

Riverview

PSYCHIATRIC CENTER



PERFORMANCE IMPROVEMENT REPORT

THIRD QUARTER FISCAL YEAR 2010
Jan, Feb, Mar 2010

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INTRODUCTION

A new report has been added to the comparative statistics section of this report. The additional report focuses on the Prevalence of Co-occurring Psychiatric and Substance Disorders (COPSD) and is expressed in a percent of the client population who have been admitted with COPSD. The percent of Riverview Psychiatric Center clients with COPSD is slightly higher than the national mean in both the forensic and civil stratification areas. Riverview's civil population is significantly higher than the national mean with regard to the prevalence of COPSD (RPC 60% v. National 30%) while the forensic population is only slightly higher than the national mean (RPC 60% v. National 50%).

In an attempt to identify causes of re-hospitalization among its clients, the ACT Team is conducting an analysis of the causes for hospital return and the actions of the ACT Team in providing support services to these clients before their return to inpatient status. The intent of this study is to limit the number of re-hospitalizations and to identify means for clients to return to the community utilizing existing support services. A description of this analysis can be found in the Community Forensic ACT Team section of this report.

The client injury rate remains well below the national mean. Of those clients that are injured, the seriousness of the injury is minimal, usually requiring no intervention or minor first aid. The greatest prevalence of client injuries appears to be due to self-injurious behaviors.

Continuing efforts to limit the incidence of restraint and seclusion in the management of client incidents continues. The number and duration of restraint events is up slight from past reports but remains within one standard deviation of the national mean. Seclusion events are also showing higher numbers and duration than past reports. Both of these increases may be due to a higher acuity in client incidents during the past quarter.

Deficiencies noted in the Dietary department with regard to cleanliness standards are reported to be due to staffing limitations. Several openings in this department have made it increasingly difficult to maintain the required standard while ensuring ongoing service to clients.

The completion of performance evaluations in a timely manner continues to be a problem. However, there is evidence that this low performance trend may be in the process of a reversal through the added effort of the new Human Resources Director over the past quarter and with support staff positions recently being filled. Further efforts to comply with this measure will be implemented over the next quarter.

Staff Development shows a high degree of compliance to date with an expected compliance level of 100% by the end of the training year on June 30, 2010. This performance measure includes the completion of all annual training, CPR certification, and NAPPI training for over 300 staff members.

COMMUNITY FORENSIC ACT TEAM

ASPECT: REDUCTION OF RE-HOSPITALIZATION FOR ACT TEAM CLIENTS

Indicators	Findings	Compliance	Threshold Percentile
1. The ACT Team Director will review all client cases of re-hospitalization from the community for patterns and trends of the contributing factors leading to re-hospitalization each quarter. The following elements are considered during the review: a. Length of stay in community b. Type of residence (i.e.: group home, apartment, etc) c. Geographic location of residence d. Community support network e. Client demographics (age, gender, financial) f. Behavior pattern/mental status g. Medication adherence h. Level of communication with ACT Team	3/3	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.	3/3	100%	100%

SUMMARY

1. Three total clients were re-hospitalized, all of whom were male. Two had been in the community with supported housing over one year; one had been recently discharged from Riverview (had been in community 1/6/10-3/18/10). Two of the three lived in housing less than ¼ mile from ACT, one lived three miles from ACT. All three clients had a minimum of three times per week contact with ACT and daily contact with housing program. One of the three had extensive supports in the community, one had not completed transition (under three months) to community and one had few community supports aside from work. Two of the three decompensated rapidly and the third experienced chronic medical and behavioral decompensation. All three appeared to be adhering to medication regimen.
2. The ACT Team has become more consistent in attending treatment team meetings while clients are in the hospital, specifically including increased communication between ACT Psychiatrist and inpatient treatment providers and with re-starting therapy with ACT Psychologist prior to discharge. To ensure continued improved communication, ACT PSD will invite Treatment Teams from the four referring units of Riverview to ACT Grand Rounds within the next quarter (recommendation from internal assessment).

COMMUNITY FORENSIC ACT TEAM

ASPECT: INSTITUTIONAL AND ANNUAL REPORTS

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

SUMMARY

- 5 clients petitioned, 2 withdrew petitions before 10 days and 1 withdrew petition two weeks before court. For the last one, the Institutional Report was not completed within the 10 day period, but was completed and is in the chart, again due to the client's attorney stating it had been withdrawn when it had not been.
- ACT Team Leader delivers all new Court Orders to Case Managers upon receipt, who then reviews with both client and supported housing staff involved in compliance with order. This is documented in progress notes and/or reviewed in ISP treatment team.

ASPECT: INDIVIDUAL SERVICE PLANS AND PROGRESS NOTES

Indicators	Findings	Compliance	Threshold Percentile
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly contact with all clients assigned on an active status caseload.	33/39	75%	95%
2. Individual Service Plans will have measurable goals and interventions listing client strengths and areas of need related to community integration and increased court ordered privileges based on risk reduction activities.	39/39	100%	95%
3. Case notes will indicate at minimum monthly contact with all NCR clients who remain under the care of the Commissioner. These clients receive treatment services by community providers and RPC ACT monitors for court order and annual report compliance only.	9/9	100%	95%

SUMMARY

- Team now offers 3 groups, creating increased capacity for face-to-face contacts and supporting documentation. Of note is an instance of lack of documented contact for a period of 8 days, two weeks after which the client died of unknown causes (awaiting medical examiner's report). Follow up with individual case managers will be done in supervision to address this area and issue with compliance.

COMMUNITY FORENSIC ACT TEAM

- 2. ISPs also contain group attendance goals, especially with clients who are petitioning for increased court ordered privileges.

ASPECT: SUBSTANCE ABUSE AND ADDICTIVE BEHAVIOR HISTORY

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

SUMMARY

In addition to implementing substance abuse timeline, the Co-Occurring Specialist has facilitated COMPASS assessment of program, taking an active role in implementing recommendations. Use of a Breathalyzer in particular was recommended to demonstrate abstinence and/or rule out alcohol use. The PSD will request permission to purchase this tool within the next quarter.

ASPECT: PEER SUPPORT

Indicators	Findings	Compliance	Threshold Percentile
1. Engagement attempt with client within 7 days of admission.	3/3	100%	95%
2. Documented offer of peer support services.	3/3	100%	95%
3. Attendance at treatment team meetings as appropriate.	35/39	90%	95%

SUMMARY

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

ASPECT: SCREENING AND ASSESSMENT FOR RISK OF HARM TO SELF OR OTHERS

Indicators	Findings	Compliance	Threshold Percentile
1. Engagement with client within 7 days of admission.	3/3	100%	95%
2. Documented offer of peer support services.	3/3	100%	95%

SUMMARY

No issues in this aspect area.

CAPITOL COMMUNITY CLINIC

ASPECT: MED MANAGEMENT CLINIC APPOINTMENT ASSESSMENT

Indicators	Findings	Compliance	Threshold Percentile
All Outpatient clients will have Vital Signs and Weight recorded upon arrival for appointment.	There were forty -five clients scheduled in Jan . The twenty-three that came in for appointments did have their vitals taken before their clinic appointment.	100%	100%
	There were thirty-three clients scheduled in the month of Feb , Twenty-six of the clients were actually seen. The twenty-six clients had vitals taken before their appt.	100%	
	In March there were fifty-eight clients scheduled. Forty-three were seen. Of the forty-three, forty -two had their vitals taken before their clinic appt. one client did not have vitals taken before Appt. The person came in very late.	98%	

SUMMARY

For the third quarter there were 92 clients. Of the quantity stated, 91 had their vitals taken before their appointment. One client did not have vitals done in the month of March. The P.A. will do vitals when the client comes in late. Review of monthly staff meetings and forward reports quarterly to RPC

ACTIONS

Clients coming in late, conflicts with next appointment. Have clients come in earlier than appointment. Some clients are not receptive to coming in early for appointment. Will continue to work with the clients on this aspect. Will ask PA to do vitals on late clients.

CAPITOL COMMUNITY CLINIC

ASPECT: DENTAL CLINIC CONSULT TIMELINESS

Indicators	Findings	Compliance	Threshold Percentile
All clients from RPC Units to be seen in the clinic will have a completed consult received in the clinic 24hrs prior to the clinic visit or sent with client and staff at time of visit.	Jan. Had thirty-three in-house clients. Out of the thirty-three, two of the clients did not have consults at the time of visit.	94%	90%
	Feb. Had twenty-seven in-house clients. Out of the twenty- seven, four consults Not received at the time of visit.	85%	
	March had fifty-one in-house clients of the fifty-one clients, all had consults at the time of dental visit.	100%	

SUMMARY

In **Jan.** there were thirty-three RPC clients. Of the thirty-three, two did not have consults at the time of the dental visits. One from Upper Saco, one from lower Kennebec.

In **Feb.** there were twenty-seven RPC clients of the twenty-four clients four did not have the consult at time of dental visit. One Lower Kennebec, one Lower Saco, One Upper Kennebec, one Upper Saco

In **March** there were fifty-one in-house clients and every client did have consults at the time of dental visit.

ACTIONS

A memo was sent to each unit reminding them of the consult policy. Our medical care coordinator calls the day before to remind them of the paper work needed for the visit and if the in-house clients 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

Indicators	Findings	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.	Jan. Ten extractions. Post instructions verbalized to each client. Clients repeated back to dental assistant. Clients understood the Instructions without difficulty.	100%	100%
	Feb. One extraction. Post instructions verbalized to each client. Client repeated back to dental assistant. Client understood the instructions without difficulty.	100%	
	March: Sixteen extractions. Post instructions verbalized to each client. Clients repeated back to dental assistant. Clients understood the instructions without difficulty.	100%	

SUMMARY

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

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

CAPITOL COMMUNITY CLINIC

ASPECT: DENTAL CLINIC 24 HOUR POST EXTRACTION FOLLOW-UP

Indicators	Findings Quarter 3	Compliance	Threshold Percentile
1. After all dental extractions, the clients will receive a follow-up phone call from the clinic within 24hrs of procedure to assess for complications.	Jan. there ten were extractions. Follow up 24-hour phone call. The pts had no complications post extractions.	100%	100%
	Feb. One extraction with 24 hour follow up phone call. The pts. that were called, had no post procedure complications	100%	
	March: Sixteen extraction with a 24 hour fellow up post extraction call with No complication	100%	

SUMMARY

There were twenty-seven extractions. Dental clients in the third 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 LK	Findings UK	Findings LS	Findings US	Findings Total
1	I felt I had enough privacy in the hospital.	9	7	4	4	24
2	If I had a choice of hospitals, I would still choose this one.	11	5	4	6	26
3	Do you know someone who can help you get what you want or stand up for your rights?	9	5	11	3	28
4	I am better able to deal with crisis.	8	2	7	4	21
5	I deal more effectively with daily problems.	7	6	7	6	26
6	My symptoms are not bothering me as much.	10	6	13	3	32
7	Staff here believed that I could grow, change and recover.	11	4	14	5	34
8	My pain was managed.	5	5	9	7	26
9	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	11	2	14	5	32
10	Staff were sensitive to my cultural background.	6	0	7	2	15
11	The medications I am taking help me control symptoms that used to bother me.	6	1	12	5	24
12	The surroundings and atmosphere at the hospital helped me get better.	6	1	9	4	20
13	My contact with my doctor was helpful.	7	3	5	2	17
14	Did anyone tell you about your rights?	4	-1	2	-1	4
15	The hospital environment was clean and comfortable.	5	4	-2	3	10
16	I do better in social situations.	7	4	6	1	18
17	Both I and my doctor or therapist from the community were actively involved in my hospital treatment plan.	5	2	2	-1	8
18	I was treated with dignity and respect.	2	0	0	-2	0

CLIENT SATISFACTION

#	Indicators	Findings LK	Findings UK	Findings LS	Findings US	Findings Total
19	My other medical conditions were treated.	3	7	10	3	23
20	My family and/or friends were able to visit me.	2	8	10	2	22
21	I felt this hospital stay was necessary.	4	9	15	4	32
22	I participated in planning my discharge.	5	10	17	3	35
23	I felt comfortable asking questions about my treatment and medications.	1	5	8	3	17
24	I was encouraged to use self-help/support groups.	4	3	15	4	26
25	My complaints and grievances were addressed.	7	2	10	2	21
26	I felt safe while I was in the hospital.	6	1	11	4	22
27	I felt free to complain without fear of retaliation.	7	4	12	3	26
28	I felt safe to refuse medication or treatment during my hospital stay.	-3	3	1	3	4
29	I had a choice of treatment options.	7	3	15	2	27
30	I was given information about how to manage my medication side effects.	7	3	5	2	17
31	My contact with nurses and therapists was helpful.	8	6	15	4	33
32	Are you told ahead of time of changes in your privileges, appointments, or daily routine?	5	5	3	-1	12

SUMMARY

The highest possible score for each indicator is 60 (n = 30). A score above zero (neutral) indicates an overall positive response. Scores are weighted based on a Likert Scale. There were 15 indicator that increased in satisfaction and 17 that decreased. The most significant increases are in **bold** and significant decreases in **red**. Indicators 2, 3, 5, 6, 7, and 9 continue to have high satisfaction and 23, 25, 28, 30, and 32 continue to be low. There are some trends between units that should be noted. There are several areas that indicate less satisfaction on the upper units.

ACTIONS

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

COMPARATIVE STATISTICS

The comparative statistics reports include the following elements:

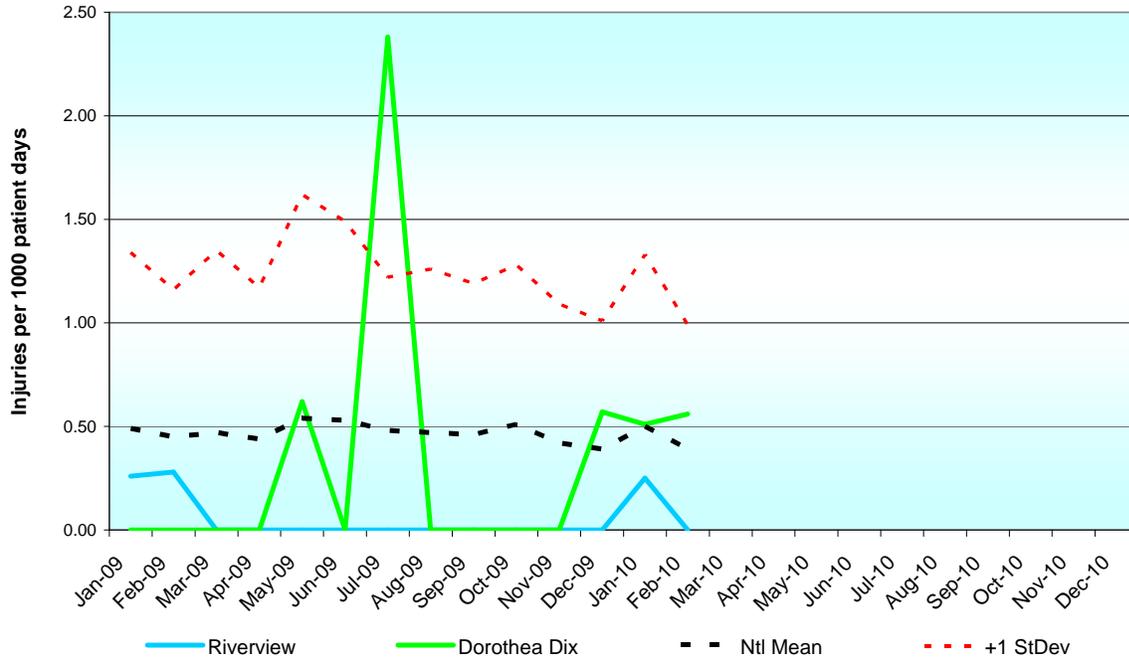
- Client Injury Rate
- Elopement Rate
- Medication Error Rate
- 30 Day Readmit Rate
- Percent of Clients Restrained
- Hours of Restraint
- Percent of Clients Secluded
- Hours of Seclusion
- Prevalence of Co-occurring Psychiatric and Substance Abuse Disorders

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

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

COMPARATIVE STATISTICS

Client Injury Rate



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

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

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

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

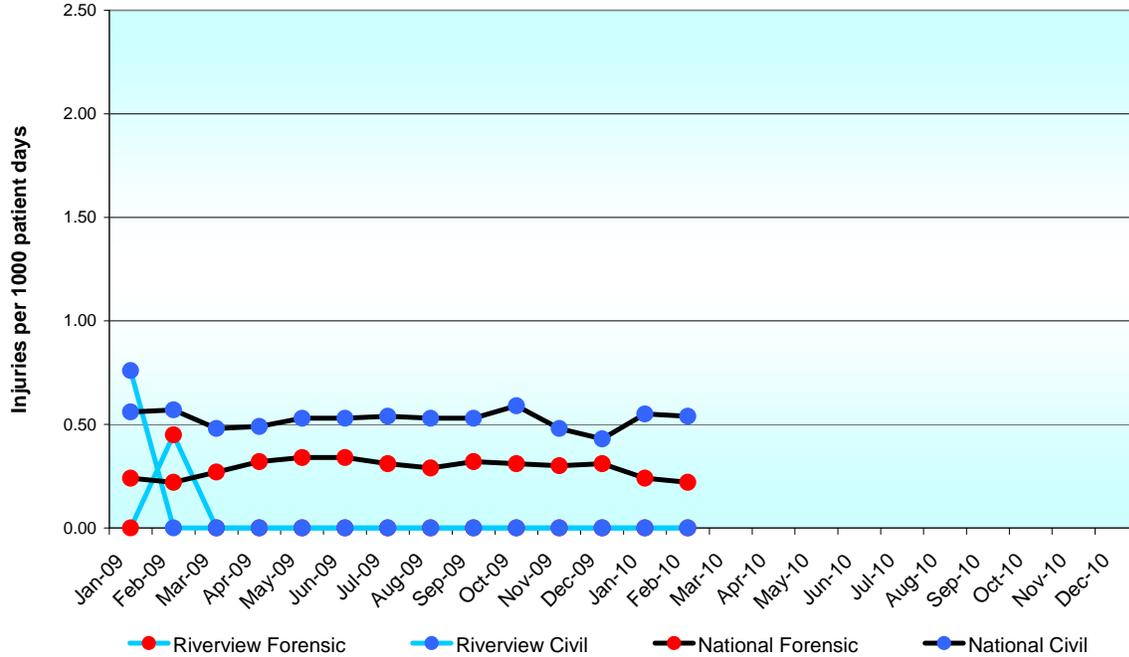
- No Treatment – The injury received by a client may be examined by a clinician but no treatment is applied to the injury.
- Minor First Aid – The injury received is of minor severity and requires the administration of minor first aid.
- Medical Intervention Needed – The injury received is severe enough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

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

COMPARATIVE STATISTICS

Client Injury Rate

Forensic Stratification



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

Client Injuries	January	February	March	3 rd Qtr 2010
Total	25	21	16	61

ASPECT: Client Injury Segmentation – Severity by Month

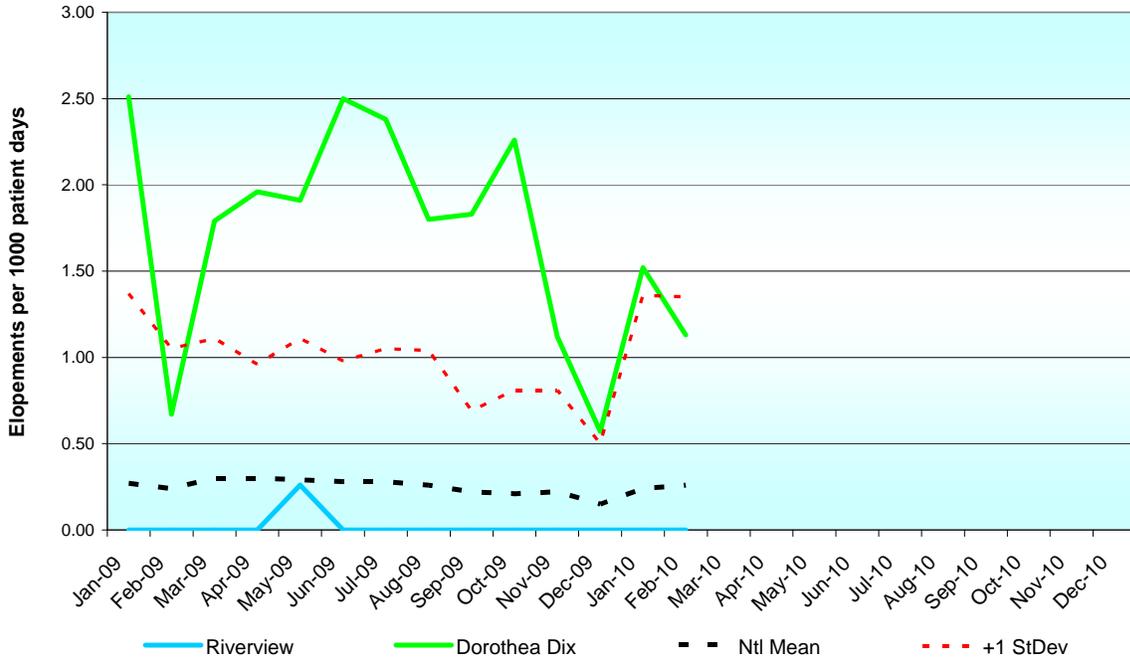
Severity	January	February	March	3 rd Qtr 2010
No Treatment	24	13	11	48
Minor First Aid	1	8	4	13
Medical Intervention Required	0	0	0	0
Hospitalization Required	0	0	0	0
Death Occurred	0	0	0	0

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

Type - Cause	January	February	March	3 rd Qtr 2010
Accident – Unwitnessed Fall	2	1	2	5
Accident – Witnessed Fall	1	3	2	6
Assault – Patient to Patient	1	1	2	4
Self Injury – Agitation	19	7	6	32
Self Injury – Unwitnessed Fall	0	1	0	1
Self Injury – Other	0	6	3	9

COMPARATIVE STATISTICS

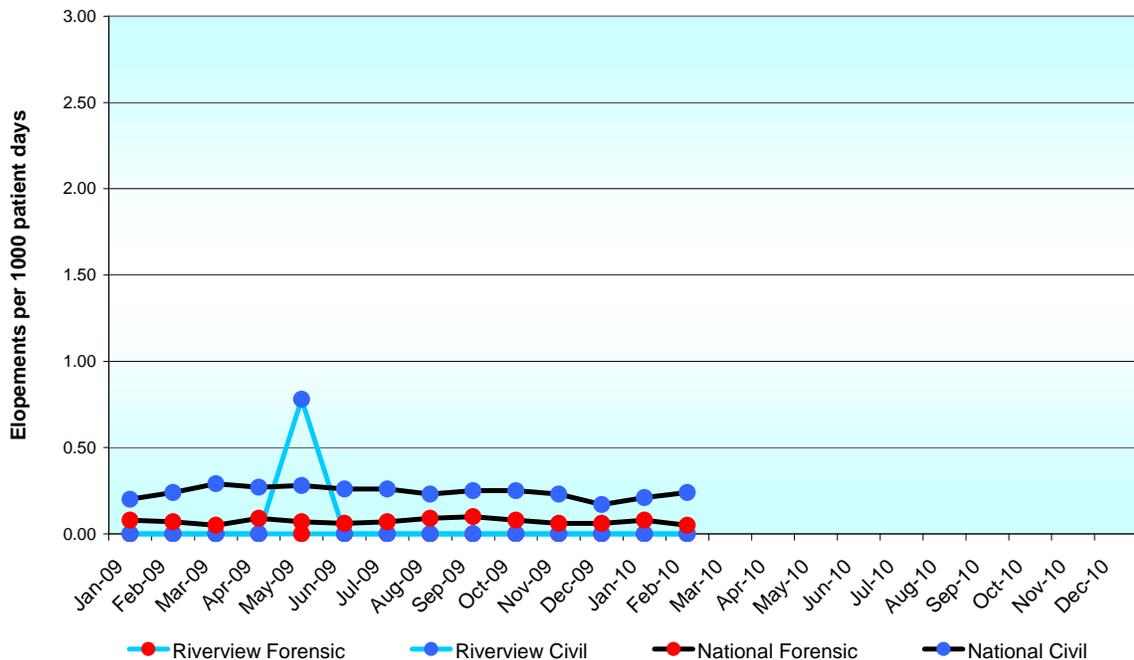
Elopement



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.

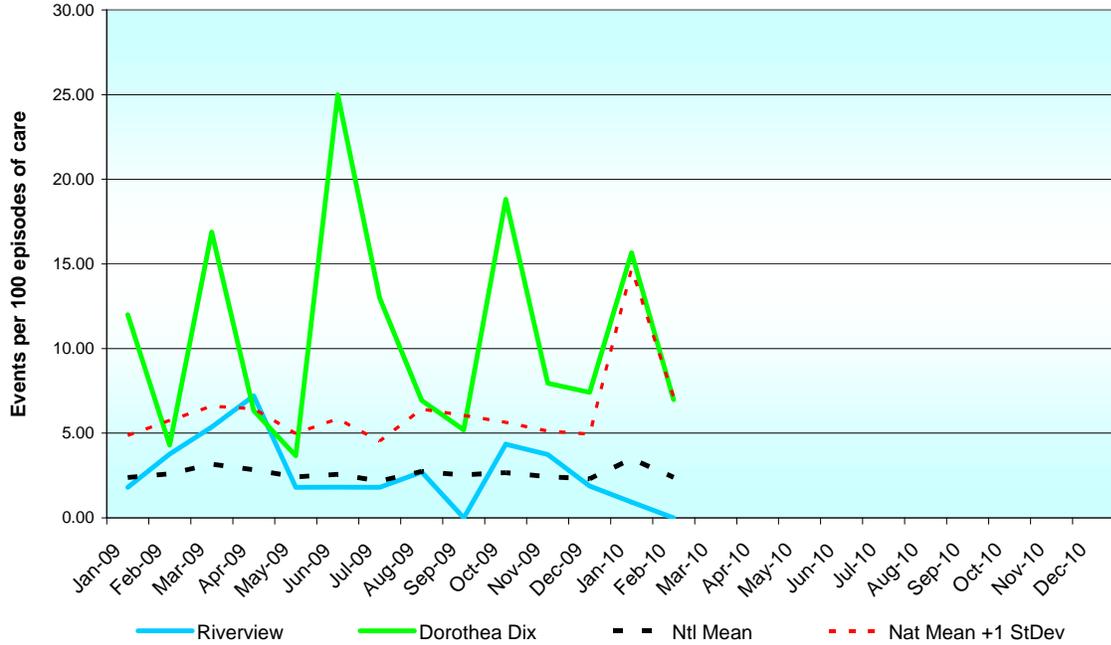
Elopement

Forensic Stratification



COMPARATIVE STATISTICS

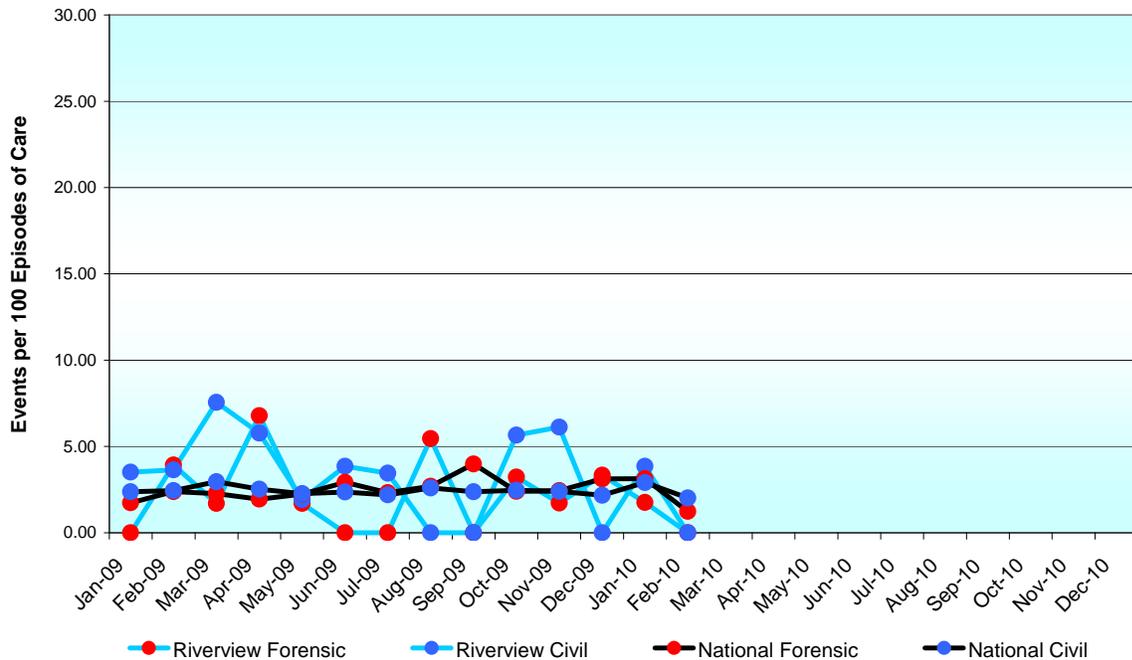
Medication Errors



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.

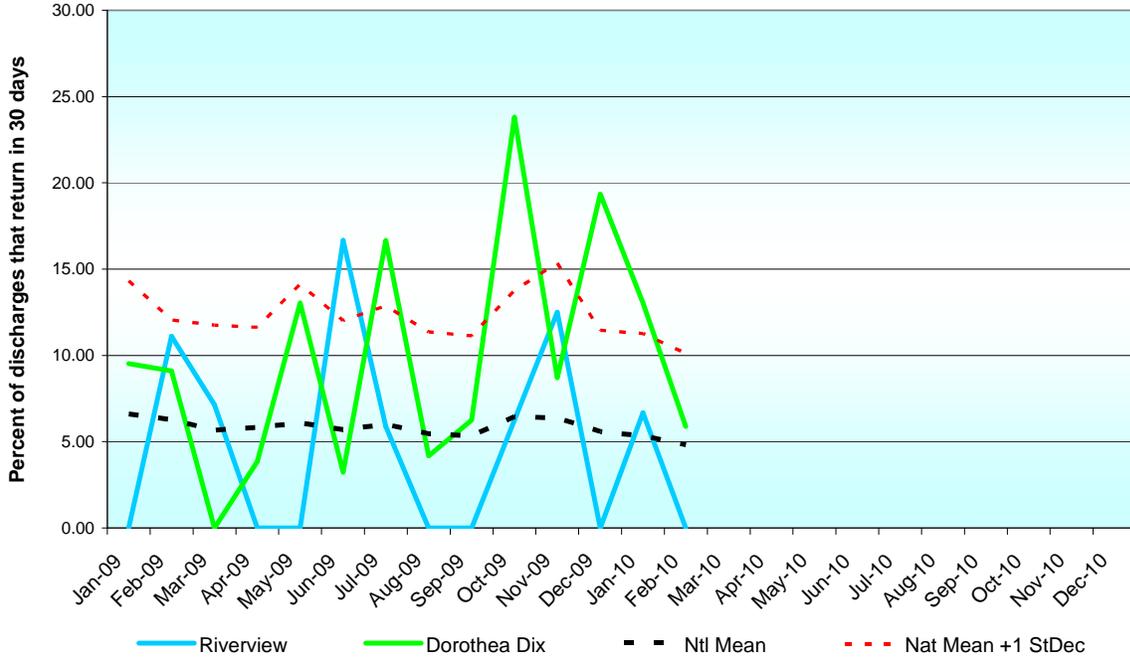
Medication Errors

Forensic Stratification



COMPARATIVE STATISTICS

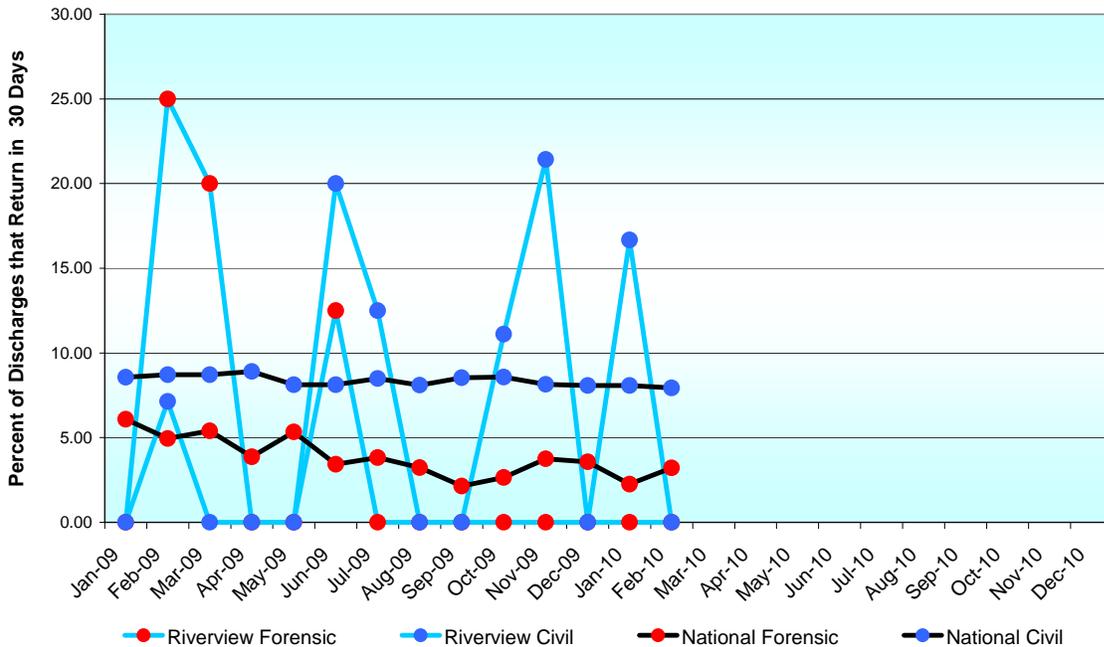
30 Day Readmit



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.

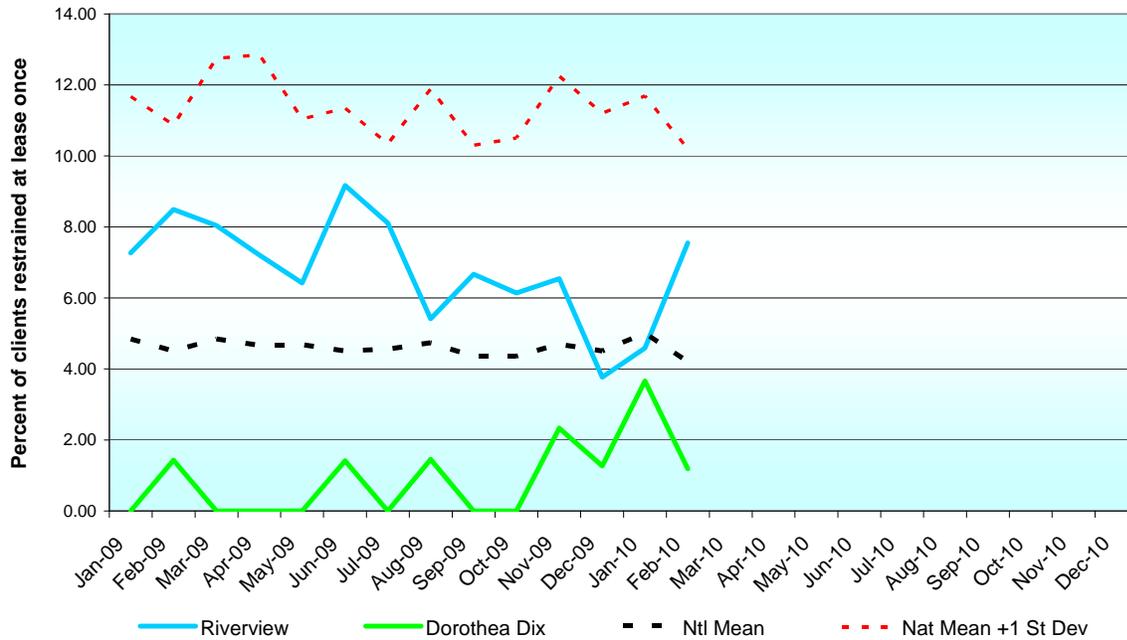
30 Day Readmit

Forensic Stratification



COMPARATIVE STATISTICS

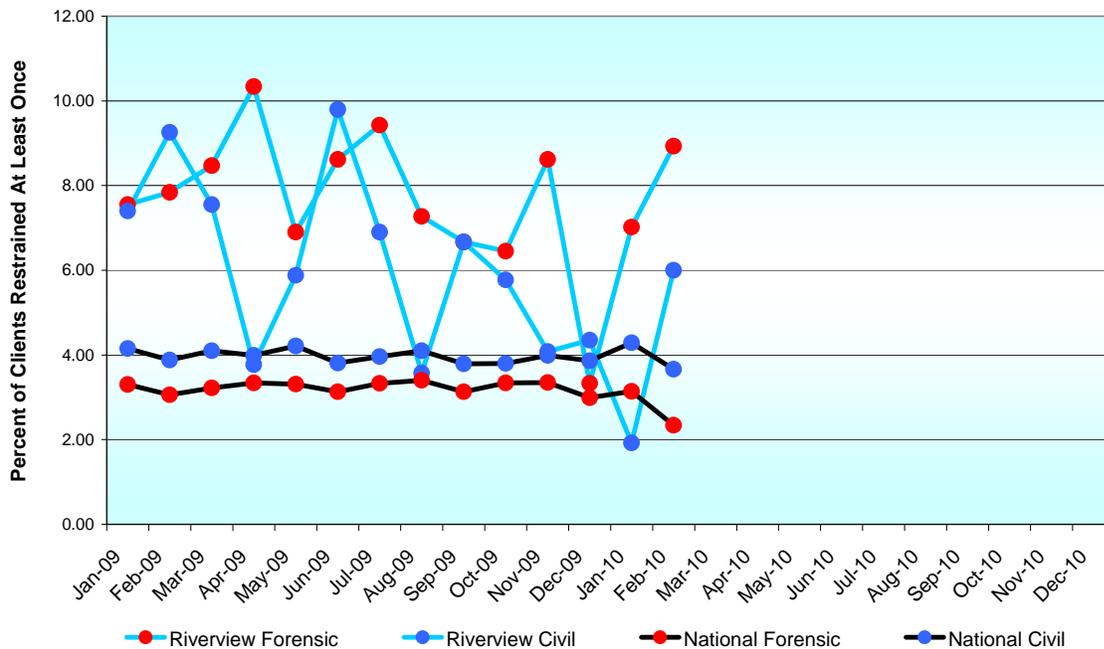
Percent of Clients Restrained



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.

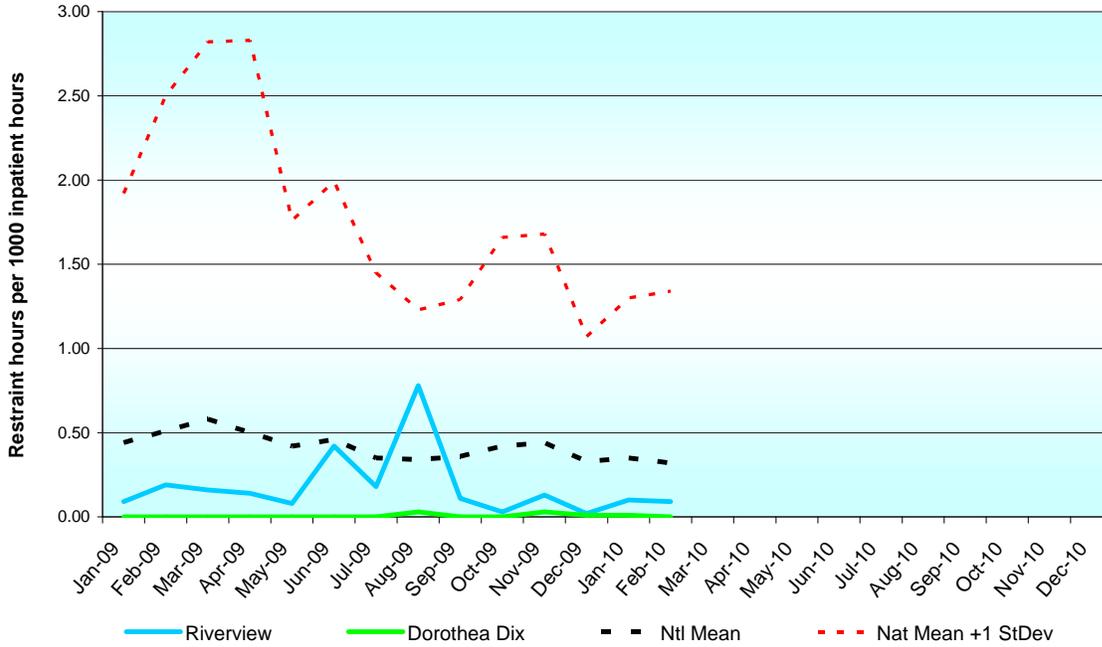
Percent of Clients Restrained

Forensic Stratification



COMPARATIVE STATISTICS

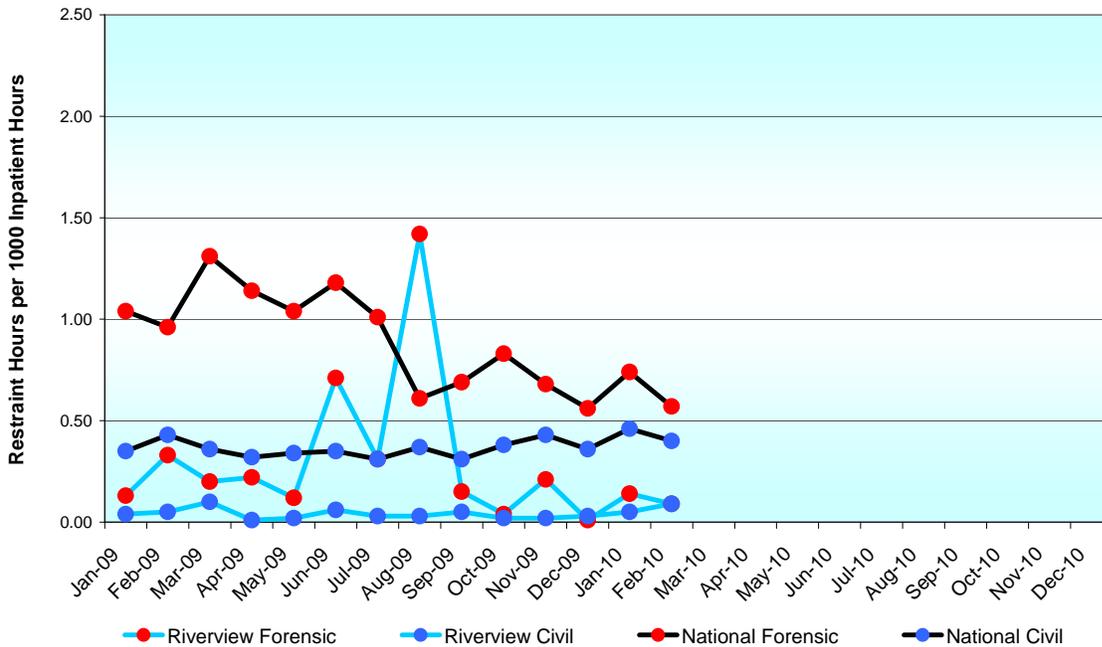
Restraint Hours



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.

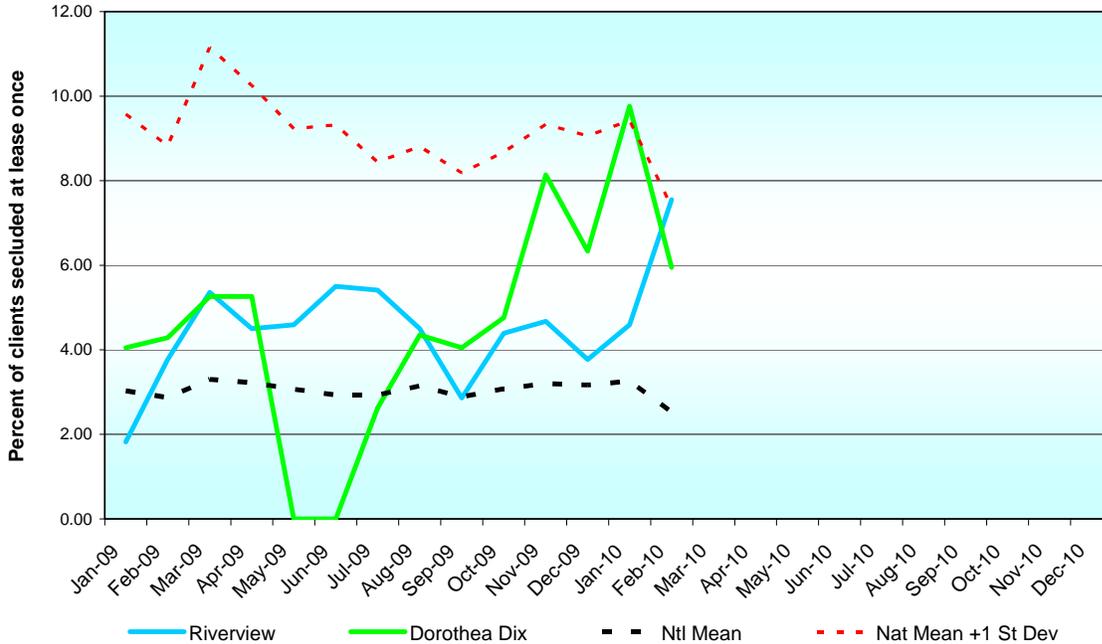
Restraint Hours

Forensic Stratification



COMPARATIVE STATISTICS

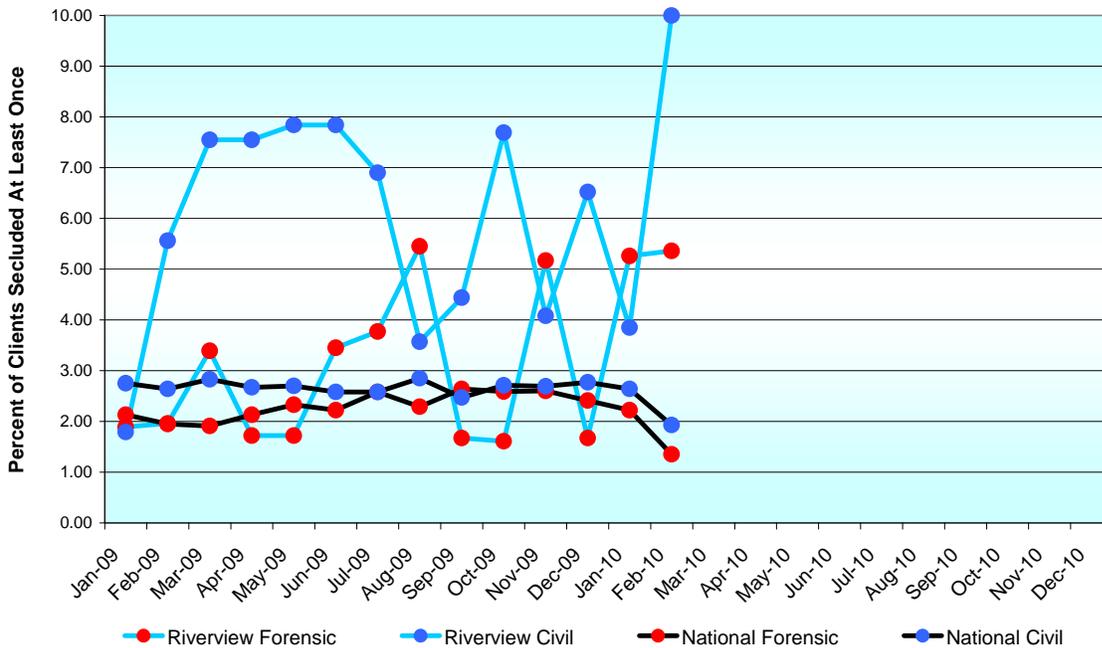
Percent of Clients Secluded



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.

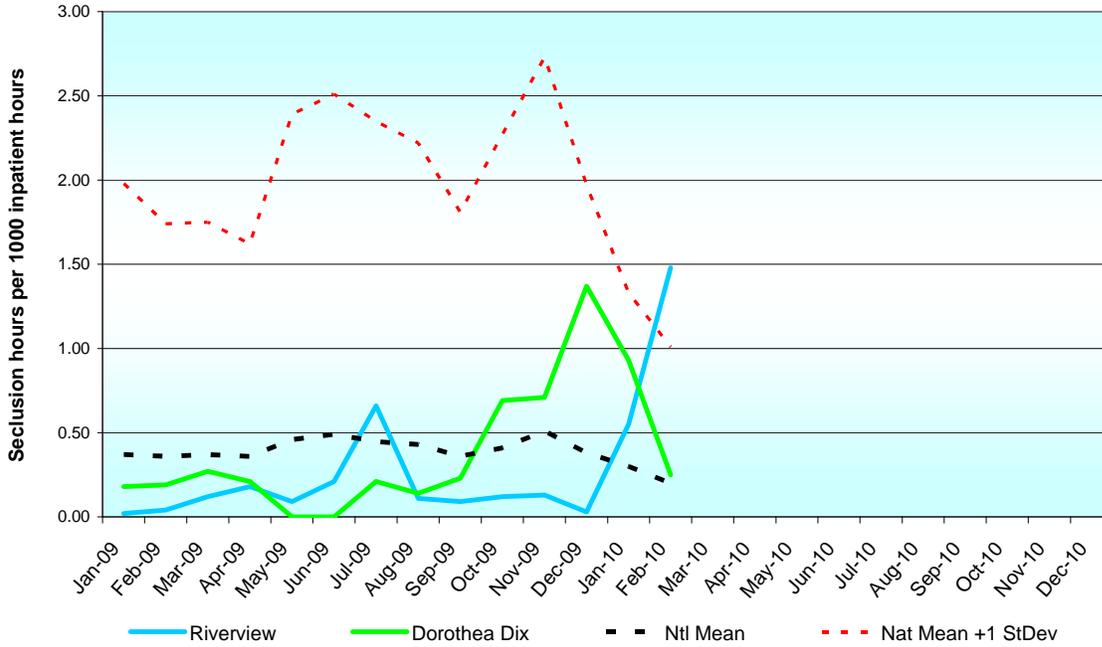
Percent of Clients Secluded

Forensic Stratification



COMPARATIVE STATISTICS

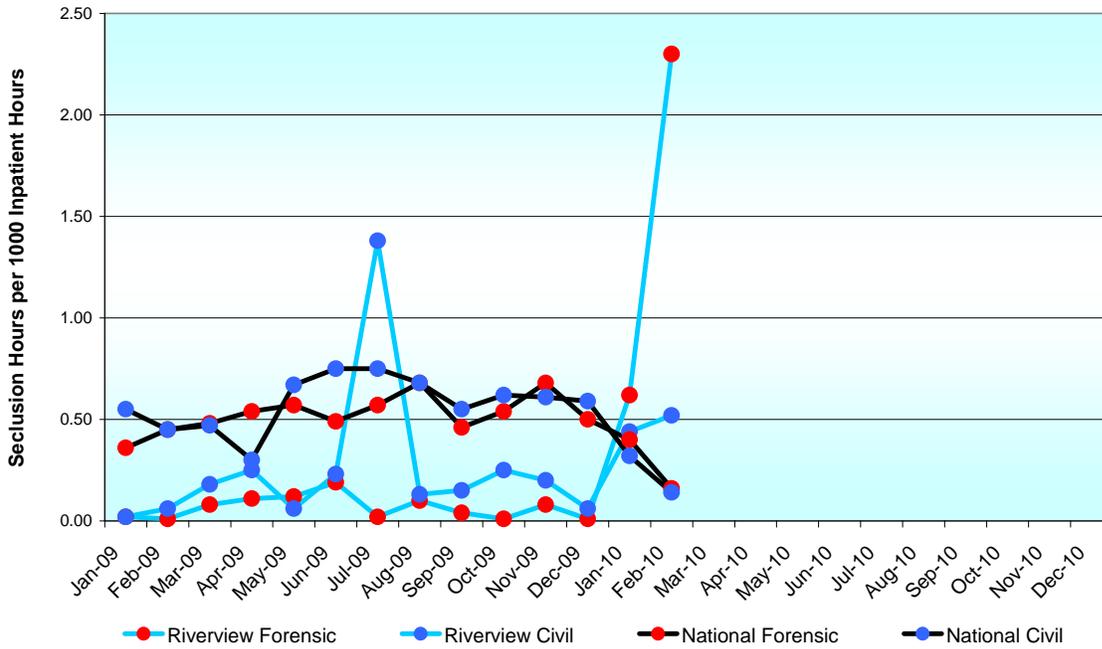
Seclusion Hours



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



COMPARATIVE STATISTICS

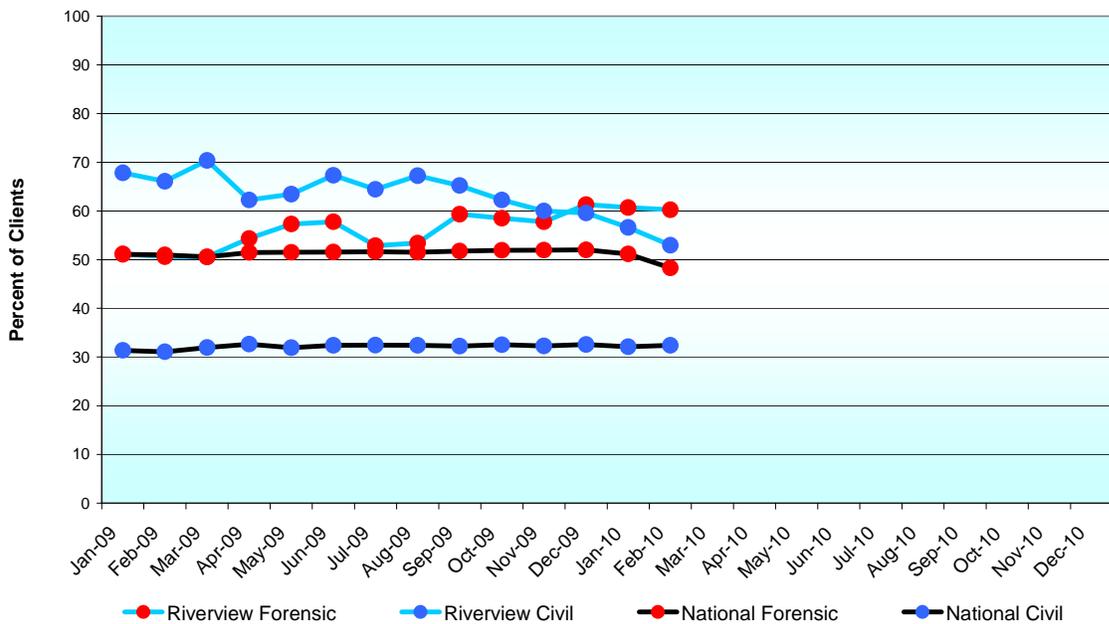
Prevalence of Co-occurring Psychiatric and Substance Abuse Disorders



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

Prevalence of Co-occurring Psychiatric and Substance Abuse Disorders

Forensic Stratification



DIETARY

ASPECT: CLEANLINESS OF MAIN KITCHEN

Indicators	Findings	Compliance	Threshold Percentile
1. All convection ovens (4) were thoroughly cleaned monthly.	11 of 12	92%	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	16 of 18	89%	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	19 of 24	79%	95%
7. All trash cans (5) and bins (1) were cleaned daily	341 of 540	63%	95%
8. All carts(9) used for food transport (tiered) were cleaned daily	686 of 810	85%	100%
9. All hand sinks (4) were cleaned daily	304 of 360	84%	95%
10. Racks(3) used for drying dishes were cleaned daily	207 of 270	77%	100%

SUMMARY

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

Threshold percentiles were not met regarding:

Convection ovens, 92%.

Shelves used for the storage of clean pots and pans 89%.

Steam kettles 79%.

All trash cans and bins 63%.

Hand sinks 84%.

Racks used for drying dishes 77%.

Improvements were shown in the following areas:

Convection ovens were cleaned at a 92% rate.

Dishmachine: 100%.

Walk-in coolers 100%.

All tiered carts used for food transport were not cleaned at 100% threshold, however the rate has increased 2%.

The department continues to struggle with the completion of daily cleaning tasks. This is due to the continued staffing shortage. Vacant positions January- March 2010: PT Food service worker, Pt Cook,

DIETARY

Food Services Manager. The Dietary team has shown improvement working together to successfully complete federal and state mandated regulations regarding food safety and sanitation.

Overall Compliance: 78%

ACTIONS

General staff meetings include 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. Client employees provide assistance completing daily tasks, as appropriate. D.S.M. will share results of this CPI indicator with staff. It is expected that the Dietary department will have all positions filled by June 2010.

NEXT REPORTING DATE

July 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.	2255 requests for information (132 requests for client information and 2123 police checks) were released for quarter 3 2010.	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	15 new employees/contract staff in quarter 3 2010.	100%	100%
Confidentiality/Privacy issues tracked through incident reports.	0 privacy-related incident reports during quarter 3 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 3, 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 46 discharges in quarter 3 2010. Of those, 42 were completed by 30 days. Note: There were 4 incomplete record from the previous reporting period.	91 %	80%
Discharge summaries will be completed within 15 days of discharge.	45 out of 46 discharge summaries were completed within 15 days of discharge during quarter 3 2010.	98 %	100%
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	5 forms were revised in quarter 3 2010 (see minutes).	100%	100%
Medical transcription will be timely and accurate.	Out of 944 dictated reports, 868 were completed within 24 hours.	92%	90%

SUMMARY

The indicators are based on the review of all discharged records. There was 91% compliance with record completion, with 4 incomplete records from a previous reporting period. There was 98% 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 92% 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?	32 of 32	100%	100%
2. Was linen free of any holes or rips coming back from vendor?	31 of 32	97%	95%
3. Did we have enough linen on units via complaints from unit staff?	30 of 32	94%	90%
4. Was linen covered on units?	28 of 32	88%	95%
5. Did vendor provide a 24 hr. turn around service as specified in the contract?	30 of 32	94%	100%
6. Did we receive an adequate supply of mops and rags from vendor?	31 of 32	97%	95%
7. Was linen bins clean returning from vendor?	32 of 32	100%	100%

SUMMARY

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 #4 & #5. The overall compliance for this quarter was 96%. This shows a 2% decrease from last quarters' report.

1. During random inspections, Linen returned from vendor was worn out and not taken out of service.
2. Housekeeping did not have enough mops brought back from the vendor.
3. Linen stored in the clean linen rooms on Lower Saco & Upper Kennebec were not covered.
4. Linen coming back from the vendor were not delivered to Riverview in a timely fashion.

ACTIONS

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

- ✓ The housekeeping staff on each unit will monitor the quantity of wash mops and rags delivered to their respective units and report to the Housekeeping Supervisor immediately.
- ✓ The housekeeping staff on each unit will monitor the linen 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 worn out linens and the timeliness of their deliveries.

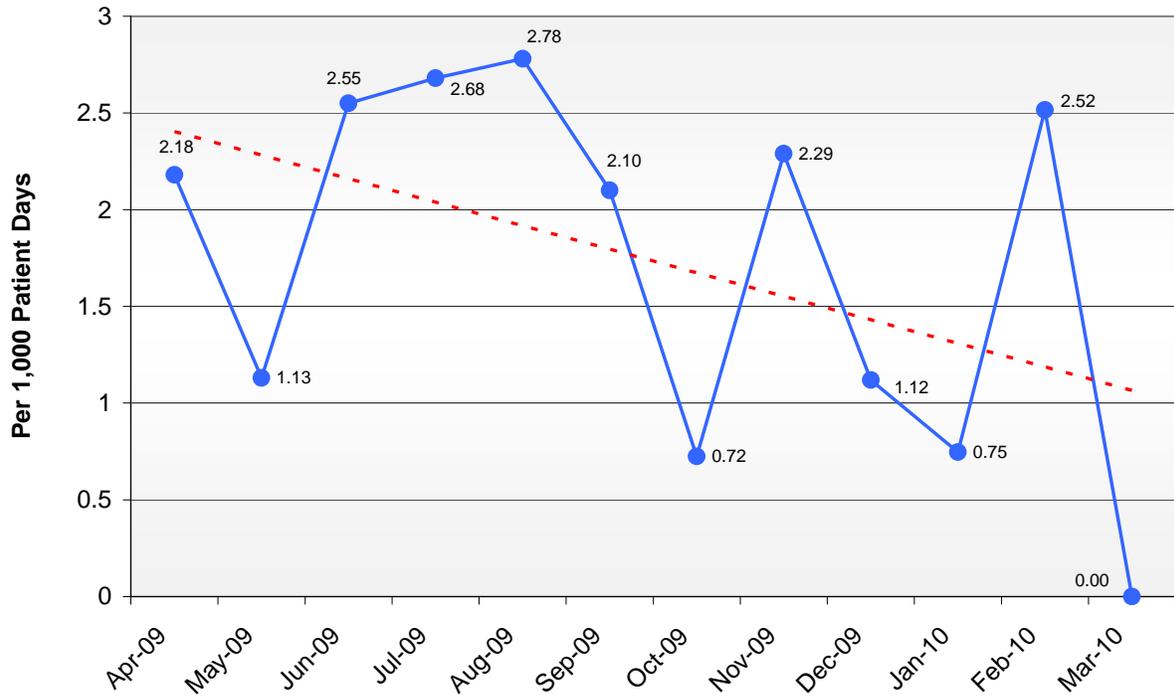
NEXT REPORTING DATE

July 2010

HUMAN RESOURCES

ASPECT: Direct Care Staff Injuries

Reportable (Lost Time & Medical) Direct Care Staff Injuries



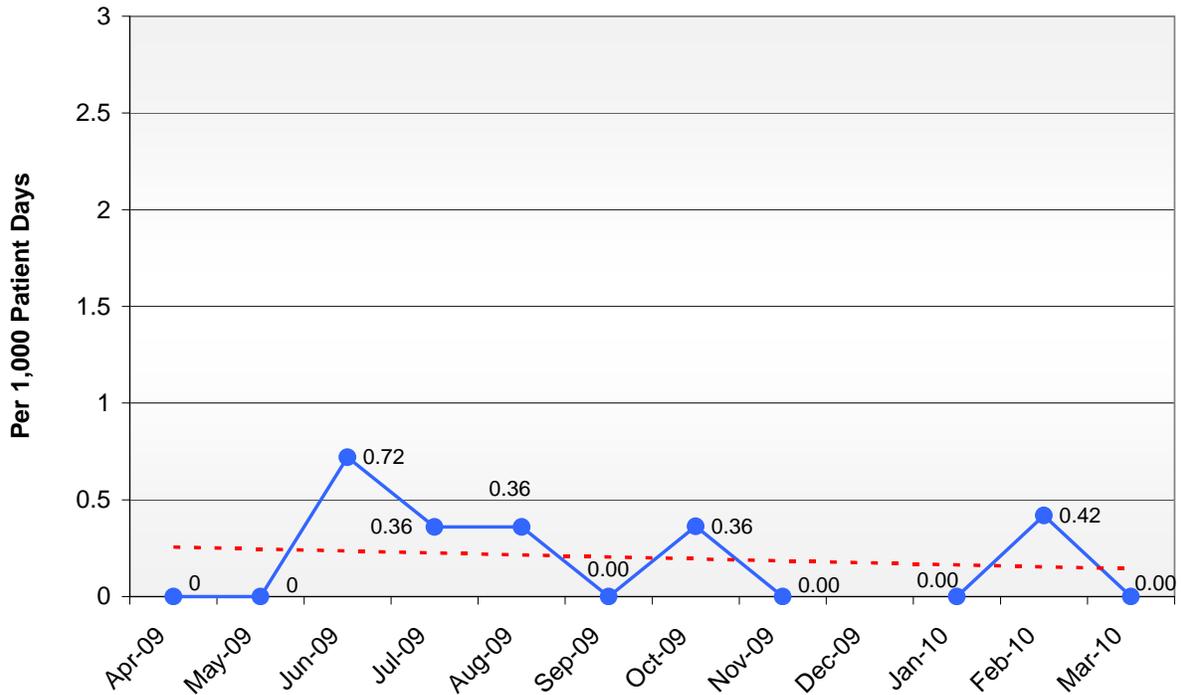
Summary

The trend line for reportable injuries sustained by direct care staff continues to show an average decline in the number of injuries reported. While there is significant variation in the number of injuries from month to month, the total number of direct care staff that sought medical attention or lost time due to injury for the 3rd fiscal quarter 2010 was 8 as compared to 11 for the 2nd fiscal quarter 2010 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

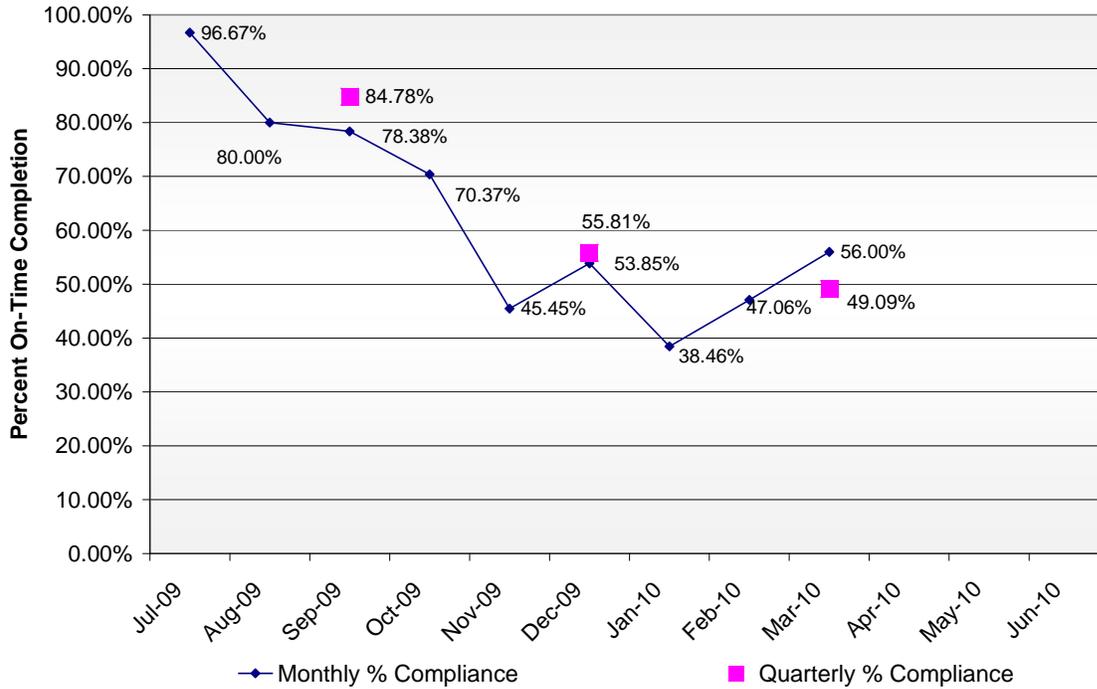
The average percent of non-direct care staff who sought medical attention or lost time from work remains low. The annual trend line shows an overall slight decline in the rate of injury; however, this change is insignificant considering the total number of non-direct care staff injuries. Only one non-direct care staff member sought medical attention or lost time due to injury during the 3rd fiscal quarter 2010. This is comparable to both the 2nd and 1st fiscal quarters of 2010.

HUMAN RESOURCES

ASPECT: Management of Human Resources – Performance Evaluations

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

Performance Evaluation Compliance



Summary

This quarter represents, what appears to be, the bottom of a downward trend and the potential reversal of this trend toward greater compliance in the completion of performance evaluations.

The results from the 3rd quarter 2010 show that 49.09% of the performance evaluations were completed on time. The results from the 2nd quarter 2010 show a 55.81% rate and the results from the 1st quarter 2010 showed an 84.78% completion rate.

As of April 15, 2010, two (2) evaluations from January, five (5) evaluations from February, and seven (7) evaluations from March are still outstanding.

To reverse this trend, an ongoing effort to remind managers of their timelines for the completion of performance evaluations is being made. This effort includes periodic email reminders and meeting announcements.

ASPECT: Management of Human Resources – Personnel Management

Overtime hours and mandated shift coverage

Reporting Period	Overtime Hours	Mandated Shift Coverage
January 2010	3735.83	23
February 2010	3311.00	31
March 2010	3179.25	22

INFECTION CONTROL

ASPECT: HOSPITAL ACQUIRED INFECTION

Indicators	Findings	Compliance	Threshold Percentile
Total number of infections for the third quarter for fiscal year 2009-2010, per 1000 patient days.	22/2.89	100% within standard	5.8 or less
Hospital acquired infection rate, per 1000 patient days.	6/ 2.38	100% within standard	5.8 or less

SUMMARY

Riverview Psychiatric Center conducts a total house surveillance. There was approximately half the number of infections compared with the total number of infections reported in the second quarter 2009-2010. No clusters and no clear indication to explain why the decrease in the overall infection rate.

ASPECT: H1N1 INFLUENZA VACCINATION

- Number of direct care staff: 340
- Number of direct care staff vaccinated against H1N1 Influenza: 206 or 61%
- Number of direct care staff declining the H1N1 Influenza vaccine: 72 or 21%
- Number of direct care staff who have not declined or accepted the H1H1 vaccine: 62 or 18%

ACTION

- Continue total house surveillance.
- Continue to stress hand and respiratory hygiene.
- Ongoing education

LIFE SAFETY

ASPECT: LIFE SAFETY

OVERALL COMPLIANCE: 96%

Indicators	Findings	Compliance	Threshold Percentile
1. Total number of fire drills and actual alarms conducted during the quarter compared to the total number of alarm activations required per Life Safety Code, that being (1) drill per shift, per quarter.	3/3	100%	100%
2. Total number of staff who knows what R.A.C.E. stands for.	107/107	100%	95%
3. Total number of staff who knows how to acknowledge the fire alarm or trouble alarm on the enunciator panel.	100/107	93%	95%
4. Total number of staff who knows the emergency number.	107/107	100%	95%
5. During unannounced safety audits conducted by the Safety Officer, this represents the total number of staff who displays identification tags.	99/107	92%	95%
6. During unannounced safety audits conducted by the Safety Officer, this represents the total number of direct care staff who carries a personal duress transmitter.	98/107	91%	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 March 23, 2010.

During drills, the following was discovered:

1. On one unit some staff seemed both reluctant to acknowledge the fire alarm panel and others did not remember how to do that.
2. On another unit being monitored by the Safety Officer, staff did not seek any information from the fire panel.
3. One staff person did not have a fire key.
4. There were some phones throughout the facility did not have the emergency number listed because the phones were replacements.

LIFE SAFETY

ACTIONS

Actions taken after drills were the following:

1. The evaluator gave a mini presentation after the event.
2. The Safety Officer conducted a mini training session with all staff on the fire panel.
3. The staff member was issued a fire key from Support Services.
4. Stickers were placed on those phones.

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

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.)	1944/2002	97%	95%

Summary

Foot patrols continue to be done despite those rare times that the officers are on other details which take priority over the "foot patrol". We had hoped to have an officer "tour system" in

LIFE SAFETY

place by this report, but a delay in the contract renewal process did not leave us with sufficient time to adopt a system. We are anticipating something for the last quarter.

Actions

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

MEDICAL STAFF

ASPECT: COMPLETION OF AIMS

Indicators	Findings	Compliance	Threshold Percentile
Charts of clients at Riverview for six or more months are reviewed. Each client should have an AIMS exam done upon admission and every six months thereafter.	Over a 3-mo period 127 of 140 were in compliance	91%	90%

SUMMARY

AIMS testing is being done upon admission, and follow-up tests need to be done every six months thereafter. The compliance rate has increased from 29% in the 3rd quarter of FY09 to 77% for the 1st quarter of FY10, to 90% for the 2nd quarter of FY10, and 91% in the 3rd 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. In this second phase, inter-unit transfer records are reviewed.	For Jan and Feb 2010, there were 11 transfers; 5 forms were completed correctly.	45%	90%

SUMMARY

Starting in January, the committee reviewed completion of the inter-unit transfer form. For January and February, there were 11 transfers.

ACTIONS

The committee will continue monitoring inter-unit transfer forms to assure they are completed correctly. 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	79 of 79	100%
2. Staffing numbers within appropriate acuity level for unit	79 of 79	100%
3. Debriefing completed	79 of 79	100%
4. Dr. Orders	79 of 79	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	11 of 11	100%
2. Staffing numbers within appropriate acuity level for unit	11 of 11	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 – Jan.-March 2010 NASMHPD reportable variances

Date	Omit	Co-mission	Float	New	O/T	Unit Acuity	Staff Mix
1/17/10	Pharmacy	Error in stocking	N/A	N/A	N/A	LK	
1/22/10	Pharmacy	Did not discontinue	N/A	N/A		LK	
2/09/10	Pharmacy	No stop date	Y	1 mos	No	LS	
3/09/10	Y		N	No	Y	LK	4RN, 0 LPN., 7 MHW
3/26/10	Y		N	Y	No	LK	2 RN., 2 LPN, 7 MHW
3/23/10	Y		N	Y	No	LKSCU	3 RN, 1 LPN, 7 MHW
3/23/10	Y		N	No	No	LKSCU	3 RN, 1 LPN, 7 MHW
3/23/10	Y		N	No	No	LKSCU	3 RN, 1 LPN, 7 MHW
3/23/10	Y		Y	No	No	UK	2 RN, 1 LPN, 5 MHW

SUMMARY

There were a total of nine (9) reportable errors. Three (3) involved pharmacy and did not involve staffing effectiveness evaluation. Nursing reportable medication variance data indicated the following:

One (1) error was incorrectly written by NP.

Six (6) were omissions.

One (1) error involved Pharmacy not putting stop date on medication.

One (1) error involved a Pharmacy stocking errors.

One (1) error involved a medication not being discontinued by pharmacy as ordered.

Most of the errors occurred on the more acute Lower Kennebec unit with three (3) occurring in the Special Care Unit.

Three (3) errors involved a relatively new nurse 12/09.

The staffing was appropriate on all units when Med Errors occurred. Factors of the acuity of the unit and newness of the nurse contributed to 3 errors.

ACTION

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

NURSING

ASPECT: PAIN MANAGEMENT

Indicator		Findings	Compliance
Pre-administration	Assessed using pain scale	1478 of 1488	99%
Post-administration	Assessed using pain scale	1295 of 1488	87%

SUMMARY

This indicator has improved for pre-assessment at 99% and post assessment has decreased to 87% from 91% last quarter. This is the area that needs constant monitoring and reinforcement.

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	29 of 58	50%
2. STGs/ Interventions are written, dated and numbered	59 of 59	100%
3. STGs are measurable and observable	58 of 59	98%
4. STGs/Interventions are modified/met as appropriate	49 of 60	82%
5. GAP note written in appropriate manner at least every 24 hours	57 of 57	100%
6. STGs/Interventions tie directly to documentation.	40 of 60	67%
7. MHW notes cosigned by RN, including back of the flow sheet.	35 of 60	58%
8. MHW flow sheets document a level of functional skill support provided, consistent with the identified area of need, delivered within last 24 hours.	43 of 52	83%
9. Weekly Summary note completed. Encompassing everything from that week.	19 of 54	35%
10. BMI on every treatment Plan	42 of 60	70%

SUMMARY

There is general improvement in indicators in most areas this quarter. 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 this quarter was 74% as compared to 64% last quarter. There was a great increase in MHW notes cosigned from 31% last quarter to 58% this quarter. GAP notes written in appropriate manner at least every 24 hours increased from 95% to 100% due to the continuing effort focused on that particular indicator. Short-term goals/interventions are written, dated, and numbered increased from 97% to 100%. Short-term goals tie directly to documentation increased from 61% to 67%. Weekly summary notes have remained the same at 35%. MHW flow sheets document functional support has increased from 39% to 83%.

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 revised 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	50 of 50	100%
2. All sections completed or deferred within document	50 of 50	100%
3. Initial Safety Treatment Plan initiated	43 of 50	86%
4. All sheets required signature authenticated by assessing RN	46 of 50	92%
5. Medical Care Plan initiated if Medical problems identified	15 of 31	48% (19 N/A) (1 ref)
6. Informed Consent sheet signed	43 of 46	96% (4 ref)
7. Potential for violence assessment upon admission	49 of 50	98%
8. Suicide potential assessed upon admission	50 of 50	100%
9. Fall Risk assessment completed upon admission	24 of 34	71% (16 na)
10. Score of 5 or above incorporated into problem need list	4 of 7	57% (37 na)

SUMMARY

This area is monitored upon admission. Overall compliance has decreased from 97% to 85%. The one area needing attention is informed consent.

ACTION

Work with Professional Staff during the next quarter to assure that Medical Care Plan initiated and problem need list initiated.

PEER SUPPORT

ASPECT: INTEGRATION OF PEER SPECIALISTS INTO CLIENT CARE

Indicators	Findings	Compliance	Threshold Percentile
1. Attendance at Comprehensive Treatment Team meetings.	406 of 452	90%	80%
2. Level II grievances responded to by RPC on time.	3 of 3	100%	100%
3. Attendance at Service Integration meetings.	46 of 46	100%	100%
4. Contact during admission.	49 of 50	98%	100%
5. Level I grievances responded to by RPC on time.	43 of 48	90%	100%
6. Client satisfaction surveys completed.	30 of 45	67%	75%

SUMMARY

Overall compliance is 90%, up 3% from last quarter. All indicators increased in compliance from last quarter except one. Attendance at comprehensive treatment team meeting increased 2%, response to level II grievance is up 9%, level I grievances up 8%, attendance at service integration meetings increased 6%, and the return rate for client satisfaction surveys increase by 9%. Of the 5 grievances that were responded to beyond the due date, 1 was from Upper Saco and 4 were from Lower Saco. All late grievances were between 1 and 7 days late. Contact with all clients during admission dropped by 2%. One client did not have documented contact, but did have contact with peer support during admission. The client has since been discharged and the peer specialist assigned to work with him has left employment with the peer support program.

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 January 1, 2010 through March 31, 2010 and ensure that controlled substances are not being diverted from unit stock and discrepancies are being addressed in a timely manner.

Discrepancies Recorded	Incidences	Pharmacy Corrected	NOD Correction	Suspected Diversion	Actual Diversion
21	15	7	14	0	0

SUMMARY

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

All of the 21 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.

PHARMACY & THERAPEUTICS

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

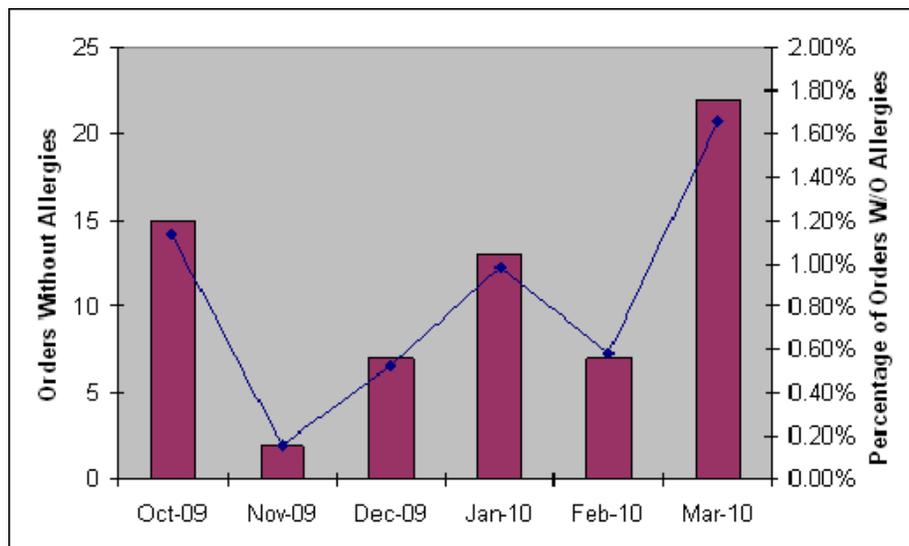
ASPECT: ORDER WRITING POLICY

Indicators	Findings	Compliance	Threshold Percentile
All order sheets are required to have that patient's allergies listed at the top of the sheet	January 13 orders received by pharmacy without allergies listed and an estimated 1325 orders total received by pharmacy.	99.0%	98.0%
	February 7 orders received by pharmacy without allergies listed and an estimated 1200 orders total received by pharmacy.	99.4%	98.0%
	March 22 orders received by pharmacy without allergies listed and an estimated 1325 orders total received by pharmacy	98.4%	98.0%

Summary

There were a total of 42 orders sent to the pharmacy during Q3 without allergy information written at the top of the page. An estimated 3850 total orders were received during that time period. Total compliance during this time period is 98.9%. All orders received without allergies listed were faxed back to their respective units for clarification.

Data starting in October 2009 is shown graphically below.



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.	81 of 100	81%
2. A minimum of three psychosocial educational interventions are assigned daily.	96 of 100	96%
3. A minimum of four groups is prescribed for the weekend.	81 of 100	81%
4. The client is able to state what his assigned psycho-social-educational interventions are and why they have been assigned.	83 of 99	84%
5. The client can correctly identify assigned RN and MHW. (Or where the information is available to him / her)	94 of 99	95%
6. The medical record documents the client's active participation in Morning Meeting within the last 24 hours.	57 of 100	57%
7. The client can identify personally effective distress tolerance mechanisms available within the milieu.	91 of 99	92%
8. Level and quality of client's use of leisure within the milieu are documented in the medical record over the last 7 days.	100 of 100	100%
9. Level and quality of social interactions within the milieu are documented in the medical record over the last 7 days.	94 of 100	94%
10. Suicide potential moderate or above incorporated into CSP	39 of 45	87%
11. Allergies displayed on order sheets and on spine of medical record.	100 of 100	100%
12. By the 7 th day if Fall Risk prioritized as active-was it incorporated into CSP	43 of 52	83%

SUMMARY

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

ACTION

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

PROGRAM SERVICES

ASPECT-MILIEU TREATMENT

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

SUMMARY

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

ACTION

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

PSYCHOLOGY

ASPECT: EVALUATION REFERRAL COMPLETION TIME

For the first quarter of the calendar year 2101, the Psychology Department received 9 evaluation referrals and completed 7. Across all examiners, average time to completion was 11.5.

Dr. Elizabeth Houghton-Faryna completed 5 evaluations with an average time of 13.

Dr. Boos-Blaszyk completed 1, with a completion time of 2.

Ms. Karen Cote completed 1, with a completion time of 13.

ASPECT: PSYCHOLOGY CASE REVIEW

A total of 16 therapy cases were reviewed across all providers.

Rankings on the first category (Goals Time Limited & Measurable) was 100 %.

Rankings on the second category (Goals from Comprehensive Treatment Plan) was 100 %.

Rankings on the third category (Client Understands Goals) was 100 %.

ASPECT: CO-OCCURRING DISORDERS PROGRAM

The Co-Occurring Disorders Program was also evaluated. Consumer satisfaction was high, with all 5 clients surveyed reporting that they have improved. In terms of developing treatment plans for clients diagnosed with co-occurring disorders, psychiatric staff appear to be completing these plans in about 50% of all cases.

REHABILITATION SERVICES

ASPECT: READINESS ASSESSMENTS, COMPREHENSIVE SERVICE PLANS & PROGRESS NOTES

OVERALL COMPLIANCE: 94%

Indicators	Findings	Compliance
1. Readiness assessment and treatment plan completed within 7 days of admission.	30 of 30	100%
2. Rehabilitation short term goals on Comprehensive Service Plan are measurable and time limited.	28 of 30	93%
3. Rehabilitation progress notes indicate treatment being offered as prescribed on Comprehensive Service Plan.	28 of 30	93%
4. Rehabilitation progress notes indicate progress towards addressing identified goals on the Comprehensive Service Plan.	27 of 30	90%

SUMMARY

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

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

Indicator #2 & 3-Two 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 clients treatment. This was reviewed with RT's at the meeting on 1/8/10 and the RT from this unit was not present for this meeting.

Indicator #4-In review of the charts there were three charts between two units that did not accurately reflect the progress towards addressing identified goals from the CSP. The documentation reflected the client's involvement in groups but did not address the identified goals for those groups. Director of Rehabilitation Services held documentation inservice at the Department meeting scheduled for 1/13/10 and there has been some progress on all units in the charting on these clients after the meeting. There have been two new staff added to the department and the documentation process will need to be reviewed with these staff to ensure it meets the standards set in the department.

In regards to all indicators, the Director will continue to audit charts and provide individual supervision for all RT's to ensure expectations of indicators are achieved. The Director also has brought the treatment planning process in regards to documentation on progress towards goals to the Clinical Council for review by all disciplines as all treatment offered is currently not being captured in progress notes. Department Heads to review with their disciplines and the process to continue to be reviewed by Clinical Council.

SOCIAL WORK

ASPECT: PRELIMINARY CONTINUITY OF CARE MEETING & COMPREHENSIVE PSYCHOSOCIAL ASSESSMENTS

Indicators	Findings	Compliance	Threshold Percentile
1. Preliminary Continuity of Care meeting completed by end of 3 rd day	30/30	100%	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.	0/0	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.	29/30	96%	100%
3d. Community Provider Participation in Preliminary Continuity of Care meeting.	9/15	60%	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.	27/30	90%	100%
4b. Annual Psychosocial Assessment completed and current in chart	30/30	100%	100%

SUMMARY

Indicator 3d has increased from the 2nd quarter from 46% to 60% but remains under the threshold percentile. We continue to work on the aspect area with the department to brainstorm community participation in this preliminary meeting. Director is now attending quarterly provider meetings to continue open and positive communication with community providers to provide continued continuity of care when clients come in to the hospital. 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 down this quarter from 93% in the second 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.	3/8	37%	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.	8/8	100%	100%
3. Annual Reports (due Dec) to the commissioner for all inpatient NCR clients are submitted annually	N/A	N/A	100%

SUMMARY

Indicator 1 increased from 25% last quarter to 37% this quarter and we continue to streamline the institutional report process with the use of better predicting and tracking of petitions. In addition we continue to work on the structure of the Institutional Reports for ease of use and focusing on the coordination of information gathering for the reports.

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.	13/14	92%	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

Indicator 2a at 92% because computer program for the report malfunction and report was not sent that week. The report for the next week encompassed two weeks including the week missed due to malfunction.

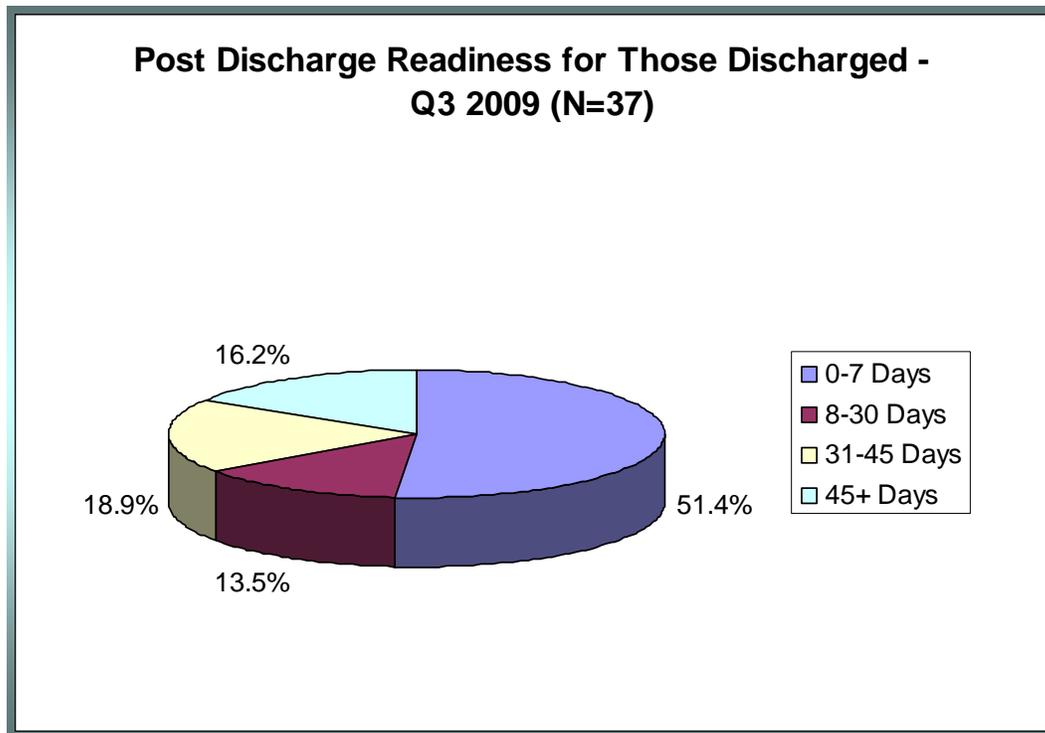
SOCIAL WORK

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.	43/45	95%	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.	57/60	95%	96%

SUMMARY

Indicator 3 is down slightly from the 2nd quarter by 1% and will continue to be monitored.



This chart shows the percent of civil clients who were discharged within 7 days of their discharge readiness to be at 51.4% for this third quarter. Cumulative percentages and targets are as follows:

- Within 7 days = 51.4% (target 75%)
- Within 30 days = 64.9% (target 90%)
- Within 45 days = 83.8% (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.	12 of 12 completed orientation	100%	100 %
2. New employees will complete CPR training within 30 days of hire.	12 of 12 completed CPR training	100%	100 %
3. New employees will complete NAPPI training within 60 days of hire.	12 of 12 completed Nappi training	100%	100 %
4. Riverview and Contract staff will attend CPR training bi-annually.	310 of 313 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%	302 of 361 have completed annual training	84%	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%	381 of 383 have completed annual training	99%	100 %

FINDINGS

The indicators are based on the requirements for all new/current staff to complete mandatory training and maintain current certifications. **12 out of 12 of** (100%) new Riverview/Contracted employees completed these trainings. **310 of 313** (99%) Riverview/Contracted employees are current with CPR certification. **302 of 361** (84%) Riverview/Contracted employees are current in Nappi training. **381 of 383** (100%) employees are current in Annual training. All indicators remained at 100 % compliance for quarter 3-FY 2010.

PROBLEM

Indicator #4 is a problem area at this time. 1 contract staff is not current but is scheduled for the April CPR class. 2 direct care staff are out on leave at this time and will attend the first class upon their arrival back to work. Indicators 5 and 6 are on target and will be at 100% by the end of the training calendar, which is June 30, 2010.

STATUS

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

ACTIONS

No actions needed at this time.