Riverview
PSYCHIATRIC CENTER

PERFORMANCE IMPROVEMENT REPORT

FIRST QUARTER
July-August-September 2008

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Introduction:

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

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

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

The Integrated Summary continues to show areas for improvement, particularly documenting client preference and needs not yet addressed.

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

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

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

INFECTION CONTROL

ASPECT: HOSPITAL INFECTION CONTROL
OVERALL COMPLIANCE: 100%-within standards

Indicators	Number	Rate	Threshold Rate
Total number of infections for the 1st quarter of the fiscal year, per 1000 patient days	38	4.75	5.8 or less
Hospital Acquired (healthcare associated) Infection rate, infections per 1000 patient-days	3	0.30	5.8 or less

Summary:

Surveillance accomplished by chart reviews, review of antibiotic prescribing (used for infections or prophylaxis), and clinical staff reporting. This quarter, RPC had 3 hospital acquired infections per 1000 patient days, for a rate of 0.30. This is well within the threshold percentile. The total number of infections for the quarter is 38 for a rate of 4.75. This also is within the threshold percentile and below the accepted 2 standard deviation. Hand hygiene continues to be stressed to staff and clients. The hospital is increasing the availability of Purell on each unit. Also individual 1 ounce bottles will be available for all staff at the annual training fair on Oct. 30th. Informational e-mails have been routinely sent out to staff regarding the flu, availability of vaccines and clinics. Posters displayed to remind staff and clients to cover coughs and sneezes to stop the spread of infections.

HOUSEKEEPING

ASPECT: SHOWER CLEANLINESS/SAFETY
OVERALL COMPLIANCE: 98.5%

Indicators	Findings	Compliance	Threshold Percentile
1. Was shower clean?	75 of 75	100%	85%
2. Was shower curtain @ the proper length?	75 of 75	100%	90%
3. Was “P” seal clean?	74 of 75	99%	90%
4. Was “P” seal secure?	74 of 75	99%	95%

5. Did all lights work in room?	73 of 75	97%	95%
6. Were all anti-slip strips secure?	71 of 75	95%	85%
7. Was shower mat secure?	75 of 75	100%	95%

Summary

The indicators are based on the inspection of shower stalls its accessories on U. Saco, L. Saco, U. Kennebec, and L. Kennebec. All bathroom types were reviewed randomly, 75 times this quarter. All areas were above threshold percentile. The security of the "P" seals at the bottom of each shower to retain the water inside also improved from 91% last quarter to 99% this quarter, and now above the threshold percentile rate of 95%. All compliance rates for each criterion went up or maintained the same rate compared to last quarter. The overall compliance this quarter was 98.5%. This is up 2.5% from last quarter. The Housekeeping Staff, as well as Custodial Worker II positions will monitor each shower in their respective areas and report any slips strips that are unsecured or need replacing.

DIETARY

ASPECT: Meal Ticket Accuracy (New Indicator)
OVERALL COMPLIANCE: 99.3%

Indicators	Findings	Compliance	Threshold Percentile
1. Main Entree	441 of 445	99%	90%
2. Vegetable	444 of 445	99.8%	85%
3. Beverage	440 of 445	98%	90%
4. Utensils	438 of 445	98%	100%
5. Food Allergies	443 of 445	99.5%	100%
6. Food Preferences	444 of 445	99.8%	90%
7. Modified Diet	444 of 445	99.8%	95%
8. Food Intolerances	445 of 445	100%	90%
9. Condiments	441 of 445	99%	80%
10. Dessert	438 of 445	99%	85%

11. Cardboard Tray For Special Care Units	183 of 183	100%	95%
12. Styrofoam Dishes For Special Care Unit	183 of 183	100%	95%

Summary:

The indicators are based on the accuracy of the meal sent to the client. The trays will be observed for accuracy using the meal ticket that is provided. This monitor will include lunch and supper on all units. Upper Saco, Lower Saco, Upper Kennebec, and Lower Kennebec. The inspection will be conducted on a weekly basis. The overall compliance this quarter was 99.3%. This was up slightly .3% this quarter compared to last quarter.

MEDICAL RECORDS

Aspect: CONFIDENTIALITY

Overall compliance: 100%

INDICATORS	COMPLIANCE	THRESHOLD PERCENTILE
1. All client information released from the Health Information department will meet all JCAHO, State, Federal & HIPAA standards.	100 %-no issues in July. 100 %-no issues in August. 100%-no issues in September.	100%
2. All new employees/contract staff will attend confidentiality/HIPAA training.	100 % -6 new employees/contract staff in July. 100% -9 new employees/contract staff in August. 100%-7 new employees/contract staff in September.	100%
3. The Director of Health Information will track the number of confidentiality/privacy issues through incident reports.	There were 0 confidentiality/Privacy-related incident reports in July. There were 0 confidentiality/privacy related-incident reports in August. There were 0 confidentiality/privacy-related incident reports in September.	Incident reports will be monitored for privacy issues. The incident rate will remain at 0%.

Summary

The indicators are based on the review of all requests for information, orientation for all new employees/contracted staff and confidentiality/privacy-related incident reports. 2238 out of 2238 (100%) requests for information (1950 police checks and 288 requests for client information) were released from the Health Information department during this quarter. 22 out of 22 (100%) new employees/contract staff attended confidentiality - HIPAA training. All indicators remained at 100 % compliance for quarter 1-FY 2009.

Aspect: Documentation & Timeliness
Overall compliance: 94%

INDICATORS	COMPLIANCE	THRESHOLD PERCENTILE
1. Records will be completed within JCAHO standards, state requirements and Medical Staff bylaws timeframes.	52 % -There were 27 discharges in July. Of those, 14 were completed by 30 days. 68 %-There were 28 discharges in August. Of those, 19 were completed within 30 days. 92 %-There were 24 discharges in September. Of those, 22 were completed within 30 days.	All records will be completed within 30 days of discharge. The completion rate will remain at or above 80%.
2. Discharge summaries will be completed within 15 days of discharge.	96 % - 26 out of 27 were completed within 15 days in July. 96 % -27 out of 28 were completed within 15 days in August. 100 % -24 out of 24 were completed within 15 days in September.	The completion rate will remain at 100%.
3. Forms used in the medical record will be reviewed by the Medical Record Committee.	100%- 0 forms were approved/revised in July (see minutes). 100 %- 0 forms were approved/revised in August (see minutes). 100 %- 0 forms were approved/revised in September (see minutes).	100%
4. Medical transcription will be timely & accurate.	81 %-Out of 157 dictated reports, 127 were completed within 24 hours in July. 90 %-Out of 119 reports, 107 were received within 24 hours in August. 75%-Out of 126 reports, 95 were received within 24 hours in September.	90%

Summary

The indicators are based on the review of all discharged records. There was 71% compliance rate with record completion within 30 days. There was 97% compliance rate with discharge summaries. Weekly "charts needing attention" lists are distributed to all medical staff, including the Medical Director, along with the Superintendent, Deputy Superintendent of Administrative Services, and the Risk Manager. There was 82% compliance rate with timely medical transcription services. Record completion (71%) & Discharge summary completion dropped (97%) below the threshold. Timely transcription compliance also dropped (82%). The transcription company changed platforms which caused some problems initially. Those problems seem to now be resolved.

MEDICAL STAFF

Aspect: Monitoring of Patient Sedation Experience on Day Following IV Sedation
Overall compliance: 100%

Indicator	Findings	Compliance	Target %
Clinical Services will make follow-up calls to all IV sedation patients within one day of sedation in order to rate sedation experience. They will be asked if they experienced continued lethargy, dizziness, nausea, vomiting or other symptoms on the day following sedation.	16 patients were sedated in the month of July. Of these, none reported nausea/vomiting post procedure. No report of symptoms on the day following procedure.	100%	100%
	15 patients were sedated in the month of August. Of these, none reported nausea/vomiting post procedure. No report of symptoms on the day following sedation.	100%	100%
	19 patients were sedated in the month of September. Of these, none reported nausea/vomiting post procedure. No report of symptoms on the day following sedation.	100%	100%

Summary:

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

Aspect: Monitoring of Client/Staff Satisfaction at Clinical Services
Overall compliance 100%

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

Summary:

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

Aspect: Complication Management after Dental Extractions

Overall compliance: 100%

Indicator	Findings	Compliance	Target %
Clinical Services will assess each patient for pain after surgical extractions. Patients will be assessed for pain, infection or other complications after surgical extractions.	There were 8 extractions in the month of July. There were no complications or symptoms of infection on the day following extraction.	100%	100%
	There were 4 extractions in the month of August. There were no complications on the day following extraction.	100%	100%
	There was 1 extraction in the month of September. There were no complications.	100%	100%

Summary:

There were 13 extractions in the first quarter, with no complications of symptoms of infection. Aftercare instructions are given both orally and in writing to every extraction patient and/or caregiver prior to leaving recovery. RPC will continue to call extraction patients 72 hours post-extraction. Review at monthly staff meetings and forward reports quarterly to RPC.

NURSING

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

Indicators Seclusion/Restraint related to staffing effectiveness:	**Findings**
1. Staff mix appropriate	63 of 63
2. Staffing numbers within appropriate acuity level for unit	63 of 63
3. Debriefing completed	63 of 63
4. Dr. Orders	63 of 63

Summary

All findings were 100% of threshold.

ASPECT: INJURIES RELATED TO STAFFING EFFECTIVENESS
OVERALL COMPLIANCE: 100%

Indicators Injuries related to staffing effectiveness:	**Findings**
1. Staff mix appropriate	18 of 18
2. Staffing numbers within appropriate acuity level for unit	18 of 18

Summary

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

Aspect: Redlining
Compliance: Redlining 99%

Indicators-Redlining	**Findings**	**Compliance**
Lower Kennebec	276 of 276	100%
Upper Kennebec	231 of 231	100%
Lower Saco	269 of 276	97%
Upper Saco	268 of 276	97%

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Summary

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

Aspect: Code cart checks
Compliance: Code cart checks 100%

Indicators-Code Cart Sign Off	**Findings**	**Compliance**
1) Lower Kennebec	276 of 276	100%
2) Upper Kennebec	275 of 276	100%

3) Lower Saco	276 of 276	100%
4) Upper Saco	275 of 276	100%
5) NOD Building Control	276 of 276	100%
6) NOD Staff Room I 580	276 of 276	100%

Summary

Continue to monitor the code carts on the shift report as an extra reminder for nursing to complete this task. The on coming Nursing Supervisor and ADONs have been checking Room I580 to make it a part of their shift report, this too needs to continue. Executive nurses have been checking the carts on the 7-3 shift in building control and room 1580. This has shown improvement from last quarter with a better monitoring process. Code carts are used in emergency situations and must be complete and ready to use. Code cart checking will continue to be reviewed with the nurse who is responsible for narcotic count and key change during each shift change. This will be monitored 1 more quarter and if compliance remains at 100%, a new indicator will be substituted.

Aspect: Pain Management
Overall compliance: PRE: 95% POST: 93% OVERALL: 94%

Aspect		Findings	Compliance
Pre-administration	Assessed using pain scale	971 of 1020	95%
Post-administration	Assessed using pain scale	947 of 1020	93%

Summary:

This indicator has dropped from 99% last quarter for Pre-administration to 95%.Post administration has gone up from 90 to 93%. A great deal of attention and effort was placed on post administration assessment with good results. Continue to track this indicator and strive for increase in both pre and post assessment in the next quarter. The two ADONs will continue to work with unit nursing staff to assure that this is done more consistently.

Aspect: Chart Review
Overall compliance: 74%

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	41 of 79	53%
2. MHW notes cosigned by RN	6 of 61	10%
3. STGs/Interventions are written, dated and numbered.	75 of 77	97%
4. STGs are measureable and observable	74 of 78	95%
5. STGs/Interventions are modified / met as appropriate.	71 of 78	91%
6. STGs/Interventions tie directly to documentation.	61 of 76	80%
7. Weekly Summary note completed.	22 of 78	43%
8. Client's current BMI in the service plan review has improved or maintained at optimal.	8 of 22	36%
9.Progress notes/flow sheets document a level of functional skill support provided, consistent with the identified area of need, delivered within last 24 hours.	10 of 23	43%

Summary

This quarter there have been 2 additional indicators # 8 and # 9. Since this was the first quarter tracked, the findings are low. The # 1 indicator concerning GAP notes written in appropriate manner at least every 24 hours has gone from 67% compliance to 53% compliance. Indicator #2 has dropped from 85% to 10%. It is unknown why this change but reeducation will be done on all units. We will discuss and educate nursing staff and continue to monitor. Indicators # 3, 4 & 5 have dramatically improved.. The unit RNs will audit 1 chart per RN and discuss during supervision. This PSD/ Nurse IV will discuss and review chart audit results at staff meetings. The RN IVs assisted by the Assistant Directors of Nursing will ascertain if Unit Nurses are aware of documentation requirements and review with each using the CSP manual and nursing documentation policy. Documentation education and expectations will continue in areas needing attention.

PSD
Aspect – Treatment Plan

Indicator	Compliance
1. Evidence of ***initial treatment plan*** (minimum of one Safety STG & one Treatment STG each having minimum of two interventions) is in place within 24 hours of admission.	96%
2. The Presenting Problem of the CSP identifies ***specific client symptoms, stated in behavioral terms***, causing admission (identifies any functional behavioral collapse)	96%
3 The CSP incorporates for treatment, all ***"active" client needs/problems*** obtained through the assessment process. ("active" as designated by the priority status "1" on the Integrated Needs / Problem List)	88%
4. Client strengths and preferences which ***can be utilized*** to achieve / enhance treatment outcomes are identified. (should be evident within the interventions)	96%

5. A ***Suicide Assessment*** is done upon admission by the physician / designee	97%
6. A ***Suicide Assessment of "moderate or high risk"*** is incorporated into the Safety Plan within 8 hours of admission.	97%
7. The CSP has a ***"Safety Goal"***, based on identified individual risks, stated in observable and behavioral terms.	100%
8. The CSP has at a minimum one ***"Treatment Goal"*** based on individual assessed needs to reduce or eliminate symptom or illness stated in observable and measurable terms.	100%
9. The CSP has at a minimum one ***"Rehabilitation Goal"*** based on assessed needs to improve self selected value roles, stated in observable and measurable terms.	96%
10. The CSP has at a minimum one ***"Transition Goal"*** based on assessed needs and reflecting client preferences stated in observable and measurable terms.	88%
11. Each CSP goal has a minimum of ***two stepped STGs***, which should reasonably lead to goal attainment, stated in clear client based behavioral terms, which are observable and measurable.	92%
12. Interventions are designated for each STG, that reasonably lead to attainment of the STG.	100%
13. Each Intervention states ***what the intervention is, how often it occurs, what the purpose is and who provides it.***	96%
14. An individual is identified (***responsible***) by name to monitor/ document the effectiveness of each intervention (progress toward or away from STG).	88%
15. The CSP is *properly authenticated* by signature AND date, of treatment team members, no later then 7 days from the date of admission. Identify participants below: (a) MD (b) RN (c) SW (d) Client / Guardian	97% 100% 100% 92% 100%
16. CSP has any assessed ***functional skill deficits*** including ***present Level of Support*** and ***Level of Support to be attained***	100%

ACTIONS:
Compliance has remained fairly steady with all of the indicators with some minor change up or down. We will continue to monitor all aspects of the treatment plan. Education will be redone during the next quarter as an annual update for all clinical staff.

PSD
Aspect - Integrated Summary

Indicator	Compliance
1. ***Integrated Summary Note*** is documented in the medical record the day of CSP meeting.	84%
2. Summary briefly identifies ***findings of assessments / needs*** (MD/RN/Rehab/SW/Psychology).	94%
.3. Summary identifies ***NEEDS not to be addressed at this time*** and why	84
4 Summary describes ***client preferences*** utilized in service planning.	84%
5. Summary identifies ***predicted community placement***.	92%

6. Summary identifies ***additional assessment/ evaluations or services*** to be sought.	88%
7. Summary describes ***level of client participation*** in planning service.	96%

ACTIONS:
A note of interest is that last quarter this group of indicators were from the Civil side and this quarter from the Saco side so there is no ability to compare. This will continue to be monitored.

PSD
Aspect – Service Plan Reviews

Indicators	Compliance
1. At a minimum ***review is completed within 14 days*** of last review for first 6 months or within the last 30 days for hospitalizations of over 6 months.	96%
2. ***Within 72 hours*** of the use of (a) seclusion, (b) restraint, (c) episode of violence, or (d) transfer a service plan review is completed.	96%
3. The ***review participants*** are documented ** **MANDATORY** (a**) MD****(b) **RN****(c) **SW****(d) **Client/Guardian****	99%
4. A ***behavioral description of client behavior related to each goal*** area is documented, supporting whether the goal was met or not "AEB"= as evidenced by (can be on the review form itself or the progress note as long as it is in narrative form)	92%
5. ***Client's self-assessment of effectiveness*** of current plan is documented.	96%
6. Evidence of ***positive client progress*** related to each goal is documented.	96%
7. The ***CSP is modified*** as a result of the review, as evidenced by target dates addressed as met or extended and dates changed. May also be evidenced by the addition or modification of STGs.	88%
8. ***Client level of participation*** in the service plan review is documented	100%
9. ***Client's current BMI*** in the service plan review has improved or maintained at optimal.	75%

ACTIONS:

Process will continue to be monitored for tracking BMI. This will not change very quickly although a lot of attention is being given to it. Exercise equipment continues to be monitored and this action will continue.

PEER SUPPORT

Aspect: Integration of Peer Specialists into client care
OVERALL COMPLIANCE: 87%

Indicators	Compliance	Findings
1. Attendance at Comprehensive Treatment Team meetings.	421 of 474	89%
2. Grievances responded to by RPC on time.	99 of 159	62%
3. Attendance at Service Integration meetings.	66 of 68	97%
4. Contact during admission.	75 of 76	99%
5. Grievances responded to by peer support on time.	159 of 159	100%
6. Client satisfaction survey completed.	34 of 50	68%

Summary:

Peer Specialists will continue to track Comprehensive Treatment Team Meeting attendance and reasons for not attending in order to problem solve ways to address the reasons for missed meetings. Peer Specialists will also learn ways to elicit reasons for clients refusing to complete satisfaction surveys. Changes to the "Client Grievance/Concern/Suggestion" policy will be implemented next quarter to allow for an additional step in the compliant process to reduce the number of grievances. Any PSD with late grievances will report weekly on grievance resolution progress to avoid being late in the future and the RPC Risk Manager will continue to send emails and call PSD to remind of due grievances.

Aspect: Client Satisfaction Survey with care
Overall compliance: 71%

Indicators	Findings	
1. Did anyone tell you about your rights?	16 of 31	52%
2. Has anyone talked to you about the kinds of services that are available to you?	20 of 31	65%
3. Are you told ahead of time of changes in your privileges, appointments, or daily routines?	18 of 31	58%
4. Do you know someone who can help you get what you want or stand up for your rights?	23 of 31	74%
5. Do you have a worker in the community?	15 of 32	47%
6. Has your worker from the community visited or contacted you since you have been in the hospital?	12 of18	67%
7. Do you know how to get in touch with your worker from the community if you need to?	14 of 19	74%
8. Do you have a community treatment plan?	16 of 30	53%
9. I feel more able to deal with crisis.	27 of 32	84%
10. I am not as bothered by my symptoms.	14 of 31	45%
11. I am better able to care for myself.	27 of 31	87%
12. I get along better with people.	27 of 32	84%
13. I am treated with dignity and respect.	27 of 33	82%
14. I feel comfortable asking questions about my treatment and medications.	26 of 30	87%
15. I understand how my medication works and the side effects.	25 of 30	83%
16. I've been told about self-help/peer support and support groups to use after discharge.	18 of 30	60%
17. I've been told about the benefits and risks of my medication.	17 of 31	55%
18. I have been given information to help me understand and deal with my	21 of 29	72%

illness.		
19. I feel my other medical conditions are being treated.	21 of 30	70%
20. My pain was managed.	16 of 27	59%
21. I feel free to make complaints and suggestions.	24 of 30	80%
22. I feel my right to refuse medication or treatment is respected.	23 of 31	74%
23. I help in planning my discharge.	28 of 30	93%
24. I feel I have had enough privacy in the hospital.	23 of 29	79%
25. I feel safe while at Riverview?	28 of 31	90%
26. If I had a choice of hospitals, I would choose this one.	20 of 29	69%

Summary

Overall satisfaction dropped 18% from last quarter. Satisfaction with care was highest on Upper Saco at 96%. Lower Saco had the lowest satisfaction level at 63%, while Upper Kennebec and Lower Kennebec were 81% and 70% respectively. Peer support will encourage and support clients to voice their concerns and needs with their treatment teams regarding these aspects of care. A new process has been developed to address client concerns/suggestions/grievances that will assist clients in getting their needs addressed more efficiently. PSDs will initiate unit procedures to ensure clients are routinely informed of daily schedules and privilege changes. Director of Social Work Services shall implement a procedure to ensure (as consented to) that community support staff are routinely contacted and informed of course of treatment, treatment planning meetings and invited to visit or contact clients to maintain therapeutic relationships. Nursing services will implement a routine procedure to ensure clients have the opportunity to discuss their symptoms and are educated on ways to alleviate such symptoms a minimum of weekly with their assigned primary nurse.

SOCIAL WORK

Aspect: Preliminary Continuity of Care Meeting and Comprehensive Psychosocial Assessments
Overall Compliance: 81%

Indicators	Findings	Compliance
1. Preliminary Continuity of Care meeting completed by end of 3rd day	29/30	96%
2. Service Integration form completed by the end of the 3rd day	30/30	100%
2a. Director of Social Services reviews all readmissions occurring within 60 days of the last discharge and for each client who spent fewer than 30 days in the community, evaluated the circumstances of the readmission to determine an indicated need for resources or a change in treatment and discharge planning or the need for alternative resources. In cases where such a need or change was indicated that corrective action was taken.	3/3	100%
3a. Client Participation in Preliminary Continuity of Care meeting.	29/30	96%
3b. CCM Participation in Preliminary Continuity of Care meeting.	30/30	100%

3c. Client's Family Member and/or Natural Support (e.g., peer support, advocacy, attorney) Participation in Preliminary Continuity of Care meeting.	30/30	100%
3d. Community Provider Participation in Preliminary Continuity of Care meeting.	12/30	40%
3e. Correctional Personnel Participation in Preliminary Continuity of Care Meeting.	0/15	0%
4a. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	26/30	86%
4b. Annual Psychosocial Assessment completed and current in chart	30/30	100%

Summary

Indicator 3d: This area is up significantly from a last quarter of 16% to this quarter to 40 % this quarter. This is a direct correlation between increased communication and collaboration with the CDC office, the providers and RPC. In addition we are arranging on-going quarterly meetings with the region CDC coordinators and mental health team leaders to continue to monitor this important continuity of care area. Indicator 3e: This area has been low or indicated no participation for numerous quarters. Director will continue to monitor and work with the mental health liaison with the Department of Corrections and the jail assigned ICM staff to continue to problem solve this area. Indicator 4a: This area will continue to be monitored through individual and group supervision and on-going chart audits. The area is up 4% from last quarter.

Aspect: Institutional and Annual Reports
Overall Compliance: 83%

Indicators	Findings	Compliance
1. As part of the Individualized Treatment Meeting all Forensic clients will be prompted to indicate the initiation of a court petition.	69/72	96%
2. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	5/9	55%
3. The assigned **CCM** will review the new court order with the client and document the meeting in a progress note or treatment team note.	4/4	100%
4. Annual Reports (due Dec) to the commissioner for all NCR clients are	N/A	N/A

Summary

This area is up 55% from the last quarter which indicates a significant improvement from last quarter. The Forensic teams will continue to monitor this critical area and our on-going efforts to streamline the institutional report process.

Aspect: Client Discharge Plan Report/Referrals
Overall Compliance: 98%

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

Summary

Indicator 2a: Report was reviewed at CDPD in hardcopy but not emailed one week due to a data base issue. Issue was resolved and the next weekly report was emailed to recipients with information encompassing two weeks of reporting.

Aspect: TREATMENT PLANS AND PROGRESS NOTES
Overall Compliance: 92%

Indicators	Findings	Compliance
1. Progress notes in GAP/Incidental format will indicate at minimum weekly 1:1 meeting with all clients on assigned **CCM** caseload.	42/45	93%
2. On Upper Saco progress notes in GAP/Incidental format will indicate at minimum bi- weekly 1:1 meeting with all clients on assigned **CCM** caseload	14/15	93%
3. Treatment plans will have measurable goals and interventions listing client strengths and areas of need related to transition to the community or transition back to a correctional facility.	53/60	88%

Summary

Indicator 3: This area is up 3% from last quarter and will continue to be monitored. The department is continuing to focus on incorporating Stage of Change language in discharge and engagement plans with clients. This focus will support clients to identify the challenges in the community that resulted in hospitalization and can assist them with identifying how to manage those challenges going forward post discharge.

PSYCHOLOGY

Aspect Co-Occurring Treatment

Overall Compliance 38%

Co-Occurring Disorders TX Integration	Findings	Compliance
1. There is evidence of an integrated co-occurring comprehensive service plan for identified clients.	13/30	43%
2. There is evidence of "stage of Change" documented in client comprehensive service plan	0/30	0%
3. There is documentation of identified client's participation in co-occurring treatment.	6/30	20%
4. Positive change in staff practices as measured by the COMPASS (Co-Morbidity Program Audit and Self-Survey for Behavioral Health Services) on each clinical unit and ACT team and Capital Clinic	No report this quarter	No report this quarter
5. Consumer Satisfaction Survey indicates clients were "encouraged to talk about and work on any mental health and alcohol and drug issues at the same time"	14/14	100%
6. Consumer satisfaction survey indicates that since beginning treatment with us, their condition is better.	15/21	71%
7. Consumer satisfaction survey reports client satisfaction with current treatment experience is better than with any other previous treatment experiences.	13/21	61%
8. Percent of clients with co-occurring disorders as reported by NASMHPD		

Summary:

Dir of Psychology will re-assign co-occurring specialist duties: identify clients not treatment planned, and report omissions to team weekly. She will also meet with Clinical Council to address findings and identify staff to conduct COMPASS and to work with unit professional staff in clarifying unit specific goals and actions.

Psychologist Service Delivery & Documentation	Findings	Compliance
1. Psychologist short-term goals on CSP are measurable and time limited.	39/45	87%
2. Psychologist progress notes indicate treatment offered as prescribed on CSP.	42/45	93%
3. Psychologist progress notes indicate client's understanding of goals and client self-assessment of progress.	39/45	87%

Summary

20-30% improvement shown in all three indicators over last quarter. Dir of Psychology will provide individual supervision for psychologists not meeting expectations. Supervisor will conduct chart reviews with identified employee and continue to review performance expectations in weekly supervision and in annual evaluation. Three new staff (counselor & interns) added to chart review this quarter.

Provide performance feedback and continuing education once monthly at staff meeting for next three months. 100% compliance expected.

SAFETY

ASPECT: LIFE SAFETY

OVERALL COMPLIANCE: 93%

Indicators	Findings	Compliance
1. Total number of staff assigned to Upper Saco and Upper Kennebec who have received training with the evacuation chair.	61/61	100%
2. Total number of staff assigned to Lower Saco and Lower Kennebec who have received training with the evacuation chair.	73/80	91%
3. Total number of staff assigned to the Float Pool who have received training with the evacuation chair.	23/26	88%
4. Total number of fire drills and actual alarms conducted during the quarter compared to the total number of alarm activations required per Life Safety Code, that being (1) drill per shift, per quarter.	3/3	100%
5. Total number of staff who knows what R.A.C.E. stands for.	52/52	100%
6. Total number of staff who knows how to acknowledge the fire alarm or trouble alarm on the enunciator panel.	52/52	100%
7. Total number of staff who knows the emergency number.	52/52	100%
8. During unannounced safety audits conducted by the Safety Officer, this represents the total number of staff who display identification tags.	15/18	83%
9. During unannounced safety audits conducted by the Safety Officer, this represents the total number of direct care staff who carry a personal duress transmitter.	13/18	72%

Summary

Both Upper units that employ the chairs are at 100% compliance and when combined with both lower units RPC is at 97%. The (3) alarms reported for the hospital meets the required number of drills per JCAHO and Life Safety Code. Indicators 5 through 7 are indicators used for the purpose of evaluating the knowledge and skills of staff as it relates to critical skills and knowledge necessary to carry out functions in the event of a fire and/or smoke emergency. RPC is at 99% compliance for this training by current staff that is permanently assigned to the units. All staff continue to receive this training during orientation. Of the (2) staff members needing to be trained, one is on FML and the

other is on Workers Comp. Once they return, the expectation is that they will be given the training.

Aspect: Fire Drills Remote Sites
Compliance: 100 %

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

Summary

By NFPA Standards, the Portland Clinic is classified as "business occupancy". It is only required to have periodic drills during the year. The Safety Officer will conduct a minimum of (3) drills per year instead of just "periodically", providing that objectives and understanding are demonstrated by staff. Safety did ask staff to practice their response to a fire event occurring during conscious sedation. We continue to perform Environmental tours and still monitor the knowledge base of staff as it relates to what they need to do in the event of an alarm or event by asking them questions and having informal 5 minute "tailgate talks".

Aspect - Securitas/RPC Security Team
Overall Compliance 38%

Indicators	Findings	Compliance
1. Security search/screening of all clients (Forensic & Civil) being admitted to Riverview for treatment. (Total # of admissions screened vs. total # of admissions).	76/76	100%
2. Security Officer "foot patrols" during Open Hospital times. (Total # of "foot patrols" done vs. total # of "foot patrols" to be done.)	1997/2024	99%
3. Security/safety checks done of the "lower" client units during the hours of 8:00 am thru 8:00 pm. (To be done 6 times in this 12 hour period.)	558/552	101%

Summary

The Securitas/RPC Security Team recorded numbers to reflect a very successful quarter. Officers will be encouraged to follow the same type of routine during their completion of security tasks in order to stay on "pace" to keep reaching or exceeding the goals set for each indicator. We have found that time management & "multi-tasking" have helped to keep reaching our target compliance numbers.

STAFF DEVELOPMENT

Aspect: New Employee and Mandatory Training

Overall Compliance: 100%

Indicators	Findings	Compliance
1. New employees will complete new employee orientation within 60 days of hire.	17 of 17 completed orientation	100%
2. New employees will complete CPR training within 30 days of hire.	13 of 13 completed CPR training	100%
3. New employees will complete NAPPI training within 60 days of hire	15 of 15 completed NAPPI training	100%
4. Riverview staff will attend CPR training bi-annually.	228 of 228 are current in CPR certifications	100%
7. Contract Employees will complete orientation within 60 days of hire. Fiscal year 08 at 100%	4 of 4 have completed annual training	100%
8. Contract Employees will completed CPR training within 30 days of hire. Fiscal year 08 at 100%	3 of 3 have completed annual training	100%
9. Contract employees will complete Nappi training within 60 days of hire. Fiscal year 08 at 100%	5 of 5 have completed annual training	100%
10. Contract employees will attend CPR training bi-annually. Fiscal year 08 at 100%	83 of 83 have completed annual training	100%

Summary

The indicators are based on the requirements for all new/current staff to complete mandatory training and maintain current certifications. 17 out 17 of (100%) new Riverview employees completed these trainings. 228 of 228 (100%) Riverview employees are current with CPR certification. 120 of 288 (42%) Riverview employees are current in NAPPI training. 17 of 288 (1%) employees are current in Annual training. All indicators remained at 100 % compliance for quarter 1-FY 2009.

Aspect: Community Provider Training

Overall Compliance: N/A

Date &	Public Sector	RPC	Total	Topic

9/16/08 - RPC	1	6	7	PGR: Deconstructing Clozapine; towards development of a medication for Alcoholism
7/8,15, 22&29/08 - RPC	0	38	38	Mental Health Specialist Training
9/15/08&9/22/08 - RPC	33	33	66	Mental Health Specialist Training
8/11/08 - RPC	17	1	18	Adherence to Psychotropic Medications
8/15/08 - RPC	34	7	41	Management of Behavior in a Clinically Violent Patient
9/24/08 - RPC	16	0	16	Dialectical Behavioral Therapy
Total # Programs 6			186	

COMMUNITY FORENSIC ACT TEAM

Aspect: Descriptive Report on various components
4th quarter

CASE MANAGEMENT:

Clients enrolled in the ACT program	
	Number of ACT clients
July, 2008	32
August, 2008	32
September 2008	30

CRISIS MANAGEMENT:

4th Quarter 2008	Client incidents	Hospitalized RPC	Hospitalized Medical
July, 2008	5	1	1
August 2008	1	0	1
September ,2008	4	2	1

SUBSTANCE ABUSE:

4th Quarter 2008	Client with Substance Abuse as a Clinical Focus	Percent of ACT Clients In SA treatment
July 2008	9	28%
August,2008	9	28%
September,2008	8	26%

ACT Clients Living Situation				
4th Quarter 2008	Clients in Supervised Settings	Clients in own apt. or with family	% of clients Supervised Settings	% of Clients in own home or with family
July, 2008	23	9	72%	28%

August,2008	23	9	72%	28%
September, 2008	23	7	77%	23%

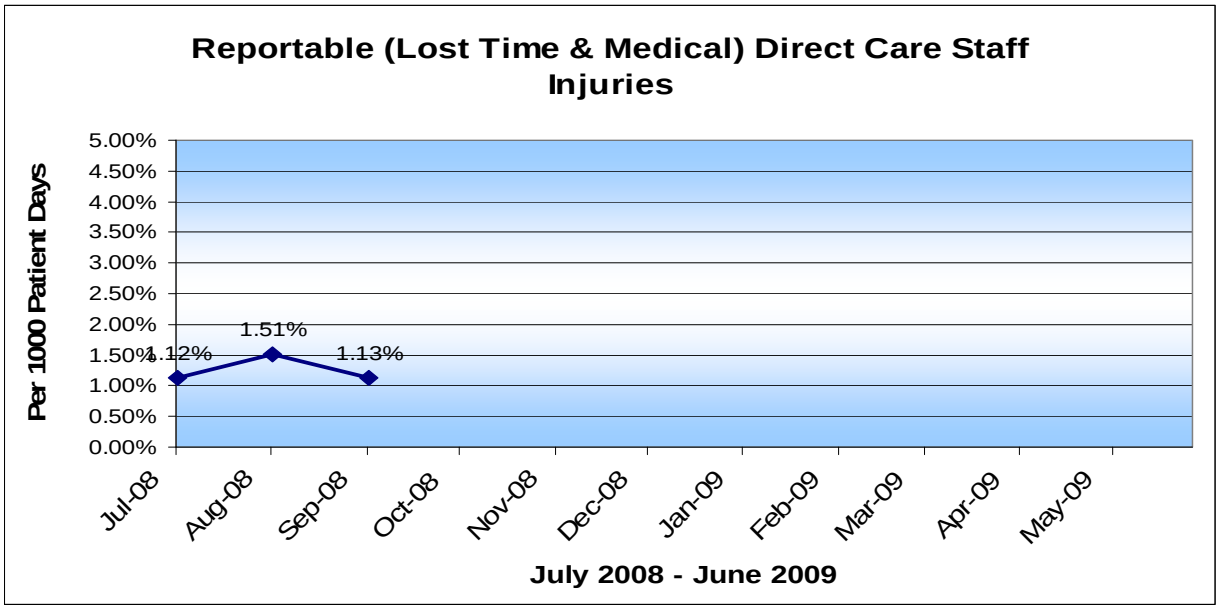
VOCATIONAL / EDUCATIONAL:

Regarding Clients working or volunteering in the community			
	# Client Community Site Work involved with VOC/ED	# of Client who offer Community Volunteer Services	# Hours worked in Community
July 2008	12	2	864
August 2008	13	2	1080
September 2008	12	2	864

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

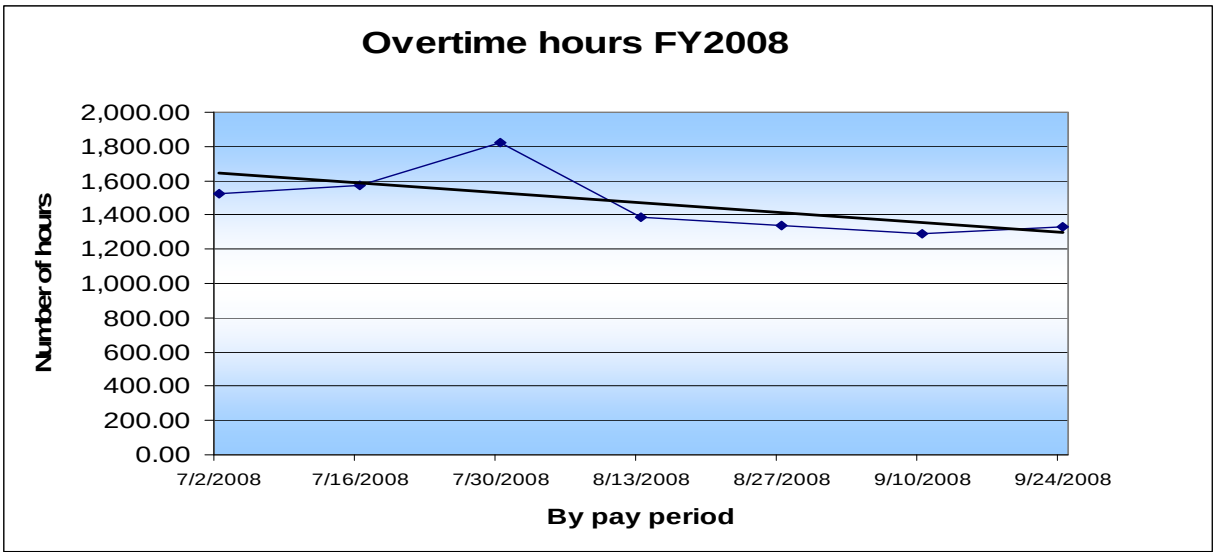
HUMAN RESOURCES

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



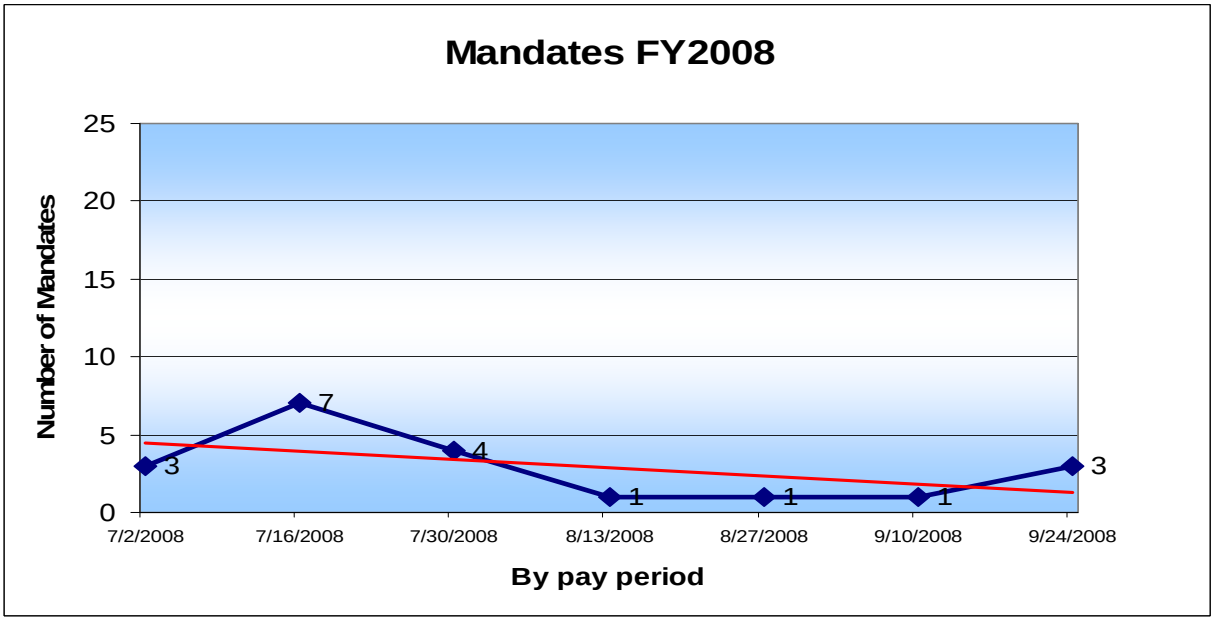
This quarter review reveals that there was a decrease in direct care staff injuries from 1.49% per 1000 patient days last quarter to 1.25% per 1000 patient days this quarter. This number represents (9) direct care staff who sought medical treatment or lost time from work, as compared to (8) last quarter. The two year average for this quarter is 1.13%.

HUMAN RESOURCES
OVERTIME



Overtime has increased this quarter as compared to last quarter. Overtime increased from 9,137.50 hours to 10,278.75 hours . As compared to the same quarter last year July 07 - September 07) we had 9,874.25 hrs of overtime, this represents an 4% increase from last year. Trend line is shown and extrapolated for future projection.

HUMAN RESOURCES
ASPECT: MANDATES



Mandated shifts have increased this past quarter as compared to last quarter. Mandates increased from 14 last quarters to 20 during this quarter. Last year we had a total of 35 mandated shifts during this same rating period July 07 - September 07), this represents a 75% decrease from last year.

ASPECT: Timely Performance Evaluations

OVERALL COMPLIANCE: 40.61%

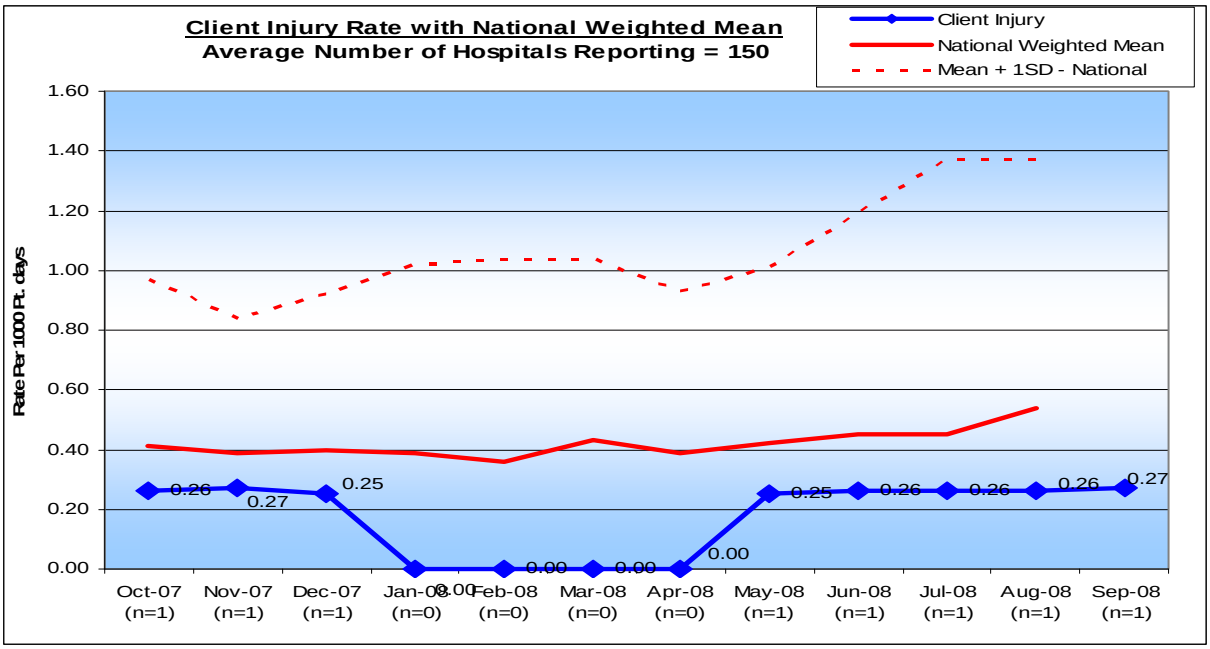
INDICATOR Employee Performance Evaluations expected to be completed within 30 days of the due date.	FINDINGS		TARGET PERCENTILE
July 2008 (May evals)	11 of 31	35.48%	85%
Aug 2008 (Jun evals)	13 of 40	32.50%	85%
Sept 2008 (Jul evals)	14 of 26	53.85%	85%

As compared to last quarter (66.42%) this quarter's *decreased* to 40.61%. As compared to the same quarter last year, 2007, we were at 95.89% compliance. This is a significant decrease. During this quarter 97 performance evaluations were sent out; 38 were received in a timely manner. One of the biggest reasons for this decrease this quarter is the manner in which Human Resources is reporting timely evaluations. In the past evaluations were reported as being timely if they were passed in, now Human Resources is recording which evaluations were completed within 30 days of the due date versus how many were turned in total. Human Resources continues to stress the importance of timely submission and requested from all Department Heads to submit their evaluations for processing of timely merit increases for staff.

PERFORMANCE TRENDS COMPARED TO NATIONAL BENCHMARKS

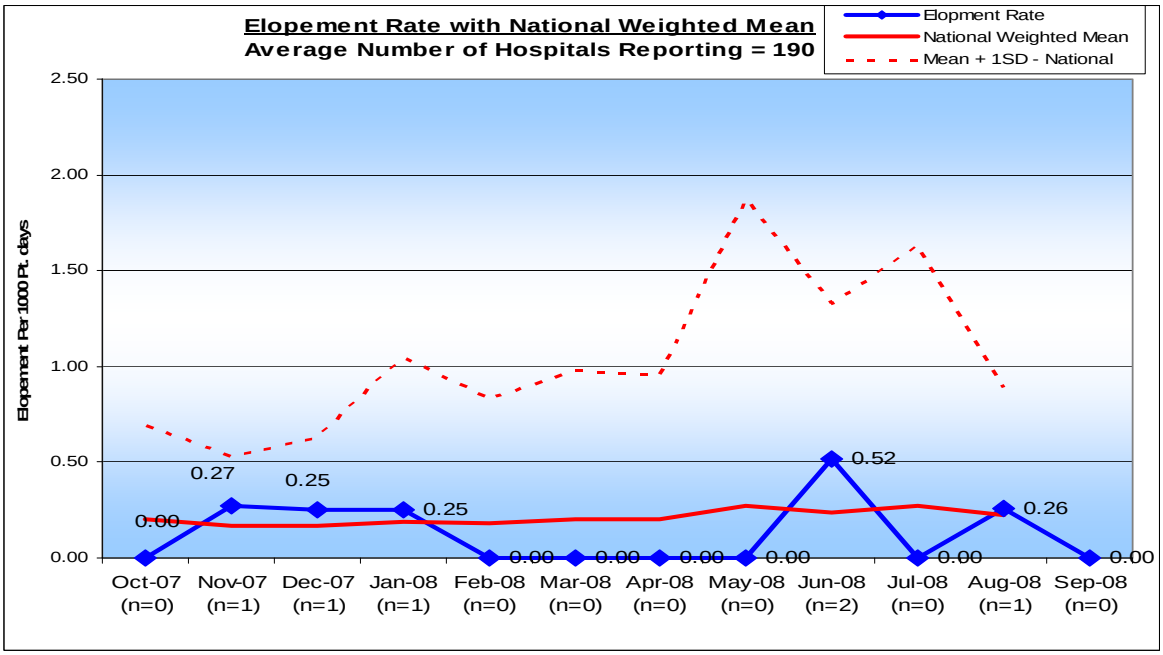
This section contains a number of graphs that compare Riverview Psychiatric Center to a national sample (the range is approximately 75-205 hospital across all aspects) of participating like facilities. Each line graph presents the national weighted mean (solid red line) and the limit of the first standard deviation (dashed red line) as reference points. Practically speaking, about 68% of participating hospitals' rates would be within the limit denoted by the dashed red line. The solid blue line represents Riverview's rate by comparison. As the majority of these graphs will show, Riverview's rates do vary above and below the weighted national mean, but are typically within the "normal" range (within the 1st Standard Deviation) of other hospitals in the sample.

CLIENT INJURY RATE GRAPH



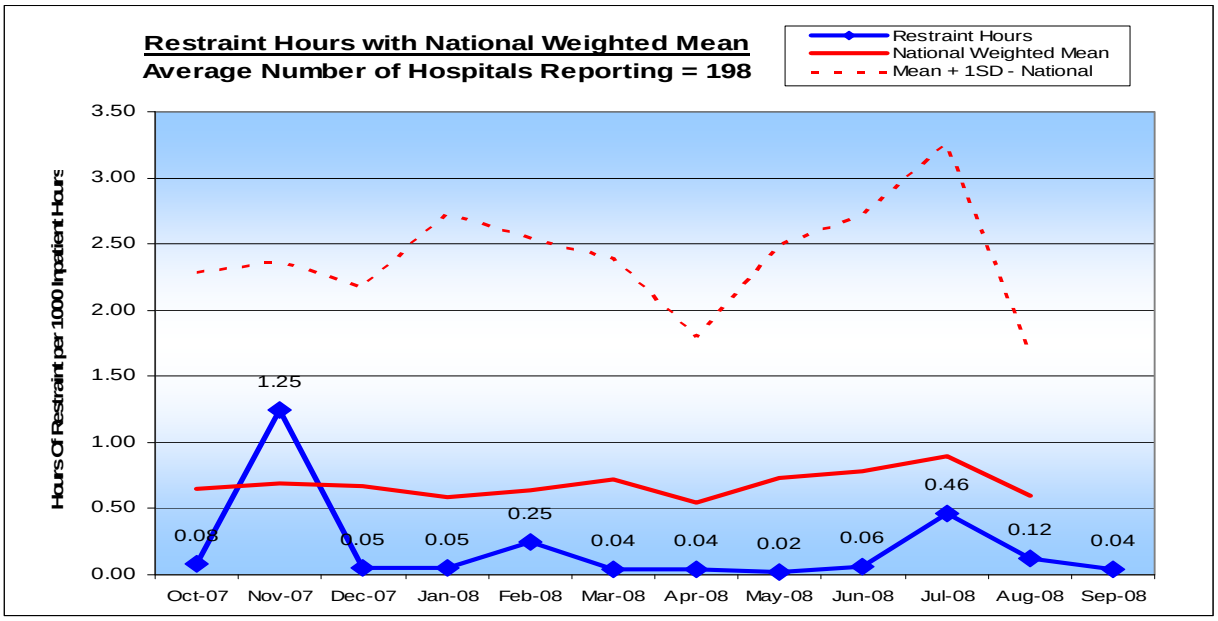
Client Injury Rate considers slips, trips and falls; self-injurious behavior; and client-to-client injury that requires more than first-aid. The numbers of such incidents are low, as shown by the little n under each month. Riverview is well within the 1st standard deviation of the national sample. Please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

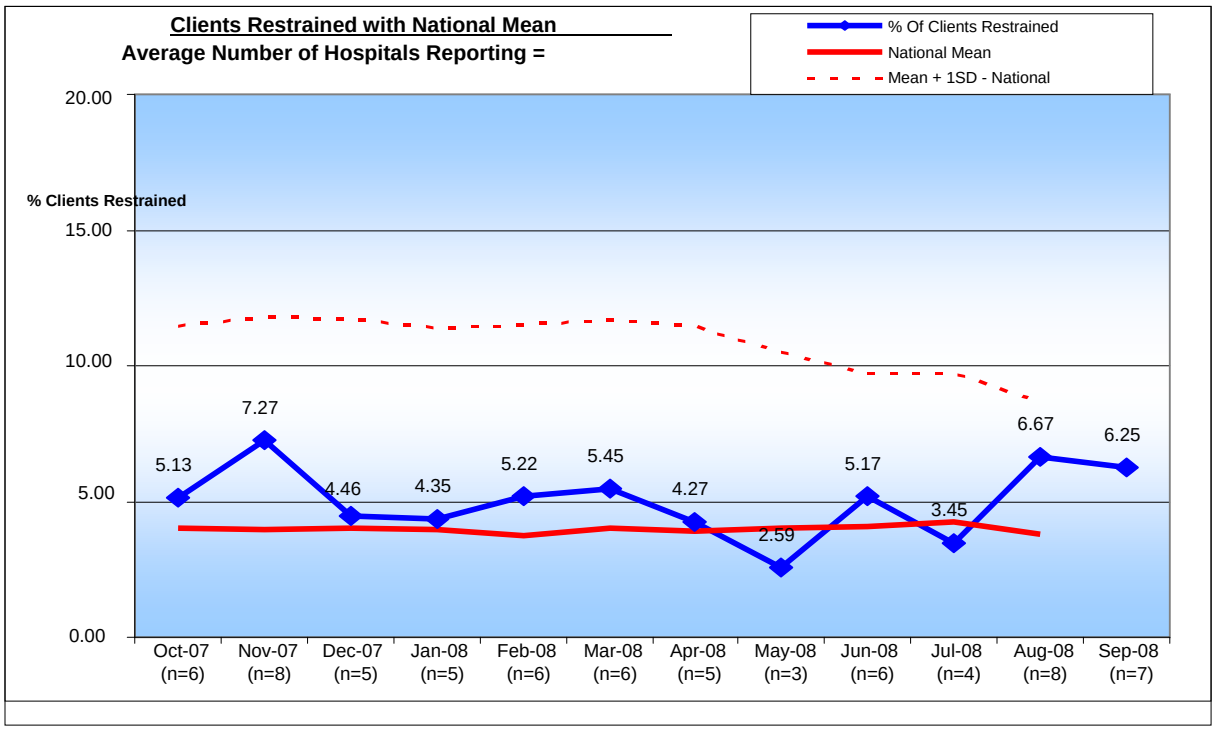
ELOPEMENT RATE GRAPH



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

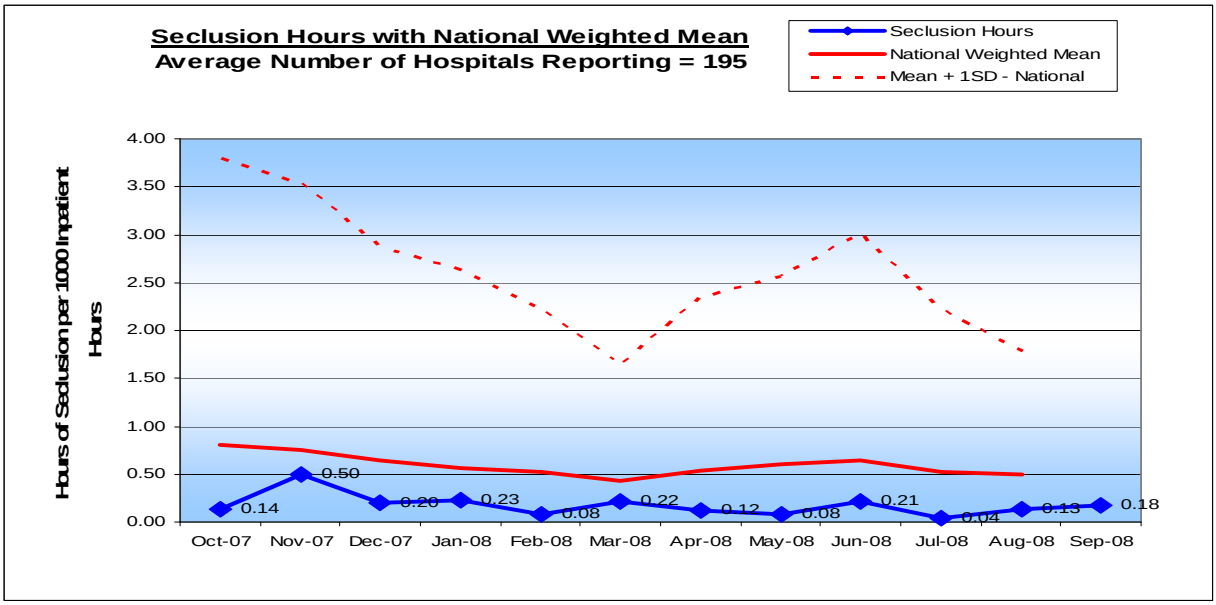
RESTRAINT GRAPHS

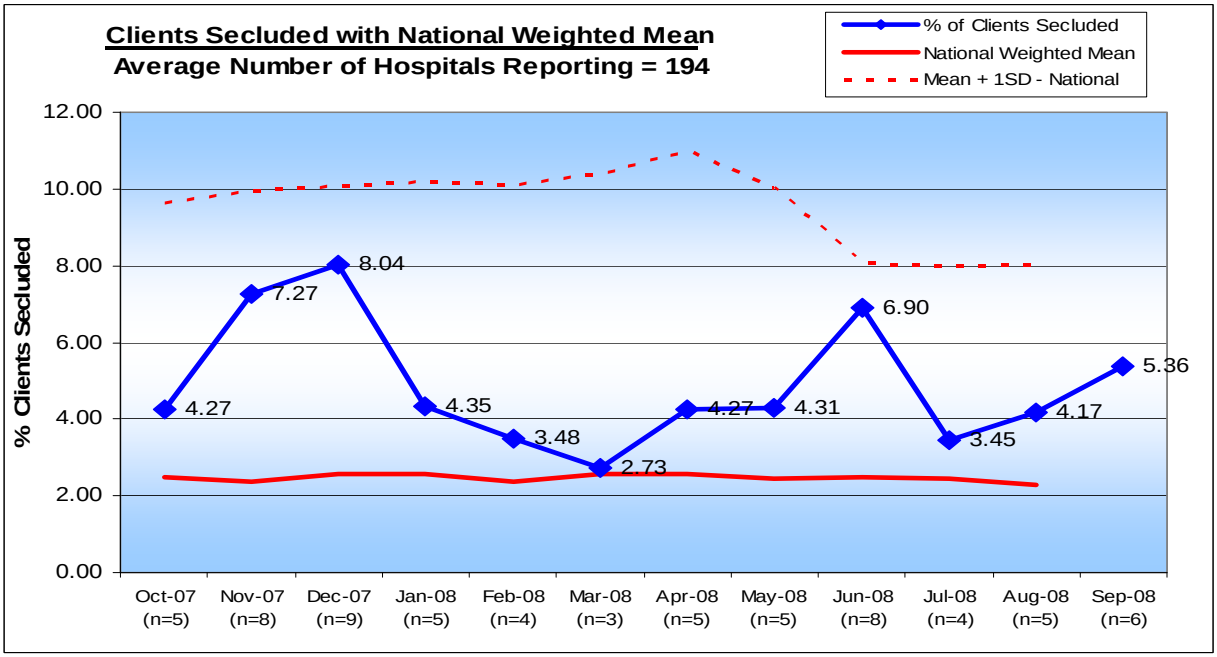




Riverview's rate of clients restrained remains above the statistical mean. The restraint hours (duration) rate remains well below the statistical mean. The data would suggest that Riverview's restraint events are short by comparison, and efforts to reduce the frequency of restraint use would have the most impact. Corrective actions we applied last quarter and RPC has seen a decline in both time and frequency. These strategies included, reducing the time for restraint order renewal from 4 hours to 1 hour; revision of debriefing process; new protocol and form to guide treatment plan revisions within 72 hours following the event , education initiatives; increased clinical, supervisory and administrative oversight; expanding opportunities for client choice is a priority to be monitored and tracked in monthly administrative reports.

SECLUSION GRAPHS





Seclusion hours (duration of events) at Riverview continue to remain below the national weighted mean. The percent of clients secluded has been level or decreasing over the past several months. The number of clients secluded has shown an increase over the past quarter and RPC will increase its efforts to reduce use of these interventions. Corrective actions already applied are: reducing the time for seclusion order renewal from 2 hours to one hour; revision of debriefing process; new protocol and form to guide treatment plan revisions within 72 hours following the event is in place; expanding opportunities for client choice is a priority to be monitored and tracked in monthly administrative reports; education initiatives; increased clinical, supervisory and administrative oversight; Expansion of the multi-sensory rooms to all other units is expected to decrease the use of seclusions.

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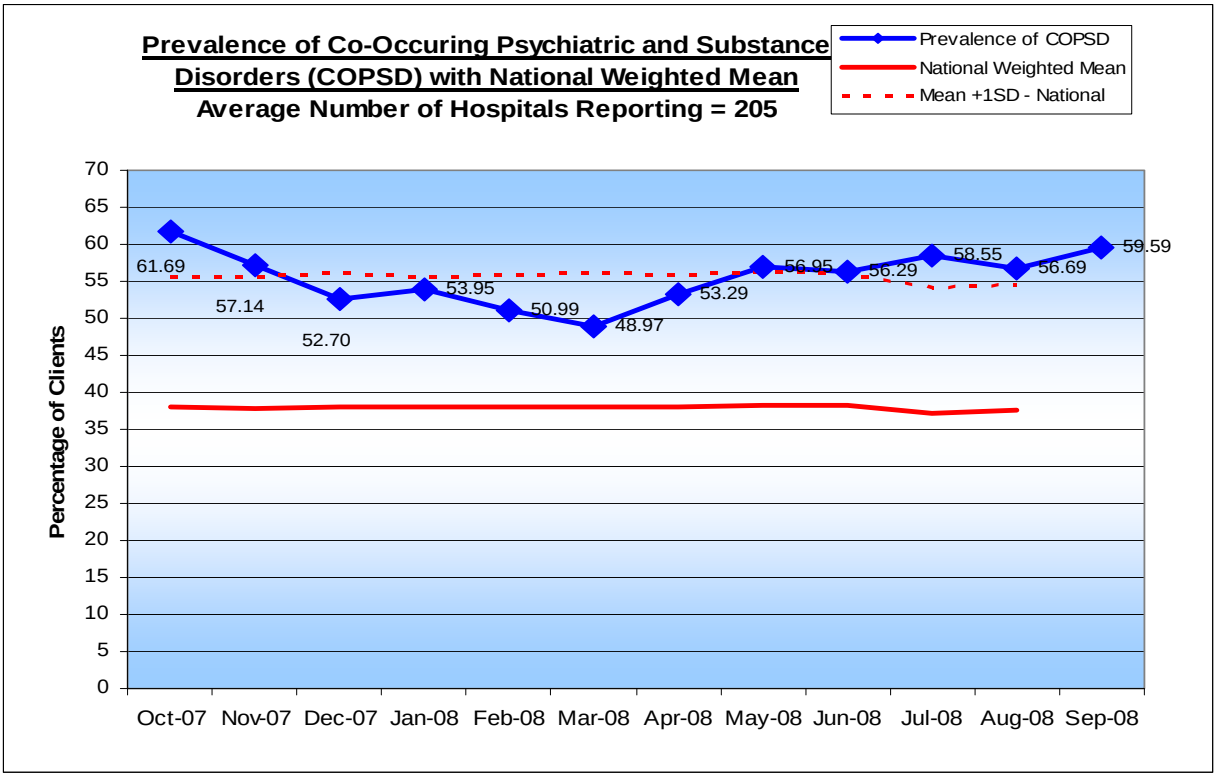
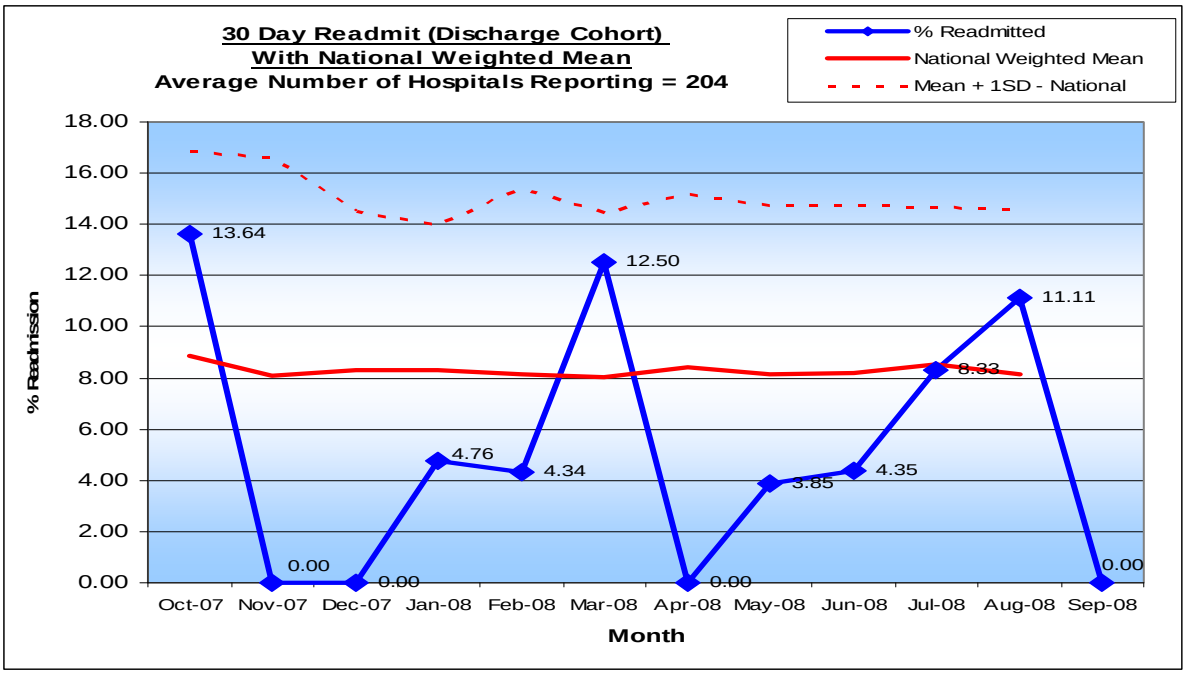
CO-OCCURING PSYCHIATRIC AND SUBSTANCE ABUSE DISORDERS GRAPH



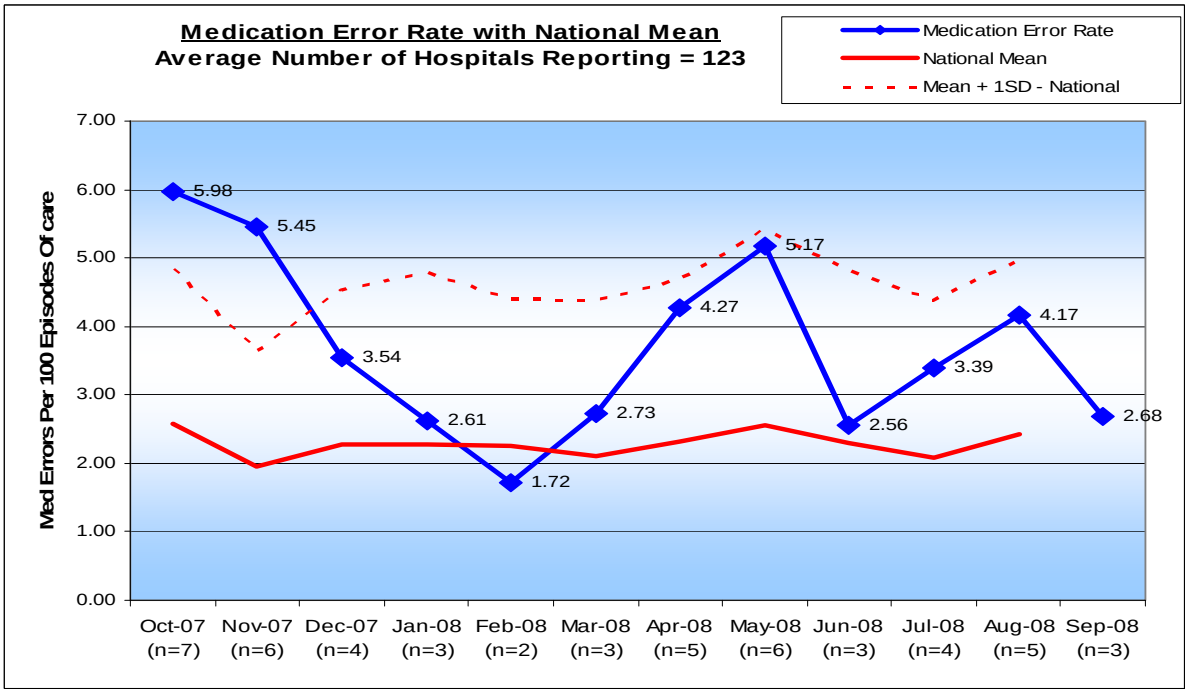
RPC has collaborative effort with Spring Harbor Hospital Co-Occurring Disorders providers to contract with RPC to develop a Co-Occurring program. Though RPC is currently a bit above the trend line, this is an indicator current initiatives are working as anticipated; with the advent of this program to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

THIRTY DAY READMIT GRAPH



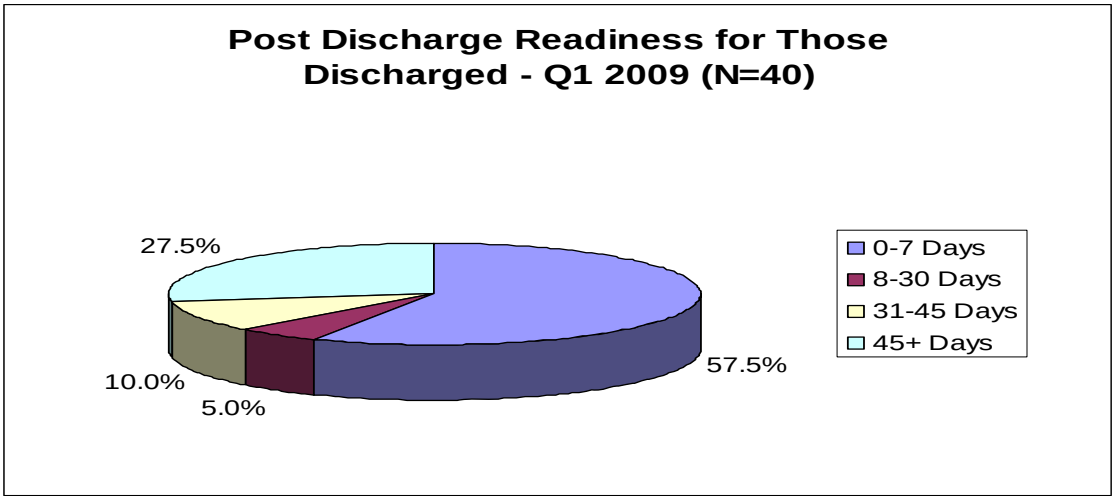
30 Day Readmission Rate is at or below the mean of the 205 other facilities reporting on this indicator, except in September 07 and March 08. Thirty day readmission rate is calculated considering the percent of discharges for the facility that returned within 30 days of a discharge of the same client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

MEDICATION ERROR RATE WITH NATIONAL MEAN GRAPH



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

POST DISCHARGE PRIOR READINESS CIVIL CLIENTS



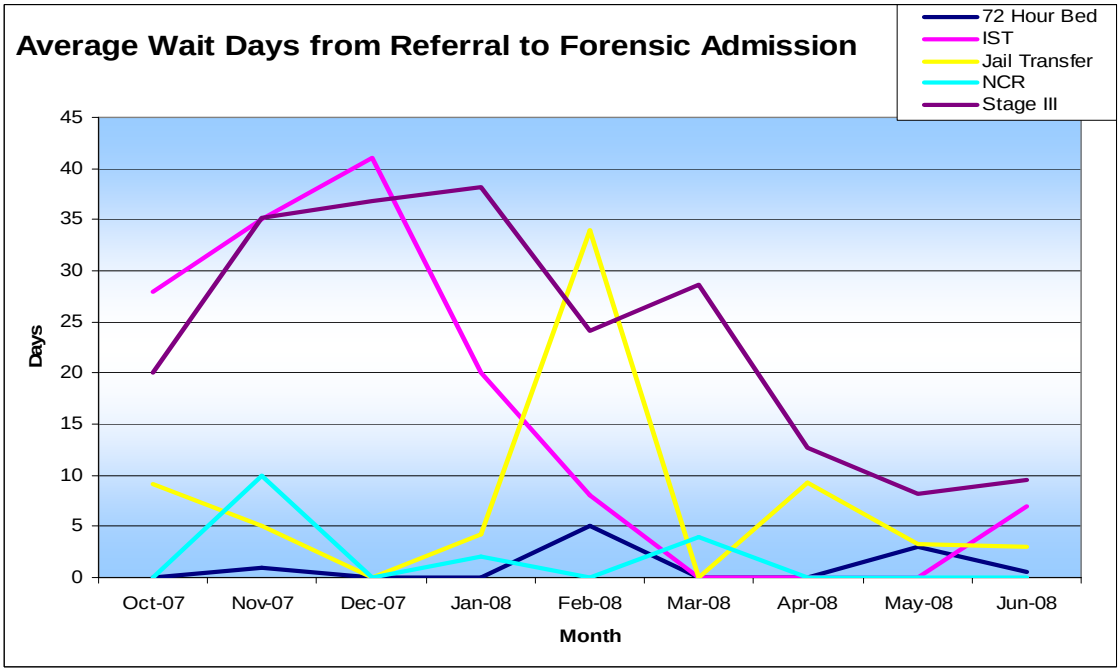
This chart shows the percent of civil clients who were discharged within 7 days of their discharge readiness to be at 57.5 % for this quarter compared to 48.5% last quarter; however the 45 days + showed a significant increase from 12.1 % last quarter to 27.5% . Cumulative percentages and targets are as follows:

- **Within 7 days = 57.5 % (target 75%)**
- **Within 30 days = 62.5 % (target 90%)**
- **Within 45 days = 72.5 % (target 100%)**

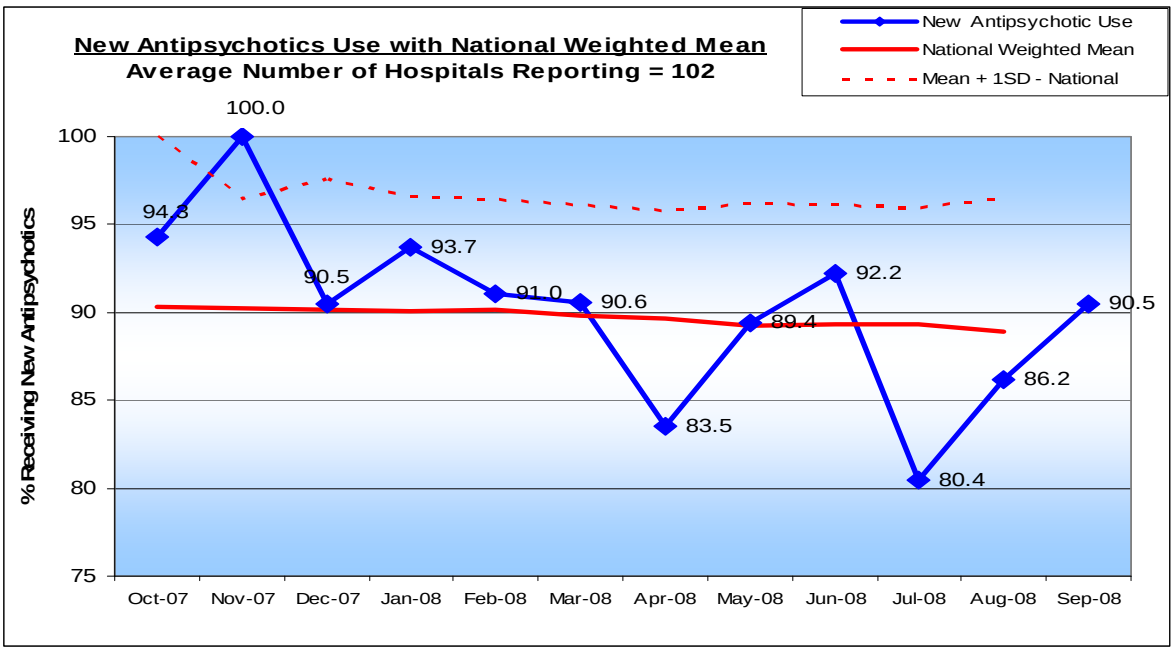
There is slight improvement in all categories this quarter.

The previous 5 quarters are displayed in the table below:

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



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



This graph compares Riverview's utilization of newer, atypical antipsychotic medications with the national average. Although there is some month to month variability in our utilization, our average use very closely mirrors national trends. Of note, both Riverview and national utilization of these medications has declined over the past year after major research findings demonstrated that the efficacy and safety of the newer drugs is not necessarily superior to the older drugs