

Riverview

PSYCHIATRIC CENTER



PERFORMANCE IMPROVEMENT REPORT

FOURTH QUARTER FISCAL YEAR 2010
Apr, May, Jun 2010

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July 16, 2009



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INTRODUCTION

Close monitoring of the use of Seclusion and Restraint continues to ensure that actions of a coercive nature are used only when required and as a means to preserve the safety of the clients, staffs, and milieu. In an ongoing effort to fine tune efforts to effectively measure the use of all forms of restraint, the restraint measure has been changed to reflect all incidence of restraint, including manual holds of any duration. A higher overall number of restraint incidents are reflected in this change. However, the duration of restraint incidents has had a corresponding decrease indicating that the vast majority of restraint incidents are of a short duration. The total number of manual hold incidents and their duration are depicted in a new graph indicating that the greatest share of the hold events are less than 5 minutes with the largest number of these events being one minute or less. These short holds may be used as a method of redirecting the client or for the initiation of therapeutic methods.

As a result of the relaxation of hiring prohibitions for state hospitals, staff deficiencies are being addressed and the number of overtime and mandated hours for staffs are decreasing.

The completion of performance evaluations for all staffs has also shown significant improvement. The current months results show a 70% compliance rate with on-time completion of performance evaluations as compared with the 49% compliance from the previous quarter.

COMMUNITY FORENSIC ACT TEAM

ASPECT: REDUCTION OF RE-HOSPITALIZATION FOR ACT TEAM CLIENTS

Indicators	Findings	Compliance	Threshold Percentile
1. The ACT Team Director will review all client cases of re-hospitalization from the community for patterns and trends of the contributing factors leading to re-hospitalization each quarter. The following elements are considered during the review: a. Length of stay in community b. Type of residence (ie: group home, apartment, etc) c. Geographic location of residence d. Community support network e. Client demographics (age, gender, financial) f. Behavior pattern/mental status g. Medication adherence h. Level of communication with ACT Team	4/4	100%	100%
2. ACT Team will work closely with inpatient treatment team to create and apply discharge plan incorporating additional supports determined by review noted in #1.	2/2	100%	100%

Summary

- Four total clients were re-hospitalized, all of whom were male. One, who eloped, had been in the community with a supported apartment for one year and appeared to be medication compliant prior to elopement; one lived in a highly structured group home for over one year and had a short (under 1 week) hospitalization; one lived in an independent apartment with supports and appeared to stop taking medications for a brief period but was unable to re-stabilize in an outpatient setting; one experienced what appears to be a cyclic recurrence of psychiatric symptoms with no interruption of medication.
- The ACT Team has become more consistent in attending treatment team meetings while clients are in the hospital, specifically including increased communication between ACT Psychiatrist and inpatient treatment providers, and with re-starting therapy with ACT Psychologist prior to discharge. The ACT Team has not yet convened meetings with providers from each unit, as was recommended from internal audit, but intends to fulfill that goal within the next quarter.

COMMUNITY FORENSIC ACT TEAM

ASPECT: INSTITUTIONAL AND ANNUAL REPORTS

Indicators	Findings	Compliance	Threshold Percentile
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of notification of submitted petition.	5/5	100%	95%
2. The assigned case manager will review the new court order with the client and document the meeting in a progress note or treatment team note.	1/1	100%	100%
3. Annual Reports (due Dec) to the commissioner for all out-patient Riverview ACT NCR clients are submitted annually	n/a this quarter	100%	100%

Summary

- 5 clients petitioned, of those, 1 withdrew petition. All had Institutional reports completed on time.
- ACT Team Leader delivers all new Court Orders to Case Managers upon receipt, who then reviews with both client and supported housing staff involved in compliance with order. This is documented in progress notes and/or reviewed in ISP treatment team.

ASPECT: INDIVIDUAL SERVICE PLANS AND PROGRESS NOTES

Indicators	Findings	Compliance	Threshold Percentile
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly contact with all clients assigned on an active status caseload.	35/39	80%	95%
2. Individual Service Plans will have measurable goals and interventions listing client strengths and areas of need related to community integration and increased court ordered privileges based on risk reduction activities.	39/39	100%	95%
3. Case notes will indicate at minimum monthly contact with all NCR clients who remain under the care of the Commissioner. These clients receive treatment services by community providers and RPC ACT monitors for court order and annual report compliance only.	9/9	100%	95%

Summary

- Team now offers 4 groups, (one added since last quarterly report) creating increased capacity for face-to-face contacts and supporting documentation. Follow up with ACT Team by Quality Assurance Director and with individual case managers was done in supervision to address this area and issue with compliance.
- ISPs also contain group attendance goals, especially with clients who are petitioning for increased court ordered privileges. An extensive chart review was conducted to ensure all clients who attended groups were identified as either having or needing specific group attendance goals. Case managers were made aware of need for consistency in group attendance and ISP goals.

COMMUNITY FORENSIC ACT TEAM

ASPECT: SUBSTANCE ABUSE AND ADDICTIVE BEHAVIOR HISTORY

Indicators	Findings	Compliance	Threshold Percentile
1. Age of onset documented in Comprehensive Assessment	34/34	100%	95%
2. Duration of behavior documented in C.A. and progress notes	34/34	100%	95%
3. Pattern of behavior documented in C.A. and progress notes	34/34	100%	95%

Summary

In addition to implementing substance abuse timeline, the Co-Occurring Specialist has facilitated COMPASS assessment of program, taking an active role in implementing recommendations. Initially, the use of a Breathalyzer in particular was recommended to demonstrate abstinence and/or rule out alcohol use. Upon further exploration, observed urinalyses testing for alcohol within an 80hr window was recommended. The ACT PSD is consulting with Maine PreTrial and Mercy Recovery Center to determine cost and insurance coverage issues..

ASPECT: PEER SUPPORT

Indicators	Findings	Compliance	Threshold Percentile
1. Engagement attempt with client within 7 days of admission.	3/3	100%	95%
2. Documented offer of peer support services.	3/3	100%	95%
3. Attendance at treatment team meetings as appropriate.	15/18	85%	95%

Summary

As in prior report, Peer Support Specialist makes every effort to attend treatment team meetings at ACT offices and in hospital; absent only if client expresses desire not to have Peer Support present when asked or due to schedule conflict/change.

CAPITOL COMMUNITY CLINIC

ASPECT: DENTAL CLINIC POST EXTRACTION PREVENTION OF COMPLICATIONS

Indicators	Findings	Compliance	Threshold Percentile
<p>a. All clients with tooth extractions, will be assessed and have teaching post procedure, on the following topics, as provided by the Dentist or Dental Assistant</p> <ul style="list-style-type: none"> • Bleeding • Swelling • Pain • Muscle soreness • Mouth care • Diet • Signs/symptoms of infection <p>b. The client, post procedure tooth extraction, will verbalize understanding of the above by repeating instructions given by Dental Assistant/Hygienist.</p>	<p>April: Eight extractions. Post instructions verbalized to each client. Client repeated back to dental Assist. understood the Instructions. With out difficulty.</p>	100%	100%
	<p>May : Six extraction Post instructions verbalized to each client. client repeated back to dental Assist. client understood the instructions. With out difficulty.</p>	100%	
	<p>June: Three extractions. Post instructions verbalized to each client. Client repeated back to dental Assist. understood the Instructions. With out difficulty.</p>	100%	100%

Summary

There were seventeen extractions in the forth quarter all clients had been educated on each topic listed above with post extraction, after care instructions were given both orally and in writing. Clients had no issues repeating and understanding the oral instructions.

A follow up post procedure phone call is done to check on clients progress. Of the twenty-seven calls, there were no issues or complications post procedure. Reports reviewed at monthly staff meetings and forward reports quarterly to RPC.

CAPITOL COMMUNITY CLINIC

ASPECT: DENTAL CLINIC 24 HOUR POST EXTRACTION FOLLOW-UP

Indicators	Findings	Compliance	Threshold Percentile
After all dental extractions, the clients will receive a follow up phone call from the clinic within 24hrs of procedure to assess for complications.	April :there were eight were extractions. Follow up 24-hour phone call.	100%	100%
	The pts had no complications post extractions.	100%	
	May : sixteen extraction with 24 hour follow up phone call. The pts. that were called, had no post Procedure complications	100%	
	June : three extraction with a 24 hour fellow up post extraction call with No complication	100%	

Summary

There were twenty-seven extractions. Dental clients in the forth quarter were called 24 hours after extraction. Each client that was called reported no post procedure complications. Review of monthly staff meetings and forward reports quarterly to RPC.

CAPITOL COMMUNITY CLINIC

ASPECT: DENTAL CLINIC CONSULT TIMELINESS

Indicators	Findings	Compliance	Threshold Percentile
All clients from RPC Units to be seen in the clinic will have a completed consult received in the clinic 24hrs prior to the clinic visit or sent with client and staff at time of visit.	APRIL. Had thirty-three in-house clients. Out of the thirty-three, all of the clients did have consults at the time of visit.	100%	90%
	MAY. Had twenty-seven in-house clients. All, twenty-seven, did receive consults at the time of visit.	100%	
	JUNE had forty-seven in-house clients of the forty-seven, one client did not have consults at the time of dental visit.	98 %	

Summary:

In **APRIL**, there were thirty-three RPC clients. Of the thirty-three, all of the clients did have consults at the time of the dental visits.

In **MAY**, there were twenty-seven RPC clients. All of the twenty-seven consults were performed at the time of dental visit.

In **JUNE**, there were forty-seven in-house clients. One client did not have consults at the time of dental visit.

Actions

A memo was sent to each unit reminding them of the consult policy. Our medical care coordinator calls the day before to remind them of the paper work needed for the visit and if the in-house clients come without proper documentation the visit is held or rescheduled until the appropriate paper work is presented. We also sent out a letter to all units thanking them for the hard work in getting the consults to the dental clinic at time of visit.

CAPITOL COMMUNITY CLINIC

ASPECT: MED MANAGEMENT CLINIC APPOINTMENT ASSESSMENT

Indicators	Findings	Compliance	Threshold Percentile
All Outpatient clients will have Vital Signs and Weight recorded upon arrival for appointment.	There were forty-seven clients scheduled in APRIL . The thirty-nine that came in for appointments did have their vitals taken before their clinic appointment.	100%	100%
	There were forty-seven clients scheduled in the month of MAY , Thirty-six of the clients were actually seen. The thirty-six clients had vitals taken before their appointment.	100%	
	In JUNE there were fifty-four clients scheduled. Thirty-five were seen .Of the thirty-five thirty-three had their vitals taken before their clinic appointment. Two clients did not want vitals taken.	94%	

Summary

For the fourth quarter there were 148 clients. Of the quantity stated, 146 had their vitals taken before their appt. two client did not have vitals done in the month of June. Patients were very agitated. Clients are in the assisted living program and frequently have their vitals taken at the residences prior to their appointment.

Actions

This Client is accompanied by care taker who will be asked to have the vital signs taken at residence before appointments.

CLIENT SATISFACTION

ASPECT: CLIENT SATISFACTION WITH CARE

#	Indicators	Findings LK		Findings UK		Findings LS		Findings US	Findings Total	
1	I am better able to deal with crisis.	25%	-50%	42%	+8%	79%	+65%	No data	48%	+9%
2	My symptoms are not bothering me as much.	75%	-17%	27%	+9%	64%	+49%	No data	48%	+5%
3	The medications I am taking help me control symptoms that used to bother me.	42%	-33%	42%	-6%	79%	+40%	No data	52%	+7%
4	I do better in social situations.	50%	-17%	42%	-28%	57%	+32%	No data	48%	+14%
5	I deal more effectively with daily problems.	58%	0%	38%	+5%	50%	+25%	No data	46%	+4%
6	I was treated with dignity and respect.	17%	-66%	35%	+8%	57%	+11%	No data	37%	-15%
7	Staff here believed that I could grow, change and recover.	25%	-67%	50%	-21%	36%	-14%	No data	40%	-15%
8	I felt comfortable asking questions about my treatment and medications.	50%	+8%	50%	-14%	43%	+11%	No data	48%	+6%
9	I was encouraged to use self-help/support groups.	33%	-59%	38%	-24%	71%	+21%	No data	46%	-6%
10	I was given information about how to manage my medication side effects.	-17%	-67%	23%	-23%	58%	+33%	No data	22%	-2%
11	My other medical conditions were treated.	42%	-8%	0%	+7%	57%	+14%	No data	26%	-13%
12	I felt this hospital stay was necessary.	-20%	-70%	46%	-39%	36%	+4%	No data	30%	-2%
13	I felt free to complain without fear of retaliation.	0%	-58%	12%	+9%	29%	+11%	No data	13%	-14%
14	I felt safe to refuse medication or treatment during my hospital stay.	-17%	-57%	0%	-7%	21%	+14%	No data	2%	-5%
15	My complaints and grievances were addressed.	17%	-33%	42%	-13%	21%	+29%	No data	31%	+14%
16	I participated in planning my discharge.	8%	-62%	50%	-21%	0%	-21%	No data	27%	-3%

CLIENT SATISFACTION

#	Indicators	Findings LK		Findings UK		Findings LS		Findings US	Findings Total	
17	Both I and my doctor or therapist from the community were actively involved in my hospital treatment plan.	50%	0%	27%	-13%	14%	+7%	No data	29%	+16%
18	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	50%	+30%	31%	-31%	-14%	-14%	No data	23%	+23%
19	The surroundings and atmosphere at the hospital helped me get better.	17%	-13%	58%	-8%	29%	-7%	No data	40%	+2%
20	I felt I had enough privacy in the hospital.	33%	+13%	42%	+15%	43%	+7%	No data	40%	+3%
21	I felt safe while I was in the hospital.	25%	-15%	50%	+14%	64%	+10%	No data	48%	-5%
22	The hospital environment was clean and comfortable.	42%	-8%	23%	+48%	79%	+18%	No data	42%	-16%
23	Staff were sensitive to my cultural background.	25%	+12%	4%	+38%	43%	+14%	No data	19%	-12%
24	My family and/or friends were able to visit me.	58%	+18%	62%	-37%	57%	+3%	No data	60%	+14%
25	I had a choice of treatment options.	0%	-70%	15%	+2%	21%	-15%	No data	13%	-25%
26	My contact with my doctor was helpful.	83%	+23%	42%	-34%	79%	+40%	No data	62%	+23%
27	My contact with nurses and therapists was helpful.	42%	-28%	59%	-26%	64%	+21%	No data	56%	+10%
28	If I had a choice of hospitals, I would still choose this one.	8%	+38%	33%	-8%	36%	+32%	No data	28%	+21%
29	Did anyone tell you about your rights?	-17%	-87%	14%	+7%	50%	-4%	No data	17%	-28%
30	Are you told ahead of time of changes in your privileges, appointments, or daily routine?	8%	-62%	0%	+21%	43%	+25%	No data	15%	-13%
31	Do you know someone who can help you get what you want or stand up for your rights?	17%	-63%	59%	-16%	64%	+10%	No data	50%	-5%
32	My pain was managed.	33%	-17%	14%	+22%	57%	-45%	No data	31%	+10%

CLIENT SATISFACTION

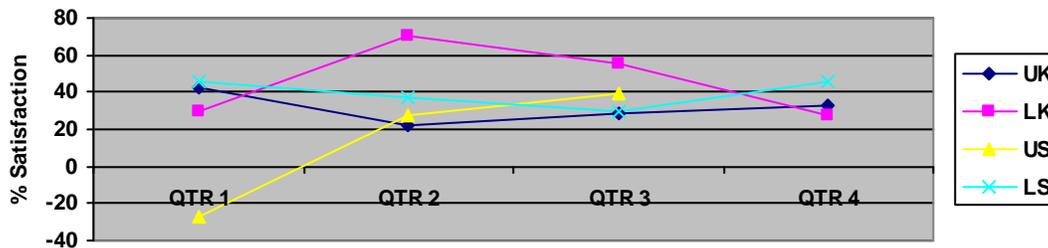
Summary

The highest possible score for most indicators is 54 (n = 27). Positive scores indicate satisfaction, while negative scores indicate dissatisfaction. Percentages are calculated using actual weighted scores and highest possible score for each indicator. The first column for each unit indicates the score for 4th quarter and the second column for each unit shows increases/decreases from 3rd quarter. Overall satisfaction for 4th quarter hospital-wide remained steady.

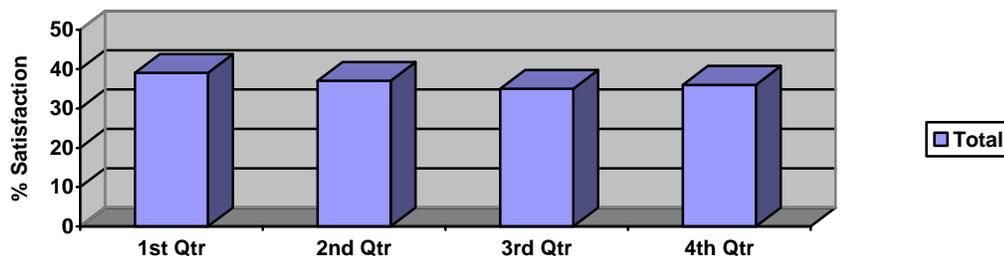
- **Upper Kennebec:** Satisfaction increased by 5% overall. There were 18 indicators that showed a decrease from last quarter. All but 3 indicators show positive satisfaction with those 3 scoring neutral.
- **Lower Saco:** Satisfaction increased 16% overall. There were 6 indicators that showed a decrease from last quarter. Only 1 indicator showed dissatisfaction with 1 scoring neutral.
- **Lower Kennebec:** Satisfaction decreased by 28% overall. There were 22 indicators that decreased from last quarter. Four indicators showed dissatisfaction and 2 indicating a neutral response.
- **Upper Saco:** no data was available for comparison.

There were 16 indicators that dropped in satisfaction from last quarter, but all indicators showed overall satisfaction. Indicators 7, 16, and 19 decreased on all units. Satisfaction with getting complaints and grievances addressed on the civil side decreased. The rights and participation domains had lowest satisfaction overall. There were 2 trends that are notable: lowest satisfaction in the rights domain was on the civil side and satisfaction was lowest for participation on the forensic side.

Satisfaction by Unit



Total Satisfaction



Actions

- Department heads will make recommendations and changes on how to improve satisfaction of care in areas that are indicated
- Superintendent will utilize client forums to get input from clients for areas of improvement

COMPARATIVE STATISTICS

The comparative statistics reports include the following elements:

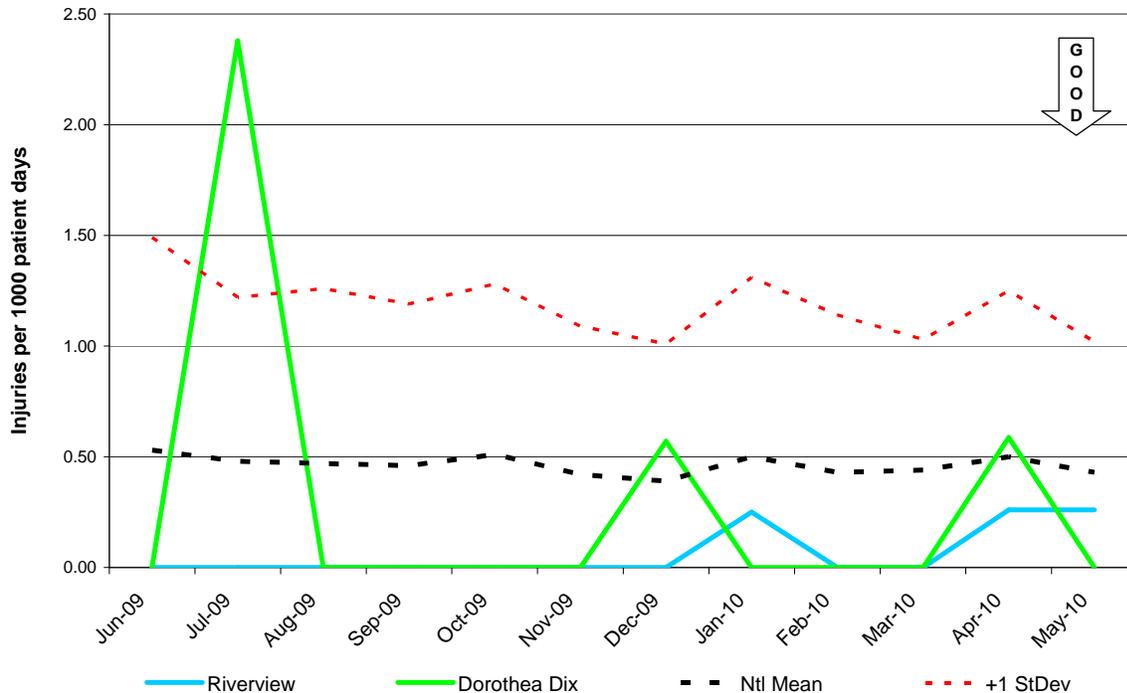
- Client Injury Rate
- Elopement Rate
- Medication Error Rate
- 30 Day Readmit Rate
- Percent of Clients Restrained
- Hours of Restraint
- Percent of Clients Secluded
- Hours of Seclusion
- Prevalence of Co-occurring Psychiatric and Substance Abuse Disorders

In addition to the areas of performance listed above, each of the comparative statistics areas includes a graph that depicts the stratification of forensic and non-forensic (civil) services provided to clients. This is new information that is being provided by the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI). NRI is charged with collecting data from state mental health facilities, aggregating the data and providing feedback to the facilities as well as report findings of performance to the Joint Commission.

According to NRI, “forensic clients are those clients having a value for Admission Legal Status of “4” (Involuntary-Criminal) and having any value for justice system involvement (excluding no involvement). Clients with any other combination of codes for these two fields are considered non-forensic.”

COMPARATIVE STATISTICS

Client Injury Rate



This graph depicts the number of client injury events that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days.

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

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

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

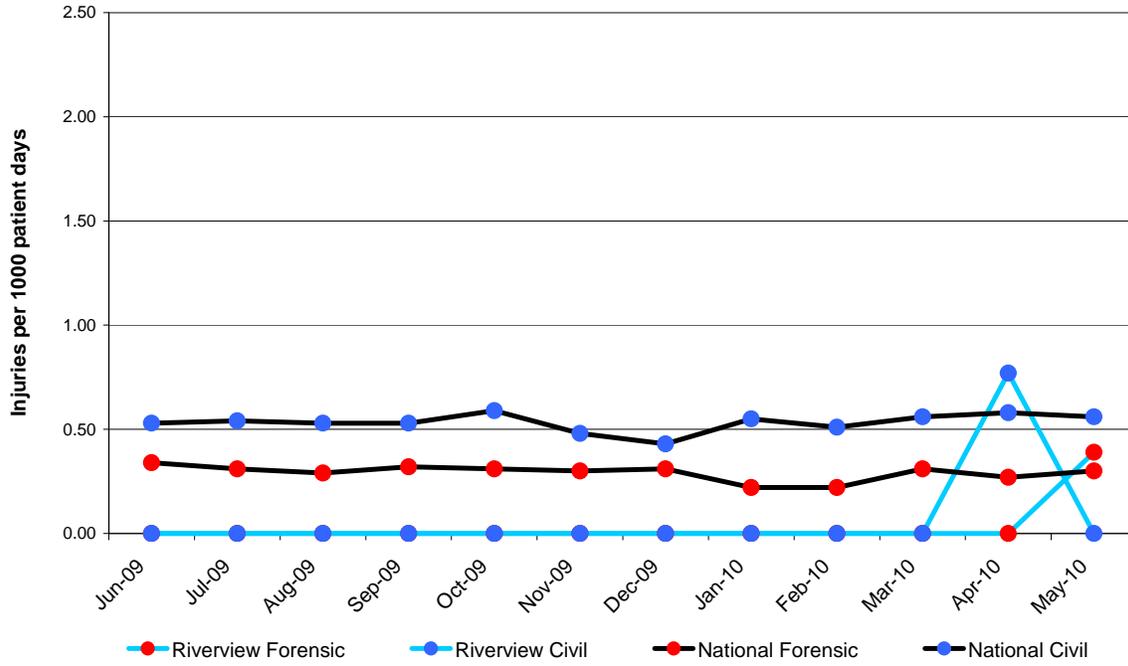
- No Treatment – The injury received by a client may be examined by a clinician but no treatment is applied to the injury.
- Minor First Aid – The injury received is of minor severity and requires the administration of minor first aid.
- Medical Intervention Needed – The injury received is severe enough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

The comparative statistics graph only includes those events that are considered “Reportable” by NRI.

COMPARATIVE STATISTICS

Client Injury Rate

Forensic Stratification



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

Client Injuries	April	May	June	4 th Qtr 2010
Total	25	19	7	51

ASPECT: SEVERITY OF INJURY BY MONTH

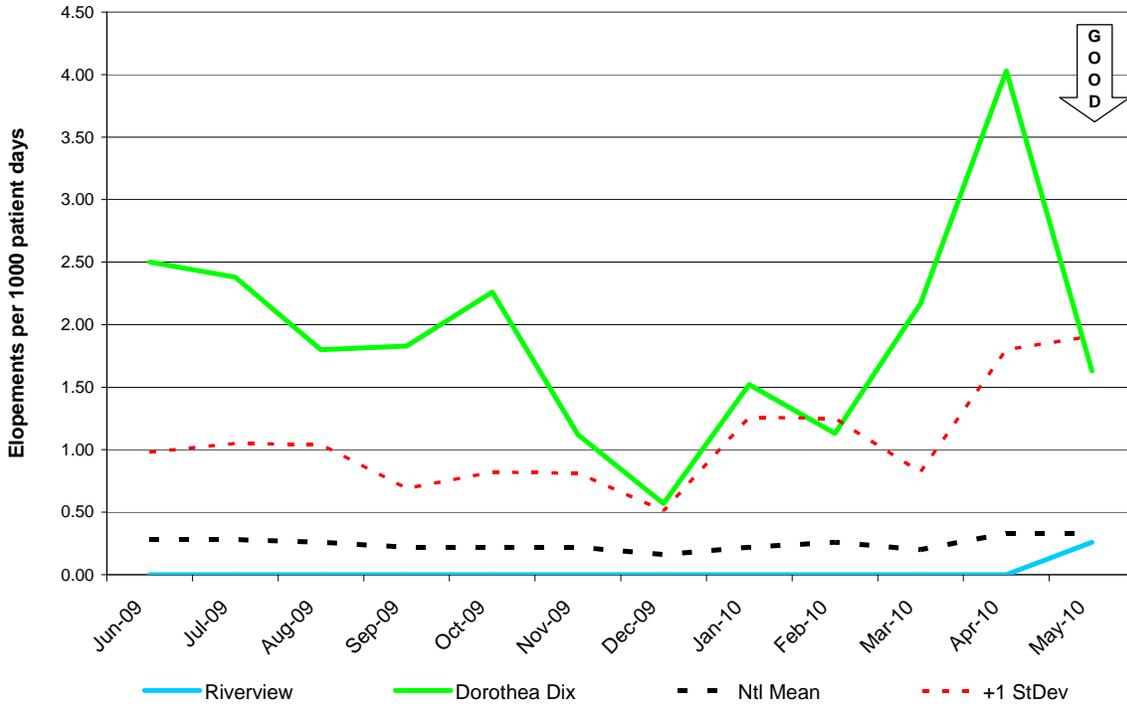
Severity	April	May	June	4 th Qtr 2010
No Treatment	15	16	5	36
Minor First Aid	9	2	2	13
Medical Intervention Required	1	1	0	2
Hospitalization Required	0	0	0	0
Death Occurred	0	0	0	0

ASPECT: TYPE AND CAUSE OF INJURY BY MONTH

Type - Cause	April	May	June	4 th Qtr 2010
Accident – Unwitnessed Fall	1	7	2	7
Accident – Witnessed Fall	2	5		3
Accident – Other	1		2	3
Assault – Patient to Patient	8	6		9
Self Injury – Agitation	11	1		12
Self Injury – Other	2		3	

COMPARATIVE STATISTICS

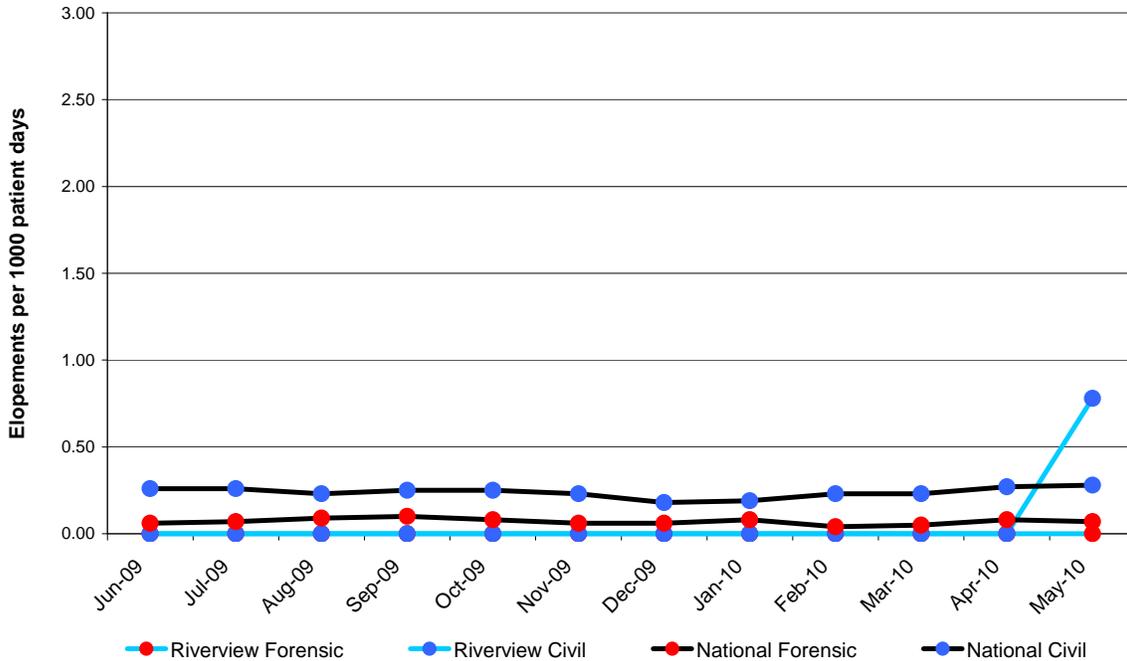
Eloperment



Number of elopements that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days.

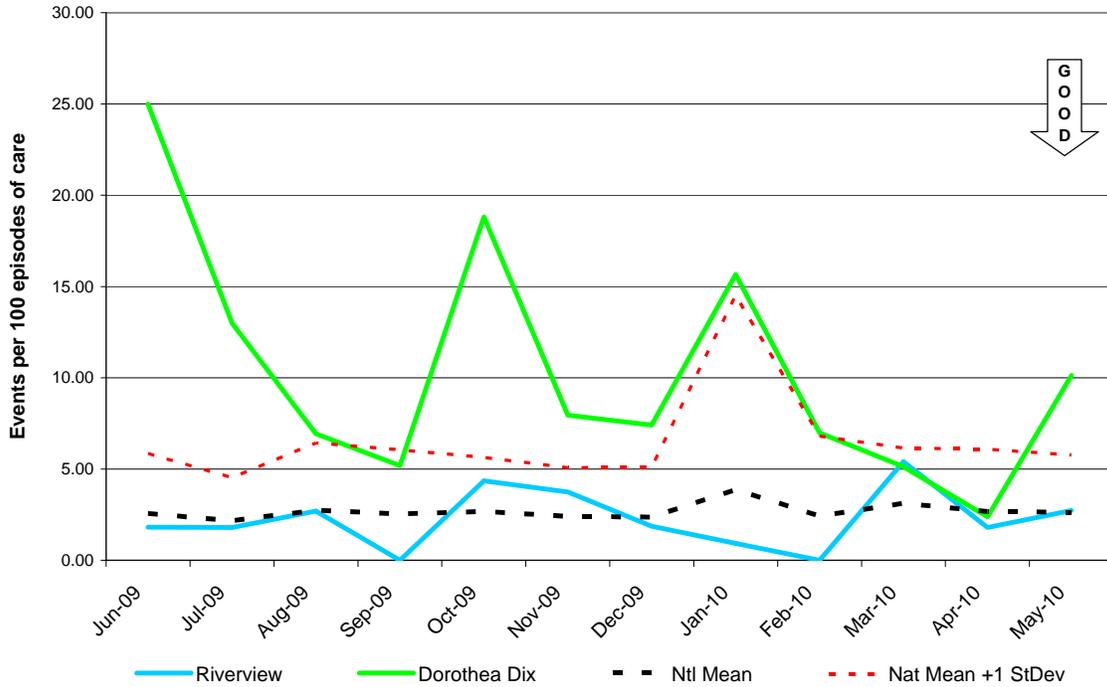
Eloperment

Forensic Stratification



COMPARATIVE STATISTICS

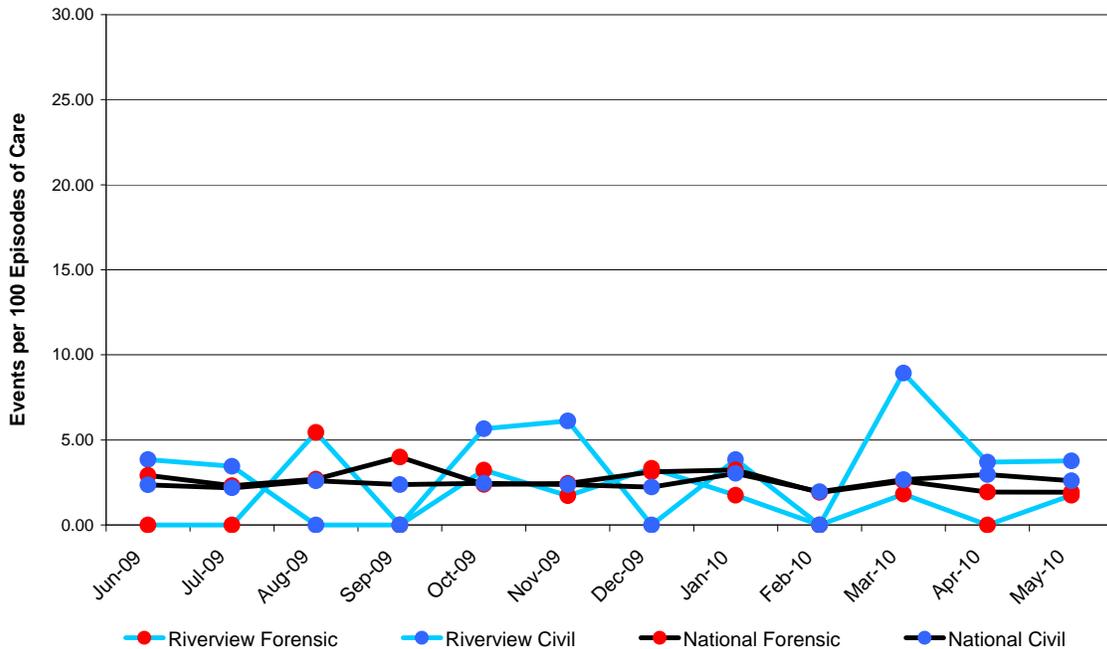
Medication Errors



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

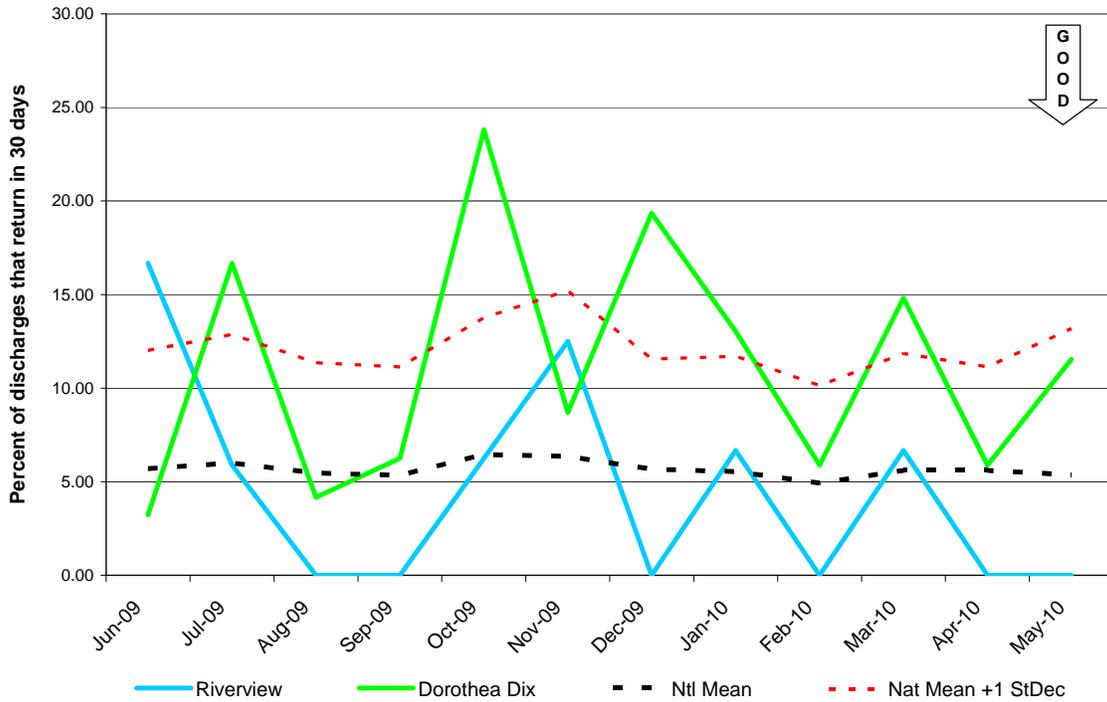
Medication Errors

Forensic Stratification



COMPARATIVE STATISTICS

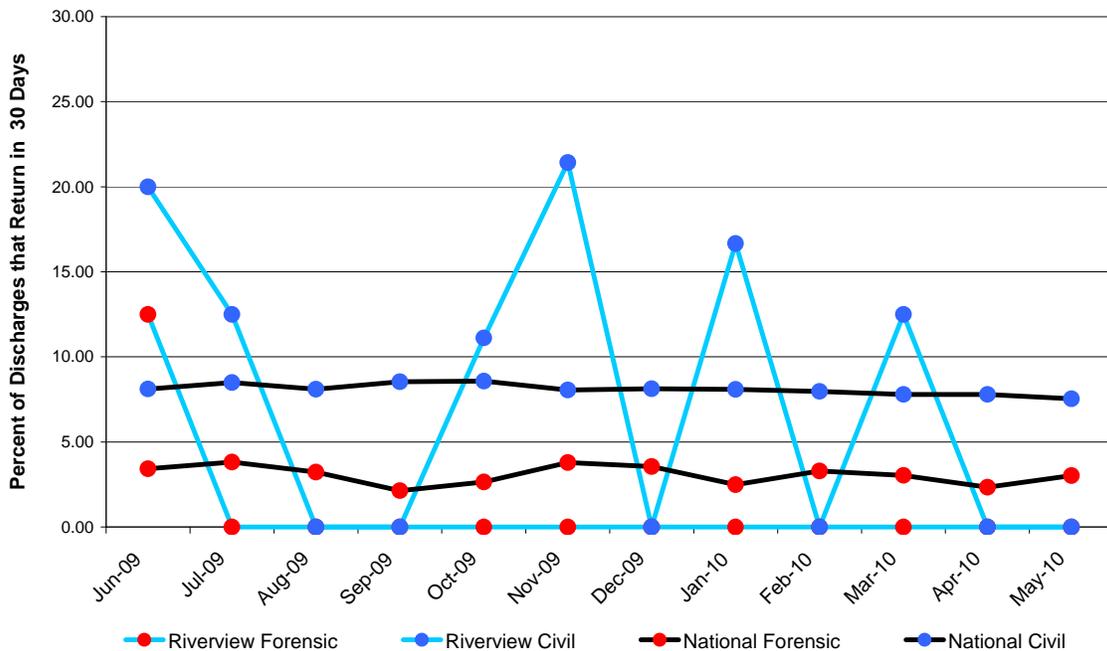
30 Day Readmit



Percent of discharges from the facility that returned within 30 days of a discharge of the same client from the same facility. For example, a rate of 10.0 means that 10% of all discharges were readmitted within 30 days.

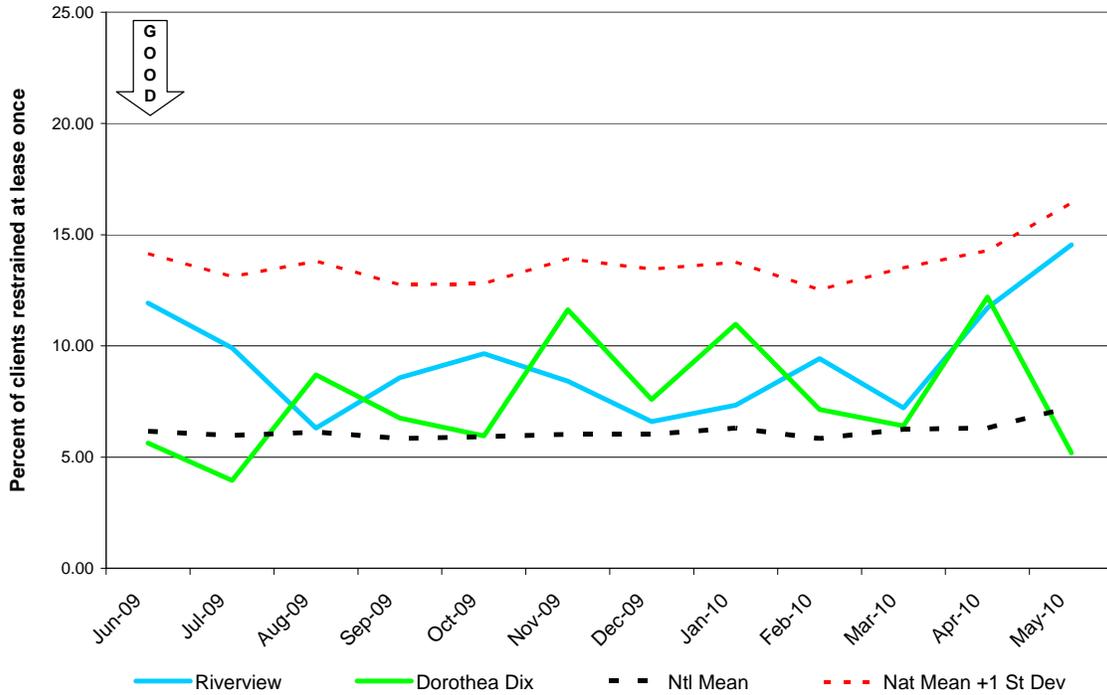
30 Day Readmit

Forensic Stratification



COMPARATIVE STATISTICS

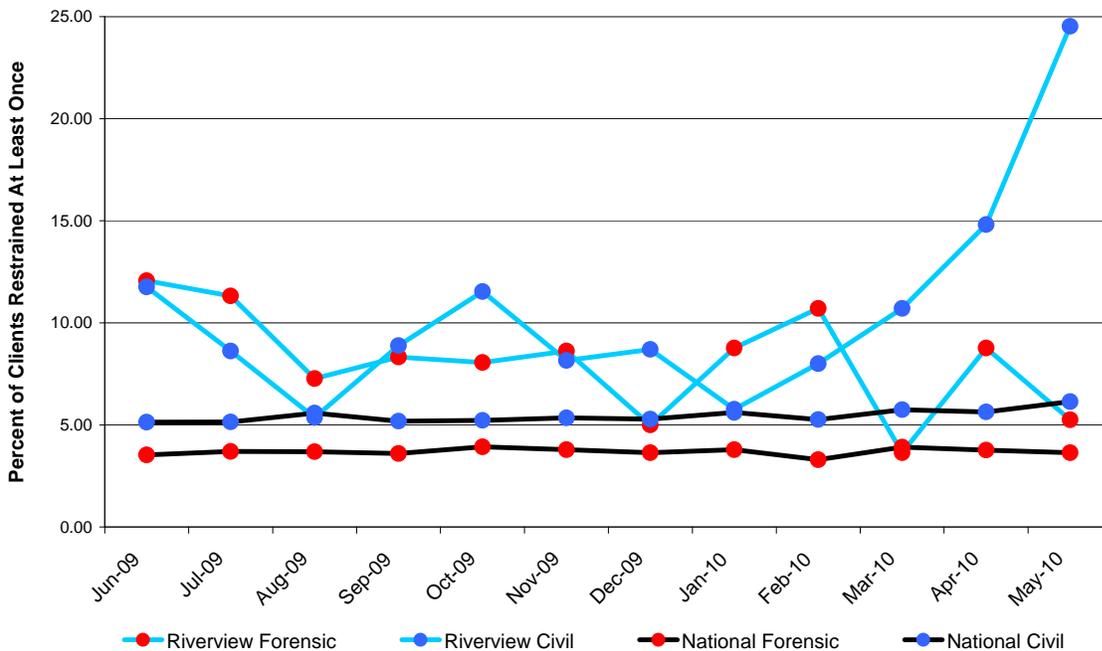
Percent of Clients Restrained



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

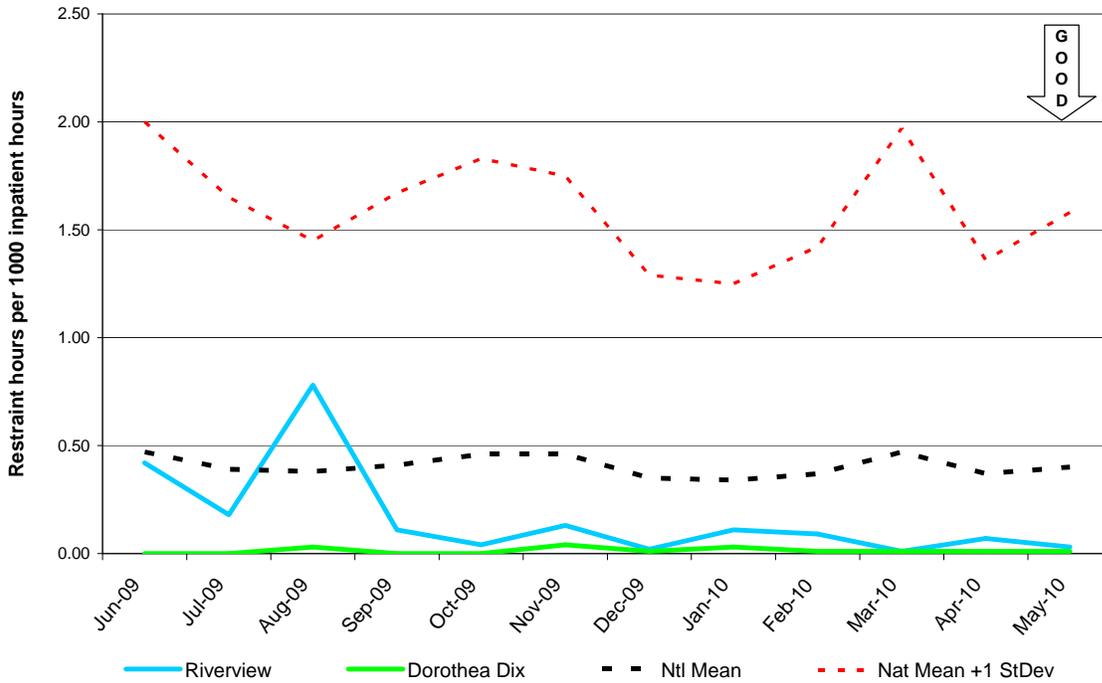
Percent of Clients Restrained

Forensic Stratification



COMPARATIVE STATISTICS

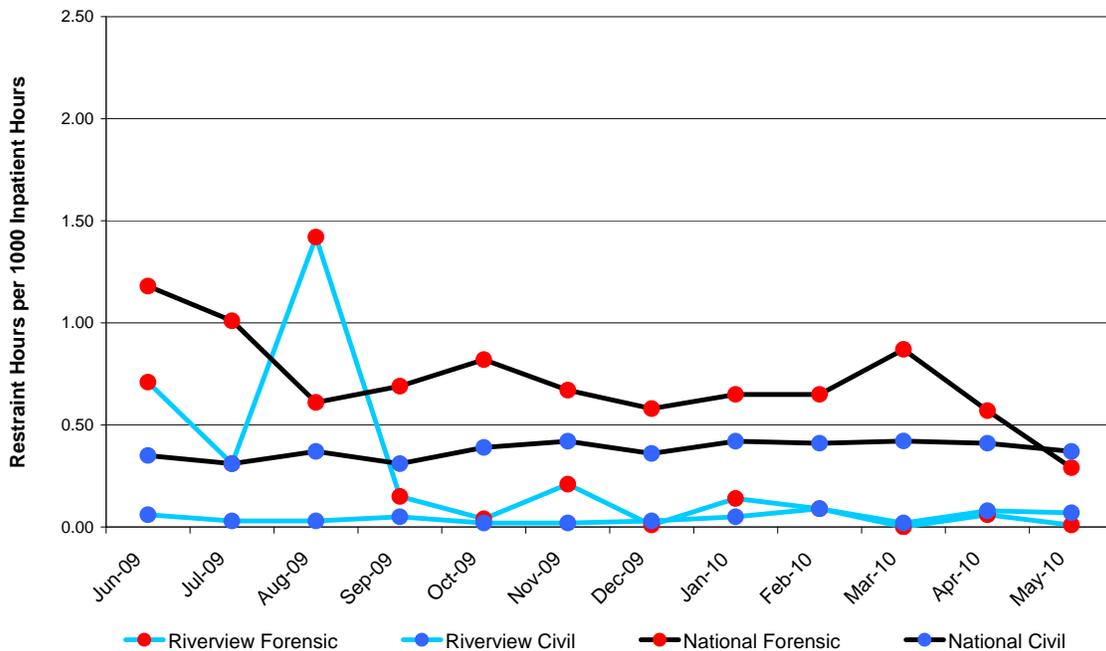
Restraint Hours



Number of hours clients spent in restraint for every 1000 inpatient hours - includes all forms of restraint of any duration. For example, a rate of 1.6 means that 2 hours were spent in restraint for each 1250 inpatient hours.

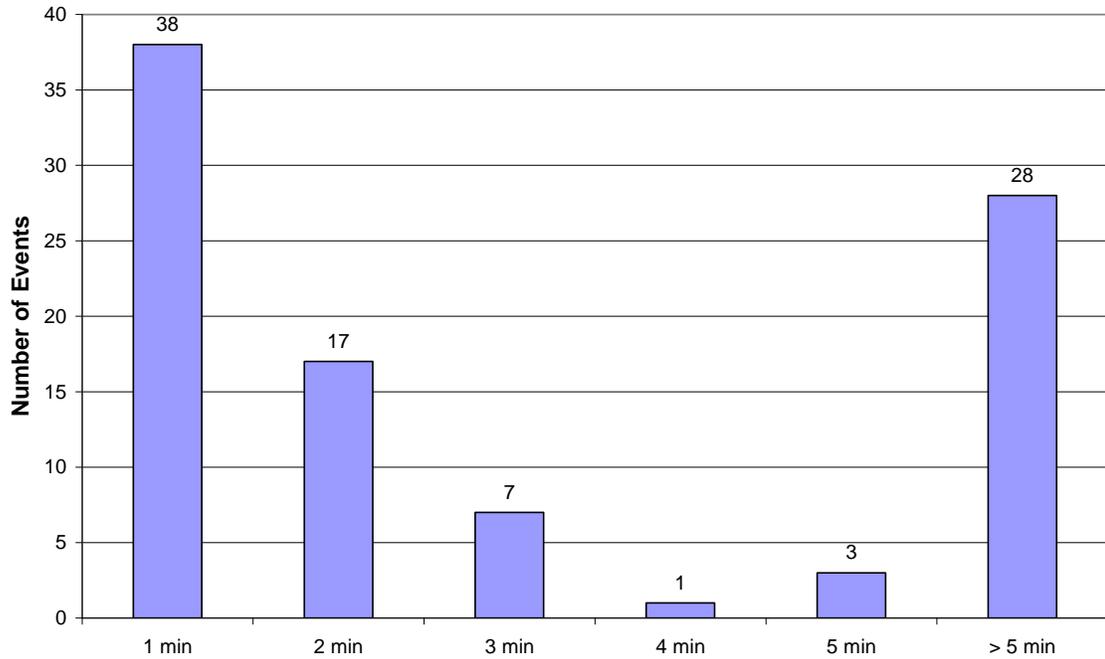
Restraint Hours

Forensic Stratification

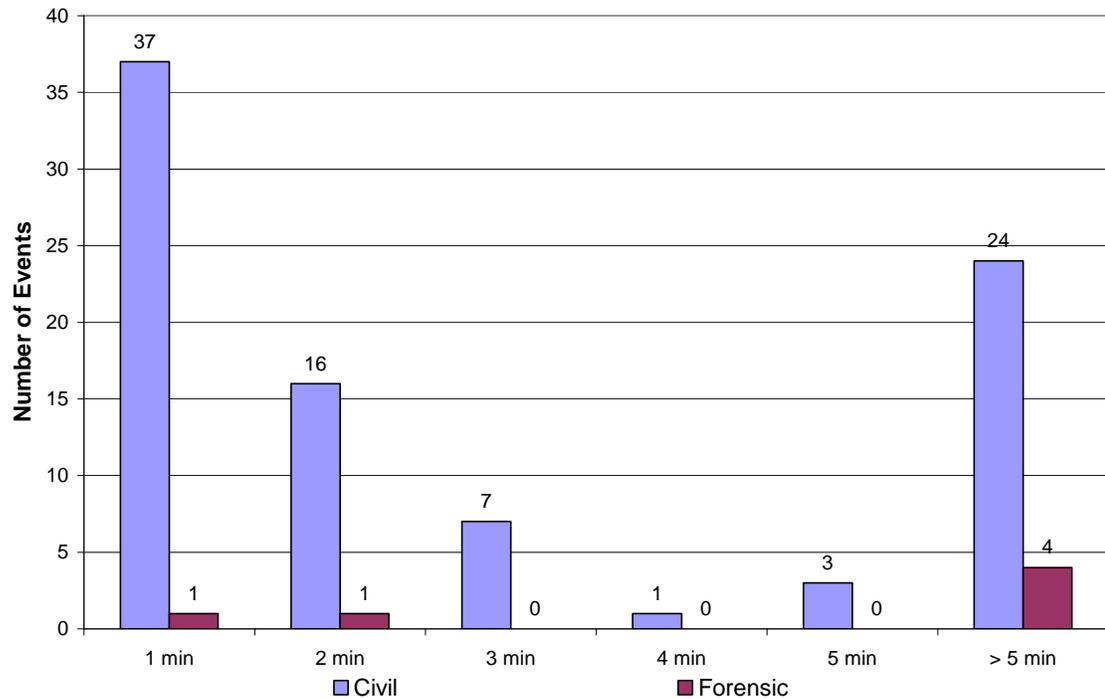


COMPARATIVE STATISTICS

Duration of Manual Hold (Restraint) Events

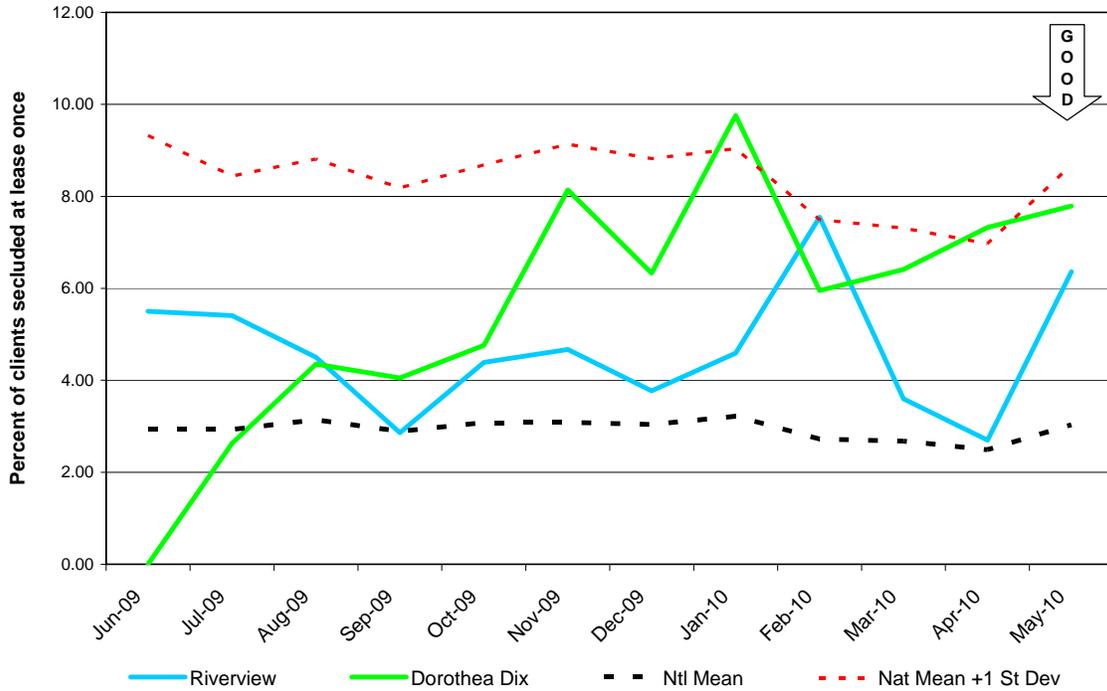


Duration of Manual Hold (Restraint) Events



COMPARATIVE STATISTICS

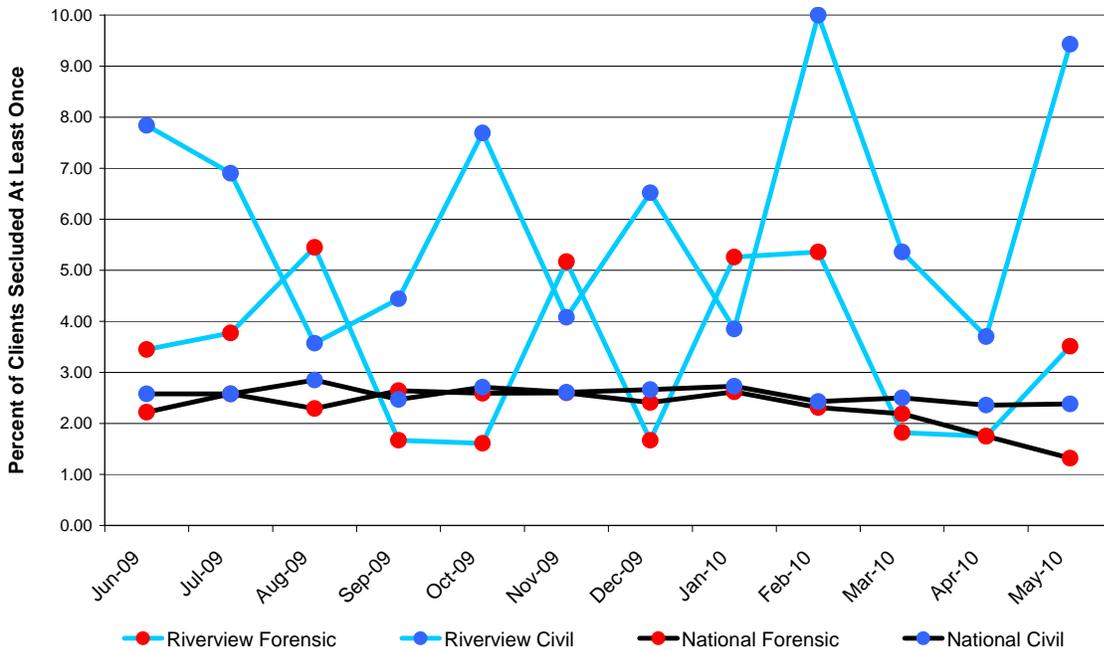
Percent of Clients Secluded



Percent of unique clients who were secluded at least once. For example, a rate of 3.0 means that 3% of the unique clients served were secluded at least once.

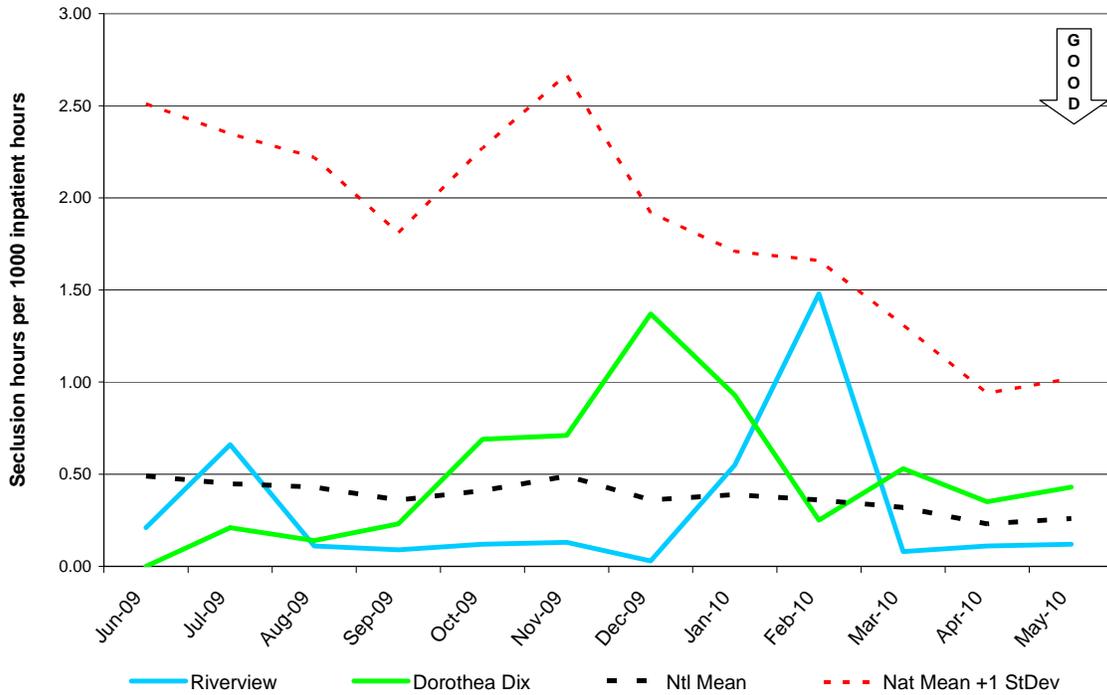
Percent of Clients Secluded

Forensic Stratification



COMPARATIVE STATISTICS

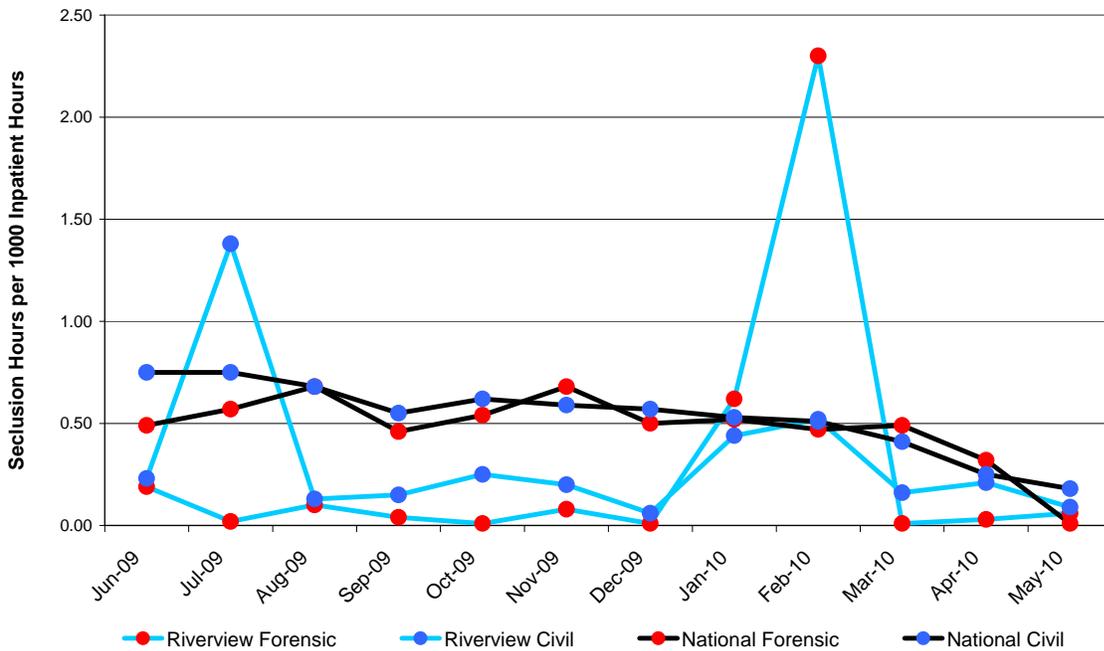
Seclusion Hours



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

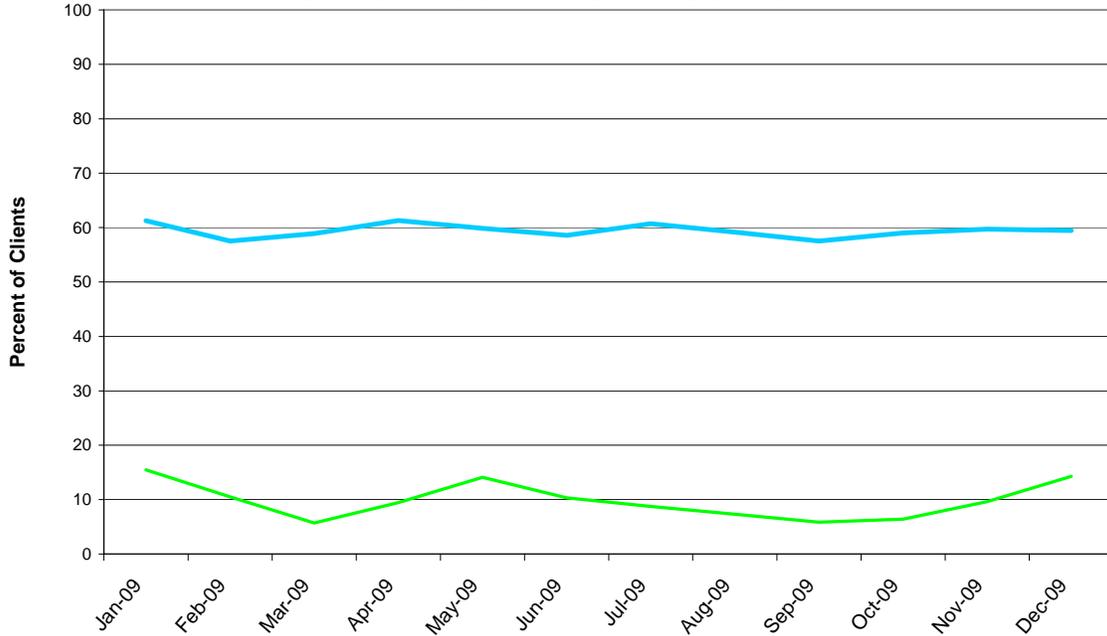
Seclusion Hours

Forensic Stratification



COMPARATIVE STATISTICS

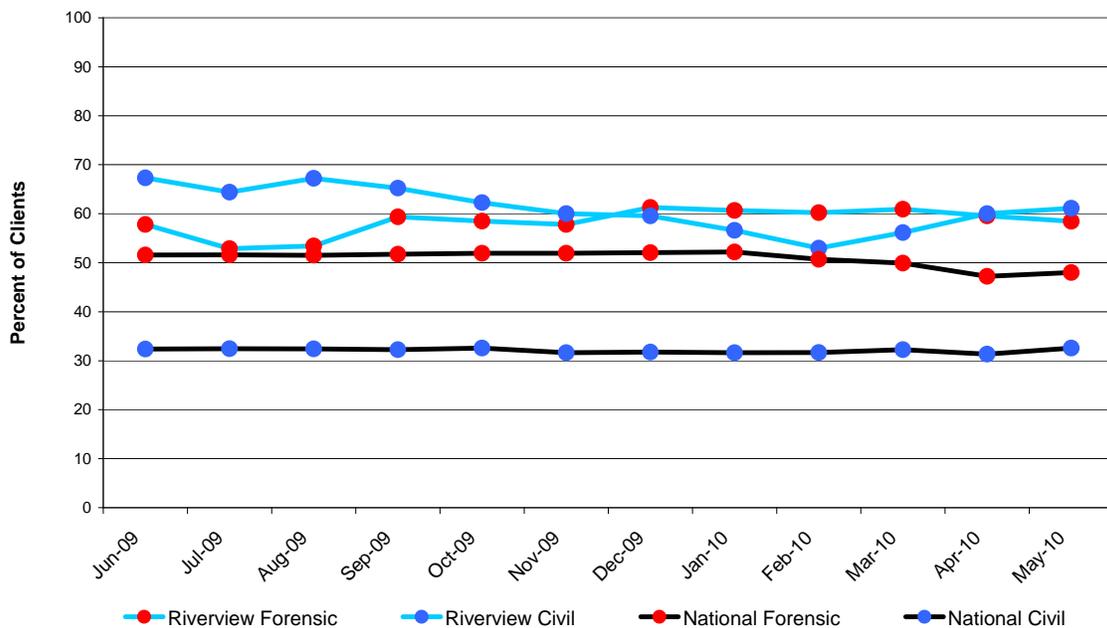
Prevalence of Co-occurring Psychiatric and Substance Abuse Disorders



Prevalence of all clients served during the months shown that are reported with Co-occurring Psychiatric and Substance Disorders (COPSD).

Prevalence of Co-occurring Psychiatric and Substance Abuse Disorders

Forensic Stratification



DIETARY

ASPECT: CLEANLINESS OF MAIN KITCHEN

Indicators	Findings	Compliance	Threshold Percentile
1. All convection ovens (4) were thoroughly cleaned monthly.	10 of 12	83%	100%
2. Dish machine was de-limed monthly	3 of 3	100%	100%
3. Shelves (6) used for storage of clean pots and pans were cleaned monthly	18 of 18	100%	100%
4. Knife cabinet was thoroughly cleaned monthly	3 of 3	100%	100%
5. Walk in coolers were cleaned thoroughly monthly.	6 of 6	100%	100%
6. Steam kettles (2) were cleaned thoroughly on a weekly basis	26 of 28	93%	95%
7. All trash cans (5) and bins (1) were cleaned daily	462 of 546	85%	95%
8. All carts(9) used for food transport (tiered) were cleaned daily	794 of 819	97%	100%
9. All hand sinks (4) were cleaned daily	336 of 364	92%	95%
10. Racks(3) used for drying dishes were cleaned daily	222 of 273	81%	100%

Summary

These indicators are based on state and federal compliance standards. Sanitary conditions shall be maintained in the storage, preparation and distribution of food throughout the facility. Written cleaning and sanitizing assignments shall be posted and implemented for all equipment, food contact surfaces, work areas and storage areas.

Threshold percentiles were not met regarding: Convection ovens, 83%. Steam kettles 93%. All trash cans and bins 85%. Hand sinks 92%. Racks used for drying dishes 81%.

Improvements were shown in the following areas: Shelves used for storage of clean pot/pan were cleaned 100% April-June. Steam kettles improved from 79% to 93%. Trash bins improved from 63% to 85%. Hand sinks improved from 64%-92%. Racks for drying dishes improved from 77%-81%.

Vacant positions April-June 2010: PT Food service worker, Food Services Manager. The Dietary team has shown improvement working together to successfully complete federal and state mandated regulations regarding food safety and sanitation.

Overall Compliance: 93%

Actions

- The Food Service Manager position has been filled.
- FSM will review all cleaning schedules on a daily basis to assure staff completion.
- Cleaning schedules will be modified to reflect changes in staff availability.
- Weekly staff meetings include discussion and staff suggestions for successful completion of these tasks.
- Results of this CPI indicator will be discussed with staff.

HEALTH INFORMATION MANAGEMENT

ASPECT: DOCUMENTATION & TIMELINESS

Indicators	Findings	Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	There were 57 discharges in quarter 4 2010. Of those, 54 were completed by 30 days.	95 %	80%
Discharge summaries will be completed within 15 days of discharge.	55 out of 57 discharge summaries were completed within 15 days of discharge during quarter 4 2010.	96 %	100%
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	2 forms were revised in quarter 4 2010 (see minutes).	100%	100%
Medical transcription will be timely and accurate.	Out of 1023 dictated reports, 886 were completed within 24 hours.	87%	90%

Summary

The indicators are based on the review of all discharged records. There was 95% compliance with record completion, with 4 incomplete records from a previous reporting period. There was 96% compliance with discharge summary completion. Weekly "charts needing attention" lists are distributed to medical staff, including the Medical Director, along with the Superintendent, Chief Operating Officer, Risk Manager and the Quality Improvement Manager. There was 87% compliance with timely & accurate medical transcription services.

Actions

Continue to monitor.

HEALTH INFORMATION MANAGEMENT

ASPECT: CONFIDENTIALITY

Indicators	Findings	Compliance	Threshold Percentile
All client information released from the Health Information department will meet all Joint Commission, State, Federal & HIPAA standards.	2982 requests for information (179 requests for client information and 2803 police checks) were released for quarter 4 2010.	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	24 new employees/contract staff in quarter 4 2010.	100%	100%
Confidentiality/Privacy issues tracked through incident reports.	0 privacy-related incident reports during quarter 4 2010.	100%	100%

Summary

The indicators are based on the review of all requests for information, orientation for all new employees/contract staff and confidentiality/privacy-related incident reports. No problems were found in quarter 4, however compliance with current law and HIPAA regulations need to be strictly adhered to requiring training, education and policy development at all levels.

Actions

The above indicators will continue to be monitored.

HOUSEKEEPING

ASPECT: LINEN CLEANLINESS AND QUALITY

Indicators	Findings	Compliance	Threshold Percentile
1. Was linen clean coming back from vendor?	37 of 37	100%	100%
2. Was linen free of any holes or rips coming back from vendor?	30 of 37	81%	95%
3. Did we have enough linen on units via complaints from unit staff?	36 of 37	97%	90%
4. Was linen covered on units?	37 of 37	100%	95%
5. Did vendor provide a 24 hr. turn around service as specified in the contract?	35 of 37	95%	100%
6. Did we receive an adequate supply of mops and rags from vendor?	37 of 37	100%	95%
7. Was linen bins clean returning from vendor?	36 of 37	97%	100%

Summary

Seven different criteria are to be met for acceptability. The indicators are based on the inspections of linen closets throughout the facility including the returned linen from the vendor. All linen types were reviewed randomly this quarter. All indicators are within threshold percentiles except for #2, #5, & #7. The overall compliance for this quarter was 96%. This is shows a 0% change from last quarters' report.

1. During random inspections, Linen returned from vendor was worn out and not taken out of service.
2. Linen was not coming back from the vendor to the facility in the proper carts.
3. Linen coming back from the vendor were not delivered to Riverview in a timely fashion.

Actions

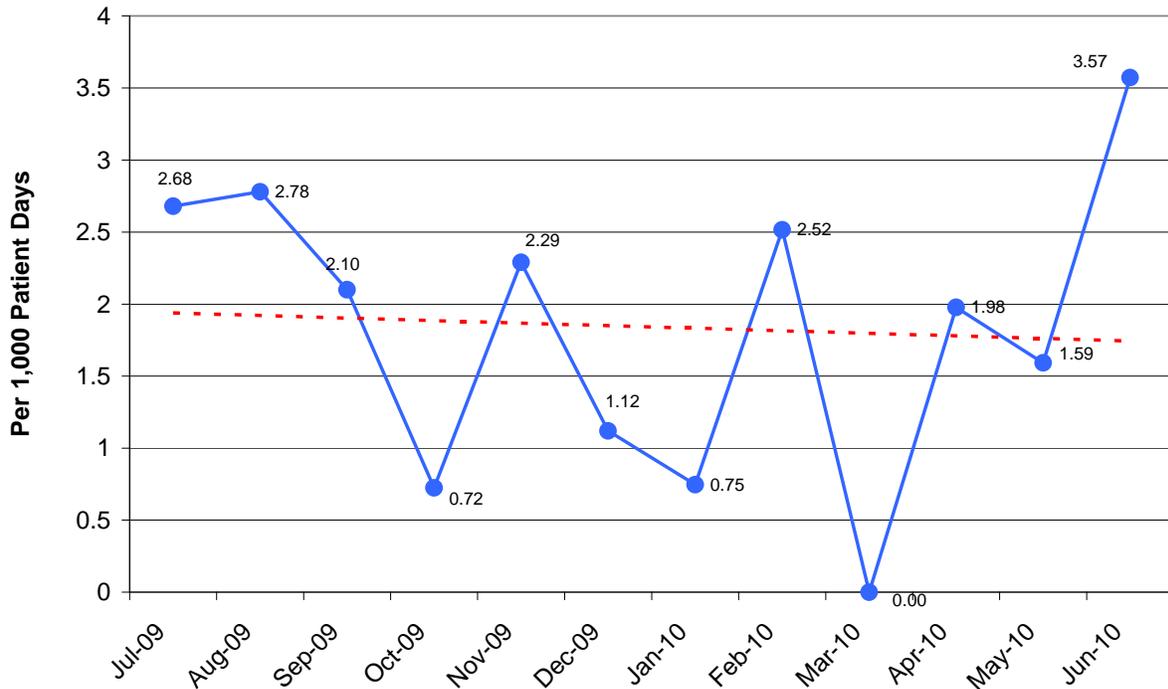
The Housekeeping Department has done the following actions to remedy the above problem indicators:

- ✓ The housekeeping staff on each unit will monitor the quantity of wash mops and rags delivered to their respective units and report to the Housekeeping Supervisor immediately.
- ✓ The housekeeping staff on each unit will monitor the linen for wear or holes.
- ✓ Housekeeping supervisor will report in staff meetings these results to make the Housekeeping staff aware of the status of this indicator.
- ✓ Housekeeping supervisor contacted linen vendor and advised them of the problem of the worn out linens and the timeliness of their deliveries.

HUMAN RESOURCES

ASPECT: DIRECT CARE STAFF INJURIES

Reportable (Lost Time & Medical) Direct Care Staff Injuries



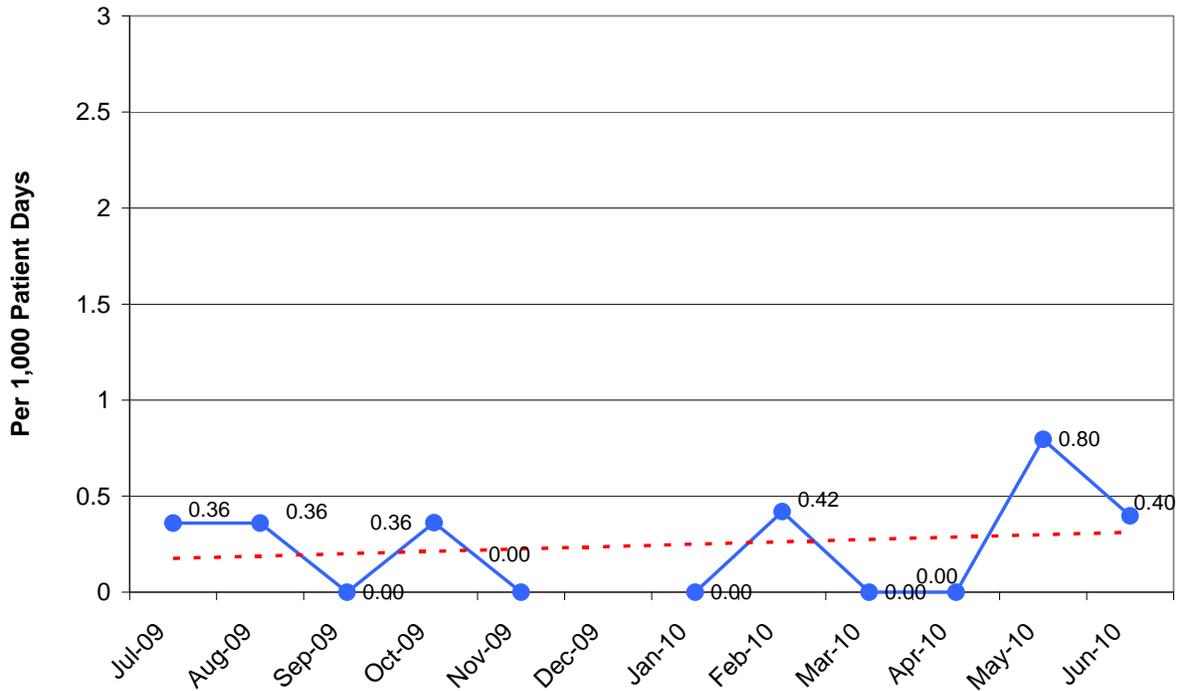
Summary

The trend line for reportable injuries sustained by direct care staff continues to show an average decline in the number of injuries reported. Recent increases in the number of direct care staff injured is being monitored to determine what correlation, if any, is apparent between the incidence of client events, the use of certain treatment modalities, and the frequency of coercive events.

HUMAN RESOURCES

ASPECT: NON-DIRECT CARE STAFF INJURIES

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



Summary

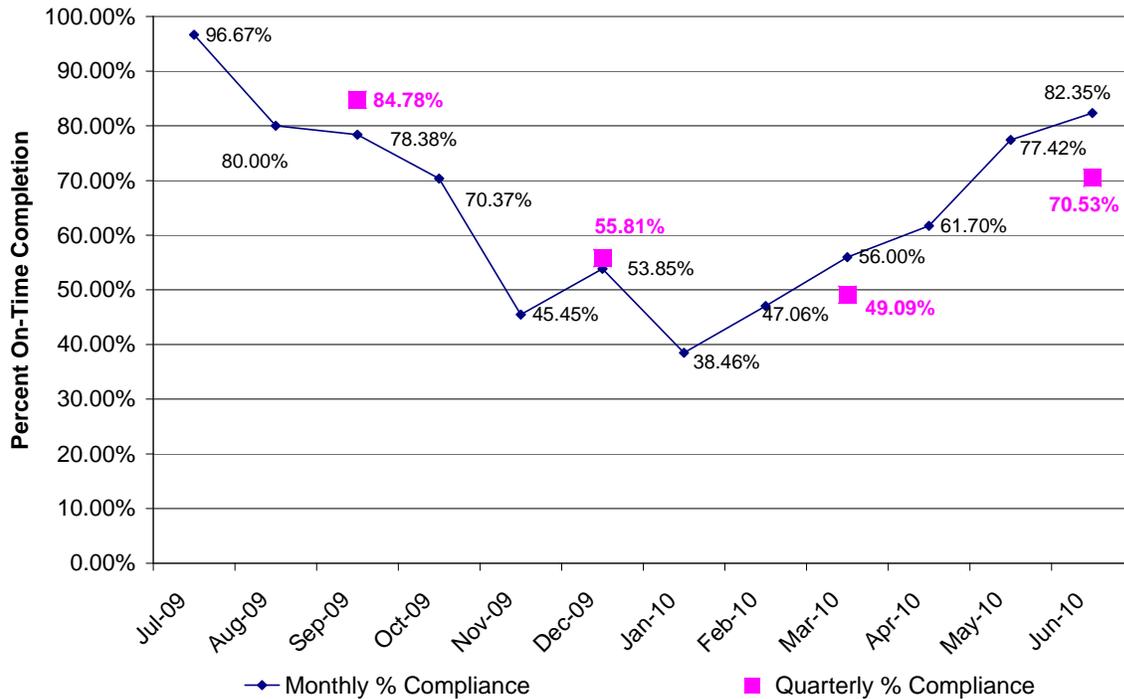
The average percent of non-direct care staff who sought medical attention or lost time from work remains low. The annual trend line shows an overall slight increase in the rate of injury; however, this change is insignificant considering the total number of non-direct care staff injuries. As with the incidence of direct care staff injuries, close monitoring of surrounding events and activities is being conducted to determine correlations between injury rates and work activities.

HUMAN RESOURCES

ASPECT: PERFORMANCE EVALUATIONS COMPLETION

Completion of performance evaluations within 30 days of the due date.

Performance Evaluation Compliance



Summary

This quarter has shown significant improvement in the completion of performance evaluations.

The cumulative results from the 3rd quarter 2010 showed that 49.09% of the performance evaluations were completed on time. The 4th quarter has shown an improvement for the quarter with a final result of 70.53% compliance in the timely completion of performance evaluations.

In an effort to sustain this improvement, an ongoing effort to remind managers of their timelines for the completion of performance evaluations will be continued. This effort will include periodic email reminders and meeting announcements.

ASPECT: PERSONNEL MANAGEMENT

Overtime hours and mandated shift coverage

Reporting Period	Overtime Hours	Mandated Shift Coverage
April 2010	2580.00	3
May 2010	2511.75	14
June 2010	2548.00	7

With the relaxation of the hiring freeze for hospital positions and the continued focus on recruiting staff to fill open vacancies, significant improvements in the levels of overtime and mandated shift staffing has been realized.

INFECTION CONTROL

ASPECT: HOSPITAL ACQUIRED INFECTION

Indicators	Findings	Compliance	Threshold Percentile
Total number of infections for the fourth quarter of the fiscal year, per 1000 patient days	31/3.8	100 % within standard	5.8 or less
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	15/1.9	100% within standard	5.8 or less

Summary

The hospital maintains total house surveillance. The total number of infections increased by eight (8) infections in the fourth quarter, mostly likely due to a spike in overall infection rates in April 2010. Thirteen of the fifteen (15) infections identified were various types of skin infections. Nine of the skin infections were on the Kennebec units. No clear indication of why the increase in skin infections in April 2010.

Two clients were diagnosed with community acquired methicillin resistant staphylococcus aureus (MRSA).

Action

- Continue total house surveillance
- Continue to encourage and observe hand hygiene

LIFE SAFETY

ASPECT: LIFE SAFETY

Indicators	Findings	Compliance	Threshold Percentile
1. 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%	100%
2. Total number of staff who knows what R.A.C.E. stands for.	160/160	100%	95%
3. Total number of staff who knows how to acknowledge the fire alarm or trouble alarm on the enunciator panel.	160/160	100%	95%
4. Total number of staff who knows the emergency number.	160/160	100%	95%
5. During unannounced safety audits conducted by the Safety Officer, this represents the total number of staff who displays identification tags.	164/170	96%	95%
6. During unannounced safety audits conducted by the Safety Officer, this represents the total number of direct care staff who carries a personal duress transmitter.	167/170	98%	95%

Summary

The (3) alarms reported for the hospital meets the required number of drills per JCAHO and Life Safety Code. Indicators 2 through 4 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.

During drills, the following was discovered:

1. In one area, a supervisor was unsure how they could account for a staff person providing services on another unit.
2. One fire report was not complete.
3. There were some phones throughout the facility did not have the emergency number listed because the phones were replacements.

Actions

Actions taken after drills were the following:

1. The Safety Officer discussed various ways to account for staff in other areas.
2. The Safety Officer assisted staff with the proper filing of the report.
3. Stickers were placed on those phones.

The Safety Officer continues to conduct mini presentations with regard using the remote annunciator panels located through facility and other objectives relative to emergency procedures. Staff's knowledge of these area has improved. We continue with environmental tours and safety audits to assure that staff is in possession of required safety equipment and facility ID's. We continue to ask Supervisors to be vigilant with regard to their staff not carrying the required equipment. We continue to monitor these indicators during safety fairs, along with those during the tours and audits.

LIFE SAFETY

ASPECT: FIRE DRILLS REMOTE SITES

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

Summary

There was an unannounced drill conducted by the Safety Officer during the fourth quarter. Unfortunately, due to dental services being performed on a client, we made the decision to not interrupt those services for the purpose of conducting the drill utilizing the alarms throughout the building. We will make an attempt to accomplish that during the next drill. We continue to perform environmental tours during which time we ask them questions as it relates to what actions they must take in the event of a fire and/or smoke emergency.

Actions

No actions are required at this time other than coordinate the next planned drill with other participants.

LIFE SAFETY

ASPECT: SECURITAS/RPC SECURITY TEAM

Indicators	Findings	Compliance	Threshold Percentile
1. Security Officer "foot patrols" during Open Hospital times. (Total # of "foot patrols" done vs. total # of "foot patrols" to be done.)	1973/2002	98%	95%

Summary

Foot patrols continue to be done despite those rare times that the officers are on other details which take priority over the "foot patrol". We have awarded a contract to Securitas and are working to put together the "tour system". We anticipate having something in place for the next quarter.

Actions

We continue our attempt to accomplish all foot patrols, but again, other tasks which are placed at a greater priority get assigned first. We continue our work on the tour system.

MEDICAL STAFF

ASPECT: COMPLETION OF AIMS

Indicators	Findings	Compliance	Threshold Percentile
Charts of clients at Riverview for six or more months are reviewed. Each client should have an AIMS exam done upon admission and every six months thereafter.	For April, May and June 2010, 119 of 139 were in compliance	86%	90%

Summary

AIMS testing is being done upon admission, and follow-up tests need to be done every six months thereafter. The compliance rate has increased from 29% in the 3rd quarter of FY09 to 77% for the 1st quarter of FY10, to 90% for the 2nd quarter, and 91% in the 3rd quarter, but dropped to 86% this quarter.

Actions

Due to this recent drop, we will monitor AIMS testing on clients at the hospital for another three months. Psychiatrists will be provided with a monthly list indicating which clients are due for AIMS testing each month. Feedback to individual psychiatrists is given at the Peer Review Committee.

ASPECT: JUSTIFICATION FOR DISCHARGE ON MULTIPLE ANTIPSYCHOTICS

Indicators	Findings	Compliance	Threshold Percentile
Patients discharged on multi-antipsychotic medications will have clinical justification based on HBIPS definitions documented in the discharge summary.	Over a 2-mo period (April-May) there were a total of 37 discharges. Two of these patients were discharged on 2 or more antipsychotics; none were justified.	0%	80%

Summary

The number of clients discharged on multiple antipsychotics has been decreased over the past six months. However, there remain one or two cases a month that the Medical Staff have not justified.

Actions

We will continue to monitor justification documentation on patients discharged. Psychiatrists will be provided with a monthly list. Feedback to individual psychiatrists is given at the Peer Review Committee.

NURSING

ASPECT: SECLUSION/RESTRAINT RELATED TO STAFFING EFFECTIVENESS

Indicators Seclusion/Restraint related to staffing effectiveness:	Findings	Compliance
1. Staff mix appropriate	90 of 90	100%
2. Staffing numbers within appropriate acuity level for unit	90 of 90	100%
3. Debriefing completed	88 of 90	98%
4. Dr. Orders	90 of 90	100%

SUMMARY

The indicators of “Seclusion/Restraint Related To Staffing Effectiveness” has remained consistent with only a minor negative deviation from 100% to 98% in completing debriefing after incident.

ACTION

We believe that this 2% decline in documentation of debriefing may be related to increased acuity during this measurement period. However, it is the intent of nursing to continue to pursue maximum compliance as expected and achievable in the upcoming quarter.

ASPECT: INJURIES RELATED TO STAFFING EFFECTIVENESS

Indicators Injuries related to staffing effectiveness:	Findings	Compliance
1. Staff mix appropriate	19 of 19	100%
2. Staffing numbers within appropriate acuity level for unit	19 of 19	100%

SUMMARY

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. The staffing numbers are within the appropriate level for the current staffing plan and the acuity level.

ACTIONS

This is an important issue that is of concern to all. The Director of Nursing is working in concert with the Superintendent and Risk management to monitor and measure trends and variables that contribute to staff injury. The focus is on appropriate use of stat calls for support to heighten awareness of safety and the obvious support in numbers for lifting and other manual activities.

NURSING

ASPECT: MEDICATION ERRORS AS IT RELATES TO STAFFING EFFECTIVENESS

NURSING: Staffing levels during medication errors – Jan.-March 2010 NASMHPD reportable variances

Date	Omit	Co-mission	Float	New	O/T	Unit Acuity	Staff Mix
4/08/10	Pharmacy	Error in stocking	N/A	N/A	N/A	UK	
4/15/10	Pharmacy	Error in stocking	N/A	N/A		LK	
4/22/10	N	Admin Past Stop Date	N	No	No	LS	3RN, 1LPN, 7 MHW
4/30/10	N	Extra dose given	N	No	No	LK	4RN, 7MHW
5/05/10	N	4 mg dose ordered, 4 tabs given 4mg each	Y	No	Y	US	3RN, 1LPN, 5 MHW
5/24/10	N	Wrong Medication Given	Y	No	No	LKSCU	3 RN, 1 LPN, 7MHW
5/20/10	N	Dose was to be held but was given in error	N	No	No	UK	2 RN, 0 LPN, 5 MHW
5/13/10	Y	Antibiotic Ointment Omitted	Y	No	No	LKSCU	3 RN, 1 LPN, 7 MHW
6/02/10	Y	Med Admin one hour late	N	No	No	LK	4 RN, 0LPN, 7MHW
06/18/10	Y	Long Acting IM Monthly Med Omitted	N	No	No	UK	2RN, 1 LPN, 5MHW
06/22/10	N	Wrong Med, Wrong Dose IM	N	Yes	No	UK	3RN, 0 LPN, 5 MHW

SUMMARY

There were a total of eleven (11) reportable errors. Two (2) involved pharmacy and did not involve staffing effectiveness evaluation. Nursing reportable medication variance data indicated the following:

Three (3) were omissions.

One (1) error involved Medication being given after the stop date.

Two (2) errors involved a Pharmacy stocking incorrectly.

Two (2) errors were wrong dose given.

Two (2) errors were due to Wrong Medication being given

One (1) error was due to an extra dose being given. (Ordered daily, given twice daily)

ACTION

Assure complete and thorough education of new Nurse by reviewing the process and revising as necessary. Allow more time for them to function in medication delivery under supervision.

NURSING

ASPECT: PAIN MANAGEMENT

Indicator		Findings	Compliance
Pre-administration	Assessed using pain scale	1245 of 1249	100%
Post-administration	Assessed using pain scale	1103 of 1249	88%

SUMMARY

The “Pre-administration assessment” indicator met the maximum compliance of 100% this quarter and there is a slight improvement from 87% to 88% in “Post-administration” assessment using the pain scale. The modest improvement in “Post-administration” assessment is expected to increase with the advent of implementation of the pharmacy module of our Electronic Medical Record.

ACTION

We believe that the increase in compliance for “Post-administration” assessment is a result of strategy implemented in the past quarter. Nursing will continue to place a great deal of attention and effort on post administration assessment and management of the related documentation. Nursing will continue to track this indicator and strive for increase in post assessment in the next quarter. The two ADONs will continue to work with unit nursing staff to assure that this is done consistently.

NURSING

ASPECT: CHART REVIEW

Indicators	Findings	Compliance
1. CSP identifies functional needs including present Level of Support and what level of support the goal is	31 of 55	56%
2. STGs/ Interventions are written, dated and numbered	60 of 60	100%
3. STGs are measurable and observable	60 of 60	100%
4. STGs/Interventions are modified/met as appropriate	59 of 60	98%
5. GAP note written in appropriate manner at least every 24 hours	60 of 60	100%
6. STGs/Interventions tie directly to documentation.	56 of 60	93%
7. MHW notes cosigned by RN, including back of the flow sheet.	55 of 60	92%
8. MHW flow sheets document a level of functional skill support provided, consistent with the identified area of need, delivered within last 24 hours.	45 of 57	79%
9. Weekly Summary note completed. Encompassing everything from that week.	35 of 60	58%
10. BMI on every treatment Plan	43 of 60	72%

SUMMARY

There is improvement in 9 out of 10 indicators in this section. Reliability continues to be enhanced by the utilization of a single reviewer. The compliance percentage in the 9 areas of improvement range from a 2% increase in “STGs are measurable and observable” to a remarkable 26% jump in “STGs/Interventions tied directly to documentation.” The single area of decrease in compliance was a minimal change from 83% to 79% in “MHW flow sheets documenting a level of function skill support provided, consistent with the identified area of need, delivered within last 24 hours with a close size in sample.”

ACTION

As in the current measurement period, unit RNs will audit 1 chart per RN and discuss during supervision. The Nurse Educator responsible for chart audit will continue to meet with individual nurses following each chart audit. The PSD/ Nurse IV will continue to discuss and review chart audit results at staff meetings. The increase in compliance appreciated during this measurement period will continue to stimulate continued vigilance in proceeding with the template designed for weekly notes and expectations of maintaining current levels while striving for measurable achievable results for the next quarter activities

NURSING

ASPECT: INITIAL CHART COMPLIANCE

Indicator	Findings	Compliance
1. Universal Assessment completed by RN within 24 hours	38 of 38	100%
2. All sections completed or deferred within document	38 of 38	100%
3. Initial Safety Treatment Plan initiated	38 of 38	100%
4. All sheets required signature authenticated by assessing RN	32 of 38	89%
5. Medical Care Plan initiated if Medical problems identified	11 of 22	50% (5 N/A)
6. Informed Consent sheet signed	35 of 36	97% (2 ref)
7. Potential for violence assessment upon admission	37 of 37	100%
8. Suicide potential assessed upon admission	37 of 38	97%
9. Fall Risk assessment completed upon admission	30 of 37	81%
10. Score of 5 or above incorporated into problem need list	3 of 17	18% (4 NA)

SUMMARY

This area is monitored upon admission. Initial Safety Treatment Plan initiation improved by 14% over results of the previous Quarter; Fall Risk Assessment improved by 10% in collection but lost ground on percent of Fall Risk Score of 5 or above being incorporated into the problem need list. (The decline in this area may be related to the relative statistical significance of the measured sample.)

ACTION

Work with Professional Staff during the next quarter to increase awareness of the interdependence of each subsection in this category. Review sample size to seek a constant statistically significant numerical representation for analysis.

PEER SUPPORT

ASPECT: INTEGRATION OF PEER SPECIALISTS INTO CLIENT CARE

Indicators	Findings	Compliance	Threshold Percentile
1. Attendance at Comprehensive Treatment Team meetings.	401 of 444	90%	80%
2. Level II grievances responded to by RPC on time.	2 of 2	100%	100%
3. Attendance at Service Integration meetings.	49 of 49	100%	100%
4. Contact during admission.	51 of 51	100%	100%
5. Level I grievances responded to by RPC on time.	23 of 24	96%	100%
6. Client satisfaction surveys completed.	27 of 45	60%	50%

Summary

Overall compliance is 87%, down 3% from last quarter. Attendance at treatment team meetings and contact during admission increased slightly. Response time for Level II grievances and peer support attendance at service integration meetings continues to stay at 100%. The number of surveys completed by clients dropped 7% with not specific reasons for refusal. There was only 1 late Level I grievance (by 1 day) for this quarter increasing compliance by 6% from last quarter. The number of Level I grievances has dropped 50% from 3rd quarter and has steadily decreased over the past year. It is unclear whether this is due to clients resolving their complaints at a lower level or fear of retaliation for making complaints. There has been anecdotal information for both reasons.

PHARMACY & THERAPEUTICS

Verifying that a patient is not allergic to a medication that is being prescribed is essential to the safety of any medication safety system. One of the many methods Riverview uses to prevent the administration of a medication known to be an allergen to that patient is to list that patient's allergies at the top of the order sheets. Occasionally the pharmacy received orders without allergies

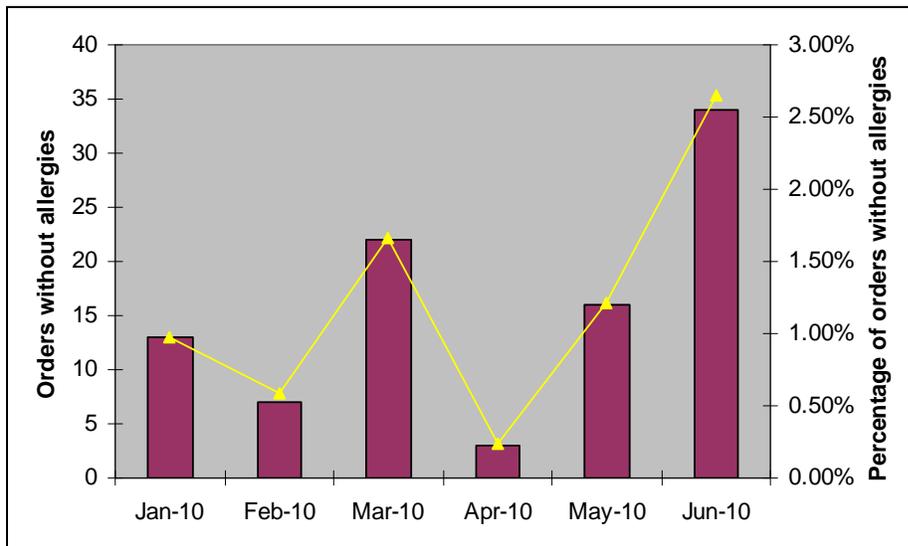
ASPECT: ORDER WRITING POLICY

Indicators	Findings	Compliance	Threshold Percentile
All order sheets are required to have that patient's allergies listed at the top of the sheet	April 3 orders received by pharmacy without allergies listed and an estimated 1325 orders total received by pharmacy.	99.8%	98.0%
	May 16 orders received by pharmacy without allergies listed and an estimated 1200 orders total received by pharmacy.	98.8%	98.0%
	June 34 orders received by pharmacy without allergies listed and an estimated 1325 orders total received by pharmacy	97.3%	98.0%

Summary

There were a total of 42 orders sent to the pharmacy during Q4 without allergy information written at the top of the page. An estimated 3885 total orders were received during that time period. Total compliance during this time period is 98.6%. All orders received without allergies listed were faxed back to their respective units for clarification.

Data starting in January 2010 is shown graphically below.



PHARMACY & THERAPEUTICS

ASPECT: DIVERSION OF CONTROLLED SUBSTANCES

Controlled substances are potentially habit forming medications that are useful in the treatment of specific disease states. Under proper supervision these medications are used to treat a wide variety of disease states effectively, easing the suffering of millions of Americans. If used improperly they can become addictive and destroy lives.

Due to their addictive side effects controlled substances have a high potential for being diverted for a number of different uses. For this reason Riverview has many safeguards to prevent the diversion of controlled substances.

Riverview utilizes Automatic Dispensing Cabinets (produced by McKesson called AcuDose machines) as the primary medication delivery system. This technology provides excellent documentation for all medications which are stored in the ADCs, including controlled substances. All medication transactions are tracked. All controlled substance transactions require 2 users and a count of the medication in the pocket to be entered into the machine. If the quantity entered differs from the quantity in the computer's database that ADC will register the error and will notify the user. Until the discrepancy is resolved by a Riverview employee credentialed to do so the word discrepancy will appear on that ADC alerting all users of the problem.

Pharmacists, NODs, and members of nursing leadership privileged by the Director of Nursing are allowed to correct discrepancies. Another user of the ADC must also sign off with the above described staff to resolve the discrepancy electronically. If the pharmacy is open, the discrepancies will be corrected by the pharmacy. If the pharmacy is closed the discrepancies will be corrected by the NOD.

The ADC software creates a report daily at 0730 alerting the pharmacy of any open discrepancies called the "AcuDose-Rx Discrepancy By Station Report." A pharmacist reviews these reports daily (or the next day the pharmacy is open for weekends and holidays).

The goal of this report is to review all ADC discrepancies from April 1, 2010 through June 30, 2010 and ensure that controlled substances are not being diverted from unit stock and discrepancies are being addressed in a timely manner.

Discrepancies Recorded	Incidences	Pharmacy Corrected	NOD Correction	Suspected Diversion	Actual Diversion
30	23	9	14	0	0

A review of the AcuDose-Rx Discrepancy By Station Report showed not active discrepancies reported.

All of the 30 discrepancies recorded were all accounted for by user error and correction of previously created error. (A discrepancy will sometimes be purposely created to correct a previous mistake. For example, if there was 1 tablet in the ADC and the nurses finger slips and presses both the "1" and "2" key at the same time thus accidentally entering a quantity of 12. The computer will then believe that 12 is the correct quantity. A second discrepancy will have to be created to correct the computer quantity to 1.)

The above data shows strong evidence that controlled substances are not being diverted from the ADCs and that any discrepancies created are being addressed in a timely manner.

PROGRAM SERVICES

ASPECT: ACTIVE TREATMENT IN ALL FOUR UNITS

Indicator	Findings	Compliance
1. Documentation reveals that the client attended 50% of assigned psycho-social-educational interventions within the last 24 hours.	59 of 80	74%
2. A minimum of three psychosocial educational interventions are assigned daily.	73 of 80	91%
3. A minimum of four groups is prescribed for the weekend.	60 of 80	75%
4. The client is able to state what his assigned psycho-social-educational interventions are and why they have been assigned.	60 of 76	79%
5. The client can correctly identify assigned RN and MHW. (Or where the information is available to him / her)	68 of 76	89%
6. The medical record documents the client's active participation in Morning Meeting within the last 24 hours.	47 of 80	59%
7. The client can identify personally effective distress tolerance mechanisms available within the milieu.	69 of 76	91%
8. Level and quality of client's use of leisure within the milieu are documented in the medical record over the last 7 days.	79 of 80	99%
9. Level and quality of social interactions within the milieu are documented in the medical record over the last 7 days.	74 of 80	93%
10. Suicide potential moderate or above incorporated into CSP	23 of 26	88%
11. Allergies displayed on order sheets and on spine of medical record.	80 of 80	100%
12. By the 7 th day if Fall Risk prioritized as active-was it incorporated into CSP	20 of 33	61%

SUMMARY

Overall compliance for all indicators is 80% which is an increase from 77%. Client attending psychosocial education is at 81%, which is up from 78% last quarter. The indicator that the client is able to state what his assigned psychosocial education interventions is at 84%, which is up from 83% last quarter. The indicator suicide potential moderate or above is incorporated into the CSP is at 87% which is a decrease from 95% last quarter. Eleven indicator numbers 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, and 12 have improved since last quarter. One indicator has decreased; documentation of active participation in morning meeting from 64% to 57%.

ACTION

Continue to focus on the area that has been below threshold over the next quarter with continuous pressure to improve. This will be addressed through staff meetings and community meetings. Continued work with the clients on daily group assignment and weekend group assignment. There will be work done with staff on documentation of client's active participation.

PROGRAM SERVICES

ASPECT: MILIEU TREATMENT

Indicator	Compliance
1. Percentage of clients participating in Morning Meeting	54%
2. Percentage of clients who establish a daily goal.	69%
3. Percentage of clients who attend Wrap Up group in the evening or address with primary staff, the status of their daily goal.	59%
4. Percentage of clients attending Community Meeting	71%

SUMMARY

Overall compliance in this area is 63% which is down from 72%. Clients establishing a daily goal at 69%; this is down from last quarter. Percentage of clients attending community meeting is at 71%down from 75%. Percentage of clients who attended wrap up has decreased from 69% to 59%.

ACTION

Continue to monitor and encourage clients in all of the areas.

REHABILITATION SERVICES

ASPECT: READINESS ASSESSMENTS, COMPREHENSIVE SERVICE PLANS & PROGRESS NOTES

Indicators	Findings	Compliance
1. Readiness assessment and treatment plan completed within 7 days of admission.	30 of 30	100%
2. Rehabilitation short term goals on Comprehensive Service Plan are measurable and time limited.	29 of 30	97%
3. Rehabilitation progress notes indicate treatment being offered as prescribed on Comprehensive Service Plan.	28 of 30	93%
4. Rehabilitation progress notes indicate progress towards addressing identified goals on the Comprehensive Service Plan.	29 of 30	97%

Summary

This is the fourth quarter review of the above indicators and will continue to be focused on and monitored to ensure continuity of care from assessment to progress notes.

Indicator #1- All assessments and annual updates reviewed were completed in the allotted time frame. No issues at this time with the completion of the assessment and treatment plan.

Indicator #2 & 3- One of the charts reviewed on one unit did not have updated goals on the CSP present in the chart. The Director met with the Recreation Therapist assigned to that unit and discovered that a current treatment plan had been completed but was not updated in the chart. Reminded the RT the importance of getting the plans into the chart as soon as they are developed. This was one of the reasons for the progress notes not being reflective of the goals that were written on the plan being documented. The other chart that had progress notes that did not indicate the treatment being offered were written by a new staff member in the department and I met with the RT on this unit to review the documentation protocols to ensure new employees were writing notes accurately.

Indicator #4- This indicator was impacted by the above indicator #3.

In regards to all indicators, the Director will continue to audit charts and provide individual supervision for all RT's to ensure expectations of indicators are achieved. The treatment planning process continues to need review and a new process of referrals to the Treatment Mall as well as documentation of progress at the Treatment Mall is being reviewed as part of Clinical Leaders.

SOCIAL WORK

ASPECT: PRELIMINARY CONTINUITY OF CARE MEETING AND COMPREHENSIVE PSYCHOSOCIAL ASSESSMENTS

Indicators	Findings	Compliance	Threshold Percentile
1. Preliminary Continuity of Care meeting completed by end of 3 rd day	29/30	96%	100%
2. Service Integration form completed by the end of the 3rd day	30/30	100%	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%	100%
3a. Client Participation in Preliminary Continuity of Care meeting.	29/30	96%	90%
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%	100%
3d. Community Provider Participation in Preliminary Continuity of Care meeting.	10/15	66%	90%
3e. Correctional Personnel Participation in Preliminary Continuity of Care Meeting.	1/15	7%	90%
4a. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	28/30	93%	100%
4b. Annual Psychosocial Assessment completed and current in chart	29/30	96%	100%

Summary

Indicator 3d has increased from the 3rd quarter from 60% to 66% but remains under the threshold percentile. We continue to work on the aspect area with the department to brainstorm community participation in this preliminary meeting. Director is continuing to attending quarterly provider meetings to foster increased and positive communication with community providers to provide continued continuity of care when clients come in to the hospital. Indicator 3e went to 7% but participation remains virtually non-existent as it has for numerous quarters for varying reasons. Of significance to report is during this quarter in June a statewide meeting was held with various mental health corrections personnel in an effort to enhance communication and participation in client treatment by the mental health personnel such as the intensive case managers assigned to the jails and prisons. Indicators 4a is and 4b are slightly under thresholds and are addressed in individual and group supervision.

SOCIAL WORK

ASPECT: INSTITUTIONAL AND ANNUAL REPORTS

Indicators	Findings	Compliance	Threshold Percentile
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	5/5	100%	95%
2. The assigned CCM will review the new court order with the client and document the meeting in a progress note or treatment team note.	6/6	100%	100%
3. Annual Reports (due Dec) to the commissioner for all inpatient NCR clients are submitted annually	N/A	N/A	100%

Summary

Indicator 1 increased from 37% last quarter to 100% this quarter. This success was achieved by a strong effort from all team members to meet this important timeframe.

ASPECT: CLIENT DISCHARGE PLAN REPORT/REFERRALS

Indicators	Findings	Compliance	Threshold Percentile
1. The Client Discharge Plan Report will be updated/ reviewed by each Social Worker minimally one time per week.	8/13	61%	95%
2. The Client Discharge Plan Report will be reviewed/ updated minimally one time per week by the Director of Social Services.	8/13	61%	100%
2a. The Client Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	8/13	61%	100%
3. Each week the Social Work team and Director will meet and discuss current housing options provided by the respective regions and prioritize referrals.	12/13	92%	100%

The aspect areas 1, 2, and 3 were reduced because on four occasions the program that generates the reports was malfunctioning and not accessible. On the other occasion the director was on vacation. Each time the report program malfunctioned the next week a double report was sent that captured the missed information from the reporting period. On two occasions hardcopy data from the Meditech census reports was used in place of the report to discuss client status at the Wednesday meeting. Of the 9 opportunities when the program was functioning except for during a vacation the report was successfully distributed to the designated recipients.

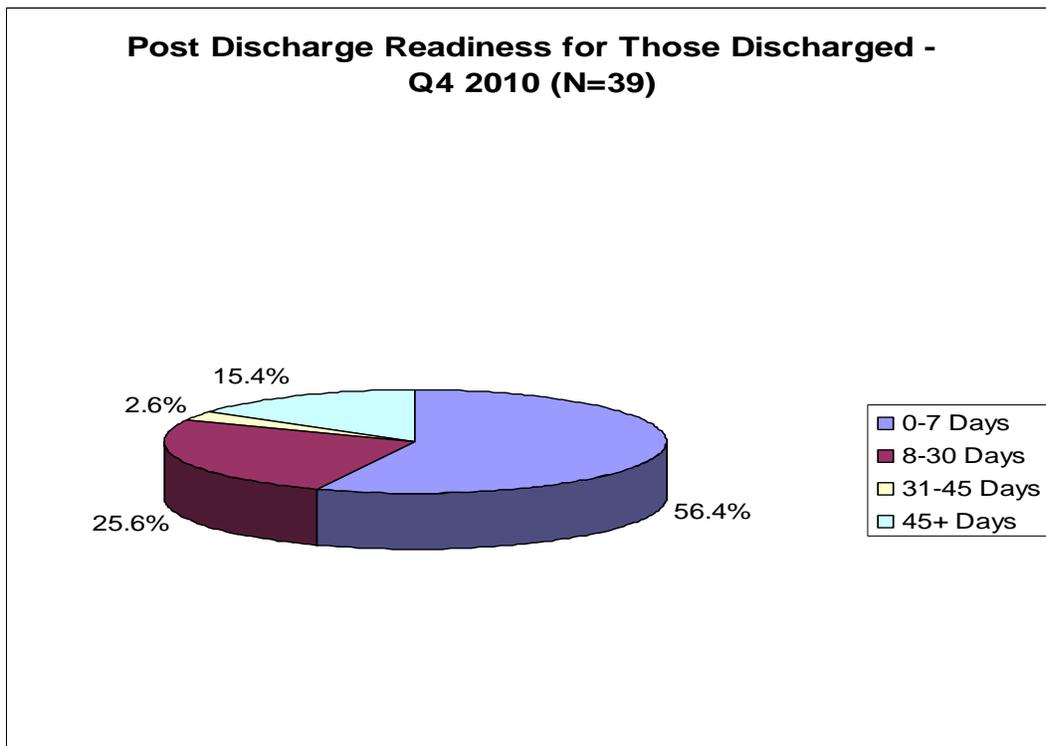
SOCIAL WORK

ASPECT: TREATMENT PLANS AND PROGRESS NOTES

Indicators	Findings	Compliance	Threshold Percentile
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all clients on assigned CCM caseload.	41/45	91%	95%
2. On Upper Saco progress notes in GAP/Incidental format will indicate at minimum bi- weekly 1:1 meeting with all clients on assigned CCM caseload	15/15	100%	95%
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.	58/60	96%	95%

Summary

Indicator 1 is down slightly from the 2nd quarter by 4% and will continue to be monitored.



This chart shows the percent of civil clients who were discharged within 7 days of their discharge readiness to be at 56.4% for this fourth quarter. Cumulative percentages and targets are as follows:

- Within 7 days = 56.4% (target 75%)
- Within 30 days = 82% (target 90%)
- Within 45 days = 84.6% (target 100%)

STAFF DEVELOPMENT

ASPECT: NEW EMPLOYEE AND MANDATORY TRAINING

<i>Indicators</i>	<i>Findings</i>	<i>Compliance</i>	<i>Threshold Percentile</i>
1. New employees will complete new employee orientation within 60 days of hire.	24 of 24 completed orientation	100%	100 %
2. New employees will complete CPR training within 30 days of hire.	24 of 24 completed CPR training	100%	100 %
3. New employees will complete NAPPi training within 60 days of hire.	24 of 24 completed Nappi training	100%	100 %
4. Riverview and Contract staff will attend CPR training bi-annually.	332 of 332 are current in CPR certifications	100%	100 %
5. Riverview and Contract staff will attend NAPPi training annually. Goal to be at 100% by end of fiscal training year 09/10 on June 30 th . Fiscal year 08/09 at 98%	380 of 381 have completed annual training	99.7%	100 %
6. Riverview and Contract staff will attend Annual training. Goal is to be at 100% by end of fiscal training year 09/10 on June 30 th . Fiscal year 08/09 at 100%	401 of 401 have completed annual training	100%	100 %

Findings

The indicators are based on the requirements for all new/current staff to complete mandatory training and maintain current certifications. **24 out of 24** (100%) new Riverview/Contracted employees completed these trainings. **332 of 332** (100%) Riverview/Contracted employees are current with CPR certification. **380 of 381** (99.7%) Riverview/Contracted employees are current in Nappi training. **401 of 401** (100%) employees are current in Annual training. All indicators remained at 100 % compliance for quarter 4-FY 2010.

Problem

Indicator number 5 is a problem this quarter as it is below the 100% threshold.

Status

This is the fourth quarter of report for these indicators. Continue to monitor.

Actions

One staff member did not complete the mandatory Nappi training due to FML. The staff member has been scheduled for the next available recertification in September.