UTI	0	0	0	0	0	0	0	0	0	0	0	
URI	0	0	0	0	0	0	0	0	0	0	0	
LRI	0	0	0	0	0	0	0	0	0	0	0	
SKIN	0	0	0	0	0	0	0	0	0	0	0	
Totals	0	0	0	0	0	0	0	0	0	0	0	
Infection Rate	0	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 2013 = 3631
 2nd Quarter 2013 = 4101
 3rd Quarter 2013 = 4052
 4th Quarter 2013 = 3802

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

1st Quarter 2014 = 3256
 2nd Quarter 2014 = 3550
 3rd Quarter 2014 = 3453
 4th Quarter 2014 =

STRATEGIC PERFORMANCE EXCELLENCE

2.) INFECTION CONTROL PERFORMANCE ISSUES

I.C. STANDARD IC.02.01.01 AND 01.05.01:

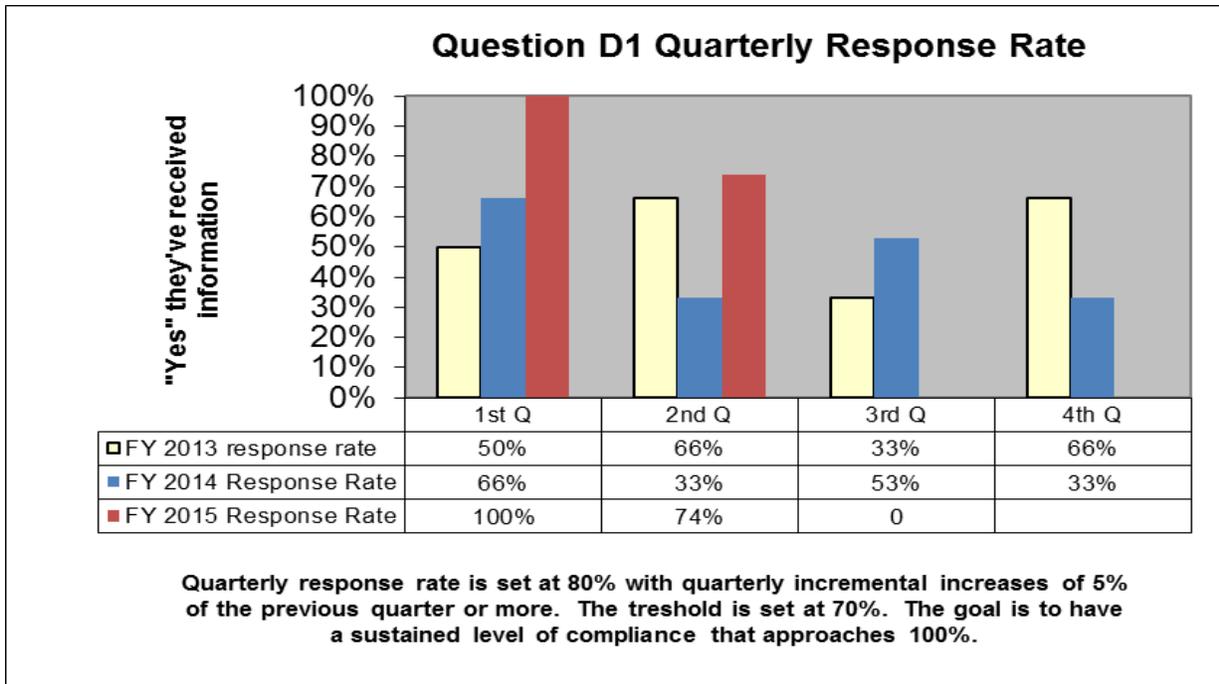
IC Standard 02.01.01 EP #7 and 01.05.01 EP #7 the hospital implement a methods to communicate responsibilities for preventing and controlling infection to visitors, patients, and families? (Information for visitors, patients, and families includes hand and respiratory hygiene practices).

Goal for FY2015

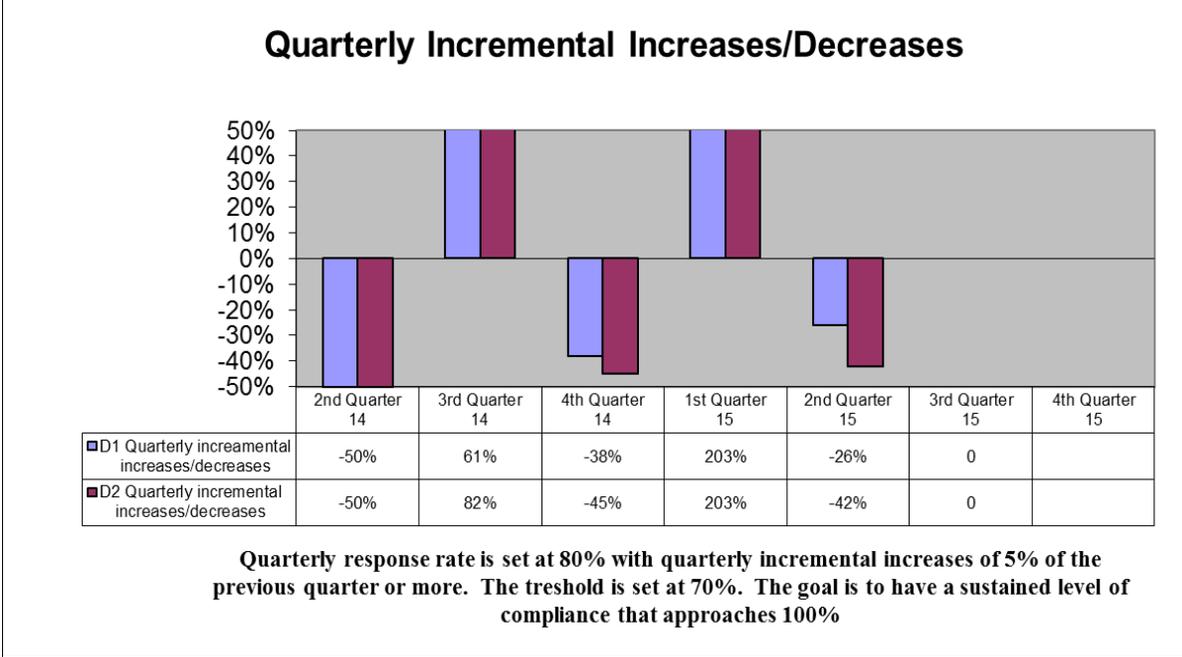
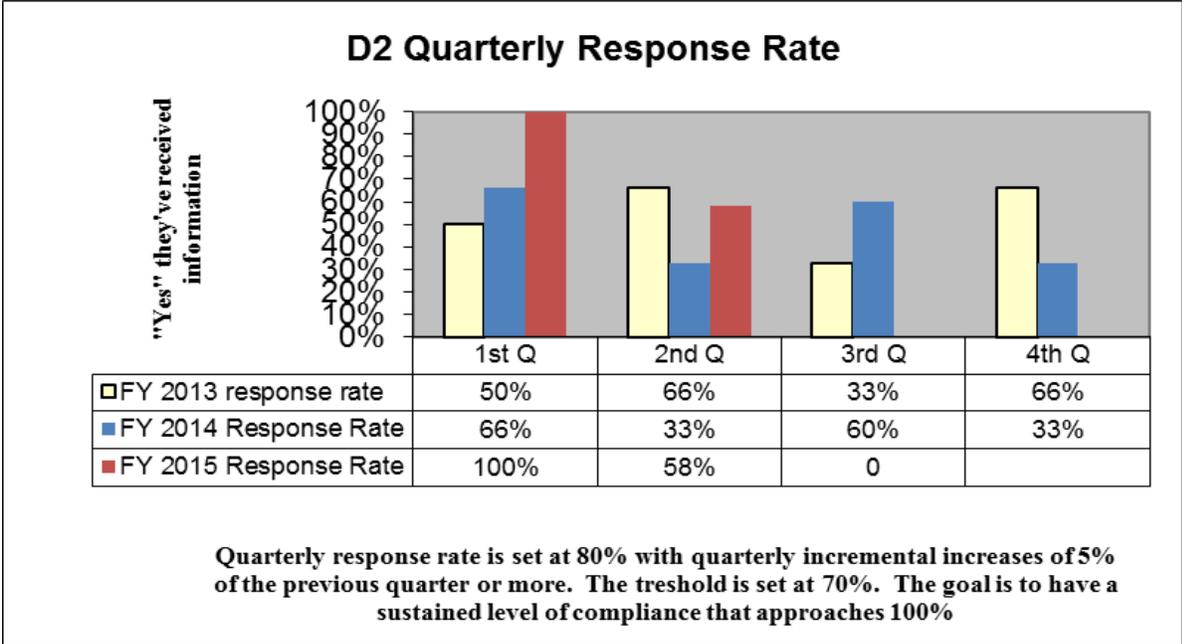
Quarterly response rates for question D1 and D2 agree and strongly agree is set at **80%** with quarterly incremental increases of 5% of the previous quarter or more. The threshold is set at **70%**. *The standard goal is to have a sustained level of compliance that approaches 100%. Once the goal of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

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

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



STRATEGIC PERFORMANCE EXCELLENCE



STRATEGIC PERFORMANCE EXCELLENCE

PLAN OF ACTION

***Patient and family education questionnaires were not distributed during the third quarter of 2015 due to infection control nurse being out on leave. The zeros represent “not applicable.”**

For 3rd Quarter FY 2015 there were 0 questionnaires distributed, 0 questionnaires were completed and returned for a quarterly return rate of 0%.

*Questions D1 and D2 have been removed from the NRI patient discharge survey. IC RN has been tasked with offering a short IC survey that will capture questions D1 and D2. IC will continue to monitor.

3.) PROMOTION OF 2014-2015 INFLUENZA IMMUNIZATIONS

The goal for FY 2015 is to have an incremental increase of 4% of the previous year over the next six years. This would place the facility at the national goal of achieving 90% flu vaccination compliance. The standard goal is to have a sustained level of compliance that approaches and achieves the 90% compliance rate established in the national influenza initiative for 2020. Our compliance rate for 2014-2015 is 75%. That is a 4.2% increase from last year.

4.) PATIENT HAND HYGIENE

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

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

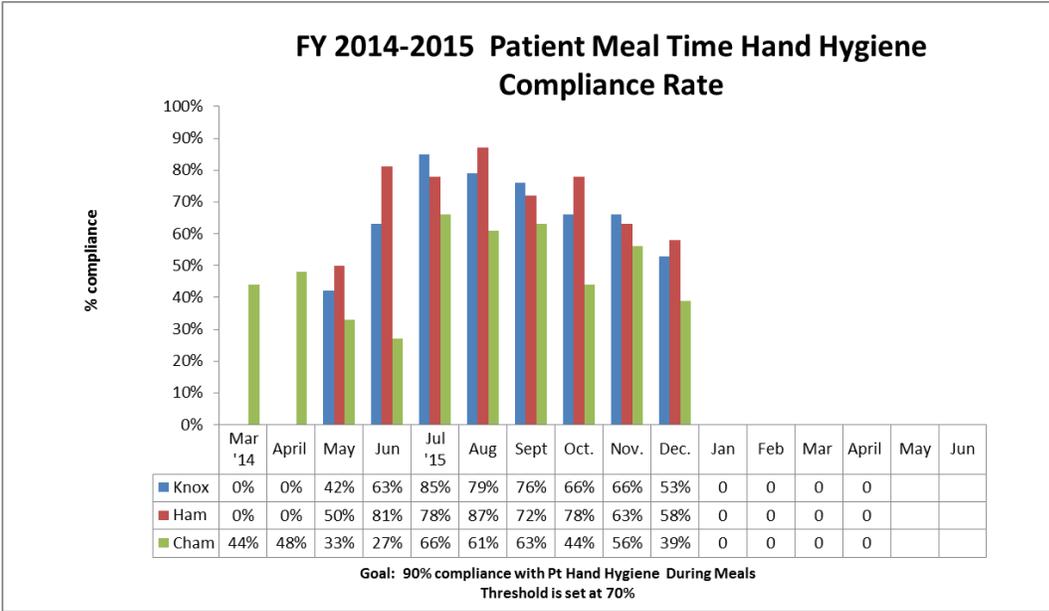
Baseline Data: 4th Q 2014

Knox= 35% compliance rate

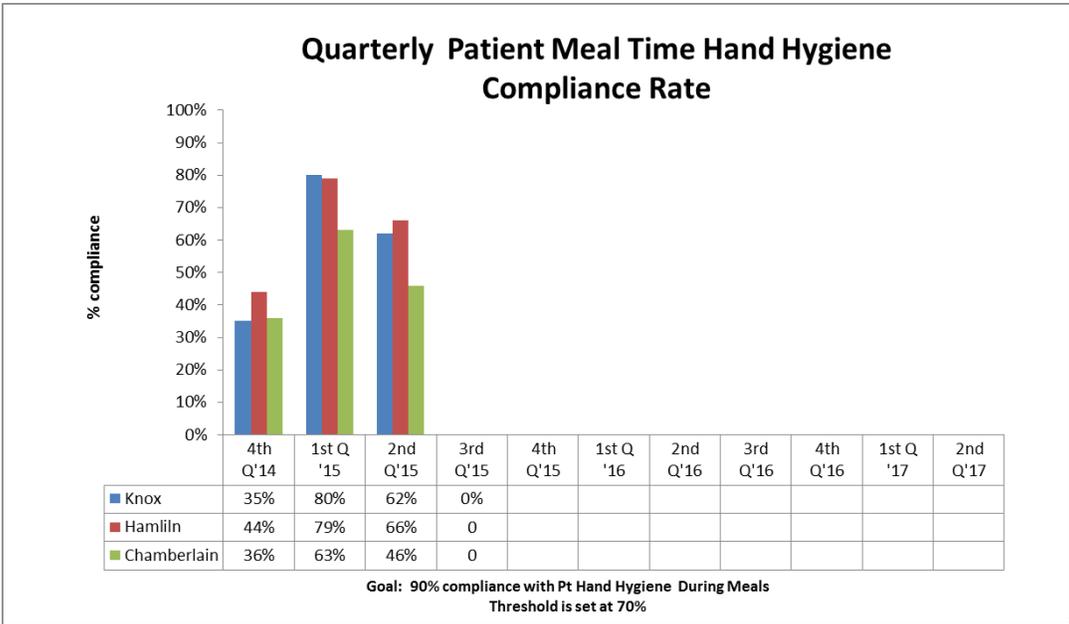
Hamlin= 44% compliance rate

Chamberlain= 36% compliance rate

STRATEGIC PERFORMANCE EXCELLENCE



*The zeros listed for the months of January, February, March, and April reflect a time span where data was not collected due to infection control nurse being out on leave. The zeros represent “not applicable.”



Evaluation/Plan of Action:

*The zeros listed for third quarter 2015 reflect a time span where data was not collected due to infection control nurse being out on leave. The zeros represent “not applicable.”

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

STRATEGIC PERFORMANCE EXCELLENCE

Occupational Therapy

Lisa J. Hall, OTR/L

Strategic Objectives							
Client Recovery, Communication	Unit	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal
Measure 1 Name- Timely completion of initial evaluation to guide OT services.	Eval complete on time	-	90%	90%	90%	90%	100%
<i>Measure 1 Description-</i> OTR/L must complete and document in the medical record initial OT evaluation within 10 calendar days of admission.							
<u>Quarterly Results</u>		FY 14 89%	32/32 100%	29/29 100%	100%		
Measure 2 Name- Timely completion of discharge information to next level of care.	Discharge SBAR, on time	-	90%	90%	90%	90%	100%
<i>Measure 2 Description-</i> OTR/L must complete and document in the medical record SBAR discharge hand off within 4 calendar days following discharge for any patient who received OT TX during that admission.							
<u>Quarterly Results</u>		FY14 92%	15/15 100% Second quarter met	9/9 100% Third quarter met	N/A		

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

Comments: Effective 1/1/15- initial evaluation must be in the medical record within 7 calendar days.

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

Garry Miller, RPh

Strategic Objectives								
Safety in Culture and Actions	Unit	Baseline 2014	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
<u>Pyxis CII Safe Comparison</u>	Rx	0%	0%	0%	0%	0%	0%	Goal of no discrepancies in any transactions between Pyxis and CII
<i>Daily and monthly comparison of Pyxis vs CII Safe transactions</i>								
Quarterly Results								
<u>Veriform Medication Room Audits</u>	All	93%	90%	90%	90%	90%	90%	Overall compliance is 92% YTD
<i>Monthly comprehensive audits of 38 criteria</i>								
Quarterly Results								
<u>Pyxis Discrepancies</u>	All	6.7	0	0	0	0	0	Trending of monthly data from Knowledge Portal.
<i>Monthly monitoring and trending of Pyxis discrepancies.</i>								
Quarterly Results								
			21 (7/mo)	25 (8/mo)	22 (7/mo)			
<u>Fiscal Accountability</u>	Unit	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
<u>Discharge Prescriptions</u>	Rx	\$353 22 drugs	\$114 6 drugs	\$172 7 drugs	\$121 2 drugs			Significant savings and decrease achieved in discharge prescriptions
<i>Monitoring and Tracking of dispensed Discharge Prescriptions</i>								

STRATEGIC PERFORMANCE EXCELLENCE

Social Services

Susan Wengrzynek, LMSW-CC

Quality Management FY 2015

Methodology A Grievance process is required by Maine statute and the AMHI Consent Decree. The process, set out in a state regulation, entitles The Rights of Recipients of Mental Health Services. Written responses must be delivered in five days, with five days more if the grievant is notified. Nursing Service policy states that the Nurse Supervisor must see the patient within 2 hours of notification by the unit.

Baseline Data: All new grievances starting in July 2014

- Baseline compliance = 90%.

Goal for FY 2015: 100% compliance for completion of psychosocial assessment within 5 days of admission.

Quarter	Month	# of Grievances	Compliance %	Overall Compliance for Quarter
1Q2015	July 2014	8	100%	97.7%
	August 2014	13	92.3%	
	September 2014	7	100%	
2Q2015	October 2014	2	50%	94.4%
	November 2014	1	0%	
	December 2014	28	50%	
3Q2015	January 2015	24	75%	62.3%
	February 2015	11	45.4%	
	March 2015	3	66.6%	
4Q2015	April 2015			
	May 2015			
	June 2015			

STRATEGIC PERFORMANCE EXCELLENCE

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

Priority Focus Areas – 3rd Quarter FY 2015

Measure Name	Measure Description	Unit	Baseline	Target	Comments
<u>MANDT:</u> DDPC and Contract staff will complete MANDT training annually.	All DDPC employees and contract staff are required to complete MANDT training annually. (Epharm is excluded.)	211 (both DDPC employees and contract staff.)	91%	100%	Staff Education will work with the training scheduler to facilitate 100% compliance in MANDT training.
<u>CPR:</u> DDPC and Contract staff will maintain CPR certification by attending CPR training biannually.	All DDPC employees and contract staff are required to complete CPR training annually. Epharm and contract medical staff are excluded.)	228 (both DDPC employees and contract staff.)	91%	100%	Staff Education will work with the training scheduler to facilitate 100% compliance in CPR training.
<u>New Employee:</u> New employees will complete new employee orientation within 60 days of hire.	Process will include following up with new employees, review of the orientation record and requirements to determine if standard is met.	10 new hires during the 3 rd quarter. 6 full time employees and 4 contract staff.	100%	100%	We will move new employee orientation onto Quality Management. We will assess October 2015 to ensure sustained compliance.
<u>Impaired Licensed Practitioner:</u> DDPC and Contract staff will receive policy MS #13 annually.	All DDPC employees and contract staff are required to be educated in DDPC policy MS #13 (Epharm is excluded.)	230 (both DDPC employees and contract staff.)	97%	100%	We will move ILP onto Quality Management. We will assess October 2015 to ensure sustained compliance.
<u>Pain:</u> DDPC requires all RNs and Medical Staff to complete annual PAIN education packets.	All licensed independent practitioners are educated on assessing/managing pain.	79 (both DDPC employees and contract staff.) 19 MD/60 RN	96%	100%	We will move Pain onto Quality Management. We will assess October 2015 to ensure sustained compliance.

STRATEGIC PERFORMANCE EXCELLENCE

MANDT Training – Quality Management/Performance Improvement

Both direct and non-direct care employees of Dorothea Dix Psychiatric Center (DDPC) are trained 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 MANDT is to utilize non-physical de-escalation techniques with patients in order to prevent potentially violent outbursts and promote the safety of all patients in an atmosphere of trust. 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.

Methodology:

- The Staff Education Department will conduct quarterly audits of employee MANDT certification status using the education database.
- For direct care staff the:
The numerator will be the quarterly combined number of direct care staff that attended MANDT training and the denominator will be quarterly combined number of direct care staff scheduled for MANDT training.
- For non-direct care staff the:
The numerator will be the quarterly combined number of non-direct care staff that attended MANDT training and the denominator will be quarterly combined number of non-direct care staff scheduled for MANDT training.

Baseline Data: Direct Care Staff 100% 4/1/15
Non-Direct Care Staff 77% 4/1/15

Goal: The goal is 100% MANDT certification for both direct and non-direct care staff.

Data:

Quality Management Results- MANDT Training Direct Care Staff						
	Baseline	Q1	Q2	Q3 FY 2015	Q4	YTD
Target	April 2015 100%			100%		
Actual				100%		

STRATEGIC PERFORMANCE EXCELLENCE

Performance Improvement Results- MANDT Training Non-Direct Care Staff						
	Baseline	Q1	Q2	Q3 FY 2015	Q4	YTD
Target	April 2015 77%			100%		
Actual				77%		

Analysis of Data:

Overall analysis of the data reveals 91% MANDT compliance rate when direct care and non-direct care are combined. When direct care and non-direct care staff are compared separately, the data reveals deficiencies. The data reveals 100% compliance for direct care with only 77% of non-direct care in compliance. It is the goal of SED to increase the ratio of non-direct care staff while maintaining the current met goal of 100% for direct care staff.

Plan of Action:

- Staff education will complete monthly audits.
- Staff education will coordinate to create MANDT-Light (Defensive) version for non-direct care staff that qualify.
- Staff education will send monthly reports to department heads and Superintendent of employees out of compliance.

CPR Training – Quality Management/Performance Improvement

All employees of Dorothea Dix Psychiatric Center (DDPC) are to be CPR certified. 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.

Methodology:

- The Staff Education Department will conduct quarterly audits of the CPR certification status of all DDPC employees using the education database.
- For direct care staff:
The numerator will be the quarterly combined number of direct care staff that attended CPR certification and the denominator will be quarterly combined number of direct care staff scheduled for the CPR certification training.
- For non-direct care staff:
The numerator will be the quarterly combined number of non-direct care staff that attended CPR certification and the denominator will be quarterly combined number of non-direct care staff scheduled for the CPR certification training.

Baseline Data: Direct Care Staff 100% 4/1/15
Non-Direct Care Staff 76% 4/1/15

STRATEGIC PERFORMANCE EXCELLENCE

Goal: The goal is 100% CPR certification for both direct care and non-direct care staff

Data:

Quality Management Results- CPR Training Direct Care Staff						
	Baseline	Q1	Q2	Q3 FY 2015	Q4	YTD
Target	April 2015 100%			100%		
Actual				100%		

Performance Improvement Results- CPR Training Non-Direct Care Staff						
	Baseline	Q1	Q2	Q3 FY 2015	Q4	YTD
Target	April 2015 76%			100%		
Actual				76%		

Analysis of Data:

Overall analysis of the data reveals 91% CPR compliance rate when direct care and non-direct care are combined. When direct care and non-direct care staff are compared separately, the data reveals deficiencies. The data reveals 100% compliance for direct care with only 76% of non-direct care in compliance. It is the goal of SED to increase the ratio of non-direct care staff while maintaining the current met goal of 100% for direct care staff.

Plan of Action:

- Staff education will complete monthly audits.
- Staff education will collaborate with outside agencies to increase number of classes available, as needed, to ensure compliance of all staff.

STRATEGIC PERFORMANCE EXCELLENCE

Therapeutic Recreation

Lisa J. Hall, OTR/L

Strategic Objectives							
Client Recovery, Communication	Unit	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal
<p><u>Measure 1 Name-</u> Timely completion of initial evaluation to guide TR services.</p> <p><u>Measure 1 Description-</u> CTRS must complete and document in the medical record both components of the Recreation Assessment within 10 calendar days of admission.</p>	<p><u>Assess-ment complete on time</u></p>	-	90%	90%	90%	90%	100%
<u>Quarterly Results</u>		FY 14 78%	28/31 90%	24/29 83%	100%		
<p><u>Measure 2 Name-</u> Timely completion of discharge information to next level of care.</p> <p><u>Measure 2 Description-</u> CTRS must complete and document in the medical record SBAR discharge hand off within 4 calendar days following discharge for any patient who received TR TX during that admission.</p>	<p><u>Discharge SBAR, on time</u></p>	-	90%	90%	90%	90%	100%
<u>Quarterly Results</u>		FY 14 91%	29/29 100% Second quarter met	23/25 92% Third quarter met	100%		

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

Comments

Measure 1: Q1- three out of compliance by 1 day, 1 provider
Effective 1/1/15, the initial evaluation must be in the medical record within 7 calendar days.

Measure 2: April 2015- All indicators met for at least 3 consecutive months, plan to move to quality management with auditing for sustained compliance. Please see new performance improvement measure for April 2015 and FY2016 (Direct Contact Hours).

STRATEGIC PERFORMANCE EXCELLENCE

Therapeutic Recreation
 (Occupational Therapy, Therapeutic
 Recreation, Clinical Dietician, Psychology,
 Substance Abuse, Clinical Social Work)

Lisa J. Hall, OTR/L

PERFORMANCE IMPROVEMENT FY2016 - Effective March 2015

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 choice 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.

Methodology: Each week staff will monitor and document the time spent face to face with patients, including time in treatment planning / discharge meetings. Individual data will be submitted to the Director of Therapeutic Services to aggregate and analyze.

The numerator will be the quarterly combined number of direct contact hours provided for each individual department, the denominator will be the quarterly combined hours worked by staff for each individual department, based on a 37.5 hour work week.

Goal: 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.

Data Results

A. Measure Name: Direct Patient Contact- Occupational Therapy Type of Measure: Performance Improvement

Results							
	Unit	Baseline	Q1 (April- June)	Q2 (July- Sept)	Q3 (Oct- Dec 15)	Q4 (Jan 16- March)	YTD
Target	Percent of time spent in direct patient contact.	March 2015 36%	55%	65%	70%	70%	
Actual							

STRATEGIC PERFORMANCE EXCELLENCE

B. Measure Name: Direct Patient Contact- Therapeutic Recreation
Type of Measure: Performance Improvement

Results							
	Unit	Baseline	Q1 (April- June)	Q2 (July- Sept)	Q3 (Oct- Dec 15)	Q4 (Jan 16- March)	YTD
Target	Percent of time spent in direct patient contact.	March 2015 55%	55%	65%	70%	70%	
Actual							

C. Measure Name: Direct Patient Contact- Clinical Services
Type of Measure: Performance Improvement

Results							
	Unit	Baseline	Q1 (April- June)	Q2 (July- Sept)	Q3 (Oct- Dec 15)	Q4 (Jan 16- March)	YTD
Target	Percent of time spent in direct patient contact.	March 2015 35%	55%	65%	70%	70%	
Actual							

D. Measure Name: Direct Patient Contact- Clinical Dietician
Type of Measure: Performance Improvement

Results							
	Unit	Baseline	Q1 (April- June)	Q2 (July- Sept)	Q3 (Oct- Dec 15)	Q4 (Jan 16- March)	YTD
Target	Percent of time spent in direct patient contact.	March 2015 31%	55%	65%	70%	70%	
Actual							

Data Analysis:

March 2015- all providers are well below the goal. Given the indirect care duties of various job classes, it may become apparent that each job class will require a different direct patient contact goal.

Action Plan:

April 2015- Staff were informed of this PI plan and given the choice of what indirect and non-patient care tasks they decrease. Documentation remains a priority. Plan to explore options to streamline documentation, consider group co-facilitators to share documentation.

STRATEGIC PERFORMANCE EXCELLENCE

Utilization Review

Leanne McLean, RN

Percent of Acute Days as a Subset of Total Patient Days

1st Quarter Calendar Year 2015 - 3rd Quarter Fiscal Year 2015

