

# Riverview

PSYCHIATRIC CENTER



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QUARTERLY REPORT ON  
ORGANIZATIONAL PERFORMANCE EXCELLENCE

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THIRD STATE FISCAL QUARTER 2014  
January, February, March 2014

Robert J. Harper  
Acting Superintendent

April 23, 2014

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## Glossary of Terms, Acronyms & Abbreviations

ACT	Assertive Community Treatment
ADC	Automated Dispensing Cabinets (for medications)
ADON	Assistant Director of Nursing
AOC	Administrator on Call
CCM	Continuation of Care Management (Social Work Services)
CCP	Continuation of Care Plan
CMS	Centers for Medicare & Medicaid Services
CoP	Community of Practice or Conditions of Participation (CMS)
CPI	Continuous Process (or Performance) Improvement
CPR	Cardio-Pulmonary Resuscitation
CSP	Comprehensive Service Plan
GAP	Goal, Assessment, Plan Documentation
HOC	Hand off communications.
IMD	Institute for Mental Disease
ICDCC	Involuntary Civil District Court Commitment
ICDCC-M	Involuntary Civil District Court Commitment, Court Ordered Medications
ICDCC-PTP	Involuntary Civil District Court Commitment, Progressive Treatment Plan
IC-PTP+M	Involuntary Commitment, Progressive Treatment Plan, Court Ordered Medications
ICRDCC	Involuntary Criminal District Court Commitment
INVOL CRIM	Involuntary Criminal Commitment
INVOL-CIV	Involuntary Civil Commitment
ISP	Individualized Service Plan
IST	Incompetent to Stand Trial
LCSW	Licensed Clinical Social Worker
LPN	License Practical Nurse
TJC	The Joint Commission (formerly JCAHO, Joint Commission on Accreditation of Healthcare Organizations)
MAR	Medication Administration Record
MRDO	Medication Resistant Disease Organism (MRSA, VRE, C-Dif)
NAPPI	Non Abusive Psychological and Physical Intervention
NASMHPD	National Association of State Mental Health Program Directors
NCR	Not Criminally Responsible
NOD	Nurse on Duty
NP	Nurse Practitioner
NPSG	National Patient Safety Goals (established by the Joint Commission)
NRI	NASMHPD Research Institute, Inc.
OT	Occupational Therapist
PA or PA-C	Physician's Assistant (Certified)
PCHDCC	Pending Court Hearing
PCHDCC+M	Pending Court Hearing for Court Ordered Medications

## Glossary of Terms, Acronyms & Abbreviations

PPR	Periodic Performance Review – a self-assessment based upon TJC standards that are conducted annually by each department head.
PSD	Program Services Director
PTP	Progressive Treatment Plan
R.A.C.E.	Rescue/Alarm/Confine/Extinguish
RN	Registered Nurse
RT	Recreation Therapist
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration (Federal)
SAMHS	Substance Abuse and Mental Health Services, Office of (Maine DHHS)
SBAR	Acronym for a model of concise communications first developed by the US Navy Submarine Command. S = Situation, B = Background, A = Assessment, R = Recommendation
SD	Standard Deviation – a measure of data variability.
Seclusion, Locked	Client is placed in a secured room with the door locked.
Seclusion, Open	Client is placed in a room and instructed not to leave the room.
SRC	Single Room Care (seclusion)
URI	Upper respiratory infection
UTI	Urinary tract infection
VOL	Voluntary – Self
VOL-OTHER	Voluntary – Others (Guardian)
MHW	Mental Health Worker

## INTRODUCTION

The Riverview Psychiatric Center Quarterly Report on Organizational Performance Excellence has been created to highlight the efforts of the hospital and its staffs to provide evidence of a commitment to client recovery, safety in culture and practices and fiscal accountability. The report is structure to reflect a philosophy and contemporary practices in addressing overall organizational performance in a systems improvement approach instead of a purely compliance approach. The structure of the report also reflects a focus on meaningful measures of organizational process improvement while maintaining measures of compliance that are mandated though regulatory and legal standards.

The methods of reporting are driven by a national accepted focused approach that seeks out areas for improvement that were clearly identified as performance priorities. The American Society for Quality, National Quality Forum, Baldrige National Quality Program and the National Patient Safety Foundation all recommend a systems-based approach where organizational improvement activities are focused on strategic priorities rather than compliance standards.

There are three major sections that make up this report:

The first section reflects compliance factors related to the Consent Decree and includes those performance measure described in the Order Adopting Compliance Standards dated October 29, 2007. Comparison data is not always available for the last month in the quarter and is included in the next report.

The second section describes the hospital's performance with regard to Joint Commission performance measures that are derived from the Hospital-Based Inpatient Psychiatric Services (HBIPS) that are reflected in the Joint Commissions quarterly ORYX Report and priority focus areas that are referenced in the Joint Commission standards;

- I. Data Collection (PI.01.01.01)
- II. Data Analysis (PI.02.01.01, PI.02.01.03)
- III. Performance Improvement (PI.03.01.01)

The third section encompasses those departmental process improvement projects that are designed to improve the overall effectiveness and efficiency of the hospital's operations and contribute to the system's overall strategic performance excellence. Several departments and work areas have made significant progress in developing the concepts of this new methodology.

As with any change in how organizations operate, there are early adopters and those whose adoption of system changes is delayed. It is anticipated that over the next year, further contributors to this section of strategic performance excellence will be added as opportunities for improvement and methods of improving operational functions are defined.

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# CONSENT DECREE

## Consent Decree Plan

V1) The Consent Decree Plan, established pursuant to paragraphs 36, 37, 38, and 39 of the Settlement Agreement in Bates v. DHHS defines the role of Riverview Psychiatric Center in providing consumer-centered inpatient psychiatric care to Maine citizens with serious mental illness that meets constitutional, statutory, and regulatory standards.

The following elements outline the hospital's processes for ensuring substantial compliance with the provisions of the Settlement Agreement as stipulated in an Order Adopting Compliance Standards dated October 29, 2007.

## Client Rights

V2) Riverview produces documentation that clients are routinely informed of their rights upon admission in accordance with ¶ 150 of the Settlement Agreement;

Indicators	4Q2013	1Q2014	2Q2014	3Q2014
1. Clients are routinely informed of their rights upon admission	100% 19/20 1 refusal	98% 52/55 2 refused	100% 45/45 (15/15 for Lower Saco)	100% 44/45 1 refused (15/15 for Lower Saco)

Clients are informed of their rights and asked to sign that information has been provided to them. If they refuse, the staff documents the refusal and sign, date & time the refusal.

V3) Grievance tracking data shows that the hospital responds to 90% of **Level II** grievances within five working days of the date of receipt or within a five-day extension.

Indicators	4Q2013	1Q2014	2Q2014	3Q2014
1. Level II grievances responded to by RPC on time.	0/0	50% 3/6	100% 1/1	0/0
2. Level I grievances responded to by RPC on time.	98% 58/59	98% 59/60	100% 61/61	97% 67/69

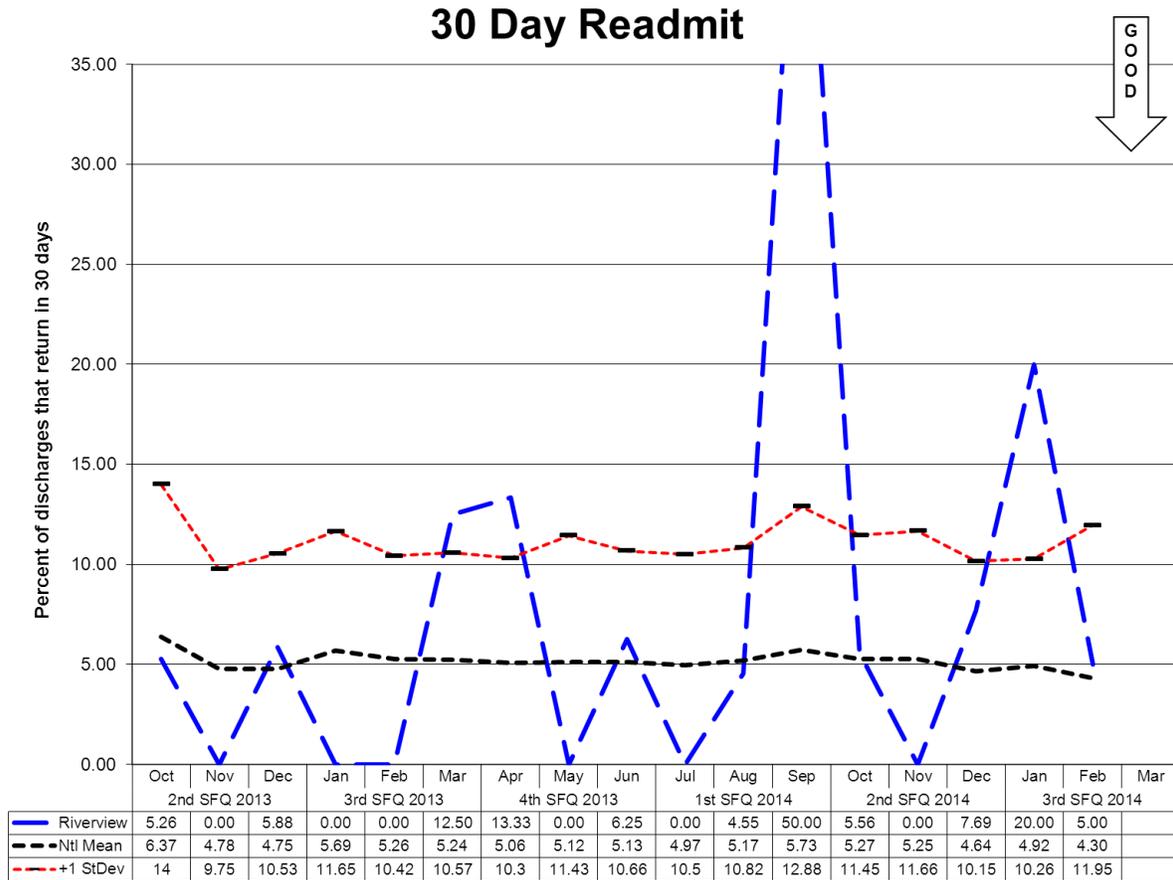
## Admissions

V4) Quarterly performance data shows that in 4 consecutive quarters, 95% of admissions to Riverview meet legal criteria;

Legal Status on Admission	4Q2013	1Q2014	2Q2014	3Q2014
ICDCC	17	30	15	29
ICRDCC				
INVOL CRIM				1
INVOL CRIM – Forensic Evaluation	16	24	18	19
INVOL CRIM – IST	3	5	12	8
INVOL CRIM – NCR		3	8	3
INVOL CRIM – Jail Transfer				
INVOL-CIV		1	3	3
PCHDCC	3			
PCHDCC+M				
PCHDSS-PTP-R	1			1
VOL	3		1	1

# CONSENT DECREE

V5) Quarterly performance data shows that in 3 out of 4 consecutive quarters, the % of readmissions within 30 days of discharge does not exceed one standard deviation from the national mean as reported by NASMHPD



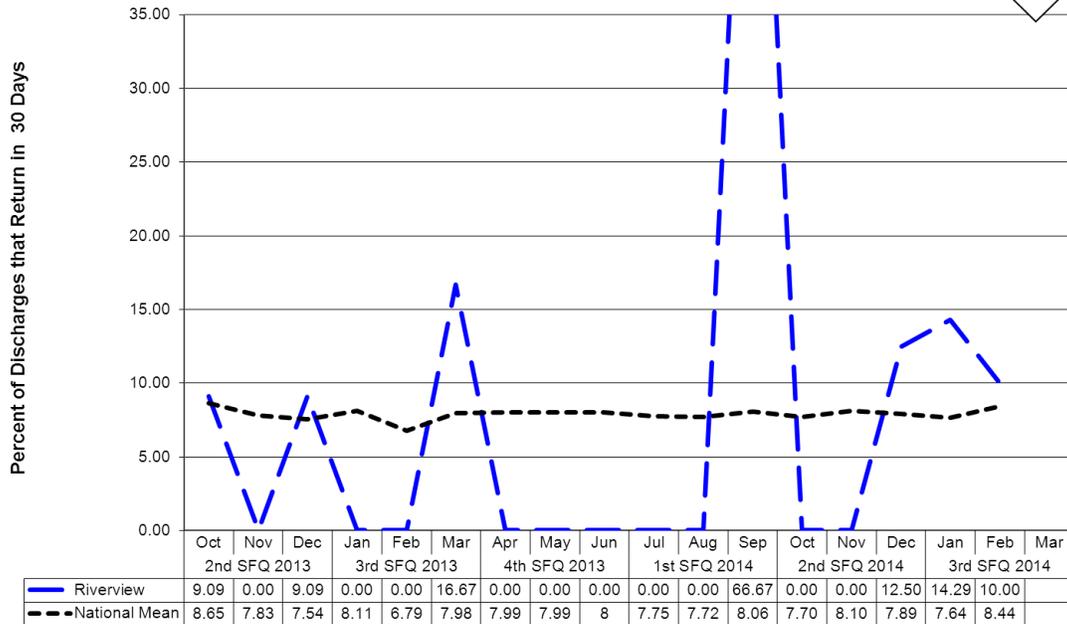
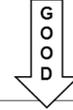
This graph depicts the percent of discharges from the facility that returned within 30 days of a discharge of the same client from the same facility. For example, rates of 10.0 means that 10% of all discharges were readmitted within 30 days.

The graphs shown on the next page depict the percent of discharges from the facility that returned within 30 days of a discharge of the same client from the same facility stratified by forensic or civil classifications. For example, rates of 10.0 means that 10% of all discharges were readmitted within 30 days. The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

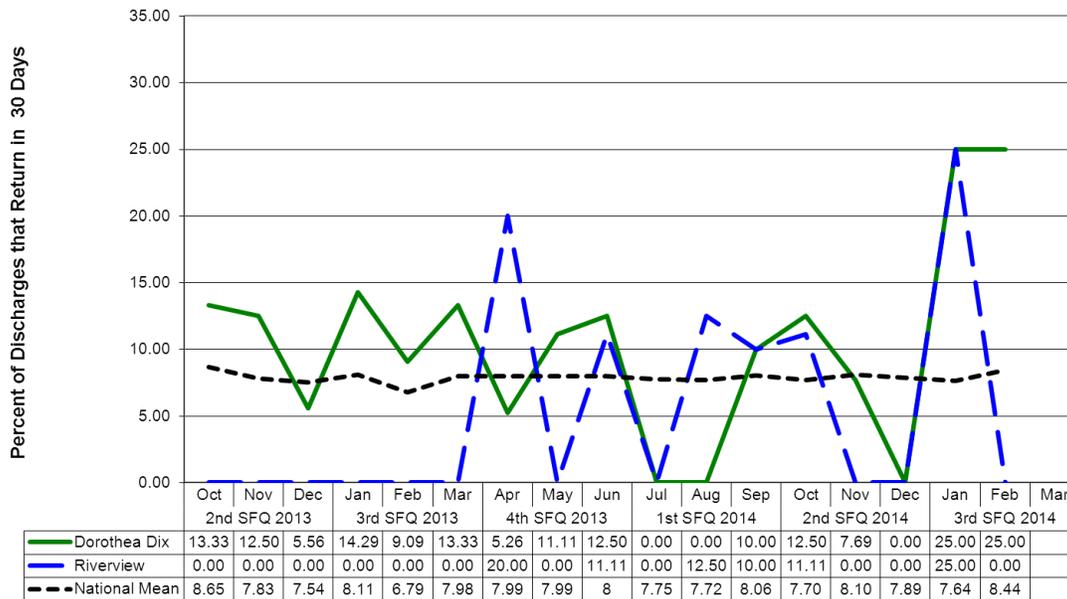
Reasons for client readmission are varied and may include decompensating or lack of compliance with a PTP to name a few. Specific causes for readmission are reviewed with each client upon their return. These graphs are intended to provide an overview of the readmission picture and do not provide sufficient granularity in data elements to determine trends for causes of readmission.

# CONSENT DECREE

## 30 Day Readmit Forensic Stratification



## 30 Day Readmit Civil Stratification



# CONSENT DECREE

V6) Riverview documents, as part of the Performance Improvement & Quality Assurance process, that the Director of Social Work 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 to determine whether the readmission indicated a need for resources or a change in treatment and discharge planning or a need for different resources and, where such a need or change was indicated, that corrective action was taken;

### REVIEW OF READMISSION OCCURRING WITHIN 60 DAYS

Indicators	4Q2013	1Q2014	2Q2014	3Q2014
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.	100% 3/3	100% 2/2	100% 1/1	0/0

In this aspect area one of the clients that returned is on the Progressive Treatment program with the Riverview ACT team and as part of his court ordered treatment plan was returned to the hospital after displaying increased symptoms in his current group home. Client will remain on PTP and return to placement once stable. The second client is under Progressive Treatment with a provider in Portland he eloped from his group home placement and was re-admitted to Riverview as part of his court ordered treatment plan for increased symptomology. Client will also return to his placement under the PTP. The third client was discharged at his request to the Oxford St Shelter after refusing all placement offerings from his team. Client was assigned to a case manager and psychiatric providers. Client left the shelter and was re-admitted to Riverview after he was found wandering in the community exhibiting aggressive behaviors and psychotic symptoms. Team will work with client to identify needs and wants and set up a discharge plan if client will accept that provides him with a more stable living environment that can provide a compliment of mental health services.

# CONSENT DECREE

## REDUCTION OF RE-HOSPITALIZATION FOR ACT TEAM CLIENTS

Indicators	4Q2013	1Q2014	2Q2014	3Q2014
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: <ul style="list-style-type: none"> <li>a. Length of stay in community</li> <li>b. Type of residence (i.e.: group home, apartment, etc.)</li> <li>c. Geographic location of residence</li> <li>d. Community support network</li> <li>e. Client demographics (age, gender, financial)</li> <li>f. Behavior pattern/mental status</li> <li>g. Medication adherence</li> <li>h. Level of communication with ACT Team</li> </ul>	100% 5 clients were returned to RPC; 4 for psychiatric symptoms, one for relapse while in supervised apartment.	100% 2 clients were returned to RPC for psychiatric instability,	100% 1 client was returned to RPC for psychiatric instability due to substance abuse relapse	100% 1 client was returned to DDPC for psychiatric instability, client remains in DDPC
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.	100%	100%	100%	100% Regular contact with DDPC treatment team

### Current Quarter Summary

1. Readmission was male, age 53; client readmitted is socioeconomically disadvantaged, had been living in his independent apartment for two years, has family support and uses resources that are available such as transportation, educational opportunities, leisure activities. Client was apparently medication adherent, and had been attending appointments as scheduled with the DDPC Clinic for medication management and psychotherapy.
2. The ACT Team and the inpatient unit of DDPC are working collaboratively toward maximizing the opportunity for success upon return to his apartment in Bangor.

# CONSENT DECREE

V7) Riverview certifies that no more than 5% of patients admitted in any year have a primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.

Client Admission Diagnoses	3Q13	1Q14	2Q14	3Q14	TOT
ADJUSTMENT DISORDER WITH DEPRESSED MOOD					0
ADJUSTMENT DISORDER WITH ANXIETY	1				1
ADJUST DISORDER WITH MIXED ANXIETY & DEPRESSED MOOD	1	2	1		4
ADJUSTMENT REACTION NOS	1	1			2
ALCOHOL ABUSE-IN REMISS				1	1
ANXIETY STATE NOS	1				1
ATTN DEFICIT W HYPERACT	1	1	2		4
BIPOLAR I DISORDER, SINGLE MANIC EPISODE, UNSPECIFIED				1	1
BIPOL I, REC EPIS OR CURRENT MANIC, SEVERE, SPEC W PSYCH BEH				2	2
BIPOL I, MOST RECENT EPISODE (OR CURRENT) MIXED, UNSPEC			3		3
BIPOLAR DISORDER, UNSPECIFIED	5	9	4	5	23
DELUSIONAL DISORDER	2			2	4
DEPRESS DISORDER-UNSPEC			3		3
DEPRESSIVE DISORDER NEC	2	6		4	12
DRUG ABUSE NEC-IN REMISS				1	1
FACTITIOUS DIS W PREDOMINANTLY PSYCHOLOGICAL SIGNS & SYMPTOM			1		1
FACTITIOUS ILL NEC/NOS			1		1
HEBEPHRENIA-UNSPEC			1		1
IMPULSE CONTROL DIS NOS	2		1		3
INTERMITT EXPLOSIVE DIS	1	2		1	4
MILD INTELLECTUAL DISABILITIES				1	1
MOOD DISORDER IN CONDITIONS CLASSIFIED ELSEWHERE					0
OTH PERSISTENT MENTAL DIS DUE TO COND CLASS ELSEWHERE					0
PARANOID SCHIZO-CHRONIC	8	10	3	2	23
PARANOID SCHIZO-UNSPEC	1	2	1	4	8
PERSON FEIGNING ILLNESS		1	1		2
POSTTRAUMATIC STRESS DISORDER	3	4		5	12
PSYCHOSIS NOS	4	5	10	10	29
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED	9	12	13	14	48
SCHIZOPHRENIA NOS-CHR	1		1	1	3
SCHIZOPHRENIA NOS-UNSPEC	2			1	3
SCHIZOPHRENIFORM DISORDER, UNSPECIFIED	1		1		2
UNSPECIFIED EPISODIC MOOD DISORDER	4	8	6	9	27
UNSPECIFIED NONPSYCHOTIC MENTAL DISORDER			3		3
<b>Total Admissions</b>	<b>50</b>	<b>63</b>	<b>56</b>	<b>64</b>	<b>233</b>
Admitted with primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	0.00%	0.00%	0.00%	3.23%	0.86%

# CONSENT DECREE

## Peer Supports

Quarterly performance data shows that in 3 out of 4 consecutive quarters:

V8) 100% of all clients have documented contact with a peer specialist during hospitalization;

V9) 80% of all treatment meetings involve a peer specialist.

Indicators	4Q2013	1Q2014	2Q2014	3Q2014
1. Attendance at Comprehensive Treatment Team meetings. (v9)	87% 362/418	84% 408/488	86% 352/411	86% 395/458
2. Attendance at Service Integration meetings. (v8)	79% 26/33	95% 53/56	100% 41/41	86% 55/64
3. Contact during admission. (v8)	100% 46/46	100% 56/56	100% 57/57	100% 64/64

## Treatment Planning

V10) 95% of clients have a preliminary treatment and transition plan developed within 3 working days of admission;

Indicators	4Q2013	1Q2014	2Q2014	3Q2014
1. Preliminary Continuity of Care meeting completed by end of 3 <sup>rd</sup> day	100% 30/30	100% 30/30	100% 30/30	100% 30/30
2. Service Integration form completed by the end of the 3rd day	100% 30/30	100% 30/30	100% 30/30	100% 30/30
3a. Client Participation in Preliminary Continuity of Care meeting.	100% 30/30	100% 30/30	100% 30/30	100% 30/30
3b. CCM Participation in Preliminary Continuity of Care meeting.	100% 30/30	100% 30/30	100% 30/30	100% 30/30
3c. Client's Family Member and/or Natural Support (e.g., peer support, advocacy, attorney) Participation in Preliminary Continuity of Care meeting.	100% 30/30	93% 28/30	90% 27/30	100% 30/30
4a. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	90% 27/30	96% 29/30	93% 28/30	93% 28/30
4b. Initial Comprehensive Assessment contains summary narrative with conclusion and recommendations for discharge and social worker role	100% 30/30	96% 29/30	100% 30/30	100% 30/30
4c. Annual Psychosocial Assessment completed and current in chart	N/A	100% 15/15	100% 15/15	100% 15/15

Summary: For area 4A we had two psych-social assignments that were started but not completed within the 7 day timeframe required. Both staff were addressed in individual supervision.

# CONSENT DECREE

V11) 95% of clients also have individualized treatment plans in their records within 7 days thereafter;

Indicators	4Q2013	1Q2014	2Q2014	3Q2014
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all clients on assigned <b>CCM</b> caseload.	96% 44/45	96% 29/30	93% 28/30	86% 26/30
2. 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.	91% 55/60	100% 30/30	100% 30/30	96% 29/30

**Summary: Area 1. Director addressed this issue with individual staff in supervision and with the entire team at group staff meeting.**

**Area 2. Director addressed issue that a plan in chart was recently timed out and due for update with individual staff member.**

V12) Riverview certifies that all treatment modalities required by ¶155 are available.

The treatment modalities listed below as listed in ¶155 are offered to all clients according to the individual client's ability to participate in a safe and productive manner as determined by the treatment team and established in collaboration with the client during the formulation of the individualized treatment plan.

Treatment Modality	Provision of Services Normally by....			
	Medical Staff Psychology	Nursing	Social Services	Rehabilitation Services/ Treatment Mall
Group and Individual Psychotherapy	X			
Psychopharmacological Therapy	X			
Social Services			X	
Physical Therapy				X
Occupational Therapy				X
ADL Skills Training		X		X
Recreational Therapy				X
Vocational/Educational Programs				X
Family Support Services and Education		X	X	X
Substance Abuse Services	X			
Sexual/Physical Abuse Counseling	X			
Intro to Basic Principles of Health, Hygiene, and Nutrition		X		X

# CONSENT DECREE

An evaluation of treatment planning and implementation, performed in accordance with **Attachment D**, demonstrates that, for 90% of the cases reviewed:

V13) the treatment plans reflect

- Screening of the patient's needs in all the domains listed in ¶61;
- Consideration of the patient's need for the services listed in ¶155;
- Treatment goals for each area of need identified, unless the patient chooses not, or is not yet ready, to address that treatment goal;
- Appropriate interventions to address treatment goals;
- Provision of services listed in ¶155 for which the patient has an assessed need;
- Treatment goals necessary to meet discharge criteria; and
- Assessments of whether the patient is clinically safe for discharge;

V14) the treatment provided is consistent with the individual treatment plans;

V15) if the record reflects limitations on a patient's rights listed in ¶159, those limitations were imposed consistent with the Rights of Recipients of Mental Health Services

An abstraction of pertinent elements of a random selection of charts is periodically conducted to determine compliance with the compliance standards of the consent decree outlined in parts V13, V14, and V15.

This review of randomly selected charts revealed substantial compliance with the consent decree elements. Individual charts can be reviewed by authorized to validate this chart review.

# CONSENT DECREE

## Medications

V16) Riverview certifies that the pharmacy computer database system for monitoring the use of psychoactive medications is in place and in use, and that the system as used meets the objectives of ¶168.

Riverview utilizes a Pyxis Medstation 4000 System for the dispensing of medications on each client care unit. A total of six devices, one on each of the four main units and in each of the two special care units, provide access to all medications used for client care, the pharmacy medication record, and allow review of dispensing and administration of pharmaceuticals.

A database program, HCS Medics, contains records of medication use for each client and allows access by an after-hours remote pharmacy service to these records, to the Pyxis Medstation 4000 System. The purpose of this after-hours service is to maintain 24 hour coverage and pharmacy validation and verification services for prescribers.

Records of transactions are evaluated by the Director of Pharmacy and the Medical Director to validate the appropriate utilization of all medication classes dispensed by the hospital. The Pharmacy and Therapeutics Committee, a multidisciplinary group of physicians, pharmacists, and other clinical staff evaluate issues related to the prescribing, dispensing, and administration of all pharmaceuticals.

The system as described is capable of providing information to process reviewers on the status of medications management in the hospital and to ensure the appropriate use of psychoactive and other medications.

The effectiveness and accuracy of the Pyxis Medstation 4000 System is analyzed regularly through the conduct of process improvement and functional efficiency studies. These studies can be found in the [Medication Management](#) and [Pharmacy Services](#) sections of this report.



# CONSENT DECREE

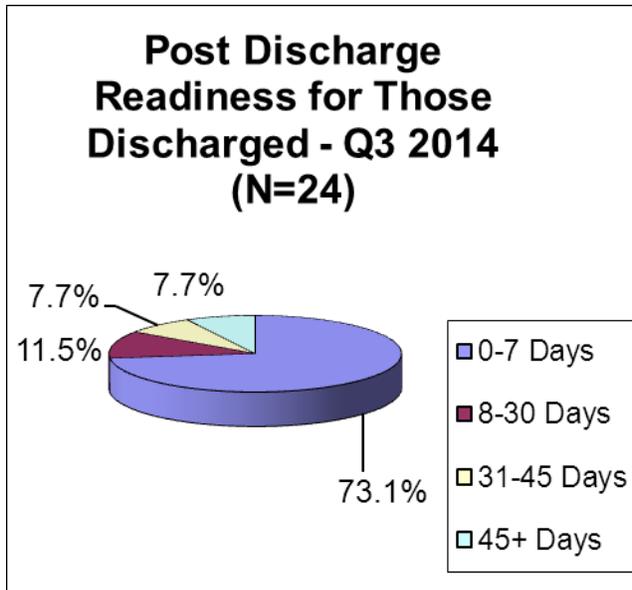
## Discharges

Quarterly performance data shows that in 3 consecutive quarters:

V17) 70% of clients who remained ready for discharge were transitioned out of the hospital within 7 days of a determination that they had received maximum benefit from inpatient care;

V18) 80 % of clients who remained ready for discharge were transitioned out of the hospital within 30 days of a determination that they had received maximum benefit from inpatient care;

V19) 90% of clients who remained ready for discharge were transitioned out of the hospital within 45 days of a determination that they had received maximum benefit from inpatient care (with certain clients excepted, by agreement of the parties and court master).



Cumulative percentages & targets are as follows:

- Within 7 days = (18) 73.1% (target 70%)
- Within 30 days = (22) 84.6% (target 80%)
- Within 45 days = (23) 92.3% (target 90%)
- Post 45 days = (1) 7.7% (target 0%)

### Barriers to Discharge Following Clinical Readiness

#### Residential Supports (2) 8%

- 1 client discharged 27 days post clinical readiness
- 1 client discharged 32 days post clinical readiness

#### Housing (3) 12%

- 1 client discharged 13 days post clinical readiness
- 1 client discharged 41 days post clinical readiness
- 1 client discharged 73 days post clinical readiness

#### Treatment Services (0) 0%

No barriers in this area

The previous four quarters are displayed in the table below

		Within 7 days	Within 30days	Within 45 days	45 +days
Target >>		70%	80%	90%	< 10%
2Q2014	N=20	73.1%	84.6%	92.3%	7.7%
1Q2014	N=26	73.1%	84.6%	92.3%	7.7%
4Q2013	N=30	70%	86.7%	93.3%	6.7%
3Q2013	N=22	77.3%	86.4%	90.0%	9.1%

# CONSENT DECREE

An evaluation of treatment and discharge planning, performed in accordance with **Attachment D**, demonstrates that, for 90% of the cases reviewed:

V20) Treatment and discharge plans reflect interventions appropriate to address discharge and transition goals;

V21a) For patients who have been found not criminally responsible or not guilty by reason of insanity, appropriate interventions include timely reviews of progress toward the maximum levels allowed by court order; and the record reflects timely reviews of progress toward the maximum levels allowed by court order;

V21) Interventions to address discharge and transition planning goals are in fact being implemented;

V21a) For patients who have been found not criminally responsible or not guilty by reason of insanity, this means that, if the treatment team determines that the patient is ready for an increase in levels beyond those allowed by the current court order, Riverview is taking reasonable steps to support a court petition for an increase in levels.

Indicators	4Q2013	1Q2014	2Q2014	3Q2014
1. The Client Discharge Plan Report will be updated/reviewed by each <b>Social Worker minimally one time per week.</b>	100% 13/13	100% 12/12	100% 11/11	100% 9/9
2. The Client Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	100% 13/13	100% 12/12	100% 11/11	100% 9/9
2a. The Client Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	100% 13/13	91% 11/12	100% 11/11	100% 9/9
3. Each week the Social Work team and Director will meet and discuss current housing options provided by the respective regions and prioritize referrals.	100% 13/13	91% 11/12	100% 11/11	100% 9/9

**Summary:**

**Meeting was cancelled once in the quarter due snowstorm and the Access Database was down and could not be used to distribute report for two weeks in March. A large report encompassing weeks that were missed was distributed in March when the database went back on-line.**

# CONSENT DECREE

V22) The Department demonstrates that 95% of the annual reports for forensic patients are submitted to the Commissioner and forwarded to the court on time.

Indicators	4Q2013	1Q2014	2Q2014	3Q2014
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	80% 8/10	12% 1/8	0% 0/4	0% 0/2
2. The assigned <b>CCM</b> will review the new court order with the client and document the meeting in a progress note or treatment team note.	100% 4/4	100% 2/2	100% 4/4	100% 3/3
3. Annual Reports (due Dec) to the commissioner for all inpatient NCR clients are submitted annually			100% 92/92	N/A

**Summary: Area 1 a. Two reports were filed at 16 days and 25 days respectively which are outside of the 10 day standard.**

# CONSENT DECREE

## Staffing and Staff Training

V23) Riverview performance data shows that 95% of direct care staff has received 90% of their annual training.

Indicators	1Q SFY 13-14	2Q SFY 13-14	3Q SFY 13-14	4Q SFY 13-14	YTD Findings
1. Riverview and Contract staff will attend CPR training bi-annually.	*40/46 87%	*64/67 95.5%	55/58 94.8%		92.4%
2. Riverview and Contract staff will attend NAPPI training annually.	*101/120	*137/157	*See #4. Below	*See # 4 Below	85%
3. Riverview and Contract staff will attend Annual training.	*11/25	*78/81	34/36 88%		85.5%
4. Riverview and contract staff will attend MOAB training annually	Changed to MOAB on 1/16/14	Changed to MOAB on 1/16/14	172/408 42%		42%

### **1Q SFY 13-14**

1. \*Of the six employees who are not in compliance, two staff are on Workers Compensation status, two staff are on Family Medical Leave, one transferred and missed training due to family emergency. All are scheduled for next available training.

One staff is out of the country,

2. \*Of the nineteen employees who are not in compliance two are on Workers compensation leave, one is on LOA. Those remaining are scheduled for the next available training.

3. \*Of the eleven staff who are not in compliance; two staff are on Workers compensation, one is out of the country, one has transferred to another department. Supervisors of remaining staff have been informed they are in non-compliance and corrective actions have been taken.

### **2Q SFY 13-14**

1. Three employees who are out of compliance are on leave status.

2. Eight of the employees are on leave status. The remaining twelve will be attending the next offered behavior management /physical intervention training.

3. The three the individuals who are not in compliance are on leave status.

### **3Q SFY 13-14**

1. The three employees who are out of compliance are on leave status.

2. RPC began using MOAB as their Behavior Management Program January 16<sup>th</sup> 2014. Since that time 197/197 (active) nurses and mental health workers have received.

3. One staff is on leave status, the other staff has been informed they are out of compliance and corrective action has been taken.

# CONSENT DECREE

**Goal:** SD will provide opportunities for employees to gain, develop and renew skills knowledge and aptitudes.

**Objective:** 100% of employees will be provided with an opportunity both formal and informal training and/or learning experiences that contribute to individual growth and improved performance in current position.

SD will survey staff annually and develop trainings to address training needs as identified by staff.

## Current Status:

### 1Q SFY 13-14

Employee Education needs survey distributed to employees in March of 2013.

As a result of identified needs, the training entitled **Personality Disorder Characteristics and Effective Interventions** was developed and presented in August 2013.

August 19 & 26 2013, Susan C. Righthand, Ph.D, a nationally recognized speaker and consultant in the field of psychological assessment and treatment of sex offenders, conducted a *two part* training entitled: **Working Effectively with Adult Sexual Offenders: Characteristics, Assessment, and Interventions** available to all Riverview Psychiatric Center Employees.

August 20, 2013 Dr. Kenneth Beattie provided an in-service entitled: **The Psychology of Working with Emotionally Challenging and Emotionally Challenged Clients**. This training was developed in response to the Employee Education needs survey distributed to employees in March of 2013 and made available to all Riverview Psychiatric Center employees.

August 5, 2013, **Single Wrist Restraint Application** training was held to provide an opportunity to practice skills taught in the Initial NAPPI course provided to New Employees and NAPPI Recertification Class provided on a monthly basis through-out the year to Riverview Psychiatric Center employees. Over sixty unit staff attended.

### 2Q SFY 13-14

Patricia Deegan Ph D. provided **Recovery Oriented Care** training which included lessons from her own recovery from schizophrenia while teaching practical strategies for:

- Balancing the Dignity of Risk with the Duty to Care when supporting individual involvement in decision making.
- Navigating the Neglect/Overprotect Continuum, especially when folks appear to be making self-defeating choices.
- Practicing leadership-for-recovery in the workplace.

On January 18<sup>th</sup>, James Claiborn, Ph. D, provided training entitled **Understanding Behavior and Treatment Planning** in which participants learned:

How to identify, define and describe behavior.

# CONSENT DECREE

How to develop interventions that reinforce behavior we want to increase and extinguish behavior we want to decrease.

**STAT Drills were** offered throughout the month of November and December to provide staff with the opportunity to develop and enhance behavior intervention techniques and improve overall skill level when dealing with clients having difficulty maintaining positive behavior.

## **3Q SFY 13-14**

Staff was provided training in Policy revisions and Regulatory standards in January 2014. Additionally Recovery Oriented Care and Personal Medicine training was rolled out at the end of March 2014.

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**Goal:** SD will develop and implement a comprehensive mentoring program to assist new employees in gaining the skills necessary to do their job.

**Objective:** 100% of new Mental Health Workers will be paired with a mentor and will satisfactorily complete 12 competency areas on the unit orientation prior to being assigned regular duties requiring direct care of patients.

## **Current Status:**

### **1Q SFY 13-14**

100% of new Mental Health Workers were paired with a mentor and satisfactorily completed competency areas in the Unit Orientation.

### **2Q SFY 13-14**

100% of new Mental Health Workers were paired with a mentor and satisfactorily completed competency areas in the Unit Orientation.

- In addition, mentor meetings were re-initiated to assist mentors in gaining, developing and renewing skills in which to increase new employees with the opportunity to learn specific job duties associated with their position and/or care of individuals receiving services.

### **3Q SFY 13-14**

100% of new Mental Health Workers were paired with a mentor and satisfactorily completed competency areas in the Unit Orientation.

# CONSENT DECREE

V24) Riverview certifies that 95% of professional staff have maintained professionally-required continuing education credits and have received the ten hours of annual cross-training required by ¶216;

DATE	HRS	TITLE	PRESENTER
3Q2012	14	January - March 2012	Winter Semester (see 1Q13 Quarterly Report)
4Q2012	11	April – June 2012	Spring Semester (see 1Q13 Quarterly Report)
1Q2013	3	July – September 2012	Summer Hiatus (see 1Q13 Quarterly Report)
2Q2013	9	October – December 2012	Fall Semester (see 2Q13 Quarterly Report)
3Q2013	11	January – March 2013	Winter Semester (see 3Q13 Quarterly Report)
4Q2013	12	April – June 2013	Spring Semester (see 4Q13 Quarterly Report)
1Q2014	5.5	July - September 2013	Summer Semester (see 1Q14 Quarterly Report)
2Q2014	7	October – December 2013	Fall Semester (see 2Q14 Quarterly Report)
1/2/2014	1	New Year for Riverview	Brendan Kirby MD
1/9/2014	1	Fixing Healthcare	Art DiRocco, PhD
1/30/2014	1	Lobbying for American Psychiatric Assoc.	Alex Raev, MD
2/6/2014	1	Addiction and Relapse	Ben Nordstrom, MD
2/13/2014	1	Treatment of Chronic Low Back Pain in a Psychiatric Population	Bobby Morton, PMHNP
2/20/2014	1	Treatment of Chronic Low Back Pain in a Psychiatric Population - Part II	Bobby Morton, PMHNP
2/27/2014	1	Bridging the Gap Between Cultural Sensitivity and Cultural Competence by Using Therapeutic Techniques and Common Sense	Candice Claiborne, Psychology Intern
3/6/2014	1	Treatment of Chronic Low Back Pain in a Psychiatric Population - Cognitive Behavioral Therapy	Bobby Morton, PMHNP
3/13/2014	1	Springtime for Riverview: Review of ideas outlined in New Year's session and to further the dialogue that is starting	Brendan Kirby MD
3/18/2014	1	Peer Review Committee	Medical Staff including case presentation by Miriam Davidson, PMHNP
3/20/2014	1	An Evolutionary Perspective on Antisocial Behavior	Ken Beattie, PhD
3/26/2014	3	Two Case Presentations	Miriam Davidson, PMHNP Art DiRocco, PhD Will Torrey, MD Alex DeNesnera, MD Matthew Friedman, MD
3/27/2014	1	Revisiting an Icon: The Case for Client BB	Tim Cooper, Psychology Intern

# CONSENT DECREE

V25) Riverview certifies that staffing ratios required by ¶202 are met, and makes available documentation that shows actual staffing for up to one recent month;

Staff Type	Consent Decree Ratio
General Medicine Physicians	1:75
Psychiatrists	1:25
Psychologists	1:25
Nursing	1:20
Social Workers	1:15
Mental Health Workers	1:6
Recreational/Occupational Therapists/Aides	1:8

With 92 beds, Riverview regularly meets or exceeds the staffing ratio requirements of the consent decree.

Staffing levels are most often determined by an analysis of unit acuity, individual monitoring needs of the clients who residing on specific units, and unit census.

V26) The evaluation of treatment and discharge planning, performed in accordance with **Attachment D**, demonstrates that staffing was sufficient to provide patients access to activities necessary to achieve the patients' treatment goals, and to enable patients to exercise daily and to recreate outdoors consistent with their treatment plans.

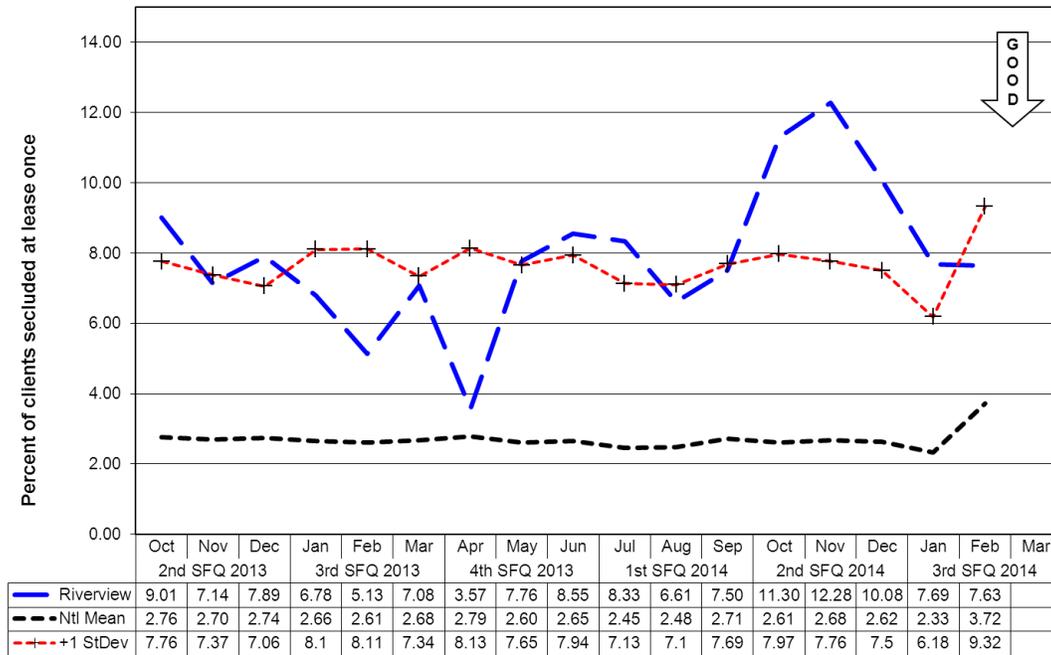
Treatment teams regularly monitor the needs of individual clients and make recommendations for ongoing treatment modalities. Staffing levels are carefully monitored to ensure that all treatment goals, exercise needs, and outdoor activities are achievable. Staffing does not present a barrier to the fulfillment of client needs. Staffing deficiencies that may periodically be present are rectified through utilization of overtime or mandated staff members.

# CONSENT DECREE

## Use of Seclusion and Restraints

V27) Quarterly performance data shows that, in 5 out of 6 quarters, total seclusion and restraint hours do not exceed one standard deviation from the national mean as reported by NASMHPD;

### Percent of Clients Secluded



This graph depicts the percent of unique clients who were secluded at least once. For example, rates of 3.0 means that 3% of the unique clients served were secluded at least once.

The following graphs depict the percent of unique clients who were secluded at least once stratified by forensic or civil classifications. For example, rates of 3.0 means that 3% of the unique clients served were secluded at least once.

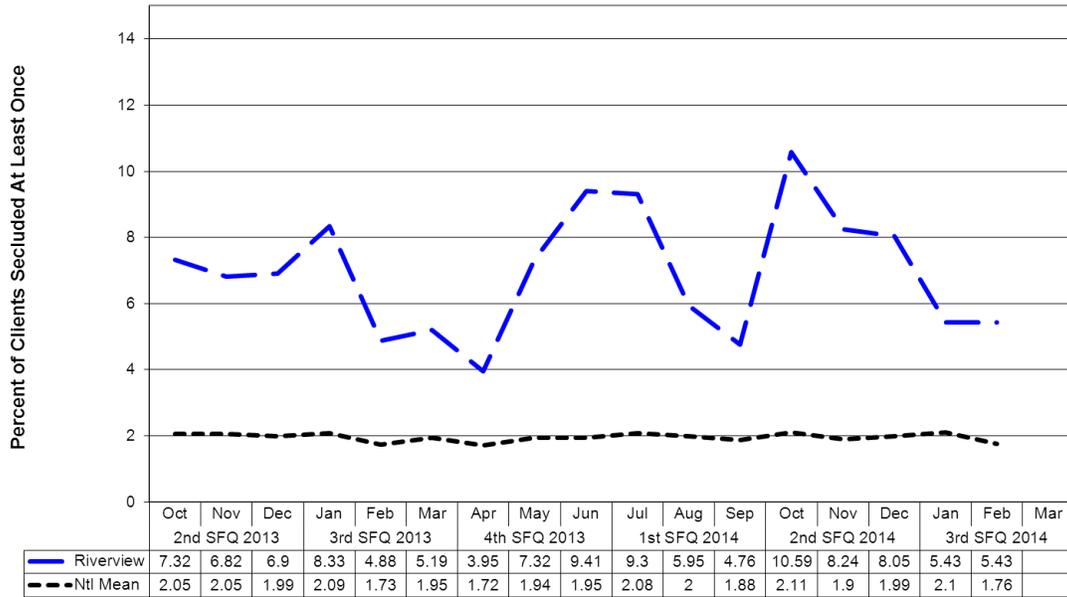
The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

**\*Please Note: The seclusion cases for January 2014 are currently under review. Data is subject to change and if needed will be corrected in the next quarterly report.**

# CONSENT DECREE

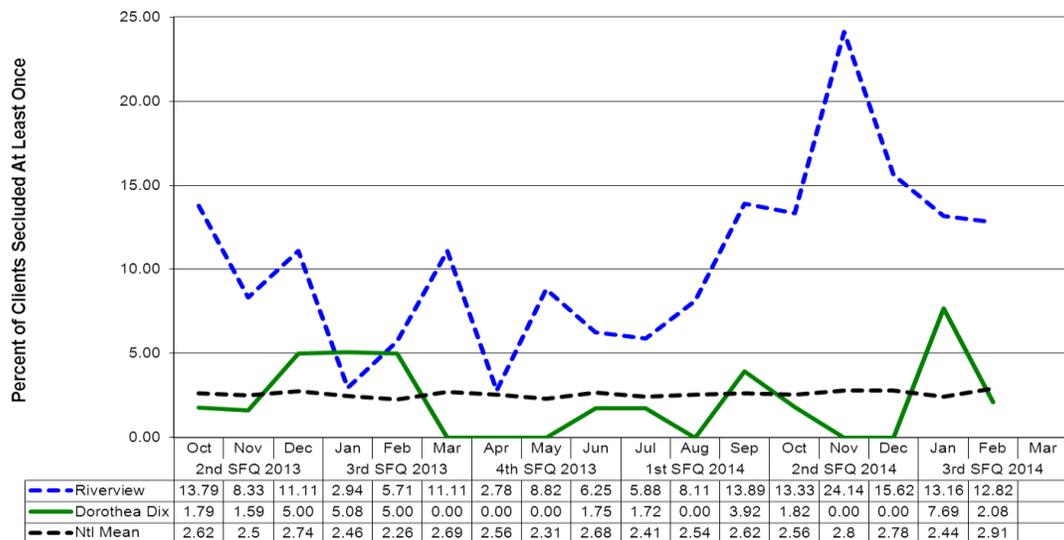
## Percent of Clients Secluded

Forensic Stratification



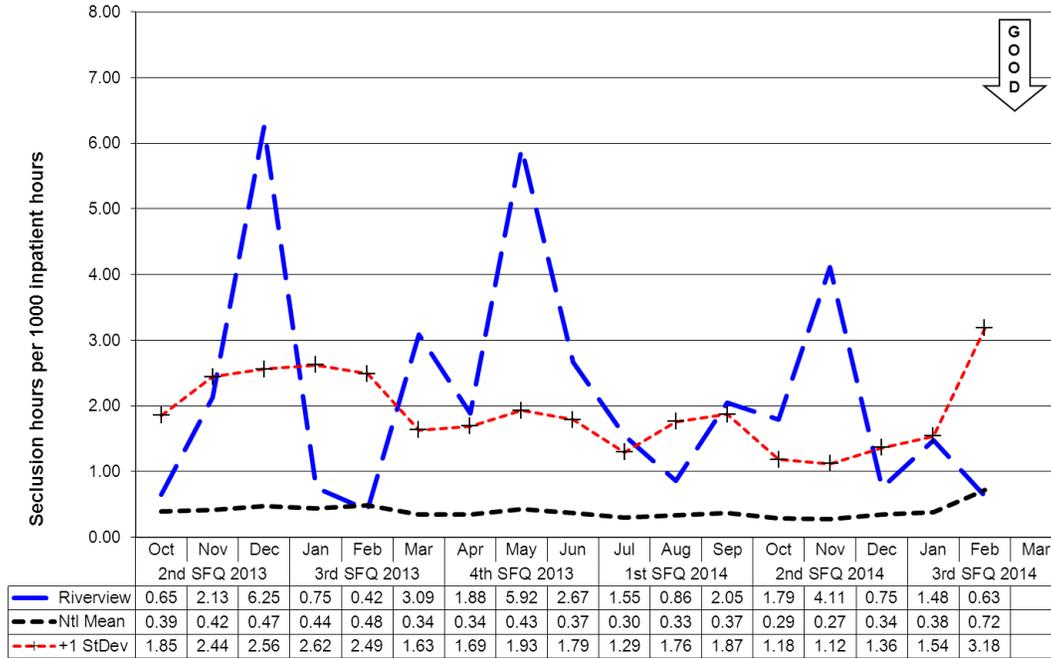
## Percent of Clients Secluded

Civil Stratification



# CONSENT DECREE

## Seclusion Hours



This graph depicts the 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.

The outlier values shown in May and June reflect the events related to a single individual during this period. This individual was in seclusion for extended periods of time due to extremely aggressive behaviors that are focused on staff. It was determined that the only way to effectively manage this client and create a safe environment for both the staff and other clients was to segregate him in an area away from other clients and to provide frequent support and interaction with staff in a manner that ensured the safety of the staff so engaged.

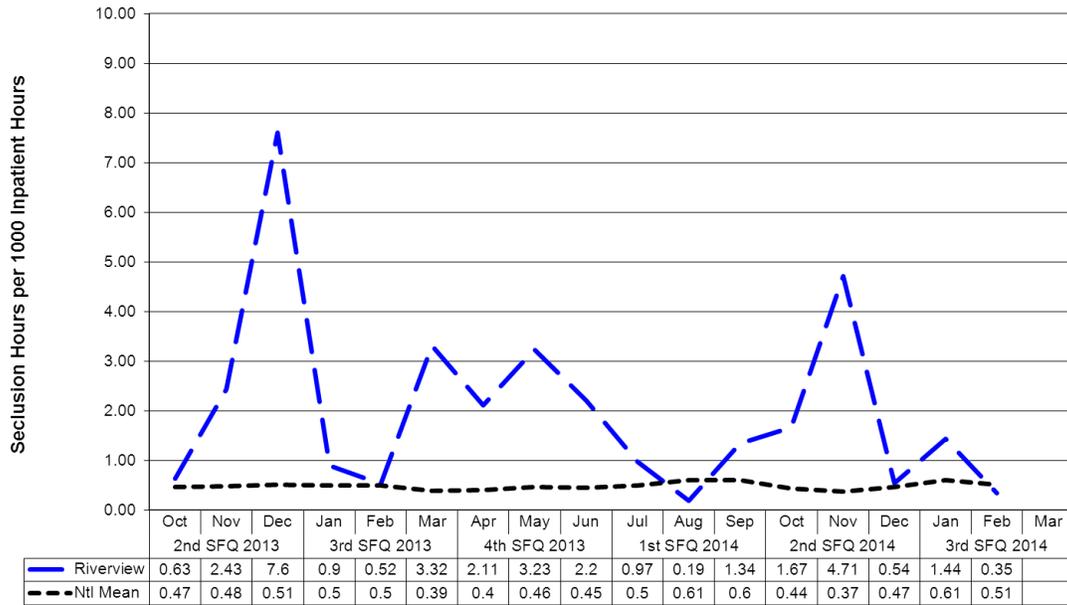
The following graphs depict the number of hours clients spent in seclusion for every 1000 inpatient hours stratified by forensic or civil classifications. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours.

The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

# CONSENT DECREE

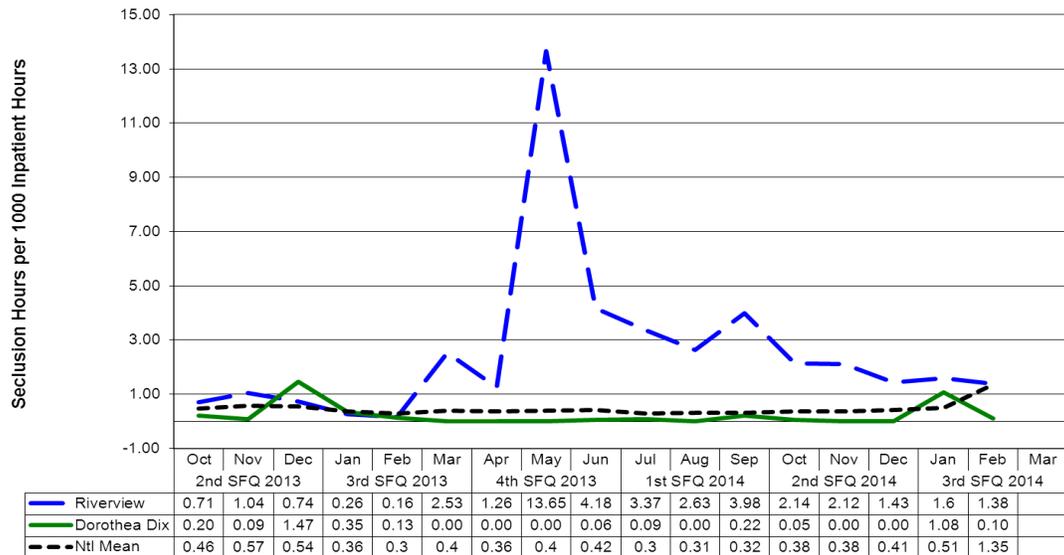
## Seclusion Hours

Forensic Stratification



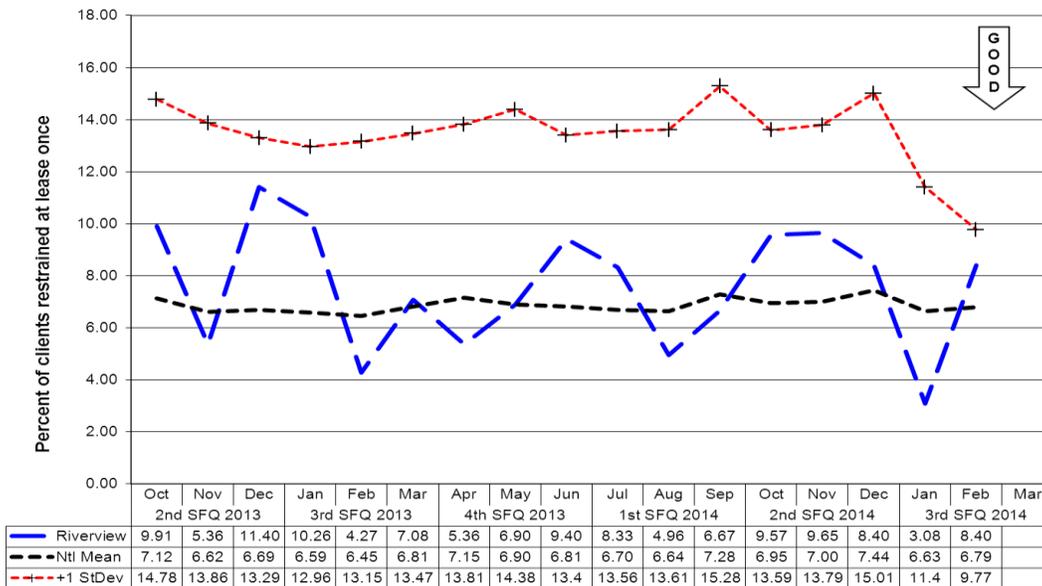
## Seclusion Hours

Civil Stratification



# CONSENT DECREE

### Percent of Clients Restrained



This graph depicts the percent of unique clients who were restrained at least once – includes all forms of restraint of any duration. For example, rates of 4.0 means that 4% of the unique clients served were restrained at least once.

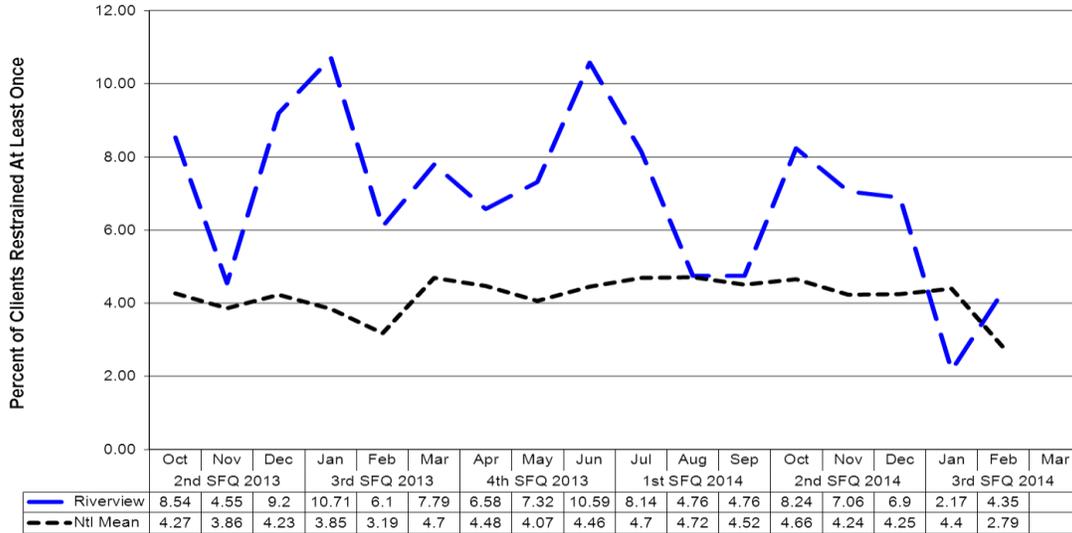
The following graphs depict the percent of unique clients who were restrained at least once stratified by forensic or civil classifications – includes all forms of restraint of any duration. For example, rates of 4.0 means that 4% of the unique clients served were restrained at least once.

The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

# CONSENT DECREE

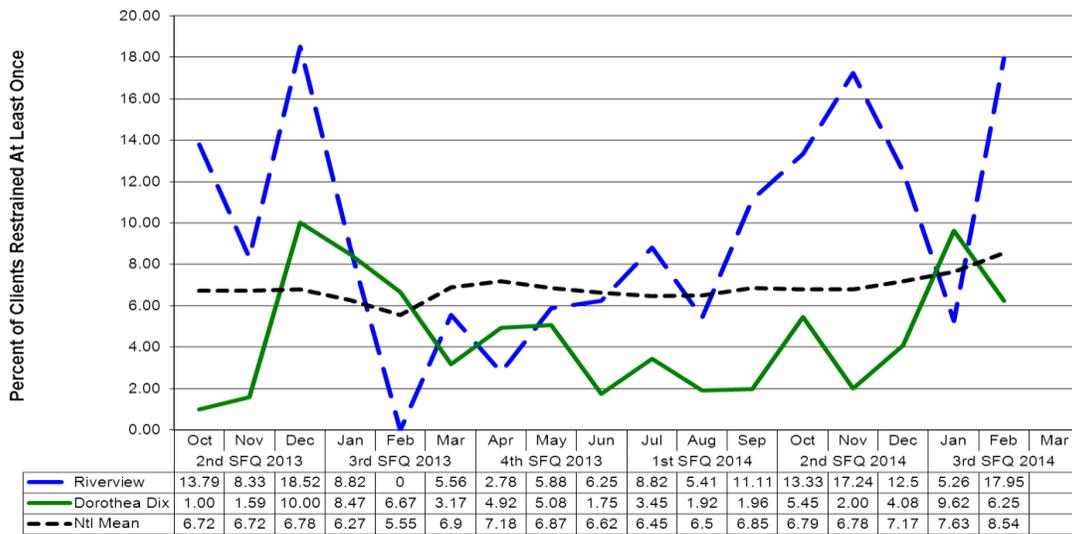
## Percent of Clients Restrained

Forensic Stratification



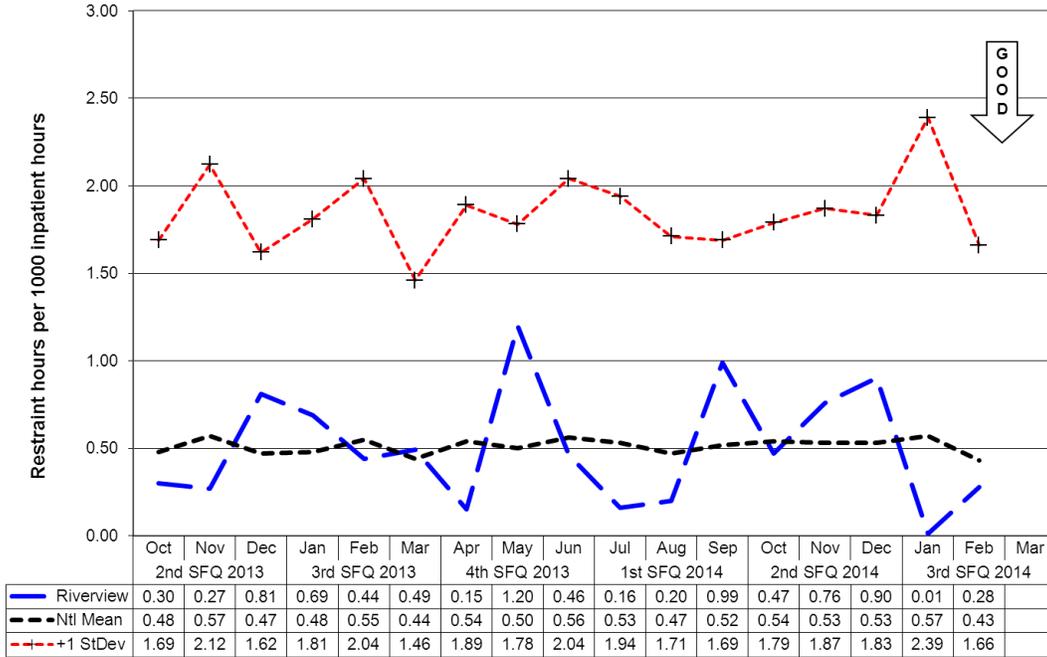
## Percent of Clients Restrained

Civil Stratification



# CONSENT DECREE

## Restraint Hours



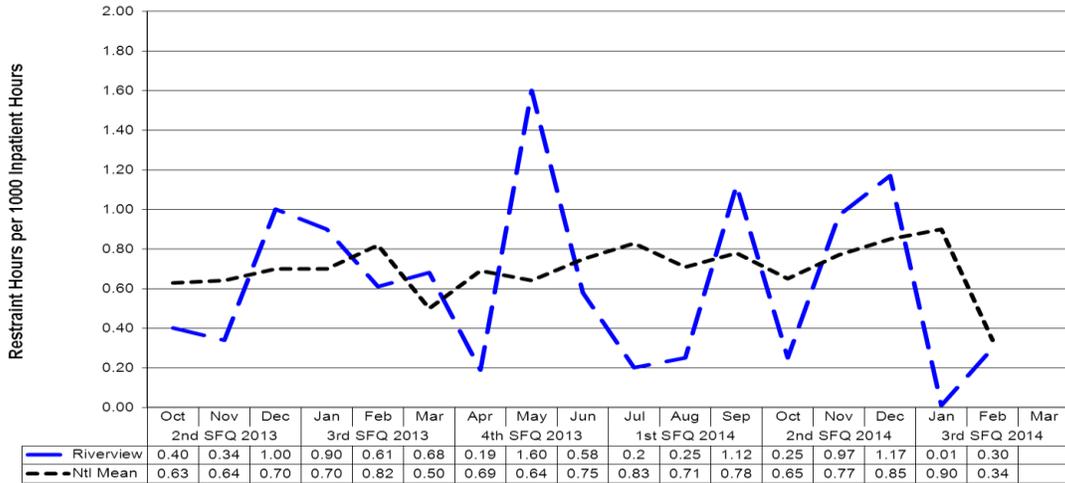
This graph depicts the number of hours clients spent in restraint for every 1000 inpatient hours - includes all forms of restraint of any duration. For example, a rate of 1.6 means that 2 hours were spent in restraint for each 1250 inpatient hours.

The following graphs depict the number of hours clients spent in restraint for every 1000 inpatient hours stratified by forensic or civil classifications - includes all forms of restraint of any duration. For example, a rate of 1.6 means that 2 hours were spent in restraint for each 1250 inpatient hours.

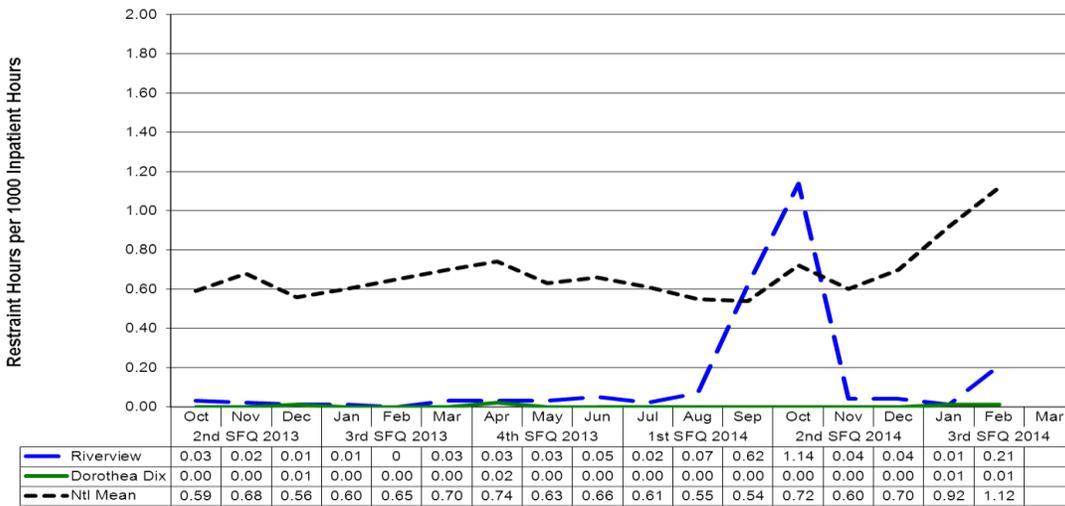
The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

# CONSENT DECREE

**Restraint Hours**  
Forensic Stratification



**Restraint Hours**  
Civil Stratification



# CONSENT DECREE

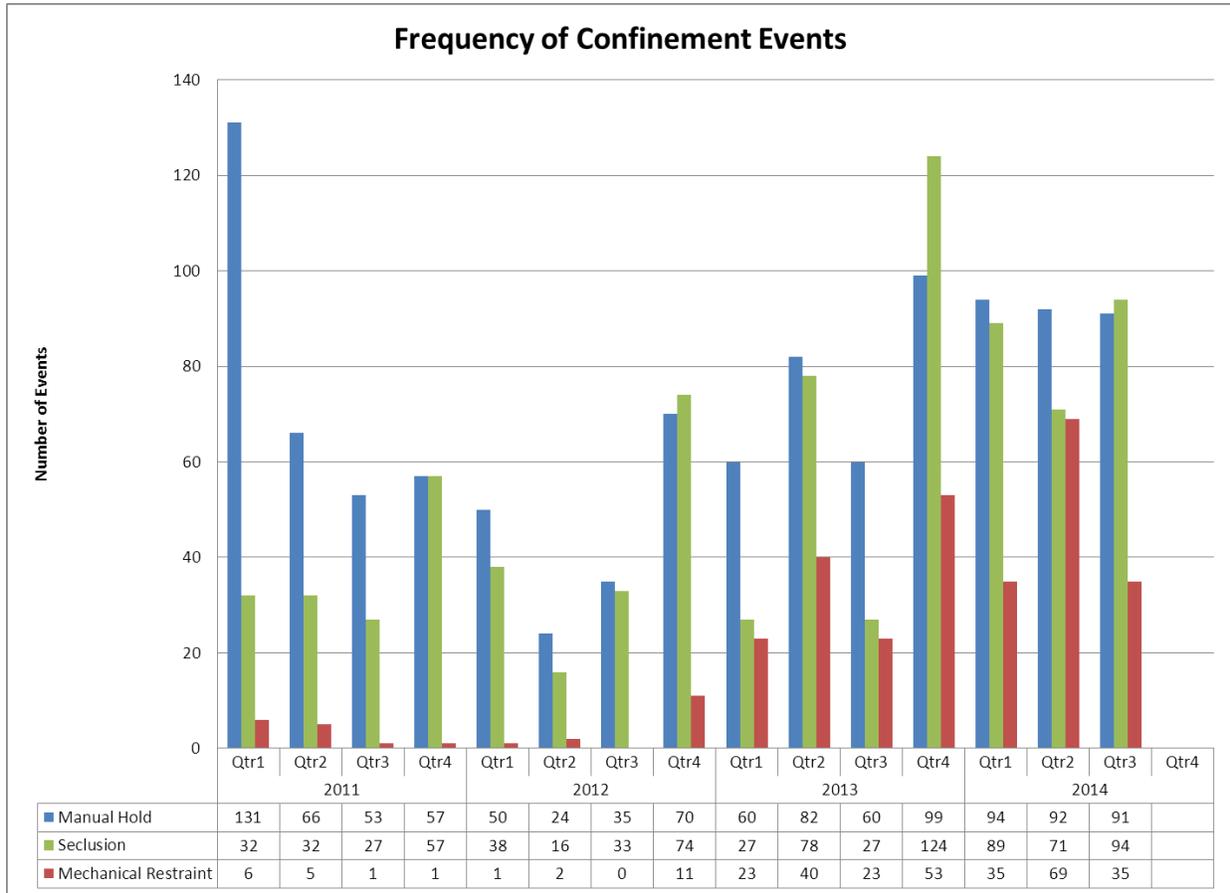
## Confinement Event Detail

3<sup>rd</sup> Quarter 2014

	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
MR3374	37	24	29	90	41.67%	41.67%
MR7495	17	9	7	33	15.28%	56.94%
MR2187	5		8	13	6.02%	62.96%
MR6963	3		8	11	5.09%	68.06%
MR7189	6		4	10	4.63%	72.69%
MR4841	2		5	7	3.24%	75.93%
MR4985	3		2	5	2.31%	78.24%
MR7032	2		3	5	2.31%	80.56%
MR7340	2		2	4	1.85%	82.41%
MR3120	1		3	4	1.85%	84.26%
MR6330			3	3	1.39%	85.65%
MR7394	3			3	1.39%	87.04%
MR5267	1		2	3	1.39%	88.43%
MR7127			3	3	1.39%	89.81%
MR0814			3	3	1.39%	91.20%
MR4814			3	3	1.39%	92.59%
MR7452	3			3	1.39%	93.98%
MR7489	1	1	1	3	1.39%	95.37%
MR6714	1		1	2	0.93%	96.30%
MR7480	1		1	2	0.93%	97.22%
MR7494			1	1	0.46%	97.69%
MR1057	1			1	0.46%	98.15%
MR7363			1	1	0.46%	98.61%
MR5206			1	1	0.46%	99.07%
MR4271			1	1	0.46%	99.54%
MR0417		1		1	0.46%	100.00%
	<b>89</b>	<b>35</b>	<b>92</b>	<b>216</b>		

33% (26/80) of average hospital population experienced some form of confinement event during the 3<sup>rd</sup> fiscal quarter 2014. Five of these clients (6% of the average hospital population) accounted for 73% of the containment events. The trend in frequency of confinement event, specifically the increase in the trend related to mechanical restraints is due to a few high acute clients requiring special management to ensure the safety of the milieu.

# CONSENT DECREE



Since December 2012, Riverview has been admitting an increasing number of forensic clients that are extremely violent and difficult to manage. This increase in high acuity clients has required the use of specialized management techniques that ensure the safety of these clients, other clients, and staff while attempting to maintain a therapeutic milieu.

Best practices from other forensic facilities and recommendations from experts in forensic client management from other State of Maine departments have been considered in the management of these clients.

# CONSENT DECREE

V28) Riverview demonstrates that, based on a review of two quarters of data, for 95% of seclusion events, seclusion was employed only when absolutely necessary to protect the patient from causing physical harm to self or others or for the management of violent behavior;

### Factors of Causation Related to Seclusion Events

	3Q13	4Q13	1Q14	2Q14	3Q14
Danger to Others/Self	50	124	71	88	92
Danger to Others					
Danger to Self	1				
% Dangerous Precipitation	100%	100%	100%	100%	100%
Total Events	51	124	71	88	92

V29) Riverview demonstrates that, based on a review of two quarters of data, for 95% of restraint events involving mechanical restraints, the restraint was used only when absolutely necessary to protect the patient from serious physical injury to self or others;

### Causation Related to Mechanical Restraint Events

	3Q13	4Q13	1Q14	2Q14	3Q14
Danger to Others/Self	40	53	29	51	35
Danger to Others					
Danger to Self				1	
% Dangerous Precipitation	100%	100%	100%	100%	100%
Total Events	40	53	29	52	35

V30) Riverview demonstrates that, based on a review of two quarters of data, for 95% of seclusion and restraint events, the hospital achieved an acceptable rating for meeting the requirements of paragraphs 182 and 184 of the Settlement Agreement, in accordance with a methodology defined in **Attachments E-1 and E-2**.

**See Pages 29 & 30**

# CONSENT DECREE

## Confinement Events Management

### Seclusion Events (92) Events

Standard	Threshold	Compliance	Standard	Threshold	Compliance
The record reflects that seclusion was absolutely necessary to protect the patient from causing physical harm to self or others, or if the patient was examined by a physician or physician extender prior to implementation of seclusion, to prevent further serious disruption that significantly interferes with other patients' treatment.	95%	100%	The medical order states time of entry of order and that number of hours in seclusion shall not exceed 4.	85%	100%
			The medical order states the conditions under which the patient may be sooner released.	85%	100%
			The record reflects that the need for seclusion is re-evaluated at least every 2 hours by a nurse.	90%	100%
The record reflects that lesser restrictive alternatives were inappropriate or ineffective. This can be reflected anywhere in record.	90%	100%	The record reflects that the 2 hour re-evaluation was conducted while the patient was out of seclusion room unless clinically contraindicated.	70%	100%
The record reflects that the decision to place the patient in seclusion was made by a physician or physician extender.	90%	100%	The record includes a special check sheet that has been filled out to document reason for seclusion, description of behavior and the lesser restrictive alternatives considered.	85%	100%
The decision to place the patient in seclusion was entered in the patient's records as a medical order.	90%	100%	The record reflects that the patient was released, unless clinically contraindicated, at least every 2 hours or as necessary for eating, drinking, bathing, toileting or special medical orders.	85%	100%
The record reflects that, if the physician or physician extender was not immediately available to examine the patient, the patient was placed in seclusion following an examination by a nurse.	90%	100%			
The record reflects that the physician or physician extender personally evaluated the patient within 30 minutes after the patient has been placed in seclusion, and if there is a delay, the reasons for the delay.	90%	100%	Reports of seclusion events were forwarded to medical director and advocate.	90%	100%
			The record reflects that, for persons with mental retardation, the regulations governing seclusion of clients with mental retardation were met.	85%	100%
The record reflects that the patient was monitored every 15 minutes. (Compliance will be deemed if the patient was monitored at least 3 times per hour.)	90%	100%	The medical order for seclusion was not entered as a PRN order.	90%	100%
			Where there was a PRN order, there is evidence that physician was counseled.	95%	N/A
Individuals implementing seclusion have been trained in techniques and alternatives.	90%	100%			
The record reflects that reasonable efforts were taken to notify guardian or designated representative as soon as possible that patient was placed in seclusion.	75%	100%			

# CONSENT DECREE

## Confinement Events Management

### Mechanical Restraint Events (35) Events

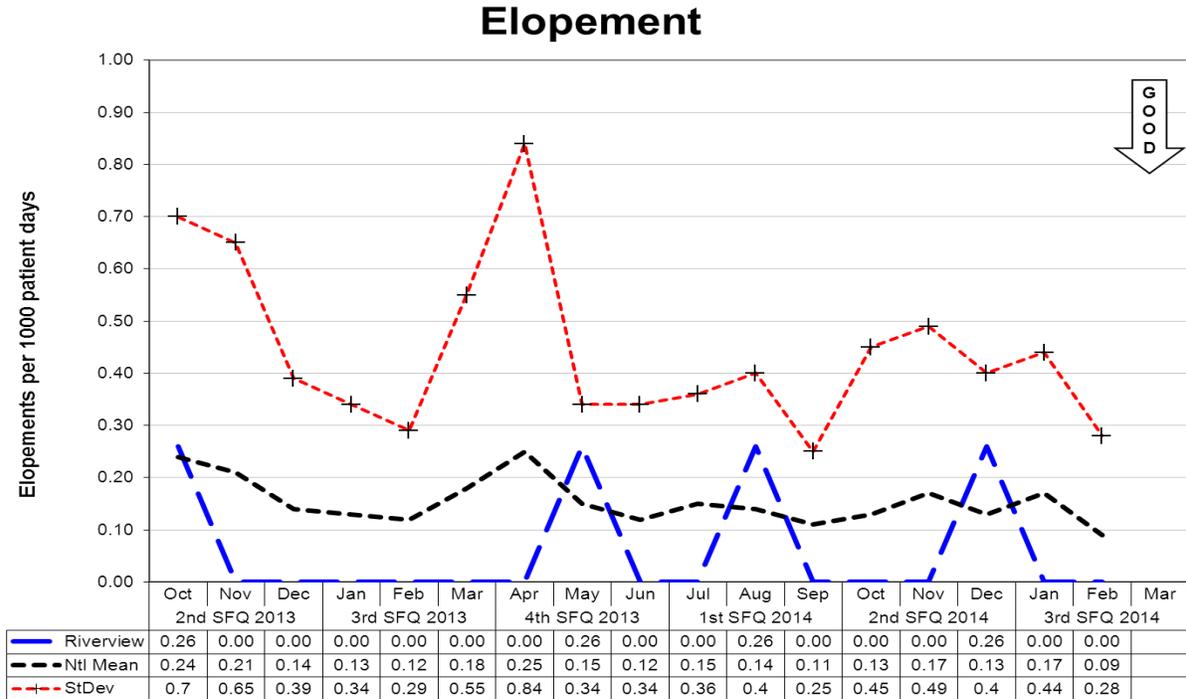
<u>Standard</u>	<u>Threshold</u>	<u>Compliance</u>
The record reflects that restraint was absolutely necessary to protect the patient from causing serious physical injury to self or others.	95%	100%
The record reflects that lesser restrictive alternatives were inappropriate or ineffective.	90%	100%
The record reflects that the decision to place the patient in restraint was made by a physician or physician extender	90%	100%
The decision to place the patient in restraint was entered in the patient's records as a medical order.	90%	100%
The record reflects that, if a physician or physician extended was not immediately available to examine the patient, the patient was placed in restraint following an examination by a nurse.	90%	100%
The record reflects that the physician or physician extender personally evaluated the patient within 30 minutes after the patient has been placed in restraint, or, if there was a delay, the reasons for the delay.	90%	100%
The record reflects that the patient was kept under constant observation during restraint.	95%	100%
Individuals implementing restraint have been trained in techniques and alternatives.	90%	100%
The record reflects that reasonable efforts taken to notify guardian or designated representative as soon as possible that patient was placed in restraint.	75%	100%
The medical order states time of entry of order and that number of hours shall not exceed four.	90%	100%
The medical order shall state the conditions under which the patient may be sooner released.	85%	100%

<u>Standard</u>	<u>Threshold</u>	<u>Compliance</u>
The record reflects that the need for restraint was re-evaluated every 2 hours by a nurse.	90%	100%
The record reflects that re-evaluation was conducted while the patient was free of restraints unless clinically contraindicated.	70%	100%
The record includes a special check sheet that has been filled out to document the reason for the restraint, description of behavior and the lesser restrictive alternatives considered.	85%	100%
The record reflects that the patient was released as necessary for eating, drinking, bathing, toileting or special medical orders.	90%	100%
The record reflects that the patient's extremities were released sequentially, with one released at least every fifteen minutes.	90%	100%
Copies of events were forwarded to medical director and advocate.	90%	100%
For persons with mental retardation, the applicable regulations were met.	85%	100%
The record reflects that the order was not entered as a PRN order.	90%	100%
Where there was a PRN order, there is evidence that physician was counseled.	95%	N/A
A restraint event that exceeds 24 hours will be reviewed against the following requirement: If total consecutive hours in restraint, with renewals, exceeded 24 hours, the record reflects that the patient was medically assessed and treated for any injuries; that the order extending restraint beyond 24 hours was entered by Medical Director (or if the Medical Director is out of the hospital, by the individual acting in the Medical Director's stead) following examination of the patient; and that the patient's guardian or representative has been notified.	90%	100%

# CONSENT DECREE

## Client Elopements

V31) Quarterly performance data shows that, in 5 out of 6 quarters, the number of client elopements does not exceed one standard deviation from the national mean as reported by NASMHPD



This graph depicts the 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.

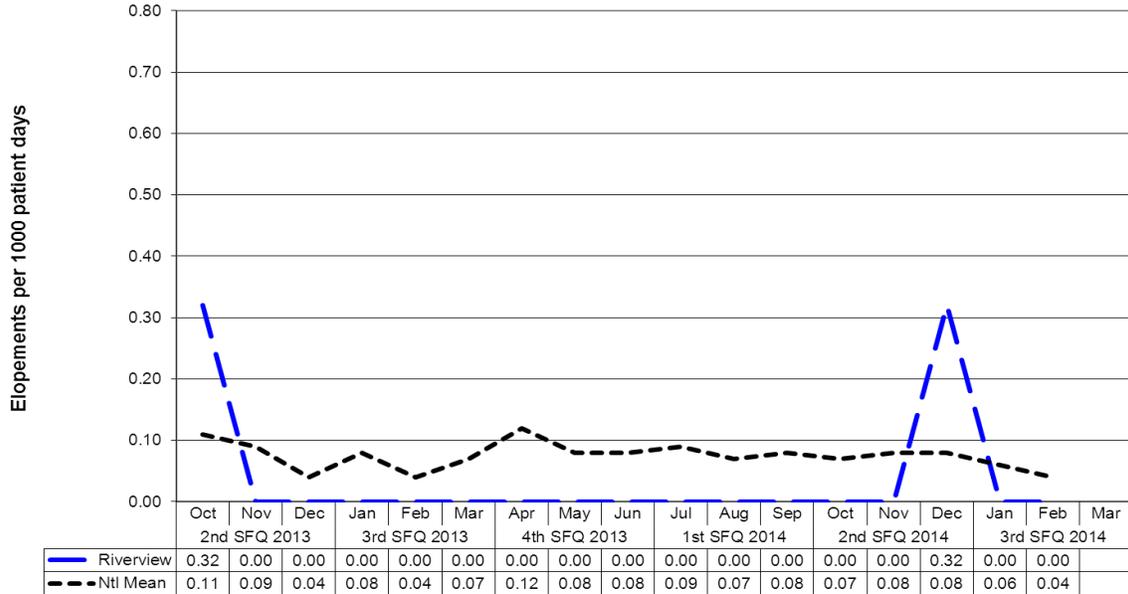
An elopement is defined as any time a client is “absent from a location defined by the client’s privilege status regardless of the client’s leave or legal status.”

The following graphs depict the number of elopements stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days.

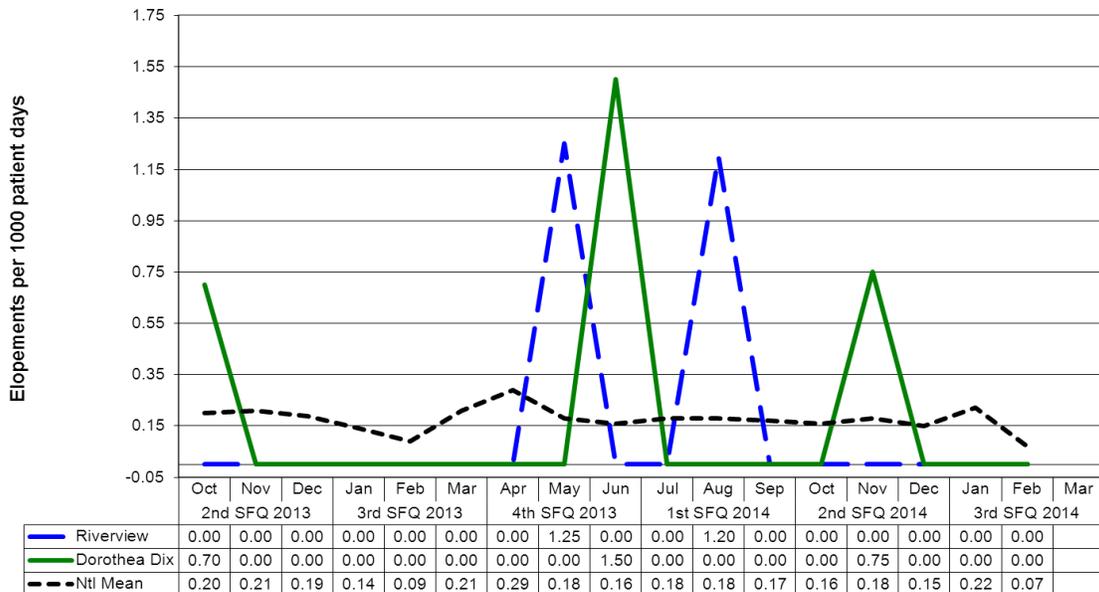
The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

# CONSENT DECREE

## Eloperment Forensic Stratification



## Eloperment Civil Stratification



# CONSENT DECREE

## Client Injuries

V32) Quarterly performance data shows that, in 5 out of 6 quarters, the number of client injuries does not exceed one standard deviation from the national mean as reported by NASMHPD.

The NASMHPD 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

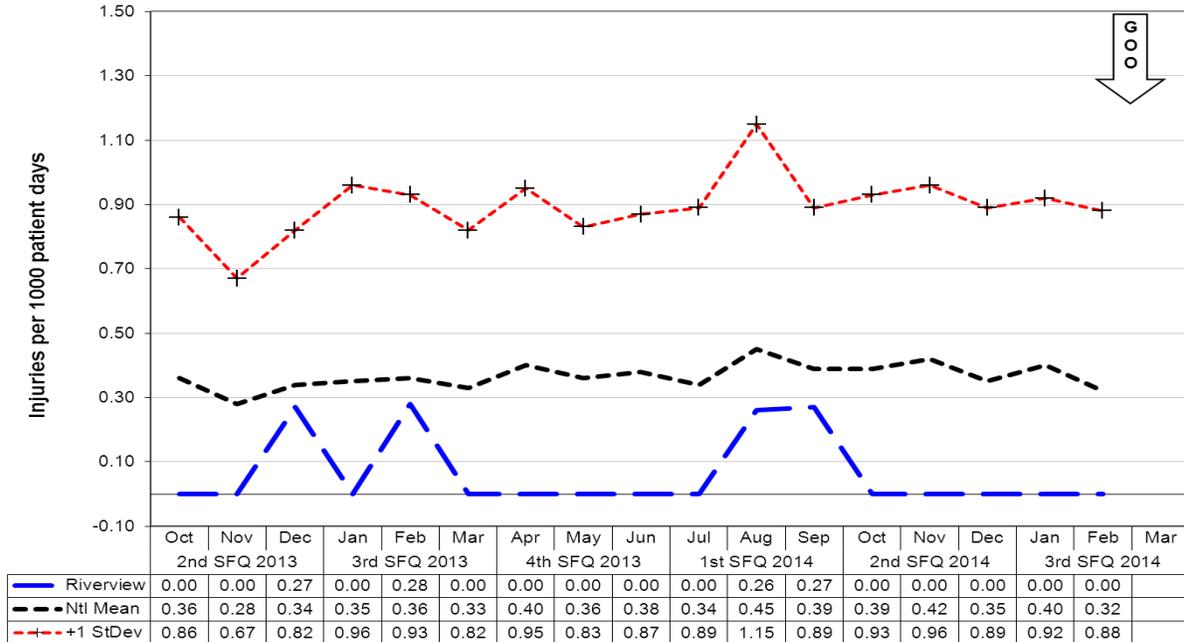
Reportable injuries include those that require: 3) Medical Intervention, 4) Hospitalization or where, 5) Death Occurred.

- 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 it 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 NASMHPD.

# CONSENT DECREE

## 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.

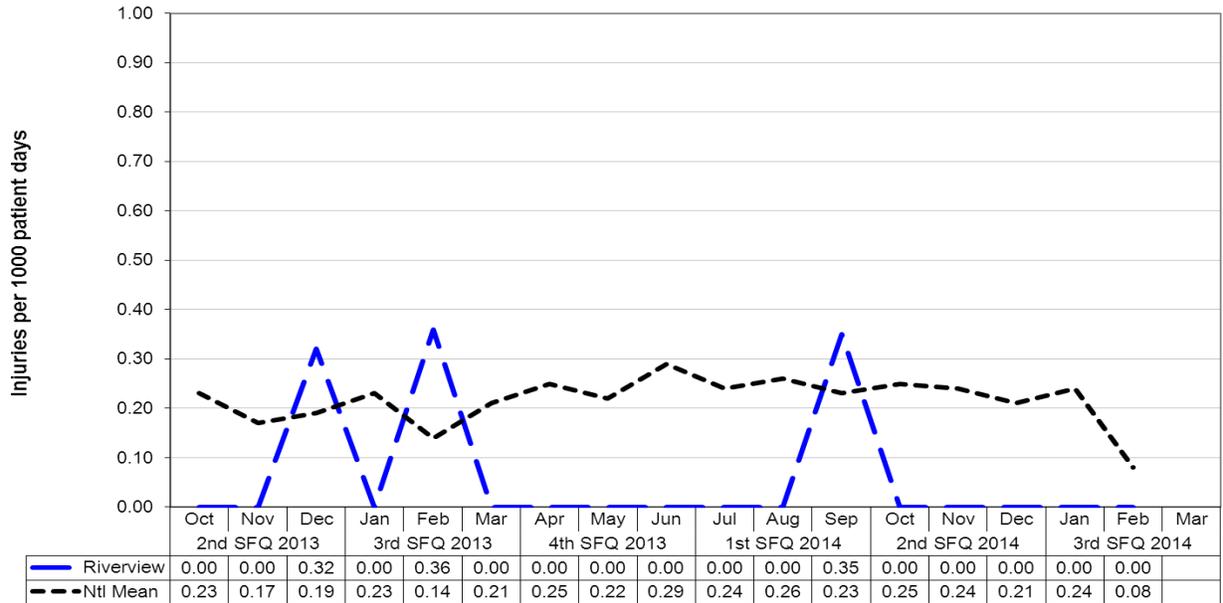
The following graphs depict the number of client injury events stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days.

The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

# CONSENT DECREE

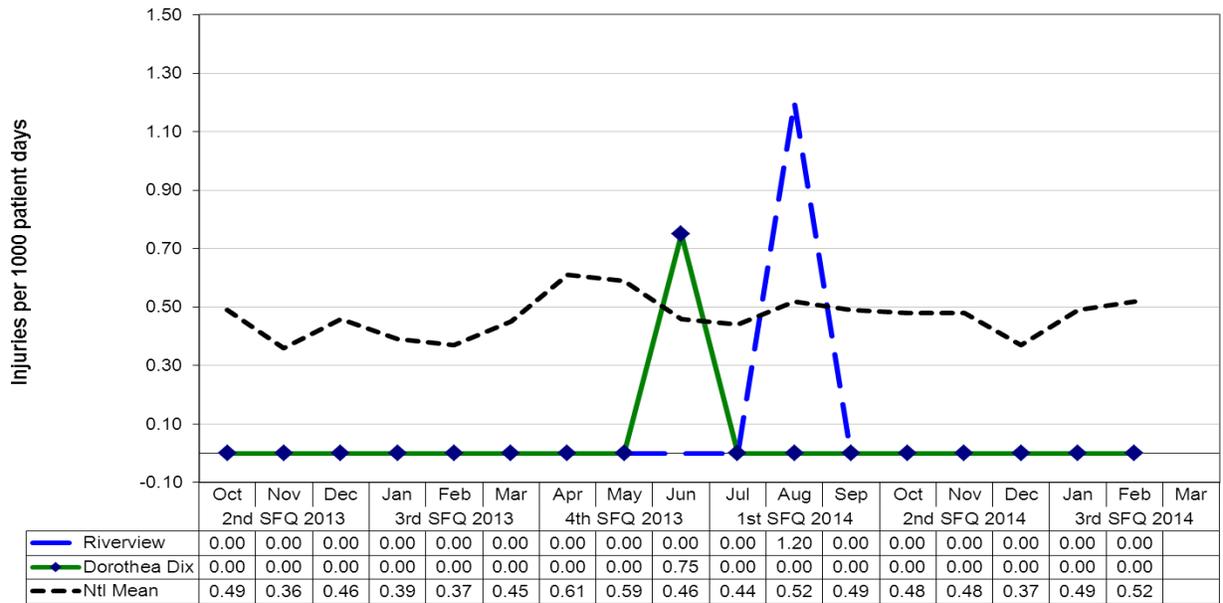
## Client Injury Rate

Forensic Stratification



## Client Injury Rate

Civil Stratification



# CONSENT DECREE

## Severity of injury by Month

Severity	JAN	FEB	MAR	3Q2014
No Treatment	33	37	47	117
Minor First Aid				
Medical Intervention Required				
Hospitalization Required				
Death Occurred				
<b>Total</b>	<b>33</b>	<b>37</b>	<b>47</b>	<b>117</b>

## Type and Cause of Injury by Month

Type - Cause	JAN	FEB	MAR	3Q2014
Accident – Fall Unwitnessed	6	1	3	10
Accident – Fall Witnessed	4	3	5	12
Accident – Other	2	1	1	4
Assault – Client to Client	17	16	18	51
Self-Injurious Behavior	4	16	20	40
<b>Total</b>	<b>33</b>	<b>37</b>	<b>47</b>	<b>117</b>

Changes in reporting standards related to “criminal” events as defined by the “State of Maine Rules for Reporting Sentinel Events”, effective February 1, 2013 as defined the by “National Quality Forum 2011 List of Serious Reportable Events” the number of reportable “assaults” that occur as the result of client interactions increased significantly. This change is due primarily as a result of the methods and rules related to data collection and abstraction.

Falls continues to be the predominant cause of potentially injurious events not related to the assaults discussed previously. Fall incidents remain a focus of the hospital. None of the fall incidents required treatment of any kind but are address as to causation during the Falls Process Review Team Meeting held each month.

Further information on Fall Reduction Strategies can be found under the [Joint Commission Priority Focus Areas](#) section of this report.

# CONSENT DECREE

## Patient Abuse, Neglect, Exploitation, Injury or Death

V33) Riverview certifies that it is reporting and responding to instances of patient abuse, neglect, exploitation, injury or death consistent with the requirements of ¶¶ 192-201 of the Settlement Agreement.

Type of Allegation	4Q2013	1Q2014	2Q2014	3Q2014
Abuse Physical	3	3	4	10
Abuse Sexual	5	4	2	5
Abuse Verbal		1	1	4
Coercion/Exploitation	1			
Neglect				1

Riverview utilizes several vehicles to communicate concerns or allegations related to abuse, neglect or exploitation.

1. Staff members complete an incident report upon becoming aware of an incident or an allegation of any form of abuse, neglect, or exploitation.
2. Clients have the option to complete a grievance or communicate allegations of abuse, neglect, or exploitation during any interaction with staff at all levels, peer support personnel, or the client advocates.
3. Any allegation of abuse, neglect, or exploitation is reported both internally and externally to appropriate stakeholders, include:
  - Superintendent and/or AOC
  - Adult Protective Services
  - Guardian
  - Client Advocate
4. Allegations are reported to the Risk Manager through the incident reporting system and fact-finding or investigations occur at multiple levels. The purpose of this investigation is to evaluate the event to determine if the allegations can be substantiated or not and to refer the incident to the client’s treatment team, hospital administration, or outside entities.
5. When appropriate to the allegation and circumstances, investigations involving law enforcement, family members, or human resources may be conducted.
6. The Human Rights Committee, a group consisting of consumers, family members, providers, and interested community members, and the Medical Executive Committee receive a report on the incidence of alleged abuse, neglect, and exploitation monthly.

# CONSENT DECREE

## Performance Improvement and Quality Assurance

V34) Riverview maintains Joint Commission accreditation;

Riverview successfully completed an accreditation survey with The Joint Commission on November 11-13, 2013. A triennial accreditation survey is expected to occur in November 2016 or earlier.

The surveyors identified five areas of direct impact that required a review and revision of hospital processes within 45 days

The surveyors identified four BHC and sixteen HAP areas of indirect impact that required a review and revision of hospital processes within 60 days. Three of the HAP areas were clarified within the ten days and were accepted.

V35) Riverview maintains its hospital license;

Riverview maintains licensing status as required through the Department of Health and Human Services Division of Licensing and Regulatory Services Centers for Medicare and Medicaid Services.

V36) The hospital does not lose its CMS certification (for the entire hospital excluding Lower Saco SCU so long as Lower Saco SCU is a distinct part of the hospital for purposes of CMS certification) as a result of patient care issues;

The hospital was terminated from the Medicare Provider Agreement on September 2, 2013 for failing to show evidence of substantial compliance by August 27, 2013. A revisit by CMS occurred on September 16<sup>th</sup> and 17<sup>th</sup>, 2013. The Medicare Provider Agreement will not be accepted unless CMS finds that the reason for termination of the previous agreement has been removed and there is reasonable assurance that it will not recur; and that the hospital has fulfilled, or has made satisfactory arrangements to fulfill, all of its statutory and regulatory responsibilities of its previous agreement. See Section 1866(c) of the Social Security Act and 42 C.F.R.§489.57. Riverview is currently in the process of applying for recertification.

V37) Riverview conducts quarterly monitoring of performance indicators in key areas of hospital administration, in accordance with the Consent Decree Plan, the accreditation standards of the Joint Commission, and according to a QAPI plan reviewed and approved by the Advisory Board each biennium, and demonstrates through quarterly reports that management uses that data to improve institutional performance, prioritize resources and evaluate strategic operations.

Riverview complies with this element of substantial compliance as evidenced by the current Integrated Plan for Performance Excellence, the data and reports presented in this document, the work of the Integrated Performance Excellence Committee and sub-groups of this committee that are engaged in a transition to an improvement orientated methodology that is support by the Joint Commission and is consistent with modern principles of process management and strategic methods of promoting organizational performance excellence.

# JOINT COMMISSION

## Hospital-Based Inpatient Psychiatric Services (ORYX Data Elements)

### The Joint Commission Quality Initiatives

In 1987, The Joint Commission announced its *Agenda for Change*, which outlined a series of major steps designed to modernize the accreditation process. A key component of the *Agenda for Change* was the eventual introduction of standardized core performance measures into the accreditation process. As the vision to integrate performance measurement into accreditation became more focused, the name ORYX® was chosen for the entire initiative. The ORYX initiative became operational in March of 1999, when performance measurement systems began transmitting data to The Joint Commission on behalf of accredited hospitals and long term care organizations. Since that time, home care and behavioral healthcare organizations have been included in the ORYX initiative.

The initial phase of the ORYX initiative provided healthcare organizations a great degree of flexibility, offering greater than 100 measurement systems capable of meeting an accredited organization's internal measurement goals and the Joint Commission's ORYX requirements. This flexibility, however, also presented certain challenges. The most significant challenge was the lack of standardization of measure specifications across systems. Although many ORYX measures appeared to be similar, valid comparisons could only be made between healthcare organizations using the same measures that were designed and collected based on standard specifications. The availability of over 8,000 disparate ORYX measures also limited the size of some comparison groups and hindered statistically valid data analyses. To address these challenges, standardized sets of valid, reliable, and evidence-based quality measures have been implemented by The Joint Commission for use within the ORYX initiative.

### Hospital-Based Inpatient Psychiatric Services (HBIPS) Core Measure Set

Driven by an overwhelming request from the field, The Joint Commission was approached in late 2003 by the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD) and the NASMHPD Research Institute, Inc. (NRI) to work together to identify and implement a set of core performance measures for hospital-based inpatient psychiatric services. Project activities were launched in March 2004. At this time, a diverse panel of stakeholders convened to discuss and recommend an overarching initial framework for the identification of HBIPS core performance measures. The Technical Advisory Panel (TAP) was established in March 2005 consisting of many prominent experts in the field.

The first meeting of the TAP was held May 2005 and a framework and priorities for performance measures was established for an initial set of core measures. The framework consisted of seven domains:

Assessment

Treatment Planning and Implementation

Hope and Empowerment

Patient Driven Care

Patient Safety

Continuity and Transition of Care

Outcomes

The current HBIPS standards reflected in this report are designed to reflect these core domains in the delivery of psychiatric care.

# JOINT COMMISSION

## Admissions Screening (HBIPS 1)

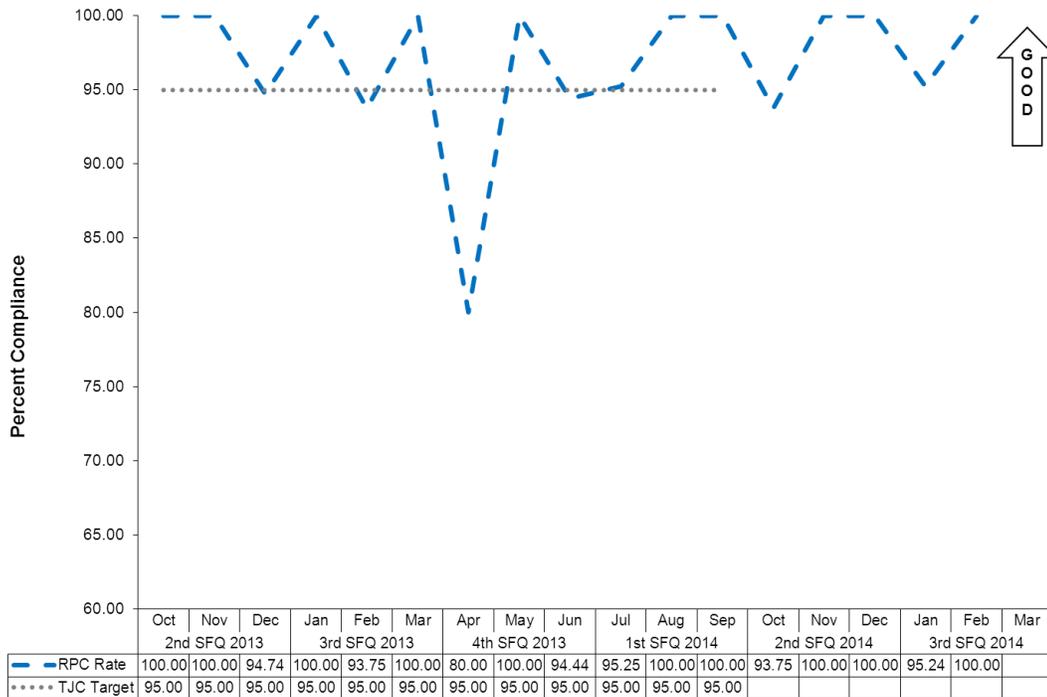
For Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths

### Description

Patients admitted to a hospital-based inpatient psychiatric setting who are screened within the first three days of admission for all of the following: risk of violence to self or others, substance use, psychological trauma history and patient strengths

### Rationale

Substantial evidence exists that there is a high prevalence of co-occurring substance use disorders as well as history of trauma among persons admitted to acute psychiatric settings. Professional literature suggests that these factors are under-identified yet integral to current psychiatric status and should be assessed in order to develop appropriate treatment (Ziedonis, 2004; NASMHPD, 2005). Similarly, persons admitted to inpatient settings require a careful assessment of risk for violence and the use of seclusion and restraint. Careful assessment of risk is critical to safety and treatment. Effective, individualized treatment relies on assessments that explicitly recognize patients' strengths. These strengths may be characteristics of the individuals themselves, supports provided by families and others, or contributions made by the individuals' community or cultural environment (Rapp, 1998). In the same way, inpatient environments require assessment for factors that lead to conflict or less than optimal outcomes.



# JOINT COMMISSION

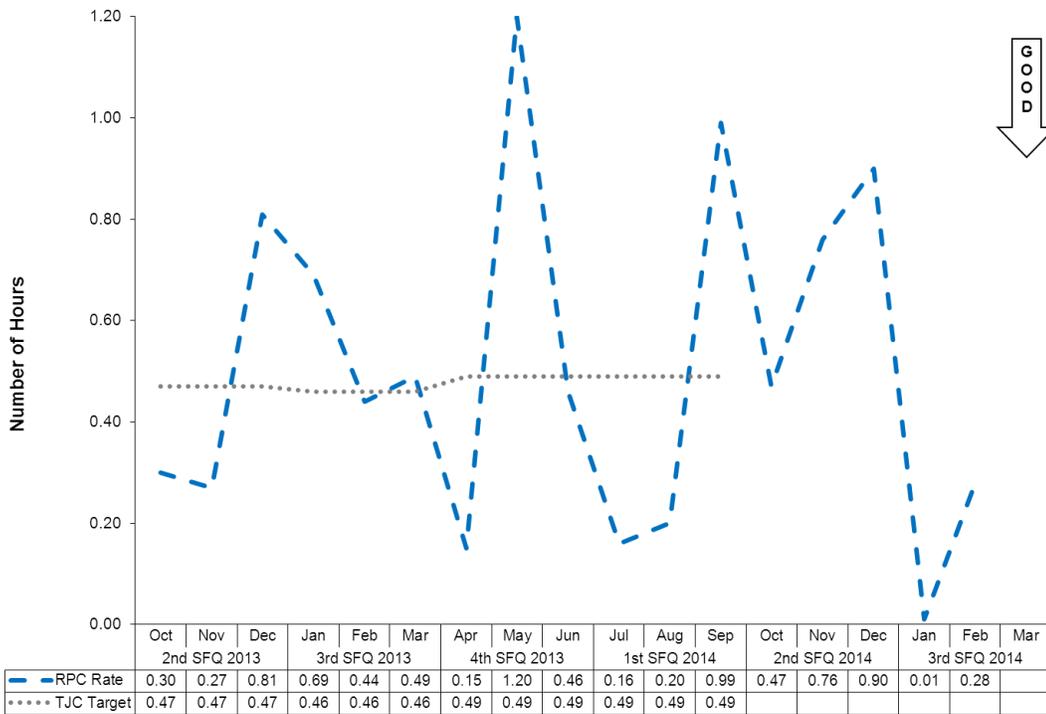
## Physical Restraint (HBIPS 2) Hours of Use

### Description

The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting was maintained in physical restraint.

### Rationale

Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint and seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).



# JOINT COMMISSION

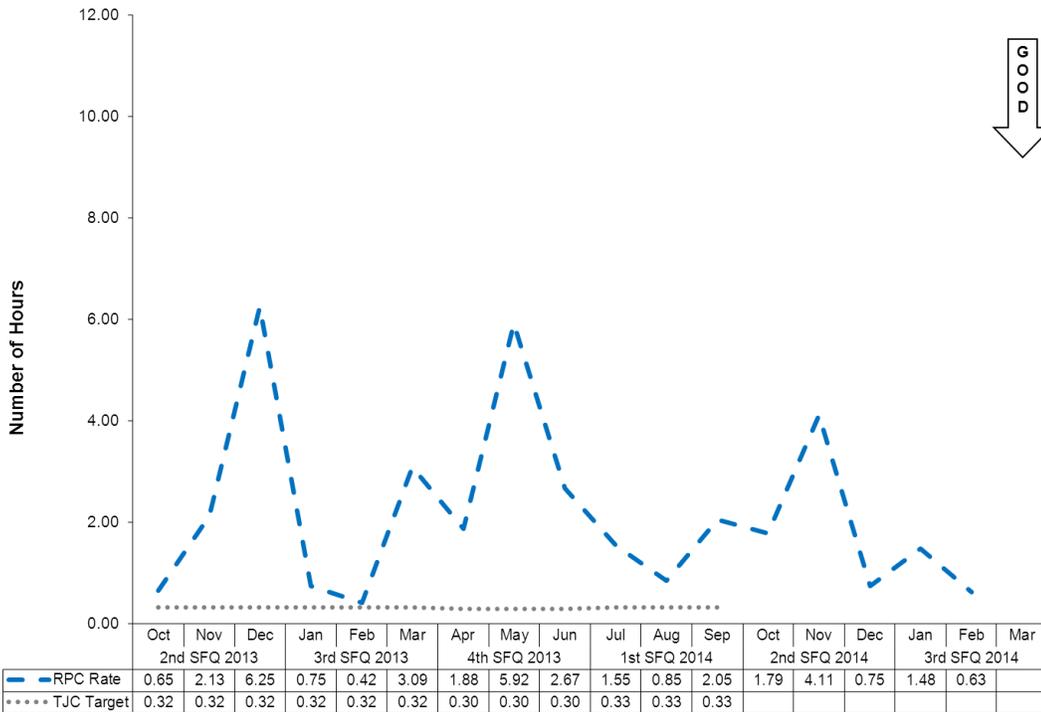
## Seclusion (HBIPS 3) Hours of Use

### Description

The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting was held in seclusion.

### Rationale

Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).



# JOINT COMMISSION

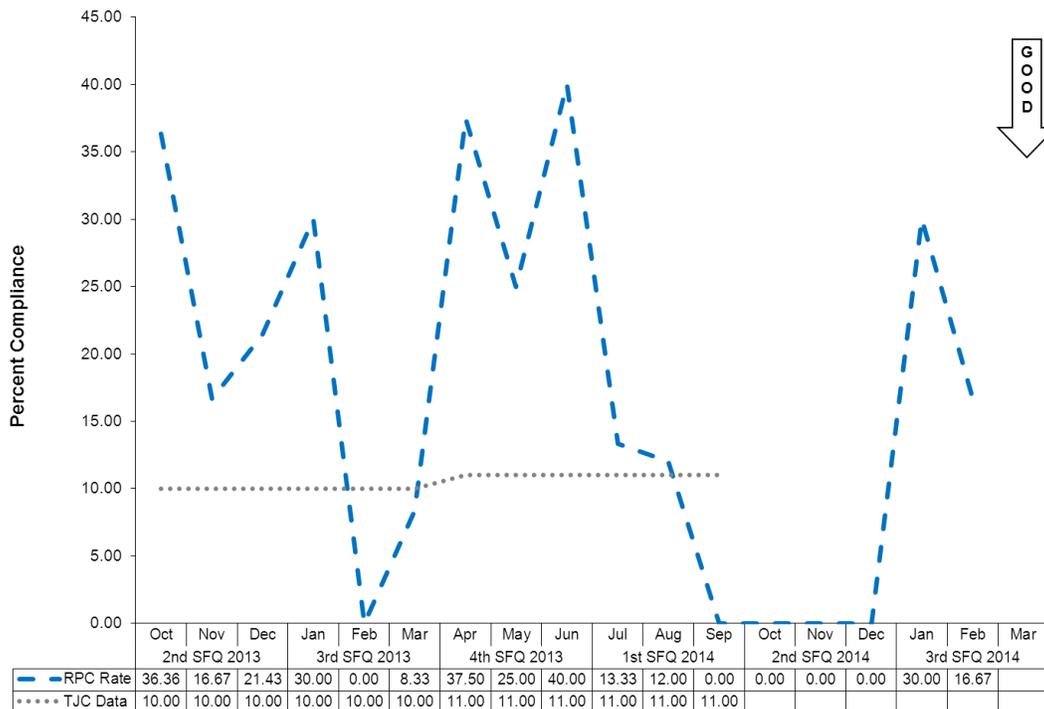
## Multiple Antipsychotic Medications on Discharge (HBIPS 4)

### Description

Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications

### Rationale

Research studies have found that 4-35% of outpatients and 30-50% of inpatients treated with an antipsychotic medication concurrently received 2 or more antipsychotics (Covell, Jackson, Evans, & Essock, 2002; Ganguly, Kotzan, Miller, Kennedy, & Martin, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; Kreyenbuhl, Valenstein, McCarthy, Ganocy, & Blow, 2006; Stahl & Grady, 2004). One study reported 4.6% of patients concurrently received 3 or more antipsychotics (Jaffe & Levine, 2003). These findings are seen across diverse sectors: state mental health authorities, the Veterans Health System and Medicaid-financed care. Antipsychotic polypharmacy can lead to greater side effects, often without improving clinical outcomes (Ananth, Parameswaran, & Gunatilake, 2004; Stahl & Grady, 2004). As a result, a range of stakeholders have called for efforts to reduce unnecessary use of multiple antipsychotics (Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; National Association of State Mental Health Program Directors, 2001; University HealthSystem Consortium, 2006). Practice guidelines recommend the use of a second antipsychotic only after multiple trials of a single antipsychotic have proven inadequate (American Psychiatric Association [APA] Practice Guidelines, 2004). Randomized controlled trials (RCTs) provide some evidence to support augmentation with a second antipsychotic in *treatment resistant* patients. Most of these studies were limited to augmentation of clozapine with another second-generation antipsychotic (Tranulis, Skalli, Lalonde, & Nicole, 2008). Among patients *without* a documented history of previous treatment failures of antipsychotic monotherapy, multiple RCTs and other controlled trials failed to show a benefit of antipsychotic polypharmacy over monotherapy (Ananth, Parameswaran, & Gunatilake, 2004; Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Potkin, Thyrum, Alva, Bera, Yeh, & Arvanitis, 2002; Shim et al., 2007; Stahl & Grady, 2004). Clinical circumstances, such as shorter inpatient stays, may require hospitals to discharge a patient on multiple antipsychotics with an aftercare plan to transition to monotherapy. In such cases, effective communication between the inpatient and aftercare clinician is an essential element of care.



# JOINT COMMISSION

## Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)

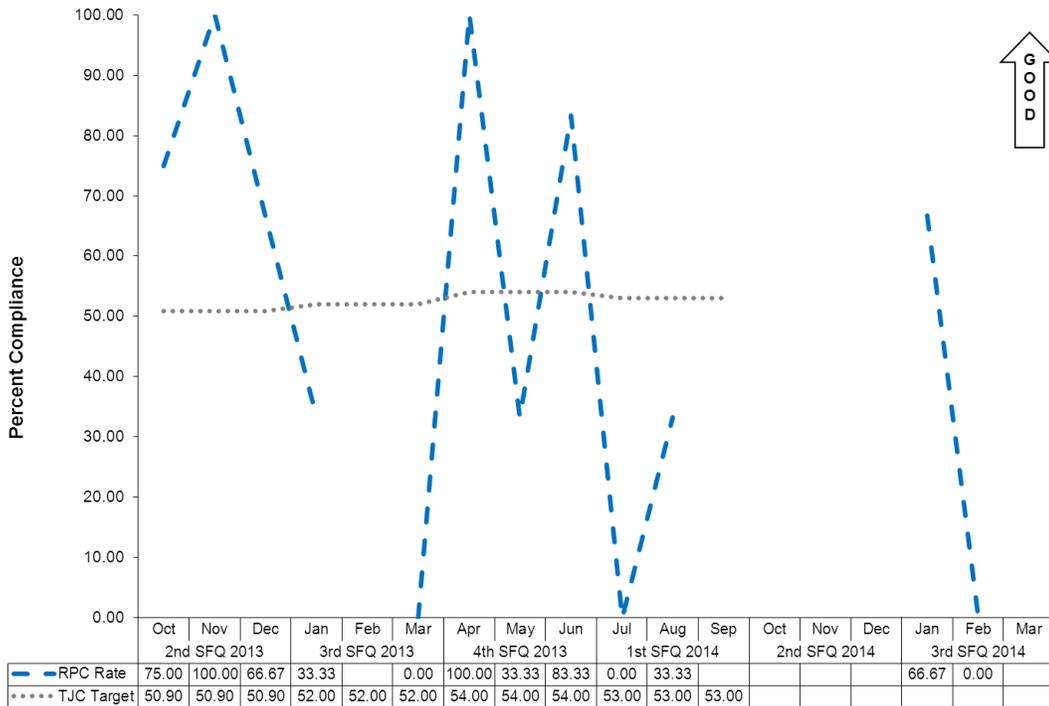
### Description

Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification

### Rationale

Research studies have found that 4-35% of outpatients and 30-50% of inpatients treated with an antipsychotic medication concurrently received 2 or more antipsychotics (Covell, Jackson, Evans, & Essock, 2002; Ganguly, Kotzan, Miller, Kennedy, & Martin, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; Kreyenbuhl, Valenstein, McCarthy, Ganocy, & Blow, 2006; Stahl & Grady, 2004). One study reported 4.6% of patients concurrently received 3 or more antipsychotics (Jaffe & Levine, 2003). These findings are seen across diverse sectors: state mental health authorities, the Veterans Health System and Medicaid-financed care. Antipsychotic polypharmacy can lead to greater side effects, often without improving clinical outcomes (Ananth, Parameswaran, & Gunatilake, 2004; Stahl & Grady, 2004). As a result, a range of stakeholders have called for efforts to reduce unnecessary use of multiple antipsychotics (Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; National Association of State Mental Health Program Directors, 2001; University HealthSystem Consortium, 2006).

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# JOINT COMMISSION

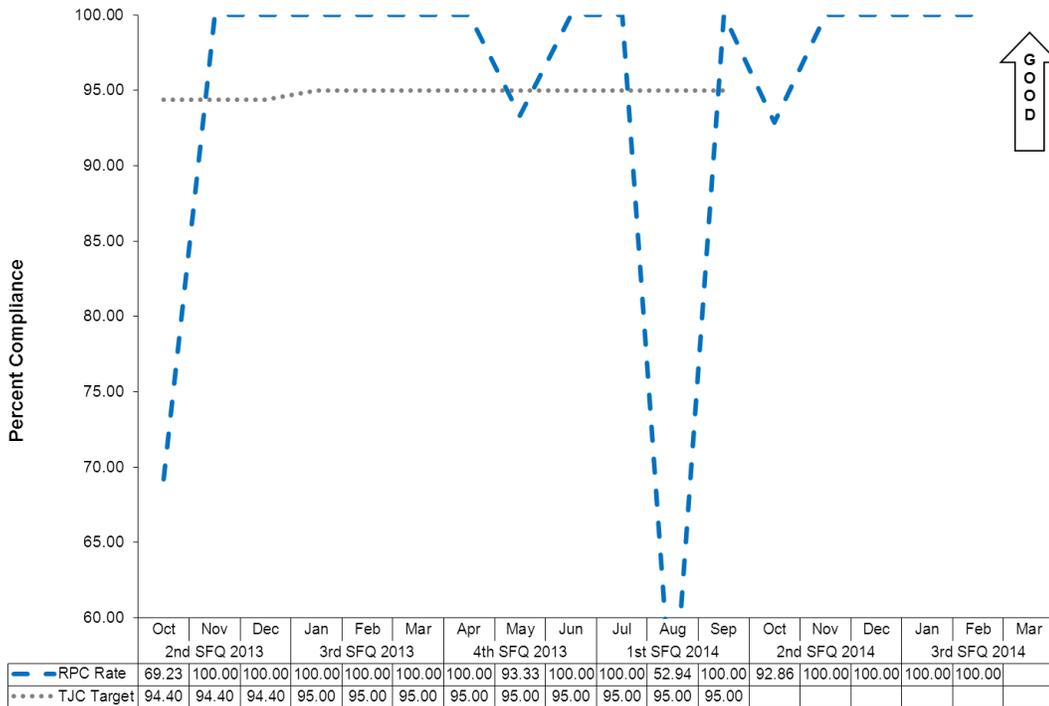
## Post Discharge Continuing Care Plan (HBIPS 6)

### Description

Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan created

### Rationale

Patients may not be able to fully report to their next level of care health-care provider their course of hospitalization or discharge treatment recommendations. The aftercare instructions given the patient may not be available to the next level of care provider at the patient's initial intake or follow-up appointment. In order to provide optimum care, next level of care providers need to know details of precipitating events immediately preceding hospital admission, the patient's treatment course during hospitalization, discharge medications and next level of care recommendations (American Association of Community Psychiatrists [AAP], 2001).



# JOINT COMMISSION

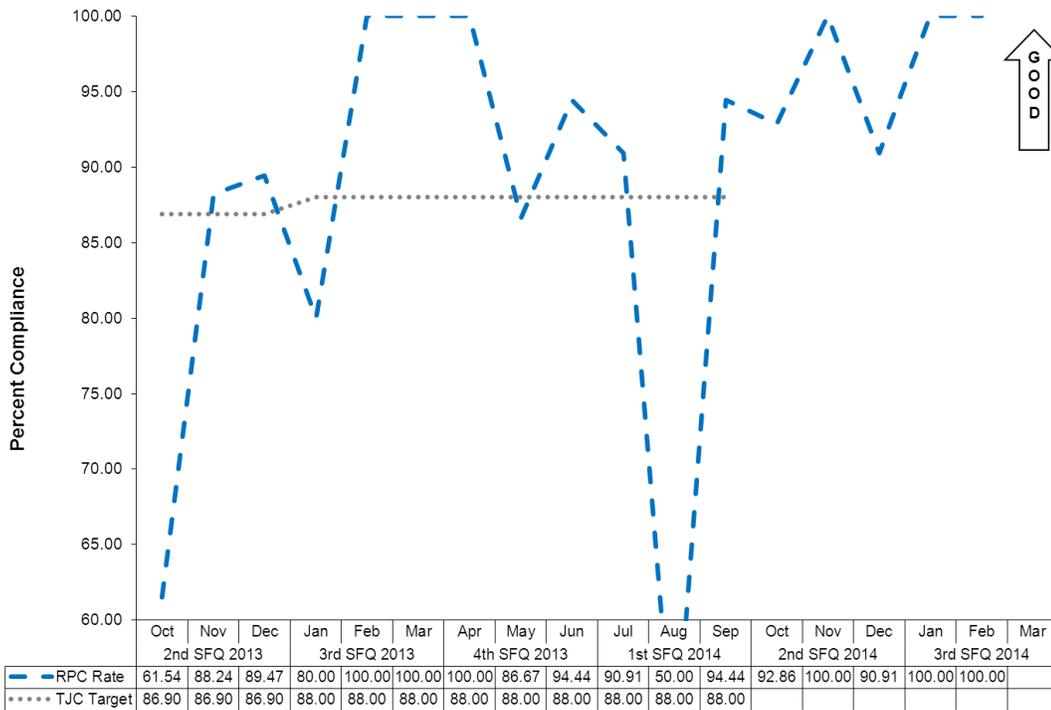
## Post Discharge Continuing Care Plan Transmitted (HBIPS 7) To Next Level of Care Provider on Discharge

### Description

Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity

### Rationale

Patients may not be able to fully report to their next level of care health-care provider their course of hospitalization or discharge treatment recommendations. The aftercare instructions given the patient may not be available to the next level of care provider at the patient's initial intake or follow-up appointment. In order to provide optimum care, next level of care providers need to know details of precipitating events immediately preceding hospital admission, the patient's treatment course during hospitalization, discharge medications and next level of care recommendations (American Association of Community Psychiatrists [AAP], 2001).



# JOINT COMMISSION

## Management of Contracted Care, Treatment and Services

TJC LD.04.03.09 The same level of care should be delivered to patients regardless of whether services are provided directly by the hospital or through contractual agreement. Leaders provide oversight to make sure that care, treatment, and services provided directly are safe and effective. Likewise, leaders must also oversee contracted services to make sure that they are provided safely and effectively.

<b>Final Report of FY 2014 Clinical Contracts</b>		
<b>Contractor</b>	<b>Program Administrator</b>	<b>Summary of Performance</b>
Amistad Peer Support Services	Stephanie George-Roy Director of Social Services	Two indicators did not meet expectations; 2 of 69 grievances were not responded to on time and Peer Support attendance at Service Integration Meetings was 94% (target is 100%).
Community Dental, Region II	Dr. Brendan Kirby Medical Director	All indicators met standards.
Comprehensive Pharmacy Services	Dr. Brendan Kirby Medical Director	All indicators met standards.
Dartmouth Medical School	Robert J. Harper Superintendent	All indicators met or exceeded standards.
Disability Rights Center	Robert J. Harper Superintendent	All indicators met standards.
Healthreach	Dr. Brendan Kirby Medical Director	All indicators met standards.
Liberty Staffing	Dr. Brendan Kirby Medical Director	All indicators met standards.
MaineGeneral Medical Center – Laboratory Services	Dr. Brendan Kirby Medical Director	All indicators met standards.
MD-IT	Amy Tasker Health Information Management Director	All indicators met standards.
Medical Staffing and Services of Maine, Inc.	Dr. Brendan Kirby Medical Director	All indicators met standards.
Motivational Services	Dr. Brendan Kirby Medical Director	All indicators met standards.
Occupational Therapy Consultation and Rehab Services	Janet Barrett Director of Rehabilitation	All indicators met or exceeded standards.
Securitas Security Services	Robert Patnaude Director of Security	All indicators met or exceeded standards.

# JOINT COMMISSION

## Capital Community Clinic Adverse Reactions to Sedation or Anesthesia

TJC PI.01.01.01 EP6: The hospital collects data on the following: adverse events related to using moderate or deep sedation or anesthesia. (See also LD.04.04.01, EP 2)

### Dental Clinic Timeout/Identification of Client

Indicators	4Q2013	1Q2014	2Q2014	3Q2014
National Patient Safety Goals	<b>April</b> 100%	<b>July</b> 100%	<b>October</b> 100%	<b>January</b> 100%
Goal 1: Improve the accuracy of Client Identification.	2/2	6/6	3/3	2/2
Capital Community Dental Clinic assures accurate client identification by: asking the client to state his/her name and date of birth.	<b>May</b> 100%	<b>August</b> 100%	<b>November</b> 100%	<b>February</b> 100%
	7/7	2/2	1/1	2/2
A time out will be taken before the procedure to verify location and numbered tooth. The time out section is in the progress notes of the patient chart. This page will be signed by the Dentist as well as the dental assistant.	<b>June</b> 100%	<b>September</b> 100%	<b>December</b> 100%	<b>March</b> 100%
	7/7	4/4	2/2	7/7
	<b>Total</b> 100%	<b>Total</b> 100%	<b>Total</b> 100%	<b>Total</b> 100%
	16/16	12/12	6/6	11/11

### Dental Clinic Post Extraction Prevention of Complications and Follow-up

Indicators	4Q2013	1Q2014	2Q2014	3Q2014
1. 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	<b>April</b> 100%	<b>July</b> 100%	<b>October</b> 100%	<b>January</b> 100%
	2/2	6/6	3/3	2/2
• Bleeding	<b>May</b> 100%	<b>August</b> 100%	<b>November</b> 100%	<b>February</b> 100%
• Swelling	7/7	2/2	1/1	2/2
• Pain	<b>June</b> 100%	<b>September</b> 100%	<b>December</b> 100%	<b>March</b> 100%
• Muscle soreness	7/7	4/4	2/2	7/7
• Mouth care	<b>Total</b> 100%	<b>Total</b> 100%	<b>Total</b> 100%	<b>Total</b> 100%
• Diet	16/16	12/12	6/6	11/11
• Signs/symptoms of infection				
2. The client, post procedure tooth extraction, will verbalize understanding of the above by repeating instructions given by Dental Assistant/Hygienist.				
3. Post dental extractions, the clients will receive a follow-up phone call from the clinic within 24hrs of procedure to assess for post procedure complications				

# JOINT COMMISSION

## Healthcare Acquired Infections Monitoring and Management Upper Kennebec, Lower Kennebec, Upper Saco

NPSG.07.03.01 Implement evidence-based practices to prevent health care–associated infections due to multidrug-resistant organisms in acute care hospitals.

Indicators	Findings	Compliance	Threshold Percentile
Total number of infections for the first quarter of the fiscal year, per 1000 patient days	28 – 5.02	100 %	1 SD within the mean
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	11 – <b>1.9</b>	100%	1 SD within the mean

**HAI** – Hospital Associated Infections  
**CAI** – Community Acquired Infections

**Idiosyncratic Infections** – Infection secondary to self-injury

**Lower Kennebec:**

- External otitis – HAI
- Vaginal yeast infection – CAI
- Perianal Rash → Staph or Strep – HAI
- Bursitis & Cellulitis secondary to a fall – HAI
- Severe Onychomycosis – CAI
- Folliculitis – CAI
- Gingivitis – CAI
- Minor Abrasion – Prophylactic treatment – CAI
- UTI – HAI

**Upper Saco:**

- Thrush – CAI
- Dental abscess – CAI
- Tinea Pedis – CAI
- LLL Pneumonia – HAI
- Tooth Abscess – CAI
- Chronic Sinusitis – CAI
- C. difficile – HAI
- Oral Thrush – HAI
- New infiltrate>aspiration pneumonia – HAI
- Pharyngitis secondary to candida – HAI

**Lower Kennebec SCU:**

- Bite wound - idiosyncratic
- Laceration of left antecubital space - idiosyncratic
- Cellulitis right medial ankle - idiosyncratic
- Serous otitis - HAI

**Upper Kennebec**

- Dental Infection - CAI
- Dental – deep decay - CAI
- Dental abscess - CAI
- C. difficile – CAI
- Tinea Pedis - HAI
- Angular Cheilitis - CAI

**Patient Days:** 5576

**Summary:** Hospital associated infection rates remain below or within one standard deviation of the mean. One client was hospitalized at Maine General Medical Center for pneumonia when she became infected with C. difficile. She has had at least (2) incidents of recurrent pneumonia and C. difficile.

Infections are scattered throughout the hospital without evidence of cross transmission. The most common type of infection is skin infection. Skin infections are often a result of poor hygiene; or secondary to chronic medical illness i.e. diabetes.

The three (3) incidents of idiosyncratic infections were related to one client.

**Plan:** Continue Total House Surveillance.

# JOINT COMMISSION

## Healthcare Acquired Infections Monitoring and Management Lower Saco

NPSG.07.03.01 Implement evidence-based practices to prevent health care–associated infections due to multidrug-resistant organisms in acute care hospitals.

Indicators	Findings	Compliance	Threshold Percentile
Total number of infections for the third quarter of the fiscal year, per 1000 patient days	27 – 17.3	100%	1 SD within the mean
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	5– 3.1	100%	1 SD within the mean

Hospital Acquired Infection is any infection present, incubating or exposed to more than 72 hours **after admission** (unless the patient is off hospital grounds during that time) or declared by a physician, a physician’s assistant or advanced practice nurse to be HAI.

A Community Acquired Infection is any infection present, incubating or exposed to prior to admission, while on pass; during off-site medical, dental, or surgical care; by a visitor, any prophylaxis treatment of a condition or treatment of a condition for which the patient has a history of chronic infection no matter how long the patient has been hospitalized; or declared by the physician, physician’s assistant, or advanced practice nurse to be a community acquired infection.

Idiosyncratic Infection is any infection that occurs after admission and is the result of the patient’s action toward himself or herself.

**Patient Days:** 1612

**Hospital Associated Infections (HAI):** 3 – 5.2

- \*UTI
- \*Chalazion with conjunctivitis
- \*Abscess at injection site
- \* Tinea pedis
- \* URI

**Community Associated Infections (CAI):**

- \*Chronic dystrophic left great toe-prophylactic treatment
- \*Right second digit→erythema & abscess
- \*Recurrent facial cellulitis & Folliculitis Barbae→not counted
- \*Dental infection – 8
- \*Post surgical prophylaxis
- \*Chronic sinusitis
- \*Folliculitis
- \*Ingrown toe nail, early cellulitis left great toe
- \*Acne Rosacea
- \*Bilateral Upper Thigh Intertrigo
- \* Candida Intertrigo left breast
- \*Impetiginous rosacea with pustules & exudate
- \*Cellulitis right ear secondary to rosacea & folliculitis
- \*Laceration of forearm.-prophylactic treatment
- \*Prophylactic treatment of urinary incontinence
- \*Chronic dystrophic left great toe-prophylactic Rx
- \*Right second digit→erythema & abscess
- \*Recurrent Facial cellulitis & folliculitis Barbae>not counted
- \*Post surgical prophylaxis
- \*Chronic Sinusitis

**Summary:** The hospital associated infection rate (HAI) is within one standard deviation of the mean. No unusual infections. The community acquired infection rate (CAI) is significant for skin infections which are typically due to poor hygiene and/or chronic medical problems/conditions endogenous to the individual.

**Plan:** Continue total house surveillance.

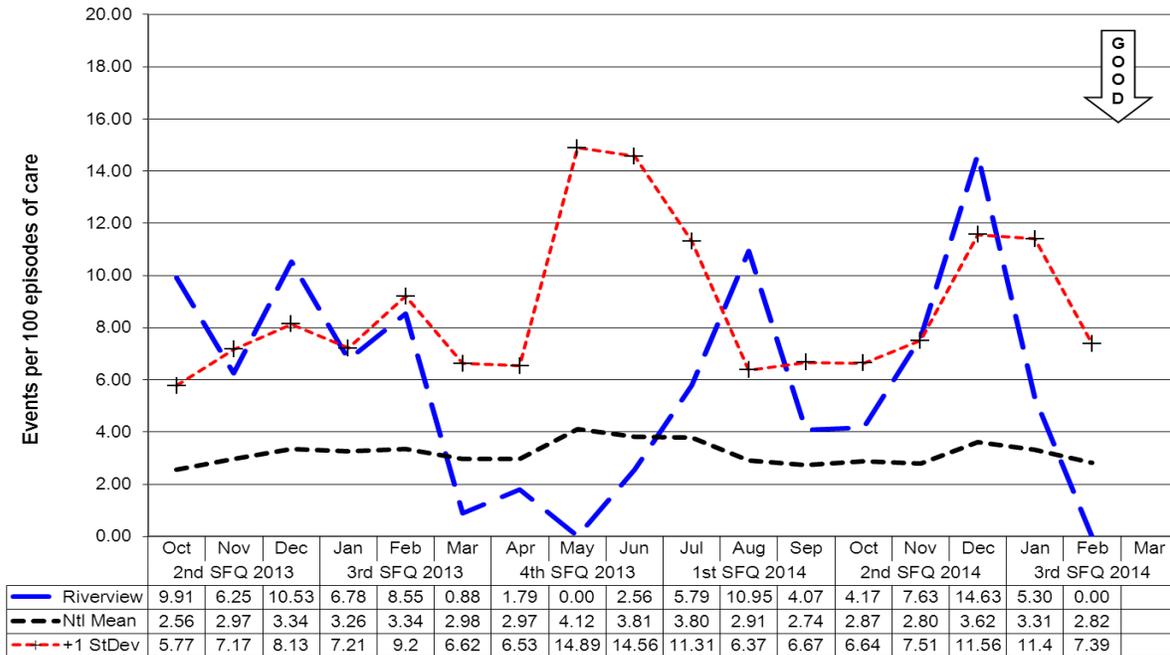
# JOINT COMMISSION

## Medication Management Medication Errors and Adverse Reactions

TJC PI.01.01.01 EP14: The hospital collects data on the following: Significant medication errors. (See also LD.04.04.01, EP 2; MM.08.01.01, EP 1)

TJC PI.01.01.01 EP15: The hospital collects data on the following: Significant adverse drug reactions. (See also LD.04.04.01, EP 2; MM.08.01.01, EP 1)

### Medication Errors



This graph depicts the 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.

**\*Please Note:** Due to an error with our Electronic Medical Record, Riverview medication error rates for January and February 2014 are not accurate. Please see page 54 for a complete list of medication errors during this time period. The graph will be updated to reflect accurate data in the next quarterly report.

# JOINT COMMISSION

Medication variances are classified according to four major areas related to the area of service delivery. The error must have resulted in some form of variance in the desired treatment or outcome of care. A variance in treatment may involve one incident but multiple medications; each medication variance is counted separately irrespective of whether it involves one error event or many. Medication error classifications include:

## Prescribing

An error of prescribing occurs when there is an incorrect selection of drug, drug dose, dosage form, quantity, route, concentration, rate of administration, or instructions for use of a drug product ordered or authorized by physician or other legitimate prescriber. Errors may occur due to improper evaluation of indications, contraindications, known allergies, existing drug therapy and other factors. Illegible prescriptions or medication orders that lead to client level errors are also defined as errors of prescribing. In identifying and ordering the appropriate medication to be used in the care of the client.

## Dispensing

An error of dispensing occurs when the incorrect drug, drug dose or concentration, dosage form, or quantity is formulated and delivered for use to the point of intended use.

## Administration

An error of administration occurs when there is an incorrect selection and administration of drug, drug dose, dosage form, quantity, route, concentration, rate of administration, or instructions for use of a drug product ordered or authorized by physician or other legitimate prescriber.

## Complex

An error which resulted from two or more distinct errors of different types is classified as a complex error.

## Review, Reporting and Follow-up Process

The Medication Variances Process Review Team (PRT) meets weekly to evaluate the causation factors related to the medication variances reported on the units and in the pharmacy and makes recommendations, through its multi-disciplinary membership, for changes to workflow, environmental factor, and client care practices. The team consists of the Medical Director (or designee), the Director of Nursing (or designee), the Director of Pharmacy (or designee), and the Clinical Risk Manager or the Performance Improvement Manager.

The activities and recommendations of the Medication Variances PRT are reported monthly to the Integrated Performance Excellence Committee.

# JOINT COMMISSION

## Medication Management - Administration Process Medication Errors Related to Staffing Effectiveness

<u>Date</u>	<u>OMIT</u>	<u>Co-mission</u>	<u>Float</u>	<u>New</u>	<u>O/T</u>	<u>Unit Acuity</u>	<u>Staff Mix</u>
1/5/2014	Y	TRANSCRIPTION	N	N	N	US	3 RN,5 MHW
1/11/2014	N	OMISSION X1	Y	N	N	US	3 RN,5 MHW
1/17/2014	N	TRANSCRIPTION	N	N	N	US	NOT AVAILABLE
1/17/2014	N	WRONG TIME	N	N	N	US	2 RN, 1 LPN, 4 MHW
1/17/2014	Y	TRANSCRIPTION	N	N	N	UK	NOT GIVEN
1/20/2014	N	OMISSION X1	N	N	N	UK	2 RN, 1 LPN, 4 MHW
1/20/2014	N	OMISSION X2	N	N	N	LS MAIN	NOT GIVEN
1/24/2014	Y	OMISSION X1	N	N	N	US	2 RN, 1 LPN, 6 MHW
1/27/2014	Y	MAR NOT SIGNED	N	N	N	US	NOT AVAILABLE
1/30/2014	N	OMISSION X1	Y	N	N	LK	1 RN, 1 LPN, MHW 4
2/3/2014	N	OMISSION X1	Y	N	N	LK	1 RN, 1 LPN, 4 MHW
2/3/2014	Y	OMISSION X1	N	N	N	UK	3 RN, 4 MHW
2/3/2014	N	OMISSION X1	N	N	N	LSSCU	1 RN, 4 MHW
2/4/2014	N	WRONG DOSE	N	N	N	LSSCU	4 RN, 7 MHW
2/10/2014	Y	OMISSION X1	N	N	N	US	3 RN, 6 MHW
2/11/2014	N	OMISSION X1	N	N	N	UK	NOT AVAILABLE
2/12/2014	Y	OMISSION X2	N	N	N	LK SCU	3 RN, 1 LPN, 6 MHW
2/14/2014	N	WRONG MED	N	N	N	US	3 RN, 4 MHW
2/15/2014	N	PHARMACY ERROR	N	N	N	US	NA
2/15/2014	N	WRONG TIME	N	N	N	LK	2 RN, 5 MHW
2/19/2014	N	PHARMACY ERROR	N	N	N	LS	3 RN, 1 LPN, 8 MHW
2/21/2014	Y	OMISSION X3/PA ERROR	N	N	N	US	NOT AVAILABLE
2/21/2014	Y	UNAPP ABBREV X6/PA ERROR	N	N	N	US	NA
2/21/2014	Y	PHARMACY ERROR	N	N	N	LS, LSSCU	NA
2/22/2014	N	OMISSION X1	N	N	N	UK	2 RN, 5 MHW
2/22/2014	N	WRONG DOSE ACETAMINOPHEN	N	Y	N	US	2 RN, 4 MHW
2/26/2014	y	WRONG TIME	Y	Y	N	LK	2 RN, 5 MHW
2/27/2014	N	PHARMACY ERROR	N	N	N	LS	4 RN, 1 LPN, 9 MHW
3/3/2014	N	WRONG TIME	Y	N	N	LS	4 RN, 1 LPN, 9 MHW
3/4/2014	N	WRONG TIME	N	N	N	LK	3 RN, 1 LPN, 7 MHW
3/4/2014	Y	WRONG TIME	N	N	N	US	2 RN, 6 MHW
3/5/2014	N	OMISSION X1	N	N	N	UK	2 RN, 1 LPN, 2 MHW
3/6/2014	Y	OMISSION X1	N	N	N	UK	2 RN, 1 LPN, 2 MHW
3/6/2014	N	CONTR. DRUG COUNT ERROR	N	N	N	UK	NOT AVAILABLE
3/7/2014	N	OMISSION X1	N	N	N	LSMAIN	3 RN, 3 MHW
3/11/2014	Y	PRESCRIBER ERROR	N	N	N	LS SCU	3 RN, 1 LPN, 7 MHW
3/12/2014	N	OMISSION X2	N	N	N	LK MAIN	3 RN, 1 LPN, 7 MHW
3/13/2014	N	GIVEN WITHOUT VALID ORDER	N	N	N	LS SCU	4 RN, 6 MHW
3/15/2014	N	OMISSION X2	N	N	N	LS SCU	4 RN, 1 LPN, 8 MHW
3/16/2014	N	WRONG DOSE ATIVAN	N	N	N	LS SCU	3 RN, 8 MHW

# JOINT COMMISSION

## Medication Management - Administration Process Medication Errors Related to Staffing Effectiveness

3/21/2014	N	WRONG TIME	N	N	N	LS MAIN	3 RN, 7 MHW		
3/24/2014	N	EXTRA DOSE TRAMADOL	Y	N	N	US	2 RN, 4 MHW		
3/24/2014	Y	PHARMACY ERROR	N	N	N	NA	3 RN, 1 LPN, 7 MHW		
3/24/2014	Y	NP PRESCRIBING ERROR	Y	Y	N	UK	2 RN, 3 MHW		
3/25/2014	N	OMISSION X1	N	N	N	US	4 RN, 1 LPN, 5 MHW		
3/26/2014	N	WRONG TIME	N	N	N	UK	3 RN, 4 MHW		
3/26/2014	Y	PRESCRIBER ERROR	N	N	N	LS MAIN	NOT AVAILABLE		
3/26/2014	Y	OMISSION X1-NOVOLOG	N	N	N	LS MAIN	3 RN, 6 MHW		
3/28/2014	Y	WRONG DOSE LACTAID	N	N	N	LK SCU	2 RN, 1 LPN, 6 MHW		
3/28/2014	Y	OMISSION X1	N	N	N	LS MAIN	1 RN, 3 MHW		
3/29/2014	Y	WRONG CLIENT	N	N	N	LS SCU	4 RN, 6 MHW		
3/30/2014	Y	EXTRA DOSE VALIUM	Y	Y	N	LS MAIN	3 RN, 7 MHW		
3/30/2014	Y	EXTRA DOSE ATIVAN	N	N	N	LS SCU	2 RN, 1 LPN, 6 MHW		
3/30/2014	Y	OMISSION X1	N	N	N	US	4 RN, 1 LPN, 5 MHW		
3/30/2014	N	OMISSION X1	N	N	N	US	4 RN, 1 LPN, 5 MHW		
<b>Totals</b>	<b>24</b>		<b>8</b>	<b>4</b>	<b>0</b>	<b>LS: 19</b>	<b>US: 17</b>	<b>LK: 8</b>	<b>UK: 10</b>
<b>Percent</b>	<b>43.64%</b>		<b>14.55%</b>	<b>7.27%</b>	<b>0.00%</b>	<b>34.55%</b>	<b>30.91%</b>	<b>14.55%</b>	<b>0.18%</b>

### Summary

There were a total of 55 medication errors this quarter (44 last quarter and 38 the quarter before). 23 medication errors were omissions, 8 medications were given at the wrong time, 7 were dose related, 5 were pharmacy errors, 3 were transcription related, 3 were prescriber errors, 1 was a medication given without a valid order, 1 was given to the wrong client, 1 was given the wrong medication, 1 was related to a controlled drug count error, 1 was an PA error, and 1 was MAR not signed. 8 of the medication errors were committed by staff floating to another unit or by staff who have been designated as "floats." 4 of the 55 errors were by new staff here at RPC.

### Actions

All nursing related medication errors were noted to have appropriate staffing levels. One of the actions to consider may be to return to a designated medication nurse for each unit. Nurse Pharmacy Committee meets monthly and is working towards identifying issues with medication management and identifying solutions to issues identified. Medication errors are reviewed weekly by Pharmacist, Medical Director, Risk Manager and Executive Nurse after the RN IV on the unit reviews the error with the staff person responsible for individual teaching and issue / process identification. Pharmacy is looking into different programs that can be added to Pyxis to help reduce the possibility of medications errors.

# JOINT COMMISSION

## Medication Management - Dispensing Process

Joint Commission Measures of Success								
Medication Management	Unit	Baseline 2013	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
<u>Controlled Substances Loss Data</u>	All		0%	0%	0%		0%	10 discrepancies between Pyxis and CII Safe transactions in Q3
<i>Daily Pyxis-CII Safe Compare Report</i>								
<b>Quarterly Results</b>			0.3%	0%	2.5%			
<i>Monthly CII Safe Vendor Receipt Report</i>	Rx	0	0	0	0	0	0	No discrepancies between CII Safe and vendor transactions for Q1,Q2,Q3
<b>Quarterly Results</b>			0	0	0			
<i>Monthly Pyxis Controlled Drug discrepancies</i>	All	11	0	0	0	0	0	Goal of "0" discrepancies involving controlled drugs dispensed from Pyxis
<b>Quarterly Results</b>			23	39	57			
<u>Medication Management Monitoring</u>								
<i>Measures of drug reactions, adverse drug events and other management data</i>	Rx	8/year	0	0	0	0		4 ADR's reported in Q3
<b>Quarterly Results</b>			1	2	4			
<i>Resource Documentation Reports of Clinical Interventions</i>	Rx	185 reports in 2013						100% of all clinical interventions are documented
<b>Quarterly Results</b>			79	86	120			
<u>Psychiatric Emergency Process</u>	All		N/A	N/A	100%	100%	100%	Goal of 100% compliance as measured by monthly audit tool
<i>Monthly audit of all psych emergencies measured against 9 criteria</i>								*2/1/14 to 2/25/14 and **2/26/14 to 3/24/14
<b>Quarterly Results</b>					*77% and **97%			

# STRATEGIC PERFORMANCE EXCELLENCE

## Pharmacy Services

Department: Pharmacy Responsible Party: Garry Miller, R.Ph.

### CMS Plan of Correction Tag #A-494 and Tag #A-506

Medication Management	Unit	Baseline Oct 2013	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
<u>Controlled Substances Records</u>	Lower Saco	100%	100%	100%	100%		100%	Goal of 100% compliance in tracking CII Safe transactions
<i>Monthly CII Safe Transactions Report Generated and Reviewed</i>								
<b>Quarterly Results</b>			100% (Oct)	100% (Nov&Dec)	100%			
<i>Monthly CII Safe Transactions Report Separately Maintained</i>	Rx	100%	100%	100%	100%			Transaction Reports separately maintained for Lower Saco
<b>Quarterly Results</b>			100% (Oct)	100% (Nov&Dec)	100%			
<u>After-Hours Drug Access Monitoring</u>								
<i>Monitor daily after-hours drug distribution reports</i>	Rx	100%	100%	100%	100%			Monitor daily after hours drug distribution reports to ensure compliance with policy
<b>Quarterly Results</b>			100% (Oct)	100% (Nov&Dec)	1			1 after-hours drug removed from Nitcab for Lower Saco during Q3

The key indicators in Medication Management are focused on preventing Controlled Substances loss and monitoring/trending of adverse drug reactions and clinical interventions. *Controlled Substances Loss* reviews two key reports generated by the Pyxis CII Safe which compare controlled drug transactions between the pharmacy's CII Safe and the various Pyxis Med stations; and, the purchasing data from our drug wholesaler and the corresponding CII Safe transactions. In both instances, we are looking for zero variation. *Medication Management Monitoring* is comprised of the reporting, review and monitoring of adverse drug reactions (ADR's) and Clinical Interventions as documented in the Resource Documentation tool to generate historical and graphical analysis which is reported to the P&T Committee regularly. TJC requires ongoing reporting and surveillance of adverse drug reactions, medication errors and medication related issues to the hospital wide performance improvement program with the goal of strategies to minimize their occurrence.

# JOINT COMMISSION

## **Inpatient Consumer Survey**

TJC PI.01.01.01 EP16: The hospital collects data on the following: Patient perception of the safety and quality of care, treatment, and services.

The **Inpatient Consumer Survey (ICS)** is a standardized national survey of customer satisfaction. The National Association of State Mental Health Program Directors Research Institute (NRI) collects data from state psychiatric hospitals throughout the country in an effort to compare the results of client satisfaction in five areas or domains of focus. These domains include Outcomes, Dignity, Rights, Participation, and Environment.

Inpatient Consumer Survey (ICS) has been recently endorsed by NQF, under the Patient Outcomes Phase 3: Child Health and Mental Health Project, as an outcome measure to assess the results, and thereby improve care provided to people with mental illness. The endorsement supports the ICS as a scientifically sound and meaningful measure to help standardize performance measures and assures quality of care.

### **Rate of Response for the Inpatient Consumer Survey**

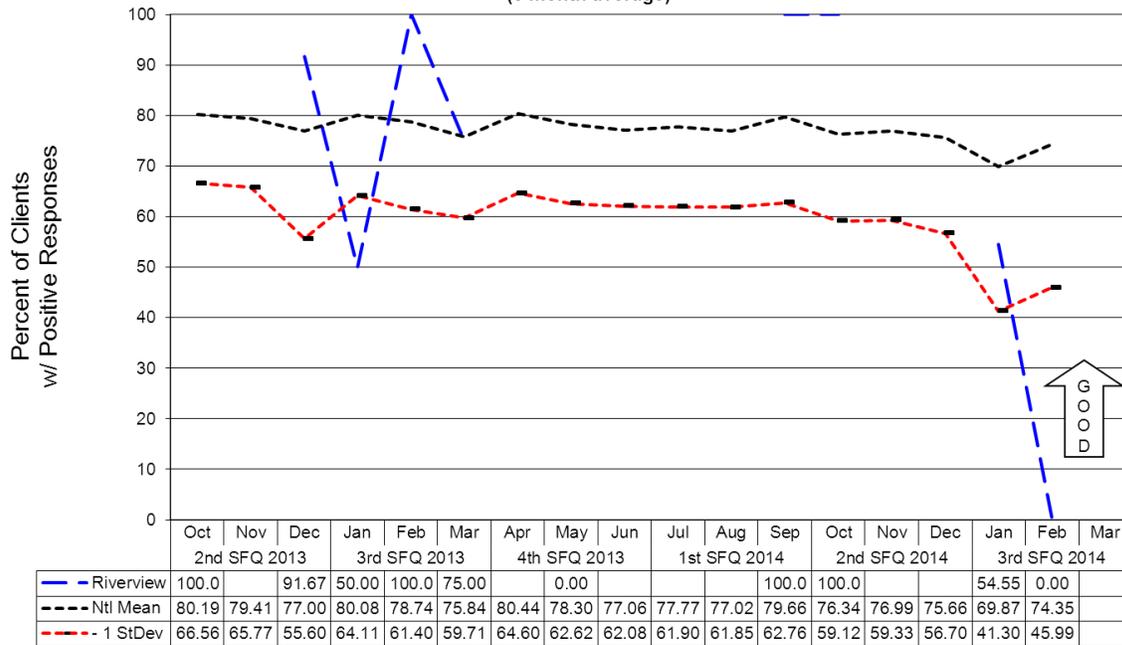
Due to the operational and safety need to refrain from complete openness regarding plans for discharge and dates of discharge for forensic clients, the process of administering the inpatient survey is difficult to administer. Whenever possible the peer support staff work to gather information from clients on their perception of the care provided to them while at Riverview Psychiatric Center.

The Peer Support group has identified a need to improve the overall response rate for the survey. This process improvement project is defined and described in the section on [Client Satisfaction Survey Return Rate](#) of this report.

There is currently no aggregated data on a forensic stratification of responses to the survey.

# JOINT COMMISSION

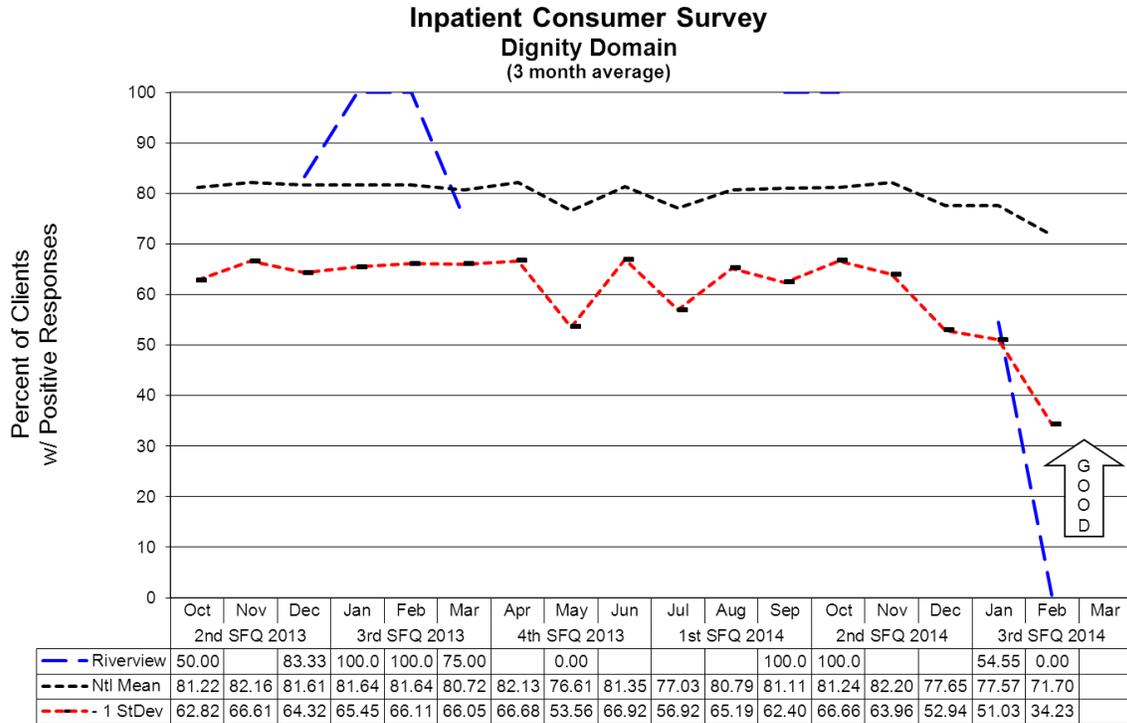
## Inpatient Consumer Survey Outcome Domain (3 month average)



### Outcome Domain Questions

1. I am better able to deal with crisis.
2. My symptoms are not bothering me as much.
3. I do better in social situations.
4. I deal more effectively with daily problems.

# JOINT COMMISSION

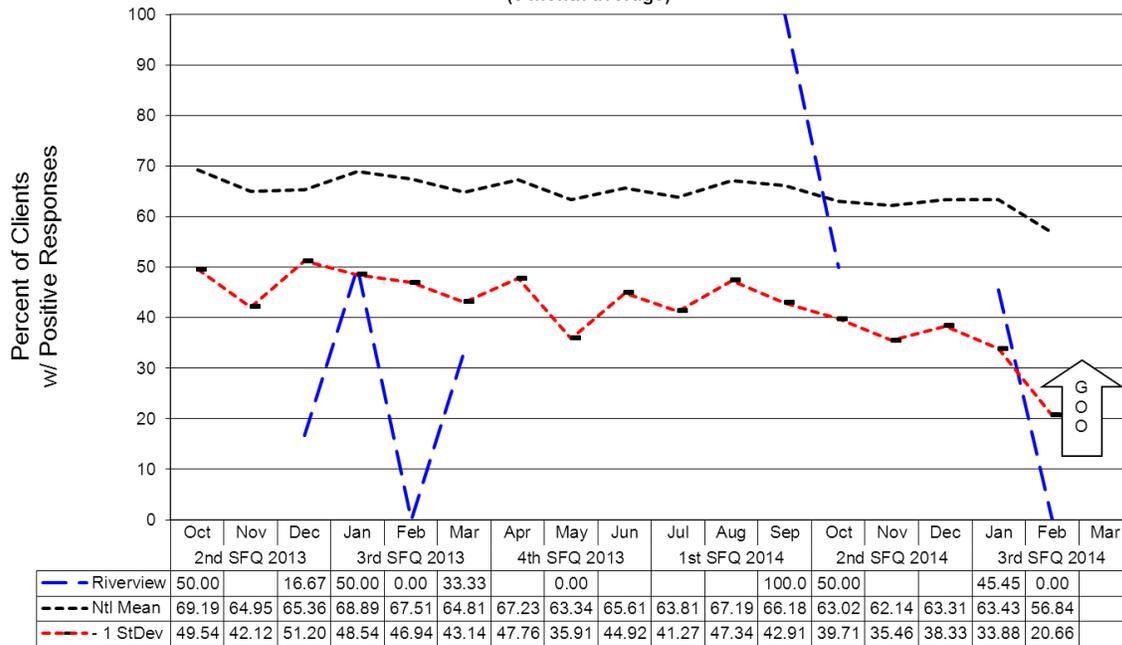


### Dignity Domain Questions

1. I was treated with dignity and respect.
2. Staff here believed that I could grow, change and recover.
3. I felt comfortable asking questions about my treatment and medications.
4. I was encouraged to use self-help/support groups.

# JOINT COMMISSION

**Inpatient Consumer Survey  
Rights Domain  
(3 month average)**

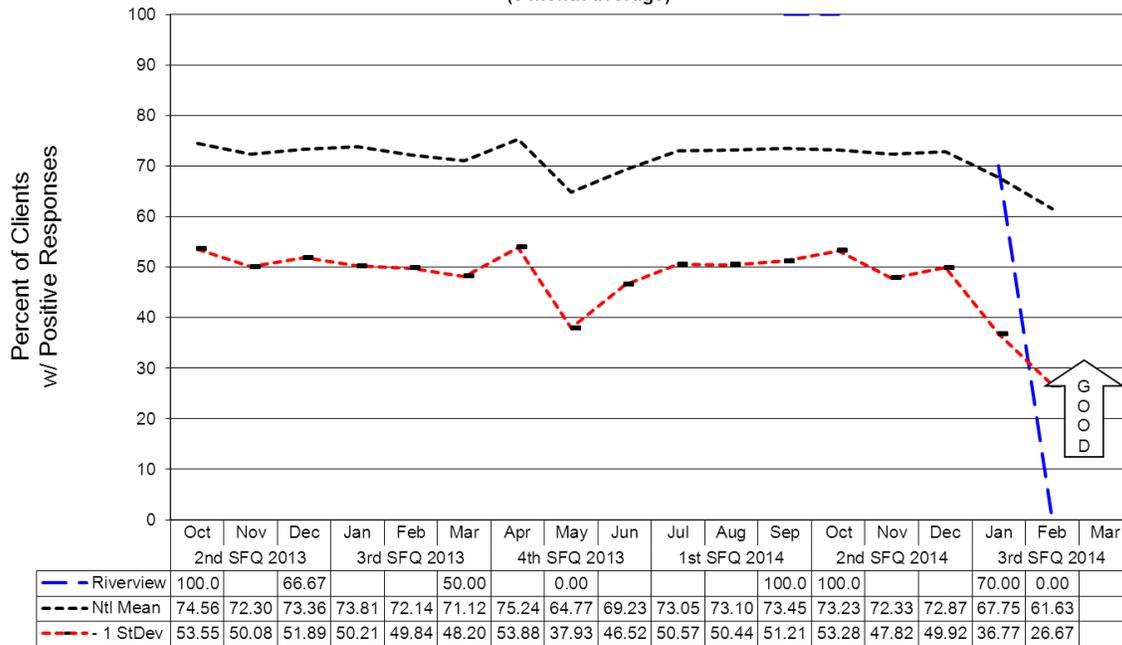


**Rights Domain Questions**

1. I felt free to complain without fear of retaliation.
2. I felt safe to refuse medication or treatment during my hospital stay.
3. My complaints and grievances were addressed.

# JOINT COMMISSION

**Inpatient Consumer Survey  
Participation Domain  
(3 month average)**

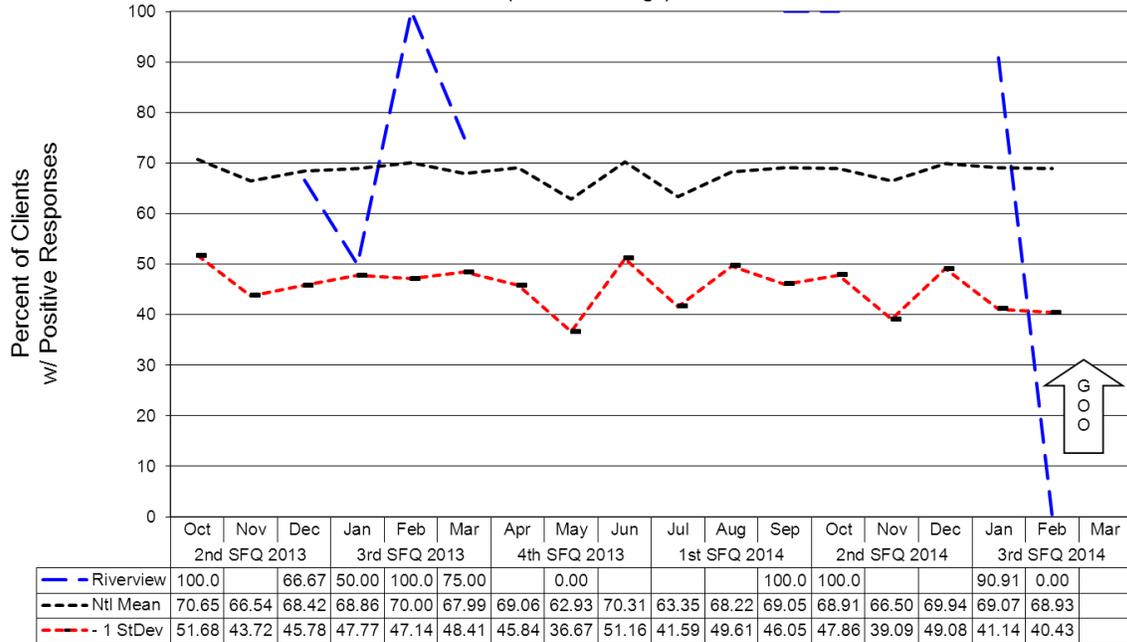


### Participation Domain Questions

1. I participated in planning my discharge.
2. Both I and my doctor or therapists from the community were actively involved in my hospital treatment plan.
3. I had an opportunity to talk with my doctor or therapist from the community prior to discharge.

# JOINT COMMISSION

**Inpatient Consumer Survey  
Environment Domain  
(3 month average)**



**Environment Domain**

1. The surroundings and atmosphere at the hospital helped me get better
2. I felt I had enough privacy in the hospital.
3. I felt safe while I was in the hospital.
4. The hospital environment was clean and comfortable.

Data aggregation on this domain began in October 2011. A trend analysis pattern related to this data is only now becoming apparent.

# JOINT COMMISSION

## Pain Management

TJC **PC.01.02.07**: The hospital assesses and manages the patient's pain.

Indicator	4Q2013	1Q2014	2Q2014	3Q2014
Pre-administration	68%	70%	74% 2774 of 3749	88% 3217 out of 3652
Post-administration	59%	60%	63% 2362 of 3749	78% 2866 out of 3652

### SUMMARY

Both “Pre” and “Post” assessments continue to be up from previous quarters. The number of pain medications given this quarter is slightly lower than the previous quarter (3652 PRN meds for pain this quarter compared to 3749 PRN pain meds last quarter).

### ACTIONS

Will meet with the clinical managers to let them know that nursing needs to be more vigilant about assessing pre and post administration pain assessment. Will recommend having the oncoming shift check with the off going shift for any pain meds given that may need an assessment. Pharmacy is looking at future possibilities with Pyxis to see if a program can be installed that will alert nurses that an assessment is due/ needed.

# JOINT COMMISSION

## Fall Reduction Strategies

TJC PI.01.01.01 EP38: The hospital evaluates the effectiveness of all fall reduction activities including assessment, interventions, and education.

TJC PC.01.02.08 The hospital assesses and manages the patient's risks for falls.

EP01: The hospital assesses the patient's risk for falls based on the patient population and setting.

EP02: The hospital implements interventions to reduce falls based on the patient's assessed risk.

Falls Risk Management Team has been created to be facilitated by a member of the team with data supplied by the Risk Manager. The role of this team is to conduct root cause analyses on each of the falls incidents and to identify trends and common contributing factors and to make recommendations for changes in the environment and process of care for those clients identified as having a high potential for falls.

### Type of Fall by Client and Month

Fall Type	Client	JAN	FEB	MAR	3Q2014
Un-witnessed	MR1883			1	1
	MR7358		1		1
	MR7340		1		1
	MR6868			1	1
	MR4814*	1			1
	MR0102			1	1
	MR4946*	1			1
	MR7452		1		1
	MR7489			1	1
	MR3120*			1	1
MR6963*	2			2	

Witnessed	MR7363			1	1
	MR4814*	5			5
	MR4946*			1	1
	MR6963*	2			2
	MR3120*			1	1

\* Clients have experienced both witnessed and un-witnessed falls during the reporting quarter.

### Review, Reporting and Follow-up Process

The Falls Assessment and Prevention Process Review Team (PRT) meets monthly to evaluate the causation factors related to the falls reported on the units and makes recommendations, through its multi-disciplinary membership, for changes to workflow, environmental factor, and client care practices.

The activities and recommendations of the Falls PRT are reported monthly to the Integrated Performance Excellence Committee.

# JOINT COMMISSION

## Measures of Success

### CTS.01.04.01

**For organizations that serve adults with serious mental illness. The organization documents whether the adult has a psychiatric advance directive.**

**Responsible for Reporting: Director of Social Work/ACT Director**

#### Corrective Action Taken:

WHO: The ACT Program Director is ultimately responsible for the corrective action and overall and ongoing compliance.

WHAT: Staff training was conducted in bi-weekly administrative meeting directing all case managers to use standard Disability Rights Psychiatric (Mental Health) Advanced Directive form and to date completion or declination to complete directive.

WHEN: Care, Treatment and Services issue was discussed with case managers in all-staff meeting 12-27-13, document to be used was copied and placed in admission and annual documentation folder.

HOW: The Program Director and Team Leader will perform bi-weekly reviews of charts to assess ongoing compliance, reporting findings to staff in bi-weekly administrative meetings.

Evaluation Method: Plan for assessing effectiveness of the corrective action taken:

- Sample size: Based on an ADC of 50, 30 records will be selected using random selection.
- Random sampling method used will be to identify six charts from 5 total shelves by selecting every other chart from right to left until 30 are identified.
- Frequency of the audit will be bi-weekly, reviewing six to eight charts per session, totaling up to 48 charts reviewed by the end of four months.
- Monitor for four consecutive months (expectation a minimum of 90% compliance)
- 30 = total number of charts reviewed for psychiatric advanced directives
- 28= total number of psychiatric advanced directives present in the chart or documented as having been offered but declined by client.
- The audit results will be reported by the program Director and Team Leader to the staff at each administrative meeting, the IPEC Committee, as well as to the Social Work Program Director.

#### **RESULTS:**

***After monitoring 1-2-14 until present, the total records reviewed =42 from bi-weekly audits.***

***Of the 42 records, 21 (50%) had indicated in documentation that clients declined psychiatric advanced directives, 9 (23%) were lacking documentation and 12 (27%) had documented psychiatric advanced directives but were not all the same kind.***

***The Team will consistently use the DRC psychiatric advanced directives with clients from 2014 forward.***

# JOINT COMMISSION

## Measures of Success

### CTS.02.02.07

**The organization reassesses each individual served, as needed**

**Responsible for Reporting: Director of Social Work/ACT Director**

#### Corrective Action Taken:

WHO: The ACT Program Director is ultimately responsible for the corrective action and overall ongoing compliance.

WHAT: Staff training was conducted in bi-weekly administrative meeting identifying the discovery of Annual Comprehensive Assessments being worded exactly the same as the previous year, and the necessity of writing new annual assessments for each client including any changes in progress or functioning. It was also identified that there was a missing Annual Comprehensive Assessment in one reviewed record, the standard of keeping at least the current and past year's Annual Comprehensive Evaluation was reiterated.

WHEN: This corrective action was also conducted in a bi-weekly administrative meeting on 12-27-13. No further procedures or policies were needed.

HOW: The Program Director and Team Leader will perform bi-weekly reviews of records to assess ongoing compliance, reporting findings to staff in bi-weekly administrative meetings for immediate correction, if indicated.

Evaluation Method: Plan for assessing effectiveness of the corrective action taken:

- Sample size: Based on an ADC of 50, 30 records will be selected using random selection.
- Random sampling method used will be to identify six charts from 5 total shelves by selecting every other chart from left to right until 30 are identified.
- Frequency of the audit will be bi-weekly, reviewing six to eight charts per session, totaling up to 48 charts reviewed by the end of four months.
- Monitor for four consecutive months (expectation a minimum of 90% compliance)
- 30 = total number of charts reviewed for presence and accuracy of Comprehensive Annual Assessment
- 28= minimum total number of Comprehensive Annual Assessments present in the chart and distinct from previous year.
- The audit results will be reported by the program Director and Team Leader to the staff at each administrative meeting, the IPEC Committee, as well as to the Social Work Program Director.

#### **RESULTS:**

**42 Charts were reviewed, 70% had updated comprehensive assessments, 20% were present but outdated and 10% were missing (not entered by ACT, RPC Comprehensive Assessment was in referral packet).**

**Case Managers have been individually notified as well as in Administrative meeting bi-weekly, and are meeting with clients to complete missing and outdated assessments within 2-3 weeks of notification.**

# JOINT COMMISSION

## Measures of Success

### HR.01.06.01

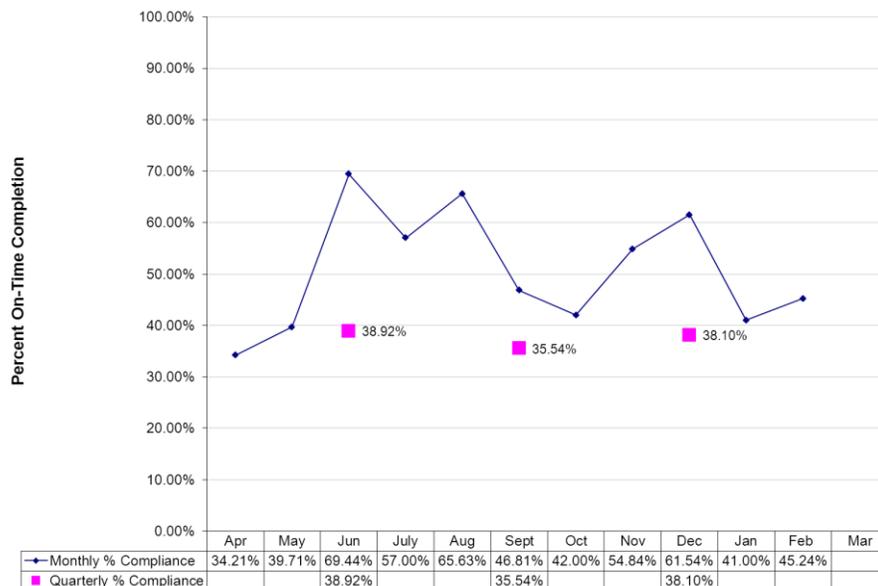
Staff competence is assessed and documented once every three years, or more frequently as required by organization policy or in accordance with law and regulation.

Responsible for Reporting: HR Director

Performance appraisals are not being accepted by Human Resources without the competency attached. If the competency is not attached the entire appraisal is being handed back to the person turning it in.

	December 2014	January 2014	February 2014	Total
Performance evaluations completed on time (with competency assessment)	24	13	19	56
Performance evaluations late (with competency assessment)	39	32	42	113
Evaluation Compliance	61.54%	41%	45.24%	49.56%

Performance Evaluation Compliance



# JOINT COMMISSION

## Measures of Success

### EC.02.01.01

The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment.

**Responsible for Reporting:** Director of Support Services

**INDICATOR:** Faucet Checks

**FINDING:** *EC.02.01.01 The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment.*

**OBJECTIVE:** Have all bathrooms checked every 7 ½ minutes for patient safety (ligature) until faucets have been replaced with an approved anti-ligature model.

**THOSE RESPONSIBLE FOR MONITORING:** Clinical staff and Director of Support Services

**METHODS OF MONITORING:** Monitoring would be performed by:

- Direct observation for each bathroom by Clinical Staff

**METHODS OF REPORTING:** Reporting would occur by the following method:

- Daily activity bathroom faucet check sheets

**THOSE RESPONSIBLE FOR REPORTING:** Director of Support Services

**UNIT:** Number of actual checks / number of potential checks on all identified ligature problematic faucets on each patient unit.

**Stated Goal:** 90%

# JOINT COMMISSION

## Measures of Success

### EC.02.01.01, continued.

Bathroom Faucet Checks	Unit	Stated Goal	January	Actual % for January	February	March	Actual % for Quarter
<b>Lower Kennebec Unit</b>							
The denominator is the total of potential checks for the month on all unit faucets in this patient area. The numerator is all faucets checked daily every 7 1/2 minutes. Any blanks on the faucet check sheet will count as a missed check. Monitoring of the checks will start January 2014 and continue for four months or until the faucets have been replaced.	$\frac{\text{\# of actual checks}}{\text{\# of potential checks}}$	90% of bathroom checks completed	5947	99.9%	† See below	† See below	99.9%
			5952				

### SUMMARY OF EVENTS

► **The Lower Kennebec Unit met the goal of greater than 90% for this quarter.**

† All faucets that were identified as a ligature risk were all replaced by 1/31/14 on the Lower Kennebec Unit. (Work Order # 11312). There were no required checks needed after that date.

Bathroom Faucet Checks	Unit	Stated Goal	January	Actual % for January	February	Actual % for February	March	Actual % for Quarter
<b>Upper Kennebec Unit</b>								
The denominator is the total of potential checks for the month on all unit faucets in this patient area. The numerator is all faucets checked daily every 7 1/2 minutes. Any blanks on the faucet check sheet will count as a missed check. Monitoring of the checks will start January 2014 and continue for four months or until the faucets have been replaced.	$\frac{\text{\# of actual checks}}{\text{\# of potential checks}}$	90% of bathroom checks completed	5904	99.2%	4718	99.5%	† See below	99.35%
			5952		4739			

### SUMMARY OF EVENTS

► **The Upper Kennebec Unit met the goal of greater than 90% for this quarter.**

† All faucets that were identified as a ligature risk were all replaced by 2/28/14 on the Upper Kennebec Unit. (Work Order # 11313). There were no required checks needed after that date.

# JOINT COMMISSION

## Measures of Success

### EC.02.01.01, continued.

Bathroom Faucet Checks	Unit	Stated Goal	January	Actual % for January	February	Actual % for February	March	Actual % for March	Actual % for Quarter
<b>Upper Saco Unit</b>									
<p>The denominator is the total of potential checks for the month on all unit faucets in this patient area. The numerator is all faucets checked daily every 7 1/2 minutes. Any blanks on the faucet check sheet will count as a missed check. Monitoring of the checks will start January 2014 and continue for four months or until the faucets have been replaced.</p>	<u># of actual checks</u>	90% of bathroom checks completed	<u>5934</u>	99.7%	<u>4704</u>	99.3%	<u>2688</u>	<u>100%</u>	<b>99.67%</b>
	# of potential checks		5952	4739	2688	† See below			

### SUMMARY OF EVENTS

► **The Upper Saco Unit met the goal of greater than 90% for this quarter.**

† All faucets, but 2 bathroom locations that were identified as a ligature risk were all replaced by 3/14/14 on the Upper Saco Unit. (Work Order # 11315). The unit continues to do checks on the 2 other bathroom locations.

# JOINT COMMISSION

## Measures of Success

### EC.02.01.01, continued.

Bathroom Faucet Checks	Unit	Stated Goal	January	Actual % for January	February	Actual % for February	March	Actual % for Quarter
<b>Lower Saco Unit</b>								
The denominator is the total of potential checks for the month on all unit faucets in this patient area. The numerator is all faucets checked daily every 7 1/2 minutes. Any blanks on the faucet check sheet will count as a missed check. Monitoring of the checks will start January 2014 and continue for four months or until the faucets have been replaced.	# of actual checks	90% of bathroom checks completed	5888	98.9%	4697	99.1%	† See asterisk below	99%
	# of potential checks		5952		4739			

### SUMMARY OF EVENTS

► **The Lower Saco Unit met the goal of greater than 90% for this quarter.**

† All faucets that were identified as a ligature risk were all replaced by 2/10/14 on the Lower Saco Unit. (Work Order # 11314). There were no required checks needed after that date.

# JOINT COMMISSION

## Measures of Success

### ED.02.06.01

Interior spaces meet the need of the patient population and are safe and suitable to the care, treatment, and services provided.

**Responsible for Reporting:** Director of Support Services

**INDICATOR:** Bedroom Ligature / Oxygen Storage Assessments

**FINDING:** *EC.02.06.01 Interior spaces meet the need of the patient population and are safe and suitable to the care, treatment, and services provided.*

**OBJECTIVE:** (1) Have all bedrooms checked throughout the hospital for any ligature risks every month  
(2) Check each unit for proper oxygen storage, ensuring that empty tanks are segregated from full tanks and labelled accordingly.

**THOSE RESPONSIBLE FOR MONITORING:** Director of Support Services

**METHODS OF MONITORING:** Monitoring would be performed by:

- Direct observation of each bedroom for any ligature risks
- Direct observation of proper storage of oxygen canisters

**METHODS OF REPORTING:** Reporting would occur by the following method:

- Monthly activity using the Bedroom Ligature / Oxygen Storage Assessment check sheets

**THOSE RESPONSIBLE FOR REPORTING:** Director of Support Services

**UNIT:** Perform bedroom ligature / Oxygen Storage Assessments

**Stated Goal:** 100%

# JOINT COMMISSION

## Measures of Success

### ED.02.06.01, continued.

Bedroom Ligature / Oxygen Storage Checks	Unit	Stated Goal	Jan	Actual % for Jan	Feb	Actual % for Feb	Mar	Actual % for Mar	Actual % for Quarter
<p><b>Lower Kennebec Unit</b></p> <p>The Director of Support Services (or his designee) will perform monthly environment of care rounds (January 2014 thru April 2014) and assess ongoing compliance for both findings. The rounds consist of inspecting every patient room for oxygen tubing or other potential ligature evident in the room and ensuring the oxygen tanks are properly stored. The Director of Support Services will report findings to the monthly meeting of the Environment of Care Committee and the monthly meeting of IPEC (quality committee) under the "safety" agenda item.</p>	Perform bedroom ligature / Oxygen Storage Assessments	100% of checks completed	Monthly Check completed	100%	Monthly Check completed	100%	Monthly Check completed	100%	100%

### SUMMARY OF EVENTS

► The Lower Kennebec Unit met the goal of 100% for this quarter.

# JOINT COMMISSION

## Measures of Success

### ED.02.06.01, continued.

Bedroom Ligature / Oxygen Storage Checks	Unit	Stated Goal	Jan	Actual % for Jan	Feb	Actual % for Feb	Mar	Actual % for Mar	Actual % for Quarter
<p><b>Upper Kennebec Unit</b></p> <p>The Director of Support Services (or his designee) will perform monthly environment of care rounds (January 2014 thru April 2014) and assess ongoing compliance for both findings. The rounds consist of inspecting every patient room for oxygen tubing or other potential ligature evident in the room and ensuring the oxygen tanks are properly stored. The Director of Support Services will report findings to the monthly meeting of the Environment of Care Committee and the monthly meeting of IPEC (quality committee) under the "safety" agenda item.</p>	Perform bedroom ligature / Oxygen Storage Assessments	100% of checks completed	Monthly Check completed	100%	Monthly Check completed	100%	Monthly Check completed	100%	100%

### SUMMARY OF EVENTS

► The Upper Kennebec Unit met the goal of 100% for this quarter.

# JOINT COMMISSION

## Measures of Success

### ED.02.06.01, continued.

Bedroom Ligature / Oxygen Storage Checks	Unit	Stated Goal	Jan	Actual % for Jan	Feb	Actual % for Feb	Mar	Actual % for Mar	Actual % for Quarter
<p><b>Upper Saco Unit</b></p> <p>The Director of Support Services (or his designee) will perform monthly environment of care rounds (January 2014 thru April 2014) and assess ongoing compliance for both findings. The rounds consist of inspecting every patient room for oxygen tubing or other potential ligature evident in the room and ensuring the oxygen tanks are properly stored. The Director of Support Services will report findings to the monthly meeting of the Environment of Care Committee and the monthly meeting of IPEC (quality committee) under the "safety" agenda item.</p>	Perform bedroom ligature / Oxygen Storage Assessments	100% of checks completed	Monthly Check completed	100%	Monthly Check completed	100%	Monthly Check completed	100%	100%

### SUMMARY OF EVENTS

► The Upper Saco Unit met the goal of 100% for this quarter.

# JOINT COMMISSION

## Measures of Success

### ED.02.06.01, continued.

Bedroom Ligature / Oxygen Storage Checks	Unit	Stated Goal	Jan	Actual % for Jan	Feb	Actual % for Feb	Mar	Actual % for Mar	Actual % for Quarter
<b>Lower Saco Unit</b>									
The Director of Support Services (or his designee) will perform monthly environment of care rounds (January 2014 thru April 2014) and assess ongoing compliance for both findings. The rounds consist of inspecting every patient room for oxygen tubing or other potential ligature evident in the room and ensuring the oxygen tanks are properly stored. The Director of Support Services will report findings to the monthly meeting of the Environment of Care Committee and the monthly meeting of IPEC (quality committee) under the "safety" agenda item.	Perform bedroom ligature / Oxygen Storage Assessments	100% of checks completed	Monthly Check completed	100%	Monthly Check completed	100%	Monthly Check completed	100%	100%

### SUMMARY OF EVENTS

► The Lower Saco Unit met the goal of 100% for this quarter.

# JOINT COMMISSION

## Measures of Success

### MM.03.01.01

The hospital stores medications according to manufacturers' recommendations, or in the absence of such recommendations, according to a pharmacist's instructions.

**Responsible for Reporting: Director of Nursing**

The hospital stores medications according to the manufacturer's recommendations or, in the absence of such recommendations, according to a pharmacist's instructions.

Refrigerator temperatures are monitored on each unit for four consecutive months until 90% compliance is achieved.

Unit	February		March		April	May
Lower Kennebec – Main	28/28	100%	31/31	100%		
Lower Kennebec – SCU	28/28	100%	31/31	100%		
Lower Saco – Main	28/28	100%	31/31	100%		
Lower Saco – SCU	28/28	100%	31/31	100%		
Upper Kennebec	28/28	100%	30/31	97%		
Upper Saco	27/28	96%	31/31	100%		
<b>TOTAL</b>	<b>167/168</b>	<b>99%</b>	<b>185/186</b>	<b>99%</b>		

# JOINT COMMISSION

## Measures of Success

### PC.02.01.15

Care, treatment and services are provided to the patient in an interdisciplinary, collaborative manner.

Responsible for Reporting: Clinical Director

**ASPECT: CHART REVIEW EFFECTIVENESS  
JANUARY, FEBRUARY, MARCH 2014**

**LOWER KENNEBEC**

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	10 15	67%
2. STGs/ Interventions relate directly to content of GAP note.	15 of 15	100%
3. Weekly Summary note completed.	7 of 15	47%
4. BMI on every Treatment Plan.	15 of 15	100%
5. Diabetes education Teaching checklist shows documentation of client teaching (diabetic clients)	1 of 15 14 N/A	100%
6. Multidisciplinary Teaching checklist active being completed.	14 of 15	93%
7. Dental education Teaching checklist	14 of 15	93%

**ASPECT: CHART REVIEW EFFECTIVENESS  
JANUARY, FEBRUARY, MARCH 2014**

**UPPER KENNEBEC**

Indicators	Findings	Compliance
8. GAP note written in appropriate manner at least every 24 hours	13 of 15	87%
9. STGs/ Interventions relate directly to content of GAP note.	15 of 15	100%
10. Weekly Summary note completed.	15 of 15	100%
11. BMI on every Treatment Plan.	15 of 15	100%
12. Diabetes education Teaching checklist shows documentation of client teaching (diabetic clients)	2 of 15 13 N/A	100%
13. Multidisciplinary Teaching checklist active being completed.	14 of 15	93%
14. Dental education Teaching checklist	14 of 15	93%

# JOINT COMMISSION

## Measures of Success

PC.02.01.15, continued.

**ASPECT: CHART REVIEW EFFECTIVENESS  
JANUARY, FEBRUARY, MARCH 2014**

**LOWER SACO**

<b>Indicators</b>	<b>Findings</b>	<b>Compliance</b>
15. GAP note written in appropriate manner at least every 24 hours	13 of 15	87%
16. STGs/ Interventions relate directly to content of GAP note.	15 of 15	100%
17. Weekly Summary note completed.	5 of 15	33%
18. BMI on every Treatment Plan.	15 of 15	100%
19. Diabetes education Teaching checklist shows documentation of client teaching (diabetic clients)	3 of 15 12 N/A	100%
20. Multidisciplinary Teaching checklist active being completed.	15 of 15	100%
21. Dental education Teaching checklist	13 of 15	87%

**ASPECT: CHART REVIEW EFFECTIVENESS  
JANUARY, FEBRUARY, MARCH 2014**

**UPPER SACO**

<b>Indicators</b>	<b>Findings</b>	<b>Compliance</b>
22. GAP note written in appropriate manner at least every 24 hours	11 of 15	73%
23. STGs/ Interventions relate directly to content of GAP note.	15 of 15	100%
24. Weekly Summary note completed.	15 of 15	100%
25. BMI on every Treatment Plan.	15 of 15	100%
26. Diabetes education Teaching checklist shows documentation of client teaching (diabetic clients)	1 of 15 14 N/A	100%
27. Multidisciplinary Teaching checklist active being completed.	14 of 15	93%
28. Dental education Teaching checklist	11 of 15	73%

# JOINT COMMISSION

## Measures of Success

### PC.02.03.03

The hospital helps the patient with his or her personal hygiene and grooming activities.

Responsible for Reporting: Director of Nursing

Unit: Lower Kennebec

Hand Hygiene Measure: Staff will offer hand gel to clients prior to breakfast, lunch and dinner on 24 days per month.

Hand Hygiene Measure: Staff will measure client hand hygiene practice at breakfast, lunch and dinner on 24 days per month.

	Dec. 2013	Jan. 2014	February	March	April	May	June
Hand gel offered at breakfast 24 days/month	7/24 =29%	21/24=88%	18/24=75%	7/24=30%			
Number of Clients	112	246	216	85			
Number of Clients offered	112	246=100%	143=66%	85=100%			
Number of Clients washed	23	88	67	36			
Compliance Rate – How many clients washed?	21%	36%	31%	42%			
		Third Quarter Client HH Rate: 35%			Fourth Quarter Client HH Rate:		
		Third Quarter Data Collection: 64%			Fourth Quarter Data Collection:		
Hand gel offered at lunch 24 days/month	7/24=29%	19/24=79%	18/24=75%	7/24=30%			
Number of Clients	105	245	196	101			
Number of Clients offered	105	245=100%	196=100%	101=100%			
Number of Clients washed	24	123	139	22			
Compliance Rate – How many washed?	23%	50%	71%	22%			
		Third Quarter Client HH Rate: 48%			Fourth Quarter Client HH Rate::		
		Third Quarter Data Collection: 61%			Fourth Quarter Data Collection:		
Hand gel offered at dinner 24 days/month	21/24=88%	22/24=92%	19/24=79%	21/24=88%			
Number of Clients	145	223	167	217			
Number of Clients offered	145	223=100%	167=100%	190=88%			
Number of Clients washed	45	80	147	162			
Compliance Rate – How many washed?	31%	36%	88%	75%			
		Third Quarter Client HH Rate 66%			Fourth Quarter Client HH Rate::		
		Third Quarter Data Collection: 86%			Fourth Quarter Client HH Rate:		

# JOINT COMMISSION

## Measures of Success

### PC.02.03.03, continued.

#### Unit: Lower Kennebec SCU

**Hand Hygiene Measure:** Staff will offer hand gel to clients prior to breakfast, lunch and dinner on 24 days per month.

**Hand Hygiene Measure:** Staff will measure client hand hygiene practice at breakfast, lunch and dinner on 24 days per month.

	Dec. 2013	Jan. 2014	February	March	April	May	June
Hand gel offered <b>at breakfast</b> 24 days/month	6/24=25%	2/24=8%↓	3/24=13%	5/24=21%			
Number of Clients	25	5	16	24			
Number of Clients offered	25	5=100%	16=100%	18=75%			
Number of Clients washed	7	4	6	2			
Compliance Rate – <b>How many clients washed?</b>	28%	80%	38%	8%			
				Third Quarter HH Rate: 27%		Fourth Quarter HH Rate:	
				Third Quarter Data Collection: 14%		Fourth Quarter Data Collection:	
Hand gel offered <b>at lunch</b> 24 days/month	6/24=25%	2/24=8%↓	3/24=13%	4/24=17%			
Number of Clients	24	5	17	14			
Number of Clients offered	24	5=100%	17=100%	8=57%			
Number of Clients washed	7	4	8	4			
Compliance Rate – <b>How many washed?</b>	29%	80%	47%	50%			
				Third Quarter HH Rate: 44%		Fourth Quarter HH Rate:	
				Third Quarter Data Collection: 13%		Fourth Quarter Data Collection:	
Hand gel offered <b>at dinner</b> 24 days/month	9/24=38%	3/24=13%↓	7/24=21%	9/24=38%			
Number of Clients	39	11	52	64			
Number of Clients offered	39	11=100%	52=100%	64=100%			
Number of Clients washed	12	6	26	16			
Compliance Rate – <b>How many washed?</b>	31%	55%	50%	25%			
				Third Quarter HH Rate: 39%		Fourth Quarter HH Rate:	
				Third Quarter Data Collection: 24 %		Fourth Quarter Data Collection:	

# JOINT COMMISSION

## Measures of Success

**PC.02.03.03, continued.**

**Unit: Upper Kennebec**

**Hand Hygiene Measure:** Staff will offer hand gel to clients prior to breakfast, lunch and dinner on 24 days per month.

**Hand Hygiene Measure:** Staff will measure client hand hygiene practice at breakfast, lunch and dinner on 24 days per month.

	Dec. 2013	Jan. 2014	February	March	April	May	June
Hand gel offered <b>at breakfast</b> 24 days/month	↑	0	0	0			
Number of Clients		18	19	22			
Number of Clients offered		0	0	0			
Number of Clients washed		0	0	0			
9Compliance Rate - <b>How many clients washed?</b>		0	0	0			
		Third Quarter HH Rate: 0			Fourth Quarter HH Rate:		
		Data Collection: 0			Fourth Quarter Data Collection:		
Hand gel offered <b>at lunch</b> 24 days/month		0	0	0			
Number of Clients		18	19	22			
Number of Clients offered		0	0	0			
Number of Clients washed		0	0	0			
Compliance Rate – <b>How many washed?</b>		0	0	0			
		Third Quarter HH Rate:: 0			Fourth Quarter HH Rate:		
		Data Collection: 0			Data Collection:		
Hand gel offered <b>at dinner</b> 24 days/month		0	0	0			
Number of Clients		18	19	22			
Number of Clients offered		0	0	0			
Number of Clients washed	↓	0	0	0			
Compliance Rate – <b>How many washed?</b>		0	0	0			
		Third Quarter HH Rate: 0			Fourth Quarter HH Rate::		
		Third Quarter Data Collection: 0			Fourth Quarter Data Collection:		

# JOINT COMMISSION

## Measures of Success

### PC.02.03.03, continued.

Unit: Lower Saco

**Hand Hygiene Measure:** Staff will offer hand gel to clients prior to breakfast, lunch and dinner on 24 days per month.

**Hand Hygiene Measure:** Staff will measure client hand hygiene practice at breakfast, lunch and dinner on 24 days per month.

	Dec. 2013	Jan. 2014	February	March	April	May	June
Hand gel offered <b>at breakfast</b> 24 days/month	16/24=67%	24/24=100%↑	8/24=33%↓	13/24=54%			
Number of Clients	164	335	97	160			
Number of Clients offered	164=100%	330=99%↓	69=71%↓	160=100%			
Number of Clients washed	53	141	41	65			
Compliance Rate - <b>How many clients washed?</b>	32%	42%	42%	41%			
	Third Quarter HH Rate: 42%				Fourth Quarter HH Rate:		
	Third Quarter Data Collection: 94%				Fourth Quarter Data Collection:		
Hand gel offered <b>at lunch</b> 24 days/month	12/24=50%	24/24=100%	8/24=33%	13/24=54%			
Number of Clients	127	334	99	162			
Number of Clients offered	127=100%	333=98%	71=72%	162=100%			
Number of Clients washed	48	170	48	67			
Compliance Rate – <b>How many washed?</b>	38%	52%↑	68%↑	41%			
	Third Quarter HH Rate: 54%				Fourth Quarter HH Rate:		
	Third Quarter Data Collection: 95%				Fourth Quarter Data Collection:		
Hand gel offered <b>at dinner</b> 24 days/month	18/24=75%	23/24=96%↑	11/24=46%↓	11/24=45%			
Number of Clients	189	384	136	136			
Number of Clients offered	189=100%	384=100%	136=100%	136=100%			
Number of Clients washed	44	109	56	57			
Compliance Rate – <b>How many washed?</b>	23%	28%↑	42%↑	42%			
	Third Quarter HH Rate: 37%				Fourth Quarter HH Rate:		
	Third Quarter Data Collection: 100%				Third Quarter Data Collection:		

# JOINT COMMISSION

## Measures of Success

### PC.02.03.03, continued.

Unit: Lower Saco SCU

**Hand Hygiene Measure:** Staff will offer hand gel to clients prior to breakfast, lunch and dinner on 24 days per month.

**Hand Hygiene Measure:** Staff will measure client hand hygiene practice at breakfast, lunch and dinner on 24 days per month.

	Dec. 2013	Jan. 2014	February	March	April	May	June
Hand gel offered <b>at breakfast</b> 24 days/month	1/24=4%	4/24=17%↑	13/24=24%↑	1/24=4%			
Number of Clients	4	12	49	6			
Number of Clients offered	4	12=100%	49=100%	6=100%			
Number of Clients washed	2	9	24	2			
Compliance Rate – <b>How many clients washed?</b>	50%	75%↑	50%↓	33%			
		Third Quarter HH Rate: <b>53%</b>			Fourth Quarter HH Rate:		
		Third Quarter Data Collection: <b>100%</b>			Fourth Quarter Data Collection:		
Hand gel offered <b>at lunch</b> 24 days/month	↑	3/24=13%↑	9/24=38%↑	0/24=0			
Number of Clients		9	38	0			
Number of Clients offered		9=100%	38=100%	0			
Number of Clients washed		6	21	0			
Compliance Rate – <b>How many washed?</b>	↓	67%↑	55%↓	0			
		Third Quarter HH Rate: <b>0</b>			Fourth Quarter HH Rate:		
		Third Quarter Data Collection: <b>0</b>			Fourth Quarter Data Collection:		
Hand gel offered <b>at dinner</b> 24 days/month	1/24=4%	1/24=4%	15/24=63%	15/24=63%			
Number of Clients	4	3	69	85			
Number of Clients offered	4	3=100%	69=100%	85=100%			
Number of Clients washed	4	1	34	34			
Compliance Rate – <b>How many washed?</b>	100%	33%↓	49%↑	40%			
		Third Quarter HH Rate: <b>44%</b>			Fourth Quarter HH Rate:		
		Third Quarter Data Collection: <b>100%</b>			Fourth Quarter Data Collection:		

# JOINT COMMISSION

## Measures of Success

### PC.02.03.03, continued.

#### Unit: Upper Saco

**Hand Hygiene Measure:** Staff will offer hand gel to clients prior to breakfast, lunch and dinner on 24 days per month

**Hand Hygiene Measure:** Staff will measure client hand hygiene practice at breakfast, lunch and dinner on 24 days per month.

	Dec. 2013	Jan. 2014	February	March	April	May	June
Hand gel offered <b>at breakfast</b> 24 days/month	5/24=21%	3/24=13%↓	0	0			
Number of Clients	27	11	21	19			
Number of Clients offered	27	11=100%	0	0			
Number of Clients washed	8	2	0	0			
Compliance Rate – <b>How many clients washed?</b>	<b>30%</b>	<b>18%</b>	<b>0</b>	<b>0</b>			
				Third Quarter HH Rate:: <b>4%</b>		Fourth Quarter HH Rate:	
				Third Quarter Data Collection:		Fourth Quarter Data Collection:	
Hand gel offered <b>at lunch</b> 24 days/month	4/24=17%	3/24=13%↓	0	0			
Number of Clients	39	21	21	19			
Number of Clients offered	39	21=100%	0	0			
Number of Clients washed	18	11	0	0			
Compliance Rate – <b>How many washed?</b>	<b>46%</b>	<b>52%</b>	<b>0</b>	<b>0</b>			
				Third Quarter HH Rate:: <b>0</b>		Fourth Quarter HH Rate:	
				Third Quarter HH Rate: <b>0</b>		Fourth Quarter HH Rate:	
Hand gel offered <b>at dinner</b> 24 days/month	1/24=4%	0	0	0			
Number of Clients	13	21	21	19			
Number of Clients offered	13	0	0	0			
Number of Clients washed	4	0	0	0			
Compliance Rate – <b>How many washed?</b>	<b>31%</b>	<b>0</b>	<b>0</b>	<b>0</b>			
				Third Quarter Report: <b>0</b>		Fourth Quarter Report:	
				Third Quarter HH Rate: <b>0</b>		Fourth Quarter Data Collection:	

# JOINT COMMISSION

## Measures of Success

### PC.02.03.03, continued.

Unit: Treatment Mall

**Hand Hygiene Measure:** Staff will offer hand gel to clients prior to the mid-morning snack for twenty (20) days per month.

**Hand Hygiene Measure:** Staff will measure client hand hygiene practice at the mid-morning snack.

	Dec. 2013	Jan. 2014	February	March	April	May	June
Hand gel offered at the mid-morning snack	18/20=90%	21/21=100%	18/20=90%	20/20=100%			
Number of Clients	207	217	200	240			
Number of Clients offered	207	217	200	240			
Number of Clients washed	99	102	90	92			
Compliance Rate – <b>How many clients washed?</b>	<b>49%</b>	<b>49%</b>	<b>45%</b>	<b>38%</b>			
	Third Quarter HH Rate: <b>43%</b>			Fourth Quarter HH Rate:			
	Third Quarter Data Collection: <b>98%</b>			Fourth Quarter Data Collection:			

# JOINT COMMISSION

## Measures of Success

### PC.03.03.29

Patients are debriefed after the use of restraint or seclusion for behavioral health purposes.

Responsible for Reporting: Superintendent

Month	Number of charts reviewed	Charts compliant with debriefing content and safety meetings documented in the treatment plan within 72 hours	Compliance
February 2014	31	21	67%
March 2014	37	28	75%
<b>Total</b>	<b>68</b>	<b>49</b>	<b>72%</b>

# JOINT COMMISSION

## Measures of Success

### RC.01.02.01

Entries in the medical records are authenticated.

### PC.04.01.05

The hospital provides written discharge instructions in a manner that the patient and/or the patient’s family or caregiver can understand.

Responsible for Reporting: Clinical Director/Director of Nursing

January 2014

Indicators	Findings	Compliance	Threshold Percentile
All Progress notes are authenticated within 7 days	All progress notes are currently being authenticated within the 7 day timeframe	100%	90%
Discharge Instructions are in a manner that the client and/or family member/caregiver understand.	22 Closed records were reviewed, 19 of those included the D/C pharmacy labels, 22 were documented that medication teaching was Completed In Client Friendly Language at Discharge	100%	90%

**Summary:** Indicators are based on 100% of progress notes created per month. Physicians’ progress notes are audited to ensure authentication is occurring within 7 days of availability in the EMR per RPC’s Medical Record Completion Policy (MS.3.20).

The indicators for the Discharge Instructions (consolidated aftercare form) are based on 100% of discharges occurring each month over 4 consecutive months.

**Actions:** The above indicators will be reviewed for 4 consecutive months (beginning in January 2014) providing review yields 90% threshold or above per TJC corrective action plan.

# JOINT COMMISSION

## Measures of Success

RC.01.02.01, PC.04.01.05, continued

February 2014

Indicators	Findings	Compliance	Threshold Percentile
All Progress notes are authenticated within 7 days	All progress notes are being authenticated within the 7 day period	100%	90%
Discharge Instructions are in a manner that the client and/or family member/caregiver understand.	12 Closed records were reviewed, 10 of those included the D/C pharmacy labels, 11 were documented that medication teaching was Completed In Client Friendly Language at Discharge	92%	90%

**Summary:** Indicators are based on 100% of progress notes created per month. Physicians' progress notes are audited to ensure authentication is occurring within 7 days of availability in the EMR per RPC's Medical Record Completion Policy (MS.3.20).

The indicators for the Discharge Instructions (consolidated aftercare form) are based on 100% of discharges occurring each month over 4 consecutive months.

**Actions:** The above indicators will be reviewed for 4 consecutive months (beginning in January 2014) providing review yields 90% threshold or above per TJC corrective action plan.

# JOINT COMMISSION

## Measures of Success

RC.01.02.01, PC.04.01.05, continued

March 2014

Indicators	Findings	Compliance	Threshold Percentile
All Progress notes are authenticated within 7 days	All progress notes are being authenticated within the 7 day period	100%	90%
Discharge Instructions are in a manner that the client and/or family member/caregiver understand.	17 Closed records were reviewed, 17 of those included the D/C pharmacy labels, 15 were documented that medication teaching was Completed In Client Friendly Language at Discharge	88%	90%

**Summary:** Indicators are based on 100% of progress notes created per month. Physicians' progress notes are audited to ensure authentication is occurring within 7 days of availability in the EMR per RPC's Medical Record Completion Policy (MS.3.20).

The indicators for the Discharge Instructions (consolidated aftercare form) are based on 100% of discharges occurring each month over 4 consecutive months.

**Actions:** The above indicators will be reviewed for 4 consecutive months (beginning in January 2014) providing review yields 90% threshold or above per TJC corrective action plan.

# STRATEGIC PERFORMANCE EXCELLENCE

## Priority Focus Areas For Strategic Performance Excellence

In an effort to ensure that quality management methods used within the Maine Psychiatric Hospitals System are consistent with modern approaches of systems engineering, culture transformation, and process focused improvement strategies and in response to the evolution of Joint Commission methods to a more modern systems-based approach instead of compliance-based approach



### **Building a framework for client recovery by Ensuring fiscal accountability and a culture of organizational safety through the promotion of...**

- The conviction that staffs are concerned with doing the right thing in support of client rights and recovery;
- A philosophy that promotes an understanding that errors most often occur as a result of deficiencies in system design or deployment;
- Systems and processes that strive to evaluate and mitigate risks and identify the root cause of operational deficits or deficiencies without erroneously assigning blame to system stakeholders;
- The practice of engaging staffs and clients in the planning and implementing of organizational policy and protocol as a critical step in the development of a system that fulfills ethical and regulatory requirements while maintaining a practicable workflow;
- A cycle of improvement that aligns organizational performance objectives with key success factors determined by stakeholder defined strategic imperatives.
- Enhanced communications and collaborative relationships within and between cross-functional work teams to support organizational change and effective process improvement;
- Transitions of care practices where knowledge is freely shared to improve the safety of clients before, during, and after care;
- A just culture that supports the emotional and physical needs of staffs, clients, and family members that are impacted by serious, acute, and cumulative events.

# STRATEGIC PERFORMANCE EXCELLENCE

## Strategic Performance Excellence Model Reporting Process

Department of Health and Human Services Goals

- Protect and enhance the health and well-being of Maine people
- Promote independence and self sufficiency
- Protect and care for those who are unable to care for themselves
- Provide effective stewardship for the resources entrusted to the department



Dorothea Dix and Riverview Psychiatric Center  
**Priority Focus Areas**

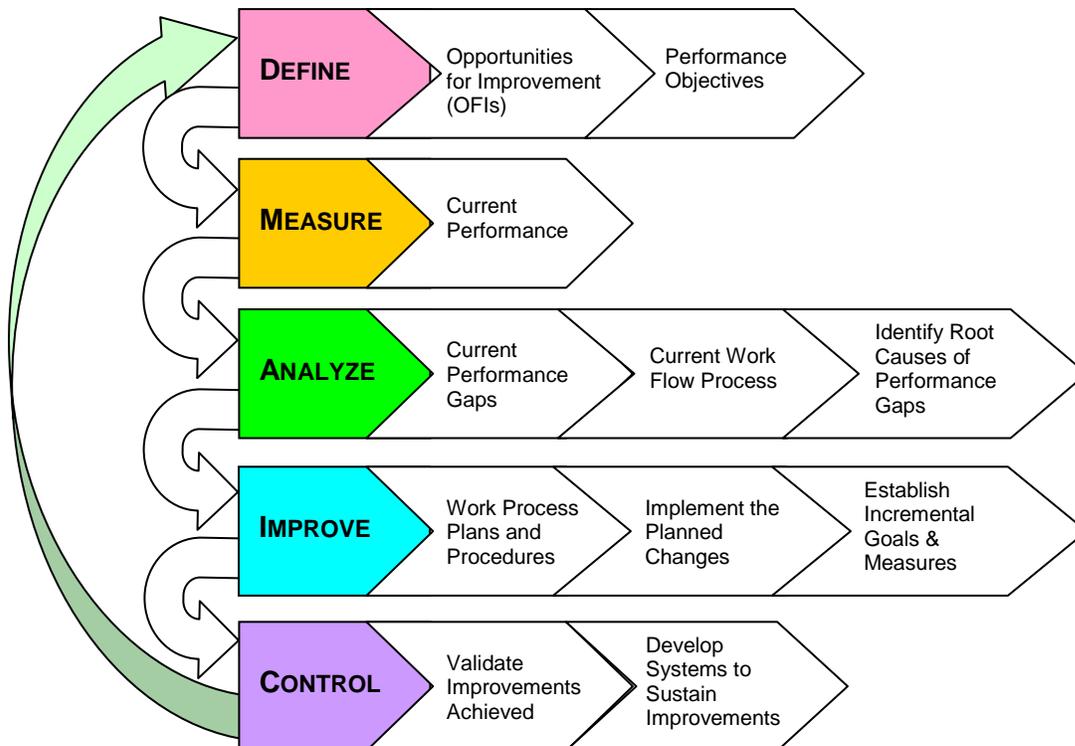


**Ensure and Promote Fiscal Accountability by...**  
Identifying and employing efficiency in operations and clinical practice  
Promoting vigilance and accountability in fiscal decision-making.

**Promote a Safety Culture by...**  
Improving Communication  
Improving Staffing Capacity and Capability  
Evaluating and Mitigating Errors and Risk Factors  
Promoting Critical Thinking  
Supporting the Engagement and Empowerment of Staffs

**Enhance Client Recovery by...**  
Develop Active Treatment Programs and Options for Clients  
Supporting clients in their discovery of personal coping and improvement activities.

Each Department Determines Unique Opportunities and Methods  
to Address the Hospital Goals  
The Quarterly Report Consists of the Following



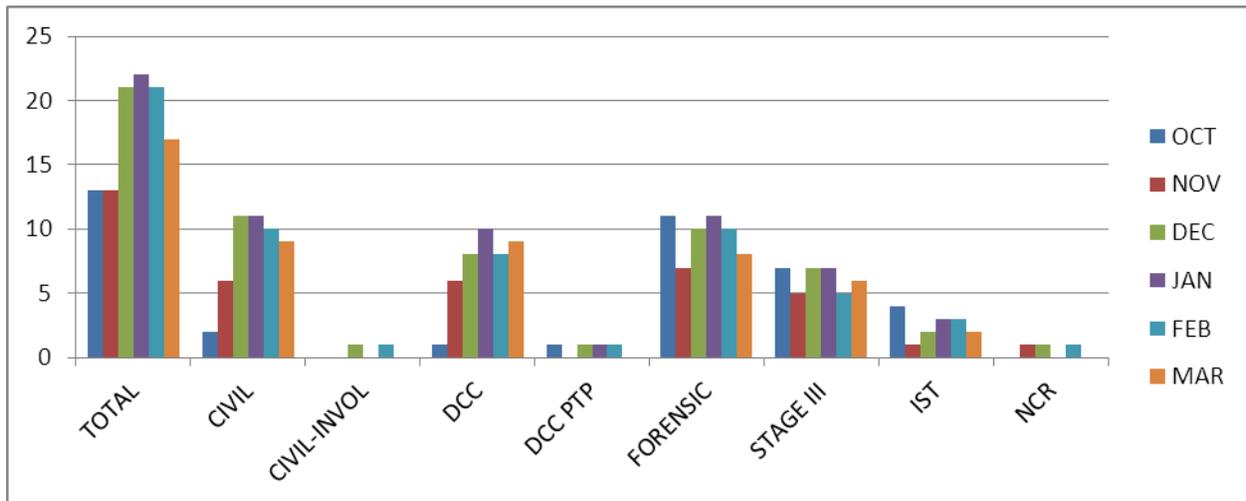
# STRATEGIC PERFORMANCE EXCELLENCE

## Admissions Process Improvement Activities

The Admissions office is going through another transition with staff. I, Jamie Meader, am once again working as the Admissions Coordinator starting in the beginning of March. The IMHU program is now up and running. So far we have referred 2 individuals to the program and they have been accepted. There have not been any other referrals that have met the criteria at this time. I will continue to collaborate with MSP and Dr. Fitzpatrick on any issues as they may arise.

Below are the reports for the last quarter. These contain information from October until the end of March, specifically related to Admissions, Discharges, Wait Length and Length of Stay.

Admission Data Graph



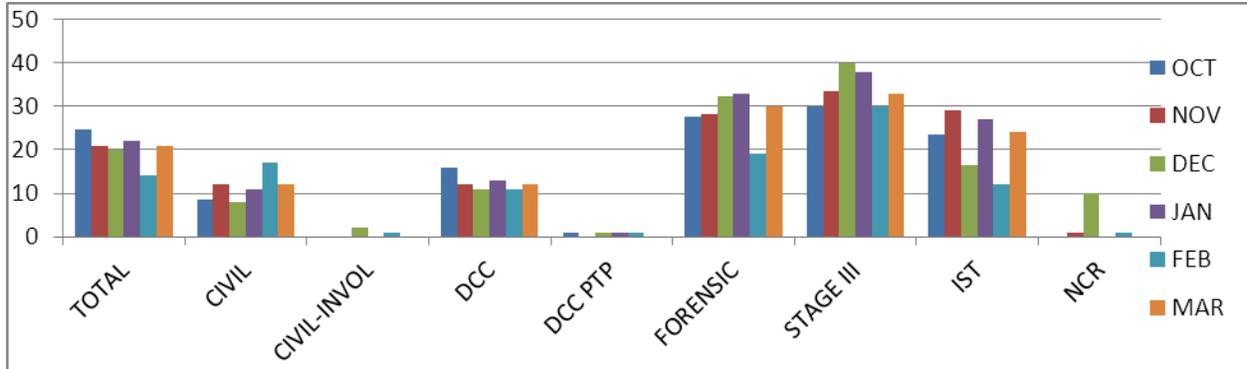
Admission Data

ADMISSIONS	OCT	NOV	DEC	JAN	FEB	MAR
TOTAL	13	13	21	22	21	17
CIVIL	2	6	11	11	10	9
CIVIL-INVOL	0	0	1	0	1	0
DCC	1	6	8	10	8	9
DCC PTP	1	0	1	1	1	0
FORENSIC	11	7	10	11	10	8
STAGE III	7	5	7	7	5	6
IST	4	1	2	3	3	2
NCR	0	1	1	0	1	0

# STRATEGIC PERFORMANCE EXCELLENCE

## Admissions Office

Wait Length Graph



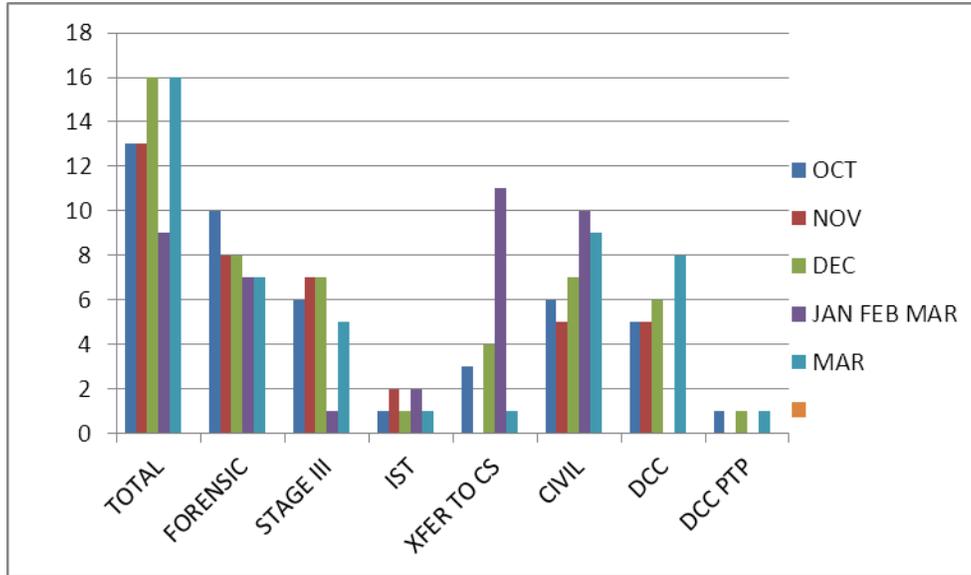
Wait Length Data

WAIT	OCT	NOV	DEC	JAN	FEB	MAR
TOTAL	25	21	20	22	14	21
CIVIL	9	12	8	11	17	12
CIVIL-INVOL	0	0	2	0	1	0
DCC	16	12	11	13	11	12
DCC PTP	1	0	1	1	1	0
FORENSIC	28	28	32	33	19	30
STAGE III	30	34	40	38	30	33
IST	24	29	17	27	12	24
NCR	0	1	10	0	1	0

# STRATEGIC PERFORMANCE EXCELLENCE

## Admissions Office

Discharge Data Graph



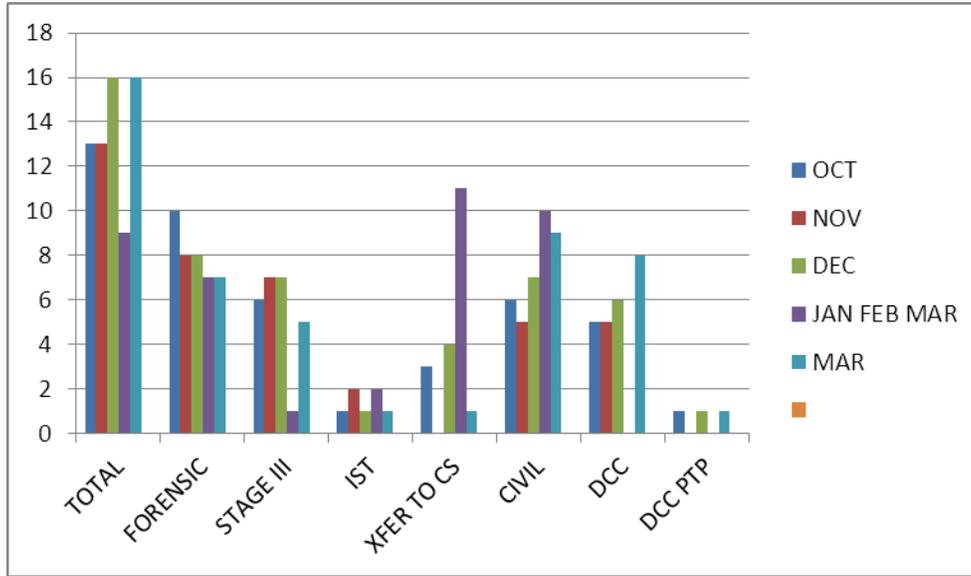
Discharge Data

DISCHARGES	OCT	NOV	DEC	JAN	FEB	MAR
TOTAL	13	13	16	22	12	16
FORENSIC	10	8	8	9	8	7
STAGE III	6	7	7	7	5	5
IST	1	2	1	1	2	1
XFER TO CS	3	0	4	2	4	1
CIVIL	6	5	7	11	4	9
DCC	5	5	6	10	3	8
DCC PTP	1	0	1	0	0	1

# STRATEGIC PERFORMANCE EXCELLENCE

## Admissions Office

Length of Stay Data Graph



Length of Stay Data

LOS	OCT	NOV	DEC	JAN	FEB	MAR
FORENSIC	33	18	41	52	156	71
STAGE III	28	34	29	21	22	49
IST	118	115	63	133	73	64
CIVIL	53	89	99	58	310	91
DCC	61	89	116	72	159	96
DCC PTP	16	0	3	0	0	49

# STRATEGIC PERFORMANCE EXCELLENCE

## Dietary Services

Responsible Party: Kristen Piela DSM

Strategic Objective: Safety in Culture and Actions													
Hand Hygiene Compliance: In an effort to monitor and sustain appropriate hand hygiene, the Dietary department measures compliance of the Dietary employees when returning from a scheduled break.													
	1st Quarter 2014			2nd Quarter 2014			3rd Quarter 2014			4th Quarter 2014			
Baseline	Target Baseline	Findings	Compliance	Target – Q1 + 12%	Findings	Compliance	Target – Q2 + 12%	Findings	Compliance	Target – Q3 + 12%	Findings	Compliance	Goal
85%	85%	16/30	53%	65%	33/57	58%	70%	55/66	83%				80-90%

**Data:**  
55 compliant observations / 66 hand hygiene observations = 83% hand hygiene compliance rate

- Summary:**
- Hand hygiene compliance has increased by 25%.
  - Hand hygiene observations have increased; 57 observations last quarter to 66 observations this first quarter. However: "The World Health Organization *Manual for Observers* recommends observing a minimum of 200 opportunities during each measurement period in each department or ward to allow for meaningful comparison before and after hand hygiene improvement interventions."
  - Updating hand hygiene signage and placing them in different locations brought attention to the task and appears to have had a positive impact on hand hygiene compliance.
  - Use of the reformatted Hand Hygiene Tool has simplified the data collection process and slightly improved the total number of observations.

- Action Plan:**
- Per the WHO recommendation, DSM will assign additional staff to observe HH practices.
  - Continue use of the improved Hand Hygiene Tool.
  - Encourage employees to adhere to hand hygiene via verbal interaction/reminders.
  - The Food Service Manager will present this quarterly report at the departmental staff meeting.

# STRATEGIC PERFORMANCE EXCELLENCE

## Dietary Services

Responsible Party: Kristen Piela DSM

Strategic Objective: Safety in Culture and Actions										
Nutrition Screen Completion: In an effort to monitor, improve and sustain timely completion of the nutrition screen for all admissions to RPC; decertified unit. The Registered Dietitian will review each Nutrition Screen within the Initial Nursing Admission Data. This screen will be completed by Nursing within 24 hours of admission.										
	2 <sup>nd</sup> Quarter 2014			3 <sup>rd</sup> Quarter 2014			4 <sup>th</sup> Quarter 2014			
Baseline 95-100%	Established Baseline	Findings	Compliance	Jan-March 2014 Target – Q2 + 1%	Findings	Compliance	April-June 2014 Target – Q3 + 0%	Findings	Compliance	Goal 95-100%
26/26					60/63	95%				95-100%

**Data:**

60 Nutrition screens completed w/in 24 hours of admission

63 Total Admissions = 95% of nutrition screens completed within 24 hours of admission

**Summary:**

- The Registered Dietitian reviewed the nutrition screens of the 63 client admissions for this quarter.
- Upon review, the RD discovered 3 nutrition screens incomplete.
- All incomplete nutrition screens were documented on the Lower Kennebec unit; two of the three clients were admitted on a Friday.

**Action Plan:**

- RD will continue correspondence with nursing staff regarding the discovery of an incomplete nutrition screens and request completion, as appropriate.
- Present quarterly report at departmental staff meeting and IPEC meeting.

# STRATEGIC PERFORMANCE EXCELLENCE

## Environment of Care

### INDICATOR

GROUNDS SAFETY/SECURITY INCIDENTS

### DEFINITION

Safety/Security incidents occurring on the grounds at Riverview. Grounds being defined as *“outside the building footprint of the facility, being the secured yards, parking lots, pathways surrounding the footprint, unsecured exterior doors, and lawns. Incidents being defined as, “Acts of thefts, vandalism, injuries, mischief, contraband found, and safety / security breaches. These incidents shall also include “near misses, being of which if they had gone unnoticed, could have resulted in injury, an accident, or unwanted event”.*

### OBJECTIVE

Through inspection, observation, and aggressive incident management, an effective management process would limit or eliminate the likelihood that a safety/security incident would occur. This process would ultimately create and foster a safe environment for all staff, clients, and visitors.

### THOSE RESPONSIBLE FOR MONITORING

Monitoring would be performed by Safety Officer, Security Site-Manager, Security Officers, Operations Supervisor, Operations staff, Director of Support Services, Director of Environmental Services, Environmental Services staff, Supervisors, and frontline staff.

### METHODS OF MONITORING

Monitoring would be performed by;

- Direct observation
- Cameras
- Patrol media such as “Vision System”
- Assigned foot patrol

**METHODS OF REPORTING:** Reporting would occur by one or all of the following methods;

- Daily Activity Reports (DAR’s)
- Incident Reporting System (IR’s)
- Web-based media such as the Vision System

### UNIT

Hospital grounds as defined above

### BASELINE

To be determined after compilation of data during the months from July 2013 to June 2014.

### 2014 Q1-Q4 TARGETS

Baseline – 5% each Q

# STRATEGIC PERFORMANCE EXCELLENCE

## Environment of Care

Department: Safety & Security Responsible Party: Bob Patnaude  
Safety Officer

Strategic Objectives								
Safety in Culture and Actions	Unit	Baseline	Q1 Target Actual	Q2 Target Actual	Q3 Target Actual	Q4 Target Actual	Goal	Comments
<b>Grounds Safety &amp; Security Incidents</b>	# of Incidents	*Baseline of 10	(16)	(24)	(7)	(10)	Baseline -5%	
Safety/Security incidents occurring on the grounds at Riverview, which include "Acts of thefts, vandalism, injuries, mischief, contraband found, and safety / security breaches"			-5% (24)	-5% (7)	-5% (10)	-5		

### SUMMARY OF EVENTS

The Q3 Target was (7). Our actual number was (10); an increase this quarter. We are pleased that in all of the events, our Security staff or clinical staff had discovered/processed the event before there was a negative impact to the Organization. We feel that the reporting, which follows below, continues to provide a very clear picture of Safety and Security events, how they are handled, and that the use of surveillance equipment plays an integral part in combating safety and security threats to people and property. Our aggressive rounds by Security continues to prove its' worth with regard to Security's presence and patrol techniques.

EVENT	DATE	TIME	LOCATION	DISPOSITION	COMMENTS
1. Safety Concern (Small flashlight found outside)	01/23/14	2140hrs.	Staff Parking Lot	Owner claimed	1. Security found in lot 2. Owner was corrections officer/retrieved 3. Safety notified 4. SEC IR # 611 completed
2. Safety Concern (Returning client in family's presence, smoking in non-smoking area)	01/25/14	1758hrs.	Visitor Lot	Security and Clinical staff educated family members and client	1. Security observed 2. Family and client reminded of smoking policy 3. Charge Nurse, NOD, and Safety notified 4. SEC IR #612 SEC completed
3. Security Threat (Intoxicated male on property)	01/25/14	1935hrs.	Front Lobby	Capitol Police and Augusta Police investigated	1. Male entered lobby 2. Capitol Police and Augusta PD, Safety, and NOD notified. 3. Incident investigated 4. OPS IR #1262 completed

# STRATEGIC PERFORMANCE EXCELLENCE

## Environment of Care

4. Security Threat (Graffiti/Slurs written on staff vehicle)	01/30/14	0507hrs	Staff Parking Lot	Capitol Police notified.	<ol style="list-style-type: none"> <li>1. Employee discovered</li> <li>2. NOD, Safety, Operations, CFO, PD notified</li> <li>3. Security disposed of item</li> <li>4. IR #567 SEC completed/Safety notified</li> </ol>
5. Security Concern (Suspicious vehicle/individual in Visitor Parking Lot)	02/08/14	0410hrs.	Visitor Parking Lot	Security and Augusta PD investigated	<ol style="list-style-type: none"> <li>1. Security discovered during rounds</li> <li>2. Operations and Augusta PD notified</li> <li>3. Individual waiting for meeting to be held in the AM</li> <li>4. NOD notified</li> <li>5. SEC IR # 622 SEC completed/Safety notified</li> </ol>
6. State Vehicle maintenance (State Vehicle lights left on/battery drained)	02/22/14	1711hrs.	State Vehicle Parking Area	Security investigated Maintenance notified	<ol style="list-style-type: none"> <li>1. Security responded</li> <li>2. Security called Maintenance who tended to issue</li> <li>3. SEC IR # 629 completed/Safety notified</li> </ol>
7. Safety Concern (large frost heave in Staff parking Lot)	02/23/14	0415hrs	Staff parking Lot	Security placed cones. Maintenance notified	<ol style="list-style-type: none"> <li>1. Security discovered during rounds</li> <li>2. Safety Cones placed/maintenance notified</li> <li>3. SEC IR # 630 completed/Safety notified</li> </ol>
8. Safety Threat (Matches found in State Vehicle)	02/25/14	1145hrs.	State Vehicle	Disposed them Follow-up as to last know operator	<ol style="list-style-type: none"> <li>1. Staff discovered</li> <li>2. Security disposed of</li> <li>3. Follow-up with last known operator</li> <li>3. SEC IR # 631 completed/Safety notified</li> </ol>
9. Safety Concern (RPC Staff person on AMHI grounds late at night)	02/27/14	0216hrs.	AMHI Grounds	Security spoke to staff of concern	<ol style="list-style-type: none"> <li>1. Capitol Police discovered during rounds</li> <li>2. Safety Concern relayed to staff although no prohibition against.</li> <li>3. SEC IR # 634 completed/Safety notified</li> </ol>
10. Safety Concern (Client behind Maintenance shed)	03/08/14	1445hrs.	Maint. area	Security moved client along. Nothing out of place	<ol style="list-style-type: none"> <li>1. Security discovered during rounds</li> <li>2. Client moved along. Clinical staff and NOD notified</li> <li>3. SEC IR # 636 completed/Safety notified</li> </ol>

# STRATEGIC PERFORMANCE EXCELLENCE

## Harbor Treatment Mall

<i>Objectives</i>	<i>4Q2013</i>	<i>1Q2014</i>	<i>2Q2014</i>	<i>3Q2014</i>
<i>1. Hand-off communication sheet was received at the Harbor Mall within the designated time frame.</i>	<i>60% 25/42</i>	<i>71% 30/41</i>	<i>69% 29/42</i>	<i>79% 33/42</i>
<i>2. SBAR information completed from the units to the Harbor Mall.</i>	<i>88% 37/42</i>	<i>86% 36/42</i>	<i>88% 37/42</i>	<i>81% 34/42</i>

**Unit: All three units January, February, and March 2014**

**Accountability Area: Harbor Mall**

**Aspect: Harbor Mall Hand-off Communication**

**Overall Compliance: 80 %**

**DEFINE:** To provide the exchange of client-specific information between the client care units and the Harbor Mall for the purpose of ensuring continuity of care and safety within designated time frames.

**MEASURE:** Indicator number one has increased from 69% last quarter to 79% for this quarter. Indicator number two has decreased from 88% last quarter to 81% this quarter.

**ANALYZE:** Overall compliance has increased from 79% for last quarter to 80% for this quarter. Indicator number one remained the same for all three months. Indicator number two decreased to 81% for March. The amount of time the sheets are late has decreased. Continue to concentrate on both indicators to improve current performance gaps.

**IMPROVE:** I will review the results at Nursing Leadership.

**CONTROL:** The plan is to continue to monitor the data and follow up with any unit(s) who may be having difficulties in developing a consistent system that works for them to meet the objectives.

# STRATEGIC PERFORMANCE EXCELLENCE

## Health Information Technology (Medical Records)

### Documentation and Timeliness

#### Upper Saco, Lower Kennebec, Upper Kennebec

Indicators	Findings	Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	There were 28 discharges in quarter 3 2014. Of those, 26 were completed by 30 days.	93%	80%
Discharge summaries will be completed within 15 days of discharge.	28 out of 28 discharge summaries were completed within 15 days of discharge during quarter 3 2014.	100 %	100%
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	9 forms were approved/ revised in quarter 3 2014 (see minutes).	100%	100%
Medical transcription will be timely and accurate.	Out of 803 dictated reports, 803 were completed within 24 hours.	100%	90%

**Summary:** The indicators are based on the review of all discharged records. There was 93% compliance with record completion. Weekly “charts needing attention” lists are distributed to medical staff, including the Medical Director, along with the Superintendent, Risk Manager and the Quality Improvement Manager. There was 100% compliance with timely & accurate medical transcription services.

**Actions:** Continue to monitor.

# STRATEGIC PERFORMANCE EXCELLENCE

## Health Information Technology (Medical Records)

### Documentation and Timeliness

#### Lower Saco

Indicators	Findings	Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	There were 23 discharges in quarter 3 2014. Of those, 22 were completed by 30 days.	97%	80%
Discharge summaries will be completed within 15 days of discharge.	23 out of 23 discharge summaries were completed within 15 days of discharge during quarter 3 2014.	100 %	100%
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	9 forms were approved/ revised in quarter 3 2014 (see minutes).	100%	100%
Medical transcription will be timely and accurate.	Out of 803 dictated reports, 803 were completed within 24 hours.	100%	90%

**Summary:** The indicators are based on the review of all discharged records. There was 97% compliance with record completion. Weekly “charts needing attention” lists are distributed to medical staff, including the Medical Director, along with the Superintendent, Risk Manager and the Quality Improvement Manager. There was 100% compliance with timely & accurate medical transcription services.

**Actions:** Continue to monitor.

# STRATEGIC PERFORMANCE EXCELLENCE

## Health Information Technology (Medical Records)

### Confidentiality

Indicators	3Q14 Findings	3Q14 Compliance	Threshold Percentile
All client information released from the Health Information department will meet all Joint Commission, State, Federal & HIPAA standards.	5283 requests for information (115 requests for client information and 5168 police checks) were released for quarter 3 2014.	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	New employees/contract staff in quarter 3 2014.	100%	100%
Confidentiality/Privacy issues tracked through incident reports.	0 privacy-related incident report during quarter 3 2014.	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 related to release of information from the Health Information department and training of new employees/contract staff, 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.

# STRATEGIC PERFORMANCE EXCELLENCE

## Health Information Technology (Medical Records) Release of Information for Concealed Carry Permits

### Define

The process of conducting background checks on applicants for concealed carry permits is the responsibility of the two State psychiatric hospitals. Clients admitted to private psychiatric hospitals, voluntarily or by court order, are not subject to this review. Delays in the processing of background checks has become problematic due to an increasing volume of applications and complaints received regarding delays in the processing of these requests

### Analyze

Data collected for the 3<sup>rd</sup> quarter 2014 showed that we received 5168 applications. This is a decrease from last quarter (2<sup>nd</sup> quarter 2014) when we received 5328 applications.

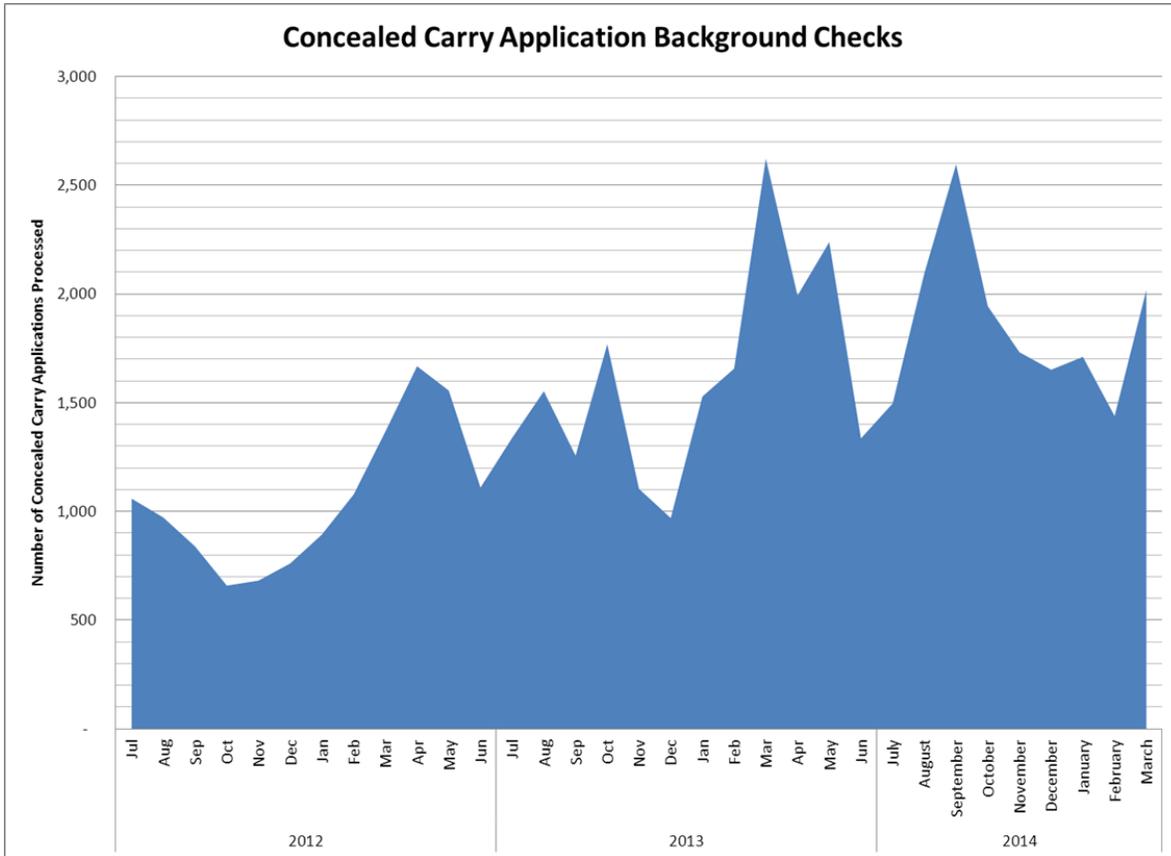
### Improve

The process has been streamlined as we have been working with the state police by eliminating the mailing of the applications from them to RPC and DDPC. RPC has reactivated the medical records email to receive lists of the applicants from the state police that include the DOB and any alias they may have had. This has cut down on paper as well as time taken sorting all the applications. Due to the change in how we process the applications, we no longer have data on the Max and Avg Receipt Delay and Processing Time.

**NOTE:** At the end of the reporting period, there were 0 police checks outstanding for Riverview Psychiatric Center.

FY 2013/2014	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
# Applications Received	1993	2239	1336	1497	2096	2596	1944	1732	1652	1711	1439	2018
Avg Receipt Delay	26	42	66	82	76	30	-	-	-	-	-	-
Max Receipt Delay	451	504	1694	1568	258	508	-	-	-	-	-	-
Avg Processing Time	8	13	15	13	11	3	-	-	-	-	-	-
Max Processing Time	11	20	19	45	15	7	-	-	-	-	-	-

# STRATEGIC PERFORMANCE EXCELLENCE



Over the past two years the number of applications for concealed carry permits has increased significantly. While there is a seasonal drop in applications during the winter months the overall trend has been upward with March 2013 showing the highest volume of applications to date.

# STRATEGIC PERFORMANCE EXCELLENCE

## Human Resources

### Define

Completion of performance evaluations according to scheduled due dates continues to be problematic.

### Measure

Current results are consistently below the 85% average quarterly performance goal.

### Analyze

A thorough analysis of the root causes for lack of compliance with this performance standard is indicated.

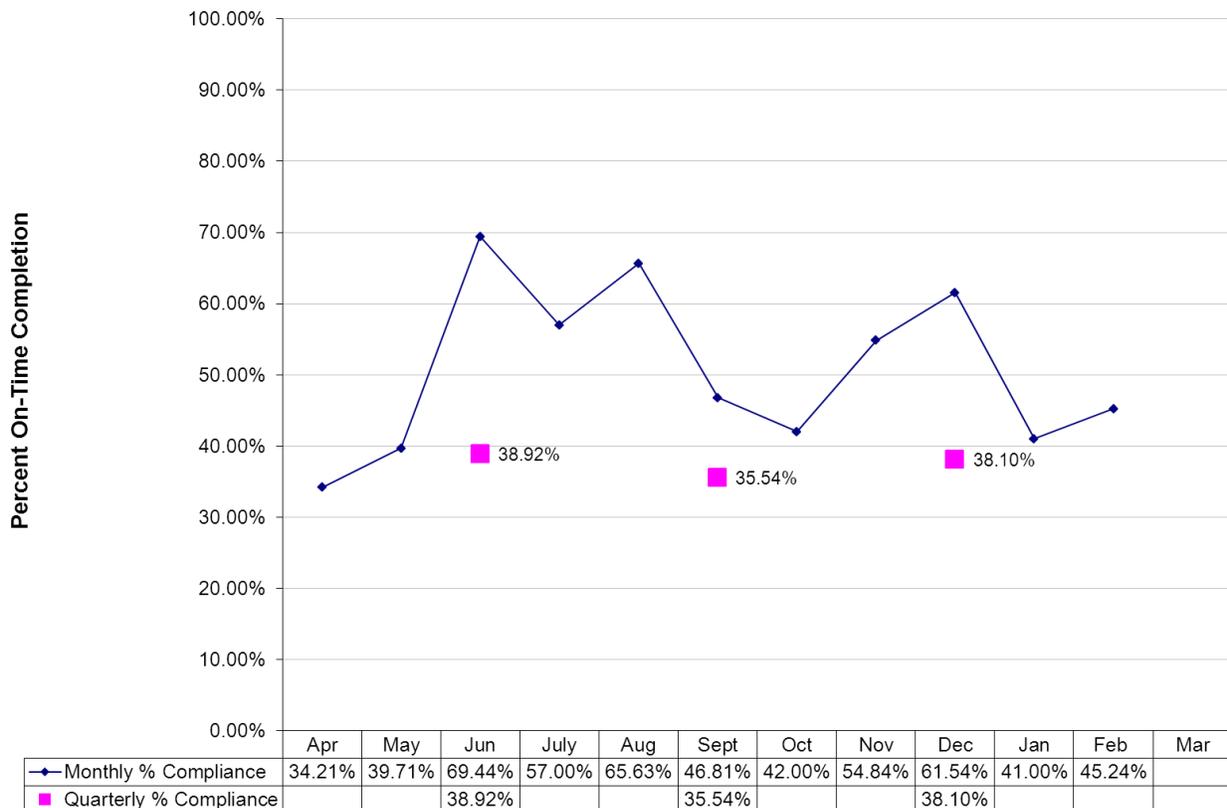
### Improve

In the interim, the Personnel Director has begun the process of reporting to hospital leadership the status of performance evaluation completion at least monthly so follow-up with responsible parties can be accomplished.

### Control

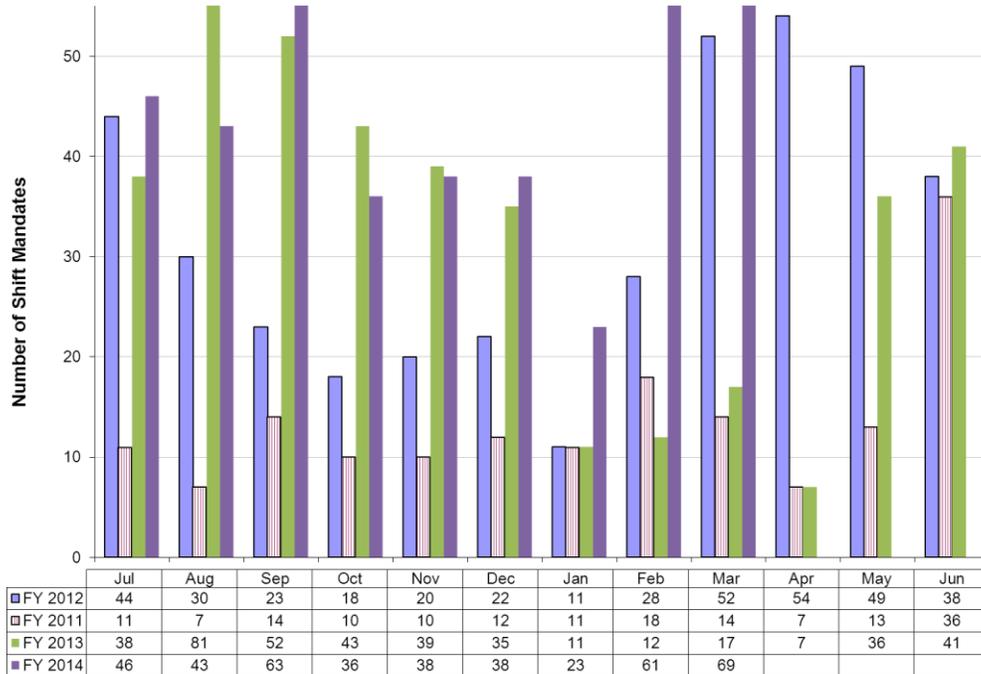
Plans to modify hospital performance evaluation goals for supervisory personnel will include the completion of subordinate performance evaluations in a timely manner as a critical supervisory function.

### Performance Evaluation Compliance

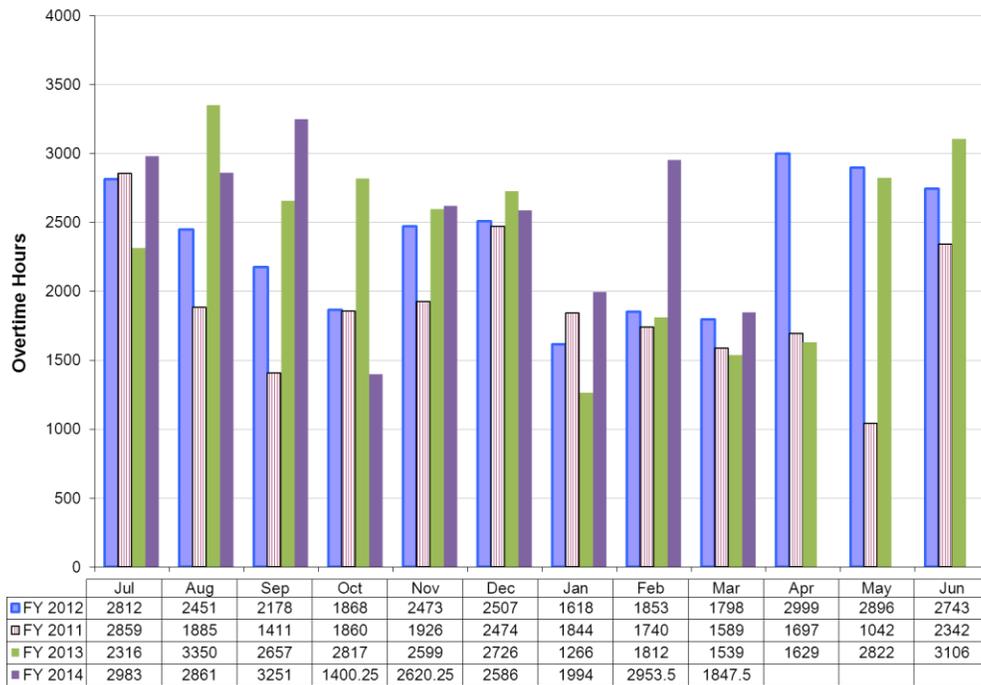


# STRATEGIC PERFORMANCE EXCELLENCE

**Monthly Mandated Shifts**

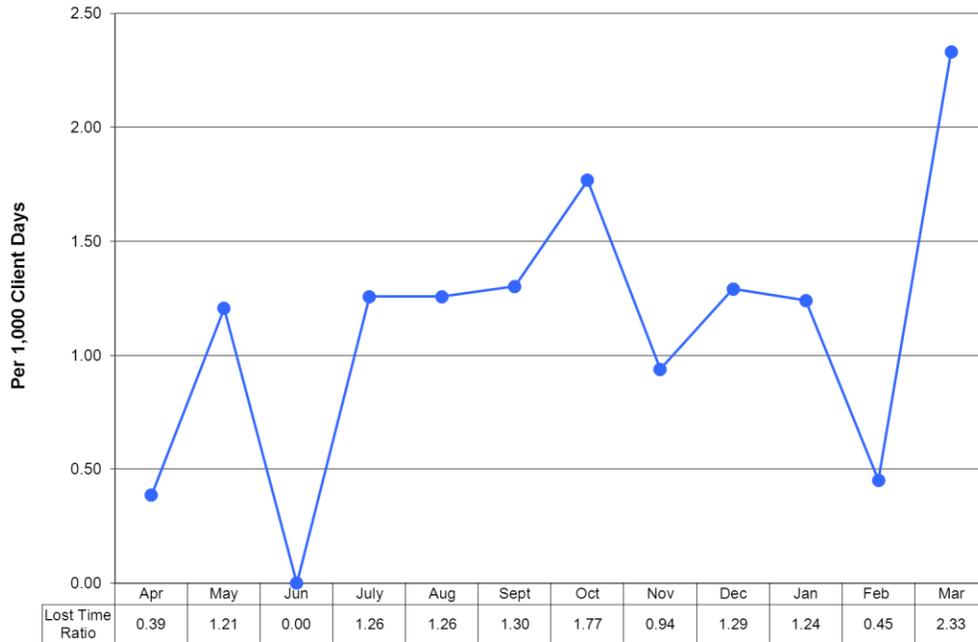


**Monthly Overtime**

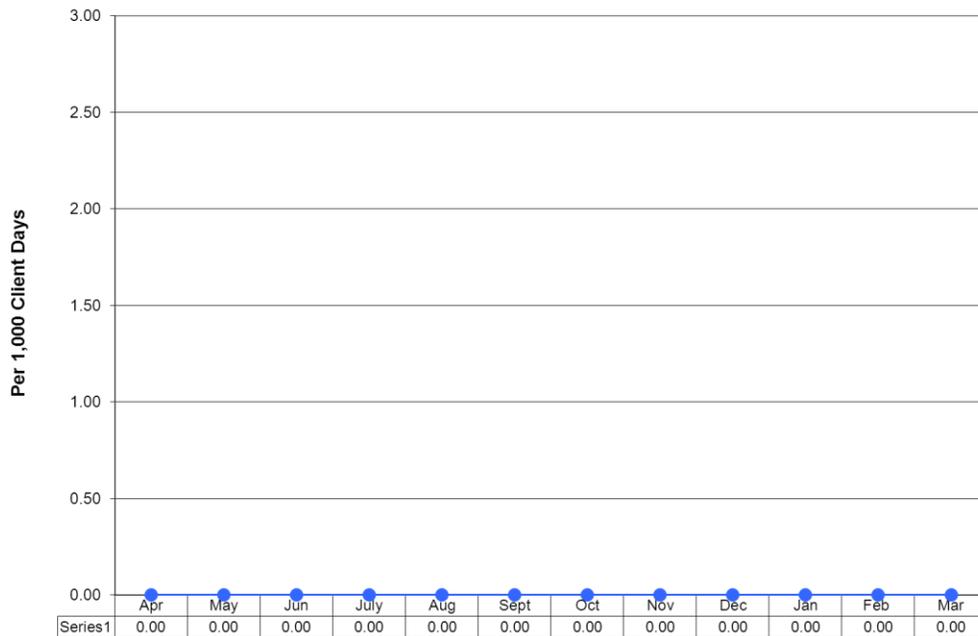


# STRATEGIC PERFORMANCE EXCELLENCE

### Reportable (Lost Time & Medical) Direct Care Staff Injuries



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



# STRATEGIC PERFORMANCE EXCELLENCE

## Medical Staff

April 15, 2014

### PROGRESS AND EVOLVING PROCESS WITH REGARD TO MEDICAL STAFF PERFORMANCE IMPROVEMENT:

Since taking over as clinical director at Riverview Psychiatric Center on January 1, 2014, an area of particular interest has been the medical staff performance improvement process. This is not surprising given that medical staff performance improvement had been severely in abeyance early in 2013 when CMS evaluated the hospital. Attempting to have a functional, effective, and eventually excellent medical staff performance improvement plan is a primary target of my clinical directorship. This report will focus on, not only specific aspects of the plan, but also the evolving process and progress relating to medical staff performance improvement.

Specific aspects of medical staff performance improvement include:

1. The antibiotic monitoring indicator.
2. The multiple antipsychotics while hospitalized indicator.
3. The metabolic monitoring indicator.
4. The timeliness of psychological testing indicator.
5. The introduction of the COTREI rating scale indicator.
6. Medical staff engagement in case reports and detailed case discussions.
7. Discussion of implementation of patient satisfaction surveys in the hospital setting.
8. The status of monthly record reviews.
9. Reporting items including – cognitive impairment throughout hospitalization, two or more antipsychotics at the time of discharge, creatinine clearance of patient's older than 60 who are diabetic or who are on lithium, medication side effect reports, six monthly AIMS testing on inpatients.

**NOTE ON PROCESS:** On initially taking over the clinical director position, the peer review and performance committee met on a monthly basis for a period of 1 hour. Although this continues, I have identified that the committee needs to be augmented by more specific meetings between those sessions and, to this end, I have set up a meeting with Dr. Miranda Cole, Pharmacist, on a monthly basis to focus specifically on the three current pharmacy-related indicators, but also to use this time evaluating those indicators, viewing the potential future for those indicators, and making consideration as to where those indicators may lead in terms of further performance improvement measures.

In a similar way, I meet with Dr. DiRocco, the director of psychology and in twice-monthly, 1-hour meetings we, among other things, ensure that we follow what is currently the two psychology department indicators, their implementation, results, etc.

Further, it is noted that the Director of Psychology already attends the peer review and performance improvement committee meetings, but that Dr. Cole, Pharmacist, has begun attending these in addition. The value of the extra meetings is also evidenced by an ability to mutually assign homework and update on the indicators and process. This is in addition to any assignments that may be given to other medical staff members during the peer review and performance improvement committee meeting itself.

The following will be an outline of each individual indicator to give some idea of the discussion and direction that it is felt each indicator is moving.

1. Appropriate antibiotic prescribing. We are currently in the process of monitoring to ensure that the antibiotic order sheet is being used at least at a 90 percent frequency over a 4-month period. In addition, we are monitoring for the presence of corresponding progress note with each prescription. It is envisaged that the future of this monitor will develop into appropriate choice of antibiotics and this will require further meeting between Dr. Cole, Pharmacist, and the internists at the hospital.

# STRATEGIC PERFORMANCE EXCELLENCE

2. Poly-antipsychotic prescribing during hospitalization. Work on this indicator has shown that reduction in prescription of multiple antipsychotics during hospitalization has reduced considerably. In particular, use of four and three antipsychotics for a given individual has reduced markedly. Instances of prescribing two antipsychotics have reduced and further, closer evaluation of appropriateness of combination prescribing has been undertaken. That is, if two antipsychotics used, using two distinct chemical classes is viewed as more appropriate than two medications from within one class. The future of this indicator includes transitioning to an electronic process where physician is automatically contacted either at the point of admission or at the point of adding a second antipsychotic medication. Given that there is a national indicator for appropriateness of using two antipsychotic medications at the time of discharge, it is hoped the future this indicator may well involve an appropriate meshing with this indicator. The possibility of reviewing overall poly-pharmacy as an indicator is a suggestion which has emerged from following this indicator itself. This is an example of how an active performance improvement process leads the discussing physicians in the direction of thinking of further performance improvement ideas.
3. The metabolic monitoring indicator. A baseline evaluation of a vast majority of the inpatients has been completed. Documenting patient refusal for this indicator would be appropriate, as this will clearly indicate if our baseline efforts are completed or if lacking information is present for another reason. The next step with this monitor will be to ensure that appropriate laboratory work is being ordered and, in turn, that the appropriate work is being ordered at the APA/ADA-recommended appropriate interval. The future of this monitor will then be designed to identify individuals with diabetes or metabolic syndrome secondary to prescription of new generation antipsychotics. Clarification of treatment recommendations and how to monitor these responses will be a further step. Making a connection between performance improvement indicator and education of medical staff, it is noted that there are available CME modules focusing on this issue in particular. For example, metabolic monitoring for patients on antipsychotic medications CME Magazine, December 20, 2013. Implementation of this CME module for medical staff is being strongly considered.
4. Timeliness of psychological testing. I am not convinced that this indicator is producing value, but as this is a time of transition in the psychology department, it is appropriate to continue monitoring to ensure that a wait for psychological services does not increase. It is noted that monitoring the absolute amount of psychological testing may be appropriate at present as the psychology department enhances its availability, both through revision of services provided and actual availability of psychologists.
5. Introduction of COTREI. The community outpatient treatment readiness inventory is to be used for the NCR, or not criminally responsible, population in the hospital. Initial target is to obtain a COTREI evaluation of each patient in the hospital setting from both a psychologist and psychiatrist. It is expected that this will reach a 90-percent threshold over the next 4 months and I continue to discuss, both at committee and individually with Dr. DiRocco, Director Of Psychology, the progress of this monitor. The monitor itself is at a stage of introducing the material to clinical staff, but it is envisaged that this tool will provide a set language for evaluating the clinical progress of individuals within that program and hopefully eventually, the indicator will guide treatment planning in the lengthy 6 to 9 month intervals between Superior Court attendance that occurs during the NCR recovery process. Further usefulness of this monitor will relate to researching the population and predicting likelihood of relapse or other difficulties that may be experienced based on specific aspects of the indicator. In turn, this may help focus treatment for resistant or likely difficult areas for given individuals.
6. Case reports. During peer review and performance improvement committee meetings, a number of detailed case presentations have now occurred with follow-up occurring in subsequent months, looking at the discussed recommendations and ensuring follow-through with such recommendations. A future in this regard will include review of a number of the case studies in an effort to evaluate whether specific recommendations are made more frequently than in an individual case.

# STRATEGIC PERFORMANCE EXCELLENCE

7. Satisfaction surveys. One of the medical staff suggested looking at use of a satisfaction survey for the patients within the hospital. Satisfaction surveys of customers in any area have been used as a quality improvement tool across multiple organizations and businesses. As evidenced by Quint Studer's work in improving hospital performance, patient satisfaction surveys can be an integral part of driving quality in healthcare. Discussion of the feasibility of implementing such a program within the hospital will be presented by Dr. Davis at the April peer review and performance improvement committee meeting.
8. Medical record reviews. Medical staff has engaged in basic review of admission notes, progress notes, and discharge notes. It has previously been noted that this material, though gathered, has not been integrated into a systematic performance improvement process. Dr. Kirby will be meeting in future with Joseph Reddick, Director Of Quality Services for the hospital, to discuss improving use of medical staff time in documentation review to ensure that the valuable physician time is used in a helpful, quality driven way.
9. Reporting items. It is noted above that there are a number of quality items, which continue to be reported on by medical staff. Ensuring that this information is appropriately delivered, particularly at pharmacy and therapeutics and other committees, has been a focus of the performance improvement efforts.

**CHALLENGE:** An immediate challenge in med staff PI is to have immediate and detailed access to each monitor's actual figures, graphs, tables, etc. and I will be working to ensure this in the near future.

**CONCLUSION:** Engagement in the medical staff performance improvement process, setting up appropriate meetings between committee, and working through these issues at committee level, has improved my ability to monitor how medical staff performance improvement will best work within Riverview Psychiatric Center, its medical and allied staffs. Rather than simply attempting to find a valid indicator and dismissing those that appear less valid, working through each indicator in detail and constantly evaluating it for its current situation, possible productivity, and possible future as an indicator, as well as making connections to necessary education and watching for opportunities for further indicators appears to be a much more productive way of engaging in performance improvement. The commitment to changing from a now functional performance improvement system to a highly reliable performance improvement system which strives for and continues to pursue excellence now becomes the target.

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Clinical Director

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# STRATEGIC PERFORMANCE EXCELLENCE

## Medical Staff Timeliness of Psychological Testing

**Data Collection:** All requests for psychological testing or evaluation were reviewed during the time period of January, February, and March 2014. The date of the request, the medical staff member requesting the information, the date of initiation of testing and date of completion of testing were determined for comparison to target norms.

**Findings:** During the period in question, there were a total of 23 requests for psychological services.

The table below shows the breakdown of services provided for the 3rd quarter of 2014:

Service	Referrals	Avg. Days to Complete	Max Days	% w/in 30 days
Therapeutic intervention	3	4	6	100.0%
Individual Counseling	6	2.8	6	100.0%
Psych Consults	5	3.8	6	100.0%
Assessments	9	8.2	18	100.0%
Referral total	23	5.3	% completed	100.0%
Incomplete	0			

**Analysis:** The Psychology department has set a goal of improving the value of psychological services provided to clients and the staff of Riverview. The delivery of diagnostic and psychotherapeutic services in a timely and efficient manner has been made a priority for the department as a whole. At present, as the chart above shows, the department is able to document improvement in the delivery of psychological services in a timely manner. All psychological service referrals were addressed within the acceptable time line of 30 days. In other areas, data is being collected on individuals identified as NCR clients to aid in the success of outpatient placement. Current progress towards the goal of 90 percent or better data collection on NCR clients who will be moving into the community is at 37 percent. The target goal date for this performance improvement effort is July 1<sup>st</sup> 2014. This is up from 12 percent as of early March 2014.

# STRATEGIC PERFORMANCE EXCELLENCE

## **Medical Staff Timeliness of Psychological Testing**

**Plans:** Activities supporting in-service training and psychological research have been initiated to improve the quality of services and to gain useful information related to the efficacy of treatment for our clients. Recovery oriented treatment groups led by peer facilitators have been undertaken as of this date. Measures of quality of services provided are being collected each session.

The psychology department continues providing interns and practicum students with the opportunity to study and learn at Riverview over the course of a calendar year. There are currently two interns completing a one year rotation and two more who have already been selected for the new academic year beginning in July 2014. The goal of the internship program is to provide a well-rounded and focused learning opportunity for graduate students in psychology. We are also attempting to expand the program to four interns for the 2014 – 15 internship rotation. The department has also been contacted by a foreign student from Germany who has heard about the Riverview Psychiatric Center and is interested in a practicum experience from July to mid-September.

# STRATEGIC PERFORMANCE EXCELLENCE

## Medical Staff Metabolic Monitoring of Atypical Antipsychotics

	January	February	March
<b>Census (Beginning + Admissions)</b>	113	110	112
<b>Antipsychotic Orders for Clients</b>			
<b>No Antipsychotics</b>	31 (27%)	29 (26%)	30 (27%)
<b>Mono-antipsychotic therapy</b>	53 (47%)	49 (45%)	50 (45%)
<b>Two Antipsychotics</b>	22 (19%)	25 (23%)	25 (22%)
<b>Three Antipsychotics</b>	6 (5%)	7 (6%)	6 (5%)
<b>Four Antipsychotics</b>	1 (<1%)	0	1 (<1%)
<b>At least 1 antipsychotic</b>	82 (73%)	81 (74%)	82 (73%)
<b>Total on Poly-antipsychotic therapy</b>	29 (26%)	32 (29%)	32 (29%)
<b>Percentage of poly-antipsychotic therapy amongst those with orders for antipsychotics</b>	35% (29/82)	40% (32/81)	39% (32/82)
<b>More than 2 antipsychotics</b>	7 (6%)	7 (6%)	7 (6%)
<b>Poly-Antipsychotic therapy breakdown</b>			
<b>SGA + FGA</b>	12 (41%)	17 (53%)	18 (56%)
<b>2 SGAs (“Pine” + “Done”)</b>	5 (17%)	3 (9%)	4 (13%)
<b>Other (2 antipsychotic regimens)</b>	5 (17%)	5 (16%)	3 (9%)
<b>Other 2 Antipsychotic Regimen Details</b>	1) Quetiapine + Aripiprazole 2) Clozapine + Quetiapine 3) Chlorpromazine + Fluphenazine 4) Chlorpromazine + Loxapine 5) Paliperidone + Risperidone	1) Chlorpromazine + Fluphenazine 2) Chlorpromazine + Loxapine 3) Chlorpromazine + Haloperidol 4) Paliperidone + Risperidone 5) Olanzapine + Quetiapine	1) Clozapine + Olanzapine 2) Chlorpromazine + Loxapine 3) Paliperidone + Risperidone
<b>3+ Antipsychotic Regimens</b>	7 (24%) 1) Quetiapine + Haloperidol + Risperidone 2) Aripiprazole + Olanzapine + Ziprasidone 3) Chlorpromazine + Olanzapine + Lurasidone 4) Ziprasidone + Haloperidol + Aripiprazole 5) Olanzapine + Haloperidol + Quetiapine 6) Chlorpromazine + Olanzapine + Risperidone 7) Haloperidol + Olanzapine + Clozapine + Ziprasidone	7 (22%) 1) Haloperidol + Chlorpromazine + Olanzapine 2) Quetiapine + haloperidol + Risperidone 3) Aripiprazole + Olanzapine + Ziprasidone 4) Chlorpromazine + Perphenazine + Loxapine 5) Clozapine + Quetiapine + Ziprasidone 6) Haloperidol + Olanzapine + Clozapine 7) Olanzapine + Haloperidol + Quetiapine	7 (22%) 1) Aripiprazole + Olanzapine + Ziprasidone 2) Olanzapine + quetiapine + Ziprasidone 3) Clozapine + Quetiapine + Ziprasidone 4) Clozapine + Haloperidol + Olanzapine 5) Quetiapine + Olanzapine + Loxapine 6) Quetiapine + Chlorpromazine + Loxapine 7) Quetiapine + Risperidone + Ziprasidone + Haloperidol
<b>Justifiable Poly-Antipsychotic Therapy</b>	24/29 (83%) [below goal of 90%]	29/32 (91%) [above goal of 90%]	30/32 (94%) [above goal of 90%]

SGA = Second Generation Antipsychotic; FGA = First Generation Antipsychotic; “Pines” = clozapine, olanzapine, quetiapine, asenapine; “Dones” = risperidone, paliperidone, ziprasidone, lurasidone, iloperidone; prn = as needed

# STRATEGIC PERFORMANCE EXCELLENCE

## **Medical Staff Metabolic Monitoring of Atypical Antipsychotics**

### **Data Collection**

All medication profiles in the hospital were reviewed on three occasions this quarter in January, February and March. We were particularly interested in the proportion of clients who were receiving more than one antipsychotic medication, since practice guidelines by the American Psychiatric Association clearly discourage this practice. When a case of polypharmacy was encountered we further required the prescriber to justify the practice based on pre-agreed upon clinical elements required to make the justification.

### **Findings**

Over the quarter we found that about 73% of clients were receiving at least one antipsychotic medication. Of these clients, about 28% were receiving more than one such agent, and by definition was a case of polypharmacy. Within this overall percentage we noted that in January the percentage was 26, in February it was 29, and in March it was 29. This is a seemingly decrease in poly-antipsychotic therapy from the previous quarter (82% total, 34% October, 40% December, and 38% December). However, some discrepancies were identified in data collection and were resolved. We discovered that prospective data collection yields more accurate information and will continue with this going forward.

### **Analysis**

We are just below our target of 90% justified for the quarter at 89%. The trend line showed improvement over the quarter and was above threshold in February and March at 91%. The overall number of clients receiving poly-antipsychotic therapy increased from last quarter but remained relatively constant within quarter. There were 2 instances of clients receiving ultrahigh numbers of medications (greater than 3 antipsychotics) in January and March. This is an increase from last quarter and both instances have been addressed resulting in no current instances of clients receiving more than 3 antipsychotics.

### **Plan**

We will continue this monitor for another quarter since appropriate antipsychotic prescribing is both a common task in the hospital as well as one fraught with many potential negative sequellae. We will begin to prospectively gather data on polyantipsychotic therapy. We will continue to give feedback to medical staff and to look closely at all cases where it has been difficult to wean the client off high doses of multiple drugs.

# STRATEGIC PERFORMANCE EXCELLENCE

## Medical Staff Antibiotic Use Monitoring

### Data Collection

During the quarter the antibiotic monitoring form consisting of a special doctor's order sheet with details of the antibiotic indication, drug, and strength, and giving agreed upon prescribing guidelines was fully implemented. Adherence to utilization of the form and the clinical appropriateness of indications for the antibiotic orders are gathered at the end of each month and the summary is provided at the following months' Pharmacy and Therapeutics (P&T) Committee. The Peer Review Team has been identified.

### Findings

During the monitoring period there were 43 orders for antibiotics. In five instances the antibiotic order form was not utilized. Three of the five were in February and twice in March. This a 88% adherence rate for the quarter. This is a decline from the last quarter which had a 92% adherence rate. The orders for January and February have been presented at the Pharmacy and Therapeutic Committee. January had a total of 11 antibiotic orders and a 100% adherence rate to the form, February had 12 antibiotic orders and a 75% adherence rate to the form and March had 20 antibiotic orders with a 90% adherence rate to the form. Since all of the orders not on an antibiotic order form for the month of February were written by after hour prescribers, it was suspected that they needed additional education provided by the Clinical Director. The result was an increase in the utilization of the appropriate antibiotic form in March. The after hour prescriber that did not utilize the form is a new employee and will be provided with additional education.

### Plan

The Peer Review team will evaluate the appropriateness of each antibiotic order. The team will also, on an ongoing basis, review the clinical guidelines and make recommendations for changes. Other trends identified by the team will be reported as necessary. A summary will be presented at each P&T Committee Meeting. Our threshold for this monitor is that 90% of all antibiotic orders will meet clinical guidelines as developed by the Medical Executive Committee.

# STRATEGIC PERFORMANCE EXCELLENCE

## **Medical Staff Metabolic Monitoring of Atypical Antipsychotics**

### **Data Collection**

The pharmacy completed data collection of metabolic monitoring parameters for all clients in the hospital who were receiving atypical antipsychotics during the quarter. Data elements collected on all clients included BMI (Body Mass Index) and BP (blood pressure) plus lab results including HDL cholesterol, triglycerides, fasting blood sugar, and hemoglobin A1c. Also collected were the dates of the last tests and the names of the atypical drugs each client was receiving. This information is posted on the physician's shared drive and presented monthly at the Pharmacy and Therapeutics (P&T) Committee Meeting

### **Findings**

During the monitoring period there were 93 clients receiving at least one atypical antipsychotic agent. Data was completely recorded for all desired data elements for 60 of 93 (or 54%) clients. Twenty-three percent of clients were missing enough data elements that their metabolic status was unable to be determined. About 79% of the elements were available for evaluation of metabolic syndrome. Missing data elements were primarily related to lab studies, mostly due to refusal of clients to obtain blood work. Cholesterol labs were the most frequently missing (39%) and then glucose labs (27%)

### **Analysis**

At 54% we were below our target of 95% of clients on atypical antipsychotics having a complete metabolic profile available to the pharmacist and to the medical staff. This was primarily due to missing laboratory values in the data base due to refusals.

### **Plan**

Going forward, our plan will be to review the recommended metabolic monitoring frequency for each client to optimize the monitoring and prevent unnecessary lab work. We will continue to monitor the data elements of metabolic monitoring for each client prescribed a second generation antipsychotic. We will also continue to refine and improve our data entry. We will explore the concept of a metabolic clinic to better assess, identify, monitor, educate and treat clients at risk for metabolic syndrome. We will work to develop a schedule for blood draws for monitoring. We will utilize the APA and ADA guidelines to determine each client's recommended frequency of monitoring. We will explore the literature to determine action steps once a client is identified as having metabolic syndrome.

# STRATEGIC PERFORMANCE EXCELLENCE

## Nursing

### INDICATOR

#### Mandate Occurrences

### DEFINITION

When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy. This creates difficulty for the employee who is required to unexpectedly stay at work up to 16 hours. It also creates a safety risk.

### OBJECTIVE

Through collaboration among direct care staff and management, solutions will be identified to improve the staffing process in order to reduce and eventually eliminate mandate occurrences. This process will foster safety in culture and actions by improving communication, improving staffing capacity, mitigating risk factors, supporting the engagement and empowerment of staff. It will also enhance fiscal accountability by promoting accountability and employing efficiency in operations.

### THOSE RESPONSIBLE FOR MONITORING

Monitoring will be performed by members of the Staffing Improvement Task Force which includes representation of Nurses and Mental Health Workers on all units, Staffing Office and Nursing Leadership.

### METHODS OF MONITORING

Monitoring would be performed by;

- Staffing Office Database Tracking System

### METHODS OF REPORTING

Reporting would occur by one or all of the following methods;

- Staffing Improvement Task Force
- Nursing Leadership
- Riverview Nursing Staff Communication

### UNIT

Mandate shift occurrences

### BASELINE

August 2012: Nurse Mandates 24 shifts, Mental Health Worker Mandates 53 shifts

### MONTHLY TARGETS

Baseline –10% each month

# STRATEGIC PERFORMANCE EXCELLENCE

## Nursing Department Mandates Staffing Improvement Task Force

Safety in Culture and Actions	Unit	July 2013	Aug 2013	Sept 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014	Goal
<a href="#">Mandate Occurrences – Nurses</a>	# of shifts	5	3	20	4	8	9	3	12	15	13
When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy.											
<a href="#">Mandate Occurrences – Mental Health Workers</a>	# of shifts	51	30	98	32	30	29	20	49	54	49
When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy.											

### Comments

Nursing mandates were up this quarter from 21 last quarter to 30 this quarter. MHW mandates were also up from 91 last quarter to 123 this quarter.

# STRATEGIC PERFORMANCE EXCELLENCE

## Peer Support

### INDICATOR

Client Satisfaction Survey Return Rate

### DEFINITION

There is a low number of satisfaction surveys completed and returned once offered to clients due to a number of factors.

### OBJECTIVE

To increase the number of surveys offered to clients, as well as increase the return rate.

### THOSE RESPONSIBLE FOR MONITORING

Peer Services Director and Peer Support Team Leader will be responsible for developing tracking tools to monitor survey due dates and surveys that are offered, refused, and completed. Full-time peer support staff will be responsible for offering surveys to clients and tracking them until the responsibility can be assigned to one person.

### METHODS OF MONITORING

- Biweekly supervision check-ins
- Monthly tracking sheets/reports submitted for review

### METHODS OF REPORTING

- Client Satisfaction Survey Tracking Sheet
- Completed surveys entered into spreadsheet/database

### UNIT

All client care/residential units

### BASELINE

Determined from previous year's data.

### QUARTERLY TARGETS

Quarterly targets vary based on unit baseline with the end target being 50%.

# STRATEGIC PERFORMANCE EXCELLENCE

## Peer Support

Inpatient Client Survey – Improving the Rate of Return

Department: Peer Support Responsible Party: Chris Monahan

Strategic Objectives								
Client Recovery	Unit	Baseline	FY14 Q1	FY14 Q2	FY14 Q3	FY14 Q4	Goal	Comments
<b>CSS Return Rate</b>								
<i>The client satisfaction survey is the primary tool for collecting data on how clients feel about the services they are provided at the hospital. Data collection has been low on all units and the way in which the surveys are administered has challenges based on the unit operations and performance of the peer support worker.</i>	LK	15%	5%	18%	10%		50%	<i>Percentages are calculated based on number of people eligible to receive a survey vs. the number of people who completed the surveys.</i>
	LS	5%	4%	8%	10%	50%	50%	
	UK	45%	39%	47%	30%		50%	
	US	30%	100%	33%			50%	

**Summary:** 60 (51 discharges / 9 annuals) surveys were offered to clients. The number of refusals and surveys not returned, brought the completed total to only 14 surveys.

# STRATEGIC PERFORMANCE EXCELLENCE

## Summary of Inpatient Client Survey Results

#	Indicators	1Q2014	2Q2014	3Q2014	Average
		Findings	Findings	Findings	Score
1	I am better able to deal with crisis.	70%	69%	73%	71%
2	My symptoms are not bothering me as much.	78%	71%	63%	71%
3	The medications I am taking help me control symptoms that used to bother me.	65%	75%	83%	74%
4	I do better in social situations.	69%	73%	65%	69%
5	I deal more effectively with daily problems.	70%	69%	68%	69%
6	I was treated with dignity and respect.	70%	75%	73%	73%
7	Staff here believed that I could grow, change and recover.	73%	69%	80%	74%
8	I felt comfortable asking questions about my treatment and medications.	63%	69%	70%	67%
9	I was encouraged to use self-help/support groups.	65%	77%	70%	71%
10	I was given information about how to manage my medication side effects.	65%	63%	65%	64%
11	My other medical conditions were treated.	63%	71%	75%	70%
12	I felt this hospital stay was necessary.	63%	63%	65%	64%
13	I felt free to complain without fear of retaliation.	60%	53%	50%	54%
14	I felt safe to refuse medication or treatment during my hospital stay.	39%	63%	55%	52%
15	My complaints and grievances were addressed.	58%	65%	68%	64%
16	I participated in planning my discharge.	67%	73%	65%	68%
17	Both I and my doctor or therapists from the community were actively involved in my hospital treatment plan.	58%	73%	65%	65%
18	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	72%	71%	63%	69%
19	The surroundings and atmosphere at the hospital helped me get better.	68%	69%	65%	67%
20	I felt I had enough privacy in the hospital.	68%	71%	63%	67%
21	I felt safe while I was in the hospital.	65%	75%	75%	72%
22	The hospital environment was clean and comfortable.	73%	75%	78%	75%
23	Staff was sensitive to my cultural background.	63%	83%	55%	67%
24	My family and/or friends were able to visit me.	78%	77%	78%	78%
25	I had a choice of treatment options.	58%	73%	60%	64%
26	My contact with my doctor was helpful.	70%	77%	68%	72%
27	My contact with nurses and therapists was helpful.	60%	79%	78%	72%
28	If I had a choice of hospitals, I would still choose this one.	58%	69%	48%	58%
29	Did anyone tell you about your rights?	58%	71%	63%	64%
30	Are you told ahead of time of changes in your privileges, appointments, or daily routine?	60%	67%	45%	57%
31	Do you know someone who can help you get what you want or stand up for your rights?	58%	71%	70%	66%
32	My pain was managed.	64%	65%	65%	65%
	<b>Overall Score</b>	<b>64%</b>	<b>71%</b>	<b>66%</b>	<b>67%</b>

**Summary:** Overall satisfaction dropped by 5% in this quarter.

# STRATEGIC PERFORMANCE EXCELLENCE

## Pharmacy Services

The IPEC reporting reflects three major areas of focus for performance improvement that have pharmacy specific indicators: **Safety in Culture and Actions, Fiscal Accountability and Medication Management** (see [Medication Management – Dispensing Process](#)). The pharmacy specific indicators for each of the priority focus areas utilizes measurable and objective data that is trended and analyzed to support performance improvement efforts and medication safety, as well as, ensure regulatory compliance and best practice in key areas.

### **Safety in Culture and Actions**

RPC's primary medication distribution system uses the Pyxis Medstations to provide an electronic "closed loop" system to dispense medications for patients. Within the Pyxis system, key data elements are reported, trended and analyzed to ensure medication safety and regulatory compliance are maintained. *Pyxis Discrepancies* created by nursing staff are monitored daily and analyzed by Pharmacy with follow up to Nursing as needed for resolution. A monthly summary is provided to the Nursing-Pharmacy Committee for further review and discussion of trends and ideas to minimize the occurrence of discrepancies by Nursing. *Pyxis Overrides of Controlled Drugs* by nursing staff is another indicator that is closely monitored and trended with follow up for resolution as needed. A monthly summary is also reviewed by the Nursing-Pharmacy Committee for action steps. The goal with each of these indicators is to minimize the occurrence of either discrepancies or overrides by action steps to address performance issues via education or system changes which help satisfy TJC requirements for monitoring the effectiveness of the Medication Management system. *Veriform Medication Room Audits* are performed on each medication room to determine compliance with established medication storage procedures and requirements. The results of the audits are shared with the nursing managers for their respective corrective actions or staff education.

### **Fiscal Accountability**

The *Discharge Prescriptions* indicator tracks the cost and number of prescription drugs dispensed to patients at discharge. This baseline data will be used to determine the best approach to implement steps to decrease this expense. The lack of a resource to perform insurance verification and research prior authorizations needed so clinicians' can make timely and informed prescribing decisions is believed to be inherent in the discharge process. Without this resource, RPC is obliged to provide discharge medications to prevent a gap in medication coverage as the patient is being transitioned to another facility. The plan of correction is to explore options and propose a resolution to RPC's Medical Director.

# STRATEGIC PERFORMANCE EXCELLENCE

## Pharmacy Services

Department: Pharmacy Responsible Party: Garry Miller, R.Ph.

Strategic Objectives								
Safety in Culture and Actions	Unit	Baseline 2013	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
<u>Pyxis CII Safe Comparison</u>								10 discrepancies between Pyxis and CII Safe transactions during Q3
<i>Daily and monthly comparison of Pyxis vs CII Safe transactions</i>	Rx		0%	0%	0%	0%		
<b>Quarterly Results</b>			0.3%	0%	2.5%			
<u>Veriform Medication Room Audits</u>								Overall compliance is 98% for Q1, Q2 and Q3
<i>Monthly comprehensive audits of criteria</i>	All	97%	100%	100%	100%	100%	90%	
<b>Quarterly Results</b>			98%	98%	98%			
<u>Pyxis Discrepancies</u>								Trending of monthly data was significantly increased for Q2 and Q3 vs Q1
<i>Monthly monitoring and trending of Pxyis discrepancies.</i>	All	63/mo	50	50	50	50	50/mo	
<b>Quarterly Results</b>			226 (75/mo)	403 (134/mo)	389 (130/mo)			
<u>Pyxis Overrides – Controlled Drugs</u>								Target goal is 10/month
<i>Monthly monitoring and trending of Pyxis overrides for Controlled Drugs</i>	All	15/month	10	10	10	10	10	
<b>Quarterly Results</b>			65	53	114			
Fiscal Accountability	Unit	2013 Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
<u>Discharge Prescriptions</u>								Significant costs are incurred in providing discharge drugs.
<i>Monitoring and Tracking of dispensed Discharge Prescriptions</i>	Rx	\$8440 334 drugs	\$5262 418 drugs	\$4184 252 drugs	\$2679 359 drugs			

# STRATEGIC PERFORMANCE EXCELLENCE

## Program Services

### Define

Client participation in on-unit groups and utilization of resources to relieve distress is variable but should be promoted to encourage activities that support recovery and the development of skills necessary for successful community integration.

### Measure

The program services team will measure the current status of program participation and resource utilization to identify a baseline for each of the four units.

### Analyze

Analysis of the barriers to utilization will be conducted in an attempt to determine causation factors for limited participation.

### Improve

Strategies for encouraging increased participation in on-unit groups and the utilization of resources to relieve distress will be identified in a collaborative manner with client and staff participation.

### Control

Ongoing review of utilization of programs and resources will be conducted to determine whether unit practice has changed and improvements are sustainable.

INDICATOR	Baseline	Quarterly Improvement Target	Improvement Objective
1. How many on unit groups were offered each week Day shift → Evenings →			14
2. Number of clients attending day groups on unit or facilitated by day staff (# of clients in all of day groups divided by # of day groups provided)			
3. Number of clients attending evening groups on unit or facilitated by evening staff (# of clients in all of evenings groups divided by # of evening groups provided)			
4. Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended.			100%
5. The client can identify distress tolerance tools on the unit			100%
6. The client is able to can identify his or her primary staff.			100%

# STRATEGIC PERFORMANCE EXCELLENCE

## Program Services Lower Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. How many on unit groups were offered each week Day shift → Evenings →	Days 7 Evenings 7	100%	14 weekly
2. Number of clients attending day groups on unit or facilitated by day staff (approx.)	3	60%	5/group
3. Number of clients attending evening groups on unit or facilitated by evening staff (approx.)	4	80%	5/group
4. Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended	9/10	90%	100%
5. The client can identify distress tolerance tools on the unit	9/10	90%	100%
7. The client is able to state who his primary staff is	8/10	80%	100%

### EVALUATION OF EFFECTIVENESS

On unit groups continue each day of the week on the day and evening shifts. There has been an increase in the number of clients that can identify coping tools on the unit. This may be a result of promotion of these items in this quarter. There is a slight decrease in the number of clients who identified their primary worker. The percentage of on unit groups on the treatment plans has improved this quarter from 50% to 90%. This is attributed to the QA checks that nursing leadership is performing on the treatment plans.

### ISSUES

Participation in on unit groups is not meeting the threshold. Attendance varies with census, client movement through admission, discharge and transfers on the acute lower Kennebec unit.

### ACTIONS

An emphasis on personal medicine and recovery education as well as implementation will continue through the next quarter

# STRATEGIC PERFORMANCE EXCELLENCE

## Program Services Upper Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. How many on unit groups were offered each week Day shift → Evenings →	Days 7 Evenings 7	100%	14weekly
2. Number of clients attending day groups on unit or facilitated by day staff (approx.)	3/5	60%	5/group
3. Number of clients attending evening groups on unit or facilitated by evening staff (approx.)	4/5	80%	5/group
4. Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended	4/10	40%	100%
5. The client can identify distress tolerance tools on the unit	9/10	90%	100%
7. The client is able to state who his primary staff is	9/10	90%	100%

**EVALUATION OF EFFECTIVENESS** On unit groups are offered daily on the day and evening shifts. The percentage of on unit groups on the treatment plan has decreased this quarter from 90% to 40%. The unit acuity and census has increased. Regular assigned unit nursing staff has had a slight decrease.

**ISSUES** Participation in on unit groups is not meeting the threshold. The team will continue to evaluate feedback from clients on group satisfaction.

**ACTIONS** Measures to in cooperate on unit groups on all client treatment plans have been put in place. An emphasis on personal medicine and recovery education as well as implementation will continue through the next quarter.

# STRATEGIC PERFORMANCE EXCELLENCE

## Program Services Lower Saco

INDICATOR	FINDINGS	%	THRESHOLD
<b>1. How many on unit groups were offered each week</b> Day shift → Evenings →	Main/SCU 36 / 12 27 / 10	100% 100%	<b>7 / 7 = 14</b> <b>7 / 7 = 14</b>
<b>2. Number of clients attending day groups on unit or facilitated by day staff</b> (# of clients in all of day groups divided by # of day groups provided)	4.5 / 1.5		N/A
<b>3. Number of clients attending evening groups on unit or facilitated by evening staff</b> (# of clients in all of evenings groups divided by # of evening groups provided)	3.5 / 1		N/A
<b>4. Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended</b>	10	100%	<b>100%</b>
<b>5. The client can identify distress tolerance tools on the unit</b>	30/30	100%	<b>100%</b>
<b>7. The client is able to state who his primary staff is</b>	30/30	100%	<b>100%</b>

### EVALUATION OF EFFECTIVENESS

#### ISSUES

The Lower Saco unit on-unit groups by MHWS and professional staff is on-going and well established. Documentation in the Meditech has improved. This treatment effort continues to be reflected in the treatment plans. The on-unit groups have been a regular part of each client’s daily activity and are incorporated in their Rx plans. A high level of acuity on any given day can negatively impact levels of attendance and interest. Recreational Therapy staff members are more consistent in documenting participation and nursing staff have improved documentation over the past quarter. Only an occasional new client may need to be reminded about available tools/activities to help relieve distress.

#### ACTIONS

RT staff members are very important in providing diversion and therapy groups to Lower Saco clients, which needs to be maintained. The unit is offering many more groups weekly than the threshold; We have added new staff acuity specialist positions, which have helped address acuity situations and further improved overall quality of groups.

# STRATEGIC PERFORMANCE EXCELLENCE

## Program Services Upper Saco

INDICATOR	FINDINGS	%	THRESHOLD
<b>1. How many on unit groups were offered each week</b> Day shift → Evenings →	14 9	100% 100%	<b>Days/ Even.</b> <b>7 / 7 = 14</b>
<b>2. Number of clients attending day groups on unit or facilitated by day staff</b> (# of clients in all of day groups divided by # of day groups provided)	1.5avg./14grps		N/A
<b>3. Number of clients attending evening groups on unit or facilitated by evening staff</b> (# of clients in all of evenings groups divided by # of evening groups provided)	4avg./9grps		N/A
<b>4. Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended</b>	3	30%	<b>100%</b>
<b>5. The client can identify distress tolerance tools on the unit</b>	30/30	100%	<b>100%</b>
<b>7. The client is able to state who his primary staff is</b>	30/30	100%	<b>100%</b>

### EVALUATION OF EFFECTIVENESS

#### ISSUES

There continues to be a need to better reflect this on-unit treatment effort in the treatment plans. Nearly all of the clients on Upper Saco attend the hospital treatment mall with a high level of participation and attendance with off-unit treatment. Off unit groups are reflected in the treatment plans and are a regular part of physician orders. As in previous reports, there needs to be increased effort at reflecting on-unit groups in the treatment plans, especially for weekends and for clients not regularly attending the hospital treatment mall.

#### ACTIONS

Newly admitted clients quickly become familiar with distress tolerance tools (MP3 players, cards, exercise machines, etc.) and how to access them. They also know their assigned primary staff. Additional efforts need to be made to get all on-unit offered groups in individual treatment plans. Continued efforts are being made to offer groups to those clients that have less activity at the hospital treatment mall. Treatment planning on-unit groups and follow-up documentation issues are being identified with the new nursing leader.

# STRATEGIC PERFORMANCE EXCELLENCE

## Rehabilitation Services

Department: Rehabilitation Services Responsible Party: Janet Barrett

Strategic Objectives							
Client Recovery	<u>Baseline</u>	<u>Q1 Target</u>	<u>Q2 Target</u>	<u>Q3 Target</u>	<u>Q4 Target</u>	<u>Goal</u>	<u>Comments</u>
<p><b><u>Vocational Incentive Program Treatment Plans</u></b></p> <p><i>The objective of this improvement project is to ensure vocational treatment plans are initiated on all clients within 5 days of beginning work and will be reviewed and updated if necessary every 30 days. Documentation on interventions in the treatment plans will reflect progress towards interventions and will be documented on weekly.</i></p>	55%	92%	95%	98%	100%	The treatment plans will be reviewed more regularly and updated at each client 30 day treatment team meeting.	All charts reviewed but 1 had current plans in the chart. The plan was completed by the employment specialist but was missing in the chart. New one printed and placed in the chart. 2 charts missing bi weekly documentation
<b><u>Quarterly Results</u></b>		95%	88%	93%			

Client Recovery	<u>Baseline</u>	<u>Q1 Target</u>	<u>Q2 Target</u>	<u>Q3 Target</u>	<u>Q4 Target</u>	<u>Goal</u>	<u>Comments</u>
<p><b><u>Recreational Therapy Assessments &amp; Treatment Plans</u></b></p> <p><i>The objective of this improvement project is to ensure that Recreational Therapy assessments are completed within 7 days of admission and that a treatment plan is initiated after the assessment and will be reviewed and updated if necessary every 30 days. Documentation on interventions in the treatment plans will reflect progress towards interventions and will be documented on weekly.</i></p>	75%	85%	90%	95%	100%	The treatment plans will be reviewed more regularly and updated at each client treatment team meeting or if there is any change in client status	All plans updated and documentation in the chart for this quarter.
<b><u>Quarterly Results</u></b>		85%	91%	100%			

# STRATEGIC PERFORMANCE EXCELLENCE

## Rehabilitation Services

Department: Rehabilitation Services Responsible Party: Janet Barrett

Strategic Objectives							
Client Recovery & Safety in Culture and Actions	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
<p><b><u>Occupational Therapy referrals and doctors orders.</u></b></p> <p><i>The objective of this improvement project is to ensure each client receiving Occupational Therapy Services from RPC OT staff has a doctor's order as well as a referral form completed prior to the initiation of services.</i></p>	33%	50%	75%	100%	100%	To increase the percentage of referrals and doctor's orders by 25 % each quarter until we attain 100% compliance.	Only 1 client which the Dr.'s order was written the day services started but the referral was not received until 3 days later.
<b><u>Quarterly Results</u></b>		91%	81%	96%			