

Riverview

PSYCHIATRIC CENTER



PERFORMANCE IMPROVEMENT REPORT

SECOND QUARTER FISCAL YEAR 2010
Oct, Nov, Dec 2009

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INTRODUCTION

The comparative statistics reports for this quarter have been changed in response to requests from the Riverview Psychiatric Center Advisory Board. These requests include the addition of an in depth explanation of data analysis methods and data types related to client injuries and information on differentiation, if any, between statistics on forensic services facilities/populations and civil services facilities/populations.

The Riverview Psychiatric Center, in collaboration with Dorothea Dix Psychiatric Center is currently developing a method of extracting and recording detailed information on events related to client injuries and client incidents. This method will require the expanded use of the existing MEDITECH system in recording data regarding client incidents and the outcomes of these incidents. It is expected that this expanded use will also provide opportunities for tracking behavioral trends and potentially evaluating the efficacy of therapeutic interventions that are designed to limit client incidents.

The National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) has recently made available a new report on Forensic Stratification for the Comparative Statistics factors. Graphs that depict the stratification of comparative statistics factors according to forensic and civil services are included in the comparative statistics section of this report.

In collaboration with the Peer Support group and with the input of the Disability Rights Center, Riverview Psychiatric Center has revised its process for responding to and tracking client grievances. This revised method is designed to more accurately comply with standards of compliance and track the process of grievance management. The report on grievance management included in the Peer Support section differentiates between Level 1 and Level II grievance processes in order to present a more accurate picture of compliance with the provisions of the Consent Decree according to the negotiated Compliance Standards.

The following measures of success and opportunities for improvement at Riverview Psychiatric Center are outlined in this report:

1. The grievance process changes as well as a renewed focus on managing client grievances has resulted in a significant increase in the level of performance. This process, in time, is intended to result in a renewed focus on fulfilling client needs within the framework of the Rights of Recipients and the mission of DHHS.
2. The Community Forensic ACT Team has changed its process improvement focus from reporting on levels of service provided and the recidivism of clients to identification of the reasons for this recidivism and the barriers to maintaining independent living support systems for discharged clients.
3. Overall client satisfaction is up as compared to the last quarter. Work continues on improving personal autonomy and ensuring consistency between client care units.
4. With the recent hire of a Director of Human Resources and the replacement of an HR assistant, barriers to maintaining an effective performance evaluation system and providing personnel services to both staffs and leadership should be reduced and performance in key success factors related to Human Resources management should show improvement.

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: <ol style="list-style-type: none"> Length of stay in community Type of residence (ie: group home, apartment, etc) Geographic location of residence Community support network Client demographics (age, gender, financial) Behavior pattern/mental status Medication adherence Level of communication with ACT Team 	7/7	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.	6/7	85%	100%

Summary

Indicator 1: Seven (7) clients were re-hospitalized during this past quarter; of those,

One (1) client returned due to illegal drug use, was in supported apartment in community for approximately 6 months.

One (1) client became symptomatic while on a monitored medication regime requiring hospitalization, client had a 6 month period of stability and was receiving support in an apartment.

One (1) client was hospitalized after an extended duration of stability for a 2 month period. Client experienced successful stabilization after medication change

One (1) client returned within one week from supported apartment due to med non-compliance which lead to clinical instability. Client remains hospitalized.

One (1) client returned after 1 yr of moderately successful living in a group home due to increase in symptoms and agitation. Client remains hospitalized.

One (1) client was hospitalized from a supervised apartment living situation for time limited period to adjust and increase medications which stabilized the situation in 72 hrs and client returned to the supported apartment.

One (1) client returned for 3 weeks from a group home to address medication non-compliance, treatment engagement issues and generalized depression. Client improved during hospitalization and returned to group home.

There was a trend noted that just over half (4 of 7) returned after a significant period of stabilization while living in supported apartments or group homes, suggesting that an ACT level of care in conjunction with a highly structured rehabilitative living environment can work to minimize long durations of destabilization thus more rapid reduction of symptoms and re-stabilization. All clients who were re-hospitalized lived in Augusta.

COMMUNITY FORENSIC ACT TEAM

Indicator 2: The ACT Team needs to become more consistent in attending treatment team meetings while clients are in the hospital; ACT PSD has worked with Social Work Director to address communication gaps and increase collaboration between ACT Case Managers, Treatment Team Coordinators and Social Workers.

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. (Oct.26 2009 court)	5/6	85%	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.	6/6	100%	100%
3. Annual Reports (due Dec) to the commissioner for all out-patient Riverview ACT NCR clients are submitted annually	30/30	100%	100%

Summary

Indicator 1: This area fell below the threshold percentile due to a communication breakdown between the client and the team. Case Manager will now confirm with client's attorney if client has withdrawn or altered a petition.

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 on assigned on an active status caseload.	37/37	100%	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.	37/37	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.	8/8 completed by Bruce Samuels	100%	95%

Summary

Indicator 3: Program Service Director Mary Beyer takes over as monitor January 1, 2010.

COMMUNITY FORENSIC ACT TEAM

Aspect: Substance Abuse and Addictive Behavior History

Indicators	Findings	Compliance	Threshold Percentile
1. age of onset documented in Comprehensive Assessment	30/30	100%	95%
2. duration of behavior documented in C.A. and progress notes	30/30	100%	95%
3. pattern of behavior documented in C.A. and progress notes	30/30	100%	95%

Summary

In addition to the information in the comprehensive assessment the Co-Occurring Disorders Specialist is developing timeline for each client to more clearly illustrate differential diagnoses, progression of substance abuse and progress in recovery.

Aspect: Peer Support

Indicators	Findings	Compliance	Threshold Percentile
1. Engagement attempt with client within 30 days of admission.	37/37	100%	95%
2. Documented offer of peer support services.	37/37	100%	95%
3. Attendance at treatment team meetings as appropriate.	35/37	94%	95%

Summary

Indicator 3: 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: Medical Clinic Appointment Assessment Fiscal Year 2009-2010

Indicators	Findings Quarter 2	Compliance	Threshold Percentile
All Outpatient clients will have Vital Signs and Weight recorded upon arrival for appointment.	There were forty -three clients in Oct. The forty-three that came in for appts., did have their vitals taken before their clinic apt.	100%	100%
	There were Forty-Four clients scheduled in the month of November , forty-three clients had vitals taken before their appt. with the P.A. One client refused vitals.	98%	
	In December there were thirty-nine clients scheduled. Thirty-four did have their vitals taken before their clinic appt. four did not have vitals taken before Appt.	88%	

Summary

For the second quarter there were 126 clients. Of the quantity stated, 121 had their vitals taken before their appt. 1 client refused to have vitals done in the month of November. In December 4 client's vitals were done after the appt. Review of monthly staff meetings and forward reports quarterly to RPC

Actions:

Clients coming in late, conflicts with next appt. Have clients come in earlier than appt. Some clients are not receptive to coming in early for appt. Will continue to work.

CAPITOL COMMUNITY CLINIC

ASPECT: Clinic Consult Timeliness Fiscal Year 2009-2010

Indicators	Findings Quarter 2	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.	October had seventeen in-house clients. Out of the seventeen, two of the clients did not have consults at the time of visit.	88%	90%
	November had ten in-house clients. Out of the ten there were two consults not received at the time of visit.	80%	
	Dec. had thirty-two in-house clients one of the clients did not have consults at the time of dental visit.	97%	

Summary

In **Oct.** there were seventeen RPC clients. Of the seventeen, two did not have consults at the time of the dental visits. One from Lower Saco, one from Lower Kenn. .

In **November** there were ten RPC clients of the ten clients two did not have the consult at time of dental visit. Two from Lower Saco.

In **Dec.** There were thirty-two in-house clients and one did not have consults at the time of dental visit. The one consult not sent was from Lower Kenn.

Actions

A second 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 comes without proper documentation the visit is held or rescheduled until the appropriate paper work is presented.

CAPITOL COMMUNITY CLINIC

ASPECT: Dental clinic post extraction prevention of complications fiscal year 2009-2010

Indicators	Findings Quarter 2	Compliance	Threshold Percentile
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. <ul style="list-style-type: none"> • Bleeding • Swelling • Pain • Muscle soreness • Mouth care • Diet • Signs/symptoms of infection b. The client, post procedure tooth extraction, will verbalize understanding of the above by repeating instructions given by Dental Assistant/Hygienist.	Oct. one extraction. Post instructions verbalized to each client. Client repeated back to dental Assist. understood the Instructions. With out difficulty.	100%	100%
	November 0 extractions. December. 4 extractions. Post instructions verbalized to each client. Client repeated back to dental Assist. understood the Instructions. With out difficulty.	100%	100%

Summary

There were five extractions in the second 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.

CAPITOL COMMUNITY CLINIC

ASPECT: Dental Clinic 24 hour Post Extraction Follow-up Fiscal Year 2009-2010

Indicators	Findings Quarter 2	Compliance	Threshold Percentile
After all dental extractions, the client will receive a follow-up phone call from the clinic within 24hrs of procedure to assess for complications.	Oct. there was 1extractions. Follow up 24-hour phone call. The pts had no complications post extractions.	100%	100%
	November 0 extractions with 24 hour follow up phone call. The pts that were called, had no post Procedure complications	100%	
	Dec. 4 extraction with a 24 hour fellow up post extraction call with No complication	100%	

Summary

There were five dental clients in the second quarter that 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

CLIENT SATISFACTION

ASPECT: Client satisfaction with care

Indicators	Findings	+ / - (from 1 st QTR)
I felt I had enough privacy in the hospital.	33	+23
If I had a choice of hospitals, I would still choose this one.	31	+27
Do you know someone who can help you get what you want or stand up for your rights?	31	+17
I am better able to deal with crisis.	27	+16
I deal more effectively with daily problems.	26	+16
My symptoms are not bothering me as much.	25	+10
Staff here believed that I could grow, change and recover.	25	+7
My pain was managed.	25	+10
I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	23	+15
Staffs were sensitive to my cultural background.	23	+17
The medications I am taking help me control symptoms that used to bother me.	22	+7
The surroundings and atmosphere at the hospital helped me get better.	21	+18
My contact with my doctor was helpful.	21	+10
Did anyone tell you about your rights?	21	+5
The hospital environment was clean and comfortable.	19	+3
I do better in social situations.	18	+5
Both I and my doctor or therapist from the community was actively involved in my hospital treatment plan.	18	+6
I was treated with dignity and respect.	16	-1
My other medical conditions were treated.	16	+13

CLIENT SATISFACTION

My family and/or friends were able to visit me.	15	+3
I felt this hospital stay was necessary.	12	+10
I participated in planning my discharge.	11	+3
I felt comfortable asking questions about my treatment and medications.	10	-9
I was encouraged to use self-help/support groups.	8	-7
My complaints and grievances were addressed.	7	-6
I felt safe while I was in the hospital.	6	-13
I felt free to complain without fear of retaliation.	3	-3
I felt safe to refuse medication or treatment during my hospital stay.	3	-6
I had a choice of treatment options.	0	-7
I was given information about how to manage my medication side effects.	-1	-13
My contact with nurses and therapists was helpful.	-1	-11
Are you told ahead of time of changes in your privileges, appointments, or daily routine?	-1	-9

Summary

Overall client satisfaction was up from last quarter. The highest possible score for each indicator is 46 (n = 23). A score above zero (neutral) indicates an overall positive response. Scores are weighted based on a Likert Scale. Clients overall are satisfied with the care they receive at RPC. Written comments by clients reflected this, as well as dissatisfaction with lack of personal autonomy and inconsistency with applying policies, rules, and guidelines.

Actions

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

COMPARATIVE STATISTICS

The comparative statistics reports include the following elements:

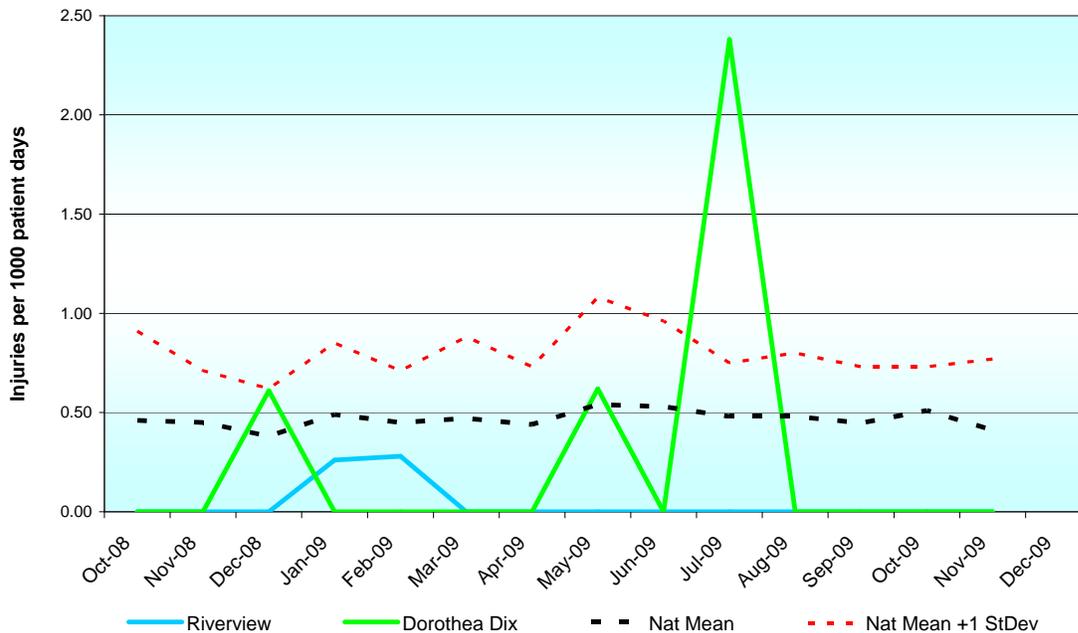
- Client Injury Rate
- Elopement Rate
- Medication Error Rate
- 30 Day Readmit Rate
- Percent of Clients Restrained
- Hours of Restraint
- Percent of Clients Secluded
- Hours of Seclusion

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.

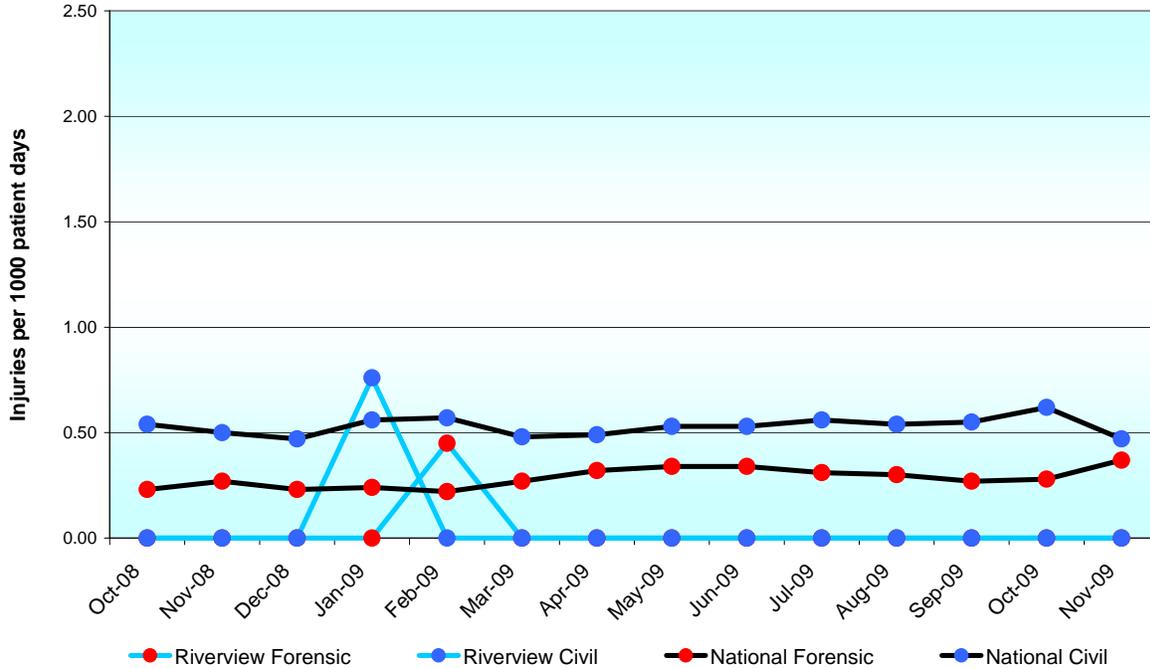
- No Treatment – The injury received by a client may be examined by a clinician but no treatment is applied to the injury.
- Minor First Aid – The injury received is of minor severity and requires the administration of minor first aid.
- Medical Intervention Needed – The injury received is severe enough 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.

ASPECT: Client Injury Segmentation – Severity by Month

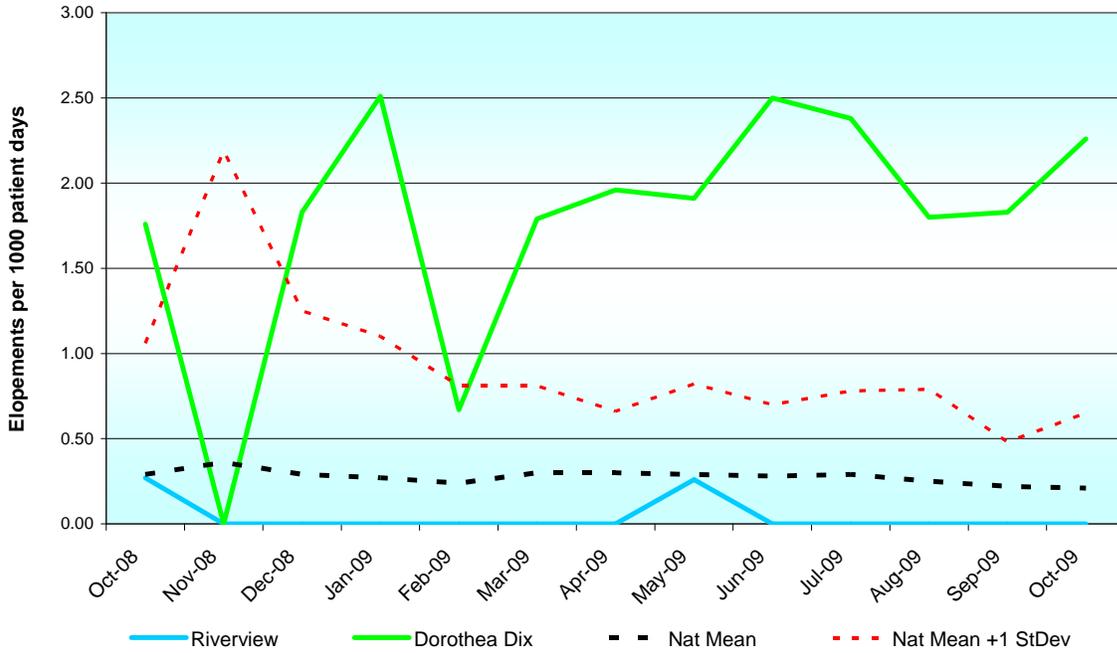
Severity	October	November	December	2 nd Quarter 2010
No Treatment	37	0	31	68
Minor First Aid	51	3	43	94
Medical Intervention Required	0	0	0	0
Hospitalization Required	0	0	0	0
Death Occurred	0	0	0	0

ASPECT: Client Injury Segmentation – Type and Cause of Injury by Month

Type - Cause	October	November	December	2 nd Quarter 2010
Accident – Unwitnessed Fall	0	3	1	4
Accident – Witnessed Fall	3	1	4	8
Assault – Patient to Patient	21	16	20	57
Assault – Patient to Staff	39	36	30	105
Behavioral – Destruction of Property	15	6	6	27
Self Injury – Agitation	10	12	11	33

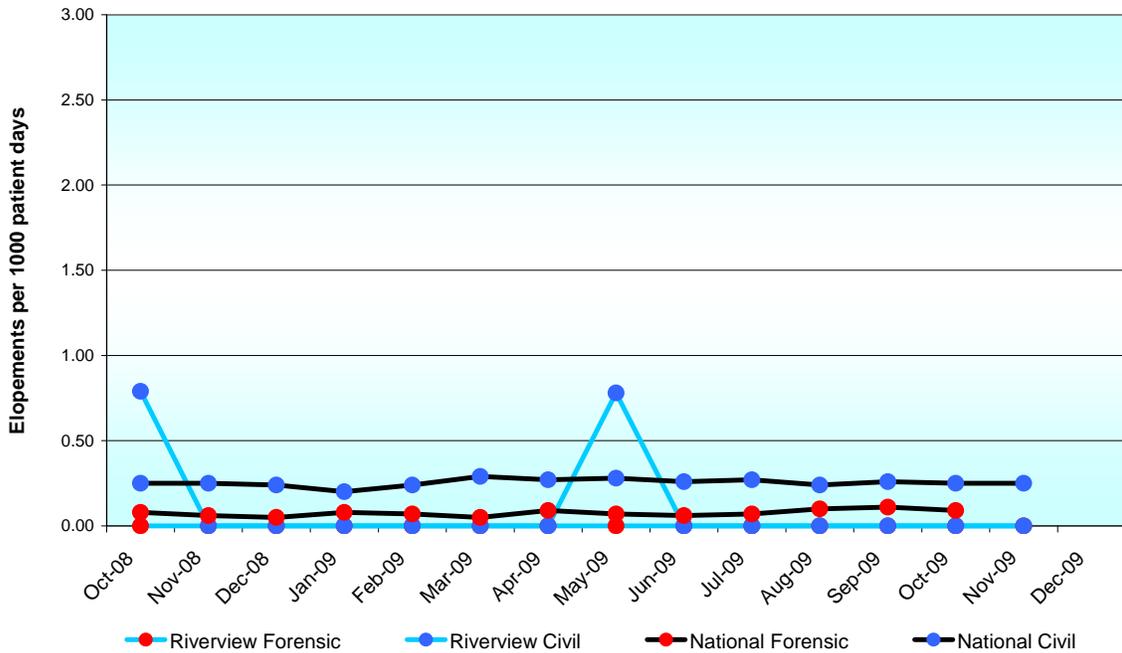
COMPARATIVE STATISTICS

Elopement



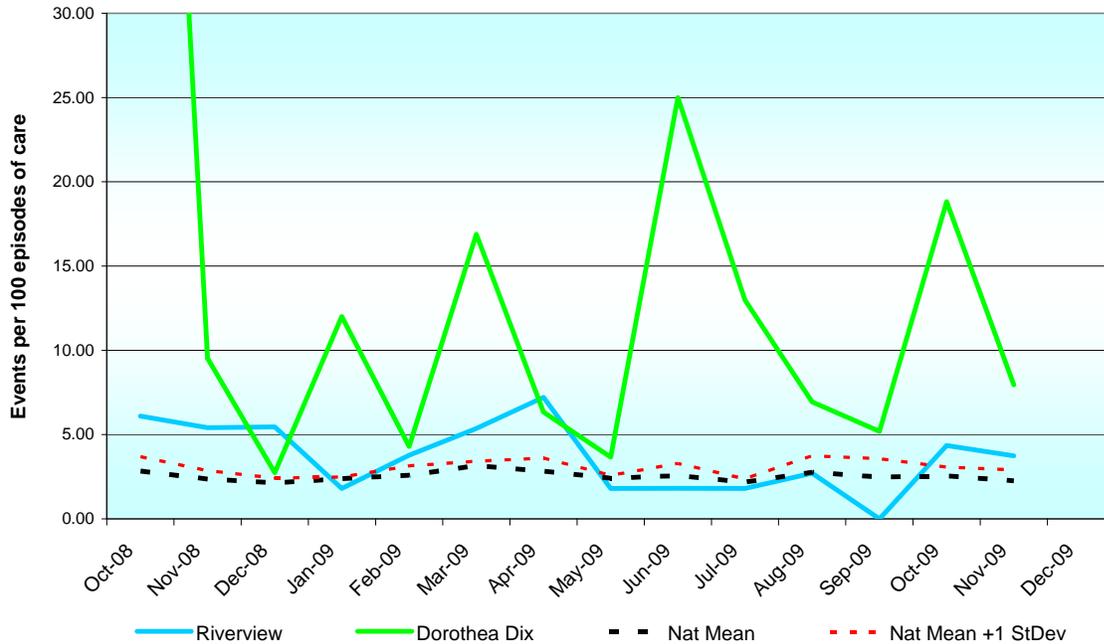
Number of elopements that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days.

Elopement Forensic Stratification



COMPARATIVE STATISTICS

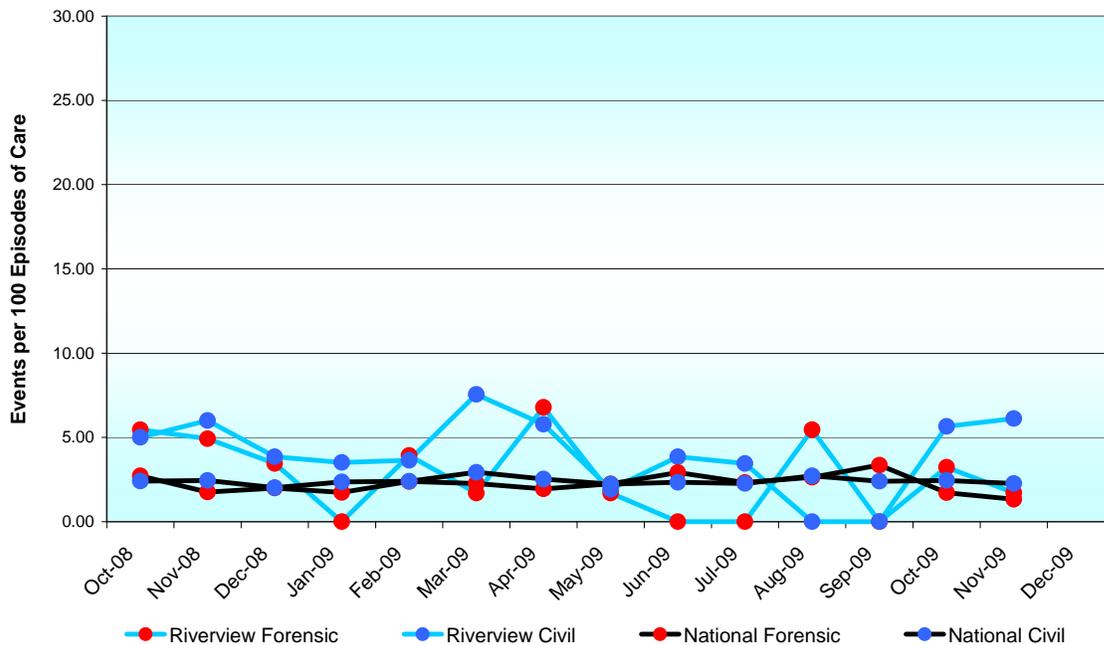
Medication Errors



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.

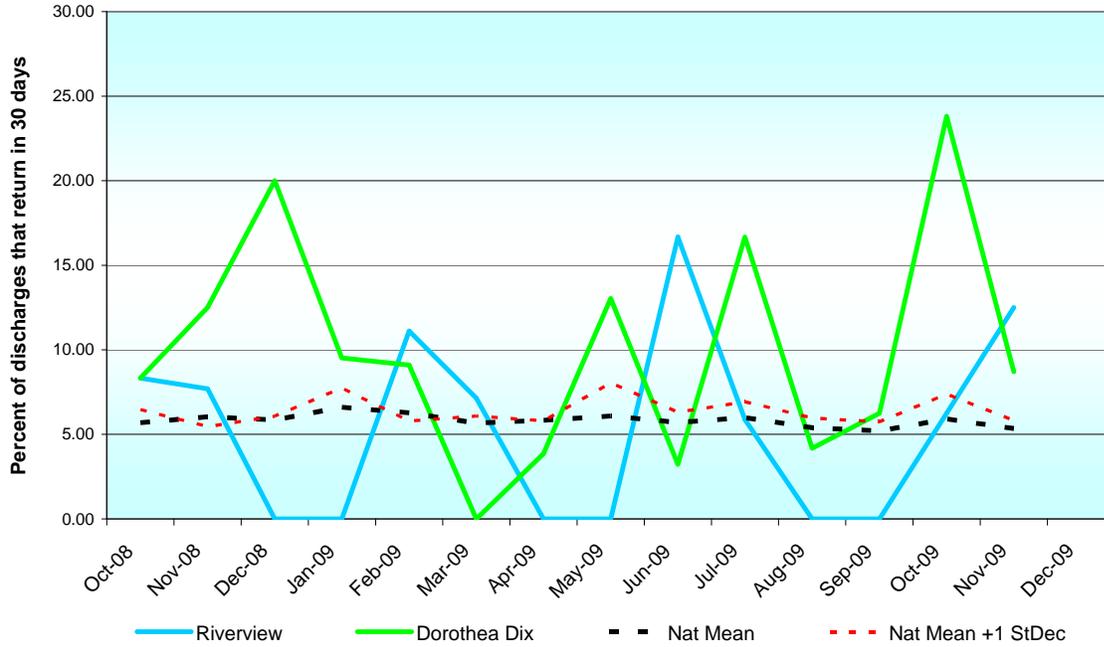
Medication Errors

Forensic Stratification



COMPARATIVE STATISTICS

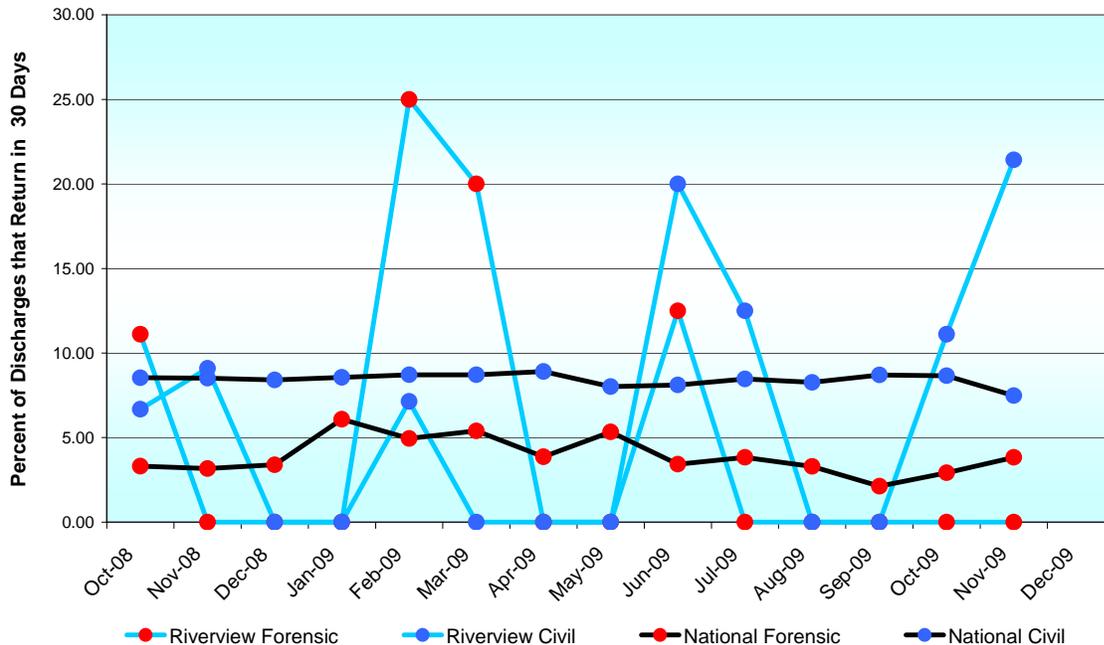
30 Day Readmit



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.

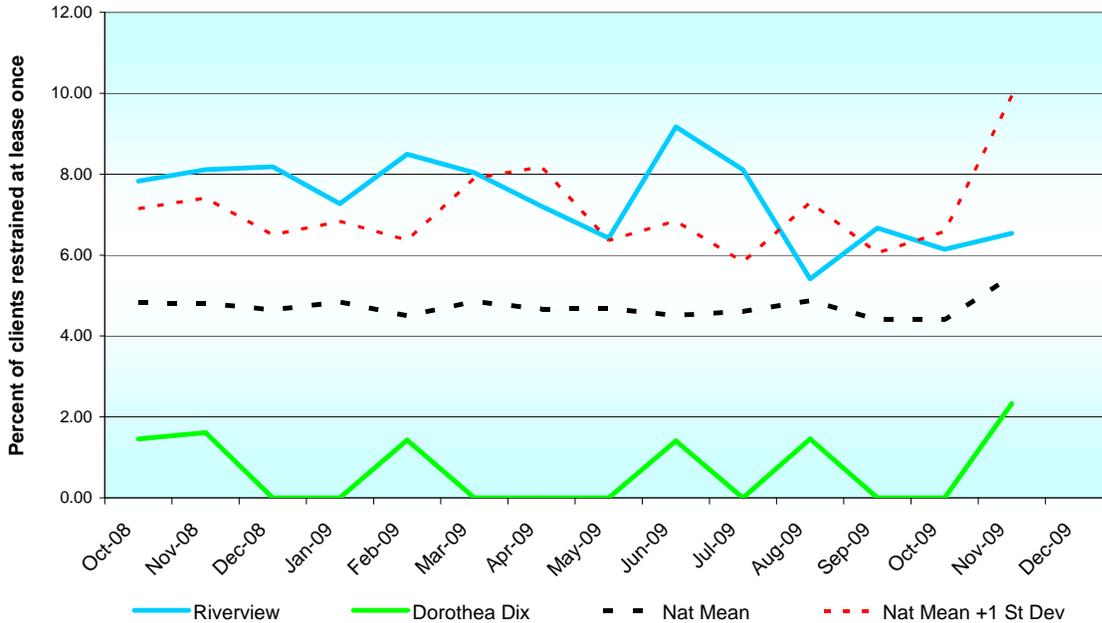
30 Day Readmit

Forensic Stratification



COMPARATIVE STATISTICS

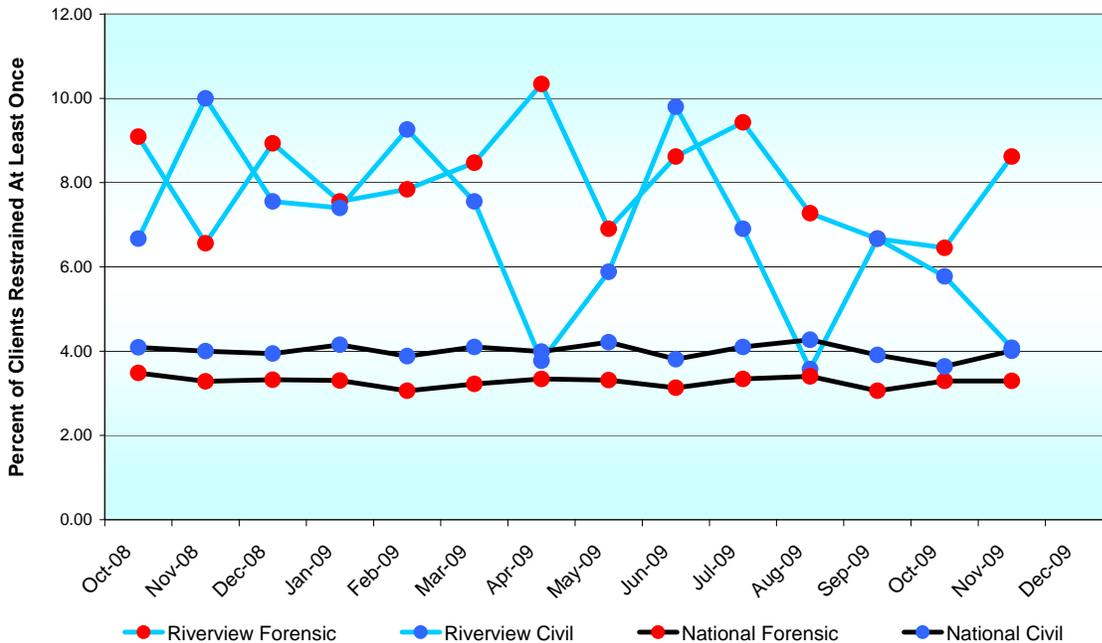
Percent of Clients Restrained



Percent of unique clients who were restrained at least once - excludes manual holds less than 5 minutes. For example, a rate of 4.0 means that 4% of the unique clients served were restrained at least once.

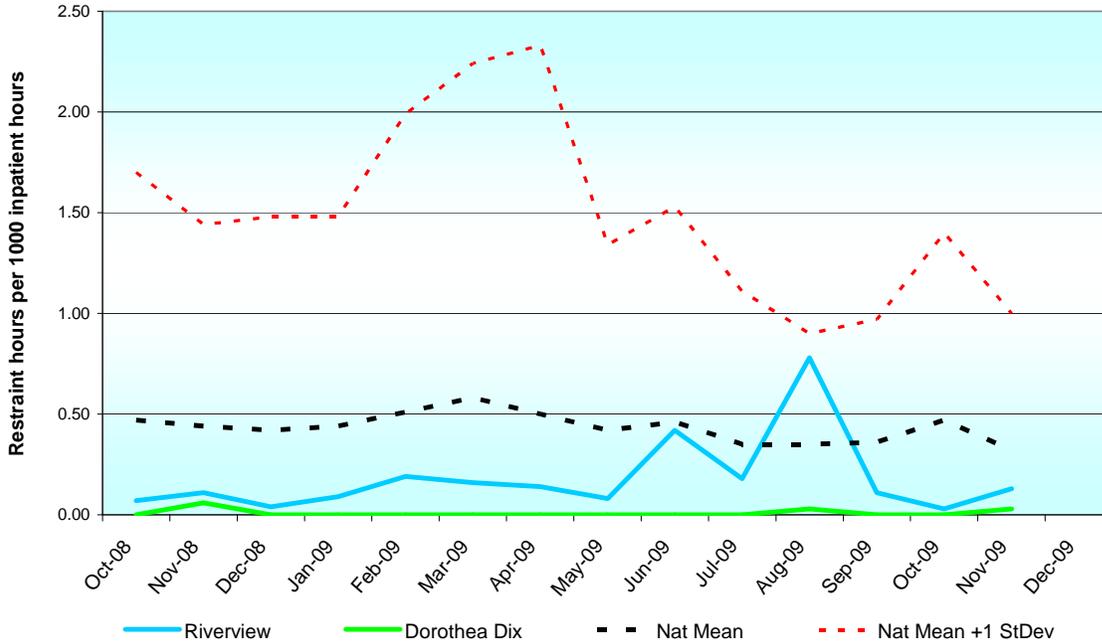
Percent of Clients Restrained

Forensic Stratification



COMPARATIVE STATISTICS

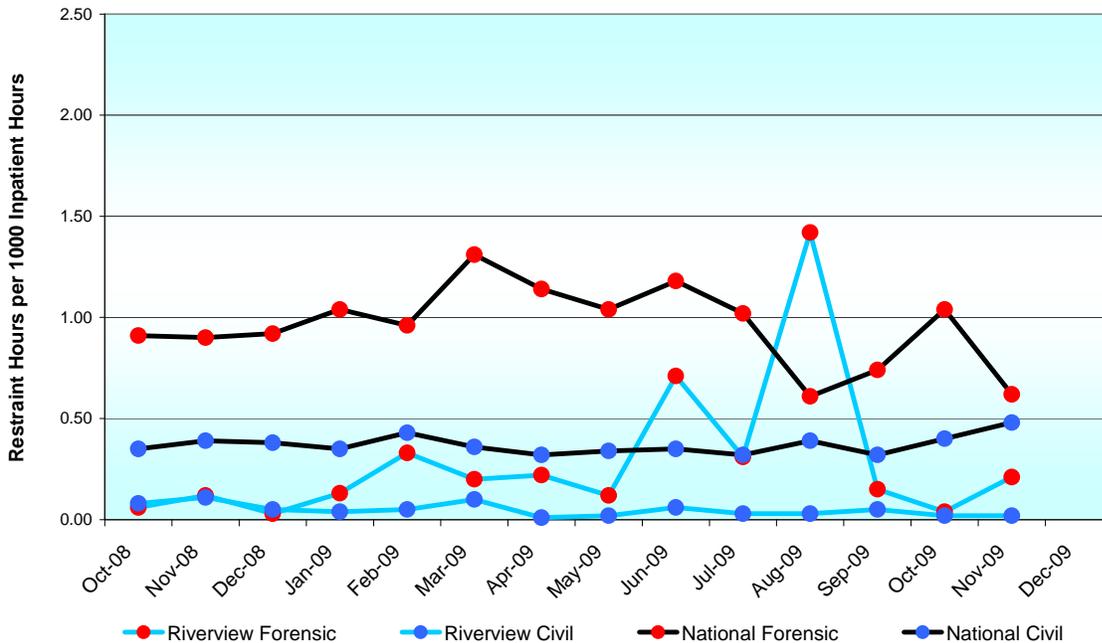
Restraint Hours



Number of hours clients spent in restraint for every 1000 inpatient hours - excludes manual holds less than 5 minutes. For example, a rate of 1.6 means that 2 hours were spent in restraint for each 1250 inpatient hours.

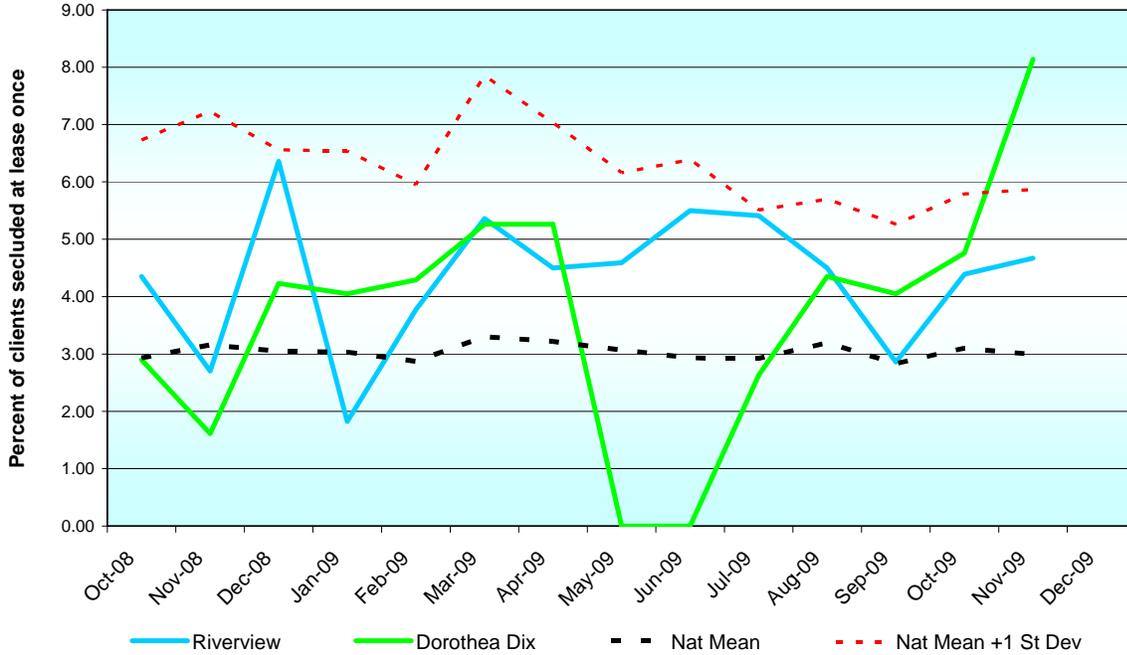
Restraint Hours

Forensic Stratification



COMPARATIVE STATISTICS

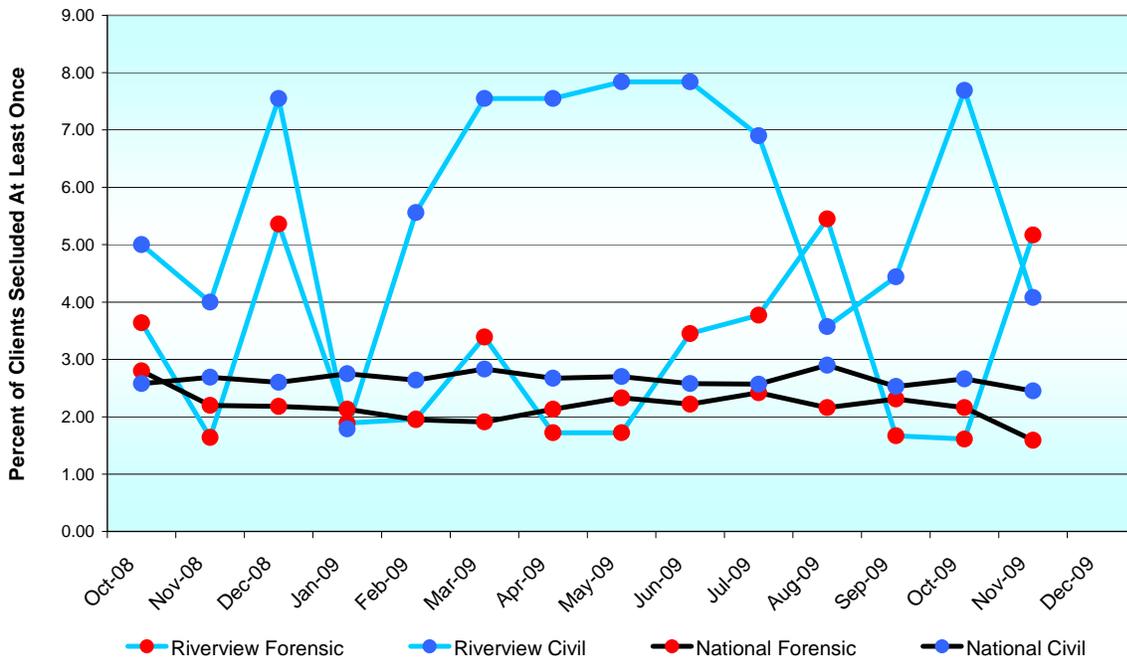
Percent of Clients Secluded



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.

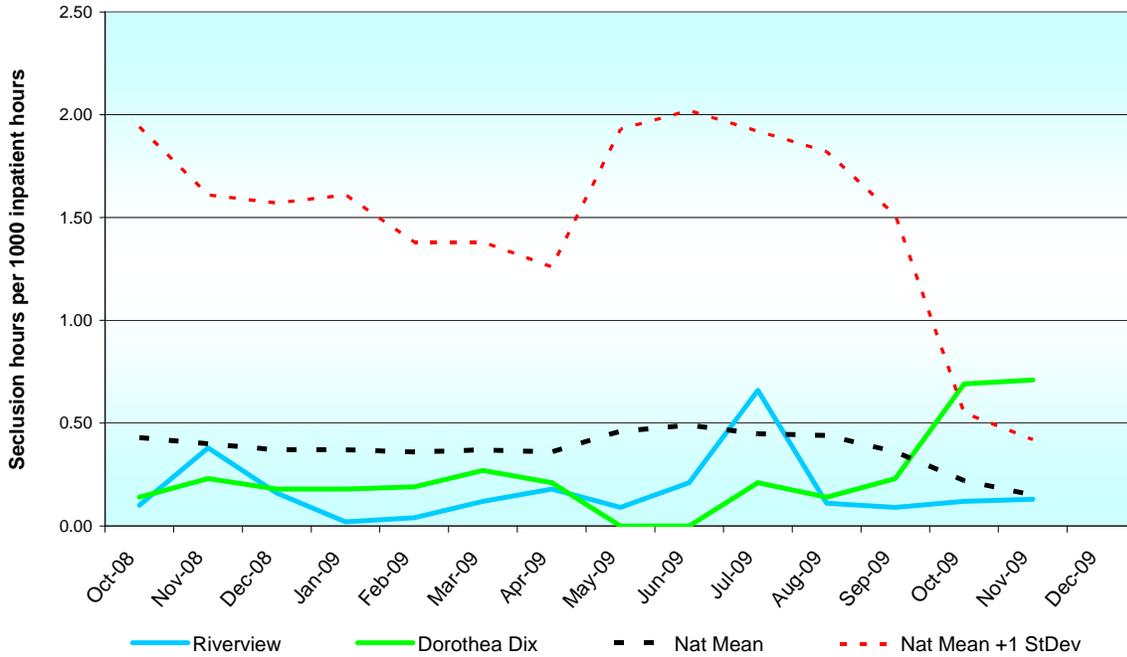
Percent of Clients Secluded

Forensic Stratification



COMPARATIVE STATISTICS

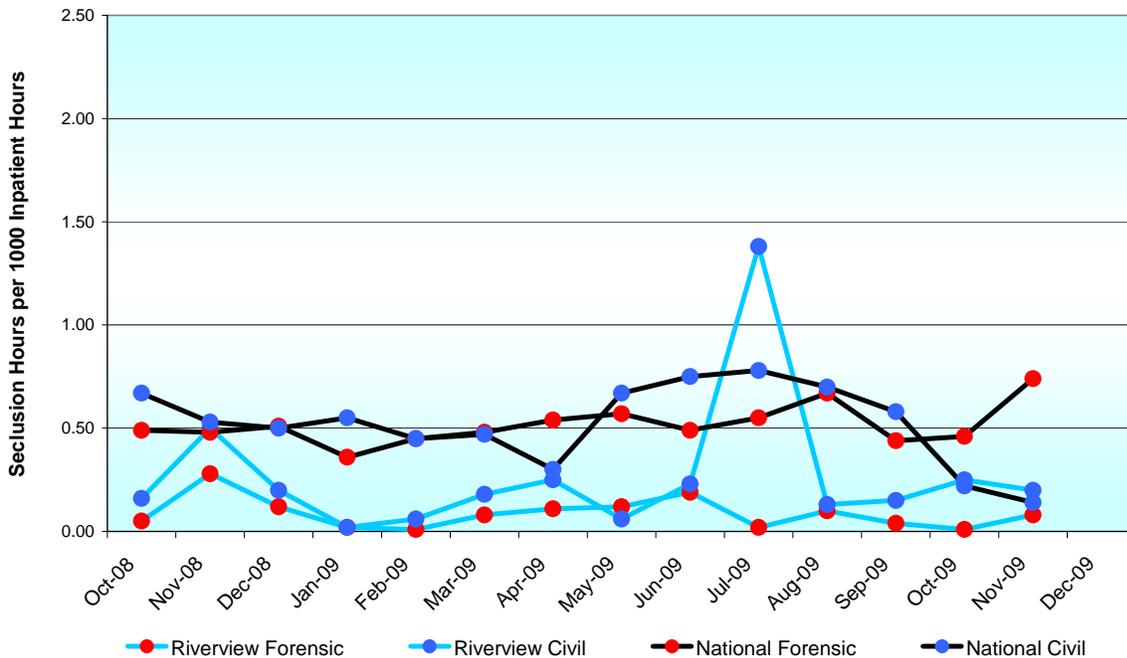
Seclusion Hours



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



DIETARY

ASPECT: Cleanliness of Main Kitchen

Indicators	Findings	Compliance	Threshold Percentile
1. All convection ovens (4) were thoroughly cleaned monthly.	8 of 12	67%	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	18 of 24	75%	95%
7. All trash cans (5) and bins (1) were cleaned daily	365 of 552	66%	95%
8. All carts(9) used for food transport (tiered) 4 small, 5 large were cleaned daily	717 of 828	87%	100%
9. All hand sinks (4) were cleaned daily	296 of 368	80%	95%
10. Racks(3) used for drying dishes were cleaned daily	264 of 276	96%	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 are posted and implemented for all equipment, food contact surfaces, work areas and storage areas.

Threshold percentiles were not met regarding: Convection ovens, one not thoroughly cleaned in the months of October and December. All steam kettles were not cleaned weekly; October-December. All trash cans and bins were not cleaned daily; October-December. All tiered carts used for food transport were not cleaned daily; October-December. All hand sinks were not cleaned daily October-December. Racks used for drying dishes were not cleaned daily; October-December.

Improvements were shown in the following areas: The walk-in coolers were cleaned thoroughly; 100%

DIETARY

compliance. Food transport carts were cleaned with 84% compliance the second quarter. The third quarter shows an 87% compliance rate. Racks used for drying dishes were 89% are now 96%. The dish machine has been de-limed every month since January. The knife cabinet has been thoroughly cleaned every month since January.

- The cleaning schedule was revised and posted using a color coded format that highlights the importance of the tasks.
- The general staff meeting includes discussion and staff suggestions for successful completion of these tasks.
- The cleaning schedule is reviewed on a daily basis to assure that essential cleaning is completed.
- The Housekeeping Department provides assistance with accomplishing certain tasks, when requested.
- The D.S.M. will shares results of this CPI indicator with staff.

Overall Compliance: 81.2%

Actions

Dietary employees require annual training which includes efficient use of time.

DSM will hire a Food Services Manager to effectively coordinate daily staff assignments.

DSM will hire a PT Food Service Worker.

DSM will hire a PT acting capacity Cook.

Cleaning tasks will be reassigned and appropriately designated as these positions become filled.

Next Reporting Date: *April 2010*

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.	2378 requests for information (113 requests for client information and 2265 police checks) were released for quarter 2 2010.	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	23 new employees/contract staff in quarter 2 2010.	100%	100%
Confidentiality/Privacy issues tracked through incident reports.	0 privacy-related incident reports during quarter 2 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 2, 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.

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 55 discharges in quarter 2 2010. Of those, 46 were completed by 30 days. Note: There was 1 incomplete record from the previous reporting period.	84 %	80%
Discharge summaries will be completed within 15 days of discharge.	54 out of 55 discharge summaries were completed within 15 days of discharge during quarter 2 2010.	98 %	100%
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	6 forms were revised in quarter 2 2010 (see minutes).	100%	100%
Medical transcription will be timely and accurate.	Out of 617 dictated reports, 612 were completed within 24 hours.	99%	90%

Summary

The indicators are based on the review of all discharged records. There was 84 % compliance with record completion, with 1 incomplete record from a previous reporting period. There was 99 % 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 99 % compliance with timely & accurate medical transcription services.

Actions

Continue to monitor.

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?	36 of 37	97%	95%
3. Did we have enough linen on units via complaints from unit staff?	37 of 37	100%	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?	37 of 37	100%	100%
6. Did we receive an adequate supply of mops and rags from vendor?	33 of 37	89%	95%
7. Was linen bins clean returning from vendor?	37 of 37	100%	100%

Summary

Seven (7) 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 #6. The overall compliance for this quarter was 98%. This shows a 2% increase from last quarters report.

1. During random inspections, Linen was returned with holes.
2. Housekeeping did not have enough mops.

Actions

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

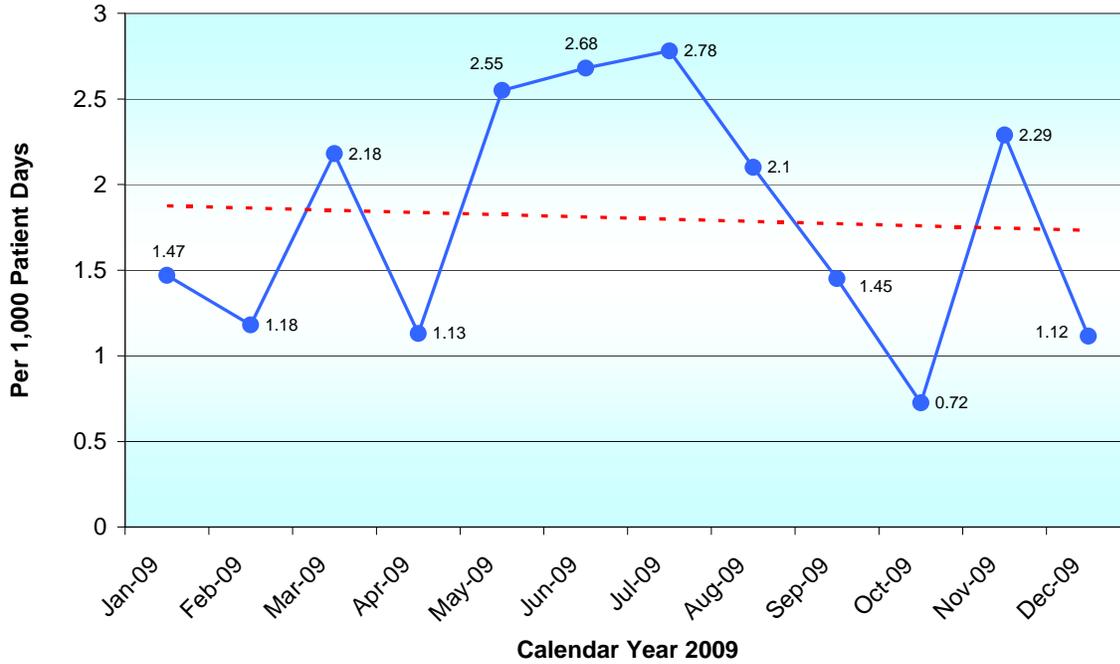
- ✓ The housekeeping staff on each unit will monitor the quantity of wash mops and rags delivered to their respective units.
- ✓ The housekeeping staff on each unit will monitor the linen to assure the consistency of linens being covered.
- ✓ Housekeeping supervisor will report in staff meetings these 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 ripped and or linens with holes.

Next Reporting Date: *April 2010*

HUMAN RESOURCES

ASPECT: Direct Care Staff Injuries

Reportable (Lost Time & Medical) Direct Care Staff Injuries



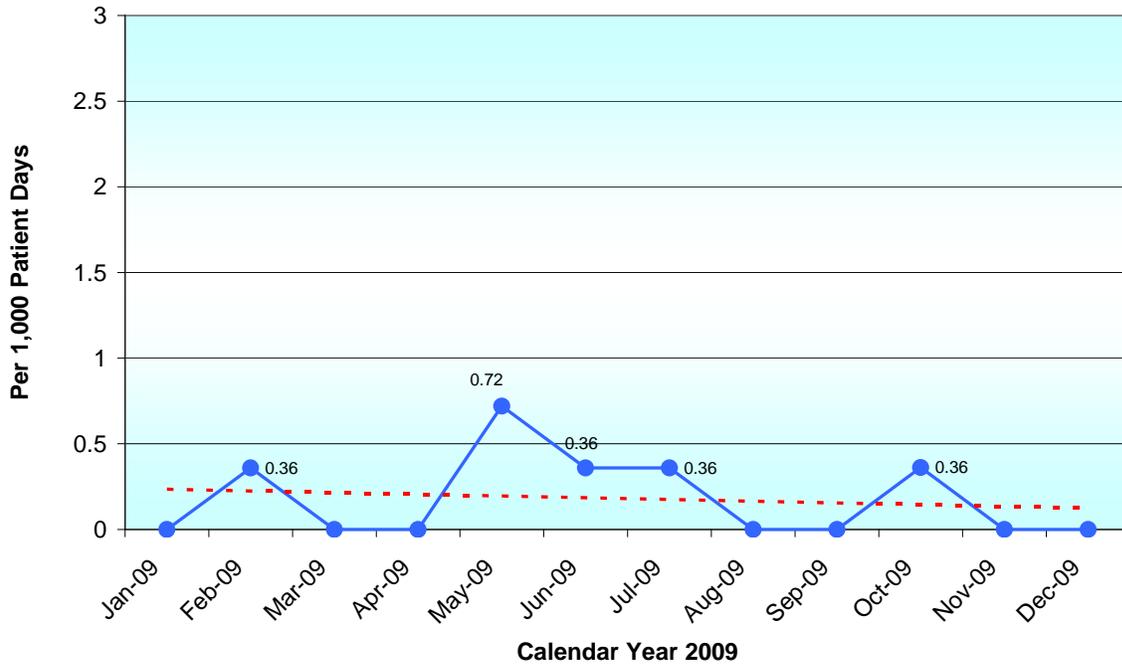
Summary

The calendar year trend line for reportable injuries sustained by direct care staff shows a slight decline in the number of injuries reported. This slight decline is not significant, however, since there is wide variation in the individual results from each month. The total number of direct care staff that sought medical attention or lost time due to injury for the 2nd fiscal quarter 2010 was 11 compared to 17 for the 1st fiscal quarter 2010 and 18 for the 4th fiscal quarter 2009.

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 that sought medical attention or lost time from work for the 2nd quarter 2010 has remained at 0.12% per 1,000 patient days. The annual trend line shows an overall slight decline in the rate of injury; however, this change is insignificant considering the total number of non-direct care staff injuries. Only one non-direct care staff member sought medical attention or lost time due to injury during the 2nd fiscal quarter 2010. This is comparable to the 1st fiscal quarter 2010.

HUMAN RESOURCES

ASPECT: Management of Human Resources – Performance Evaluations

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

Reporting Period	Findings	Compliance	Threshold Percentile
October 2009	19 of 27	70.37%	85%
November 2009	15 of 33	45.45%	
December 2009	14 of 26	53.85%	
Quarterly Mean	48 of 86	55.81%	

Summary

This quarter represents a significant decline in performance from the previous quarter. This results from the 2nd quarter 2010 show that 55.81% of performance evaluations were completed within 30 days of the due date. The results from the 1st quarter 2010 showed an 84.78% completion rate. The results from the 4th quarter 2009 showed a 63.08% completion rate. As of January 8, 2010, two (2) evaluations from October 2009, eleven (11) evaluations from November 2009, and twelve (12) evaluations from December 2009 are still outstanding.

Due to a vacancy in the Director of Human Resources (Personnel Officer) position and the loss of a HR assistant due to transfer, the HR functions at Riverview Psychiatric Center have been managed by part-time administrators from the DHHS main office and one HR/payroll assistant. Both of these positions have been filled and it is anticipated that tighter controls of the performance evaluation system will now be possible to manage.

ASPECT: Management of Human Resources – Personnel Management

Overtime hours and mandated shift coverage

Reporting Period	Overtime Hours	Mandated Shift Coverage
October 2009	3091.25	12
November 2009	2993.75	17
December 2009	4577.00	30

INFECTION CONTROL

ASPECT: Hospital Acquired Infection

Indicators	Findings	Compliance	Threshold Percentile
Total number of infections for the second quarter of the fiscal year, per 1000 patient days	47/5.8	100 % within standard	5.8 or less
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	13/1.6	100% within standard	5.8 or less

Summary

The hospital maintains total house surveillance. Data is collected via antibiotic reports, lab and/or radiology reports, chart review and clinical findings. The hospital infection rate is at the threshold percentile 5.8 and within an acceptable range. The hospital acquired infection (HAI) rate is below the threshold percentile 5.8 and consistent with the first quarterly HAI rate.

There was a slight spike in the total number of infections in October 2009, specifically skin infections. No clusters of infections specific to any one unit noted. One client was diagnosed with methicillin resistant staphylococcus aureus (MRSA) infection. One client was admitted with a history of MRSA infection; and one client colonized with MRSA.

The following factors most likely contributed to the overall increase in the second quarterly hospital infection rate.

- There was an increase in skin infections in October 2009.
- There were no urinary tract infections (UTI) in the first quarter; and nine urinary tract infections in the second quarter.
- The (few) clients diagnosed with skin and urinary tract infections were known to have chronic infections related to obesity, diabetes and general poor health and/or self injury.

Action

Hand hygiene continues to be stressed to employees and clients. Purell hand sanitizer is readily available. Posters reflecting hand hygiene are throughout the facility. House Keeping works diligently to maintain overall cleanliness. Members of the Infection Control Committee are encouraging employees to clean medical equipment, counters and exam tables after each individual use.

Sixty eight (68) percent of employees were vaccinated against seasonal flu. Approximately 150 clients and staff have received the H1N1 flu shot. Employee Health continues to vaccinate and educate as many staff and clients as possible.

Nursing will continue to identify clients at high risk for infection secondary to chronic medical problems; and provide individual care, education and encouragement.

Employee, visitor and client surveillance is ongoing.

LIFE SAFETY

ASPECT: Life Safety

OVERALL COMPLIANCE: 97%

Indicators	Findings	Compliance	Threshold Percentile
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%
Total number of staff who knows what R.A.C.E. stands for.	148/148	100%	95%
Total number of staff who knows how to acknowledge the fire alarm or trouble alarm on the enunciator panel.	148/148	100%	95%
Total number of staff who knows the emergency number.	139/148	93%	95%
During unannounced safety audits conducted by the Safety Officer, this represents the total number of staff who display identification tags.	159/168	94%	95%
During unannounced safety audits conducted by the Safety Officer, this represents the total number of direct care staff who carries a personal duress transmitter.	94/98	95%	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. #'s 2-5 also reflect the response during a recent training fair held on December 3, 2009. Numbers captured for #6 were different from #5 since many of those in the training fair were not required to carry a transmitter.

Actions

The Safety Officer continues to conduct mini presentations with regard using the remote annunciator panels located through facility. Staff's knowledge of this 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

COMPLIANCE: 100 %

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 first quarter. A drill is planned for the 3rd quarter and will involve pulling the building alarm and collaborating with the property owner, the other building occupants, and the local emergency services. 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.

ASPECT: Securitas/RPC Security Team

OVERALL COMPLIANCE: 98%

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.)	1848/1895	97%	95%
2. Security/safety checks done of the "lower" client units during the hours of 8:00 am thru 8:00 pm. (To be done 6 times in this 12 hour period.)	552/552	100%	95%

Summary

#1 & #2 Foot patrols continue to be done despite those rare times that the officers are on other details which take priority over the "foot patrol".

Actions

Since #2 has been at 100% for a number of reporting quarters, Securitas and the Safety Officer will formulate new indicators for the next reporting period.

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.	Over a 3-mo period 78 of 87 were in compliance	90%	90%

Summary

AIMS testing is being done upon admission, but follow-up tests every six months are not, therefore, making the hospital non-compliant with its policy. Clients' charts were reviewed for completion of AIMS in October and December. By the end of the 2nd quarter the totals showed 78 of 87 charts were in compliance. The compliance rate increased from 29% in the 3rd quarter of FY09 to 77% for the 1st quarter of FY10, to 90% for the 2nd quarter of FY10.

Actions

We will continue to monitor AIMS testing on clients at the hospital for the remainder of this fiscal year. 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: Completion of Medication Reconciliation Admission/Transfer/ Discharge Sheet

Indicators	Findings	Compliance	Threshold Percentile
Charts of clients admitted at Riverview are reviewed. Each client should have a Medication Reconciliation done upon admission, transfer and discharge.	From Sept 19 through mid-Oct there were 22 admissions with 21 forms completed.	95%	90%

Summary

Starting in August, the committee reviewed completion of the Medication Reconciliation form upon admission. From August 1 through September 18, there were 19 completed forms for 27 admissions. We reviewed these again in October, with 21 completed forms for 22 admissions.

Actions

The committee will discontinue monitoring Medication Reconciliation forms completed upon admission. Beginning in January the committee will monitor the form's use during transfers. Psychiatrists will be provided with a monthly list. Feedback to individual psychiatrists is given at the Peer Review Committee.

NURSING

ASPECT: Seclusion and Restraint Related to Staffing Effectiveness

Indicators Seclusion/Restraint related to staffing effectiveness:	Findings	Compliance
1. Staff mix appropriate	65 of 65	100%
2. Staffing numbers within appropriate acuity level for unit	65 of 65	100%
3. Debriefing completed	65 of 65	91%
4. Dr. Orders	65 of 65	100%

Summary

All findings were 100%..This indicator has shown gradual improvement.

Action

This will continue to be followed up by the Nurse IV on the unit and the Assistant Director of Nursing for the unit. The expectation is that the debriefing will be completed even if it is not done immediately.

ASPECT: Injuries related to Staffing Effectiveness

Indicators Injuries related to staffing effectiveness:	Findings	Compliance
1. Staff mix appropriate	8 of 8	100%
2. Staffing numbers within appropriate acuity level for unit	8 of 8	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. Injuries have decreased from last quarter. The staffing numbers are within the appropriate level for the current staffing plan and the acuity level.

Actions

Nursing will continue to monitor this indicator. Another staffing effectiveness indicator has been added for Medication errors.

NURSING

ASPECT Medication errors as it relates to Staffing Effectiveness

NURSING: Staffing levels during medication errors – Oct-Dec 2009 NASMHPD reportable variances

Date	Omit	Co-mission	Float	New	O/T	Unit Acuity	Staff Mix
09/29/09		Y	N	No	No	LKSCU 7-3	4RN, 0 LPN, 7 MHW
10/2/09	Y		N	No	No	LKSCU 7-3	3 RN, 1 LPN, 7 MHW,
10/7/09	Y		Y	1 mos	No	LS-7-3	4 RN, 0LPN, 7 MHW (regular staffing)
10/15/09		Y	N	No	No	LKSCU	4RN, 1 LPN., 6 MHW
10/21/09		Y	Y	1 mos	No	LKSCU	4 RN., 0 LPN, 7 MHW
11/1/09	Y		N	No	No	LS	3 RN, 0 LPN, 7 MHW
11/18/09		Y	N	No	No	LS	3 RN, olpn, 7 MHW
11/30/09		Y	Y	No	No	LS	3 Rn, 1 LPN, 7 MHW
12/6/09		Y	Y	No	No	LS	3 RN, 1 LPN, 7 MHW

Summary

There were a total of nine (9) reportable errors. Two (2) involved pharmacy and did not involve staffing effectiveness evaluation. Nursing reportable medication variances data indicated the following:

Six(6) errors were comissions,

Three(3) were omissions.

One(1) error involved a Physician prescribing error.

One(1)error involved a medication being "put on hold".

One (1)error involved an incorrect doses being given of a titrated med requiring monitoring.

Two(2) errors involved improper labeling by the Pharmacy.

Three(3) errors involved Contract Nurses.

All of the errors occurred on the more acute Lower Units with two (2) occurring in the Special Care Unit.

During this quarter we had hired more Contract Nurses to meet the Staffing needs of the hospital.

Action

Assure complete and thorough education of new Contract Nurses by reviewing the process and revising as necessary. Allow more time for them to function in medication delivery under supervision. We will not put new Contract nurses in the Special Care Units to give medications until they have been here longer and demonstrate competency.

NURSING

ASPECT: Pain Management

Indicator		Findings	Compliance
Pre-administration	Assessed using pain scale	1497 of 1511	97%
Post-administration	Assessed using pain scale	1148 of 1511	91%

Summary

This indicator is about the same as last quarter for pre-assessment at 97% and post assessment has improved to 91% from 85% last quarter due to consistent efforts and education. This is a significant improvement.

Action

Nursing will continue to place a great deal of attention and effort on post administration assessment. 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	17 of 40	43%
2. STGs/ Interventions are written, dated and numbered	57 of 59	97%
3. STGs are measurable and observable	57 of 59	97%
4. STGs/Interventions are modified/met as appropriate	38 of 54	70%
5. GAP note written in appropriate manner at least every 24 hours	55 of 58	95%
6. STGs/Interventions tie directly to documentation.	36 of 59	61%
7. MHW notes cosigned by RN, including back of the flow sheet.	18 of 58	31%
8. MHW flow sheets document a level of functional skill support provided, consistent with the identified area of need, delivered within last 24 hours.	14 of 36	39%
9. Weekly Summary note completed. Encompassing everything from that week.	19 of 54	35%
10. BMI on every treatment Plan	40 of 58	69%

Summary

There were changes this quarter with the indicators being monitored with some new indicators being added and some removed. A consistent chart reviewer has been collecting data this quarter which adds to the reliability. The compliance in this quarter has varied greatly from the previous quarter. Overall compliance last quarter was 74% with overall compliance this quarter at 64%. There was a great decrease in MHW notes cosigned from 55% last quarter to 31% this quarter. GAP notes written in appropriate manner at least every 24 hours increased greatly from 75%% to 95% due to the major effort focused on that particular indicator. Short-term goals/interventions are written, dated, and numbered increased from 96% to 97%. Short-term goals tie directly to documentation decreased greatly from 100% to 61% and may reflect the consistency of the data collector. Weekly summary notes have decreased from 70% to 35%. We note slippage in the weekly note documentation...

Action

The areas that reflected low percentages this quarter will be the focus for the next quarter Actions from last quarter will continue. The 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. A template has been developed for weekly notes and will be implemented hospital wide. Reeducation concerning cosigning of MHW notes and documentation will be conducted. Education and expectations will continue in areas needing attention. This documentation area will continue to be a high priority for the next quarter.

NURSING

ASPECT: Initial Chart Compliance

Indicator	Findings	Compliance
1. Universal Assessment completed by RN within 24 hours	26 of 26	100%
2. All sections completed or deferred within document	26 of 26	100%
3. Initial Safety Treatment Plan initiated	24 of 26	92%
4. All sheets required signature authenticated by assessing RN	26 of 26	100%
5. Medical Care Plan initiated if Medical problems identified	2 of 2	100% (24 N/A)
6. Informed Consent sheet signed	20 of 26	77%
7. Potential for violence assessment upon admission	26 of 26	100%
8. Suicide potential assessed upon admission	26 of 26	100%
9. Fall Risk assessment completed upon admission	26 of 26	100%

Summary

This area is monitored upon admission. Overall compliance is 97%. The one area needing attention is informed consent.

Action

Work with Professional Staff during the next quarter to assure that informed consent is obtained.

PEER SUPPORT

ASPECT: Integration of Peer Specialists into client care

Indicators	Findings	Compliance	Threshold Percentile
1. Attendance at Comprehensive Treatment Team meetings.	430 of 486	88%	80%
2. Level II grievances responded to by RPC on time.	10 of 11	91%	100%
3. Attendance at Service Integration meetings.	47 of 50	94%	100%
4. Contact during admission.	59 of 59	100%	100%
5. Level I grievances responded to by RPC on time.	71 of 87	82%	100%
6. Client satisfaction surveys completed.	23 of 40	58%	75%

Summary

Overall compliance is 87%, up 3% from last quarter. Two indicators have changed since last quarter. Peer support's response time to grievances has been eliminated due to continued 100% compliance with time frame. Response time by RPC for level I and level II grievances are being tracked separately. Compliance with response time for level I grievances increased by 32% from last quarter. RPC has made significant changes in the tracking process to improve response times. There were also increases in compliance with attendance at comprehensive treatment team meetings and completed client satisfaction surveys. There was a slight drop in compliance in attendance at service integration meetings. This is primarily due to clients refusing to have peer support present.

PHARMACY & THERAPEUTICS

ASPECT: Acu-Dose Discrepancies (Potential for Diversion)

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 October 1, 2009 through December 31, 2009 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
55	33	14	19	0	0

Summary

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

All of the 55 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.	78 of 100	78%
2. A minimum of three psychosocial educational interventions are assigned daily.	70 of 100	70%
3. A minimum of four groups is prescribed for the weekend.	79 of 100	79%
4. The client is able to state what his assigned psycho-social-educational interventions are and why they have been assigned.	83 of 100	83%
5. The client can correctly identify assigned RN and MHW. (Or where the information is available to him / her)	92 of 100	92%
6. The medical record documents the client's active participation in Morning Meeting within the last 24 hours.	64 of 100	64%
7. The client can identify personally effective distress tolerance mechanisms available within the milieu.	93 of 100	93%
8. Level and quality of client's use of leisure within the milieu are documented in the medical record over the last 7 days.	74 of 80	93%
9. Level and quality of social interactions within the milieu are documented in the medical record over the last 7 days.	78 of 80	98%
10. Suicide potential moderate or above incorporated into CSP	42 of 44	95%
11. Allergies displayed on order sheets and on spine of medical record.	99 of 100	99%
12. By the 7 th day if Fall Risk prioritized as active-was it incorporated into CSP	41 of 54	76%

Summary

Overall compliance for all indicators is 77%. The indicators have changed since last quarter with some being removed and some new indicators added. Client attending psycho-social education is at 78% which is up from 65% last quarter. The indicator that the client is able to state what his assigned psychosocial education interventions are is at 83%, which is up from 73% last quarter. The indicator suicide potential moderate or above is incorporated into the CSP is at 95% which is a great increase from 62% last quarter. Seven indicators numbers 5,6,7,8,9,10 and 11 remain approximately the same as last quarter. Two indicators have decreased; a minimum of three psychosocial educational interventions assigned daily has decreased from 95% to 70% this quarter. A minimum of four groups prescribed for the weekend is at 79% which is down from 86% last quarter. Indicator number 12 has been modified from last quarter and is at 76% this quarter.

Action

Continue to focus on the 2 areas that have been consistently below threshold over the next quarter. This will be addressed through staff meetings and community meetings. Continued work with the clients on daily group assignment and weekend group assignment...

PROGRAM SERVICES

Aspect-Milieu Treatment

Indicator	Compliance
1. Percentage of clients participating in Morning Meeting	63%
2. Percentage of clients who establish a daily goal.	83%
3. Percentage of clients who attend Wrap Up group in the evening or address with primary staff, the status of their daily goal.	69%
4. Percentage of clients attending Community Meeting	75%

Summary

Overall compliance in this area is 72% which is up from last quarter. Clients establishing a daily goal is at 83%, which is up from 78% last quarter. Percentage of clients attending community meeting is at 75% as it was last quarter. Percentage of clients who attended wrap up has decreased from 73% to 69%.

Action

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

PSYCHOLOGY

PSYCHOLOGY CHART AUDIT QI: 2ND QUARTER (OCTOBER THRU DECEMBER, 2009)

Generally, there has been a consistent increase in conformity to the 3 quality improvement objectives, rising from 94% in October to 100% in December. The major difficulty had been on the first objective: "Psychologist interventions on client's comprehensive service plan are measurable and time limited." This obviously was resolved by December, as the result of increased supervision and staff education on the issue. The second objective "Psychologist progress note indicates treatment offered as prescribed on comprehensive service plan" was at 98% in October and 100% by December. The third objective, "Psychologist progress notes reflect client's understanding of treatment goal and progress" was consistently at 100%. Total number of patients audited was 26.

Month	Interventions measurable	Treatment as prescribed	Client understanding
October	94%	98%	100%
November	100%	100%	100%
December	100%	100%	100%

Testing Referrals Fiscal Year 2008-2009

There were 54 testing referrals to the psychology department during this past fiscal year. This compares with 57 the year prior, which, given that through a portion of the past fiscal year not all psychology slots were filled, is within expectations. Currently, through the first half of the 2009-2010, there have been 35 evaluation referrals.

Co-occurring chart audit: Dates audited: 11-9 through 11-30-09

Total number of admissions for the month of November is 16 and all these charts were audited. Eleven charts had a diagnosis of co-occurring substance abuse and mental illness included in them.

Unit	Female Clients	Male Clients
Lower Saco	0	6
Upper Saco	0	0
Lower Kennebec	1	4
Upper Kennebec	0	0

Diagnosing Psychiatrist	Co-occurring diagnoses
Dr. D	3
Dr. W	2
Dr. C	3
Dr. M	3
Dr. B	0
Dr. K	0

Summary

1. There is evidence of co-occurring comprehensive service plan for 6 out of 11 identified client's charts.
2. There is evidence of "Stage of Change" documented in client comprehensive service plan for 6 out of 11 identified client's charts.
3. There is documentation of identified client's participation in co-occurring treatment in 6 out of 11 identified client's charts.

REHABILITATION SERVICES

Unit: ALL

Accountability Area: Rehabilitation Services

Aspect: Readiness Assessments, Comprehensive Service Plans and Progress Notes

Overall Compliance: 89%

Indicators	Findings	Compliance
1. Readiness assessment and treatment plan completed within 7 days of admission.	29 of 30	97%
2. Rehabilitation short term goals on Comprehensive Service Plan are measurable and time limited.	27 of 30	90%
3. Rehabilitation progress notes indicate treatment being offered as prescribed on Comprehensive Service Plan.	27 of 30	90%
4. Rehabilitation progress notes indicate progress towards addressing identified goals on the Comprehensive Service Plan.	24 of 30	80%

Summary

This is the second 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- One client assessment was not completed within the time frame due initial refusal from the client to complete and then a long holiday weekend. The assessment was then completed on the next business day but did not fall within the time frame.

Indicator #2 & 3-three of the charts reviewed on one unit did not have updated goals on the CSP present in the chart. The Director will meet with the Recreation Therapist assigned to that unit and remind them to review and update CSP's in a timely manner to reflect any necessary changes in the client's treatment. This will be reviewed with all RT's at the next scheduled meeting on 1/8/10.

Indicator #4-In review of the charts there were six charts between three units that did not accurately reflect the progress towards addressing indetified goals form the CSP. The documentation reflected the client's involvement in groups but did not address the identified goals for those groups. Director of Rehab. Services to hold documentation inservice at the Department meeting scheduled for 1/13/10.

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.

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	30/30	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.	2/2	100%	100%
3a. Client Participation in Preliminary Continuity of Care meeting.	30/30	100%	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.	28/30	93%	100%
3d. Community Provider Participation in Preliminary Continuity of Care meeting.	7/15	46%	90%
3e. Correctional Personnel Participation in Preliminary Continuity of Care Meeting.	0/15	0%	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	30/30	100%	100%

Summary

Indicator 3d is down slightly from the 1st quarter and remains low under the threshold percentile. We continue to work on the aspect area with the department to brainstorm community participation in this preliminary meeting. The challenge continues to be the short time frame in which the meeting occurs after admission and we have a higher percentage of participation at the 7 day treatment meeting and on-going meetings over the course of the clients entire stay at the facility. In addition the elimination of grant funding for community agencies may have an impact on this indicator aspect in remaining quarters. Indicator 3e has remains at 0 as it has for numerous quarters for varying reasons most clients refuse participation from jail personnel in their treatment meetings and the lack of mental health resources in the jails impacts participation. We are engaged in on-going meetings regarding forensic issues and will continue to discuss this on-going issue with the mental health liaison. Indicator 4a This area is up this quarter from 83% in the first quarter and will continues to be monitored and addressed in individual supervision with staff.

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.	2/8	25%	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.	5/5	100%	100%
3. Annual Reports (due Dec) to the commissioner for all inpatient NCR clients are submitted annually	34/34	34/34	100%

Summary

Indicator 1 decreased 18% from last quarter and we continue to streamline the institutional report process with the use of better predicting and tracking of petitions. The Upper Saco team had a process meeting to address this issue and each component of the Institutional Report. In addition a point person was designated to organize the process and keep all contributors on track with the established completion deadlines. The Forensic drive, on-going Forensic projections and forecasting meetings have assisted in the streamlining process and will continue to assist in meeting this goal area more successfully in future quarters.

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.	14/14	100%	95%
2. The Client Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	14/14	100%	100%
2a. The Client Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	14/14	100%	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.	14/14	100%	100%

Summary

Compliant in all indicators in this aspect area.

SOCIAL WORK

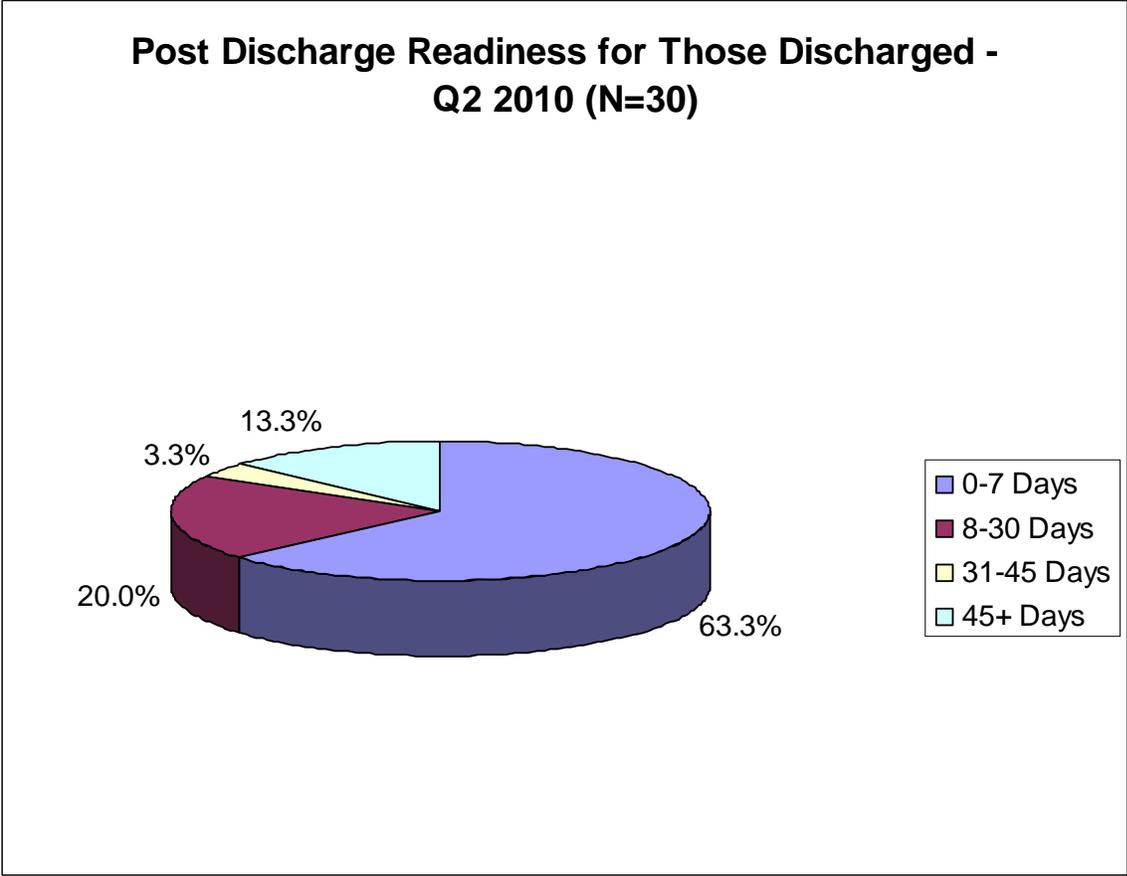
Aspect: TREATMENT PLANS AND PROGRESS NOTES

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%	96%

Summary

Indicator 1 is down slightly from the 4^{1st} quarter of 93% and will continue to be monitored. The social work department is on-line with the new Meditech electronic record system and utilizing the progress note function successfully.

SOCIAL WORK



This chart shows the percent of civil clients who were discharged within 7 days of their discharge readiness to be at 63.3% for this second quarter. Cumulative percentages and targets are as follows:

- Within 7 days = 63.3% (target 75%)
- Within 30 days = 83.3% (target 90%)
- Within 45 days = 86.6% (target 100%)

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.	19 of 19 completed orientation	100%	100 %
2. New employees will complete CPR training within 30 days of hire.	19 of 19 completed CPR training	100%	100 %
3. New employees will complete NAPPI training within 60 days of hire.	19 of 19 completed Nappi training	100%	100 %
4. Riverview and Contract staff will attend CPR training bi-annually.	316 of 317 are current in CPR certifications	99%	100 %
5. Riverview and Contract staff will attend NAPPI training annually. Goal to be at 100% by end of fiscal training year 2010 on June 30 th . Fiscal year 09 at 100%	203 of 365 have completed annual training	56%	100 %
6. Riverview and Contract staff will attend Annual training. Goal is to be at 100% by end of fiscal training year 2010 on June 30 th . Fiscal year 09 at 100%	342 of 378 have completed annual training	90%	100 %

Findings

The indicators are based on the requirements for all new/current staff to complete mandatory training and maintain current certifications. **19 out of 19** (100%) new Riverview/Contracted employees completed these trainings. **316 of 317** (99%) Riverview/Contracted employees are current with CPR certification. **203 of 365** (56%) Riverview/Contracted employees are current in Nappi training. **342 of 378** (90%) employees are current in Annual training. All indicators remained at 100 % compliance for quarter 2-FY 2010.

Problem

One Contract employee did not attend CPR due to illness. Contract employee is schedule for the next class in January

Status

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

Actions

Contract employee scheduled for January CPR class.