

Riverview

PSYCHIATRIC CENTER



PERFORMANCE IMPROVEMENT REPORT

SECOND QUARTER
October-November-December 2008

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Introduction:

Riverview's rate of clients restrained remains above the National statistical mean. The restraint hours (duration) rate remains however, well below the statistical mean. The data would suggest that Riverview's restraint events are short by comparison, and efforts to reduce the frequency of restraint are what the hospital will focus on.

Seclusion hours (duration of events) at Riverview continue to remain below the national weighted mean. The percent of clients secluded has been level or decreasing over the past several months. The number of clients secluded however, increased over the past quarter and RPC will increase its efforts to reduce the use of this intervention.

Chart Reviews results remain mixed, with some areas (interventions and measurable goals) reflect improvements, while presence of GAP notes every 24 hours, MHW notes being co-signed and staff completing Weekly Summary notes areas needing attention.

Community provider participation is another area that continues to remain below expectations and can prolong or complicate discharge planning and placements

The presence of psychological assessments, notes, and development of client short-term goals showed remarkable improvements. Staff Development, Dietary, Security, Medical records and Confidentiality are at full compliance.

Client injuries remain well below the National Mean, as does Elopement rates, and 30 day re-admit rates.



COMMUNITY FORENSIC ACT TEAM

ASPECT: Descriptive Report on various components

CASE MANAGEMENT:

Clients enrolled in the ACT program	
	Number of ACT clients
October 2008	30
November 2008	30
December 2008	30

CRISIS MANAGEMENT:

	Client incidents	Hospitalized RPC	Hospitalized Medical
October 2008	2	1	0
November 2008	3	1	0
December 2008	4	0	0

SUBSTANCE ABUSE:

	Client with Substance Abuse as a Clinical Focus	Percent of ACT Clients In SA treatment
October 2008	9	30%
November 2008	9	30%
December 2008	8	27%

ACT CLIENTS LIVING SITUATION:

	Clients in Supervised Settings	Clients in own apt. or with family	% of clients Supervised Settings	% of Clients in own home or with family
October 2008	24	6	80%	20%
November 2008	24	6	72%	28%
December 2008	24	6	77%	23%

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
October 2008	13	2	1080
November 2008	14	2	930
December 2008	13	2	1080

Summary:

Riverview ACT struggled this quarter with attrition of staff from the team and was still not fully staffed at the end of December. Seven persons were served in the Progressive Treatment Program. One person was released from the forensic system; Custody of the Commissioner.

DIETARY

ASPECT: Meal Ticket Accuracy
OVERALL COMPLIANCE: 98.6%

Indicators	Findings	Compliance	Threshold Percentile
1. Main Entree	381 of 381	100%	90%
2. Vegetable	381 of 381	100%	85%
3. Beverage	380 of 381	99.7%	90%
4. Utensils	380 of 381	99.7%	100%
5. Food Allergies	380 of 381	99.7%	100%
6. Food Preferences	380 of 381	99.7%	90%
7. Modified Diet	380 of 381	99.7%	95%
8. Food Intolerances	381 of 381	100%	90%
9. Condiments	381 of 381	100%	80%
10. Dessert	381 of 381	100%	85%
11. Cardboard Tray For Special Care Units	169 of 169	100%	95%
12. Styrofoam Dishes For Special Care Unit	169 of 169	100%	95%

Summary:

The indicators are based on the accuracy of the meal sent to the client. The trays will be observed for accuracy using the meal ticket that is provided. This monitor will include lunch and supper on Upper Saco, Lower Saco, Upper Kennebec, and Lower Kennebec. The inspection will be conducted on a weekly basis. The overall compliance this quarter was 98.6%. This was down slightly .7% this quarter compared to last quarter. This CPI indicator will now be a monitor since we have consistently met the required threshold. Dietary will be establishing a new indicator looking at the accuracy of client information that has been placed in the “Geri-Menu” program.

HOUSEKEEPING

ASPECT: Shower Cleanliness/Safety

OVERALL COMPLIANCE: 99%

Indicators	Findings	Compliance	Threshold Percentile
1. Was shower clean?	101 of 101	100%	85%
2. Was shower curtain @ the proper length?	101 of 101	100%	90%
3. Was "P" seal clean?	101 of 101	100%	90%
4. Was "P" seal secure?	100 of 101	99%	95%
5. Did all lights work in room?	101 of 101	100%	95%
6. Were all anti-slip strips secure?	98 of 101	97%	85%
7. Was shower mat secure?	98 of 101	97%	95%

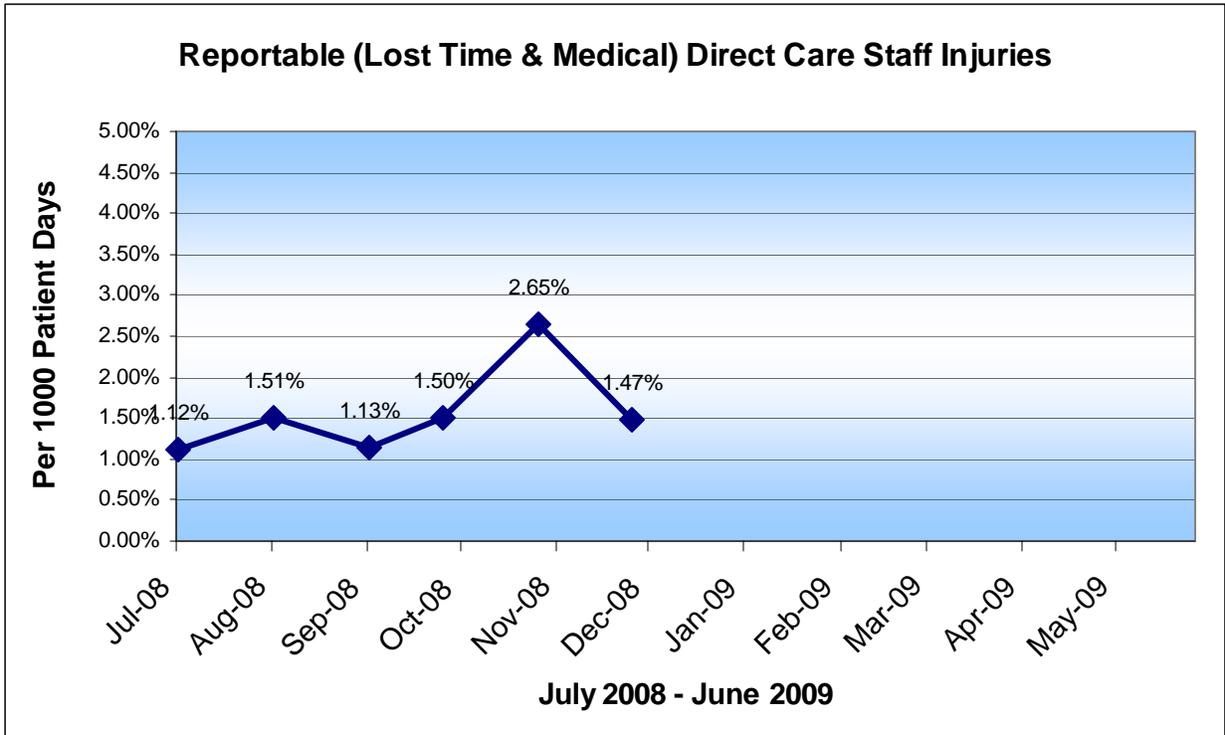
Summary:

The indicators are based on the inspection of shower stalls and accessories on U. Saco, L. Saco, U. Kennebec, and L. Kennebec. All bathroom types were reviewed randomly, 101 times this quarter. All areas were above threshold percentile. The security of the "P" seals at the bottom of each shower to retain the water inside maintained a 99% this quarter compared to last quarter, and now above the threshold percentile rate of 95%. All compliance rates for each criterion went up or maintained the same rate compared to last quarter. The overall compliance this quarter was 99%. This is up .5% from last quarter. This CPI indicator will now be a Housekeeping monitor, since we have consistently met the required threshold. A new indicator will be established and will be reported on next quarter.

HUMAN RESOURCES

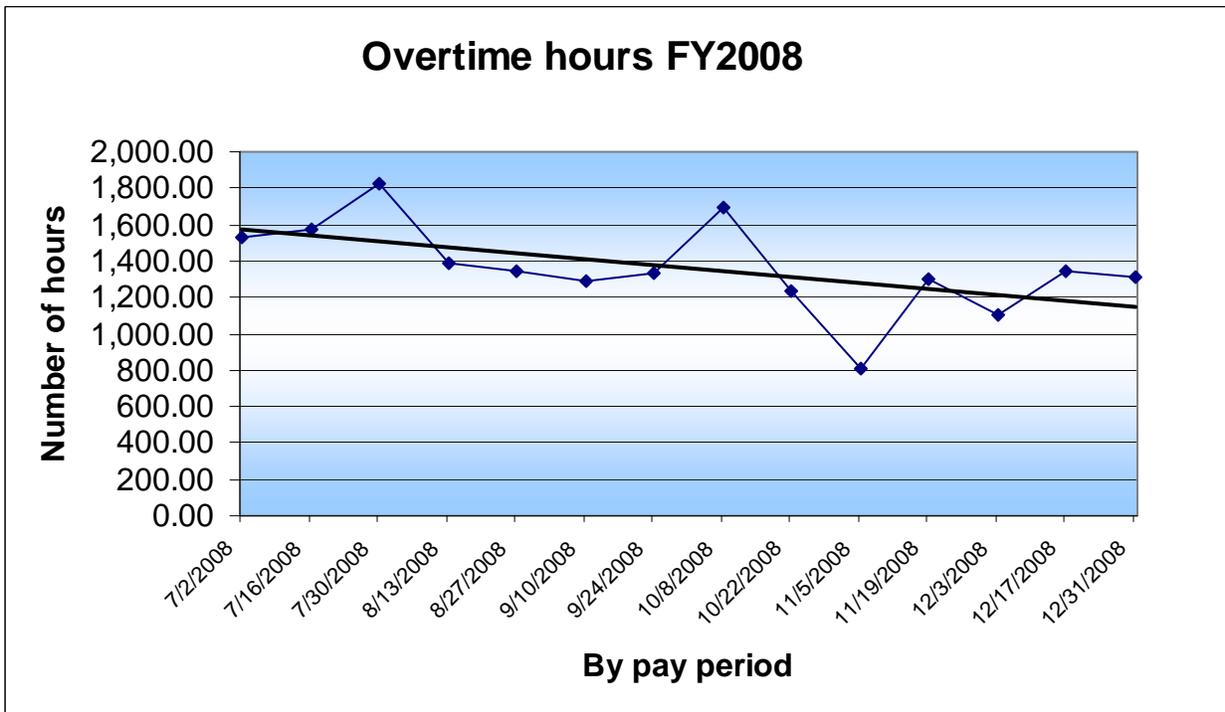
HUMAN RESOURCES / RISK MANAGEMENT

ASPECT: Direct care staff injury resulting in lost time & medical care



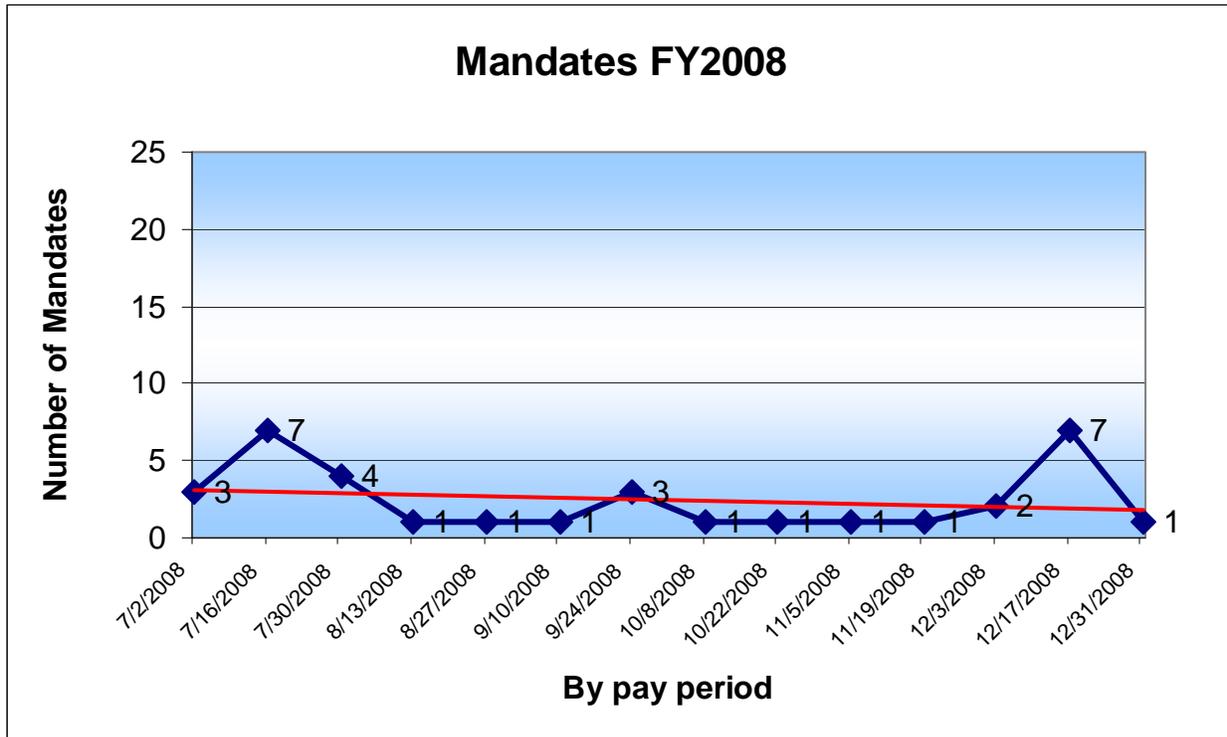
This quarter review reveals that there was a **increase** in direct care staff injuries from 1.25% per 1000 patient days last quarter to 1.87% per 1000 patient days this quarter. This number represents (15) direct care staff who sought medical treatment or lost time from work, as compared to (9) last quarter. The two-year average for this quarter is 1.77%.

HUMAN RESOURCES OVERTIME



Overtime has **decreased** this quarter as compared to last quarter. Overtime decreased from 10,278.75 hours to 8,799.75 hours . As compared to the same quarter last year we had 8,338.75 hrs of overtime, this represents an 5% increase from last year. Trend line is shown and extrapolated for future projection.

**HUMAN RESOURCES
ASPECT: MANDATES**



Mandated shifts have **decreased** this past quarter as compared to last quarter. Mandates decreased from 20 last quarter to 14 during this quarter. Last year we had a total of 20 mandated shifts during this same rating period, this represents a 30% decrease from last year.

**ASPECT: Management of Human Resources
OVERALL COMPLIANCE: 63.05%**

Indicator Employee Performance Evaluations expected to be completed within 30 days of the due date.	Findings		Target Percentile
October 2008 (August evals)	27 of 41	65.85%	85%
November 2008 (September evals)	15 of 27	55.56%	85%
December 2008 (October evals)	21 of 31	67.74%	85%

As compared to last quarter (40.61%) this quarter's *increased* to 63.05%. There was no data to compare to the same quarter last year, 2007. During this quarter 99 performance evaluations were sent out; 63 were received in a timely manner. Human Resources continue to stress the importance of timely submission of performance evaluations to supervisors.

INFECTION CONTROL

ASPECT: Hospital Infection Control
OVERALL COMPLIANCE: 100%-within standards

Indicators	Number	Rate	Threshold Rate
Total number of infections for the 2 nd quarter of the fiscal year, per 1000 patient days	32	3.96	5.8 or less
Hospital Acquired (healthcare associated) Infection rate, infections per 1000 patient-days	1	0.12	5.8 or less

Summary:

Infection rate for this period is well below the accepted two standard deviation for threshold action. Hand hygiene continues to be stressed to staff and clients. The hospital is increasing the availability of Purell on each unit. Also individual 1-ounce bottles are available for all staff. Informational e-mails have been routinely sent out to staff regarding the flu, availability of vaccines and clinics. Posters displayed to remind staff and clients to cover coughs and sneezes to stop the spread of infections.

MEDICAL RECORDS

ASPECT: Confidentiality
OVERALL COMPLIANCE: 100%

Indicators	Compliance	Threshold Percentile
1. All new employees and contract staff will attend confidentiality/HIPAA training.	100% - 0 new employees/contract staff in October. 100% - 10 new employees/contract staff in November. 100% - 6 new employees/contract staff in December.	100%
2. The Director of Health Information will track the number of	There were 0 confidentiality/Privacy-related incident reports in October.	Incident reports will be monitored for privacy

confidentiality/privacy issues through incident reports.	There were 0 confidentiality/privacy related-incident reports in November.	issues. The incident rate will remain at 0%.
	There were 0 confidentiality/privacy-related incident reports in December.	

Summary:

16 out of 16 (100%) new employees/contract staff attended confidentiality/HIPAA training. All indicators remained at 100% compliance for quarter 2-FY 2009.

ASPECT: Documentation & Timeliness

Indicators	Compliance	Threshold Percentile
1. Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	93% - There was 27 discharges in October. Of those, 25 were completed by 30 days. 80% - There was 15 discharges in November. Of those, 12 were completed within 30 days. 100% - There was 20 discharges in December. Of those, 20 were completed within 30 days.	All records will be completed within 30 days of discharge. The completion rate will remain at or above 80%.
2. Discharge summaries will be completed within 15 days of discharge.	92% - 25 out of 23 were completed within 15 days in October. 100% - 15 out of 15 were completed within 15 days in November. 100% - 20 out of 20 were completed within 15 days in December.	The completion rate will remain at 100%.
3. Forms used in the medical record will be reviewed by the Medical Record Committee.	100%- 0 forms were approved/revise in October (see minutes). 100%- 7 forms were approved/revise in November (see minutes). 100 %- 0 forms were approved/revise in December (see minutes).	100%
4. Medical transcription will be timely & accurate.	80%-Out of 152 reports, 122 were completed within 24 hours in October. 90%-Out of 107 reports, 96 were completed within 24 hours in November. 73%-Out of 150 reports, 110 were completed within 24 hours in December.	90%

Summary:

The indicators are based on the review of all discharged records. There was 91% compliance rate with record completion within 30 days. There was 97% compliance rate

with discharge summaries. Weekly “charts needing attention” lists are distributed to all medical staff, including the Medical Director, along with the Superintendent, Deputy Superintendent of Administrative Services, and the Risk Manager. There was 81% compliance rate with timely medical transcription services.

MEDICAL STAFF

ASPECT: Assessment and Reduction of Client BMIs
OVERALL COMPLIANCE: 100%

Indicator	Findings	Compliance	Target %
All clients with elevated BMIs will have a comprehensive peer review of current treatment plans with a goal of encouraging weight loss	October – reviewed all clients focusing on 4 clients with BMIs over 25	100%	100%
	November – reviewed all clients focusing on 5 clients with BMIs from 40.5 – 53.5	100%	100%
	December – reviewed all clients focusing on 6 clients with BMIs from 40 – 52.9	100%	100%

Summary:

31% of hospital clients are overweight (BMI 25 – 29); 34% are obese (BMI 30 – 39); and 9% are extremely obese (BMI 40+), 26% have ideal body weight. Med staff will continue to track BMIs, correlating lipid profile and blood sugar data for all hospital clients.

ASPECT: Monitoring of Pt. Sedation Experience on Day Following IV Sedation
OVERALL COMPLIANCE: 100%

Indicator	Findings	Compliance	Target %
Clinical Services will make follow-up calls to all IV sedation patients within one day of sedation in order to rate sedation experience. They will be asked if they experienced continued lethargy, dizziness, nausea, vomiting or other symptoms on the day following sedation.	14 patients were sedated in the month of October. Of these, none reported nausea/vomiting post procedure. No report of symptoms on the day following procedure.	100%	100%
	21 patients were sedated in the month of November. Of these, none reported nausea/vomiting post procedure. No report of symptoms on the day following sedation.	100%	100%
	19 patients were sedated in the month of December. Of these, none reported nausea/vomiting post procedure. No report of symptoms on the day following sedation.	100%	100%

Summary:

44 patients were sedated in the second quarter, with none reporting nausea/vomiting post procedure and no report of symptoms on the day following the procedure.

ASPECT: Monitoring of Client/Staff Satisfaction at Clinical Services

OVERALL COMPLIANCE: 100%

Indicator	Findings	Compliance	Target %
Clinical Services will provide every client and/or caregiver with a satisfaction survey sheet after their appointment in order to rate performance of medical/dental staff as well as treatment received.	25 out of 25 survey sheets collected in October were positive for services received, as well as for staff performance. There were no complaints.	100%	100%
	25 out of 25 survey sheets collected in November were positive for services received as well as for staff performance. There were no complaints.	100%	100%
	25 out of 25 survey sheets collected in December were positive for services received as well as for staff performance. There were no complaints.	100%	100%

Summary:

25 survey sheets were collected for each month of the quarter. Compliance for all three months was 100% for survey sheets reviewed. RPC will continue to collect 25 survey sheets per month. Review at monthly staff meetings and forward reports quarterly to RPC.

ASPECT: Complication Management after Dental Extractions

OVERALL COMPLIANCE: 100%

Indicator	Findings	Compliance	Target %
Clinical Services will assess each patient for pain after surgical extractions. Patients will be assessed for pain, infection or other complications after surgical extractions.	There were 6 extractions in the month of October. There were no complications or symptoms of infection on the day following extraction.	100%	100%
	There were 7 extractions in the month of November. There were no complications on the day following extraction.	100%	100%
	There were 4 extractions in the month of December. There were no complications.	100%	100%

Summary:

There were 17 extractions in the second quarter, with no complications or symptoms of infection. Aftercare instructions are given both orally and in writing to every extraction patient and/or caregiver prior to leaving recovery. RPC will continue to call extraction

patients 72 hours post-extraction. Review at monthly staff meetings and forward reports quarterly to RPC.

NURSING

ASPECT: Seclusion and Restraint Related to Staffing Effectiveness
OVERALL COMPLIANCE: 93%

Indicators Seclusion/Restraint related to staffing effectiveness:	Findings	Compliance
1. Staff mix appropriate	58 of 58	100%
2. Staffing numbers within appropriate acuity level for unit	58 of 58	100%
3. Debriefing completed	42 of 58	73%
4. Dr. Orders	58 of 58	100%

Summary:

All findings were 100% except debriefing. This will be followed up by the Nurse IV on the unit and the Assistant Director of Nursing for the unit. The expectation is that the debriefing will be completed even if it not done immediately.

ASPECT: Injuries Related to Staffing Effectiveness
OVERALL COMPLIANCE: 100%

Indicators Injuries related to staffing effectiveness:	Findings	Compliance
1. Staff mix appropriate	25 of 25	100%
2. Staffing numbers within appropriate acuity level for unit	25 of 25	100%

Summary:

Overall staff injuries are monitored for Direct Care by Risk Management and Human Resources. Human Resources and Environment of Care monitor for staff injuries due to the environment. Injuries have decreased. The staffing numbers are within the appropriate level for the current staffing plan and the acuity level. This indicator will continued to be monitored.

ASPECT: Redlining
OVERALL COMPLIANCE: Redlining 99%

Indicators-Redlining	Findings	Compliance
Lower Kennebec	272 of 276	99%
Upper Kennebec	273 of 276	99%
Lower Saco	268 of 276	97%
Upper Saco	274 of 276	99%

Summary:

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. This continues to be high compliance and will be monitored for one more quarter and then dropped and a new indicator will be added.

ASPECT: Code cart checks

OVERALL COMPLIANCE: Code cart checks 99%

Indicators-Code Cart Sign Off	Findings	Compliance
1) Lower Kennebec	268 of 276	97%
2) Upper Kennebec	275 of 276	100%
3) Lower Saco	276 of 276	100%
4) Upper Saco	275 of 276	100%
5) NOD Building Control	275 of 276	100%
6) NOD Staff Room I 580	275 of 276	100%

Summary:

Continue to monitor the code carts on the shift report as an extra reminder for nursing to complete this task. Following this quarter, this indicator will be dropped and monitor to see if it sustains a high percentage. A new monitor concerning education will be substituted.

ASPECT: Pain Management

OVERALL COMPLIANCE: PRE: 100% POST: 92 % OVERALL: 96 %

Aspect		Findings	Compliance
Pre-administration	Assessed using pain scale	1164 of 1166	100%
Post-administration	Assessed using pain scale	1067 of 1166	92%

Summary:

This indicator has improved from last quarter with preassessment at 100% and post assessment at 92%. We will continue to place a great deal of attention and effort on post admission assessment. We will continue to track this indicator and strive for increased post assessment in the next quarter. The two ADON's will continue to work with unit nursing staff to assure that this is done more consistently.

ASPECT: Chart Review

OVERALL COMPLIANCE: 62%

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	28 of 50	56%
2. MHW notes cosigned by RN	9 of 44	20%
3. STGs/Interventions are written, dated and numbered.	42 of 49	86%
4. STGs are measureable and observable	47 of 50	94%
5. STGs/Interventions are modified / met as appropriate.	40 of 50	80%
6. STGs/Interventions tie directly to documentation.	38 of 49	78%
7. Weekly Summary note completed.	26 of 50	52%
8. Client's current BMI in the service plan review has improved or maintained at optimal.	32 of 47	69%
9. Progress notes/flow sheets document a level of functional skill support provided, consistent with the identified area of need, delivered within last 24 hours.	32 of 60	53%

Summary:

The overall compliance in this documentation area has decreased. The two indicators that were added last quarter have increased. BMI documentation increased from 36% to 69%. Documentation of functional level increased from 43 % to 53 %. GAP notes written has increased from 53% to 56%. MHW notes signed by nurse has increased from 10% to 20%. The weekly summary notes documentation has increased from 43% to 52%. Most areas have improved or remained the same but need continued monitoring and education. The unit RN's will audit one chart per RN and discuss during supervision. The PSD/Nurse IV will continue to discuss and review chart audit results at staff meetings. The RN IV's assisted by the ADON 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. The Nurses doing the chart audits will meet with individual staff to educate individuals on their documentation problems. This documentation will be a high focus for the next quarter.

PEER SUPPORT

ASPECT: Integration of Peer Specialists into client care

OVERALL COMPLIANCE: 91%

Indicators	Compliance	Findings
1. Attendance at Comprehensive Treatment Team meetings.	452 of 475	95%
2. Grievances responded to by RPC on time.	22 of 41	54%
3. Attendance at Service Integration meetings.	60 of 60	100%
4. Contact during admission.	65 of 65	100%
5. Grievances responded to by peer support on time.	41 of 41	100%
6. Client satisfaction survey completed.	22 of 48	46%

Summary:

Overall compliance is up 4%. 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. Peer Specialists will also learn ways to elicit reasons for clients refusing to complete satisfaction surveys and develop a system to ensure all clients are offered a satisfaction survey prior to discharge. Any PSD with late grievances will report weekly on grievance resolution progress to avoid being late in the future and the RPC Risk Management Department will continue to send emails and call PSD to remind of due grievances.

ASPECT: Client Satisfaction Survey with care

OVERALL COMPLIANCE: 65%

Indicators	Findings	
1. Did anyone tell you about your rights?	10 of 19	53%
2. Has anyone talked to you about the kinds of services that are available to you?	13 of 20	65%
3. Are you told ahead of time of changes in your privileges, appointments, or daily routines?	10 of 19	53%
4. Do you know someone who can help you get what you want or stand up for your rights?	14 of 20	70%
5. Do you have a worker in the community?	12 of 19	63%
6. Has your worker from the community visited or contacted you since you have been in the hospital?	10 of 15	67%
7. Do you know how to get in touch with your worker from the community if you need to?	11 of 14	79%
8. Do you have a community treatment plan?	9 of 20	45%
9. I feel more able to deal with crisis.	14 of 19	74%
10. I am not as bothered by my symptoms.	11 of 20	55%
11. I am better able to care for myself.	17 of 19	89%

12. I get along better with people.	16 of 19	84%
13. I am treated with dignity and respect.	14 of 18	78%
14. I feel comfortable asking questions about my treatment and medications.	20 of 20	100%
15. I understand how my medication works and the side effects.	14 of 18	78%
16. I've been told about self-help/peer support and support groups to use after discharge.	8 of 20	40%
17. I've been told about the benefits and risks of my medication.	9 of 19	47%
18. I have been given information to help me understand and deal with my illness.	8 of 20	40%
19. I feel my other medical conditions are being treated.	7 of 18	39%
20. My pain was managed.	10 of 16	63%
21. I feel free to make complaints and suggestions.	14 of 18	78%
22. I feel my right to refuse medication or treatment is respected.	10 of 19	53%
23. I help in planning my discharge.	13 of 19	68%
24. I feel I have had enough privacy in the hospital.	13 of 19	68%
25. I feel safe while at Riverview?	16 of 20	80%
26. If I had a choice of hospitals, I would choose this one.	11 of 17	65%

Summary:

Overall satisfaction dropped 6% from last quarter. Satisfaction with care was highest on Lower Kennebec at 73%. Upper Saco had the lowest satisfaction level at 52%, while Upper Kennebec and Lower Saco were 62% and 56% respectively. Peer support will encourage and support clients to voice their concerns and needs with their treatment teams regarding these aspects of care. A new process has been developed to address client concerns/suggestions/grievances that will assist clients in getting their needs addressed more efficiently. PSDs will initiate unit procedures to ensure clients are routinely informed of daily schedules and privilege changes. 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. 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.

PROGRAM SERVICE

ASPECT: Active Treatment

OVERALL COMPLIANCE: 80%

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.	85%
3. Documentation demonstrates that the client attended all assigned psycho-social-educational interventions within last 24 hours.	49%

4. A minimum of three psychosocial educational interventions are assigned daily.	97%
5. A minimum of four groups is prescribed for the weekend.	66%
6. The client is able to state what his assigned psycho-social-educational interventions are and why they have been assigned?	61%
7. The client can correctly identify assigned RN and MHW.	81%
8. The medical record documents the clients active participation in Morning Meeting within the last 24 hours	58%
9. The client can identify personally effective distress tolerance mechanisms available within the milieu.	93%
10. Level and quality of client's use of leisure within the milieu are documented in the medical record within the last 7 days.	100%
11. Level and quality of social interactions within the milieu are documented in the medical record over the last 7 days.	95%

Summary:

Indicators #3, and #8 all fell below threshold this quarter with some variability between units. Both admissions units fell below threshold on indicators #5 & #6. All other indicators were above set thresholds. Program Service Directors will discuss variability between units and systemic changes needed. PSD's will review below threshold finding for their units at their unit professional staff meetings.

**ASPECT: Milieu Treatment
OVERALL COMPLIANCE: 60%**

Indicator	Compliance
1. Percentage of clients participating in Morning Meeting	59%
2. Percentage of clients who establish a daily goal	68%
3. Percentage of clients who attend Wrap-Up Group in evening	53%
4. Percentage of clients attending Community Meeting	63%
5. Number of staff who have an affirmation at Comm Mtg of clients who have an affirmation “ “	Ave. 1 per wk. Ave. 3
6. Number of clients who have a conflict at Comm Mtg staff who have a conflict “ “	Ave. 2 Ave. 1

Summary:

The forensic transitional unit (US) was above threshold on indicators #1- 4. The three remaining units fell below threshold on indicators #1, #3 & #4. The two admissions units fell below threshold on #2. Program Service Directors will review various strategies for increasing client participation in milieu treatment.

Indicators #5 & 6 were revised to include total number of staff & clients per month/quarterly that use “I” statements in community meetings. PSD & Nurse IV’s will be required to attend all community meetings to model “I” statements. All professional staff on each unit will review and practice “I” statements within this next quarter.

PSYCHOLOGY

ASPECT: Co-Occurring Treatment

OVERALL COMPLIANCE: 63%

Co-Occurring Disorders TX Integration	Findings	Compliance
1. There is evidence of an integrated co-occurring comprehensive service plan for identified clients.	17/27	63%
2. There is evidence of “stage of Change” documented in client comprehensive service plan	12/27	44%
3. There is documentation of identified client’s participation in co-occurring treatment.	7/27	26%
4. Consumer Satisfaction Survey indicates clients were “encouraged to talk about and work on any mental health and alcohol and drug issues at the same time”	14/15	93%
5. Consumer Satisfaction Survey indicates that since beginning treatment with us, their condition is better.	11/15	73%
6. Consumer Satisfaction Survey reports client satisfaction with current treatment experience is better than with any other previous treatment experiences.	12/15	80%
7. Percent of clients with co-occurring disorders as reported by NASMHPD		56%

Summary:

Service plans improved 23% this quarter from 21% to 44% with improvement in all aspects. Client participation in co-occurring treatment continues to fall far below expectations. Change in duties made to co-occurring staff will continue have been somewhat effective and will continue.

Consumer Satisfaction increased 5% this quarter from 77% to 82%.

NASMHPD reported percentages of RPC clients diagnosed with co-occurring disorders continues to be higher than national average. We attribute this to improved admissions assessments.

ASPECT: Psychological Services
OVERALL COMPLIANCE: 91%

Psychologist Service Delivery & Documentation	Findings	Compliance
1. Psychologist short-term goals on CSP are measurable and time limited.	26/32	81%
2. Psychologist progress notes indicate treatment offered as prescribed on CSP.	31/32	97%
3. Psychologist progress notes indicate client's understanding of goals and client self-assessment of progress.	29/32	96%

Summary:

Improvement continues this past quarter from 89% to 91%. Peer review chart audits will begin next quarter. Psychologists will provide feedback and report findings to supervisors for performance reviews and weekly supervision follow-up. 100% compliance expected.

REHABILITATION SERVICES

ASPECT: Readiness Assessments, Comprehensive Service Plans and Progress Notes
OVERALL COMPLIANCE: 83%

Indicators	Compliance
1. Readiness assessment and treatment plan completed within 7 days of admission.	93%
2. Rehabilitation short term goals on Comprehensive Service Plan are measurable and time limited.	80%
3. Rehabilitation progress notes indicate treatment being offered as prescribed on Comprehensive Service Plan.	80%
4. Rehabilitation progress notes indicate progress towards addressing identified goals on the Comprehensive Service Plan.	70%

Summary:

This is the first quarter review of the above indicators. The Director of Rehab Services will ask all RT's to keep running list of assesments that need to be done and the date due, so that the covering RT will be aware of the work that needs to be completed. The

Director will meet with individual Recreation Therapist on the unit to review individualized treatment planning and progress note writing monthly.

SAFETY

ASPECT: Life Safety
OVERALL COMPLIANCE: 94%

Indicators	Findings	Compliance
1. Total number of staff assigned to Upper Saco and Upper Kennebec who have received training with the evacuation chair.	58/61	95%
2. Total number of staff assigned to Lower Saco and Lower Kennebec who have received training with the evacuation chair.	79/80	98%
3. Total number of staff assigned to the Float Pool who have received training with the evacuation chair.	25/26	96%
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.	84/84	100%
6. Total number of staff who knows how to acknowledge the fire alarm or trouble alarm on the enunciator panel.	83/84	98%
7. Total number of staff who knows the emergency number.	84/84	100%
8. During unannounced safety audits conducted by the Safety Officer, this represents the total number of staff who display identification tags.	19/22	86%
9. During unannounced safety audits conducted by the Safety Officer, this represents the total number of direct care staff who carry a personal duress transmitter.	17/22	77%

Summary:

Both Upper units that employ the chairs are at 95% compliance and when combined with both lower units RPC is at 97%. The (3) alarms reported for the hospital meets the required number of drills per JCAHO and Life Safety Code. Indicators 5 through 7 are indicators used for the purpose of evaluating the knowledge and skills of staff as it relates to critical skills and knowledge necessary to carry out functions in the event of a fire and/or smoke emergency. One important initiative for this fiscal year is to conduct

a hospital-wide census during such events utilizing two-way radios. The most recent drill showed an improvement in that area. RPC is at 97% compliance for this training by current staff that is permanently assigned to the units. All staff continues to receive this training during orientation. Staff members needing to be trained have just come back from leave and will be trained by Jan 31st.

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.	1 drill	100%

Summary:

By NFPA Standards, the Portland Clinic is classified as “business occupancy”. It is only required to have periodic drills during the year. The Safety Officer will conduct a minimum of (3) drills per year instead of just “periodically”, providing that objectives and understanding are demonstrated by staff. During the last drill, the Safety Officer led a scenario of which a client was under conscious sedation. The practical included evacuating the client along with transitioning and continuing critical monitoring equipment necessary during the procedure. Staff had been given notice that that was to occur and had ample time to prepare. Staff performed well during both the drill and the handling of a client under those conditions. We continue to perform Environmental tours and still monitor the knowledge base of staff as it relates to what they need to do in the event of an alarm or event by asking them questions and having informal 5 minute “tailgate talks”.

ASPECT: Securitas/RPC Security Team

OVERALL COMPLIANCE: 99%

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).	65/65	100%
2. Security Officer “foot patrols” during Open Hospital times. (Total # of “foot patrols” done vs. total # of “foot patrols” to be done.)	2006/2024	99%
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.)	552/552	100%

Summary

There have been multiple reports related to the assistance Security has given with regard to assisting the organization maintaining safety and security during Open Hospital times. Those checks have resulted in the “Open Hospital” initiative which began just a short time ago. Security continues to reach its goal with regard to the indicators above and has begun the process of formulating new indicators for the 3rd quarter.

SOCIAL WORK

ASPECT: Preliminary Continuity of Care Meeting and Comprehensive Psychosocial Assessments

OVERALL COMPLIANCE: 80%

Indicators	Findings	Compliance
1. Preliminary Continuity of Care meeting completed by end of 3 rd day	29/30	93%
2. Service Integration form completed by the end of the 3rd day	30/30	100%
2a. Director of Social Services reviews all re-admissions 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 such a need or change was indicated that corrective action was taken.	4/4	100%
3a. Client Participation in Preliminary Continuity of Care meeting.	28/30	93%
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.	11/30	36%
3e. Correctional Personnel Participation in Preliminary Continuity of Care Meeting.	0/15	0%
4a. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	26/30	86%
4b. Annual Psychosocial Assessment completed and current in chart	30/30	100%

Summary:

Indicator 3d: This area is down slightly from a last quarter of 40% to this quarter a measure of 36%. While this is a slight decrease will continue to monitor and foster support from the regional supervisors and the CDC offices. We are continuing with on-

going quarterly meetings with the region CDC coordinators and mental health team leaders to continue to monitor this important continuity of care area. In addition a CDC coordinator attends the weekly Wednesday discharge planning meeting to address community issues as needed. Indicator 3e: This area has been low or indicated no participation for numerous quarters. Director will continue to monitor and work with the mental health liaison with the Department of Corrections and the jail assigned ICM staff to continue to problem solve this area. Indicator 4a: This area will continue to be monitored through individual and group supervision and on-going chart audits.

ASPECT: Institutional and Annual Reports

OVERALL COMPLIANCE: 79%

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.	67/70	95%
2. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	1/5	20%
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.	3/3	100%
4. Annual Reports (due Dec) to the commissioner for all inpatient NCR clients are submitted annually	29/29	100%

Summary:

Indicator 1 is down 35% from the first quarter report. This is a significant decline from the last quarter report. The Forensic teams will continue to monitor this critical area and our on-going efforts to streamline the institutional report process. In addition this issue will be brought to Clinical Leaders for discussion on how to have more positive performance consistency in this aspect area.

ASPECT: Client Discharge Plan Report/Referrals

OVERALL COMPLIANCE: 96%

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.	12/13	92%
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%

Summary:

Indicator 2a: Report was not updated fully one week as needed by all social workers. It was reviewed and adjusted by the Director and addressed with the team.

Indicator 2a: Report was reviewed at CDPD in hardcopy but not emailed on one occasion. The subsequent weekly report was emailed to recipients with information encompassing two weeks of reporting.

ASPECT: Treatment Plans and Progress Notes

OVERALL COMPLIANCE: 90%

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.	42/45	93%
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	14/15	93%
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.	53/60	86%

Summary:

Indicator 3: This area is down slightly 2% from last quarter and will continue to be monitored. The department is continuing to focus on incorporating Stage of Change language in discharge and engagement plans with clients. This is an aspect area that will be focused on over the next quarter for higher performance results. While in general the plans are meeting basic requirements they need to improve on content and address issues that lead to hospitalization. In addition the plans need to have a pro-active prevention focus that will make transition back into the community successful.

STAFF DEVELOPMENT

ASPECT: New Employee and Mandatory Training

OVERALL COMPLIANCE: 100%

Indicators	Findings	Compliance
1. New employees will complete new employee orientation within 60 days of hire.	15 of 15 completed orientation	100%
2. New employees will complete CPR training within 30 days of hire.	15 of 15 completed CPR training	100%

3. New employees will complete NAPPI training within 60 days of hire	15 of 15 completed NAPPI training	100%
4. Riverview staff will attend CPR training bi-annually.	212 of 212 are current in CPR certifications	100%
5. Contract Employees will complete orientation within 60 days of hire.	1 of 1 have completed annual training	100%
6. Contract Employees will completed CPR training within 30 days of hire.	1 of 1 have completed annual training	100%
7. Contract employees will complete Nappi training within 60 days of hire.	1 of 1 have completed annual training	100%

Summary

The indicators are based on the requirements for all new/current staff to complete mandatory training and maintain current certifications. 15 out of 15 of (100%) new Riverview employees completed these trainings. 212 of 212 (100%) Riverview employees are current with CPR certification. 146 of 294 (50%) Riverview employees are current in NAPPI training. 267 of 298 (90%) employees to date are current in Annual training. All indicators remained at 100 % compliance for quarter 2-FY 2009.

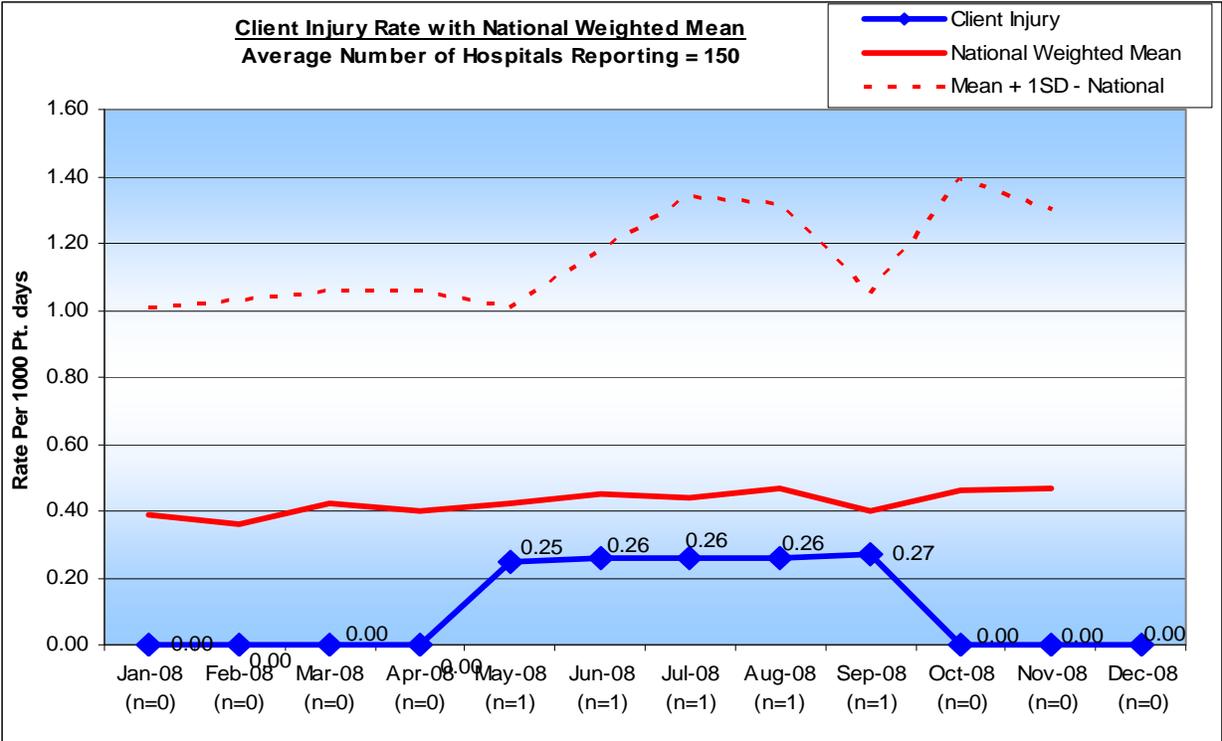
ASPECT: Community Provider Training

Date &	Public Sector	RPC	Total	Topic
10/6, 10/15, 10/27 - RPC	52	51	103	Mental Health Specialist Training
10/7 - RPC	1	5	6	Trajectories in Development of Autism Spectrum Disorder
10/14 - RPC	0	10	10	Personalized Treatment of Depression Using Brain Imaging and Genotyping
10/21 - RPC	0	9	9	The New Science of Psychosomatic Medicine
10/28 - RPC	1	5	6	Non-Pharmacological Somatic Treatments for PTSD
11/4 - RPC	1	6	7	Man can not live by pills alone: Religion and recovery from severe mental illness
12/2 - RPC	1	5	6	Brain Architecture: The basis plan
12/9 – RPC	1	4	5	Mental Heath Treatment Engagement among returning Veterans
12/16 - RPC	1	4	5	Enhancing the Validity of Effectiveness Trials
Total # Programs 11			157	

PERFORMANCE TRENDS COMPARED TO NATIONAL BENCHMARKS

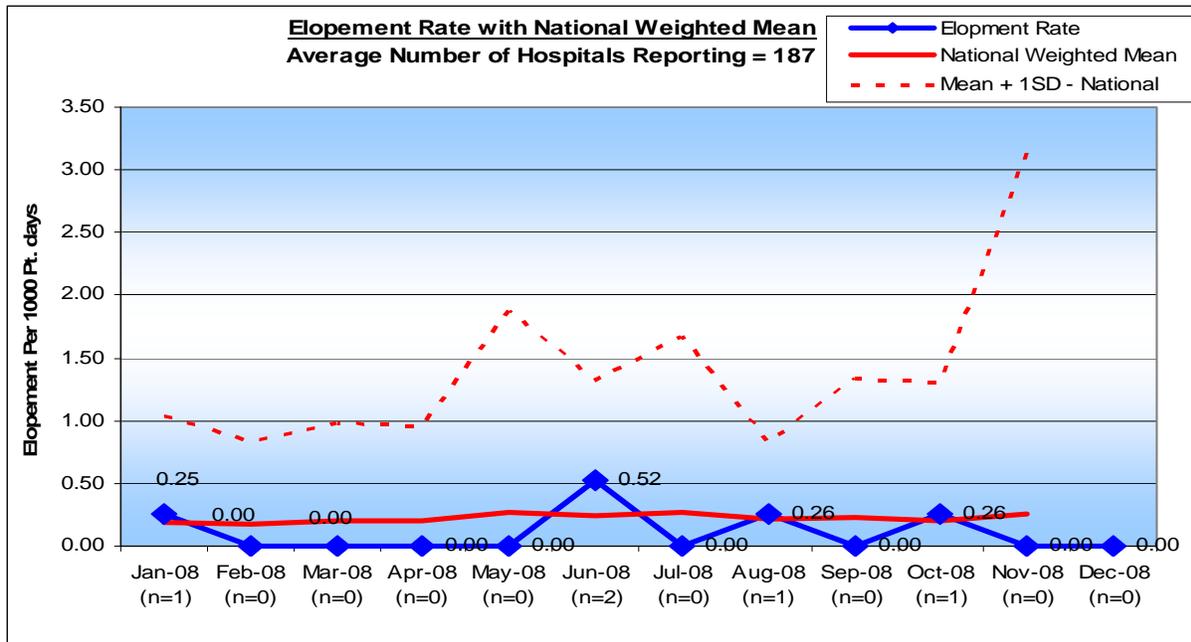
This section contains a number of graphs that compare Riverview Psychiatric Center to a national sample (the range is approximately 75-205 hospital across all aspects) of participating like facilities. Each line graph presents the national weighted mean (solid red line) and the limit of the first standard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



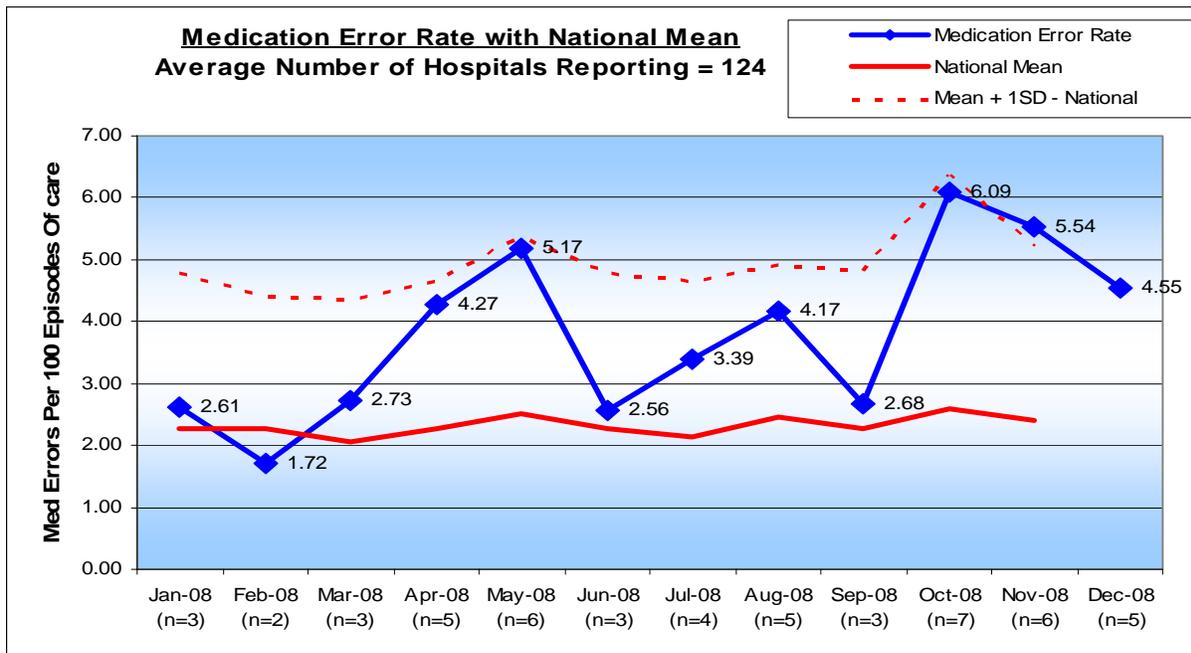
Client Injury Rate considers slips, trips and falls; self-injurious behavior; and client-to-client injury that requires more than first aid. The numbers of such incidents are low, as shown by the little "n" under each month. Riverview is well within the 1st standard deviation of the national sample. 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 0 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. The treatment team evaluates elopement risk and is treatment planned if necessary to keep the client and the community safe. RPC's elopement rate remains extremely low.

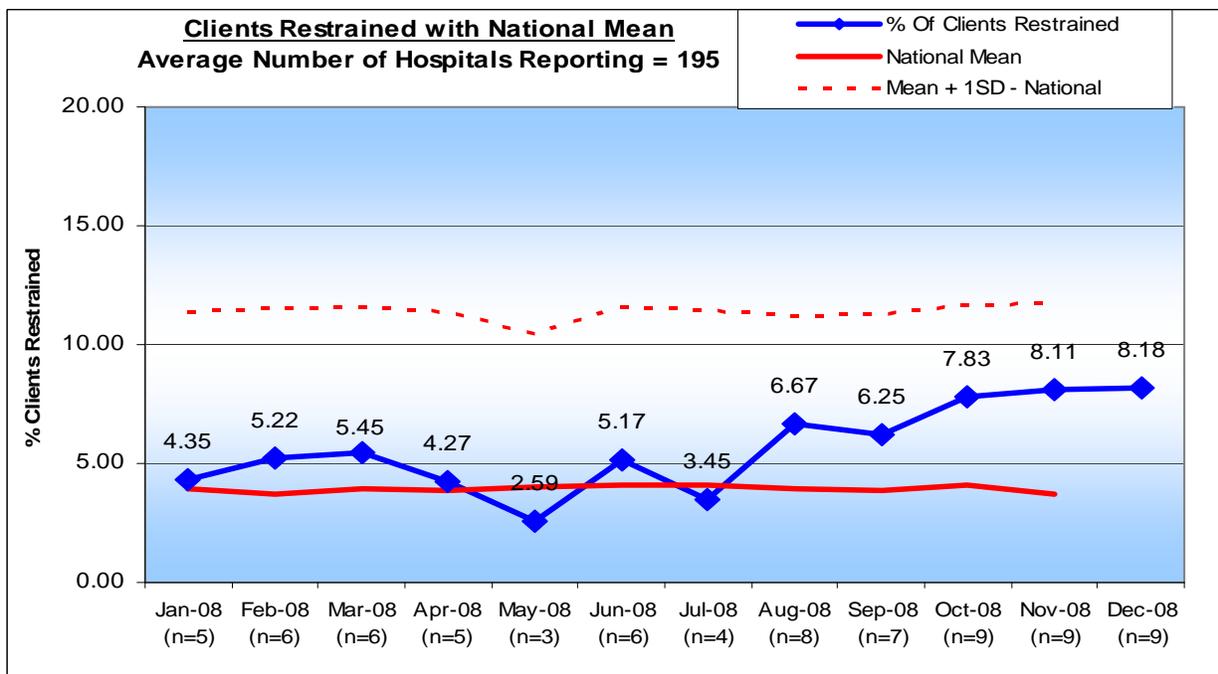
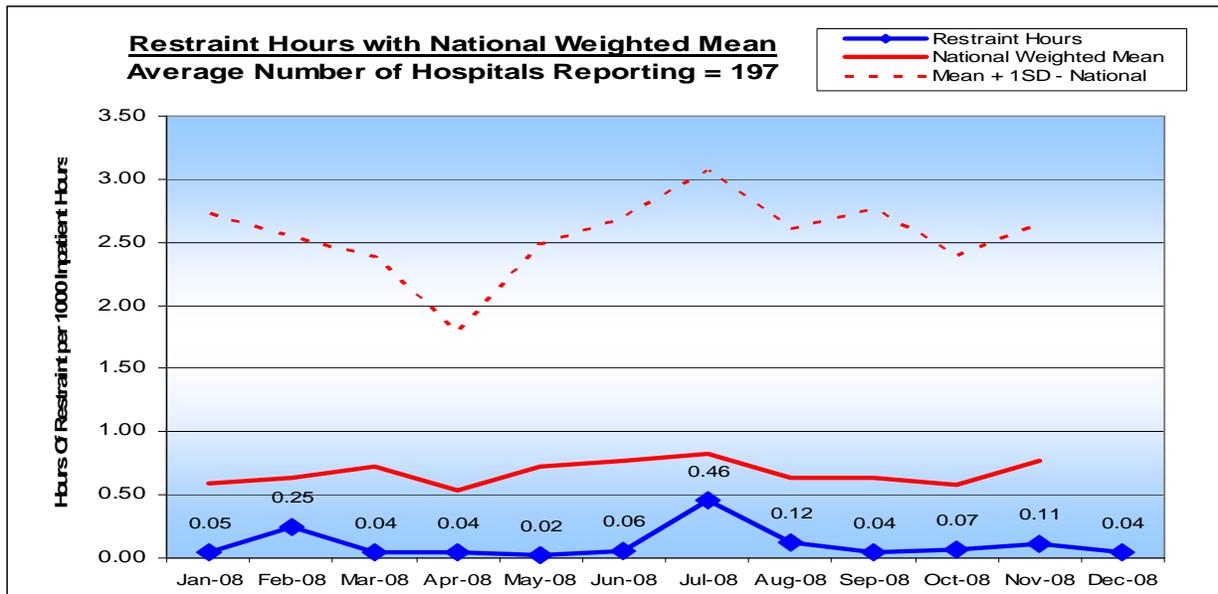
MEDICATION ERROR RATE WITH NATIONAL MEAN GRAPH



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

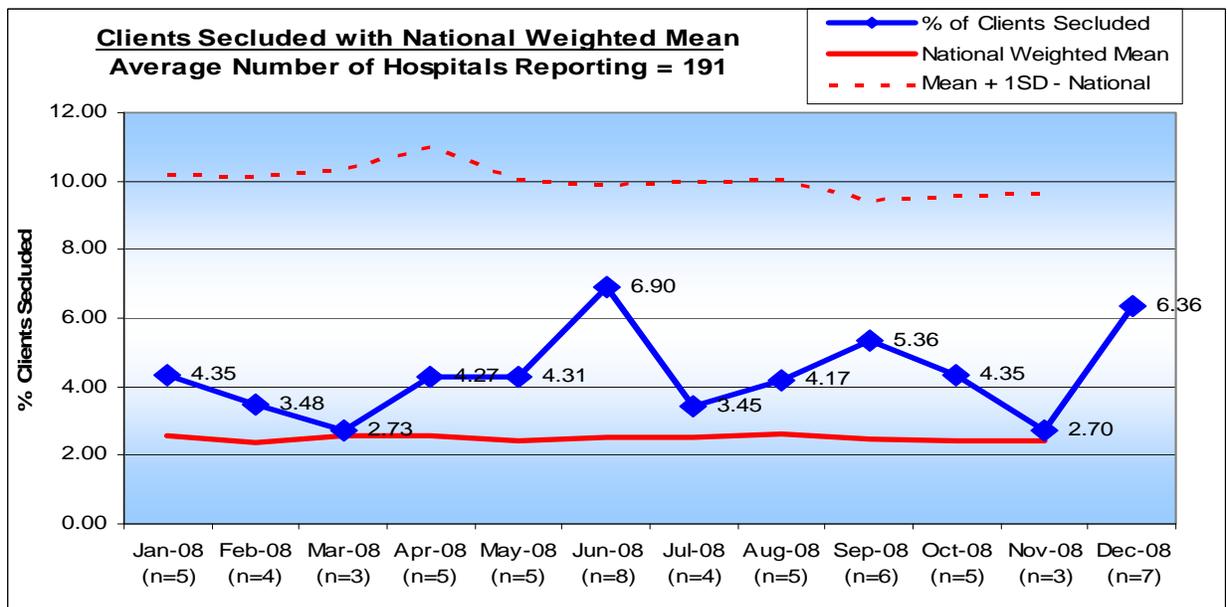
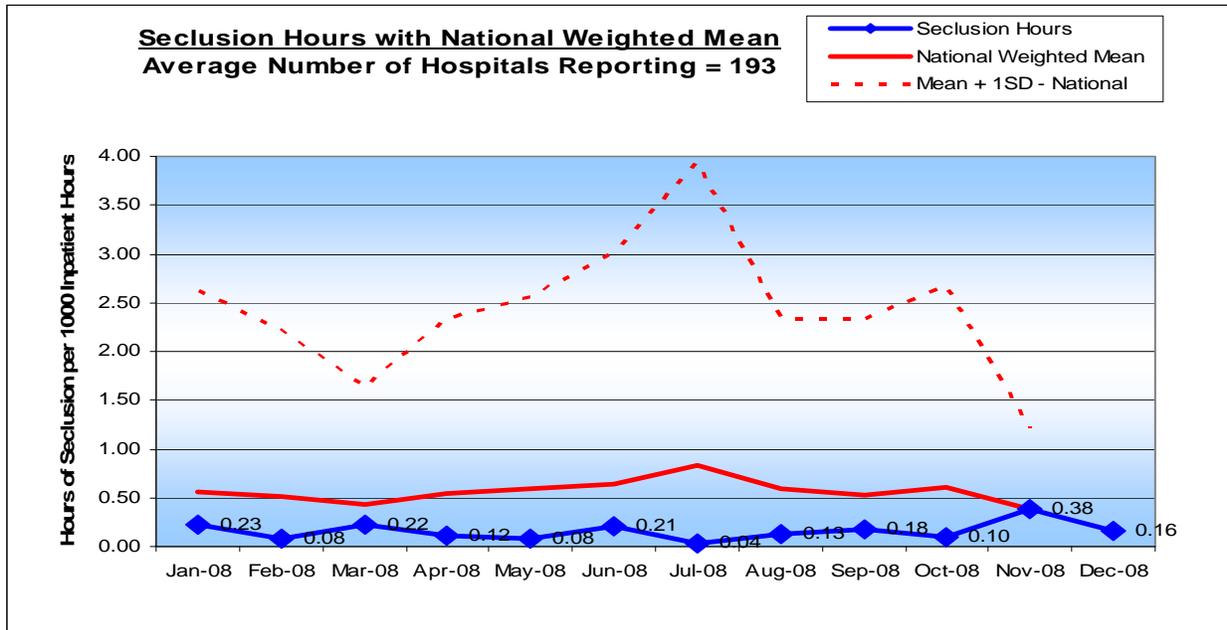
capturing the vast majority of medication errors providing the opportunity to correct process or performance issues.

RESTRAINT GRAPHS



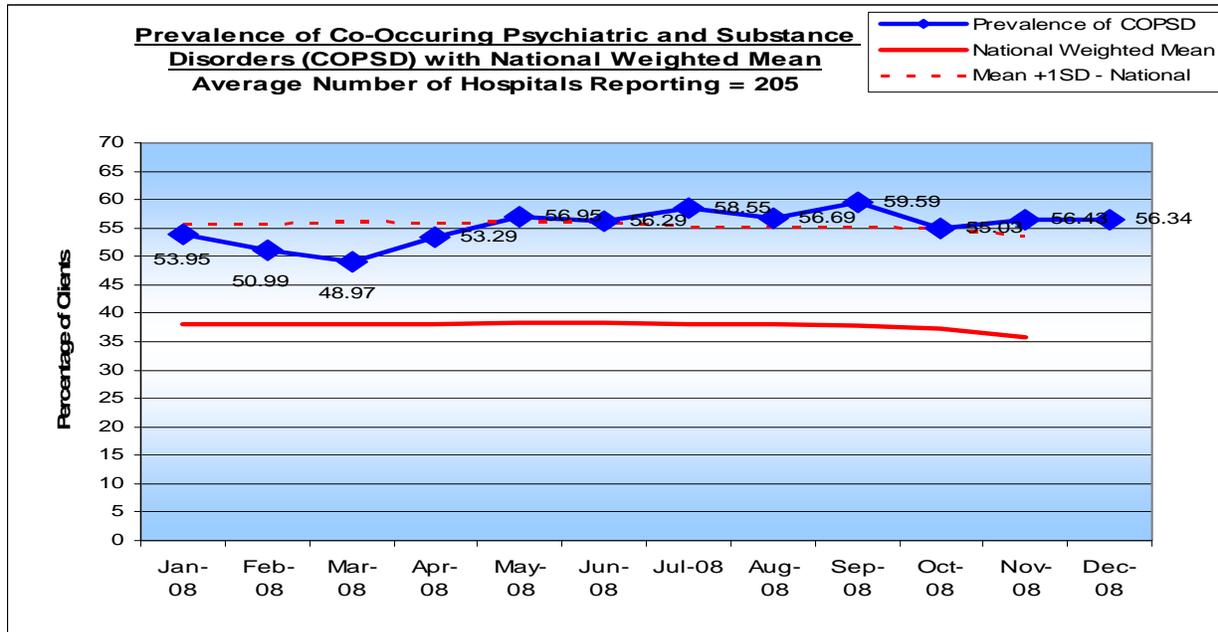
Riverview's rate of clients restrained remains above the statistical mean. The restraint hours (duration) rate remains well below the statistical mean. The data would suggest that Riverview's restraint events are short by comparison, and efforts to reduce the frequency of restraint use would have the most impact. Corrective actions were applied last quarter and RPC has seen a decline in both time and frequency. These strategies included, 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, 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



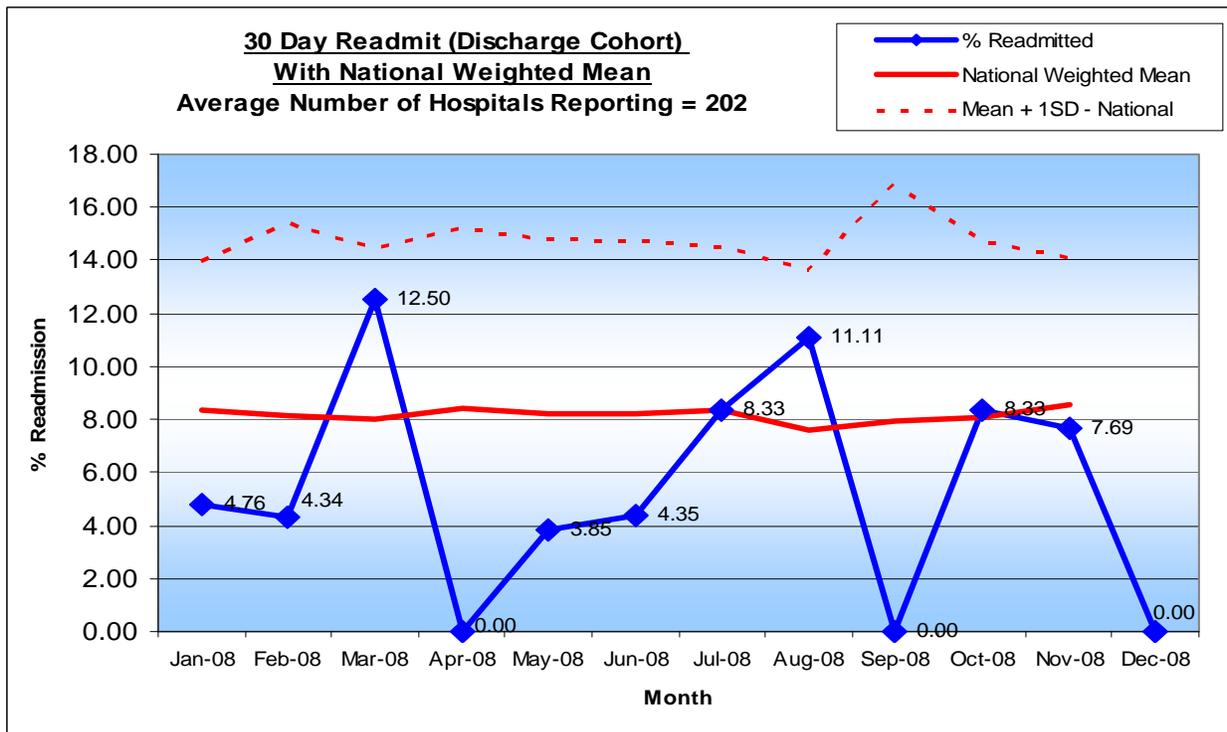
Seclusion hours (duration of events) at Riverview continue to remain below the national weighted mean. The percent of clients secluded has been level or decreasing over the past several months. The number of clients secluded has shown an increase over the past quarter and RPC will increase its efforts to reduce use of these interventions. Corrective actions already 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; Expansion of the multi-sensory rooms to all other units is expected to decrease the use of seclusions.

CO-OCCURRING PSYCHIATRIC AND SUBSTANCE ABUSE DISORDERS GRAPH



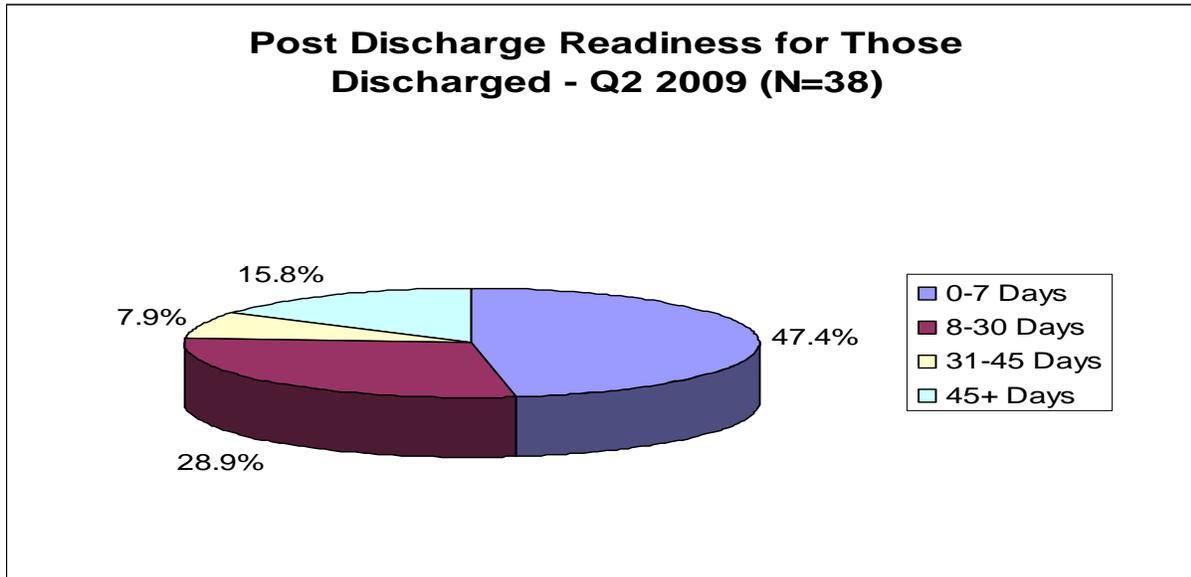
RPC has collaborative effort with Spring Harbor Hospital Co-Occurring Disorders providers to contract with RPC to develop a Co-Occurring program. Though RPC is currently slightly above the trend line, this is an indicator current initiatives are working as anticipated; with the advent of this program 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 this quarter with this indicator slightly above in September 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.

POST DISCHARGE PRIOR READINESS CIVIL CLIENTS



This chart shows the percent of civil clients who were discharged within 7 days of their discharge readiness to be at 47.4 % for this quarter compared to 57.5% last quarter; however the 30 days showed a significant increase from 5 % last quarter to 28.9%. Cumulative percentages and targets are as follows:

- Within 7 days = 47.4 % (target 75%)
- Within 30 days = 76.3 % (target 90%)
- Within 45 days = 84.2 % (target 100%)

The previous 5 quarters are displayed in the table below:

Quarter	Within 7 days	Within 30days	Within 45 days	45 +days
Target	75%	90%	100%	0%
Q2 2009	47.4%	76.3%	84.2%	15.8%
Q1 2009	57.5%	62.5%	72.5%	27.5%
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%

RPC continues to show improvements in the average wait time for all forensic admissions since the Oct-07 to March 08 peaks.