
Riverview

PSYCHIATRIC CENTER



PERFORMANCE IMPROVEMENT REPORT

FOURTH QUARTER
SFY 06
APRIL MAY AND JUNE

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INTRODUCTION:	4
SECTION I: DEPARTMENTAL QA- PI	4
INFECTION CONTROL	4
MEDICAL STAFF	5
NURSING	7
ASPECT: CLIENT SATISFACTION SURVEY	12
PEER SUPPORT:	15
PROGRAM SERVICE DIRECTORS/NURSING	16
REHABILITATION	20
REHABILITATION	21
STAFF DEVELOPMENT	23
SECTION II RIVERVIEW UNIQUE INFORMATION	25
BUDGET	25
HUMAN RESOURCES	26
HUMAN RESOURCES	28
VACANCY RATE	28
HUMAN RESOURCES AND RISK MANAGEMENT	29
STAFF INJURY	29
SECTION III PERFORMANCE MEASUREMENT TRENDS COMPARED TO NATIONAL BENCHMARKS	30
CLIENT INJURY RATE GRAPH	30

ELOPEMENT RATE GRAPH 31

RESTRAINT GRAPHS..... 32

SECLUSION GRAPHS 33

CO-OCCURRING PSYCHIATRIC AND SUBSTANCE ABUSE DISORDERS GRAPH 35

THIRTY DAY RE-ADMISSION RATE..... 36

AVERAGE LENGTH OF STAY FOR THOSE CLIENTS DISCHARGED 37

APPENDIX A- DRC CASES CLOSED – FOURTH QUARTER 06..... 38

Introduction:

The quarterly report will be presented in four different sections. Section I focuses on various departmental quality assessment and process improvement indicators. Each department has identified indicators, established thresholds, and concurrently collects data and assesses the data to help make the improvement actions be data driven and measurable. Implementation and evaluation of all departmental improvement actions is ongoing, and is intended to help each department to continuously improve the services they offer to clients at Riverview Psychiatric Center. Section II includes Budget and Human Resources data with trends unique to Riverview. Section III focuses on Performance Measurement trend information comparing Riverview Psychiatric Center to the National Norms for similar Psychiatric facilities. Sections IV pertains to Committee-driven or otherwise authorized Process Improvement Team Activities.

Section I: Departmental QA- PI

INFECTION CONTROL

ASPECT: HOSPITAL INFECTION CONTROL

OVERALL COMPLIANCE: Hospital average (36 months): 2.87

4th Quarter April, May, June, 2006 Infection Control			
Indicators :	Number	Rate	Threshold Rate
Hospital Acquired infection rate, based on 1000 patient-days	23	2.83	2 standard deviations (5.26)

Findings: Infection rate is obtained by total house surveillance of inpatients. Surveillance is accomplished by chart reviews, review of antibiotic prescribing (for infections or prophylaxis) and clinical staff reporting. The usual types of infections were seen, such as minor skin, urinary tract, upper respiratory, ear and eye infections were noted during this period. However, no infection or location trends were apparent

Problem: While inpatient infection rate is determined monthly, Riverview also maintains two clinic settings where outpatients undergo dental procedures, including extractions. Clinic Services in Portland performs some of these procedures with patients undergoing conscious sedation. These procedures have been classified by regulatory agencies as outpatient surgical procedures and as such, formal infection surveillance is necessary.

Status: Hospital acquired infection rate for this period was 2.83, slightly below the 36-month average and within the 2 standard deviation threshold of action (5.26 infections per 1000 patient-days). There have been no Capital Community Clinic outpatient infections identified.

Actions: All new employees continue to receive orientation regarding infection control and proper hand hygiene. Annual training requirements were met during the April training fair.

Additionally, infection prevention information was reviewed with the night shift staff by the NOD.

Surveillance of potential and actual infections will continue for inpatients, with the addition of documented surveillance processes of infections for dental clinic outpatients who have undergone dental extraction procedures. Dental clinics in Augusta and Portland practice standard precautions with all dental office and patient care activities and have begun to monitor and document any suspected post dental extraction infections. The next report will list the number of these cases, if found.

MEDICAL STAFF

ASPECT: INTERNAL PEER REVIEW: Documentation of Physical Exams.

OVERALL COMPLIANCE: 70%

April, May, June, 2006- Documentation of Physical Exams			
Indicator	Findings	Compliance	Target%
Total documentation of physical exams reviewed will meet minimum passing requirements as detailed in the “physical exam peer review form.”	18 of 24 notes met minimum requirements	75%	90%
All individual practitioner’s documentation of physical exams will meet minimum passing requirements.	3 of 6 individuals met minimum requirements	50%	100%

Findings: The documentation of individual physical exams continues to fall below the target compliance rate of 90%.

Problem: The overall compliance is still under target rate of 95%.

Status: Overall compliance rose slightly this quarter from 54% (3rd quarter) to 59%.

Actions: Documentation of physical exams will continue to be monitored and discussed at Medical Staff meetings. Medical Director will review physical exam form to suggest format changes, such as signature line and date/time line on each page.

MEDICAL STAFF

ASPECT: INTERNAL PEER REVIEW: Medical Staff Progress Notes

OVERALL COMPLIANCE: 100%

April, May, June, 2006 - Med Staff Progress Notes			
Indicator	Findings	Compliance	Target %
Total progress notes reviewed will meet minimum passing requirements as detailed in the “progress note peer review form.”	92 of 92 notes met minimum requirements	100%	90%
All individual practitioner’s progress notes will meet minimum passing requirements.	10 of 10 individuals met minimum requirements	100%	100%

Findings: Psychiatric staff is performing very well on this monitor.

Problem: None noted.

Status: The overall compliance went up from 98% to 100%.

Actions: This monitor will end with this quarter.

MEDICAL STAFF

ASPECT: STAFF PRESCRIBING ERRORS

OVERALL COMPLIANCE: 100%

April, May, June, 2006 -Prescribing Errors.			
Indicator	Findings	Compliance	Target %
No medical staff members will have more than two prescribing errors in any given month.	Zero in April Zero in May Zero in June	100%	100%

Findings: There were no prescribing errors reported in April, May or June of the 4th quarter.

Problem: None noted.

Status: Medical staff members continue to have very low levels of prescribing errors.

Actions: Monitor ending with this quarter. Pharmacists began reporting any variances on orders to Risk Management to Medical Director, Pharmacy and Therapeutics Medication Variance meeting to Med Executive Committee.

MEDICAL STAFF

ASPECT: MONITORING FOR IV SEDATION PORTLAND CLINIC

OVERALL COMPLIANCE: 100%

April, May, June 2006 - O2 Sat rate post conscious sedation.			
Indicator	Findings	Compliance	Target%
Sedation patients will have an O2 sat on room air of 92% or greater before going to recovery	14 pts sedated Lowest baseline SAT 93% Lowest final SAT 95%	100%	100%
May 2006			
Sedation patients will have an O2 sat on room air of 92% or greater before going to recovery	28 pts sedated Lowest baseline SAT 93% Lowest final SAT 96%	100%	100%
June 2006			
Sedation patients will have an O2 sat on room air of 92% or greater before going to recovery	4 pts sedated Lowest baseline SAT 94% Lowest final SAT 96%	100%	100%

Findings: 46 clients received sedation services in the quarter. All clients had their oxygen saturations (SAT) at or above the threshold prior to going to the recovery room.

Problem: No problem detected.

Status: All clients receiving IV sedation had adequate oxygenation prior to leaving operatory for the recovery room.

Actions: Continue to monitor 02 SATs both pre-op and prior to admission to recovery. Continue to report at monthly staff meeting and send quarterly report to the Medical Director.

MEDICAL STAFF -CAPITOL COMMUNITY CLINIC

ASPECT: COURT MANDATED PSYCHIATRIC APPOINTMENTS

OVERALL COMPLIANCE: 98%

April, May, June, 2006- Court Mandated OP Clinic Appointment Kept			
Indicator	Findings	Compliance	Target %
Forensic clients keeping appointment in Capitol Community Clinic	118 appointments 116 kept	98%	100%

Findings: 118 appointments; 116 appointments kept. One missed appointment in April due to breakdown of the ICM’s vehicle en route to pick up the client. One missed appointment in June due to medical illness and hospitalization of one forensic client

Problems: One client was rescheduled immediately. The other clients was send by the Forensic PSD at the Hospital, and was rescheduled immediately after discharge from the hospital..

Status: 98% compliance with court mandated psychiatric appointments for the past two quarters. 100% of clients made appointments or had legitimate reasons for not being able to keep scheduled appointments this quarter.

Actions: Continue to track. Both clients were under continual supervision, liaison for community forensic services, making a hospital visit to one of the clients.

NURSING

ASPECT: SECLUSION AND RESTRAINT RELATED TO STAFFING EFFECTIVENESS

OVERALL COMPLIANCE: 97%

Indicators	Findings	Compliance	Threshold Percentile
1. Staff mix appropriate	103 of 103	100%	100%
2. Staffing numbers within appropriate acuity level	103 of 103	100%	100%
3. Debriefing completed	89 of 103	86%	100%
4. Dr. order	103 of 103	100%	100%

Findings: All staff effectiveness indicators are at 100% with the exception of debriefing at 86%. The average is 97%. Seven of the 15 debriefings occurred on unit A, and five on unit B, one on Unit C, 7 to 3 shift. Two occurred on Unit B, 3 to 11 shift. Ten of 13

missing debriefings occurred on the day shift.

Problems: Staff debriefing is below threshold. It was determined that this is below threshold due to the understanding of some nurses that a clinical leader such as a PSD, an RN IV or NOD is required to complete the debriefing. The responsibility for completing the debriefing belongs to the senior executive nurse there at the end of the event. In the absence of a PSD or RNIV, the RN III would conduct the debriefing with the responding team present.

Status: Staff debriefing decreased by 1%, however continues to be the only indicator which is below threshold. New action plan to begin this quarter was for Risk Manager to notify respective staff to complete a debriefing and return to ADON. ADON received one of 15 missing debriefings; Due to findings, the Risk Manager and ADON met to work on an improved process of collecting missing debriefings. All aspects continue to be at 100% except for debriefing.

Actions: A new debriefing form is being developed and will be piloted beginning in the middle of July. This is a more comprehensive alternative to the former debriefing. Staff, including RN III's will be reeducated to the rationale for completing a staff debriefing immediately after the event. It will be reiterated that the debriefings must occur after any restraint or seclusion as well a after a STAT call. The clerical support is copying late debriefings for ADON. The CRM is sending emails to have debriefing prior to end of day when debriefing not attached to Incident report; Ward clerks have been notified the debriefing is not part of the record and to forward to CRM if in filing.

NURSING

ASPECT: UNIVERSAL ASSESSMENT

OVERALL COMPLIANCE: 86%

4 th Quarter April May and June 2006- Universal Assessment			
Indicators	Findings	Compliance	Threshold Percentile
1. Nursing assessment completed by RN within 24 hours of admission	54 of 67	81%	100%
2. Sections completed or deferred with documentation	49 of 67	73%	85%
3. Initial nursing careplan initiated	65 of 67	97%	100%
4. Items triggered to integrated problem needs	52 of 67	79%	85%
5. All sheets authenticated by assessing RN	65 of 67	97%	100%

Findings: There were sixty-seven client charts audited for the 4th quarter. There was a

variation in each of the indicators listed. Thirteen of sixty-seven admission assessments were not completed within the standard of 24 hours. Eighteen of sixty seven assessments were incomplete without documentation of reason (psychosis, agitation, refusal). Two nursing Care Plans were not initiated, not deferred and were completed by 48 hours after admission. Fourteen assessments had items not triggered to “integrated problem needs”, and were not deferred. There was one missing RN signature.

Problems: All indicators are below threshold for this aspect. Indicator # 1, for completion of nursing assessment within 24 hours decreased from 96% to 81%. Indicator # 3, for nursing care plan initiated upon admission decreased from 100% to 97%. This indicates a need of more education in orientation of new nurses. On 3 occasions the client refused the assessment, and the RN did not defer to oncoming shift or document the refusal. This is a training issue that will be addressed in Orientation and with nurses on a regular basis. If part of the assessment is not completed, it will be carried to the next shift.

Status: Indicator # 2, completion of sections, increased from 51% to 73%, # 4, triggers to integrated problems, increased from 61% to 79%, and # 5 increased from 96 % to 98%. This is due to continued education by nursing leaders, and positive reinforcement provided by chart auditors in the form of “Quality Assurance Alerts” issued for deficient charts as well as the charts in compliance.

Actions: Nursing Leadership has been working to develop a new Nursing Assessment tool which will be more comprehensive. This is expected to be implemented by August 31st. Implementation will include re-education to the process and closer supervision by nurse managers (RN IV’s). Supervision will occur on a weekly basis with feedback being given to nurses for improvement. Supervision will be documented.

NURSING

ASPECT: NURSING DOCUMENTATION

OVERALL COMPLIANCE: 79%

4 th Quarter April May and June 2006 Nursing Documentation			
Indicators	Findings	Compliance	Threshold Percentile
1. NAP Notes at a minimum			
a. Identifies STG/objective	102 of 133	77%	90%
b. Once a shift by MHW or RN	69 of 133	52%	95%
c. Minimally Q 24 hours by RN	106 of 133	80%	95%
d. MHW notes signed by RN	127 of 131	97%	90%
2. Active Treatment			
a. Identifies intervention	120 of 132	91%	90%
b. Describes intervention	62 of 132	47%	90%
c. Assessment completed	123 of 132	93%	90%
d. Plan	125 of 131	95%	90%

Findings: Documentation compliance has been inconsistent in quality. This is due to staff's continued difficulty with the process in general, despite ongoing training, quality assurance, and supervision. Staff finds difficulty with the complexity of the documentation process.

Problems: The frequency of MHW and RN notes has declined. Short term goals are not being identified in the NAP note.

Status: While three of the indicators decreased, four increased and one remained the same. Overall documentation remains unchanged from last quarter. Four of the eight indicators were above threshold, two for the first time. This suggests an improvement in "Active Treatment" documentation, and a decline in "NAP notes minimum", sections a, b, and c. The latter is due, in part, to the subjectivity of the auditors and their respective understanding of data the data collection process. The auditing process will be changed with one auditor to assure reliability.

Actions: The DON and the Nursing Leadership group have begun to explore an alternate documentation process. It will contain the same components though less cumbersome and more comprehensive process. The Nurse IVs will help to educate direct care staff on the expectations of documentation. Chart audits will continue. The RN IVs, will help to educate direct care staff on the expectations of documentation. Chart audits will continue. All audits will be assigned to one RN IV to perform all audits.

NURSING

APECT: PAIN MANAGEMENT

OVERALL COMPLIANCE: 95%

4 th Quarter April May and June 2006- Pain Management			
Indicators	Findings	Compliance	Threshold Percentile
1. Pain assessed upon admission	113 of 113	100%	85%
2. Pain assessed using pain scale.	63 of 71	89%	95%
3. Pre-administration of pain meds assess using pain scale.	872 of 876	99%	95%
4. Post- administration of pain meds assessed using pain scale.	828 of 876	95%	95%

Findings: All admitted clients were assessed upon admission using the pain scale. Of the 113 charts audited, 71 identified pain as being present. 63 of these clients were rated using the pain scale of 1 to 10, and 8 were not. The eight who were not rated, post administration, five clients were sleeping, and three were not assessed post pain medication. Pain assessment data is being collected weekly for the assessment of pain pre

and post medication administration of pain.

Problems: Assessment using the pain scale upon admission after identifying pain decreased from 98% to 89%.

Status: Three areas of pain assessment increased as indicated above. Upon admission, compliance increased from 98% to 100%. Pre-administration of pain medication increased from 98% to almost 100% (99.5%). Post-administration also increased from 93% to 95%. All three of these indicators were within the threshold percentile, the latter, for the first time. Assessment using the pain scale upon admission was not in compliance. The pain scales added to the PRN stickers for pain, which served as a reminder to medications administrators to perform the post assessment. The failure to post assess occurred, most frequently, when the LPN gave the medication, and the RN did not document the assessment on the sticker.

Actions: During the next monthly LPN/RN meeting, facilitator will discuss this problem with attendees. The plan of correction will be that if client is deemed needing pain medication, the RN will assess, give medication and then reassess. This will take the LPN out of the middle of the process.

NURSING

ASPECT: CODE CART & REDLINING

OVERALL COMPLIANCE: REDLINING 96% CODE CART 97%;

April, May and June 2006 Code Cart/Redlining			
Indicators- Redlining	Findings	Compliance	Threshold Percentile
Lower Kennebec	268 of 273	98%	100%
Upper Kennebec	257 of 260	99%	100%
Lower Saco	243 of 273	89%	100%
Upper Saco	263 of 273	96%	100%
Indicators- Code Cart Sign Off	Findings	Compliance	Threshold Percentile
1) Lower Kennebec	258 of 273	95%	100%
2) Upper Kennebec	265 of 273	98%	100%
3) Lower Saco	267 of 273	98%	100%
4) Upper Saco	253 of 273	93%	100%
5) NOD Building Control	271 of 273	99%	100%

6) NOD Staff Room I 580	271 of 273	99%	100%
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Findings: Compliance with both redlining and Code Cart sign offs are running at 97% and 96%, respectively. The variance from 100% represents shifts the RN did not check the Code Cart or perform the redlining function for that shift. The variances occurred across the shifts and units with the exception of one unit, which had a slightly higher incidence of the variance for red-lining. This is due to multiple nurses new to nursing and new to the RPC. In addition the high turn-over on this unit, supervision has been inconsistent due to a long-standing RN IV vacancy. There have been several RN's, each working part time, acting capacity, therefore, supervision has also been inconsistent.

Problems: All of the units' Code Carts are not at 100%. All of the red-lining is not at 100%.

Status: Redlining compliance has decreased from 98% to 96% and code cart compliance has increased from 94% to 97% as a result of direct counseling of nurse involved.

Actions: Each staff not completing red lining or checking the code cart will be issued a quality assurance alert with a copy for respective supervisor, RN IV or PSD. The noncompliant nurse will be counseled and mentored to complete this very important check.

ASPECT: CLIENT SATISFACTION SURVEY

Total Compliance 78%

INDICATORS	COMPLIANCE		THRESHOLD PERCENTILE
1. Has anyone informed you about your rights?	13 of 17	76%	85%
2. Has anyone talked to you about the kinds of services that are available to you?	16 of 17	94%	85%
3. Are you informed ahead of time of changes in your privileges, appointments or daily routines?	11 of 17	65%	85%
4. Do you know someone who can help you get what you want or stand up for your rights?	15 of 17	88%	85%
5. Has your Community Worker visited or contacted you since you have been in the hospital?	14 of 17	82%	85%
6. Do you know how to get in touch with your Community Worker if you need to?	16 of 17	94%	85%

7. Do you have an Individualized Support Plan (ISP)?	14 of 17	82%	85%
8. I feel more confident in my ability to deal with crisis situations?	13 of 17	76%	85%
9. I am less bothered by my symptoms now?	14 of 17	82%	85%
10. I am better able to function?	14 of 17	82%	85%
11. I do better in social situations?	12 of 17	71%	85%
12. I experience less difficulty in my life?	13 of 17	76%	85%
13. I am treated with dignity and respect?	15 of 17	88%	85%
14. I feel comfortable asking questions about my treatment and medications?	14 of 17	82%	85%
15. I am encouraged to use self-help/peer support and support groups after discharge?	12 of 17	71%	85%
16. My medication benefits and risks were discussed with me?	10 of 17	59%	85%
17. I am given information about how to understand and manage my illness?	12 of 17	71%	85%
18. My other medical conditions are being treated?	17 of 17	100%	85%
19. I feel free to voice complaints and suggestions?	13 of 17	76%	85%
20. I feel my right to refuse medication or treatment is respected?	12 of 17	71%	85%
21. I participate in planning my discharge?	13 of 17	76%	85%

22. I feel I had enough privacy in the hospital?	12 of 17	71%	85%
23. I feel safe while I am in the hospital?	13 of 17	76%	85%
24. If I had a choice of hospitals, I would choose This one?	10 of 17	59%	85%

Findings: A Peer Survey Representative collects client satisfaction information in several areas. The opportunity to respond is provided to every client scheduled for discharge, as well as other clients randomly chosen to complete the survey after they have been in the hospital at least 2 weeks.

Problems: The survey demonstrates need for improvement in the following areas: 1. Areas of education, information sharing, rights, and privacy.

Status: Compliance level overall this quarter is up to 78 %. Areas that were low on previous surveys continue to be low. Many clients answered Non-applicable to questions resulting in some lower percentages

Actions: Unit staff will be directed and assisted in working on areas that fall 15% or more below the threshold. Privacy will be discussed with clients on admission and reinforced during their hospital stay. Nursing staff on the unit will continue to offer medication education opportunities and will run Medication education groups on the Mall and units. Nursing Services will initiate plans designed to increase the positive response of # 3 “Are you informed ahead of time of changes in your privileges, appointments or daily routines?” Staff will go over daily schedules with their clients. # 16- “My Medication benefits and risks were discussed with me” Nursing care delivery will be redesigned to have more direct care given to each client by primary nurses to facilitate medication education. Changes will be made by Sept 30, 2006.

PEER SUPPORT:

ASPECT: Integration of Peer Specialists into client care

OVERALL COMPLIANCE: 83%

4 th Quarter April-May-June 2006 Integration of Peer Specialists into Client Care.			
Indicators	Compliance	Findings	Threshold Percentile
1. Attendance at Comprehensive Treatment Team meetings.	418 of 525	80%	80%
2. Grievances responded to on time.	141 of 157	90%	100%
3. Attendance at Service Integration meetings.	54 of 59	92%	100%

Findings: (1) Attendance of Comprehensive Treatment Team Meetings was 80% for the 4th Quarter, up 2% from last quarter. Admissions accounted for 14 missed meetings, 29 were due to peer specialist out sick or on vacation, not wanting peer support present accounted for 6 missed meetings, and 58 meetings were due to peer specialist not being available to attend meetings due to other meeting obligations and training. April had the lowest attendance of the quarter at 73% and May the highest at 90%. Decreased attendance in April was due to being short one full-time Peer Specialist and the increase in May was due to filling that position.

(2) Number of grievances filed was up 58 from last quarter. The majority of grievances filed were on Lower Kennebec (102 of 157). There were four late grievances, one on Upper Saco (9 days late) and three on Lower Kennebec (1-2 days late). There were 12 grievances that were not responded to at the time of this report-but were not late.

(3) Five Service Integration Meetings were missed this quarter. One meeting was missed due to training at the same time and four were missed because Continuity of Care Manager did not notify Peer Specialist.

Problem: (1) Peer Specialists are not attending all client Comprehensive Treatment Team Meetings.

(2) 10 % of step one client grievances are not being responded to in a timely manner.

(3) Peer Specialists are not always notified or available for Service Integration Meetings.

Actions: Peer Specialists will continue to track Comprehensive Treatment Team Meeting attendance and reasons for not attending. The Clerical Support for the risk manager is sending emails to grievance responders on the day before grievances are due. She also assists in request for extension formally to the Superintendent and client when necessary. Peer Specialists will make additional efforts to adjust their schedules to be available for meetings and problem-solve with the Peer Support Coordinator on how to manage their schedule and overcome barriers to attending team meetings.

Peer Specialists will address reasons for missed Service Integration Meetings with Program Service Directors and Continuity of Care Managers and problem-solve on how to avoid missing meetings.

Status: (1) Peer Specialists are tracking their attendance at treatment team meetings as well as their reason for not attending meetings.

(2) The Peer Support Coordinator is meeting with the Risk Manager as needed to address late grievances on a monthly basis. Risk Management staff has implemented an email reminder to PSD to increase the likelihood of a timely response to client grievance. Clerical support will file Incident report if staff not responsive to all reminders and doesn't request assistance to file for an extension.

(3) Peer Specialists have adjusted schedules to ensure that there are fewer conflicts with treatment team schedules. Peer Support Coordinator is providing coverage when necessary and able.

(4) Peer Support Coordinator and Peer Specialists will meet with Program Service Directors as needed to address reasons for missed Service Integration Meetings.

(5) A new indicator will be added beginning in July: "Contact during hospitalization," with a 100% threshold.

PROGRAM SERVICE DIRECTORS/Nursing

ASPECT: COMPREHENSIVE SERVICE PLAN

OVERALL COMPLIANCE 93%

April-May-June 2006 – Comprehensive Service Plan Reviews			
Indicators	Findings	Compliance	Threshold Percentile
1. Initial treatment documented within 24 hours.	41/41	100%	100%
2. Preliminary Continuity of Care meeting completed by end of 3rd day.	41/41	100%	95%
3a. Client Participation in Preliminary Continuity of Care meeting.	36/41	88%	80%
3b. CCM Participation in Preliminary Continuity of Care meeting.	41/41	100%	80%
3c. Client's Family Member Participation in Preliminary Continuity of Care meeting.	39/41	95%	80%
3d. Community Provider Participation in Preliminary Continuity of Care meeting.	20/33	61% *	80%
3e. Correctional Personnel Participation in preliminary Continuity of Care meeting.	2/11	18% *	80%
4. Presenting Problem in behavioral terms.	40/41	98%	85%

5. Strengths and preferences are identified.	41/41	100%	85%
6. Client LTG is observable and measurable	35/36	97%	85%
7. Comprehensive Plan complete by the 7th day.	41/41	100%	100%
8. STG/Objectives are written, dated, numbered observable and measurable.	36/36	100%	85%
10. Interventions are identified.	31/31	100%	85%
11a. Integrated Needs/Assessment Prioritized by scale at bottom of sheet.	39/41	95%	85%
11b. Integrated Needs/Assessment Contains all needs/ issues/problems.	39/41	95%	85%
12. Active medical issues addressed via Medical/ Nursing care plans.	40/41	98%	85%

Findings: This indicator tracks the compliance with aspects of the comprehensive service plan documentation with samples from all units of the hospital. The overall compliance rate is 93%. Some of the sample sizes vary across Indicators for this Aspect. This is due to inconsistencies across different raters that were corrected mid-quarter; indicators that were rated in the manner intended were left in the data set, those that were not were eliminated from the data. Next report should reflect equal sample sizes for all indicators on this aspect.

Problems: By Indicator Number: 3d. This continues to be an area in need of improvement on all units, still falling well below threshold of 80%; 3e. Newly added indicator—baseline.

Status: In short, compliance on but two of these indicators (3d and 3e, which is new) has been above established thresholds over 6 months. Compliance was above threshold and the same as last report on 4 indicators (1, 2, 3b, 11b). Compliance was improved on 9 indicators from last report (3c, 3d, 4, 5, 6, 7, 8, 10, 12). Of those, all but 3d are above thresholds. Compliance declined on 2 indicators, but still well above thresholds on both (3a, 11a).

Actions: 3d. Community provider participation: still much variance on this across all units although overall compliance is improving (14% improvement over last report). As this is improving, PSD will continue to give community providers are given ample lead time to be aware of the timing of meetings and offer of phone participation if appropriate to client's needs, offering some flexibility in meeting times to accommodate outside stakeholders, development of ICM tracking database towards more routine reporting (still in progress), regular discharge readiness meetings with hospital staff, regional team leaders, and other stakeholders (e.g., court master, adult mental health services system director, specific agencies in person or by phone) when participation has been problematic or less than

adequate; PSD or CCM Director communication/referral of specific or repeated problems getting community providers to the table with Regional Team Leaders and or Deputy Superintendent for additional follow up at that level. These actions will be reviewed with the newly hired CCM Director, with the request to develop relevant Performance Indicators such that this can be effectively monitored and resolved.

3e. This is a new indicator related to corrections personnel at meetings: this indicator was added to break-out corrections staff from "community provider" participation. ALL of the variability in this was on Lower Saco this month. Corrective Action is Deputy Superintendent will apprise Lower Saco's Acting PSD and newly hired CCM Director of this as a focused need, and direct that calls to jails be made and documented in the chart, phone participation offered, and sending jails quarterly performance data on this indicator beginning next quarterly report.

PROGRAM SERVICE DIRECTORS/NURSING

ASPECT: SERVICE PLAN REVIEWS

OVERALL COMPLIANCE 98% (429/439)

April-May-June 2006 for Quarterly Report on Service Plan Reviews			
Indicators	Findings	Compliance	Threshold Percentile
1. Completed no later than 14 days for the first 6 months and monthly thereafter.	Total 54/54 *1 N/A	100%	85%
2. Completed within 72 hours of a restrictive treatment.	Total 19/23	83% *	85%
3a. Review form documents client participated in the review	Total 49/54 *1 N/A	91%	85%
3b. Review form documents psychiatrist participated in the review	Total 55/55	100%	85%
3c. Review form documents CCM participated in the review	Total 55/55	100%	85%
3d. Review form documents nurse participated in the review	Total 55/55	100%	85%
4. Review form indicates plan as having met identified goals or not.	Total 46/55	84%*	85%

5. Review form states whether client continues to meet admission criteria or not	Total 55/55	100%	85%
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Findings: This indicator tracks the compliance with aspects of the service plan review documentation with samples from all units of the hospital. Some of the sample sizes vary across Indicators for this Aspect. On Indicator #2, this indicator only applies to clients experiencing a restrictive intervention (i.e., restraint or seclusion). On Indicators #1 and 3a, the sample was reduced by 1 as the client was discharged within 2 days of admission

Problems: 2. Performance problems circumscribed to Lower Saco. New process to guide this post-event approved in medical records and in place. 4. Compliance still approaching (84%) 85% threshold. Problems mainly on Lower Saco and Upper Kennebec.

Status: Compliance exceeds threshold on 6 indicators over past 6 months (1—further improved, 3a—1% decline, 3b—further improved, 3c—stable at 100%, 3d—stable at 100%, 5—stable at 100%). Indicator #4 continues to improve (to 84%) from last quarter (71%), but is still 1% short of target threshold. Indicator #2 declined to drop just below threshold; variance is attributable to data being more accurate now than before.

Actions: For indicators #2 and #4.

2. Service plan review within 72 hours of a restrictive intervention: corrective action has been that a form to trigger and guide efficient review process post-event has been developed, approved by medical records, and directed to be implemented on all units.

4. Documenting progress on goals: corrective actions are application of supervision & additional coaching, orientation of new nurses, use of established templates, and/or counseling/discipline appropriate to the nature of the problem. When PSDs identify variances in the process, they are to analyze cause, and produce written evidence of actions taken, summarized in the next quarterly report.

PROGRAM SERVICE DIRECTORS FOR NURSING

ASPECT: INTEGRATED SUMMARY NOTE

OVERALL COMPLIANCE 228/246 (93%)

April-May-June 2006 for Quarterly Report on Integrated Summary Note			
Indicators	Findings	Compliance	Threshold Percentile
1. Documented in the chart on the day of the Comprehensive Service Plan Meeting.	Total 41/41	100%	85%
2. Identifies Client Preferences.	Total 37/41	90%	85%

3. Identifies general needs of client -- identified on completed assessment.	Total 38/41	93%	85%
4. States whether further assessments will be needed or not.	Total 33/41	80%	85%
5. Identifies the general goals of services.	Total 39/41	95%	85%
6. Documents the client or guardian participation in the treatment planning process.	Total 40/41	98%	85%

Findings: This indicator tracks the compliance with aspects of the integrated summary note documentation with samples from all units of the hospital. The overall compliance is 93%.

Problem: Indicator # 4 Integrated Summary Note is supposed to state whether further assessments will be needed or not. Lower Saco is deficient in this area.

Status: Four Indicators exceeded thresholds for the last 6 months (1, 3, 5, 6). Indicator #2 improved to 90% (14% gain) to exceed threshold this quarter (76% last report). Indicator #4 also improved 10%, but is not yet at threshold.

Actions: Corrective actions are application of supervision & additional coaching, orientation of new nurses, use of established templates, and/or counseling/discipline appropriate to the nature of the problem. In collaboration with PSD, Nurse Educator temporarily assigned in nursing leadership role on Lower Saco will have opportunity to address this (and other documentation issues) during tenure on Lower Saco--where the majority of problems on this indicator are encountered (all other units were above threshold on this indicator).

REHABILITATION

ASPECT: CLIENT ATTENDANCE AT HARBOR MALL

OVERALL COMPLIANCE: 71%

4 th Quarter April-May-June 2006- Client Attendance at Harbor Mall			
Indicators	Findings	Compliance	Threshold Percentile
Attendance by clients scheduled to attend mall groups on a daily basis	2899 of 4080	71%	70%
Attendance at morning programming	1547 of 2188	71%	70%

Attendance at afternoon programming	1352 of 1892	71%	70%
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Findings: The sample is based on a 13-week session of the Harbor Mall from 4/01/06 to 6/30/06. For the 13-week period, the morning programming had 1547 client interactions out of a possible 2188 for a 71% total, up 3% from last report. The afternoon programming had 1352 client interactions out of 1892 for a 71% total, up 7 % from the last report. This means that for the 62 days the mall was in session we had a compliance rate of 71%. As a result of the action steps taken last quarter, there was an increase in both the morning and the afternoon programming. The Harbor Mall had an average daily attendance in the morning of 25 clients and 22 for the afternoon. This is the first quarter that we have overall met our expected outcome. Although the average number of clients went down by 2 in the morning it went up by 2 clients for the afternoon programming. The total number of contact hours has stayed exactly the same as last quarter.

Problem: The general increase in the morning program has been maintained and for this quarter the afternoon programming attendance dramatically improved. The inclusion of groups that client's suggested as well as the monitoring and reporting to the Recreation Therapist, those client's that are not engaged, has also added to the overall increase in the compliance rate.

Status: The Rehab staff has completed the Psychiatric Rehabilitation Training with Rick Forbess. A new assessment tool was developed and is being used on Upper Kennebec and Upper Saco. The suggestions from the survey were implemented with the new schedule that started on April 3rd, 2006. Engagement plans continue to actively evolve with those clients that have been refusing to participate in any groups. The morning program has improved from a 68% compliance rate to a 71% and the afternoon program went from a 64% rate to a 71%.

Actions: Engagement plans will be written on all clients that refuse more than 50% of their prescribed treatment groups. Suggestions from the end of the session questionnaire will be implemented in the new Summer schedule due to start on July 10th. Additional group leadership training will be provided for staff during the first week of July. Rehabilitation Services Director will continue to monitor the daily attendance sheets to review those clients that are refusing participation in prescribed treatment. The director will not only send the information to the Recreation Therapist, but will also follow up to see that engagement plans are written in each chart.

REHABILITATION

ASPECT: Job Coach Attendance at Comprehensive Treatment Plan Meetings

OVERALL COMPLAINE: 85%

4 th Quarter April-May-June 2006 Job Coach Attendance at Comprehensive TP Meetings.			
Indicator	Findings	Compliance	Threshold Percentile
The Vocational Staff will	54 of 63	85%	80%

attend assigned clients service plan meetings.			
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Findings: Of the 63-team meetings held in 4th quarter of 2006 the Employment Specialists attended 54 of them. Those that were missed were once again due to mandatory training and sick calls. This however did not impact us meeting our threshold percentile of 80%.

Problems: Need to develop an indicator that better shows how we are serving our clients. Voc Rehab is intending to improve the service provided by helping clients find competitive employment in the community.

Action: The Vocational Rehabilitation Department will meet as a group to develop the new indicators and review with the CPI Director.

STAFF DEVELOPMENT

ASPECT: New Employee and Mandatory Training

April May and June 2006 Staff training		
INDICATORS	COMPLIANCE	THRESHOLD PERCENTILE
1. The Director of Staff Development will track compliance with completion of new hire orientation.	<p>100 % -8 new employees/contract staff in April.</p> <p>100% -0 new employees/contract staff in May.</p> <p>100%-10 new employees/contract staff in June.</p>	100%
2. The Director of Staff Development will track completion of new employees CPR training within 30 days of hire.	<p>100 % -11 of 11 employees completed training in April.</p> <p>100% -0 of 0 employees completed training in May.</p> <p>100%-7 of 7 employees completed training in June.</p>	100%
3. The Director of Staff Development will track completion of NAPPI training within 60 days of hire.	<p>100 % -14 of 14 employees completed training in April.</p> <p>100% -0 of 0 employees completed training in May.</p> <p>100%-16 of 16 employees completed training in June.</p>	100%
4. Riverview staff will attend CPR training bi-annually.	99% - 257 of 258 employees hold current certification in CPR.	100%
5. Riverview staff will attend NAPPI training annually.	96% - 290 of 303 employees hold current NAPPI certification.	100%
6. River staff will attend Annual training.	99% - 314 of 318 employees are current in Annual training.	100%

Findings: The indicators are based on the requirements for all staff to complete mandatory training. 18 out of 18 (100%) new employees completed these trainings. 257 of 258 (99%) employees are current with CPR certification. 290 of 303 employees are current with Nappi certification. 314 of 318 employees are current in Annual training. All indicators remained at 100 % compliance for quarter 4-FY 2006.

Problem: None found. Employees continue to attend mandatory training as scheduled.

Status: No issues during quarter 4. Continue to monitor.

Actions: The above indicators will continue to be monitored

STAFF DEVELOPMENT

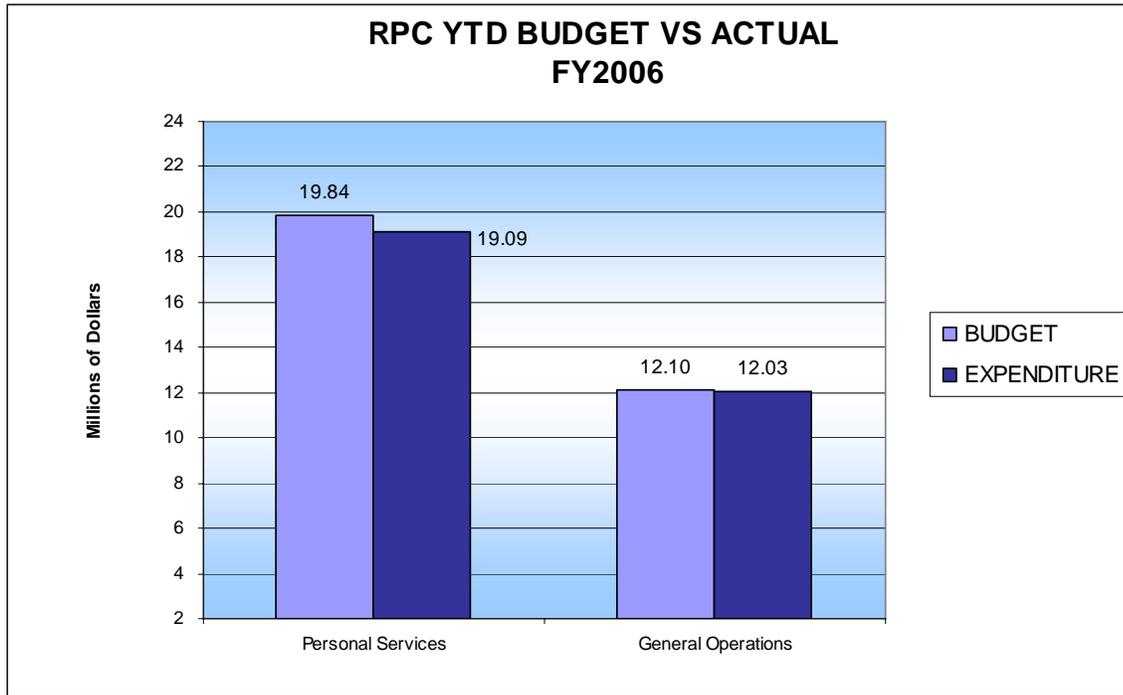
ASPECT: COMMUNITY PROVIDER TRAINING

Riverview Psychiatric Center offered several workshops and training this fourth quarter. We offered 7 different workshops in April that 93 community members attended. We offered 4 in May that 33 attended and 3 in June that 8 attended. Dialect Behavior Therapy was well attended along with the new CPR Guideline rollout that had over 70 participants. Riverview received several compliments and appreciation on the availability of the trainings that have been offered to outside agencies.

Section II Riverview Unique Information

BUDGET

Aspect: Budget Information



Findings: The hospital finished FY 06 within Budget for the 2nd year in a row.

Action: Continue Diligent monitoring of Overtime, Mandates and Contracts.

Management of Human Resources

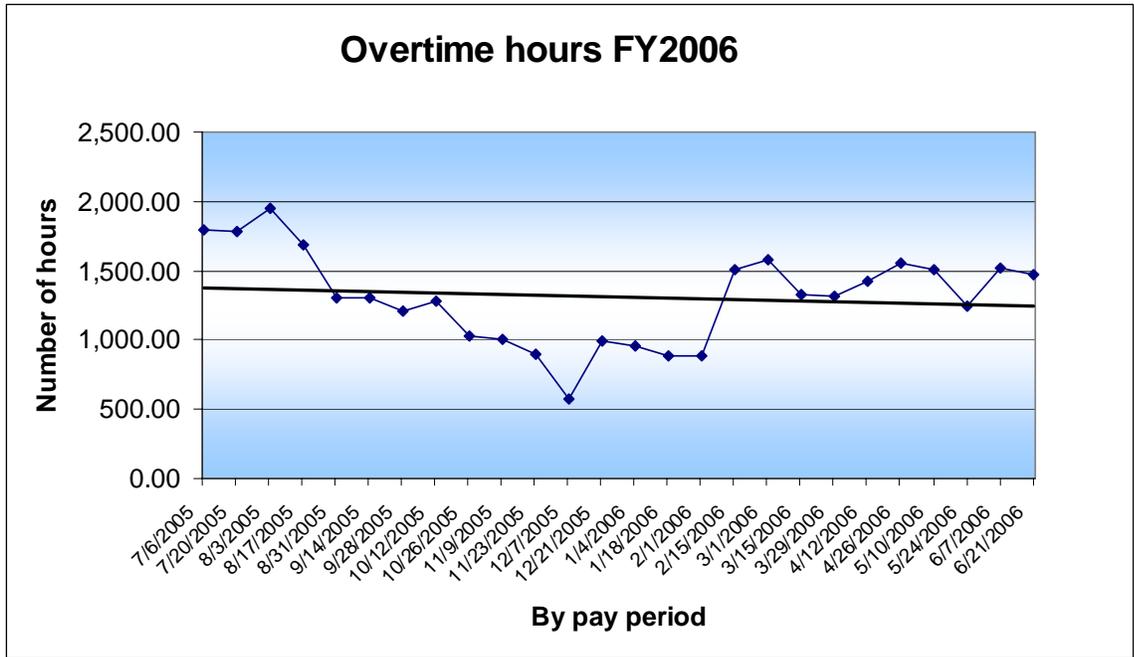
Timely Performance Evaluations

Overall Compliance: 86%

INDICATOR Employee Performance Evaluations expected to be completed within 30 days of the due date.	FINDINGS		TARGET PERCENTILE
	April 2006 (Feb evals)	14 of 24	58.3%
May 2006 (Mar evals)	24 of 24	100%	85%
June 2006 (April evals)	28 of 29	96.6%	85%

During this quarter 77 performance evaluations were sent out; 66 were received in a timely manner. This quarter significantly increase to **85.7%** as compared to last quarter (52%). This is an amazing achievement by Supervisors. Last year during the same quarter evaluations were at 71% compliance. This is the first time in the past year that we have met our goal. During this quarter Deputy Superintendent gave a directive to all Program Managers to complete performance evaluations timely with interval due dates. As a result of this directive we had an overall increase of 34%.

HUMAN RESOURCES
ASPECT: OVERTIME

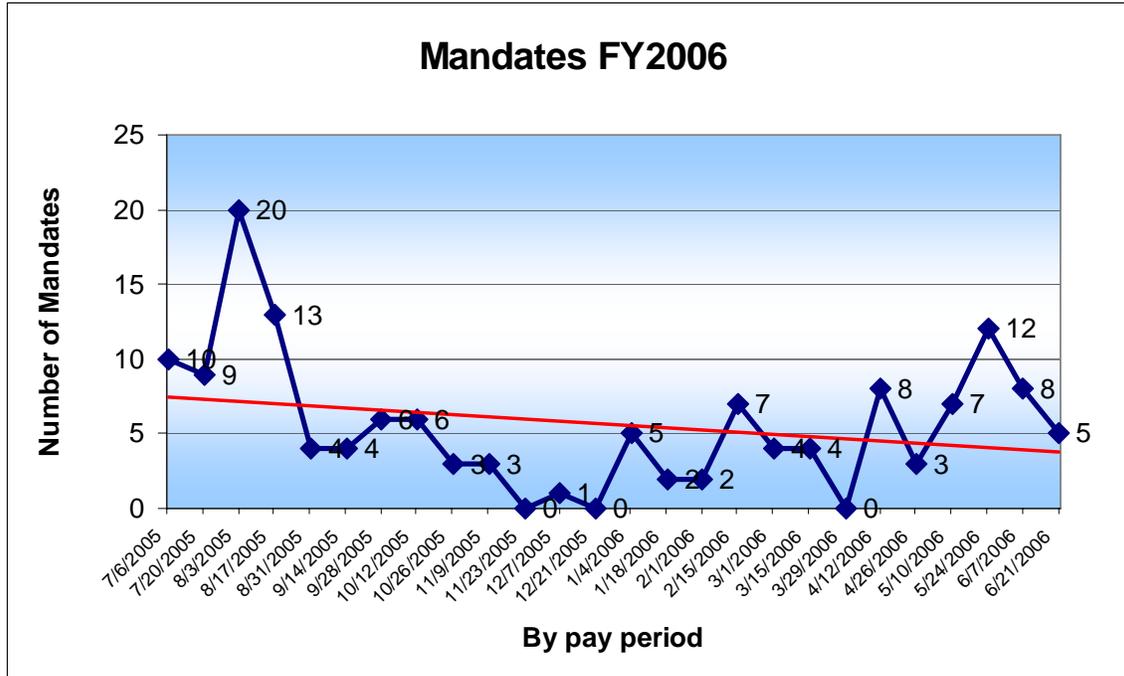


Overtime remains constant throughout the year; however did increase this quarter (Apr 06-June 06) by 4% (281 hrs) as compared to last quarter (Jan 06-Mar 06). We had an increase in nurse vacancies over this past quarter and 22 staff were involved in staff injuries from April 06 – June 06. In addition, we have 7 MHW’s out on workers’ compensation leave of absences.

During this quarter the Staffing oversight committee was formed to look at ways to reduce overtime & mandating, including staff who are on alternative work schedules (flex). Flex schedules were largely discontinued as of 4/16/06 as they have been a factor contributing to increased overtime in the facility.

HUMAN RESOURCES

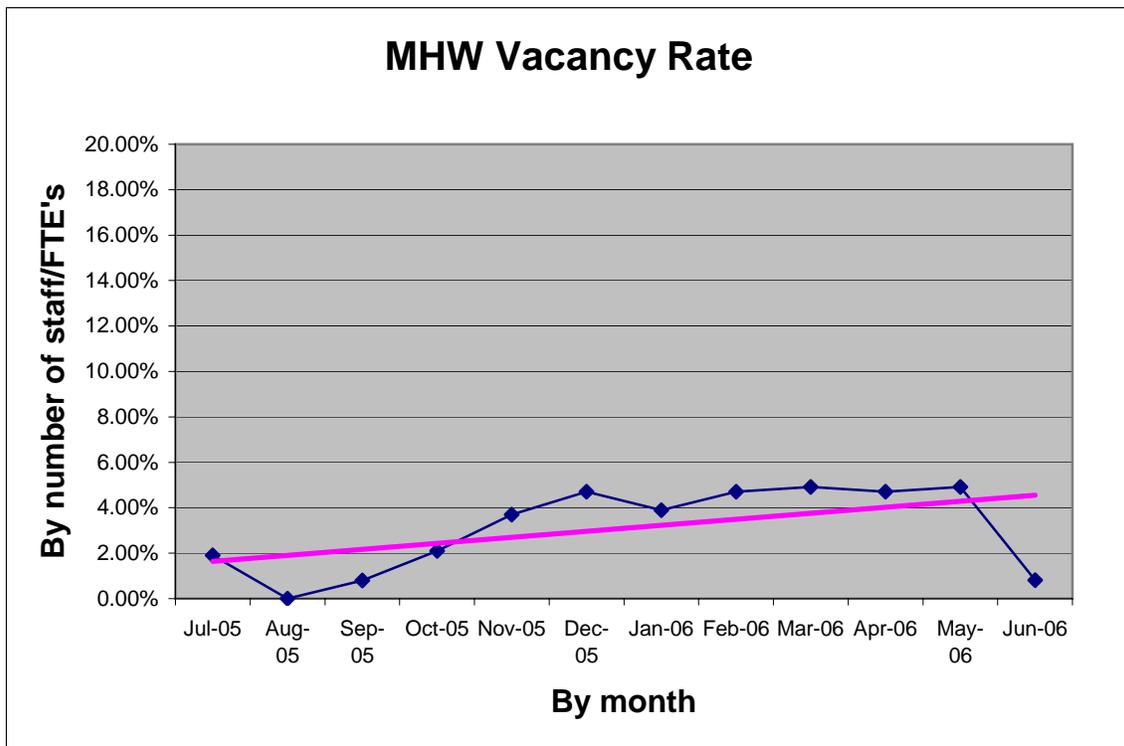
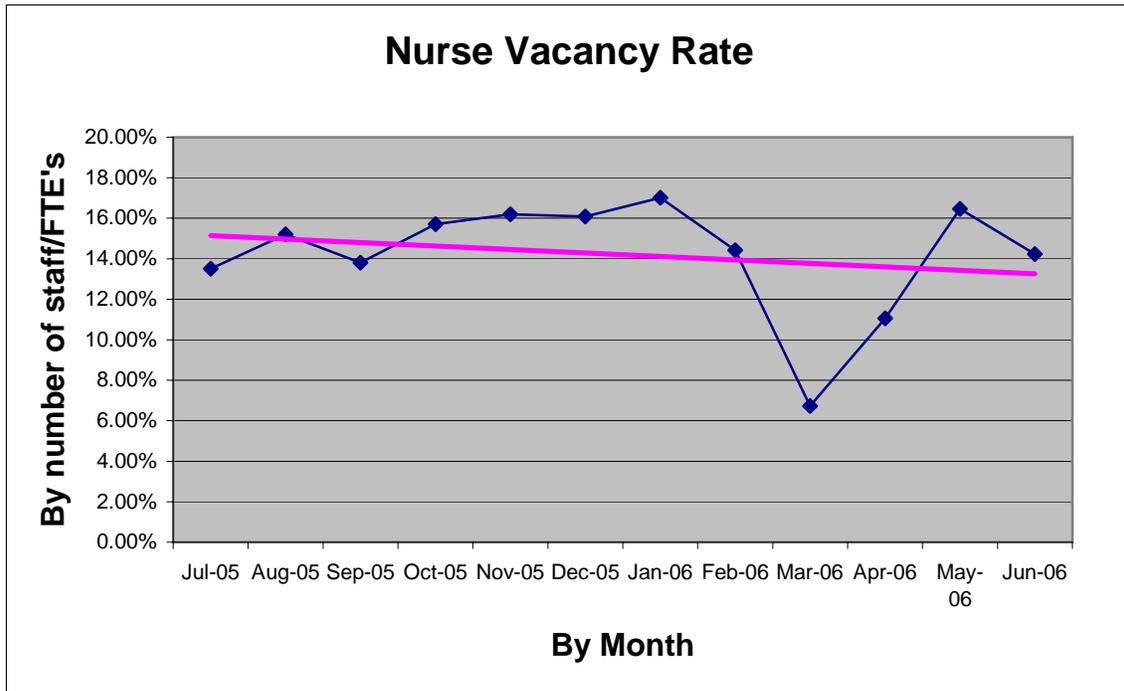
ASPECT: Mandates



Mandated shifts increased this quarter (Apr 06-Jun 06) as compared to last quarter (Jan06-Apr 06) from an average of 3.43 per pay period to an average of 7.16 per pay period. This represents 34 MHW mandates, 7 RN mandates and 2 other mandates. As compared to last year, we had 26 mandates for the same quarter (Apr 05-Jun 05) representing 23 MHW mandates, 4 RN mandates, and 1 other mandate.

Mandated shifts and overtime increased this quarter as a result of vacancies and leave of absences. In comparing the two largest reasons for overtime for last year during this quarter to this year, FY (Apr 05-Jun 05) vacancies represented 23.31% of overtime and sick usage represented 37.22% of overtime. This quarter (Apr 06-Jun 06) vacancies represent 17% of overtime and leave of absences represent 19% of overtime.

**HUMAN RESOURCES
VACANCY RATE**



Currently, the hospital has 7.5 RN vacancies and 1 MHW vacancy. Nursing vacancies have remained constant throughout the year with some exceptions. During this quarter Riverview hosted an on-site job fair on June 1st, which brought about 8 MHW, 2 RN and 4 ICM

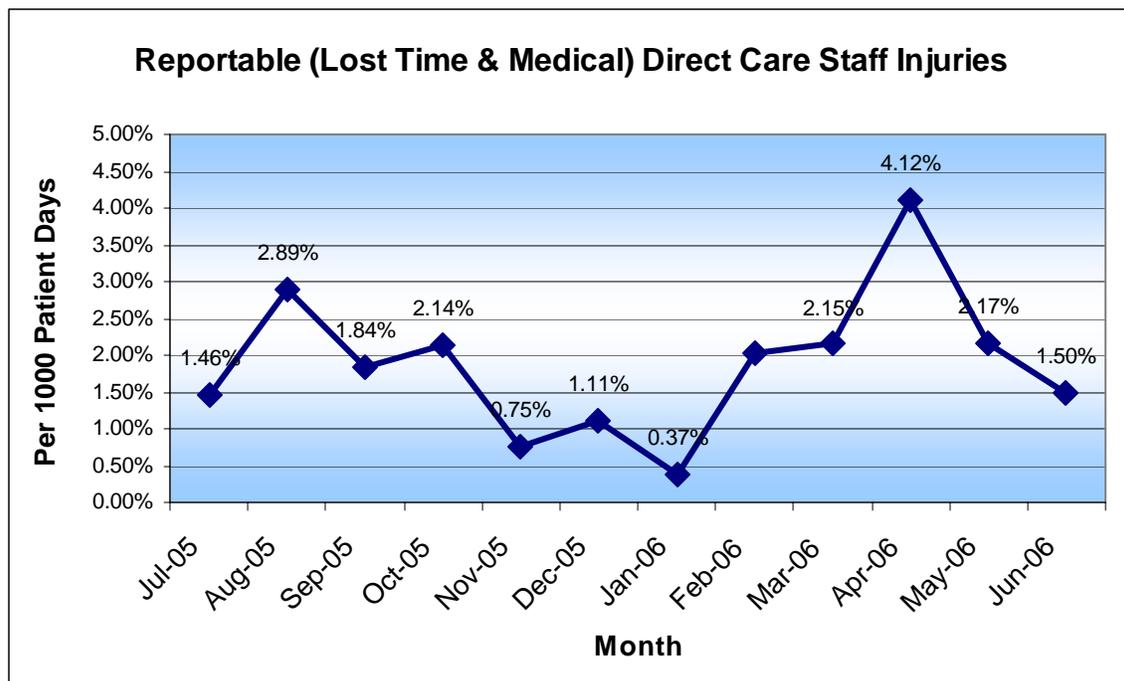
applicants. In addition, during this quarter, existing staff (non-C.N.A staff) from other departments was offered the opportunity to attend C.N.A. classes, offered tuition assistance and leave time to attend classes. This brought two housekeeping and one dietary staff person who successfully completed the classes to become Mental Health Workers. Currently, three security personnel are taking advantage of this opportunity.

International Nurses Alliance, who specializes in recruiting out-of-country nurses, ie. Canadian or Philippines has been contacted to assist in recruiting long term Nursing employees. Nursing and Human Resources will be meeting with this company to discuss what services may be available..

As compared to last FY (04-05) a slight increase in RN vacancies 13.19% up to 14.70% this FY (05-06) and a decrease in MHW vacancies 5.07% to 3.10%. As compared to Dorethea Dix, our overall vacancy rate is slightly higher 6.03% as compared to 7.00%.

HUMAN RESOURCES AND RISK MANAGEMENT

Staff Injury



This quarter's review reveals that there was an increase in direct care staff injuries from 1.51% per 1000 patient days to 2.60% per 1000 patient days. This number represents 22 direct care staff who sought medical treatment or lost time from work as compared to 13 last quarterly, primarily due to combative client injuries.

The yearly **overall average decreased this FY 05-06 as compared to FY 04-05**. The FY 04-05 year to date average was 2.39% and this FY was 1.88%.

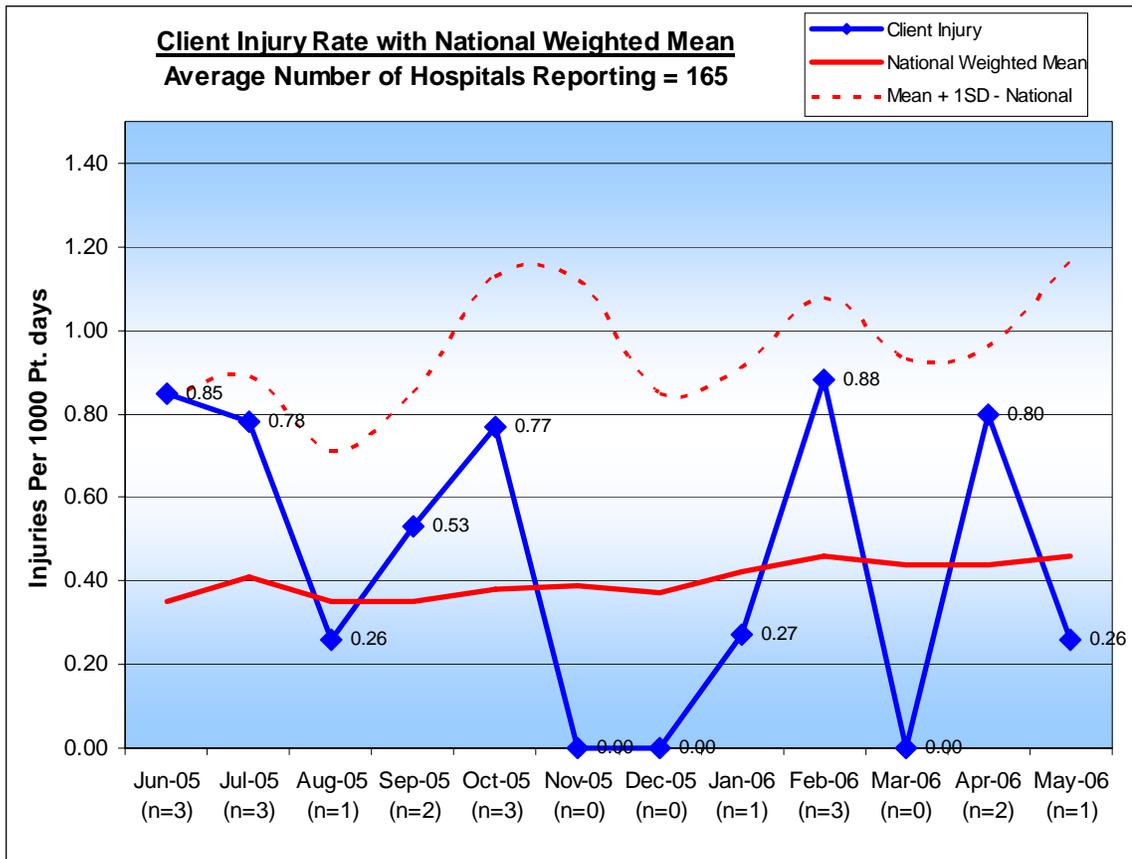
A new risk management process was implemented mid May to review incidences and analyze cause of injury. The on duty supervisor files an Incident Report, if requested writes

an analysis of the cause of the injury and plan to mitigate the risks of a reoccurrence. The injured employee writes a report regarding the injury and the Executive Leader reports to the Leadership group on Injuries.

SECTION III Performance Measurement Trends Compared to National Benchmarks.

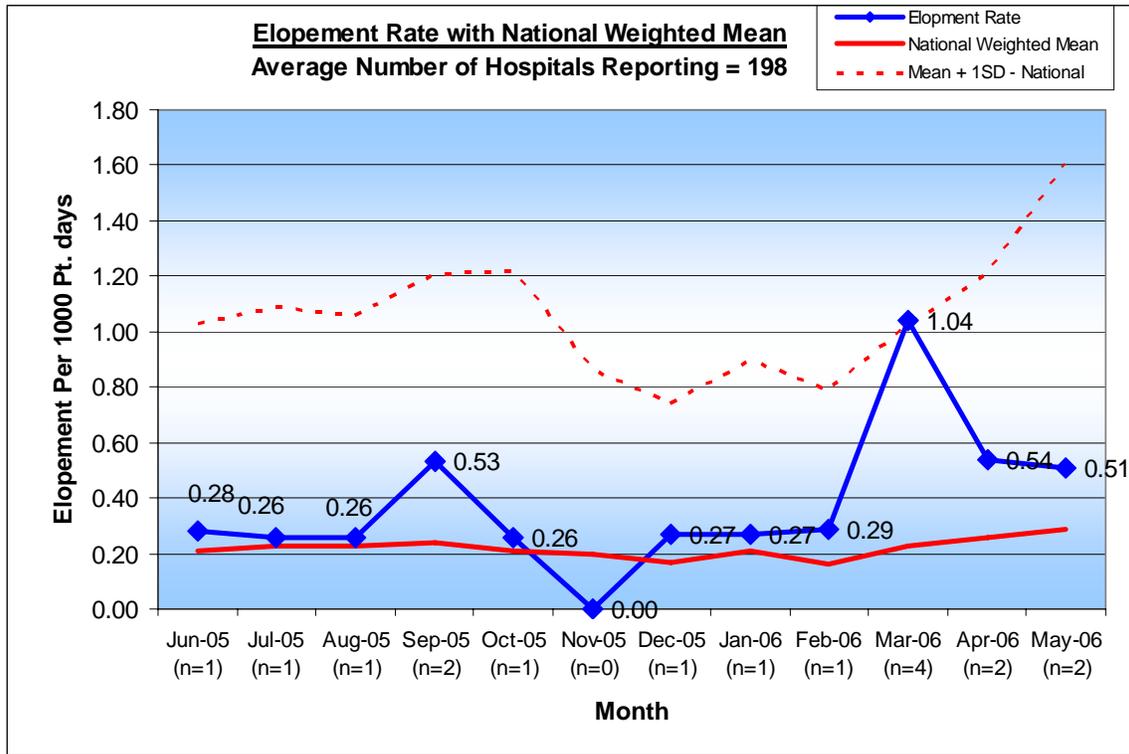
This section contains a number of graphs that compare Riverview Psychiatric Center to a national sample (the range is 75-215 hospital across all aspects) of participating like hospitals. Each line graph presents the national weighted mean (solid red line) and the limit of the first standard deviation of the national sample (dashed red line= national mean plus one standard deviation) as reference points. Practically speaking, about 68% of participating hospitals' rates would be within the limit denoted by the dashed red line. The solid blue line represents Riverview's rate by comparison. As the majority of these graphs will show, Riverview's rates do vary above and below the weighted national mean, but are typically within the "normal" range (within the 1st Standard Deviation) of other hospitals in the sample. Typically, Riverview's variation also follows variation in the national sample.

CLIENT INJURY RATE GRAPH



Client Injury Rate considers slips, trips and falls; self-injurious behavior; and client-to-client injury that requires more than first-aid. The numbers of such incidents are low. Riverview’s line, although appearing to have dramatic fluctuation, is in part the result of the scale used on the Y-axis. Riverview is well within the 1st standard deviation of the national sample. Please note the sheer number of events at Riverview is very low, between zero and 3 each month. Over the last 3 months, there were a total of 3 injuries. Taking the mean of Riverview's rate over the quarter (given client injuries are very infrequent) would put Riverview’s rate below the national mean at 0.35

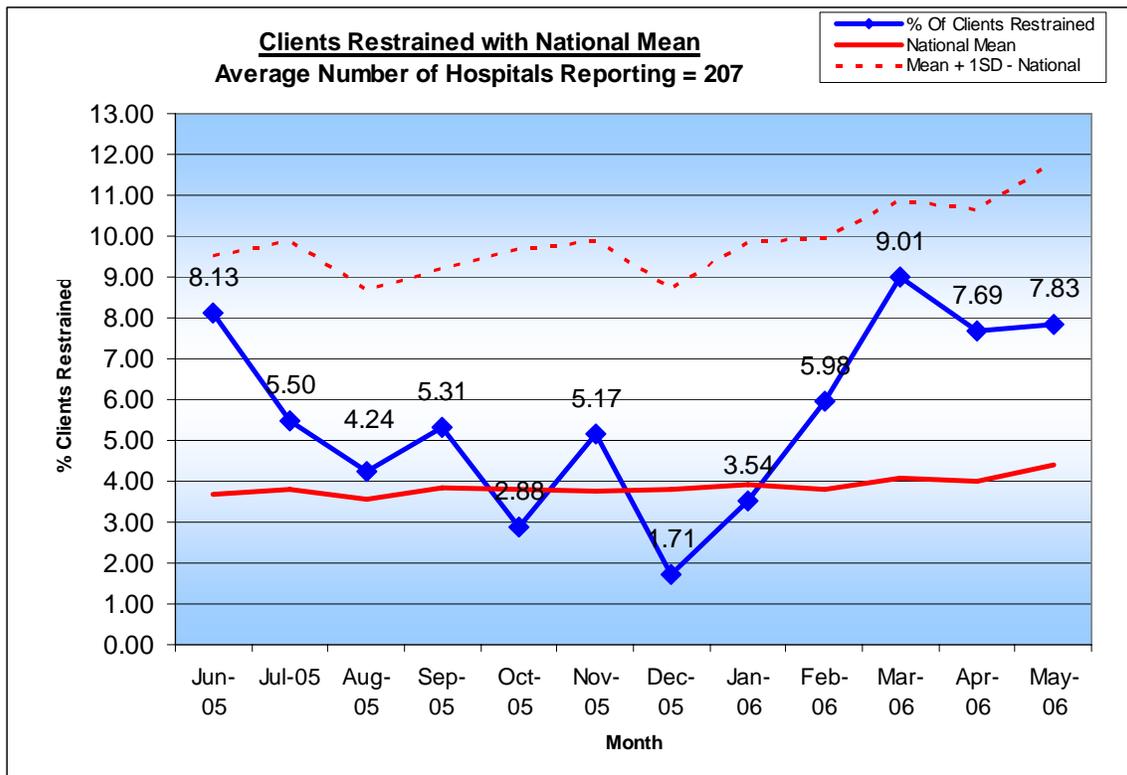
ELOPEMENT RATE GRAPH

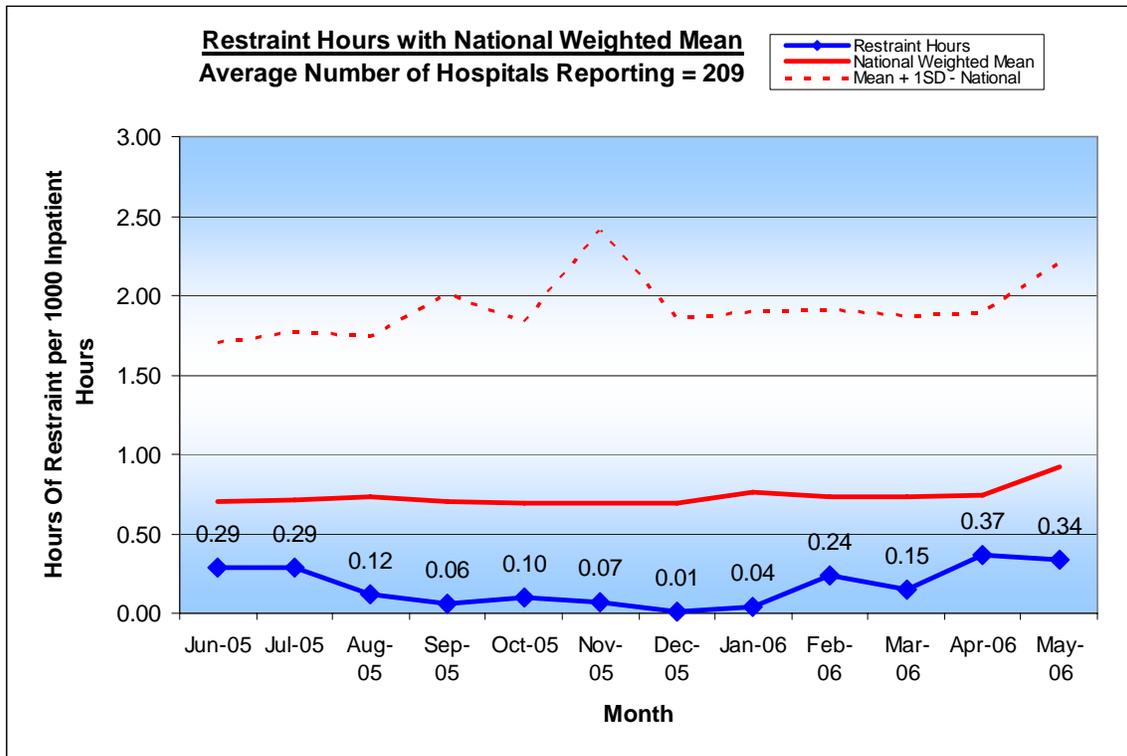


Elopement Rate is calculated per 1000 patient days. Elopement risk is evaluated by the treatment team and is treatment planned if necessary to keep the client and the community safe. Three of the elopements at RPC occurred when clients were on free time and failed to return promptly, but were not attempting to leave the hospital. All Riverview’s numbers are within the 1st standard deviation of the national sample over the quarter. Please note the sheer number of events at Riverview is very low, between 1 to 4 each month. Over the last 3 months, there were a total of 8 events meeting the hospital definition of elopement that involved 5 different clients.

RESTRAINT GRAPHS

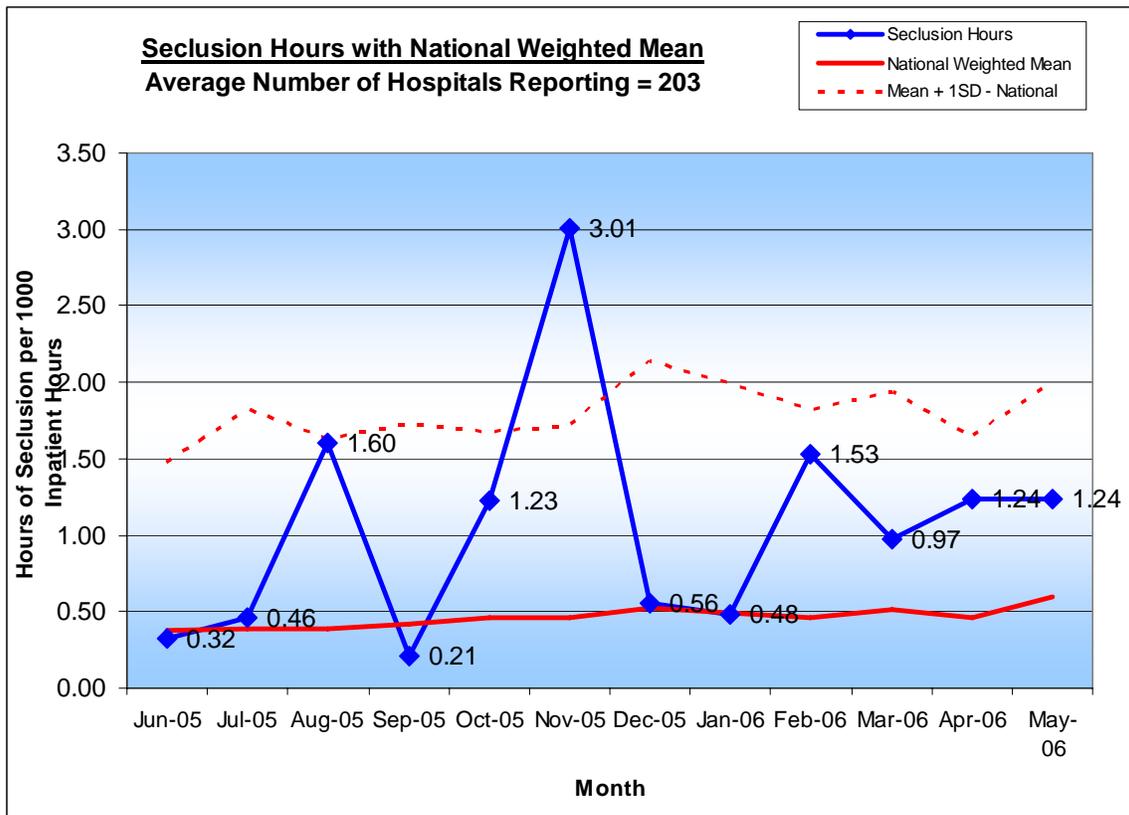
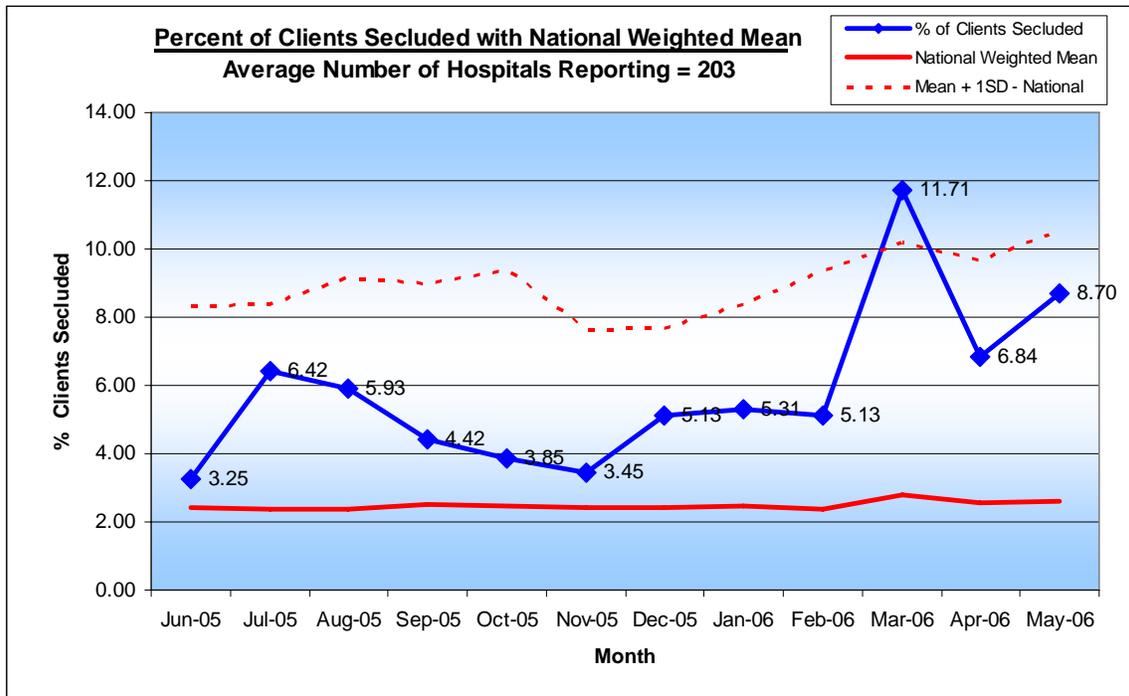
Riverview's rate of clients restrained, although above the statistical mean, is comparable to at least 68% of hospitals in the national sample. The restraint hours (duration) rate is well below the statistical mean, but also comparable to the bulk of hospitals in the national sample. The data would suggest that Riverview's restraint events are short by comparison, and efforts to reduce the frequency of restraint use would have the most impact. Corrective actions applied are: reducing the time for restraint order renewal from 4 hours to 1 hour; revision of debriefing process is in progress; new protocol and form to guide treatment plan revisions within 72 hours following the event is in place; education initiatives; increased clinical, supervisory and administrative oversight; expanding opportunities for client choice is a priority to be monitored and tracked in monthly administrative reports; the hospital has put forward a proposed tobacco-free campus policy as national data show that tobacco-related issues are often precipitants to restraint/seclusion events in a national sample (smoking/tobacco as significant precursor to restraint/seclusion events was 5% in non-smoking facilities vs. 34% in smoking facilities--7 times more).



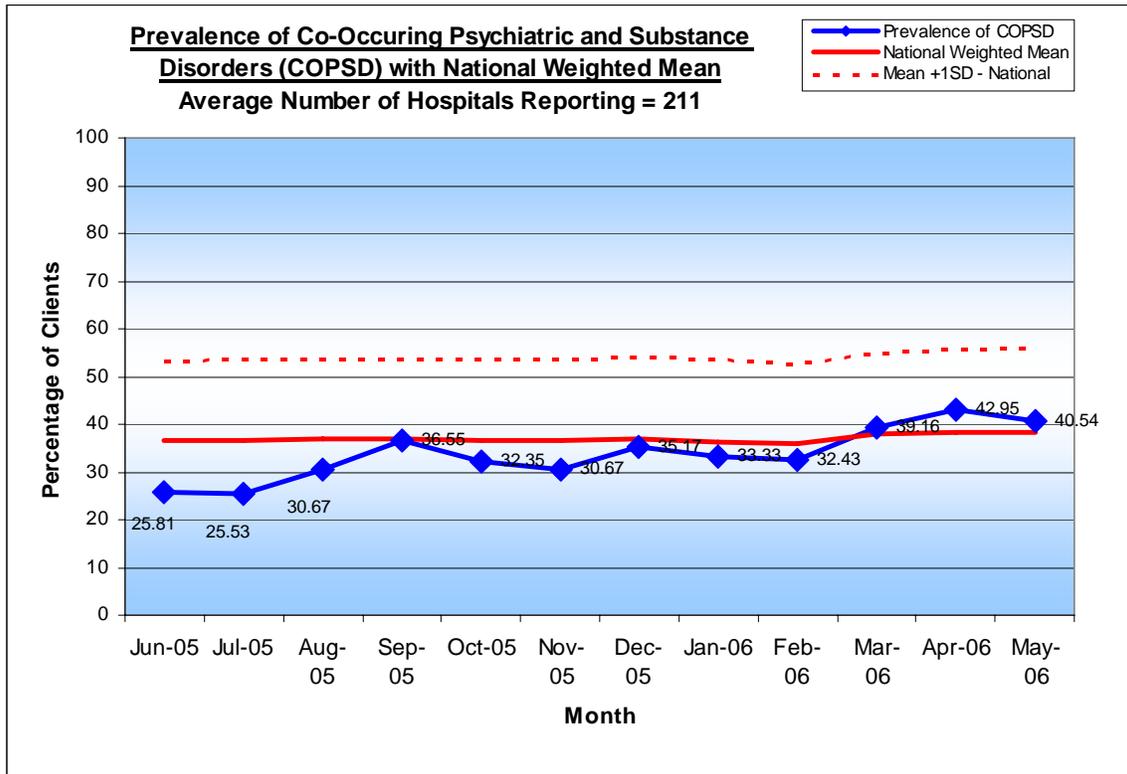


SECLUSION GRAPHS

Riverview used seclusion more frequently than 68% of hospitals in the national sample in the month of March, but the rate is generally comparable to the national sample in other months. Seclusion hours (duration of events) at Riverview, although tending to be above the national weighted mean, are within the 1st Standard Deviation of other hospitals in the national sample. Riverview's efforts to reduce use of these interventions should focus on both the frequency and duration of seclusion events. Corrective actions applied are: reducing the time for seclusion order renewal from 4 hours to 2 hours; revision of debriefing process is in progress; new protocol and form to guide treatment plan revisions within 72 hours following the event is in place; expanding opportunities for client choice is a priority to be monitored and tracked in monthly administrative reports; education initiatives; increased clinical, supervisory and administrative oversight; the hospital has put forward a proposed tobacco-free campus policy as national data show that tobacco-related issues are often precipitants to restraint/seclusion events in a national sample (smoking/tobacco as significant precursor to restraint/seclusion events was 5% in non-smoking facilities vs. 34% in smoking facilities--7 times more).

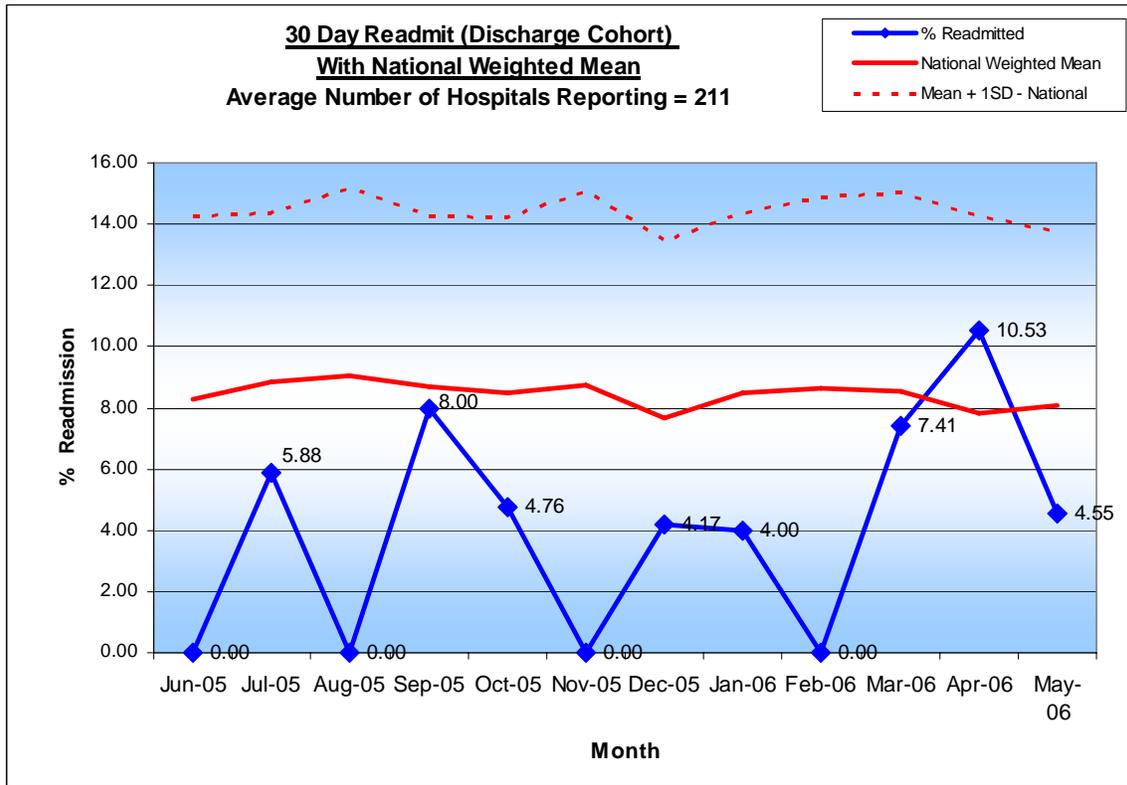


CO-OCCURRING PSYCHIATRIC AND SUBSTANCE ABUSE DISORDERS GRAPH



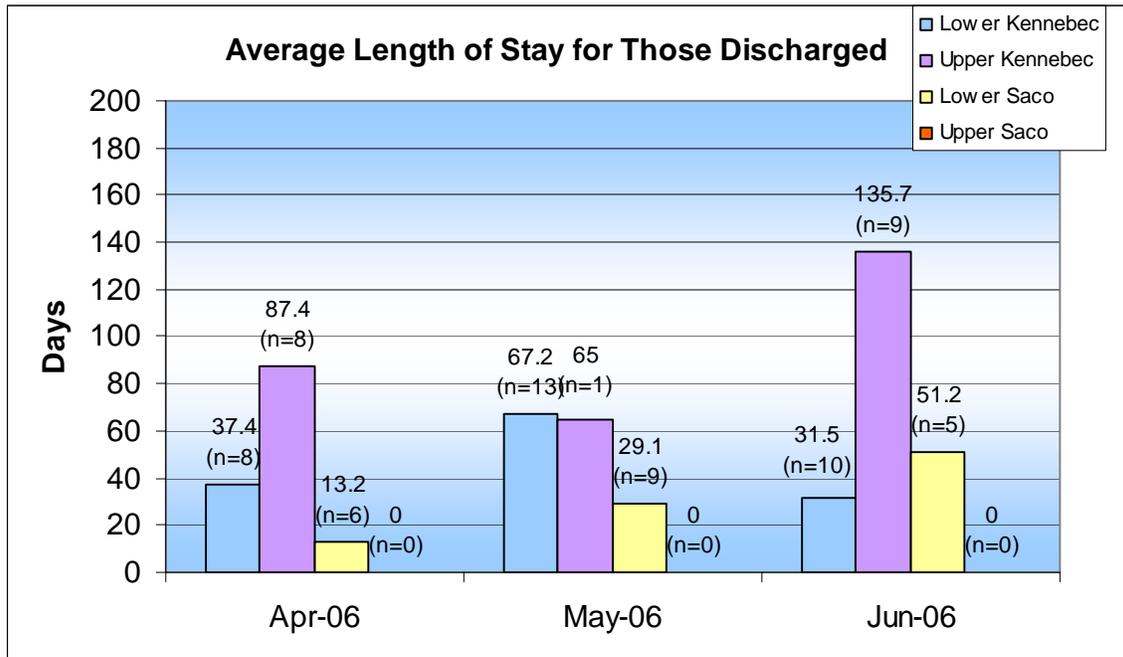
RPC has recently begun a collaborative effort with Spring Harbor Hospital Co-Occurring Disorders providers to contract with RPC to develop a Co-Occurring program. Though RPC is currently a bit above the trend line, this is an indicator current initiatives are working as anticipated; with the advent of this program to help identify and treat clients with co-occurring disorders it should rise above the trend line.

THIRTY DAY RE-ADMISSION RATE



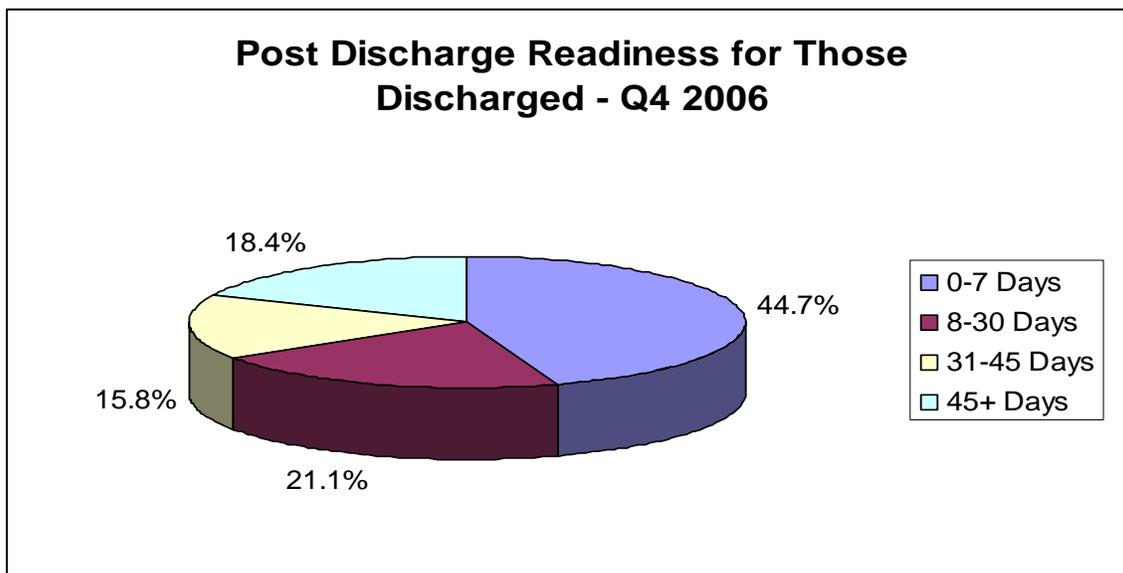
March information of 10.53% is above the mean. There were 2 readmissions of 19 clients who were discharged. One of the two clients who were readmitted was in the 72 hour rapid stabilization bed on the forensic unit who was stabilized and returned to jail, and returned shortly under a different forensic proceeding/status. If this client was not included in the data, Riverview’s rate in March would be 5.5%, and well below the national mean.

Average Length of Stay for Those Clients Discharged



This graph displays the average length of stay by unit of clients who are discharged.

Post Discharge Readiness prior to Discharge (N=38)



This chart displays the percent of clients who were discharged within 7 days of their discharge readiness to be at 44.7%; 8- 30 days post readiness 21.1%; (Cumulative within 30 days is 65.8%) 31-45days at 15.8%; (Cumulative within 45 days is 81.6%) > 45 days post discharge ready 18.4%. (Cumulative beyond 45 days is 100%)

Appendix A- DRC Cases Closed – Fourth Quarter 06