

Riverview

PSYCHIATRIC CENTER



PERFORMANCE IMPROVEMENT REPORT

SECOND QUARTER
SFY 07
OCTOBER, NOVEMBER AND DECEMBER 2006

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Introduction:

The quarterly report will be 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 be 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. 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.

Administrative Highlights:

This quarterly report has the addition of the Continuity of Care and Safety aspects and indicators as well as the Forensic Act Team Highlights. The Client Satisfaction Survey has been implemented again. All of these are welcome additions to help support meeting RPC goals. There has been substantial improvement in post discharge readiness cumulative percentages. This represents great strides in working with the community to transition persons back to their homes, families, and communities in a significantly improved timely manner. This improvement was completed without increasing events of thirty day readmission to the facility. In addition, client injuries, and restraint hours are stable and well below the national mean.

Section I: Departmental Quality Assessment & Performance Improvement

MEDICAL STAFF

Aspect: Review of Medical Staff Documentation of Physical Exams
 Overall compliance: 96%

October, November, December, 2006			
Indicator	Findings	Compliance	Target%
1. The Physical Exam was completed upon admission, or documented as a refusal.	24 out of 24	100%	100%
2. Vital signs recorded upon admission on the physical exam form.	23 out of 24	96%	100%
3. A medical problem list generated immediately after the physical exam is completed.	23 out of 24	96%	100%
4. Medication and food allergies are assessed recorded on the physical exam form.	21 out of 24	88%	100%
5. The physical exam completed within the first 24 hours of admission.	7 of 7	100%	100%

Findings:

Question 5 was added to the rating scale in December, accounting for the smaller number in that column. Overall the medical staff were much improved in their documentation and quality of

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physical exams, exceeding any quarter in the prior 18 months and at 96% for the quarter overall. One element, food and drug allergies, was somewhat lower than the other elements and will need increased scrutiny going forward.

Problems:

Regarding this aspect indicators numbered 2, 3, and 4 are identified as problems, all of which are below established thresholds.

Status:

This quarter showed improvement in overall compliance compared to the 1st quarter (96 % vs. 80%). Partly this is explainable by our change in methodology and partly by increased conscientiousness by medical staff in performing required elements of documentation. The following actions were taken during the quarter: a signature/date/time line was added to the physical exam form. The Medical Records Committee approved this change and the new form placed in the new admission packets. The Medical Director urged continued compliance at all medical staff meetings and the Medical Director directly counseled medical staff with unacceptable performance. Also the elements of the rating scale was changed slightly in consultation with the CPI Director, and the method of finding charts for review was changed in consultation with the Director of Health Information. These actions are estimated to be having the desired effect.

Actions:

For indicator #2, the corrective actions to have the medical director work with the individual staff members to place vital signs on PE, or document why unable to obtain.

For indicator #3, the corrective actions the medical director will remind individual staff of the expectation to develop medical problem list when doing initial PE.

For indicator #4 the corrective actions is for the medical director to send a reminder to all staff to pay particular attention to food and medication allergy assessment and documentation.

MEDICAL STAFF

Aspect: Review of Medical Staff Seclusion & Restraint Documentation for 2nd Quarter FY07

Overall compliance: 97%

October, November, December 2006			
Indicator	Findings	Compliance	Target %
1. "Physician Restraint and Seclusion Progress Note" is present for each Seclusion and Restraint.	13 out of 13	100%	100%
2. The form is completely filled out, signed, timed and dated.	11 out of 13	85%	100%
3. A medical staff order is present for each event.	13 out of 13	100%	100%
4. The order form is completely filled out, signed, times and dated.	13 out of 13	100%	100%
5. The restraint/seclusion event was clinically justified.	13 out of 13	100%	100%

Findings:

This is the first quarter that this element was peer reviewed by the medical staff. It was not originally in the medical staff quality improvement plan but after consultation with the hospital PI director we elected to add it because of the high risk nature of the seclusion and restraint process, and the clear need for good documentation and importance of having a valid clinical reason to utilize this emergency procedure. A new rating scale (above) was created and piloted this quarter. Overall the compliance was good as measured by the rating scale devised. We established a baseline of 97% compliance in this initial quarter.

Problems:

For this aspect, indicator #2 is identified as a problem. A “good” problem encountered was that there were relatively few case records to review because of a paucity of seclusion and restraint events that occurred in the quarter. As with documentation related to psych emergencies we found it necessary to review open charts as well as recently closed charts to come up with an adequate number for meaningful review.

Status:

No specific actions were taken beyond educating the medical staff on how to use the rating scale. With the first look at this indicator this quarter the medical staff appear to be doing a reasonably good job of documentation. As this is a new indicator, there is no prior quarter for comparison.

Actions:

We will continue this monitor into the third quarter because of the critical nature of this clinical activity. We will relook at the actual rating scale in consultation with the PI director to be certain we are capturing all critical elements as required by JCAHO and DHHS licensure. Specific to indicator #2, the one particular provider who had difficulty documenting the time, date and sign the order for seclusion or restraint, has been counseled by the Medical Director. The medical staff will be mindful to look at question 2 of the scale going forward since it had the lowest compliance at 85%.

MEDICAL STAFF

Aspect: Medical Staff Psychiatric Emergency Documentation

Overall compliance: 99%

October, November, December 2006			
Indicator	Findings	Compliance	Target %
1. The form “Notification of Psychiatric Emergency” is present for each Psych Emergency ordered, and is completed, signed, timed and dated.	18 out of 19	95%	100%
2. Progress note justifying the rationale for the psych emergency is noted in the medical record.	8 out of 8	100%	100%
3. A medical staff order is present for the psych emergency and contains appropriate medication orders.	19 out of 19	100%	100%
4. The psych emergency is clinically justified.	19 out of 19	100%	100%
5. Least restrictive methods have been attempted and failed to control the client’s dangerousness and are documented.	8 out of 8	100%	100%
6. If consecutive psych emergency, initiation of administrative hearing took place.	8 out of 8	100%	100%

Findings:

This is a new fiscal year indicator for medical staff. We are rating the quality of medical staff documentation and clinical appropriateness of psychiatric emergency declarations. Initially a four element rating scale was created for assessing each psychiatric emergency event. The four elements were: 1) the medical records form “Notification of Psychiatric Emergency” is present for each episode, 2) this form is completely filled out and signed, 3) a medical staff order is present and contains appropriate medication orders, and 4) the psychiatric emergency is clinically justified. During the current quarter we made a change in our rating scale after consultation with the risk manager to more accurately reflect the required elements of a psych emergency as described in licensure requirements and the Rights of Recipients. Subsequently three new elements were added as

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described in questions 2, 5, and 6 above. This accounts for the discrepancy in the numbers of events reviewed under the 6 different elements.

Problems:

Indicator #1 was the only identified problem area for this aspect; all other indicators were at threshold.

Status:

We demonstrated an increased compliance on the new rating scale of 99% for the current quarter as compared to 70% in the base quarter (July to September). We were able to demonstrate this improvement on a new, and we believe improved, rating scale. The rating scale appeared to the raters to be meaningful and valid. One problem encountered was that there were relatively few emergencies in the quarter to review. For example there were no flagged emergencies to be rated in November. There was also some difficulty encountered by the Medical Records Dept. in flagging all supporting documentation in order for the medical staff to review from discharged clients. We therefore changed our methodology to allow for review of any emergencies that might have occurred for clients still in the hospital as well as from those discharged within the previous 30 days..

Actions:

The new monitor was successfully integrated into the medical staff peer review process. Feedback was given to individuals about their performance. The Medical Director had several discussions with the Medical Records Dept. and the CPI Director about obtaining adequate numbers and types of records for meaningful review. We also tweaked the rating scale to make it more congruent with JCAHO and DHHS licensure standards for psych emergencies. We will continue the current scale into the third quarter because of the relative newness of the rating instrument as well the high risk nature of the procedure under review. It also requires a larger number of medical records under review to be confident of these findings.

NURSING

ASPECT: Seclusion and Restraint Related to Staffing Effectiveness

COMPLIANCE: 100%

Indicators	Findings	Compliance	Threshold Percentile
1. Staff mix Appropriate	73 of 73	100%	100%
2. Staffing numbers within appropriate acuity level for unit	73 of 73	100%	100%
3. Debriefing completed	73 of 73	100%	100%
4. Dr. Orders	73 of 73	100%	100%

Findings: There were 73 incidents of seclusion, and restraint this quarter.

Problem: No problem noted.

Status: This indicator has increased in compliance so all monitored aspects are at 100%

Actions: Continue monitoring to assure continued compliance.

NURSING

ASPECT: Code Cart / Redlining

COMPLIANCE: REDLINING 96% CODE CART 95%

Indicators-Redlining	Findings	Compliance	Threshold Percentile
Lower Kennebec	264 of 279	95%	100%
Upper Kennebec	266 of 279	95%	100%
Lower Saco	245 of 279	88%	100%
Upper Saco	269 of 279	96%	100%

Indicators-Code Cart Sign Off	Findings	Compliance	Threshold Percentile
1) Lower Kennebec	252 of 279	90%	100%
2) Upper Kennebec	268 of 279	96%	100%
3) Lower Saco	270 of 279	97%	100%
4) Upper Saco	263 of 269	94%	100%
5) NOD Building Control	270 of 279	97%	100%
6) NOD Staff Room I 580	265 of 279	85%	100%

Findings: The sample size is 279 for both red lining and code cart checking. Redlining is at 96% and remains short of the 100% expectation. Lower Saco redlining is at 88% down one percent from last quarter. Code cart checking has not yet met the 100% compliance expectation either. It continues to be below, with it being at 95% this quarter down from 97% last quarter. Room I580 is checked by the NOD; it is down to 85% this quarter and was at 99% last quarter. Some regular NOD staff has been on vacation and on extended leave.

Problem: Redlining is not being done 100% of the time on all units. Code cart checking is a critical check issue on all code carts. These are used in emergency situations and must be complete and ready to use. This is not being done and becomes a major safety issue. Redlining is the method of checking all medication orders to confirm the accuracy. This also is a critical issue and is not being done consistently Code carts are not being checked 100% of the time.

Status: All the indicators continue to be below 100%.

Action: The ADON will assure the Redlining procedure has been reviewed, and signed off by each nurse by the end of February 2007. This will also include the day and evening shift nurse reviewing the procedure for reviewing the charts to assure physician order are checked at the beginning of each shift. Each shift the charge nurse will write on the nursing daily report that chart reviews or redlining has been accomplished or not. Each shift the NOD/ Executive Nurse designee will report on the progress of the redlining procedure on each unit on the daily reports to the superintendent.

Code cart checking will need to be reviewed with the nurse who is responsible for narcotic count and key exchange during each shift change. When the medication nurse is working greater than eight hours the evening charge nurse will work with the med nurse to make sure code cart is checked. This will be recorded on the nursing shift report each shift as well. The on coming Nursing Supervisor and NOD's will check Room I-580 to make it a part of their shift report. The NOD/ Executive Nurse Designee will report each shift on the daily report to the superintendent, on all six sites of the code cart being assessed, too. Any time variances are identified, they will be reported via the incident reporting process as both redlining and code cart checking are critically important for emergency situations.

NURSING

ASPECT: PAIN MANAGEMENT

COMPLIANCE: 94%

Indicator	Findings	Compliance	Threshold Percentile
1. Pain is assessed using pain scale prior to pain medication administration.	653 of 653	100%	100%
2. Client re-assessed for pain using pain scale after pain medication delivered.	581 of 653	89%	95%

Findings: The indicator for assessing pain using pain scale pre medication administration is at 100%. The indicator for assessing pain post administration is at 89%.

Problems: Nurses have not been consistently assessing post administration of pain meds due to changes in personnel.

Status: The pre administration is at 100%. The post administration is not being done consistently. Nurses will be reeducated to assure the understanding of the need to be consistent.

Actions: Will continue to monitor. Nurses will be reeducated concerning the need to reassess. Pain sticker documentation forms will be changed to include the post assessment.

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 NURSING:
 ASPECT: NURSING DOCUMENTATION
 OVERALL COMPLIANCE 58%

Indicator	Findings	Compliance	Threshold Percentile
1. NAP notes at a minimum			
a. Identifies STG goal/objective.	35 of 61	57%	90%
b. Once per shift either MHW/RN	34 of 69	49%	95%
c. Minimally Q24 hours RN after first 72 hrs	24 of 51	47%	95%
d. MHW notes countersigned by RN	39 of 69	57%	90%
2. Active Treatment			
a. Identifies Intervention	58 of 63	92%	90%
b. Describes intervention.	17 of 63	27%	90%
c. Assessment Completed.	53 of 63	57%	90%
d. Plan	56 of 63	89%	90%

Findings: There were 69 charts audited for nursing documentation in this quarter from across the hospital. The indicator “Identifies interventions” is above threshold. The indicator “Having a Plan” is at 89% and the threshold is 90%. Other indicator aspects fall far below the desired threshold.

Problems: There remains a large 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: Compared to the last quarter of SFY06 the indicator “identifying STG” has decreased by 3%; “RN/MHW documenting once per shift” has increased 20%; the indicator “documenting minimally q 24 hours by RN” increased 6%; the indicator “signing of MHW notes by RN” has decreased by 32 %; the indicator “describing intervention” is down 18%; the “Assessment completed” is down 32 %. The documentation remains a great concern. A PIT was begun and has been working on the Comprehensive Service Plan and documentation. The anticipated changes will improve the documentation process.

Actions: A documentation PIT is underway with a variety of recommendations to be implemented by the end of February. Some of the changes and recommendations will be: The Comprehensive Service Plan will change; the method and kind of notes will change. 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. The expectation will be that using the GAP format for charting G=goal, A=assessment. And P=plan, each event of documentation will tie directly to a goal on the Comprehensive Service Plan. This will serve to allow documentation to be more concise, and to connect it to the Treatment Plan. Documentation expectations for MHW and Nurses will change regarding frequency and purpose. Indicators will change slightly as the process evolves. PIT charter and minutes available.

PEER SUPPORT

ASPECT: Integration of Peer Specialists into client care

OVERALL COMPLIANCE: 92%

Indicators	Compliance	Findings	Threshold Percentile
1. Attendance at Comprehensive Treatment Team meetings.	466 of 534	87%	80%
2. Grievances responded to by RPC on time.	132 of 139	95%	100%
3. Attendance at Service Integration meetings.	79 of 82	96%	100%
4. Contact during admission.	83 of 86	97%	100%
5. Grievances responded to by peer support on time.	139 of 139	100%	100%
6. Client satisfaction survey completed.	10 of 12	83%	80%

FINDINGS:

Overall compliance is up 1% this quarter from last quarter.

(1) Peer Specialists attended 466 of 534 treatment team meetings this quarter. Attendance is up 5% from last quarter. Admissions accounted for 21 of the missed meetings, 10 were due to other meeting obligations, 9 due to mandatory training, 12 due to peer specialist being out sick or on vacation, 8 due to no peer specialist being available to attend the meetings, and 7 were due to client not wanting peer support present.

(2) Level I grievances were responded to on time 95% of the time down 4% from last quarter. There were 7 late grievances for this quarter; 6 late on Lower Saco (2-6 days late) and 1 late on Upper Saco (2 days late).

(3) Peer Specialists attended 79 of 82 Service Integration Meetings this quarter. Attendance is down 1% from last quarter. Of the 3 missed meetings 1 was due to mandatory Amistad training, 1 was missed due to client refusing to attend the meeting, and 1 due to Continuity of Care manager not notifying peer support of the meeting.

(4) Clients had documented contact with a Peer Specialist 97% of the time for this quarter, down 2% from last quarter. Of the 3 clients that were not contacted, 1 contact was not made due the client being admitted after hours and unavailable at every attempt to make contact, 1 client was admitted

and discharged the after admission, and 1 was in administrative segregation for the duration of his admission.

(5) A Peer Specialist processed all grievances filed within 1 business day of grievance receipt for this quarter.

(6) This is a new indicator. Data was collected only during the month of December. Clients who were discharged from Riverview were given the opportunity to complete a client satisfaction survey prior to discharge. Of the 12 clients surveys were offered to, 10 completed the survey. Of the 24 questions on the survey, only 7 met or exceeded the threshold.

PROBLEM:

(1) Peer Specialists are not attending all client Comprehensive Treatment Team Meetings.

(2) All level I grievances are not being responded to within the time allowed.

(3) Peer Specialists are not attending all client Service Integration Meetings.

(4) Peer Specialist are not having documented contact with all clients admitted to RPC.

(6) Client satisfaction surveys are not being completed for all clients at RPC.

STATUS:

(1) Peer Specialist attendance at client treatment team meetings was up 5% from last quarter. The number of meetings missed due to attendance at admissions was up by 5 and up by 6 for having other meeting obligations. Not attending due to having no peer specialist available was up by 6. One less meeting was missed due to mandatory training this quarter, 23 less meetings were missed due to peer support being out sick or on vacation, and 15 less were due to clients not wanting peer support present for the meeting. The increase in compliance appears to be due to more clients wanting peer support present for their meetings and a decrease in peer support being out. Compliance was at 89% for the months of October and November and decrease in the month of December to 84%.

(2) Response to level I grievances was 95% for this quarter, down 4% from last quarter. October had an 83% compliance, November 100%, and December 95%. The late grievances for the month of October were due to the PSD on Lower Saco being out.

(3) Although Peer Specialists are not attending all client treatment team meetings, the threshold has been exceeded for the quarter as well as each month in the quarter.

(4) Peer Specialist contact with clients during admission was down 2% from last quarter. October had a 97% compliance rate, November was 92%, and December was 100%. The uncontacted clients were mostly due to the unavailability of the client for a meeting and clients being discharged within 1 day of admission.

(6) This is a new indicator for the quarter. Data was only collected for the month of December. Of the 12 clients offered surveys, 2 refused. Not all clients being discharged from RPC were offered surveys due to peer support worker not being notified of pending discharges. Clients on Upper Saco will be done annually. Peer support is awaiting a list of annual assessment dates in order to determine what clients should be surveyed.

ACTIONS:

- The Peer Support Coordinator will continue to meet with the Risk Manager as needed to address grievances that are not responded to within the time allowed.
- 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. Some meetings are missed due to mandatory peer support trainings that all Peer Specialists must attend and cannot be present for meetings. Peer Support Coordinator will confer with Peter Driscoll, Executive Director of Amistad, and Program Service Directors to provide coverage at those times.

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- Peer Specialists will make additional efforts to adjust their schedules to be available for meetings and problem-solve with the Peer Support Coordinator on how to manage their schedule and overcome barriers to attending team meetings.
- Peer Support Coordinator will address missed meetings related to Peer Specialists not being notified of Service Integration Meetings with the Social Services Director.
- Peer Support Coordinator will encourage Peer Specialists to make initial contact with newly admitted clients a priority.
- Peer Support Coordinator 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 list of annual assessment dates will be obtained from Upper Saco by the end of January 2007 so clients can be offered satisfaction surveys.
- A system will be developed for peer specialists to be notified of pending discharges so satisfaction surveys can be offered on all other units.

CLIENT SATISFACTION SURVEY

ASPECT: Satisfaction Surveys

Indicators	Findings	Compliance	Threshold Percentile
1. Has anyone informed you about your rights?	9/10	90%	85%
2. Has anyone talked to you about the services that are available to you?	9/10	90%	85%
3. Are you informed ahead of time of changes in your privileges, appointments or daily routines?	7/10	70%	85%
4. Do you know someone who can help you get what you want or stand up for your rights?	9/10	90%	85%
5. Has your Community Worker visited or contacted you since you have been in the hospital?	8/10	80%	85%
6. Do you know how to get in touch with your Community Worker?	5/10	50%	85%
7. Do you have an Individualized Support Plan (ISP)?	7/10	70%	85%
8. I feel more confident in my ability to deal with crisis situations?	8/10	80%	85%
9. I am less bothered by my symptoms now?	7/10	70%	85%
10. I am better able to function?	9/10	90%	85%
11. I do better in social situations?	7/10	70%	85%
12. I experience less difficulty in my life	6/10	60%	85%
13. I am treated with dignity and respect?	5/10	50%	85%
14. I feel comfortable asking questions about my treatment and medications?	5/10	50%	85%

15. I am encouraged to use self-help/peer support /groups after discharge?	8/10	80%	85%
16. My medication benefits and risks were discussed with me?	7/10	70%	85%
17. I am given information about how to understand and manage my illness?	6/10	60%	85%
18. My other medical conditions are being treated?	9/10	90%	85%
19. I feel free to complain without fear of retaliation?	10/10	100%	85%
20. I feel safe to refuse medication or treatment during my hospital stay?	6/10	60%	85%
21. I participate in planning my discharge?	6/10	60%	85%
22. I feel I had enough privacy in the hospital?	5/10	50%	85%
23. I feel safe while I am in the hospital?	6/10	60%	85%
24. If I had a choice of hospitals, I would still choose this one?	4/10	40%	85%

Findings: Peer Support provided clients the opportunity to offer the hospital feedback on the care they received while at RPC. The opportunity to respond is provided to every client scheduled for discharge; and to the longer term clients annually. There were only 10 clients who answered the survey out of 12 offered the survey in the month of December. There were 6 out of 24 questions answered at or above the Threshold. The rest of the questions were answered below the threshold of 85%.

Problems: There are 18 problems identified as being below threshold. They are numbers, 3, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 20, 21, 22, 23, and 24.

Status: This is a newly resumed aspect, therefore comparative quarter data is not available.

Actions:

In general, Discipline Chiefs and PSD's have been asked to review the findings of this survey with their respective staff. Additional actions below are provided by the indicator number of the identified problem.

3. To inform clients of changes in privileges, appointments, and daily routines planned actions are: Psychology Director will hold discussion in department meeting to identify how psychologists can assist on each unit; Upper Saco PSD will ensure that appointment cards are given when appointment is made, and clients will be informed of any needed lab work in advance.
- 5, 6, 7, & 21. Social Service Director will review survey findings with department to identify ways to increase contact from community support workers, help clients know how to get in touch with their community support workers, ensure clients who need an ISP have one, and to ensure optimal client participation in discharge planning.
8. To increase client confidence to deal with crisis situations planned actions are: Psychology Director will hold discussion in department meeting to identify how psychologists can assist on each unit; Peer Support will encourage clients to access the statewide Warm Line to get peer support during times of difficulty; PSD's will review treatment mall offerings that would be helpful with clients in community meetings; Treatment mall has recently initiated a new process group on Conflict Resolution.
9. To help clients cope with symptoms planned actions are: Psychology Director will hold discussion in department meeting to identify how psychologists can assist on each unit; Peer Support will encourage

clients to access peer support to share strategies that have helped others and instill the hope of recovery.

11. To help clients with social functioning planned actions are: Psychology Director will hold discussion in department meeting to identify how psychologists can assist on each unit; Peer Support will utilize intentional peer support to practice new social skills.
12. To help clients cope with life stressors planned actions are: Psychology Director will hold discussion in department meeting to identify how psychologists can assist on each unit; Peer Support will encourage clients to access peer support to discuss life stressors and share similar experiences and skills that helped them and others cope.
13. To ensure clients feel they are treated with dignity and respect planned actions are: Psychology Director will hold discussion in department meeting to identify how psychologists can assist on each unit; Peer Support will encourage and support clients in communicating with others who they feel are not treating them with dignity and respect.
- 14, 16, 17, & 20. Medical Director and Director of Nursing will review survey findings with their respective staff identify ways to help: (a) clients feel more comfortable asking questions about their treatment and medications, (b) medication risks and benefits are discussed with clients, (c) clients feel safe refusing medications or treatment during hospitalization, and (d) ensure clients receive appropriate education regarding how to understand manage their illness; Informed Consent policy will also be reviewed and revised as needed to support this effort.
15. Peer Support Director will ensure clients know of options available in the community and receive encouragement to access self-help groups, peer support networks and groups after discharge by providing clients with information at discharge about peer support networks and self-help groups in their area.
22. Peer Support Director will help clients address privacy issues planned corrective actions by encouraging and supporting clients in expressing their concerns/suggestions about their privacy to the treatment team.
23. To help clients feel safe in the hospital peer support will build trusting relationships with clients that will allow clients to share information in confidence without fear of unwanted outcomes; Safety Officer has revised and circulated contraband list to compliment the revised contraband policy scheduled for implementation in April.
24. All department heads will be asked to review survey findings with their respective staff and seek to identify ways to increase client satisfaction to the point RPC would the preferred point of care if a choice of hospital were available to clients.

PROGRAM SERVICE DIRECTORS/NURSING
 ASPECT: COMPREHENSIVE SERVICE PLAN
 OVERALL COMPLIANCE: 459/488 (94%)

Indicators	Findings	Compliance	Threshold Percentile
1. Completed no later than 14 days for the first 6 months and monthly thereafter.	62/69	90%	85%
2. Completed within 72 hours of a restrictive treatment.	3/5 (64 NA)	60%	85%
3a. Review form documents client participated in the review	63/69	91%	85%
3b. Review form documents psychiatrist participated in the review	69/69	100%	85%

3c. Review form documents CCM participated in the review	69/69	100%	85%
3d. Review form documents nurse participated in the review	69/69	100%	85%
4. Review form indicates plan as having met identified goals or not.	57/69	83%	85%
5. Review form states whether client continues to meet admission criteria or not	67/69	97%	85%

Observed Indicator Compliance: The above table provides relevant details by each indicator of this aspect. The “Findings” column shows number of cases found in compliance with the indicator per number of applicable cases audited. The “Compliance” column expresses these findings as a percentage of cases in compliance. The “Threshold Percentile” column shows the compliance target set for each indicator. One indicator (#2) was below threshold, with all the variability on Lower Saco. All other indicators were above threshold.

Findings: For this indicator the overall compliance rate was 94% and sample size was 69 charts. On indicator #2, of that n=69 sample only 5 clients experienced a restrictive treatment, thus an applicable n=5 with 64 others not applicable. There was also a new Nurse leader added to the leadership of the forensic admission unit late in the quarter, to compliment the new Program Service Director who joined the team last quarter.

Problems: Indicator #2 regarding the service plan revision being completed within 72 hours of a restrictive treatment is the only identified problem, and only on Lower Saco.

Status: Overall compliance declined from 96% last quarter to 94% this quarter.

Indicator #2 has been below threshold the two prior quarters, and continues to decline (83% to 64% last quarter to 60% this quarter). On all units except Lower Saco, the corrective actions previously applied were effective; on those units, compliance was 100%. To put this in some context, the proportion of clients in the sample who experienced a restrictive treatment also declined from last quarter (18% of the sample last quarter, 7% this quarter). All process variability continues to be exclusively from Lower Saco. In actual terms this means that 2 service plans (of 4 clients experiencing a restrictive intervention) were not reviewed within 72 hours of a restrictive intervention.

Indicator #4 is below threshold at 83%; it was above threshold at 90% last quarter following the prior quarter below threshold. In short, process stability has not yet been attained. All process variability on this indicator occurred on the forensic units only, Lower Saco and Upper Saco. On the two civil units, process stability has been preserved and the corrective actions previously applied were effective.

All other indicators are at or above threshold this quarter, and were last quarter as well.

Actions:

For indicator #2: Lower Saco PSD will review the importance, related care principles, intent, and expectations regarding reviewing and revising service plans as needed quickly following a restrictive intervention in a professional staff meeting and unit staff meetings; this shall be documented as a training for all licensed staff assigned to the unit who would have responsibility to

Final Draft

initiate service plan reviews. In addition, when there is a restrictive intervention, the PSD will personally review the chart the next business day and communicate findings and planned actions to the risk manager by the end of the day.

For indicator #4: Forensic PSDs on Upper Saco and Lower Saco shall review all Service Plan Reviews completed each week as evidenced by their signature and “[date] reviewed” until process stability above threshold has been documented and maintained for 4 consecutive weeks. This will ensure they are identifying variances from established standards more rapidly, and taking appropriate corrective actions at a local level. With the addition of the Nurse leader on Lower Saco, this will also help to develop process stability.

CONTINUITY OF CARE/Social Services Department
ASPECT: Preliminary Continuity of Care Meeting and
Comprehensive Psychosocial Assessments
OVERALL COMPLIANCE: 81%

Indicators	Findings	Compliance	Threshold Percentile
1. Preliminary Continuity of Care meeting completed by end of 3rd day	28/30	96%	100%
2. Service Integration form completed by the end of the 3rd day	28/30	95%	100%
3a. Client Participation in Preliminary Continuity of Care meeting.	27/30	90%	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	91%	80%
3d. Community Provider Participation in Preliminary Continuity of Care meeting.	10/30	33%	80%
3e. Correctional Personnel Participation in Preliminary Continuity of Care Meeting.	0/15	0%	60%
4. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission	28/30	93%	95%
5. Annual Psychosocial Assessment completed and current in chart	27/30	90%	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. This is the first quarterly report for the Social Services Department and will track variances and compliance in reference to baselines established here.

Problems:

Indicator 1 and 2: These areas fell below compliance for two reasons. One chart indicated that the acuity level of the client made engagement very difficult and the meeting did not occur until the 5th day at the facility. The second chart indicated that the meeting had been postponed for clinical reasons. The chart that was reviewed was for a forensic client who had been admitted to the hospital from corrections received directly into the Administrative Segregation area. The treatment team assessed that due to the client's mental health status the meeting should be postponed. An abbreviated Service Integration meeting was held on the 4th day of the client's admission.

Indicator 3d: Poor compliance was more common on the admission units than on the upper units for a variety of reasons. Most frequently this was due to the client choosing to not allow releases of information or participate in the assessment process to identify service providers in the community. Secondly some clients refused to have their provider participate. On two occasions the community providers were invited to the meeting but did not attend.

Indicator 3e: Forensic clients refused to allow corrections personnel to participate in their treatment, although consistently asked by CCMs with rationale for the request explained.

Indicator 4: Both of these late psychosocial assessments occurred on Lower Saco. One occurred during the transition of a new CCM to the unit. The other assessment was not completed on the set schedule due to an oversight--the assignment was not made.

Indicator 5: All of the charts that were out of compliance for this area were on Upper Kennebec. One had been assigned to the contract staff and overlooked. The other two were overdue by two weeks and have since been completed.

Status: Deferred as this is the first reporting period.

Actions:

Indicator 1 and 2: Social Services Director and CCM staff will continue to work on engaging with clients to initiate active participation in the Preliminary Meetings and work with designated teams when clinical barriers arise that impact the successful completion of these meetings within the prescribed timeframes. If the Service Integration Meeting is not held within the desired timeframe a progress note detailing the reason and contributing factors will be completed by the assigned CCM.

Indicator 3d: CCM staff will continue to process with difficult to engage clients to support them to understand the value of their community support staff being part of their preliminary care meeting and overall treatment planning process during their stay at RPC. CCM will document in weekly progress notes these on-going discussions and outcomes.

Social Services Director will engage with agencies as appropriate through the Ken-Som provider meeting when it is noted that an agency is identified, releases are secured and attendance from the agency has not occurred as requested by the client. Director will examine what the barrier to participation is and collaborate with the agency to eliminate it.

Indicator 3e: CCM staff will continue to process with difficult to engage clients to support them to understand the value of their correctional support staff being part of their preliminary care meeting and overall treatment planning process during their stay at RPC. CCM will document in weekly progress notes these on-going discussions and outcomes. CCM offering the clients the opportunity for the correctional support staff to attend their preliminary care meeting monitoring will be assessed.

Indicator 4: Director of Social Services will ensure that assigned CCM monitors prescribed timeframe for assessment and Director will run bi-weekly admission reports via the Meditech System as a trigger mechanism to additionally monitor this process. Department will continue to utilize contract staff to support this process when multiple admissions are received on the lower units in order to complete assessments within the prescribed timeline.

Indicator 5: Director of Social Services will continue to discuss work assignments during individual

supervision and CCM team meeting regarding the on-going monitoring of annual assessments. Additionally each unit has a list of annual assessment dates managed by the Ward Clerk for CCM's to utilize to monitor their specific clients and assessments.

CONTINUITY OF CARE/ Social Services

ASPECT: Forensic Unit: Institutional Reports

Overall Compliance: 88%

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.	41/41	100%	95%
2. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	2/5	40%	95%
3. The assigned CCM will review the new court order with the client and document the meeting in a progress note.	2/5	40%	95%

Findings: This aspect area began in Mid-October so the findings for indicator 1 is representative of an abbreviated part of the overall quarter. In a full quarter the baseline findings number should be close to 72.

Problems:

Indicator 2: The Institutional Reports on two occasions this quarter were completed and delivered within the 10 business day threshold. The other 3 reports were not completed within the required timeframe. It is indicated that the area that causes the deliver delay in most situations is during the review and revision stage of the report. It is indicated that this report process is time consuming but meeting the threshold must be set as a priority for this important process.

Indicator 3: All new court orders were previously reviewed informally with each client. This new PI requires a more tangible and formal process with accompanying documentation to support that the information has been explained to the client. We began this process mid quarter which accounts for the number of reviews that were not completed in a formal structure with clients.

Status: Deferred as this is the first reporting period.

Actions: Indicator 2: Director of Social Services will monitor Institutional Report Binder maintained by the Ward Clerk for pending reports. Director will engage the treatment team in unit morning rounds regarding progress with reports, potential barriers to meeting set timeframe and assistance that can be utilized from the CCM assigned to the unit to overcome potential barriers. Director of Social Services will alert Superintendent when a 10 day timeframe is exceeded and give a detail of causes and solutions for future reports.

Indicator 3: Director of Social Services will support CCM through individual supervision to monitor this process.

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.	11/13	84%	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.	11/11	100%	95%

Findings: The timeframe for this aspect area was 13 weeks. During that time the Client Discharge Plan Report was reviewed each week but on two occasions the plan was not distributed successfully. In the findings for Indicator 3 the timeframe of 11 weeks was used as a baseline due to the Department Meeting not being held because of two holidays during the quarter.

Problems: Indicator 2a: The plan was not sent out on two occasions during the quarter. One instance was attributable to staff absence due to illness. The other was due to the Social Services department not updating the report on time. On two other occasions the report did not go out via e-mail, which is the general practice; it was distributed at the Wednesday Client Discharge Planning Meeting. The practice currently to keep the document updated with timely and accurate information is that it will be updated each Wednesday by the CCM team, reviewed by the Director, and sent out each Friday.

Status: Deferred as this is the first reporting period.

Actions: Indicator 2a: Director of Social Services will ensure that all additions and corrections are made to the CDPD report minimally each Wednesday by individual CCM team members. Director will monitor for CDPD for accuracy and make needed corrections to the report. Director will engage with MIS and request that report is distributed each Friday.

CONTINUITY OF CARE/ Social Services
ASPECT: PROGRESS NOTES
Overall Compliance: 90%

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.	52/60	86%	90%
2. Contact note/progress note will indicate monthly meeting with all clients on assigned CCM caseload regarding Comprehensive Treatment Planning needs/Progress.	56/60	93%	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:

Indicator 1 and 2 are identified as problems. The threshold percentage was most affected by notes that were not completed from the Upper Kennebec Unit. The information has been processed and it has been indicated that it can be contributed to an individual time management issue that is in the process of being addressed and resolved. Additionally, the team has agreed on a weekly note format that will better streamline the process and allow for better time management of this important process in general. The team will be having on-going discussions regarding the importance of this documentation process and the building of therapeutic alliances with all clients.

Status: Deferred as this is the first reporting period.

Actions: Indicator 1 and 2: Director of Social Services will continue to discuss work assignments during individual supervision and CCM team meeting regarding the on-going completion of progress notes/treatment team note and any potential barriers to meeting the prescribed timelines for this indicator.

REHABILITATION

ASPECT: UPPER SACO CLIENT’S ATTENDANCE to prescribed treatment OVERALL COMPLIANCE: 60%

Indicator	Findings	Compliance	Threshold
1. Number of scheduled Program Hours offered	103.75 of 103.75	100%	100%
2. Number of Program Hours Attended	62.75 of 103.75	60%	75%

3. Number of Program Hours Refused	31.50 of 103.75	30%	25%
4. Number of Program Hours Excused	8 of 103.75	8%	5%
5. Level of Client Engagement	No Data Available		

Findings: The baseline for this new indicator was taken from the week of December 3rd to December 9th. Each of the charts that were reviewed showed that clients were offered a different number of program hours ranging from as little as 9 hours to the high mark of 21.75 hours. Of the 24 clients on the unit, 6 charts were reviewed. The total number of programs offered to all 6 clients was 103.75 hours. All of these hours were scheduled and provided. The problem arises in trying to account for any additional hours that should be scheduled as the “stat sheets” are not set up to capture all of the programming that is scheduled. Of the total 103.75 hours of programming offered to clients, the clients participated in 62.75 hours for a 60% total. The number of hours that client’s refused or were excused from programming represented 38% of the 103.75 hours offered. The remainder of hours not accounted for are due to the incomplete information on the “stat” sheets.

Problem: The review of 25 % of the client’s charts showed the following problems: It is difficult to clearly identify the number of hours that were prescribed to clients as information available is incomplete as well as generic to all. Assessments completed are reflective of where the client was at the time of admission and have not been updated as the client’s care has changed. There were no new Readiness Assessments completed on the 6 charts that were reviewed. Clients were each offered a variety of hours of programming, with no distinction as to why some clients are offered some programs and others are not. Information regarding whether or not clients attending all prescriptive programs is also insufficient. The “stat” sheets that are used to capture clients’ attendance to programs are incomplete. There is no procedure set forth to refer clients to programs as well as no way to measure their level of engagement in the notes that are completed with the Mall Programming.

Status: A review of the baseline data demonstrates that there are many areas in need of improvement in regards to assessing, prescribing and documenting treatment for clients.

Actions:

- A referral process will be implemented with the new Winter Session Mall schedule starting January 8th, 2007.
- A level of engagement scale will be added to the Harbor Mall Flow sheets.
- All group leaders will be educated as to the changes in the referral process as well as the note writing process.
- The newly assigned Recreation Therapist for Upper Saco will begin to assess all clients using the Readiness assessment.
- The findings will identify areas of need.
- The stat sheets will be revised to reflect current programming as well as identify the anticipated length of each program provided.
- Each client will be provided a copy of their schedule of prescribed programming by the Rehab. Staff assigned to the unit.

PSYCHOLOGY**ASPECT: CO-OCCURRING DISORDERS INTEGRATION**

2ndQuarter 2007 October and November 2006 Co-Occurring Disorders Integration			
Indicators	Findings	Compliance	Threshold
#1 There is evidence of an integrated co-occurring assessment.	15/42	35%	50%
#2 There is evidence of an assessment of “stage of change”.	27/42	64%	15%
#3 There is evidence of an integrated co-occurring comprehensive service plan for identified clients.	2/8	25%	20% 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	(100% of baseline data collected) 0% increase	Four units participating 10% Increase To be Reported Annually
#5 Improvements in client satisfaction regarding integration of treatment/ services as measured by a Client Satisfaction Survey.	Client Satisfaction Survey approved	0% Use of survey not yet implemented	10% To be Reported Quarterly

Findings:

For indicators #1-3 in October and November an additional 44 charts were audited, thresholds were established as detailed in the table. Compliance was measured as indicated above.

#1 Evidence of an integrated assessment was largely unchanged from previous months.

#2 Stage of change assessment evidenced the most significant change and far exceeded expectations.

It should be noted that findings reported do not separate stage of change for mental illness and substance abuse. While assessment for stage of change for mental illness has improved, it is unclear as to whether or not that stage of change identification for substance abuse has improved.

#3 Integrated service plan for identified clients met expectations. However, it should be noted that this is based on a very small N. #4-5 No data to report this quarter.

Problems

#1-3: Clients needing co-occurring services are not being assessed adequately. Admissions assessment documentation forms do not adequately reflect screening and assessment information for needed co-occurring treatment.

#4: Clients are not adequately assessed and treatment planned for integrated treatment and services. Treatment teams are not adequately prepared to treat co-occurring disorders in an integrated manner.

#5: Client satisfaction with integrated co-occurring treatment is unknown. Current client satisfaction survey does not adequately address co-occurring treatment.

Status

#1-3; A total of 121 chart audits have been completed. The assessment PIT reviewed the nursing assessment forms and psychosocial assessment forms and changes were made to include integrated assessment and stage of change assessment language. These forms are being piloted on selected units. Education for CCM completing psychosocial assessments is in progress.

#4; COMPASS findings continue to be reviewed by treatment teams. Co-occurring assessment and staff training are two areas identified as needing improvement on all units. Staff education regarding attitudes toward addictions has been initiated on one unit.

#5 Co-occurring client satisfaction survey has been approved.

Actions:

#1-3: An additional 25 charts will be audited each quarter. The piloted nursing assessment forms and psychosocial assessment forms to be used on all units. Comprehensive service plans to reflect integrated assessment, stage of change assessment language and criteria, and treatment goals to be developed through a PIT process.

#4 Capital Community Clinics and the Forensic ACT team to complete COMPASS assessments within the next quarter. Each unit/service area will identify specific targeted change goals within the next quarter.

#5: New satisfaction survey to be implemented. Baseline data to be established.

SAFETY

Aspect: LIFE SAFETY

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.	68/69	98%	100%
2. 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.	3/3	100%	100%
3. Total number of staff that knows what R.A.C.E. stands for.	6/6	100%	100%
4. 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.	6/6	100%	100%
5. Total number of staff that knows how to activate the nearest fire alarm pull station.	6/6	100%	100%

6. Total number of staff that knows how to acknowledge the fire alarm or trouble alarm on the enunciator panel.	6/6	100%	100%
7. Total number of staff that knows the emergency number.	6/6	100%	100%
8. Total number of staff that knows what the verbal code is used to announce a fire.	5/6	83%	100%
9. Total number of staff that knows it is necessary to close all doors after checking the room or area.	6/6	100%	100%
10. The total number of staff that knows what the acronym, P.A.S.S. stands for.	6/6	100%	100%
11. The total number of staff that knows the location of the two nearest exits to evacuate away from a fire area	6/6	100%	100%
12. The total number of staff that knows two ways that may be used to move a person who is non-ambulatory to safety.	6/6	100%	100%

Findings: 1. Upper Saco has 100% of staff trained for the evacuation chair. Upper Kennebec has (34) assigned staff out of (36) who have received the training. This equates to 94%. This is a combined total of 97%. One staff member from UK is on FMLA that brings the percentage trained to 97% with an overall percentage of both units to 98%.

2. The (3) alarms reported for the hospital meets the required number of drills per JCAHO and Life Safety Code.
Of the (3) alarms, one was a drill activated by the Safety Officer.
- 4-10. Indicators 4 through 10 are new indicators with 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.

Problems:

Indicator #8 5 out of 6 staff knows the verbal code, Code 77, used to announce a fire.

Actions:

Regarding Code 77 the verbal code to announce fire, the safety officer will bring to the safety committee to change it to “Code Red.”

SAFETY

Aspect: Fire Drills Remote Sites

Compliance: 83 %

Indicators	Findings	Compliance	Threshold Percentile
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.	1 day shift 3 night shift	66%	100%
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.	1 drill	100%	100%

Findings: Homestead had 4 drills, but did not have a drill during the evening shift. Portland Clinic had the required amount of fire drills.

Problems: There was no evening fire drill at Homestead.

Status: New indicator

Actions: The safety officer will perform a fire drill at Homestead on evening shift within the next 7 days.

STAFF DEVELOPMENT

ASPECT: New Employee and Mandatory Training

Indicators	Findings	Compliance	Threshold Percentile
1. New employees will complete new employee orientation within 60 days of hire.	8 of 8	100 %	100 %
2. New employees will complete CPR training within 30 days of hire.	8 of 8	100 %	100 %
3. New employees will complete NAPPI training within 60 days of hire.	18 of 18	100 %	100 %
4. Riverview staff will attend CPR training bi-annually.	277 of 277	100 %	100 %
5. Riverview staff will attend NAPPI Mod 1 training annually.	320 of 327	98 %	100 %
6. Riverview staff will attend NAPPI Mod 2 training annually.	258 of 266	97 %	100 %
7. Riverview staff will attend Annual training. Goal is to be at 50% after Fall training.	240 of 336 have completed annual training	71 %	50 %

Findings: The indicators are based on the requirements for all new/current staff to complete mandatory training and maintain current certifications. 8 out of 8 (100%) new employees completed these trainings. 277 of 277 (100%) employees are current with CPR certification. 240 of 336 (71 %)

employees are current in Annual training. 258 of 266 (97%) employees are current in Nappi Module 2. All indicators remained at 100 % compliance for quarter 2-FY 2006.

Problem: Indicators 5 and 6 are identified as problems as they are below established thresholds. A make-up day for Module 2 was held on December 29th for those to get their training in and 12 did not attend that day. 4 employees are out on leave and 8 did not attend.

Status: This is the second quarter of report for these indicators. CPR remains stable at 100% compliance. Annual training continues to be above the 50% threshold after the Fall Training Fair. Nappi Module 2 is below the 100% threshold by 3%. Continue to monitor.

Actions: Supervisors of those employees that are not current with their trainings have been notified and recommendations of oral counseling were made. A make-up day for Module 2 was held on December 29th for those to get their training in and 12 did not attend that day. A last chance-training day will be held in June for those that have not attended some of the modules in an attempt to get everyone trained and compliant in training.

STAFF DEVELOPMENT

ASPECT: COMMUNITY PROVIDER TRAINING

Riverview Psychiatric Center offered several workshops and training this second quarter. We offered 2 different trainings in each month of the quarter that community members attended. We offered the Nappi 4 day Initial and the CPR Recertification that was attended by 2 community members each. 1 member attended the PSR Audio Conference on Hope and Health and 15 people attended a CPR class in December as well as 4 people attending a Mental Health Support Specialist class.

This table depicts the class offered in the last quarter that the community members could attend.

BEST PRACTICES	Type of Class	Date	All participants	Material
Paths to Recovery Modulating Putative Depression Circuits using DBS	Psychiatric Grand Rounds	10/3/06 RPC	9 participants	Hard copy available
Psychodynamic Therapy	Psychiatric Grand Rounds	10/10/06 RPC	4 participants	Hard copy available
Treatment Resistant Depression	Psychiatric Grand Rounds	10/17/06 RPC	9 participants	Hard copy available
PTSD	Psychiatric Grand Rounds	10/24/06 RPC	8 participants	Hard copy available
New Frontiers in Cardiovascular Risk Management	Medical Grand Rounds	10/6/06 RPC	4 participants	Hard copy available
Extraesophageal Presentations of Gastroesophageal Reflux Disease	Medical Grand Rounds	10/13/06 RPC	8 participants	Hard copy available
Love and Death	Medical Grand Rounds	10/20/06 RPC	10 participants	Hard copy available
Islet Cell Transplantation: A Thirty Year Perspective and Beyond	Medical Grand Rounds	10/27/06 RPC	7 Participants	Hard copy available
CPR	Recertification	10/31/06	14 participants	Hard copy available

Pulmonary Rehabilitation	Medical Grand Rounds	11/3/06 RPC	6 participants	Hard copy available
The Effects of Diet on the Occurrence of Cancer and Other Major Diseases	Medical Grand Rounds	11/17/06 RPC	8 participants	Hard copy available
Food and the Brain: FMRI studies of natural systems and underlying food motivation	Psychiatric Grand Rounds	11/7/06 RPC	11 participants	Hard copy available
Recent Imaging Studies in Major Depressive Subtypes	Psychiatric Grand Rounds	11/21/06 RPC	3 participants	Hard copy available
Pulmonary Hypertension: Bench to Bedside	Medical Grand Rounds	12/1/06 RPC	5 participants	Hard copy available
Acute Stroke Update: Is an Organized Regional System of Care Coming?	Medical Grand Rounds	12/8/06 RPC	3 participants	Hard copy available
Competency Based Education	Medical Grand Rounds	12/15/06 RPC	4 participants	Hard copy available
Practice Based Learning and Improvement: Clinical Quality Improvement	Psychiatric Grand Rounds	12/5/06 RPC	7 participants	Hard copy available
Three Component Model for Primary Care Mental Health Management	Psychiatric Grand Rounds	12/12/06 RPC	6 participants	Hard copy available
CPR	Initial Class	12/12/06 RPC	9 participants	Hard copy available
CPR	Initial Class	12/19/06 RPC	14 participants	Hard copy available
MHSS	Certification	12/19/06 RPC	4 participants	Hard copy available

COMMUNITY FORENSIC ACT TEAM

Aspect: Descriptive Report on various components

Descriptive Analysis Components:

Case Load

- 27 clients served by ACT Team; 32 is ACT Team capacity. Operating at 84% capacity.
- 0 clients on wait list
- 0 clients discharged
- 1 client referred to PTP

Participation Status

- 27 (100%) of clients served under Forensic process
- 0 (0%) of clients served under Progressive Treatment Program or served as voluntary participants
- Clients electing to continue with ACT services under voluntary status—Indicator N/A at this early date

Vocational/Educational

- 9 clients (33% of clients) working at a community work site; 3 months prior to ACT services, 7 clients were working.
- 564 Total hours worked by clients served by the team
- 63 hours worked monthly per working client on average
- Clients with increased earnings as compared to last quarter—Indicator N/A at this early date
- 3 client (11% of clients) have applied for Ticket to Work Program
- 3 clients (11% clients) who are currently working in a Ticket to Work program job.

Crisis Management

- 2 Crisis intervention calls during month of December
- Both of those (100%) received between 8am-8pm; **none** received between 8pm-8am.
- 100% were resolved without resources beyond the ACT team
- None (0%) resulted in hospitalization, respite care, or intervention from law enforcement

Substance Use

- 6 clients (22% of clients) with substance use issue as a matter of clinical focus, of those--
 - 2 (33%) precontemplative stage of readiness
 - 2 (33 %) contemplative stage of readiness
 - 1 (17%) preparation stage of readiness
 - 1 (17%) action stage of readiness
 - 0 (0%) maintenance stage of readiness

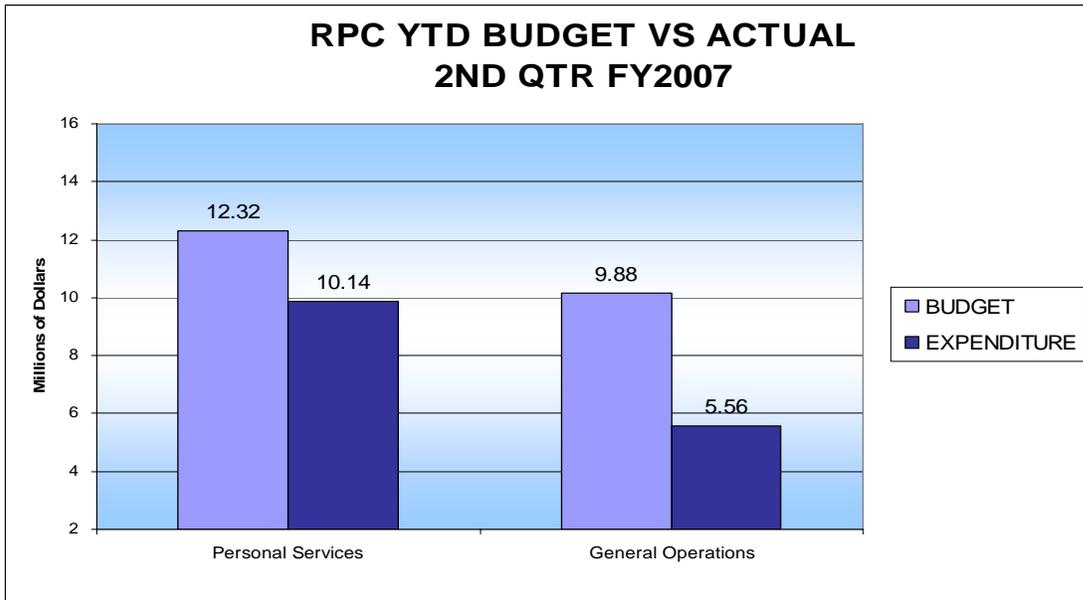
Living Situation

- 26 clients (96%) residing in a non-institutional setting for the entire month (i.e., out of jail, hospital, respite care), and of those
 - 26 clients (100%) residing in a supervised, non-institutional setting (e.g., supervised apartment, homestead) for more than 15 days of the last 30 month
 - 0 clients (0%) residing in an unsupervised, non-institutional setting (e.g., own apartment) for more than 15 days of the last 30.
- 1 client (4%) who at any time during the month was homeless, incarcerated, in a shelter, hospitalized.
 - 0 clients were Homeless
 - 0 clients were Incarcerated
 - 0 clients used a Shelter
 - 1 Hospitalized
- In the three months prior to ACT services, 23 clients were residing in supervised, non-institutional settings. In December, one of the total 27 clients received permission from Superior Court to move into an independent apartment setting.

Section II: Riverview Unique Information

BUDGET

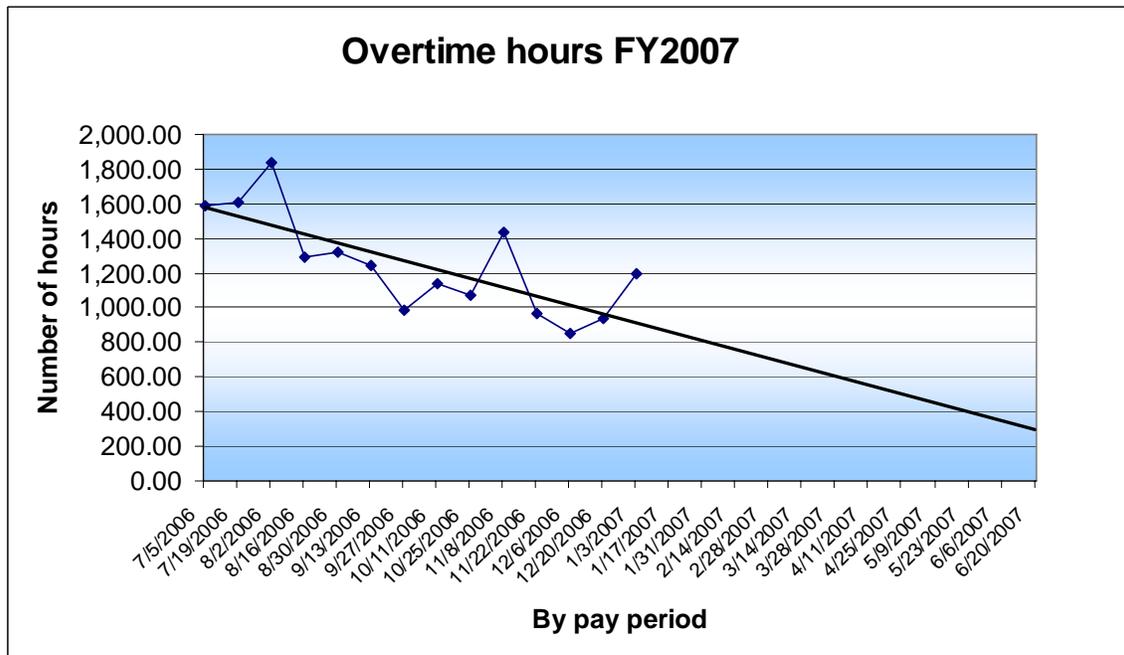
ASPECT: BUDGET INFORMATION



The hospital is currently within budget. RPC will continue monitoring and careful management of overtime and mandates as well as careful management of all contractual services via fiscal and programmatic accountability.

HUMAN RESOURCES

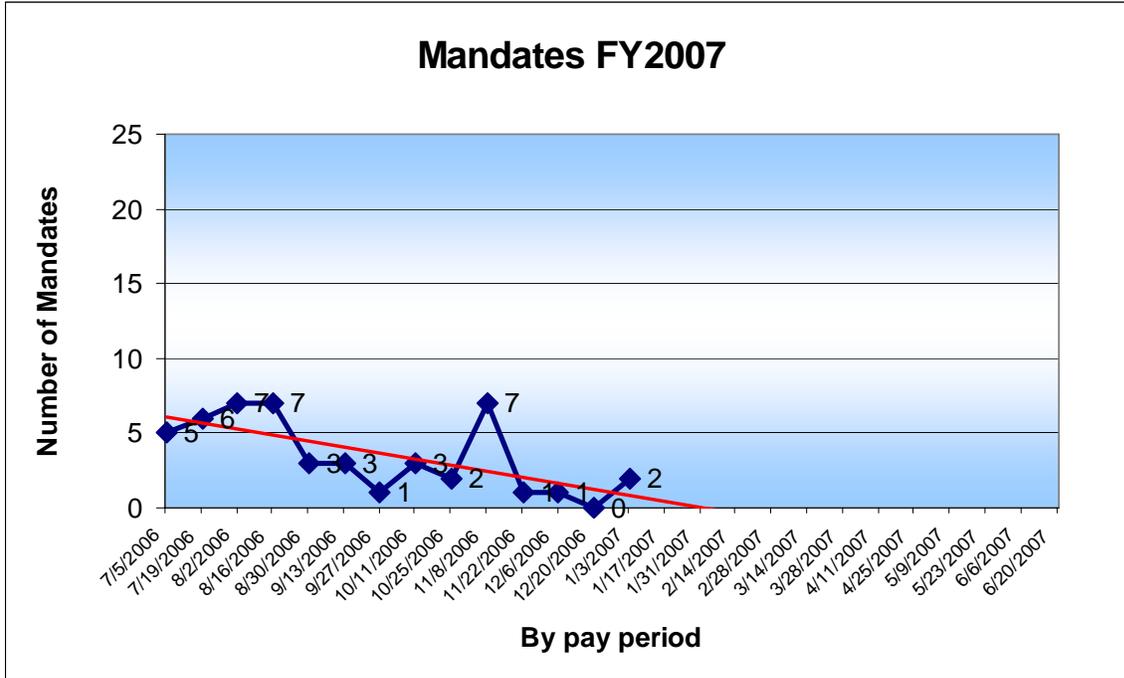
ASPECT: OVERTIME



Overtime has increased this year compared to the same time period last year. During this same time period (Oct 2005 - Dec 2005) we were at a total of 5,776 hrs of overtime. This year we are at 6397.25 hrs of overtime. This represents a 10% increase. However, we had a 35% decrease as compared to the first quarter of 2007 (July - Sept) where we had 9,874.25 hrs of overtime. During

this time period we had significant amount of overtime occur due to the 40 hour forensic training offered to MHW's.

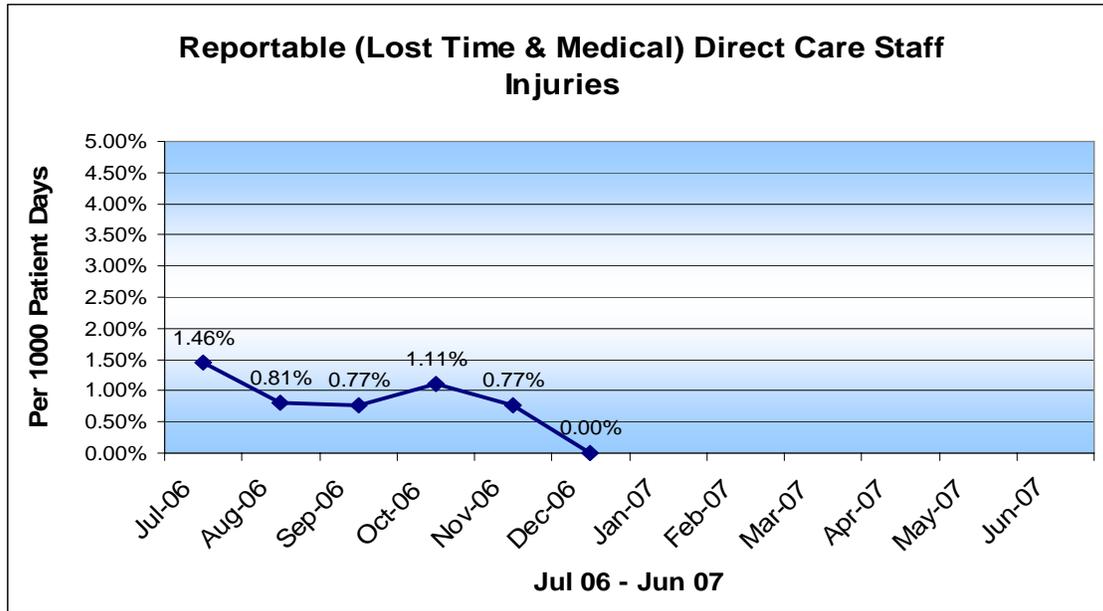
ASPECT: MANDATES



Mandated shifts have increased this second quarter of 2007 as compared to last year at this same time frame. During Oct 2005 - Dec 2005 we had 13 mandates, this year we've had 14 mandates for this same timeframe. This is a 7% increase from last year. However, we had a 44% decrease as compared to the first quarter of 2007 (July - Sept) where we had 32 mandates. Some of the increase is a result of the 40 forensic training offered over this quarter.

HUMAN RESOURCES/RISK MANAGEMENT

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



At the end of the last fiscal year a new risk management procedure was implemented to evaluate each injury cause and to try to decrease the likelihood of a reoccurrence. Each injury is reviewed by the staff member’s supervisor, and by the staff member as well as the executive leader of the supervisor at Executive Leadership meetings to review and report the above risk event to the committee and identify the safety actions implemented and provide evidence that all safety recommendations were instituted and the actions effectiveness at reducing re-occurrence.

This quarter review reveals that there was a decrease in direct care staff injuries from 1.01% per 1000 patient days to .63% per 1000 patient days. This number represents (5) direct care staff who sought medical treatment or lost time from work, as compared to (8) last quarter

Management of Human Resources

ASPECT: Performance Evaluations

OVERALL COMPLIANCE: 55.35%

INDICATOR	Findings		Target
Employee Performance Evaluations expected to be completed within 30 days of the due date.			
Oct 2006 (Aug evals)	17 of 35	48.57%	85%
Nov 2006 (Sept evals)	21 of 33	63.64%	85%
Dec 2006 (Oct evals)	14 of 26	53.84%	85%

As compared to last quarter (83.8%) this quarter’s *decreased* to 55.35%. As compared to the same quarter last year, 2005, we were at 63% compliance. During this quarter 94 performance evaluations

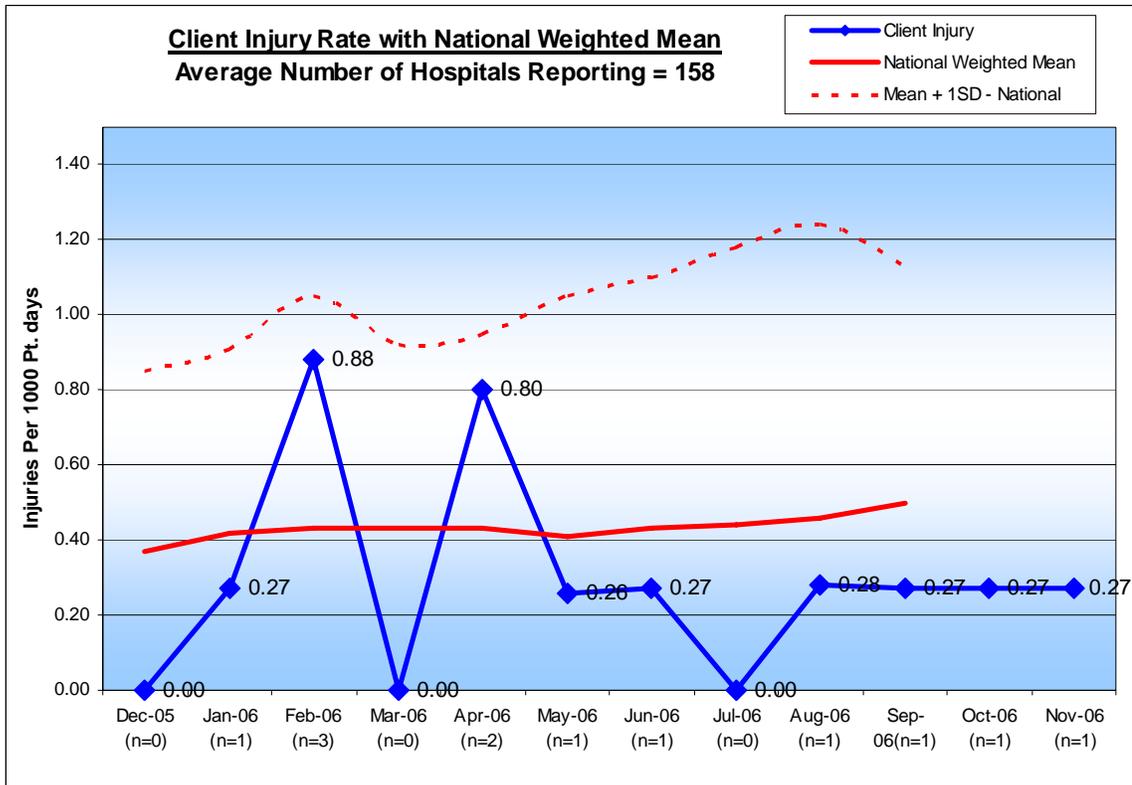
were sent out; 52 were received in a timely manner. Human Resources continue to stress the importance of timely submission and requested from all Department Heads to submit their evaluations for processing for timely merit increases for staff.

During this quarter Leadership staff recommended a reorganization of PSD's and RN IV's work assignments and the goal of the reassignment of tasks is to better assist the units in clinical oversight and reassigning supervision duties to RN III's and performance evaluation completion.

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. This quarter you will notice the national weighted mean (solid red line) and the limit of the first standard deviation (dashed red line) as reference points are not included. NRI the vendor for these non core measure comparisons has changed the process, and have not been able to provide us with the information to date. RPC rate for the indicators is represented by the solid blue line. Previous to this quarter, the majority of these graphs will show, Riverview's rates do vary above and below the "anticipated" weighted national mean, but are typically within the "normal" range (within the 1st Standard Deviation) of other hospitals in the sample.

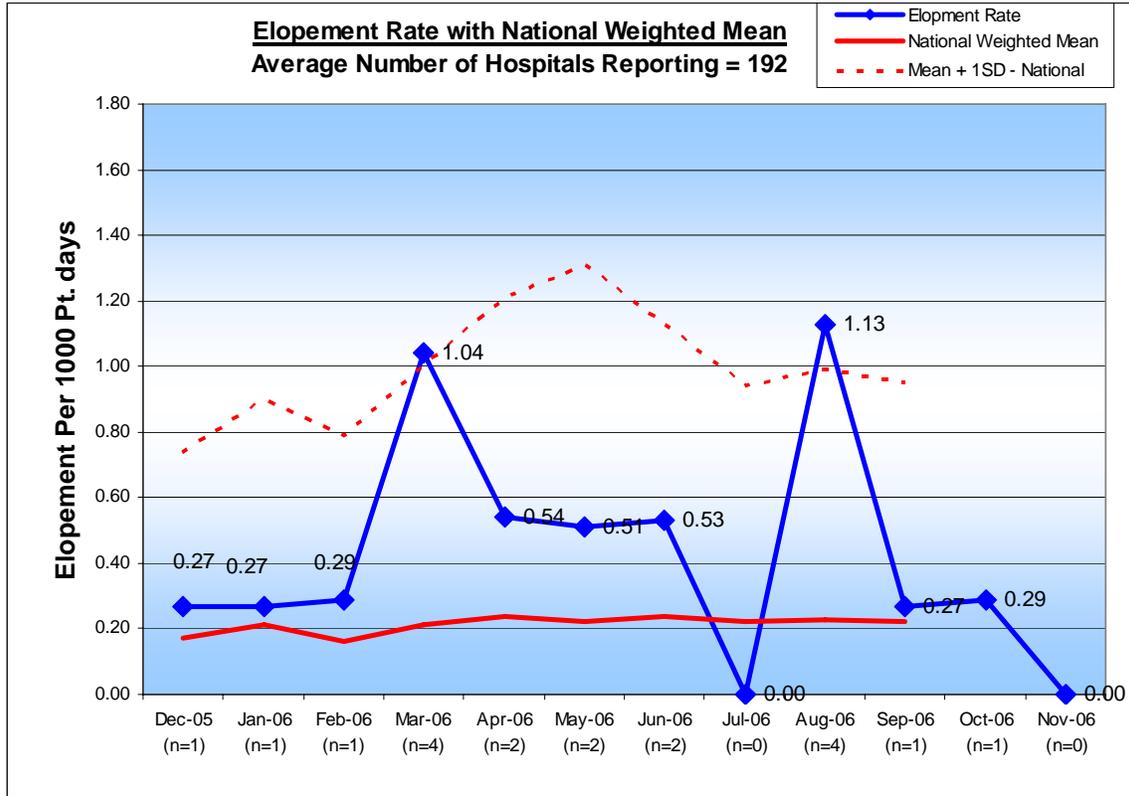
CLIENT INJURY RATE GRAPH



Client Injury Rate considers slips, trips and falls; self-injurious behavior; and client-to-client injury that requires more than first-aid. The numbers of such incidents are low, as shown by the little n under each month. Riverview's line, although appearing to have dramatic fluctuation, is in part the

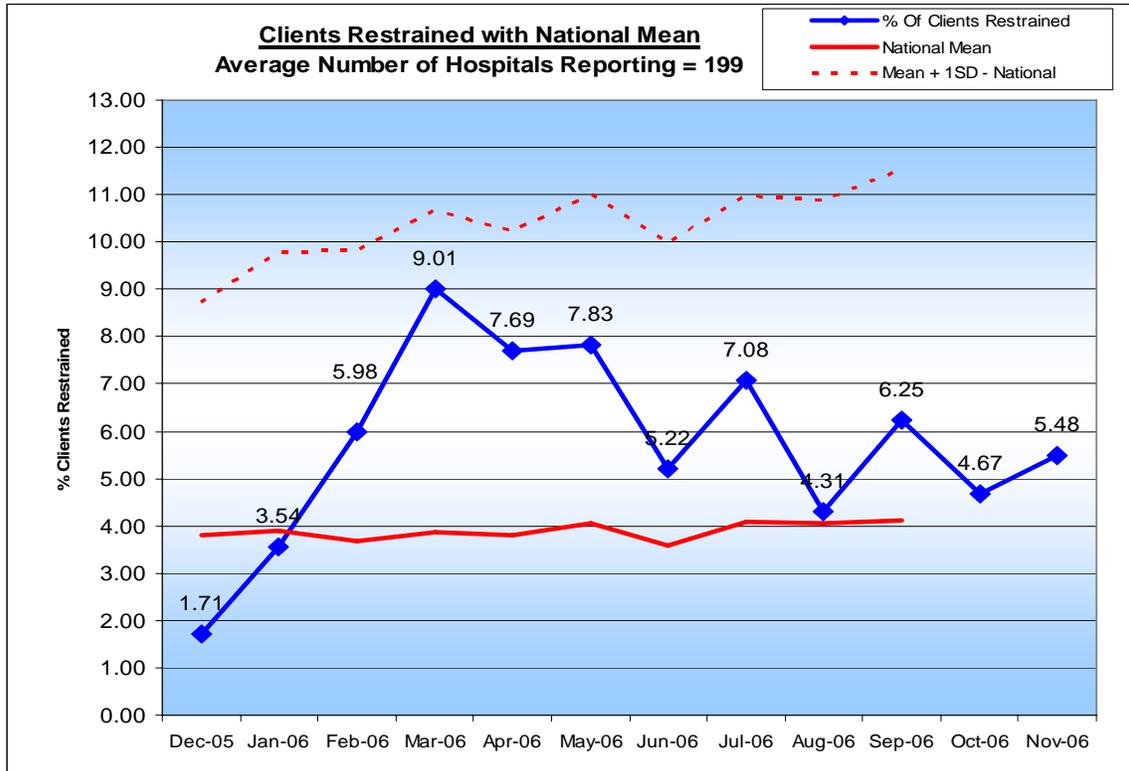
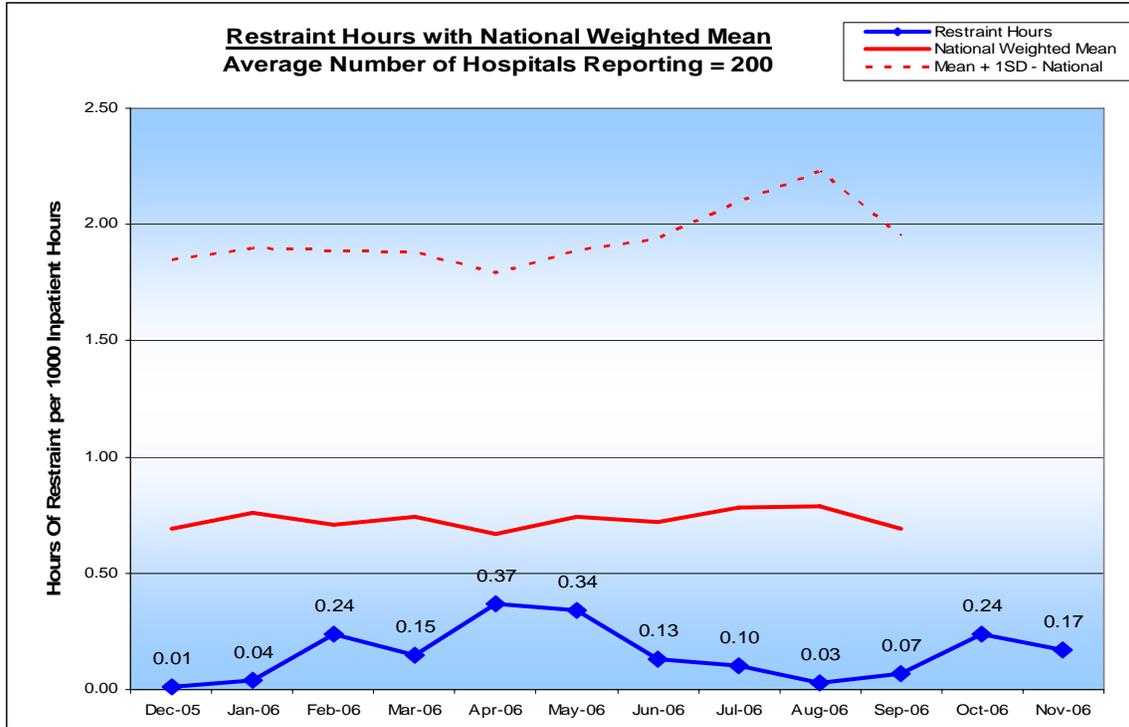
result of the scale used on the Y-axis. Riverview is well within the 1st standard deviation of the national sample. Please note the sheer number of events at Riverview is very low, between zero and 3 each month. Over the last 3 months, there were a total of 3 injuries requiring more than first aid level of care. Taking the mean of Riverview's rate over the quarter (given client injuries are very infrequent) would put Riverview's rate below the national mean at 0.27

ELOPEMENT RATE GRAPH



Elopement Rate is calculated per 1000 patient days. Elopement risk is evaluated by the treatment team and is treatment planned if necessary to keep the client and the community safe. All 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 very low, between 0 to 4 each month. Over the last 3 months reported in this graphs, there were a 2 events meeting the hospital definition of elopement.

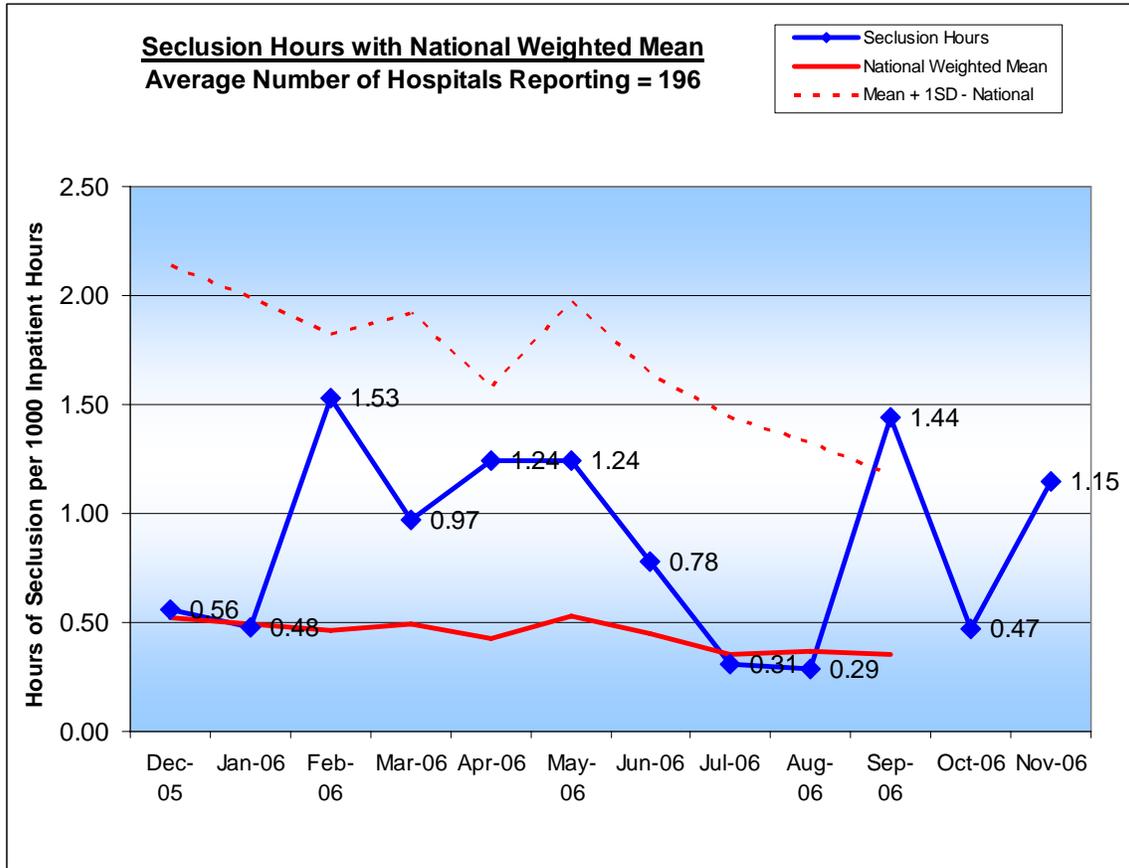
RESTRAINT GRAPHS

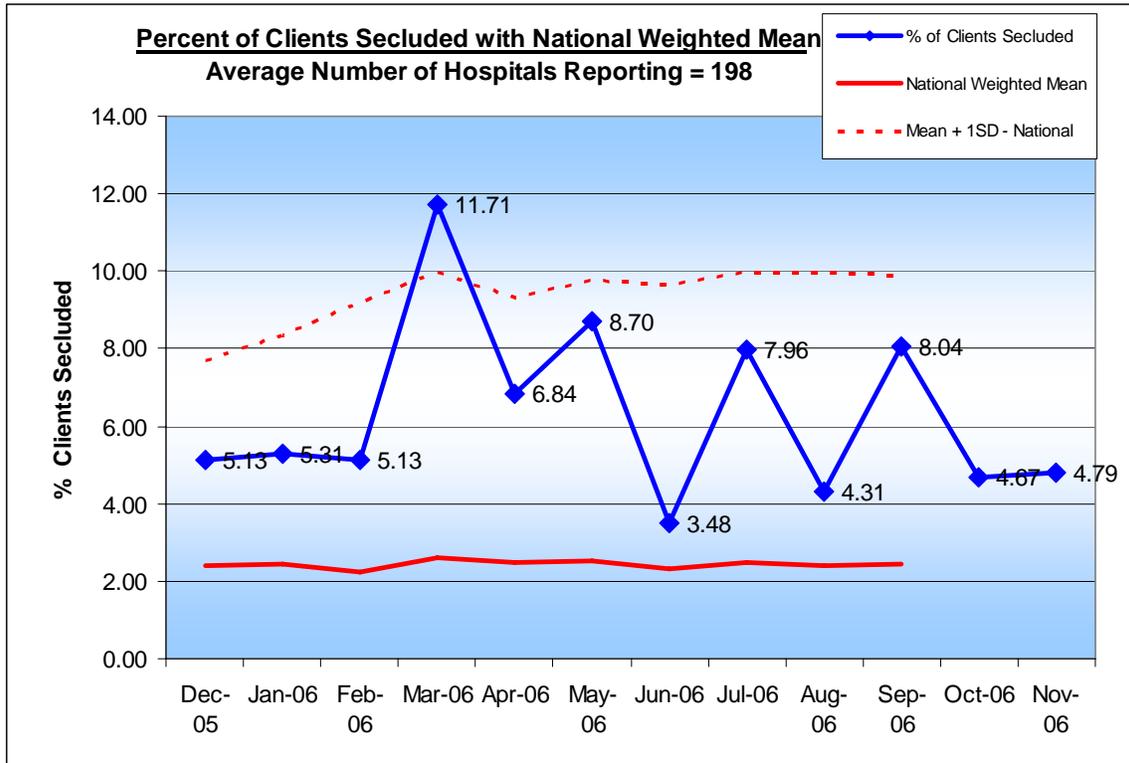


Riverview’s rate of clients restrained, although above the statistical mean, is comparable to at least 68% of hospitals in the national sample. The restraint hours (duration) rate is well below the statistical mean, but also comparable to the bulk of hospitals in the national sample. The data would suggest 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 is in progress; 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; the hospital has put forward a proposed tobacco-free campus policy as national data show that tobacco-related issues are often precipitants to restraint/seclusion events in a national sample (smoking/tobacco as significant precursor to restraint/seclusion events was 5% in non-smoking facilities vs. 34% in smoking facilities--7 times more).

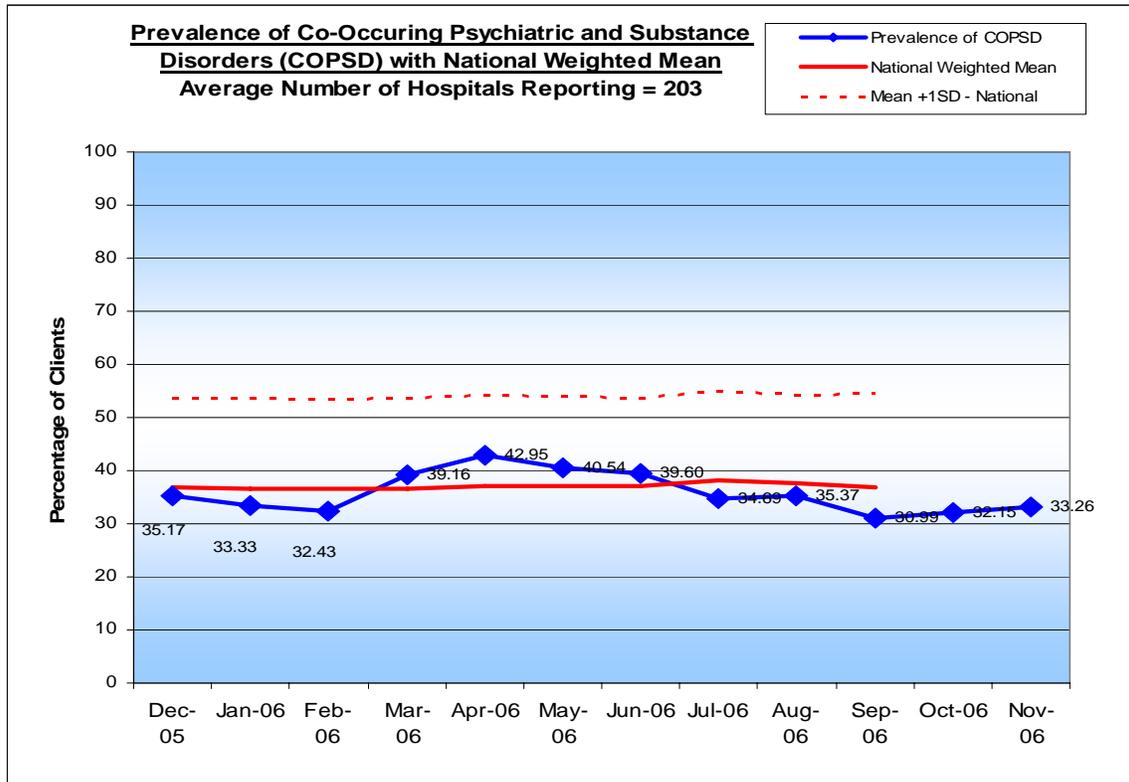
SECLUSION GRAPHS





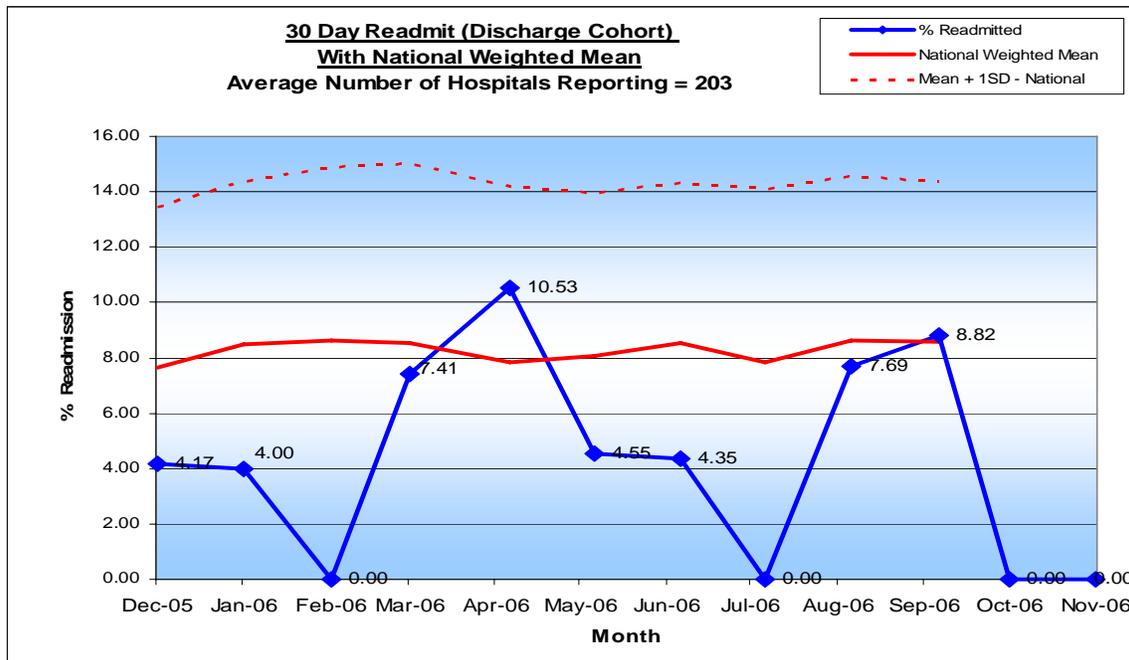
Riverview used seclusion more frequently than 68% of hospitals in the national sample in the month of March, but the rate is generally comparable to the national sample in other months. Seclusion hours (duration of events) at Riverview, although tending to be above the national weighted mean, are within the 1st Standard Deviation of other hospitals in the national sample. Riverview’s efforts to reduce use of these interventions should focus on both the frequency and duration of seclusion events. Corrective actions applied are: reducing the time for seclusion order renewal from 4 hours to 2 hours; 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; The hospital has put forward a proposed tobacco-free campus policy as national data show that tobacco-related issues are often precipitants to restraint/seclusion events in a national sample (smoking/tobacco as significant precursor to restraint/seclusion events was 5% in non-smoking facilities vs. 34% in smoking facilities--7 times more)

CO-OCCURRING PSYCHIATRIC AND SUBSTANCE ABUSE DISORDERS GRAPH



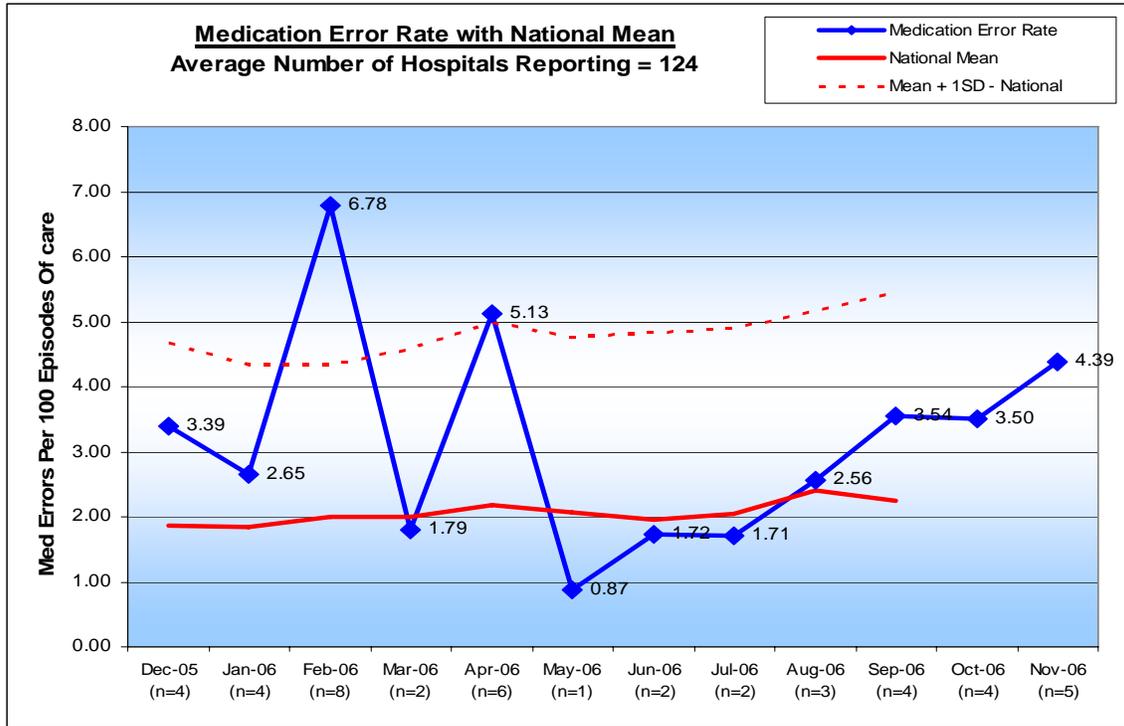
RPC has recently begun a collaborative effort with Spring Harbor Hospital Co-Occurring Disorders providers to contract with RPC to develop a Co-Occurring program. This information is gathered from admission diagnosis;

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. At RPC readmissions on the forensic unit are at will of the court are not considered in the calculation;

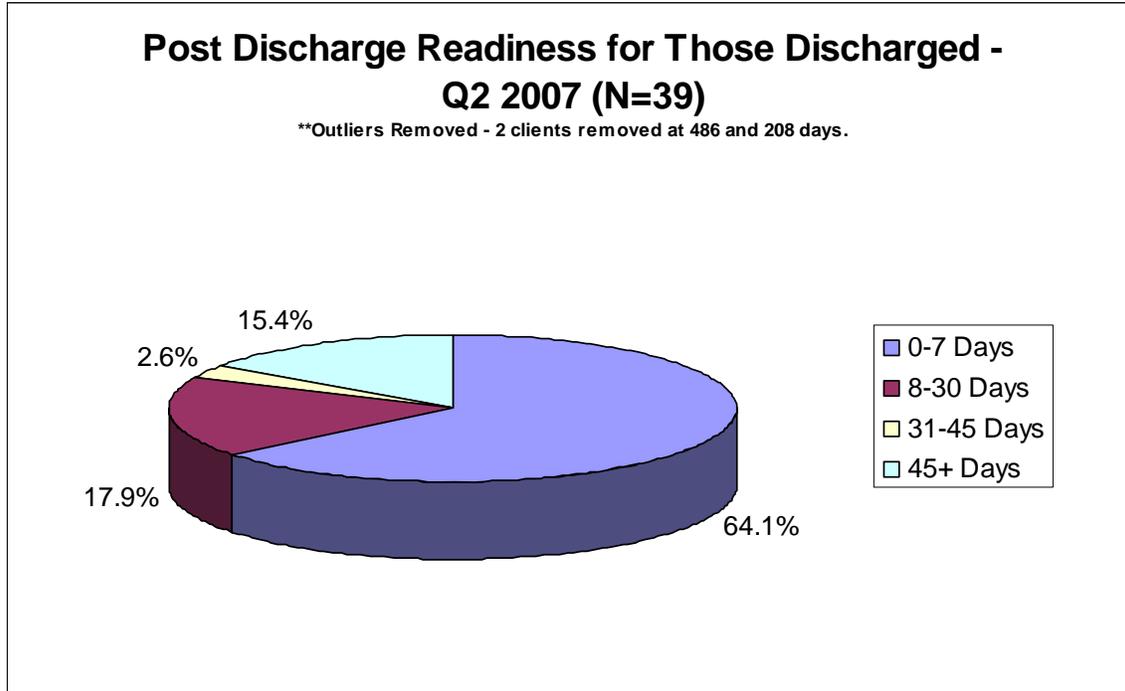
MEDICATION ERROR RATE WITH NATIONAL MEAN GRAPH



The medication error rate considers the number of medication errors for every 100 episodes of care. For example a medication error rater of 1.6 means that 2 medication errors occurred each 125 episodes of care.

The medication error rater has been at or below one standard deviation of the national mean for most of the last year in comparison to 127 like facilities. The n underneath each month are the actual number of medication variances in a given month.

POST DISCHARGE READINESS PRIOR TO DISCHARGE



This chart shows the percent of clients who were discharged within 7 days of their discharge readiness to be at 64.1%; 8- 30 days post readiness 17.9 %; 31-45days at 2.62% and Greater than 45 days post discharge ready 15.4% of clients discharged this quarter. Cumulative percentages and targets are as follows:

- Within 7 days = 64.1% (target 75%)
- Within 30 days = 92 % (target 90%)
- Within 45 days = 85.6 % (target 100%)

Last quarter cumulative percentages were as follows:

- Within 7 days = 51 % (target 75%)
- Within 30days= 73% (target 90%)
- Within 45 days=82 % (target 100%)

Section IV: Process Improvement Team Reports

Comprehensive Service Plan Process PIT:

A PIT was assigned to review and revise our comprehensive service plan form and associated processes. This was completed and the associated forms were approved at Executive Leadership, now submitted to Medical Records for formal adoption at the November meeting. In the interim, this will be piloted on Lower Kennebec to start. This paper form was also provided the team working on automating the comprehensive service plan as the structure to build the computerized infrastructure around. The planned end result is for all treatment forms to be generated via use of this application, to ensure consistency and quality across all areas of the hospital. The Director of Nursing is the chairperson. This PIT reports to Clinical Leadership and Executive Leadership Committees, and will report to ELC Feb 7, 2007.

Lab PIT

A PIT was assigned because Providers want more timely access to lab results. The medical staff now all has computer access to Clinical Work Station, where RPC client lab information is available into the system. Several docs have successfully used the system to gain access to lab data. There continues to be difficulty related to lab order entry and communication to the next shift that the client is NPO for labs. The Lab PIT will meet again to help resolve this issue, and to develop indicators to assure its continued success. The chair person of the Lab process improvement team is the medical director which reports to the Medical Executive and Executive Leadership committees. The next report should be at the Feb 7, 2007 ELC.

Mall Documentation PIT

A Performance Improvement Team was initiated to explore methods to improve documentation to and from the Harbor Mall. The process to integrate Mall Groups with the Comprehensive service plan (CSP) is multifaceted. The Treatment team will integrate Harbor Mall groups with each clients individualized CSP. Each discipline will identify Groups to include in CSP and submit referral forms to the Treatment team coordinator who in turn submits them to the Harbor mall. Group leaders will document client progress and participation in the flow sheet using information from the referral. The flow sheets will be placed in the clients charts daily by Harbor Mall staff. The treatment team member who referred the client to the group will include the client's group progress in their progress note. The Rehabilitation Department is monitoring the newly designed process. The director of Rehabilitation Services is the Chairperson for this PIT, they reported to ELC their final report in early December 2006.