PERFORMANCE IMPROVEMENT REPORT

FOURTH QUARTER REPORT

SFY 07

APRIL, MAY AND JUNE 2007

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7/31/07

Introduction.....4

Section I: Departmental Quality Assessment & Performance Improvement.....4

Medical Staff.....4

Pharmacy.....4

Nursing.....5

PSD Comprehensive Treatment Plan.....9

Peer Support.....14

Client Satisfaction Survey.....15

Continuity of Care/Social Services Department.....17

Unit: Forensic.....19

Rehabilitation.....21

Psychology.....22

Safety.....23

Securitas/RPC Security Manager.....26

Staff Development.....27

Community Forensic Act Team.....31

Section II: Riverview Unique Information.....33

Human Resources.....33

Human Resources/Risk Management.....34

Section III: Performance Measurement Trends Compared to National Benchmarks.....36

Client Injury Rate Graph.....36

Elopement Rate Graph.....37

Restraint Graphs.....38

Seclusion Graphs.....39

Co-Occurring Psychiatric and Substance Abuse Disorders Graph.....40

Thirty Day Readmit Graph.....42

Medication Error Rate with National Mean Graph.....43

Post Discharge Readiness Prior to Discharge……44

Section IV: Process Improvement Team Reports…… ….. 45

Special Quality Assessment Guide……46

Introduction:

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

Section I: Departmental Quality Assessment & Performance Improvement

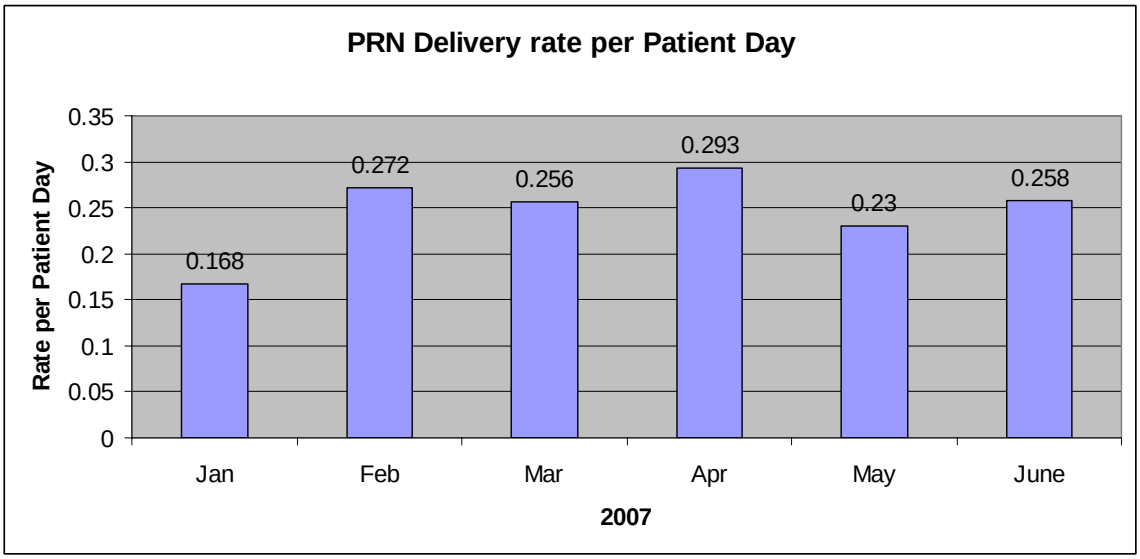
Medical Staff Peer Review and Quality Assurance
4th Quarter 2006-2007

1. The pharmacy reviewed the medication profiles of all 92 clients in the hospital. Five of the 92 clients were taking 20 or more unique, standing medications. On May 1, 2007 the Medical Staff Peer Review Committee, along with the 2 staff pharmacists, did a comprehensive pharmacological review of this population of five clients. As one might expect this group had multiple medical and psychiatric problems, tended to be long stay forensic clients, and evidenced "medication creep" over several years of hospitalization. After thorough discussion and feedback from peers, the patient's attending physicians agreed to reduce dosages and/or to eliminate medications in each of the five cases. The physicians and pharmacists felt this was a useful exercise and would revisit this topic once a quarter.

2. At the direction of the Medical Staff Peer Review Committee, the pharmacy reviewed the medication profiles of all clients in the hospital as of April 24, 2007 with particular attention being paid to the use of antipsychotic medications. On May 1, 2007 the Committee discussed the findings of this pharmacy review. There were 91 clients in the hospital. 76 (83.5%) of the 91 had a standing or prn order for an antipsychotic medication. This was further broken down as: 73/91 (80%) were receiving an atypical compound, 31/91 (34%) were receiving a typical compound, and 28/91 (31%) were receiving both. When only looking at the 76 clients who received any standing order for an antipsychotic, 95% were receiving an atypical compound, 25% were receiving a typical compound, and 20% were receiving both an atypical and a typical. Further review demonstrated that 24% of the 76 clients were receiving two or more regularly scheduled atypicals and none were receiving two or more typicals. The Committee was most interested in this latter group of clients receiving multiple atypicals. Emerging literature suggests there is no increase in efficacy from multiple atypicals. The Committee has decided to review on an ongoing basis this use of multiple atypicals and will be a future quality assurance monitor in order to assess the risk/benefit of multiple meds.

3. At the request of hospital administration we did an analysis of PRN psychotropic medication usage in the hospital over a four-month period (January to April). Zachary Smith PA, reviewed all medication administration records for all clients during this period to ascertain the usage of psychotropic and hypnotic agents that were given on a non-scheduled (PRN) basis. He compiled the data and this was presented to the June meeting of the Medical Staff Pharmacy and Therapeutics Committee for discussion. Pertinent findings were that there was general consistency among the 4 units in PRN utilization; that clonazepam, trazadone, Ambien, and Vistaril were the most commonly utilized PRN medications; and that the hospital total of all PRN doses was in the range of 15 to 25 per day. There did not appear to be any units that were outliers, nor was there any significant interunit

differences in the use of particular medications. The Medical Staff felt this report indicated appropriate utilization of unscheduled medications, while acknowledging there are no or few benchmarks to compare us to. Of potential use as a future monitor would be to ascertain that unscheduled use of medications is information the prescriber has when titrating the proper standing dose or when deciding to discontinue a PRN order, and that we continue to monitor high use medications such as clonazepam and Vistaril plus the hypnotics, when used chronically for the same client. The hypnotics especially are known to lose efficacy over time and might not be indicated for chronic use.



NURSING April, May, June 2007
ASPECT: SECLUSION & RESTRAINT RELATED TO STAFFING EFFECTIVENESS
COMPLIANCE: 100%

Indicators	Findings	Compliance	Threshold Percentile
Seclusion/Restraint related to staffing effectiveness:			
1. Staff mix appropriate	140/140	100%	100%
2. Staffing numbers within appropriate acuity level for unit	140/140	100%	100%
3. Debriefing completed	140/140	100%	100%
4. Dr. Orders	140/140	100%	100%

Findings: There were 140 events of Seclusion and Restraint
Problem: No problem noted
Status: The indicator continues to be at 100%
Actions: Continue monitoring to assure continued compliance.

ASPECT: Code Cart / Redlining
COMPLIANCE: REDLINING 98% CODE CART 99%

Indicators-Redlining	Findings	Compliance	Threshold Percentile
Lower Kennebec	263 of 267	99%	100%
Upper Kennebec	264 of 267	99%	100%
Lower Saco	251 of 267	94%	100%
Upper Saco	267 of 267	100%	100%

Indicators-Code Cart Sign Off	Findings	Compliance	Threshold Percentile
1) Lower Kennebec	262 of 267	98%	100%
2) Upper Kennebec	265 of 267	99%	100%
3) Lower Saco	264 of 267	99%	100%
4) Upper Saco	267 of 267	100%	100%
5) NOD Building Control	263 of 267	99%	100%
6) NOD Staff Room I 580	263 of 267	99%	100%

Findings: Redlining is at 98% and remains short of the 100% expectation. Lower Saco has completed redlining 94% of the time which is an increase from 87%. Lower Kennebec has completed redlining 99% of the time which is an increase from 96%. Upper Kennebec has completed redlining 99% of the time which is an increase from 97%. Upper Saco has completed redlining 100% of the time which is an increase from 98%.

Code cart checking has not yet met the 100% compliance requirement. It has risen to 99% this quarter up from 96% last quarter.

Problem: Redlining is not being done 100% of the time on all units. Code carts are not being checked 100% of the time.
Status: Redlining is the method of checking all medication orders to confirm for accuracy. While this indicator has not met the threshold of 100%, each unit reports marked improvement and the collective increase is up 3.5% from last quarter, indicating improved consistency in this area. Code carts are used in emergency situations and must be complete and ready to use. This area is up 3% from last quarter indicating increase staff consistency in assessing carts and monitoring their on-going readiness for emergency use.
Action: Redlining and code cart checking will continue to be included in each shift report completed by nursing. The night NOD will check with the charge nurse on each unit and report on the progress of the redlining procedure on each unit on the daily reports to the Superintendent. Code cart checking will continue to be reviewed with the nurse responsible for the narcotic count and key change during each shift change. The on-coming Nursing Supervisor and NOD's will check Room I-580 and make it a part of their shift report. The NOD/ Nursing Supervisor will report each shift on the daily report to the Superintendent, on all six sites of the code cart. These are ongoing actions from the last quarter and will be continued because they have made some improvement in this process.

NURSING
ASPECT: PAIN MANAGEMENT
OVERALL COMPLIANCE: PRE: 99% POST: 90% OVERALL: 95%

Aspect	Indicators	Findings	Compliance	Threshold Percentile
Pre administration	Assessed using pain scale	581 of 585	99%	100%
Post administration	Assessed using pain scale	527 of 585	90%	97%

Findings: The post administration assessment has dropped 3% since the last quarter and the pre administration assessment has dropped 1%. Data indicates Lower Saco is consistently 99–100% compliant on post Administration Upper Saco has been 86-87% compliant. The Kennebec side has been less compliant with Lower Kennebec not submitting data for this quarter; Upper Kennebec shows low compliance with post assessment. This continues to be a problem as nurses are not consistently returning to assess post pain.
Problems: The available data indicates that nurses are not consistently assessing client response to administered pain medication post administration. Pre and post assessments are the responsibility of the registered nurse and the medication administration is often given by the LPN. Improved communication and follow up is required for this process to occur consistently. The current process of pre and post assessment will be analyzed and a streamlined procedure will be developed to address this aspect area.
Status: The pre administration has decreased 1%. The post administration has decreased from 93% to 90%.
Actions: While the process is being developed, each nurse will monitor the PRN medications of their assigned clients. This will make it easier to track their individual clients pre administration and post administration relief. This will be a precursor to Primary Nursing that will be done on all units. It will be assured that data will be collected and submitted from all units.

NURSING: Quarter-February, March, April 2007
ASPECT: CHART REVIEW

COMPLIANCE: 80%

Indicators	Findings	Compliance	Threshold Percentile
1. Universal Assessment completed by RN within 24 hours	110 of 127	86%	100%
2. Care Plan Initiated	125 of 127	98%	85%
3. Client Preference Identified	79 of 127	62%	100%
4. Signature Finalizing Assessment	127 of 127	100%	100%
6. NAP notes at a minimum			
a. Identifies STG goal/objective	45 of 57	79%	90%
b. Once per shift either MHW/RN(observational note as appropriate)	41of 57	72%	95%
c. Minimally Q 24 hours RN after first 72 hours	51 of 57	89%	100%
d. MHW notes countersigned by RN	27 of 57	47%	90%
8. Initial care plan documented within 24 hours	43 of 57	75%	100%
9. Presenting problem in behavioral terms	30 of 57	53%	85%
10. Strengths identified	50 of 57	88%	85%
11. Client LTG is observable and measurable	44 of 57	77%	85%
12. Comprehensive Plan completed by the 7th day	49of 57	86%	100%
13. STG/Objectives are written, dated, numbered, observable and measurable	54 of 57	95%	85%
14. Interventions are identified	55of 57	96%	85%
15. a. Integrated Needs/Assessment prioritized by scale at bottom of sheet	39of 57	68%	85%
b. Integrated Needs/Assessment contains all needs/issues/problems found within the assessments/evaluations since admission	41 of 57	72%	85%
16. Active medical issues addressed via medical/nursing care Plans	41 of 57	72%	85%
17. Documented in the chart on the day of Comprehensive Service Plan Meeting	49 of 57	86%	85%
18. Identifies client preferences at Service Integration Meeting	47 of 57	82%	85%
19. States whether further assessments will be needed or not per MD, PA or psychiatrist	45 of 57	80%	85%
20. Identifies the unmet current goals of services	49 of 57	86%	85%

21. Documents the client or guardian participation in the treatment planning process	51 of 57	89%	85%

Findings: There were 57 charts audited from all 4 nursing units for nursing documentation in this quarter. Overall this group of indicators has increased in compliance from 57% last quarter to 81% this quarter. All of chart review aspects are considered together and were separate in the last quarter. Minimal every 24 hours of nursing documentation is up to 89% compliance from 51% last quarter. As indicated, all other areas increased also from the previous quarter.
Problems: There remains a problem in the consistency of these aspects of documentation. The problems are across units and shifts and indicate the need to redesign many aspects of the documentation process. The documentation issues are due to RN inconsistency.
Status: Although the entire documentation looks better this quarter, changes in the documentation process have been made and new indicators will be developed for the next review period.
Actions: A Documentation PIT was completed and the new process was implemented in May and it will be reported in the next quarter. The Comprehensive Service Plan has changed; the method and type of notes have changed. The documentation will be done in a continuous document with no gaps in the paperwork. The method of documenting will change from menu driven NAP notes to GAP notes without a menu. This will serve to allow documentation to be more concise and connect in a user-friendly method to the Treatment Plan. Documentation expectations for MHW and Nurses have changed regarding frequency, quality and purpose. It will become a chart that is used and current. Indicators in the aspect area may change in response to the documentation restructuring.

PSD Comprehensive Treatment Plan

Indicators	Findings	Compliance	**Threshold Percentile**
1. Comprehensive Service Plan was completed within 7 days of admission (for clients here less than 6 months).	LK 18/18 UK16/16- n/a 4 LS 19/19 n/a 1 US n/a	100%	100%
2. Current Service Plan was revised within last 14 days for the first 6 months of hospitalization—or—in the last month (for clients here longer than 6 months). Revised as evidenced by target dates changed, STGs modified or added.	LK 10/15 - N/A 3 UK 14/20 LS 13/15 n/a – 5 US n/a	74%	100%
3. Current Service Plan was revised within 72 hours of a coercive intervention (restraint, seclusion, psychiatric emergency) or significant event (e.g. transfer to another unit, episode of violence, near miss).	LK 2/4 - n/a 14 UK 6/6 – n/a 14 LS 2/3 n/a 17 US 12 n/a	62%	85%
4. At each Service Plan Review, there is a Service Plan Review note in the progress notes containing, at a minimum, the following criteria:	LK 9/11- N/A 7 UK 7/20 LS 14/15 n/a 5	67%	85%

changes made to plan to facilitate treatment/ client participation in treatment / review of progress made during review period R/T goal attainment.	US 9/12		
5. Current Service Plan documents the **client** participated in the plan. (as evidenced by signature or documented comments)	LK 14/18 UK 16/20 LS 19/19 – n/a 1 US 12/12	88%	85%
6. Current Service Plan documents the client's **psychiatrist** participated in the plan.	LK 17/18 UK 19/20 LS 19/19 n/a – 1 US 12/12	97%	85%
7. Current Service Plan documents the client's **CCM** participated in the plan.	LK 17/18 UK 19/20 LS 19/19 n/a – 1 US 12/12	97%	85%
8. Current Service Plan documents the **assigned primary nurse** participated in the plan.	LK 17/18 UK 19/20 LS 19/19 n/a – 1 US 12/12	97%	85%
9. Presenting Problem on face sheet of Service Plan is identified in behavioral terms regarding the event leading to hospitalization	LK 18/18 UK 15/20 LS 19/19 n/a – 1 US 11/12	91%	85%
10. Client Long Term Goal (at the top of each Problem Page) is observable, measurable and incorporates criteria for transition out of the hospital.	LK 16/18 UK 5/20 LS 11/19 n/a – 1 US 12/12	64%	85%
11. Strengths and preferences that may be used to facilitate treatment are identified on the service plan. (strengths are intrinsic, from the client)	LK 17/18 UK 9/20 LS 18/19 n/a – 1 US 12/12	78%	85%
12. Current Service Plan has written STGs for every active issue/problem documented in assessments.	LK 17/18 UK 8/20 LS 13/19 n/a – 1 US 10/12	70%	85%
13. All STGs are stated in observable and	LK 17/18	91%	85%

measurable terms.	UK 18/20 LS 19/18 n/a – 1 US 9/12		
14. All STGs are dated and numbered	LK 16/18 UK 8/20 LS 10/19 n/a – 1 US 10/12	64%	85%
15. Each STG has numerically identified interventions that are specific to the STG	LK 16/18 UK 1/20 LS 13/19 n/a – 1 US 10/12	60%	85%
16. All interventions are written and linked to the specific STG they address (corresponding numbers)	LK 16/18 UK 0/20 LS 14/19 n/a – 1 US 10/12	58%	85%
17. All interventions describe who will provide the intervention, the purpose of the intervention, the frequency it will be provided, and who is responsible for documenting progress toward or away from the goal.	LK 17/18 UK 18/20 LS 16/19 n/a – 1 US 11/12	90%	85%
18. At the time of each Service Plan Review any new assessments and corresponding interventions are incorporated into the plan and described in the note.	LK 13/13 - n/a 5 UK 1/17 – n/a 3 LS 8/15 n/a – 5 US 1/2 – 10 n/a	49%	85%
19. Current Service Plan documents an assessment of the efficacy of the interventions applied to the STG not fully met (eg. “partially met” or “not met”)	LK 2/7 – n/a 6 UK 9/17 – n/a 3 LS 9/16 n/a – 5 US 7/12	52%	85%
20. Unmet STGs in the CSP may not be extended more than two times before a different goal must be written.	LK 11/14 - N/A 3 UK 16/20 LS 8/12 n/a – 8 US 8/12	75%	85%
21. All active issues found in the assessments from different disciplines are documented on the Integrated Needs / Problem List	LK 18/18 UK 10/20 LS 15/19 n/a – 1 US 11/12	78%	100%
22. All active issues are prioritized according to the status scale at the bottom of the sheet.	LK 18/18 UK 18/20	97%	100%

	LS 16/19 n/a – 1 US 12/12		
23. The Review Form documents the client and/ or guardian participated in the review.	LK 10/11 - N/A 7 UK 15/20 LS 16/16 n/a – 4 US 12/12	93%	90%
24. The Review Form documents the Psychiatrist participated in the review.	LK 11/11 - N/A 7 UK 20/20 LS 16/16 n/a – 4 US 12/12	100%	100%
25. The Review Form documents that the CCM participated in the review.	LK 10/11 - N/A 7 UK 19/20 LS 14/16 n/a – 2 US 12/12	93%	100%
26. The Review Form documents that the Primary RN participated in the review.	LK 11/11 - N/A 7 UK 19/20 LS 15/16 n/a – 4 US 12/12	95%	100%
27. Each CSP has an Individualized Safety Plan that addresses concerns related to safety and strategies to minimize the risk.	LK 17/18 UK 18/20 LS 15/20	86%	100%
28. CSP includes any functional skill deficits, including present level of support and level of support to be attained.	LK 14/18 UK 2/20 LS 3/15 n/a – 2 US n/a	36%	95%

Findings: Eleven quality indicators were found above thresholds across all units. Seventeen indicators were not present above threshold levels within the hospital. Of that seventeen, twelve indicators were found to be significantly absent from one select unit. Five indicators where found to be represented in the medical records in inadequate frequencies across units.

Problems: Indicator (#2) of Service Plan reviews were present in 74% of charts reviewed with variance attributable to tardiness of 1 to 3 days or a lack of modification documented in the plan. In the cases of being late, the review form was not present, although the review meeting had occurred.

Review of documentation of Indicator (#3) of Service Plan review after restrictive treatment events, a rarely occurring event, found 3 occasions where the timeliness of the review was not reflective of the quality indicator. Meetings occurred but no documentation of the content was made in the medical record.

Service Plan review notes (#4) were found to display quality indictors with the exception limited to one unit which accounted for 13 of the hospital-wide 20 cases of variance from expectation. Although the review note is present, the quality of these notes is not representative of expectations.

Quality of long term goal statements (#10) was also found to be present across three of four hospital units. A select unit accounted for 15 of the 17 cases that varied from expectation. In the majority of cases on this unit the goal was not measurable.

The identification of strengths and preferences (#11) was well documented in reviewed cases within expectations with one unit exception accounting for 11 of 13 variances. The exceptions are identified as the strengths and preferences not reflected in EACH intervention.

Documentation of a goal for each active problem (#12) was found above thresholds on 3 of 4 units. One unit had a consistent variance in identification of transitional goals by the unit Social Worker.

Dating and number of goals and interventions, (#14, #15, #16) involves the monitoring of a process and not quality. These indicators will be eliminated and replaced.

Incorporation of new assessment and interventions (#18) was reflected consistently on one of the three treatment units. The documentation reflects an inconsistency in identification of needed assessments in one but not the other (both review note and Service Plan). In addition, significant variance is encountered with transient issues generally related to physical health (soft tissue injury, infection, and virus). No clear and manageable process to capture this information that is not related to primary psychiatric care is currently in place.

Item nineteen, is designed to ensure that assessment of goal status is made on the Service Plan. Disciplines responsible for the care monitoring inconsistently document this goal status.

Item twenty also tracks a process which may not measure the quality of the Service Plan and will be replaced.

The migration of identified needs from clinical assessments to the service plan (#21) is inconsistently completed with the exception of nursing.

Slight variance in presence of the preauthorization (#22) of client needs was observed.

Presents of authenticating signatures of Nursing staff and Social Work staff (#25, #26) was not found as expected. Although participation is occurring, signing of the form was found not to be occurring.

Safety plans (#27) were absent from 19 of the 53 charts reviewed. Nursing staff were not completing these in close proximity to admission.

Functional skill supports (#28) were not found at the frequency expected. An improvement in addressing basic fundamental functioning was found but lacking was the identification of the “level” of support to be provided by MHW staff.

Status:
Overall improvements were recorded during this review period as compared to the previous review.

Actions:

1. Director of Nursing shall be required to institute training on conducting and documenting service plan

reviews and completing safety plans for all RN4s and executive nurses by August 10, 2007. Such review will also review service reviews occurring as a result of restrictive treatment or expression of violence.

2. Director of Nursing shall arrange for training on Upper Kennebec for RN4 and Charge Nurses on Service Planning process and assess acquisition of knowledge and skill in this job duty by August 30, 2007.
3. Discipline chiefs shall conduct discipline specific training on need assessment and documentation focusing on incorporation on Service Plan and in summary notes by August 10, 2007.
4. The Director of Nursing shall develop a template for care planning of transient non-primary psychiatric care issues which are temporary in nature with expected resolution times of less than 14 days. This shall be presented to the PSD's on 8-23-07 at 9:15 AM.
5. Director of Nursing shall ensure training to all Milieu Managers (and selected MHW on units without Milieu Managers) occurs on assigning, providing, and documenting a functional support level of care by August 30, 2007. A follow up assessment of skill and knowledge acquisition occurring from this training will be completed with each participant by September 30, 2007.

PEER SUPPORT

ASPECT: Integration of Peer Specialist into client care
OVERALL COMPLIANCE: 91%

Indicators	Compliance	Findings	Threshold Percentile
1. Attendance at Comprehensive Treatment Team Meetings.	461 of 530	87%	80%
2. Grievances responded to by RPC on time.	124 of 132	94%	100%
3. Attendance at Service Integration Meetings.	61 of 64	95%	100%
4. Contact during admission.	68 of 69	99%	100%
5. Grievances responded to by peer support on time.	132 of 132	100%	100%
6. Client Satisfaction Survey completed.	33 of 44	75%	80%

Findings: Overall compliance was up 1% from last quarter.
(1) Peer Specialists attended 87% of client Treatment Team Meetings. Of the 69 meetings that were missed, 3 were due to Peer Specialists attending admissions at the same time, 2 were due to attendance at other meetings, 10 were due to mandatory training at that time, 12 were due to no Peer Specialist being available, and 42 were due to clients not wanting Peer Specialist present.
(2) RPC did not respond on time to 8 grievances. Of those 8 grievances, 4 were on Upper Saco (1 to 5 days late) and 4 were on Lower Kennebec (1 to 2 days late).
(3) Peer Specialists missed 3 Service Integration Meetings. One was missed due to Peer Specialists attending mandatory meeting and 2 were due to not being notified of meetings.
(4) Although one client admitted to RPC did not have documented contact with a Peer Specialist, there was contact made. The Peer Specialist left his position before documenting contact.
(5) All client grievances were processed on time by Peer Specialists.
(6) Of the 44 client satisfaction surveys offered to clients, 33 were completed. Clients declined completing the survey on 11 occasions.

Problem:
(1) A Peer Specialist is not always available to attend all client Comprehensive Treatment Team Meetings.
(2) All level I grievances are not being responded to by RPC within the time allowed.
(3) Peer Specialists are not attending all client Service Integration Meetings.
(4) All clients admitted to RPC did not have documented contact with a Peer Specialist.

(6) Clients are not always willing to complete a client Satisfaction Survey.

Status:

(1) Peer Specialists' attendance at client Treatment Team Meetings was up 1% from last quarter. Meetings were attended 91% of the time for April and May and only 78% in June. The decrease in June was due to a Peer Specialist being out on an extended medical leave and clients not wanting another Peer Specialist to attend their meeting.

(2) Timely response to grievances by RPC was down 2% from last quarter. The highest compliance was in April at 100% and lowest in May at 87%.

The number of grievances filed this quarter went up by 21% from last quarter. The number filed rose as the quarter went on, 21 in April, 47 in May, and 64 in June. There was a sharp increase on Lower Saco by 78% in May, mostly due to one client. There was also a sharp increase on Lower Kennebec in June, increasing 77%.

(3) Attendance at Service Integration Meetings went up 1% from last quarter.

(4) Documented contact during admission was down 1% this quarter from last. Only one client did not have a documented contact, which was on Lower Saco. The client did have contact with peer support, but the peer specialist did not document contact and is no longer an employee. No other peer specialist had contact with that client and he has been discharged.

(6) Client Satisfaction Surveys completed was up 3% this quarter. There were fewer surveys offered this quarter (down 2).

Actions:

- 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 reason for missed meetings.
- The part-time Peer Specialist's schedule will be shifted to allow for additional coverage for meetings.
- Peer Specialists will be counseled at least twice per month on issues related to missed meetings and work attendance.
- Peer Specialists will make additional efforts to adjust their schedules to be available for meetings and problem-solve with the Peer Services Director on how to manage their schedule and overcome barriers to attending team meetings.
- Peer Services Director will meet with the Social Services Director and Continuity of Care Managers as needed to coordinate meeting schedule in order to ensure Peer Support attendance.
- A system will be developed for Peer Specialists to be notified of pending discharges so satisfaction surveys can be offered on all other units.
- One Peer Specialist will be assigned to helping clients complete Satisfaction Surveys as part of their job responsibilities and counseled about successful techniques in engagement of clients to do the surveys.

CLIENT SATISFACTION SURVEY:

ASPECT: Client satisfaction with care

OVERALL COMPLIANCE: 79%

Indicators	Findings		Threshold Percentile	+/-
1. Has anyone informed you about your rights?	17 of 26	65%	85 %	-12
2. Has anyone talked to you about the kinds of services that are available to you?	18 of 26	69 %	85 %	-18
3. Are you informed ahead of time of changes in your privileges, appointments or daily routines?	17 of 26	65 %	85 %	-20
4. Do you know someone who can help you get what you want or stand up for your rights?	20 of 27	74 %	85 %	-11
5. Has your community worker visited or contacted you since you have been in the hospital?	17 of 26	65 %	85 %	-20

6. Do you know how to get in touch with your community worker if you need to?	18 of 26	69 %	85 %	-23
7. Do you have an individualized support plan (ISP)?	18 of 27	67 %	85 %	-18
8. I feel more confident in my ability to deal with crisis situations?	24 of 25	96 %	85 %	-4
9. I am less bothered by my symptoms now?	24 of 25	96 %	85 %	-4
10. I am better able to function?	26 of 27	96 %	85 %	+4
11. I do better in social situations?	23 of 26	88 %	85 %	-4
12. I experience less difficulty in my life?	21 of 26	81 %	85 %	+6
13. I am treated with dignity and respect?	22 of 27	81 %	85 %	+2
14. I feel comfortable asking questions about my treatment and medications?	25 of 29	86 %	85 %	+1
15. I am encouraged to use self-help/Peer Support and support groups after discharge?	23 of 28	82 %	85 %	-1
16. My medication benefits and risks were discussed with me?	21 of 28	75 %	85 %	+4
17. I am given information about how to understand and manage my illness?	23 of 26	88 %	85 %	+11
18. My other medical conditions are being treated?	15 of 25	60 %	85 %	-9
19. I feel free to voice complaints and suggestions?	22 of 27	81 %	85 %	-11
20. I feel my right to refuse medication or treatment is respected?	18 of 28	64 %	85 %	-5
21. I participate in planning my discharge?	25 of 28	89 %	85 %	-3
22. I feel I had enough privacy in the hospital?	23 of 27	85 %	85 %	+21
23. I feel safe while I am in the hospital?	25 or 26	96 %	85 %	+4
24. If I had a choice of hospitals, I would choose this one?	16 of 24	67 %	85 %	+13

Findings: Overall compliance was down 1% from last quarter.
Of the 24 indicators, 9 met or exceeded threshold and 15 were below threshold. The number of items that met or exceeded threshold was down by 2 from last quarter. Items that did not meet threshold were up by 2.

Problem:
Clients are not satisfied with all aspects of care provided during hospitalization at RPC.

Status:
Increases and decreases in findings are indicated in the above table.
Ten items that were below threshold last quarter, remained as such; six of the items that were above threshold last quarter remained above threshold. Of those that remained below threshold, 4 increased 2-13% while 7 decreased 1-18%; of those that remained above threshold, 3 increased by 1-4% while the others decreased 1-3%.

Some of the identified concerns by clients were:

- Not being informed of privilege, appointment, and routine schedule changes ahead of time;
- Don't always feel comfortable asking questions about treatment and medications;
- Risks and benefits of medication were not discussed with them

Actions:

- Peer Support will encourage and support clients to voice their concerns and needs with their Treatment Teams regarding these aspects of care.
- Peer Support will provide feedback to RPC about client concerns/suggestions.

CONTINUITY OF CARE/Social Services Department
ASPECT: Preliminary Continuity of Care Meeting and Comprehensive Psychosocial Assessments
Overall Compliance: 85%

Indicators	Findings	Compliance	Threshold Percentile
1. Preliminary Continuity of Care meeting completed by end of 3rd day.	28/30	93%	100%
2. Service Integration form completed by the end of the 3rd day.	28/30	93%	100%
2a. For any client readmitted within 30 days, CCM should assess with the client problematic behaviors, level and type of access to community supports and any other critical issues that contributed to re-hospitalization. Assessment should be documented in a progress note.	1/1	100%	100%
3a. **Client Participation** in Preliminary Continuity of Care meeting.	28/30	93%	80%
3b. **CCM Participation** in Preliminary Continuity of Care meeting.	30/30	100%	100%
3c. Client's **Family Member and/or Natural Support (e.g., peer support, advocacy, attorney) Participation** in Preliminary Continuity of Care meeting.	29/30	96%	80%
3d. **Community Provider Participation** in Preliminary Continuity of Care meeting.	16/30	53%	80%
3e. **Correctional Personnel Participation** in Preliminary Continuity of Care Meeting.	2/15	13%	60%
4. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	27/30	90%	95%
5. Annual Psychosocial Assessment completed and current in chart.	29/30	96%	95%

Findings:
The sample size for this aspect was 15 charts for the quarter from each of the two admission units, Lower Saco and Lower Kennebec for the indicators 1-3d. For indicator 3e the sample was for Lower Saco only. For indicator 5 the sample was 15 charts for the quarter from both Upper Saco and Upper Kennebec.
Problems: Indicators 1 and 2 fell below compliance as indicated with one client from Lower Saco SCU and one client from Lower Kennebec. Both clients refused to participate in the Service Integration Meeting and were approached daily for several days following admission. One form was partially completed with historical information available on one of the clients who had previous admissions at RPC. The other form was minimally completed but not in its entirety. The client remained very guarded and struggled to engage for several weeks into his admission.

Indicator 3d fell below the threshold percentile this quarter and registered at 53%. As reported last quarter in several instances clients declined to sign releases for assigned community providers to attend and participate in the initial Service Integration Meeting. Additionally impacting this area is the short timeframe in which this meeting occurs after admission to the facility. On several occasions providers could not attend but had given input to the assigned CCM or had made arrangements to attend the 7 day meeting.

Indicator 3e fell below the threshold percentile and for this quarter remained at 13%. As stated in previous quarters clients routinely refuse to have corrections personnel as part of their treatment team. Their were two occurrences that corrections personnel, corrections social worker and a probation officer were involved in the Service Integration process.

Indicator 4: While this area is up from 86% to 90% it still fell below the threshold percentile for two reasons this quarter. The first is that three clients had acuity levels that though the report was initiated within designated time frames it was completed after the seven day threshold due to struggles to engage in the information gathering process. The other incident on LK was due to human error. The assignment was designated to be completed by a contract staff on the weekend. A time restriction was encountered and while many assessments were completed, 2 were not. One was completed immediately and met the 7 day standard but the other was out of compliance and completed 2 days late.
Status: Monitor all aspect areas and utilize individual supervision and team meetings to brainstorm continued ways to engage clients and continued dialogs with service providers.
Corrective Actions:
Indicators 1 and 2: These areas will continue to be focused on and monitored. For clients who may struggle with the process due to their level of acuity or challenges the process can begin immediately upon admission which would provide an increased opportunity for the process to be complete by the 3rd day. Last quarter the compliance in this area was 93 % which is where it remained for this 4th quarter report.
Indicator 3d: Though this indicator fell below the threshold percentile for this report it was up from 33% second quarter to 50% in the third quarter to 53% this quarter which represents a cumulative increase of 20%. The Department will continue to focus on fostering the value of community providers in the overall treatment process and continue to encourage clients to allow them to be part of their course of treatment at RPC. We will continue to attend the Ken-Som Provider meeting at MaineGeneral to facilitate stronger relationships between RPC and community providers.

Indicator 3e: Though this indicator fell below the threshold percentile it is up from zero participation second quarter to 13% in the third quarter where it remained for this fourth quarter report. The department will continue to monitor this area and strategies to increase participation and support clients to see the potential value in their communication with the corrections system. A CCM from LS will also begin participating at the Community Corrections Provider meeting held at the Sheriff's Department the last Wednesday of each month.
Indicator 4: This area will continue to be monitored through individual supervision and on-going engagement strategies with clients.

Unit: Forensic
Accountability Area: Continuity of Care/Social Services
Aspect: Institutional Reports
Overall Compliance: 98%

Indicators	Findings	Compliance	Threshold Percentile
1. As part of the Individualized Treatment Meeting all Forensic clients will be prompted to indicate the initiation of a court petition.	63/63	100%	95%
2. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	4/5	80%	95%
3. The assigned **CCM** will review the new court order with the client and document the meeting in a progress note or treatment team note.	3/3	100%	95%

Findings: This is the second full quarterly report for this aspect area and encompasses all represented Client Treatment Meetings.
Problems: In one instance on LS an intuitional report was not completed within the 10 day requirement. The institutional report though did not met the threshold, was submitted prior to court and the client had a successful petition.
Status: Last quarter this aspect area had an overall compliance of 88%.This quarter the area is at 98% which indicates a 10 % increase in compliance. The increase can again be attributed to an improved tracking system and a commitment by team members to prioritize this important process and designating a single point person for gathering signatures and delivery the reports to the court clerk's office.
Corrective Actions: Continued vigilance of the 10 day deadline and continued communication with team members. Establish new indicator to track annual reports.

Accountability Area: Continuity of Care/Social Services
Aspect: Client Discharge Plan Report/Referrals
Overall Compliance: 92%

Indicators	Findings	Compliance	Threshold Percentile
1. The Client Discharge Plan Report will be updated/reviewed by each **CCM minimally one time per week.**	12/13	92%	80%
2.The Client Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	13/13	100%	95%

2a. The Client Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	11/13	84%	95%
3. Each week the CCM team and Director will meet and discuss current housing options provided by the respective regions and prioritize referrals.	12/12	100%	95%

Findings: The timeframe for this aspect area was 13 weeks. During that time the report was sent out on 9 occasions via email. The report was distributed to stakeholders in hardcopy on two occasions at the Wednesday meeting. For two weeks the plan was in a restructuring phase and was not distributed.
Problems: Indicator 2a. On both occasions an updated report was not distributed because the document was being restructured to encompass a new format and structure.
Status: The new format for the report is instituted and the report has been sent out consistently for the last nine weeks including the week of the holiday. Additionally the Director of the department is trained and now distributes the document to the distribution list.
Corrective Actions: Continue monitoring as indicated and ensure that an updated and streamlined report is distributed week. Utilize individual supervision to support staff with new report format.

Accountability Area: Continuity of Care / Social Services
Aspect: PROGRESS NOTES
Overall Compliance: 93%

Indicators	Findings	Compliance	Threshold Percentile
1. Contact notes/progress notes will indicate at minimum weekly 1:1 meeting with all clients on assigned **CCM** caseload.	55/60	91%	90%
2. Contact note/progress note will indicate monthly meeting with all clients on assigned CCM caseload regarding Comprehensive Treatment Planning needs/progress.	57/60	95%	95%
3. On Upper Saco contact notes/progress notes will indicate at minimum bi- weekly 1:1 meeting with all clients on assigned **CCM** caseload	14/15	93%	90%

Findings: This aspect area includes chart samples from all units except as noted in Indicator 3 which represents information from Upper Saco only.
Problems: There are no indicators that fell below threshold.
Status: The overall compliance was up 1% for this aspect area in quarter three and 2% for the fourth quarter for an increase cumulatively or 3%. The department will continue to monitor this area and continue to focus on monitoring compliance and for the new report a focus on content of notes.
Corrective Actions: None for this quarter.

REHABILITATION

ASPECT: UPPER SACO CLIENT'S ATTENDANCE to prescribed treatment
COMPLIANCE: 84.0%

Indicators	Findings	Compliance	Threshold
Number of Scheduled Program Hours Offered	60 of 60	100.0%	100%
Number of Program Hours Attended	48 of 60	80.0%	75%
Number of Program Hours Refused	9 of 60	15.0%	25%
Number of Program Hours Excused	3 of 60	5%	5%
Level of Engagement	48 out of 166	3.5 average	4.0 average

Findings: Data for this indicator was taken from the week of June 17th to June 23rd. Each of the charts that were reviewed showed that clients were offered a different number of program hours ranging from as little as 6.25 hours to the high mark of 19.0 hours. Of the 24 clients on the unit, 6 charts were reviewed. The total number of programs offered to all 6 clients was 85.0 hours. Of the total 85.0 hours of programming offered to clients, the clients participated in 71.0 hours for an 84% total. The number of hours that clients refused or were excused from programming represented 14.03% of the 85.0 hours offered. Clients were rated on a scale from 1-4, with 1 being distracted/disengaged and 4 being actively engaged in discussion or activity. For this report period, clients averaged a 3.5, which is an increase from the last quarter by .5%

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Problem: The referral system continues to be a problem; however there was a suggestion to simplify the form and starting with the new session in July, this form will be used. Additionally, meetings have occurred with all Department Directors and perhaps monitoring the use of these forms and procedure will be tracked for the next quarter. In review of the client's charts, not all prescribed treatment is specifically reflected in their care plans.

Status: All notes reviewed for this quarter had the level of engagement section completed by the group leader. The revised referral forms have been given to all Discipline Directors and a system will be set up to monitor compliance with this expectation. Finding documentation of all programs offered this quarter was difficult as there is no centralized location to look for this information and perhaps it is not all being recorded.

Actions:

- The Director of Rehabilitation Services will monitor the clients who are prescribed treatment and do not have referrals.
- All care plans will be reviewed and reflect a minimum of 3 prescribed treatment hours per client per day.
- The Director of Rehabilitation Services will establish a procedure for collecting all hours of client attendance to programs in one central location.

PSYCHOLOGY

ASPECT: CO-OCCURING DISORDERS INTEGRATION

4th Quarter 2007 March 06, April, May 2007 Co-Occurring Disorders Integration			
Indicators	Findings	Compliance	Threshold
1. There is evidence of an integrated co-occurring assessment. 2. There is evidence of an assessment of "stage of change." 3. There is evidence of an integrated co-occurring Comprehensive Service Plan for identified clients.	57/57 31/57 32/40	100% 54% 80%	100% 100% 85% To be Reported Quarterly
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.	COMPASS completed on four treatment units	No report this quarter	Four units participating 10% Increase To be Reported Annually 1st 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."	10/10	100%	85%
6. Consumer Satisfaction Survey indicates that since beginning treatment with us, their condition is better.	11/15	73%	95%
7. Consumer Satisfaction Survey reports client satisfaction with current treatment experience is better than with any other previous treatment experiences.	7/15	46%	85%

Findings:

For indicators #1-3 57 charts were audited indicating 40 clients positive for co-occurring disorders.

1. Evidence of an integrated assessment met goal of 100% for the first time. This is most likely due to changes in admissions form and education of admitting physicians.
2. Threshold not met. Stage of change assessment evidenced a gradual increase from 0% last quarter to 100% for month of May. Improvement is most likely due to implementation of new psychosocial assessment form in April.
3. Indicator below threshold. Integrated Service Plan for identified clients again improved from 50% last quarter. As assessments improve ISP's are expected to evidence increased integration next quarter.
4. No data to report this quarter.

For indicators #5-7. A total of 15 surveys were administered. Of those 10 were co-occurring identified clients.

5. Goal met. Threshold exceeded this quarter.
6. Below threshold. Consumer satisfaction with treatment outcome is slightly down this quarter. No speculation as to why this happened.
7. Indicator below threshold. However there was a significant positive increased from 22% last quarter to 73%. Data collected this quarter is combined co-occurring clients and mental health only clients. Despite this change in data pool there is still a positive trend.
8. Goal met. This is Approx. 12% above national mean.

Problems:

1. No problem threshold attained
2. New psychosocial assessment has not been fully implemented.
3. The ISP does not accurately reflect co-occurring issues assessed.
4. NA
5. Threshold exceeded- no problem
6. Consumer satisfaction with outcome is slightly down this quarter. No speculation as to why this happened.
7. The trend is positive but indicator remains significantly below threshold.
8. No problem

Status:

1. Threshold attained. Continue to monitor for sustained results.
2. New psychosocial assessments are now being used consistently. Expect threshold to be attained next month.
3. Positive trend continues. Changes to ISP are still in progress. Continue to monitor.
4. COMPASS assessment conducted with ACT team to be added to data set.
5. 15 Surveys completed this quarter. Satisfaction with treatment outcome exceeded expectations. Continue to monitor to establish trend.
6. Indicator below threshold. Continue to monitor to establish trend.
7. Continue to monitor for positive trend.
8. Problems with data collection & input were addressed. Appropriate diagnosis codes in place. Education with admitting personal continued.

Actions:
1-3 A minimum of 25 charts will be audited each quarter. Continue to work on staff education re: co-occurring plans in ISP.
4. Capital Community Clinic to complete COMPASS assessments within the next quarter.
5-7. Work with Co-occurring Specialist to meet goal of 25 satisfaction surveys each quarter. Monitor trends. Continue education with Riverview "co-occurring coaches" and with unit staff regarding addressing needs of co-occurring clients. Consumer added to coaches group. Develop rapid cycle change process for "welcoming" attitudes by staff as evidenced in the treatment plan review meetings.
8. Monitor for continued positive trend and goal attainment.

SAFETY
ASPECT: LIFE SAFETY
OVERALL COMPLIANCE: 96%

Indicators	Findings	Compliance	Threshold Percentile
1. Total number of staff assigned to Upper Saco and Upper Kennebec who have received training with the evacuation chair.	61/61	100%	100%

2. Total number of staff assigned to Lower Saco and Lower Kennebec who have received training with the evacuation chair.	35/89	39%	100%
3. Total number of fire drills and actual alarms conducted at RPC during the quarter compared to the total number of alarm activations required per Life Safety Code, that being (1) drill per shift, per quarter.	5/3	100%	100%
4. Total number of staff that knows what R.A.C.E. stands for.	16/16	100%	100%
5. Total number of staff that knows if there was there a one-on-one or situation requiring one-on-one, i.e. client would not leave room that they should stay with them.	16/16	100%	100%
6. Total number of staff that knows how to activate the nearest fire alarm pull station.	16/16	100%	100%
7. Total number of staff that knows how to acknowledge the fire alarm or trouble alarm on the enunciator panel.	16/16	100%	100%
8. Total number of staff that knows the emergency number.	14/16	87%	100%
9. Total number of staff that knows what the verbal code is used to announce a fire.	16/16	100%	100%
10. Total number of staff that knows it is necessary to close all doors after checking rooms or areas.	16/16	100%	100%
11. The total number of staff that knows what the acronym, P.A.S.S. stands for.	16/16	100%	100%
12. The total number of staff that knows the locations of the two nearest exits to evacuate away from a fire area	6/6	100%	100%
13. The total number of staff that knows two ways that may be used to move a person who is non-ambulatory to safety.	16/16	100%	100%

Findings:

1. Upper Saco and Upper Kennebec have 100% of staff trained in use of the evacuation chair.
2. Lower Saco has 24 out of 46 who have received the training, 52%. Lower Kennebec has 11 out of 43 who have received the training or 39%.
3. There were 5 fire alarms reported for the hospital of which 2 drills were activated by the Safety Officer.

Problems:

1. A decision has been made to train all staff in the use of the evacuation chair. This quarter has started

that training. Although we are only at 39% compliance, we are still adequately staffed to assure that there will always be available staff to move a client utilizing an evacuation chair.

8. (14) of (16) staff knew the emergency number. One staff member said that you dial 9-1-1, and the other person was not sure what number to dial. The correct answer is 4-3999.

Status:

3-12. These are new indicators, and are monitored through the fire drills and the HAP surveys. Further results of this monitoring will be reflected in the next quarterly report.
Upper unit staff is trained on using the evacuation chair. Lower Unit Staff is at 39%.

Action: Staff on Lower Units will be trained in the use of the evacuation chair by the end of July.

SAFETY
Aspect: Fire Drills Remote Sites
Compliance: 83 %

Indicators	Findings	Compliance	Threshold Percentile
1. Total number of fire drills and actual alarms conducted at Homestead compared to the total number of alarm activations required per Life Safety Code, that being (1) drill per shift, per quarter.	4/3	100%	100%
2. Total number of fire drills and actual alarms conducted at Portland Clinic compared to the total number of alarm activations required per Life Safety Code (1) drill.	2 drills	100%	100%

Findings:

Homestead had 4 alarms.

- 3 alarms were unannounced drills
- 1 alarm was due to dust in an attic detector

Further note: Homestead has always been reported by calendar quarters; therefore, these numbers reflect January, February, and March. The reason being that these drills did not fall into the rotation of the new reporting schedule is the fact that as of April 2nd, the Homestead operation was turned over to a new agency. Continuing the drill history, the Homestead, still under the administrative control of Riverview up to April 2nd, was, and ended its status as being in compliance.

Portland Clinic had the required amount of fire drills. This clinic only operates during the day.

Problems:

During one drill at the Portland Clinic, the Safety Officer felt that staff was not quite aggressive enough during the sweep of clearing the area. Although the end result was satisfactory, it was felt that the actual sweep could be more efficient. This was discussed during the critique and placed as a review point during the 2nd one. It was during the 2nd drill that staff performed the sweep much better.

Status:

As of April 2nd, the Homestead is no longer under the administrative control of Riverview and will no longer be reported by the Safety Officer.

The Safety Officer will continue to monitor the evacuation sweeps by the Portland Clinic staff.

Securitas/RPC Security manager
Aspect: Safety/security
Overall Compliance: 102%/98% (compliance#/possible#)

Indicators	Findings	Compliance	Threshold Percentile
1. Security search/screening of all clients (Forensic & Civil) being admitted to Riverview for treatment. (total # of admissions screened vs. total # of admissions).	69/69	100%	100%
2. Security Officer "foot patrols" during Open Hospital times. (Total # of "foot patrols" done vs. total # of "foot patrols" to be done.)	1385/1392	99%	100%
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.)	538/504	107%	95%

Findings: The Securitas/RPC Security Team fell just 1% short of meeting the threshold percentile for Open Hospital time foot patrol checks. The threshold for security screening admissions and safety/security checks of the Lower Client units were met.
Problems: The problems not reaching our goal percentage were due to no officers available during times when multiple security tasks needed to be performed. The few times during this quarter we were not able to do foot patrols during open hospital times, was due to client admissions, and officers escorting contractors in the facility.
Status:

Actions:
Admissions continue as a top priority. The Lower Unit checks usually get done in a "mutli-task" fashion, along with visitor escorts. Securitas Director will monitor the foot patrol sheets daily and will work with staff to prioritize when necessary to meet the goal of 100%.

STAFF DEVELOPMENT

ASPECT: New Employee and Mandatory Training

4th Quarter STFDIQSFY07 April, May, June 07 Staff Development			
Indicators	**Findings**	**Compliance**	**Threshold Percentile**
1. New employees will complete new employee orientation within 60 days of hire.	20 of 20 completed orientation	100 %	100 %
2. New employees will complete CPR training within 30 days of hire.	26 of 26 completed CPR training	100 %	100 %
3. New employees will complete NAPPI training within 60 days of hire.	23 of 23 completed Nappi training	100 %	100 %
4. Riverview staff will attend CPR training bi-annually.	287 of 287 are current in CPR certifications	100 %	100 %
5. Riverview staff will attend NAPPI training annually. Goal to be at 100% by end of fiscal year in June.	351 of 351 have completed annual training	100 %	100 %
6. River staff will attend Annual Training. Goal is to be at 100% in June.	363 of 364 have completed annual training	99 %	100 %

Findings: The indicators are based on the requirements for all new/current staff to complete mandatory training and maintain current certifications. 20 out of 20 (100%) new employees completed these trainings. 287 of 287 (100%) employees are current with CPR certification. 351 of 351 (99%) employees are current in Nappi training. 363 of 364 (99%) employees are current in Annual training. 1 contract employee did not attend the required mandatory training as scheduled. All indicators remained at 100 % compliance for quarter 4-FY 2006.

Problem: Indicator 6 is identified as a problem as it is below established threshold. 1 contract employee did not attend the required mandatory training as scheduled.

Status: This is the fourth quarter of report for these indicators. CPR remains stable at 100% compliance. Annual training is at 99% for the year after 3 scheduled Training Fairs. 1 employee did not attend his scheduled time as Supervisor scheduled him for training during the Training Fair. Supervisor was notified and the staff is scheduled for the fall fair. Continue to monitor.

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

STAFF DEVELOPMENT
ASPECT: COMMUNITY PROVIDER TRAINING

Topic	Type	Date(s)	Level of Participation	Information Packets/Publications
BEST PRACTICES				
Sleep and ADHD	Psychiatric Grand Rounds	4/10/07 RPC	7 Participants	Hard copy available
Update on ECT: 2007	Psychiatric Grand Rounds	4/17/07 RPC	3 Participants	Hard copy available
Preventing Depression in Age-Related Macular Degeneration	Psychiatric Grand Rounds	4/24/07 RPC	7 Participants	Hard copy available
Functional Dyspepsia - An Evidence Based Approach	Medical Grand Rounds	4/6 RPC	5 Participants	Hard copy available
Concepts for the Pathogenesis of Idiopathic Pulmonary Fibrosis: The Role of Vascular Remodeling and Circulating Mesenchymal Progenitor	Medical Grand Rounds	4/13/07 RPC	4 Participants	Hard copy available
Communities of Clinical Practice	Medical Grand Rounds	4/20/07 RPC	6 Participants	Hard copy available
The Silent Treatment: Harnessing RNA Interference	Medical Grand Rounds	4/27/07 RPC	5 Participants	Hard copy available
CPR	Initial	4/09/07	20 Participants	Hard copy available
CPR	Initial	4/10/07	12 Participants	Hard copy available
Investigation Training Part1	In-service	4/24/07	28 Participants	Hard Copy Available
Mental Health Specialist Training	In-service	4/17,23&27/07 RPC	62 Participants	Hard copy available

A New Age in Mild TBA	Psychiatric Grand Rounds	5/8/07 RPC	8 Participants	Hard copy available
Cognitive and Biological Dimensions of Chronic Insomnia: Theory and Practice	Psychiatric Grand Rounds	5/15/07 RPC	8 Participants	Hard copy available
Unraveling the Mysteries of Intraocular Tumors	Medical Grand Rounds	5/4/07 RPC	6 Participants	Hard copy available
Intracranial Aneurysms: Current Practices and Future Directions	Medical Grand Rounds	5/11/07 RPC	4 Participants	Hard copy available
Senior Resident Research Presentations	Medical Grand Rounds	5/18/07 RPC	8 Participants	Hard copy available
CPR	Re-Certification	5/11/07 RPC	6 Participants	Hard copy available
CPR	Initial Class	5/17/07 RPC	10 Participants	Hard copy available
CPR	Re-Certification	5/25/07 RPC	17 Participants	Hard copy available
Mental Health Specialist Training	In-service	5/21&30/07 RPC	58 Participants	Hard copy available
Proactive Communications	In-service	5/21/07 RPC	9 Participants	Hard copy available
Investigation Training Part 2	In-Service	5/15/07 RPC	18 Participants	Hard copy available
Adventures in Quality Improvement: Adult Depression Care in the Dartmouth-Hitchcock Resident Psychopharmacology Clinic	Psychiatric Grand Rounds	6/5/07 RPC	6 Participants	Hard copy available Hard copy available
The Neurobiology of Child Abuse: Treatment Implications	Psychiatric Grand Rounds	6/12/07 RPC	10 Participants	Hard copy available
Update on CT Screening for Lung Cancer	Medical Grand Rounds	6/1/07 RPC	3 Participants	Hard copy available

Pathophysiology of Diarrhea	Medical Grand Rounds	6/8/07 RPC	5 Participants	Hard copy available
Acute Lung Injury: Pathogenesis and Treatment	Medical Grand Rounds	6/15/07 RPC	5 Participants	Hard copy available
Clinical Pharmacogenomics in the Treatment of Breast Cancer	Medical Grand Rounds	6/22/07 RPC	4 Participants	Hard copy available
Emergent Themes in Liver Stem Cell Biology: The Niche, Quiescence, Self-renewal, and Plasticity	Medical Grand Rounds	6/29/07 RPC	4 Participants	Hard copy available
CPR	Initial Class	6/12/07 RPC	8 Participants	Hard copy available
CPR	Re-Certification	6/20/07 RPC	14 Participants	Hard copy available
Bi-Polar Disorder	In-Service	6/19/07 RPC	20 Participants	Hard copy available
Mental Health Specialist Training	In-Service	6/4,5,11/07 RPC	69 Participants	Hard copy available

COMMUNITY FORENSIC ACT TEAM

Aspect: Descriptive Report on various components
April, May, June 2007

Case Management

April 31 Clients
May 31 Clients
June 34 Clients

Number of Crisis Calls

April 4 Clients
May 4 Clients
June 4 Clients

Resolution of Crisis calls

	Hospitalized	Home	Law enforcement a
April	3	1	0
May	2	2	1
June	3	1	2

SUBSTANCE ABUSE

Number of clients with substance abuse as a matter of clinical focus

April 8 Clients
May 8 Clients
June 8 Clients

LIVING SITUATION

Number of Clients residing in supervised setting

April 4 Clients
May 4 Clients
June 4 Clients

Number of clients in own apartments

April 4 Clients
May 4 Clients
June 4 Clients

VOCATIONAL / EDUCATIONAL

Number of clients working at community work sites

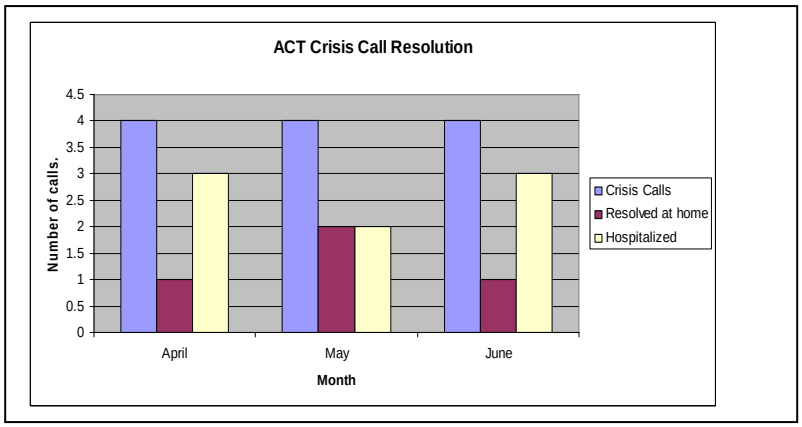
April 11
May 12
June 14

Number of clients working under Ticket to Work

April 3
May 3
June 3

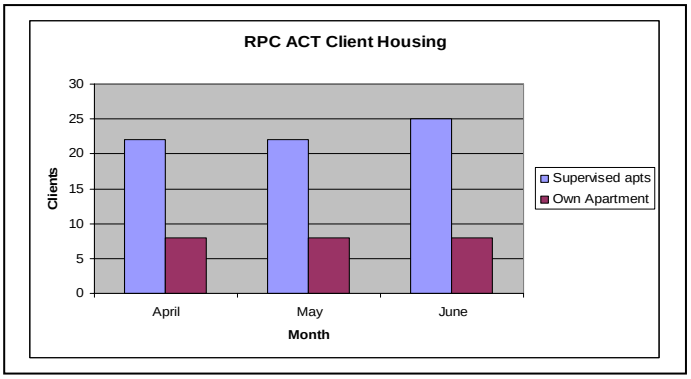
Number of clients volunteering in the community

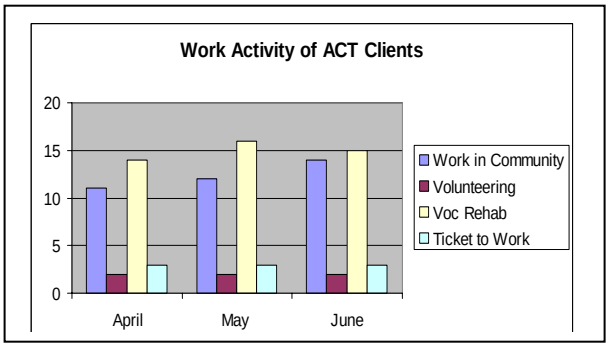
April 2
May 2
June 2



Stages of Change readiness of ACT Population

3 clients Precontemplative Stage of readiness
3 clients Contemplative Stage of readiness
1 client Preparation stage of readiness
1 client Action Stage of Readiness
0 clients At the Maintenance Stage of readiness



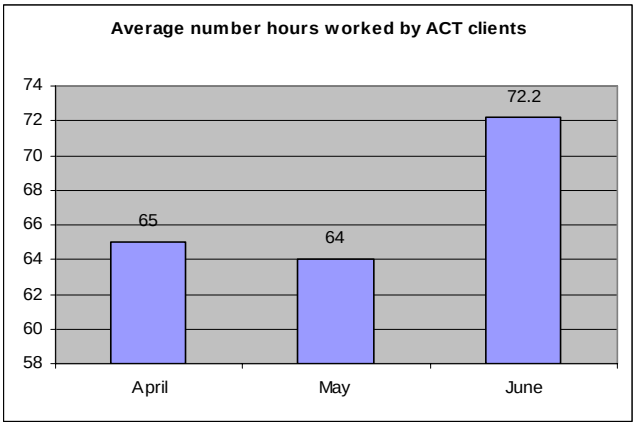


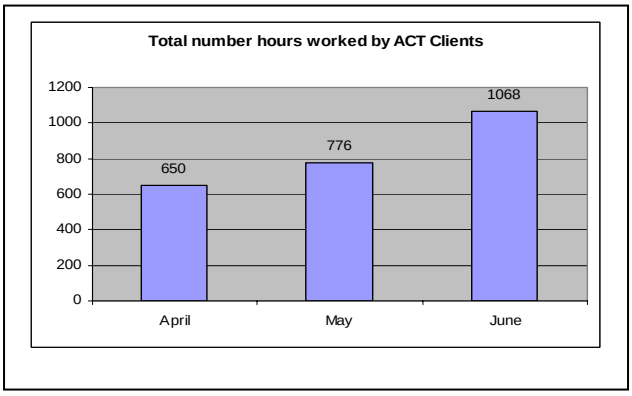
The Number of Clients engaged with Vocational Rehabilitation

April	14
May	16
June	15

Work Hours of ACT Clients

Month	Total	Average
April	650	65
May	776	64
June	1068	72.2

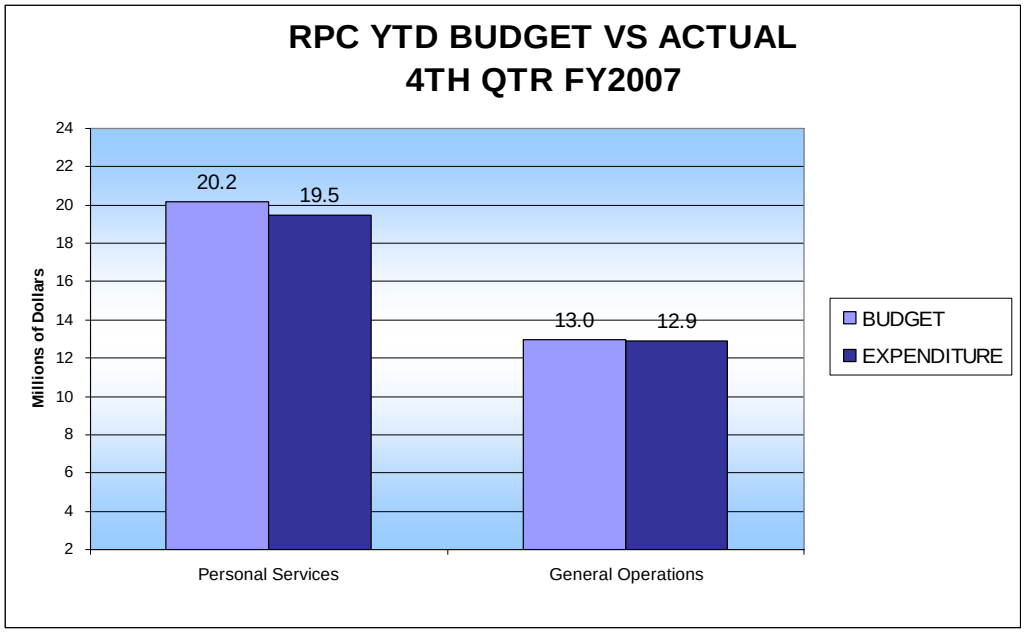




Section II: Riverview Unique Information

BUDGET

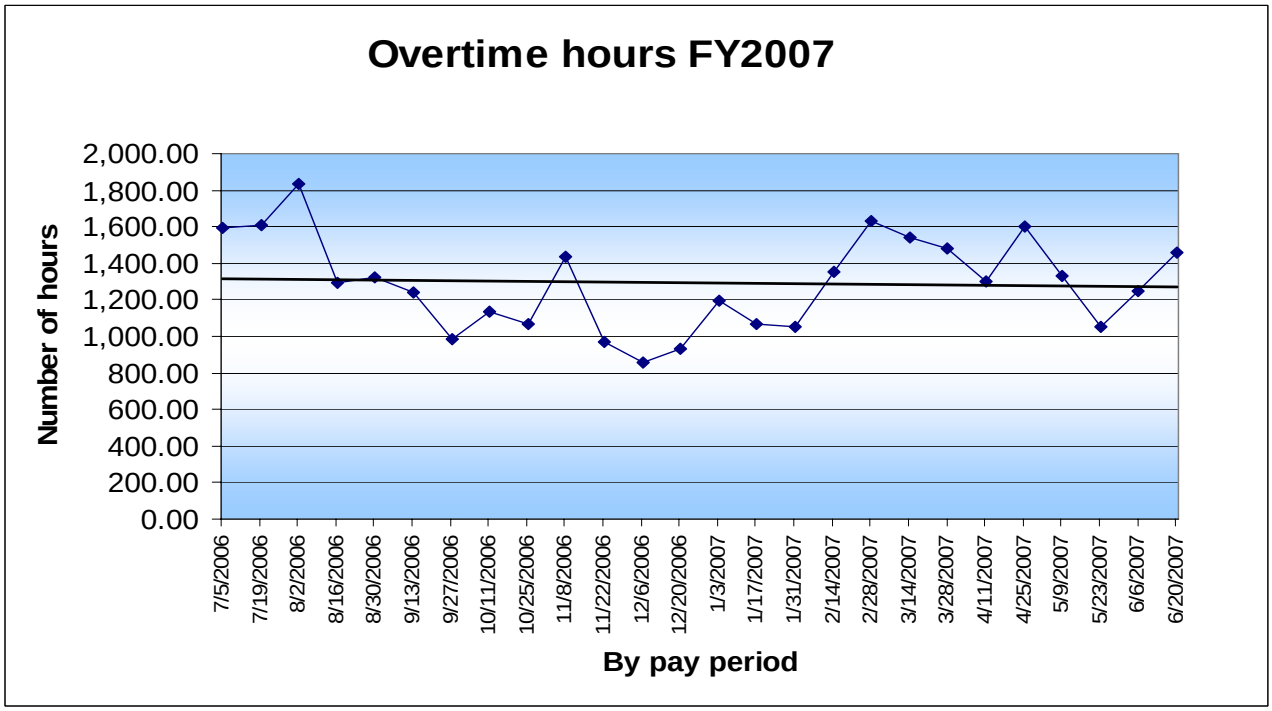
ASPECT: BUDGET INFORMATION



The hospital currently continues to stay within budget. Action plan includes continuing to carefully monitor and manage overtime and mandates. Continue aggressive management of all contractual services via fiscal and programmatic accountability.

HUMAN RESOURCES

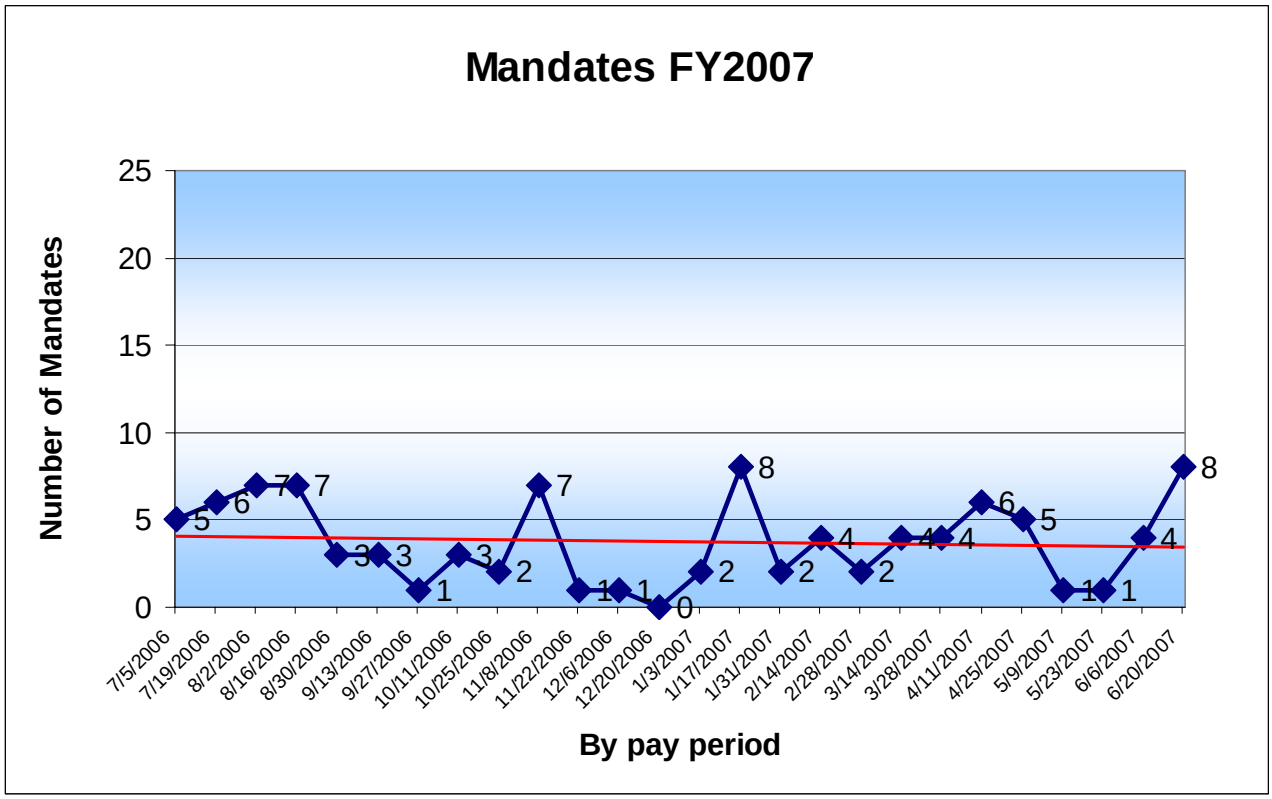
Overtime



Overtime has decreased this fiscal (06-07) year as compared to last year (FY 05-06). This past year we had a total of 33,596.75 hrs of overtime as compared to 33,986 hrs last year.

HUMAN RESOURCES

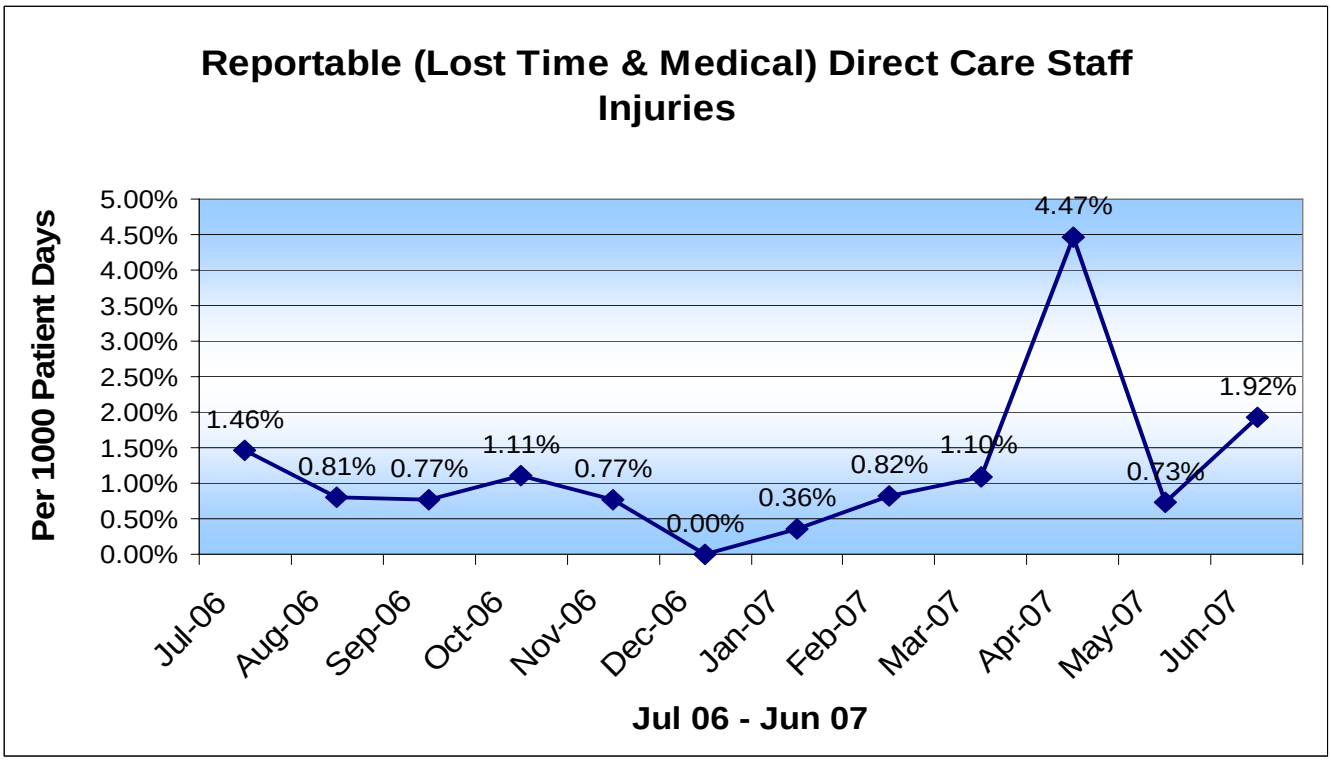
ASPECT: MANDATES



Mandated shifts have significantly decreased this past fiscal year (06-07) as compared to last fiscal year (05-06). Last year we had a total of 146 mandated shifts, this year we had 97. This represents a 44% decrease.

HUMAN RESOUCES/RISK MANAGEMENT

ASPECT: Direct Care Staff Injury resulting in lost time & medical care



This quarter review reveals that there was an increase in direct care staff injuries from .76% per 1000 patient days to 2.37% per 1000 patient days. This number represents (20) direct care staff who sought medical treatment or lost time from work, as compared to (6) last quarter. A closer review of injuries in April revealed five clients committing assaults on staff resulting in seven staff lost time injuries. 3 of the five clients involved smoked at admission (60%). Approximately 65% of clients served smoke cigarettes. Six of the seven staff were smokers reflecting a 86% of those injured. This is roughly a 300% over representation (28% of Riverview staff smoke) of staff who smoke in April (the month of tobacco ban implementation) injuries.

HUMAN RESOUCES

ASPECT: Performance evaluations.

OVERALL COMPLIANCE: 63.73 %

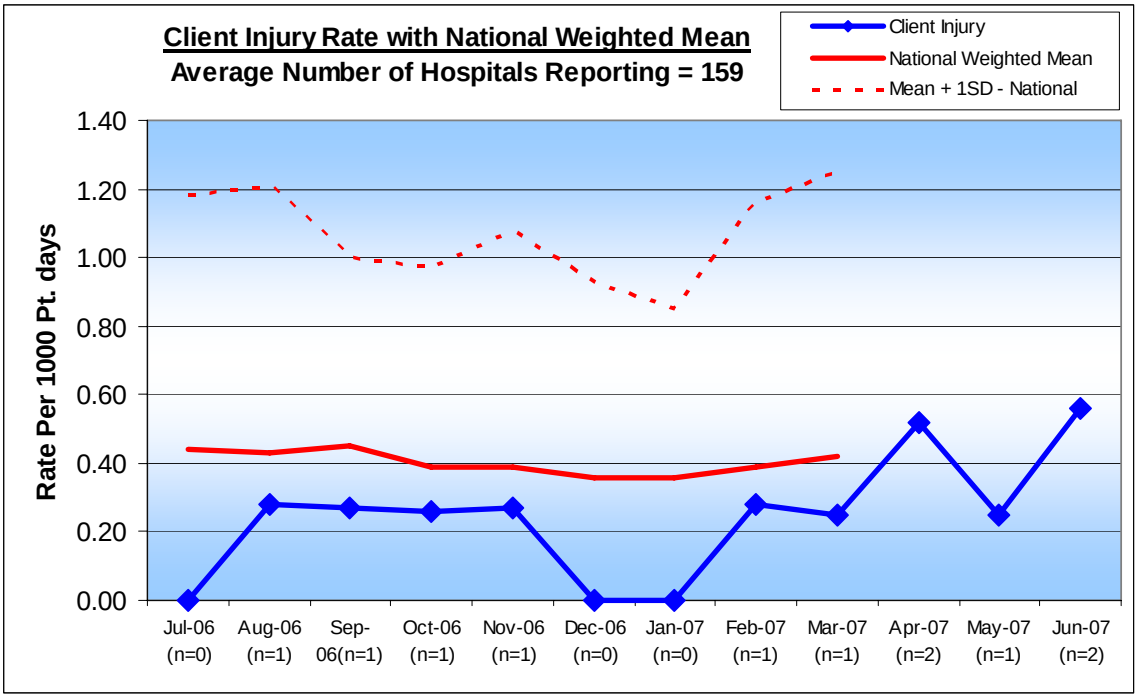
INDICATOR Employee Performance Evaluations expected to be completed within 30 days of the due date.	**FINDINGS**		**TARGET PERCENTILE**
Apr 2007 (Feb evals)	12 of 29	41.38%	85%
May 2007 (Mar evals)	18 of 29	62.07%	85%
June 2007 (Apr evals)	28 of 33	84.84%	85%

As compared to last quarter (71.6%) this quarter's decreased to 63.73%. As compared to the same quarter last year, 2006, we were at 85.7% compliance. During this quarter 91 performance evaluations were sent out; 58 were received in a timely manner. Human Resources continue 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.

Section III: Performance Measurement Trends Compared to National Benchmarks.

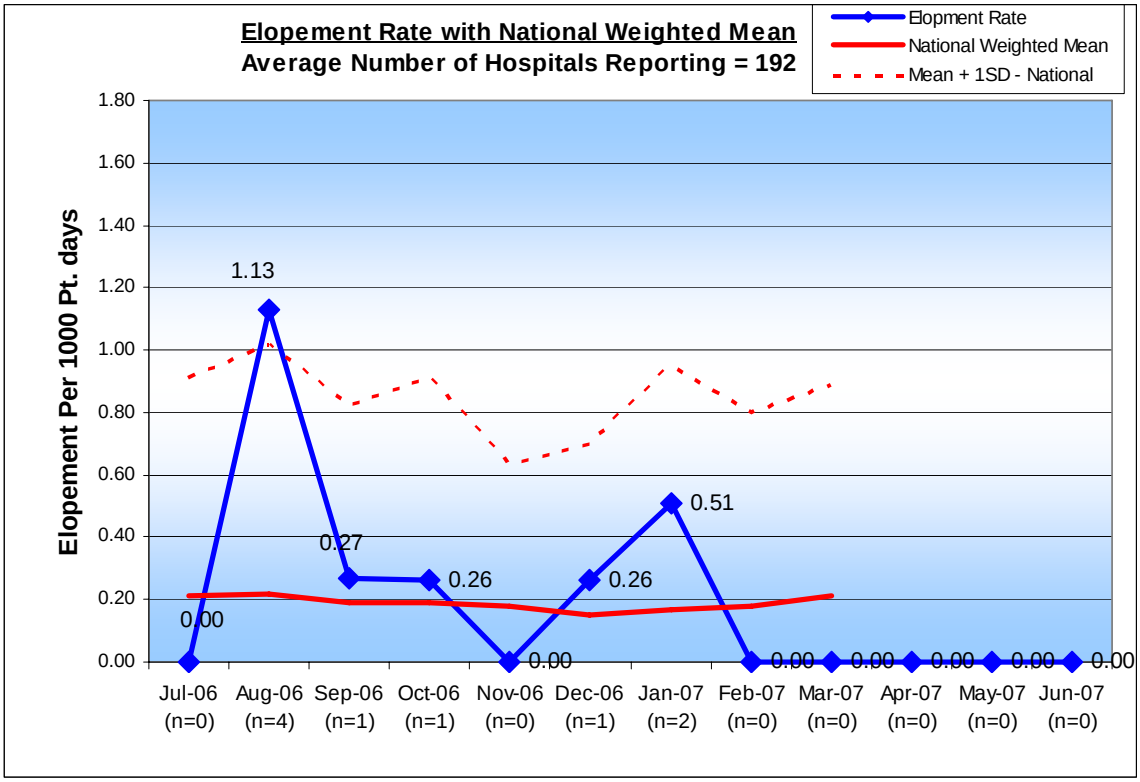
This section contains a number of graphs that compare Riverview Psychiatric Center to a national sample (the range is approximately 75-215 hospital across all aspects) of participating like facilities. Each line graph presents the national weighted mean (solid red line) and the limit of the first standard 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



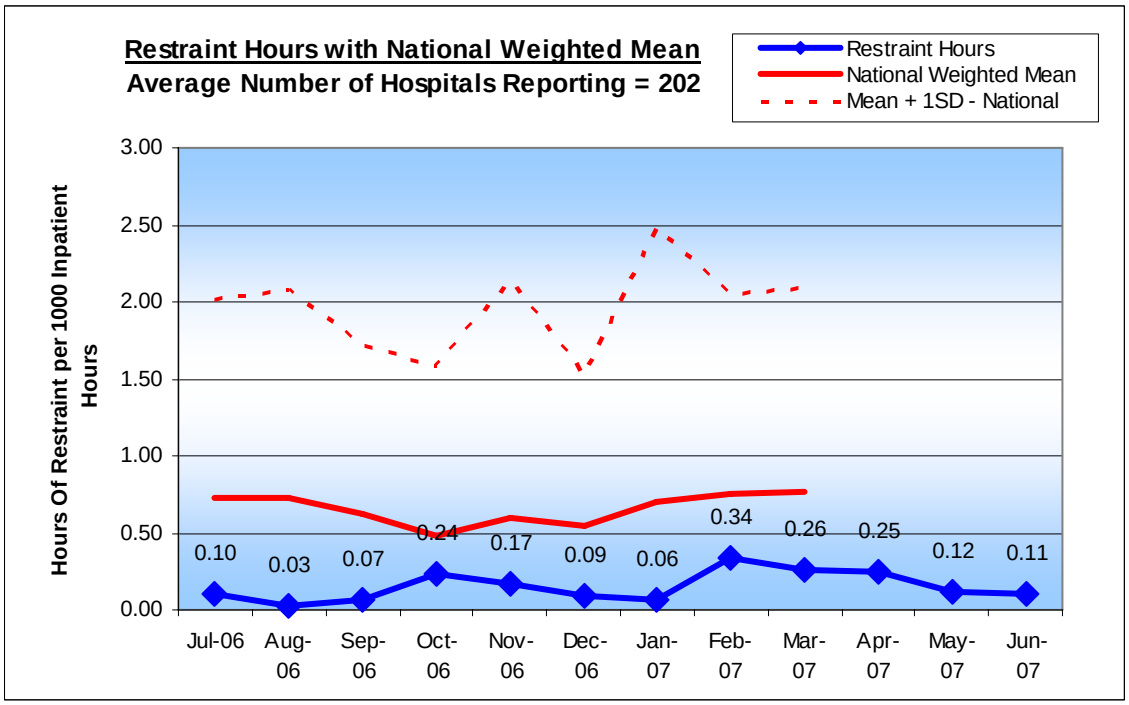
Client Injury Rate considers slips, trips and falls; self-injurious behavior; client-to-client injury, and client injury of unknown origin which requires more than first-aid. The numbers of such incidents are low, as shown by the little n under each month. Riverview's line, although appearing to have dramatic fluctuation, is in part the result of the scale used on the Y-axis. Riverview is well within the 1st standard deviation of the national sample. Please note the sheer number of events at Riverview is very low, between zero and 3 each month. Over the last 3 months, there were four incidents requiring more than first aid level of care.

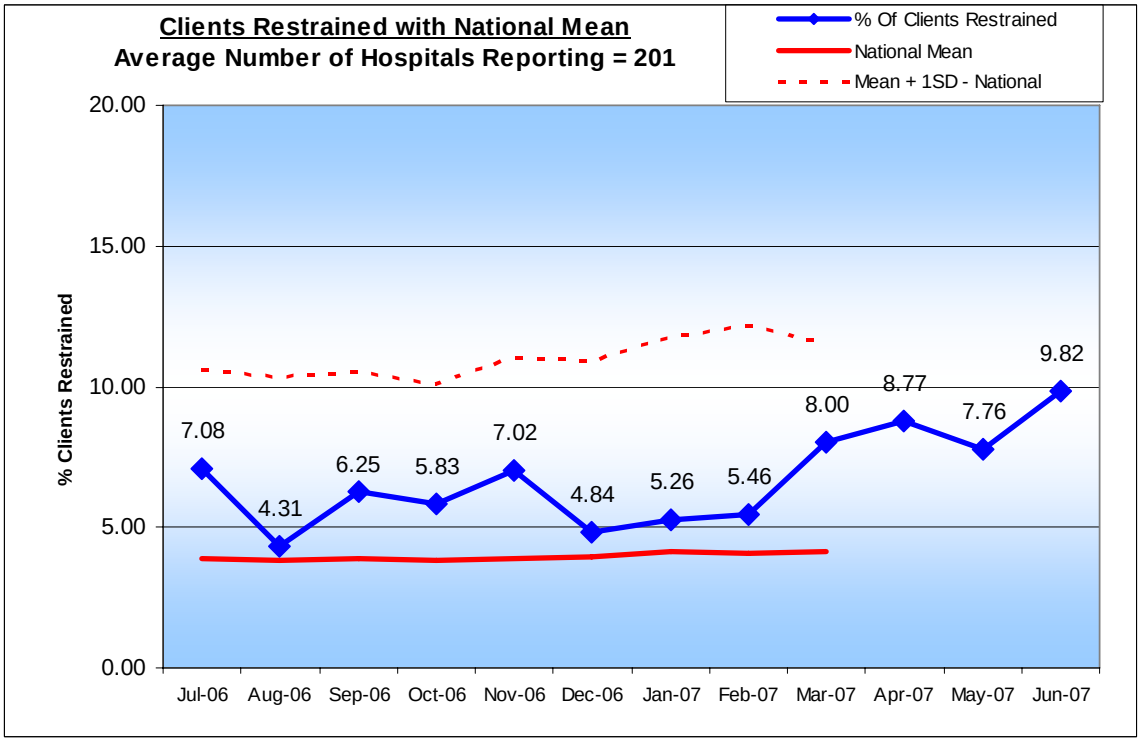
ELOPEMENT RATE GRAPH



Elopement Rate is calculated per 1000 patient days. Elopement risk is evaluated by the Treatment Team on admission and the client has a Treatment Plan developed if indicated as a concern**.** Riverview's numbers are within the 1st standard deviation of the national sample over the quarter. Please note the sheer number of events at Riverview is between 0 to 4 incidents each month over the last year. Over the last 3 months, this graphic portrays a flat line at zero; there have not been any elopements. In March, after much discussion and training with all health care providers over the previous six weeks, the levels policy was implemented as intended, to try to decrease the number of clients who eloped while on free time.

RESTRAINT GRAPHS

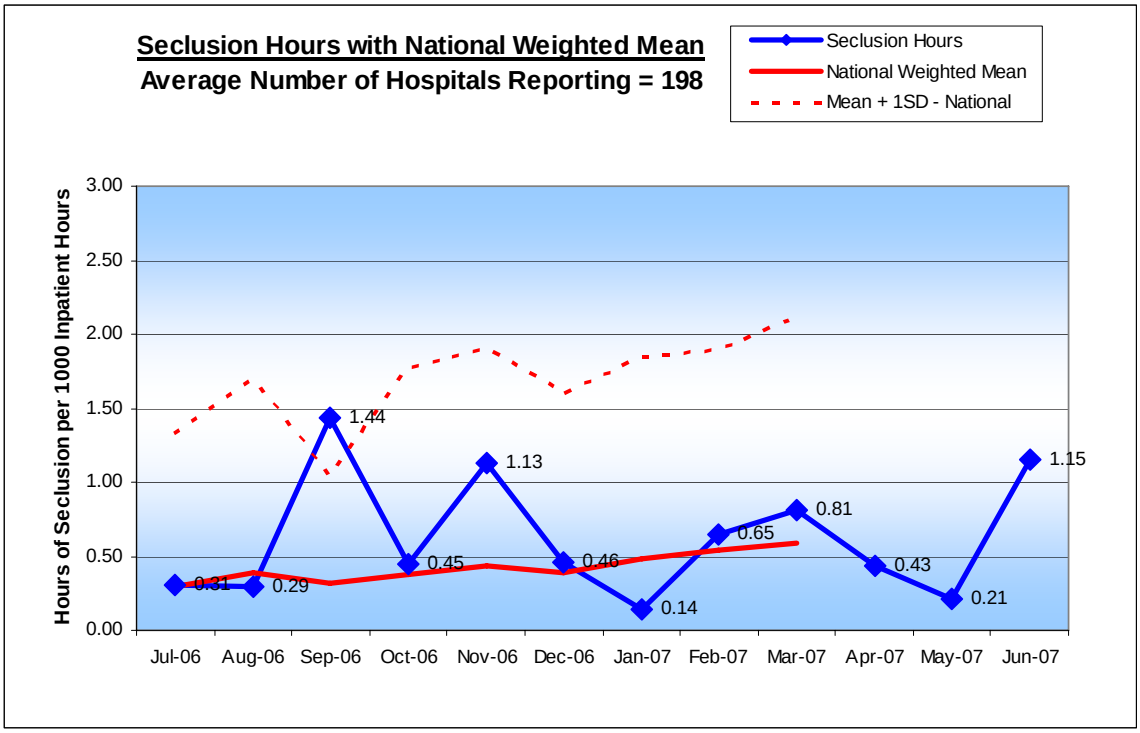


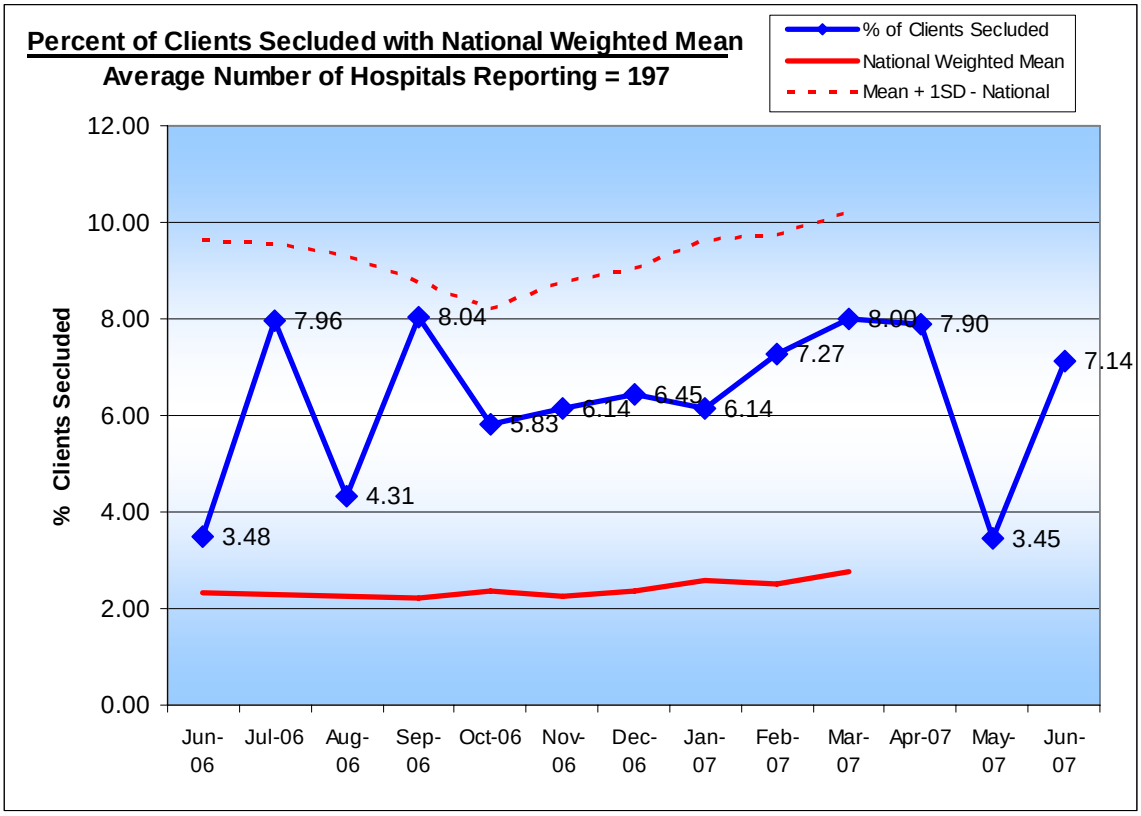


Riverview's rate of clients restrained, although above the statistical mean, is comparable to at least 68% of hospitals in the national sample. The restraint hours (duration) rate is well below the statistical mean, but also comparable to the bulk of hospitals in the national sample. The data would suggest that Riverview's restraint events are short by comparison, and efforts to reduce the frequency of restraint use would have

the most impact. Corrective actions applied are: reducing the time for restraint order renewal from 4 hours to 1 hour; revision of debriefing process; new protocol and form to guide treatment plan revisions within 72 hours following the event is in place; education initiatives; increased clinical, supervisory and administrative oversight; expanding opportunities for client choice is a priority to be monitored and tracked in monthly administrative reports; in the next quarter the executive nurse function will provide leadership into the late evening hours; the Nurse IV will be monitoring the clients every fifteen minutes to assure clients are able to gain their autonomy as soon as assessed ready.

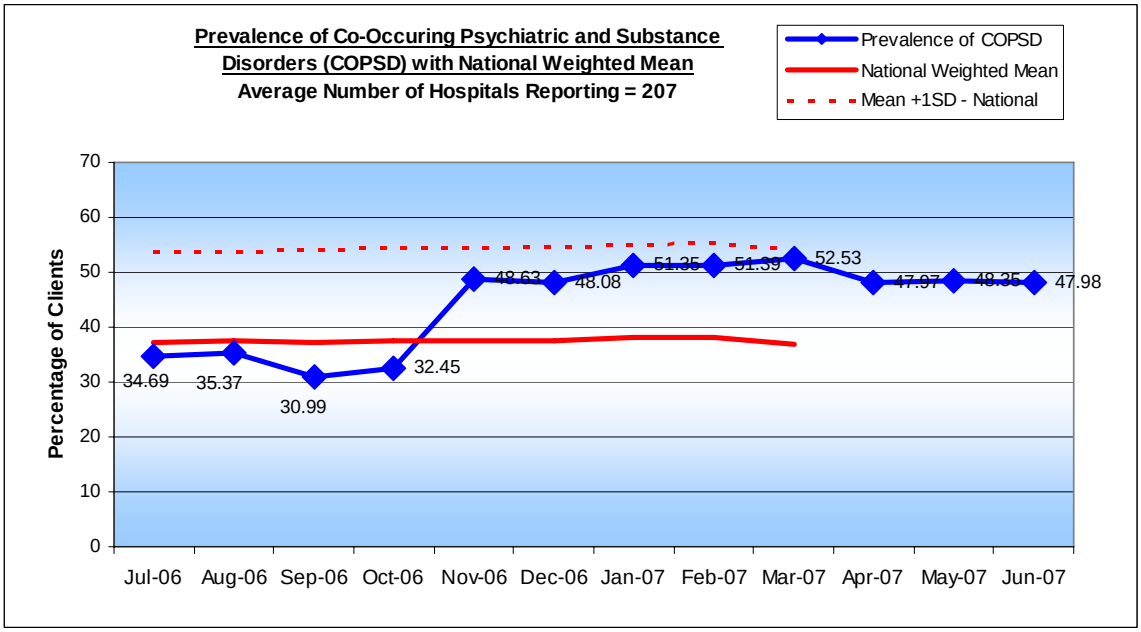
SECLUSION GRAPHS





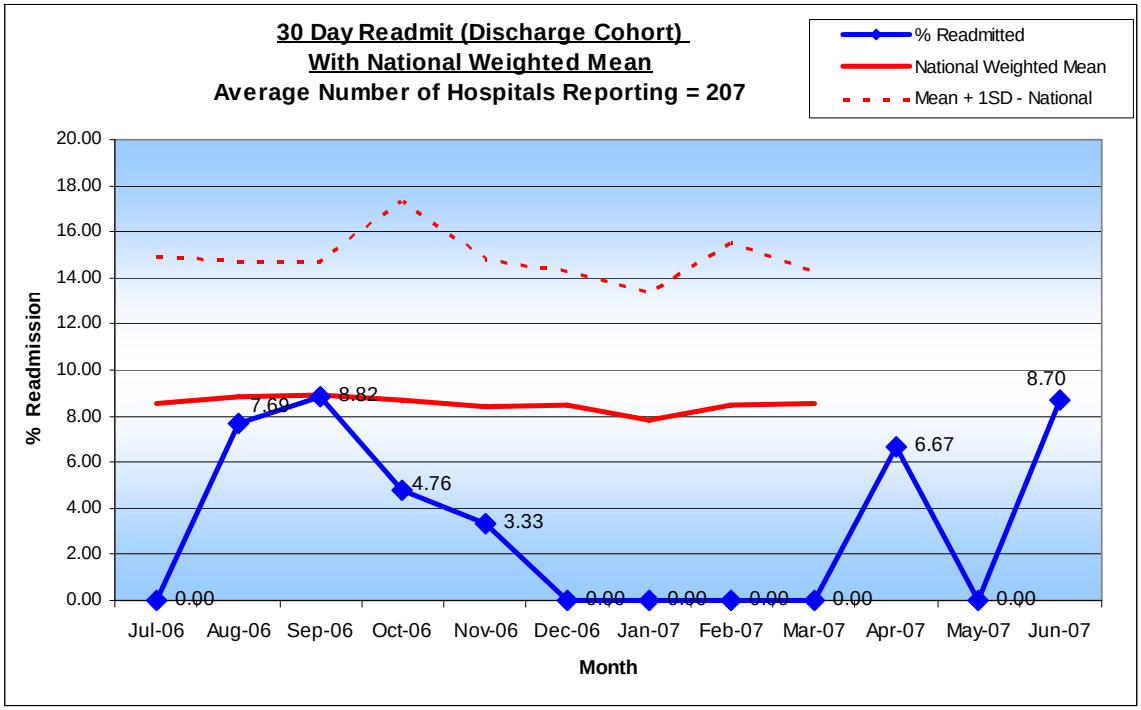
Seclusion hours (duration of events) at Riverview, although tending to be above the national weighted mean, are within the 1st Standard Deviation of other hospitals in the national sample. Riverview's efforts to reduce use of these interventions focus on both the frequency and duration of seclusion events. Corrective actions applied are: reducing the time for seclusion order renewal from 2 hours to one hour; revision of debriefing process; new protocol and form to guide Treatment Plan revisions within 72 hours following the event is in place; expanding opportunities for client choice is a priority to be monitored and tracked in monthly administrative reports; education initiatives; increased clinical, supervisory and administrative oversight. Over the next quarter, the Executive Nurse will be present over an extended day to model, teach and support evening staff in utilizing best practice to try to decrease both the frequency and duration of seclusion. The Nurse IV's will be doing the client assessments every fifteen minutes so as to help model, teach and support all staff in assisting the client to regain their autonomy as soon as possible.

CO-OCCURING PSYCHIATRIC AND SUBSTANCE ABUSE DISORDERS GRAPH



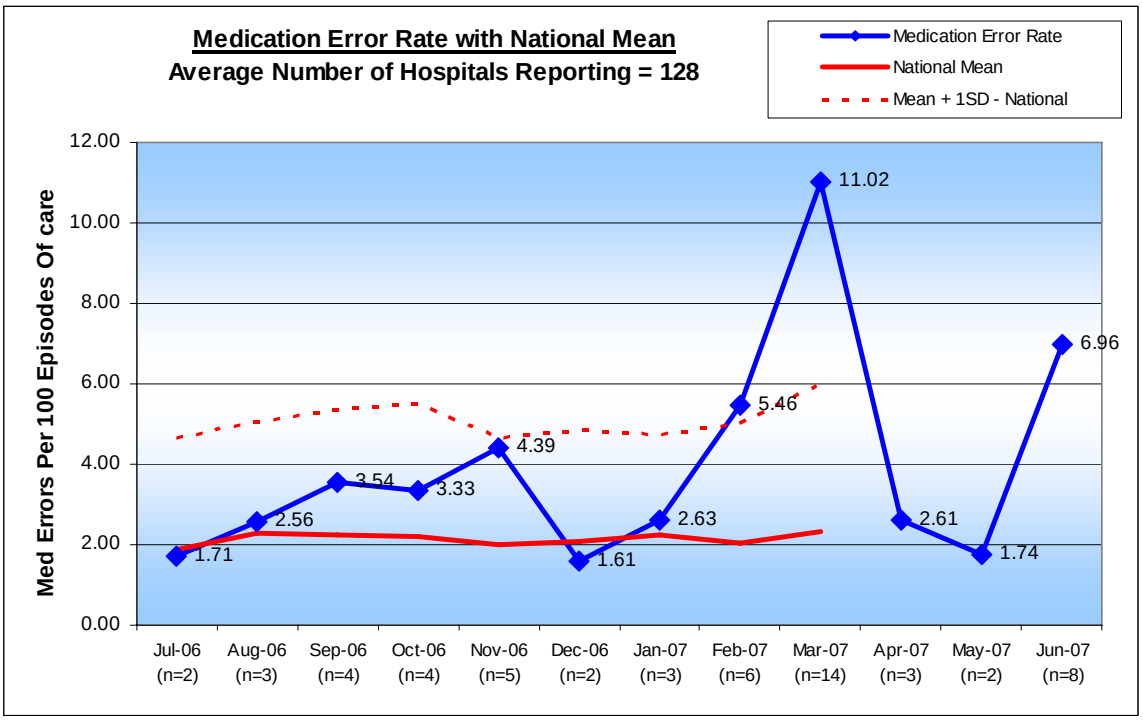
RPC has recently begun a collaborative effort with Spring Harbor Hospital Co-Occurring Disorders providers to contract with RPC to develop a Co-Occurring program. RPC is above the trend line, this is an indicator current initiatives are working as anticipated; with the advent of this program to help 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 209 other facilities reporting on this indicator. 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. In April, one client was readmitted to Forensics from jail. In June, one client was re-admitted from jail for another stage III evaluation; and one client was readmitted from the RPC Forensic ACT team under the PTP (Progressive Treatment Program) for non-compliance with medication.

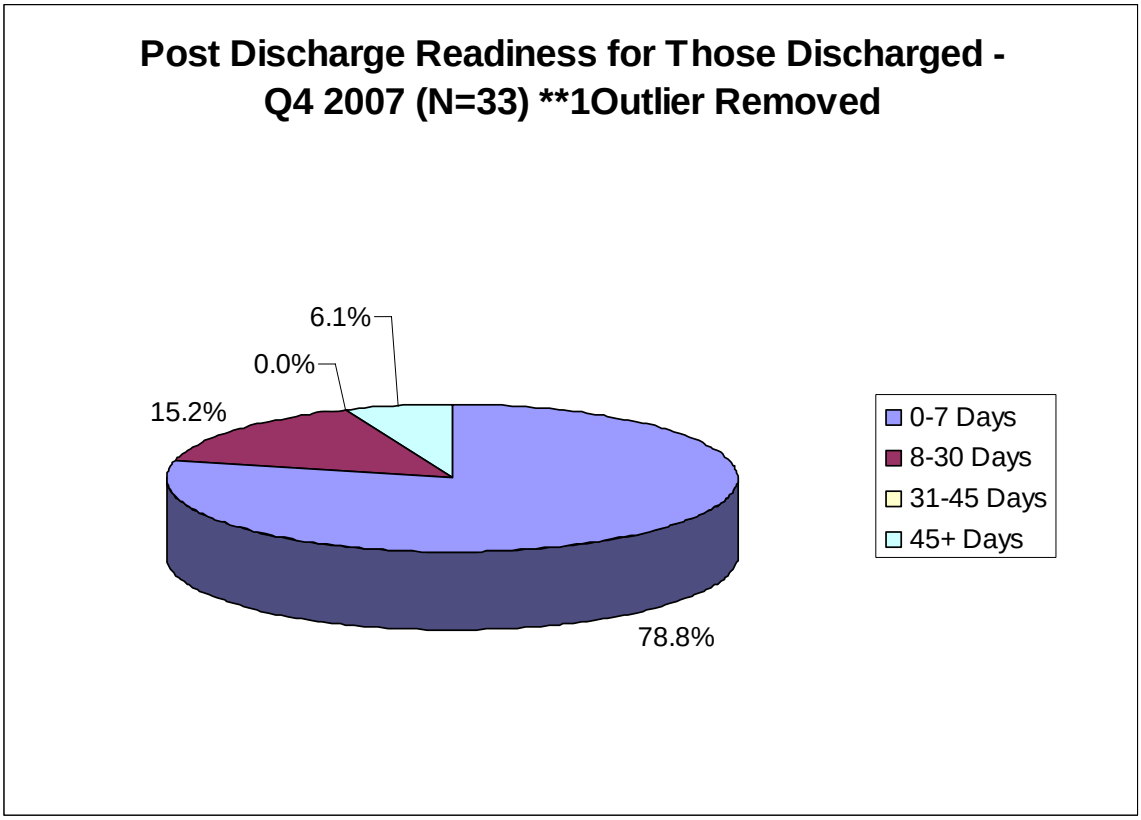
MEDICATION ERROR RATE WITH NATIONAL MEAN GRAPH



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.

The medication surveillance has been modified several times starting in late February, and has not stabilized as of this time. The medication variances reported are self-reported variances, above the national mean would indicate that staff is diligent about reporting variances. This is honorable, and reflects the care staff provides when administering medications.

POST DISCHARGE READINESS



This chart shows the percent of clients who were discharged within 7 days of their discharge readiness to be at 78.8% 8- 30 days post readiness 15.2%; Greater than 45 days post discharge ready 6.1% of clients discharged this quarter. Cumulative percentages and targets are as follows:

- Within 7 days = 78.8% (target 75%)
- Within 30 days = 78.8% (target 90%)
- Within 45 days = 94% (target 100%)

There was one outlier at 413 days. The outlier was from upper Kennebec. Lack of community resources did not play a part in why he was still with us. He had refused to consider anything and had a fixed delusion that he owned property in Canada and his family was coming to pick him up. All of which was investigated and found to be untrue. In June after persistent engagement with him for many months he was finally discharged.

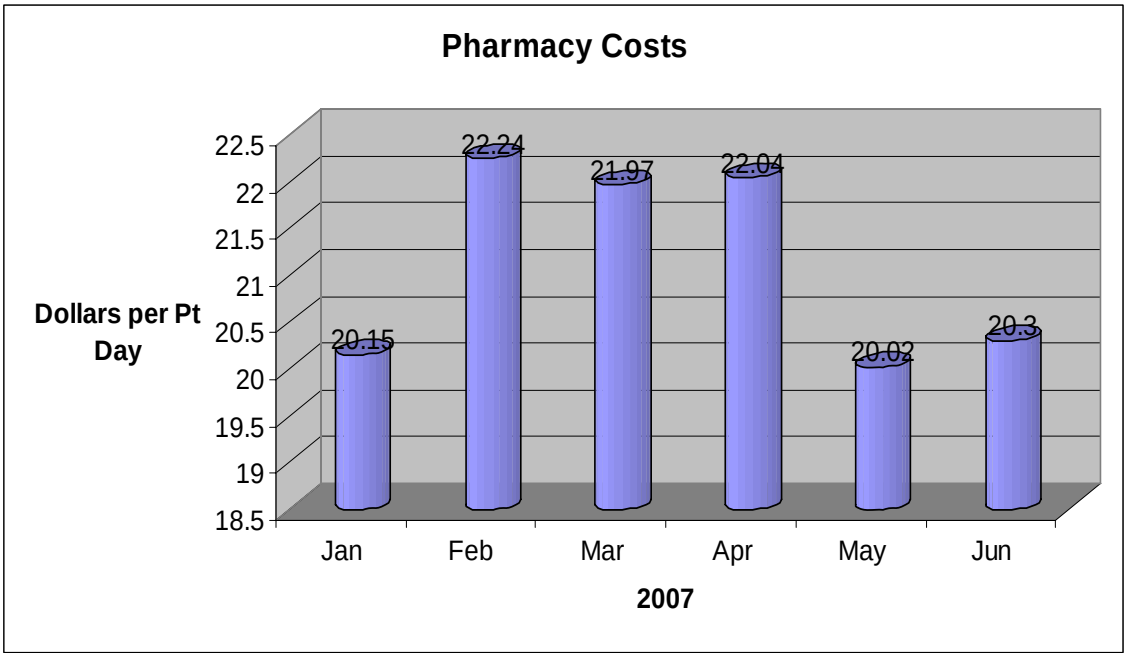
Section IV: Process Improvement Team Reports

1. The Client/Family Education PIT convened on 5/09/07. The team developed a charter with the goal of improving both client and family education and the documentation of such. We are currently exploring ways to streamline the process and are considering new forms and attaching it to the treatment plan review.
2. The PIT formed to increase the documentation of effect of prn pain medication after administration. The PIT had the following recommendations: The nurse who administers the client a PRN for pain medication is responsible for completing the PRN Medication Administration sticker (top and bottom). If the nurse cannot complete the bottom half, they need to communicate this to the oncoming nurse to assure completion of the documentation. These recommendations also apply to the pain scale tracking sheet which is kept in the med room. The DON further increased the likelihood of this occurring by making the recommendation that the client's primary nurse be responsible for prn administration and documentation.
3. A Fall Prevention PIT was formed to assure direct care staff is appropriately educated in their responsibilities during initial nursing assessment, and after a client fall. A new fall follow-up was designed; staff training has been designed and will occur by the 15th of August. The new fall follow-up form will begin being used at that time, it will be completed by the RN IV's by the end of shift, and necessary update of the client care plan will occur at that time as well. The fall variance form will cease, and falls will be captured on the hospital incident reporting form.

Special Quality Assessment Activity

Effects on Hospital Performance Indicators related to Tobacco Ban Condition. As a special Quality Assessment activity the hospital took a review of the performance indicators related to implementation of the smoking ban. No significant effect can be traced to the implementation f the smoking ban with the following possible exceptions.

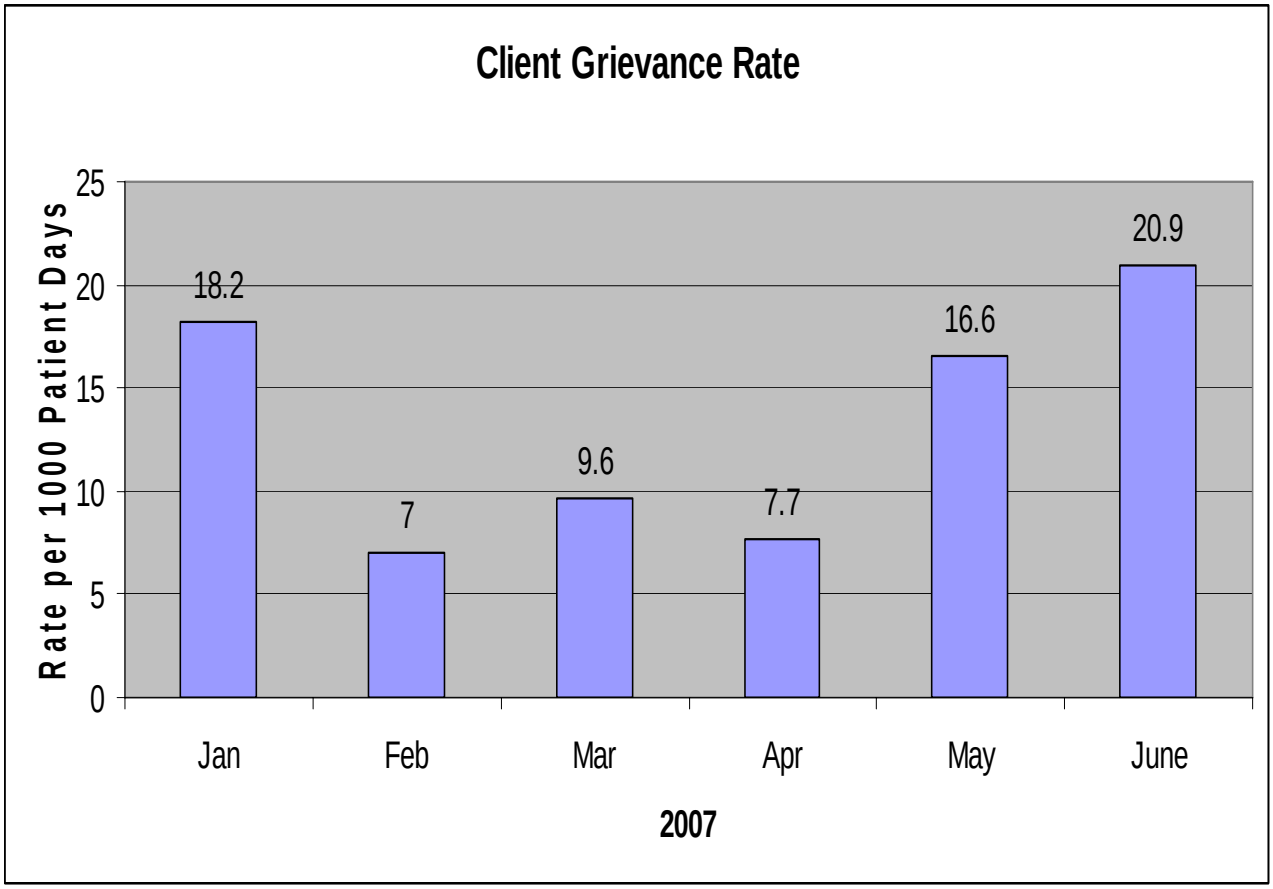
1. Pharmacy costs grow over three month period apparently related to PRN utilization.
   a. NRT accounts for March and April $.29 and $.38 per patient day respectively.
   b. PRN variances match expense curve.
   c. Chantix $90 per 30 days per prescription.



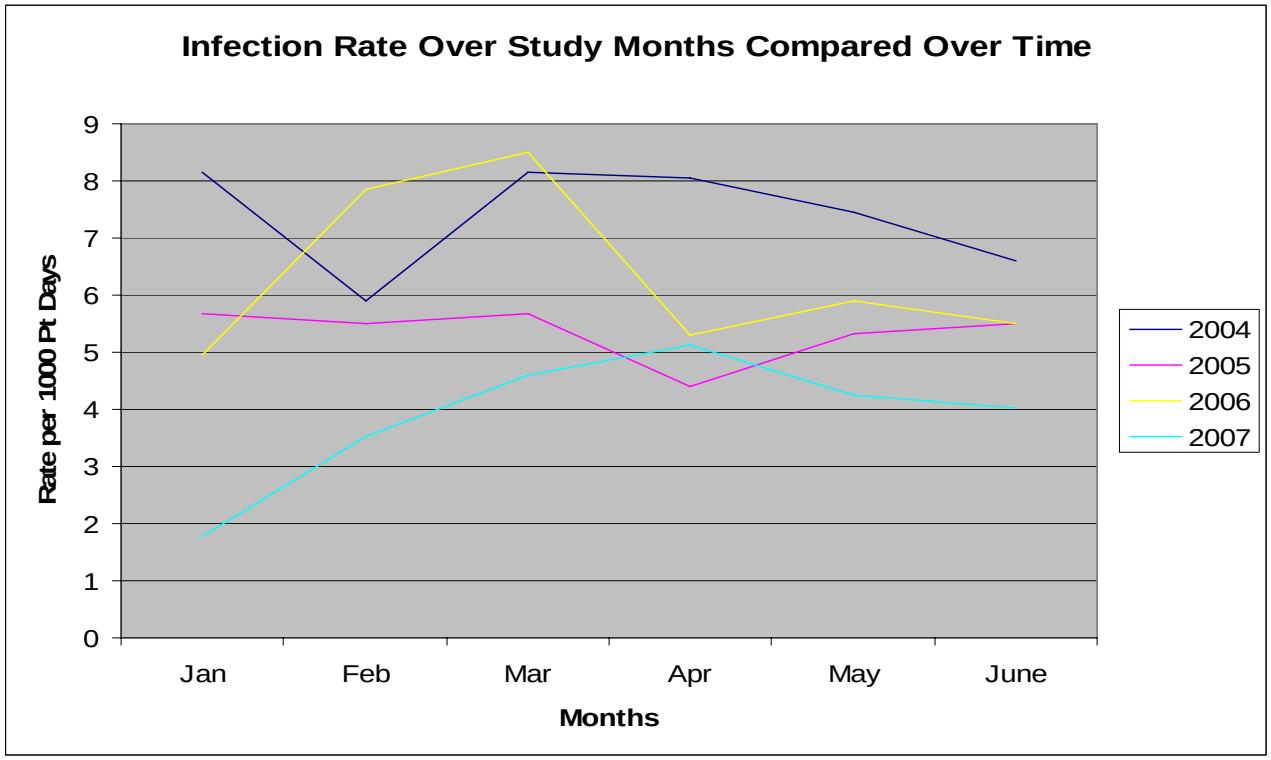
2. Staff who smoke increase risk for lost time injury during the implementation month.

3. Client elopement rate reduced as level policy revised reflecting a change in practice of allowing clients to smoke in front of building.

4. Client grievance rate increased although the increase is largely a result of a specific forensic client (large number of grievances of this client are NOT related to smoking issues).
   a. A Select client filed 16 of 47 grievances for the month of May and 20 of 57 for the month of June.
   b. Eliminating these from the sample would yield a grievance rate for May of 10.99 and June of 13.55.



5. Hospital Infection rate reductions may be linked to reduced smoking.



Conclusion of the assessment of the impact of tobacco ban policy on performance measures of the hospital indicate that the ban has no significant impact on clinical outcomes. Fiscal impacts are relatively short lived and appear to adjust to pre –ban conditions. Little can be taken from this study to legitimately justify a public policy exception to tobacco regulation.