Riverview
PSYCHIATRIC CENTER

PERFORMANCE IMPROVEMENT REPORT

FOURTH QUARTER
April May and June 2008

DAVID PROFFITT, SUPERINTENDENT

07/15/08

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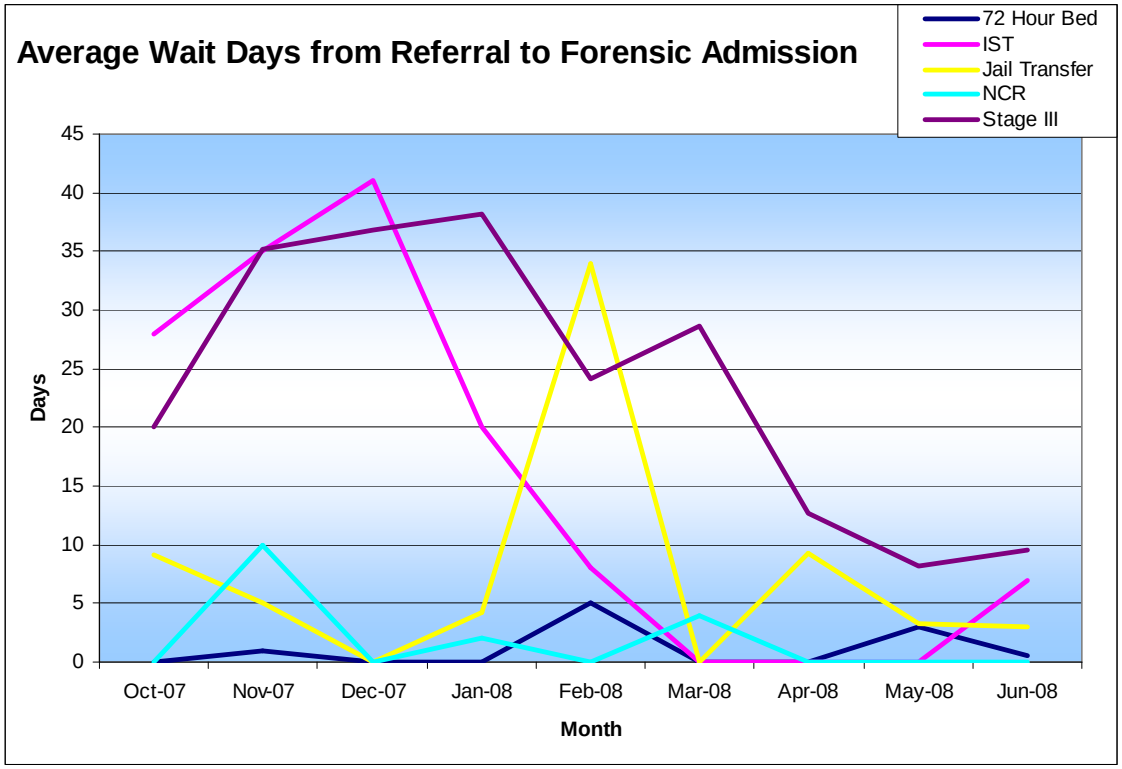
Introduction:

This quarter Riverview clients and staff celebrated the civil admission unit being mechanical restraint free for a year. Significant reductions in Seclusion, mechanical restraint and Hands on Holds in both frequency and duration are also evident through-out Riverview Psychiatric Center.

Significant improvements in the presence of quality indicators in hospital care planning have also been achieved. Emphasis in assessment of these outcomes will shift to the nursing department rather then the Program Service Managers for the next quarter. PSDs shall establish new indicators for the monitoring and enhancement of the therapeutic milieus on each unit.

Additionally, significant enhancement of access to the facility by forensic admission sources has been attained. Flexibility in client management within the hospital, improved coordination with referral sources, and improved coordination with DDPC has allowed this achievement to be manifested.

Percentage of discharges in close proximity to determination of discharge readiness has not met expectations for this quarter and has mildly deteriorated over the last four quarters



Increased focus on staff injury rates, mandated shifts, and client grievances shall be made over next quarter. Additionally the hospital is planning to contract for a survey Specialists to assist in assessing both client and employee satisfaction to assist in the assessment of opportunities to improve.

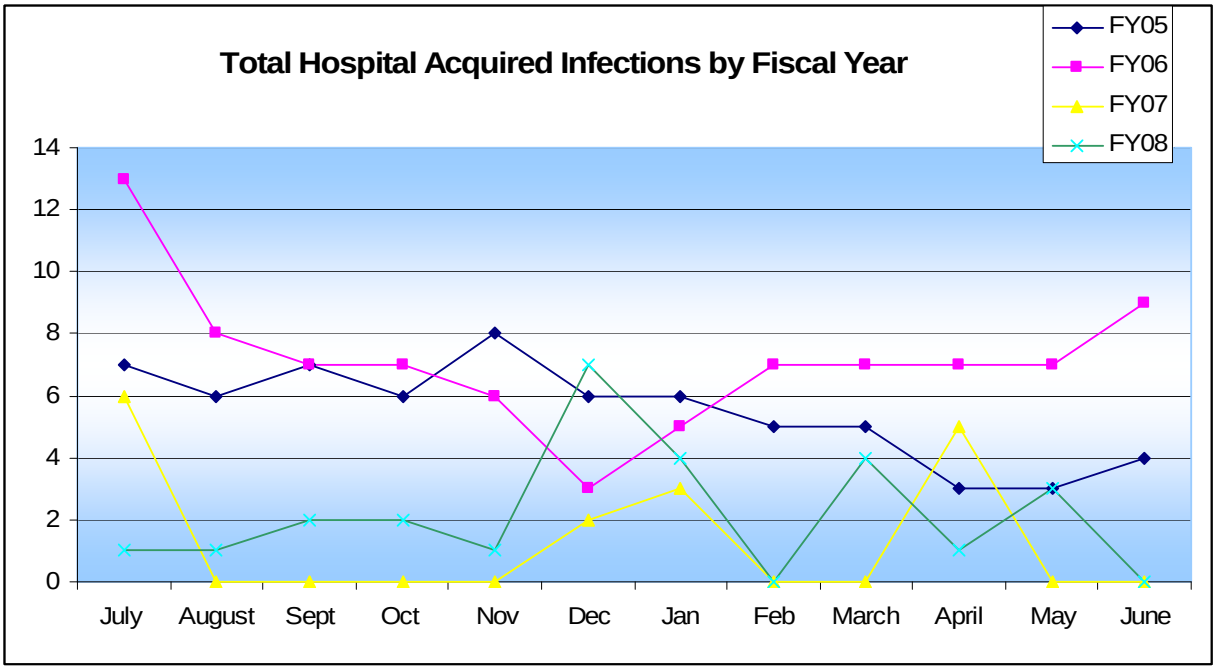
Section I: Departmental Quality Assessment & Performance Improvement

Infection Control
Aspect: Hospital acquired infection
Overall Compliance:
OVERALL COMPLIANCE: Hospital average for 4th quarter 2008

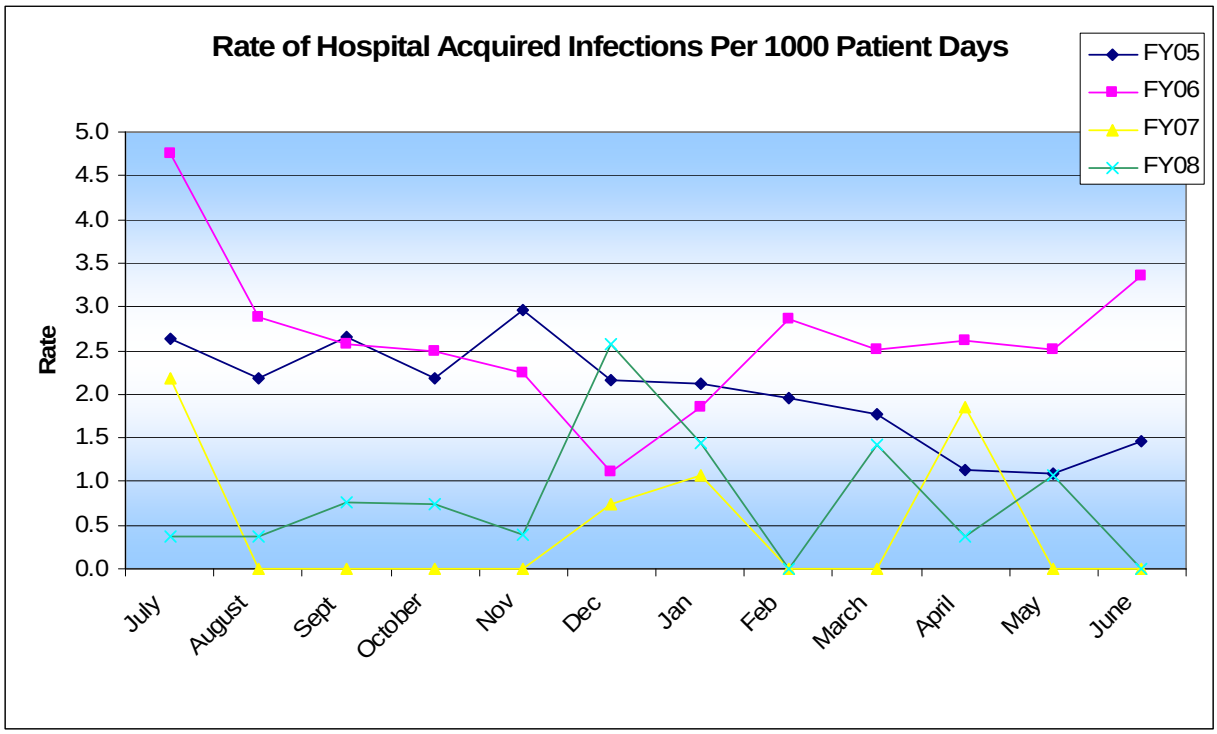
Indicators	Number	Rate
Hospital Acquired (healthcare associated) Infection rate per 1000 patient-days	**4**	**0.49**

Actions:
Hand hygiene and cough hygiene continues to be stressed to staff and clients.
Education for staff and clients regarding cleaning gym equipment after use will continue.

Displayed in the following two graphs are the hospital acquired infection by numbers of client infections per month and then by rate per 1000 patient days.
The goal of the hospital is to stay 5.8% per 1000 patient days or less which has been accomplished for the last four years.



Information Management



Aspect: Confidentiality
Overall compliance: 100%

INDICATORS	COMPLIANCE
1. All client information released from the Health Information department will meet all JCAHO, State, Federal & HIPAA standards.	100 %-no issues in April. 100 %-no issues in May. 100%-no issues in June.
2. All new employees/contract staff will attend confidentiality/HIPAA training.	100 % -7 new employees/contract staff in April. 100% -8 new employees/contract staff in May. 100%-5 new employees/contract staff in June.

3. The Director of Health Information will track the number of confidentiality/privacy issues through incident reports.	There were 0 confidentiality/Privacy-related incident reports in April. There were 0 confidentiality/privacy related-incident reports in May. There were 0 confidentiality/privacy-related incident reports in June.

Actions: The introduction and compliance with current law and HIPAA regulations requires initial and annual training and education as well as policy development at all levels.
The above indicators will continue to be monitored.

Information Management
Aspect: Documentation & Timeliness
Overall compliance: 94%

INDICATORS	COMPLIANCE
1. Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	77 % -There were 26 discharges in April. Of those, 20 were completed by 30 days. 74 %-There were 23 discharges in May. Of those, 17 were completed within 30 days. 96 %-There were 24 discharges in June. Of those, 23 were completed within 30 days.
2. Discharge summaries will be completed within 15 days of discharge.	96 % - 25 out of 26 were completed within 15 days in April. 100 % -23 out of 23 were completed within 15 days in May. 100 % -24 out of 24 were completed within 15 days in June.
3. Forms used in the medical record will be reviewed by the Medical Record Committee.	100%- 0 forms were approved/revised in April (see minutes). 100 %- 10 forms was approved/revised in May (see minutes). 100 %- 8 forms were approved/revised in June (see minutes).
4. Medical transcription will be timely & accurate.	94 %-Out of 210 dictated reports, 198 were completed within 24 hours in April. 100 %-Out of 153 reports, 153 were received within 24 hours in May. 100%-Out of 135 reports, 135 were received within 24 hours in June.

Actions: Weekly lists are distributed to all medical staff, including the Medical Director, along with the Superintendent, Deputy Superintendent of Administrative Services, and the Risk Manager. The first month of the quarter had a completion rate of 96%, but increased to 100% the following two months.

MEDICAL STAFF
Aspect: Review of Suicide Risk Assessment on clients for 4th Quarter FY08
Overall compliance: 88.4 %

Indicator	Findings/Score			Compliance			Avg
	April	May	June	Apr	May	June	
1. Presence or absence of current suicidal ideation/intent is documented.	13 of 14	22 of 23	20 of 20	93%	96%	100%	**96%**
2. Presence or absence of current suicidal plan is documented.	13 of 14	23 of 23	20 of 20	93%	100%	100%	**98%**
3. Presence or absence of current suicidal command hallucinations is documented.	11 of 14	22 of 23	19 or 20	79%	96%	95%	**90%**
4. Presence or absence of current feelings of hopelessness/ helpless-ness is documented	11 of 14	23 of 23	20 of 20	79%	100%	100%	**93%**
5. Presence or absence of prior suicide attempts is documented.	7 of 14	14 of 23	17 of 20	50%	61%	85%	**65%**

Actions: Ongoing feedback was given to individual providers, by the Medical Director, over the quarter resulting in improved performance all around. The quality of suicide risk assessment documentation has improved.
Director of Performance Improvement will send a reminder to all providers to document prior suicide attempts during admission psychiatric assessment by July 15th, 2008.

Nursing
Aspect: Seclusion and Restraint Related to Staffing Effectiveness
Compliance: 100%

Indicators	Findings
Seclusion/Restraint related to staffing effectiveness:	
1. Staff mix appropriate	57 of 57
2. Staffing numbers within appropriate acuity level for unit	57 of 57
3. Debriefing completed	57 of 57

4. Dr. Orders	57 of 57

Actions: None at this time will continue to monitor.

A new staffing effectiveness indicator will be added to monitor staff levels when there is an injury. Overall staff injuries are monitored by Risk Management and Human Resources for direct care and by Human Resources' and Environment of Care for staff injuries due to the environment. Injuries are decreasing and the staffing office indicates staffing numbers are within the appropriate acuity level for the units.

Nursing
Aspect: Redlining
Compliance: Redlining 99%

Indicators-Redlining	Findings	Compliance
Lower Kennebec	275 of 276	100%
Upper Kennebec	275 of 276	100%
Lower Saco	269 of 276	97%
Upper Saco	272 of 276	99%

Actions: The two ADONs will monitor the Redlining checks daily to assure compliance.
The evening and night NOD will continue to check with the charge nurse on each unit and report on the progress of the redlining procedure on each unit on the daily nursing report.

Nursing
Aspect: Code cart checks
Compliance: Code cart checks 99%

Indicators-Code Cart Sign Off	Findings	Compliance
1) Lower Kennebec	274 of 276	99%
2) Upper Kennebec	276 of 276	100%
3) Lower Saco	273 of 276	99%
4) Upper Saco	276 of 276	100%
5) NOD Building Control	273 of 276	99%
6) NOD Staff Room I 580	274 of 276	99%

Actions: Continue to monitor the code carts on the shift report as an extra reminder for nursing to complete this task. The on coming Nursing Supervisor and ADONs have been checking Room I-580 to make it a part of their shift report, this too needs to continue. Executive nurses have been checking the carts on the 7-3 shift in building control and room 1580. Due to their absence there has been inconsistency in schedule. Director of Nursing will make a schedule for those two carts to be checked. Code carts are used in emergency situations and must be complete and ready to use. Code cart checking will continue to be reviewed with the nurse who is responsible for narcotic count and key change during each shift change.
Nurses will be thanked for their diligence in completing this important task.

Nursing
Aspect: Pain Management
Overall compliance: PRE: 99% POST: 93% OVERALL: 96%

Aspect		Findings	Compliance
Preadministration	Assessed using pain scale	895 of 900	99%
Post-administration	Assessed using pain scale	833 of 900	93%

Actions:
Continue to track this indicator and strive for increase in post assessment in the next quarter. The two ADONs will continue to work with unit nursing staff to assure that this is done more consistently.

NURSING 4th Quarter SFY 2008
Aspect: Chart Review
Overall compliance: 74%

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	93 of 138	67%
2. MHW notes cosigned by RN	64 of 75	85%
3. STGs/Interventions are written, dated and numbered.	118 of 138	86%
4. STGs are measureable and observable	11 of 138	80%
5. STGs/Interventions are modified / met as appropriate.	124 of 138	90%
6. STGs/Interventions tie directly to documentation.	127 of 138	91%
7. Weekly Summary note completed.	26 of 133	20%

Actions:
- The nurses who audit the charts will continue to educate unit nurses.
- The unit RNs will audit 1 chart per RN and discuss during supervision. (This was not done last

quarter but will be done this quarter)

- PSD/ Nurse IV will discuss and review chart audit results at staff meetings.
- The RN IVs will ascertain if Unit Nurses are aware of documentation requirements and review with each using the CSP manual and nursing documentation policy.
- Documentation education and expectations will continue in areas needing attention.

PSD

Aspect – **Treatment Plan**

Indicator	Compliance
1. Evidence of ***initial treatment plan*** (minimum of one Safety STG & one Treatment STG each having minimum of two interventions) is in place within 24 hours of admission.	100%
2. The Presenting Problem of the CSP identifies ***specific client symptoms, stated in behavioral terms***, causing admission (identifies any functional behavioral collapse)	100%
3 The CSP incorporates for treatment, all ***"active" client needs/problems*** obtained through the assessment process. ("active" as designated by the priority status "1" on the Integrated Needs / Problem List)	100%
4. Client strengths and preferences which ***can be utilized*** to achieve / enhance treatment outcomes are identified. (should be evident within the interventions)	100%
5. A ***Suicide Assessment*** is done upon admission by the physician / designee	97%
6. A ***Suicide Assessment of "moderate or high risk"*** is incorporated into the Safety Plan within 8 hours of admission.	93%
7. The CSP has a ***"Safety Goal"***, based on identified individual risks, stated in observable and behavioral terms.	100%
8. The CSP has at a minimum one ***"Treatment Goal"*** based on individual assessed needs to reduce or eliminate symptom or illness stated in observable and measurable terms.	100%
9. The CSP has at a minimum one ***"Rehabilitation Goal"*** based on assessed needs to improve self selected value roles, stated in observable and measurable terms.	97%
10. The CSP has at a minimum one ***"Transition Goal"*** based on assessed needs and reflecting client preferences stated in observable and measurable terms.	90%
11. Each CSP goal has a minimum of ***two stepped STGs***, which should reasonably lead to goal attainment, stated in clear client based behavioral terms, which are observable and measurable.	100%
12. Interventions are designated for each STG, that reasonably lead to attainment of the STG.	100%
13. Each Intervention states ***what the intervention is, how often it occurs, what the purpose is and who provides it.***	100%
14. An individual is identified (***responsible***) by name to monitor/ document the effectiveness of each intervention (progress toward or away from STG).	100%

15. The CSP is ***properly authenticated*** by signature AND date, of treatment team members, no later then 7 days from the date of admission. Identify participants below: (a) MD (b) RN (c) SW (d) Client / Guardian	97% 100% 100% 100% 90%
16. CSP has any assessed ***functional skill deficits*** including ***present Level of Support*** and ***Level of Support to be attained***	100%

30 charts reviewed.

ACTIONS:

1) Nursing staff will receive training from PSDs and RN4s on tracing the TASR and making sure that it gets incorporated into the CSP if moderate or high.

PSD
Aspect **- Integrated Summary**

Indicator	Compliance
1. ***Integrated Summary Note*** is documented in the medical record the day of CSP meeting.	100%
2. Summary briefly identifies ***findings of assessments / needs*** (MD/RN/Rehab/SW/Psychology).	100%
3. Summary identifies ***NEEDS not to be addressed at this time*** and why (deferred as denoted by "2" priority status on the Integrated Needs / Problem List.)	N/A none deferred
4. Summary describes ***client preferences*** utilized in service planning.	100%
5. Summary identifies ***predicted community placement***.	100%
6. Summary identifies ***additional assessment/ evaluations or services*** to be sought.	100%
7. Summary describes ***level of client participation*** in planning service.	100%

15 Records reviewed

ACTIONS:
None instituted at this time

PSD
Aspect **– Service Plan Reviews**

Indicators	Compliance
1. At a minimum ***review is completed within 14 days*** of last review for first 6 months or within the last 30 days for hospitalizations of over 6 months.	100%
2. ***Within 72 hours*** of the use of (a) seclusion, (b) restraint, (c) episode of	100%

violence, or (d) transfer a service plan review is completed.	
3. The ***review participants*** are documented (a***) MD***** (b) ***RN***** (c) ***SW***** (d) ***Client/ Guardian***** ** ***MANDATORY***	93%
4. A ***behavioral description of client behavior related to each goal*** area is documented, supporting whether the goal was met or not "AEB"= as evidenced by (can be on the review form itself or the progress note as long as it is in narrative form)	97%
5. ***Client's self-assessment of effectiveness*** of current plan is documented.	93%
6. Evidence of ***positive client progress*** related to each goal is documented.	93%
7. The ***CSP is modified*** as a result of the review, as evidenced by target dates addressed as met or extended and dates changed. May also be evidenced by the addition or modification of STGs.	90%
8. ***Client level of participation*** in the service plan review is documented	100%
9. ***Client's current BMI*** in the service plan review has improved or maintained at optimal.	77%

32 Reviews

ACTIONS:

1. Director of Nursing shall ensure a process that BMI is recorded and tracked on the nursing cardex.
2. Deputy Superintendent of clinical Services shall work with Clinical Council to develop care pathways for addressing client characteristic of high BMI for Executive Medical Staff approval by 8-30-08.
3. Director of Rehabilitation shall establish a mechanism to monitor unit exercise equipment utilization on a monthly basis by 8-15-08.
4. Program Service Directors shall address in each Community Meeting through out next reporting period opportunities available for client exercise.

PSD

Aspect - **Active Treatment**

Indicator	Compliance
1. CSP has, and documentation in progress notes and or flow sheets demonstrate ***identified functional need/s*** (Space maintenance / hygiene / clothes care / time management / self expression) [nursing assessment and care plan] ***including present Level of Support and what Level of support is the goal.***	97%
2. Progress notes / flow sheets document ***a level of functional skill support provided, consistent with the identified*** area of need, delivered within last 24 hours.	72% 10% LK

3. Documentation demonstrates that the client ***attended all assigned psycho-social-educational interventions within last 24 hours.***	47%
4. A ***minimum of three psychosocial educational interventions are assigned daily.***	95%
5. A ***minimum of four groups is prescribed for the weekend***.	41%
6. The client is ***able to state what his assigned psycho-social-educational interventions are and why they have been assigned?***	47%
7. The client can ***correctly identify assigned RN and MHW***.	70% LK 10%
8. The medical record ***documents the clients active participation in Morning Meeting within the last 24 hours***	83% 10% - UK
9. The client can ***identify personally effective distress tolerance mechanisms available within the milieu.***	88%
10. ***Level and quality of client's use of leisure within the milieu*** are documented in the medical record within the last 7 days.	97%
11. ***Level and quality of social interactions*** within the milieu are documented in the medical record over the last 7 days.	94%

32 per month

ACTIONS:

1. PSD will work with Treatment Team Coordinator to ensure that all clients are treatment planned for weekend groups.
2. Each unit thought the Community Meeting process, shall develop a specific observable process to encourage all clients attend assigned psycho-social-educational interventions.
3. Milieu managers shall establish a recommended Mental health Worker procedure for educating clients concerning assigned groups on a daily basis and initiate training on procedure by 8-15-08.
4. Program Services Director of Upper Kennebec shall ensure a welcoming process to encourage client participation in morning meetings is executed by 7-15-08.
5. RN4's shall ensure all unit mental health workers are trained in documentation flow sheet to capture clients participation in unit activities (including morning meeting) and level of functional supports.

PEER SUPPORT

Aspect: Integration of Peer Specialists into client care

OVERALL COMPLIANCE: 86%

Indicators	Compliance	Findings
1. Attendance at Comprehensive Treatment Team meetings.	469 of 502	93%
2. Grievances responded to by RPC on time.	185 of 326	57%
3. Attendance at Service Integration meetings.	61 of 61	100%
4. Contact during admission.	73 of 73	100%
5. Grievances responded to by peer support on time.	326 of 326	100%
6. Client satisfaction survey completed.	21 of 35	60%

ACTIONS:

1. Peer Specialists will continue to track Comprehensive Treatment Team Meeting attendance and reasons for not attending in order to problem solve ways to address the reasons for missed meetings.
2. A part-time peer specialist will be assigned to the lower units to assist in coverage of team meetings.
3. Mandatory training for peer specialists will be arranged to allow for availability of a peer specialist to attend meetings.
4. Peer Specialists will learn ways to elicit reasons for clients refusing to complete satisfaction surveys.
5. Changes to the "Client Grievance/Concern/Suggestion" policy are being considered to allow for an additional step in the compliant process to reduce the number of grievances.
6. PSD with late grievances will report weekly on grievance resolution progress to avoid being late in the future.
7. Risk Manager will continue to send emails and call PSD to remind of due grievances.

Client Satisfaction Survey
Aspect: Client satisfaction with care
Overall compliance: 89%

Indicators	Findings		+/-
1. Did anyone tell you about your rights?	15 of 19	79%	+8%
2. Has anyone talked to you about the kinds of services that are available to you?	14 of 19	74%	0%
3. Are you told ahead of time of changes in your privileges, appointments, or daily routines?	12 of 20	60%	+14%
4. Do you know someone who can help you get what you want or stand up for your rights?	16 of 20	80%	-7%
5. Do you have a worker in the community?	9 of 17	53%	-6%
6. Has your worker from the community visited or contacted you since you have been in the hospital?	7 of 11	64%	+1%
7. Do you know how to get in touch with your worker from the community if you need to?	10 of 11	91%	+38%
8. Do you have a community treatment plan?	13 of 21	62%	+19%
9. I feel more able to deal with crisis.	18 of 18	100 %	+32%
10. I am not as bothered by my symptoms.	11 of 19	58%	+10%
11. I am better able to care for myself.	15 of 19	79%	-3%
12. I get along better with people.	17 of 18	94%	+29%
13. I am treated with dignity and respect.	16 of 18	89%	+1%
14. I feel comfortable asking questions about my treatment and medications.	16 of 20	80%	-2%
15. I understand how my medication works and the side effects.	15 of 20	75%	-6%
16. I've been told about self-help/peer support and support groups to use after discharge.	14 of 20	70%	-8%
17. I've been told about the benefits and risks of my medication.	14 of 20	70%	-2%
18. I have been given information to help me understand and deal with my illness.	16 of 18	89%	+19%
19. I feel my other medical conditions are being treated.	15 of 19	79%	+34%

20. My pain was managed.	10 of 19	53%	-6%
21. I feel free to make complaints and suggestions.	18 of 20	90%	-1%
22. I feel my right to refuse medication or treatment is respected.	18 of 20	90%	+44%
23. I help in planning my discharge.	17 of 20	85%	+9%
24. I feel I have had enough privacy in the hospital.	15 of 20	75%	+4%
25. I feel safe while at Riverview?	16 of 19	84%	+9%
26. If I had a choice of hospitals, I would choose this one.	14 of 19	74%	+6%

Overall satisfaction with care was highest on Lower Saco at 84%. Lower Kennebec had the lowest satisfaction level at 55%, while Upper Saco and Upper Kennebec were 79% and 77% respectively. Satisfaction dropped 13% from last quarter on Lower Kennebec while it increased 1% on Upper Kennebec and 14% on Lower Saco. There was no data on Upper Saco last quarter.

ACTIONS:

1. Peer support will encourage and support clients to voice their concerns and needs with their treatment teams regarding these aspects of care.
2. Peer support will encourage clients to use community meetings as a forum for addressing concerns.
3. Peer support will provide feedback to RPC about client concerns/suggestions.
4. PSD's will initiate unit procedures to ensure clients are routinely informed of daily schedules and privilege changes.
5. Director of Social Work Services shall implement a procedure to ensure (as consented to) that community support staff are routinely contacted and informed of course of treatment, treatment planning meetings and invited to visit or contact clients to maintain therapeutic relationships.
6. Nursing services will implement a routine procedure to ensure clients have the opportunity to discuss their symptoms and are educated on ways to alleviate such symptoms a minimum of weekly with their assigned primary nurse.

Unit: ALL
Accountability Area: Social Work
Aspect: Preliminary Continuity of Care Meeting and Comprehensive Psychosocial Assessments
Overall Compliance: 77%

Indicators	Findings	Compliance
1. Preliminary Continuity of Care meeting completed by end of 3rd day	27/30	90%
2. Service Integration form completed by the end of the 3rd day	30/30	100%
2a. Director of Social Services reviews all readmissions occurring within 60 days of the last discharge and for each client who spent fewer than 30 days in the community, evaluated the circumstances of the readmission to determine an indicated need for resources or a change in treatment and discharge planning or the need for alternative resources. In cases where	5/5	100%

such a need or change was indicated that corrective action was taken.		
3a. **Client Participation** in Preliminary Continuity of Care meeting.	27/30	90%
3b. **CCM Participation** in Preliminary Continuity of Care meeting.	30/30	100%
3c. Client's **Family Member and/or Natural Support (e.g., peer support, advocacy, attorney) Participation** in Preliminary Continuity of Care meeting.	30/30	100%
3d. **Community Provider Participation** in Preliminary Continuity of Care meeting.	5/30	16%
3e. **Correctional Personnel Participation** in Preliminary Continuity of Care Meeting.	0/15	0%
4a. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	25/30	83%
4b. Annual Psychosocial Assessment completed and current in chart	28/30	93%

Actions:
Indicators 1 and 2: These areas will continue to be focused on and monitored. Clients with high acuity at admission will continue to pose a challenge to this aspect area and will require increased attention and engagement.
Indicator 3d: This indicator area remains a challenge for the department in part because the rapid timeframe in which the Service Integration Meeting occurs causes challenges in the notification process with providers. We have a greater level of participation with providers during the initial and on-going treatment planning process. . In some instances clients declined to sign releases for assigned community providers to attend and participate in the initial Service Integration Meeting. On several occasions providers could not attend but had given input to the assigned CCM or had made arrangements to attend the 7 day meeting. The turn around time for this initial meeting is very short and often providers are not able to make this short deadline for attendance. We have also struggled with Community Systems issues that continue to impact the attendance of providers at all types of meetings that occur during a client's treatment course. We continue to have conversations with department stakeholders, consent decree coordinators and team leaders to address this on-going issue.
Indicator 3e: This is an area that has had traditionally low indicator numbers most quarters. The Director will continue to seek support from the MH Team Leaders and the new ICM staff who have been recently assigned to the various jails to address this ongoing issue and need area. We have had increased contact with jail assigned ICM staff over the course of treatment.
Indicator 4: This area will continue to be monitored through individual and group supervision and on-going chart audits.

Unit: Forensic
Accountability Area: Social Work
Aspect: Institutional and Annual Reports
Overall Compliance: 66%

Indicators	Findings	Compliance

1. As part of the Individualized Treatment Meeting all Forensic clients will be prompted to indicate the initiation of a court petition.	79/81	97%
2. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	0/9	0%
3. The assigned **CCM** will review the new court order with the client and document the meeting in a progress note or treatment team note.	2/2	100%
4. Reports to the commissioner for all NCR clients are submitted annually.	N/A	N/A

Actions: Indicator 2 : The Forensic Team members along with Dr. Nelson meet to discuss the issue of meeting the deadline of 10 business days and the issues the team has had over this quarter. We discussed streamlining the process as it relates to the structure and content of each report, creating Institutional Report templates, and a common drive to share information without delay in regards to the editing process. We also clarified the roles of each team member in regard to who had responsibility for the various components of the report and the identified expectation each member has with the process. The team agreed in consensus to adopt this improved process and make the necessary changes to meet this expectation area.

Unit: ALL
Accountability Area: Social Work
Aspect: Client Discharge Plan Report/Referrals
Overall Compliance: 98%

Indicators	Findings	Compliance
1. The Client Discharge Plan Report will be updated/reviewed by each **Social Worker minimally one time per week.**	12/13	92%
2.The Client Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	13/13	100%
2a. The Client Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	13/13	100%
3. Each week the Social Work team and Director will meet and discuss current housing options provided by the respective regions and prioritize referrals.	13/13	100%

Actions: None needed.

Unit: ALL
Accountability Area: Social Work
Aspect: TREATMENT PLANS AND PROGRESS NOTES
Overall Compliance: 92%

Indicators	Findings	Compliance
1. Progress notes in GAP/Incidental format will indicate at minimum weekly 1:1 meeting with all clients on assigned **CCM** caseload.	41/45	91%
2. On Upper Saco progress notes in GAP/Incidental format will indicate at minimum bi- weekly 1:1 meeting with all clients on assigned **CCM** caseload	15/15	100%
3. Treatment plans will have measurable goals and interventions listing client strengths and areas of need related to transition to the community or transition back to a correctional facility.	51/60	85%

Actions:
Indicator 3: Continued monitoring of the process with unit teams and focus on engagement/strengths based treatment planning. Director is working with the team to develop a treatment plan template to utilize as it relates to transition discharge. In addition a focus going forward will be to integrating the Stage of Change Language into social work treatment plans as it relates to understanding the issues that occur in the community that lead to hospitalization.

PSYCHOLOGY

ASPECT: CO-OCCURING DISORDERS INTEGRATION

Indicators	Findings	Compliance
1. There is evidence of an integrated co-occurring comprehensive service plan for identified clients.	22/38	58%
2. There is evidence of "stage of Change" documented in client comprehensive service plan	2/59	3%
3. There is documentation of identified client's participation in co-occurring treatment.	6/38	16%
4. Positive change in staff practices as measured by the COMPASS (Co-Morbidity Program Audit and Self-Survey for Behavioral Health Services) on each clinical unit and ACT team and Capital Clinic	No report this quarter	No report this quarter

Actions:
1 & 3 Consult with coaches group and clinical leaders to identify educational gaps and to identify a rapid cycle change process. Met with Med staff to address findings.
2. Meet with Social Work staff to move stage of change assessment into CSP.
4. Identify staff to substitute for absent Co-occurring coordinator to work with unit professional staff in clarifying unit specific goals and actions.

Co-Occurring Disorders Consumer Satisfaction	Findings	Compliance
5. Consumer Satisfaction Survey indicates clients were "encouraged to talk about and work on any mental health and alcohol and drug issues at the	15/6	100%

same time"		
6. Consumer satisfaction survey indicates that since beginning treatment with us, their condition is better.	21/25	84%
7. Consumer satisfaction survey reports client satisfaction with current treatment experience is better than with any other previous treatment experiences.	15/25	60%
8. Percent of clients with co-occurring disorders as reported by NASMHPD	53% Nat. Mean 32% (Feb.,Mar.April)	53%

Action
5. Survey question to be changed for next quarter.
6-7 Efforts to increase the number of surveys this quarter was successful. Group leaders will be instructed to focus on client perceptions and feedback to clients in co-occurring groups.
8. Monitor for continued compliance.

Indicators	Findings	Compliance
1. Psychologist short-term goals on CSP are measurable and time limited.	20/30	67%
2. Psychologist progress notes indicate treatment offered as prescribed on CSP.	19/30	63%
3. Psychologist progress notes indicate client's understanding of goals and client self-assessment of progress.	18/30	60%

Actions: For all three indicators:
1. Individual psychologists who are not meeting expectations have been identified. Supervisor has reviewed performance expectations in weekly supervision and in annual evaluation.
2. Three new staff (counselor & interns) will be added to chart review next quarter. Review of goals and staff education to be conducted 7/10/08.

Safety
Aspect: Life Safety 4th quarter SFY2008
Overall Compliance: 99%

Indicators	Findings	Compliance
1. Total number of staff assigned to Upper Saco and Upper Kennebec who have received training with the evacuation chair.	66/66	100%

2. Total number of staff assigned to Lower Saco and Lower Kennebec who have received training with the evacuation chair.	77/78	99%
3. Total number if staff assigned to the Float Pool who have received training with the evacuation chair.	19/20	95%
4. Total number of fire drills and actual alarms conducted during the quarter compared to the total number of alarm activations required per Life Safety Code, that being (1) drill per shift, per quarter.	3/3	100%
5. Total number of staff who knows what R.A.C.E. stands for.	160/160	100%
6. Total number of staff who knows that if there was a one-on-one or situation requiring one-on-one, i.e. client would not leave room, that they should stay with them.	160/160	100%
7. Total number of staff who knows how to activate the nearest fire alarm pull station.	160/160	100%
8. Total number of staff who knows how to acknowledge the fire alarm or trouble alarm on the enunciator panel.	156/160	97%
9. Total number of staff who knows the emergency number.	160/160	100%
10. Total number of staff who knows what the verbal code is used to announce a fire.	160/160	100%
11. Total number of staff who knows it is necessary to close all doors after checking rooms or areas.	160/160	100%
12. The total number of staff who knows what the acronym, P.A.S.S. stands for.	160/160	100%
13. The total number of staff who knows the locations of the two nearest exits to evacuate away from a fire area	160/160	100%
14. The total number of staff who knows two ways that may be used to move a person who is non-ambulatory to safety.	160/160	100%

Action:
1. Staff who did not have a fire key or emergency sticker, were given one.
2. Annunciator panel training will be added to annual review.

SAFETY
Aspect: Fire Drills Remote Sites

Compliance: 100 %

Indicators	Findings	Compliance
1. Total number of fire drills and actual alarms conducted at Portland Clinic compared to the total number of alarm activations required per Life Safety Code (3) drills per year based on the fact that it is business occupancy.	3 drills	100%

Actions: There are no problems to report at this time.
Continue with Fire drills.

Securitas/RPC Security manager
Month: 4th Quarter FY 08 (April, May, & June)
Accountability Area: Securitas/RPC Security Team
Overall Compliance: 99%/98% (compliance#/possible#)

Indicators	Findings	Compliance
1. Security search/screening of all clients (Forensic & Civil) being admitted to Riverview for treatment. (Total # of admissions screened vs. total # of admissions).	73/73	100%
2. Security Officer "foot patrols" during Open Hospital times. (Total # of "foot patrols" done vs. total # of "foot patrols" to be done.)	1989/2002	98%
3. Security/safety checks done of the "lower" client units during the hours of 8:00 am thru 8:00 pm. (To be done 6 times in this 12 hour period.)	556/546	99%

Actions: The Security Management Team will continue to guide our officers toward operating "daily" in the way of using good time management skills to complete the required numbers for this report. For the near future, there is no need for any type of "corrective action" as long as we are able to stay on course & continue with our diligent work practices.

STAFF DEVELOPMENT
ASPECT: New Employee and Mandatory Training

4th Quarter STFDIQ3SFY08 April, May and June 2008 Staff Development			
Indicator	**Findings**	**Compliance**	**Threshold Percentile**
1. New employees will complete new employee orientation within 60 days of hire.	13 of 13	100%	100 %
2. New employees will complete CPR training within 30 days of hire.	8 of 8	100%	100 %

3. New employees will complete NAPPI training within 60 days of hire.	12 of 12	100%	100 %
4. Riverview staff will attend CPR training bi-annually.	309 of 309 s	100%	100 %
5. Riverview staff will attend NAPPI training annually. Goal to be at 100% by end of fiscal training year 08 on June 30th.	359 of 365	98%	100 %
6. Riverview staff will attend Annual training. Goal is to be at 100% by end of fiscal training year 08 on June 30th.	384 of 384	100%	100 %

Actions: Supervisors of those employees who are not current with their training have been notified and recommendations of counseling were made as well as scheduling them for the next available class. Staff Development has discussed the importance of completion of mandatory training with employees and supervisors. All employees who are currently not up to date in mandatory training are scheduled for the next available class.

STAFF DEVELOPMENT
ASPECT: COMMUNITY PROVIDER TRAINING

Public Education- Standard 34 April May June 2008				
Date	Public Sector	RPC	Total	Topic
4/1/08		5	5	PGR:Seasonal Affective Disorder: A review and new research on cognitive-behavioral therapy.
4/8/08		10	10	PGR:Relationship between depression and heart disease.
4/15/08		9	9	PGR: New Directions in Treatment of ADHD: Dosage and Sequensing Studies of Behavioral, Pharmacological, and Combined Treatments.
4/22/08		6	6	PGR: Imaging Genetics: Exploring the Interplay of Genes, Brain & Behavior in the Pathophysiology of Psychatric Disorders
4/29/08		10	10	PGR: Schizophrenia
4/4/08		5	5	MGR: Temporary Ventricular Assist: A Bridge to the Future
4/11/2008 -		5	5	MGR: The Physician Workforce Crisis. Will DMHC offer an evidenced based response
4/18/2008 -		5	5	MGR: Melanoma Update - 2008
4/25/2008 –		5	5	MGR:Bariatric Surgery: If it was a pill, would you prescribe it.
5/6/08 –		7	7	PGR: New Directions in Treatment of ADHD: Dosage and Sequencing Studies of Behavioral, Pharmacological, and Combined Treatments.

5/13/08 –		10	10	PGR: Antidepressant Medications and Suicidal Behavior
5/20/08 -		6	6	PGR: Rural Substance Abuse: What we know and Don't Know.
5/2/08 -		6	6	MGR: Genetic Testing and Cancer Risk Assessment - The Dartmouth Experience
5/6/08		4	4	MGR: Bestowing Values, Hopes and Life's Lessons: The Spiritual Legacy Traditions
5/16/08		3	3	Special MGR:Resident Research Day
5/23/08		3	3	MGR: Evidence Based Management of Localized and Locally Advanced Adenocarcinoma of the Prostate
5/30/08		5	5	MGR: Why is health so hard? An American public policy mystery
6/3/08		10	10	PGR: Can you Diagnosis and Treat Preschool Children with PTSD?
6/10/08		5	5	PGR: Collaborative chronic care models for bipolar disorder: results of two long-term, multi-site randomized controlled trials
6/17/08	1	4	5	PGR: Trauma through the Eyes of a Young Child: Intervention and Treatment
6/6/08		5	5	MGR: Public reporting and Pay for Performance in Healthcare
6/13/08/08		5	5	MGR: DMEDS, DOM, and DMS: What really happens within our clerkships and fellowships?
6/20/08		6	6	MGR: Hereditary Angiodema: C1 Inhibitor Mutation to Cellular Constipation
6/27/08		4	4	MGR: Evidence Based Public Policy: Lessons from the National Kidney Allocation System
4/8/2008	60		60	Trauma (Crisis & Counseling Group)
4/10/08		29	29	Dr Jennings: A Framework for Healing and Recovery
4/16/2008	25		25	Trauma (UMA group)
5/5/08 & 5/6/08	47	29	76	Healing Self Injury
5/15 & 29/2008		32	32	Mental Health Specialist Training
5/28/08		13	13	Motivational Interviewing
6/10/2008	32		32	Behavior Has Meaning
6/10/2008 -		13	13	Experiential Rehabilitative Techniques
6/19/2008 -		12	12	The Language of Comforting
6/20/2008	22		22	Language Dysfluency & Diagnostic Severity
6/20/2008 -		9	9	Dialectical Behavioral Therapy
6/27/2008	8		8	Dealing with Difficult Behaviors
Various Dates - RPC		52	52	Mental Health Specialist Training
Totals			**527 participants**	**Programs Offered 36**

COMMUNITY FORENSIC ACT TEAM
Aspect: Descriptive Report on various components
4th quarter

CASE MANAGEMENT:

Clients enrolled in the ACT program	
	Number of ACT clients
April, 2008	32
May, 2008	33
June 2008	34

Riverview ACT Team is now serving all but one of the clients previously case managed by their ICM. One client intends to grieve this change of case managers. ACT case management is presently at capacity.

CRISIS MANAGEMENT:

4th Quarter 2008	Client incidents	Hospitalized RPC	Hospitalized Medical
April, 2008	1	1	0
May 2008	2	1	0
June,2008	3	2	1

SUBSTANCE ABUSE:

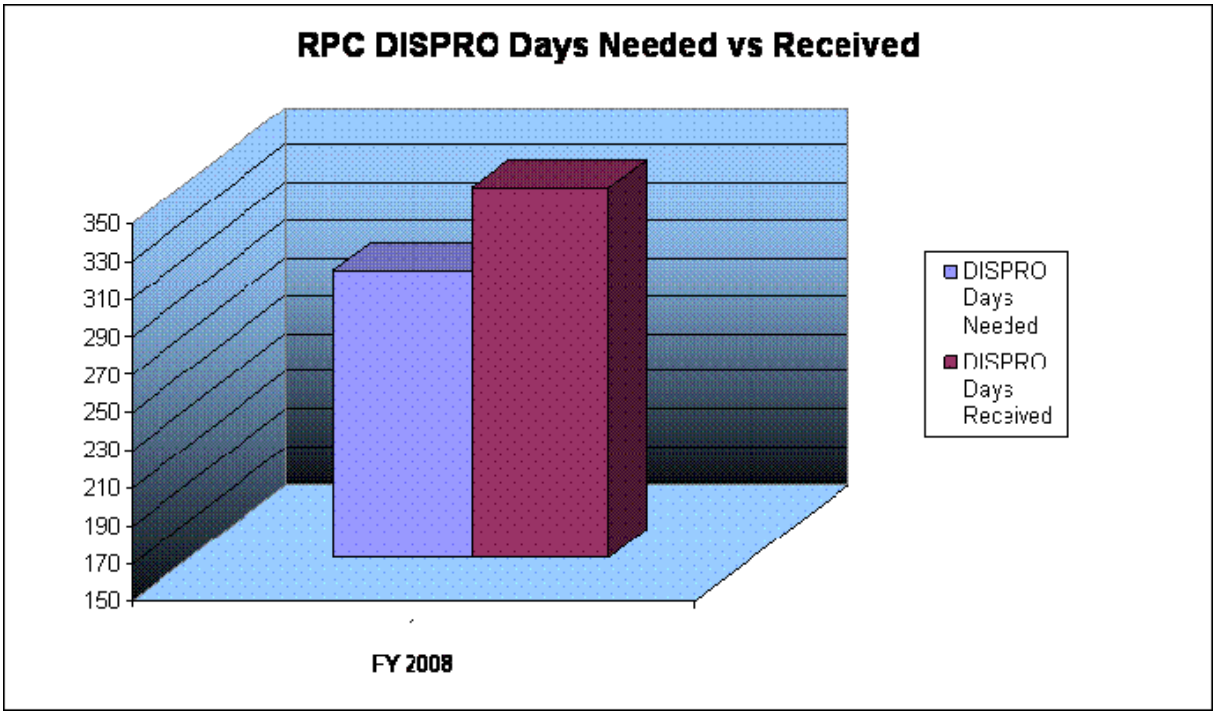
4th Quarter 2008	Client with Substance Abuse as a Clinical Focus	Percent of ACT Clients In SA treatment
April 2008	9	28%
May,2008	9	27%
June,2008	9	26%

ACT Clients Living Situation				
4th Quarter 2008	Clients in Supervised Settings	Clients in own apt. or with family	% of clients Supervised Settings	% of Clients in own home or with family
April, 2008	24	9	75%	28%
May,2008	24	9	72.7%	27%
June, 2008	24	9	70%	26%

VOCATIONAL / EDUCATIONAL:

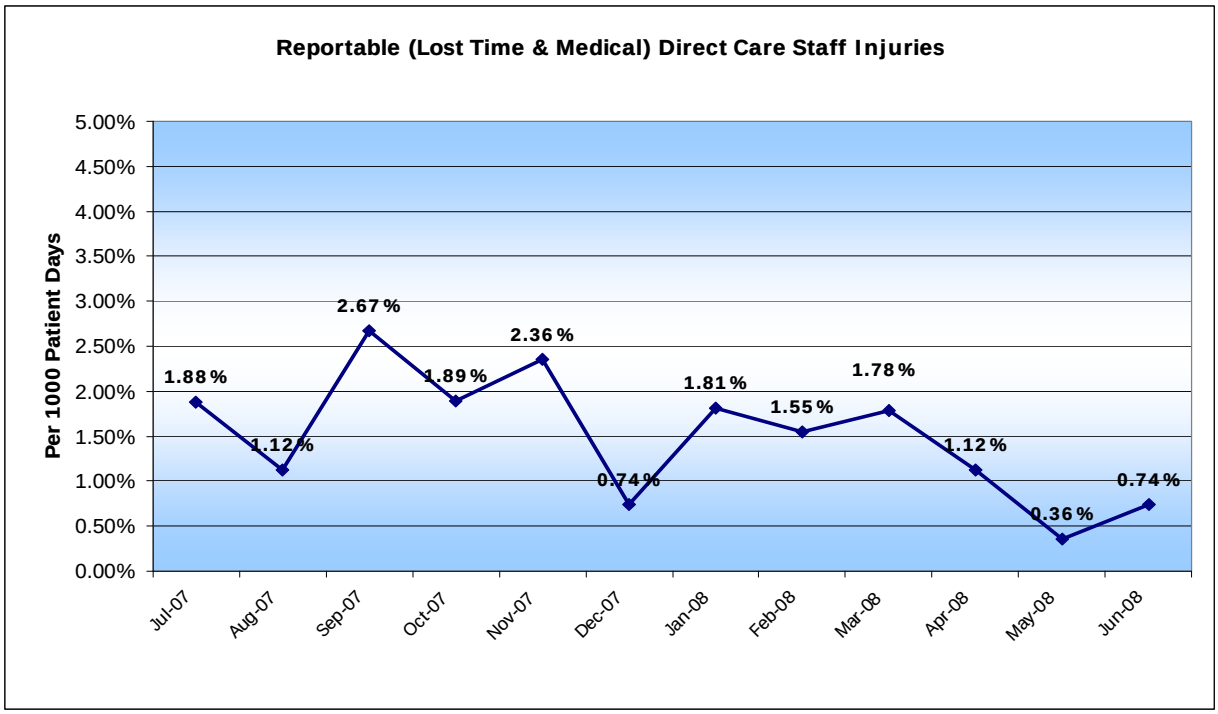
Regarding Clients working or volunteering in the community			
	# Client Community Site Work involved with VOC/ED	# of Client who offer Community Volunteer Services	# Hours worked in Community
April,2008	14	2	1004
May,2008	11	3	752
June,2008	13	3	1168

Section II: Riverview Unique Information
BUDGET
ASPECT: BUDGET INFORMATION



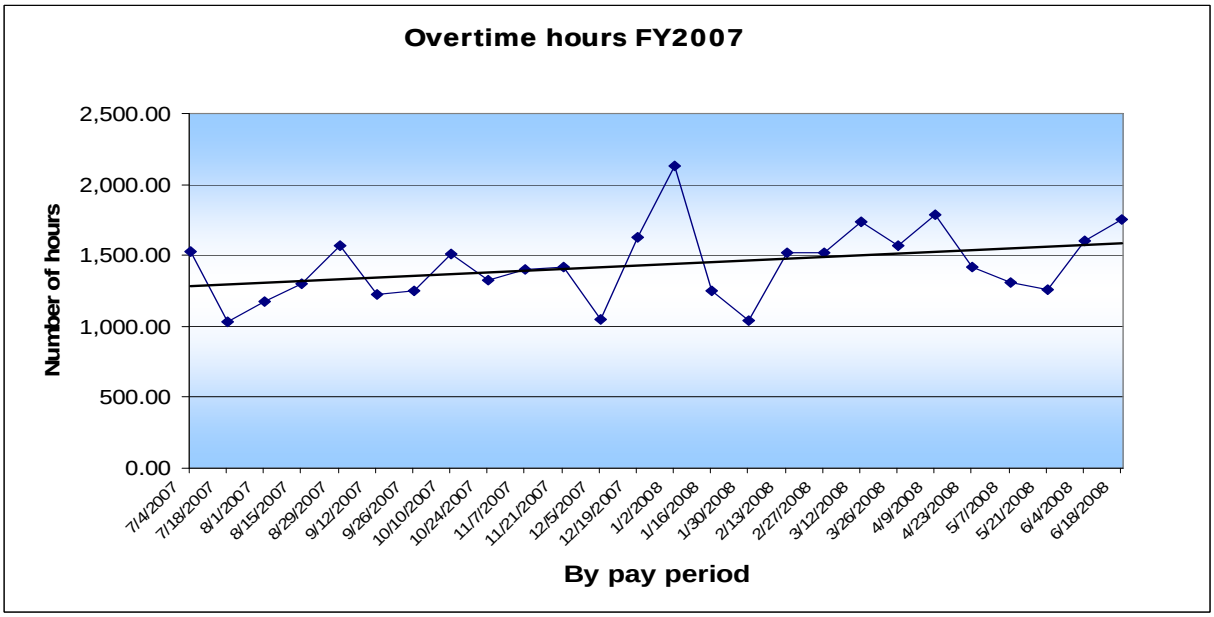
The hospital exceeded the DISPRO Target by 13% securing federal funding.

HUMAN RESOUCES/RISK MANAGEMENT
ASPECT: **Direct Care Staff Injury resulting in lost time & medical care**



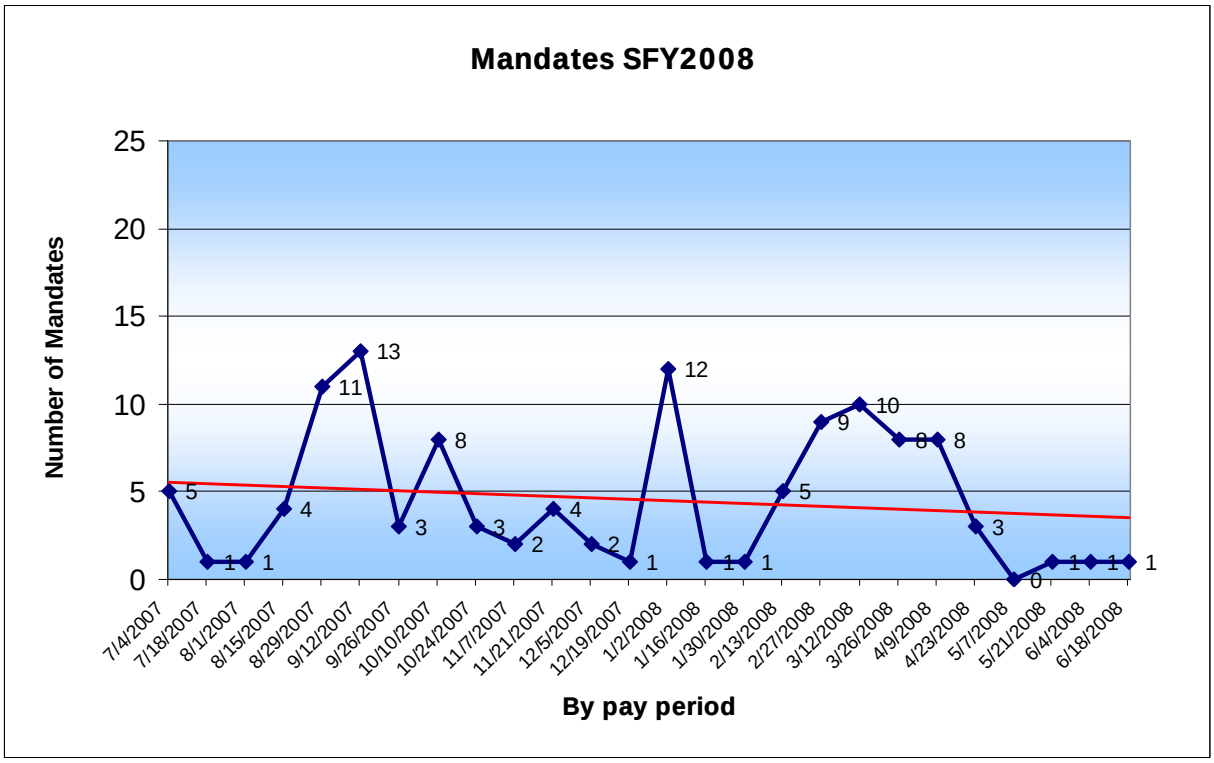
This quarter review reveals that there was a decrease in direct care staff injuries from 1.71% per 1000 patient days last quarter to 0.74% per 1000 patient days this quarter. This number represents (8) direct care staff who sought medical treatment or lost time from work, as compared to (16) last quarter. The two year average is 0.17%.

HUMAN RESOURCES
OVERTIME



Overtime has decreased this quarter as compared to last quarter. Overtime declined from 10,764.00 hours to 9,137.50 hours . As compared to the same quarter last year (April 07 - June 07) we had 7,996.75 hrs of overtime. This quarter we have 9,137.50 hrs of overtime, this represents an 14% increase from last year.

HUMAN RESOURCES
ASPECT: MANDATES



Mandated shifts have decreased this past quarter as compared to last quarter. Mandates declined from 46 last quarter to 14 during this quarter. Last year we had a toal of 7 mandated shifts during this same rating period April 07 - June 07), this year we had 14. This represents a 50% increase from last year.

Management of Human Resources
ASPECT: Timely Performance Evaluations
OVERALL COMPLIANCE: 66.42%

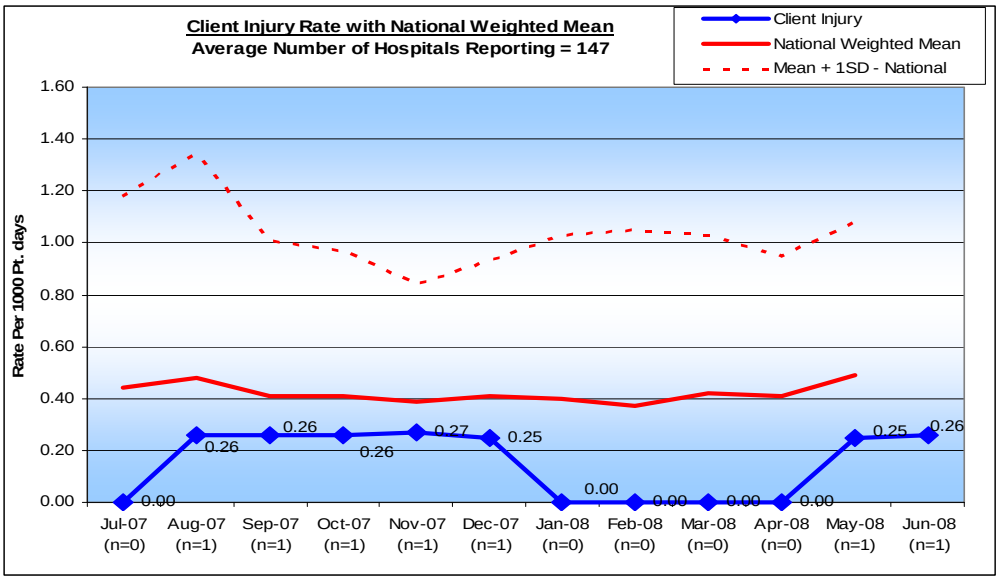
INDICATOR	FINDINGS	
April 2008 (February evals)	16 of 26	61.54%
May 2008 (March evals)	15 of 23	65.22%
June 2008 (April evals)	29 of 40	72.5%

As compared to last quarter (80.65%) this quarter's performance evaluations decreased to 66.42%. As compared to the same quarter last year, 2007, we were at 63.73% compliance. During this quarter 89 performance evaluations were sent out; 60 were received in a timely manner.

Section III: Performance Measurement Trends Compared to National Benchmarks.

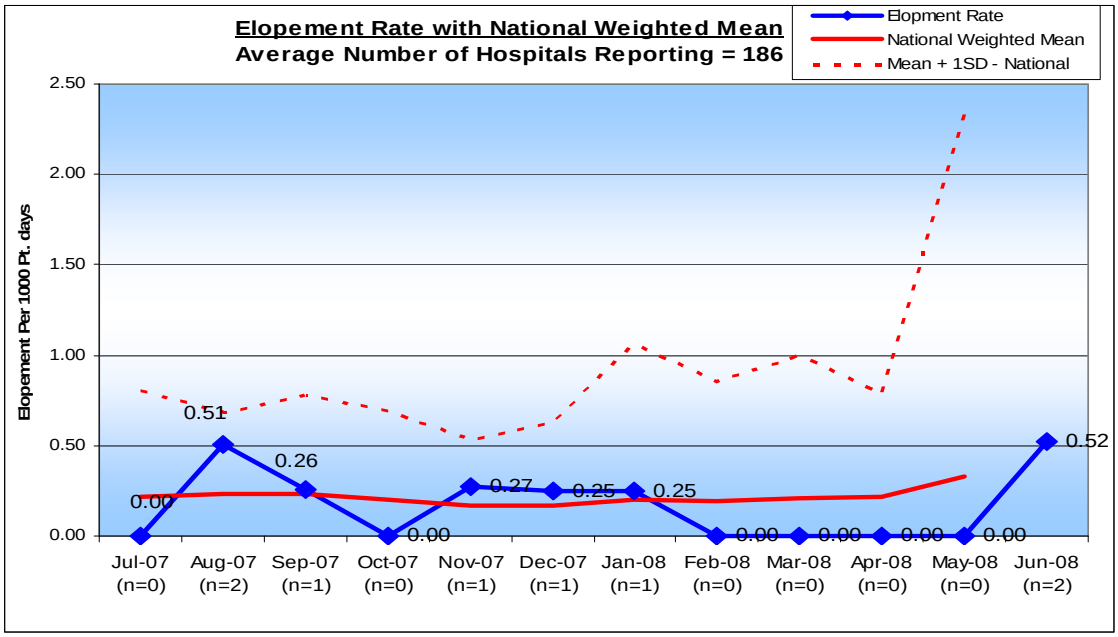
This section contains a number of graphs that compare Riverview Psychiatric Center to a national sample (the range is approximately 75-205 hospital across all aspects) of participating like facilities. Each line graph presents the national weighted mean (solid red line) and the limit of the first standard deviation (dashed red line) 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.

CLIENT INJURY RATE GRAPH



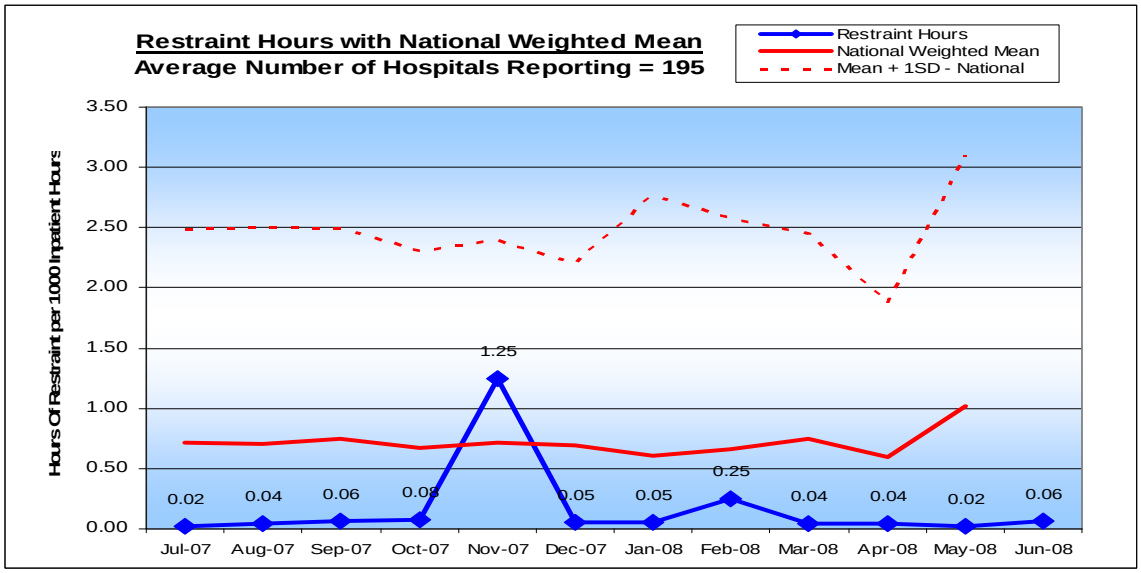
Client Injury Rate considers slips, trips and falls; self-injurious behavior; and client-to-client injury that requires more than first-aid. The numbers of such incidents are low, as shown by the little n under each month. Riverview is well within the 1st standard deviation of the national sample. Please note the sheer number of events at Riverview is very low, between zero and 1 each month. Over the last 3 months reported in this graph, there were 2 injuries requiring more than first aid level of care.

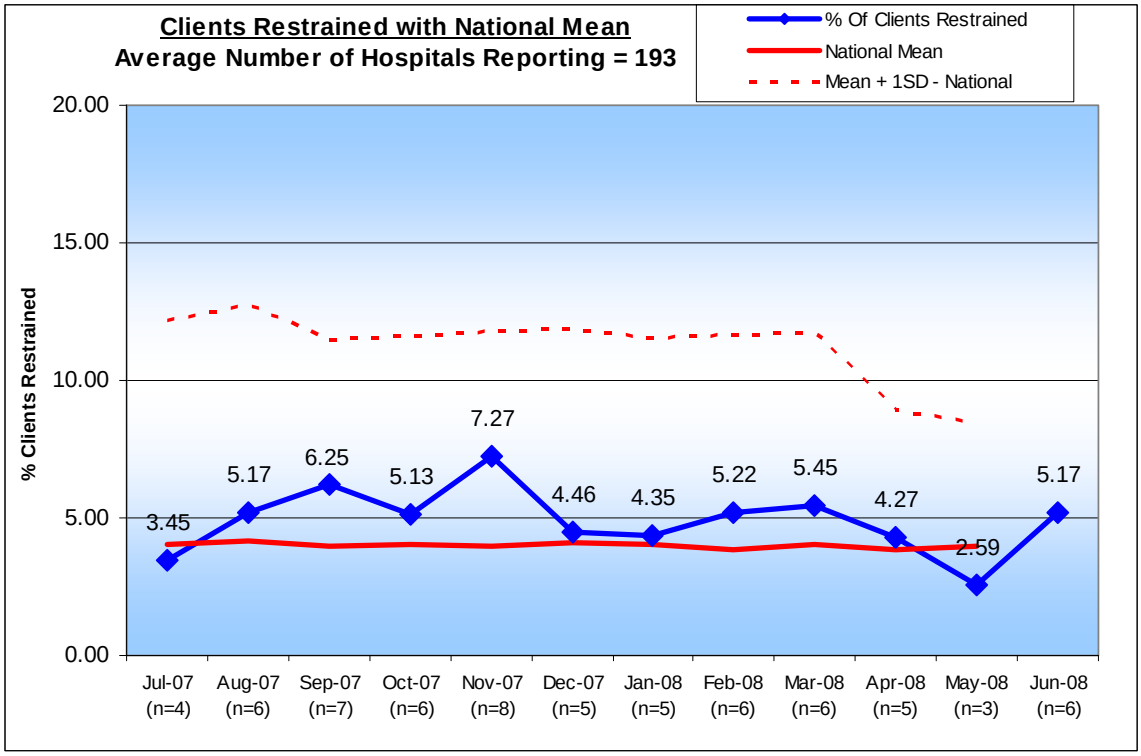
ELOPEMENT RATE GRAPH



Elopement Rate is calculated per 1000 patient days. Elopement is defined as the client not being where expected at any given time, for instance if the client is supposed to return at 8 pm but is late and does not call to report the circumstance the client is considered to have eloped. Elopement risk is evaluated by the treatment team and is treatment planned if necessary to keep the client and the community safe.

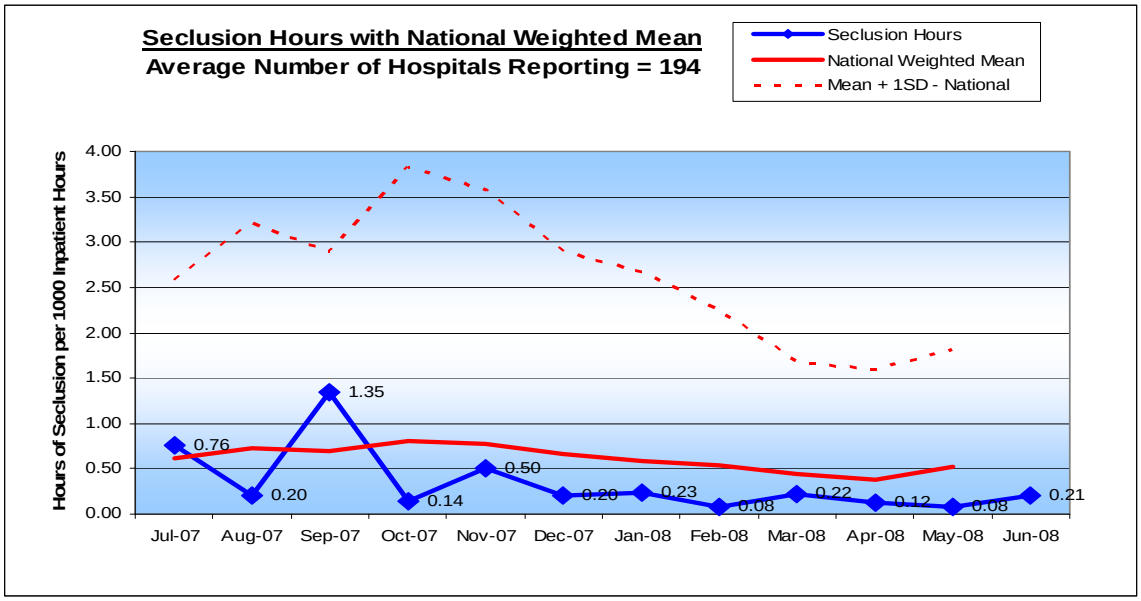
RESTRAINT GRAPHS

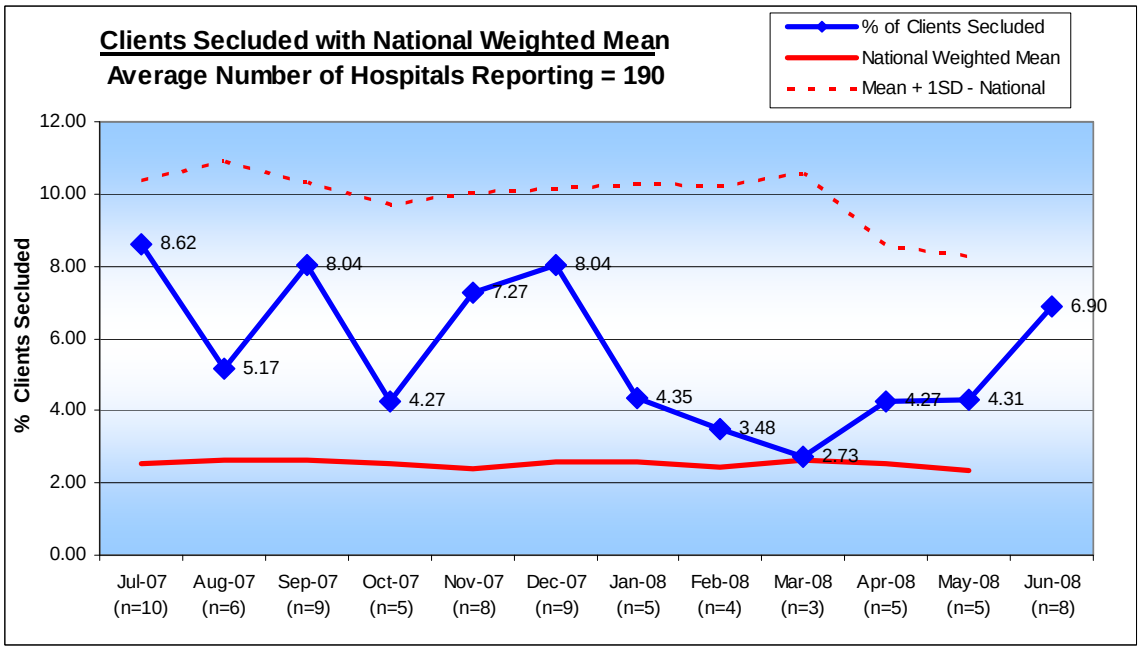




Riverview's rate of clients restrained, although above the statistical mean, is comparable to at least 68% of hospitals in the national sample. The restraint hours (duration) rate is well below the statistical mean, but also comparable to the bulk of hospitals in the national sample. The data would suggest 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; 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.

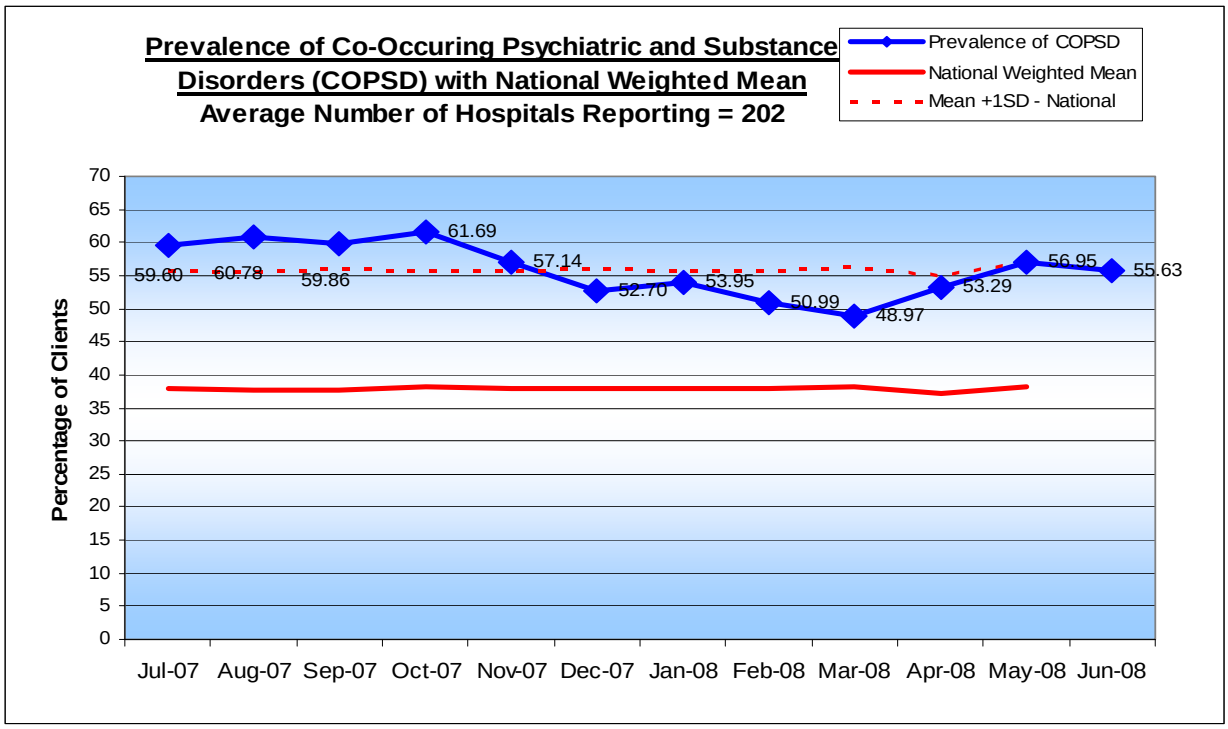
SECLUSION GRAPHS





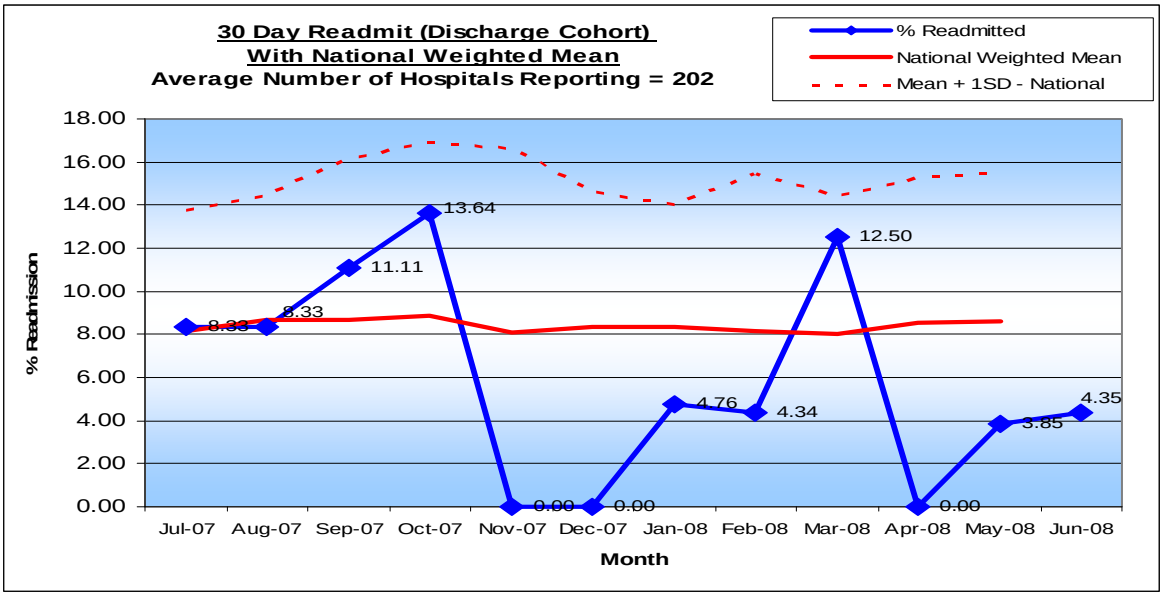
Seclusion hours (duration of events) at Riverview are tending to be below the national weighted mean n of other hospitals in the national sample. The percent of clients secluded has been decreasing over the last quarter. Riverview's efforts to reduce use of these interventions should focus on both the frequency and duration of seclusion events. Corrective actions applied are: reducing the time for seclusion order renewal from 2 hours to one hour; revision of debriefing process; 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;

CO-OCCURING PSYCHIATRIC AND SUBSTANCE ABUSE DISORDERS GRAPH



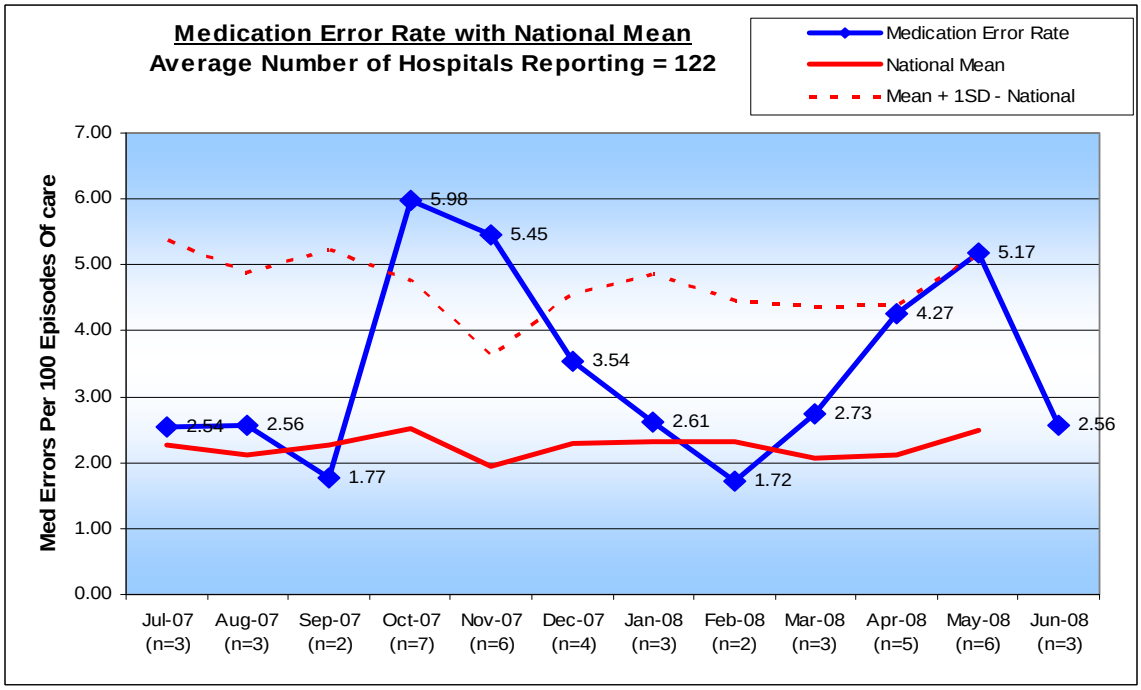
RPC has collaborative effort with Spring Harbor Hospital Co-Occurring Disorders providers to contract with RPC to develop a Co-Occurring program. Though RPC is currently a bit above the trend line, this is an indicator current initiatives are working as anticipated; with the advent of this program to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

THIRTY DAY READMIT GRAPH



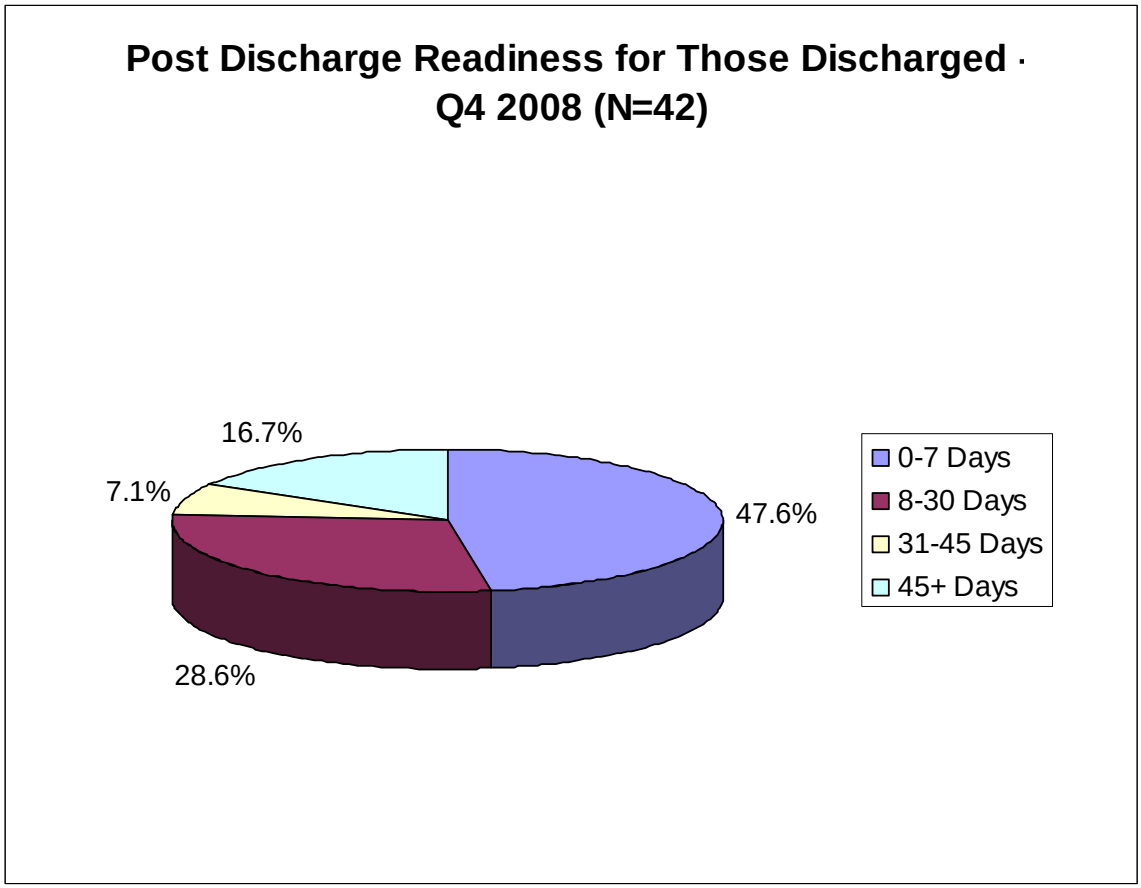
30 Day Readmission Rate is at or below the mean of the 205 other facilities reporting on this indicator, except in September 07 and March 08. Thirty day readmission rate is calculated considering the percent of discharges for the facility that returned within 30 days of a discharge of the same client from the same facility. All RPC readmissions that occur in less than 30 days of discharge are reviewed by the Director of Social Work Services.

MEDICATION ERROR RATE WITH NATIONAL MEAN GRAPH



The medication error rate considers the number of medication errors for every 100 episodes of care. For example a medication error rate of 1.6 means that 2 medication errors occurred each 125 episodes of care. Higher error rate indicates Riverview is capturing the vast majority of medication errors providing the opportunity to correct process or performance issues.

POST DISCHARGE PRIOR READINESS CIVIL CLIENTS



Discharge Readiness is a determination made by our medical staff that the civil client no longer meets medical necessity to continue treatment in an inpatient setting. This chart depicts the elapsed time between when that determination was made and the client was actually discharged for this quarter in percentages of clients for each time category.

Cumulative percentages and targets are as follows:

- Within 7 days = 47.6 (target 75%)
- Within 30 days = 76.2 (target 90%)
- Within 45 days = 83.3 (target 100%)

Cumulative percentages for each time category and the target percentages over the last 5 quarters are listed below. There is slight improvement in all categories this quarter.

Quarter	Within 7 days	Within 30days	Within 45 days	45 +days
Target	75%	90%	100%	0%
Q4 2008	47.6%	76.2%	83.3%	16.7%
Q3 2008	42%	73%	78%	22%
Q2 2008	65.6%	79.3 %	82.7 %	17.3%
Q1 2008	61.1%	89.9 %	94.1%	5.9%
Q4 2007	78.8 %	94%	94%	6.1%