

# Riverview

PSYCHIATRIC CENTER



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## PERFORMANCE IMPROVEMENT REPORT

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FIRST QUARTER  
SFY 07  
JULY, AUGUST AND SEPTEMBER

DAVID PROFFITT, SUPERINTENDENT

10/23/2006

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**Introduction:**

The quarterly report will be presented in four different sections. Section I focuses on various departmental quality assessment and process improvement indicators. Each department has identified indicators, established thresholds, and concurrently collects data and assesses the data to help make the improvement actions be data driven and measurable. Implementation and evaluation of all departmental improvement actions is ongoing, and is intended to help each department to continuously improve the services they offer to clients at Riverview Psychiatric Center. Section II includes budget and Human resources data with trends unique to Riverview. Section III focuses on Performance Measurement trend information comparing Riverview Psychiatric Center to the National Norms for similar Psychiatric facilities. Sections IV pertains to committee-driven or otherwise authorized Process Improvement Team Activities.

**Section I: Departmental Quality Assessment & Performance Improvement**

Medical and Nursing departmental indicators have been retracted. Departmental QA is being reconstructed quality calendars will be accomplished by November 10, 2006 to be reported in the next quarterly report;

***PEER SUPPORT***

ASPECT: Integration of Peer Specialists into client care

OVERALL COMPLIANCE: 91 %

1 <sup>st</sup> Quarter 2007 July, August and September Peer Specialists			
Indicators	Compliance	Findings	Threshold Percentile
1. Attendance at Comprehensive Treatment Team meetings.	414 of 503	82%	80%
2. Grievances responded to by RPC on time.	172 of 173	99%	100%
3. Attendance at Service Integration meetings.	66 of 68	97%	100%
4. Contact during admission.	83 of 84	99%	100%
5. Grievances responded to by	173 of 173	100%	100%

peer support on time.			
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**Findings:** Overall compliance is up 8% this quarter.

(1) Peer Specialists attended 414 of 503 treatment team meetings this quarter. Admissions accounted for 16 of the missed meetings, 4 were due to other meeting obligations, 10 due to mandatory training, 35 due to peer specialist being out sick or on vacation, 2 due to no peer specialist being available to attend the meetings, and 22 were due to client not wanting peer support present.

(2) Level I grievances were responded to on time 99% of the time. There was 1 late grievance for this quarter (1 day late on Lower Saco in the month of July). This is primarily due to the implementation of a new reminder system being put in to place.

(3) Peer Specialists attended 66 of 68 Service Integration Meetings this quarter. Attendance is up 5% from last quarter. The 2 missed meetings were due to Peer Specialists attending a mandatory training.

(4) Clients had documented contact with a Peer Specialist 99% of the time for this quarter. One contact was not made due the client being admitted overnight and discharged the following day before contact could be made. This is a new indicator as of July 2006.

(5) This is a new indicator as of July 2006. A Peer Specialist processed all grievances filed within 1 business day of grievance receipt for this quarter.

**Problems:** All indicators on this aspect are at or above established thresholds. However, there is still room for improvement.

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

(2) Level I grievances are not being responded to on time 1% of the time.

(3) Peer Specialists are not always notified or available for Service Integration Meetings.

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

**Status:**

(1) Overall percentage of attendance at treatment team meetings was up 2% from last quarter. Peer Specialists missed 107 meetings last quarter and only missed 89 this quarter. September had the highest attendance rate this quarter at 84% (July, 81% and August 82%). Attendance has consistently been within this range. Peer Specialists continue to track their attendance at treatment team meetings as well as their reason for not attending meetings.

(2) Grievance responses were on time for both August and September. The Peer Support Coordinator is meeting with the Risk Manager as needed to address late grievances on a monthly basis. The newly implemented reminder system appears to be successful in getting responses to grievances on time.

(3) Peer Specialists have adjusted schedules to ensure that there are fewer conflicts with treatment team and Service Integration Meeting schedules. Peer Support Coordinator is providing coverage when necessary and able. This coverage is limited, but does increase overall attendance.

**Actions:**

(1&3) Peer Specialists will continue to track Comprehensive Treatment Team Meeting attendance and reasons for not attending in order to problem solve ways to address the reason for missed meetings.

- Some meetings are missed due to mandatory peer support trainings that all Peer Specialists must attend and cannot be present for meetings.
- Peer Support Coordinator will confer with Peter Driscoll, Executive Director of Amistad, and Program Service Directors to provide coverage at those times. Peer Specialists will make additional efforts to adjust their schedules to be available for meetings and problem-solve with the Peer Support Coordinator on how to manage their schedule and overcome barriers to attending team meetings.
- Peer Support Coordinator will address missed meetings related to Peer Specialists not being notified of Service Integration Meetings with the Social Services Director.
- Peer Support Coordinator will meet with the Social Services Director and Continuity of Care Managers as needed to coordinate meeting schedule in order to ensure Peer Support attendance

(2) The Peer Support Coordinator will continue to meet with the Risk Manager as needed to address grievances that are not responded to within the time allowed.

(4) Peer Support Coordinator will encourage Peer Specialists to make initial contact with newly admitted clients a priority.

***PROGRAM SERVICE DIRECTORS/NURSING***

ASPECT: COMPREHENSIVE SERVICE PLAN

OVERALL COMPLIANCE: 91% (617/680)

1 <sup>st</sup> Quarter 2007 July, August and September 2006 Comprehensive Service Plan			
Indicators	Findings	Compliance	Threshold Percentile
1. Initial treatment documented within 24 hours.	44/45	98%	100%
2. Preliminary Continuity of Care (service integration) meeting completed by end of 3 <sup>rd</sup> day.	43/45	96%	95%
3a. Client Participation in Preliminary Continuity of Care meeting.	42/45	93%	80%
3b. CCM Participation in Preliminary Continuity of Care meeting.	43/45	96%	80%
3c. Client's Family Member and/or Natural Support (e.g., peer support, advocacy, attorney) Participation in Preliminary Continuity of Care meeting.	42/45	93%	80%

3d. Community Provider Participation in Preliminary Continuity of Care meeting.	15/37 8 n/a	41%	80%
3e. Correctional Personnel Participation in Preliminary Continuity of Care Meeting.	1/15 30 n/a	06%	80%
4. Presenting Problem in behavioral terms.	44/45	98%	85%
5. Strengths and preferences are identified.	44/45	98%	85%
6. Client LTG is observable and measurable	39/45	87%	85%
7. Comprehensive Plan complete by the 7 <sup>th</sup> day.	44/45	98%	100%
8. STG/Objectives are written, dated, numbered, observable and measurable.	45/45	100%	85%
10. Interventions are identified.	44/45	98%	85%
11a. Integrated Needs/Assessment Prioritized by scale at bottom of sheet.	42/45	93%	85%
11b. Integrated Needs/Assessment Contains all needs/ issues/problems found within the assessments/evaluations since admission.	44/45	98%	85%
12. Active medical issues addressed via Medical/ Nursing care plans.	41/43 2 in good health	95%	85%

**Observed Indicator Compliance:** The above table provides relevant details by each indicator of this aspect. The “Findings” column shows number of cases found in compliance with the indicator per number of applicable cases audited. The “Compliance” column expresses these findings as a percentage of cases in compliance. The “Threshold Percentile” column shows the compliance target set for each indicator. Three indicators were below threshold: 3d--Community Provider Participation in Preliminary Continuity of Care meeting; 3e,--Correctional Personnel Participation in Preliminary Continuity of Care Meeting; and 7--Comprehensive Plan complete by the 7<sup>th</sup> day. **All other indicators were above desired threshold.**

**Findings:** For this indicator the overall compliance rate was 91% and sample size was 45 charts. However, the applicable sample was lower for 3 indicators: #3d Community Provider Participation in Preliminary Continuity of Care meeting as only 37 of the 45 clients had community providers; #3e Correctional Personnel Participation in Preliminary Continuity of Care Meeting as only 15 clients had involvement with corrections (all from the forensic admission unit); and #12 Active medical issues addressed via Medical/ Nursing care plans as 2 clients were in very good physical health. During this quarter the admission units experienced a fluctuating census, but high acuity at times. There was also a change in the leadership of the forensic admission unit with the addition of a new

Program Service Director and CCM vacancy on that unit. Participation from community providers was generally poor and highly variable across units (best participation at 64% on Lower Kennebec, poorest participation of 27% on Lower Saco). Participation by correctional staff was only applicable to Lower Saco clients this quarter, and the participation rate was a mere 06%. Comprehensive Service Plans being completed by the end of the 7<sup>th</sup> day of hospitalization was below threshold, but this is due to only 1 plan being late in the sample.

**Problems:** Only three indicators are identified as problems, with compliance below established thresholds: Community Provider participation, Correctional staff participation, and Comprehensive Service Plan completion by the 7<sup>th</sup> day of hospitalization

**Status:** Last quarter there were two indicators below threshold, and those same two remain significantly below threshold this quarter: 3d--Community Provider Participation in Preliminary Continuity of Care meeting and 3e--Correctional Personnel Participation in Preliminary Continuity of Care Meeting. This quarter there is a third indicator just below threshold (100% last quarter vs. 98% this quarter). All other indicators remain above threshold, just like last quarter. Within those, only #6 related to the Long-Term Goal being observable and measurable showed notable fluctuation from last quarter (a 10% decline, but still above threshold). The bulk of the variability in that indicator was seen on one unit, Upper Kennebec. The corrective actions planned last quarter to the identified problems with 3d and 3e were started, but are yet to be systematically applied as there was a delay in successfully recruiting a permanent, full-time Social Services Director and filling two vacancies in that department. A permanent Social Services Director was hired, oriented and is currently developing a Social Service Department Performance Improvement plan, with these indicators as a focus in that plan. In addition, there was a change in the Program Service Director on Lower Saco where all of the clients with involvement from correctional personnel applies.

**Actions:** (by indicator number):

#3d. Social Services Director has been assigned this as a focus for that Department's Performance Improvement Plan to be implemented during the month of October, reported to the Deputy Superintendent and Program Service Directors monthly.

#3e. Social Services Director has been assigned this as a focus for that Department's Performance Improvement Plan to be implemented during the month of October, reported to the Deputy Superintendent and Program Service Directors monthly.

#7. The slight variance in this indicator around a target threshold of 100% represents an isolated and uncommon event. Corrective Actions applied to the process have been largely successful. Monitoring will continue under the department of Nursing as any continued process variability would be attributable to the practices of a professional nurse.

On all of the other indicators not mentioned above, the Program Services Directors have maintained process stability above threshold. With this in mind, continued monitoring on this aspect will be moved to the department of nursing.

PROGRAM SERVICE DIRECTORS/NURSING  
ASPECT: SERVICE PLAN REVIEWS  
OVERALL COMPLIANCE: 96% (405/424)

1 <sup>st</sup> Quarter 2007 July, August and September 2006 Service Plan Reviews			
Indicators	Findings	Compliance	Threshold Percentile
1. Completed no later than 14 days for the first 6 months and monthly thereafter.	55/59	93%	85%
2. Completed within 72 hours of a restrictive treatment.	7/11 49 n/a	64%	85%
3a. Review form documents client participated in the review	55/59	93%	85%
3b. Review form documents psychiatrist participated in the review	59/59	100%	85%
3c. Review form documents CCM participated in the review	59/59	100%	85%
3d. Review form documents nurse participated in the review	59/59	100%	85%
4. Review form indicates plan as having met identified goals or not.	53/59	90%	85%
5. Review form states whether client continues to meet admission criteria or not	58/59	98%	85%

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

**Findings:** For this indicator the overall compliance rate was 96% and sample size was 59 charts. During this quarter the admission units experienced a fluctuating census, but high acuity at times. There was also a change in the leadership of the forensic admission unit with the addition of a new Program Service Director. The one indicator below threshold was on Lower Saco.

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

**Status:** Last report indicator #2 was also below threshold (83% last quarter vs. 64% current quarter); on all units except Lower Saco, the corrective action from last quarter to apply a new form that triggers and guides efficient review process post-event was effective. On Lower Saco, this was not applied and this is a major focus of intervention on the Lower Saco unit next quarter. Last quarter indicator #4 was also below threshold, and is now above threshold (improvement of 6%); it is thought the inclusion of the nurse educator on Lower Saco in the staffing pattern, active performance feedback, enhanced orientation processes, and use of established template assisted in this.

**Actions:** Regarding indicator #2, this appears to be an individual performance (vs. process) issue at this point. In addition to any continued monitoring by the department of Nursing, PSDs will continue to monitor and report findings on all Service Plan Review aspects until process stability is attained on all units, and to ensure PSDs continue to closely review Service Plans and associated processes, and develop corrective actions if needed.

PROGRAM SERVICE DIRECTORS FOR NURSING  
 ASPECT: INTEGRATED SUMMARY NOTE  
 OVERALL COMPLIANCE: 75% (203/270)

1 <sup>st</sup> Quarter 2007 July, August and September 2006 Integrated Summary Note			
Indicators	Findings	Compliance	Threshold Percentile
1. Documented in the chart on the day of the Comprehensive Service Plan Meeting.	40/45	89%	85%
2. Identifies Client Preferences identified at admission and Service Integration Meeting as	33/45	73%	85%
3. Identifies general needs of client -- identified on completed assessment.	31/45	69%	85%
4. States whether further assessments will be needed or not.	28/45	62%	85%
5. Identifies the general goals of services.	34/45	75%	85%
6. Documents the client or guardian participation in the treatment planning process.	37/45	82%	85%

**Observed Indicator Compliance:** The above table provides relevant details by each indicator of this aspect. The “Findings” column shows number of cases found in compliance with the indicator per number of applicable cases audited. The “Compliance” column expresses these findings as a percentage of cases in compliance. The “Threshold Percentile” column shows the compliance target set for each indicator. The only indicator above threshold this quarter is #1. All other indicators are below threshold.

**Findings:** For this indicator the overall compliance rate was 75% and sample size was 45 charts. During this quarter the admission units experienced a fluctuating census, but high acuity at times. There was also a change in the leadership of the forensic admission unit with the addition of a new Program Service Director, and changes in nursing leadership on that unit as well as Upper Kennebec. Documentation pertaining to this indicator is typically completed by a Nurse, and thus, this aspect is particularly sensitive to changes in associated Nursing processes, changes in nurses, orientation of new nurses, and the like. There were many such changes in the nurse staffing on the units with the poorest variability on this aspect. This quarter the civil units had the best performance (87% overall compliance on both units) and Lower Saco the poorest (52% overall compliance with all indicators significantly below threshold). This is viewed primarily as a charge nurse issue combined with changes in leadership on Lower Saco such that monitoring of performance indicators suffered.

**Problems:** Indicators 2, 3, 4, 5 and 6 were all below threshold, and significantly so. Looking at the unit-based data, most of the variability on this aspect is associated with Lower Saco. Some of the remaining variability was on Lower Kennebec.

**Status:** Last quarter, the only indicator below threshold was #4, and the vast majority of the process variability was on Lower Saco. Compared to last quarter, there were across the board significant declines this quarter on all of the indicators, with only one (#1) remaining above threshold, as follows:

- #1 down 11%
- #2 down 17%
- #3 down 24%
- #4 down 18%
- #5 down 20%
- #6 down 16%

Root cause appears to be related to variability within nursing staff, processes and resources on this aspect generally.

**Actions:** Warranted corrective action appears to be general to this aspect, particularly on two units--not focal indicators or all units. On the units with most variability, Program Service Directors identify that there has been poor utilization of the previously established (and effective) template to guide writing these summaries. When the template is utilized by the author of the summary, there are good results. Thus, this is seen as a problem of consistent implementation. The PSDs will ensure this expectation is communicated to all staff writing these summaries on their unit. They will post a copy of the template in any location this summary is likely to be written and communicate the expectation to any staff member working on the unit who would write such a summary. The DON will review the same with any staff member in the float pool. It is

hypothesized the addition of the specialized forensic stipend and associated pay differential will help stabilize the staffing on Lower Saco which would enhance teamwork over time, and skill development to stay on the unit. Deputy Superintendent is collaborating with the Director of Nursing and PSDs for assessment, development of corrective actions, and future Performance Improvement monitoring.

PROGRAM SERVICE DIRECTORS  
 ASPECT: PROGRESS NOTES  
 OVERALL COMPLIANCE: 95% (114/120)

1 <sup>st</sup> Quarter 2007 July, August and September 2006 Progress Notes.			
Indicators	Findings	Compliance	Threshold Percentile
1. Review note indicates changes made in the plan to implement further progress.	57/60	95%	85%
2. Level of client participation in active treatment is documented.	57/60	95%	85%

**Observed Indicator Compliance:** The above table provides relevant details by each indicator of this aspect. The “Findings” column shows number of cases found in compliance with the indicator per number of applicable cases audited. The “Compliance” column expresses these findings as a percentage of cases in compliance. The “Threshold Percentile” column shows the compliance target set for each indicator. Both indicators are above threshold, again.

**Findings:** Overall compliance on this aspect is 95% with a sample size of 60. All indicators are above threshold.

**Problems:** There are no identified problems this quarter, again.

**Status:** Process stability has been consistently maintained.

**Actions:** It does not appear necessary to continue to monitor this aspect. By mutual agreement with the Deputy Superintendent, Director of Nursing will provide any continued monitoring to maintain adequate compliance.

**REHABILITATION**

ASPECT: CLIENT ATTENDANCE AT HARBOR MALL  
 OVERALL COMPLIANCE: 80%

Indicators	Findings	Compliance	Threshold Percentile
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Attendance by clients scheduled to attend mall groups on a daily basis	2548 of 3195	80%	70%
Attendance at morning programming	1294 of 1647	79%	70%
Attendance at afternoon programming	1254 of 1548	81%	70%

**Findings:**

The sample is based on a 12-week session of the Harbor Mall from 7/10/06 to 9/29/06. For the 12-week period, the morning programming had 1294 client interactions out of a possible 1647 for a 79% total, up 8% from last report. The afternoon programming had 1254 client interactions out of 1548 for a 81% total, up 10 % from the last report. This means that for the 59 days the mall was in session there was a compliance rate of 80%. As a result of the action steps taken last quarter, there was an increase in both the morning and the afternoon programming. The average daily attendance for the morning and afternoon programming was 21 clients. The Mall programming not only met but exceeded our expected outcome by 10%.

**Problem:**

The system and changes that have been put in place over the past 12 months in regards to client participation in Treatment Mall programs has resulted in the achievement of the desired overall compliance rate for the past two quarters. An informal monitoring will continue however the focus will shift. The next issue to look at will be if the average number of clients attending programming on the mall is only about one quarter of the hospital, what are the other 75% of the clients doing with their time?

**Status:**

In December of 2004 the morning and afternoon programming hit its lowest rate of 60% for the morning and 55% for the afternoon leaving an overall compliance rate of 57%. In the past two quarters that number has increased by 23%. The increase communication, change in expectations, Psych Rehab training as well as training that was provided to group leaders in July along with incorporation of client suggestions have all been contributing factors to the dramatic increase in compliance. Clients with engagement plans are getting more involved in their prescribed treatment while others continue to require the interventions written on their plans. The past 6 months have shown that the improvement have not only sustained, they continue to increase.

**Actions:** Develop a new plan to look at the following questions:

1. What percent of clients stay on the unit rather than attending the mall for treatment?
2. What programs are offered to clients who are unable to attend the Mall?
3. What is the total number of treatment hours that each client is receiving?
4. What percent of time is there on and off the unit programs available for clients?

REHABILITATION

ASPECT: Job Coach Attendance at Comprehensive Treatment Plan Meetings

OVERALL COMPLAINT: 85%

Indicator	Findings	Compliance	Threshold Percentile
The Job Coach will attend assigned clients' treatment plan meetings.	41 of 48	85%	85%

**Findings:** Of the 48-team meetings, the Employment Specialists attended 41 of them. The meetings that were missed were due to the assigned Employment Specialist being out on vacation, last minute changes in the scheduled time, along with the lack of a system to communicate any changes made to the original schedule.

**Problem:** There was no system in place that captures the dates of when all team meetings are for those client's involved in the Vocational Rehabilitation program. Team coordinators do not send schedules or notices to the Employment Specialist or the Employment Specialist Supervisor nor does the Employment Specialist or supervisor seek out schedules. The Employment Specialist was relying on attendance at each unit's morning rounds to get information regarding scheduled team meetings. If an Employment Specialist was unable to attend the morning meeting, any schedule changes that were discussed did not get communicated to the Voc. Rehab. Staff. The Employment Specialist did not communicate with one another or with their supervisor in regards to finding coverage for team meetings that they would be unable to attend. Although the last report indicated a need to change this indicator, there is a need to develop such a system prior to moving onto a different indicator.

**Status:** Although the compliance rate for the past several months was met, the month of July showed that an efficient system had yet to be developed to ensure continued compliance. Lack of information, poor communication and schedule changes were just a few of the reasons identified. At this point the Voc. Program has obtained access to the team schedules, developed a master schedule of all client's team meetings for the Employment Specialist. The Employment Specialist has also started working on finding another coach or supervisor to cover any meetings that they are unable to attend. All of these action steps have brought the department back into compliance for the quarter.

**Actions:**

- There is one Employment Specialist assigned to each unit in the morning to review the meeting schedule and make changes to the master schedule.
- The Employment Specialist Supervisor will ask the Treatment Team Coordinators to communicate any schedule changes to ensure that appropriate changes are made to the master schedule.

- The Employment Specialist Supervisor will continue to have monthly meetings with the Employment Specialist to review client progress in the event they cover a team meeting or report on a client in our program.
- This monitor will continue for the remainder of this quarter to ensure that all new systems remain effective.

**PSYCHOLOGY**

**ASPECT: CO-OCCURRING DISORDERS INTEGRATION**

1 <sup>st</sup> Quarter 2007 July August and September 2006 Co-occurring Disorders Integration			
Indicators	Findings	Compliance	Threshold
#1 There is evidence of an integrated co-occurring assessment.	26/77	34%	50%
#2 There is evidence of an assessment of “stage of change”.	4/77	5.2%	15%
#3 There is evidence of an integrated co-occurring comprehensive service plan for identified clients.	11/77	14%	20%  To be Reported Quarterly
#4 Positive change in staff practices as measured by the COMPASS (Co-Morbidity Program Audit and Self-Survey for Behavioral Health Services) on each clinical unit.	COMPASS completed on four treatment units	(100% of baseline data collected)  0% increase	Four units participating 10% Increase  To be Reported Annually
#5 Improvement in client satisfaction regarding integration of treatment/ services as measured by a Client Satisfaction Survey.	Client Satisfaction Survey recommended	0% Use of survey has not yet been approved.	10%  To be Reported Quarterly

**Findings:**

For indicators #1-3, 77 charts were audited; thresholds were established as detailed in the table. Compliance was measured as indicated above.

#4 s: The goal of four treatment units completing the COMPASS (Co morbidity Program Audit and Self-Survey for Behavioral Health Services) this past quarter was met. Findings evidence variation from unit to unit as expected; however co-occurring assessment and staff training were two areas that were consistently identified across units as needing improvement. Integrated assessment was identified on two units as an area in need of improvement.

#5: No findings to date

### **Problems**

#1-3: Clients needing co-occurring services are not being assessed adequately.

Admissions assessment documentation forms do not adequately reflect screening and assessment information for needed co-occurring treatment.

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

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

### **Status**

Baseline data and thresholds were established for these new indicators.

**Actions**#1-3: Continue collection of chart reviews to meet goal of 100 charts in order to establish baseline data. Change nursing assessment forms, psychosocial assessment forms, and comprehensive service plans to reflect integrated assessment, stage of change assessment language and criteria, and treatment goals. Education for staff conducting assessments is being planned. To be completed for next quarterly report. A performance improvement team has initiated a review of the admissions nursing assessments and psychosocial assessments.

#4: Findings are being reviewed for feedback to the units. Capital Community Clinic and the Forensic ACT team have also agreed to complete COMPASS assessments within the next quarter. Each unit/service area will identify specific targeted change goals within the next quarter.

#5: New satisfaction survey proposed- to be approved. Satisfaction survey proposal to be presented to Quality Council in November. Client satisfaction baseline data will be collected once an agreed upon survey and method have been approved.

**STAFF DEVELOPMENT**

ASPECT: New Employee and Mandatory Training

1 <sup>st</sup> Quarter SFY2007 July, August, September 06 Staff Development			
Indicators	Findings	Compliance	Threshold Percentile
1. The Director of Staff Development will track compliance with completion of new hire orientation.	8/8 employees completed mandatory training during orientation.	100%	100%
2. The Director of Staff Development will track completion of new employees CPR training within 30 days of hire.	11/11 New hire completed CPR within 30days of hire	100%	100%
3. The Director of Staff Development will track completion of NAPPI training within 60 days of hire.	19/19 employees completed NAPPI training with in 60 days of hire	100%	100%
4. Riverview staff will attend CPR training bi-annually.	267 of 269 employees hold current certification in CPR.	99%	100%
5. Riverview staff will attend NAPPI training annually.	317 of 330 employees hold current NAPPI certification	96%.	100%
6. Riverview staff will attend Annual training.	325 of 330 employees are current in Annual training	98%	100%

**Findings:** The indicators are based on the requirements for all staff to complete mandatory training. 8 out of 8 (100%) new employees completed these trainings. 267 of 269 (99%) employees are current with CPR certification. 317 of 330 (96%) employees are current with Nappi certification. 325 of 330 (98%) employees are current in Annual training. All indicators remained at 100 % compliance for quarter 1-FY 2006.

**Problem:** Indicators 4, 5, and 6 are identified as problems as they are below established thresholds.

**Status:** This is the second quarter of report for these indicators, there has been no change in number of staff with current CPI and Nappi training, and Annual training has decreased 1%.

**Actions:** Identify individuals who are not current and send the information to the staff member's supervisor to assure classes are taken by 12/15/06. There was annual training opportunity offered three times on October 18<sup>th</sup> which may improve the numbers for next quarter.

## STAFF DEVELOPMENT

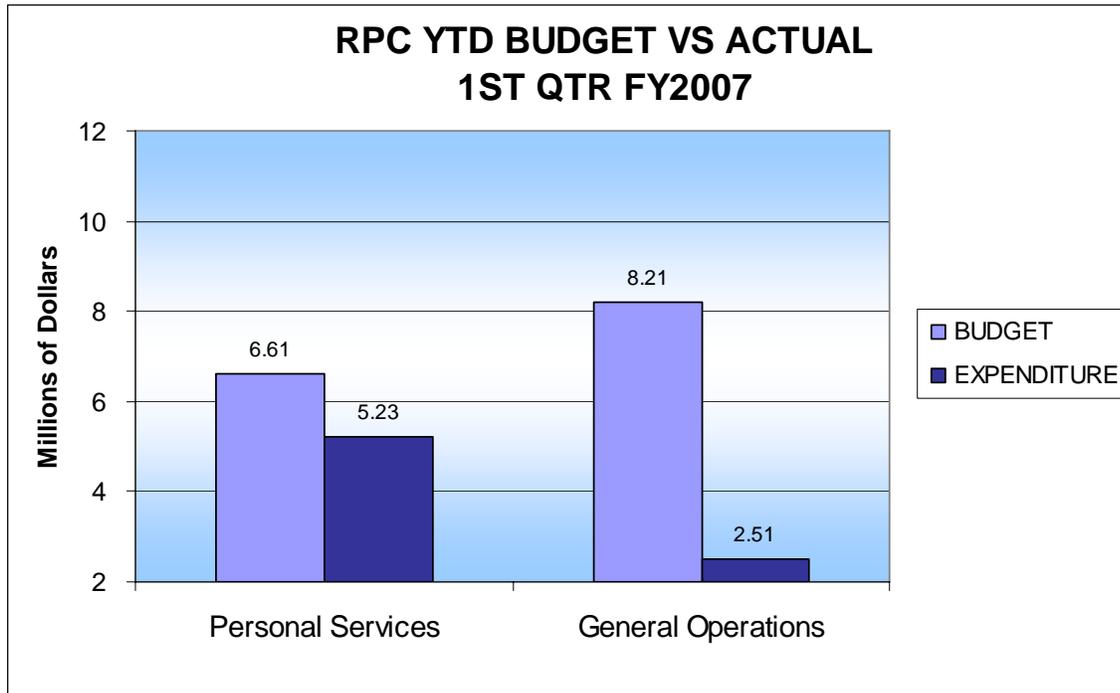
### ASPECT: COMMUNITY PROVIDER TRAINING

Riverview Psychiatric Center offered several workshops and training this first quarter. We offered 4 different workshops in July that 19 community members attended. We offered 6 in August that 12 attended and 10 in September that 14 attended. The Respect Seminar Part II was well attended along with the CPR Instructor course that had 14 participants. Riverview received several compliments and appreciation on the availability of the trainings that have been offered to outside agencies.

**Section II: Riverview Unique Information**

***BUDGET***

ASPECT: BUDGET INFORMATION



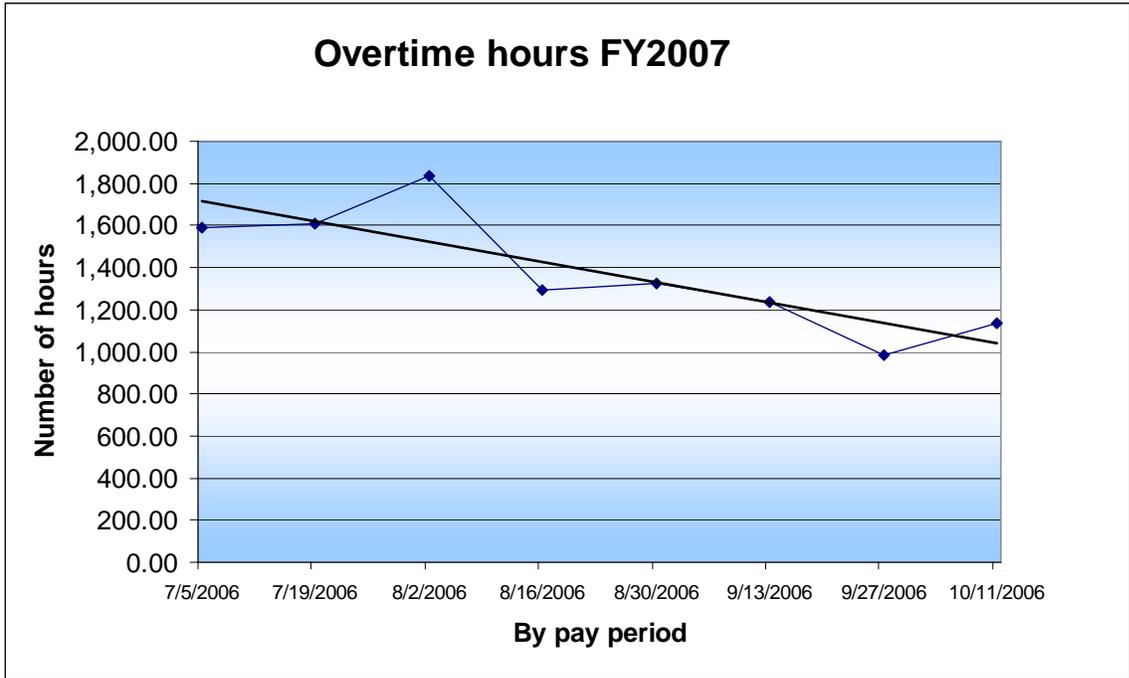
The hospital is currently within budget. Overtime has decreased due to careful scheduling of staff.

Action: Continued monitoring and careful management of overtime and mandates.

Continued aggressive management of all contractual services via fiscal and programmatic accountability

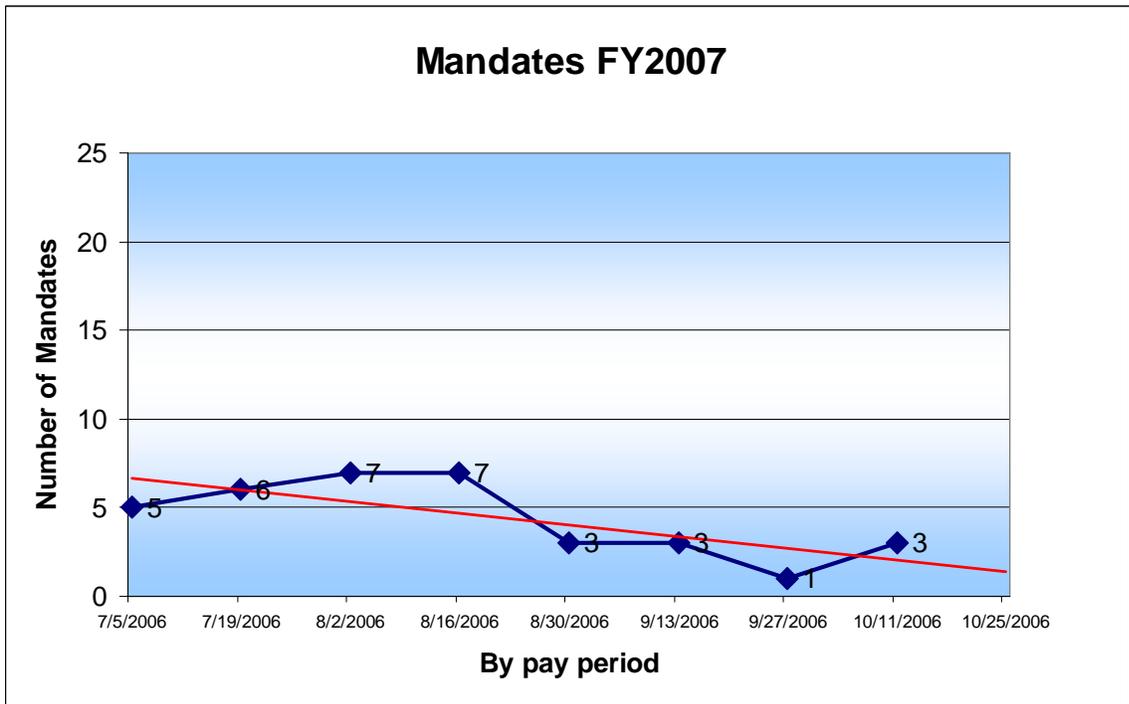
**HUMAN RESOURCES**

**ASPECT: OVERTIME**



Overtime has decreased this year compared to the same time period last year. During July2005-Sept 2005 there was a total of 11,032 hours of overtime. This year there were 9,874.25 hours of overtime. This represents a 10% decrease. Trend line is shown and extrapolated for future projection.

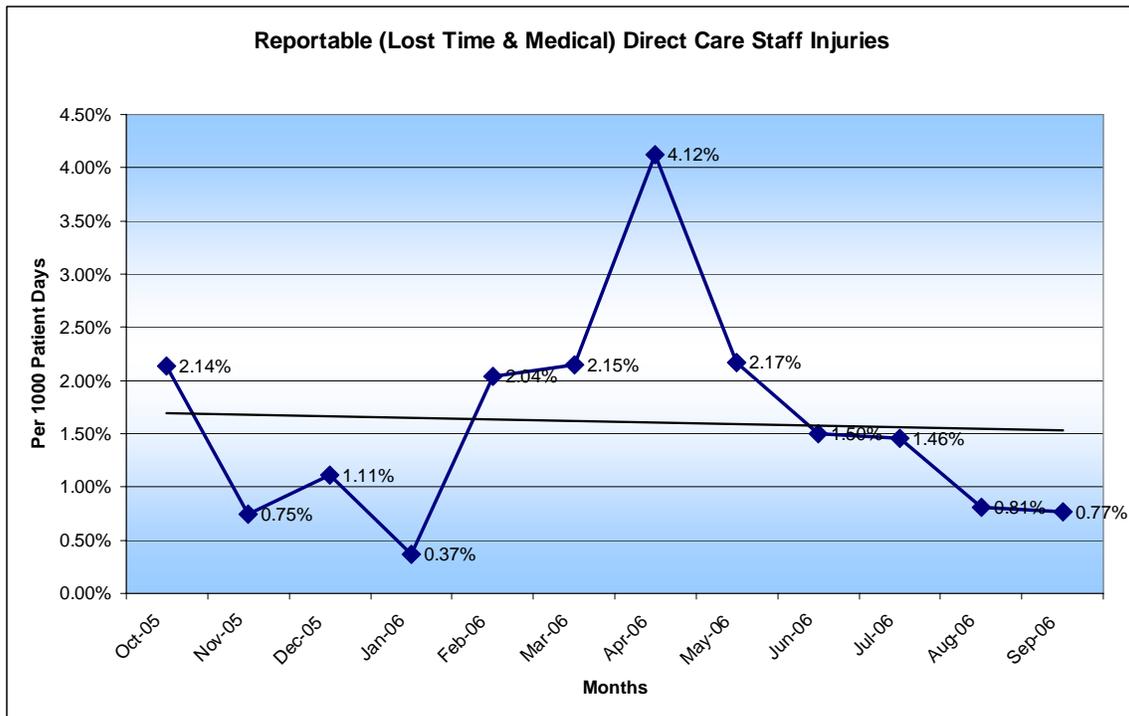
**ASPECT: MANDATES**



Mandated shifts have drastically decreased this first quarter of 2007 as compared to last year at this same time frame. During July 2005 - Sept 2005 66 staff were mandated to stay on during the next shift to assure adequate staffing, this year 32 staff have had to be mandated to assure adequate staff for this same timeframe. This is a 52% decrease from last year. Trend line is shown, extrapolated for future projection.

**HUMAN RESOURCES/RISK MANAGEMENT**

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

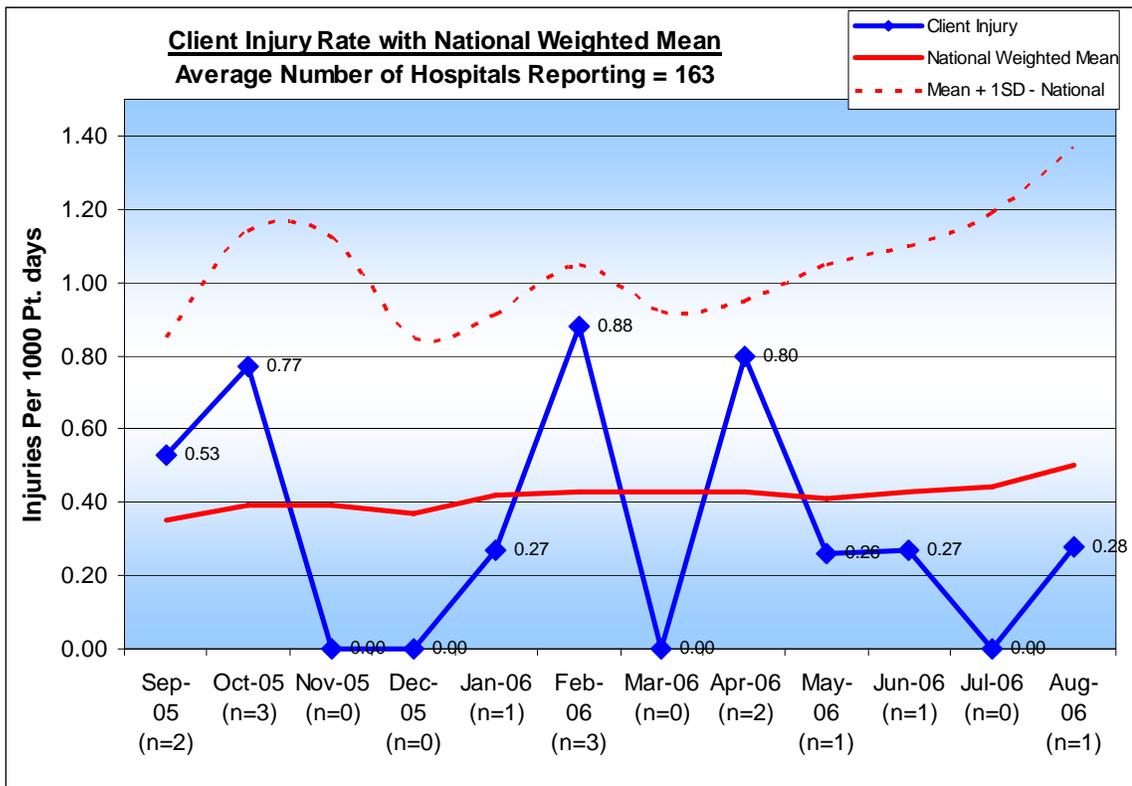


At the end of the last fiscal year a new risk management procedure was implemented to evaluate each injury cause and to try to decrease the likelihood of a reoccurrence. Each injury is reviewed by the staff member’s supervisor, and by the staff member as well as the executive leader of the supervisor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

### Section III: Performance Measurement Trends Compared to National Benchmarks.

This section contains a number of graphs that compare Riverview Psychiatric Center to a national sample (the range is approximately 75-215 hospital across all aspects) of participating like facilities. Each line graph presents the national weighted mean (solid red line) and the limit of the first standard deviation (dashed red line) as reference points. Practically speaking, about 68% of participating hospitals' rates would be within the limit denoted by the dashed red line. The solid blue line represents Riverview's rate by comparison. As the majority of these graphs will show, Riverview's rates do vary above and below the weighted national mean, but are typically within the "normal" range (within the 1<sup>st</sup> Standard Deviation) of other hospitals in the sample.

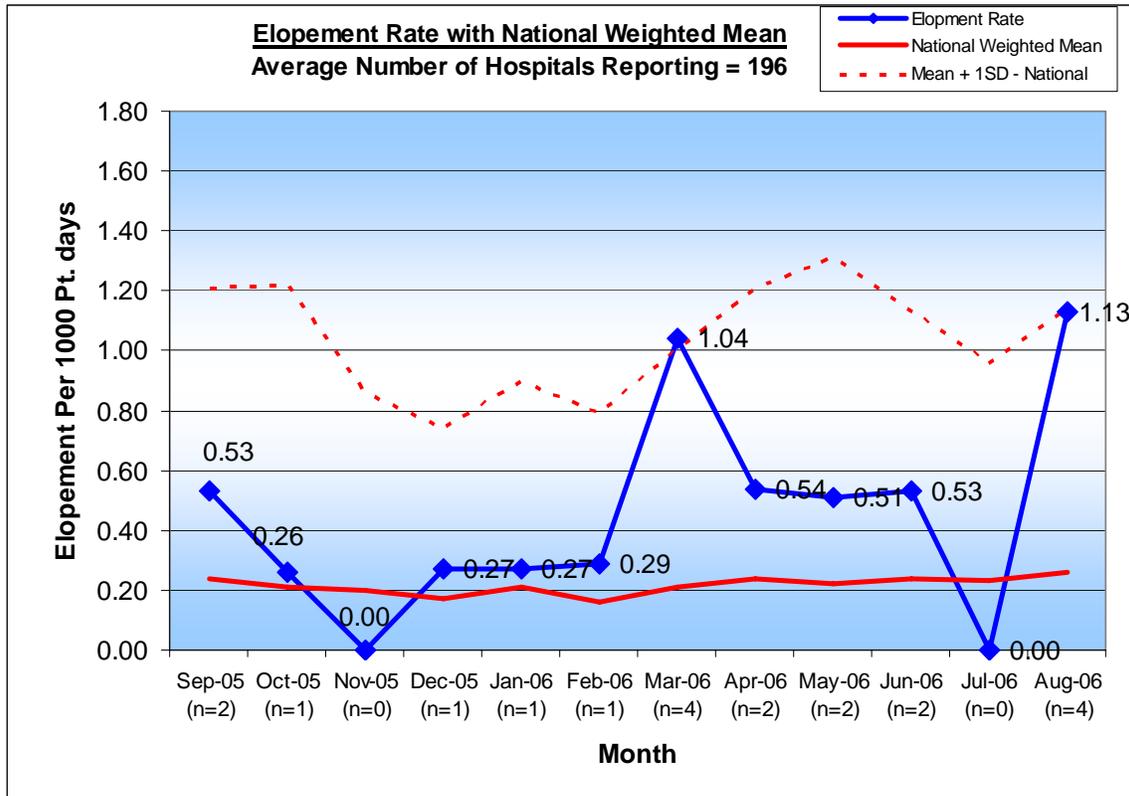
#### CLIENT INJURY RATE GRAPH



**Client Injury Rate** considers slips, trips and falls; self-injurious behavior; and client-to-client injury that requires more than first-aid. The numbers of such incidents are low, as shown by the little n under each month. Riverview's line, although appearing to have dramatic fluctuation, is in part the result of the scale used on the Y-axis. Riverview is well within the 1<sup>st</sup> standard deviation of the national sample. Please note the sheer

number of events at Riverview is very low, between zero and 3 each month. Over the last 3 months, there were a total of 2 injuries requiring more than first aid level of care. Taking the mean of Riverview's rate over the quarter (given client injuries are very infrequent) would put Riverview's rate below the national mean at 0.18.

**ELOPEMENT RATE GRAPH**

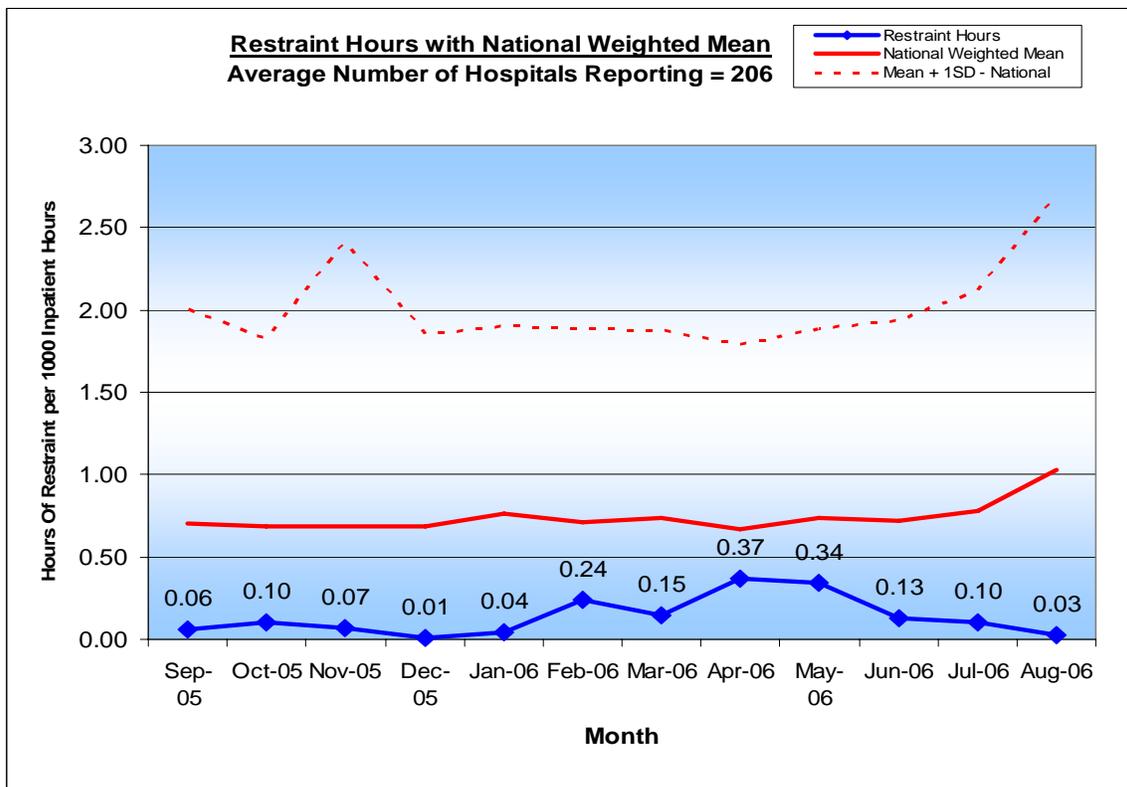


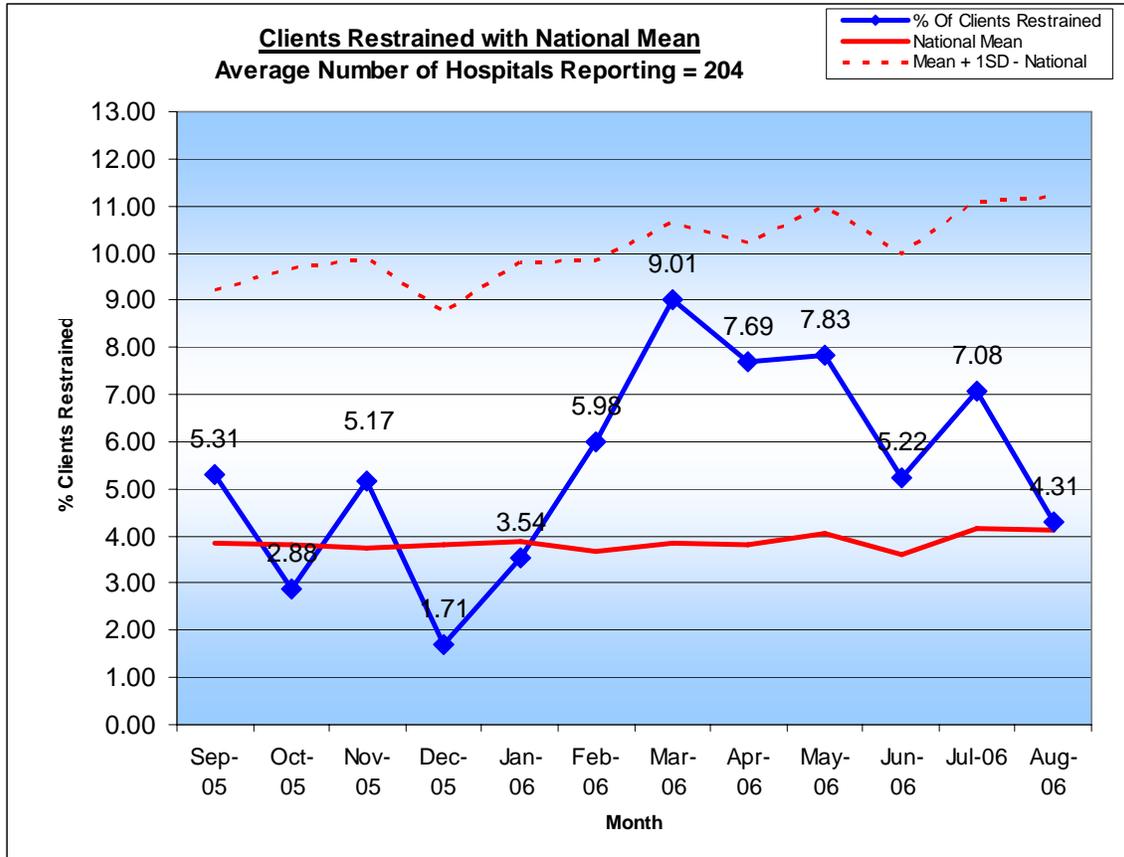
**Elopement Rate** is calculated per 1000 patient days. Elopement risk is evaluated by the treatment team and is treatment planned if necessary to keep the client and the community safe. All Riverview's numbers are within the 1<sup>st</sup> standard deviation of the national sample over the quarter. Please note the sheer number of events at Riverview is very low, between 1 to 4 each month. Over the last 3 months reported in this graphs, there were a 6 events meeting the hospital definition of elopement. In August, there were 4 "elopements"; three of the elopements occurred when clients were out on free time who did not return in a timely fashion.

**RESTRAINT GRAPHS**

Riverview's rate of clients restrained, although above the statistical mean, is comparable to at least 68% of hospitals in the national sample. The restraint hours (duration) rate is

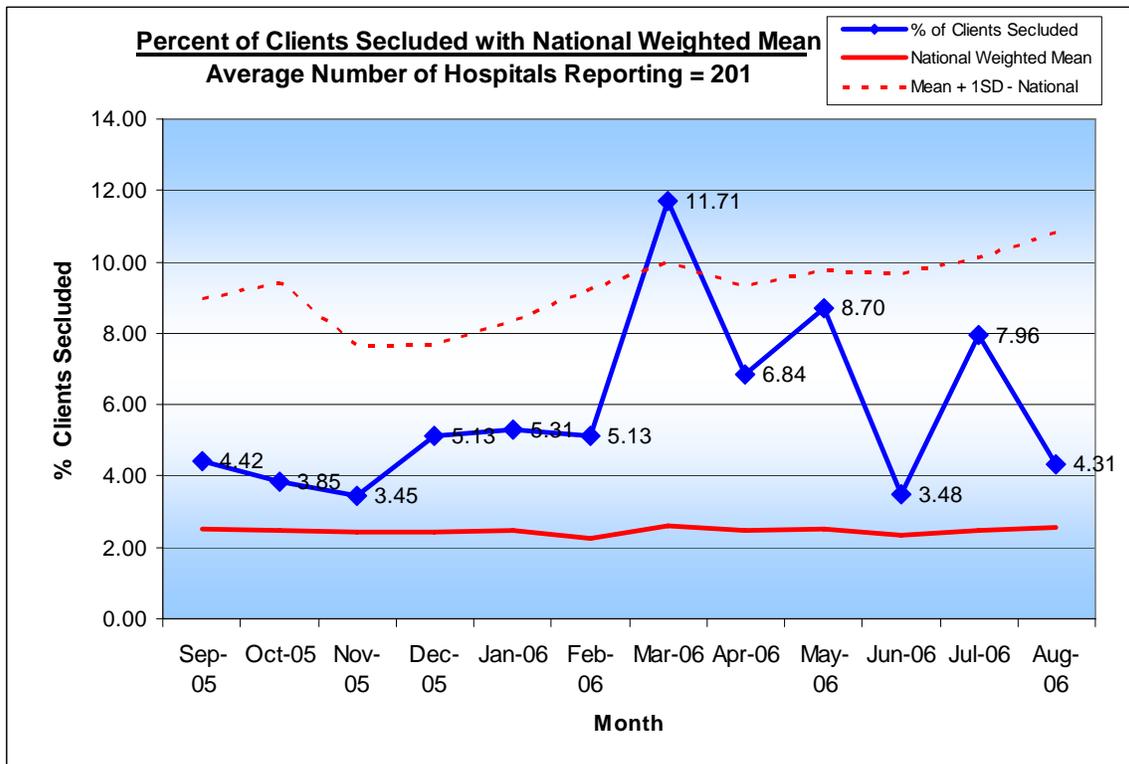
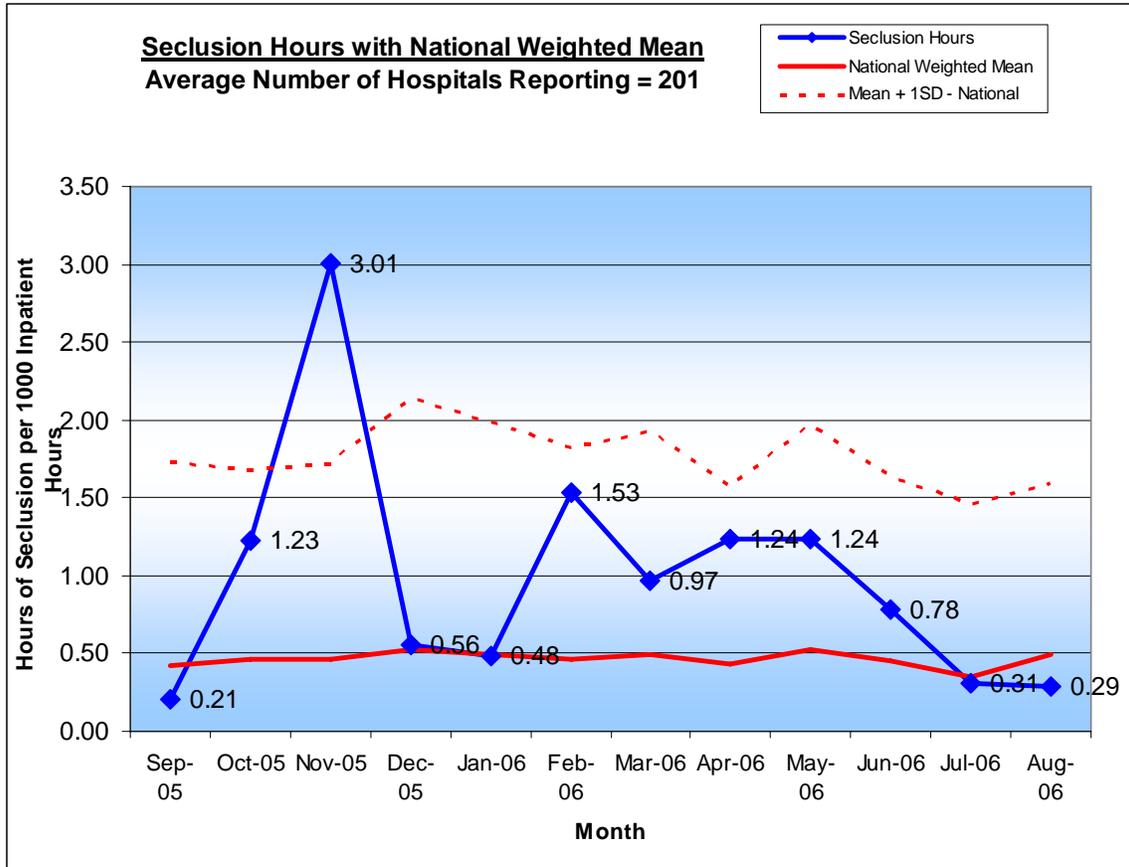
well below the statistical mean, but also comparable to the bulk of hospitals in the national sample. The data would suggest that Riverview’s restraint events are short by comparison, and efforts to reduce the frequency of restraint use would have the most impact. Corrective actions applied are: reducing the time for restraint order renewal from 4 hours to 1 hour; revision of debriefing process is in progress; new protocol and form to guide treatment plan revisions within 72 hours following the event is in place; education initiatives; increased clinical, supervisory and administrative oversight; expanding opportunities for client choice is a priority to be monitored and tracked in monthly administrative reports; the hospital has put forward a proposed tobacco-free campus policy as national data show that tobacco-related issues are often precipitants to restraint/seclusion events in a national sample (smoking/tobacco as significant precursor to restraint/seclusion events was **5%** in non-smoking facilities vs. **34%** in smoking facilities--7 times more).



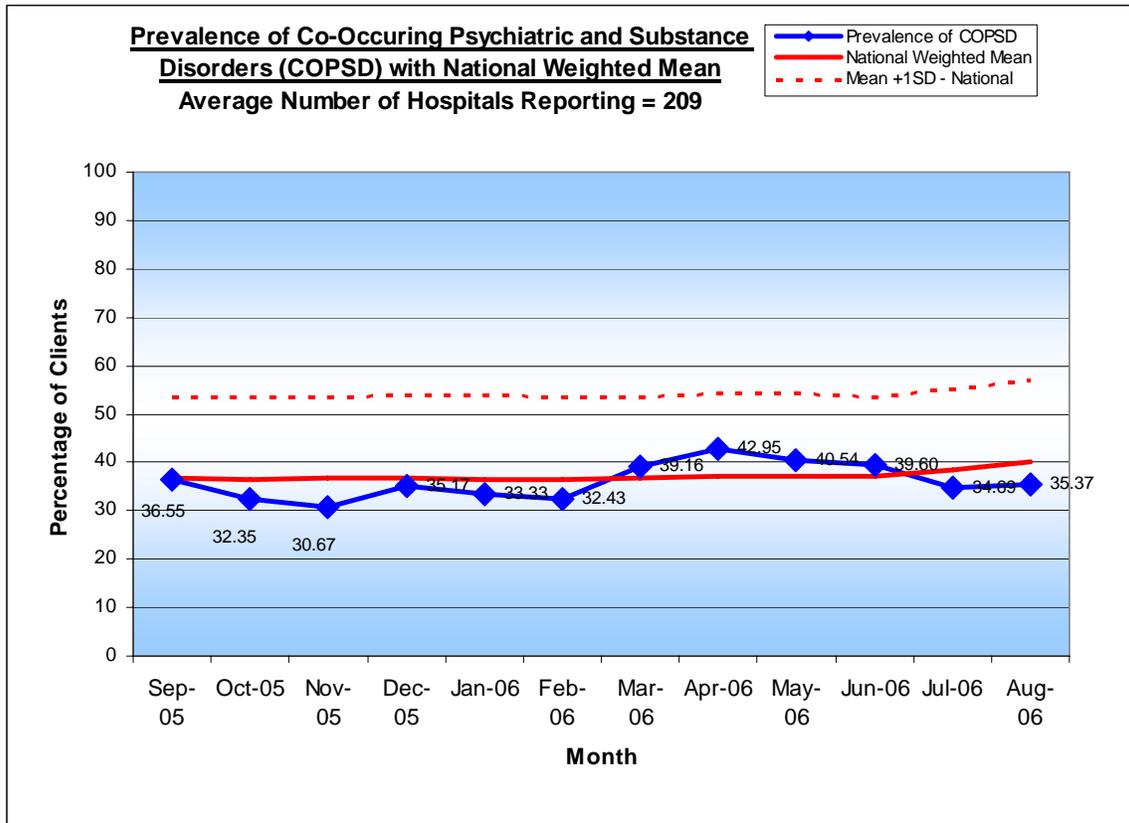


***SECLUSION GRAPHS***

Riverview used seclusion more frequently than 68% of hospitals in the national sample in the month of March, but the rate is generally comparable to the national sample in other months. Seclusion hours (duration of events) at Riverview, although tending to be above the national weighted mean, are within the 1<sup>st</sup> Standard Deviation of other hospitals in the national sample. Riverview’s efforts to reduce use of these interventions should focus on both the frequency and duration of seclusion events. Corrective actions applied are: reducing the time for seclusion order renewal from 4 hours to 2 hours; revision of debriefing process is in progress; new protocol and form to guide treatment plan revisions within 72 hours following the event is in place; expanding opportunities for client choice is a priority to be monitored and tracked in monthly administrative reports; education initiatives; increased clinical, supervisory and administrative oversight; the hospital has put forward a proposed tobacco-free campus policy as national data show that tobacco-related issues are often precipitants to restraint/seclusion events in a national sample (smoking/tobacco as significant precursor to restraint/seclusion events was 5% in non-smoking facilities vs. 34% in smoking facilities--7 times more)

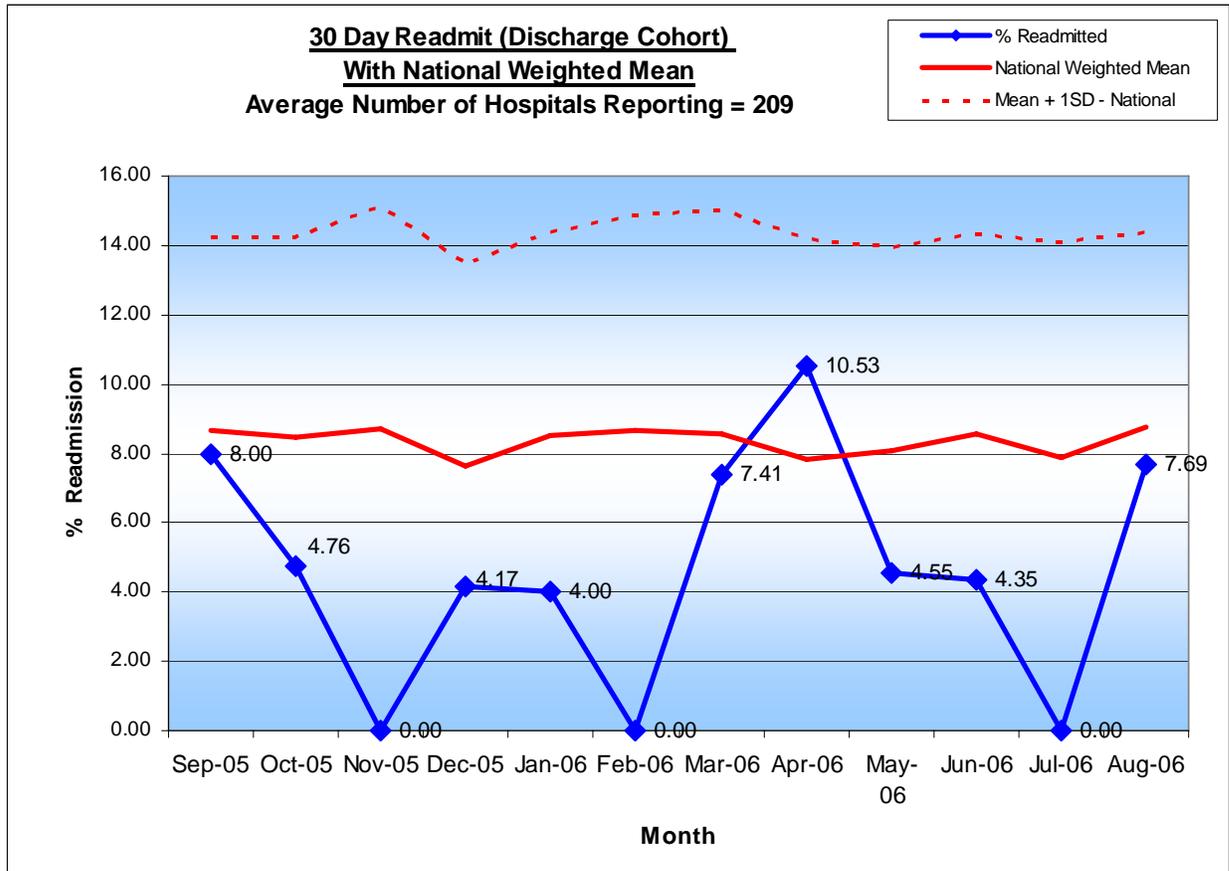


**CO-OCCURRING PSYCHIATRIC AND SUBSTANCE ABUSE DISORDERS GRAPH**



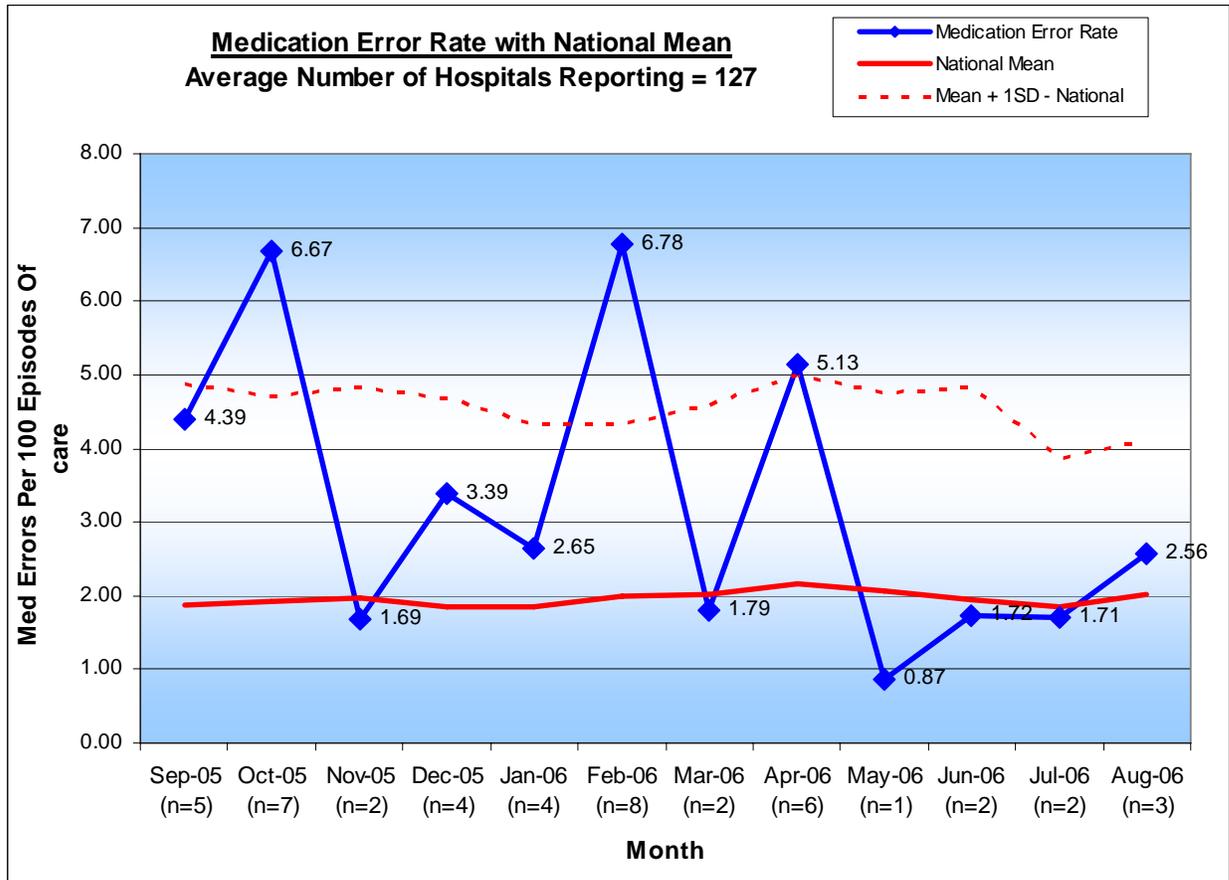
RPC has recently begun a collaborative effort with Spring Harbor Hospital Co-Occurring Disorders providers to contract with RPC to develop a Co-Occurring program. Though RPC is currently a bit above the trend line, this is an indicator current initiatives are working as anticipated; with the advent of this program to help identify and treat clients with co-occurring disorders it should rise above the trend line. This information is gathered from admission diagnosis.

**THIRTY DAY READMIT GRAPH**



30 Day Readmission Rate is at or below the mean of the 209 other facilities reporting on this indicator. Thirty day readmission rate is calculated considering the percent of discharges for the facility that returned within 30 days of a discharge of the same client from the same facility. At RPC readmissions on the forensic unit are at will of the court are not considered in the calculation. In June there was one client readmitted within 30 days, July none and August one client who left against medical advice returned and one client who had been in the 72 hour diagnostic bed on the forensic unit was returned for further treatment.

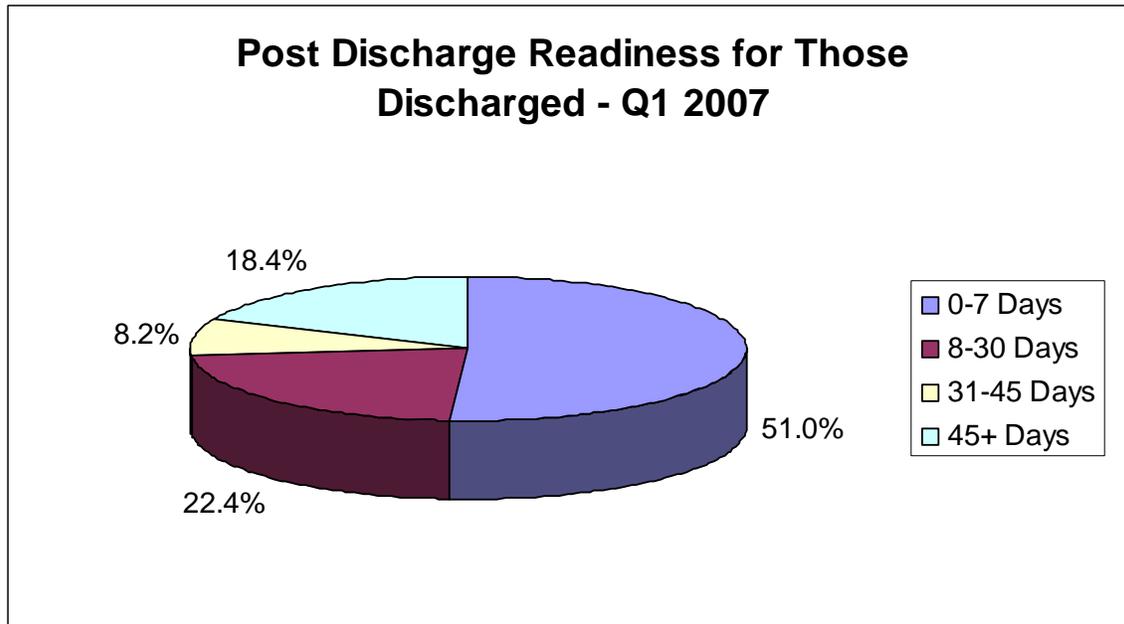
**MEDICATION ERROR RATE WITH NATIONAL MEAN GRAPH**



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

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

## ***POST DISCHARGE READINESS PRIOR TO DISCHARGE***



This chart shows the percent of clients who were discharged within 7 days of their discharge readiness to be at 51.%; 8- 30 days post readiness 22.4%; 31-45days at 8.2% and Greater than 45 days post discharge ready 18.4% of clients discharged this quarter.

Cumulative percentages and targets are as follows:

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

Last quarter cumulative percentages were as follows:

- Within 7 days =44.7% (target 75%)
- Within 30days=65.8% (target 90%)
- Within 45 days=81.6% (target 100%)

### **Section IV: Process Improvement Team Reports**

Comprehensive Service Plan Process PIT:

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

#### Privacy PIT

A PIT was assigned to review and revise the Privacy Policy. A revised policy is expected to be reviewed by many and presented to the policy committee and leadership committee by November 15<sup>th</sup>, 2006.

#### Lab PIT

A PIT was assigned because Providers want electronic access to lab results. Providers are not advised when clients refuse or are not available for prescribed lab tests. The contractor was invited to a meeting, there was much discussion about ways to have providers be able to access the lab results through the Hospitals web site, or through tiny term. This PIT is scheduled to meet the first week in November with a plan to have a resolution to the issue, or to explore alternative lab contracts by November 30, 2006.

#### Mall Documentation PIT

A Performance Improvement Team was initiated to explore methods to improve documentation to and from the Harbor Mall. The process to integrate Mall Groups with the Comprehensive service plan (CSP) is multifaceted. The Treatment team will integrate Harbor Mall groups with each clients individualized CSP. Each discipline will identify Groups to include in CSP and submit referral forms to the Treatment team coordinator who in turn submits them to the Harbor mall. Group leaders will document client progress and participation in the flow sheet using information from the referral. The flow sheets will be placed in the clients charts daily by Harbor Mall staff. The treatment team member who referred the client to the group will include the client's group progress in their progress note.