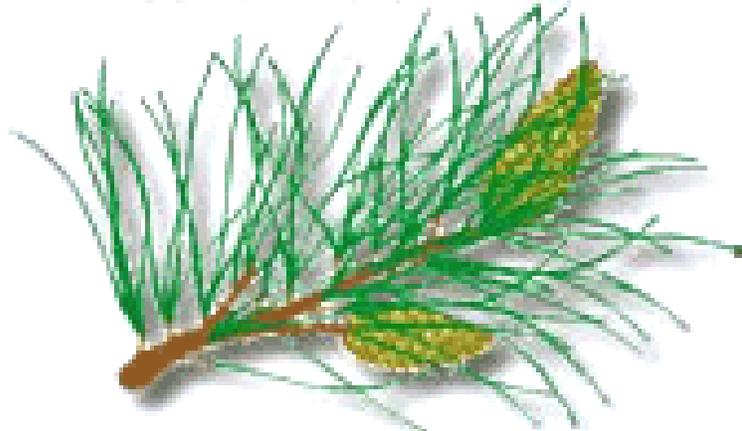


*Dorothea Dix*



*Psychiatric Center*

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**QUARTERLY REPORT ON  
ORGANIZATIONAL PERFORMANCE EXCELLENCE**

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**FOURTH STATE FISCAL QUARTER 2015**  
April, May, June 2015

**Sharon Sprague**  
Superintendent  
August 18, 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,

*Joseph Riddick*

Joseph Riddick

Director of Integrated Quality and Informatics



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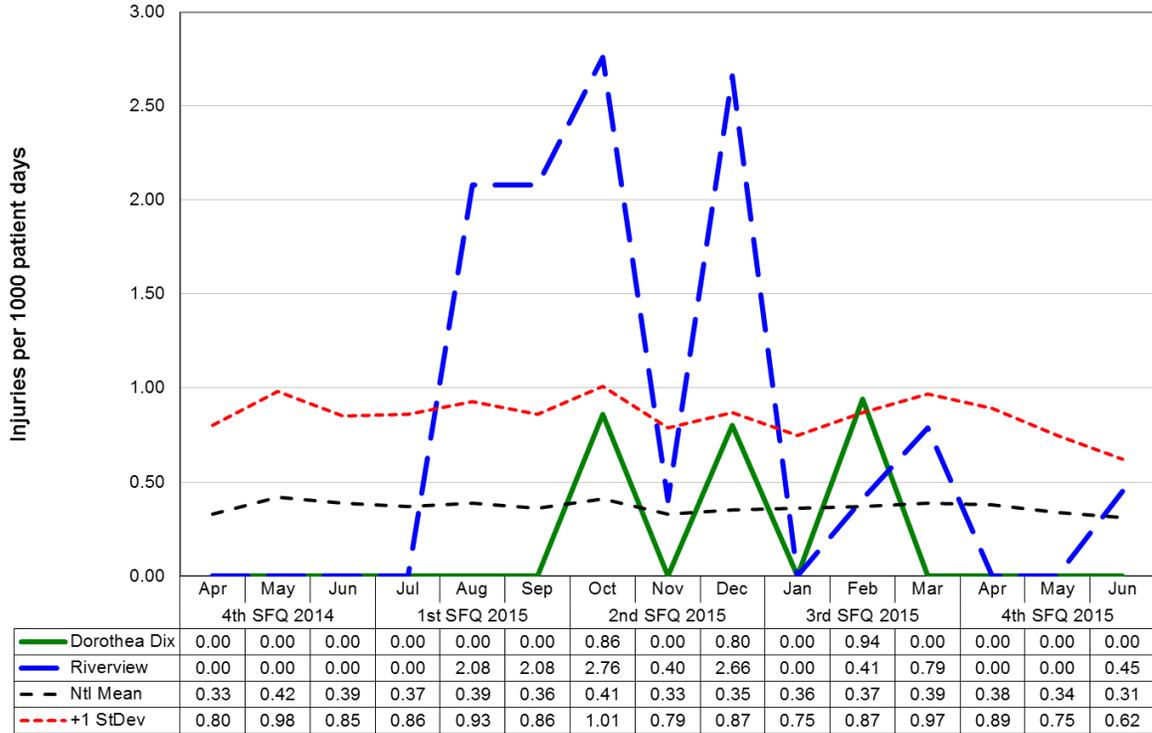
# COMPARATIVE STATISTICS

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

“Non-reportable” injuries include those that require:

- No Treatment
- Minor First Aid

“Reportable” injuries include those that require:

- 3) Medical Intervention
- 4) Hospitalization
- 5) Death Occurred

- 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

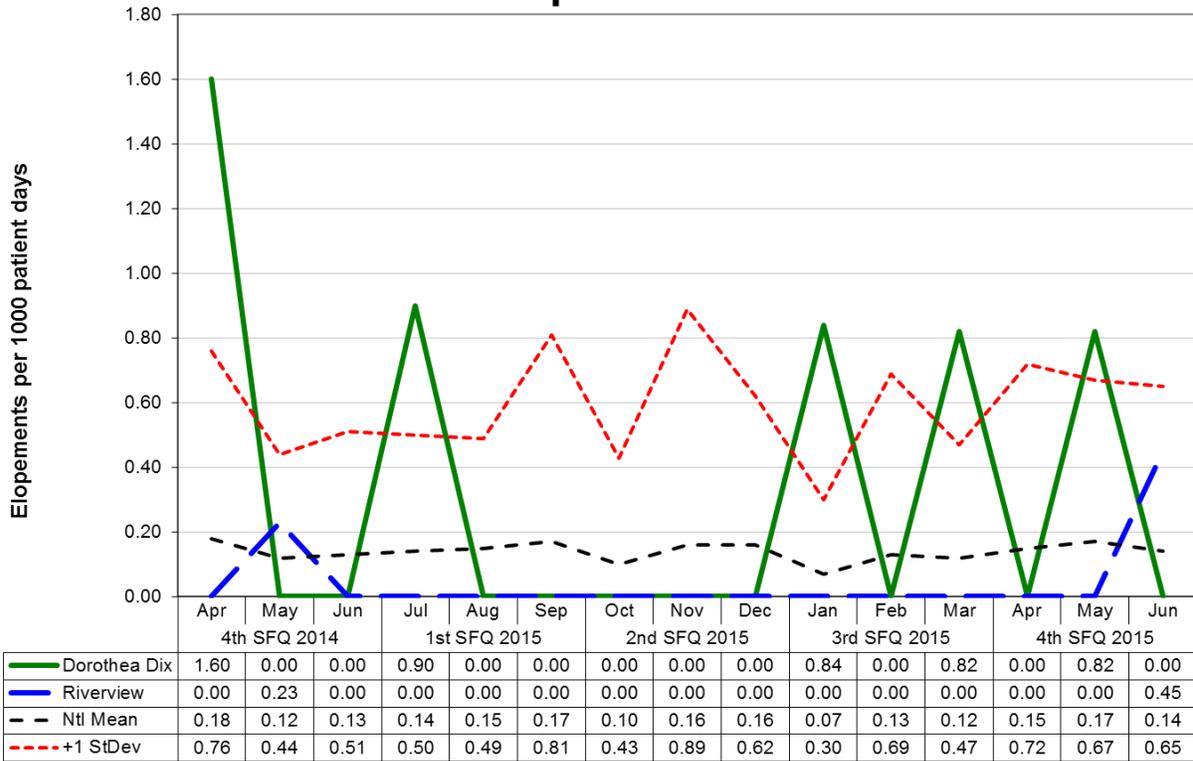
Type - Cause	April	May	June	4Q2015
Accident – Fall	1		1	2
Accident – Other	1			1
Assault – Patient to Patient		1		1
Injury – Other		1	1	2
Self-Injurious Behavior	2	1	2	5
<b>Total</b>	<b>4</b>	<b>3</b>	<b>4</b>	<b>11</b>

### Severity of Injury by Month

Severity	April	May	June	4Q2015
No Treatment	3	0	4	7
Minor First Aid	1	3	0	4
Medical Intervention Required				
Hospitalization Required				
Death Occurred				
<b>Total</b>	<b>4</b>	<b>3</b>	<b>4</b>	<b>11</b>

# COMPARATIVE STATISTICS

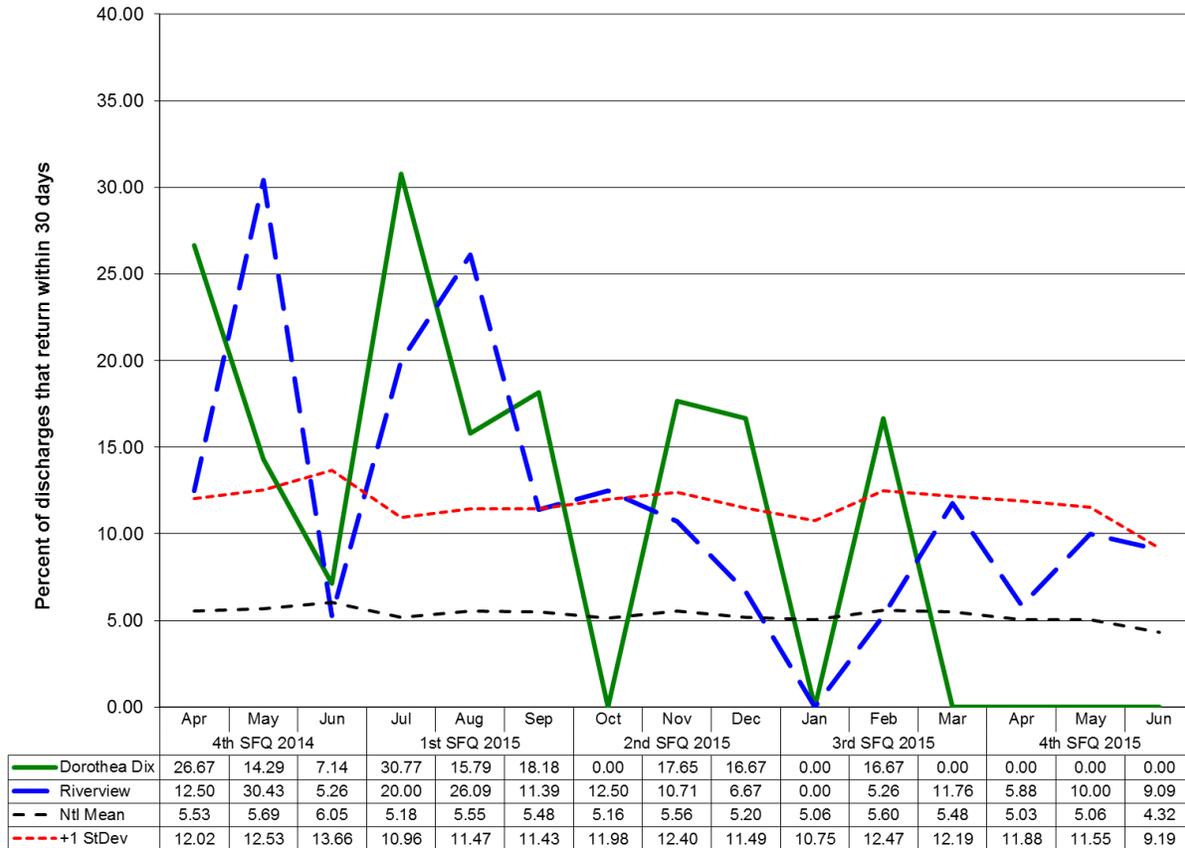
## Elopement



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

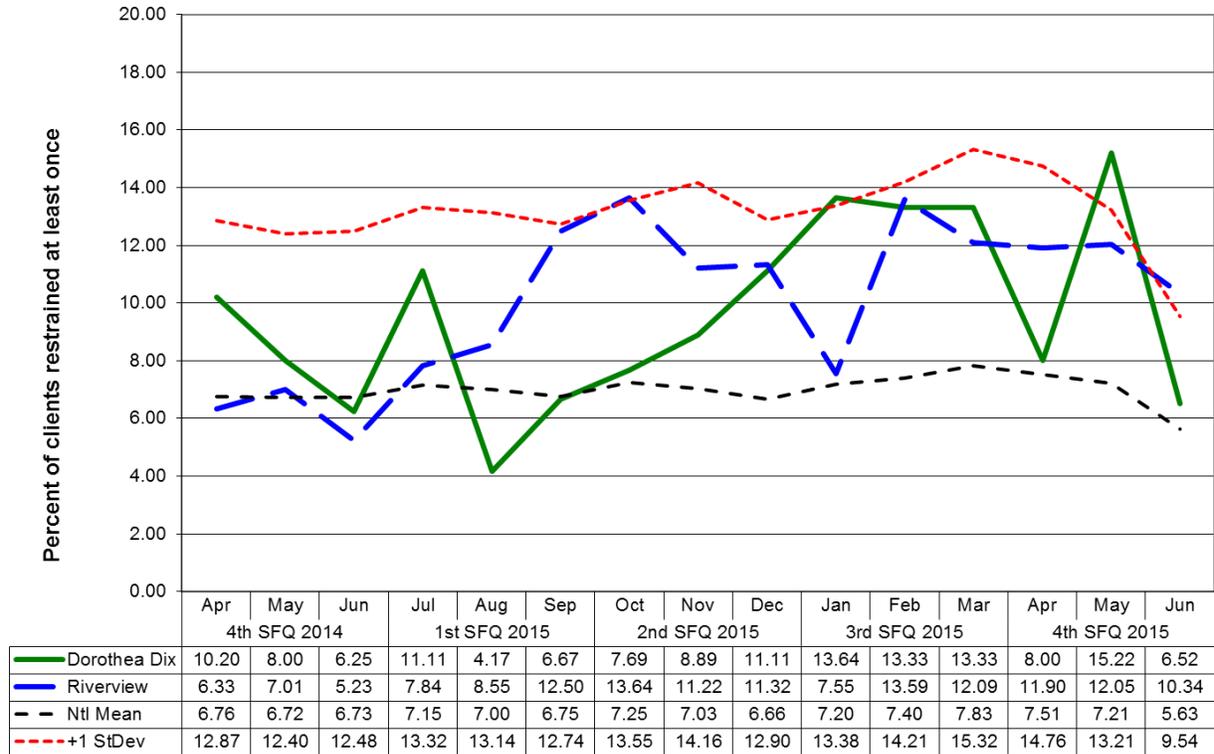


Percent of discharges from the facility that returned within 30 days of a discharge of the same patient from the same facility. For example, a rate of 10.0 means that 10% of all discharges were readmitted within 30 days.

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

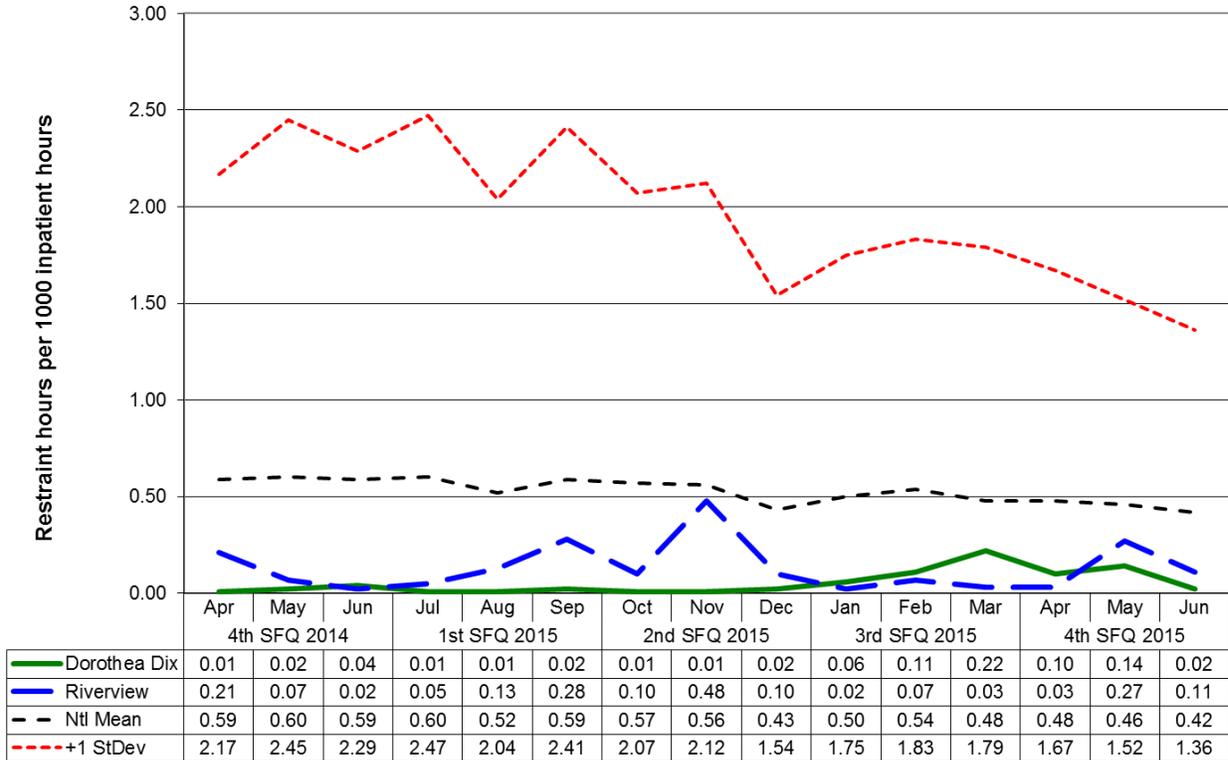
## Percent of Clients Restrained



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

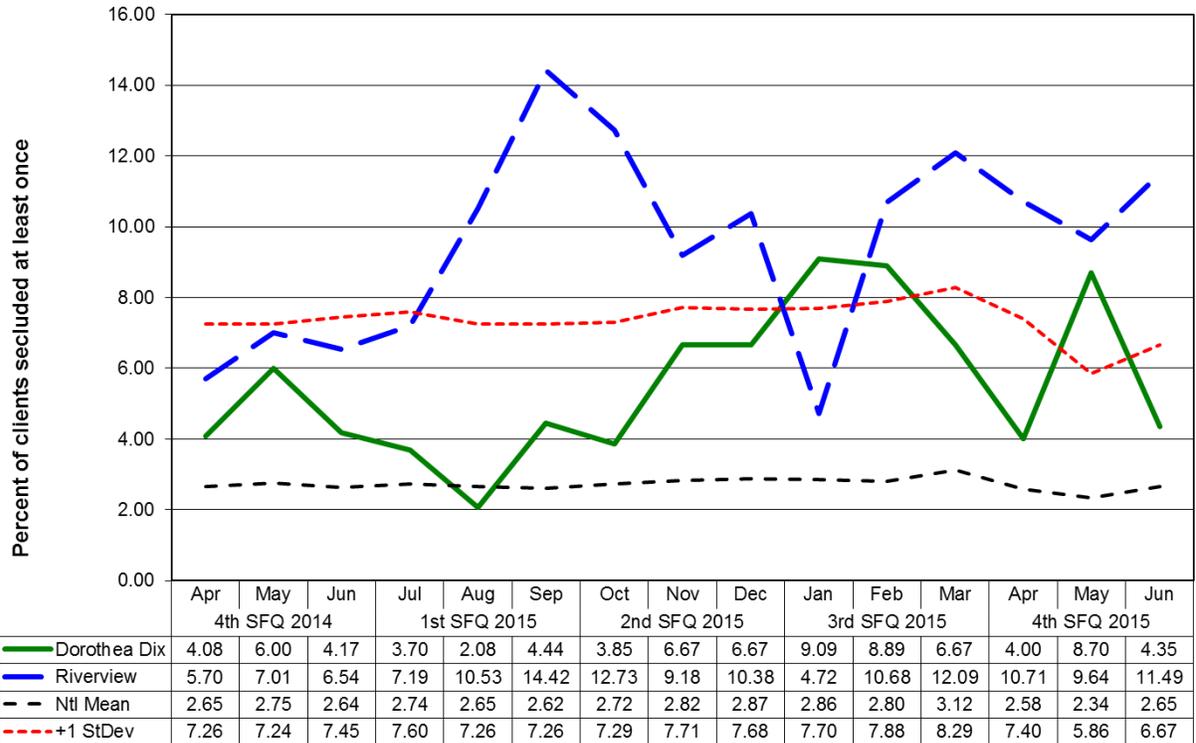
## Restraint Hours



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

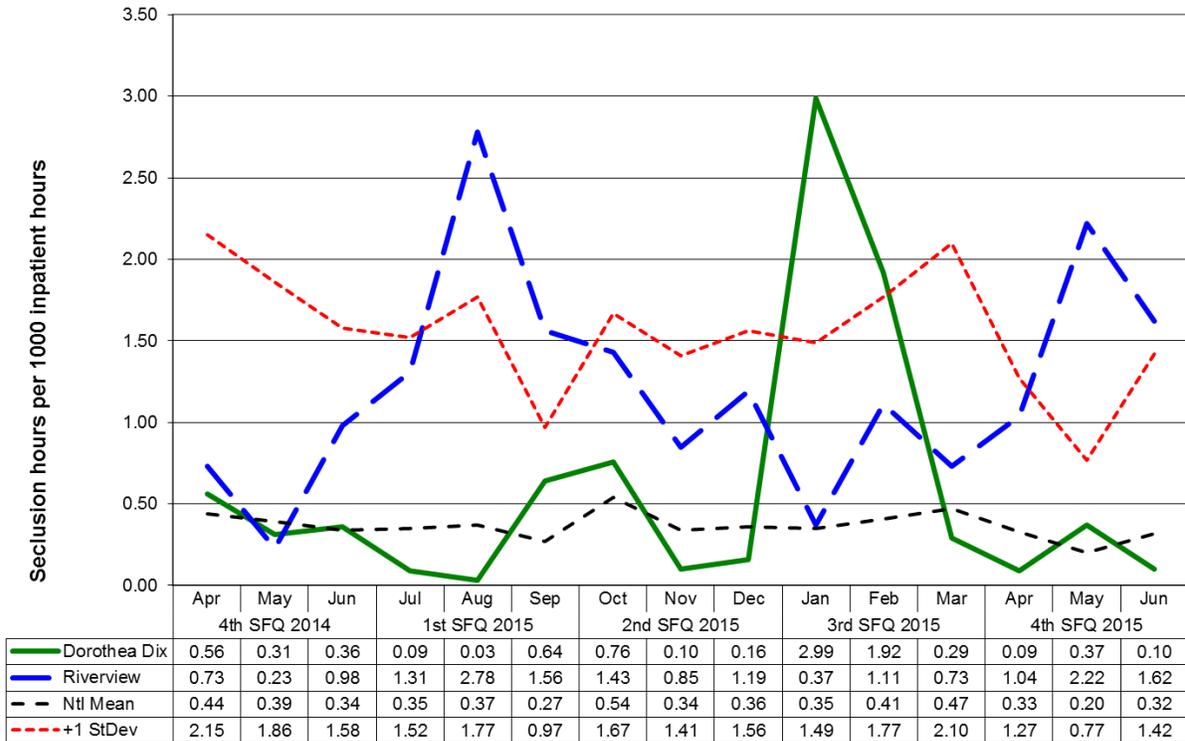
## Percent of Clients Secluded



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.

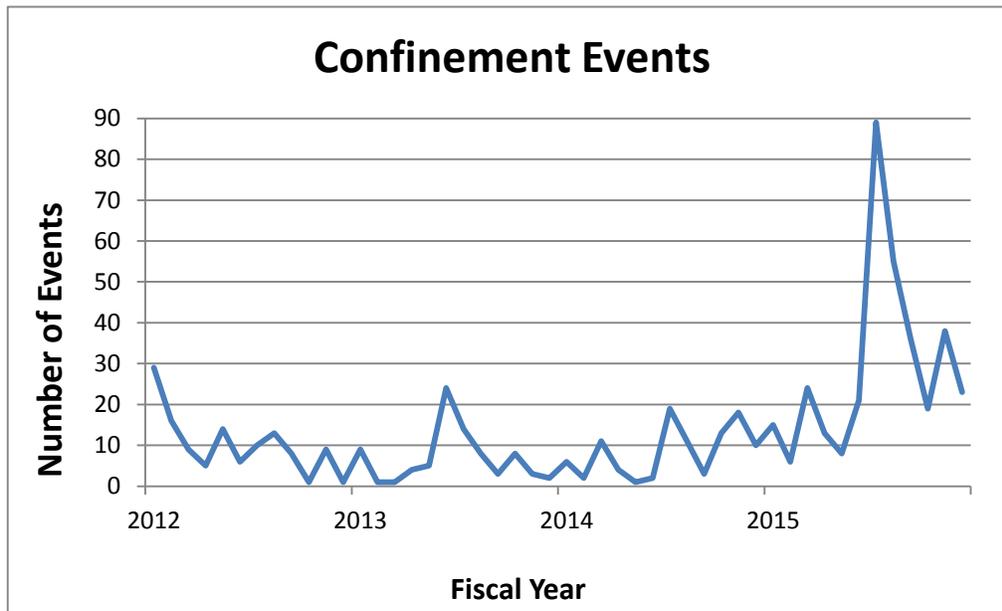
# COMPARATIVE STATISTICS

## Confinement Event Breakdown

Patient ID	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
MD00001705	36	4	7	47	63.51%	63.51%
MD00000535	6	0	3	9	12.16%	75.68%
MD00001303	4	0	1	5	6.76%	82.43%
MD00001305	4	0	1	5	6.76%	89.19%
MD00001955	3	0	1	4	5.41%	94.59%
MD00001933	1	0	1	2	2.70%	97.30%
MD00001892	1	0	0	1	1.35%	98.65%
MD00000103	1	0	0	1	1.35%	100.00%
	<b>56</b>	<b>4</b>	<b>14</b>	<b>74</b>		

Unit	Manual Hold	Locked Seclusion
Chamberlain	36	8
Hamlin	11	4
Knox	9	2

Event	Apr	May	June
Manual Hold	14	23	19
Locked Seclusion	2	10	2



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

# JOINT COMMISSION

## **Hospital Based Inpatient Psychiatric Services (ORYX Data Elements)**

### **The Joint Commission Quality Initiatives**

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

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

### **Hospital Based Inpatient Psychiatric Services (HBIPS) Core Measure Set**

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

## JOINT COMMISSION

The first meeting of the TAP was held May 2005 and a framework and priorities for performance measures was established for an initial set of core measures. The framework consisted of seven domains:

- Assessment
- Treatment Planning and Implementation
- Hope and Empowerment
- Patient Driven Care
- Patient Safety
- Continuity and Transition of Care
- Outcomes

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

# JOINT COMMISSION

## Admissions Screening (HBIPS 1)

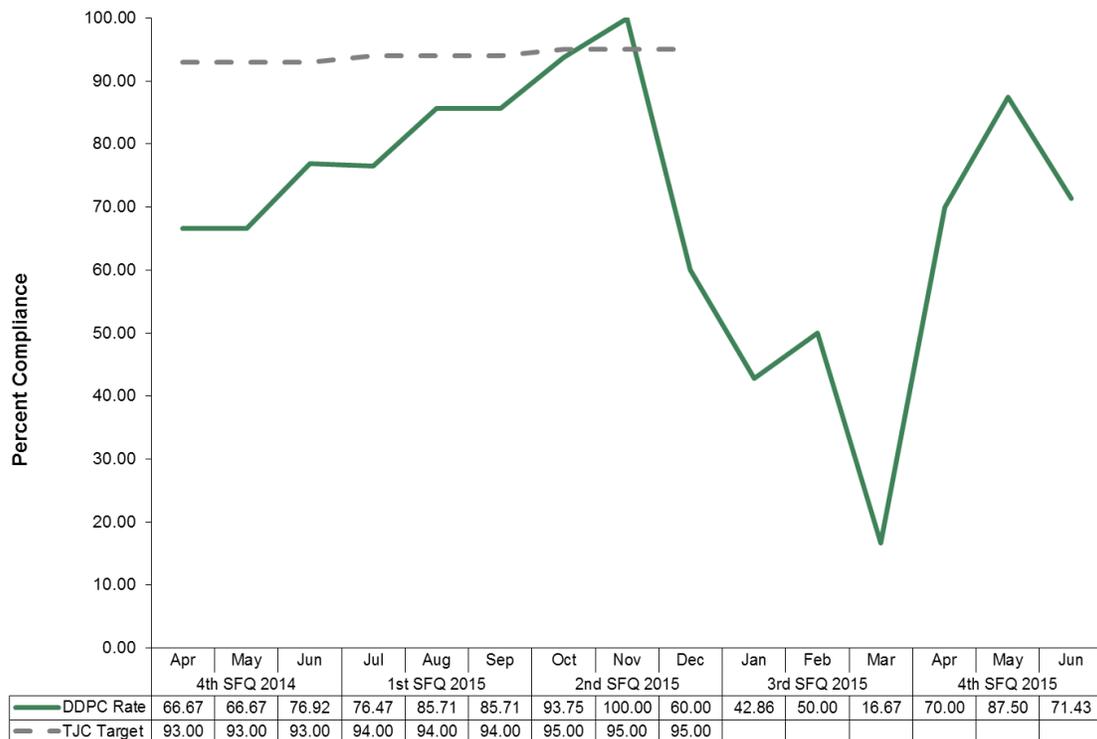
For Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths

### Description

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

### Rationale

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



# JOINT COMMISSION

## Physical Restraint (HBIPS 2)

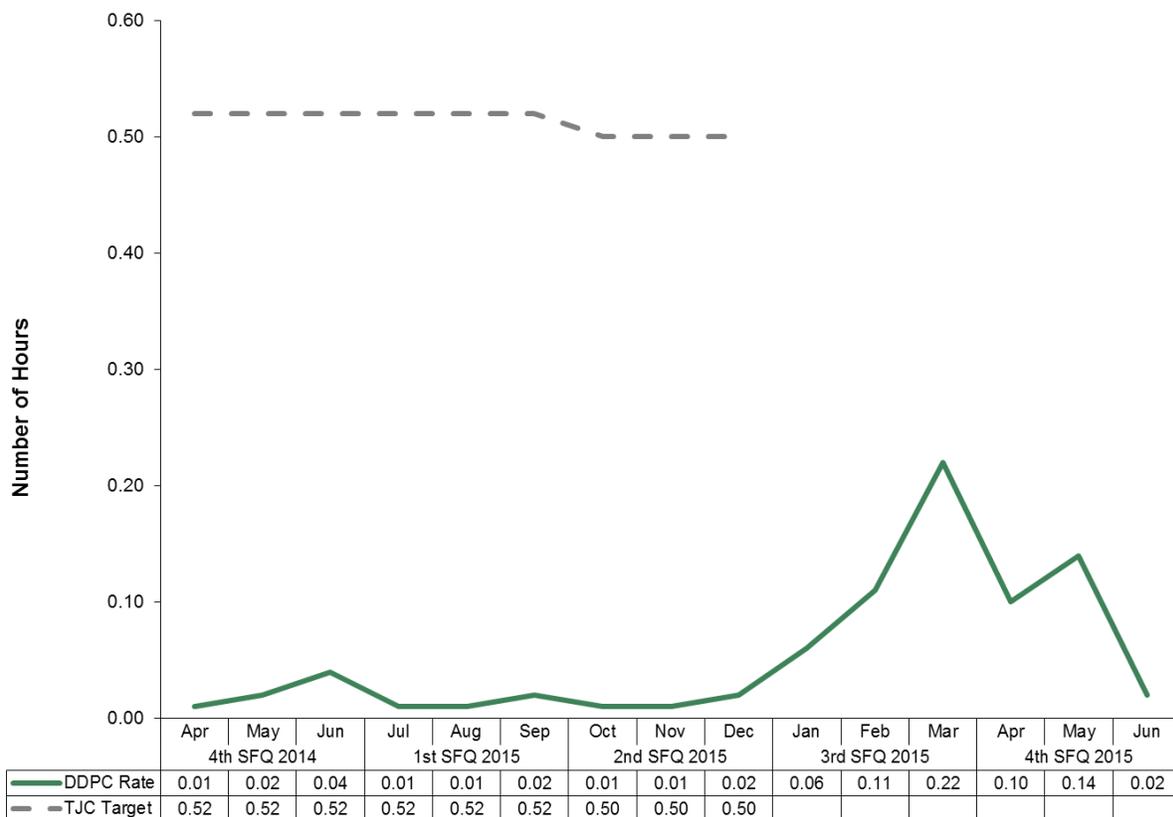
Hours of Use

### Description

The total number of hours that all patients admitted to a hospital based, inpatient psychiatric setting were maintained in physical restraint.

### Rationale

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



# JOINT COMMISSION

## Seclusion (HBIPS 3)

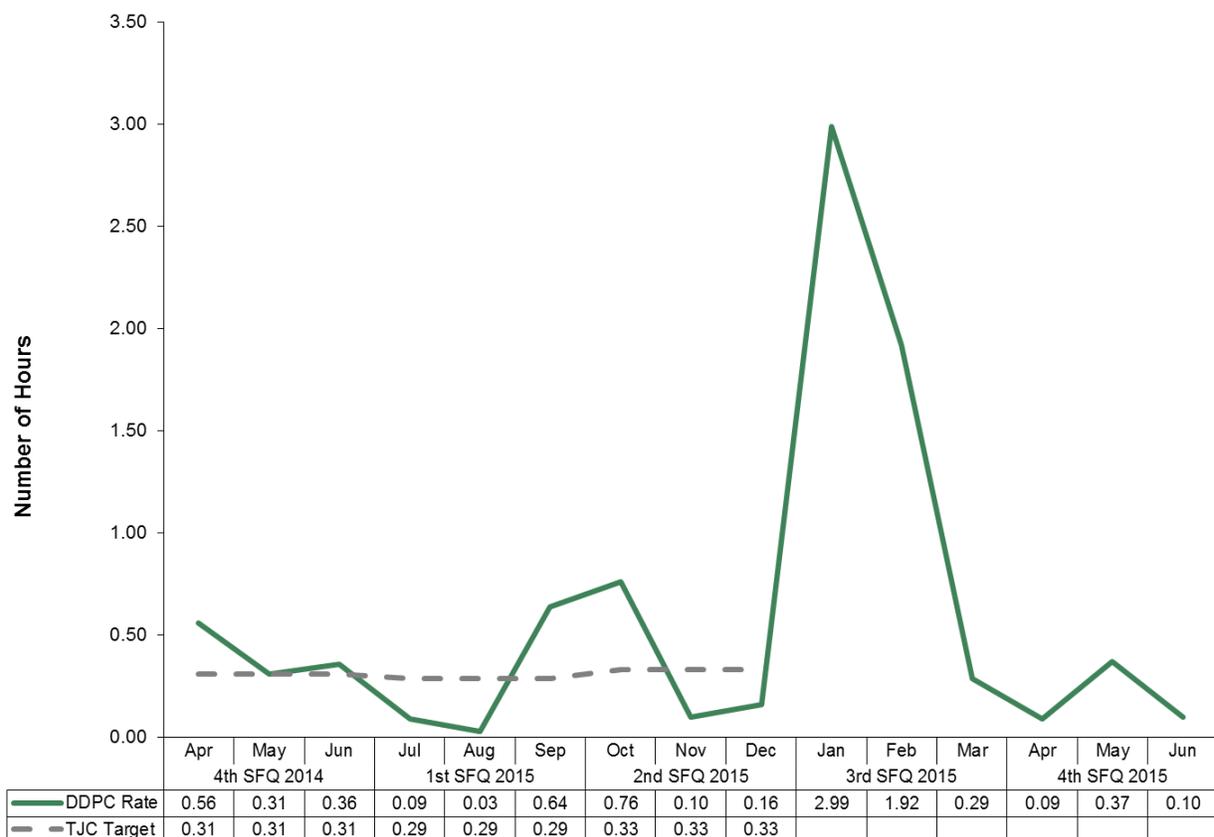
Hours of Use

### Description

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

### Rationale

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



# JOINT COMMISSION

## **Multiple Antipsychotic Medications on Discharge (HBIPS 4)**

### **Description**

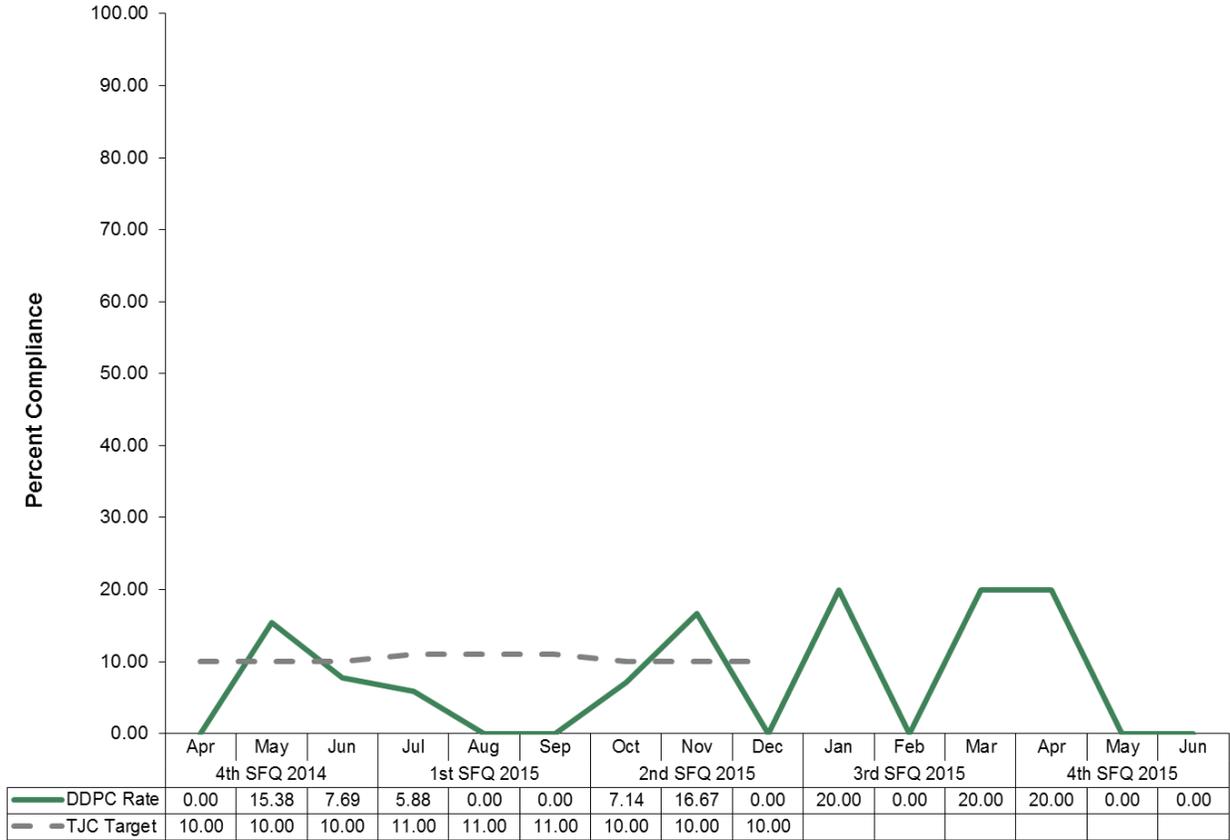
Patients discharged from a hospital based inpatient psychiatric setting on two or more antipsychotic medications.

### **Rationale**

Research studies have found that 4-35% of outpatients and 30-50% of inpatients treated with an antipsychotic medication concurrently received 2 or more antipsychotics (Covell, Jackson, Evans, & Essock, 2002; Ganguly, Kotzan, Miller, Kennedy, & Martin, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; Kreyenbuhl, Valenstein, McCarthy, Ganoczy, & 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.

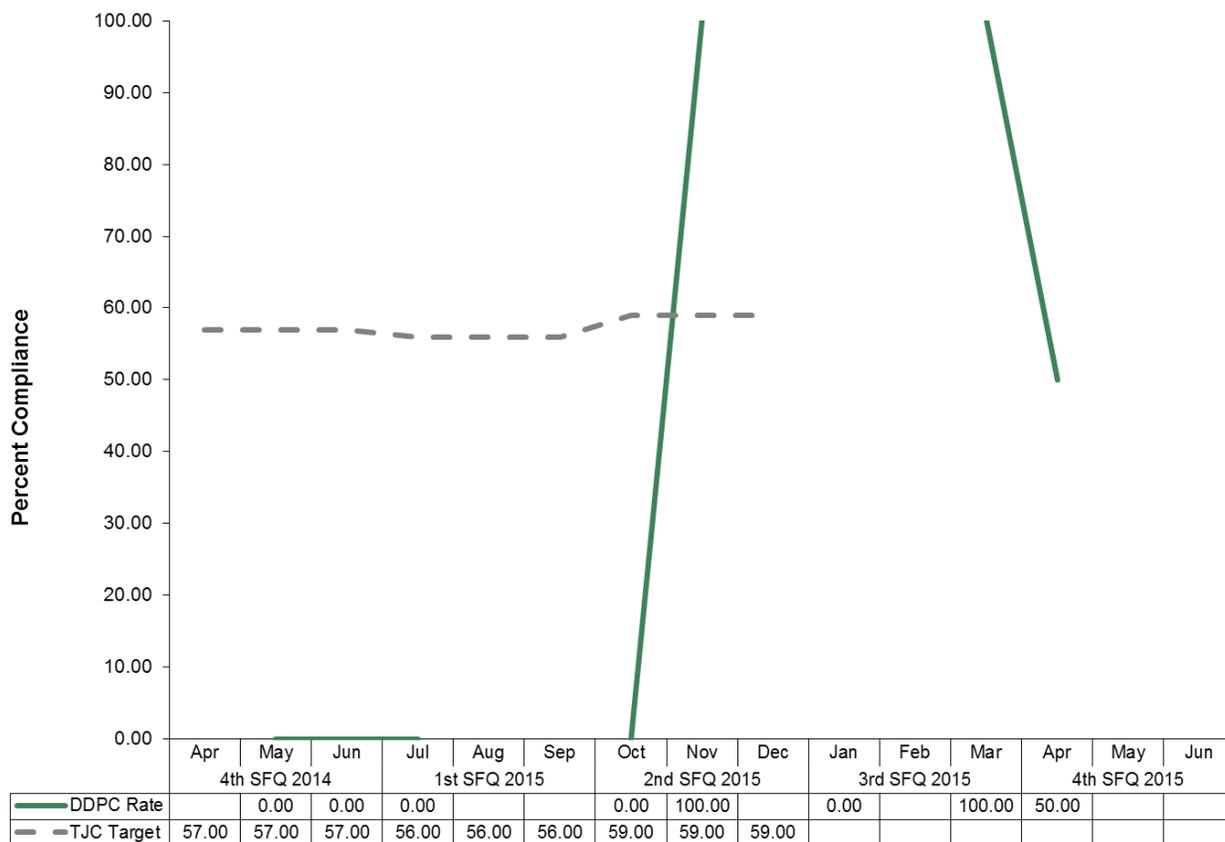
### **Rationale**

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, Ganoczy, & 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

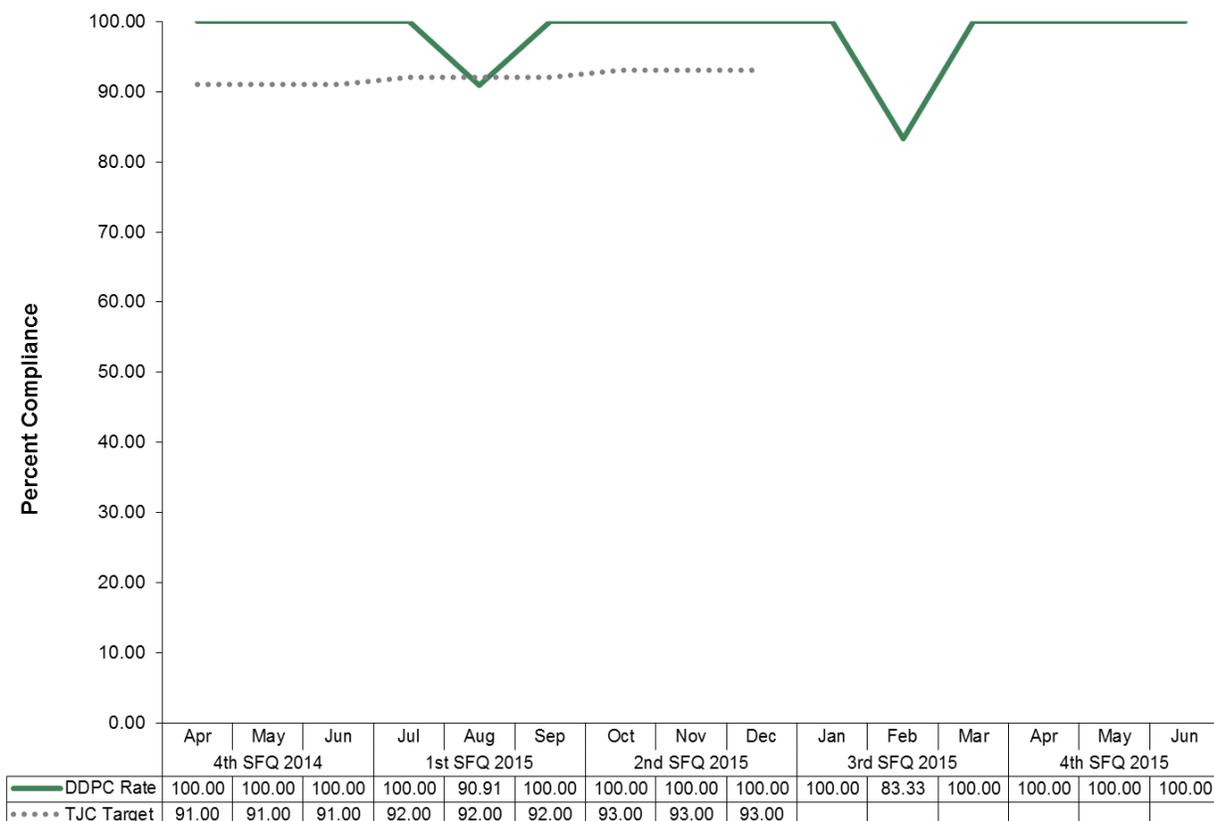
## Post Discharge Continuing Care Plan (HBIPS 6)

### 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 [AAP], (2001).



# JOINT COMMISSION

## Post Discharge Continuing Care Plan Transmitted (HBIPS 7)

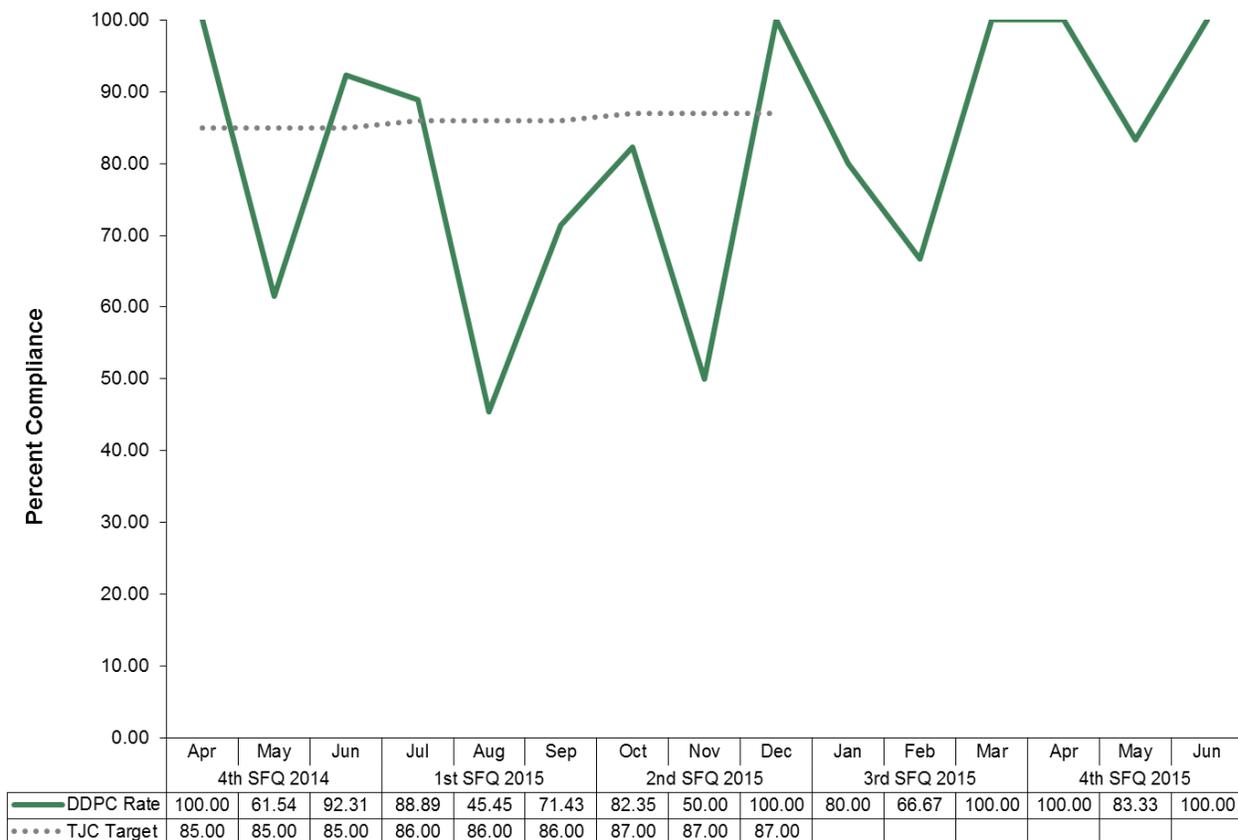
To Next Level of Care Provider on Discharge

### Description

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

### Rationale

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



# JOINT COMMISSION

## Contracts Management

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

<b>FY 2015 Quarter 4 Results</b>		
<b>Contractor</b>	<b>Program Administrator</b>	<b>Summary of Performance</b>
ABM Mechanical	Herbert Gibson Director of Facilities	All indicators met or exceeded standards.
Affiliated Laboratory	Janet Babcock Director of Nursing	All indicators met or exceeded standards.
Cardinal Health	Sharon Sprague Superintendent	Three indicators did not meet standards: (1) Services and required reports to be provided in a timely manner, (2) Providing documents for the Pharmacists before commencement of contracted services, and (3) Providing HR with annual packet including evaluations. All others met or exceeded standards.
Casella Waste Systems	Herbert Gibson Director of Facilities	Indicator met standards.
CES, Inc.	Herbert Gibson Director of Facilities	All indicators met standards.
Comprehensive Pharmacy Services	Sharon Sprague Superintendent	Two indicators did not meet standards: (1) Receipt of required documentation in a timely manner and (2) Providing discharge counseling on the Wilson Treatment Mall. All others met or exceeded standards.
Harriman Associates	Herb Gibson Director of Facilities	All indicators exceeded standards.

## JOINT COMMISSION

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

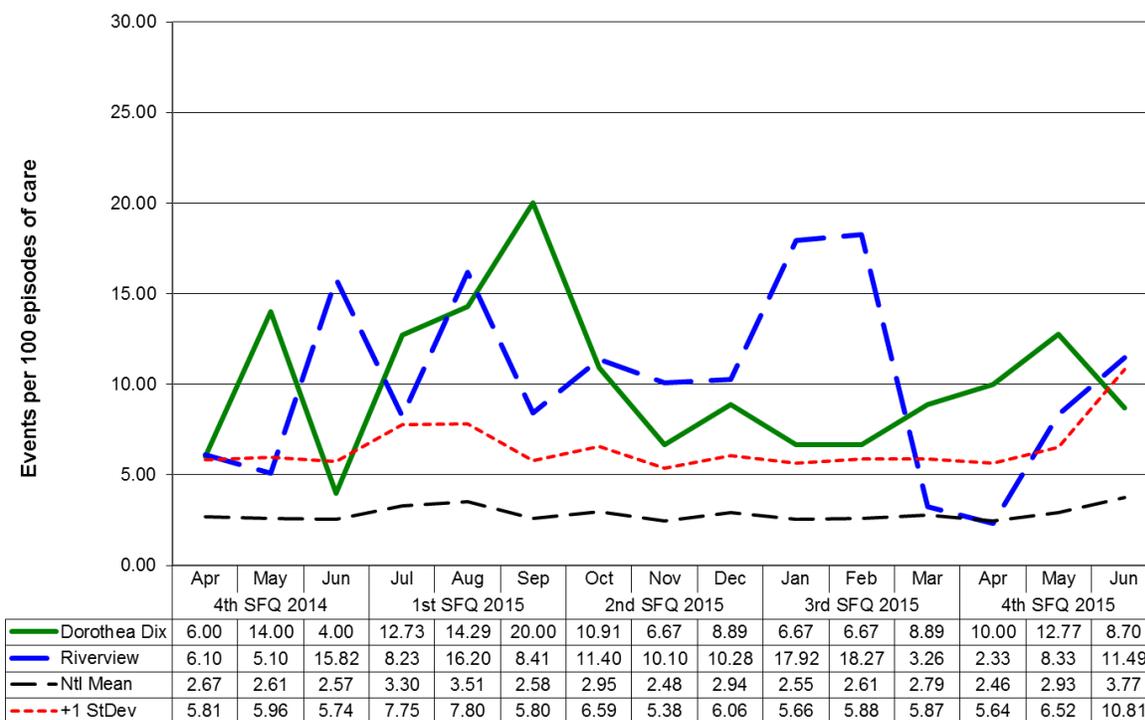
# JOINT COMMISSION

## Medication Management Medication Errors and Adverse Reactions

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

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

### Medication Errors

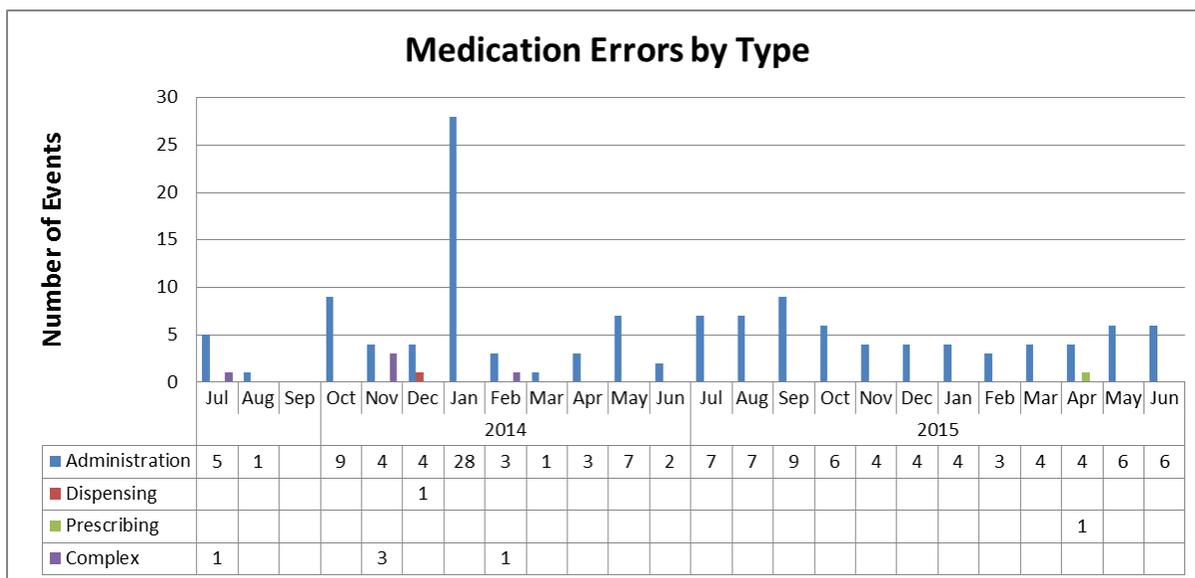


Number of medication error events that occurred for every 100 episodes of care (duplicated patient count). For example, a rate of 1.6 means that 2 medication error events occurred for each 125 episodes of care.

# JOINT COMMISSION

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

- **Prescribing:** An error of prescribing occurs when there is an incorrect selection of drug, drug dose, dosage form, quantity, route, concentration, rate of administration, or instructions for use of a drug product ordered or authorized by physician or other legitimate prescriber. Errors may occur due to improper evaluation of indications, contraindications, known allergies, existing drug therapy and other factors. Illegible prescriptions or medication orders that lead to patient level errors are also defined as errors of prescribing in identifying and ordering the appropriate medication to be used in the care of the patient.
- **Dispensing:** An error of dispensing occurs when the incorrect drug, drug dose or concentration, dosage form, or quantity is formulated and delivered for use to the point of intended use.
- **Administration:** An error of administration occurs when there is an incorrect selection and administration of drug, drug dose, dosage form, quantity, route, concentration, rate of administration, or instructions for use of a drug product ordered or authorized by physician or other legitimate prescriber.
- **Complex:** An error which resulted from two or more distinct errors of different types is classified as a complex error.



# JOINT COMMISSION

## Medication Dispensing Process

Fred Lapatinsky, PharmD

Measure	Unit	Baseline 2014	Goal	Q1	Q2	Q3	Q4
<b>Controlled Substance Loss Data:</b>							
Daily Pyxis-CII Safe Compare Report.	All	0%	0% Target: Actual:	0% 0%	0% 0%	0% 0.7%	0% 0%
Monthly CII Safe Vendor Receipt Report.	Rx	0	0 Target: Actual:	0 0	0 0	0 0	0 0
Monthly Pyxis Controlled Drug discrepancies.	All	5/mo	0 Target: Actual:	0 20 (7/ mo)	0 35 (12/ mo)	0 30 (10/ mo)	0 17 (6/ mo)
<b>Medication Management Monitoring:</b>							
Measures of drug reactions, adverse drug events and other management data.	Rx	2/year	Actual:	1	1	3	0
Resource Documentation Reports of Clinical Interventions.	Rx	51	Actual:	58	63	79	52

# 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:**

	<b>April</b>	<b>May</b>	<b>June</b>	<b>4Q2015</b>
Number of Patients Discharged	10	8	7	<b>25</b>
Number of Survey Responses	3	2	3	<b>8</b>
Survey Response Rate	<b>30%</b>	<b>25%</b>	<b>43%</b>	<b>32%</b>

## JOINT COMMISSION

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

	<b>April</b>	<b>May</b>	<b>June</b>	<b>4Q2015</b>
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) 67%	(2) 100%	(3) 100%	<b>(7)</b> <b>88%</b>
When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.	(3) 100%	(2) 100%	(3) 100%	<b>(8)</b> <b>100%</b>
When I left the hospital, I clearly understood the purpose for taking each of my medications.	(2) 67%	(2) 100%	(3) 100%	<b>(7)</b> <b>88%</b>

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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:**

	<b>April</b>	<b>May</b>	<b>June</b>	<b>4Q2015</b>
Number of patients discharged	10	8	7	<b>25</b>
Number of survey responses	4	0	2	<b>6</b>
Survey response rate	40%	0%	29%	<b>24%</b>

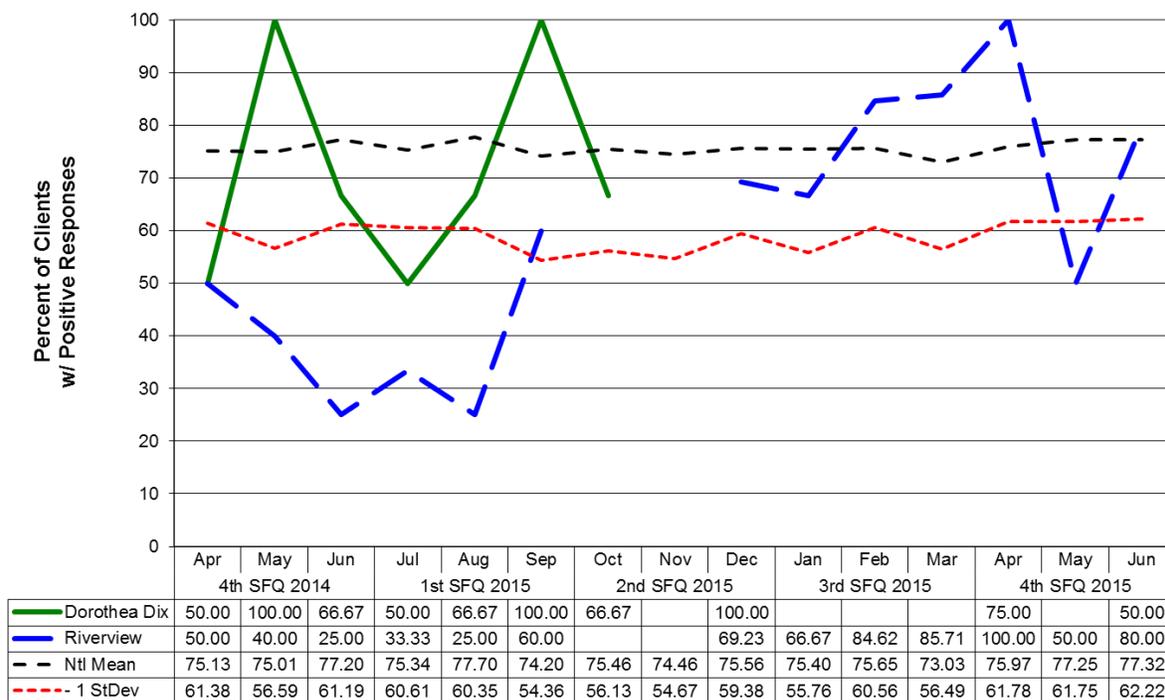
Surveys are distributed to all patients prior to discharge and when returned are tabulated in a database created for the purpose of collecting and uploading the data elements to NRI. On a monthly basis, the data is uploaded to NRI and aggregated with the results of the Riverview Psychiatric Center and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

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 patients 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.

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

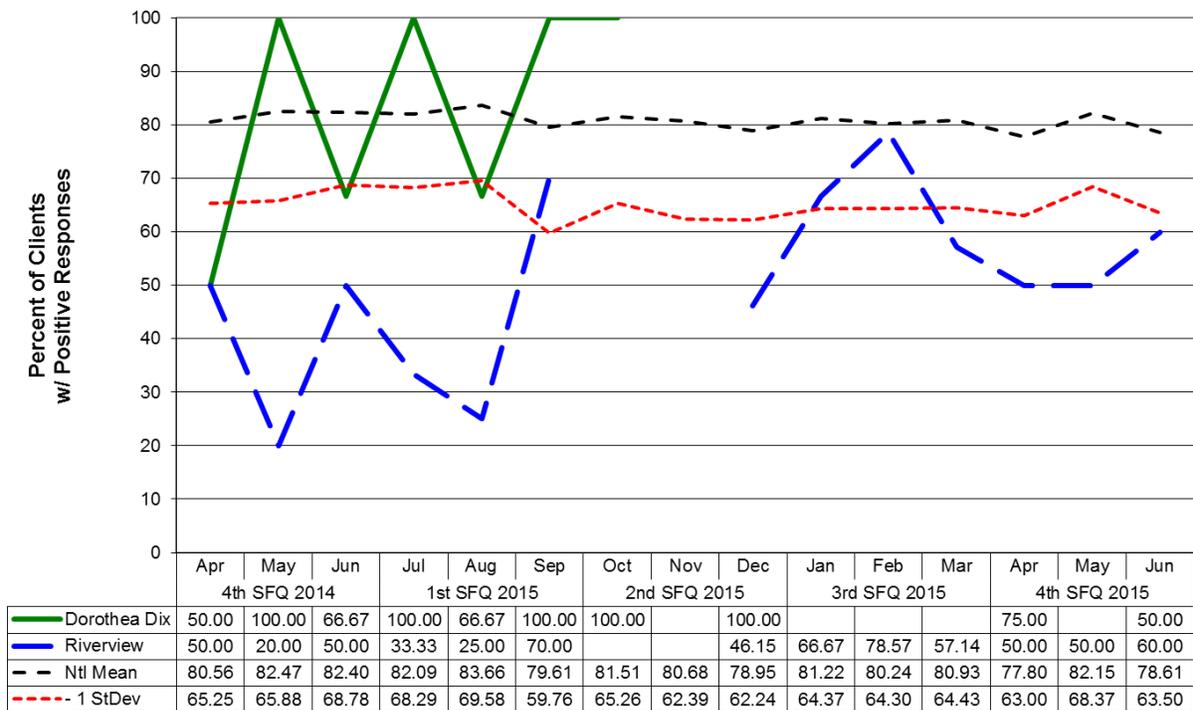


### Outcome Domain

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.

# JOINT COMMISSION

## Inpatient Consumer Survey Dignity Domain

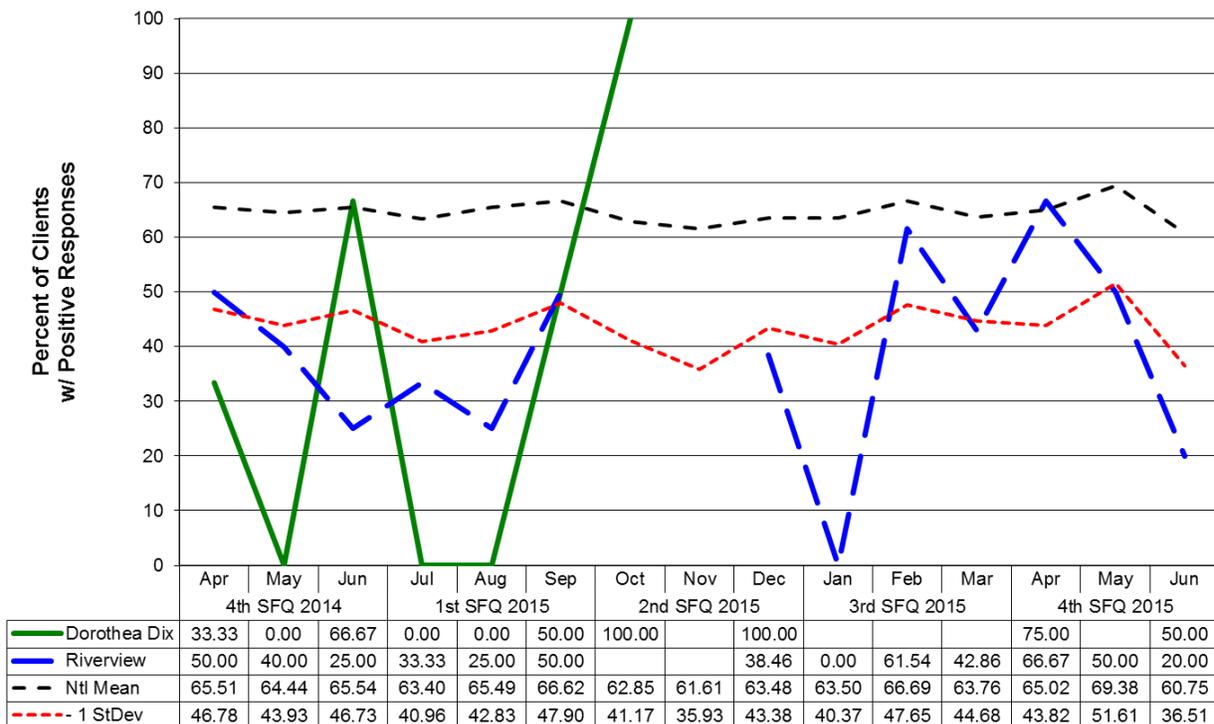


### Dignity Domain

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.

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## Inpatient Consumer Survey Rights Domain

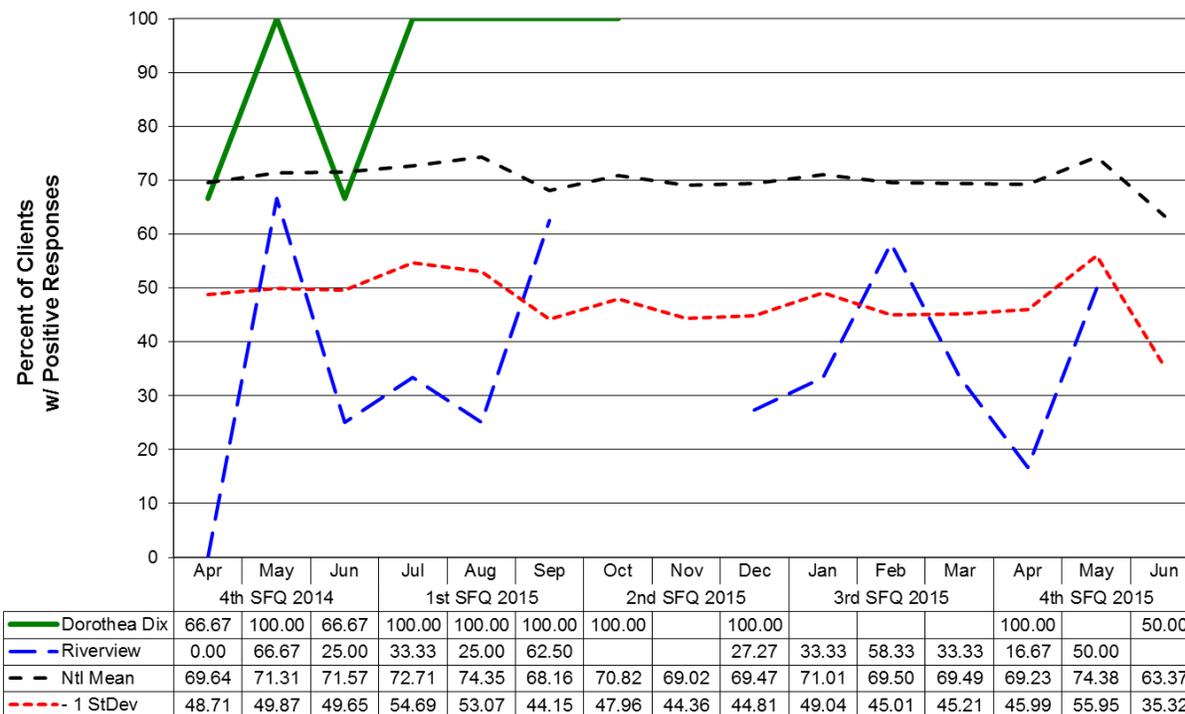


### Rights Domain

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.

# JOINT COMMISSION

## Inpatient Consumer Survey Participation Domain

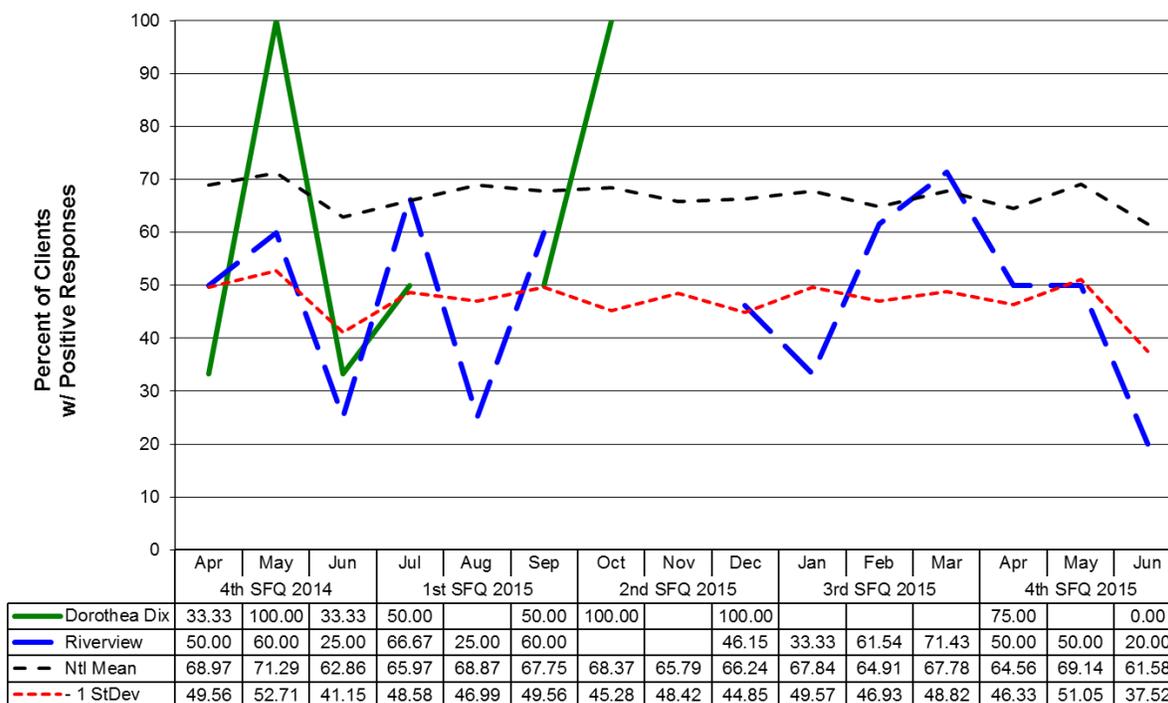


### Participation Domain

1. I participated in planning my discharge.
2. Both I and my doctor, or therapist from the community, were actively involved in my hospital treatment plan.
3. I had an opportunity to talk with my doctor or therapist from the community prior to discharge.

# JOINT COMMISSION

## Inpatient Consumer Survey Environment Domain

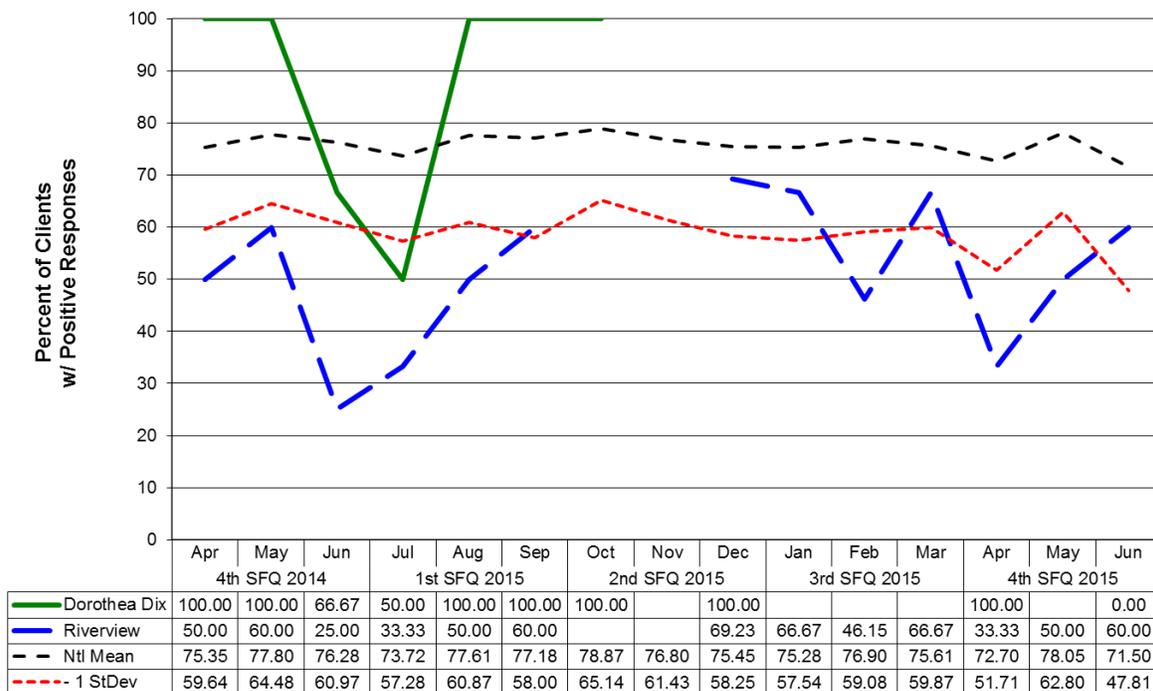


### Environment Domain

1. The surroundings and atmosphere at the hospital helped me get better.
2. I felt I had enough privacy in the hospital.
3. I felt safe while I was in the hospital.
4. The hospital environment was clean and comfortable.

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## Inpatient Consumer Survey Empowerment Domain



### Empowerment Domain

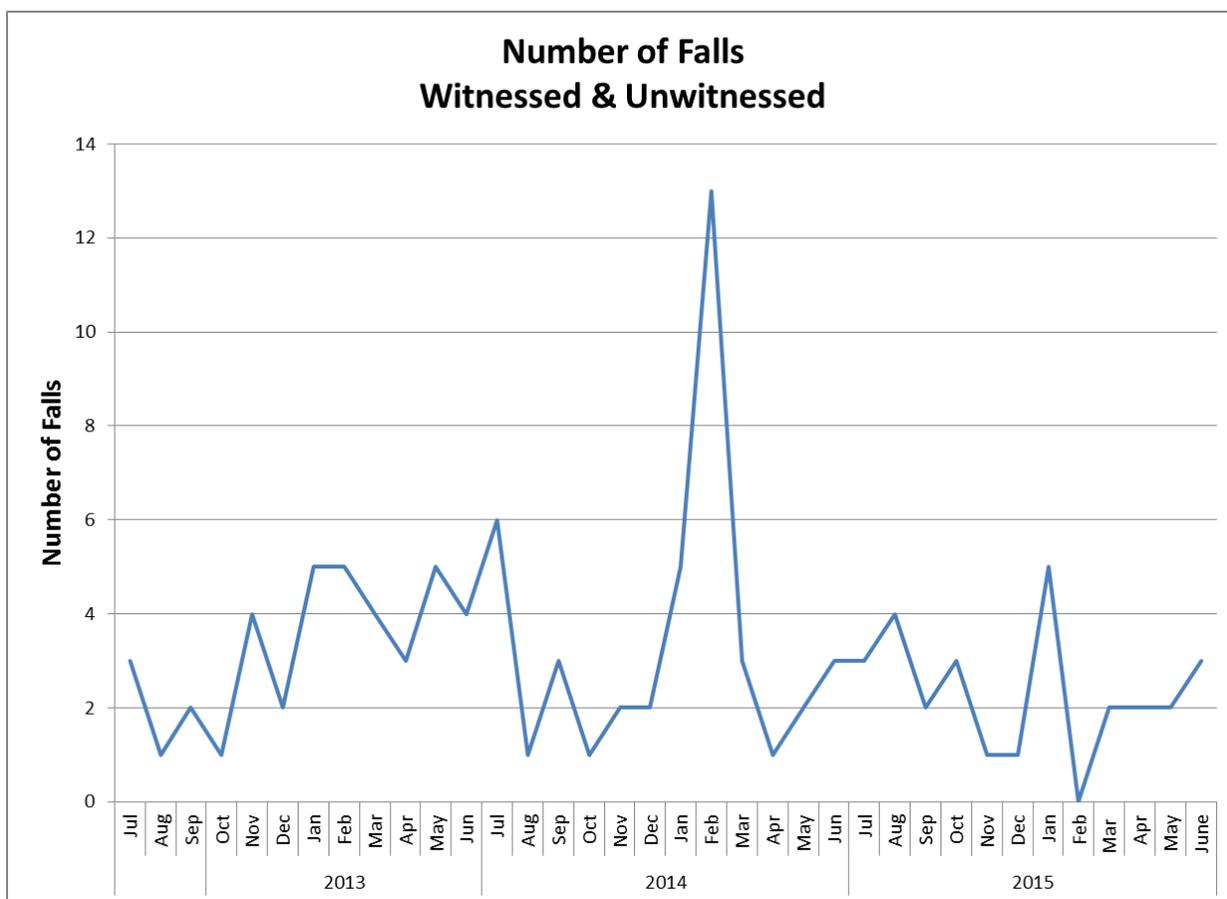
1. I had a choice of treatment options.
2. My contact with my doctor was helpful.
3. My contact with nurses and therapists was helpful.

# JOINT COMMISSION

## Fall Reduction Strategies

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

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



# JOINT COMMISSION

## Falls Reduction Nursing Interventions

Janet Babcock, RN

### 4Q2015 Patient Falls Report

**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 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 IPEC (Integrated Performance Excellence Committee) which meets monthly.

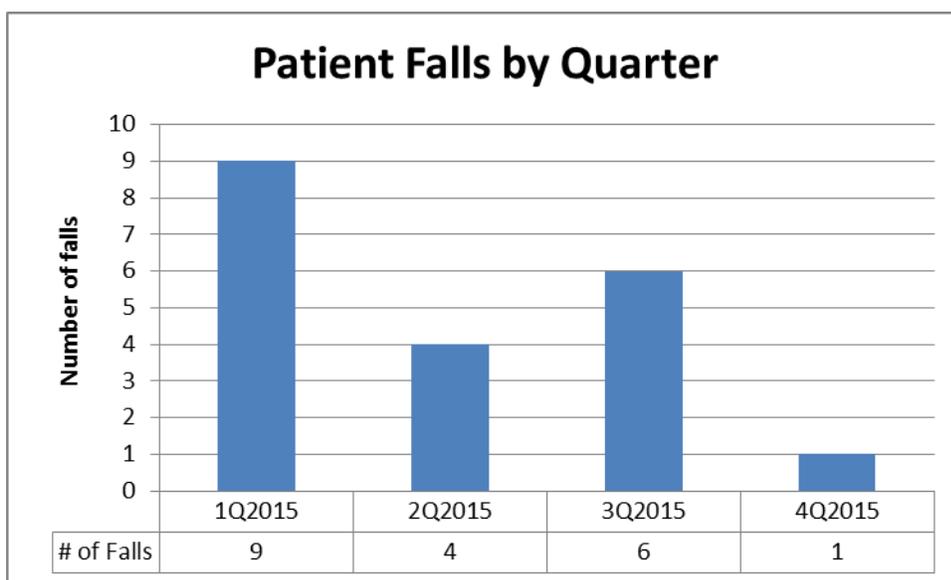
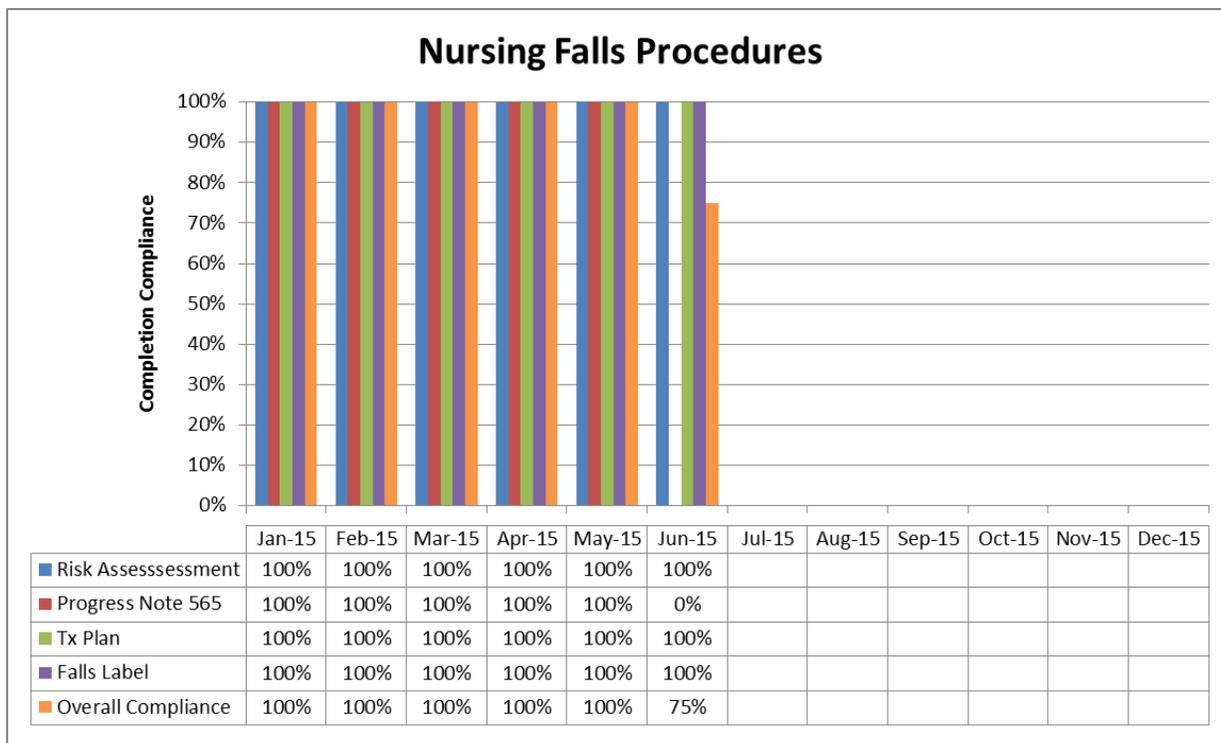
**Baseline Data:** Effective March 2014, Nursing has been compliant with the POC since June 2013. Baseline data was gathered in February 2013. It is still evident that nurses continue to struggle with the implementation of some elements of this procedure.

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

All patient falls in 4Q2015	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	
1 (including falls that do not meet definition)	Yes: 1 No: 0 N/A: 0	Yes: 0 No: 1	Yes: 0 No: 0 N/A: 1	Yes: 1 No: 0 N/A: 0	
<b>Overall Compliance</b>	<b>100%</b>	<b>0%</b>	<b>100%</b>	<b>100%</b>	<b>75%</b>

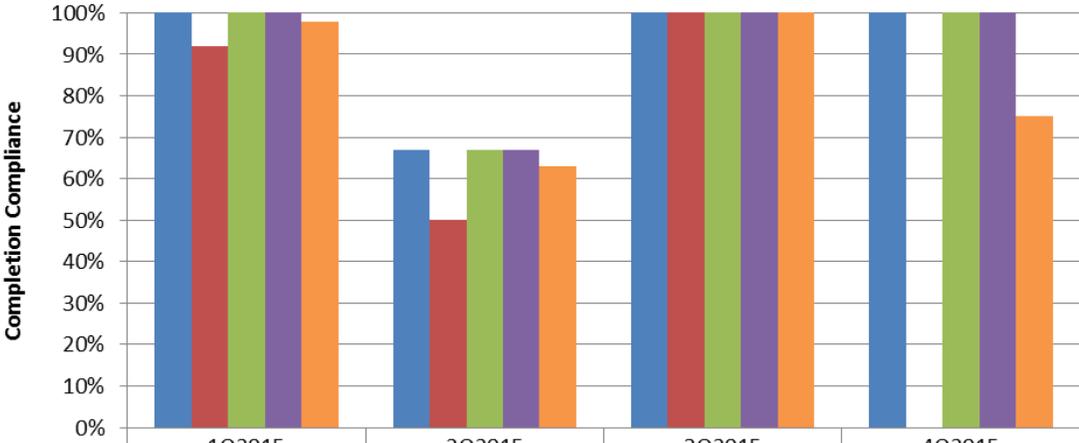
# JOINT COMMISSION

**Plan of Action:** There was 1 fall in the 4<sup>th</sup> quarter of FY 2015. In April there were 0 falls, May had 0 falls, and June had 1 fall. Compliance with Nursing Falls Procedure F-10 for entire 4th Quarter was 75% which is down by 25% in the 3rd Quarter, which was at 100% compliance. Will continue to follow up and audit all falls.



# JOINT COMMISSION

## Nursing Falls Procedure Quarterly Data



	1Q2015	2Q2015	3Q2015	4Q2015
■ Risk Assessment	100%	67%	100%	100%
■ Progress Note 565	92%	50%	100%	0%
■ Tx Plan	100%	67%	100%	100%
■ Falls Label	100%	67%	100%	100%
■ Overall Compliance	98%	63%	100%	75%

# JOINT COMMISSION

## Pain Assessment

Elements of Performance for Joint Commission Standard PC.01.02.07

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

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

### **Pain Assessment Nursing Interventions**

**Janet Babcock, RN**

#### **Pain Re-Assessment Audit Form**

##### **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 noncancer pain) and patient populations (e.g., elderly patients, children, minorities, substance abusers) are undertreated. Data from a 1999 survey suggest that only 1 in 4 individuals with pain receive appropriate therapy (Berry. P., Chapman. C., Covington. E., Dahl. J., Katz. J., Miaskowski. C., Mc Lean. M., 2001. Pain: Current understanding of assessment, Management, and treatment).

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

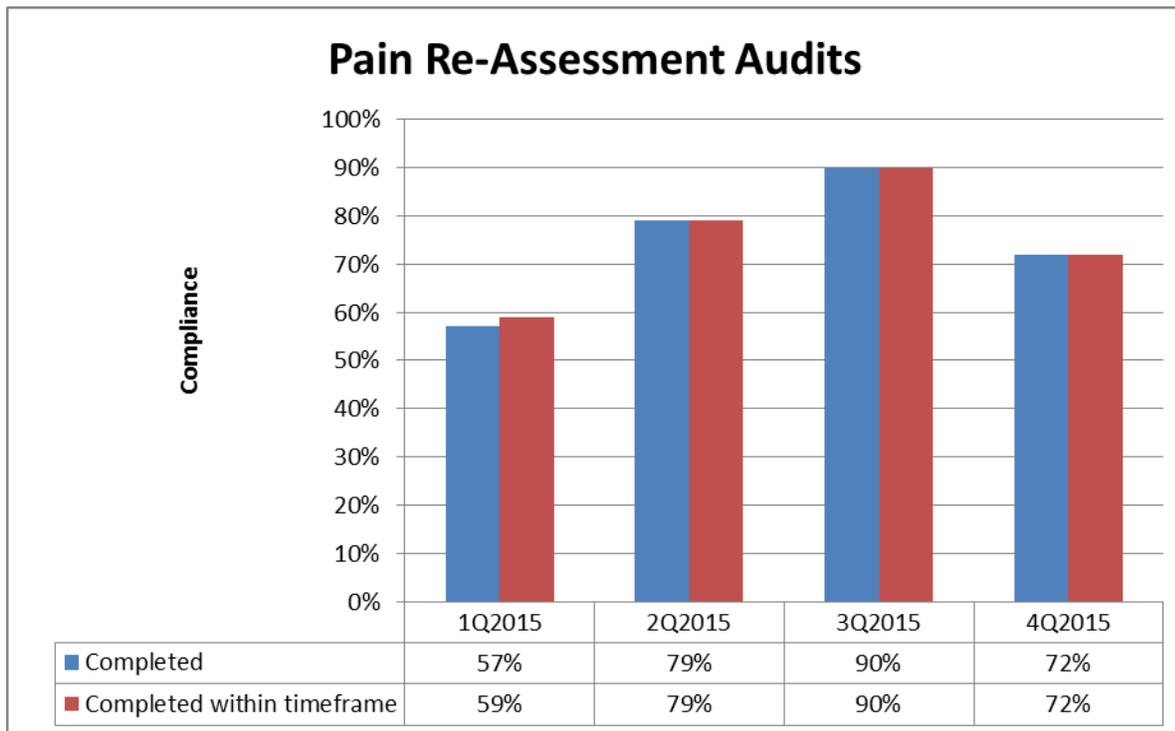
# JOINT COMMISSION

**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
106	57	41	41	72%	72%



**Plan of Action:** The compliance rate for the 4<sup>th</sup> Quarter was 72%, compared to 90% in the 3rd 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

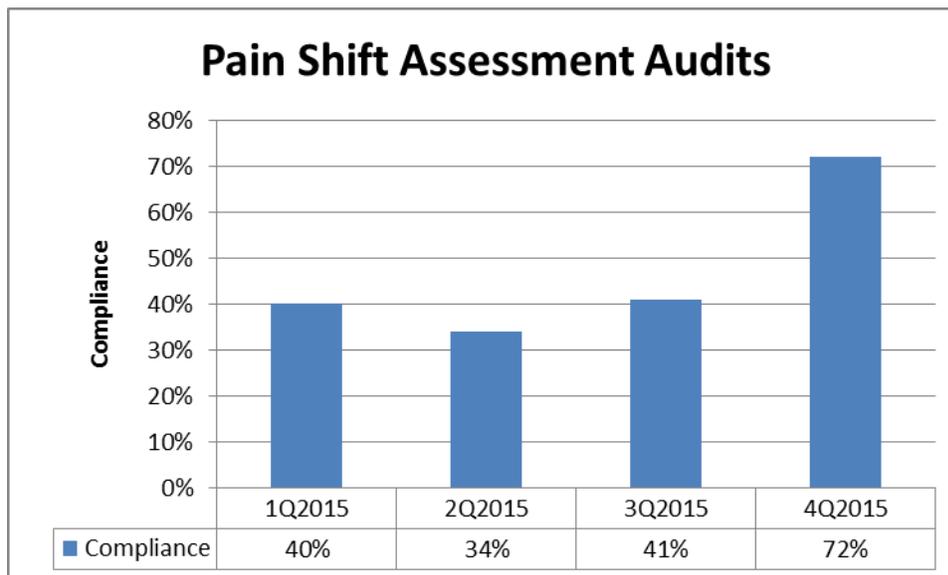
### Pain Assessment: (Patient Recovery)

**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
106	52	49%



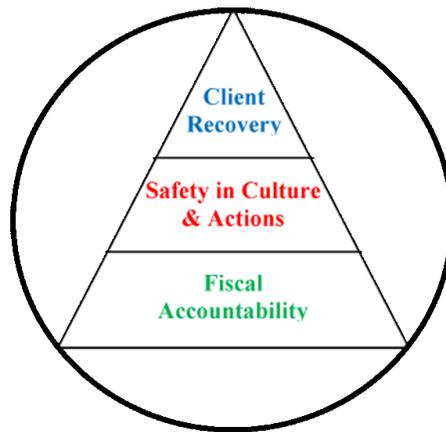
**Plan of Action:** We are still below our goal of 90%. Nursing Management has addressed this and will reinforce with the CNM's to monitor that pain is being assessed and reassessed every shift and CNM's will address staff that are not completing these assessments.

# STRATEGIC PERFORMANCE EXCELLENCE

## 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;
- Enhanced communications and collaborative relationships within and between cross-functional work teams to support organizational change and effective process improvement;

# STRATEGIC PERFORMANCE EXCELLENCE

- 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.

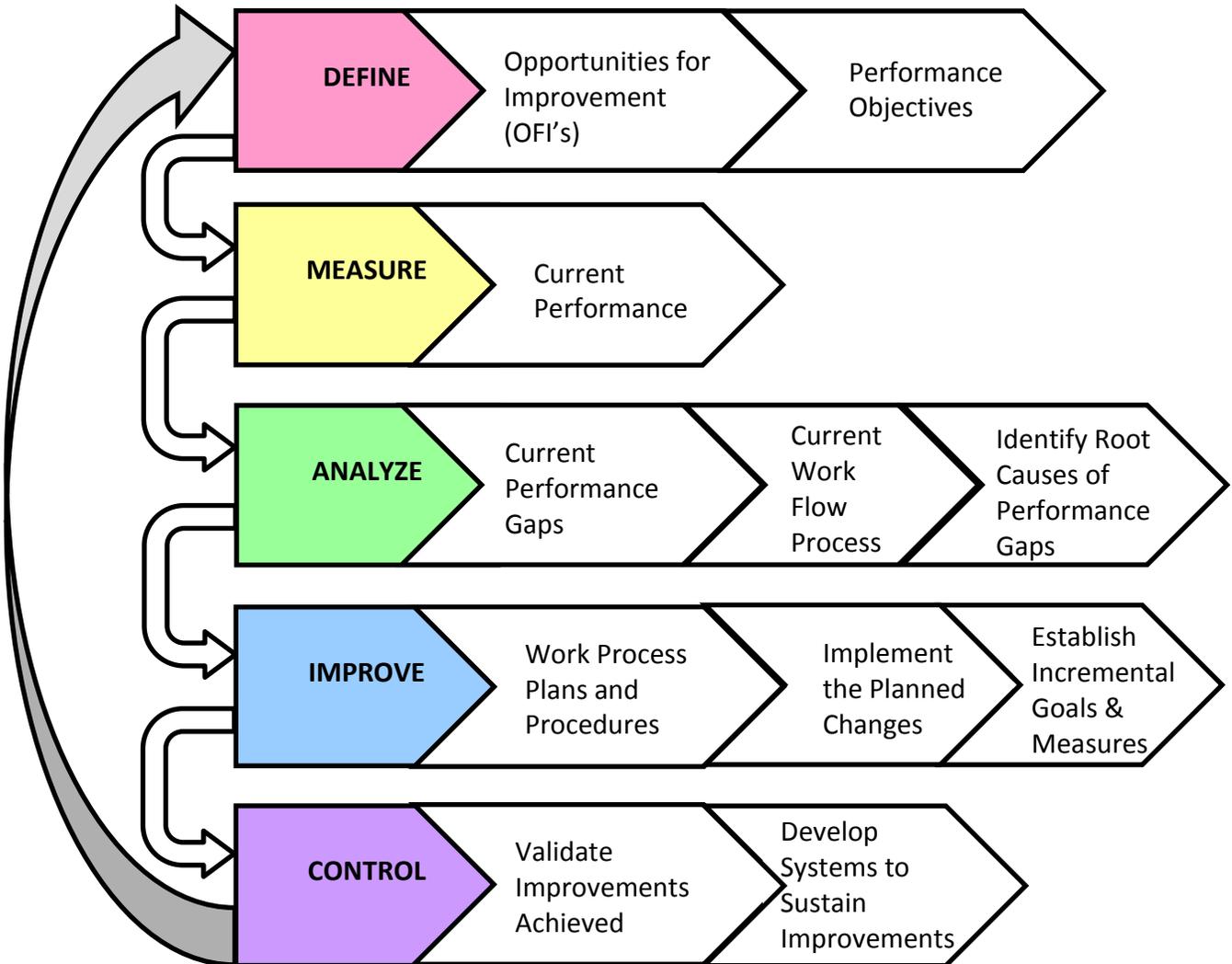
### Enhance Patient Recovery by...

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

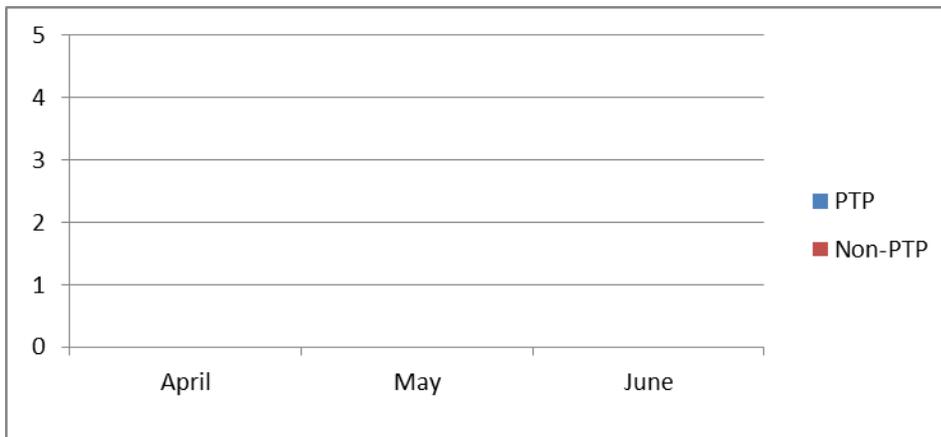
**Indicator:** Patients readmitted within 30 days of discharge. Tracking all readmissions within 30 days of discharge will allow for a modified Root Cause Analysis to be completed so problem areas in discharge planning or community services can be addressed which will improve patient discharge outcomes.

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

**Baseline Data:** None

**Goal for FY 2016:** Goal will be determined once sufficient baseline data is obtained.

### Graph:



**Analysis:** No readmissions for the 4<sup>th</sup> quarter.

**Plan of Correction:** In July of 2015 Social Services will begin tracking 30 day readmissions for both PTP and non-PTP and will complete a modified Root Cause Analysis' to determine any areas of discharge planning that need to be corrected.

# 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	1Q2015	2Q2015	3Q2015	4Q2015
Identification Data	37/37 100%	29/29 100%	19/19 100%	25/25 100%
Medical History, including chief complaint; HPI; past, social & family hx., ROS, and physical exam w/in 24 hours, conclusion and plan	37/37 100%	27/29 93%	19/19 100%	25/25 100%
Summary of patient's psychosocial needs as appropriate to the patients *	36/37 97%	25/29 86%	16/19 84%	19/25 76%
Psychiatric Evaluation in patient's record w/in 24 hours of admission	35/37 95%	29/29 100%	19/19 100%	25/25 100%
Physician Orders (TO/VO w/in 72 hr.)	36/36 100%	28/29 97%	16/19 84%	21/25 84%
Evidence of appropriate informed consent Unable or refused 4Q2015 = 6	36/36 100%	25/27 93%	19/19 100%	19/19 100%
Clinical observations including the results of therapy.	32/32 100%	27/27 100%	19/19 100%	25/25 100%
Nursing discharge Progress Note with time of discharge departure	36/36 100%	29/29 100%	19/19 100%	25/25 100%
<i>Consultation reports, when applicable</i>	20/20 100%	16/16 100%	10/11 91%	11/11 100%
Final Diagnosis (es) DSM-Principal Diagnosis	37/37 100%	29/29 100%	19/19 100%	25/25 100%
Results of autopsy, when performed	N/A	N/A	N/A	N/A
<i>Advance Directive Status on admission and Social Worker follow up after admission</i>	35/36 97%	26/29 90%	18/19 95%	25/25 100%
Notice of Privacy	36/37 100%	29/29 100%	17/19 89%	25/25 100%
<i>Chart Completion w/in 30 days of discharge date/discharge summary completed within 30 days</i>	34/37 92%	27/29 93%	18/19 95%	23/25 92%
Discharge Packet sent to follow up provider within 5 days of discharge	36/36 100%	27/29 93%	15/16 94%	24/25 96%

\* 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

	<b>3Q2015 Total</b>	<b>Apr 2015</b>	<b>May 2015</b>	<b>Jun 2015</b>	<b>4Q2015 Total</b>
Terminations – Voluntary	1	3	1	1	5
Terminations – Involuntary	0	0	0	1	1
New Hires	4	4	3	0	7
<b>Sick Time Used</b>					
Sick Time Used	3,118.50	928.15	1156.35	928.70	3013.20
FML Used	1,322.95	503.50	563.50	670.10	1737.10
Overtime	6,055.65	1994.00	1820.50	1543.50	5358.00
AWOL	513.65	155.60	72.10	73.65	301.35
<b>Workers Compensation Incidents:</b>					
Medical	2	0	1	3	4
Patient Related	10	1	5	2	8
<b>Total # of Incidents</b>	<b>15</b>	<b>1</b>	<b>6</b>	<b>5</b>	<b>12</b>
# of Incidents w/ Lost Time	3	0	3	0	3

# 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:**

<u>1<sup>st</sup> Quarter:</u>	July – September	FY 2015 = 0 H.A. Infections
<u>2<sup>nd</sup> Quarter:</u>	October – December	FY 2015 = 0 H.A. Infections
<u>3<sup>rd</sup> Quarter:</u>	January – March	FY 2015 = 0 H.A. Infections
<u>4<sup>th</sup> Quarter:</u>	April – June	FY 2015 = 0 H.A. Infections

H. A. Infections	FY 2013	FY 2014	FY 2015
1 <sup>st</sup> Quarter H.A.I. Rate	0	0	0
2 <sup>nd</sup> Quarter H.A.I. Rate	0	0	0
3 <sup>rd</sup> Quarter H.A.I. Rate	0	0	0
4 <sup>th</sup> Quarter H.A.I. Rate	0	0	0
Average H.A. Infection Rate	0	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	0
URI	0	0	0	0	0	0	0	0	0	0	0	0
LRI	0	0	0	0	0	0	0	0	0	0	0	0
Skin	0	0	0	0	0	0	0	0	0	0	0	0
<b>Totals</b>	0	0	0	0	0	0	0	0	0	0	0	0
<b>Infection Rate</b>	0	0	0	0	0	0	0	0	0	0	0	0

# STRATEGIC PERFORMANCE EXCELLENCE

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

1 <sup>st</sup> Quarter 2013 = 3631	1 <sup>st</sup> Quarter 2014 = 3712	1 <sup>st</sup> Quarter 2015 = 3256
2 <sup>nd</sup> Quarter 2013 = 4101	2 <sup>nd</sup> Quarter 2014 = 3659	2 <sup>nd</sup> Quarter 2015 = 3550
3 <sup>rd</sup> Quarter 2013 = 4052	3 <sup>rd</sup> Quarter 2014 = 3557	3 <sup>rd</sup> Quarter 2015 = 3453
4 <sup>th</sup> Quarter 2013 = 3802	4 <sup>th</sup> Quarter 2014 = 3397	4 <sup>th</sup> Quarter 2015 = 3422

## 2) Infection Control Performance Issues

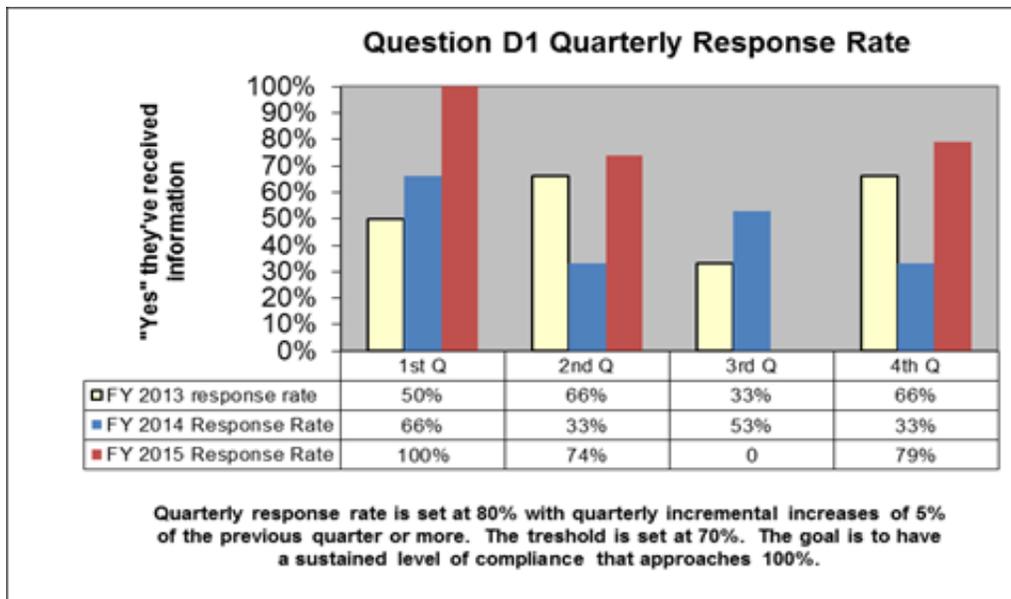
### I.C. Standard IC.02.01.01 and 01.05.01:

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

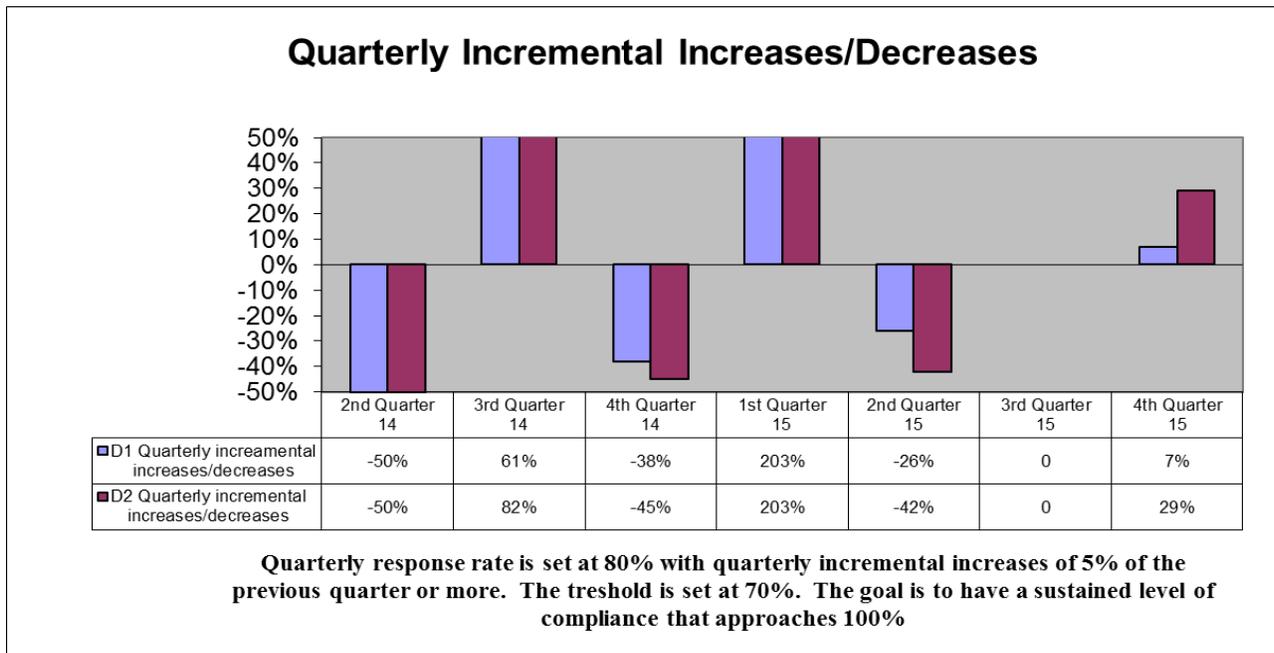
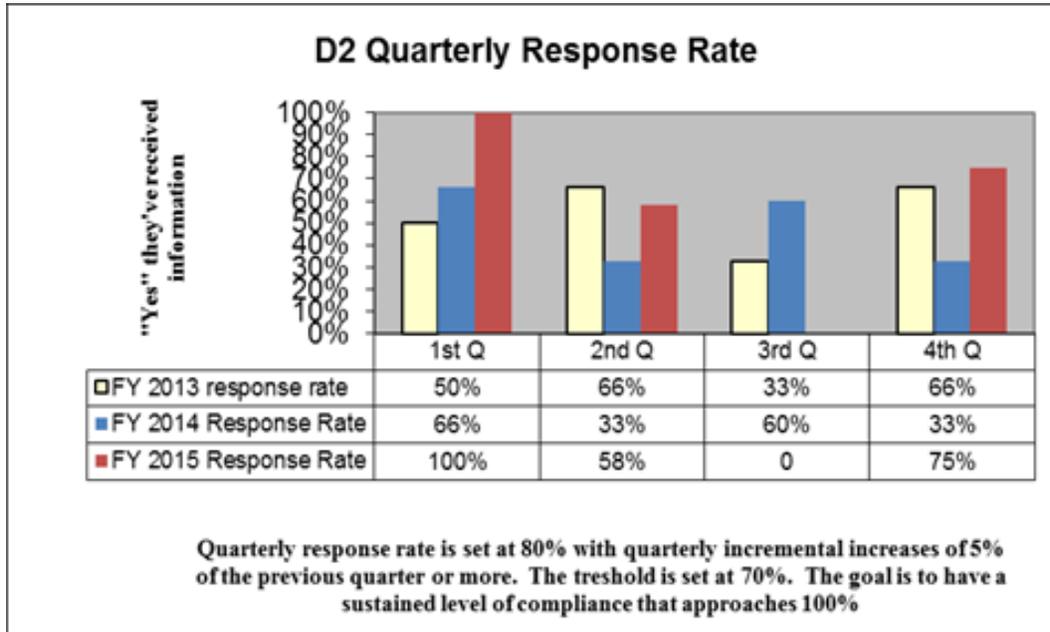
**Goal for FY2015:** Quarterly response rates for question D1 and D2 agree and strongly agree is set at 80% with quarterly incremental increases of 5% of the previous quarter or more. The threshold is set at 70%. *The standard goal is to have a sustained level of compliance that approaches 100%. Once 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:**

For 4<sup>th</sup> Quarter FY 2015 there were 24 questionnaires distributed, 24 questionnaires were completed and returned for a quarterly return rate of 100%.

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

### **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 81%. That is a 4.5% increase from last year.

### **4) Patient Hand Hygiene**

**Goal for FY 2015:** 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.

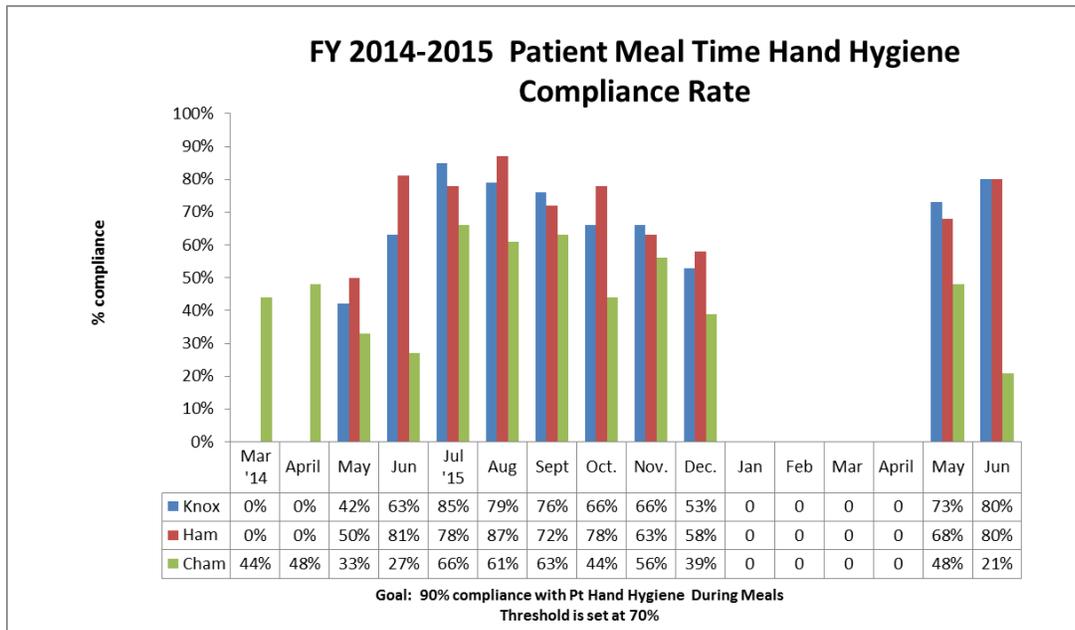
#### **Baseline Data: 4<sup>th</sup> Q 2014**

Knox= 35% compliance rate

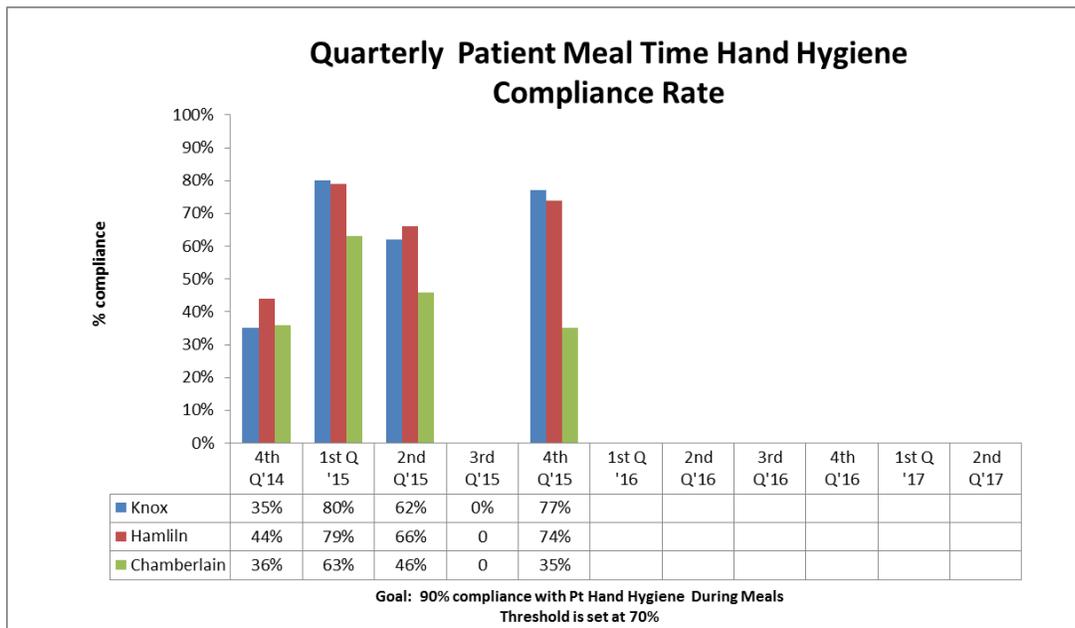
Hamlin= 44% compliance rate

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

# 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 seclusions/restraints 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.

**Performance Threshold:** 90%

**Goal:** 100%

**Type of Measure:** Performance Improvement

		Results					
	Unit	Baseline	Q1	Q2	Q3	Q4	YTD
<b>Target</b>	Compliance with restraint documentation	To Be Determined	N/A	N/A	100%	100%	<b>100%</b>
<b>Actual</b>			N/A	N/A	90%	89%	<b>89.5%</b>

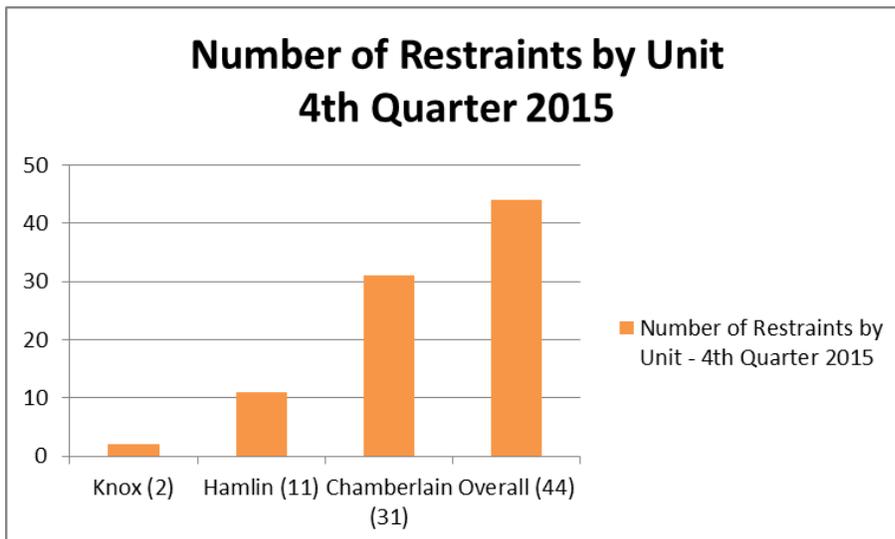
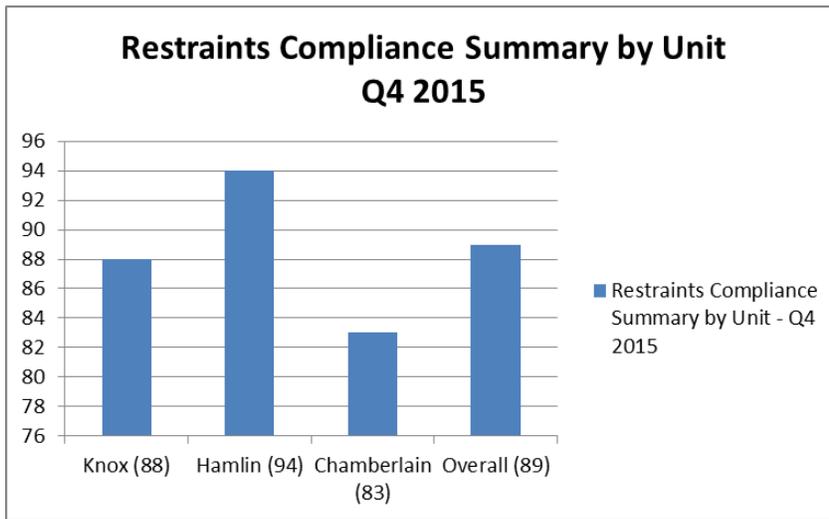
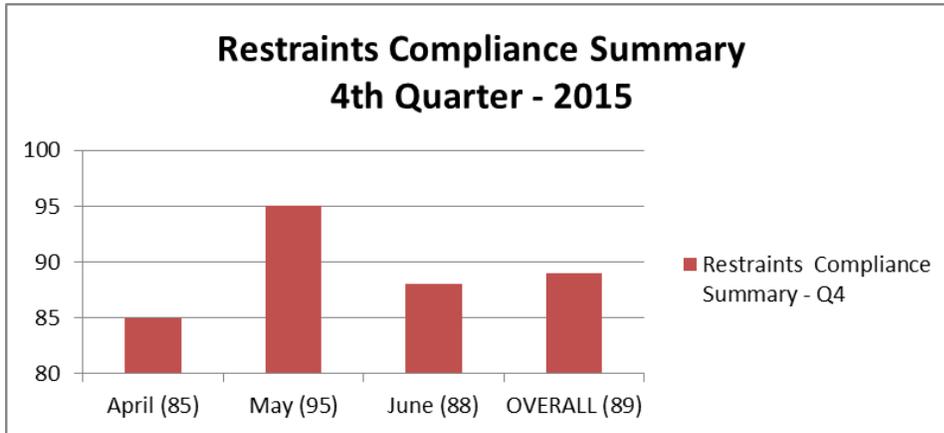
**Data Analysis:** Nurses have not met the restraint documentation threshold of 90% for the 4<sup>th</sup> Quarter of 2015. April 2015 saw a compliance of 85%, May compliance was at 95%, and June compliance was at 88%, which yields an overall compliance of 89% for the 4<sup>th</sup> Quarter.

Restraint documentation compliance was also recorded for the 4<sup>th</sup> Quarter. Knox Unit had a compliance of 88%, Hamlin a compliance of 94%, and Chamberlain a compliance of 83% with an overall compliance of 89% in the 4<sup>th</sup> Quarter.

Knox had 2 restraints in the 4<sup>th</sup> Quarter, Hamlin had 11, and Chamberlain had 31. There were a total of 44 restraints across the three inpatient units during the 4<sup>th</sup> Quarter.

**Action Plan:** Nursing staff will continue to audit the documentation of patient restraints on a monthly basis, and re-evaluate quarterly, and again yearly.

# STRATEGIC PERFORMANCE EXCELLENCE



# STRATEGIC PERFORMANCE EXCELLENCE

**II. Measure Name: Seclusion Audits – Patient Safety**

**Measure Description:** Proper documentation is the only way to demonstrate and provide a record that the clinical criteria and assessments for seclusions/restraints 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.

**Performance Threshold:** 90%

**Goal:** 100%

**Type of Measure:** Performance Improvement

		Results					
	Unit	Baseline	Q1	Q2	Q3	Q4	YTD
<b>Target</b>	Compliance with Seclusion Documentation	To Be Determined	N/A	N/A	100%	100%	<b>100%</b>
<b>Actual</b>			N/A	N/A	87%	88%	<b>87.5%</b>

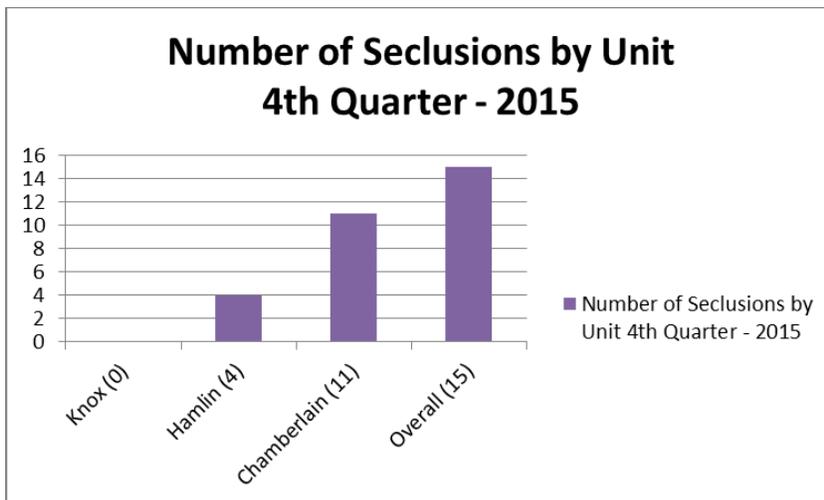
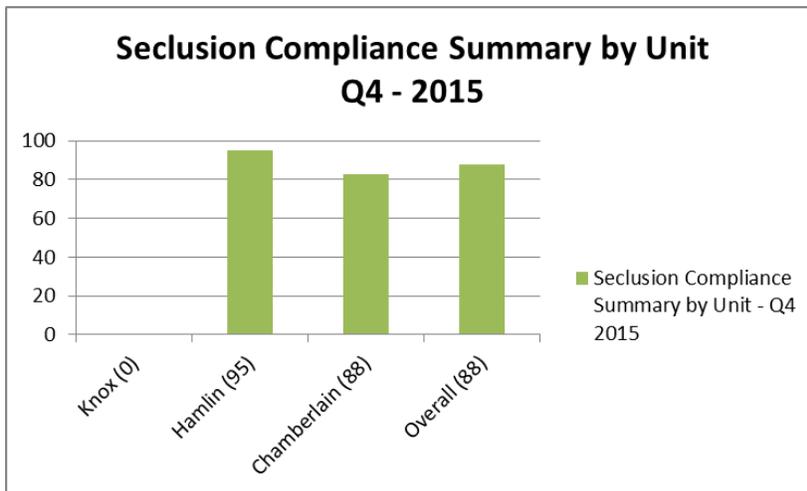
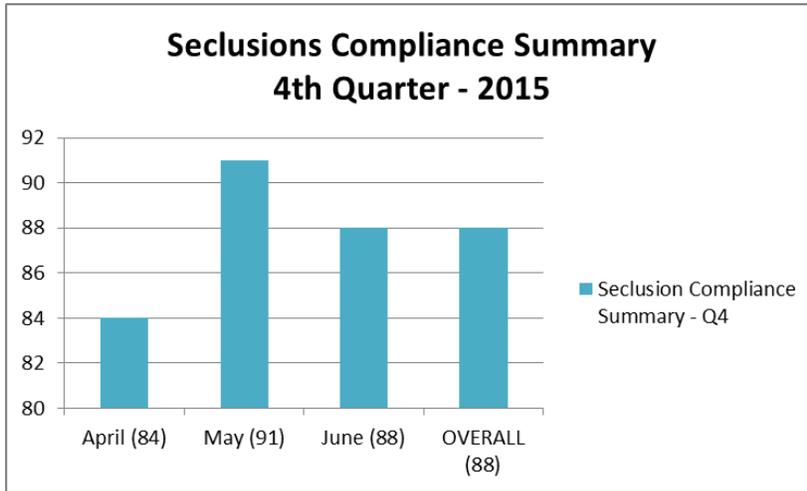
**Data Analysis:** Nurses have not met the designated seclusion documentation threshold of 90% for the 4<sup>th</sup> Quarter of 2015. April 2015 saw a compliance of 84%, May compliance was at 91%, and June compliance was at 88%, which yields an overall compliance of 88% for the 4<sup>th</sup> Quarter.

Seclusion documentation compliance was also recorded for the 4<sup>th</sup> Quarter. Knox Unit had no seclusions in the 4<sup>th</sup> quarter; Hamlin had compliance of 95%, and Chamberlain had a compliance of 88% with an overall compliance of 88% in the 4<sup>th</sup> Quarter.

Knox had 0 seclusions in the 4<sup>th</sup> Quarter, Hamlin had 4, and Chamberlain had 11. There were a total of 15 seclusions across the three inpatient units during the 4<sup>th</sup> Quarter.

**Action Plan:** Nursing staff will continue to audit the documentation of patient seclusions on a monthly basis, and re-evaluate quarterly, and again yearly.

# STRATEGIC PERFORMANCE EXCELLENCE



# STRATEGIC PERFORMANCE EXCELLENCE

## Pharmacy Services

**Fred Lapatinsky, PharmD**

Measure	Unit	Baseline 2014	Goal	Q1	Q2	Q3	Q4
<b>Safety in Culture and Actions:</b>							
Pyxis CII Safe Comparison: Daily and monthly comparison of Pyxis vs CII Safe Transactions.	Rx	0 %	0% Target: Actual:	0% 0%	0% 0%	0% 0.7%	0% 0%
Veriform Medication Room Audits: Monthly comprehensive audits of 38 criteria.	All	93%	90% Target: Actual:	90% 91%	90% 97%	90% 89%	90% 95%
Pyxis Discrepancies: Monthly monitoring and trending of Pyxis discrepancies (average # of non-cs discrepancies per station).	All	6.7	0/mo Target: Actual:	0 21 (7/ mo)	0 25 (8/ mo)	0 22 (7/ mo)	0 26 (9/ mo)
<b>Fiscal Accountability:</b>							
Discharge Prescriptions: Monitoring and tracking of dispensed discharge prescriptions.	Rx	\$353 22 Drugs		\$114 6 drugs	\$172 7 drugs	\$121 2 drugs	\$585 33 drugs

# STRATEGIC PERFORMANCE EXCELLENCE

## Social Services

**Robyn Fransen, LSW-C**

**Indicator:** Grievances addressed in a timely manner. 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.

**Methodology:** Grievances are entered into the Grievance Log. 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.

**Goal for FY 2016:** 100% compliance with Nursing and Social Services addressing grievances within their specified timeframe.

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	1	0%	66.6%
	May 2015	4	50%	
	June 2015	4	100%	

**Analysis:** 3Q2015 and 4Q2015 compliance does not yet meet the goal.

**Plan of Correction:** In July of 2015 Social Services will begin analyzing reasons for complaints and grievances to begin looking for trends and resolutions. Social Services will also break down the data collection by unit staff, Nurse Supervisors and Social Work, and whether forms were completely correctly and whether grievances were addressed in a timely manner.

# STRATEGIC PERFORMANCE EXCELLENCE

## Staff Education and Development

Jenny Bamford-Perkins, MSN, RN

### Priority Focus Areas – 4<sup>th</sup> Quarter FY 2015

Measure Name	Measure Description	Unit	Baseline	Target	Comments
<b>MANDT:</b>  DDPC and contract staff will complete MANDT/SSRT training annually.	All DDPC employees and contract staff are required to complete MANDT/SSRT training annually.	215 DDPC employees  10 contract Medical Staff	91%	100%	Staff Education will work with the training scheduler to facilitate 100% compliance in MANDT/SSRT training. Two additional instructors have been trained.
<b>CPR:</b>  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.	225 (both DDPC employees and contract staff)	99% (2 non-direct staff uncertified)	100%	Staff Education will work with the training scheduler to facilitate 100% compliance in CPR training.
<b>First Aid:</b>  DDPC and contract staff will maintain First Aid certification by attending First Aid training biannually.	All DDPC employees and contract staff are required to complete First Aid training biannually.	225 (both DDPC employees and contract staff)	20%	100%	Staff Education will work with the training scheduler to facilitate 100% compliance in First Aid training. Two additional instructors will be added.

## STRATEGIC PERFORMANCE EXCELLENCE

Measure Name	Measure Description	Unit	Baseline	Target	Comments
<p><b>New Employee:</b></p> <p>New employees will complete new employee orientation within 60 days of hire.</p>	<p>Process will include following up with new employees, review of the orientation record and requirements to determine if standard is met.</p>	<p>12 new employees during the 4<sup>th</sup> quarter.</p>	<p>100%</p>	<p>100%</p>	<p>We will move new employee orientation onto Quality Management. We will assess October 2015 to ensure sustained compliance.</p>
<p><b>Impaired Licensed Practitioner:</b></p> <p>DDPC and contract staff will receive policy MS #13 annually.</p>	<p>All DDPC employees and contract staff are required to be educated in DDPC policy MS #13.</p>	<p>230 (both DDPC employees and contract staff)</p>	<p>97%</p>	<p>100%</p>	<p>We will move ILP onto Quality Management. We will assess October 2015 to ensure sustained compliance.</p>
<p><b>Pain:</b></p> <p>DDPC requires all RNs and Medical Staff to complete annual PAIN education packets.</p>	<p>All licensed independent practitioners are educated on assessing/managing pain.</p>	<p>79 (both DDPC employees and contract staff)</p> <p>19 MD/ 60 RN</p>	<p>96%</p>	<p>100%</p>	<p>We will move Pain onto Quality Management. We will assess October 2015 to ensure sustained compliance.</p>

# STRATEGIC PERFORMANCE EXCELLENCE

## MANDT Training - 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 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%  
Non-Direct Care Staff 78%

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

### Data:

215 Total Employees			
Direct Care Staff: 129 Total		Non-Direct Care Staff: 86 Total	
MANDT Compliant	Not MANDT Compliant	MANDT Compliant	Not MANDT Compliant
129	0	67	19

### 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 and 78% of non-

# STRATEGIC PERFORMANCE EXCELLENCE

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 has coordinated with the MANDT instructors to create MANDT-Light (Defensive)/Safety Response Skills Training (SRST) version for non-direct care staff that qualify. The first class occurred in July 2015.
- Staff Education will send monthly reports to department heads and the Superintendent notifying them of employees out of compliance.

## **CPR Training - 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:** 99% effective July 2, 2015

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

# STRATEGIC PERFORMANCE EXCELLENCE

**Data:**

<b>225 Total Employees</b>			
<b>Direct Care Staff CPR: 139 Total</b>		<b>Non-Direct Care Staff CPR: 86 Total</b>	
<b>Certified</b>	<b>Not Certified</b>	<b>Certified</b>	<b>Not Certified</b>
<b>139</b>	<b>0</b>	<b>84</b>	<b>2</b>

**Analysis of Data:**

Overall analysis of the data reveals 99% 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 improvements from 3<sup>rd</sup> quarter where non-direct staff was at 76%, currently at 98% compliance. Direct care staff continues to remain at 100% compliance. It is the goal of SED has met the quarter three goal of increasing the ratio of non-direct care staff while maintaining the current met goal of 100% for direct care staff. Staff Education will continue to strive for this goal.

**Plan of Action:**

- Staff Education will complete monthly audits.
- Staff Education will increase the number of instructors in the hospital to make classes more available. The goal is for staff education to have two additional instructors certified by 10/31/2015, doubling the numbers of instructors in the hospital.

### **First Aid Training – Performance Improvement**

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

**Methodology:**

- The Staff Education Department will conduct quarterly audits of the First Aid certification status of all DDPC employees using the education database.
- For direct care staff: The numerator will be the quarterly combined number of direct

## STRATEGIC PERFORMANCE EXCELLENCE

care staff that attended First Aid certification and the denominator will be quarterly combined number of direct care staff scheduled for the First Aid certification training.

- For non-direct care staff: The numerator will be the quarterly combined number of non-direct care staff that attended First Aid certification and the denominator will be quarterly combined number of non-direct care staff scheduled for the First Aid certification training.

**Baseline Data:** Direct Care Staff: 12%  
Non-Direct Care Staff 31%

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

**Data:**

<b>225 Total Employees</b>			
<b>Direct Care Staff First Aid: 139 Total</b>		<b>Non-Direct Care Staff First Aid: 86 Total</b>	
<b>Certified</b>	<b>Not Certified</b>	<b>Certified</b>	<b>Not Certified</b>
<b>17</b>	<b>122</b>	<b>27</b>	<b>59</b>

**Analysis of Data:**

Overall analysis of the data reveals 20% First Aid compliance rate amongst both direct care staff and non-direct care staff. It is the goal of SED for 100% of staff to be certified. Staff education will continue to strive for this goal.

**Plan of Action:**

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

# STRATEGIC PERFORMANCE EXCELLENCE

## Therapeutic Services

Lisa J. Hall, OTR/L

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

### 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.

**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	4Q2015	1Q2016	2Q2016	3Q2016	YTD
<b>Target</b>	Percent of time spent in direct patient contact.	36% March 2015	55%	65%	70%	70%	
<b>Actual</b>			46%				

**Q4 Comments:** All three individual providers increased direct care time from baseline. They are making progress towards the goal.

# STRATEGIC PERFORMANCE EXCELLENCE

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

Results							
	Unit	Baseline	4Q2015	1Q2016	2Q2016	3Q2016	YTD
<b>Target</b>	Percent of time spent in direct patient contact.	55% March 2015	55%	65%	70%	70%	
<b>Actual</b>			52%				

**Q4 Comments:** Of the nine staff in the department, five improved their direct care hours. Three providers had three or more weeks of missing data, excluding vacation, from the 11 weeks total. Overall regression from goal attainment.

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

Results							
	Unit	Baseline	4Q2015	1Q2016	2Q2016	3Q2016	YTD
<b>Target</b>	Percent of time spent in direct patient contact.	35% March 2015	55%	65%	70%	70%	
<b>Actual</b>			32%				

**Q4 Comments:** Of the five staff in the department two increased their direct care hours and one remained unchanged. Overall regression from goal.

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

Results							
	Unit	Baseline	4Q2015	1Q2016	2Q2016	3Q2016	YTD
<b>Target</b>	Percent of time spent in direct patient contact.	31% March 2015	55%	65%	70%	70%	
<b>Actual</b>			23%				

# STRATEGIC PERFORMANCE EXCELLENCE

**Q4 Comments:** Provider reports difficulty engaging patients and poor attendance at on unit groups. Regression from goal.

**E. Measure Name: Direct Patient Contact - Chaplain**  
**Type of Measure: Performance Improvement**

Results							
	Unit	Baseline	4Q2015	1Q2016	2Q2016	3Q2016	YTD
<b>Target</b>	Percent of time spent in direct patient contact.	30% May 2015	55%	65%	70%	70%	
<b>Actual</b>			36%				

**Q4 Comments:** The Chaplain joined the department in May 2015; first week was used for baseline. The Chaplain works 20 hours per week. Making progress toward goal.

**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.

July 2015 -

- Re-defining the role of Psychologist with a change in schedule and return to referral based treatment with a goal of increased utilization of services (currently 25% for Psychology). Effective August 2, 2015.
- Create a group schedule with co-facilitators for each group in order to increase availability to treat more patients in off unit locations and assist with documentation. Effective August 2015.
- Discuss potential use of behavioral activation treatment model to increase engagement. Discussed in full staff meeting on July 15, 2015. Presented by Dr. Bruce Freedberg, Psychologist.

## STRATEGIC PERFORMANCE EXCELLENCE

- Continue to explore options for per occurrence documentation that will meet CMS/TJC standards, yet be more efficient. Draft Treatment Documentation Flow Sheet awaiting approval for goal of August 2015 implementation.
- Individual meetings for all providers who decreased from their baseline and did not meet the goal of 55% productivity in order to better understand their individual barriers and needs. This involves six providers.
- Explore ways to get patients more invested in following through with recommended treatment.
- Trial patient schedules and processes to improve attendance at recommended groups.

# STRATEGIC PERFORMANCE EXCELLENCE

## Utilization Review

Leanne McLean, RN

### Percent of Acute Days as a Subset of Total Patient Days

2nd Quarter Calendar Year 2015 - 4th Quarter Fiscal Year 2015

