Riverview
PSYCHIATRIC CENTER

QUARTERLY REPORT ON

ORGANIZATIONAL PERFORMANCE EXCELLENCE

FIRST STATE FISCAL QUARTER 2015
July, August, September 2014

Lower Kennebec, Upper Kennebec, Upper Saco

Robert J. Harper
Acting Superintendent

October 22, 2014

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Glossary of Terms, Acronyms & Abbreviations

ADC	Automated Dispensing Cabinets (for medications)
ADON	Assistant Director of Nursing
AOC	Administrator on Call
CCM	Continuation of Care Management (Social Work Services)
CCP	Continuation of Care Plan
CH/CON	Charges/Convicted
CMS	Centers for Medicare & Medicaid Services
CIVIL	Voluntary, No Criminal Justice Involvement
CIVIL-INVOL	Involuntary Civil Court Commitment (No Criminal Justice Involvement)
CoP	Community of Practice or Conditions of Participation (CMS)
CPI	Continuous Process (or Performance) Improvement
CPR	Cardio-Pulmonary Resuscitation
CSP	Comprehensive Service Plan
DCC	Involuntary District Court Committed
DCC-PTP	Involuntary District Court Committed, Progressive Treatment Plan
GAP	Goal, Assessment, Plan Documentation
HOC	Hand off communications.
IMD	Institute for Mental Disease
ICDCC	Involuntary Civil District Court Commitment
ICDCC-M	Involuntary Civil District Court Commitment, Court Ordered Medications
ICDCC-PTP	Involuntary Civil District Court Commitment, Progressive Treatment Plan
IC-PTP+M	Involuntary Commitment, Progressive Treatment Plan, Court Ordered Medications
ICRDCC	Involuntary Criminal District Court Commitment
INVOL CRIM	Involuntary Criminal Commitment
INVOL-CIV	Involuntary Civil Commitment
ISP	Individualized Service Plan
IST	Incompetent to Stand Trial
LCSW	Licensed Clinical Social Worker
LEGHOLD	Legal Hold
LPN	License Practical Nurse
TJC	The Joint Commission (formerly JCAHO, Joint Commission on Accreditation of Healthcare Organizations)
MAR	Medication Administration Record
MHW	Mental Health Worker
MRDO	Medication Resistant Disease Organism (MRSA, VRE, C-Dif)
NAPPI	Non Abusive Psychological and Physical Intervention
NASMHPD	National Association of State Mental Health Program Directors
NCR	Not Criminally Responsible
NOD	Nurse on Duty
NP	Nurse Practitioner

Glossary of Terms, Acronyms & Abbreviations

NPSG	National Patient Safety Goals (established by the Joint Commission)
NRI	NASMHPD Research Institute, Inc.
OT	Occupational Therapist
PA or PA-C	Physician's Assistant (Certified)
PCHDCC	Pending Court Hearing
PCHDCC+M	Pending Court Hearing for Court Ordered Medications
PPR	Periodic Performance Review – a self-assessment based upon TJC standards that are conducted annually by each department head.
PSD	Program Services Director
PTP	Progressive Treatment Plan
PRET	Pretrial Evaluation
R.A.C.E.	Rescue/Alarm/Confine/Extinguish
RN	Registered Nurse
RT	Recreation Therapist
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration (Federal)
SAMHS	Substance Abuse and Mental Health Services, Office of (Maine DHHS)
SBAR	Acronym for a model of concise communications first developed by the US Navy Submarine Command. S = Situation, B = Background, A = Assessment, R = Recommendation
SD	Standard Deviation – a measure of data variability.
Seclusion, Locked	Client is placed in a secured room with the door locked.
Seclusion, Open	Client is placed in a room and instructed not to leave the room.
SRC	Single Room Care (seclusion)
STAGE III	60 Day Forensic Evaluation
URI	Upper respiratory infection
UTI	Urinary tract infection
VOL	Voluntary – Self
VOL-OTHER	Voluntary – Others (Guardian)

INTRODUCTION

The Riverview Psychiatric Center Quarterly Report on Organizational Performance Excellence has been created to highlight the efforts of the hospital and its staffs to provide evidence of a commitment to client recovery, safety in culture and practices and fiscal accountability. The report is structure to reflect a philosophy and contemporary practices in addressing overall organizational performance in a systems improvement approach instead of a purely compliance approach. The structure of the report also reflects a focus on meaningful measures of organizational process improvement while maintaining measures of compliance that are mandated though regulatory and legal standards.

The methods of reporting are driven by a national accepted focused approach that seeks out areas for improvement that were clearly identified as performance priorities. The American Society for Quality, National Quality Forum, Baldrige National Quality Program and the National Patient Safety Foundation all recommend a systems-based approach where organizational improvement activities are focused on strategic priorities rather than compliance standards.

There are three major sections that make up this report:

The first section reflects compliance factors related to the Consent Decree and includes those performance measure described in the Order Adopting Compliance Standards dated October 29, 2007. Comparison data is not always available for the last month in the quarter and is included in the next report.

The second section describes the hospital's performance with regard to Joint Commission performance measures that are derived from the Hospital-Based Inpatient Psychiatric Services (HBIPS) that are reflected in the Joint Commissions quarterly ORYX Report and priority focus areas that are referenced in the Joint Commission standards;

I. Data Collection (PI.01.01.01)
II. Data Analysis (PI.02.01.01, PI.02.01.03)
III. Performance Improvement (PI.03.01.01)

The third section encompasses those departmental process improvement projects that are designed to improve the overall effectiveness and efficiency of the hospital's operations and contribute to the system's overall strategic performance excellence. Several departments and work areas have made significant progress in developing the concepts of this new methodology.

As with any change in how organizations operate, there are early adopters and those whose adoption of system changes is delayed. It is anticipated that over the next year, further contributors to this section of strategic performance excellence will be added as opportunities for improvement and methods of improving operational functions are defined.

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CONSENT DECREE

Consent Decree Plan

V1) The Consent Decree Plan, established pursuant to paragraphs 36, 37, 38, and 39 of the Settlement Agreement in Bates v. DHHS defines the role of Riverview Psychiatric Center in providing consumer-centered inpatient psychiatric care to Maine citizens with serious mental illness that meets constitutional, statutory, and regulatory standards.

The following elements outline the hospital's processes for ensuring substantial compliance with the provisions of the Settlement Agreement as stipulated in an Order Adopting Compliance Standards dated October 29, 2007.

Client Rights

V2) Riverview produces documentation that clients are routinely informed of their rights upon admission in accordance with ¶ 150 of the Settlement Agreement;

Indicators	2Q2014	3Q2014	4Q2014	1Q2015
1. Clients are routinely informed of their rights upon admission	100% 30/30	100% 29/30	100% 26/32	97% 44/45

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

Clients are informed of their rights and asked to sign that information has been provided to them. If they refuse, the staff documents the refusal and sign, date & time the refusal.

3Q2014: 1 refused
4Q2014: 3 refused, 3 lacked capacity

V3) Grievance tracking data shows that the hospital responds to 90% of **Level II** grievances within five working days of the date of receipt or within a five-day extension.

Indicators	2Q2014	3Q2014	4Q2014	1Q2015
1. Level II grievances responded to by RPC on time.	100% 1/1	N/A	100% 2/2	100% 1/1
2. Level I grievances responded to by RPC on time.	100% 61/61	97% 67/69	100% 51/51	100% 86/86

**This data is for the entire hospital (including Lower Saco)*

CONSENT DECREE

Admissions

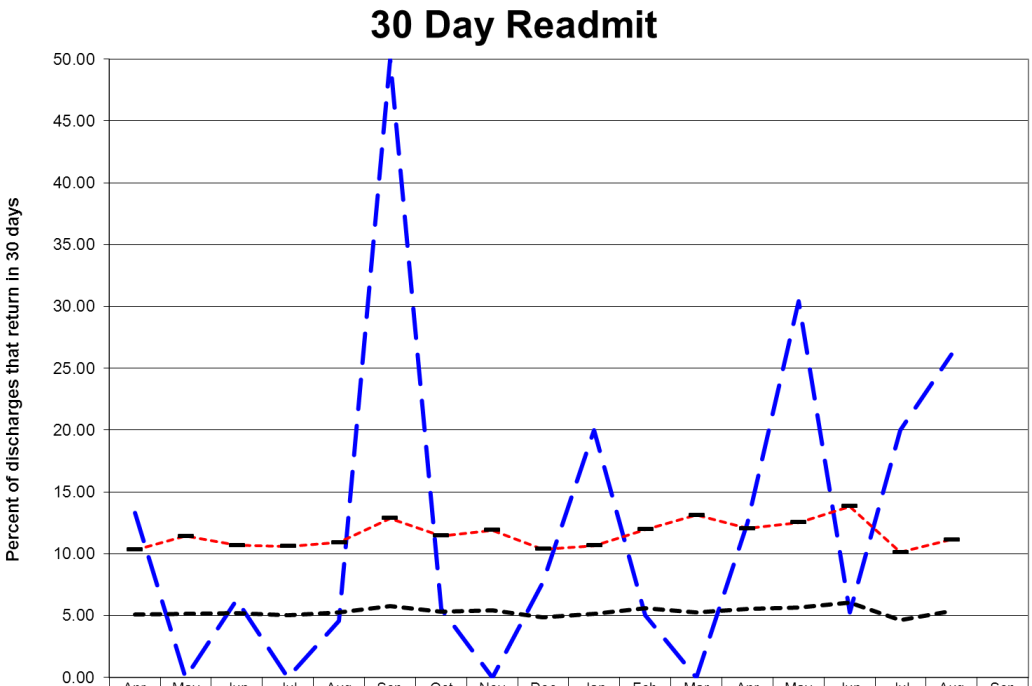
V4) Quarterly performance data shows that in 4 consecutive quarters, 95% of admissions to Riverview meet legal criteria;

Legal Status on Admission	2Q2014	3Q2014	4Q2014	1Q2015	Total
CIVIL TOTAL	**18**	**31**	**26**	**35**	**110**
VOL			1		1
CIVIL-INVOL	3	2	1	8	14
DCC	14	28	23	25	90
DCC PTP	1	1	1	2	5
FORENSIC TOTAL	**5**	**5**	**0**	**3**	**13**
STAGE III		2			2
JAIL TRANS					0
IST	4	2			6
NCR	1	1		3	5
GRAND TOTAL	**23**	**36**	**26**	**38**	**123**

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

CONSENT DECREE

V5) Quarterly performance data shows that in 3 out of 4 consecutive quarters, the % of readmissions within 30 days of discharge does not exceed one standard deviation from the national mean as reported by NASMHPD



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	13.33	0.00	6.25	0.00	4.55	50.00	5.56	0.00	7.69	20.00	5.00	0.00	12.50	30.43	5.26	20.00	26.09	
Ntl Mean	5.06	5.12	5.17	5.04	5.24	5.75	5.30	5.42	4.86	5.12	5.62	5.24	5.54	5.65	6.04	4.64	5.36	
+1 StDev	10.30	11.41	10.69	10.59	10.90	12.87	11.44	11.89	10.36	10.65	11.95	13.13	12.04	12.53	13.82	10.11	11.14	

**This data is for the entire hospital (including Lower Saco)*

This graph depicts the percent of discharges from the facility that returned within 30 days of a discharge of the same client from the same facility. For example; a rate of 10.0 means that 10% of all discharges were readmitted within 30 days.
The graphs shown on the next page depict the percent of discharges from the facility that returned within 30 days of a discharge of the same client from the same facility stratified by forensic or civil classifications. For example; a rate of 10.0 means that 10% of all discharges were readmitted within 30 days. The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

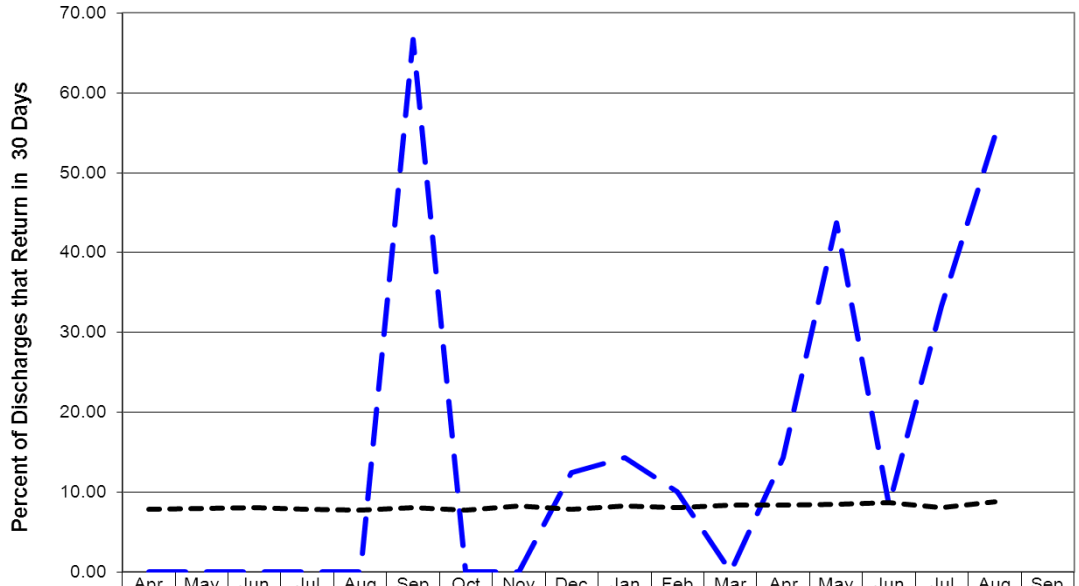
Reasons for client readmission are varied and may include decompensating or lack of compliance with a PTP to name a few. Specific causes for readmission are reviewed with each client upon their return. These graphs are intended to provide an overview of the readmission picture and do not provide sufficient granularity in data elements to determine trends for causes of readmission.

Note: In August 2013 the Lower Saco unit was decertified; patients had to be discharged and readmitted in our Meditech Electronic Medical Record System, even though they were not actually discharged from the hospital. This caused the numbers in August 2013 to increase. Starting in August 2013 and going forward anytime that a patient transfers units in the hospital (either from or to Lower Saco) we must now discharge them and readmit them in Meditech, which causes them to show up in this graph as a 30 Day Readmission, even though technically they never left the hospital.

CONSENT DECREE

30 Day Readmit

Forensic Stratification

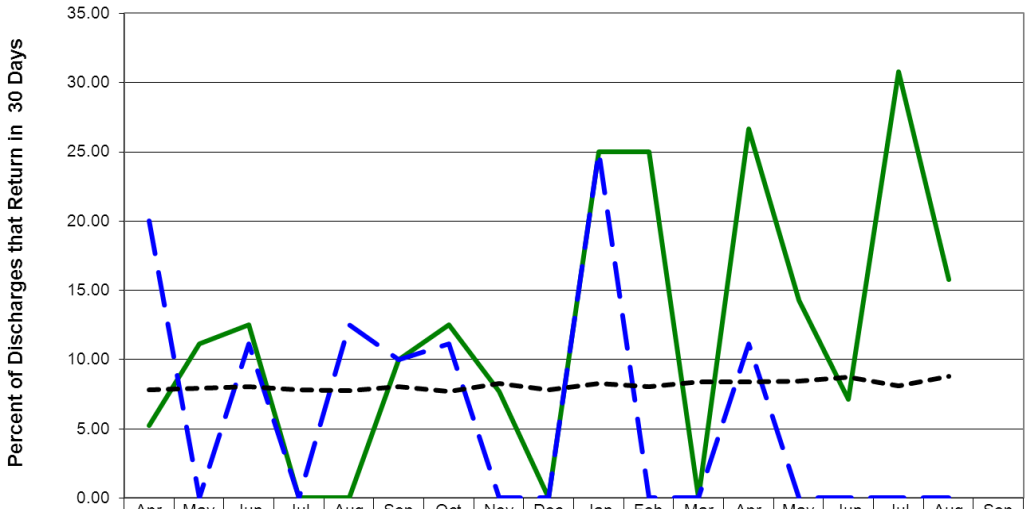


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	0.00	0.00	0.00	0.00	0.00	66.67	0.00	0.00	12.50	14.29	10.00	0.00	14.29	43.75	8.33	33.33	54.55	
National Mean	7.81	7.92	8.02	7.81	7.73	8.07	7.71	8.27	7.82	8.30	8.07	8.39	8.41	8.44	8.72	8.08	8.76	

**This data is for the entire hospital (including Lower Saco)*

30 Day Readmit

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Dorothea Dix	5.26	11.11	12.50	0.00	0.00	10.00	12.50	7.69	0.00	25.00	25.00	0.00	26.67	14.29	7.14	30.77	15.79	
Riverview	20.00	0.00	11.11	0.00	12.50	10.00	11.11	0.00	0.00	25.00	0.00	0.00	11.11	0.00	0.00	0.00	0.00	
National Mean	7.81	7.92	8.02	7.81	7.73	8.07	7.71	8.27	7.82	8.30	8.07	8.39	8.41	8.44	8.72	8.08	8.76	

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

CONSENT DECREE

V6) Riverview documents, as part of the Performance Improvement & Quality Assurance process, that the Director of Social Work 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 to determine whether the readmission indicated a need for resources or a change in treatment and discharge planning or a need for different resources and, where such a need or change was indicated, that corrective action was taken;

REVIEW OF READMISSION OCCURRING WITHIN 60 DAYS

Indicators	2Q2014	3Q2014	4Q2014	1Q2015
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 such a need or change was indicated that corrective action was taken.	100% 1/1	N/A	100% 1/1	100% 3/3

**This data is for the entire hospital (including Lower Saco)*

CONSENT DECREE

REDUCTION OF RE-HOSPITALIZATION FOR OUTPATIENT TREATMENT CLIENTS

Indicators	2Q2014	3Q2014	4Q2014	1Q2015
1. The Program Service Director of Outpatient Treatment will review all client cases of re-hospitalization from the community for patterns and trends of the contributing factors leading to re-hospitalization each quarter. The following elements are considered during the review: a. Length of stay in community b. Type of residence (i.e.: group home, apartment, etc) c. Geographic location of residence d. Community support network e. Client demographics (age, gender, financial) f. Behavior pattern/mental status g. Medication adherence h. Level of communication with Outpatient Treatment	100% 1 client was returned to RPC for psychiatric instability due to substance abuse relapse	100% 1 client was returned to DDPC for psychiatric instability, client remains in DDPC	100% 1 client returned to RPC for psychiatric instability from group home, remains in RPC on Upper Saco	100% 2 clients returned to RPC for psychiatric instability manifested by assault of staff in their residence. Both remain in RPC.
2. Outpatient Treatment will work closely with inpatient treatment team to create and apply discharge plan incorporating additional supports determined by review noted in #1.	100%	100%	100%	100% Attendance at all treatment team meetings.

**This data is for the entire hospital (including Lower Saco)*

Summary:

Area 1) Both patients were male, in their mid to late 60's, both in residential care where medication was managed for them. Both are socially isolated and dependent upon fixed income. Both were over 10 miles from RPC Outpatient Treatment (formerly known as ACT). Patient #1 had been in their placement for approximately 1 year and Patient #2 had been at their placement for less than 6 months (this client had never fully stabilized in his community placement).

Area 2) RPC Outpatient Treatment is working closely with the Upper Saco unit to discharge Patient #1 back to his community placement in Waterville by the end of September. Patient #2 remains at RPC awaiting a referral to an outpatient setting.

Note: The ACT Team is now called Outpatient Treatment.

CONSENT DECREE

V7) Riverview certifies that no more than 5% of patients admitted in any year have a primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.

Client Admission Diagnoses	**2Q14**	**3Q14**	**4Q14**	**1Q15**	**TOTAL**
ADJUST DISORDER WITH MIXED ANXIETY & DEPRESSED MOOD	1				**1**
BIPOL I, MOST RECENT EPIS (OR CURRENT) MANIC, UNSPEC				1	**1**
BIPOL I, MOST RECENT EPISODE (OR CURRENT) MIXED, UNSPEC	3			1	**4**
BIPOL I, REC EPIS OR CURRENT MANIC, SEVERE, SPEC W PSYCH BEH		2		1	**3**
BIPOL I, SINGLE MANIC EPISODE, UNSPECIFIED		1			**1**
BIPOLAR DISORDER, UNSPECIFIED		4	1	2	**7**
DELUSIONAL DISORDER		1	1		**2**
DEPRESSIVE DISORDER NEC		3		2	**5**
HEBEPHRENIA-UNSPEC	1			1	**2**
MILD INTELLECTUAL DISABILITIES		1			**1**
OTHER AND UNSPECIFIED BIPOLAR DISORDERS, OTHER				2	**2**
PARANOID SCHIZO-CHRONIC	2	1	5	5	**13**
PARANOID SCHIZO-UNSPEC	1	4			**5**
POSTTRAUMATIC STRESS DISORDER		1	2	1	**4**
PSYCHOSIS NOS	6	6	4	4	**20**
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED	7	9	9	12	**37**
SCHIZOPHRENIA NOS-CHR		1	2	2	**5**
SCHIZOPHRENIFORM DISORDER, UNSPECIFIED	1		2	1	**4**
UNSPECIFIED EPISODIC MOOD DISORDER				3	**3**
UNSPECIFIED NONPSYCHOTIC MENTAL DISORDER	1	2			**3**
Total Admissions	**23**	**36**	**26**	**38**	**123**

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

CONSENT DECREE

Peer Supports

Quarterly performance data shows that in 3 out of 4 consecutive quarters:

V8) 100% of all clients have documented contact with a peer specialist during hospitalization;

V9) 80% of all treatment meetings involve a peer specialist.

Indicators	2Q2014	3Q2014	4Q2014	1Q2015
1. Attendance at Comprehensive Treatment Team meetings. (v9)	86% 352/411	86% 395/458	89% 417/466	*45% 183/404
2. Attendance at Service Integration meetings. (v8)	100% 41/41	86% 55/64	100% 46/46	100% 80/80
3. Contact during admission. (v8)	100% 57/57	100% 64/64	100% 62/62	100% 80/80

**This data is for the entire hospital (including Lower Saco)*

*Note: In mid-July some of the indicators in the Peer Support contract were changed so that the Peer Support staff would have more time for community integration with patients. Peer Support received a copy of the consent decree plan in September and only then became aware of the 80% standard. The Peer Support contract was then changed back to meet this standard.

CONSENT DECREE

Treatment Planning

V10) 95% of clients have a preliminary treatment and transition plan developed within 3 working days of admission;

Indicators	2Q2014 (4 units)	3Q2014 (3 units only)	4Q2014 (3 units only)	1Q2015 (3 units only)
1. Service Integration meeting and form completed by the end of the 3rd day	100% 30/30	100% 15/15	100% 15/15	100% 15/15
2.Client Participation in Service Integration meeting.	100% 30/30	100% 15/15	100% 15/15	87% 13/15
3.Social Worker Participation in Service Integration meeting.	100% 30/30	100% 15/15	100% 15/15	100% 15/15
4.Client's Family Member and/or Natural Support (e.g., peer support, advocacy, attorney) participation in Service Integration meeting	90% 27/30	100% 15/15	60% 9/15	100% 15/15
5 .Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	93% 28/30	90% 18/20	90% 18/20	93% 14/15
6. Initial Comprehensive Assessment contains summary narrative with conclusion and recommendations for discharge and social worker role	100% 30/30	100% 20/20	100% 20/20	100% 15/15
7. Annual Psychosocial Assessment completed and current in chart	100% 15/15	100% 12/12	100% 14/14	100% 15/15

**2Q2014 data is for the entire hospital (including Lower Saco); 3Q2014, 4Q2014, and 1Q2015 data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

Summary:

Area 2) Two clients declined to meet for the Service Integration Meeting both were followed up with and did meet but not within designated timeframe.

Area 5) One assessment was not completed for a readmission for the Lower Kennebec unit and the patient was in the hospital for a total of ten days. This was discovered during a closed chart audit and the Social Work Director in consultation with the Medical Records Director completed an assessment based on admission assessment documentation and it was put into the closed record with the current October date of completion.

CONSENT DECREE

V11) 95% of clients also have individualized treatment plans in their records within 7 days thereafter;

Indicators	2Q2014 (4 units)	3Q2014 (3 units only)	4Q2014 (3 units only)	1Q2015 (3 units only)
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all clients on assigned **CCM** caseload.	93% 28/30	83% 19/23	80% 16/20	83% 25/30
2. 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.	100% 30/30	96% 22/23	85% 17/20	100% 30/30

**2Q2014 data is for the entire hospital (including Lower Saco); 3Q2014, 4Q2014, and 1Q2015 data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

Summary:

Area 1) There were 5 records that did not indicate a note was done during a weekly period. This was impacted by staffing issues within the Social Work Department and it is being addressed at staff meeting and in supervision.

V12) Riverview certifies that all treatment modalities required by ¶155 are available.

The treatment modalities listed below as listed in ¶155 are offered to all clients according to the individual client's ability to participate in a safe and productive manner as determined by the treatment team and established in collaboration with the client during the formulation of the individualized treatment plan.

Treatment Modality	Provision of Services Normally by….			
	Medical Staff Psychology	Nursing	Social Services	Rehabilitation Services/ Treatment Mall
Group and Individual Psychotherapy	X			
Psychopharmacological Therapy	X			
Social Services			X	
Physical Therapy				X
Occupational Therapy				X
ADL Skills Training		X		X
Recreational Therapy				X
Vocational/Educational Programs				X
Family Support Services and Education		X	X	X
Substance Abuse Services	X			
Sexual/Physical Abuse Counseling	X			
Intro to Basic Principles of Health, Hygiene, and Nutrition		X		X

CONSENT DECREE

An evaluation of treatment planning and implementation, performed in accordance with **Attachment D**, demonstrates that, for 90% of the cases reviewed:

V13) The treatment plans reflect

- Screening of the patient's needs in all the domains listed in ¶61;
- Consideration of the patient's need for the services listed in ¶155;
- Treatment goals for each area of need identified, unless the patient chooses not, or is not yet ready, to address that treatment goal;
- Appropriate interventions to address treatment goals;
- Provision of services listed in ¶155 for which the patient has an assessed need;
- Treatment goals necessary to meet discharge criteria; and
- Assessments of whether the patient is clinically safe for discharge;

V14) The treatment provided is consistent with the individual treatment plans;

V15) If the record reflects limitations on a patient's rights listed in ¶159, those limitations were imposed consistent with the Rights of Recipients of Mental Health Services

An abstraction of pertinent elements of a random selection of charts is periodically conducted to determine compliance with the compliance standards of the consent decree outlined in parts V13, V14, and V15.

This review of randomly selected charts revealed substantial compliance with the consent decree elements. Individual charts can be reviewed by authorized to validate this chart review.

CONSENT DECREE

Medications

V16) Riverview certifies that the pharmacy computer database system for monitoring the use of psychoactive medications is in place and in use, and that the system as used meets the objectives of ¶168.

Riverview utilizes a Pyxis Medstation 4000 System for the dispensing of medications on each client care unit. A total of six devices, one on each of the four main units and in each of the two special care units, provide access to all medications used for client care, the pharmacy medication record, and allow review of dispensing and administration of pharmaceuticals.

A database program, HCS Medics, contains records of medication use for each client and allows access by an after-hours remote pharmacy service to these records, to the Pyxis Medstation 4000 System. The purpose of this after-hours service is to maintain 24 hour coverage and pharmacy validation and verification services for prescribers.

Records of transactions are evaluated by the Director of Pharmacy and the Medical Director to validate the appropriate utilization of all medication classes dispensed by the hospital. The Pharmacy and Therapeutics Committee, a multidisciplinary group of physicians, pharmacists, and other clinical staff evaluate issues related to the prescribing, dispensing, and administration of all pharmaceuticals.

The system as described is capable of providing information to process reviewers on the status of medications management in the hospital and to ensure the appropriate use of psychoactive and other medications.

The effectiveness and accuracy of the Pyxis Medstation 4000 System is analyzed regularly through the conduct of process improvement and functional efficiency studies. These studies can be found in the Medication Management and Pharmacy Services sections of this report.

CONSENT DECREE

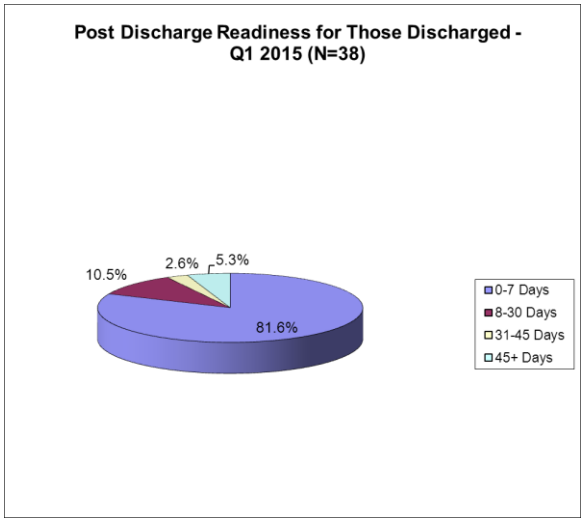
Discharges

Quarterly performance data shows that in 3 consecutive quarters:

V17) 70% of clients who remained ready for discharge were transitioned out of the hospital within 7 days of a determination that they had received maximum benefit from inpatient care;

V18) 80 % of clients who remained ready for discharge were transitioned out of the hospital within 30 days of a determination that they had received maximum benefit from inpatient care;

V19) 90% of clients who remained ready for discharge were transitioned out of the hospital within 45 days of a determination that they had received maximum benefit from inpatient care (with certain clients excepted, by agreement of the parties and court master).



Cumulative percentages & targets are as follows:

Within 7 days = (31) 81.6% (target 70%)
Within 30 days = (35) 92.1% (target 80%)
Within 45 days = (36) 94.7% (target 90%)
Post 45 days = (2) 5.3% (target 0%)

Barriers to Discharge Following Clinical Readiness

Housing (5) 13%

2 clients discharged 8-30 days post clinical readiness/housing barrier (18 & 22 days)
1 client discharged 31-45 days post clinical readiness/housing barrier (44 days)
2 clients discharged 45+days post clinical readiness/housing barrier (47 & 74 days)

Residential Supports (0)

No barriers in this area

Treatment Services (0)

No barriers in this area

Other (2) 5%

2 clients discharged 8-30 days post clinical readiness due to care coordination for discharge (9 and 15 days)

The previous four quarters are displayed in the table below

		Within 7 days	Within 30days	Within 45 days	45 +days
	Target >>	70%	80%	90%	< 10%
4Q2014	N=17	70.6%	94.1%	94.1%	5.9%
3Q2014	N=24	73.1%	84.6%	92.3%	7.7%
2Q2014	N=20	73.1%	84.6%	92.3%	7.7%
1Q2014	N=26	73.1%	84.6%	92.3%	7.7%

**This data is for the entire hospital (including Lower Saco)*

CONSENT DECREE

An evaluation of treatment and discharge planning, performed in accordance with **Attachment D**, demonstrates that, for 90% of the cases reviewed:

V20) Treatment and discharge plans reflect interventions appropriate to address discharge and transition goals;

V20a) For patients who have been found not criminally responsible or not guilty by reason of insanity, appropriate interventions include timely reviews of progress toward the maximum levels allowed by court order; and the record reflects timely reviews of progress toward the maximum levels allowed by court order;

V21) Interventions to address discharge and transition planning goals are in fact being implemented;

V21a) For patients who have been found not criminally responsible or not guilty by reason of insanity, this means that, if the treatment team determines that the patient is ready for an increase in levels beyond those allowed by the current court order, Riverview is taking reasonable steps to support a court petition for an increase in levels.

Indicators	2Q2014	3Q2014	4Q2014	1Q2015
1. The Client Discharge Plan Report will be updated/reviewed by each **Social Worker minimally one time per week.**	100% 11/11	100% 9/9	91% 11/12	100% 13/13
2. The Client Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	100% 11/11	100% 9/9	91% 11/12	76% 10/13
2a. The Client Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	100% 11/11	100% 9/9	91% 11/12	76% 10/13
3. Each week the Social Work team and Director will meet and discuss current housing options provided by the respective regions and prioritize referrals.	100% 11/11	100% 9/9	91% 11/12	100% 13/13

**This data is for the entire hospital (including Lower Saco)*

Summary:

Areas 2 and 3) The report was not sent out during the quarter on 3 occasions due to the Director being out on FMLA and technical issues with the document.

CONSENT DECREE

V22) The Department demonstrates that 95% of the annual reports for forensic patients are submitted to the Commissioner and forwarded to the court on time.

Indicators	2Q2014	3Q2014	4Q2014	1Q2015
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	0% 0/4	0% 0/2	50% 3/6	25% 1/4
2. The assigned **CCM** will review the new court order with the client and document the meeting in a progress note or treatment team note.	100% 4/4	100% 3/3	100% 4/4	100% 6/6
3. Annual Reports (due Dec) to the commissioner for all inpatient NCR clients are submitted annually	100% 92/92	N/A	N/A	N/A

**This data is for the entire hospital (including Lower Saco)*

Summary:

Area 1) Four Institutional Reports were done in the quarter and one was completed within the 10 day timeframe and the other three were completed 13 days, 17days and 36 days respectively.

CONSENT DECREE

Staffing and Staff Training

V23) Riverview performance data shows that 95% of direct care staff have received 90% of their annual training.

Indicators	1Q2015	2Q2015	3Q2015	4Q2015	YTD Findings
1. Riverview and Contract staff will attend CPR training bi-annually.	100% 62/62				100%
2. Riverview and Contract staff will attend Annual training.	96% 109/113				96%
3. Riverview and contract staff will attend MOAB training bi-annually	92% 389/424				92%

**This data is for the entire hospital (including Lower Saco)*

1Q2015

1. Employees who are out of compliance have been notified and corrective action is being taken.
2. MOAB was initiated in January 2014. Since the initiation date 398 staff have been trained leaving 35 employees still in need of training. MOAB is offered at least monthly.

Goal #1: SD will provide opportunities for employees to gain, develop and renew skills knowledge and aptitudes.

Objective: 100% of employees will be provided with an opportunity both formal and informal training and/or learning experiences that contribute to individual growth and improved performance in current position.

SD will survey staff annually and develop trainings to address training needs as identified by staff.

Current Status:

1Q2015: Motivational Interviewing was provided in September 2014.

Goal #2: SD will develop and implement a comprehensive mentoring program to assist new employees in gaining the skills necessary to do their job.

Objective: 100% of new Mental Health Workers will be paired with a mentor and will satisfactorily complete 12 competency areas on the unit orientation prior to being assigned regular duties requiring direct care of patients.

Current Status:

1Q2015: 100% of new Mental Health Workers were paired with a mentor and satisfactorily completed competency areas in the Unit Orientation.

CONSENT DECREE

V24) Riverview certifies that 95% of professional staff have maintained professionally-required continuing education credits and have received the ten hours of annual cross-training required by ¶216;

DATE	HRS	TITLE	PRESENTER
DATE	HRS	TITLE	PRESENTER
3Q2012	14	January - March 2012	Winter Semester (see1Q13 Quarterly Report)
4Q2012	11	April – June 2012	Spring Semester (see1Q13 Quarterly Report)
1Q2013	3	July – September 2012	Summer Hiatus (see1Q13 Quarterly Report)
2Q2013	9	October – December 2012	Fall Semester (see2Q13 Quarterly Report)
3Q2013	11	January – March 2013	Winter Semester (see 3Q13 Quarterly Report)
4Q2013	12	April – June 2013	Spring Semester (see 4Q13 Quarterly Report)
1Q2014	5.5	July - September 2013	Summer Semester (see 1Q14 Quarterly Report)
2Q2014	7	October – December 2013	Fall Semester (see 2Q14 Quarterly Report)
3Q2014	15	January – March 2014	Winter Semester (see 3Q14 Quarterly Report)
4Q2014	16	April – June 2014	Spring Semester (see 4Q14 Quarterly Report)
7/15/2014	1	Peer Review Committee	Brendan Kirby, MD
8/6/2014	1	MOAB Training	Shawn McFarland
8/19/2014	1	Peer Review Committee	Miriam Davidson, PMHNP
8/28/2014	1	When home is no longer home: some guidelines for mental health professionals when working with refugees from Somalia	Jennifer Brotsky, PsyD
9/4/2014	1	Treatment Planning	Art DiRocco, PhD, Brendan Kirby, MD, Lisa Manwaring
9/11/2014	1	Review of a Long Term Riverview Patient	Art DiRocco, PhD Noel Ngai, Psychology Intern
9/16/2014	1	Peer Review Committee	Brendan Kirby, Md
9/17/2014	1	Metabolic Monitoring	Miranda Cole, PharmD
9/18/2014	1	Review of a Long Term Riverview Patient, Part II	Art DiRocco, PhD Noel Ngai, Psychology Intern
9/22/2014	4	Motivational Interviewing: The Basics	Stephen R. Andrew, LCSW, LADC, CCS, CGP
9/23/2014	4	Motivational Interviewing: The Basics	Stephen R. Andrew, LCSW, LADC, CCS, CGP
9/25/2014	1	Seizures, Psychosis or Something Else?	David Dettmann, DO

**This data is for the entire hospital (including Lower Saco)*

CONSENT DECREE

V25) Riverview certifies that staffing ratios required by ¶202 are met, and makes available documentation that shows actual staffing for up to one recent month;

Staff Type	Consent Decree Ratio
General Medicine Physicians	1:75
Psychiatrists	1:25
Psychologists	1:25
Nursing	1:20
Social Workers	1:15
Mental Health Workers	1:6
Recreational/Occupational Therapists/Aides	1:8

With 72 beds, Riverview regularly meets or exceeds the staffing ratio requirements of the consent decree.

Staffing levels are most often determined by an analysis of unit acuity, individual monitoring needs of the clients who residing on specific units, and unit census.

V26) The evaluation of treatment and discharge planning, performed in accordance with **Attachment D**, demonstrates that staffing was sufficient to provide patients access to activities necessary to achieve the patients' treatment goals, and to enable patients to exercise daily and to recreate outdoors consistent with their treatment plans.

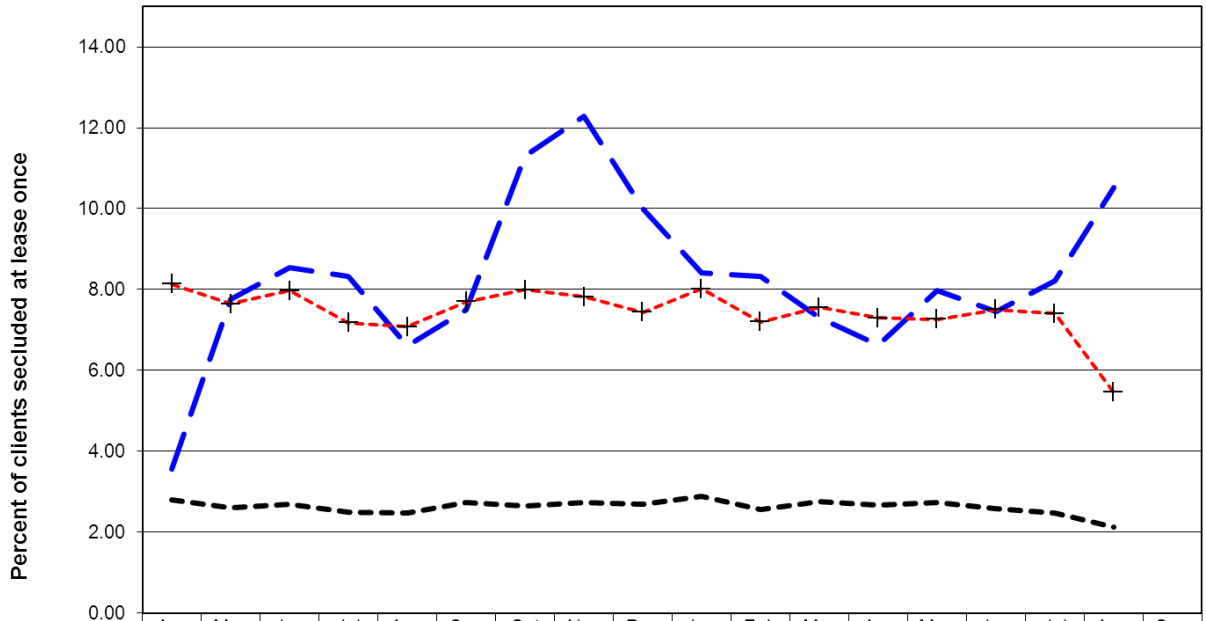
Treatment teams regularly monitor the needs of individual clients and make recommendations for ongoing treatment modalities. Staffing levels are carefully monitored to ensure that all treatment goals, exercise needs, and outdoor activities are achievable. Staffing does not present a barrier to the fulfillment of client needs. Staffing deficiencies that may periodically be present are rectified through utilization of overtime or mandated staff members.

CONSENT DECREE

Use of Seclusion and Restraints

V27) Quarterly performance data shows that, in 5 out of 6 quarters, total seclusion and restraint hours do not exceed one standard deviation from the national mean as reported by NASMHPD;

Percent of Clients Secluded



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	3.57	7.76	8.55	8.33	6.61	7.50	11.30	12.28	10.00	8.40	8.33	7.30	6.62	7.97	7.46	8.21	10.53	
Ntl Mean	2.79	2.61	2.69	2.49	2.48	2.73	2.65	2.74	2.69	2.89	2.56	2.76	2.66	2.74	2.58	2.47	2.13	
+1 StDev	8.13	7.64	7.97	7.18	7.08	7.70	7.99	7.82	7.44	8.01	7.20	7.56	7.30	7.26	7.50	7.41	5.46	

**This data is for the entire hospital (including Lower Saco)*

This graph depicts the percent of unique clients who were secluded at least once. For example, rates of 3.0 means that 3% of the unique clients served were secluded at least once.

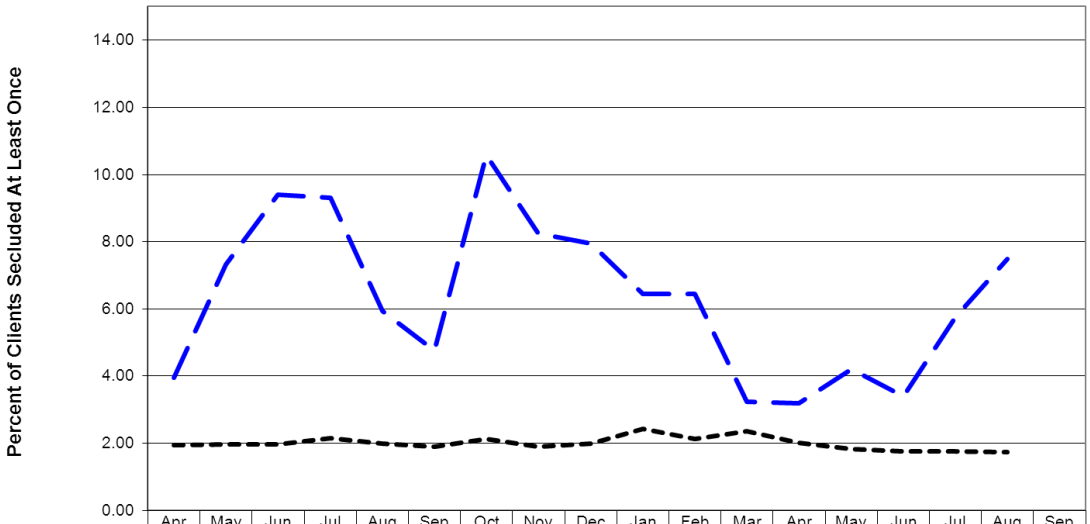
The following graphs depict the percent of unique clients who were secluded at least once stratified by forensic or civil classifications. For example; rates of 3.0 means that 3% of the unique clients served were secluded at least once.

The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Percent of Clients Secluded

Forensic Stratification

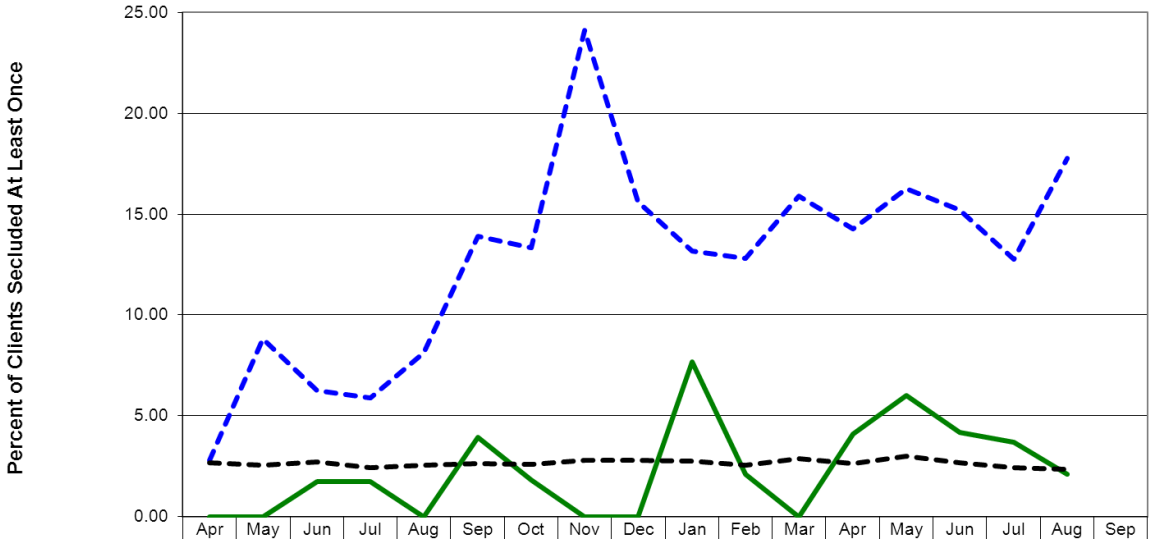


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	3.95	7.32	9.41	9.30	5.95	4.76	10.59	8.24	7.95	6.45	6.45	3.23	3.19	4.21	3.41	5.75	7.48	
Ntl Mean	1.94	1.97	1.97	2.15	1.99	1.89	2.14	1.89	1.99	2.44	2.12	2.35	2.02	1.82	1.76	1.77	1.74	

**This data is for the entire hospital (including Lower Saco)*

Percent of Clients Secluded

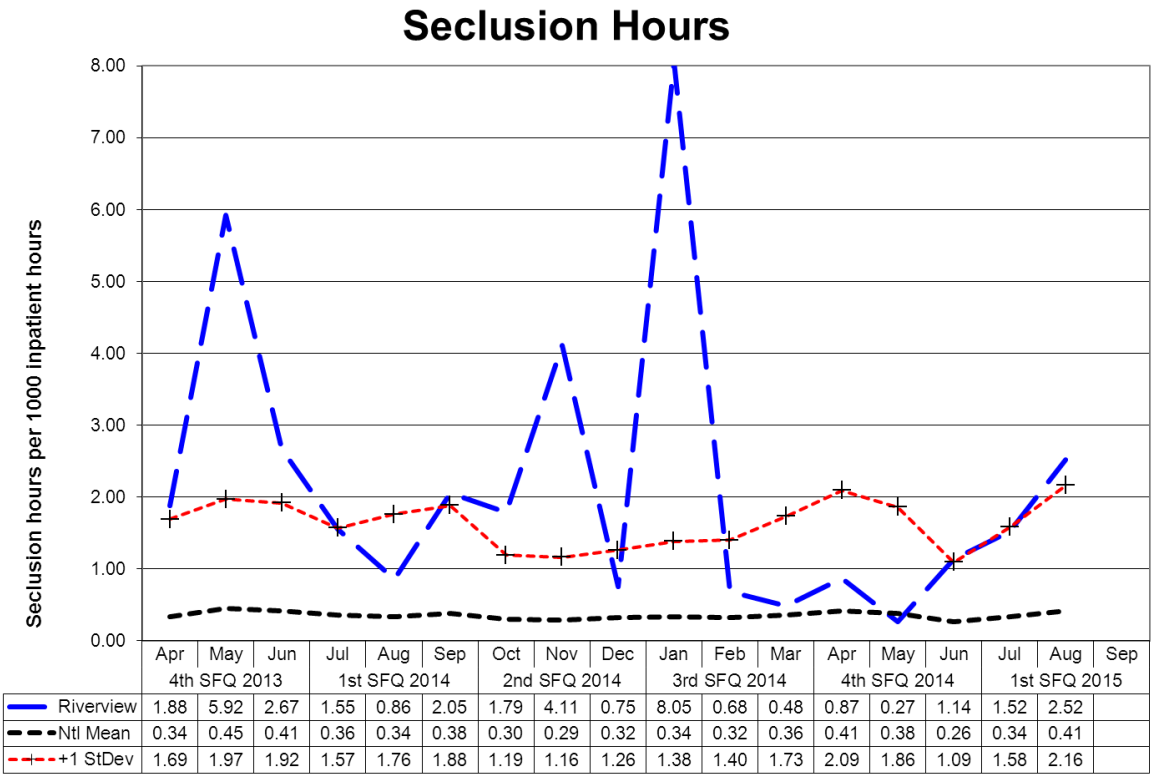
Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	2.78	8.82	6.25	5.88	8.11	13.89	13.33	24.14	15.62	13.16	12.82	15.91	14.29	16.28	15.22	12.77	17.78	
Dorothea Dix	0.00	0.00	1.75	1.72	0.00	3.92	1.82	0.00	0.00	7.69	2.08	0.00	4.08	6.00	4.17	3.70	2.08	
Ntl Mean	2.68	2.53	2.71	2.43	2.54	2.62	2.57	2.77	2.79	2.76	2.56	2.86	2.62	2.98	2.66	2.41	2.33	

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

CONSENT DECREE



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	1.88	5.92	2.67	1.55	0.86	2.05	1.79	4.11	0.75	8.05	0.68	0.48	0.87	0.27	1.14	1.52	2.52	
Ntl Mean	0.34	0.45	0.41	0.36	0.34	0.38	0.30	0.29	0.32	0.34	0.32	0.36	0.41	0.38	0.26	0.34	0.41	
+1 StDev	1.69	1.97	1.92	1.57	1.76	1.88	1.19	1.16	1.26	1.38	1.40	1.73	2.09	1.86	1.09	1.58	2.16	

**This data is for the entire hospital (including Lower Saco)*

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

The outlier values shown in May and June reflect the events related to a single individual during this period. This individual was in seclusion for extended periods of time due to extremely aggressive behaviors that are focused on staff. It was determined that the only way to effectively manage this client and create a safe environment for both the staff and other clients was to segregate him in an area away from other clients and to provide frequent support and interaction with staff in a manner that ensured the safety of the staff so engaged.

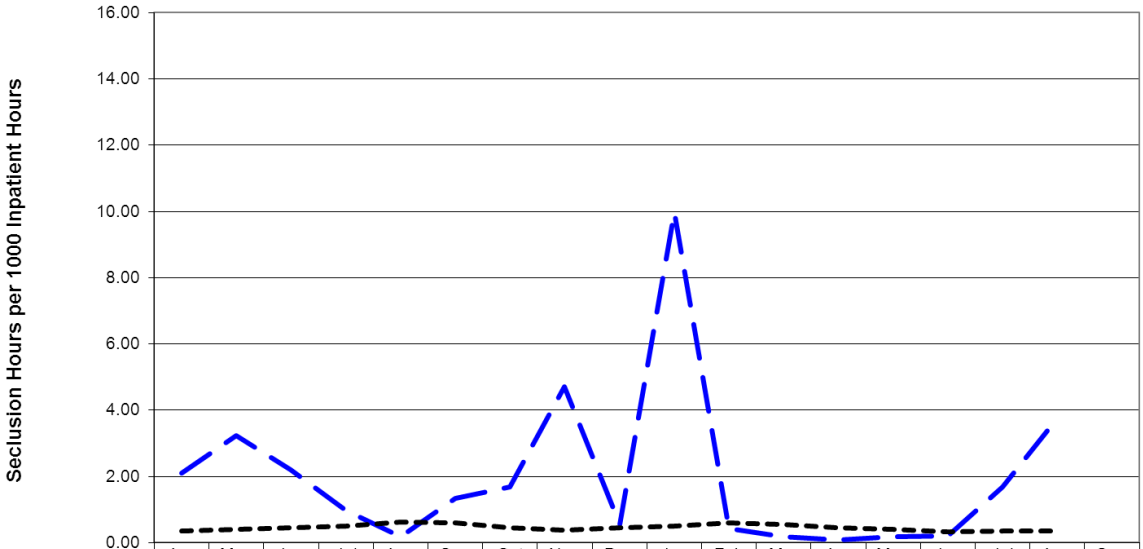
The following graphs depict the number of hours clients spent in seclusion for every 1000 inpatient hours stratified by forensic or civil classifications. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours.

The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Seclusion Hours

Forensic Stratification

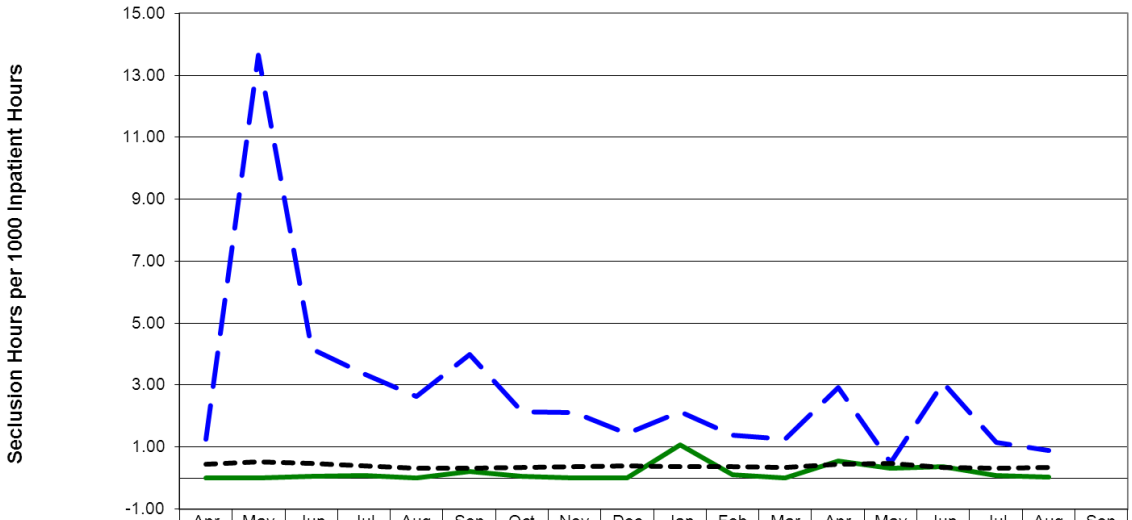


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	2.11	3.23	2.20	0.97	0.19	1.34	1.67	4.71	0.54	9.99	0.43	0.17	0.09	0.18	0.20	1.68	3.74	
Ntl Mean	0.36	0.40	0.45	0.51	0.61	0.60	0.44	0.37	0.45	0.51	0.60	0.56	0.46	0.40	0.33	0.36	0.36	

**This data is for the entire hospital (including Lower Saco)*

Seclusion Hours

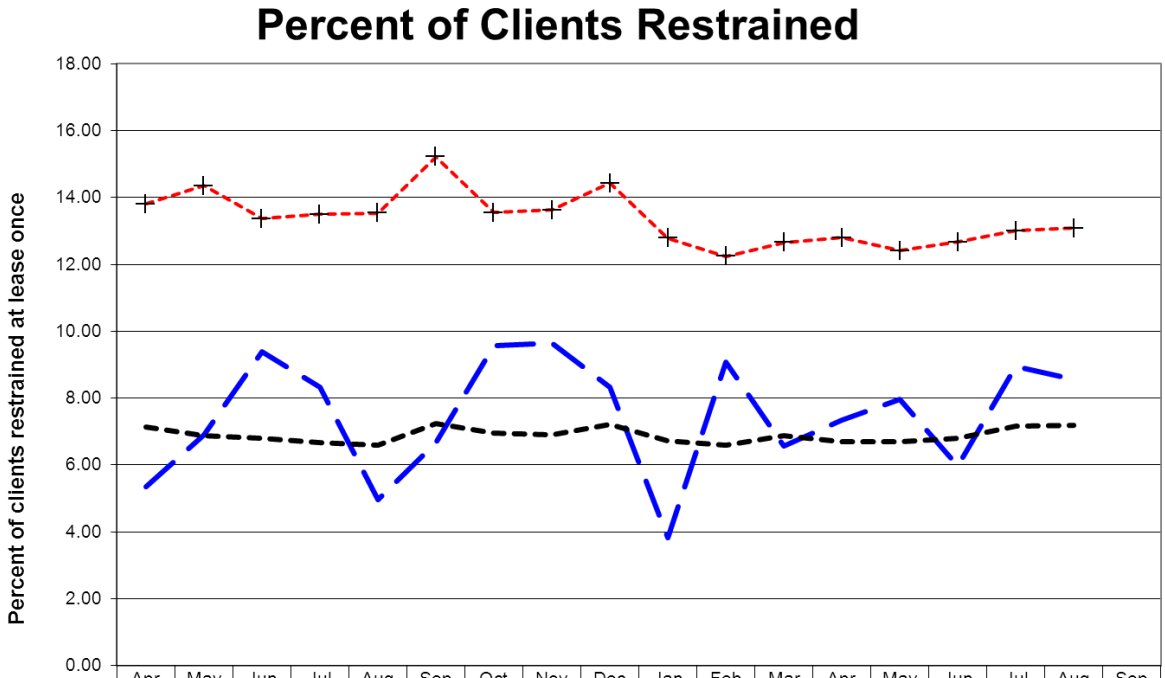
Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	1.26	13.65	4.18	3.37	2.63	3.98	2.14	2.12	1.43	2.14	1.38	1.26	2.92	0.49	3.09	1.15	0.90	
Dorothea Dix	0.00	0.00	0.06	0.09	0.00	0.22	0.05	0.00	0.00	1.08	0.10	0.00	0.56	0.31	0.36	0.09	0.03	
Ntl Mean	0.44	0.53	0.46	0.40	0.32	0.32	0.33	0.38	0.39	0.36	0.36	0.33	0.44	0.46	0.35	0.32	0.33	

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

CONSENT DECREE



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	5.36	6.90	9.40	8.33	4.96	6.67	9.57	9.65	8.33	3.82	9.09	6.57	7.35	7.97	5.97	8.96	8.55	
Ntl Mean	7.15	6.88	6.80	6.67	6.59	7.24	6.95	6.90	7.22	6.73	6.60	6.87	6.71	6.71	6.79	7.17	7.19	
+1 StDev	13.81	14.35	13.37	13.50	13.54	15.21	13.55	13.63	14.43	12.79	12.24	12.66	12.80	12.41	12.67	13.01	13.08	

**This data is for the entire hospital (including Lower Saco)*

This graph depicts the percent of unique clients who were restrained at least once – includes all forms of restraint of any duration. For example; a rate of 4.0 means that 4% of the unique clients served were restrained at least once.

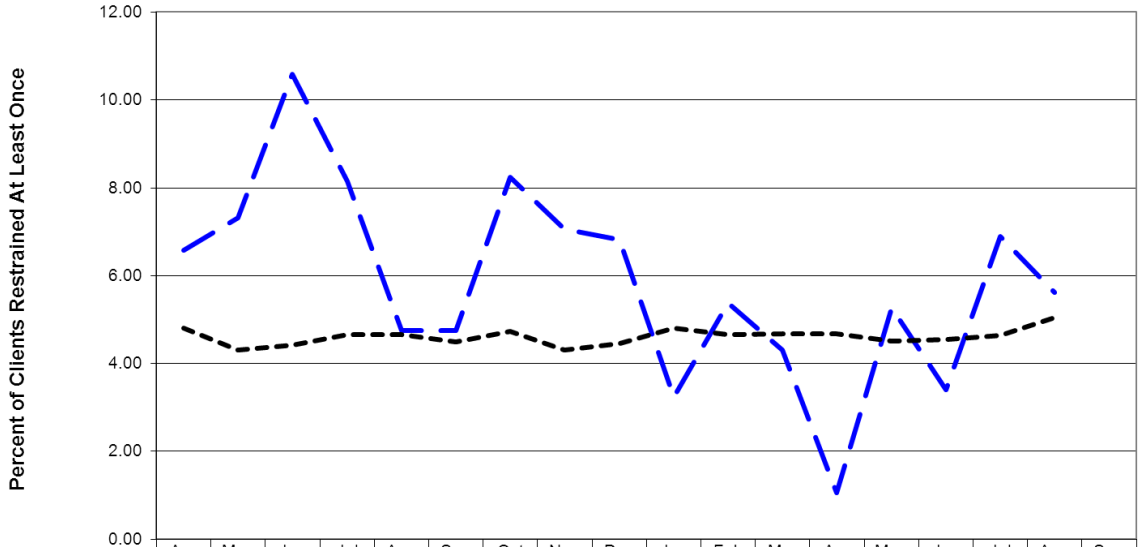
The following graphs depict the percent of unique clients who were restrained at least once stratified by forensic or civil classifications – includes all forms of restraint of any duration. For example; a rate of 4.0 means that 4% of the unique clients served were restrained at least once.

The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Percent of Clients Restrained

Forensic Stratification

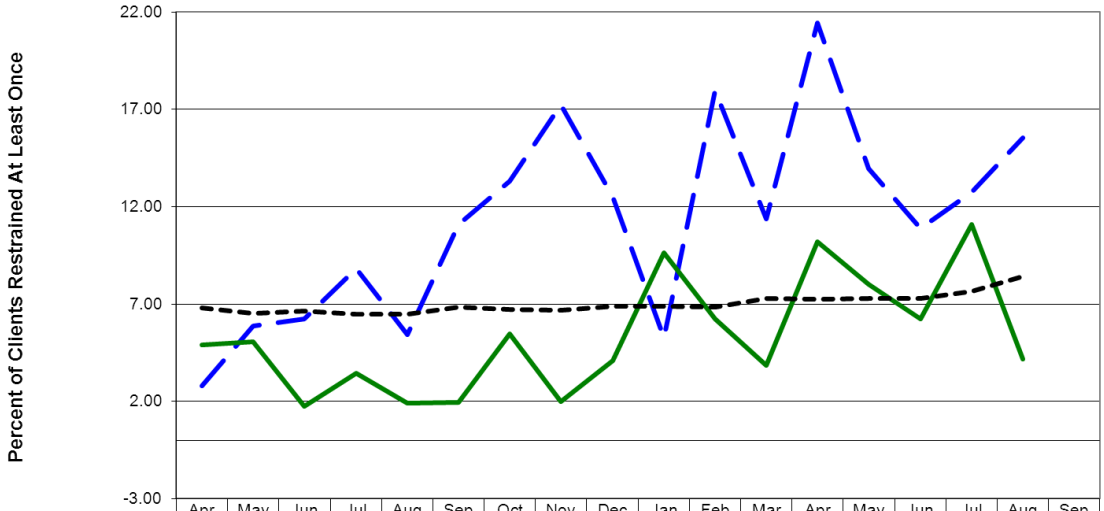


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	6.58	7.32	10.59	8.14	4.76	4.76	8.24	7.06	6.82	3.23	5.38	4.30	1.06	5.26	3.41	6.90	5.61	
Ntl Mean	4.81	4.30	4.42	4.66	4.66	4.49	4.73	4.31	4.46	4.81	4.66	4.67	4.68	4.51	4.54	4.64	5.05	

**This data is for the entire hospital (including Lower Saco)*

Percent of Clients Restrained

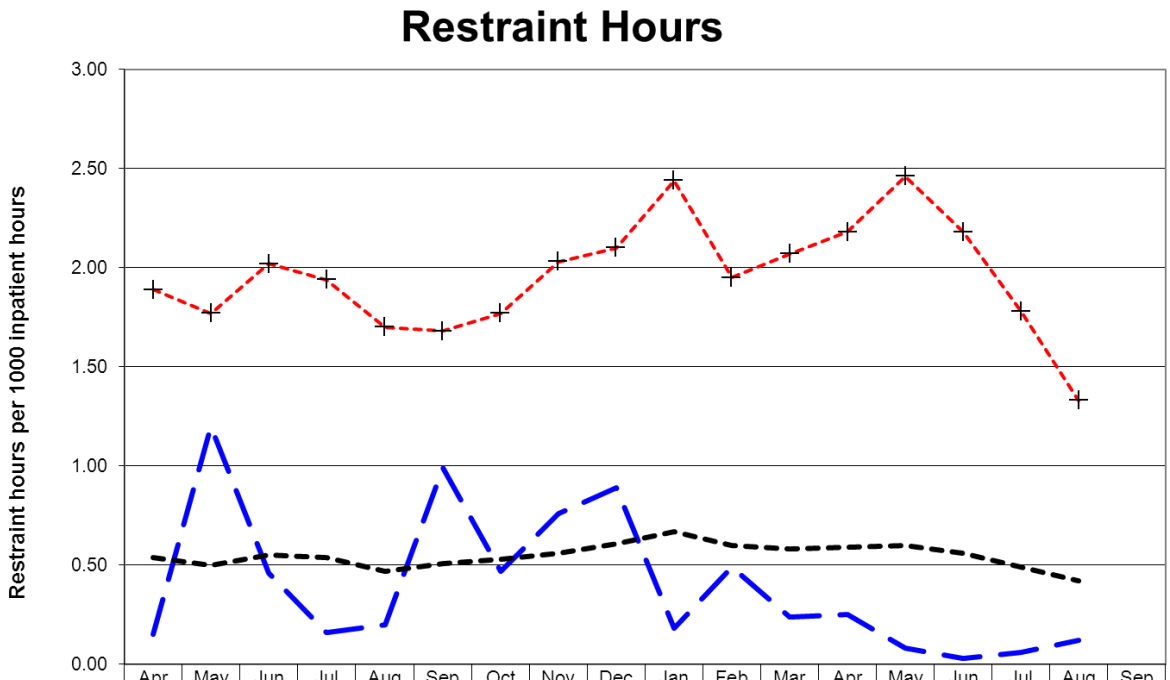
Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	2.78	5.88	6.25	8.82	5.41	11.11	13.33	17.24	12.50	5.26	17.95	11.36	21.43	13.95	10.87	12.77	15.56	
Dorothea Dix	4.92	5.08	1.75	3.45	1.92	1.96	5.45	2.00	4.08	9.62	6.25	3.85	10.20	8.00	6.25	11.11	4.17	
Ntl Mean	6.80	6.50	6.66	6.46	6.49	6.85	6.72	6.69	6.89	6.88	6.86	7.29	7.26	7.30	7.27	7.66	8.43	

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

CONSENT DECREE



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	0.15	1.20	0.46	0.16	0.20	0.99	0.47	0.76	0.89	0.18	0.49	0.24	0.25	0.08	0.03	0.06	0.12	
Ntl Mean	0.54	0.50	0.55	0.54	0.47	0.51	0.53	0.56	0.61	0.67	0.60	0.58	0.59	0.60	0.56	0.49	0.42	
+1 StDev	1.89	1.77	2.02	1.94	1.70	1.68	1.77	2.03	2.10	2.44	1.95	2.07	2.18	2.46	2.18	1.78	1.33	

**This data is for the entire hospital (including Lower Saco)*

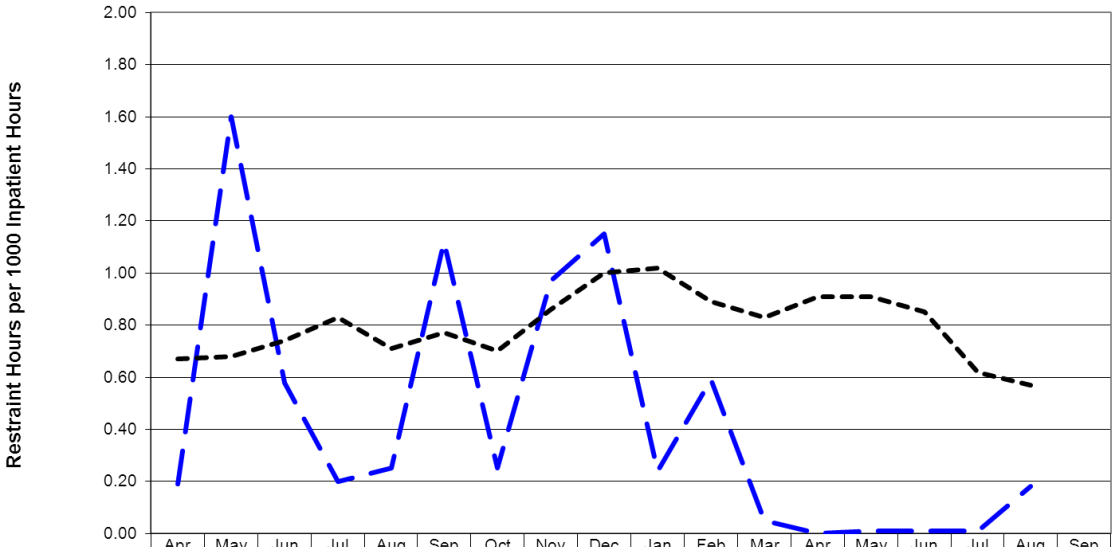
This graph depicts the number of hours clients spent in restraint for every 1000 inpatient hours - includes all forms of restraint of any duration. For example; a rate of 1.6 means those 2 hours were spent in restraint for each 1250 inpatient hours.
The following graphs depict the number of hours clients spent in restraint for every 1000 inpatient hours stratified by forensic or civil classifications - includes all forms of restraint of any duration. For example; a rate of 1.6 means those 2 hours were spent in restraint for each 1250 inpatient hours.

The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Restraint Hours

Forensic Stratification

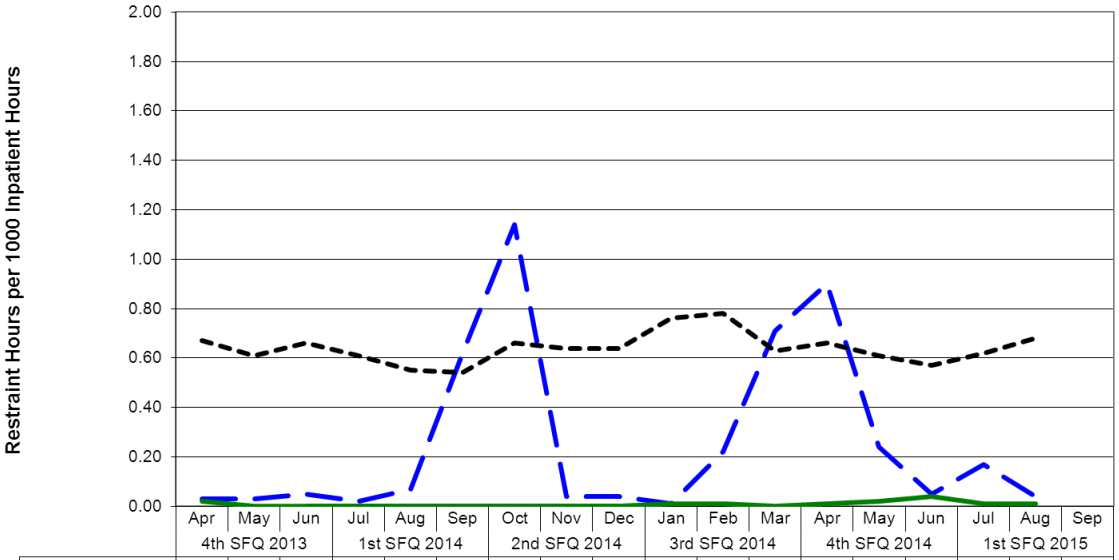


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	0.19	1.60	0.58	0.20	0.25	1.12	0.25	0.97	1.15	0.24	0.59	0.05	0.00	0.01	0.01	0.01	0.18	
Ntl Mean	0.67	0.68	0.74	0.83	0.71	0.77	0.70	0.86	1.00	1.02	0.89	0.83	0.91	0.91	0.85	0.62	0.57	

**This data is for the entire hospital (including Lower Saco)*

Restraint Hours

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	0.03	0.03	0.05	0.02	0.07	0.62	1.14	0.04	0.04	0.01	0.22	0.71	0.90	0.24	0.05	0.17	0.04	
Dorothea Dix	0.02	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.01	0.00	0.01	0.02	0.04	0.01	0.01	
Ntl Mean	0.67	0.61	0.66	0.61	0.55	0.54	0.66	0.64	0.64	0.76	0.78	0.63	0.66	0.61	0.57	0.62	0.68	

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

CONSENT DECREE

Confinement Event Detail

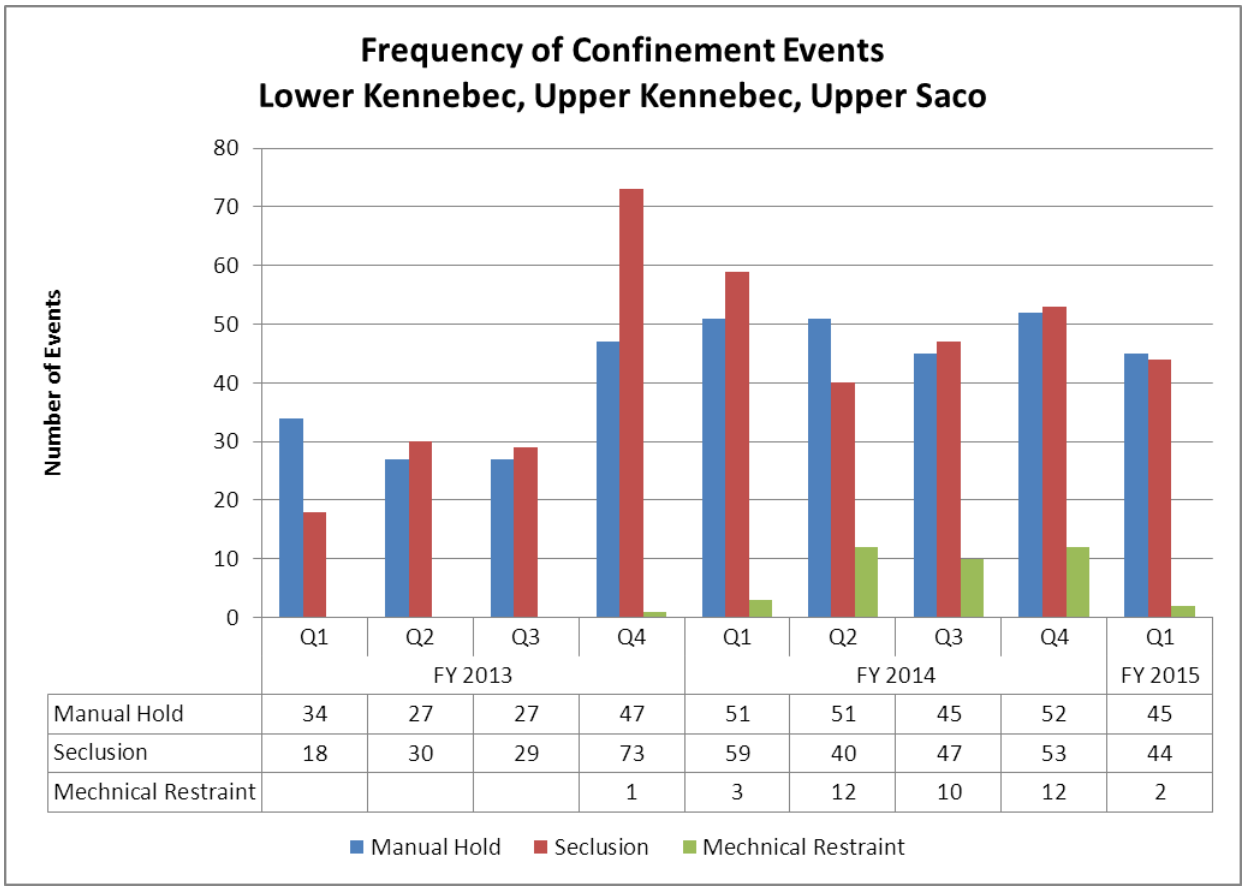
1st Quarter 2015

Patient ID	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
MR2187	10		6	16	17.58%	17.58%
MR7495	8	1	5	14	15.38%	32.97%
MR7564	6		4	10	10.99%	43.96%
MR763	4		3	7	7.69%	51.65%
MR5199	3		3	6	6.59%	58.24%
MR7607	2		3	5	5.49%	63.74%
MR657	2		2	4	4.40%	68.13%
MR7127	3		1	4	4.40%	72.53%
MR29	1	1	2	4	4.40%	76.92%
MR7484	1		2	3	3.30%	80.22%
MR5625	1		2	3	3.30%	83.52%
MR4296			3	3	3.30%	86.81%
MR7363	1		1	2	2.20%	89.01%
MR5213	1			1	1.10%	90.11%
MR91			1	1	1.10%	91.21%
MR7394			1	1	1.10%	92.31%
MR68	1			1	1.10%	93.41%
MR698			1	1	1.10%	94.51%
MR5068	1			1	1.10%	95.60%
MR1416			1	1	1.10%	96.70%
MR6145			1	1	1.10%	97.80%
MR852			1	1	1.10%	98.90%
MR7468			1	1	1.10%	100.00%
	45	**2**	**44**	**91**		

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

38% (23/60) of average hospital population experienced some form of confinement event during the 1st fiscal quarter 2015. Five of these clients (8% of the average hospital population) accounted for 58.24% of the containment events.

CONSENT DECREE



	FY 2013 Q1	FY 2013 Q2	FY 2013 Q3	FY 2013 Q4	FY 2014 Q1	FY 2014 Q2	FY 2014 Q3	FY 2014 Q4	FY 2015 Q1
Manual Hold	34	27	27	47	51	51	45	52	45
Seclusion	18	30	29	73	59	40	47	53	44
Mechnical Restraint				1	3	12	10	12	2

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

CONSENT DECREE

V28) Riverview demonstrates that, based on a review of two quarters of data, for 95% of seclusion events, seclusion was employed only when absolutely necessary to protect the patient from causing physical harm to self or others or for the management of violent behavior;

Factors of Causation Related to Seclusion Events

	2Q14	3Q14	4Q14	1Q15	Total
Danger to Others/Self	40	47	52	13	**152**
Danger to Others			2	31	**33**
Danger to Self					
% Dangerous Precipitation	100%	100%	100%	100%	**100%**
Total Events	**40**	**47**	**54**	**44**	**185**

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

V29) Riverview demonstrates that, based on a review of two quarters of data, for 95% of restraint events involving mechanical restraints, the restraint was used only when absolutely necessary to protect the patient from serious physical injury to self or others;

Factors of Causation Related to Mechanical Restraint Events

	2Q14	3Q14	4Q14	1Q15	Total
Danger to Others/Self	12	10	11	1	**34**
Danger to Others				1	**1**
Danger to Self			1		**1**
% Dangerous Precipitation	100%	100%	100%	100%	**100%**
Total Events	**12**	**10**	**12**	**2**	**36**

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

V30) Riverview demonstrates that, based on a review of two quarters of data, for 95% of seclusion and restraint events, the hospital achieved an acceptable rating for meeting the requirements of paragraphs 182 and 184 of the Settlement Agreement, in accordance with a methodology defined in **Attachments E-1 and E-2.**

See Pages 30 & 31

CONSENT DECREE

Confinement Events Management

Seclusion Events (44) Events

Standard	Threshold	Compliance
The record reflects that seclusion was absolutely necessary to protect the patient from causing physical harm to self or others, or if the patient was examined by a physician or physician extender prior to implementation of seclusion, to prevent further serious disruption that significantly interferes with other patients' treatment.	95%	100%
The record reflects that lesser restrictive alternatives were inappropriate or ineffective. This can be reflected anywhere in record.	90%	100%
The record reflects that the decision to place the patient in seclusion was made by a physician or physician extender.	90%	100%
The decision to place the patient in seclusion was entered in the patient's records as a medical order.	90%	100%
The record reflects that, if the physician or physician extender was not immediately available to examine the patient, the patient was placed in seclusion following an examination by a nurse.	90%	100%
The record reflects that the physician or physician extender personally evaluated the patient within 30 minutes after the patient has been placed in seclusion, and if there is a delay, the reasons for the delay.	90%	100%
The record reflects that the patient was monitored every 15 minutes. (Compliance will be deemed if the patient was monitored at least 3 times per hour.)	90%	100%
Individuals implementing seclusion have been trained in techniques and alternatives.	90%	100%
The record reflects that reasonable efforts were taken to notify guardian or designated representative as soon as possible that patient was placed in seclusion.	75%	100%

Standard	Threshold	Compliance
The medical order states time of entry of order and that number of hours in seclusion shall not exceed 4.	85%	100%
The medical order states the conditions under which the patient may be sooner released.	85%	100%
The record reflects that the need for seclusion is re-evaluated at least every 2 hours by a nurse.	90%	100%
The record reflects that the 2 hour re-evaluation was conducted while the patient was out of seclusion room unless clinically contraindicated.	70%	100%
The record includes a special check sheet that has been filled out to document reason for seclusion, description of behavior and the lesser restrictive alternatives considered.	85%	100%
The record reflects that the patient was released, unless clinically contraindicated, at least every 2 hours or as necessary for eating, drinking, bathing, toileting or special medical orders.	85%	100%
Reports of seclusion events were forwarded to medical director and advocate.	90%	100%
The record reflects that, for persons with mental retardation, the regulations governing seclusion of clients with mental retardation were met.	85%	100%
The medical order for seclusion was not entered as a PRN order.	90%	100%
Where there was a PRN order, there is evidence that physician was counseled.	95%	N/A

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

CONSENT DECREE

Confinement Events Management

Mechanical Restraint Events (2) Events

Standard	Threshold	Compliance
The record reflects that restraint was absolutely necessary to protect the patient from causing serious physical injury to self or others.	95%	100%
The record reflects that lesser restrictive alternatives were inappropriate or ineffective.	90%	100%
The record reflects that the decision to place the patient in restraint was made by a physician or physician extender	90%	100%
The decision to place the patient in restraint was entered in the patient's records as a medical order.	90%	100%
The record reflects that, if a physician or physician extended was not immediately available to examine the patient, the patient was placed in restraint following an examination by a nurse.	90%	100%
The record reflects that the physician or physician extender personally evaluated the patient within 30 minutes after the patient has been placed in restraint, or, if there was a delay, the reasons for the delay.	90%	100%
The record reflects that the patient was kept under constant observation during restraint.	95%	100%
Individuals implementing restraint have been trained in techniques and alternatives.	90%	100%
The record reflects that reasonable efforts taken to notify guardian or designated representative as soon as possible that patient was placed in restraint.	75%	100%
The medical order states time of entry of order and that number of hours shall not exceed four.	90%	100%
The medical order shall state the conditions under which the patient may be sooner released.	85%	100%

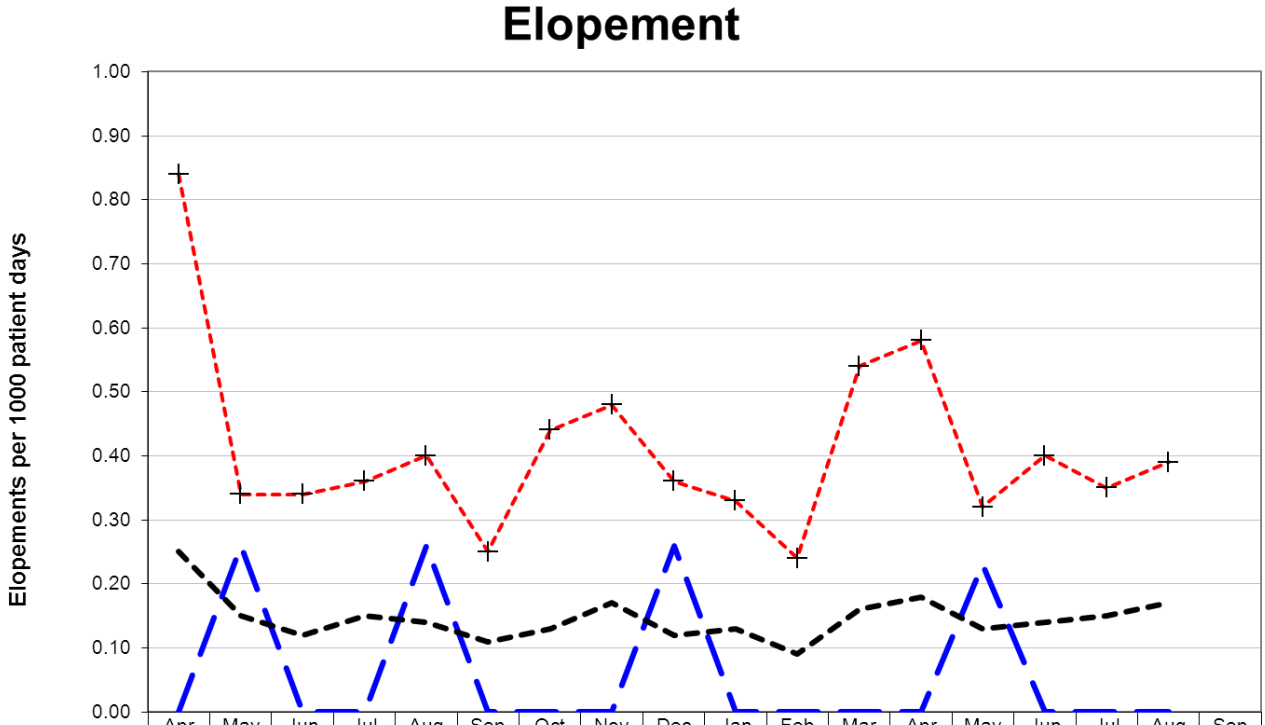
Standard	Threshold	Compliance
The record reflects that the need for restraint was re-evaluated every 2 hours by a nurse.	90%	100%
The record reflects that re-evaluation was conducted while the patient was free of restraints unless clinically contraindicated.	70%	100%
The record includes a special check sheet that has been filled out to document the reason for the restraint, description of behavior and the lesser restrictive alternatives considered.	85%	100%
The record reflects that the patient was released as necessary for eating, drinking, bathing, toileting or special medical orders.	90%	100%
The record reflects that the patient's extremities were released sequentially, with one released at least every fifteen minutes.	90%	100%
Copies of events were forwarded to medical director and advocate.	90%	100%
For persons with mental retardation, the applicable regulations were met.	85%	100%
The record reflects that the order was not entered as a PRN order.	90%	100%
Where there was a PRN order, there is evidence that physician was counseled.	95%	N/A
A restraint event that exceeds 24 hours will be reviewed against the following requirement: If total consecutive hours in restraint, with renewals, exceeded 24 hours, the record reflects that the patient was medically assessed and treated for any injuries; that the order extending restraint beyond 24 hours was entered by Medical Director (or if the Medical Director is out of the hospital, by the individual acting in the Medical Director's stead) following examination of the patient; and that the patient's guardian or representative has been notified.	90%	100%

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

CONSENT DECREE

Client Elopements

V31) Quarterly performance data shows that, in 5 out of 6 quarters, the number of client elopements does not exceed one standard deviation from the national mean as reported by NASMHPD.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	0.00	0.26	0.00	0.00	0.26	0.00	0.00	0.00	0.26	0.00	0.00	0.00	0.00	0.23	0.00	0.00	0.00	
Ntl Mean	0.25	0.15	0.12	0.15	0.14	0.11	0.13	0.17	0.12	0.13	0.09	0.16	0.18	0.13	0.14	0.15	0.17	
StDev	0.84	0.34	0.34	0.36	0.40	0.25	0.44	0.48	0.36	0.33	0.24	0.54	0.58	0.32	0.40	0.35	0.39	

**This data is for the entire hospital (including Lower Saco)*

This graph depicts the number of elopements that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days.

An elopement is defined as any time a client is "absent from a location defined by the client's privilege status regardless of the client's leave or legal status."

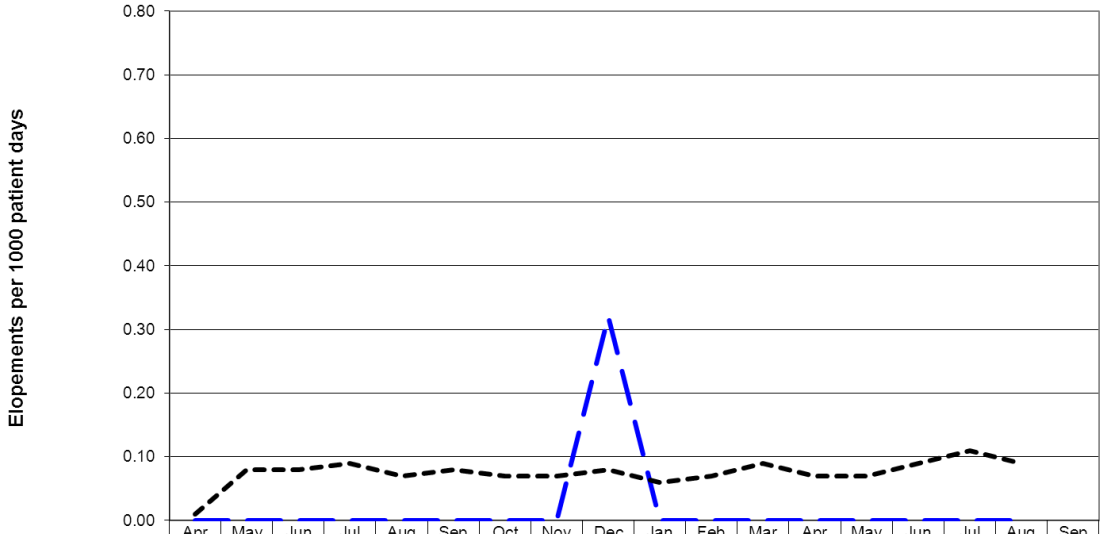
The following graphs depict the number of elopements stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days.

The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Elopement

Forensic Stratification

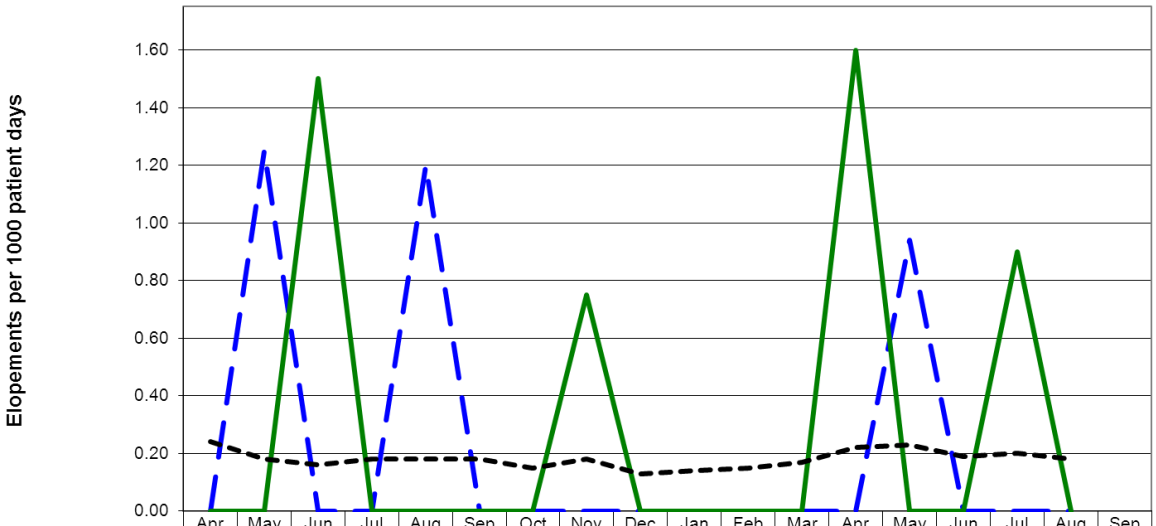


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.32	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Ntl Mean	0.01	0.08	0.08	0.09	0.07	0.08	0.07	0.07	0.08	0.06	0.07	0.09	0.07	0.07	0.09	0.11	0.09	

**This data is for the entire hospital (including Lower Saco)*

Elopement

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	0.00	1.25	0.00	0.00	1.20	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.94	0.00	0.00	0.00	
Dorothea Dix	0.00	0.00	1.50	0.00	0.00	0.00	0.00	0.75	0.00	0.00	0.00	0.00	1.60	0.00	0.00	0.90	0.00	
Ntl Mean	0.24	0.18	0.16	0.18	0.18	0.18	0.15	0.18	0.13	0.14	0.15	0.17	0.22	0.23	0.19	0.20	0.18	

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

CONSENT DECREE

Client Injuries

V32) Quarterly performance data shows that, in 5 out of 6 quarters, the number of client injuries does not exceed one standard deviation from the national mean as reported by NASMHPD.

The NASMHPD standards for measuring client injuries differentiate between injuries that are considered reportable to the Joint Commission as a performance measure and those injuries that are of a less severe nature. While all injuries are currently reported internally, only certain types of injuries are documented and reported to NRI for inclusion in the performance measure analysis process.

"Non-reportable" injuries include those that require: 1) No Treatment, or 2) Minor First Aid

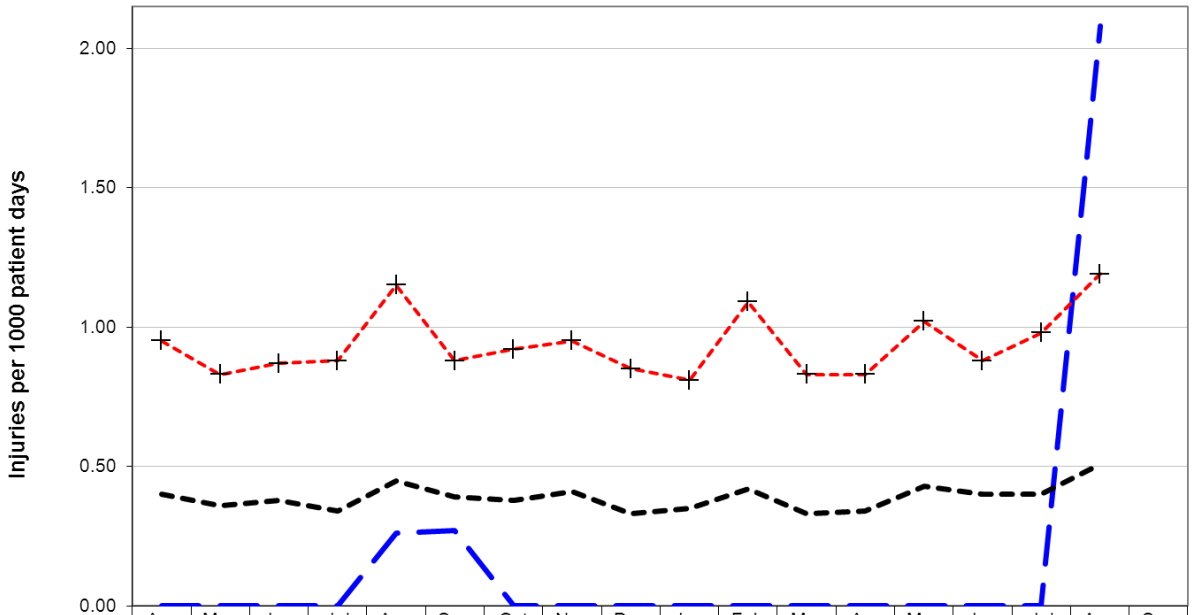
Reportable injuries include those that require: 3) Medical Intervention, 4) Hospitalization or where, 5) Death Occurred.

- No Treatment – The injury received by a client may be examined by a clinician but no treatment is applied to the injury.
- Minor First Aid – The injury received is of minor severity and requires the administration of minor first aid.
- Medical Intervention Needed – The injury received is severe enough to require the treatment of the client by a licensed practitioner, but does not require hospitalization.
- Hospitalization Required – The injury is so severe that it requires medical intervention and treatment as well as care of the injured client at a general acute care medical ward within the facility or at a general acute care hospital outside the facility.
- Death Occurred – The injury received was so severe that if resulted in, or complications of the injury lead to, the termination of the life of the injured client.

The comparative statistics graph only includes those events that are considered "Reportable" by NASMHPD.

CONSENT DECREE

Client Injury Rate



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	0.00	0.00	0.00	0.00	0.26	0.27	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.08	
Ntl Mean	0.40	0.36	0.38	0.34	0.45	0.39	0.38	0.41	0.33	0.35	0.42	0.33	0.34	0.43	0.40	0.40	0.51	
+1 StDev	0.95	0.83	0.87	0.88	1.15	0.88	0.92	0.95	0.85	0.81	1.09	0.83	0.83	1.02	0.88	0.98	1.19	

**This data is for the entire hospital (including Lower Saco)*

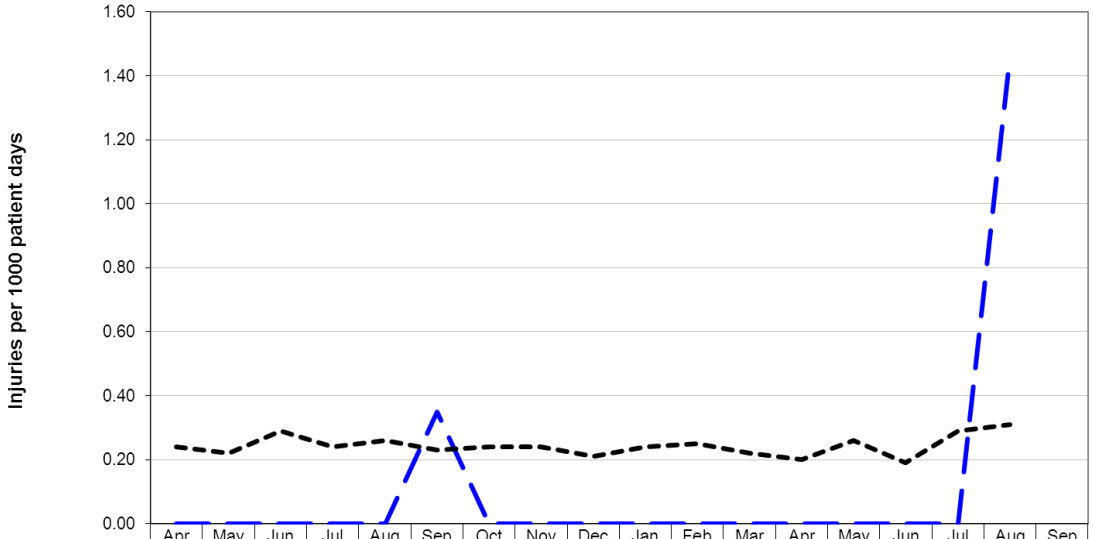
This graph depicts the number of client injury events that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days.
The following graphs depict the number of client injury events stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days.

The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Client Injury Rate

Forensic Stratification

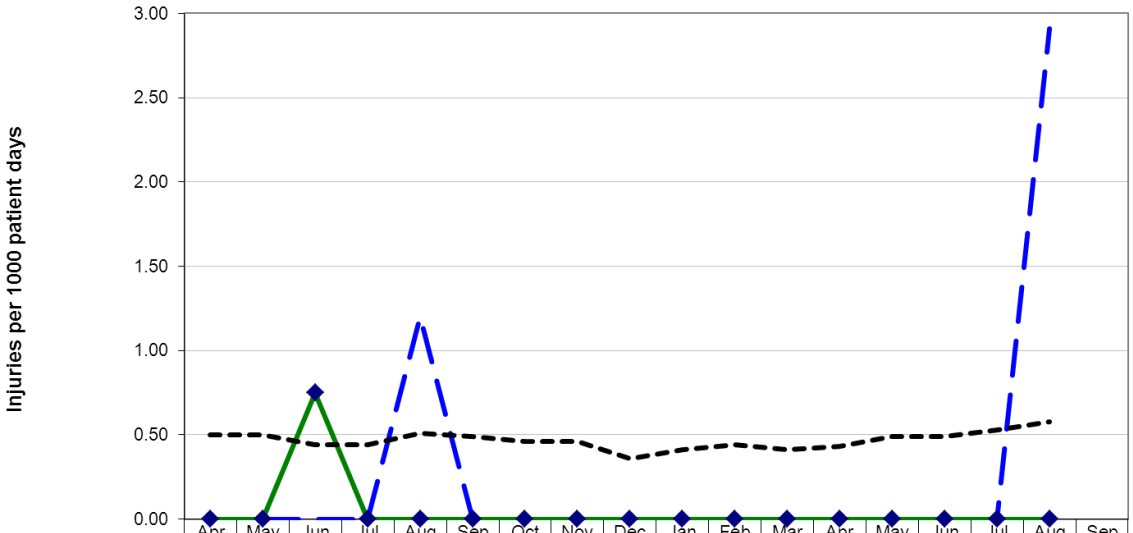


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	0.00	0.00	0.00	0.00	0.00	0.35	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.46	
Ntl Mean	0.24	0.22	0.29	0.24	0.26	0.23	0.24	0.24	0.21	0.24	0.25	0.22	0.20	0.26	0.19	0.29	0.31	

**This data is for the entire hospital (including Lower Saco)*

Client Injury Rate

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	0.00	0.00	0.00	0.00	1.20	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.91	
Dorothea Dix	0.00	0.00	0.75	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Ntl Mean	0.50	0.50	0.44	0.44	0.51	0.49	0.46	0.46	0.36	0.41	0.44	0.41	0.43	0.49	0.49	0.53	0.58	

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

CONSENT DECREE

Severity of Injury by Month

Severity	JULY	AUG	SEPT	1Q2015
No Treatment	7	2	8	**17**
Minor First Aid		2	3	**5**
Medical Intervention Required	1	1	2	**4**
Hospitalization Required			1	**1**
Death Occurred				
Total	**8**	**5**	**14**	**27**

Type and Cause of Injury by Month

Type - Cause	JULY	AUG	SEPT	1Q2015
Accident – Environmental	1			**1**
Accident – Fall Unwitnessed	3	3	2	**8**
Accident – Fall Witnessed	2	1	5	**8**
Accident – Other	1		5	**6**
Medical		1	1	**2**
Self-Injurious Behavior	1			**1**
Unknown			1	**1**
Total	**8**	**5**	**14**	**27**

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

Changes in reporting standards related to "criminal" events as defined by the "State of Maine Rules for Reporting Sentinel Events", effective February 1, 2013 as defined the by "National Quality Forum 2011 List of Serious Reportable Events" the number of reportable "assaults" that occur as the result of client interactions increased significantly. This change is due primarily as a result of the methods and rules related to data collection and abstraction.

Falls continues to be the predominant cause of potentially injurious events not related to the assaults discussed previously. Fall incidents remain a focus of the hospital. None of the fall incidents required treatment of any kind but are address as to causation during the Falls Process Review Team Meeting held each month.

Further information on Fall Reduction Strategies can be found under the Joint Commission Priority Focus Areas section of this report.

Note: Numbers in previous reports were higher as we included both incidents and injuries in these figures. This report only includes injuries.

CONSENT DECREE

Patient Abuse, Neglect, Exploitation, Injury or Death

V33) Riverview certifies that it is reporting and responding to instances of patient abuse, neglect, exploitation, injury or death consistent with the requirements of ¶¶ 192-201 of the Settlement Agreement.

Type of Allegation	2Q2014	3Q2014	4Q2014	1Q2015
Abuse Physical	5	7	6	3
Abuse Sexual	2	2	10	5
Abuse Verbal		4	3	2
Coercion/Exploitation				2
Neglect		1		1

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

Note: Previous quarter's data has been adjusted as we removed allegations of patient abuse, neglect, and exploitation that occurred outside of the hospital from the data

Riverview utilizes several vehicles to communicate concerns or allegations related to abuse, neglect or exploitation.

1. Staff members complete an incident report upon becoming aware of an incident or an allegation of any form of abuse, neglect, or exploitation.
2. Clients have the option to complete a grievance or communicate allegations of abuse, neglect, or exploitation during any interaction with staff at all levels, peer support personnel, or the client advocates.
3. Any allegation of abuse, neglect, or exploitation is reported both internally and externally to appropriate stakeholders, include:
   - Superintendent and/or AOC
   - Adult Protective Services
   - Guardian
   - Client Advocate
4. Allegations are reported to the Risk Manager through the incident reporting system and fact-finding or investigations occur at multiple levels. The purpose of this investigation is to evaluate the event to determine if the allegations can be substantiated or not and to refer the incident to the client's treatment team, hospital administration, or outside entities.
5. When appropriate to the allegation and circumstances, investigations involving law enforcement, family members, or human resources may be conducted.
6. The Human Rights Committee, a group consisting of consumers, family members, providers, and interested community members, and the Medical Executive Committee receive a report on the incidence of alleged abuse, neglect, and exploitation monthly.

CONSENT DECREE

Performance Improvement and Quality Assurance

V34) Riverview maintains Joint Commission accreditation;

Riverview successfully completed an accreditation survey with The Joint Commission on November 11-13, 2013. The Joint Commission conducted an unannounced visit on July 28-29, 2014. The hospital maintains its accreditation with the Joint Commission. The hospital will conduct a required annual self-assessment in October 2014. A triennial accreditation survey is expected to occur in November 2016 or earlier.

The hospital has 13 Measures of Success that are being monitored for the Joint Commission.

V35) Riverview maintains its hospital license;

Riverview maintains licensing status as required through the Maine Department of Health and Human Services Division of Licensing and Regulatory Services.

V36) The hospital seeks CMS certification;

The hospital was terminated from the Medicare Provider Agreement on September 2, 2013 for failing to show evidence of substantial compliance in eight areas by August 27, 2013. The hospital reapplied for certification in December 2013 and a 3 day site visit was conducted in May 2014. CMS found the hospital out of substantial compliance in one area and the hospital was denied certification. In July, a Performance Improvement Team was appointed to address Treatment Planning which was the one area of substantial non-compliance. Also, in July, the hospital applied for another certification visit. The hospital expects that visit to occur in the Fall of 2014.

V37) Riverview conducts quarterly monitoring of performance indicators in key areas of hospital administration, in accordance with the Consent Decree Plan, the accreditation standards of the Joint Commission, and according to a QAPI plan reviewed and approved by the Advisory Board each biennium, and demonstrates through quarterly reports that management uses that data to improve institutional performance, prioritize resources and evaluate strategic operations.

Riverview complies with this element of substantial compliance as evidenced by the current Integrated Plan for Performance Excellence, the data and reports presented in this document, the work of the Integrated Performance Excellence Committee and sub-groups of this committee that are engaged in a transition to an improvement orientated methodology that is support by the Joint Commission and is consistent with modern principles of process management and strategic methods of promoting organizational performance excellence. The Advisory Board approved the Integrated Plan for Performance Excellence in August 2014 including Maine Division of Licensing and Regulatory Services required language that the hospital will comply with all federal and state hospital Conditions of Participation.

CONSENT DECREE

Maine Department of Licensing and Regulatory Services
Conditional License Requirements
Status Update
June 2014

Riverview Psychiatric Center's was provided a conditional license on September 13, 2013 in response to the CMS de-certification. The hospital was provided conditions of participation to maintain the license. On May 13, 2014 an addendum to the conditional license was given to the hospital.

The hospital shall ensure that patients are free from abuse, including neglect, in accordance with the Regulations and the Conditions of Participation for Hospitals. The hospital will create and maintain a formal, documented, and proactive approach to identify events and occurrences that may contribute to abuse and neglect. During orientation and through an ongoing training program, the hospital will provide all employees with information regarding abuse and neglect, and related reporting requirements, including prevention, intervention, and detection. The hospital will ensure, in a timely and thorough manner, objective investigations of all allegations of abuse, neglect, or mistreatment. The hospital shall ensure that any incidents of abuse, neglect, or mistreatment are reported and analyzed, and the appropriate corrective action occurs.	The hospital has a policy on protecting patients from abuse and neglect. It is maintained with all hospital polices. The hospital continues to use an Incident Reporting System. All incident reports are reviewed daily. Fact findings and investigations are conducted on suspected cases of abuse or neglect. All incidents of suspected abuse and neglect are reported to APS. All new employees are training in the policies regarding abuse, neglect and exploitation. They also receive training on risk management and identifying and reporting incidents through the Incident Reporting system.
The hospital shall ensure that restraint or seclusion may only be imposed to ensure the immediate physical safety of a patient, a staff member, or others and must be discontinued at the earliest possible time in accordance with the Regulations and the Conditions of Participation for Hospitals. The hospital shall ensure the decision to use restraint or seclusion is driven by a documented and comprehensive individual patient assessment. The hospital shall ensure that once the unsafe situation ends, the use of restraint or seclusion is discontinued at the earliest possible time. The hospital shall monitor the utilization of restraint and seclusion. The hospital shall ensure that weapons (including pepper spray and Tasers) are not utilized in the application of healthcare restraint or seclusion.	The hospital policy on restraint and seclusion states that they may only be used to ensure the immediate physical safety of patients, staff, and others. Restraints and seclusions are used only when other de-escalation techniques have failed. Restraints and seclusion, by policy and practice, are ended at the earliest possible time. The Incident Reporting form used by the hospital requires staff to document the times used for any seclusion and restraint. All seclusion restraint events are documented on Incident Report forms. These are reviewed on a daily basis and follow-up is initiated as required. The hospital maintains a data base of all seclusion and restraint events; these are analyzed and reported in the quarterly report. The hospital staff will not use nor will they give

CONSENT DECREE

	permission to use weapons, including pepper spray and Tasers, in application of healthcare restraint or seclusion.
The hospital shall ensure that a registered nurse supervises and evaluates the nursing care for each patient, in accordance with the Regulations and the Conditions of Participation for Hospitals. The hospital shall ensure that the nursing care for each patient is evaluated on admission and on an ongoing basis in accordance with accepted standards of nursing practice and hospital policies.	Buck Pushard, Director of Nursing, supervises and evaluates the nursing care for patients. All patients receive an assessment at admission and on an ongoing basis as required by standards of practice and in accordance with policies.
The hospital shall ensure that the least restrictive intervention which is effective will be utilized in cases of restraint or seclusion in accordance with the Regulations and the Conditions of Participation for Hospitals. The hospital shall ensure that less restrictive interventions have been determined by staff to be ineffective to protect the patient or others from harm prior to the introduction of more restrictive measures.	Hospital policy on seclusion and restraint require the use of least restrictive means for patient intervention. Documentation is required that least restrictive means are used and are ineffective before more restrictive means are implemented.
The hospital shall ensure that orders for restraint or seclusion are never written as a standing order, or on an as needed basis, in accordance with the Regulations and the Conditions of Participation for Hospitals. The hospital shall ensure that the ongoing authorization of restraint or seclusion is not permitted.	By hospital policy, restraint and seclusion orders are never written as a standing order or PRN. Each incident of restraint or seclusion requires a separate order. Medical Staff have been trained on this policy.
The hospital shall ensure that all medical records are accurately written, in accordance with the Regulations and the Conditions of Participation for Hospitals. The hospital shall ensure that all medical records accurately and completely document all orders, test results, evaluations, care plans, treatments, interventions, care provided, and the patient's response to those treatments, interventions, and care.	The hospital policy on medical records requires accuracy of reporting. All orders, test results, evaluations, care plans, treatments, interventions, care provided and the patient's response to those treatments, interventions and care are included in the medical records. All staff and contractors receive training on documentation.
The hospital shall ensure that the Medical Staff is responsible for the quality of medical care provided to patients in accordance with the Regulations and the Conditions of Participation	The Medical Staff by-laws state that the medical staff is responsible for the quality and medical care provided to patients. The hospital meets staffing standards set by the Conditions of

CONSENT DECREE

for Hospitals, and that the Governing Body has a sufficient method for ensuring the delivery of quality medical care. This will include all patients regardless of their location.	Participation and the Consent Decree.
The hospital shall ensure that performance improvement activities track medical errors and adverse patient events, analyze their causes, and implement preventative actions and mechanisms that include feedback and learning throughout the hospital in accordance with the Regulations and the Conditions of Participation for Hospitals. The hospital shall ensure that the event analysis includes what happened, why it happened, and what can be done to prevent recurrence. The hospital shall ensure that an action plan is developed to include a specific plan for corrective action which incorporates evidence-based practice, responsibility for implementation, dates for completion, and ongoing monitoring of the implemented corrective actions.	All medical errors and adverse events are tracked and analyzed. Dr. Kirby, Clinical Director, reviews all errors and reports them to medical staff. The hospital uses The Joint Commission model for root cause analyses for adverse events at the hospital. Results from any root cause analyses are reported to the Executive Leadership Committee and Medical Leadership at the hospital. Action plans are developed, implemented and reviewed for compliance.
The Governing Body shall ensure that the hospital is operated in compliance with the hospital's policies and procedures in accordance with the Regulations and the Conditions of Participation for Hospitals. The hospital will ensure effective policy management through an enterprise-level process.	The Governing Board was trained in April on the High Reliability framework for Healthcare Institutions. This Joint Commission framework is being implemented throughout the hospital for quality improvement. Leadership has been trained and High Reliability is included in all employee orientation. The hospital's proposed QAPI plan will be reviewed by the Advisory Board at their August meeting seeking approval including discussion about other continuous quality improvement methodologies to be used.
The monitoring of the requirements of the Conditional License shall be included in the facility's quality assurance and performance improvement program and made available to the Department upon request.	The results of the Conditional License were reported at the IPEC meeting in June and are included in the performance improvement plan. Progress in meeting the standards will be reviewed at each meeting.
Subject to the Department's approval, the hospital shall obtain the services of a qualified consultant as described further herein. During the remainder of this amended Conditional License, the hospital shall consult with the qualified consultant to:	The hospital has a contract with Dartmouth Medical School to provide consultation and guidance. Drs. Paul Gorman and Will Torrey have visited the hospital and produced an initial report of findings. The Department has a contract with Holly Harmon,

CONSENT DECREE

Monitor the hospital to determine compliance with the amended Conditional License, Rules and applicable laws. Each month, the qualified consultant shall submit a written report to the Department, which contains detailed information about the conditions described herein, any recommendations or suggestions submitted to the hospital, and progress notes on the hospital's compliance with the Regulations and the Conditions of Participation; and Provide routine consultation and guidance to promote lasting culture change, to develop and maintain an organizational culture which advocates safety, quality, patient rights, and the Rights of Recipients of Mental Health Services.	R.N., to provide technical assistance to the hospital on quality improvement.

JOINT COMMISSION

Hospital-Based Inpatient Psychiatric Services (ORYX Data Elements)

The Joint Commission Quality Initiatives

In 1987, The Joint Commission announced its *Agenda for Change,* which outlined a series of major steps designed to modernize the accreditation process. A key component of the *Agenda for Change* was the eventual introduction of standardized core performance measures into the accreditation process. As the vision to integrate performance measurement into accreditation became more focused, the name ORYX® was chosen for the entire initiative. The ORYX initi

data to The Joint Commission on behalf of accredited hospitals and long term care organizations. Since that time, home care and behavioral healthcare organizations have been included in the ORYX initiative.

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

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

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

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

Assessment

Treatment Planning and Implementation

Hope and Empowerment

Patient Driven Care

Patient Safety

Continuity and Transition of Care

Outcomes

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

JOINT COMMISSION

Admissions Screening (HBIPS 1)

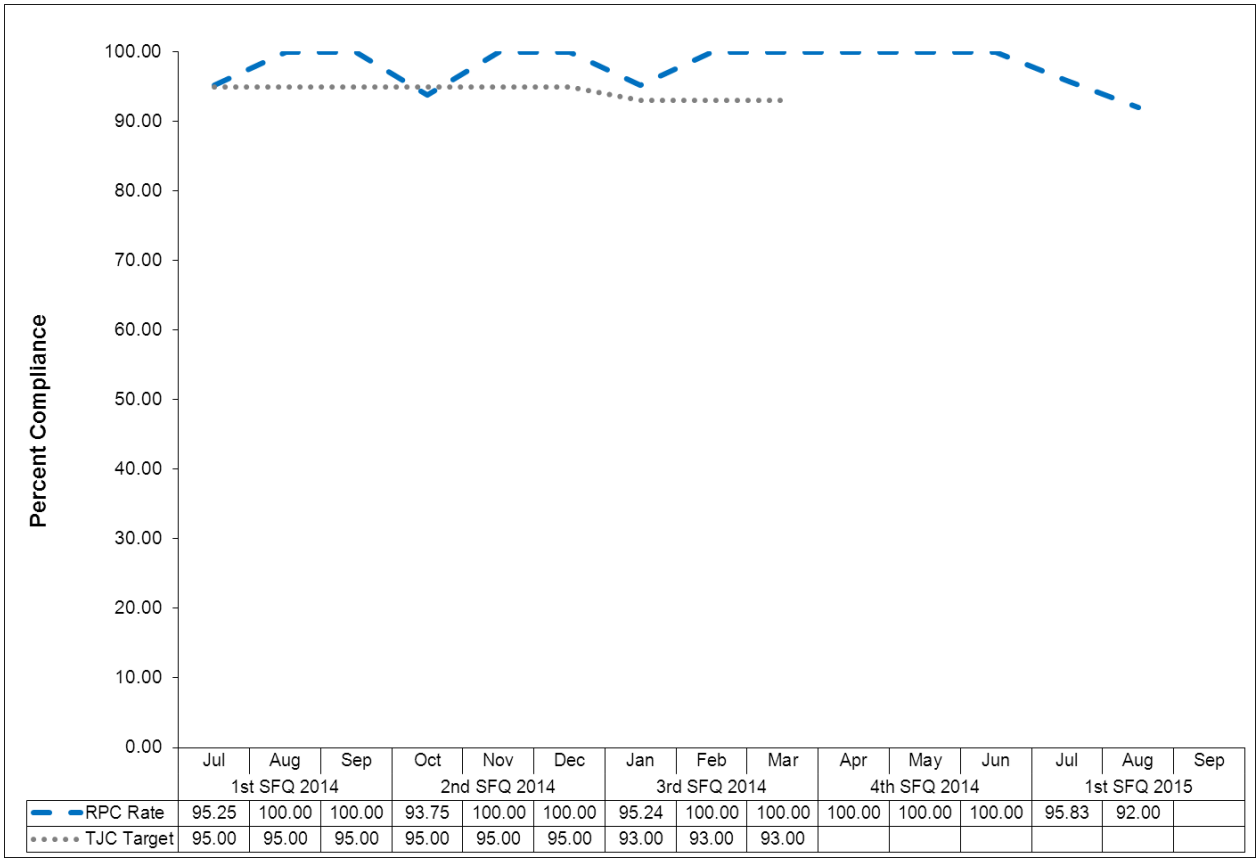
For Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths

Description

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

Rationale

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



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
RPC Rate	95.25	100.00	100.00	93.75	100.00	100.00	95.24	100.00	100.00	100.00	100.00	100.00	95.83	92.00	
TJC Target	95.00	95.00	95.00	95.00	95.00	95.00	93.00	93.00	93.00						

**This data is for the entire hospital (including Lower Saco)*

JOINT COMMISSION

Physical Restraint (HBIPS 2)

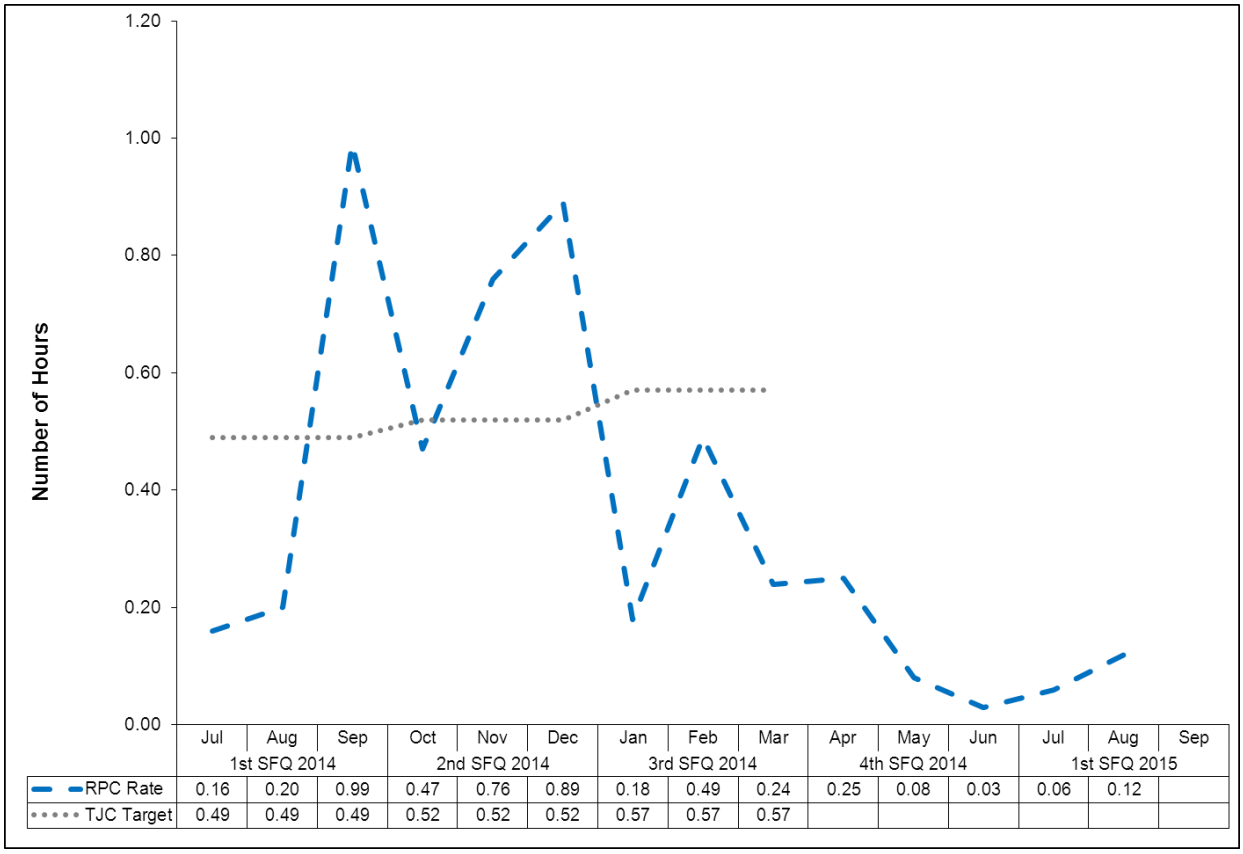
Hours of Use

Description

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

Rationale

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



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	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
RPC Rate	0.16	0.20	0.99	0.47	0.76	0.89	0.18	0.49	0.24	0.25	0.08	0.03	0.06	0.12	
TJC Target	0.49	0.49	0.49	0.52	0.52	0.52	0.57	0.57	0.57						

**This data is for the entire hospital (including Lower Saco)*

JOINT COMMISSION

Seclusion (HBIPS 3)

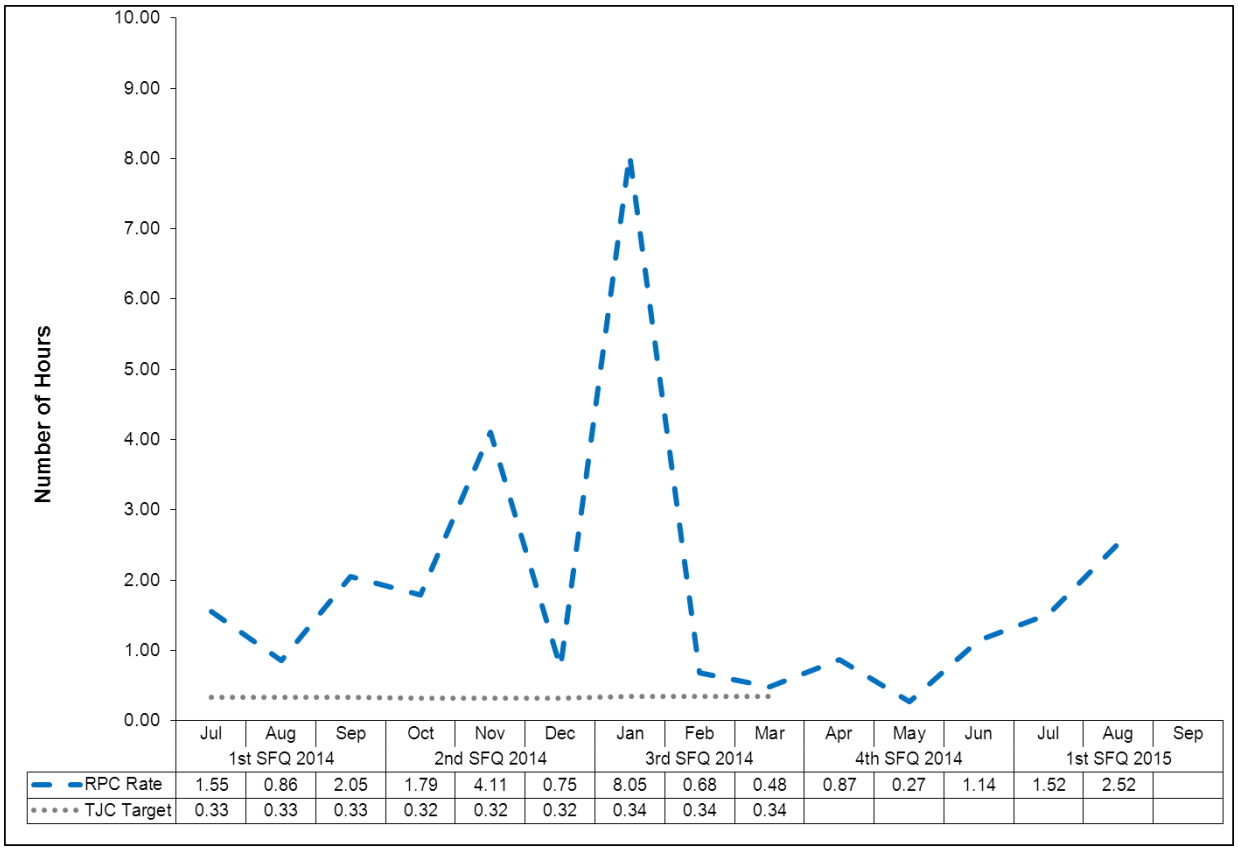
Hours of Use

Description

The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting was held in seclusion

Rationale

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



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
RPC Rate	1.55	0.86	2.05	1.79	4.11	0.75	8.05	0.68	0.48	0.87	0.27	1.14	1.52	2.52	
TJC Target	0.33	0.33	0.33	0.32	0.32	0.32	0.34	0.34	0.34						

**This data is for the entire hospital (including Lower Saco)*

JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)

Description

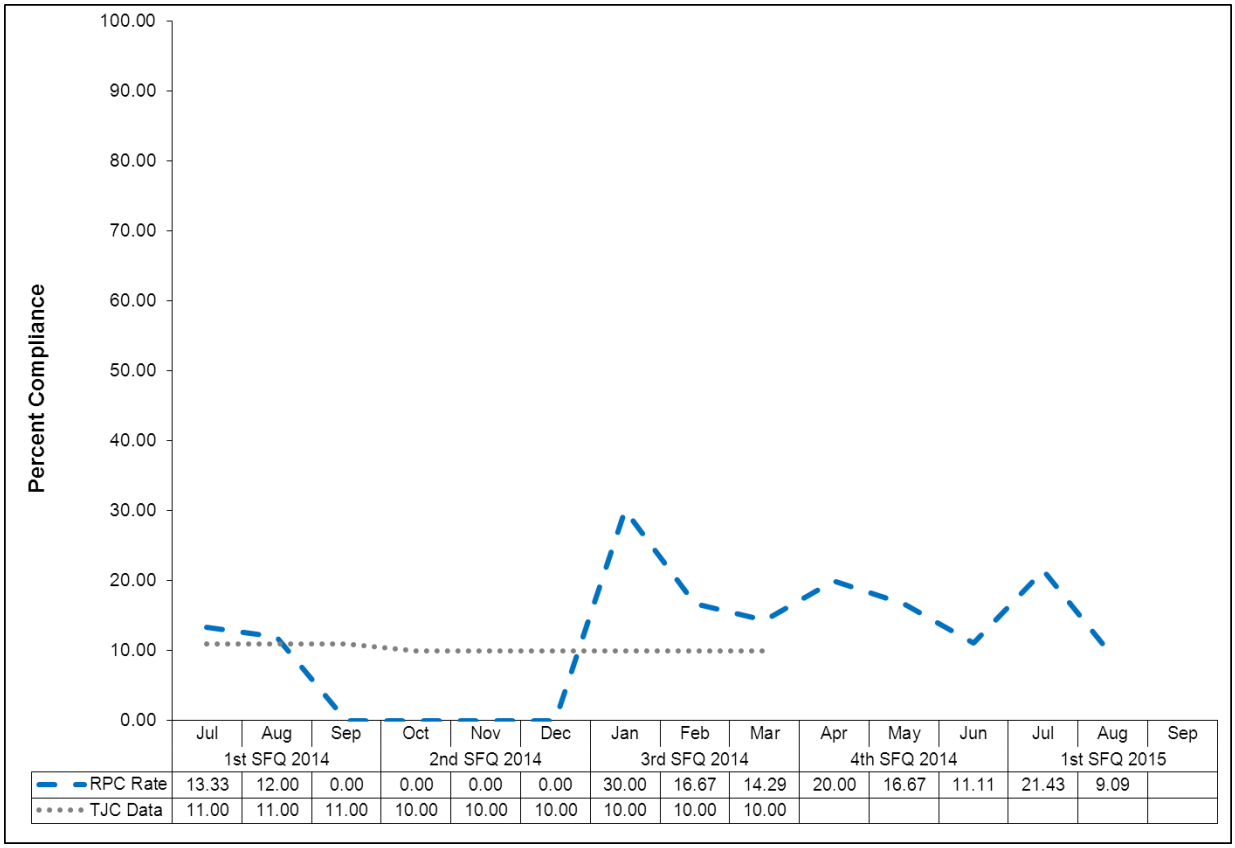
Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications

Rationale

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

JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)



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	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
RPC Rate	13.33	12.00	0.00	0.00	0.00	0.00	30.00	16.67	14.29	20.00	16.67	11.11	21.43	9.09	
TJC Data	11.00	11.00	11.00	10.00	10.00	10.00	10.00	10.00	10.00						

**This data is for the entire hospital (including Lower Saco)*

JOINT COMMISSION

Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)

Description

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

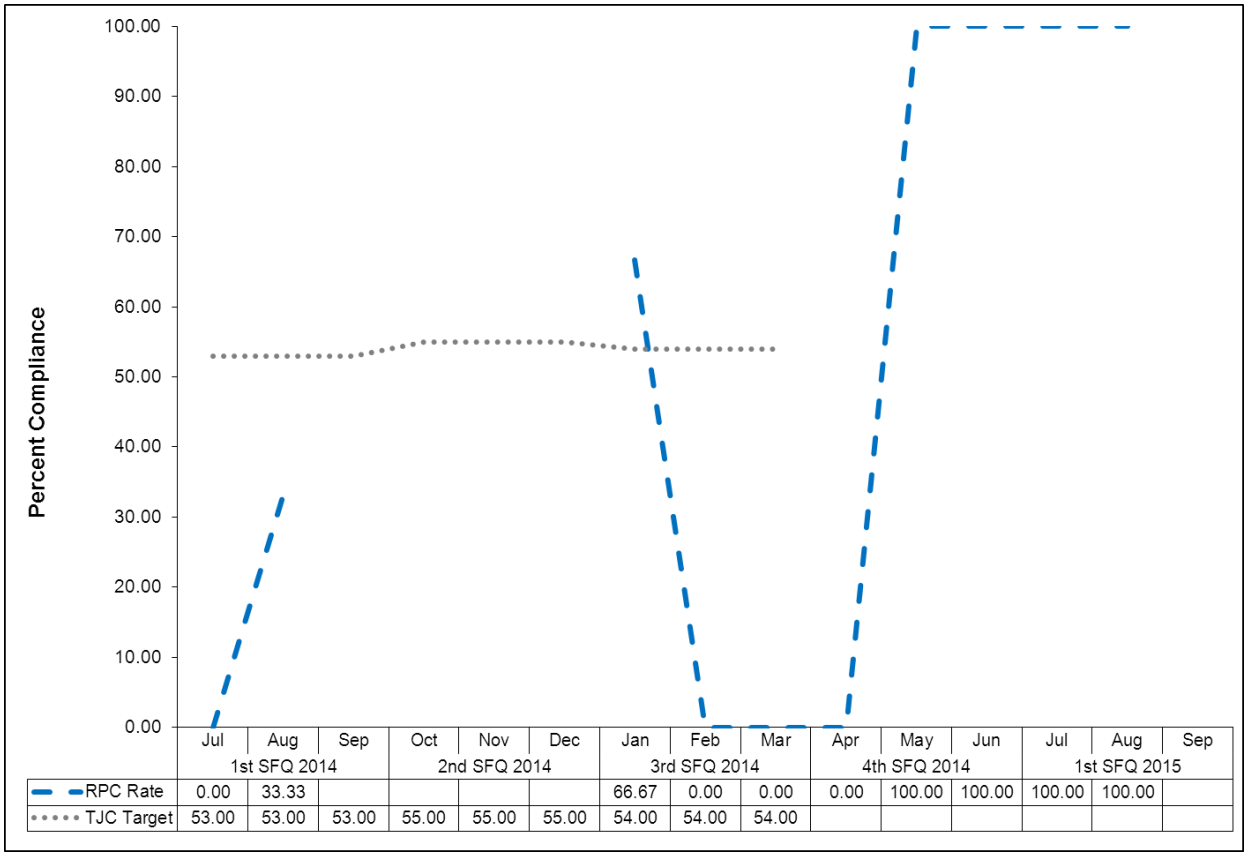
Rationale

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

Practice guidelines recommend the use of a second antipsychotic only after multiple trials of a single antipsychotic have proven inadequate (American Psychiatric Association [APA] Practice Guidelines, 2004). Randomized controlled trials (RCTs) provide some evidence to support augmentation with a second antipsychotic in *treatment resistant* patients. Most of these studies were limited to augmentation of clozapine with another second-generation antipsychotic (Tranulis, Skalli, Lalonde, & Nicole, 2008). Among patients *without* a documented history of previous treatment failures of antipsychotic monotherapy, multiple RCTs and other controlled trials failed to show a benefit of antipsychotic polypharmacy over monotherapy (Ananth, Parameswaran, & Gunatilake, 2004; Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Potkin, Thyrum, Alva, Bera, Yeh, & Arvanitis, 2002; Shim et al., 2007; Stahl,& Grady, 2004). Clinical circumstances, such as shorter inpatient stays, may require hospitals to discharge a patient on multiple antipsychotics with an aftercare plan to transition to monotherapy. In such cases, effective communication between the inpatient and aftercare clinician is an essential element of care.

JOINT COMMISSION

Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)



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	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
RPC Rate	0.00	33.33					66.67	0.00	0.00	0.00	100.00	100.00	100.00	100.00	
TJC Target	53.00	53.00	53.00	55.00	55.00	55.00	54.00	54.00	54.00						

**This data is for the entire hospital (including Lower Saco)*

Note: when the rate is blank for a month it means that no patients in that month were discharged on multiple antipsychotic medications.

JOINT COMMISSION

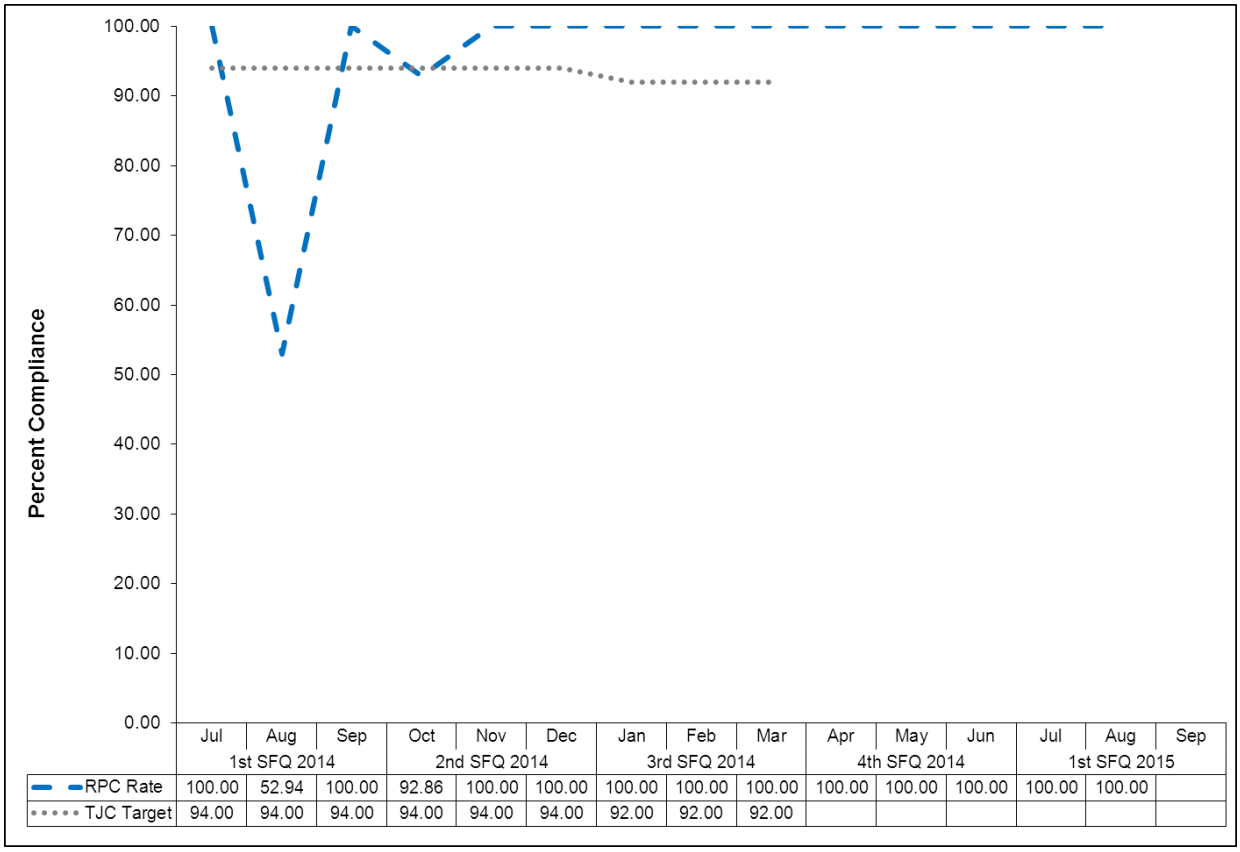
Post Discharge Continuing Care Plan (HBIPS 6)

Description

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

Rationale

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



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
RPC Rate	100.00	52.94	100.00	92.86	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	
TJC Target	94.00	94.00	94.00	94.00	94.00	94.00	92.00	92.00	92.00						

**This data is for the entire hospital (including Lower Saco)*

JOINT COMMISSION

Post Discharge Continuing Care Plan Transmitted (HBIPS 7)

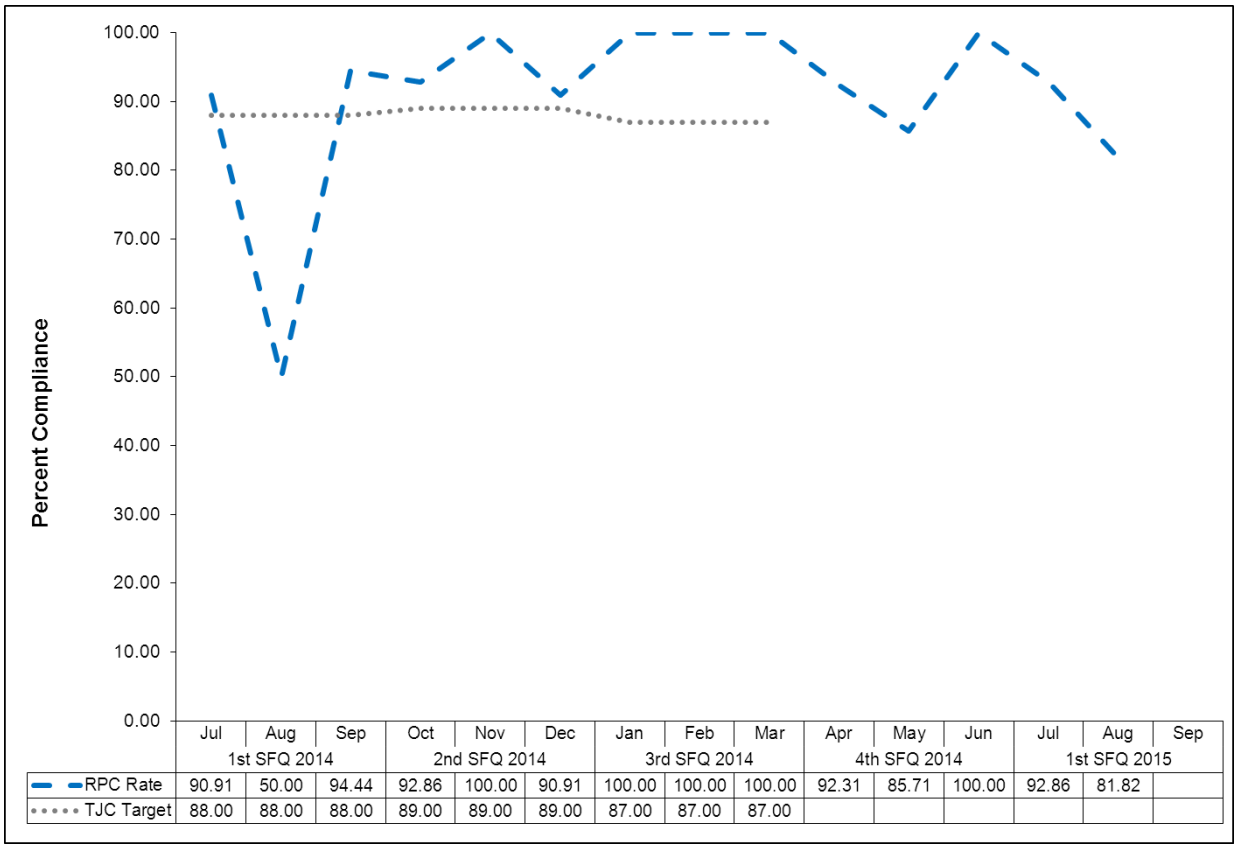
To Next Level of Care Provider on Discharge

Description

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

Rationale

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



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	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
RPC Rate	90.91	50.00	94.44	92.86	100.00	90.91	100.00	100.00	100.00	92.31	85.71	100.00	92.86	81.82	
TJC Target	88.00	88.00	88.00	89.00	89.00	89.00	87.00	87.00	87.00						

**This data is for the entire hospital (including Lower Saco)*

JOINT COMMISSION

Contract Performance Indicators

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

FY 2015 Quarter 1 Results		
Contractor	**Program Administrator**	**Summary of Performance**
Amistad Peer Support Services	Stephanie George-Roy Director of Social Services	One indicator did not meet standards, all others exceeded standards.
Community Dental, Region II	Dr. Brendan Kirby Clinical Director	All indicators met standards.
Comprehensive Pharmacy Services	Dr. Brendan Kirby Clinical Director	All indicators met standards.
Com-Tec Security	Debora Proctor Executive Housekeeper	All indicators met standards.
Cummins Northeast	Richard Levesque Director of Support Services	No services provided during timeframe.
Dartmouth Medical School	Robert J. Harper Acting Superintendent	All indicators exceeded standards.
Disability Rights Center	Robert J. Harper Acting Superintendent	All indicators met standards.
G & E Roofing	Richard Levesque Director of Support Services	Indicator exceeded standard.
Goodspeed & O'Donnell	Dr. Brendan Kirby Clinical Director	No services provided during timeframe.
Holly Harmon Consulting Services	Ricker Hamilton Deputy Commissioner of Programs	All indicators exceeded standards.
Lavallee Brensinger Architects	Richard Levesque Director of Support Services	All indicators met or exceeded standards.
Liberty Healthcare – After Hours Coverage	Dr. Brendan Kirby Clinical Director	All indicators met or exceeded standards.
Liberty Healthcare – Physician Staffing	Dr. Brendan Kirby Clinical Director	All indicators met or exceeded standards.
Maine General Community Care/Healthreach	Dr. Brendan Kirby Medical Director	All indicators met standards.
Maine General Medical Center – Laboratory Services	Dr. Brendan Kirby Clinical Director	All indicators met standards.
Main Security Surveillance	Debora Proctor Executive Housekeeper	All indicators met standards.
MD-IT Transcription Service	Amy Tasker Director of Health Information	All indicators met standards.
Mechanical Services	Richard Levesque Director of Support Services	All indicators met standards.
Medical Staffing and Services of Maine	Dr. Brendan Kirby Clinical Director	All indicators met standards.
Motivational Services	Dr. Brendan Kirby Clinical Director	All indicators met or exceeded standards.

JOINT COMMISSION

FY 2015 Quarter 1 Results		
Contractor	**Program Administrator**	**Summary of Performance**
Occupational Therapy Consultation and Rehabilitation Services	Janet Barrett Director of Rehabilitation	All indicators exceeded standards.
Otis Elevator	Richard Levesque Director of Support Services	All indicators met standards.
Pine Tree Legal Assistance	Dr. Brendan Kirby Clinical Director	No services provided during timeframe.
Project Staffing – Outpatient Services Coordinator	Mary Beyer Program Service Director, Outpatient Services	Position started on 9/22/14, no evaluation was completed for this timeframe.
Project Staffing – Barber	Janet Barrett Director of Rehabilitation	Indicator met standard.
Project Staffing – Multi Cultural Training Specialist	Janet Barrett Director of Rehabilitation	Indicator exceeded standard.
Project Staffing – Per Diem Nurses	Roland Pushard Director of Nursing	All indicators met standards.
Project Staffing – Post Doctoral Fellowship	Dr. Brendan Kirby Clinical Director	All indicators met or exceeded standards.
Project Staffing – Pre-Doctoral Intern	Dr. Brendan Kirby Clinical Director	All indicators met or exceeded standards.
Project Staffing – Recovery Training Specialist	Susan Bundy Staff Development Coordinator	Indicator met standard.
Project Staffing – Teacher	Janet Barrett Director of Rehabilitation	All indicators met standards.
Protection One	Richard Levesque Director of Support Services	No services provided during timeframe.
Securitas Security Services	Philip Tricarico Safety Compliance Officer	All indicators met or exceeded standards.
Unifirst Corporation	Richard Levesque Director of Support Services	All indicators met standards.
Waste Management	Debora Proctor Executive Housekeeper	1 indicator did not meet standard, all others met standards.

**This data is for the entire hospital (including Lower Saco)*

JOINT COMMISSION

Capital Community Clinic

Adverse Reactions to Sedation or Anesthesia

TJC PI.01.01.01 EP6: The hospital collects data on the following: adverse events related to using moderate or deep sedation or anesthesia. (See also LD.04.04.01, EP 2)

Dental Clinic Timeout/Identification of Client

Indicators	2Q2014	3Q2014	4Q2014	1Q2015	Total
National Patent Safety Goals Goal 1: Improve the accuracy of Client Identification. Capital Community Dental Clinic assures accurate client identification by: asking the client to state his/her name and date of birth. A time out will be taken before the procedure to verify location and numbered tooth. The time out section is in the progress notes of the patient chart. This page will be signed by the Dentist as well as the dental assistant.	**October** 100% 3/3 **November** 100% 1/1 **December** 100% 2/2 **Total** 100% 6/6	**January** 100% 2/2 **February** 100% 2/2 **March** 100% 7/7 **Total** 100% 11/11	**April** 100% 11/11 **May** N/A 0/0 **June** 100% 2/2 **Total** 100% 13/13	**July** 100% 5/5 **August** 100% 2/2 **September** 100% 3/3 **Total** 100% 10/10	100% 40/40

Dental Clinic Post Extraction Prevention of Complications and Follow-up

Indicators	2Q2014	3Q2014	4Q2014	1Q2015	Total
1. All clients with tooth extractions, will be assessed and have teaching post procedure, on the following topics, as provided by the Dentist or Dental Assistant • Bleeding • Swelling • Pain • Muscle soreness • Mouth care • Diet • Signs/symptoms of infection 2. The client, post procedure tooth extraction, will verbalize understanding of the above by repeating instructions given by Dental Assistant/Hygienist. 3. Post dental extractions, the clients will receive a follow-up phone call from the clinic within 24hrs of procedure to assess for post procedure complications	**October** 100% 3/3 **November** 100% 1/1 **December** 100% 2/2 **Total** 100% 6/6	**January** 100% 2/2 **February** 100% 2/2 **March** 100% 7/7 **Total** 100% 11/11	**April** 100% 11/11 **May** N/A 0/0 **June** 100% 2/2 **Total** 100% 13/13	**July** 100% 5/5 **August** 100% 2/2 **September** 100% 3/3 **Total** 100% 10/10	100% 40/40

**This data is for the entire hospital (including Lower Saco)*

JOINT COMMISSION

Healthcare Acquired Infections Monitoring and Management
Upper Kennebec, Lower Kennebec, Upper Saco

NPSG.07.03.01 Implement evidence-based practices to prevent health care–associated infections due to multidrug-resistant organisms in acute care hospitals.

Hospital Acquired Infection is any infection present, incubating or exposed to more than 72 hours **after admission** (unless the patient is off hospital grounds during that time) or declared by a physician, a physician's assistant or advanced practice nurse to be HAI.

A Community Acquired Infection is any infection present, incubating or exposed to prior to admission, while on pass; during off-site medical, dental, or surgical care; by a visitor, any prophylaxis treatment of a condition or treatment of a condition for which the patient has a history of chronic infection no matter how long the patient has been hospitalized; or declared by the physician, physician's assistant, or advanced practice nurse to be a community acquired infection.

Idiosyncratic Infection is any infection that occurs after admission and is the result of the patient's action toward himself or herself.

Indicators	1Q15 Findings	1Q15 Compliance	Threshold Percentile
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	9/4.8	100%	1 SD within the mean

*9 (total # of HAI / 1864 (patient days) x 1000 (calculation is per 1000 inpatient days) = 4.8

Patient Days: 1,864
Total Infections: 20
Total Hospital Acquired Infections: 9
Total Community Acquired Infections: 11
Total Idiosyncratic Infections: 0

Lower Kennebec:
- Cellulitis – HAI
- Onychogryposis and mycosis of all toe nails – CAI
- Seborrheic dermatitis – CAI
- HIV – CAI
- Dental Abscess – CAI
- Liquid diarrhea>bacterial overgrowth in upper gut – CAI.
- Sinusitis – HAI
- Pneumonia hx of lung infections- HAI

Upper Kennebec:
- Paronychia of right index finger – CAI
- UTI - HAI
- Sore Throat with history of Strept – Treat empirically – CAI
- Candida Pruritis secondery to antibiotic use – CAI
- Dental infection requiring multiple extractions – CAI
- Bacteremia secondery to poor glucose control – CAI

JOINT COMMISSION

Upper Kennebec, continued:

- Sinusitis – HAI
- Recurrent Sore Throat with a hx of Strep Pharyngitis – not counted

Upper Saco:

- URI with acute viral rhinosinusitis – HAI
- Acne flare – CAI (already counted previously)
- URI – pharyngitis with dysphagia/atypical pneumonitis – HAI
- Laryngitis with abnormal vocal cords>Monilial infection - HAI
- Conjunctivitis – HAI
- Dental infection multiple extraction required, appt. scheduled.-CAI

Plan: Ongoing surveillance; and encourage good respiratory and hand hygiene.

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

JOINT COMMISSION

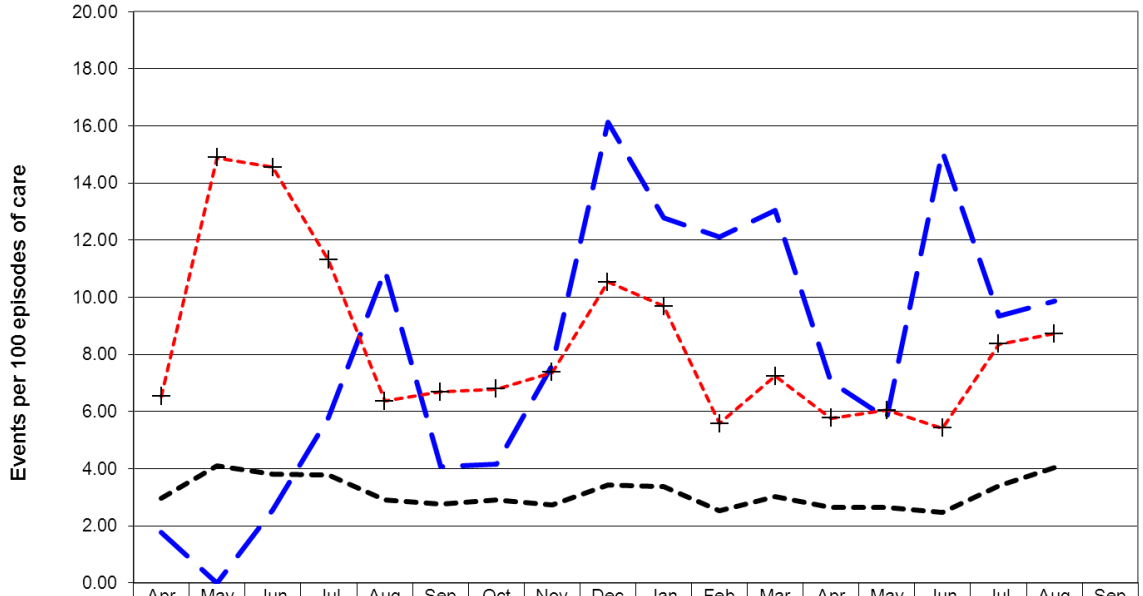
Medication Management

Medication Errors and Adverse Reactions

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

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

Medication Errors



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	1.79	0.00	2.56	5.79	10.95	4.07	4.17	7.63	16.13	12.78	12.12	13.04	7.04	5.76	15.11	9.35	9.86	
Ntl Mean	2.97	4.12	3.81	3.80	2.91	2.77	2.92	2.74	3.45	3.39	2.52	3.03	2.65	2.66	2.48	3.41	4.06	
+1 StDev	6.53	14.89	14.56	11.31	6.37	6.69	6.79	7.38	10.53	9.69	5.59	7.25	5.78	6.05	5.43	8.36	8.73	

**This data is for the entire hospital (including Lower Saco)*

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

JOINT COMMISSION

Medication Management – Medication Variances

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

Prescribing

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

Dispensing

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

Administration

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

Complex

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

Review, Reporting and Follow-up Process

The Medication Variances Process Review Team (PRT) meets weekly to evaluate the causation factors related to the medication variances reported on the units and in the pharmacy and makes recommendations, through its multi-disciplinary membership, for changes to workflow, environmental factor, and client care practices. The team consists of the Medical Director (or designee), the Director of Nursing (or designee), the Director of Pharmacy (or designee), and the Clinical Risk Manager or the Performance Improvement Manager.

The activities and recommendations of the Medication Variances PRT are reported monthly to the Integrated Performance Excellence Committee.

JOINT COMMISSION

Medication Management - Administration Process
Medication Errors Related to Staffing Effectiveness

Date	OMIT	Co-mission	Float	New	O/T	Unit	Staff Mix	
7/10/2014	N	Wrong time	N	Y	N	UK	3 RN, 0 LPN, 4 MHW	
7/10/2014	N	Wrong time	N	N	N	US	3 RN, 0 LPN, 4 MHW	
7/25/2014	Y	Risperdal	N	N	N	LK	3 RN, 1 LPN, 7 MHW	
7/28/2014	Y	x 4 meds	N	N	N	US	3 RN, 1 LPN, 4 MHW	
8/8/2014	Y	Penicillin	N	Y	N	UK	4 RN, 0 LPN, 5 MHW	
8/13/2014	Y	Vitamin C	N	N	N	UK	2 RN, 1 LPN, 4 MHW	
8/13/2014	Y	Zyprexa	Y	Y	N	LK	4 RN, 0 LPN, 7 MHW	
8/14/2014	N	Expired x 5 doses	N	Y	N	US	2 RN, 1 LPN, 5 MHW	
8/21/2014	N	Wrong time	N	N	N	UK	3 RN, 0 LPN, 4 MHW	
8/25/2014	N	Wrong dose	N	N	N	UK	2 RN, 1 LPN, 4 MHW	
8/27/2014	Y	Risperdal	Y	N	N	US	2 RN, 0 LPN, 3 MHW	
8/31/2014	N	Wrong time x 3	N	N	N	US	3 RN, 0 LPN, 4 MHW	
9/1/2014	N	Wrong dose	N	N	N	UK	3 RN, 1 LPN, 4 MHW	
9/3/2014	N	Wrong med	N	N	N	US	3 RN, 0 LPN, 4 MHW	
9/24/2014	Y	Prolixin	N	N	N	UK	3 RN, 1 LPN, 4 MHW	
Totals	**10**		**2**	**8**	**0**	**US: 15**	**LK: 2**	**UK: 7**
Percent	**42%**		**8%**	**33%**	**0%**	**63%**	**8%**	**29%**

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

*Each dose of medication is documented as an individual variance (error)

JOINT COMMISSION

Summary

There were a total of 24 medication errors this quarter:

10	omissions
2	wrong dose given
6	given at wrong time
1	wrong medication given
5	given after order expired

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

Actions

All nursing related medication errors were noted to have appropriate staffing levels. Medication errors are reviewed weekly with pharmacy, nursing administration and the Medical Director. New systems are being looked at to track as well as alert nurses to minimivf2ze medication errors by having pop up screens for when a medication is too soon to be given, etc. The RN IV or clinical manger on the unit reviews medication errors with staff assigned to their unit if an error is committed.

JOINT COMMISSION

Medication Management - Dispensing Process

Medication Management	Unit	Baseline 2014	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Controlled Substance Loss Data *Daily Pyxis-CII Safe Compare Report*	All	0.875%	0%	0%	0%	0%	0%	No discrepancies between Pyxis and CII Safe transactions in July & August
Quarterly Results			0%					
Monthly CII Safe Vendor Receipt	Rx	0	0	0	0	0	0	No discrepancies between CII Safe and vendor transactions for July & August
Quarterly Results			0					
Monthly Pyxis Controlled Drug discrepancies	All	22	0	0	0	0	0	Goal of "0" discrepancies involving controlled drugs dispensed from Pxyis trended from Knowledge Portal for July & August
Quarterly Results			41 (21/mo)					
Medication Management Monitoring Measures of drug reactions, adverse drug events and other management data	Rx	8/year	0	0	0	0		2 ADR's reported in July & August
Quarterly Results			2					
Resource Documentation Reports of Clinical Interventions	Rx	395 reports in 2014						*To be reported in total for Q1 in October
Quarterly Results			*N/A					

**This data is for the entire hospital (including Lower Saco)*

JOINT COMMISSION

Medication Management	Unit	Baseline 2014	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Psychiatric Emergency Process Monthly audit of all psych emergencies measured against 9 criteria	All	90%	100%	100%	100%	100%	100%	Goal of 100% compliance as measured by monthly audit tool
Quarterly Results			94% (July & Aug)					Written notification of the end of PE still needs improvement
Contract KPI's								
Operational Audit *Weekly audit of 3 operational indicators from CPS contract*	Rx		100%	100%	100%	100%	100%	Goal of 100% compliance as measured by monthly audit tool for July and August *July 18, July 31 and August 21
Quarterly Results			100%			100%		

**This data is for the entire hospital (including Lower Saco)*

JOINT COMMISSION

Inpatient Consumer Survey

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

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

Inpatient Consumer Survey (ICS) has been recently endorsed by NQF, under the Patient Outcomes Phase 3: Child Health and Mental Health Project, as an outcome measure to assess the results, and thereby improve care provided to people with mental illness. The endorsement supports the ICS as a scientifically sound and meaningful measure to help standardize performance measures and assures quality of care.

Rate of Response for the Inpatient Consumer Survey

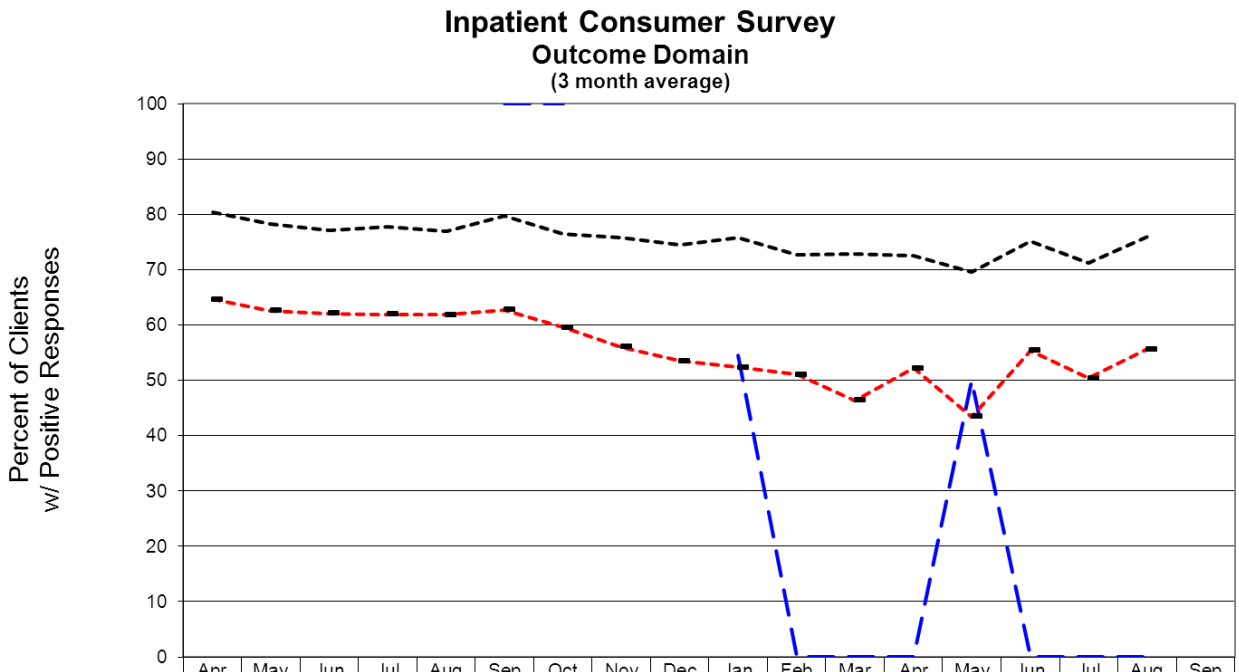
Due to the operational and safety need to refrain from complete openness regarding plans for discharge and dates of discharge for forensic clients, the process of administering the inpatient survey is difficult to administer. Whenever possible the peer support staff work to gather information from clients on their perception of the care provided to then while at Riverview Psychiatric Center.

The Peer Support group has identified a need to improve the overall response rate for the survey. This process improvement project is defined and described in the section on Client Satisfaction Survey Return Rate of this report.

There is currently no aggregated date on a forensic stratification of responses to the survey.

Note: when the Riverview field is blank for a month it means that no patients responded to the survey questions on that page in that particular month.

JOINT COMMISSION



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview		0.00				100.0	100.0			54.55	0.00	0.00	0.00	50.00	0.00	0.00	0.00	
Ntl Mean	80.44	78.30	77.06	77.70	77.02	79.66	76.53	75.76	74.46	75.84	72.62	72.88	72.49	69.52	75.13	71.28	75.95	
1 StDev	64.60	62.62	62.08	61.96	61.85	62.76	59.53	56.01	53.52	52.32	51.03	46.37	52.19	43.40	55.39	50.41	55.62	

**This data is for the entire hospital (including Lower Saco)*

Outcome Domain Questions

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

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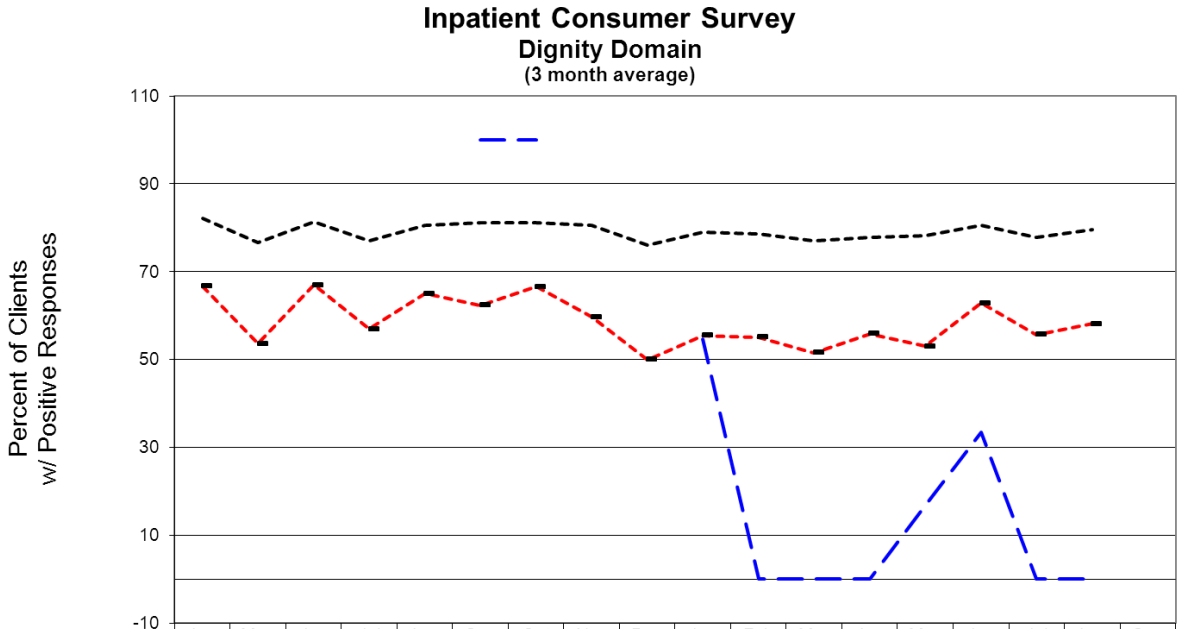

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	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview		0.00				100.0	100.0			54.55	0.00	0.00	0.00	16.67	33.33	0.00	0.00	
Ntl Mean	82.13	76.61	81.35	77.03	80.63	81.16	81.11	80.56	76.11	79.02	78.51	77.06	77.90	78.16	80.61	77.85	79.58	
1 StDev	66.68	53.56	66.92	56.92	64.95	62.31	66.61	59.70	50.00	55.45	55.09	51.56	55.84	53.02	62.85	55.71	58.14	

**This data is for the entire hospital (including Lower Saco)*

Dignity Domain Questions

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

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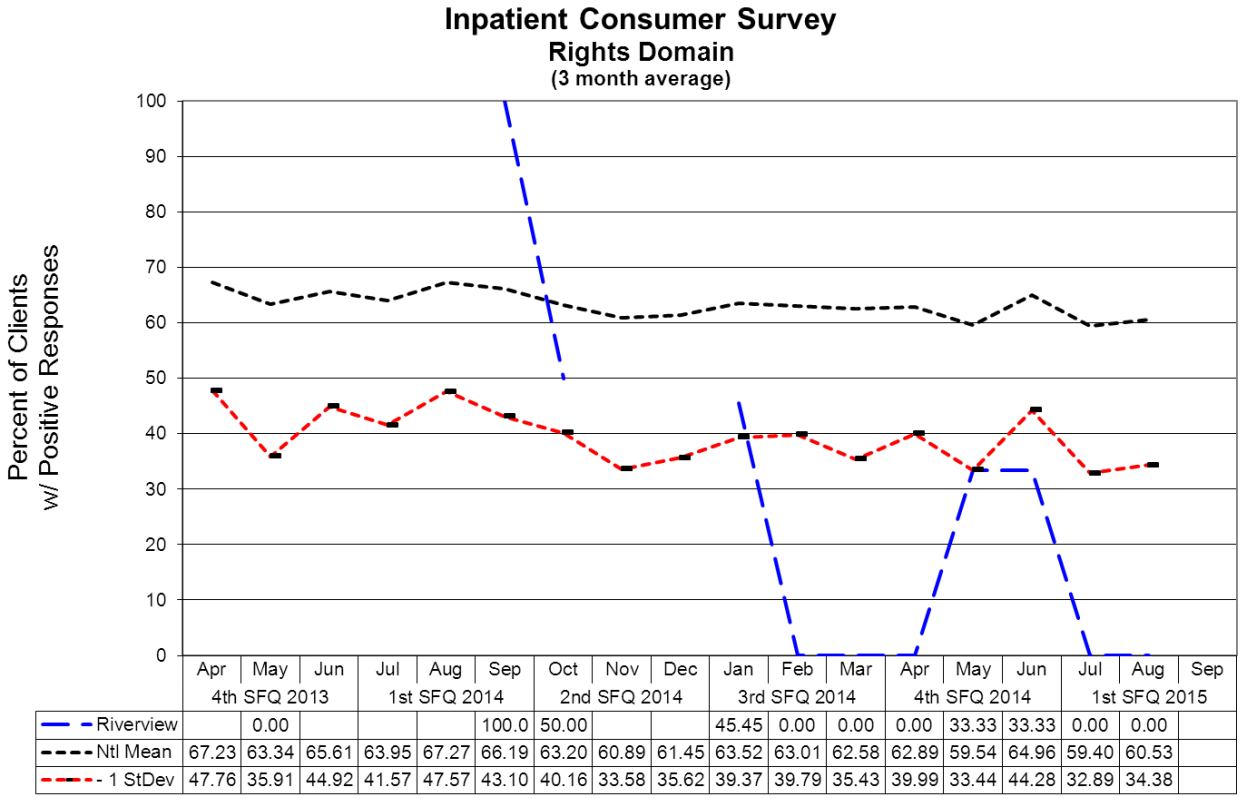


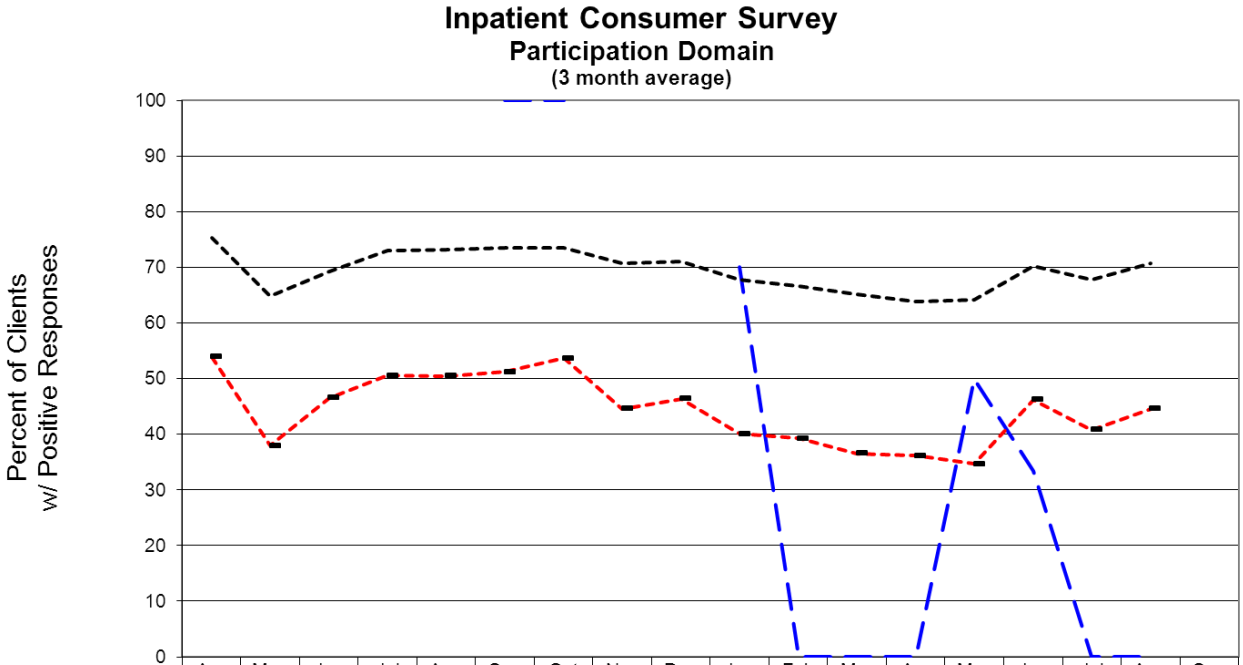
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Riverview		0.00				100.0	50.00			45.45	0.00	0.00	0.00	33.33	33.33	0.00	0.00	
Ntl Mean	67.23	63.34	65.61	63.95	67.27	66.19	63.20	60.89	61.45	63.52	63.01	62.58	62.89	59.54	64.96	59.40	60.53	
1 StDev	47.76	35.91	44.92	41.57	47.57	43.10	40.16	33.58	35.62	39.37	39.79	35.43	39.99	33.44	44.28	32.89	34.38	

**This data is for the entire hospital (including Lower Saco)*

Rights Domain Questions

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

JOINT COMMISSION



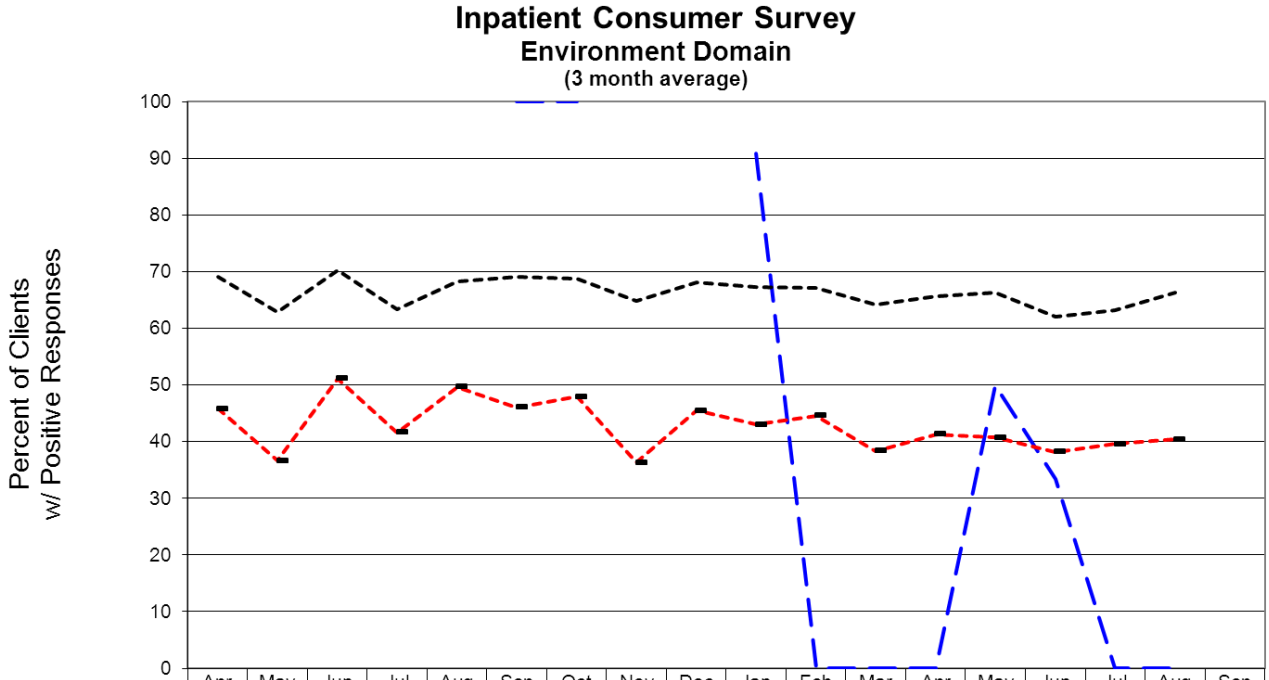
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview		0.00				100.0	100.0			70.00	0.00	0.00	0.00	50.00	33.33	0.00	0.00	
Ntl Mean	75.24	64.77	69.23	73.05	73.10	73.45	73.48	70.66	71.00	67.75	66.66	65.11	63.93	64.14	70.20	67.70	70.66	
1 StDev	53.88	37.93	46.52	50.57	50.44	51.21	53.64	44.58	46.37	40.11	39.24	36.57	36.13	34.65	46.22	40.80	44.55	

**This data is for the entire hospital (including Lower Saco)*

Participation Domain Questions

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

JOINT COMMISSION



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview		0.00				100.0	100.0			90.91	0.00	0.00	0.00	50.00	33.33	0.00	0.00	
Ntl Mean	69.06	62.93	70.31	63.35	68.22	69.05	68.81	64.83	68.08	67.23	67.09	64.18	65.73	66.29	61.99	63.15	66.23	
- 1 StDev	45.84	36.67	51.16	41.59	49.61	46.05	47.95	36.30	45.48	43.06	44.60	38.36	41.30	40.75	38.20	39.58	40.44	

**This data is for the entire hospital (including Lower Saco)*

Environment Domain

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

JOINT COMMISSION

Pain Management

TJC **PC.01.02.07:** The hospital assesses and manages the patient's pain.

Indicator	2Q2014	3Q2014	4Q2014	1Q2015
Pre-administration	74% 2774/3749	88% 3217/3652	90% 2811/3114	84% 2481/2965
Post-administration	63% 2362/3749	78% 2866/3652	80% 2477/3114	72% 2126/2965

**This data is for the entire hospital (including Lower Saco)*

SUMMARY

Total number of PRN pain medications administered continues to decrease since last quarter (2965 compared to 3114). Nurse documentation regarding PRN pain medication has declined since last quarter (both pre-assessment and post-assessment of patient), with percentages of compliance being the lowest of the 2014 calendar year to date.

ACTIONS

Will meet with clinical managers to let them know nursing needs to increase vigilance regarding pre and post assessment of patient's pain. If documentation does not improve, will educate individual nurses as necessary on the importance of documentation in this area. Will recommend having the oncoming shift check with the off going shift for any pain meds given that may need an assessment. Pharmacy is looking at future possibilities with Pyxis to see if a program can be installed that will alert nurses that an assessment is due/ needed.

JOINT COMMISSION

Fall Reduction Strategies

TJC PI.01.01.01 EP38: The hospital evaluates the effectiveness of all fall reduction activities including assessment, interventions, and education.

TJC PC.01.02.08 The hospital assesses and manages the patient's risks for falls.
EP01: The hospital assesses the patient's risk for falls based on the patient population and setting.
EP02: The hospital implements interventions to reduce falls based on the patient's assessed risk.

Falls Risk Management Team has been created to be facilitated by a member of the team with data supplied by the Risk Manager. The role of this team is to conduct root cause analyses on each of the falls incidents and to identify trends and common contributing factors and to make recommendations for changes in the environment and process of care for those clients identified as having a high potential for falls.

Type of Fall by Client and Month

Fall Type	Client	JULY	AUGUST	SEPT	1Q2015
	MR00003191*		2		2
	MR00000016*	1			1
	MR00007468		1		1
	MR00007045			1	1
	MR00007127	1			1
	MR00007452	1			1
	MR00007032			1	1
	MR00007448	1		2	3
	MR00003191*	1		1	2
	MR00000016*			1	1
	MR00006966		1		1
	MR00007363			1	1

* Clients have experienced both witnessed and un-witnessed falls during the reporting quarter.

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

Review, Reporting and Follow-up Process

The Falls Assessment and Prevention Process Review Team (PRT) meets monthly to evaluate the causation factors related to the falls reported on the units and makes recommendations, through its multi-disciplinary membership, for changes to workflow, environmental factor, and client care practices.

The activities and recommendations of the Falls PRT are reported monthly to the Integrated Performance Excellence Committee.

JOINT COMMISSION

Measures of Success

CTS.01.04.01
For organizations that serve adults with serious mental illness. The organization documents whether the adult has a psychiatric advance directive.

Responsible for Reporting: Program Service Director, Outpatient Services

Corrective Action Taken:

WHO: The Program Service Director, Outpatient Services, is ultimately responsible for the corrective action and overall and ongoing compliance.

WHAT: Staff training was conducted in bi-weekly administrative meeting directing all case managers to use standard Disability Rights Psychiatric (Mental Health) Advanced Directive form and to date completion or declination to complete directive.

WHEN: Care, Treatment and Services issue was discussed with case managers in all-staff meeting 12-27-13, document to be used was copied and placed in admission and annual documentation folder.

HOW: The Program Director and Team Leader will perform bi-weekly reviews of charts to assess ongoing compliance, reporting findings to staff in bi-weekly administrative meetings.
Evaluation Method: Plan for assessing effectiveness of the corrective action taken:
• Sample size: Based on an ADC of 50, 30 records will be selected using random selection.
• Random sampling method used will be to identify six charts from 5 total shelves by selecting every other chart from right to left until 30 are identified.
• Frequency of the audit will be bi-weekly, reviewing six to eight charts per session, totaling up to 48 charts reviewed by the end of four months.
• Monitor for four consecutive months (expectation a minimum of 90% compliance)
• 30 = total number of charts reviewed for psychiatric advanced directives
• 28= total number of psychiatric advanced directives present in the chart or documented as having been offered but declined by client.
• The audit results will be reported by the program Director and Team Leader to the staff at each administrative meeting, the IPEC Committee, as well as to the Social Work Program Director.

RESULTS:

Feb	March	April	May	June	July	Aug	Sept
58%	82%	78%	79%	100%	78%	90%	100%

**This data is for the entire hospital (including Lower Saco)*

JOINT COMMISSION

Measures of Success

CTS.02.02.07
The organization reassesses each individual served, as needed

Responsible for Reporting: Program Service Director, Outpatient Services

Corrective Action Taken:

WHO: The ACT Program Director is ultimately responsible for the corrective action and overall ongoing compliance.

WHAT: Staff training was conducted in bi-weekly administrative meeting identifying the discovery of Annual Comprehensive Assessments being worded exactly the same as the previous year, and the necessity of writing new annual assessments for each client including any changes in progress or functioning. It was also identified that there was a missing Annual Comprehensive Assessment in one reviewed record, the standard of keeping at least the current and past year's Annual Comprehensive Evaluation was reiterated.

WHEN: This corrective action was also conducted in a bi-weekly administrative meeting on 12-27-13. No further procedures or policies were needed.

HOW: The Program Director and Team Leader will perform bi-weekly reviews of records to assess ongoing compliance, reporting findings to staff in bi-weekly administrative meetings for immediate correction, if indicated.
Evaluation Method: Plan for assessing effectiveness of the corrective action taken:
• Sample size: Based on an ADC of 50, 30 records will be selected using random selection.
• Random sampling method used will be to identify six charts from 5 total shelves by selecting every other chart from left to right until 30 are identified.
• Frequency of the audit will be bi-weekly, reviewing six to eight charts per session, totaling up to 48 charts reviewed by the end of four months.
• Monitor for four consecutive months (expectation a minimum of 90% compliance)
• 30 = total number of charts reviewed for presence and accuracy of Comprehensive Annual Assessment
• 28= minimum total number of Comprehensive Annual Assessments present in the chart and distinct from previous year.
• The audit results will be reported by the program Director and Team Leader to the staff at each administrative meeting, the IPEC Committee, as well as to the Social Work Program Director.

RESULTS:

Feb	March	April	May	June	July	Aug	Sept
83%	100%	78%	100%	92%	100%	90%	100%

**This data is for the entire hospital (including Lower Saco)*

JOINT COMMISSION

Measures of Success

HR.01.06.01
Staff competence is assessed and documented once every three years, or more frequently as required by organization policy or in accordance with law and regulation.

Responsible for Reporting: HR Director

RESULTS:

	Dec 2014	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	June 2014	July 2014	Aug 2014	Total
Performance evaluations completed on time (with competency assessment)	24	13	19	11	12	29	21	16	22	**167**
Total # of performance evaluations due (with competency assessment)	39	32	42	32	32	35	32	27	50	**321**
Evaluation Compliance	**62%**	**41%**	**45%**	**34%**	**38%**	**83%**	**66%**	**59%**	**44%**	**52%**

**This data is for the entire hospital (including Lower Saco)*

*Data not yet available for September 2014

JOINT COMMISSION

Measures of Success

PC.02.03.03
The hospital helps the patient with his or her personal hygiene and grooming activities.

Responsible for Reporting: Director of Nursing

Hand Hygiene Measure: Staff will offer hand gel to clients prior to breakfast, lunch and dinner on 30 days per month.

Results:

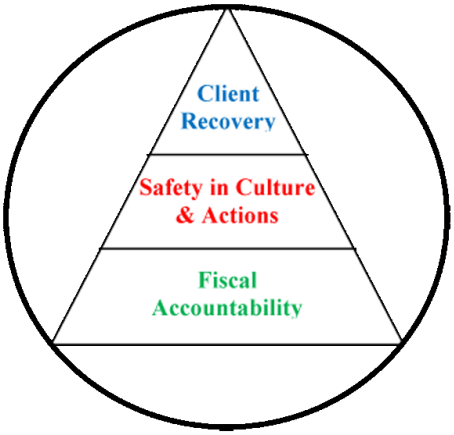
	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	June 2014	July 2014	Aug 2014	Sep 2014	Mean Rate
Lower Kennebec	68%	82%	61%	65%	96%	100%	100%	97%	100%	**85%**
Lower Kennebec SCU	10%	18%	25%	95%	96%	94%	100%	100%	98%	**71%**
Upper Kennebec	46%	46%	46%	100%	100%	100%	100%	89%	93%	**80%**
Upper Saco	97%	94%	97%	100%	90%	96%	98%	96%	96%	**96%**
Mean Rate	**55%**	**60%**	**57%**	**90%**	**96%**	**98%**	**100%**	**96%**	**97%**	**83%**

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

STRATEGIC PERFORMANCE EXCELLENCE

Priority Focus Areas for Strategic Performance Excellence

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



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

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

STRATEGIC PERFORMANCE EXCELLENCE

Strategic Performance Excellence Model Reporting Process

Department of Health and Human Services Goals

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

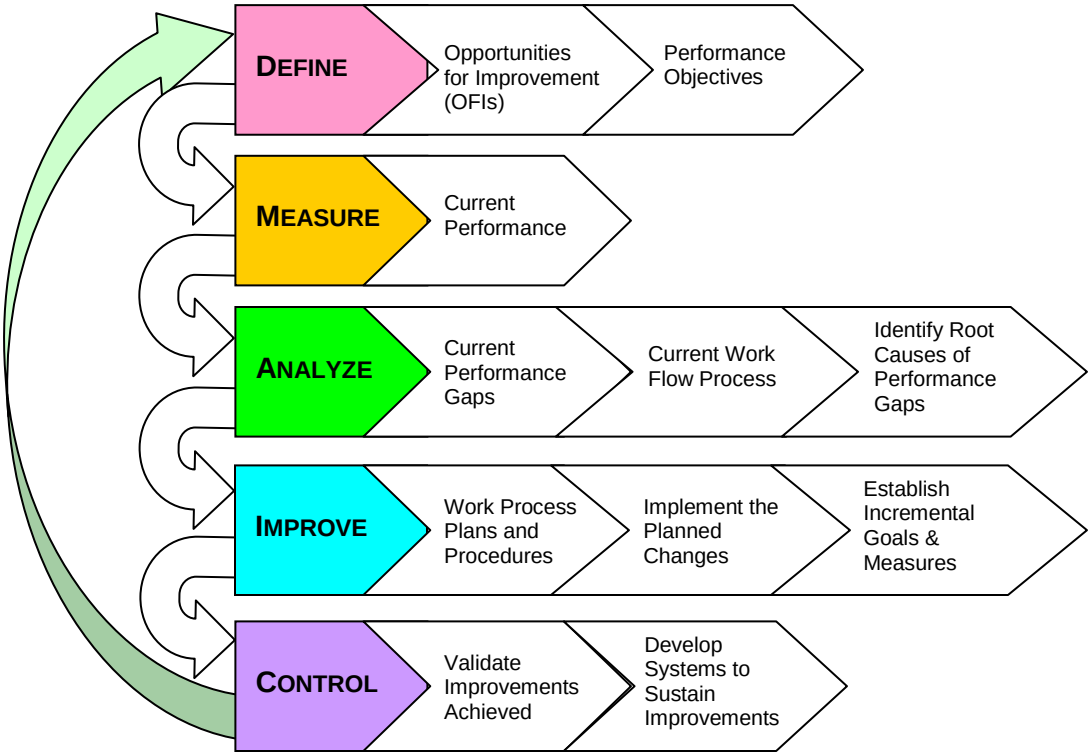
Dorothea Dix and Riverview Psychiatric Centers
Priority Focus Areas

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

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

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

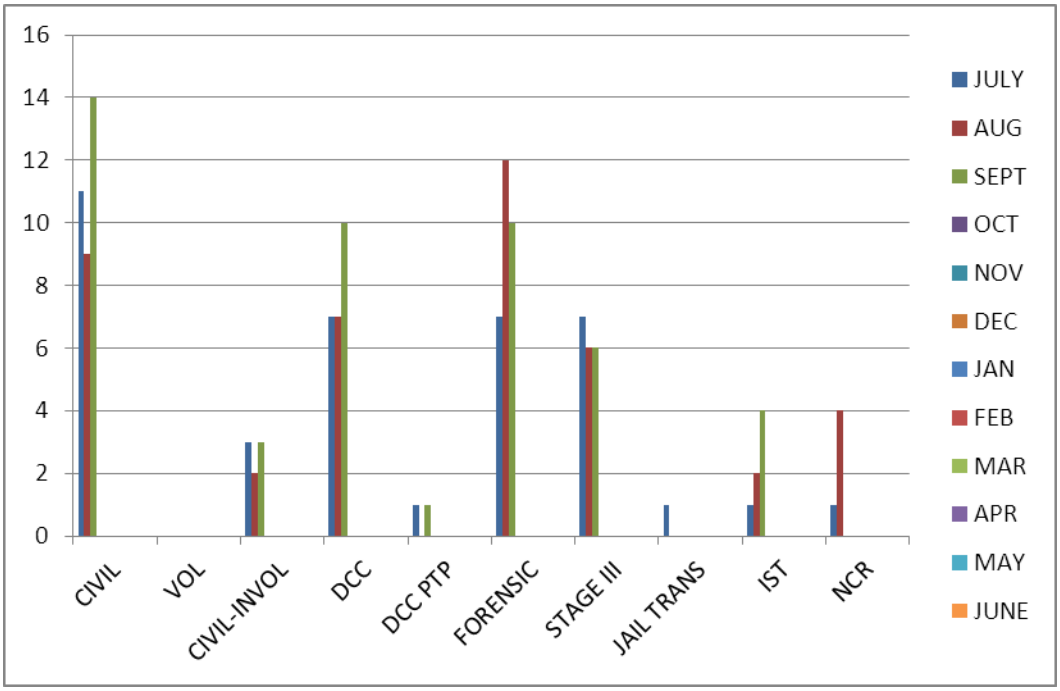
Each Department Determines Unique Opportunities and Methods
to Address the Hospital Goals
The Quarterly Report Consists of the Following



STRATEGIC PERFORMANCE EXCELLENCE

Admissions Office Quarterly Report
1Q2015

Admission Data Graph



Admission Data

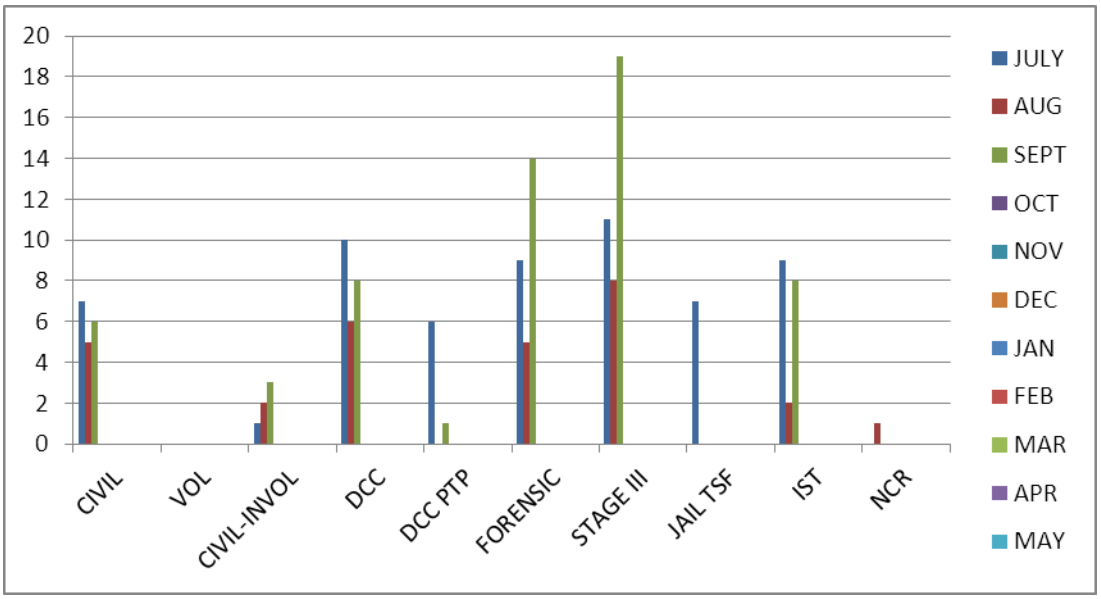
ADMISSIONS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTAL
CIVIL	**11**	**9**	**15**										**35**
VOL	0	0	0										0
CIVIL-INVOL	3	2	3										8
DCC	7	7	11										25
DCC PTP	1	0	1										2
FORENSIC	**10**	**12**	**11**										**33**
STAGE III	7	6	7										20
JAIL TRANS	1	0	0										1
IST	1	2	4										7
NCR	1	4	0										5
TOTAL	**21**	**21**	**26**										**68**

**This data is for the entire hospital (including Lower Saco)*

STRATEGIC PERFORMANCE EXCELLENCE

Admissions Office Quarterly Report, continued.

Average Number of Days Waiting



Average Number of Days Waiting Data

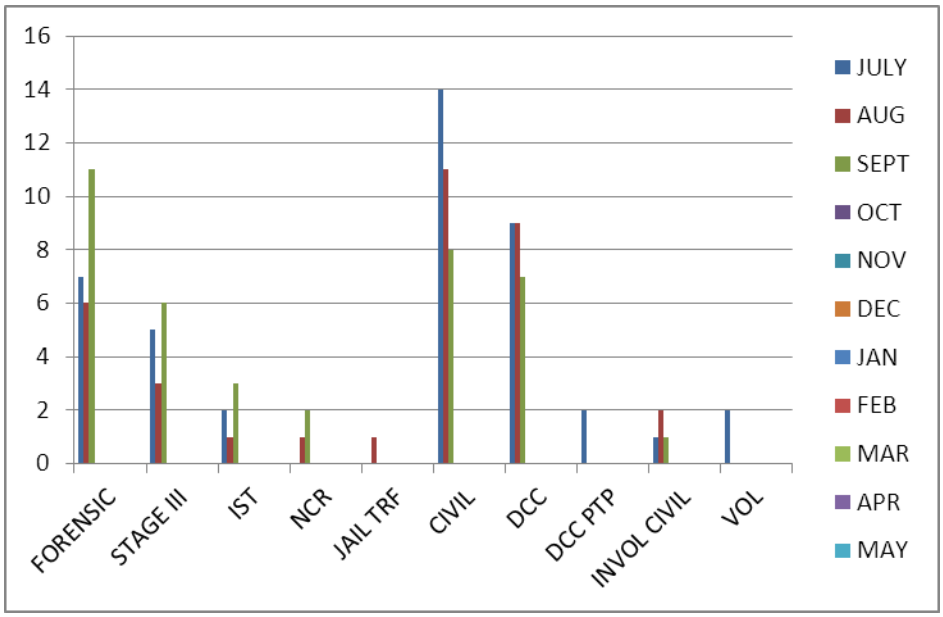
WAIT	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTAL
CIVIL	**7**	**5**	**6**										**18**
VOL	0	0	0										0
CIVIL-INVOL	1	2	3										6
DCC	10	6	8										24
DCC PTP	6	0	1										7
FORENSIC	**9**	**5**	**14**										**28**
STAGE III	11	8	19										38
JAIL TSF	7	0	0										7
IST	9	2	8										19
NCR	0	1	0										1
TOTAL	**8**	**5**	**9**										**22**

**This data is for the entire hospital (including Lower Saco)*

STRATEGIC PERFORMANCE EXCELLENCE

Admissions Office Quarterly Report, continued.

Discharge Graph



Discharge Data

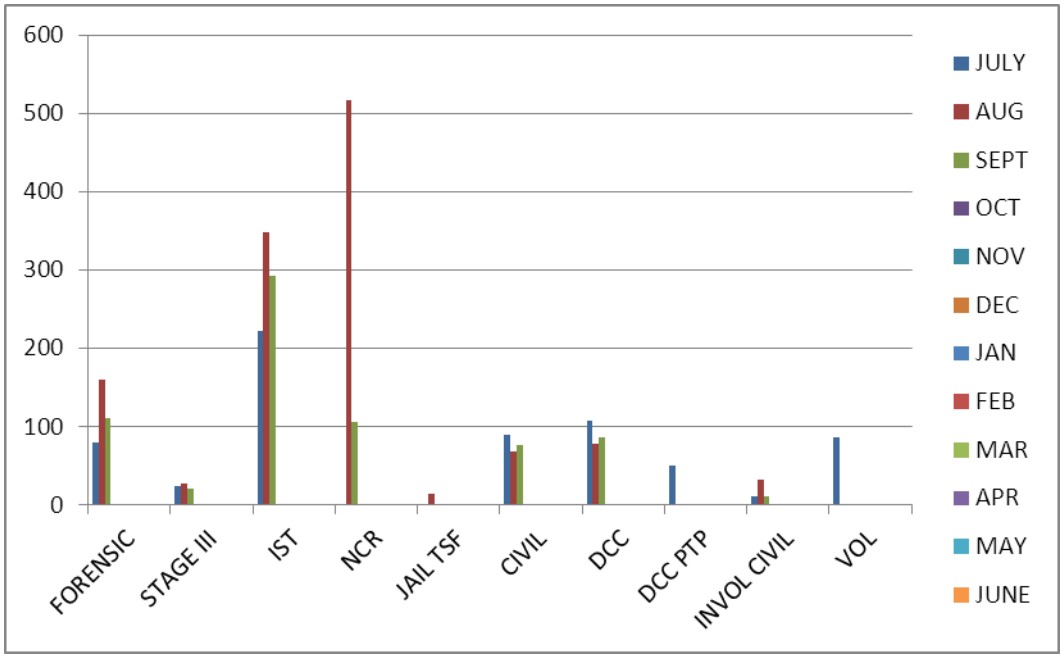
DISCHARGES	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTAL
FORENSIC	**7**	**6**	**11**										**24**
STAGE III	5	3	6										14
IST	2	1	3										6
NCR	0	1	2										3
JAIL TRF	0	1	0										1
CIVIL	**14**	**11**	**8**										**33**
DCC	9	9	7										25
DCC PTP	2	0	0										2
INVOL CIVIL	1	2	1										4
VOL	2	0	0										2
TOTAL	**21**	**17**	**19**										**57**

**This data is for the entire hospital (including Lower Saco)*

STRATEGIC PERFORMANCE EXCELLENCE

Admissions Office Quarterly Report, continued.

Length of Stay Graph



Length of Stay Data

LOS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTAL
FORENSIC	**80**	**160**	**111**										**351**
STAGE III	24	27	21										72
IST	222	348	293										863
NCR	0	517	106										623
JAIL TSF	0	14	0										14
CIVIL	**90**	**69**	**77**										**236**
DCC	108	78	86										272
DCC PTP	51	0	0										51
INVOL CIVIL	12	32	12										56
VOL	87	0	0										87
TOTAL	**85**	**101**	**96**										**282**

**This data is for the entire hospital (including Lower Saco)*

STRATEGIC PERFORMANCE EXCELLENCE

Capital Community Clinic
Performance Improvement and Quality Assurance Plan
FY 2015

I. Performance Indicators:

- Plaque Score evaluate patients oral hygiene at each appointment
    - Aid with oral hygiene education
    - Aid to discuss with staff and caretakers
    - Monitor at home hygiene
- Periodontal charting
    - Complete periodontal charting yearly to evaluate periodontal status

II. Quality Assurance Measures:

- Formulate a yearly treatment
    - Cross out/date treatment as completed
    - Write NV at the end of each progress note
- Take blood pressure and pulse at the start of each dental appointment
- Signed consent for all RCTs and EXTs
    - Completed by patient, dentist and assistant
- Time out taken prior to ALL extractions
    - Dentist initials time out and writes the initials of the assistant
- Patient re-identified by date of birth at the start of each appointment

**This data is for the entire hospital (including Lower Saco)*

STRATEGIC PERFORMANCE EXCELLENCE

Dietary Services

Responsible Party: Kristen Piela DSM

Strategic Objective: Safety in Culture and Actions													
Hand Hygiene Compliance: In an effort to monitor, sustain and improve hand hygiene compliance, the Dietary department measures its results through observations of Dietary staff when returning from a scheduled break.													
	1st Quarter 2015			**2nd Quarter 2015**			**3rd Quarter 2015**			**4th Quarter 2015**			
Baseline	**Target – Baseline**	**Findings**	**Compliance**	**Target – Q1 + 12%**	**Findings**	**Compliance**	**Target – Q2 + 12%**	**Findings**	**Compliance**	**Target – Q3 + 12%**	**Findings**	**Compliance**	**Goal**
53%	58%	138/ 238	58%										80-90%

**This data is for the entire hospital (including Lower Saco)*

Data:
138 compliant observations /238 hand hygiene observations =58% hand hygiene compliance rate

Summary:
- Hand hygiene compliance has increased by 5%.
- Hand hygiene observations have increased; from 187 observations last quarter to 238 observations this first quarter.
- Assigned additional staff to observe Hand Hygiene practices which increased the total number of observations, thus increased validity of the compliance rate.
- Updated hand hygiene signage and placed them in different locations.

Action Plan:
- Continue use of the current Hand Hygiene Tool.
- Switch the current observers.
- Encourage employees to adhere to hand hygiene via verbal interaction/reminders.
- The Food Service Manager will present this quarterly report at the departmental staff meeting.

STRATEGIC PERFORMANCE EXCELLENCE

Dietary Services

Responsible Party: Kristen Piela DSM

Strategic Objective: Safety in Culture and Actions

Nutrition Screen Completion: In an effort to monitor, improve and sustain timely completion of the nutrition screen for all admissions to RPC. The Registered Dietitian will review each Nutrition Screen within the Initial Nursing Admission Data. This screen will be completed by Nursing within 24 hours of admission.

	1st Quarter 2015			2nd Quarter 2015			3rd Quarter 2015			4th Quarter 2015			
Baseline	**Target – Baseline**	**Findings**	**Compliance**	**Target – Q1 + 3%**	**Findings**	**Compliance**	**Target – Q2 + 2%**	**Findings**	**Compliance**	**Target – Q3 + 3%**	**Findings**	**Compliance**	**Goal**
96%	96%	44/47	94%										95-100%

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

Data:

44 Nutrition screens completed w/in 24 hours of admission
47 Total Admissions = 94% of nutrition screens completed within 24 hours of admission

Summary:

- The Registered Dietitian reviewed the nutrition screens of the 47 admissions for this quarter.
- Upon review, the RD discovered 4 nutrition screens incomplete.
- Three incomplete nutrition screens were documented on the Lower Kennebec unit; and one was documented on Upper Saco.
- RD spoke with a nurse on each unit to facilitate completion of the screen. **Lower Kennebec**: one of the screens could have been completed within the 24 hour parameter. However, the nurse refused stating she was too busy. The other two incomplete screens were not seen by the RD until outside of 24 hours of admission. **Upper Saco:** Nutrition screen completed outside of the 24 hour parameter.

Action Plan:

- RD will continue correspondence with unit nursing staff upon the discovery of incomplete nutrition screens and request completion, as appropriate.
- RD will continue to correspond with the admission nurse to assure completion of the nutrition screens.
- Present quarterly report at departmental staff meeting and IPEC meeting.

STRATEGIC PERFORMANCE EXCELLENCE

Environment of Care

INDICATOR

GROUNDS SAFETY/SECURITY INCIDENTS

DEFINITION

DEFINITION: Safety/Security incidents occurring on the grounds at Riverview. Grounds being defined as "*outside the building footprint of the facility, being the secured yards, parking lots, pathways surrounding the footprint, unsecured exterior doors, and lawns.* Incidents being defined as, "*Acts of thefts, vandalism, injuries, mischief, contraband found, and safety / security breaches"* These incidents shall also include "*near misses, being of which if they had gone unnoticed, could have resulted in injury, an accident, or unwanted event".*

OBJECTIVE: Through inspection, observation, and aggressive incident management, an effective management process would limit or eliminate the likelihood that a safety/security incident would occur. This process would ultimately create and foster a safe environment for all staff, clients, and visitors.

THOSE RESPONSIBLE FOR MONITORING: Monitoring would be performed by Safety Officer, Security Site-Manager, Security Officers, Operations Supervisor, Operations staff, Director of Support Services, Director of Environmental Services, Environmental Services staff, Supervisors, and frontline staff.

METHODS OF MONITORING: Monitoring would be performed by;

- Direct observation
- Cameras
- Patrol media such as "Vision System"
- Assigned foot patrol

METHODS OF REPORTING: Reporting would occur by one or all of the following methods;

- Daily Activity Reports (DAR's)
- Incident Reporting System (IR's)
- Web-based media such as the Vision System

UNIT: Hospital grounds as defined above

BASELINE: 5% each Q

2014-2015 Q1-Q4 TARGETS: Baseline – 5% each Q

STRATEGIC PERFORMANCE EXCELLENCE

Environment of Care

Department: Safety & Security Responsible Party: Bob Patnaude Safety Officer

Strategic Objectives									
Safety in Culture and Actions	Unit	Baseline	Q4/14 Target Actual	Q1/15 Target Actual	Q2/15 Target Actual	Q3/15 Target Actual	Q4/15 Target Actual	Goal
Grounds Safety & Security Incidents Safety/Security incidents occurring on the grounds at Riverview, which include "*Acts of thefts, vandalism, injuries, mischief, contraband found, and safety / security breaches*	# of Incidents	* Baseline of 10	(10) -5% (6)	(6) -5% (13)	(13) -5%	Q2 Actual -5%	Q3 Actual -5%	Baseline -5%

**This data is for the entire hospital (including Lower Saco)*

SUMMARY OF EVENTS

The Q1 Target was (5). Our actual number was (13). Although we had a significant increase in incidents for this quarter we showed significant improvement for fiscal 2014. Overall our incidents were down 24%. In reviewing the increase in incidents for this quarter one area still is proving to be a concern. Vehicles and the parking lot accounted for 6 of our 13 incidents. Unlocked doors were also an issue, accounting for 4 incidents. We have instituted new protocols in how the police are called and have begun meeting with and improving our relations with Capital Police. Specifically, through our meetings, Capital Police were very helpful in dealing with item 12 below. We haven't had any problems with this area since September 17. We are pleased that in all of the events, our Security staff or clinical staff had discovered/processed the event before there was a negative impact to the Organization. Our aggressive rounds by Security continues to prove its' worth with regard to Security's presence and patrol techniques. The stability and longevity of our Security staff along with its' cohesiveness with the Clinical component of the hospital has proven to be most effective in our management of practices.

EVENT	DATE	TIME	LOCATION	DISPOSTION	COMMENTS
1. Security concern (unlocked door)	7/2/14	2015	Lower Saco hallway leading to center courtyard	Security was able to lock and secure door	1. Discovered during routine rounds. 2. See IR #671
2. Security concern (unlocked state car)	7/3/14	2135	Parking lot	Cars were locked	1. Security discovered during routine rounds 2. See IR #672
3. Security concern (unlocked state car)	7/3/14	No time given	Parking lot	Car was locked	1. Security discovered during routine rounds 2. See IR #674

STRATEGIC PERFORMANCE EXCELLENCE

EVENT	DATE	TIME	LOCATION	DISPOSTION	COMMENTS
4. Safety concern (shards of glass)	7/5/14	1640	Saco Yard	Security secured and disposed of items per NOD	1. Security discovered during fresh air break 2. See IR #673
5. Security concern (unlocked door)	7/6/14	1330	Lower Saco hallway leading to center courtyard	Security was able to lock and secure door	1. Discovered during routine rounds 2. See IR #675
6. Safety concern (patient smoking outside)	7/15/14	1556	Smoking area	Security questioned the patient and patient ceased smoking	1. Security received a call alerting them to the situation 2. Security questioned the patient who was cooperative and complied with the request to stop smoking 3. Client escorted back to Upper Kennebec
7. Safety concern (smoldering ashes in can)	7/22/14	0549	Smoking area	Security extinguished the smoldering fire	1. Operations asked security to check on a cigarette disposal ash can that was smoking 2. Security found it to be on fire and extinguished it with water from empty soda bottles
8. Security concern (suspicious vehicle with two occupants)	7/27/14	2150	Employee parking lot	Asked them to leave, they complied, Capitol PD notified	1. Security asked occupants if they could be of assistance, they said they were just looking for a place to hang out 2. Security asked them to leave and they complied 3. Capitol PD notified and would watch for vehicle
9. Security concern (driver's license found)	7/27/14	2250	Employee parking lot	Visitor notified to pick up driver's license at security	1. Employee turned a driver's license they found in the parking over to security, it belonged to a visitor 2. Visitor was notified to pick the license up at security
10. Security concern (unlocked door)	9/12/14	1648	Loading dock	Door locked	1. Security found door unlocked during rounds 2. Security locked door
11. Safety concern (tin can top found)	9/14/14	1445	Employee parking lot	Item disposed of	1. Tin can top found in employee parking lot 2. Item disposed of in secure area

STRATEGIC PERFORMANCE EXCELLENCE

EVENT	DATE	TIME	LOCATION	DISPOSTION	COMMENTS
12. Safety and security concern (contraband items in back of state owned pickup trucks)	9/17/14	0118	Lower parking are (on river side)	Capitol Police notified	1. Multiple contraband items found in back of state owned pickup trucks (shovel, rake, bungee cords, aluminum cans, canoe paddles) 2. Capitol Police notified 3. RPC to follow up with Central Fleet Management
13. Security concern (unlocked door)	9/26/14	1645	Generator room off parking area	Door locked	1. Security found the exterior door the generator room unlocked 2. Security locked and secured the door

**This data is for the entire hospital (including Lower Saco)*

STRATEGIC PERFORMANCE EXCELLENCE

Harbor Treatment Mall

Objectives	2Q2014	3Q2014	4Q2014	1Q2015
1. Hand-off communication sheet was received at the Harbor Mall within the designated time frame.	69% 29/42	79% 33/42	71% 30/42	71% 30/42
2. SBAR information completed from the units to the Harbor Mall.	88% 37/42	81% 34/42	79% 33/42	81% 34/42

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

Unit: All three units July, August, and September 2014
Accountability Area: Harbor Mall
Aspect: Harbor Mall Hand-off Communication
Overall Compliance: 77%

DEFINE: To provide the exchange of client-specific information between the client care units and the Harbor Mall for the purpose of ensuring continuity of care and safety within designated time frames.

MEASURE: Indicator number one has remained the same at 71% for both last quarter and this quarter. Indicator number two has increased from 79% last quarter to 81% this quarter.

ANALYZE: Overall compliance has increased from 75% last quarter to 77% for this quarter. Indicator number one increased all three months. Indicator number two increased all three months. Twelve HOC sheets were late for both last quarter and this quarter. Continue to concentrate on both indicators to improve current performance gaps.

IMPROVE: I will review the results at Nursing Leadership.

CONTROL: The plan is to continue to monitor the data and follow up with any unit(s) who may be having difficulties in developing a consistent system that works for them to meet the objectives.

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Documentation and Timeliness

Upper Saco, Lower Kennebec, Upper Kennebec

Indicators	1Q15 Findings	1Q15 Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes. *One record with no documented H&P located in paper record of EMR. See Closed chart audit for September for further details.*	There were 41 discharges in quarter 1 2015. Of those, 40 were completed within 30 days.	98%	80%
Discharge summaries will be completed within 15 days of discharge.	41 out of 39 discharge summaries were completed within 15 days of discharge during quarter 1 2015.	95%	100%
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	9 forms were approved/ revised in quarter 1 2015 (see minutes).	100%	100%
Medical transcription will be timely and accurate.	Out of 809 dictated reports, 809 were completed within 24 hours.	100%	90%

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

Summary: The indicators are based on the review of all discharged records. There was 98% compliance with 30 day record completion. Weekly "charts needing attention" lists are distributed to medical staff, including the Medical Director, along with the Superintendent, Risk Manager and the Quality Improvement Manager. There was 100% compliance with timely & accurate medical transcription services.

Actions: Continue to monitor.

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Confidentiality

Indicators	1Q15 Findings	1Q15 Compliance	Threshold Percentile
All client information released from the Health Information department will meet all Joint Commission, State, Federal & HIPAA standards.	3599 requests for information (158 requests for client information and 3441 police checks) were released for quarter 1 2015.	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	23 new employees/contract staff in quarter 1 2015.	100%	100%
Confidentiality/Privacy issues tracked through incident reports.	0 privacy-related incident report during quarter 1 2015.	100%	100%

**This data is for the entire hospital (including Lower Saco)*

Summary: The indicators are based on the review of all requests for information, orientation for all new employees/contract staff and confidentiality/privacy-related incident reports.

No problems were found in Quarter 1 2015 related to release of information from the Health Information department and training of new employees/contract staff, however compliance with current law and HIPAA regulations need to be strictly adhered to requiring training, education and policy development at all levels.

Actions: The above indicators will continue to be monitored.

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Medical Record Compliance

Indicators	September 2014 Findings	Compliance	Threshold Percentile
All Progress notes are authenticated within 7 days	462 progress notes were created for September. Out of those 4 were not authenticated within 7 days.	98%	90%
Discharge Instructions are in a manner that the client and/or family member/caregiver understand.	25 Closed records were reviewed, 16 of those included the D/C pharmacy labels, 21 were documented that medication teaching was Completed In Client Friendly Language at Discharge	84%	90%

**This data is for the entire hospital (including Lower Saco)*

Summary: Indicators are based on 100% of progress notes created per month. Physicians' progress notes are audited to ensure authentication is occurring within 7 days of availability in the EMR per RPC's Medical Record Completion Policy (MS.3.20).

The indicators for the Discharge Instructions (consolidated aftercare form) are based on 100% of discharges occurring each month over 4 consecutive months.

Actions: The above indicators will be reviewed for 4 consecutive months (beginning in January 2014) providing review yields 90% threshold or above per TJC corrective action plan.

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Release of Information for Concealed Carry Permits

Define

The process of conducting background checks on applicants for concealed carry permits is the responsibility of the two State psychiatric hospitals. Clients admitted to private psychiatric hospitals, voluntarily or by court order, are not subject to this review. Delays in the processing of background checks has become problematic due to an increasing volume of applications and complaints received regarding delays in the processing of these requests

Analyze

Data collected for the 1st quarter 2015 showed that we received 1861 applications. This is a decrease from last quarter (4th quarter 2014) when we received 2325 applications.

Improve

The process has been streamlined as we have been working with the state police by eliminating the mailing of the applications from them to RPC and DDPC. RPC has reactivated the medical records email to receive lists of the applicants from the state police that include the DOB and any alias they may have had. This has cut down on paper as well as time taken sorting all the applications. Due to the change in how we process the applications, we no longer have data on the Max and Avg Receipt Delay and Processing Time.

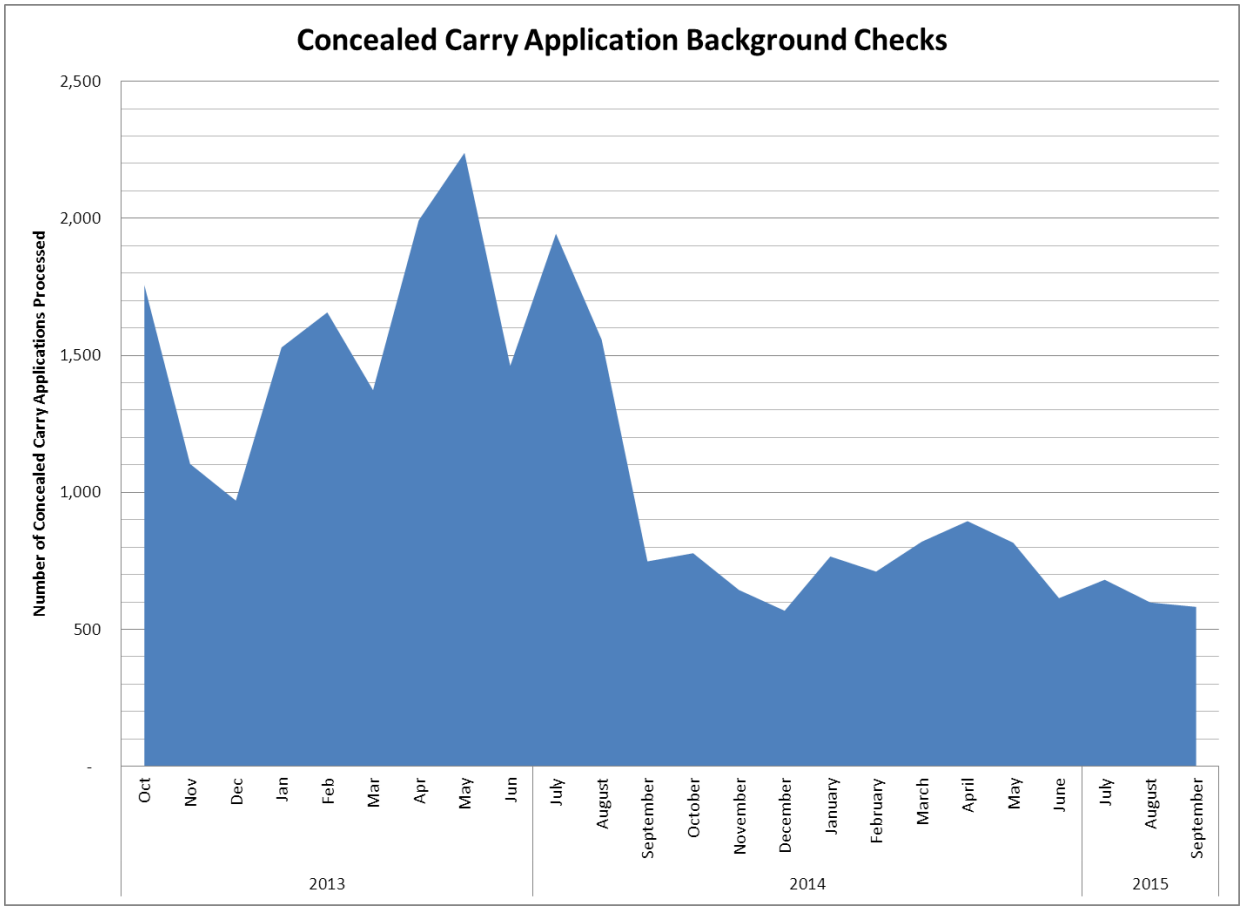
NOTE: At the end of the reporting period, there were 0 police checks outstanding for Riverview Psychiatric Center. We are now processing requests for concealed weapons checks via an emailed listing from the State Police.

OIT has also created a new patient index in which we are in the process of consolidating sources we search into this one system. Over time this will decrease time spent searching as we will no longer have to search several sources. This is ongoing.

Year	FY 2014									FY 2015		
Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
# Applications Received	778	644	568	766	711	820	895	816	614	681	598	582

**This data is for the entire hospital (including Lower Saco)*

STRATEGIC PERFORMANCE EXCELLENCE



**This data is for the entire hospital (including Lower Saco)*

STRATEGIC PERFORMANCE EXCELLENCE

Human Resources

Define

Completion of performance evaluations according to scheduled due dates continues to be problematic.

Measure

Current results are consistently below the 85% average quarterly performance goal.

Analyze

A thorough analysis of the root causes for lack of compliance with this performance standard is indicated.

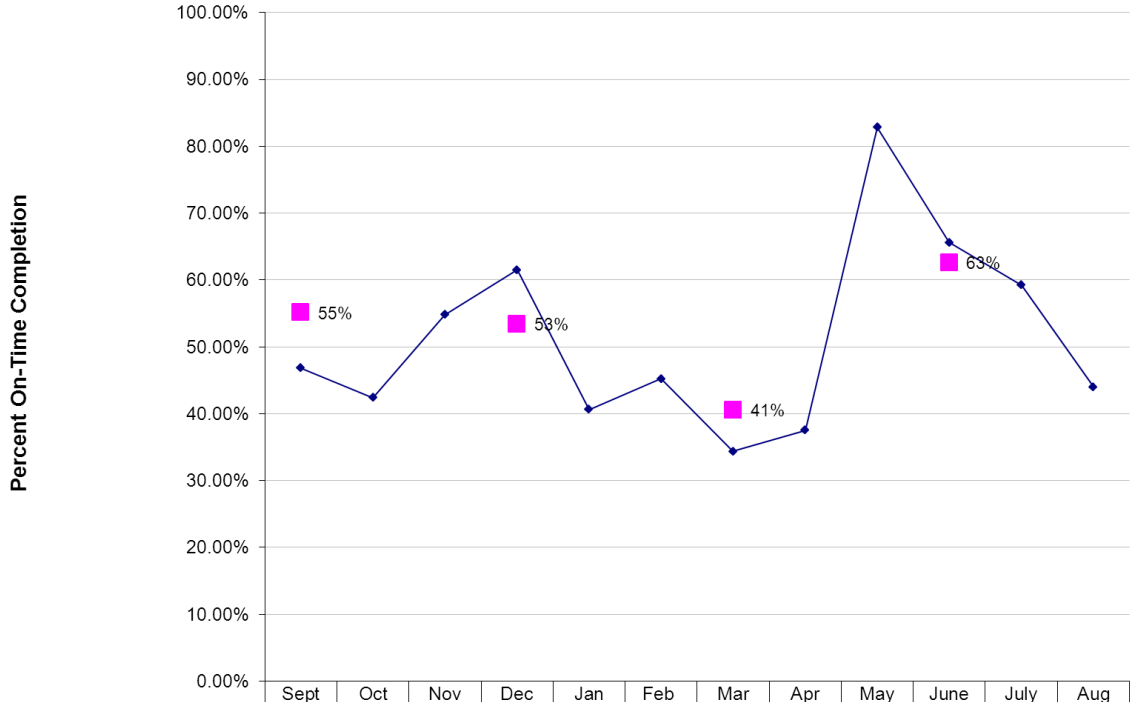
Improve

In the interim, the Personnel Director has begun the process of reporting to hospital leadership the status of performance evaluation completion at least monthly so follow-up with responsible parties can be accomplished.

Control

Plans to modify hospital performance evaluation goals for supervisory personnel will include the completion of subordinate performance evaluations in a timely manner as a critical supervisory function.

Performance Evaluation Compliance



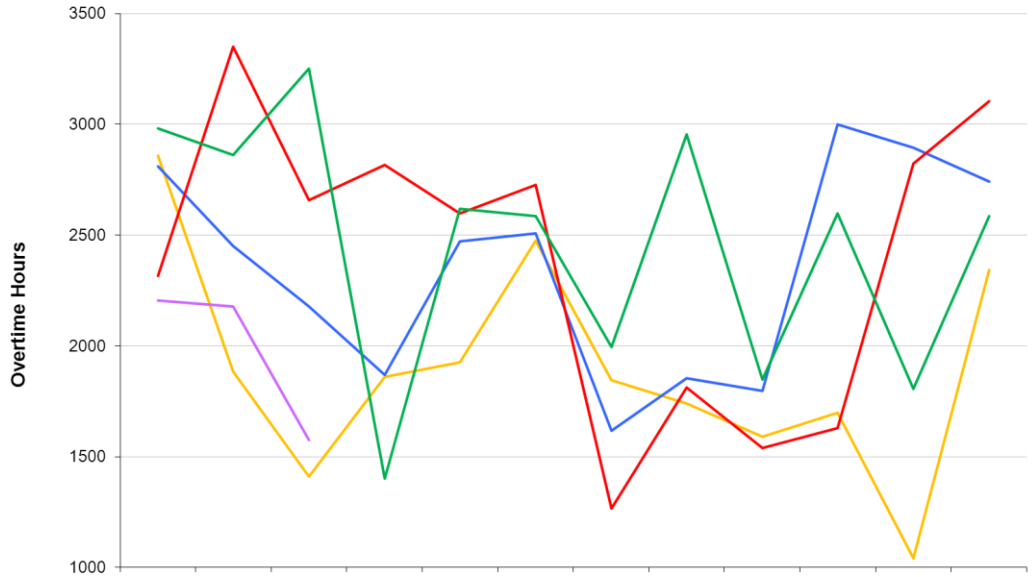
	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Monthly % Compliance	46.81%	42%	55%	62%	41%	45%	34%	38%	83%	66%	59%	44%
Quarterly % Compliance	55%			53%			41%			63%		

**This data is for the entire hospital (including Lower Saco)*

*Data not yet available for September 2014

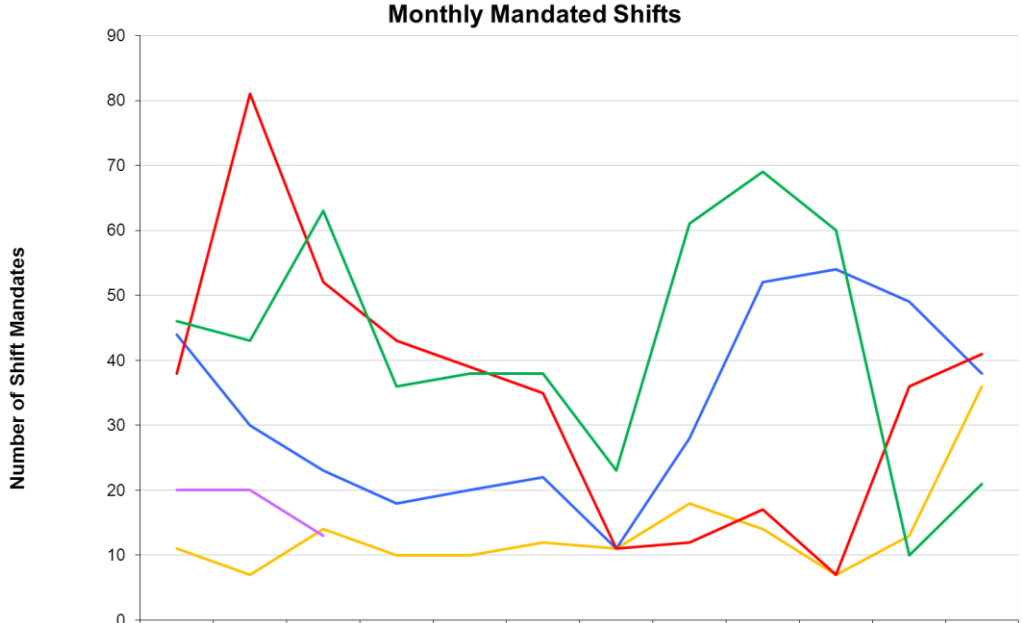
STRATEGIC PERFORMANCE EXCELLENCE

Monthly Overtime



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2011	2859	1885	1411	1860	1926	2474	1844	1740	1589	1697	1042	2342
FY 2012	2812	2451	2178	1868	2473	2507	1618	1853	1798	2999	2896	2743
FY 2013	2316	3350	2657	2817	2599	2726	1266	1812	1539	1629	2822	3106
FY 2014	2983	2861	3251	1400	2620	2586	1994	2954	1848	2599	1806	2586
FY 2015	2204	2177	1575									

Monthly Mandated Shifts

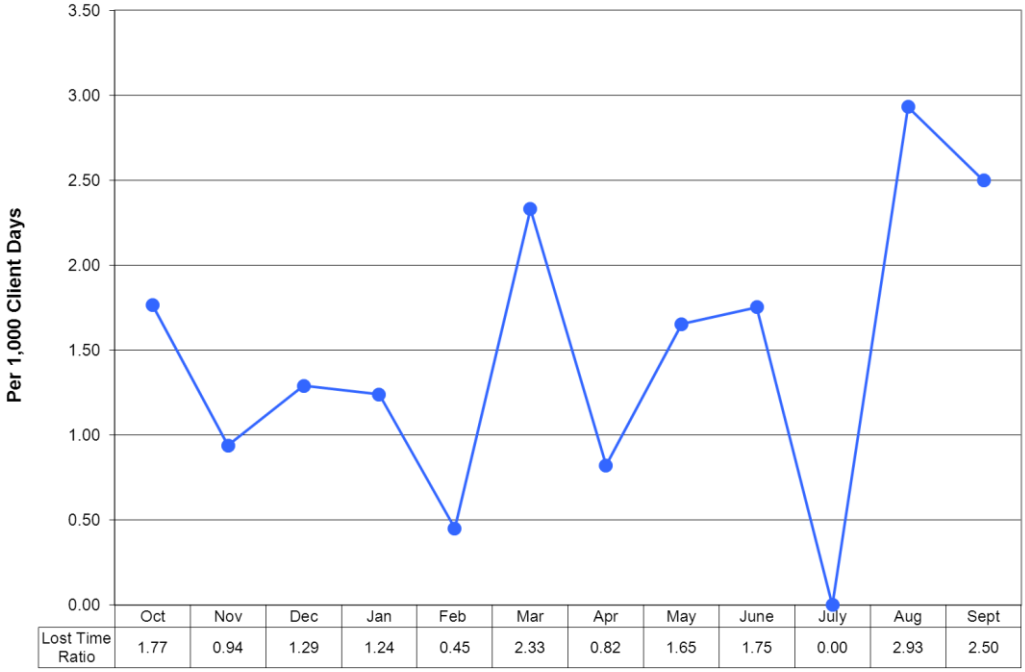


	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2011	11	7	14	10	10	12	11	18	14	7	13	36
FY 2012	44	30	23	18	20	22	11	28	52	54	49	38
FY 2013	38	81	52	43	39	35	11	12	17	7	36	41
FY 2014	46	43	63	36	38	38	23	61	69	60	10	21
FY 2015	20	20	13									

**This data is for the entire hospital (including Lower Saco)*

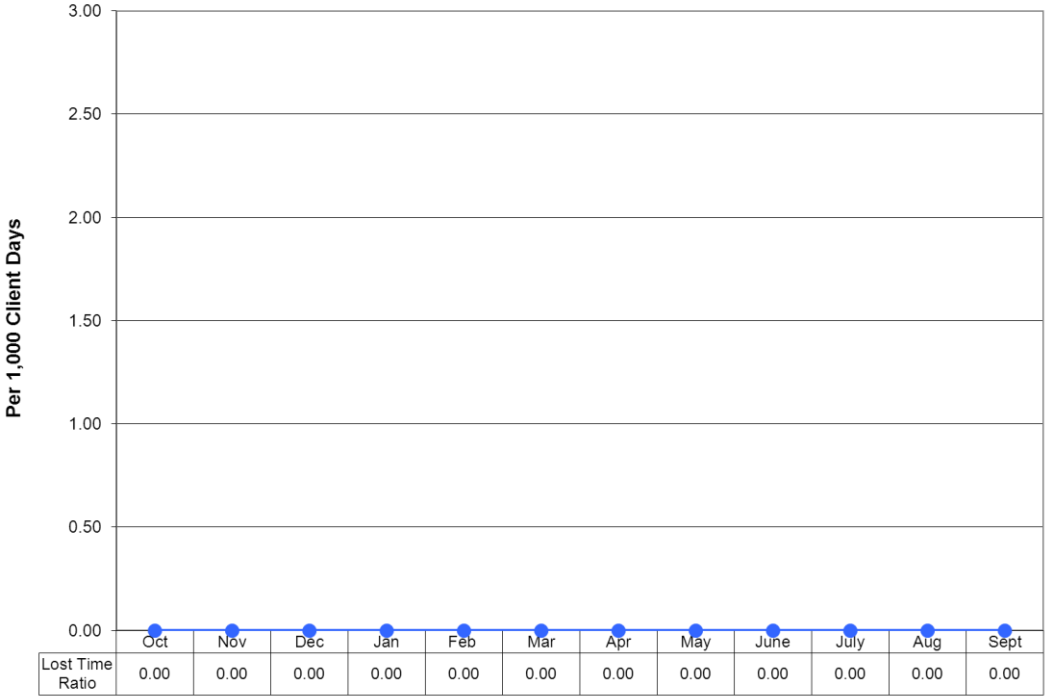
STRATEGIC PERFORMANCE EXCELLENCE

Reportable (Lost Time & Medical) Direct Care Staff Injuries



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept
Lost Time Ratio	1.77	0.94	1.29	1.24	0.45	2.33	0.82	1.65	1.75	0.00	2.93	2.50

Reportable (Lost Time & Medical) Non-Direct Care Staff Injuries



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept
Lost Time Ratio	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

**This data is for the entire hospital (including Lower Saco)*

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff
Quality Improvement Plan
2014-2015

As specified in Article Seven of the Medical Staff Bylaws, the improvement and assurance of medical staff quality and performance is of paramount importance to the hospital. This plan insures that the standards of patient care are consistent across all clinical services and all specialties and categories of responsible practitioners. Through a combination of internal and external peer review, indicator monitoring, focused case reviews of adverse outcomes or sentinel events, routine case reviews of patients with less than optimal outcomes, and the establishment of performance improvement teams when clinical process problems arise, the medical staff will insure quality surveillance and intervention activities appropriate to the volume and complexity of Riverview's clinical workload. Medical Staff Quality Improvement efforts will be fully integrated with the hospital-wide Integrated Performance Excellence Committee (IPEC) so that information can be sent to and received from other clinical and administrative units of the hospital. The Clinical Director, assisted by the President of the Medical Staff, will serve as the primary liaison between the MEC and IPEC. Oversight of the Medical Staff Performance Improvement Plan is primarily delegated to the Clinical Director in conjunction with the President of the Medical Staff, the Director of Integrated Quality and Informatics, the Superintendent, and ultimately to the Advisory Board.

The goal of the Medical Staff Quality Improvement Plan is to provide care that is:

SAFE
EFFECTIVE
PATIENT CENTERED
TIMELY
EFFICIENT
EQUITABLE
DESIGNED TO IMPROVE CLINICAL OUTCOMES

To achieve this goal, medical staff members will participate in ongoing and systematic performance improvement efforts. The performance improvement efforts will focus on direct patient care processes and support processes that promote optimal patient outcomes. This is accomplished through peer review, clinical outcomes review, variance analysis, performance appraisals, and other appropriate quality improvement techniques.

1. **Peer Review Activities**:
   a. Regularly scheduled internal peer review by full time medical staff occurs on a monthly basis at the Peer Review and Quality Assurance Committee. The group of assembled clinicians will review case histories and treatment plans, and offer recommendations for possible changes in treatment plans, for any patient judged by the attending physician or psychologist, or others (including nursing, administration, the risk manager, or the Clinical Director) , and upon request, to not be exhibiting a satisfactory response to their medical, psychological, or psychiatric regimens. Our goal is to discuss a case monthly. Detailed minutes of these reviews will be maintained, and the effectiveness of the reviews will be determined by recording feedback from the reviewed clinician as to the helpfulness of the recommendations, and by subsequent reports of any clinical improvements or changes noted in the patients discussed over time. Such intensive case reviews can also serve as the generator of new clinical monitors if frequent or systematic problem areas are uncovered.

In addition all medical staff members (full and part-time) will have a minimum of one chart every other month peer reviewed and rated for clinical pertinence of diagnosis and treatment as well as for documentation. These may include admission histories and physicals, discharge summaries, and progress notes. The results of these chart audits are available to the reviewed practitioners and trends will be monitored by the Clinical Director as part of performance review and credentialing decisions.

b. Special internal peer review or focused review. At the direction of the Clinical Director a peer chart review is ordered for any significant adverse clinical event or significant unexpected variance. Examples would be a death, seclusion or restraint of one patient for eight or more continuous hours, patient elopement, the prescribing of three or more atypical antipsychotics for the same patient at the same time, or significant patient injury attributable to a medical intervention or error.

c. External peer review occurs regularly through contracts with the Maine Medical Association and the Community Dental Clinic program. We plan to continue our recent tradition of a biannual assessment of the psychiatry service and the medical service by peers in those clinical areas based on random record assessment of 25 cases in each service. An outside dentist from Community Dental will also review 20 charts of the hospital dentist for clinical appropriateness at least annually. Our contract with the Maine Medical Association also allows for special focused peer reviews of any unexpected death or when there is a question of a significant departure from the standard of care.

2. **MEC Subcommittee and IPEC Indicator Monitoring Activities**:

The subcommittees of the MEC and the Integrated Performance Excellence Committee are the primary methods by which the medical staff monitor and analyze for trends all hospital-wide quality performance data as well as trends more specific to medical staff performance. The subcommittees, in turn, report their findings on a monthly basis to the Medical Executive Committee and to the Clinical Director for any needed action. The respective committees monitor the following indicators:

a. Integrated Performance Excellence Committee (this is not a subcommittee of the Medical Staff but the Clinical Director serves as a member and is the primary liaison to the Medical Executive Committee).
   - Psychiatric Emergencies
   - Seclusion and Restraint Events
   - Staff or Patient Injuries
   - Priority I Incident Reports
   - Other clinical/administrative department monitoring activity

b. Pharmacy and Therapeutics Committee:
   - Medication Errors Including Unapproved abbreviations
   - Adverse Drug Reactions
   - Pharmacy Interventions
   - Antibiotic Monitoring
   - Medication Use Evaluations
   - Psychiatric Emergency process

c. Medical Records Committee:
   - Chart Completion Rate/Delinquencies
   - Clinical Pertinence of Documentation of Closed Records

d. Infection Control Committee:
   - Infection Rates (hospital acquired and community acquired)
   - Staff Vaccination Rates/Titers

e. Utilization Management Committee:
   - Admission Denials
   - Timeliness of Discharges After Denials

f. Peer Review and Quality Assurance Committee:
   - Hospital-wide Core Measures and NASMHPD Data
   - Patient Satisfaction Surveys
   - Administrative concerns about quality
   - Special quality improvement monitors for the current year (see also the Appendix and number 6 below).
   - Reports from the Human Rights Committee regarding patient rights and safety issues
   - Specific case reviews

3. **Performance or Process Improvement Teams**:
When requested by or initiated by other disciplines or by hospital administration, or when performance issues are identified by the medical staff itself during its monitoring activities, the Clinical Director will appoint a medical staff member to an ad hoc performance improvement team. This is generally a multidisciplinary team looking at ways to improve hospital wide processes. Currently the following performance improvement teams involving medical staff are in existence or have recently completed their reviews:
   a. Review of treatment plans
   b. Lower Saco Unit

4. **Miscellaneous Performance Improvement Activities**:
In addition to the formal monitoring and peer review activities described above, the Clinical Director is vigilant for methods to improve the delivery of clinical care in the hospital from interactions with, and feedback from, other discipline chiefs, from patients or from their complaints and grievances, and from community practitioners who interact with hospital medical staff. These interactions may result in reports to the Medical Executive Committee, in the creation of performance improvement teams, performance of a root-cause analysis, or counseling of individual practitioners.

5. **Reports of Practitioner-specific Data to Individual Practitioners**:
The office of the Clinical Director will provide confidential outcomes of practitioner-specific data to each medical staff member within 30 days of the end of the fiscal year. This information will be available without the necessity of the practitioner requesting it. It will be placed in the confidential section of the practitioner's medical staff file and freely accessible during normal business hours. The office of the Clinical Director will notify all medical staff members when the data is available for review. Each medical staff member may discuss the data with the Clinical Director at any time.

6. **Process to amend the quality improvement plan, including adding or deleting any monitors or processes:**
Upon the recommendation of the Clinical Director, upon recommendation of the MEC as a whole after a request from any member of the medical staff, from a recommendation of the Integrated Performance Excellence Committee, or upon recommendation of the Advisory Board, this plan may be amended with appropriate approvals at any time. Examples of when amendments might be necessary are the detection of new clinical problems requiring monitoring or when it is discovered that current monitors are consistently at or near target thresholds for six consecutive months. Should the number of active clinical monitors fall below four at any time, replacement monitors will be activated within two months of termination of the previous monitor (s). The Clinical Director, the Medical Staff President, and the MEC are jointly responsible for maintaining an active monitoring system at all times and to insure that all relevant clinical service areas or services are involved in monitoring. The Director of Integrated Quality will also assist in assuring the ongoing presence of appropriate monitors.

STRATEGIC PERFORMANCE EXCELLENCE

Quality Improvement Reporting Schedule to Medical Executive Committee

IPEC:	Med. Director reports monthly
Pharmacy & Therapeutics Committee:	Chair reports monthly
Medical Records Committee:	Chair reports monthly
Infection Control Committee:	Chair reports monthly
Utilization Management Committee:	Chair reports bi-monthly
Medical Executive Committee Direct Indicators:	Clinical Director reports monthly, directly to individual provider and to the MEC
Internal Peer Review outcomes:	Clinical Director reports monthly to the Med Staff QA and Peer Review Committee, to the MEC, and to individual practitioners as necessary

APPENDIX

October, 2014

MEDICAL STAFF PHARMACY INDICATORS

MULTIPLE ANTI-PSYCHOTICS DURING HOSPITALIZATION: We continue the indicator looking at multiple antipsychotic prescriptions during the hospitalization. This performance improvement indicator has resulted in a 10 percent to 20 percent drop of multiple antipsychotic prescribing. In addition, as of the latest performance improvement meeting, no patients in the hospital are on three or more antipsychotic medications. Further, medical staff have been educated and reminded of the intent to minimize the number of people being discharged on more than one antipsychotic and that, when this occurs, it should be for one of the approved indications; i.e., three or more monotherapy trials, cross titration, or adjunctive treatment with Clozaril.

METABOLIC MONITOR: generation antipsychotics, completion of the database resulted in discussion and decision that medical staff education was the next appropriate intervention. On September 17, 2014, Miranda Cole Ph.D., Pharmacist, presented to the medical staff a monogram entitled 'Metabolic Monitoring for Patients on Antipsychotic Medications'. The response from medical staff was very positive and the upshot will be a further meeting between Dr Cole and Dr Kirby to operationalize the material discussed into a performance improvement indicator. Baseline indicates that we are 55 percent to 60 percent compliant with ensuring that our patients meet the current recommendations for metabolic monitoring. Decisions to be made include: responsibility for this testing between psychiatry and primary care physicians; whether waist circumference, a more accurate measure of metabolic problems, will be incorporated; and a decision as to when the annual monitoring for longer term patients should occur. It is hoped at October's performance improvement meeting that a suitable indicator will have been formulated at that time, and clearly it is hoped we can readily display marked improvement over our baseline.

ANTIBIOTIC PRESCRIBING: We have achieved 100 percent compliance for over 4 months with the new antibiotic order forms. This part of the performance indicator is appropriately concluded. Discussion as to whether appropriate choice of antibiotic, when necessary, should be a performance improvement indicator was discussed; however, feedback from the non-psychiatric physicians in the hospital indicated that there would be little to be gained from such a monitor as the vast majority of antibiotic choice is appropriate based on the new system. With this monitor ending, creation of a new performance improvement monitor in the pharmacy category will be discussed and implemented, again starting at the next performance improvement meeting.

PROPOSED INDICATOR - PATIENTS ON EXTREME NUMBERS OF MEDICATIONS: The monitor will focus on individuals in the hospital who are on a multitude of medications and a decision as to whether to review all patients who are one or two standard deviations above the norm will be taken when the initial data has been gathered.

ORDERS ENDING PSYCHIATRIC EMERGENCIES: Finally, a performance improvement indicator, which is run by pharmacy of direct relevance to medical staff, is ensuring that an order to end a psychiatric emergency is placed on the chart and that the emergency is not simply allowed lapse after 72 hours. Initial figures indicate that we are at a 50 percent success rate on this issue at baseline and we are monitoring the response to both e-mail and face-to-face medical staff education.
With the creation of the database looking at necessary metabolic monitoring for individuals on second-

STRATEGIC PERFORMANCE EXCELLENCE

PSYCHOLOGY FOCUSED MEDICAL STAFF PERFORMANCE IMPROVEMENT:

The COTREI, an evaluative tool for mental health acquitees, has been implemented on all inpatient NCR patients and has been carried out both by the psychiatric provider and a psychologist. Our next performance improvement indicator is to show evidence that information from this tool is incorporated into the treatment plans of all inpatients in the NCR recovery program. Dr. Kirby and Dr. DiRocco continue to meet to discuss implementation of the next phase of this indicator.

DENTAL CLINIC INDICATORS:

Dental clinic has now commenced two indicators. This occurred as a result of Dr. Kirby meeting with Dr. Ingrid Prikryl, the dentist in our clinic. Having reviewed the quality assurance and performance improvement indicators, explanation as to what performance improvement is and how it differs from, but is related to quality assurance was undertaken. Coming out of this discussion, four indicators were considered, two of which were found to be clearly appropriate for performance improvement monitoring. Both indicators are in the baseline data collection stage.

TOTAL PLAQUE SCORES: The first will be an evaluation of total plaque score on patients, followed by research with intervention and re-measurement for improvement in oral hygiene of the patient population attending the dental clinic. Research on improving hygiene in chronic psychiatric populations will be sought to define likely useful information to bring about such improvement.

PERIODONTAL CHARTING: The second issue relates to ensuring that periodontal charting by staff improves to a level ensuring that such charting occurs once a year. Currently, it appears from baseline documentation that the baseline may be starting out well below 50 percent and rapid improvement will be expected on this monitor.

FURTHER INDICATOR:

A further indicator has been added tracking the behavior of after-hours physician's assistant staff. With the engagement of our new lead physician's assistant for after-hours staff, Reid Kincaid, a monitor has been set up to look at and ensure appropriate signature of telephone orders by after-hours staff prior to leaving the building. This will be associated with the possibility, in extreme cases, that after-hours staff would lose the privilege to be able to give telephone orders, if they were not compliant with ensuring appropriate signatures by the end of their shift.

**This plan is for the entire hospital (including Lower Saco)*

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff
Poly Antipsychotic Medication Monitoring

	July	August	September
Census	96	95	104
Antipsychotic Orders for Clients			
No Antipsychotics	13 (14%)	14 (15%)	18 (17%)
Mono-antipsychotic therapy	60 (63%)	59 (62%)	66 (63%)
Two Antipsychotics	18 (19%)	22 (23%)	20 (19%)
Three Antipsychotics	5 (5%)	0	0
Four Antipsychotics	0	0	0
At least 1 antipsychotic	83 (86%)	81 (85%)	86 (83%)
Total on Poly-antipsychotic therapy	23 (24%)	22 (23%)	20 (19%)
Percentage of poly-antipsychotic therapy amongst those with orders for antipsychotics	28% (23/83)	27% (22/81)	23% (20/86)
More than 2 antipsychotics	5 (5%)	0	0
Poly-Antipsychotic therapy breakdown			
SGA + FGA	11 (48%)	21 (95%)	17 (85%)
2 SGAs ("Pine" + "Done")	6 (26%)	1 (5%)	1 (5%)
Other (2 antipsychotic regimens)	1 (4%)	0	2 (10%)
Other 2 Antipsychotic Regimen Details	1) Chlorpromazine + fluphenazine	N/A	1) Fluphenazine + chlorpromazine 2) Fluphenazine + haloperidol
3+ Antipsychotic Regimens	1) Haloperidol + quetiapine + risperidone 2) Loxapine + olanzapine + thiothixene 3) Chlorpromazine + olanzapine + perphenazine 4) Haloperidol + olanzapine + paliperidone 5) Ziprasidone + haloperidol + quetiapine	N/A	N/A
Justifiable Poly-Antipsychotic Therapy	91%	100%	98%

**This data is for the entire hospital (including Lower Saco)*

STRATEGIC PERFORMANCE EXCELLENCE

SGA = Second Generation Antipsychotic; FGA = First Generation Antipsychotic; "Pines" = clozapine, olanzapine, quetiapine, asenapine; "Dones" = risperidone, paliperidone, ziprasidone, lurasidone, iloperidone; prn = as needed; AP = Antipsychotic

Data Collection

All medication profiles in the hospital were reviewed for the months of July, August and September. We were particularly interested in the proportion of patients who were receiving more than one antipsychotic medication, since practice guidelines by the American Psychiatric Association clearly discourage this practice. When a case of polypharmacy was encountered we further required the prescriber to justify the practice based on pre-agreed upon clinical elements required to make the justification.

Findings

Over the quarter we found that about 85% of patients were receiving at least one antipsychotic medication. That is an increase in the overall number of patients receiving at least one antipsychotic. Of these patients, about 26%, a three percent decrease from last quarter (29%), were receiving more than one such agent, and by definition was a case of polypharmacy. Within this overall percentage we noted that the individual percentages for each month are as follows: July (28%), August (27%) and September (23%). The percentage of individuals' prescribed poly-antipsychotic therapy has steadily decreased since January 2014 at 33% to September 2014 at 23%. For two months in this quarter, August and September, there were no patients prescribed more than 2 antipsychotics at one time (this includes PRN or "as needed" orders). August was the first month to have no patients prescribed more than two antipsychotics and for all regimens to be justified appropriately according to the HBIPS-5 and clinically/pharmacologically. September also had no instances of more than two antipsychotics ordered. However, there were a couple of instances where the justification of poly-antipsychotic therapy was not provided. Justified poly-antipsychotic therapy for each month is as follows: July (91%), August (100%), September (98%).

Analysis

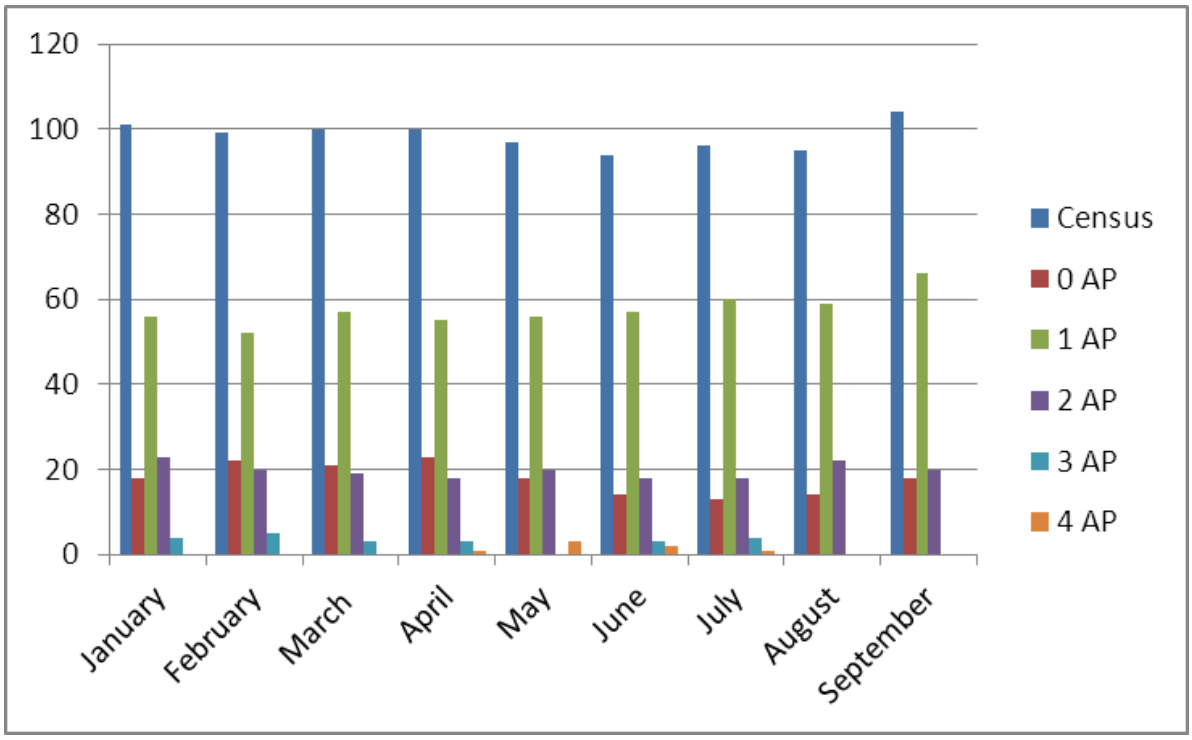
We have improved performance to reaching our goal of above 90% for each month of this quarter. The average for the quarter is 96% of justified poly-antipsychotic therapy. There was impressive improvement seen in this quarter with the increase in justified polyantipsychotic therapy as well as having two months with no patients prescribed more than 2 antipsychotics. This could be due to the increased awareness of providers with reporting at the Peer Review Committee and the Pharmacy & Therapeutics (P&T) Committee, as well as the implementation of the electronic justification form notifications.

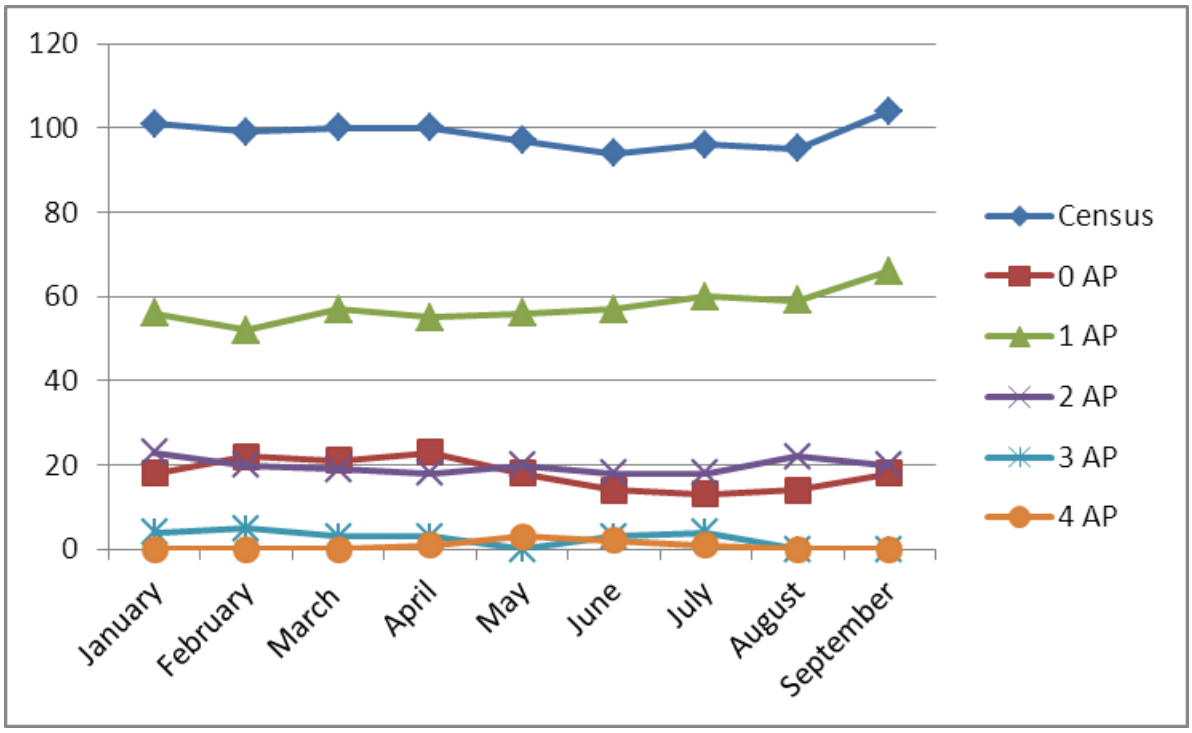
Plan

We will continue to monitor polyantipsychotic therapy for another quarter since appropriate antipsychotic prescribing is both a common task in the hospital as well as one fraught with many potential negative sequellae. We will continue to notify prescribers electronically of patients with multiple antipsychotic orders both on admission and with new orders. We will continue to prospectively gather data on polyantipsychotic therapy and follow-up with prescribers regarding the documented plan of action. It is our goal to continue this pattern of justified polyantipscyhotic therapy and zero occurrences of more than two antipsychotics prescribed at the same time.

STRATEGIC PERFORMANCE EXCELLENCE

Census & Number of Patients with 0, 1, 2, 3, & 4 Orders for Antipsychotics

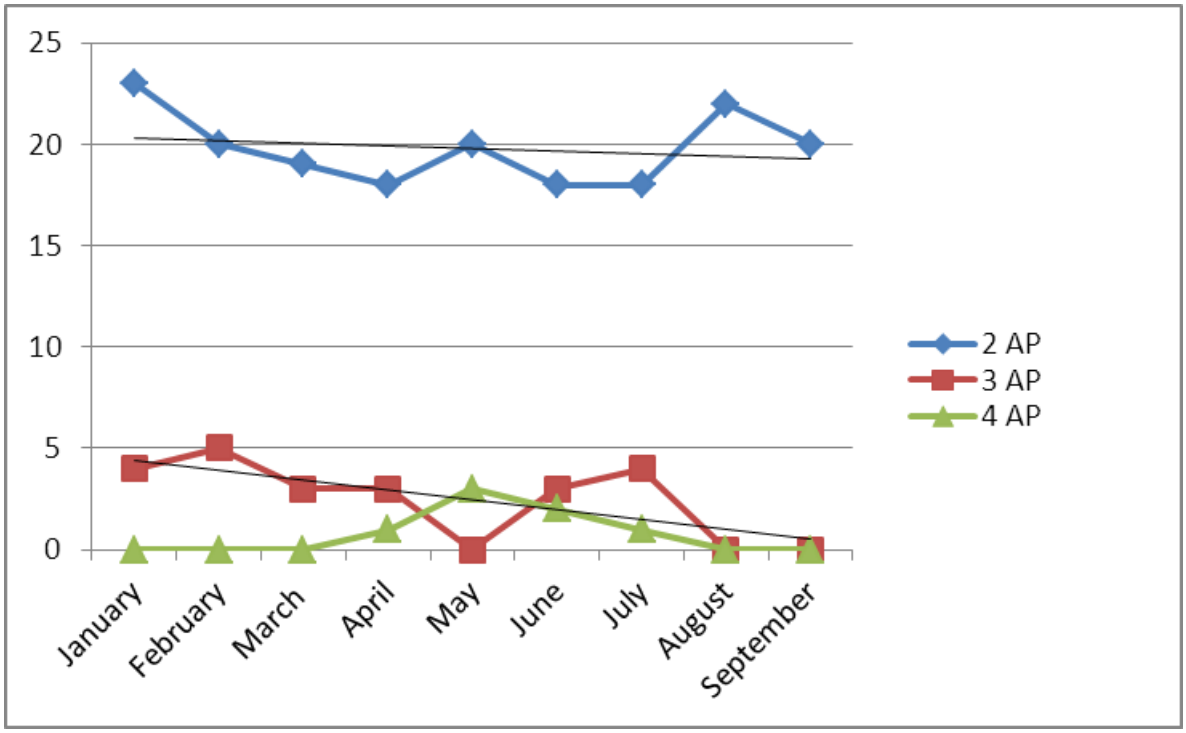




**This data is for the entire hospital (including Lower Saco)*

STRATEGIC PERFORMANCE EXCELLENCE

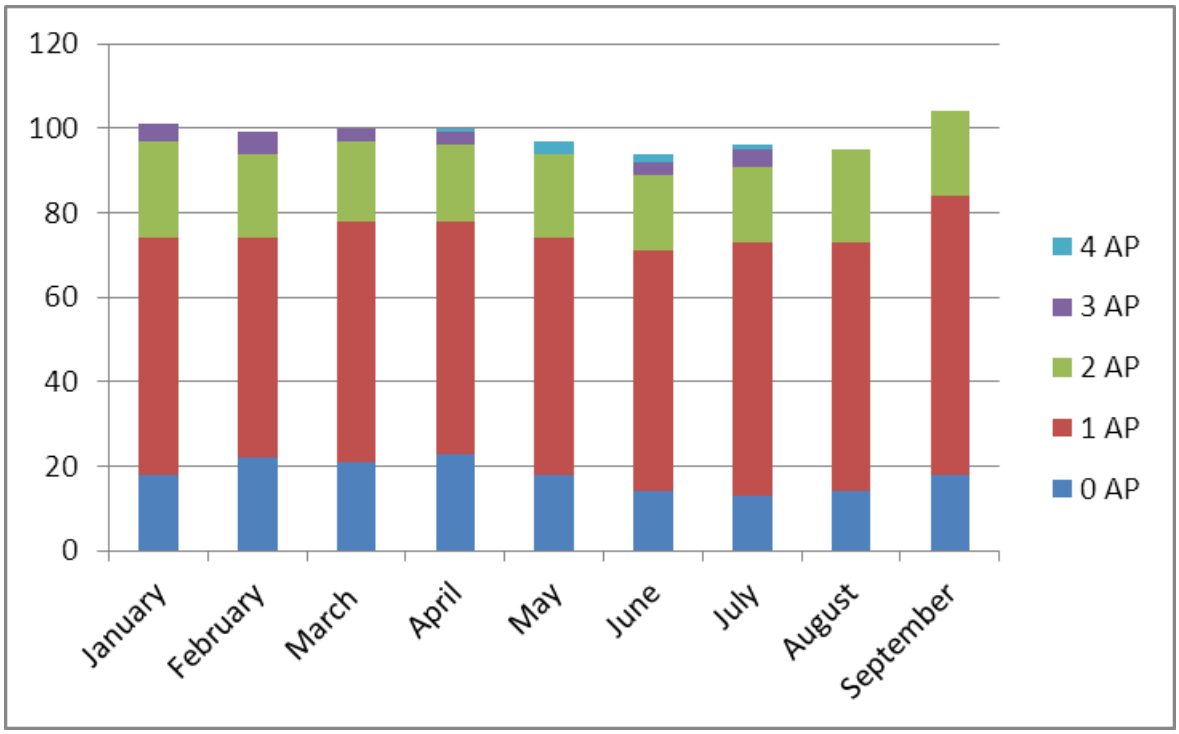
Number of Patients with 2+ Antipsychotic Orders per Month

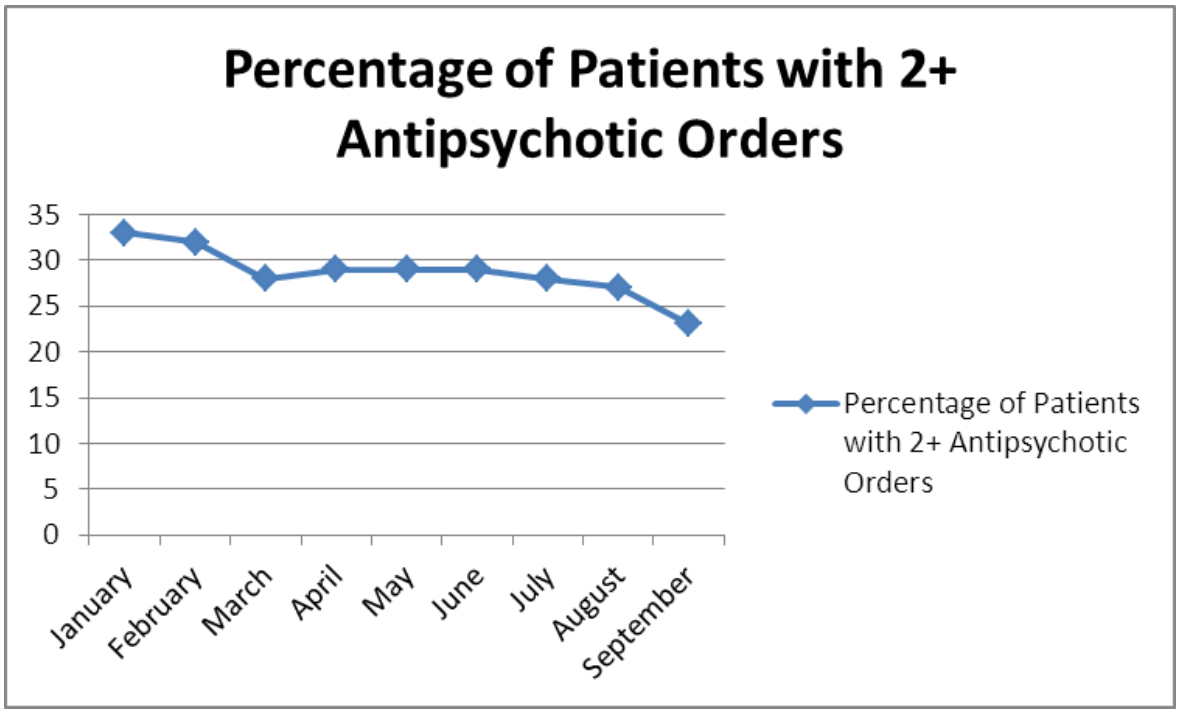


**This data is for the entire hospital (including Lower Saco)*

STRATEGIC PERFORMANCE EXCELLENCE

Number of Concurrent Antipsychotic Orders Per Patient Per Month





**This data is for the entire hospital (including Lower Saco)*

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff
Antibiotic Use Monitoring

Data Collection

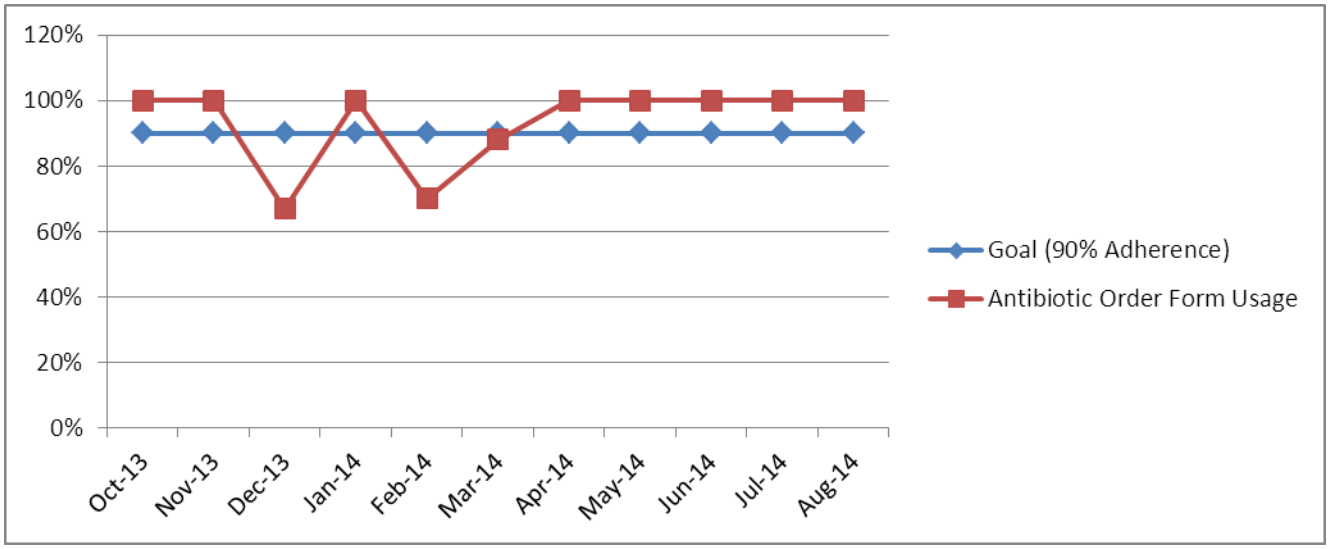
Data collection on the use of the Antibiotic Order Sheet was continued through the month of August. During the month of September where the results through August were presented to the Peer Review and Pharmacy and Therapeutics (P&T) Committee this monitor was retired due to 100% adherence of the Medical Staff utilization of the form for five consecutive months.

Findings

During the monitoring period there was an adherence rate of 100% for all months. Re-evaluation of the previous quarter's data on adherence to the Antibiotic Order Sheet increased the rate to 100% for each month. This was due to erroneous inclusion of medications not classified as antibiotics according to the AHFS classification. This information was reported to the Peer Review and P&T Committees.

Medical Staff Performance Improvement Indicator: Antibiotic Stewardship
Goal: 90% Adherence to Antibiotic Order Form for 4 Consecutive Months

	Oct '13	Nov '13	Dec '13	Jan '14	Feb '14	Mar '14	Apr '14	May '14	Jun '14	Jul '14	Aug '14	Sept '14
Goal (90% Adherence)	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Antibiotic Order Form Usage	100%	100%	67%	100%	70%	88%	100%	100%	100%	100%	100%	Retired



**This data is for the entire hospital (including Lower Saco)*

Plan

This monitor has been retired as of September 2014. We will continue to utilize the Antibiotic Order Sheet to order antibiotics and continue to assess the appropriate selection of antibiotic. We will also continue to regularly evaluate and update the guidance information on the form as necessary.

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff
Metabolic Monitoring of Atypical Antipsychotics

Data Collection

The pharmacy completed data collection of metabolic monitoring parameters for all patients in the hospital who were receiving atypical antipsychotics during the quarter. Data elements collected on all patients included BMI (Body Mass Index) and BP (blood pressure) plus lab results including HDL cholesterol, triglycerides, fasting blood sugar, and hemoglobin A1c. Also collected were the dates of the last tests and the names of the atypical drugs each patient was receiving. During this data collection period, education was provided to the medical staff on Metabolic Monitoring on September 17, 2014 as our findings have remained fairly consistent throughout the evaluation of this monitor.

Findings

During the monitoring period there were 105 patients receiving at least one atypical antipsychotic agent. Data was completely recorded for all desired data elements for about 56% of patients prescribed second generation antipsychotics for the quarter, consistent with previous reports. Twenty nine patients, or 28%, were missing enough data elements that their metabolic status was unable to be determined. About half of these were due to lab work refusals and newly admitted patients on the few days before the close of the quarter. As shown in the charts below, the majority of missing parameters require lab work (Glucose, A1c, HDL, Triglycerides) and it is missing for mostly new admissions. Conversely, the majority of missing weights and blood pressures are for patients that have been at the hospital for a longer period of time. There seems to be an alarmingly high number of patients missing a hemoglobin A1c value, however many of these patients do have fasting glucose levels that do not warrant obtaining an A1c. Therefore the second hemoglobin A1c parameter in the chart that indicates 22 values missing is more representative of patients either have no fasting blood glucose, a suspiciously high fasting blood glucose or known diabetes that would warrant us to check the A1c level.

Medical Staff Performance Improvement Indicator:

Metabolic Monitoring 2014

	April	May	June	July – September 2014
# of Patients on SGA	60	68	69	105
# of Patients with Complete/Up-to-date Parameters	34 (57%)	39 (57%)	45 (65%)	59 (56%)
# of Patients Missing/ Not Up-to-date Parameters	26 (43%)	29 (43%)	24 (35%)	46 (44%)
# of Patients Meeting Criteria for Metabolic Syndrome	14 (23%)	24 (35%)	25 (36%)	32 (30%)
# of Patients without Metabolic Syndrome	40 (67%)	33 (49%)	33 (48%)	44 (42%)
# Unable to Determine	6 (10%)	11 (16%)	11 (16%)	29 (28%)

**This data is for the entire hospital (including Lower Saco)*

STRATEGIC PERFORMANCE EXCELLENCE

Missing Parameter	Total	Current Patients	New Admissions	Lower Kennebec	Lower Saco	Upper Kennebec	Upper Saco
Weight	8	8	0	0	1	1	6
Blood Pressure	4	4	0	2	0	0	2
Glucose	22	10	12	11	7	4	0
HDL	26	10	16	10	11	5	0
Triglycerides	26	10	16	10	11	5	0
Hemoglobin A1c (also missing Glucose or glucose levels warrant A1c level)	22	11	11	11	8	3	0
Hemoglobin A1c (Total)	66	35	31	25	24	12	5

Missing Parameter	Lower Kennebec (LK)	LK SCU	LK New Admits	Lower Saco (LS)	LS SCU	LS New Admits
Weight	0	0	0	1	0	0
Blood Pressure	2	0	0	0	0	0
Glucose	1	2	8	2	1	4
HDL	0	2	8	2	1	8
Triglycerides	0	2	8	2	1	8
Hemoglobin A1c (also missing Glucose or glucose levels warrant A1c level)	2	2	7	2	2	4
Hemoglobin A1c (Total)	6	2	17	6	4	14

**This data is for the entire hospital (including Lower Saco)*

Refusals – 14 (30% of the patients with incomplete information)

Analysis

We are still below our target of 95% of patients on atypical antipsychotics having a complete metabolic profile available to the pharmacist and to the medical staff. A large contributing factor continues to be patient refusals of lab work. Another factor identified has been the proximity of admission to the end of the quarter. Additionally, there are some patients that have second generation antipsychotics ordered on a PRN or "as needed" basis, which means they may or may not regularly be taking the medication. Education was provided to the Medical Staff during this quarter on Metabolic Monitoring. However its timing was towards the end of the quarter (9/17/2014) which allowed for little to no impact on the results described in this quarterly report. It is expected that this education will impact the evaluation of this monitor during the next quarter.

Plan

Going forward, our plan will be to review the recommended metabolic monitoring frequency for each client to optimize the monitoring and prevent unnecessary lab work. We will continue to monitor the data elements of metabolic monitoring for each client prescribed a second generation antipsychotic. We will also continue to refine and improve our data entry. We will explore the concept of a metabolic clinic to better assess, identify, monitor, educate and treat clients at risk for metabolic syndrome. We will work to develop a schedule for blood draws for monitoring and perhaps add an order-set for lab work for patients prescribed second generation antipsychotics. We will utilize the APA and ADA guidelines to determine each client's recommended frequency of monitoring. We will explore the literature to determine action steps once a client is identified as having metabolic syndrome. We will collaborate with the Medical Staff on a notification process to alert them of when a patient is due or delinquent with metabolic monitoring.

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff
Polytherapy Monitoring

Data Collection

Polytherapy is defined as "combined treatment of multiple conditions with multiple medications". This differs from polypharmacy, the "treatment of a single condition with multiple medications from the same pharmacologic class or with the same mechanism of action" which our other monitor, Poly-antipsychotic therapy, addresses. Polypharmacy can lead to complex medication regimens and increases the chances of drug-drug interactions potentially negatively impacting or inhibiting another drug from exerting it intended therapeutic effect. When five or more medications are taken together there is almost a 100% chance of a drug-drug interaction. We have assessed a baseline group of patients with regards to their total number of medications prescribed and further broken it down to number of scheduled medications and number of PRN or "as needed" medications.

Findings

At baseline 78 patients were evaluated for their total number of medications prescribed, their total number of scheduled medications and their total number of PRN orders.

	Average	Range
Total Orders	11.4	4 - 37
Scheduled	5.5	0 - 21
PRNs	6	1 - 22

Medication Number Range	Number of Patients
< 5	4
5 – 9	28
10 – 14	33
15 – 19	4
20 – 24	3
25 – 29	2
> 30	1

**This data is for the entire hospital (including Lower Saco)*

Plan

Our plan is to identify a strategy to reduce polytherapy. This will include identification of obtainable goals in reduction of polytherapy, development of a process, and identification of the patients to address initially (the outliers with highest number of medications ordered). This monitor will be reported and discussed with the Medical Staff at the Peer Review and Pharmacy & Therapeutics (P&T) Committees.

STRATEGIC PERFORMANCE EXCELLENCE

Nursing

INDICATOR

Mandate Occurrences

DEFINITION

When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy. This creates difficulty for the employee who is required to unexpectedly stay at work up to 16 hours. It also creates a safety risk.

OBJECTIVE

Through collaboration among direct care staff and management, solutions will be identified to improve the staffing process in order to reduce and eventually eliminate mandate occurrences. This process will foster safety in culture and actions by improving communication, improving staffing capacity, mitigating risk factors, supporting the engagement and empowerment of staff. It will also enhance fiscal accountability by promoting accountability and employing efficiency in operations.

THOSE RESPONSIBLE FOR MONITORING

Monitoring will be performed by members of the Staffing Improvement Task Force which includes representation of Nurses and Mental Health Workers on all units, Staffing Office and Nursing Leadership.

METHODS OF MONITORING

Monitoring would be performed by;

- Staffing Office Database Tracking System

METHODS OF REPORTING

Reporting would occur by one or all of the following methods;

- Staffing Improvement Task Force
- Nursing Leadership
- Riverview Nursing Staff Communication

UNIT

Mandate shift occurrences

BASELINE

September 2013: Nurse Mandates 14 shifts, Mental Health Worker Mandates 49 shifts

MONTHLY TARGETS

10% reduction monthly x4 from baseline

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Mandates

Staffing Improvement Task Force

Mandate Occurrences: When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy.

	New Baseline Sept 2013	FY14 Q2			FY14 Q3			FY14 Q4			FY15 Q1			Goal
		Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	June 2014	July 2014	Aug2014	Sep 2014	
Nursing Mandates	14	4	8	9	3	12	15	21	2	8	4	2	1	9 (10% reduction monthly x4 from baseline)
Mental Health Worker (MHW) Mandates	49	32	30	29	20	49	54	39	8	13	16	18	12	32 (10% reduction monthly x4 from baseline)

**This data is for the entire hospital (including Lower Saco)*

Nursing mandates decreased from 31 last quarter to 7 this quarter.
MHW mandates decreased from 60 last quarter to 46 this quarter.

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Initial Chart Compliance

July – September 2014
Lower Kennebec

Indicator	Findings	Compliance
1. Universal Assessment completed by RN within 24 hours	34 of 34	100%
2. All sections completed or deferred within document	34 of 34	100%
3. Initial Safety Treatment Plan initiated	34 of 34	100%
4. All sheets required signature authenticated by assessing RN	34 of 34	100%
5. Medical Care Plan initiated if Medical problems identified	10 of 34 21 n/a 2 ref.	97%
6. Informed Consent sheet signed	32 of 34 2 ref.	100%
7. Potential for violence assessment upon admission	34 of 34	100%
8. Suicide potential assessed upon admission	34 of 34	100%
9. Fall Risk assessment completed upon admission	33 of 34 1 n/a	100%
10. Score of 5 or above incorporated into problem need list	6 of 34 28 n/a	100%
11. Dangerous Risk Tool done upon admission	33 of 34	97%
12. Score of 11 or above incorporated into Safety Problem	19 of 34 13 n/a 1 ref.	100%
13. Evidence that clients are routinely informed of their rights upon admission in accordance with ¶ 150 of the settlement agreement is found in the document of the charts reviewed.	33 of 34 1 ref.	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Initial Chart Compliance

July – September 2014
Upper Kennebec

Indicator	Findings	Compliance
1. Universal Assessment completed by RN within 24 hours	4 of 4	100%
2. All sections completed or deferred within document	4 of 4	100%
3. Initial Safety Treatment Plan initiated	4 of 4	100%
4. All sheets required signature authenticated by assessing RN	4 of 4	100%
5. Medical Care Plan initiated if Medical problems identified	4 n/a	100%
6. Informed Consent sheet signed	4 of 4	100%
7. Potential for violence assessment upon admission	4 of 4	100%
8. Suicide potential assessed upon admission	4 of 4	100%
9. Fall Risk assessment completed upon admission	4 of 4	100%
10. Score of 5 or above incorporated into problem need list	4 n/a	100%
11. Dangerous Risk Tool done upon admission	4 of 4	100%
12. Score of 11 or above incorporated into Safety Problem	4 n/a	100%
13. Evidence that clients are routinely informed of their rights upon admission in accordance with ¶ 150 of the settlement agreement is found in the document of the charts reviewed.	4 of 4	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Initial Chart Compliance

July – September 2014
Upper Saco

Indicator	Findings	Compliance
1. Universal Assessment completed by RN within 24 hours	7 of 7	100%
2. All sections completed or deferred within document	7 of 7	100%
3. Initial Safety Treatment Plan initiated	6 of 7	86%
4. All sheets required signature authenticated by assessing RN	7 of 7	100%
5. Medical Care Plan initiated if Medical problems identified	3 of 7 3 n/a	86%
6. Informed Consent sheet signed	7 of 7	100%
7. Potential for violence assessment upon admission	7 of 7	100%
8. Suicide potential assessed upon admission	7 of 7	100%
9. Fall Risk assessment completed upon admission	7 of 7	100%
10. Score of 5 or above incorporated into problem need list	1 of 7 6 n/a	100%
11. Dangerous Risk Tool done upon admission	7 of 7	100%
12. Score of 11 or above incorporated into Safety Problem	2 of 7 3 n/a	71%
13. Evidence that clients are routinely informed of their rights upon admission in accordance with ¶ 150 of the settlement agreement is found in the document of the charts reviewed.	7 of 7	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Initial Chart Compliance

July – September 2014

Total – Lower Kennebec, Upper Kennebec, Upper Saco

Indicator	Findings	Compliance
1. Universal Assessment completed by RN within 24 hours	45 of 45	100%
2. All sections completed or deferred within document	45 of 45	100%
3. Initial Safety Treatment Plan initiated	44 of 45	98%
4. All sheets required signature authenticated by assessing RN	45 of 45	100%
5. Medical Care Plan initiated if Medical problems identified	13 of 45 28 n/a 2 ref.	96%
6. Informed Consent sheet signed	43 of 45 2 ref.	100%
7. Potential for violence assessment upon admission	45 of 45	100%
8. Suicide potential assessed upon admission	45 of 45	100%
9. Fall Risk assessment completed upon admission	44 of 45 1 ref.	100%
10. Score of 5 or above incorporated into problem need list	7 of 45 38 n/a	100%
11. Dangerous Risk Tool done upon admission	44 of 45	98%
12. Score of 11 or above incorporated into Safety Problem	21 of 45 20 n/a 1 ref.	93%
13. Evidence that clients are routinely informed of their rights upon admission in accordance with ¶ 150 of the settlement agreement is found in the document of the charts reviewed.	44 of 45 1 ref.	100%

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

STRATEGIC PERFORMANCE EXCELLENCE

Peer Support

INDICATOR

Client Satisfaction Survey Return Rate

DEFINITION

There is a low number of satisfaction surveys completed and returned once offered to clients due to a number of factors.

OBJECTIVE

To increase the number of surveys offered to clients, as well as increase the return rate.

THOSE RESPONSIBLE FOR MONITORING

Peer Services Director and Peer Support Team Leader will be responsible for developing tracking tools to monitor survey due dates and surveys that are offered, refused, and completed. Full-time peer support staff will be responsible for offering surveys to clients and tracking them until the responsibility can be assigned to one person.

METHODS OF MONITORING

- Biweekly supervision check-ins
- Monthly tracking sheets/reports submitted for review

METHODS OF REPORTING

- Client Satisfaction Survey Tracking Sheet
- Completed surveys entered into spreadsheet/database

UNIT

All client care/residential units

BASELINE

Determined from previous year's data.

QUARTERLY TARGETS

Quarterly targets vary based on unit baseline with the end target being 50%.

STRATEGIC PERFORMANCE EXCELLENCE

Peer Support

Inpatient Client Survey – Improving the Rate of Return

Department: Peer Support Responsible Party: Bobbi Lin

Strategic Objectives								
Client Recovery	Unit	Baseline	FY14 Q2	FY14 Q3	FY14 Q4	FY15 Q1	Goal	Comments
CSS Return Rate								
The client satisfaction survey is the primary tool for collecting data on how clients feel about the services they are provided at the hospital. Data collection has been low on all units and the way in which the surveys are administered has challenges based on the unit operations and performance of the peer support worker.	LK	15%	18%	10%	12%	23%	50%	*Percentages are calculated based on number of people eligible to receive a survey vs. the number of people who completed the surveys.*
	UK	45%	47%	50%	12%	36%	50%	
	US	30%	33%	30%	100%	0%	50%	

**This data is for the three units only (Lower Kennebec, Upper Kennebec, and Upper Saco)*

STRATEGIC PERFORMANCE EXCELLENCE

Summary of Inpatient Client Survey Results

#	Indicators	2Q2014 Findings	3Q2014 Findings	4Q2014 Findings	1Q2015 Findings	Average Score
1	I am better able to deal with crisis.	69%	73%	59%	66%	**67%**
2	My symptoms are not bothering me as much.	71%	63%	59%	63%	**64%**
3	The medications I am taking help me control symptoms that used to bother me.	75%	83%	59%	72%	**72%**
4	I do better in social situations.	73%	65%	53%	67%	**65%**
5	I deal more effectively with daily problems.	69%	68%	53%	67%	**64%**
6	I was treated with dignity and respect.	75%	73%	63%	67%	**70%**
7	Staff here believed that I could grow, change and recover.	69%	80%	63%	72%	**71%**
8	I felt comfortable asking questions about my treatment and medications.	69%	70%	56%	67%	**66%**
9	I was encouraged to use self-help/support groups.	77%	70%	66%	69%	**71%**
10	I was given information about how to manage my medication side effects.	63%	65%	47%	61%	**59%**
11	My other medical conditions were treated.	71%	75%	57%	73%	**69%**
12	I felt this hospital stay was necessary.	63%	65%	44%	64%	**59%**
13	I felt free to complain without fear of retaliation.	53%	50%	47%	69%	**55%**
14	I felt safe to refuse medication or treatment during my hospital stay.	63%	55%	56%	42%	**54%**
15	My complaints and grievances were addressed.	65%	68%	56%	70%	**65%**
16	I participated in planning my discharge.	73%	65%	72%	72%	**71%**
17	Both I and my doctor or therapists from the community were actively involved in my hospital treatment plan.	73%	65%	63%	58%	**65%**
18	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	71%	63%	59%	63%	**64%**
19	The surroundings and atmosphere at the hospital helped me get better.	69%	65%	66%	66%	**67%**
20	I felt I had enough privacy in the hospital.	71%	63%	63%	64%	**65%**
21	I felt safe while I was in the hospital.	75%	75%	59%	67%	**69%**
22	The hospital environment was clean and comfortable.	75%	78%	59%	70%	**71%**
23	Staff were sensitive to my cultural background.	83%	55%	59%	52%	**62%**
24	My family and/or friends were able to visit me.	77%	78%	59%	61%	**69%**
25	I had a choice of treatment options.	73%	60%	50%	70%	**63%**
26	My contact with my doctor was helpful.	77%	68%	47%	63%	**64%**
27	My contact with nurses and therapists was helpful.	79%	78%	66%	72%	**74%**
28	If I had a choice of hospitals, I would still choose this one.	69%	48%	56%	55%	**57%**
29	Did anyone tell you about your rights?	71%	63%	59%	58%	**63%**
30	Are you told ahead of time of changes in your privileges, appointments, or daily routine?	67%	45%	47%	66%	**56%**
31	Do you know someone who can help you get what you want or stand up for your rights?	71%	70%	69%	80%	**73%**
32	My pain was managed.	65%	65%	59%	58%	**62%**
	Overall Score	**71%**	**66%**	**58%**	**65%**	**65%**

**This data is for the entire hospital (including Lower Saco)*

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

The IPEC reporting reflects three major areas of focus for performance improvement that have pharmacy specific indicators: **Safety in Culture and Actions, Fiscal Accountability and Medication Management** (see Medication Management – Dispensing Process)**.** The pharmacy specific indicators for each of the priority focus areas utilizes measurable and objective data that is trended and analyzed to support performance improvement efforts and medication safety, as well as, ensure regulatory compliance and best practice in key areas.

Safety in Culture and Actions

RPC's primary medication distribution system uses the Pyxis Medstations to provide an electronic "closed loop" system to dispense medications for patients. Within the Pyxis system, key data elements are reported, trended and analyzed to ensure medication safety and regulatory compliance are maintained. *Pyxis Discrepancies* created by nursing staff are monitored daily and analyzed by Pharmacy with follow up to Nursing as needed for resolution. A quarterly summary is provided to the Nursing-Pharmacy Committee for further review and discussion of trends and ideas to minimize the occurrence of discrepancies by Nursing. *Pyxis Overrides of Controlled Drugs* by nursing staff is another indicator that is closely monitored and trended with follow up for resolution as needed. A quarterly summary is also reviewed by the Nursing-Pharmacy Committee for action steps. The goal with each of these indicators is to minimize the occurrence of either discrepancies or overrides by action steps to address performance issues via education or system changes which help satisfy TJC requirements for monitoring the effectiveness of the Medication Management system. *Veriform Medication Room Audits* are performed on each medication room to determine compliance with established medication storage procedures and requirements. The results of the audits are shared with the nursing managers for their respective corrective actions or staff education. Additionally, adverse drug reactions and clinical interventions are monitored, documented and analyzed for review by the P&T Committee. ADR's are reported monthly and Clinical Interventions are reported on a quarterly basis.

Fiscal Accountability

The *Discharge Prescriptions* indicator tracks the cost and number of prescription drugs dispensed to patients at discharge. This baseline data will be used to determine the best approach to implement steps to decrease this expense. The lack of a resource to perform insurance verification and research prior authorizations needed so clinicians' can make timely and informed prescribing decisions is believed to be inherent in the discharge process. Without this resource, RPC is obliged to provide discharge medications to prevent a gap in medication coverage as the patient is being transitioned to another facility. The plan of correction is to explore options and propose a resolution to RPC's Medical Director.

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

Pharmacy

Responsible Party: Garry Miller, R.Ph.

Strategic Objectives								
Safety in Culture and Actions	Unit	Baseline 2014	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Pyxis CII Safe Comparison *Daily and monthly comparison of Pyxis vs CII Safe transactions*	Rx	0.875%	0%	0%	0%	0%		No discrepancies between Pyxis and CII Safe transactions during July & August
Quarterly Results			0%					
Veriform Medication Room Audits *Monthly comprehensive audits of criteria*	All	98%	100%	100%	100%	100%	90%	Overall compliance is 97% for July and August
Quarterly Results			97%					
Pyxis Discrepancies *Monthly monitoring and trending of Pxyis discrepancies.*	All	22/mo	25	25	25	25	25/mo	Trending of monthly data from Knowledge Portal for July & August
Quarterly Results			38 (19/mo)					
Fiscal Accountability	Unit	Baseline 2014	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Discharge Prescriptions *Monitoring and Tracking of dispensed Discharge Prescriptions*	Rx	$3998 343 drugs	$3293 135 drugs					Significant costs are incurred in providing discharge drugs.

**This data is for the entire hospital (including Lower Saco)*

STRATEGIC PERFORMANCE EXCELLENCE

Program Services

Define

Client participation in on-unit groups and utilization of resources to relieve distress is variable but should be promoted to encourage activities that support recovery and the development of skills necessary for successful community integration.

Measure

The program services team will measure the current status of program participation and resource utilization to identify a baseline for each of the four units.

Analyze

Analysis of the barriers to utilization will be conducted in an attempt to determine causation factors for limited participation.

Improve

Strategies for encouraging increased participation in on-unit groups and the utilization of resources to relieve distress will be identified in a collaborative manner with client and staff participation.

Control

Ongoing review of utilization of programs and resources will be conducted to determine whether unit practice has changed and improvements are sustainable.

INDICATOR	Baseline	Quarterly Improvement Target	Improvement Objective
1. **How many on unit groups were offered each week** **Day shift** → **Evenings** →			14
2. **Number of clients attending day groups on unit or facilitated by day staff** (# of clients in all of day groups divided by # of day groups provided**)**			
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**			
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended.**			100%
5. **The client can identify distress tolerance tools on the unit**			100%
6. **The client is able to can identify his or her primary staff.**			100%

STRATEGIC PERFORMANCE EXCELLENCE

Program Services Lower Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift** → **Evenings** →	Main / SCU 7 7	 100% 100%	Days/ Even. 7 / 7 = 14
2. **Number of clients attending day groups on unit or facilitated by day staff** (# of clients in all of day groups divided by # of day groups provided**)**	8 Avg.		N/A
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**	8 Avg.		N/A
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	22/30	73%	100%
5. **The client can identify distress tolerance tools on the unit**	24/30	80%	100%
6. **The client is able to state who his primary staff is**	26/30	86%	100%

EVALUATION OF EFFECTIVENESS

ISSUES

LK has improved in consistency unit groups and attendance. Acuity has been a factor in the sporadic attendance. We continue to look at ways to decrease the acuity as well as increase client interest / participation in unit groups. “What is Recovery” a new group facilitated by nursing has sparked some interest. Acuity Specialists on the unit also free up some staff for group participation.

ACTIONS

We will continue to try to increase not only client participation in groups but also in relating the client’s Recovery Goals to the groups offered and documenting on the group participation and progress towards goals as well.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services Upper Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift** → **Evenings** →	7 7	100%	7 / 7 = 14 7 / 7 = 14
2. **Number of clients attending day groups on unit or facilitated by day staff** (# of clients in all of day groups divided by # of day groups provided**)**	6/7	85%	N/A
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**	6/7	85%	N/A
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	10/10	100	100%
5. **The client can identify distress tolerance tools on the unit (re named coping tools)**	8/10	80%	100%
6. **The client is able to state who his primary staff is**	9/10	90%	100%

EVALUATION OF EFFECTIVENESS

On unit groups are offered once on day shift and once on evenings daily by RN. The percentage of treatment plans increased this quarter from 80 to 85 percent. Clients seem to enjoy the current groups at this time.

ISSUES

Consistent group leaders on the day shift have become an issue due to float nurses and schedules.

ACTIONS

Upper Kennebec now has two full time day RN with two more orienting and that should help with the consistency.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services Upper Saco

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift** → **Evenings** →	14 7	100% 100%	Days/ Even. 7 / 7 = 14
2. **Number of clients attending day groups on unit or facilitated by day staff** (# of clients in all of day groups divided by # of day groups provided**)**	1.5 avg/ 14 groups		N/A
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**	3 avg/ 9 groups		N/A
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	4	40%	100%
5. **The client can identify distress tolerance tools on the unit**	30/30	100%	100%
6. **The client is able to state who his primary staff is**	30/30	100%	100%

EVALUATION OF EFFECTIVENESS

ISSUES

There continues to be a need to better reflect this on-unit treatment effort in the treatment plans. Nearly all of the patients on Upper Saco attend the hospital treatment mall with a high level of participation and attendance with off-unit treatment. Off unit groups are reflected in the treatment plans and are a regular part of physician orders. As in previous reports, there needs to be increased effort at reflecting on-unit groups in the treatment plans, especially for weekends and for the patients not regularly attending the hospital treatment mall. There is documentation of this on-unit group attendance in Meditech.

ACTIONS

Additional efforts need to be made to get all on-unit offered groups in individual treatment plans. Continued efforts are being made to offer to those patients that have less activity at the hospital treatment mall. Treatment planning for on-unit groups and follow-up documentation issues are being identified with the new nurse leader.

STRATEGIC PERFORMANCE EXCELLENCE

Psychology Department

Department: Psychology Services Responsible Party: Arthur DiRocco, PhD

Current Psychology Performance Improvement Goal

The psychology department completed phase one of a performance improvement activity which resulted in the assessment of all NCR patients currently in residence at Riverview Psychiatric Center. The data collected from these assessments will be used in the next phase of the performance improvement activity to identify treatment needs and to provide a measure of outcomes for this population of patients.

Medical Staff Performance Improvement Activity

Target Goal: 90% of NCR Treatment plans will have one or more treatment goals identified and measured by treatment team use of COTREI within 4 months from October 1st, 2014.

Strategic Objectives						
NCR Patient Recovery	**Baseline**	**Oct '14 Target**	**Nov '14 Target**	**Dec '14 Target**	**Jan '15 Target**	**Goal**
Utilization of COTREI to assist in Treatment Team Planning and Goals for NCR patients The COTREI will be administered to each NCR patient at Riverview Psychiatric Recovery Center (RPRC). Areas of need identified by COTREI will be incorporated into NCR patient's treatment plan. Performance improvement will be assessed by documentation of at least one goal derived from the COTREI in 90% of NCR patients' treatment plans within 4 months of the October 1st, 2014 starting date.	5%	25%	50%	85%	100%	NCR patients will be assessed using the COTREI within 60 days of admission' every 8 months after starting their residency at RPC; and at the time of a new institutional report for a court petition.

**This data is for the entire hospital (including Lower Saco)*

STRATEGIC PERFORMANCE EXCELLENCE

Rehabilitation Services

Department: Rehabilitation Services Responsible Party: Janet Barrett

Client Recovery	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Recreational Therapy Assessments & Treatment Plans *The objective of this improvement project is to ensure that Recreational Therapy assessments are completed within 7 days of admission and that a treatment plan is initiated after the assessment and will be reviewed and updated if necessary every 30 days. Documentation on interventions in the treatment plans will reflect progress towards interventions and will be documented on weekly.*	100 %	45/45 charts				The treatment plan intervention will be reviewed every 2 weeks and updated at each client treatment team meeting if necessary or if there is any change in patient status	Our target for this indicator was reached at the end of last year but when the treatment plan processed changed we will continue to monitor the plans to ensure continued progress for 2 quarters this year
Quarterly Results		100%					

Strategic Objectives							
Client Recovery & Safety in Culture and Actions	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Occupational Therapy referrals and doctors orders. *The objective of this improvement project is to ensure each client receiving Occupational Therapy Services from RPC OT staff has a doctor's order as well as a referral form completed prior to the initiation of services.*	33% (original)	100% 27 of 27	100%	100%	100%	To maintain percentage of referrals and doctor's orders at 100 % compliance for 4 consecutive quarters.	100% compliance was achieved at the end of last year and will be monitored until we have the 4 consecutive quarters.
Quarterly Results		100%					

**This data is for the entire hospital (including Lower Saco)*